Emotional and psychological wellbeing in home care workers – a multi-method study

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This thesis is presented in fulfilment of the requirements for the degree of

Doctor of Philosophy (PhD)

Statement of Candidate

I certify that the work in this thesis entitled *"Emotional and psychological wellbeing in home care workers – a multi-method study"* has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree at any other university or institution other than Macquarie University.

I also certify that the thesis is an original piece of research and it has been written by me. Any help and assistance that I have received in my research work and the preparation of the thesis itself have been appropriately acknowledged.

In addition, I certify that all information sources and literature used are indicated in the thesis.

The research presented in this thesis was approved by the Macquarie University Human Research Ethics Committee, reference number: 5201400778, approved on the 23rd of October, 2014.

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Abstract

Employee turnover rates in the aged care sector are significantly higher than in other sectors. However, most aged care related research is conducted in residential setting and little is known about the home care setting. Using mixed method approach, this thesis aims to explore the risks contributing to emotional and psychological wellbeing of home care workers (HCWs) and is supported with four separate studies. In Study One, the organisational factors of home care are explored from management perspective in a qualitative study of eleven interviews with home care office managers. Study Two is a study of 24 interviews with HCWs. The purpose of Study Two was to determine the reported prevalence of mental illness in clients and determine if there was a presence of emotional contagion between clients and HCWs. Study Three is a quantitative study examining how positive and negative emotions influence HCWs and their overall wellbeing. Study Four is a mixed-method study designed to establish the role of self-efficacy in home care workers and design a self-efficacy measure specific to working in aged care. This research applied comprehensive thematic and content analysis of findings to examine major categories and key themes in the qualitative component, and statistical analysis with regression for the quantitative studies. HCWs reported high prevalence of mental illness in clients and high susceptibility of HCWs catching negative emotions from others. Further, the studies found common self-disclosure of presence or history of mental illness in the workforce and personal experience of supporting someone with mental illness. These findings suggests the need for improved training HCW in interpersonal interactions, reduce self-disclosure during service delivery and better access to internal and external support for employee mental health.

Publications

Bajic, J., & Jepsen, D. (2015). '*Knock knock, I am out the front' - exploring workplace risks for home care workers in Australia - conceptualising organisational risks within the context of home care*. Paper presented at Sustainable HRM and Employee Well-Being Research Symposium, Sydney, Australia, 4th November.

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Lastly, thank you to the home care organisation and their employees who took part in this research. My next challenge is to ensure that emotional and wellbeing of the workforce is on the training agenda.

List of Abbreviations

Acronym	Definition
ACSE	Aged Care Self-Efficacy
AIHW	Australian Institute of Health and Welfare
EAP	Employee Assistance Program
GSE	Generalised Self-Efficacy
HCW	Home Care Worker
RCW	Residential Care Worker
WHO	World Health Organisation

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Chapter 1

General Introduction

Care represents a unique form of work and services designed to support individuals throughout their lifespan. Everyone is affected by the organisation of care work, as we begin life and require attention as infants, during periods of sickness and infirmity before we die (Folbre & Nelson, 2000). This thesis examined the organisation of paid care services for the elderly who receive home care support in their homes. In particular, the thesis aimed to extend to the research conducted in the home care setting by investigating the emotional and psychological wellbeing of home care workers (HCWs). First, the thesis examined the organisational factors from the perspective of office managers. Second, the environmental risks for HCWs were explored including the emotional aspect of caregiving and exchanging emotions between clients and HCWs. Last, an aged care self-efficacy measure was proposed which is important as it determines worker's own perception of skills and capabilities to undertake home care duties. This chapter begins with a literature review on the increased demand for home care services, characteristics of older adults, emotional theories, a review of studies on employee wellbeing and a discussion on employee retention strategies.

The significance of research in the aged care sector has grown substantially with an increased longevity and life expectancy of the elderly worldwide (World Health Organisation [WHO], 2015). The vast majority of older adults are in good physical health and maintain independence in late stages of their lives (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011). In Australia, approximately 95 percent of older people live in private homes and the remaining live in residential homes (Australian Institute of Health and Welfare [AIHW], 2013; Productivity Commission, 2015). Elderly who experience increased need for personal care favour in-home care rather than moving into a nursing home (Broadbent, 2014). The enablement of home care support minimises government expenditure for long-term residential care (Broadbent, 2014) and introduces a new concept of client directed care and support (Ageing Disability & Home Care [ADHC], 2014).

Turning attention to employers, the challenge presented in delivering home care services is ensuring timely service, efficient co-ordination, supervision, support and above all promotion of safe working environment. The increased demand for aged care services results in shortage of qualified workers, high rates of turnover which are attributed to low job satisfaction (Staples, Hulland, & Higgins, 1999), and difficulty attracting new entrants to the sector (Simonazzi, 2009). Folbre and Nelson (2010) remind us of the importance of employee retention in care settings as long term caring relationships between care recipient and care giver often improve care outcomes.

Aged Care Workforce

Aged care workers include residential care workers (RCW), employed in a residential setting i.e., nursing home, and home care workers (HCW) employed in a community setting i.e. supporting clients in a private home. Aged care workers assist elderly with activities of daily living, social support, community outings and supplement clinical, catering and administrative employees. In Australia, to become a HCW or a RCW, a six month Certificate III course is required, combining classroom activity and a placement in a clinical setting (Community Services and Health Industry Skills Council [CSHISC], 2014). Completion of a twelve month Certificate IV course allows aged care workers to work in the role of a team leader or a care supervisor (Community Services and Health Industry Skills Council [CSHISC], 2014). The full list of units for Certificate III and IV is listed in Appendix 1.

Management studies conducted in the sector are primarily focused on the residential aspect of aged care. It could be argued the access to the residential workforce is easier than home care, as a larger number of workers travel to the same worksite. Cross-sectional and longitudinal studies in residential settings have enabled us to understand some of the common challenges faced by employees in this environment, particularly the influence of the relationship between RCW and middle management. For example, Anderson and Gaugler

(2007) found that the relationship between RCWs and middle managers is strained. Similarly Kaine (2012) reported that the employee voice does not act as a significant regulator of managerial decision-making. Meissner and Radford (2015) reported middle managers perceive the need to develop their skills in communication, self-awareness, change management, conflict resolution and leadership. The interaction between middle managers and HCWs and their influence on HCW attitudes in a home care environment has not been examined. The nature of interactions between HCWs and management needs to be considered in a home care setting, particularly as it is underpinned with distal supervision and support from.

The aged care workforce is predominately female-oriented (Folbre & Nelson, 2000) with high levels of female employment resulting in fewer family carers and higher usage of professional paid carers (Hussein, Stevens, & Manthorpe, 2013). A large proportion of workers are employed on a casual or part-time basis and come from migrant backgrounds (Hussein et al., 2013). Different cultural backgrounds and expectations were found to contribute towards reduced understanding and anticipation of client care needs (Hussein et al., 2013; Walsh & Shutes, 2013). Given the nature of the interactions between aged care workers and older adults, it could be hypothesised that the interaction may influence the clinical outcomes for older adults and affect employee wellbeing, particularly if a client's health deteriorates during the service delivery. There is some evidence that worker wellbeing increases with positive interactions with clients, however no valid explanation has been proposed to account for the contributors or the influences of undesirable interactions with clients (Duffy, Allan, Autin, & Bott, 2013). Another study suggests that high employee turnover rates are attributed to relational aspects of work, worker identity and the lack of specific type of support required for the employees in accordance with their role and the level of accountability in the organisation (Lopez, White & Carder, 2014).

Older Client Characteristics

The majority of older people achieve successful ageing, free from cognitive and emotional disturbances and are able to maintain independence well into old age (Eyers, Parker, & Brodaty, 2012). However, older adults with chronic illness and cognitive impairment are found to be more prone to developing mental illnesses, most commonly depression (Alexopoulos, 2005). Depression is a treatable condition and is considered as one of the most frequent psychiatric disorders in older adults (Huang & Carpenter, 2011). Depression is often undetected by general practitioners, as they may focus more on the physical health of older adults (Licht-Strunk, Beekman, de Haan, & van Marwijk, 2009) and especially in those transitioning into residential care (Bagley et al., 2000; Davison, McCabe, Knight, & Mellor, 2012). Older people with depression will often present with physical symptoms such as weight loss and sleep disturbances, rather than emotional and behavioural symptoms or expressing concerns about their wellbeing (Byrne et al., 2010). Further, a number of older adults have strong prejudices against psychiatry and seeking treatment for depression despite experiencing the symptoms (Eyers et al., 2012).

Undiagnosed and untreated mental illnesses may have significant implications for the individual, result in increased physical support needs (Bagley et al., 2000), increased risk of suicide and mortality (Alexopoulos, 2005; Bagley et al., 2000; Karantzas & Karantzas, 2012). However, older people are generally unlikely to acknowledge they may have a psychological condition but instead report that their emotional needs are not being met. Houtjes, van Meijel, Deeg, and Beekman (2011) examined the nature and frequency of emotional needs of older people in residential care and found on average that staff recognised less unmet needs in their elderly clients than the number of needs identified by older people by themselves. Thus, there is a need to improve the understanding and emotional supports required for older adults and further examine the influence of mental illness in older people on the aged care workforce.

On-the-Job Training

On-the-job effective training and management systems are essential to teach new skills and to assure performance of these skills during daily work activities (Burgio & Burgio, 1990). Acquiring new skills was found to improve job satisfaction, particularly in remote settings (Staples, Hulland, & Higgins, 1999). Lopez et al. (2014) proposed a conceptual model for understanding the impact of workplace learning on job satisfaction and linking on-the-job training to the quality of care provided. The benefit of on-the-job training in the aged care sector is limited even though effective training has been demonstrated to reduce turnover rates (Pillemer et al., 2008). Similarly, Donoghue (2010) argued that higher than average turnover rates are found in residential than community settings, as workers are not delegated consistent work in the delivery of person-centred care, defined as supporting each client as an individual with unique needs and promoting their respect and dignity in service delivery (Kitwood, 1997). These findings are further supported by Castle (2013) who found lower rates of staff turnover when workers are allocated to care for the same clients on each shift and understanding the unique preferences of each client, a process known as consistent assignment (Castle, 2011).

Several studies examining the skills of aged care workers on recognising emotional changes in older adults found that aged care workers had no training in this domain (e.g., Davison, McCabe, Mellor, Karantzas, & George, 2009; Karantzas & Karantzas, 2012). The lack of knowledge in aged care workforce is not limited to frontline workers, with another study reporting no significant difference in knowledge about mental illness among nurses and RCWs across 30 residential facilities (Bagley et al., 2000). These findings support the need for improved mental health training for direct care and nursing staff. More research is required to explore the role of training in the aged care context, particularly in improving recognition of emotional needs in clients.

Psychological Presence at Work

A requirement of employees to be 'fully there' physically and emotionally is a behaviour Kahn (1992) defined as psychological presence at work. Many professionals identify with their work and organisations to the extent of personalising every success and failure such as winning a contract or losing an agreement to continue to deliver services (Iacovides, Fountoulakis, Kaprinis, & Kaprinis, 2003). An example of psychological presence at work is the implementation of companionate love, feeling of intimacy and affection for another person but not necessarily experience passion. In a nursing setting, a positive association between a culture of companionate love and clients' outcomes was found to improve client mood, quality of life, satisfaction, fewer trips to the emergency room and increased families' satisfaction with the long-term care facility (Barsade & O'Neill, 2014).

However, employees are not always able to respond compassionately at workplace. First, Barrick, Mount, and Li (2013) argued that the role of individual personality, higher-order goals and job characteristics are some of the most significant contributors towards an employee's ability to sustain psychological presence at work. Second, the level of psychological flexibility, a combination of mindfulness and value-directed action, was found to contribute to enhancing the perceptual, cognitive affective, and behavioural aspects of compassion in employees (Atkins & Parker, 2012). Third, emotional labour can be challenging and may cause conflict, as individuals may find it difficult to conceal their true emotions from their supervisors, peers and clients, and continue to display emotions required by the job, particularly when faced with challenges. Last, McShane and Von Glinow (2013) expand on the discrepancy between the required and actual emotions by arguing that the bigger the discrepancy between the two states the more likely employees are to experience stress, burnout and psychological separation from true self. The above examples indicate the

complexities underpinning psychological presence at work and individual differences, particularly personality traits and emotional wellbeing.

Stress

Stress is a common feature of modern life encompassing the perception of pressure, rather than the source of pressure itself (Hart, Wearing, & Headey, 1993) and is associated with poor work performance, acute and chronic health problems, and employee burnout (Ivancevich, Matteson, Freedman, & Phillips, 1990). Stress is more pronounced in certain occupations including law enforcement (Hart et al., 1993), health (Bainbridge, Cregan, & Kulik, 2006) and the aged care sector (Beck et al., 2005). However, a relationship between stress and work performance is of little value to an organisation unless employees are performing efficiently and productively (Hart et al., 1993). In the same argument, having an efficient and productive organisation is of little value if this is achieved at the expense of employee well-being (Hart et al., 1993). The importance of workplaces to provide safe work environment and maintain employee wellbeing is posited as a drive for change behaviour in employers and researchers.

Organisational studies exploring factors associated with increased employee wellbeing and optimised organisational performance are sparse (Wright & Cropanzano, 2000). Employees perform duties in exchange for payment with other duties falling under the scope of the social exchange framework (Wayne, Shore, & Liden, 1997). The social exchange framework is defined as unspecified obligations of when one person does another a favour there is an expectation of some future return, though the exact timing and specification is often unclear (Hopkins, 2002) and is increased with improved perception of organisational support (Hunsaker, Chen, Maughan, & Heaston, 2015). Eisenberger and Stinglhamber (2011) argue that social exchange framework depends on the perceived organisational support. Employees who have high levels of perceived organisational support are found to have higher

levels of conscientiousness in performing job responsibilities, productivity and increasing job enthusiasm and reducing stress (Eisenberger & Stinglhamber, 2011).

Building on occupational stress theory, Williams and Cooper (1998) proposed the Occupational Stress Inventory which is a theory-based model and captures three key elements of the stress process including effect, source and individual differences. The effects includes job and organisational satisfaction, organisational security and commitment, state of mind, resilience, confidence, physical symptoms and energy levels, sources of pressure are identified as workload, relationships, recognition, organisational climate, personal responsibility, managerial role, home/work balance and daily hassles and individual differences include type a drive personality, patience/impatience, control, personal influence, problem focus, life work balance and social support (Williams & Cooper, 1998). The extensive nature of the OSI (Williams & Cooper, 1998) outlines the extent of factors which may contribute towards worker stress and wellbeing, such as organisational climate, as well as in collaboration, such as poor recognition, lack of social support and low confidence level.

Employee Mental Health

Emotional wellbeing of employees and work performance have been extensively explored by researchers, particularly in the measurement of mood at work and job satisfaction (George & Brief, 1992). Kahn (1990) explored the relationship between positive mood and engagement, concluding that engaged employees are psychologically present, attentive, connected and focused on their role. Further studies found employees who are in a good mood are described as being helpful (Rahman & Schnelle, 2008) and more likely to recall positive experiences (Gellis, 2001). Although emotions are likely to influence a large number of workplace decisions they could be difficult to hide from others (McShane & Von Glinow, 2013), particularly in those experiencing psychological conditions such as depression and anxiety (Huang & Carpenter, 2011).

Burnout and depression are separate entities which may share some characteristics, and in vulnerable employees who may have low levels of satisfaction from everyday work (Iacovides et al., 2003). Employees facing a highly stressful work environment, such as in a health setting, may manifest higher than average levels of anxiety, anger, behaviour disorders and depressive symptomatology (Iacovides et al., 2003). Such employees may lack skills and knowledge in recognising their changes in their emotional wellbeing status and not seek support from their managers when stressed. In those instances, improved support from management may improve the skills and abilities of employees to cope with their work and life balance. For example, Jeon et al. (2012) found that delivery of person-centred care increased perceived organisational support, reduced exhaustion and personalisation in the delivery of services. Therefore, it is important to examine the role of employee mental health status and perceived organisational support.

Theories of Emotions at Work

Turning attention to theoretical underpinning of emotions at work, it is well established that emotions are crucial in the human development by governing our interpersonal communication (Beck, 1976) and attachment (Bowlby, 1977). Positive emotions improve employee satisfaction and teamwork (Barsade & O'Neill, 2014) while negative emotions are linked to negative outcomes including anger, violence, hostility, antisocial behaviour and organisational retaliatory behaviours (Fitness, 2000). Managing emotions for pay, called emotional labour (Hochschild, 1983), involves faking, suppressing, and enhancing emotions to provide a particular emotional expression for organisational goals. Providing a 'service with a smile', as part of organisational rules is more often engaged when employees are informed which emotions are appropriate to display to customers (Allen, Pugh, Grandey, & Groth, 2010). Service workers represent the organisation and may be the only contact the customer has with the organisation (Rhoades & Eisenberger, 2002).

The concept of acted and controlled emotions does not fit well with health-related services (Cranford & Miller, 2013) where services are based on a relationship between employees and care recipients (Folbre & Nelson, 2000; Lopez, 2006). Several studies examining sharing emotions between employees (e.g.,Omdahl & O'Donnell, 1999; Pugh, 2001) drew on earlier research suggesting that both positive and negative emotions are automatically exchanged between individuals (Doherty, 1997; Hatfield, Cacioppo, & Rapson, 1994). Although an exchange of positive emotions is considered a positive experience for both parties, the exchange of negative emotions may have more severe underpinning causes, such as psychological conditions.

The increased awareness of the influence of mental illness in employees is prominent in research with a systematic review (e.g., Faragher, Cass, & Cooper, 2005) indicating that worker poor mental affects job satisfaction. Consequently organisations are increasing strategies to promoting healthy workplaces (PriceWaterhouseCoopers, 2014). Several theories have been put forward to account for this observation of increased awareness of the influence of emotions at work including emotional labour theory.

Emotional Labour Theory

According to emotional labour theory (Hochschild, 1983), an employee's ability to produce a desired and lasting emotional response in a customer plays a central role in determining the effectiveness of the employee and their execution of behaviours to achieve these goals. Emotional labour theory postulates that jobs which require emotional labour share three common characteristics including face-to-face contact with the public, require the worker to produce an emotional state in the customer and allow the employer, through training and supervision, to exercise some control over the emotional life of employees (Hochschild, 1983). Specifically, the ability of an employer to control the emotion displayed by an

employee with training and supervision, including traits such as courtesy, responsiveness, and friendliness, indicates that the emotions are acted to increase the commercial value.

To manage the demands of emotional labour, workers may adopt one of three stances: identify too closely with work and risk burnout, distinguish themselves from work by using deep acting when appropriate and distinguish themselves from their role and recognise that acting is part of the job but run the risk of becoming cynical (Hochschild, 1983). Similarly, Gardner, Fischer, and Hunt (2009) demonstrate that the emotions of leaders play an integral role in determining emotions displayed by employees, with leaders displaying emotions which are surface acting, deep acting or genuine emotions. A principle of emotive dissonance and feeling over the long run leads to strain which is managed by attempts to bring closer the acted and real emotions in employees.

Emotional labour theory has received a lot of attention and the evidence to support it is accumulating, particularly in customer contact positions where organisational display rules (e.g., "service with a smile") is followed (Allen et al., 2010). While researchers have found that organisational display rules are crucial in a commercial setting, with the ability of an employee to align their emotions with those expected by the organisation, the emotional labour theory does not fit well with health-related services (Lopez, 2006). In a health setting, service delivery is based on a relationship between workers and care recipients where both management and recipients expect the care employee to respectfully meet and anticipate clients' individual needs which is a relational service (Cranford & Miller, 2013), not emotional labour. It is unclear if this a job requirement or an organisational signal informally communicated to workers by care recipients (Cranford & Miller, 2013). Overall, emotional labour theory is one of the most researched emotional accounts, however it does not apply across all work contexts.

Emotional Contagion Theory

Emotional contagion theory is one of the most commonly used theories when explaining the natural process which occurs when emotions are exchanged between individuals (Barsade, 2002). The theory posits that people 'catch' emotional projections from others in an automatic, fast and fleeting process which is conceptualised as a multiple determined family of psychophysiological, behavioural, and social phenomena (Hatfield et al., 1994). Doherty (1997) expands on the concept stating that as people attend to others, they continuously and non-consciously mimic other's fleeting emotional expressions and synchronise their facial, vocal, postural, and instrumental expressions with those to whom they are attending. Individuals particularly susceptible to emotional contagion are those who pay close attention to others and are able to read others' emotional expressions, construe themselves as interrelated with others rather than independent and unique, tend to mimic facial, vocal, and postural expressions, and whose conscious emotional experience is powerfully influenced by peripheral feedback (Hatfield et al., 1994). Emotional contagion is described as being characterised by genetics, gender, early experience, and personality characteristics (Doherty, 1997) and is often associated with other empathy variables such as empathic concern and communicative responsiveness (Miller, Stiff, & Ellis, 1988; Omdahl & O'Donnell, 1999). Doherty (1997) developed an emotional contagion scale consisting of 15 items designed to assess the consistency of congruent responses to five basic emotions: happiness, love, fear, anger and sadness. This is the most widely used measure of emotional contagion.

The interaction between emotional contagion, empathy variables, empathetic concern and communicative effectiveness (Lamberton, Leana, & Williams, 2015), is highly relevant in a healthcare setting. Although several studies have contributed significantly towards our understanding of emotional contagion in care settings, (e.g., Barsade & O'Neill, 2014) those findings were exclusive to residential and hospital settings (Omdahl & O'Donnell, 1999) and

did not examine the home care environment. Omdahl and O'Donnell (1999) found that the combination of emotional contagion, empathic concern and communicative responsiveness explained significant proportions of the variance in stress variables. Further, emotional contagion was found to significantly reduce occupational commitment and explain a significant proportion of the variance in emotional exhaustion (Omdahl & O'Donnell, 1999). Limited research is available on the effect of empathy variables in a community setting, such as delivering services in client homes (Ayalon, Shiovitz-Ezra, & Palgi, 2012).

Overview of Chapters in This Thesis

The overall structure of this thesis takes the form of seven chapters, including this introductory chapter. Taken together, the chapters in the thesis aim to explain the mechanism of emotional and psychological wellbeing in home care workers. The review and empirical studies reported in Chapters Two to Chapter Five represent four phases of research, as outlined in Figure 1.

Study One	**Home Care Environment (Qualitative study)** • 12 week observation study • Semi-structured interviews with home care office managers (n = 11) • Major themes extracted from interviews using content analysis
Study Two	**Emotional Contagion and Mental Health (Qualitative study)** • Semi-structured interviews with home care workers (n = 24) • Major themes extracted from interviews using content analysis to inform and construct employee survey
Study Three	**Emotional Contagion (Quantitative study)** • Employee survey distributed to all HCWs of organisation A (n = 1280) • Response received from 20% (n = 267)
Study Four	**Aged Care Self-Efficacy (Mixed methods study)** • Study 1 qualitative - interviews (n = 24) • Study 2 survey item development, survey distributed to 1229 residential care workers, response received from 30% (n = 372)

- Preliminary item analysis
- Concurrent validation study - survey distributed to 1280 HCWs and response received from 22% (n = 292)

Figure 1. Research Framework, HCW (home care worker)

The first study included observation and interviews with home care office managers. The second study aimed to empirically examine purported change in emotional wellbeing in HCWs as a result of interactions with clients. The third study examined emotional contagion with a survey administered to HCWs measuring emotional variables as proposed in the second phase. Lastly, study four examined the role of self-efficacy in the aged care context. Study four consistent of three phases to develop and test a measure for aged care self-efficacy.

Each chapter represents a paper prepared for submission for publication, which is standard practice for a thesis by publication. Thus, there is some repetition from one study to the next. The map of variables examined in this thesis is presented in Figure 2.

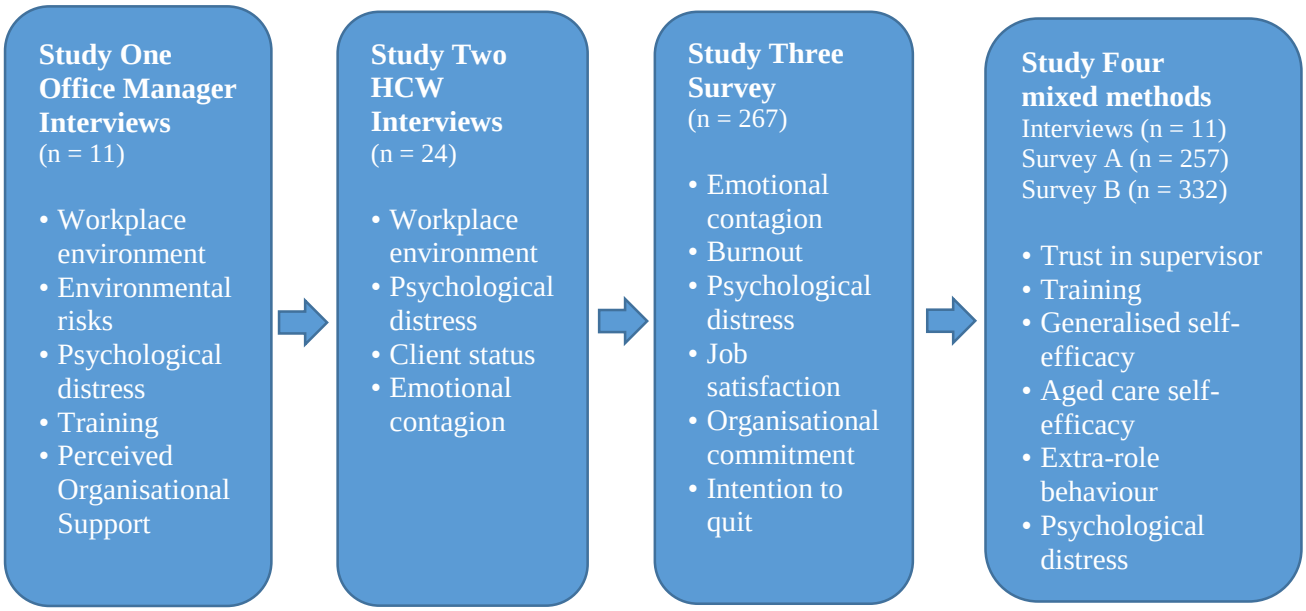

Figure 2. Map of variables in each study

To assess the role of emotions in the home care environment two separate chapters are prepared. Chapter two presents a literature review of workplace risks in a remote work environment and introduces the lack of client mental health screening as a contributing risk factor for HCWs. Chapter three introduces the concept of emotional contagion proposed by Hatfield et al. (1994) and the prevalence of psychological distress in clients. The review in Chapter three draws together research testing paths of emotional changes in clients and their influences on client care. Chapter four investigates emotional variables in the survey including emotional contagion, burnout, psychological distress on job satisfaction, organisational commitment and intention to leave. Chapter five, examines the relationship between generalised self-efficacy and aged care self-efficacy and the role of training and trust in a supervisor. Chapter five was prepared as a manuscript of three distinct studies including initial item development, preliminary item analysis and concurrent validation study. Chapter five provides a test of self-efficacy in aged care workers using the aged care self-efficacy scale. In that study, the relationship between generalised self-efficacy and aged care self-efficacy was explored as well as the relationship between training and trust in a supervisor.

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Introduction to Study One:

The first study of this thesis was a qualitative study which explored how the home care environment was organised from the perspective of office managers. The aim of the study was to identify the environmental risks in the home care contexts and supports available for home care workers. By exploring the processes from the perspective of office managers we are provided with useful insights about possible approaches home care workers adapt, for instance, whether home care workers raise concerns about safety. This study also examined some key structural home care environment characteristics that might facilitate or constrain the relationship between home care workers and managers. Understanding support characteristics provides better information on the dynamics of home care worker and manager relationships furthering strategic connections to the organisation. This first study, **At Your Doorstep – Examining Psychological Risks in Home Care** was accepted and presented at the "Sustainable HRM and Employee Well-Being Research Symposium" on 5 November, 2015 in Sydney, Australia. Useful comments from the conference reviewers provided insights for improvements.

Chapter 2

At Your Doorstep – Exploring Psychological Risks in Home Care

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This paper has been prepared for publication in Human Relations journal.

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Ms. Julie Bajic Smith was responsible for the design of this study, collection and entry of data, analysis and write-up of this paper. Associate Professor Denise Jepsen provided research supervision through all stages of the research.

Abstract

Purpose – A critical issue facing the rapidly growing aged care industry is sourcing, training and retaining suitably skilled workforce in both residential and home care. This paper investigates the association between the employment conditions and organisational factors in an Australian home care setting.

Design/methodology/approach - The study consisted of two parts. The first part was a 12 week observation of the head office of a home care employer and the second stage was 11 semi-structured interviews with a representative sample of office based managers.

Key findings – The study presents a number of employment related issues for aged care providers to address to encourage a safe working environment for home care workers. Key themes include job design, organisational factors and home care worker training and support systems. Interviews further revealed emergent themes associated with worker safety including detection of environmental risks in client homes and strategies to retain clients. Examples show the extent of personal perception issues related to worker safety, the importance of worker training in risk management and the availability of remote support for field workers.

Originality/value – The paper presents findings from a home care provider, a sector previously underrepresented in the aged care research.

Keywords: aged care, community care, employment conditions, organisational factors, training

Paper type: Research paper

Introduction

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group (World Health Organisation [WHO], 2015). In Australia, over one million individuals are receiving aged care services (Productivity Commission, 2015). This ageing of the population has resulted in rapid growth in demand for a wide range of aged care services (MacKinlay, 2014). Older people are encouraged and supported to remain in their homes (Australian Institute of Health and Welfare [AIHW], 2012) to avoid admission into residential aged care facilities and reduce the burden on the already exhausted residential-care system, which is characterised by long waitlists and an unfavourable hospital-like environment (Community Services and Health Industry Skills Council [CSHISC], 2014; Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011; Simonazzi, 2009). The in-home support offered on a client-driven model (Broadbent, 2014) allows clients to 'purchase' worker time to assist with activities of daily living and community access (Broadbent, 2014). The model has a potentially significant impact on employment conditions of home care workers (HCWs) and the organisation of their work. Exposure of HCWs to clients with varying degrees of physical and emotional support needs and varied levels of living standards may present a wide range of workplace risks and challenges which need further exploration.

This study draws on the organisational factors as an explanatory framework for the employment risks for HCWs. The HCW workday shift commences on arrival at the doorstep of a client's home in a suburban street, rather than when arriving in an office, field, or other somewhat predictable workplace environment. Being away from an office environment presents organisations with cost-cutting strategies by paying HCWs only for their time directly supporting a client.

Although little is known about the employment conditions of HCWs, on-the-job training requirements and strategies to attract new employees to the growing sector, several

studies highlight the personal safety of HCWs and the prevalence of critical incidents in the home care environment (Atkins & Parker, 2012; Fazzone, Barloon, McConnell, & Chitty, 2000; Geiger-Brown, Muntaner, McPhaul, Lipscomb, & Trinkoff, 2007). Understanding the management, or back office, view of delivering home care is particularly important to generate a deep understanding of workplace environment, behaviours and driving factors that influence organisational objectives and goals (Johns, 2001). Further, improved understanding of the organisational factors will assist in understanding factors associated with aged care job satisfaction (Edvardsson et al., 2011), employee resilience (King, Newman & Luthans, 2015), detection of workplace risks, the influence of remote supervision and HCW job requirements, training, and support. Delivering aged care services in a home is solo and unsupervised and therefore fundamentally different to delivering aged care services in a residential facility where direct supervision and support is available. These fundamental differences require an understanding of the organisational factors and support systems available to HCWs.

There are unique challenges in attracting and sustaining a competent and stable workforce in the aged care sector across both the home care and residential setting. The aged care industry workforce shortages are exacerbated by low wages, and the Australian Productivity Commission (2015) reports that some workers have insufficient skills. Low wages have been attributed to intention to quit (Seavey, 2004) and are associated with job stress and burnout, particularly in the human service profession (Shinn, Rosario, Morch, & Chestnut, 1984). Improved job satisfaction and client outcomes have been attributed to a positive relationship between a client and HCWs in a home care setting (Barsade & O'Neill, 2014; Castle, Engberg, Anderson, & Men, 2007; Edvardsson et al., 2011; Francis-Felsen et al., 1996). Although an association between low wages and skill shortage has been previously examined, the impact of skill shortage needs to be explored further.

Employees in both home and residential care settings are trained in implementing person-centred care (Kitwood, 1997), which underpins the service delivery in this sector (Yeatts & Cready, 2007) and is governed by the core need of a service recipient (i.e., client), which is love. Love in care is achieved through occupation, inclusion, attachment, comfort and identity (Kitwood, 1997). A recent study of Australian residential care (Edvardsson et al., 2011) reported a positive relationship between perceived person-centred care and job satisfaction in direct care workers. Edvardsson et al. (2011) found that increasing the support for direct care workers in providing person-centred care enhances job satisfaction and attracts new entrants to the industry. Similarly, in a home care setting Barsade and O'Neill (2014) found that implementing a culture of companionate love positively relates to HCWs' job satisfaction and team work.

Paid care work differs from other service work due to interpersonal interactions designed to enhance the intellectual, physical, and emotional capabilities of care recipients (Folbre, 2012). Paid care workers assist in meeting clients' basic physical needs and being responsive to the emotional needs of their clients through a process known as empathetic care (Lamberton, Leana, & Williams, 2013). In addition to empathetic care, paid care workers are exposed to the pressure of psychological presence at work which suggests that worker's thoughts, feelings, and beliefs are accessible in the context of role performance (Kahn, 1992). Several researchers suggest that being psychologically present at work may partly explain low job satisfaction rates in the aged care sector as the combination of delivering emotional support and being responsive to emotional needs can affect workers own wellbeing (Karsh, Booske, & Sainfort, 2005; Mittal, Rosen, & Leana, 2009; Rosen, Stiehl, Mittal, & Leana, 2011; Ryan, Nolan, Enderby, & Reid, 2004).

Organisational Factors

Context can be as valuable, sometimes even more valuable, than other findings from a study. Understanding the home care organisational factors is vital for interpreting workplace factors associated with aged care employers. Rousseau and Yitzhak (2001) highlight the importance of recognising organisational factors and their association with other variables such as workplace practices. Context can serve as a main effect on organisational behaviour and as a moderator of relationships at another level of analysis (Johns, 2001).

Home care services are well positioned in the aged care industry as the in-home support incurs less government costs than residential care (AIHW, 2013) and public hospitals. The home care setting is centred on the concept of "drop in" service, where a HCW visits an allocated number of clients in their homes in a day. HCWs support clients with activities of daily living, such as showering, attending medical appointments and cleaning (Community Services and Health Industry Skills Council [CSHISC], 2014). Older clients may require support with some aspects of daily living, such as assistance with shopping but may otherwise be in good health and have no need to relocate. Remaining in their own home is often the more preferred outcome for the clients.

In Australia, clients are assessed for eligibility for service by having an aged care assessment tool (ACAT) completed by an accredited assessor from the Department of Health (Commonwealth of Australia, 2014). Each client is allocated a set level of funding from the federal government based on their needs, as determined during the initial eligibility assessment. Government funding is often insufficient, with most clients making a co-payment to cover the cost of their home care service. In 2014 a new funding model was proposed and implemented, focusing on consumer directed care and introducing a number of new roles in home and residential care (Community Services and Health Industry Skills Council [CSHISC], 2014). The added flexibility in supporting community-based clients with personal

care, outings and social support presents additional challenges for home care providers in ensuring staff are sufficiently skilled and trained to support clients' needs.

Most aged care studies have been conducted in a residential setting, for example Castle et al. (2007), Karsh et al. (2005) and Rich, Louislepine, and Crawford (2010). Such studies attributed high staff turnover rates and low job satisfaction (Howe et al., 2012) to feelings of being unable to provide high quality care and not knowing how to support individuals with complex needs (Edvardsson et al., 2011). While these findings offer some insight into the broad attitudes of aged care workers, more research is needed in the home care context to determine factors associated with the high turnover rate in HCWs, environmental risks and supports available.

This study aims to investigate the association between the employment conditions and organisational factors in an Australian home care setting. The home care setting consists of two types of support; direct in-person support delivered by a HCW in client homes, and phone support for both the clients and HCWs provided by office-based managers. The consideration of distal supervision and support have not been previously examined in the home care setting. Distal supervision is defined as supervision delivered without direct face to face contact between an employee and the supervisor and usually taking form over the phone or in writing. The study deepens our understanding of how organisational factors shape the delivery of services in a sector growing in global significance (Brooke, Goodall, Handrus, & Mawren, 2013) and considers how workplace risks are identified and managed.

Methods

This case study is part of a wider investigation on factors associated with older client wellbeing and employee job satisfaction. An explanatory ethnographical case study methodology allowed detailed analysis of the organisation (Collins, Cartwright, & Hislop, 2013; Jepsen & Rodwell, 2008; Mercer, Heacock, & Beck, 1994). Data was collected through

multiple techniques including document analysis, observations, and interviews with key informants.

The study was conducted in a privately owned organisation with around 1500 employees that provides care and support for around 16,000 elderly and frail clients. The organisation has five departments (state offices, project and change management, business development and research, operations support, compliance and marketing). Around 900 HCWs deliver services to six to eight clients per day. Management in state offices coordinate service delivery days and times based on factors including client needs, service level agreements and HCW availability, skill base and proximity to client homes.

Review of Internal Documents

A review of documents relating to the delivery of home care services was conducted over twelve consecutive weeks in 2014. Internal organisation documents and government guidelines were reviewed to assist with deeper understanding of the organisation, services provided, eligibility for government funding, assessments and induction program for HCWs. Papers reviewed included employment policies, strategic plans, newsletters, organisational histories, induction manuals, policies, procedures and websites. Interactions between managers and phone calls to clients and HCWs were observed. Office interactions included allocation of HCWs to new clients and managing changes in HCW availability. Calls to clients included confirmation of service delivery times and changes in client availability and the schedule for the day for HCWs. Similarly, calls to HCWs included changes in client and HCW availability, allocation of additional clients and escalation of HCW concerns about a client. Findings from the document review and observations were the source of the key topics of the semi-structured interviews.

Documents reviewed revealed information for HCWs, clients and for the public. The information for HCWs included strategic plans, policies and operational procedures on

reporting requirements and recording time with clients. Information for clients included a newsletter, information about upcoming social events, client success stories and pamphlets with information on new services. Information for the public included an overview of the services, option to request a quote for service as well as career opportunities.

Interviews

After ethics approval, twelve managers were emailed an invitation to participate in an interview. Eleven managers agreed to participate and signed individual consent forms. The criterion for interview participation was that the participants had management expertise in the delivery of home care services so they would understand the HCW context, and the issues, challenges and barriers they faced. Managers not involved in the delivery of home care services, including information technology, marketing and finance were excluded from the study. Table 1 presents the demographics of interviewees, all of whom were female. The average age of interviewees was 44 years (range 31 to 61), with approximately five years tenure. Most completed formal education, with three having completed postgraduate studies.

Table 1

Characteristics of office manager interviewees

	N = 11
Education	
Year 10 (school leaver certificate)	2
Year 12 (completed high school)	2
Undergraduate degree	4
Postgraduate degree	3
Tenure with company	
Less than 3 years	3
3 - 8 years	6
More than 10 years	2
Business unit	
Operations Support and Compliance	3

State Office	2
Business Development and Research	3
Senior Management	3

Managers had different level of responsibility, skills and experience in the organisation, as indicated in Table 2.

Table 2

Demographic profile of office managers

I/V	Age (yrs)	Tenure (yrs)	Occupation	Prof/ skilled	Division	Highest level of education
1	34	1	Care Coordinator	Skilled	OpSupport/Compliance	Senior high
2	41	3	Quality Mgr	Prof	OpSupport/Compliance	Bachelor
3	41	0.3	State Mgr	Prof	State Office	Bachelor Degree
4	40	8	Portfolio Manager	Prof	BD/Research	Masters
5	46	14	Senior Mgr	Prof	Senior management	Masters
6	36	3	State Manager	Skilled	State Office	Junior high
7	44	8	Team Leader	Skilled	Customer Service	Masters
8	60	11	Region Manager	Prof	State Office	Bachelor Degree
9	62	5	Care Coordinator	Skilled	Client service	Junior high
10	30	3	Cust Serv Mgr	Skilled	OpSupport/Compliance	Senior high
11	30	2	Program Mgr	Prof	OpSupport/Compliance	Bachelor

The semi-structured interviews lasted about an hour with two conducted by phone. Three key themes were addressed in the interview plan: operational overview of the home care service delivery, training and education for HCWs, and communication and support. Interviewees were encouraged to relate their personal experiences and interpretations of their organisational factors. Interviews were digitally recorded and transcribed verbatim.

Organisational Context

Background. The head office is located in the suburbs of a capital city high-rise building. There are around 85 employees including supervisors, managers, executives and

administrators, IT technicians and three HCWs. HCWs work mostly in the field at clients' homes but may attend the office for a scheduled meeting, if they are recovering from a workplace injury and certified fit for light office duties, or to meet with their immediate supervisor less formally to discuss any issues or to drop off paperwork.

Office personnel. The two highest senior managers are the chief executive officer and the chief operating officer. Each executive is supported by a full time personal assistant. Other senior managers in the office include senior management for project and change management, business development and research, operations support and compliance, marketing, IT and human resources. The office staff administrators including a receptionist whose main job task is to meet and greet visitors (predominately representatives of external organisations or, at times, candidates attending job interviews). On a rare occasion an employee would be seen in their trademark florescent uniform, worn by HCWs in the field.

Business units. The national corporate roles include business development, finance, marketing, IT, HR and the rest are state-based operational roles. The state-based operational roles are delivered by managers in the operations support and compliance unit, which oversees the delivery of customer service and ensures compliance with legislation, management of client complaints and feedback. All HCW's concerns about client wellbeing and changes in their client's health are recorded by the state clinical service department. Managers in each of the state offices oversee the delivery of home care services by their HCWs. State offices manage the client engagement process, service delivery and reviews.

Business development and research is a single unit which investigates opportunities to expand the business service delivery and seeks opportunities within the industry to enhance service delivery. Activities performed in the unit include tendering, affiliating with research centres and universities and the private sector in development of new technologies to improve safety and comfort of clients.

The project and change management team work on new projects in collaboration with business development and research, exploring tendering opportunities to grow the business and expand service delivery. The marketing team supports all business units to ensure a positive image of the business is portrayed across all types of service delivery including domestic assistance, social support, respite care and community access.

On-site training. The organisation has three large training rooms on-site. In these rooms local community events are held including the annual open day. Key industry representatives, local and federal politicians, allied health professionals and senior organisational representatives, HCWs and clients attend these events. The organisation is rapidly expanding and customising service delivery to maintain customer satisfaction and retention. Due to its convenient location in a capital city, the head office is one of the key locations where staff training is delivered for office staff and HCWs. Office staff attend frequent informal training and peer supervision sessions with their peers and supervisors. HCWs have less informal supervision, due to the nature of their work and are therefore required to attend a two hour paid training session every three months. Across the organisation on average, ten repeat sessions are held each quarter at the head office and two to four times at other locations, with approximately 20 HCWs attending each of the sessions. The session is facilitated by state office supervisors (care coordinators, program managers and area team leaders) who are the immediate managers of HCWs. HCWs who do not live close to the head office are encouraged to attend a training session closer to them, often held in a library or a community hall hired for a two-hour period. All efforts are made by the management to minimise HCW travel time and the associated costs absorbed by the organisation.

Results

The findings are reported according to each of the themes, as outlined in Table 3. The archival records assisted in understanding the information collated from clients prior to the commencement of the service. This included the type of information collected at the assessment, government policies on service delivery standards and organisational systems for using the information to improve the service delivery.

Table 3

Operational overview of home care service delivery

Themes	Subthemes
HCW job design	Recruitment
	Remuneration including travel entitlements
	HCW reporting
Organisational factors	Client in-home assessment
	Confirmation of service delivery
HCW training and support	HCW support systems
	Quarterly training sessions
	Additional training needs
	Promotion of HCW safety
	Availability of peer support

HCW job design. Interviewee 1, care coordinator, reported that all HCWs are required to have a Certificate III or IV in Community Care. Certificate III in community care is a six month course with a theory component on the delivery of personal care, communication, advocacy, dementia, work health and safety and 100 hours of work placement hours. Certificate IV in community care is a twelve month advanced course of above topics and 160 work placement hours. In addition to the required qualifications, HCWS need to have a reliable insured vehicle and a mobile phone.

HCWs are paid by an hourly rate in addition to travel allowance. The hourly rate commences when a HCW arrives at a client's home and finishes when the HCW leaves the client's home. The hourly rate varies according to the skill level of the HCW. Penalty rates apply for finishing late at night or working on weekends or public holidays. Reimbursement

for travel is only paid for mileage between clients. HCWs are not paid for travel time or mileage to and from home, regardless of the location of their first and last client for the day. Office managers reported they worked with HCWs on trying to minimise HCW travel time by allocating clients as close to HCWs home address as possible.

Several interviewees reported that HCWs are required to have a mobile phone on them for safety and communication. The organisation has a customised mobile application which all HCWs have downloaded on their mobile phones. HCWs are required to log into the mobile application when they arrive at a client's residence and sign out when they leave. If HCWs observe changes in the health status of their clients or any problems that they encountered during their shift HCWs are required to report them either on the mobile application or call the office.

Environmental context. The purpose of the initial in-home assessment conducted by a program manager is to assess the client and determine what type of a HCW would be best suited to the client's preference and requirements. Assessments include questions about physical health, community access, cultural background, support network and other occupants of the home. Interviewee 4, Portfolio Manager, reported the Personal Wellbeing Index (PWI) is an assessment tool used occasionally to determine client's emotional wellbeing to determine if a client might need additional support.

All services are confirmed with the client within 24 hours prior to service delivery, with clients being informed of the name and the time of HCW who will attend. Many clients request morning service, particularly with personal care. The organisation promises service delivery within a two-hour time window.

HCW training and support. Ongoing professional training and support systems for HCWs were discussed by most interviewees and highlighted as a priority. HCW training is delivered quarterly and sessions cover a number of topics pertaining to the delivery of home care

services including dementia, safe manual handling, infection control and nutrition. During the session, any recent government changes to service delivery are discussed particularly updates to the reporting requirements of HCWs about client health status. Apart from changes in physical health interviewees reported many of their clients have emotional needs. Interviewees reported that training on recognising and responding to mental health in clients has not been delivered and that this would be beneficial for both office personnel and HCWs, as these quotes show:

> *"We've traditionally done just four sessions a year, it [mental health] might be one of them. My thoughts about this is that it is you can't give HCW enough information on how to deal with depression, challenging behaviours, mental health, understanding what's going on with people and being able to work with that" (#7, Customer Service Manager).*

> *"In my position, I think that it [the training] would benefit… depression is hard to detect…training should be offered, for myself as well as HCWs. I think that it is essential that training is offered. I am on the phone, I don't see clients face to face. I am not there with the client [yet] I can get screamed on the phone by the client" (#1, Customer Service Manager).*

In addition to quarterly training sessions, several interviewees reported the value of informal on-the-job training. Informal training was reportedly delivered on a frequent basis by program managers, who oversee the home care service for approximately 40 clients and have a clinical background as a nurse or an allied health professional. It was reported that due to the clinical background of the program managers that they were perceived to be the 'go-to' personnel if HCWs had any concerns about the welfare of their clients. Program managers reported that despite having clinical knowledge in addressing client health issues that they have not received formal training in mentoring, training and supervising HCWs.

> *"Training is informal PMs [program managers] will do that [deliver mental health training to HCWs]. There's that ongoing on the job sort of thing. Because they do come across it so often there are a lot of informal chats going on" (# 8, Clinical Service Manager).*

The impact of HCW isolation by working independently in the community was mentioned by several interviewees. Support systems for HCWs were described as peer support, contact with area team leaders, program managers and care co-ordinators, as well as external support through employee assistance program (EAP). Access to EAP was less promoted, with several interviewees saying they were not sure of the procedure to access the service. Interviewees acknowledged that HCWs may be affected by their relationship with the client and leave the sector, as outlined by Interviewee 7:

> *"We have had incidences of turnover in HCWs, as their relationship with the client has influenced the HCW and their job satisfaction, so they leave the organisation and industry all together"* (*#7, Customer Service Manager).*

Emerging Themes

Table 4 outlines a list of themes which emerged during the non-structured component of the interviews. The two emergent themes reflected issues related to HCW workplace risks and strategies to retain clients. Interviewees reported an organisation wide strategies to minimise HCW workplace risks with early detection and compromises to personal safety for HCWs. Interviewees reported challenges due to client privacy parameters in sharing personal information which contributed to meeting client expectations and minimising complaints.

Table 4

Emerging themes from office managers' interviews

Themes	Subthemes
HCW workplace risks	Detection of environmental risks
	HCW personal safety
Client retention	Privacy parameters
	Meeting client expectations
	Minimising complaints

HCW workplace risks. A number of interviewees, particularly those who had face to face contact with clients through the client assessment process, highlighted the importance of screening the home environment of clients to ensure the safety of HCWs. The interviewees

reported that the home screening assessments were comprehensive and covered the detection of risks and safety concerns for HCWs ranging from safe manual handling to dealing with vulnerable clients. The interviewees reported that HCWs were encouraged to contact the office if they felt their safety was in any way compromised:

> *"In the induction if there is any concern for safety they are advised to remove themselves and contact the office immediately" (#2, Policy and Quality Manager).*

> *"I believe the majority of the HCWs understand if there is a high need or high risk, they will pick up the phone" (#6, Senior Manager).*

The ongoing requirement of HCWs assessing their work environment and escalating any risks to the office that they feel may compromise worker safety reinforces the need for HCWs to remain vigilant and act independently whilst delivering home care services. Several interviewees reported the ongoing requirement to detect risks, maintain safety and maintain a rapport with a client was reported as one of the reasons for HCW resignation. The relationship between the HCW and a client was described as a possible contributor towards how HCWs may feel about their role and impact their job satisfaction:

> *"Sometimes when people [HCWs] don't know what to do, they feel very helpless and they tend to ask not to be sent back to that client or they will get anxious themselves and try to jolly the person along or try to say "woo look at all the things you've got to be happy about" things that are not necessarily helpful, despite being well intended" (#3, Senior Manager).*

Limited screening of client mental health with the personal wellbeing index, as outlined above, and the lack of HCW training in detecting mental health in clients may present additional environmental risks for HCWs, as they deal with clients who have complex mental health needs. Throughout the interviews interviewees reported the need to promote and retain client confidentiality which may further hinder information sharing and detection of risks for HCWs. Information sharing was described as limited and varied on the type of service delivery. A senior manager was asked if HCWs would be informed if a client scored

low on personal wellbeing index to improve the quality of service provision and to better assist the client:

> *"No, not. That's a bit private" (#8, Clinical Service Manager).*

Similarly, another manager stated that she would assess the level of HCWs involvement with the client prior to releasing identifying information about the client:

> *"It's a degree of impact, you could have multiple things going on but you share what's relevant. If you're just doing a domestic assistance service, you may not need to know a client's mental health diagnosis" (#5, Senior Management).*

Interviewees reported several instances where they as managers or the HCWs were exposed to risks during service delivery. Examples included several critical incidents such as exposure to violence, sexualised behaviour in clients and risk to personal safety. In some cases managers stated to applying common sense and the expectation that all workers will contact the office when a hazard is identified as these examples demonstrate:

> *"I had one lady who was quite aggressive. We were in the kitchen and something had agitated her and all of a sudden she had a knife; she was helping me peel fruit, and all of a sudden screamed out, threw her arm up in the air and I thought oh my god, here we go. So it was a little bit tense" (#9, Clinical Service Manager).*

> *"We've had a lovely gentleman who used to love to lie on the lounge when the HCWs arrived with just a towel over him watching pornographic movies. So dealing with that, just saying 'well you can't do that'" (#9, Clinical Service Manager).*

The exposure of HCWs to clients with varying level of support needs, environmental risks, the impact of isolation and remote supervision as well as the relationship with clients may all be contributing factors towards HCW's job satisfaction and lead to resignation:

> *"Yes, there have been times it's been too overwhelming for the workers. The really experienced HCW's leave the industry all together, as it affects them on a very personal level. Not necessarily because they haven't received the support, but perhaps because they may have known the client for seven or eight years and it feels like the client was a member of their own family. The HCWs feel they can't cope, and retire out of the industry" (# 7, Customer Service Manager).*

Client retention. Lastly, customer satisfaction and retention was highlighted as a crucial component of the service delivery. The interviewees discussed the number of preferences clients may have when engaging a home care provider including the service delivery time, gender and language skills of the HCW, type of services to enhance community access and the delivery of personal care services. The ongoing need to retain customers was expressed as a priority by all the interviewees. Further, several interviewees reported that if a client requested to cease the home care service, staff were trained in recommending to the client to trial a reduction in the service hours than ceasing the service completely:

> *"We do have a lot of clients who stop the service. I actually had one this morning. A lady I spoke with on Friday, today said "I am fine, I am coping". And, some are improving. But, that is not my final decision. I told the PM [Program Manager] and she called the client and said, we will keep the service but instead of four times a week, we will be there one day a week. At least we have some sort of contact. Not to stop it all together" (# 1, Customer Service Manager).*

Program Managers support the customer service department by offering informal training to care co-ordinators and administrators. The most effective method described was, with client permission, recording telephone conversations and writing scripts to use when engaging with clients:

> *"Many of the managers jump on the phones and take a couple of random calls, but it's more for educating the internal staff in terms of customer satisfaction and if the right words are being used"(# 11, Clinical Services Manager).*

Interviewees from the policy and quality unit reflected on the most frequent type of complaints received about the delivery of home care services. Interviewees reported the client complaints included feedback about their designated HCW, lack of funding or issues with invoicing, particularly if a client needed to make a co-payment for the home care service. The majority of complaints were reported to be around the quality of service provided:

> *"A client had a personality conflict with a field staff member. They had previously gotten on very well but the client effectively wanted the worker to be sacked without any reason behind it" (#5, Policy and Quality Manager).*

Discussion

Home care services are well positioned in the aged care industry as the in-home support incurs less government costs than residential care (AIHW, 2013) and public hospitals. Home care services include a range of activities such as domestic assistance, community access, social support and respite care. Older clients may require support with some aspects of daily living, such as assistance with shopping but may otherwise be in good health and have no need to relocate. Remaining in their own home is often the more preferred outcome for the clients. Home care support provides flexible employment opportunities for workers who wish to remain in an aged care setting but not in residential care. Home care however presents additional risk factors due to HCW isolation and exposure to different and unpredictable environments. Environmental uncertainty includes increased risk of unsupervised interactions with clients and safety issues in critical incidents, which were identified in this study.

Exploring environmental risk factors in delivery of home care services is important, as it improves understanding of high staff turnover rates. The aim of our study was to identify the environmental risks and the support available for HCWs. Results indicate a lack of skills training and distal organisational support delivered over the phone or via a mobile phone application specific to the organisation. In examining the organisational factors, office managers reported it is the responsibility of HCWs to determine if they are exposed to a risk in the environment and to notify the office. Results further indicated that induction process for HCWs and client assessment tools assisted in screening environmental risks for HCWs, such as detecting poor mental health status in clients. However, office managers reported not routinely screening client mental health status and, in instances where client mental health status was known, not regularly sharing this information with HCWs. The findings point to

an ongoing need for improved quality and frequency of training for HCWs on a wide range of topics including resilience (King, Newman & Luthans, 2015; Winwood, Colon & McEwen, 2013), teamwork and clinical service delivery.

Almost all interviewees reported the benefit of both formal and informal training to shape the delivery of home care service, in-person and over the phone communication and better meet client expectations. As the interviewees reflected, office managers are not in client homes as frequently, if at all, and the managers rely on the HCWs to relay the information about client status to them to make changes and arrange for client assessment, if their level of support needs has changed. It was apparent from these observations the importance of policies and procedures in place for supporting clients in their own homes. In particular, it was apparent how important it is to escalate concerns to office managers and collaboratively achieve person-centred care (Kitwood, 1997) as well as minimise the risk of a critical incidents.

Our study reveals there is more to be done to manage and minimise employee risks in home care. The interviews in particular identify the need to improve job design, assess the workplace environment, minimise the risk to personal safety and critical incidence, encourage health promotion and improve education and training as well as support systems. In this respect, the following strategies can be highlighted in particular conducting a thorough assessment of client environment prior to service delivery (e.g., environmental risks for HCWs). Improvement of internal support systems, through better communication between HCWs and their immediate managers via phone calls, emails and in face contact. Upgrading HCWs skills through training in health promotion and awareness of professional support systems for HCWs (e.g., front line supervisors and manager, other internal supports as well as EAP). Providing support in a critical incident and ensuring that both the client and the HCW

are supported and collaborating with clients on information sharing policies to improve clinical outcomes and maximise customer retention and satisfaction.

HCWs spend a significant amount of time with clients and are more likely to notice both physical and emotional changes in clients than office managers. Therefore, on-the-job training of HCWs in risk detection is even more important, particularly teaching HCWs practical skills and tasks to detect health changes in clients. This study identifies a range of concerns relating to workplace risks in the home care context, all of which may contribute to high staff turnover in the aged care industry. Detecting of environmental risks may improve retention of both HCWs and clients.

The findings point to an ongoing need for better screening of workplace conditions for HCWs. Of significance is that almost all interviewees reported the relevance and importance of training on mental health awareness and resilience. Further, a written policy on client mental health screening would drive increased awareness of implementing change in practice. This would include improved worker resilience in escalating concerns about clients, prompt for consistent screening of all clients prior to service delivery and improved practice for escalating concerns about clients who score highly on the personal wellbeing index and require a referral for treatment. Improved a procedure on screening client mental health needs would minimise the risks for workers, particularly being exposed to critical incidents and highlights the importance of education in aged care setting (Cohn, Horgas, & Marsiske, 1990), particularly as HCWs are responsible for all direct client care.

This paper has argued the case for improved awareness of contextual factors in a home care setting to capture the environmental risks for HCWs. There are a number of limitations of this paper. Firstly, HCWs and clients were not interviewed. Further, two interviews were conducted over the phone. By conducting field observations with HCWs in their interactions with clients in home care more analysis will be made available on the home

care environment from the perspective of HCWs and the clients. Direct feedback from HCWs would be particularly useful for home care providers and employers and policy makers. Second, the sample size is small and represents the views from one private home care organisation. Further, collecting data from a larger number of home care providers would allow a more representative data and views from various home care organisations.

The management implication of this paper highlight the importance of screening client home environment and client mental health to improve clinical implications for the client and assess workplace risks for HCWs. Training and supporting HCWs the importance of escalating concerns about clients who may present with poor mental health may improve clinical outcomes for the client as well as minimise workplace risks for HCWs and improve their working conditions.

Management may benefit from taking into consideration the specific training needs of HCWs and how to empower them to make decision in the field and when to escalate concerns to office managers. As HCWs have more face to face contact with clients than office managers, HCWs are more likely to notice any physical and emotional changes in their clients. Therefore, HCWs may benefit from further training on what changes to report and be offered a system which supports their ongoing learning and support.

Conclusion

We have argued that organisational factors is important in delivering home care services. HCW safety may be hindered if workplace risks are not detected prior to a HCW arriving at a doorstep of a client. The home care setting as a workplace is largely unexplored in management and human resource literature, with the findings often generalised from residential setting. The two work environments differ significantly. The skills, duties and support mechanisms for the HCWs are different to other aged care workers, including residential care workers. HCWs work in isolation and need to be well equipped and resilient

to know how to detect a risk and escalate their concerns to supervisors. However, in reality escalation of concerns rarely happens. If adequate screening of client home environments and workplace training in detecting emotional changes in clients can be prioritised, home care providers might become better employers with higher staff retention rates, attract new entrants to the industry and achieve high satisfaction in clients, and therefore, operate better organisations.

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Conclusion to Study One:

Study One revealed the home care environment from the perspective of office managers including the detection of environmental risks and supports available for home care workers (HCWs). Results indicate that HCWs work in isolation and their peer support network and management support is delivered over the phone or via a mobile phone application specific to the organisation. In examining the organisational factors, office managers reported it is the responsibility of HCWs to determine if they are exposed to a risk in the environment and to notify the office. Study One also indicated that induction process for HCWs and client assessment tools assisted in screening environmental risks for HCWs, such as detecting poor mental health status in clients. However, office managers reported not routinely screening client mental health status and, in instances where client mental health status was known, not regularly sharing this information with HCWs. Insights from Study One provide the platform from which to examine further the contextual risks for HCWs. In this context, Study Two explores interaction between HCWs and their clients.

Introduction to Study Two:

Study Two explores the role of emotions in home care setting and the unique experience of work life of the home care worker. Results from Study Two indicate that home care workers (HCWs) catch both positive and negative emotions from their clients. Participants reported that catching positive emotions had a positive effect on them and improved their own mood and wellbeing. Participants reported that catching negative emotions had a negative effect on them and deteriorated their mood. Further, exchange of negative emotions between HCWs and their clients may present as environmental and safety risks for HCWs and lead to burnout and compassion fatigue. In several instances HCWs requested to not be sent back to clients who displayed negative emotions. The theoretical underpinning of exchange of emotion between HCWs and clients, emotional contagion theory, provides a more holistic approach to understanding why and how emotion exchange occurs. Study Two's results further suggest that home care providers need to screen client mental health status to minimise environmental risks in the delivery of home care services. Findings from Study One and Study Two indicate the importance of mental health status awareness. These findings set the basis for Study Three to explore further the role of emotional contagion in a home care setting.

Chapter 3

‘It works both ways. I can support her, she can support me’: the influence of mental health and distal supervision in home care setting

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Ms. Julie Bajic Smith was responsible for the design of this study, collection and entry of data, analysis and write-up of this paper. Associate Professor Denise Jepsen provided research supervision through all stages of the research.

Abstract

The increased demand for home care services highlights a number of significant employment factors in supervising home care workers (HCWs) in a remote environment. The purpose of this paper is to addresses an important research gap by examining the role of emotions in a home care setting and more specifically the influence of client emotion on the worker wellbeing. Using semi-structured interviews with Australian HCWs, this study found sharing of emotions and breaches of professional boundaries in a home care setting. The study presents an opportunity for aged care providers to increase awareness of the impact of the client-HCW relationship which could be further enhanced with training and specific types of organisational support. The home care setting is often underrepresented in research conducted in the aged care sector. Recommendations are made to improve working conditions and support which could involve increasing face-to-face supervisor support, self-care and self-awareness.

Keywords: aged care, emotions, emotional contagion, home care work, mental health, professional boundaries, work conditions

Introduction

Global statistics indicate a growing demand for aged care services (World Health Organisation [WHO], 2015) characterised with a shortage of front line staff, high rate of employee turnover (Radford, Shacklock, & Bradley, 2015) with relatively low numbers of new entrants (Karantzas et al., 2012). Older people tend to prefer to remain living in their own homes even if they experience changes to their health status and support network (Eyers, Parker, & Brodaty, 2012). However, the large majority of those diagnosed with dementia eventually lose their independence with seventy-five percent of those aged over 80 requiring nursing home admission (Arrighi, Neumann, Lieberburg, & Townsend, 2010; Galik, Resnick, Hammersla, & Brightwater, 2014). To avoid admission to residential care and reduce the burden on the already exhausted aged care system (Australian Institute of Health and Welfare [AIHW], 2012), there is a need for timely home care services (Commonwealth of Australia, 2014). Eligibility for home care services is subject to government funding (Simonazzi, 2009), stringent eligibility criteria and affected by a shortage in paid carers (Seavey, 2004). For example, Australia has over 240,000 aged care employees in direct care roles, only a third of those are trained to work in home care (King et al., 2012), with the rest trained to work in residential care setting. Similarly, in the UK, there are over two million older people with care-related needs with 40 percent receiving no formal support from public or private sector agencies Age UK (2014). Given the growing demand for home care services there is an urgent need to address the barriers in attracting and retaining workers in this category of the aged care sector.

The aged care sector is divided into two distinct environments - residential and home care. Residential care involves delivering care and support with activities of daily living in a residential setting while home care involves care services provided to older people in their own homes (Hebson, Rubery, & Grimshaw, 2015) and generally allows more autonomy and

discretion (Folbre & Wright, 2010). The residential setting is significantly represented in management and gerontology literature. Management studies address issues such as employee voice and regulation (Kaine, 2012), culture of companionate love (Barsade & O'Neill, 2014), retention and turnover intentions (Radford et al., 2015) and employee commitment, job satisfaction and intent to leave (Karsh, Booske, & Sainfort, 2005). The impact of dementia is largely covered in gerontology and nursing literature (e.g., Olsson & Hallberg, 1998; Zimmerman et al., 2005) and a small but growing body of literature recognises the importance of screening mental health, particularly depression in older people (Australian Institute of Health and Welfare [AIHW], 2013; Davison, McCabe, Mellor, Karantzas, & George, 2009; Huang & Carpenter, 2011). There is a need for workforce researchers to further explore the role of sharing emotions between clients and home care workers (HCWs).

Emotions at work

Interpersonal interactions, based on sharing emotions and cognitive influences, have been recognised as a significant phenomenon of modern age (Maslach, Schaufeli, & Leiter, 2001). The effect of emotion sharing has been widely examined in various employment contexts including in the police force (Hart, Wearing, & Headey, 1993), hospital settings (Omdahl & O'Donnell, 1999) and residential care (Barsade & O'Neill, 2014). Care services are described as being emotionally intense (Folbre & Wright, 2010). Positive interactions are attributed to high levels of job satisfaction, positive self-esteem, organisational commitment and worker wellbeing (Tan, Foo, & Kwek, 2004). Hart et al. (1993) found more favourable levels of perceived quality of life in police officers than in comparison population norms, which were attributed to experiences that are beneficial to an officer's wellbeing. Negative interactions are attributed to absenteeism, high turnover, apathy, compassion fatigue and burnout (Dasborough, Ashkanasy, Tee, & Tse, 2009; Gascon et al., 2013). Negative emotions are

found to affect worker resilience and ability to cope with significant stress (King, Newman & Luthans, 2013).

In the aged care sector, interpersonal interactions underpin the person-centred care approach to service delivery which promotes the uniqueness of each client and their individual goals (Kitwood, 1997). The interaction between care recipient and care giver plays a crucial role in measuring care recipient satisfaction with the service and ensuring the set care tasks are completed (Folbre & Wright, 2012). While studies conducted in residential settings may help to improve our understanding of interpersonal interactions in the aged care sector (e.g., Barsade & O'Neill, 2014), those findings may not necessarily be representative of the aged care context. It is therefore important to examine the influence of interpersonal interactions between home care workers and clients and determine if there are unique aspects of interpersonal interactions specific to this type of remote service.

When people are in a certain mood, whether joy or sadness, that mood is often communicated with others (Barsade, 2002)..Hatfield, Cacioppo, and Rapson (1994) coined the emotional contagion theory which proposes that emotional projections are automatic, fast, fleeting and underpinned by psychophysiological, behavioural, and social phenomena. According to Hatfield et al., (1994) emotions are separated into two wide large domains – positive and negative. Positive emotions include love and happiness while negative emotions include sadness, anger and fear (Doherty, 1997; Hatfield et al., 1994). Theoretically, interacting with a depressed person may leave us feeling sad, whereas interacting with an upbeat and self-confident individual is likely to have a positive effect on our mood (George & Brief, 1992). Doherty (1997) positions that mimicking others is a continuous and non-conscious process and includes imitating other's fleeting emotional expressions and synchronises their facial, vocal, postural, and instrumental expressions. Given the automatic nature of emotional contagion is likely to be encountered in a variety of workplaces

particularly where employees have a face to face contact with clients, such as in care giver – care recipient roles.

Turning attention to the carers, organisations have a role to play in providing a mentally healthy workplace for all employees (PriceWaterhouseCoopers, 2014). Failing to acknowledge the importance of good mental health in a workplace may result in an increased risk of stress (Cardozo et al., 2012), particularly in the workers who may already be experiencing high levels of stress and have a history of depression (Doshi, Cen, & Polsky, 2008). Employees in a stressful work environment may manifest anxiety, anger, behaviour disorders and depressive symptomatology (Iacovides, Fountoulakis, Kaprinis, & Kaprinis, 2003) and may lack skills in recognising their own symptoms of burnout and depression. Subsequently those workers may overlook emotional changes in clients (Mellor, Davison, McCabe, & George, 2008). It is important to examine the factors contributing towards employee wellbeing in the home care context, to understand factors associated with changes to employee wellbeing status.

Home care services are mostly offered on a client-driven model allowing clients to buy worker time to assist with activities of daily living and community access (Broadbent, 2014). The model has a potentially significant impact on employment conditions of home HCWs and the organisation of their work (Broadbent, 2014). Exposure of HCWs to clients with varying degrees of physical and emotional support needs and varied levels of living standards may present a wide range of workplace risks and challenges. A recent Australian aged care study highlights the importance of managerial skills in that middle managers perceived the need to develop their communication skills, self-awareness, change management, conflict resolution and leadership skills to better support their subordinates (Meissner & Radford, 2015). Further research in the home care setting can allow better understanding of factors associated with the influence of emotional contagion on worker

wellbeing, perceived organisational support and source of organisational commitment and job satisfaction.

Dissatisfied employees

Job satisfaction has underpinned a plethora of management studies in examining employee turnover, intention to leave and attitudes towards work (Duffy, Allan, Autin, & Bott, 2013; Hunsaker, Chen, Maughan, & Heaston, 2015; Price & Mueller, 1981; Rosen, Stiehl, Mittal, & Leana, 2011). Employee attitudes may not only lead to resignation but also influence the quality of service delivery (Hannigan & Allen, 2011), in that a dissatisfied worker may not work to their full potential (Herzberg, 2003). One of the pioneering studies in examining dissatisfied employees was conducted by Hirschman (1970) who proposed that dissatisfied employees either exit, voice or remain loyal. Farrell (1983) built on theory on responses of dissatisfied employees by developing the EVLN model of exit, voice, remain loyal or neglect. The voice option includes employee attempts to change rather than escape from an objectionable state of affairs, and appeals to higher authorities. Kaine (2012) examined employee voice and regulation in the residential care setting and found employee voice does not act as a significant regulator of managerial decision making. Decision-making was influenced by both external and internal constraints. The influence of employee voice in the home care sector, however, has not been explored, and would be particularly useful in understanding the work environment, employee attitudes and behaviour.

The current study aims to address a gap in the management literature by investigating the influence of sharing emotions between older people and HCWs. Sharing of emotions from clients to HCWs is explored from the perspective of HCWs by examining the nature of client interactions, HCW escalations of concerns about clients who display negative emotions and the influence of client emotions on HCW wellbeing and overall job satisfaction. Interview data was collected from a medium sized Australian home care provider. As emotion sharing

has not been previously examined in the home care setting, the study deepens our understanding of how emotional contagion shapes the delivery of services in a growing and significant sector (Brooke, Goodall, Handrus, & Mawren, 2013).

Methodology

This study of a medium sized Australian organisation in 2014-2015 is part of a larger investigation of HCW work attitudes. Data for this study was collected in semi-structured interviews. The study was approved by the University's Human Research Ethics Committee and an organisational consent form was obtained. Twenty four HCWs participated in the interviews and signed individual consent forms. HCWs complete a minimum of six month training course to deliver personal care and social support to older people. Registered nurses and administrators were excluded from the study as they tended to have different training to HCWs and less frequent contact with clients. Participants were selected for their representativeness as outlined below.

Organisational Background

The organisation provides in-home support for 16,000 clients across Australia. Each client is allocated a set level of funding from the federal government based on their needs. Most clients make a co-payment to cover the full cost of the home care service. Some clients receive three service hours every day, while others may receive two service hours per fortnight. On average, clients receive eight support hours per week. As government funding allows clients to choose their home care service provider, the providers need to remain competitive to maintain their client load and financial viability. One way they maintain competitive is by meeting the expectations of clients with preferences for service delivery times and choice of HCW. HCWs are allocated to individual clients based on their skills, proximity to client home and availability. Each HCW services an average of six to eight clients per day. The state office coordinates service delivery days and times based on factors

including client assessed needs and service level agreements, HCW's skills, availability and proximity to clients' home.

Participants

An invitation email was sent by a human resource representative to all HCWs seeking their interest in the study. Six HCWs from each of city, regional and rural areas were selected and reimbursed with a $25 gift voucher for their time. Eighteen interviews were conducted face to face and six by phone. Characteristics of participants are included in Table 1 and their demographic profile is presented in Table 2. The average age of the participants was 52 years and average organisational tenure was between two to three years.

Table 1

Characteristics of HCWs (n = 24)

		Count	%
Gender	Male	2	8.3
	Female	22	91.6
Employment status	Full-time (permanent)	1	4.1
	Part-time (permanent)	10	41.6
	Casual	13	54.2
Education	Year 10	7	29.2
	Year 12	9	37.5
	Trade	7	29.2
	University – Undergraduate	0	
	University – Postgraduate	1	4.1
Company tenure	Less than 1	1	4.1
	1-2	11	45.85
	3-5	9	37.5
	6-10	3	12.5

Each semi-structured interview lasted about an hour and included home care context overview and client engagement as the key themes. Interviewees were encouraged to relate their personal experiences and interpretations of home care context. Interviews were recorded and transcribed verbatim by the researcher. After each interview was transcribed,

data was imported into NVivo10 software application (NVivo, 2002) to assist with qualitative data analysis (Saldana, 2009). Analyses began with open coding, categorizing chunks of data, followed by a refinement process based on deeper interpretation of meaning (Bazeley, 2013).

Table 2:
Demographic profile of HCWs

I/V #	Age (yrs)	Tenure (yrs)	Region	Employment Type	Highest level of education
1	55	5	Metropolitan 1	Full-time	Trade
2	38	5	Metropolitan 1	Casual	Senior high
3	47	3	Metropolitan 1	Part-time	Senior high
4	56	4	Metropolitan 1	Casual	Senior high
5	21	1	Metropolitan 1	Casual	Senior high
6	35	2	Metropolitan 1	Casual	Junior high
7	57	9	Rural	Casual	Junior high
8	72	7	Rural	Part-time	Junior high
9	54	3	Rural	Casual	Junior high
10	62	3	Rural	Casual	Senior high
11	64	9	Rural	Part-time	Bachelor degree
12	56	5	Rural	Part-time	Junior high
13	54	2	West Coast (Metropolitan)	Part-time	Senior high
14	63	1	West Coast (Metropolitan)	Part-time	Junior high
15	65	2	Metropolitan 2	Part-time	Senior high
16	50	2	Metropolitan 2	Casual	Senior High
17	47	1	Metropolitan 2	Casual	Junior high
18	61	1	Metropolitan 2	Part-time	Junior high
19	60	1	Metropolitan 2	Casual	Trade
20	63	3	Metropolitan 2	Casual	Junior high
21	48	2	West Coast (Metropolitan)	Casual	Postgraduate
22	48	4	West Coast (Rural)	Part-time	Junior high
23	42	1	West Coast (Metropolitan)	Part-time	Senior high
24	34	1	West Coast (Rural)	Casual	Senior high

Results

First, we report the findings from the interview plan, outlining the home care context and provide details on HCW isolation, rostering, training and support. These themes are summarised in Table 3. Following the results from the interview plan, findings from the emergent themes are reported.

Table 3

Themes from HCW interviews

Themes	Subthemes
Home Care Context	Isolation Rostering
Client Engagement	Client background Detecting emotional changes Emotional contagion

Home Care Context

We explored the influence of the home care context in different regions of Australia with questions on HCW isolation, rostering, training and support. Most HCWs reported attending their local office rarely, where they could have contact with peers and supervisors, perhaps only for quarterly training sessions. They completed their rostering and timesheets electronically. HCWs reported that they experienced isolation working on their own and that management support was usually initiated by the HCW and mostly delivered by phone.

HCW Isolation. HCWs reported working in client homes where they had little if any contact with other HCWs during shifts. Several HCWs reported a rare rostering with another worker to support a client with complex needs or receiving 24 hour care. Interactions with other HCWs were often described as being challenging due to competition for rostered hours between casual HCWs. Some described a disagreement on the style of service delivery, such as how a client prefers to be supported in the shower. HCWs described variance in the presentation of client homes, ranging from large and immaculate city homes overlooking the harbour to smaller dwellings and government-supported units where some clients lived in poor conditions. HCWs reported environmental risks such as clutter, hoarding or homes with structural damage to the flooring. Despite reporting challenges of isolation, most HCWs reported preferring to work in client homes rather than working in an office environment.

HCWs reported a number of safety risks in the home care context. In particular HCW reported difficulties in supporting clients with complex behavioural backgrounds, such as clients who previously refused home care services, who are socially isolated and clients with severe mental health illnesses such as schizophrenia. Several HCWs reported the challenges of supporting frail clients who had high physical care needs and reduced mobility, as those clients were reportedly prone to falls and required the HCWs to use manual handling equipment.

Rostering. Most HCWs were employed on a casual basis, with a small percentage employed part-time and even fewer employed full-time. HCWs reported their shifts ranged from a half hour client welfare check, a full day with a client, to an overnight stay for respite. Several reported constraints with scheduling their work day, saying they were unable to complete all the required work in the allocated time including allowing the travel time between clients. Some HCWs reported communication issues with management in relation to rostering, such as the impact of reduced hours or being rostered with a client despite requesting to be removed from that client's roster. HCWs said their feedback and changes in availability were often overlooked when rosters were prepared and that apart from emails and phone calls there were no other interaction with management, as the following quote illustrates:

"Why don't they get back to us or have some acknowledgement? I really don't know. It's not only me but its other HCWs in my group as well who have the same issue with even sending an email requesting leave, 'Will you please respond to let me know that this is okay?' You hear nothing" Participant 19, Casual, Rural, aged 60.

Client Engagement

Client Background. Prior to commencing home care services all clients are assessed for their level of physical care needs by program managers who develop a care plan. HCWs reported routinely reviewing the care plan prior to meeting clients. Most said the care plans

had sufficient information to understand the client's basic level of physical care needs. However, many reported that clients had higher levels of physical and emotional support needs than in the care plan. HCWs said they would rarely sight a mental health diagnosis or status on the care plan or be given any mental health information at any stage of the client relationship. Several HCWs outlined the importance of clients being screened for mental health conditions:

"For me, I want to read it [mental health diagnosis]. It should have all those warnings. Instead of 'client likes a sandwich with butter and cheese'" Participant 3, Part-time, Metropolitan 1, aged 47.

Several HCWs reported that despite not having any information about client mental health status, they would be able to detect a client mental health condition on their initial interactions. HCWs described strategies they use to assess client mental health, including engaging with the client, asking about their support needs, watching the client's body language and the tone of their voice. In probing, more than half the HCWs appeared to confuse symptoms of depression with dementia:

"*When we say depression and dementia they are two different words, right? It takes a while to know, at least by three visits I would be confident that it is either dementia that is affecting her or it is depression…after three visits I think I would very much know the person" Participant 4, Casual, Metropolitan 1, aged 56.*

Detecting Emotional Changes. HCWs reported having a varied level of skills in detecting emotional changes in clients. Most HCWs reported observing client emotional distress during service delivery including verbalised sadness, withdrawal, crying and suicidality. In those instances, HCWs reported they spoke with the client and focused on positive aspects of their life, rather than escalating these concerns to the office and in particular their managers. HCWs often did not acknowledge that these symptoms may form a diagnosed mental health condition. Several HCWs reported compassion fatigue, feeling of high levels of stress and inability to refuel and regenerate (Jacobson, 2006). Compassion

fatigue was reported by HCWs in dealing with clients who presented with depression and consistently complained about the quality of their lives during each shift. In probing, if concerns about depressed clients were escalated most of HCWs reported that they did not escalate such concerns:

"No I would not call the office or should I?" Participant 4, Casual, Metropolitan, aged 56.

Most HCWs perceived negative emotional needs of their clients to be a normal part of ageing and would use their own self-taught skills in supporting those clients. They said they did not receive any training on how to deal with clients who express negative emotions or the need to escalate these concerns. Instead HCWs said they would talk with clients outside the scope of usual service, talking about all the positive aspects of client lives such as family or physical location. Several HCWs reported allowing clients to open up to them about their concerns:

"I think it's good to let them just talk and tell you and then if they ask you for a bit of advice just tell them what you think and I'm hoping that's the right thing. Maybe it's not?" Participant 8, Part-Time, Rural, aged 72.

A number of HCWs reported hearing their clients vocalise suicidality. HCWs said they were not trained in how to respond to clients who present at risk of suicide. Instead, HCWs reported varied responses to clients who vocalised suicidality, from escalating it to their immediate managers to most commonly talking with the client and reinforcing the positives in their lives. Some reported challenging clients who expressed suicidality, by saying the client had many reasons to continue living and listing all the positives in clients' lives:

"I would say 'no you don't [want to die], you have a lot to live for. You have a beautiful view, what else do you want?' I would joke with the client, make them laugh" Participant 4, Casual, Metropolitan 1, aged 56.

Emotional Contagion. Consistent with emotional contagion theory, HCWs reported "catching" both positive and negative emotions from their clients. In general, HCWs reported

forming positive rapport with their clients, particularly regular service users. Most HCWs reported job satisfaction deriving from the positive influence of their interactions with clients, stating that it uplifted their mood, confidence and self-esteem. Positive emotions between clients and HCWs were reported to be shared regardless of the frequency of contact, type of assistance provided or the gender of the client:

"*They say "I'm glad you're here, you bring my sunshine". They think I bring a bit of sunshine? That makes you feel good. You think, my job's worth it" Participant 4, Casual, Metropolitan 2, aged 56.*

Several HCWs reported that being exposed to clients with negative emotions, with or without a mental health diagnosis, affected them personally despite efforts to maintain professional boundaries. Several HCWs reported "catching" negative emotions from clients even when client's mental health was discussed with the client during the service and strategies were made to boost client wellbeing.

"If you are a sensitive person who senses another person's anxiety, it is difficult not to take it on board" Participant 1, Full-Time, Metropolitan 1, aged 55.

Several HCWs reported that severe poor mental health in clients would affect them personally. In those instances HCWs reported requesting from the management not to be sent back to that client:

"He was always depressed. He's one of the clients that I requested not to see anymore because it was just very hard to deal with – I really felt bad about that but that was very hard on me" Participant 11, Part-Time, Rural, aged 64.

Emerging Themes

The interviews revealed a number of emerging themes around HCW characteristics and maintaining professional boundaries which were not planned in the semi-structured interview and are reported separately from the key research questions. Table 4 outlines the full list of themes and subthemes which emerged during the interviews and particularly related to

unique characteristics of HCWs and their understanding of maintaining professional boundaries in client homes.

Table 4

Emerging themes from HCW interviews

Themes	Subthemes
HCW Characteristics	Workplace injuries Disclosure of mental health condition(s)
Professional Boundaries	Contact with clients outside of work Oversharing personal information

HCW Characteristics

Workplace Injuries. HCW reported many personal factors contributing to their role as a HCW including skills transferred from personal caring experience and workplace injuries. It was not uncommon for HCWs to describe physical exhaustion from their role, most notably resulting in backache and lodging a workers compensation claim. Those HCWs reported undertaking lighter duties, such as checking on welfare of clients and ceasing domestic duties due to changes in their physical health status. A contributing factor towards workplace injury was described as being the client expectation and standard of cleanliness. Some HCWs said they were expected to complete tasks outside of domestic assistance, such as manual handling and lifting clients without using a hoist. HCWs reported not having been trained in how to safely lift clients and that their training was limited to how to safely move a box:

"No matter how much we use lifters we still end up doing many things manually. Not all clients can be moved with lifters, we have to move some clients, and some of them are very heavy" Participant 13, Part-Time, West Coast, aged 54.

Apart from the reported physical exhaustion from carrying out the duties, a number of

HCWs reported mental exhaustion. HCWs attributed mental exhaustion to difficulty in supporting clients with complex physical and emotional support needs. HCWs reported not receiving training in supporting clients' emotional needs:

"The HCW does not have the skills in knowing how to encourage, find things that are the motivator, the trigger for the client. Sometimes they are in there for an hour and it becomes draining for them" Participant 1, Full-Time, Metropolitan 1, aged 55.

Disclosure of mental health condition(s). Without prompting, more than half the HCWs reported a personal experience with a mental illness either history of mental health condition(s) or having a close relative with a mental health condition. They said their personal experience with a mental health condition improved their ability to detect depression in clients and understand how to best respond. HCWs referred to their skills and experience in mental health as 'life skills'. A number of HCWs reported ongoing personal difficulties in sustaining social and occupational roles due to their own poor mental health. In this example, the HCW distinguishes between her personal identity and that of a HCW by putting on her uniform:

"I've lived with it [depression] for a few years. I'm a completely different person when I put this uniform on. You'll get up of a morning, you want to cry but you push yourself as soon as you put that uniform, oh right okay, and I am off…. And when you finished work you're going home to your safe haven" Participant 7, Casual, Rural, aged 57.

Professional Boundaries

HCWs reported they were trained on the importance of maintaining professional boundaries when working in client homes. However, a number of HCWs reported ignoring organisational rules about professional boundaries and openly discussing have contact with clients outside of work hours. HCW reported sharing personal information about themselves and their personal lives.

Contact with clients outside of work. HCWs reported having contact with clients outside normal work hours, which included both time after the shift finished and attending to clients

on non-rostered days. HCWs said this type of contact was essential to assist clients and meet their holistic needs. HCWs reported they often stayed with the client longer than the allocated time, particularly with their last client of the day. It appears HCWs used unaccounted overtime as an opportunity to debrief at the end of the day and socialise with the client, an activity perhaps more common and acceptable in an office-based environment with work colleagues:

"If I run over time well that's my concern, I can stay half an hour later and even though I don't get paid for that, I'm still happy to do that" Participant 8, Part-time, Rural, aged 72.

"I'm lucky with that particular client because I don't have one after her, so I just normally clock off and I might sit there and have a chat about something. Probably not allowed to do that but I do" Participant 17, Casual, Metropolitan 2, aged 47.

Some HCWs spoke of limited flexibility with their rostering in supporting clients to attend appointments. HCWs reported that clients would miss their medical appointments as they had no transport, and that HCWs would support clients to those appointments without management's approval or knowledge:

"One of my clients needed transport to get to a specialist appointment. He needed to call our office to ask if it'll be approved. Most of the time they say no, because it's too far away. I said to him if you need an appointment make it for when I finish work, because I will take you. I don't care about being paid" Participant 24, Casual, West Coast, aged 34.

Oversharing personal information. While several HCWs stated that they separated their work from personal life and maintained professional boundaries with their clients, as outlined by Participant 17. However many HCWs had difficulties in drawing distinctions between friendships and professional boundaries with clients:

"Nobody will ever pick up on what my energy is inside because it's like you leave your personal life at home, that's the way I look at it. You leave all your baggage, emotions on the side and when you go and see your next client you cannot take it and dump it onto that client" Participant 17, Casual, Metropolitan 2, 47.

A number of HCWs reported that their personal experience encouraged them to seek employment in the aged care sector. HCWs said they often spoke with clients about their own

experience and that clients often turned to those HCWs for information on how to cope with their own circumstances. In those instances, HCWs reported sharing personal information with the client instead of escalating client concerns to management:

"She [the client] knows I lost my husband a few years back and she says to me how did you handle it? What were you like? And I said to her exactly the same as what you are now" Participant 10, Casual, Rural, aged 62.

Several HCWs reported discussing their personal problems with clients. HCWs did not appear to acknowledge this type of interaction was inappropriate and outside the scope of professional boundary:

"I used to go to these clients regularly and they know about me and I know about them. We'd be talking and I would cry, not them. I'd rest my head on her [client's] shoulder. It works both ways. I can support her, she can support me" Participant 4, Casual, Metropolitan 1, aged 56.

Discussion

The current study investigated whether the unique characteristics of home care environment affected the type of client engagement in a home care setting. The qualitative study provided an insight into the home care environment from the HCW perspective. Furthermore, the level and type of engagement with clients allowed us to better understand the underpinning constructs of "catching" both positive and negative emotions in line with emotional contagion theory (Hatfield et al., 1994). The emerging themes from the semi-structured interviews provided a rich insight into the home care workforce with HCWs disclosing their mental health status and various approaches and understandings of professional boundaries.

Consistent with predictions HCWs reported "catching" both positive and negative emotions from clients. These findings support the works of Hatfield et al. (1994) on emotional contagion theory, which suggests that emotions are exchanged automatically. Subsequently, sharing positive emotions resulted in improved relationship between clients and HCWs and increased HCW motivation to build friendships with clients. On the other hand, HCWs reported that negative emotions in clients had a negative impact on them and

their wellbeing to the extent that some would ask to be removed from allocation to clients who appeared to display negative emotions. This study did not explore the possibility and the effect of clients catching both positive and negative emotions from workers. Future research in this area may investigate this relationship.

Compassion fatigue was described by several HCWS and needs to be considered further, particularly in the context of distal supervision. Emotionally supporting aged clients who are approaching the end of their life is likely to result in compassion fatigue and burnout (Gascon et al., 2013) in HCWs who are not trained in screening mental health and emotional support needs. Consistent with these findings, Omdahl and O'Donnell (1999) found that emotional contagion significantly reduced occupational commitment in nurses and explained significant variance in emotional exhaustion. Although the emotional contagion theory proposes that the exchange of emotions is automatic (Hatfield et al., 1994), improved training on how to support clients who may have mental illness may reduce the effect of emotional contagion.

The current study found evidence of reversed emotional contagion, in that HCWs reported sharing their emotions with clients and voicing their concerns about non-care related issues (Farrell, 1983). A large proportion of HCWs reported oversharing personal information about themselves to clients. The importance of maintaining a professional boundary appeared to have little significance in the delivery of home care services. Most HCWs did not perceive this behaviour to warrant professional misconduct and instead perceived receiving emotional support from clients to be within the scope of client contact and forming positive working relationships. One explanation could be that HCWs perceive their clients to be peers.

Alarmingly, almost half the interviewees reported having personally experienced a mental health condition, most commonly depression, which they did not disclose to their

employer. Those HCWs who had personal experience with mental illness said their experience improved their ability to detect poor mental health in clients and make suggestions to clients on how to improve their coping strategies. The impact of HCW mental health status needs to be explored further, particularly in light of delivering home care services and being remotely supervised by office managers.

The interviewees described the home care context as being isolating, having little to any contact with peers, other HCWs, and relying on remote supervision and support by office managers. The described arrangement for supervision and support is different to residential setting where residential care workers travel to the same workplace location and interact with peers and supervisors (Kaine, 2012; Radford et al., 2015). HCW mostly described enjoying the independent nature of their work and interactions with clients, unless they were facing difficulties in client homes or organising their work. The most common issues included rostering, manual handling, limited communication and lack of support from office managers. Challenges in maintaining regular communication between HCWs and office managers was highlighted as a significant issue by a number of HCWs. The impact of limited communication with immediate supervisors needs to be explored further, particularly in relation to its influence on perceived organisational support and trust in supervisor (Podsakoff, MacKenzie, Moorman, & Fetter, 1990).

The client engagement covered a number of subthemes including obtaining client background information, detecting emotional changes in clients and emotional contagion. Consistent with predictions, HCWs reported having a high case load of home care clients (Community Services and Health Industry Skills Council [CSHISC], 2014; King et al., 2012) many who waited months for funding. HCWs reported many of their clients, with poor physical health and reduced mobility, experienced a mental illness (Eyers, Parker, & Brodaty, 2012). However, despite reporting high prevalence of poor mental health interviewees

reported rarely sighting client's mental health diagnosis on the care plan. HCWs reported that client privacy guided the level of information shared and that mostly it was HCWs own interpretation of client's behaviour which they perceived to be a sign of a mental health condition. HCWs reported not having completed any formal training in mental health, consistent with previous findings in home care setting Davison et al. (2009). Further, HCWs reported not having received training on recognising emotional changes in clients or the importance of escalating concerns about changes in client mental health to office managers. Some clients expressed suicidality, with HCWs reporting they were not trained to respond to such incidents or if these concerns should be escalated to management. This finding could highlight the common misconception around mental illness not being prevalent in older adults and relevance to the delivery of home care services.

The major limitations of our study include that data was collected from one organisation and that we did not interviews clients. We are uncertain of the impact of negative emotions shared by HCWs with clients. However, as the focus of our research was the workforce, future research is recommended to investigate the role of emotion sharing and factors associated with HCW wellbeing on clients. Client interviews in a residential setting could improve our understanding of HCW interactions and the influence of both positive and negative interactions from the client perspective. The current study contributes to our knowledge about sharing emotions in a home care environment.

The study highlights the importance of training HCWs on how to recognise mental health conditions in clients and escalate their concerns about client wellbeing to management rather than to attempt to resolve the issue themselves. Employers should consider the impact of poor mental health in clients as a risk factor for HCWs, particularly in the context of remote supervision, as "catching" negative emotions may affect organisational commitment and retention (Dasborough et al., 2009). Although there may be privacy implications in

sharing mental health diagnosis with casual HCWs the long-term benefit may be the promotion of healthy and safe workplaces. Employees may have undiagnosed and untreated mental health conditions and workplaces may benefit from improved education and resources on mental health in the workforce, such as promoting self-care strategies and self-awareness. Improved communication between HCW and office managers will assist in establishing training opportunities for HCWs and skill building around common barriers encountered when working in isolation. Further, practicing mindfulness before and after shifts (Kearney, Weininger, Vachon, Harrison, & Mount, 2009) may assist HCWs in separating client issues and challenges from workers own personal lives.

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Conclusion to Study Two:

Study Two extends the findings of Study One, particularly in the relevance of emotion exchange between HCWs and clients. Results from Study Two indicate that HCWs catch both positive and negative emotions from their clients. Support network and communication between HCWs and office managers plays an integral role in the frequency of escalation of client concerns and the relationship between HCWs and office managers. The theoretical underpinnings of emotional contagion theory provide a more holistic approach to understanding why and how HCWs collaborate with their clients and managers. Study Two's results further suggest that for HCWs to escalate concerns about client welfare, education and training in mental health is important. Findings from Study One and Two indicate the importance of recognising and screening mental illness in clients and improved internal organisational processes for escalating concerns. These findings set the basis for Study III to explore further the roles of emotions at work in home care setting.

Findings from Study Two not reported in this paper are referred to in Study Four. This includes information around the role of self-efficacy in decision making and escalation of concerns. These results are exclusively discussed in Study Four.

The unexpected findings of bi-directional emotional contagion and poor HCW mental health raised in Study Two were not addressed here but left for future research.

Introduction to Study Three:

The third study in this thesis examines how emotions influence HCWs with a quantitative study, and what impact both positive and negative emotions have on HCWs retention strategies and overall wellbeing. A large survey was distributed to all HCWs from one home care organisation.

At a general level, findings from both Study One and Two indicate that emotions play an integral role in HCW wellbeing, and catching negative emotions from clients affects HCWs and their wellbeing. Through the theoretical lens of emotional contagion theory, Study Three examines the role of catching both positive and negative emotions. Additionally, Study Three explores the role of burnout in HCWs and its possible causes. Factor analysis of emotional contagion was conducted in Study Three, with the full version of the analysis in Appendix Two.

Chapter 4

The role of emotional contagion in increasing burnout and employee retention variables in home care workers

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Ms. Julie Bajic Smith was responsible for the design of this study, collection and entry of data, analysis and write-up of this paper. Associate Professor Denise Jepsen provided research supervision through all stages of the research.

Abstract

The aged care workforce is rapidly growing and is characterised with high turnover, high levels of burnout and low levels of job satisfaction. Previous studies have uncovered a number of employment-related factors influencing attitudes of aged care workers. However, researchers have yet to acknowledge the role of interpersonal interactions between care givers and care recipients. The frequency and type of interpersonal interactions between home care workers (HCWs) and their clients may influence client engagement and the level of management support in the home care context. The current quantitative study investigates the role of sensitivity to emotions in predicting burnout and retention variables in Australian HCWs. Analyses reveal catching frustration from others, being psychologically distressed and having low compassion satisfaction is associated with increased burnout. Catching frustration did not predict job satisfaction, organisational commitment or intention to quit, indicating other factors are associated with retaining HCWs. Findings inform the implications of catching emotions at work.

Keywords
Burnout, emotions, emotional contagion, employee retention, home care, psychological distress, sensitivity to emotions.

Introduction

The expansion of the aged care workforce has been attributed to ageing population and increased life expectancy. In 2014 there were over 1.45 million aged care workers in the UK, a 15% growth since 2009 (Age UK, 2014). The growth experienced in the UK is similar across the globe, including Australia (Radford, Shacklock, & Bradley, 2015) and the United States (Institute of Medicine [Committee on the Future Health Care Workforce for Older Americans], 2008). However, aged care employers often experience high rates of turnover, with predominantly casual (Radford et al., 2015) and female (Karantzas et al., 2012) employees and difficulties attracting new entrants to the sector (Howe et al., 2012; Radford et al., 2015; Rosen, Stiehl, Mittal, & Leana, 2011). The increased demand for aged care services has fuelled fierce public debate on the cost of institutionalised care for the elderly and strategies to minimise government expenditure on accommodation costs by supporting the older person in their own home (Bridge, Phibbs, Kendig, Mathews, & Cooper, 2010; Productivity Commission, 2015). In the United States in 2010, the combined expenditures for the elderly and disabled totalled $73 billion, and was estimated that these costs will be over $120 billion by 2020 (Tilden, Thompson, Gajewski, & Bott, 2012).

Research on aged care has attracted scholars from various disciplines, including psychology, nursing and management. The majority of studies have been conducted in an institutionalised setting, known as residential care and less research has been conducted in community-based environment, known as home care e.g., Broadbent (2014). Given that aged care workers perform work duties in various contexts findings from one environment cannot be generalised across the entire sector. A residential care worker (RCW) employed by a nursing home travels to the same work location, works in a team and is directly supervised and supported by their manager (Radford et al., 2015). Home care workers (HCWs) travel in their own vehicle to client's homes, work alone and rely on distal supervision and support

(Cranford & Miller, 2013). The concept of home care services takes the focus away from the stereotype of employees working in an office or other shared workplace alongside co-workers and in view of supervisors (Bartel, Wrzesniewski, & Wiesenfeld, 2011).

Occupational Stress and Burnout

The aged care sector has experienced difficulties in retaining both qualified nurses and direct care workers (Radford et al., 2015). In Australia, one of the problems is the ageing workforce. The average aged care workers is 47 years old and the average retirement age is 53 years (Australian Bureau of Statistics [ABC], 2011). One of the significant contributors towards high turnover rates in the aged care sector is occupational stress (Christina Maslach, Schaufeli, & Leiter, 2001; Omdahl & O'Donnell, 1999). Occupational stress is caused by a variety of sources (Williams & Cooper, 1998) and may result in psychological distress (Cardozo et al., 2012), effect job performance (Erik. Dane & Brummel, 2014) and increase an employee's intention to quit (Karantzas et al., 2012). Identifying the sources and effects of occupational stress may reduce the effect that stress has on individuals at the workplace.

Many individuals identify and personalise their work and organisational outcomes such as winning or not winning a tender. Personalising organisational outcomes can lead to experiencing stress and burnout (Iacovides, Fountoulakis, Kaprinis, & Kaprinis, 2003). Burnout was first defined by Freudenberger (1974) as feeling of inadequate control over work, frustration, hopes and expectations and feeling of loss of life's meaning and while burnout may share many similar properties to other emotional variables, such as stress and depression was found to have separate causes. The relationship between burnout and mental health status was examined in humanitarian workers (Cardozo et al., 2012), physicians (Kearney, Weininger, Vachon, Harrison, & Mount, 2009) and nurses (Hunsaker, Chen, Maughan, & Heaston, 2015), however there are no studies on the prevalence and causes of burnout in home care workers (HCWs).

One of the significant contributors in promoting employee wellbeing is having a good mental health status (Burgess et al., 2009). Indeed, mental illnesses are common and workplaces are increasingly vigilant of the importance of good mental health outcomes for employees. A number of organisations have introduced strategies to improve detection of high levels of stress in their employees e.g., PriceWaterhouseCoopers (2014) and have offered appropriate support (Burgess et al., 2009). While broad strategies to boost employee mental health are encouraged in office based environment, in a distal setting it could be more challenging to identify employees who are at high risks of developing psychological distress. In particular, it may be more difficult to ascertain the emotional needs of employees where regular face-to-face interaction with their managers does not occur, such as in a home care setting.

Organisational Factors

The organisational factors of working in home care present challenges and environmental risks for HCWs, as their workplace is the private home of their clients. The workers work in isolation, lack direct supervision from management and are presented with additional environmental risks. The implications of isolation and the potential compromise on worker safety have been demonstrated in several studies which examined the influence of supporting clients with complex mental health needs (Fazzone, Barloon, McConnell, & Chitty, 2000; Geiger-Brown, Muntaner, McPhaul, Lipscomb, & Trinkoff, 2007). Fazzone et al. (2000) explored the source and impact of personal safety risks and identified that HCWs reported attending to unsafe conditions, experiencing frequent disruptions with organisational and administrative issues and ethical issues. The study highlighted the importance of regular training for HCWs to minimise the safety risks, improve organisational and administrative issues and achieve client outcomes and worker retention (Fazzone et al., 2000). The complexities of the home care environment present a number of challenges for home care

providers to address with screening the environment, training HCWs and providing distal support in ensuring the safety of clients and workers is maintained during the delivery of home care services.

Turning our attention to the mental health needs in clients, there is a high prevalence of mental illness in the elderly, secondary to declining physical health (e.g., Eyers, Parker, & Brodaty, 2012). Older people with poor mental health may be less inclined to instigate outward behaviours associated with mental health, such as physical violence, and be more prone to inward behaviours, such as compromising self-care strategies and an increased frequency of physical symptoms and social isolation (Bhar & Brown, 2012). Depression is the most common type of a mental health condition in the elderly and is often undiagnosed (Eyers et al., 2012), particularly in those with declining physical health (Alexopoulos, 2005) and dementia (Teresi, Abrams, Holmes, Ramirez, & Eimicke, 2001). Several studies examined the skills of aged care workers in detecting emotional changes in their clients and found that aged care workers lacked knowledge and training about mental illness (T. E. Davison, McCabe, Mellor, Karantzas, & George, 2009; Hassall & Gill, 2008; Karantzas & Karantzas, 2012). The implications of not recognising poor client mental health needs to be explored further as undetected mental illness in clients may present as a safety risk for aged care workers. Particular concern is the impact of poor client mental health in a home care context on HCWs and their wellbeing which will be examined in this paper.

Emotions in the workplace

Scholars have long been interested on how employees think but less so on how they feel in a workplace, which has largely been attributed to an assumption that emotions are not suited to rigorous research (Ashkanasy, 2002). Early studies on emotional labour, such as Hochschild (1983), recognised the importance of environmental conditions in determining

employee attitudes at work. Weiss and Cropanzano (1996) developed an affective events theory, in which environmental conditions were recognised as 'hassles and uplifts' and the accumulation of those events were seen to result in either positive or negative affect states. Subsequent studies present evidence from a diverse sample of workers in different organisational context which indicate emotions of employees play an integral importance in their work performance (Barsade & Gibson, 2007; Brief & Weiss, 2002; Reitinger, 2011). The role of emotions in a home care context requires further attention as the emotions experienced by clients may affect HCWs, particularly in the context of distal work. The influence of distal supervision in the provision of support and detection of environmental risks for HCWs needs to be explored further.

Emotional labour theory, as proposed by Hochschild (1983) suggests there is a gap between emotions experienced and displayed through a social engineering process known as display rules or "organizational feeling rules" (Lopez, 2006). While the role of display rules has been examined, particularly in customer service roles (Allen, Pugh, Grandey, & Groth, 2010) findings indicate Hochschild may have overestimated the extent to which employers are able to control workers' emotional lives (Lopez, 2006). That is, in a health setting the relationship between clients and employees is underpinned by emotional variables including empathy and compassion (Lamberton, Leana, & Williams, 2015). Pugh (2007) found workers in a remote context have difficulty establishing and maintaining professional boundaries with their clients, particularly where relationships may have a dual role, such as being a working professional and a member of the community. The role of relationships between HCWs and their clients needs to be explored further to determine if the worker-client relationship affects the HCWs and particularly how professional boundaries are maintained in a remote environment i.e., client home.

According to emotional contagion theory (Hatfield, Cacioppo, & Rapson, 1994) emotions between individuals are exchanged in an automatic, fast and fleeting process. Individuals susceptible to 'catching' emotions are those who pay close attention to others, are able to read others' emotional expressions and whose conscious emotional experience is powerfully influenced by peripheral feedback (Hatfield et al., 1994). Emotional contagion is characterised by genetics, gender, early experience, and personality characteristics (Doherty, 1997). In a sample of almost 700 employees from six organisations Petitta and Naughton (2015) demonstrated a high presence of both positive and negative emotions exchanged between workers and clients. Leaders were least associated with emotional contagion, which was attributed to good emotion management (Petitta & Naughton, 2015). The influence of catching both positive and negative emotions in a home care context needs to be explored as the exchange of emotions from clients to employees could influence employee wellbeing, particularly considering the high prevalence of poor mental health in older people (Alexopoulos, 2005).

While there are many negative emotions associated with the psychological impact of caregiving, there are several studies which promote positive outcomes, including compassion satisfaction (Hunsaker et al., 2015) and companionate love (Barsade & O'Neill, 2014). Compassion satisfaction is defined as a pleasure derived from being able to complete work and is opposite to compassion fatigue (Stamm, 2009). High levels of compassion satisfaction are attributed to high level of management support, while low levels of management support is a significant predictor of burnout (Hunsaker et al., 2015). Companionate love is defined as feelings of affection, compassion, caring, and tenderness for others at work (Barsade & O'Neill, 2014). In a longitudinal study with older adults in residential care, those older adults who perceived receiving companionate love, as part of personal and interpersonal care services provided by residential care workers, were found to have better outcomes, improved

mood, quality of life, satisfaction, and fewer trips to the emergency room (Barsade & O'Neill, 2014). Therefore, the culture of companionate love and improved management support may improve the outcomes for clients and aged care workers.

The current study examines the role of sensitivity to emotions in a home care setting and proposes a link between employee's felt emotions, psychological distress and compassion satisfaction in reducing burnout and increasing employee retention attitudes. The study partially examines emotional contagion theory, as proposed by Hatfield et al. (1994) in a home care setting, characterised with distal supervision and peer support. Factors associated with employee retention have received attention from management studies on job satisfaction, intention to quit and affective organisational commitment of employees. Employees who are satisfied with their role are less likely to resign and more likely to remain committed to the organisation (Duffy, Bott, Allan, Torrey, & Dik, 2012). We thus hypothesise being highly susceptible to catching negative emotions from others is a predictor of employee retention variables, in that employees who are highly susceptible of catching frustration are more likely to resign than those who are not highly susceptible to catching negative emotions.

Aims of the current study

Aged care providers tend to have a limited understanding of their workforce, employee motivation for retention and factors which contribute to burnout, job satisfaction, organisational commitment and intention to quit. The present study aims to improve understanding of factors associated with employee outcomes in a home care context. The study investigates the influence of emotional sensitivity, catching love, happiness and frustration, compassion satisfaction and psychological distress on burnout and employee

retention variables. To investigate the research questions, the following hypotheses are proposed:

H1: HCWs who are highly susceptible to catching frustration and experience high levels of psychological distress are prone to burnout

H2: HCWs who experience high levels of compassion satisfaction are not prone to burnout

H3: HCWs who are highly susceptible to catching frustration will experience low job satisfaction and low organisational commitment.

H4: HCWs who experience high levels of compassion satisfaction will have high level of organisational commitment

H5: HCWs who are highly susceptible to catching frustration have increased intention to quit.

Methods

Sample

Data was collected from a private organisation delivering home care services nationally in Australia. University ethics committee approval was received, organisational consent was obtained and invitations to participate were emailed to 1280 HCWs employees. Invitations linked to the online survey (Qualtrics) that was open for ten weeks. Weekly follow up emails were sent. Data was exported to SPSS Version 21.0 (IBM) for analysis.

Measures

Emotional Exhaustion. The seven item emotional exhaustion scale from Maslach Burnout Inventory (C. Maslach, Jackson, & Leiter, 1996) was used. The scale includes items such as "I feel emotionally drained from my work", "I feel frustrated by my job" and "Working with people directly puts too much stress on me". The scale ranged from (1) *never to* (7) *every day*, with higher scores indicating greater emotional exhaustion. The Alpha reliability for this scale was $\alpha = .88$.

Job Satisfaction. The six items job satisfaction scale by Schriesheim and Tsui (1980) was used to form an index whereby respondents indicate to what extent they agree with each statement on a six point scale, ranging from (1) *extremely dissatisfied* to (6) *satisfied* with higher scores indicating greater job satisfaction. The scale contains items such as "How satisfied are you with the nature of the work" and "How satisfied are you with your salary". The Alpha reliability for this scale was $\alpha = .83$.

Wellbeing-Emotional Contagion Nexus. The emotional contagion (EC) scale developed by Doherty (1997) was used which contains 15 items across five constructs (fear, sadness, love, anger and happiness) and is measured on a four point Likert scale indicating (1) *strong disagreement* to (4) *strong agreement* with higher scores demonstrating greater susceptibility to catching emotions from others. To test the structure of these constructs, inspection of the data and histograms confirmed the variables were normally distributed. The correlation matrix indicated evidence of latent factor, with several correlations above .4 and the significant Bartlett's test of sphericity and the Kaiser-Meyer Olkin statistic indicating the data was suitable for factor analysis. Factor analysis was performed to determine if more precise measurements can be elicited from the measure. All 15 items were factor analysed using maximum likelihood extraction and varimax rotation, supressing items coefficients smaller than .4. A three-factor solution explained 38% of the total variance. Each of the factors relates to specific aspect of emotional contagion, namely EC love, EC frustration and EC happy. Items which cross loaded were removed. Table 1 illustrates the three factors facets comparable to Doherty (1997). EC frustration construct contains four items, while the love and happy constructs contain three items, each. The three scales all demonstrated good reliability frustration ($\alpha = .72$), love ($\alpha = .85$) and happy ($\alpha = .73$). The full factor analysis is in Appendix Two.

Table 1
Factor analysis of emotional contagion items

	F1	F2	F3
I sense my body responding when the one I love touches me	.776		
I melt when the one I love holds me close	.762		
When I look into the eyes of the one I love, my mind is filled with thoughts of romance	.748		
I notice myself getting tense when I'm around people who are stressed out		.657	
I tense when overhearing an angry quarrel		.624	
It irritates me to be around angry people		.579	
I clench my jaws and my shoulders get tight when I see the angry faces on the news		.554	
Being with a happy persons picks me up when I'm feeling down			.658
When someone smiles warmly at me, I smile back and feel warm inside			.579
Being around happy people fills my mind with happy thoughts			.765

Compassion Satisfaction. The ten item compassion satisfaction scale was used, which forms part of Professional Quality of Life Scale (PROQOL) (Stamm, 2009). The items ask about experiences in the past 30 days: "I get satisfaction from being able to care for aged care clients", "I like my work as a carer", "I am proud of what I can do to help". Response choices are coded ranged from (1) *never to (5) very often* (5) with higher scores indicating greater compassion satisfaction. The Alpha reliability for this scale was $\alpha = .90$.

Psychological Distress. The General Wellbeing Index (GHQ) was used, which is a 12 item scale to measure psychological distress. The items ask about medical complaints and health in general, over the past few weeks. The first six items ask include items such as "Lost much sleep over worry?" "Been feeling unhappy and depressed" and "Been losing confidence in yourself" and are coded in a range from (0) not at all to (3) much more than usual with higher

scores indicating greater psychological distress. The remaining six items include items such as “Felt capable of making decisions about things?”, “Been able to face up to your problems” and “Been feeling reasonably happy, all things considered”. The responses are coded in reverse for the second half of the scale and therefore (1) *more so than usual* to (4) *much less*. We reversed the last six items and then averaged the responses to all 12 items to create the psychological distress index. The Alpha reliability for this scale was $\alpha = .84$.

Control Variables. Following the general standards of control variables set by prior research on emotions at work this study included a series of measures of individual-level attributes. Gender is coded 1 for men and 2 for women. Participants’ age and organisational tenure was recorded in years.

Plan for Analyses. Hierarchal multiple regression is used to test the hypotheses. Four models were tested - burnout, job satisfaction, organisational commitment and intention to quit. First, control variables were used age, gender and tenure. Second, main effect of emotional contagion variables (love, happy and frustration), compassion satisfaction and psychological distress were examined. Subsequent models tested for possible interaction effects between the main variables.

Results

A response rate of 22 % was achieved (n = 267) for useable responses which is in line with typical response rate in the health industry. Similar studies obtained a response rate of 29% in a hospital setting (Omdahl & O'Donnell, 1999), and 17% in residential setting (Radford et al., 2015). The modest response rate reflects difficulties in reaching HCWs, the remoteness of their role in client homes and access to a computer to complete the survey. Of the respondents, 247 (92.5%) were female, 19 (7.1%) were male and 1 (0.4%) did not disclose their gender. Mean age was 50 years with a range from 19 to 79. Our participants were older

workers, which is in line with other studies indicating that the average range of an aged care is close to retirement age (Radford, Shacklock, & Bradley, 2015).

Table 2 provides descriptive statistics and correlations for all variables. The five main predictors (compassion satisfaction, catching love, catching frustration, catching happiness and psychological distress) were correlated, in the expected directions, with all four dependent variables (burnout, job satisfaction, organisational commitment and intention to quit). The four dependant variables were moderately correlated. Burnout was negatively and significantly correlated with job satisfaction and organisational commitment. Burnout was positively and significantly correlated with intention to quit and catching frustration. Job satisfaction was positively correlated with organisational commitment and negatively correlated with the intention to quit. Organisational commitment was psychological distress, burnout and intention to quit.

A hierarchical multiple regression analysis was used to predict burnout, job satisfaction, organisational commitment and intention to quit. As recommended by Stevens (1996) the predictors were added to the regression equation in a hierarchical manner to enable the effects of the interactions between variables to be estimated separately from their main effects. Specifically, the predictors were entered in three steps: (1) control variables (age, gender and tenure), (2) emotional contagion variables (catching love, catching happiness and catching frustration), compassion satisfaction, psychological distress and (3) the three interaction terms, represented by catching frustration, compassion satisfaction and psychological distress. Catching love and catching happiness were removed from interaction analyses, as these variables did not demonstrate sufficient significance in the main effects across the four predictors. A significant change in R squared (R^2) in step 3 would indicate one or more of the predictors differentially influenced burnout and employee retention variables (job satisfaction, organisational commitment and intention to quit).

In Model 1, age, gender and tenure were entered into the regression in the first step as control variables. Together these variables were not a significant predictor of burnout, F (3, 238) = 2.41, p = .067, adjusted R^2 = .02. In the second step, catching love, catching happiness, catching frustration, compassion satisfaction and psychological distress were entered as predictors. The model adding each of the independent predictors was significant, F (8, 212) = 19.98, p = < .001, adjusted R^2 = .42. Finally, the interaction between the three variables was entered into the regression. Firstly, catching frustration and compassion satisfaction, then compassion satisfaction and psychological distress and finally catching frustration and psychological distress. When the interactions between each of the independent predictors were entered into the regression, they accounted for a significant change in variance, F (3, 201) = 16.67, p = < .05, R^2 = .47 (see Table 3). The full model including all predictors and independent variables was significant, F (11, 212) = 16.67, p <.001, adjusted R^2 = .37.

As expected in Hypothesis 1, it was predicted that HCWs who are highly susceptible to catching frustration and experience high levels of psychological distress are prone to burnout. Results indicate that catching frustration was positively correlated with burnout r = .21, n = 252, p =.001 and being psychologically distressed was positively correlated with burnout r = .60, n = 246, p <.001. Regression analysis confirms the positive relationship between HCWs who experience psychological distress and burnout (r = 1.18, p <. 001) but not between catching frustration and experiencing burnout (r = .18, p =. 07). The interaction between catching frustration and psychological distress was not a significant predictor of burnout (r = .58, p = .08), as predicted.

In Hypothesis 2 it was predicted that HCWs who experience high levels of compassion satisfaction are not prone to burnout. This was confirmed with a negative and significant correlation (r = -.46, n = 251, p <.001). Regression analysis confirms the negative

relationship between HCWs who experience high levels of compassion satisfaction and low levels of burnout (r = - .62, p < .001).

The remaining three models (Model 2, Model 3 and Model 4) examined the influence of catching frustration on job satisfaction, intention to quit and organisational commitment. In Hypothesis 3 it was predicted that HCWs who are highly susceptible to catching frustration will experience low job satisfaction and low organisational commitment. The hypothesis was tested in Model 2 and Model 3. In Model 2, age, gender and tenure were entered into the regression in the first step as control variables. Together these variables were not a significant predictor of job satisfaction, F (3, 246) = 1.58, p = .19, adjusted R^2 = .01. Catching love, catching happiness, catching frustration, compassion satisfaction and psychological distress were entered as predictors in the second step. The model adding each of the independent predictors was significant, F (8, 216) = 9.01, p = < .001, adjusted R^2 = .24. The interaction terms between catching frustration, compassion satisfaction and psychological distress were entered into the regression. When interactions between each of the independent predictors were entered into the regression, they accounted for a significant change in variance, F (3, 205) = 6.76, p = < .001, R^2 = .27 (see Table 3). The full model including all predictors and independent variables was significant, F (11, 216) = 6.76, p <.001, adjusted R^2 = .23. In Model 3, age, gender and tenure were entered into the regression in the first step as control variables. Together these variables were not a significant predictor of organisational commitment, F (3, 246) = 1.58, p = .19, adjusted R^2 = .01. Catching love, catching happiness, catching frustration, compassion satisfaction and psychological distress were entered as predictors in the second step. The model adding each of the independent predictors was significant, F (8, 211) = 9.43, p = < .001, adjusted R^2 = .24. Finally, the interaction between catching frustration, compassion satisfaction and psychological distress were entered into the regression. When the interactions between each of the independent predictors were entered

into the regression, they accounted for a significant change in variance, F (3, 200) = 8.27, p = < .001, R^2 = .28 (see Table 3). The full model including all predictors and independent variables was significant, F (11, 211) = 8.27, p <.001, adjusted R^2 = .266. In Hypothesis 3 it was predicted that HCWs who are highly susceptible to catching frustration will experience low job satisfaction and low organisational commitment. The results indicate that no significant relationship exist between these variables (job satisfaction r = -.19, p = .07, organisational commitment r = .19, p = .01). Similarly, in Hypothesis 4 it was predicted that HCWs who experience high levels of compassion satisfaction will have high level of organisational commitment. Results indicate that a significant relationship exists between compassion satisfaction and organisational commitment r = .45, p <. 001.

In Model 4 we tested Hypothesis 5 - HCWs who are highly susceptible to catching frustration have increased intention to quit. In Model 4 we entered age, gender and tenure into the regression in the first step as control variables. Together these variables were a significant predictor of intention to quit, F (3, 177) = 2.88, p = <.05, adjusted R^2 = .03. Catching love, catching happiness, catching frustration, compassion satisfaction and psychological distress were entered as predictors in the second step. The model adding each of the independent predictors was significant, F (8, 157) = 5.92, p = < .001, adjusted R^2 = .20. However, there was no significant relationship between catching frustration and intention to quit (r = .22, p = .15). Finally, the interaction between catching frustration, compassion satisfaction and psychological distress were entered into the regression. When the interactions between each of the independent predictors were entered into the regression, they accounted for a significant change in variance, F (3, 146) = 4.31, p = < .001, R^2 = .24 (see Table 3). The full model including all predictors and independent variables was significant, F (11, 157) = 4.31, p < .001, adjusted R^2 = .24. The above results demonstrate catching frustration was not a significant predictor of job satisfaction, organisational commitment or intention to quit.

Table 2
Scale means, standard deviations, reliabilities and inter-correlations.

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
1 Age	0.65	11.24	-											
2 Gender	.93	0.26	-.18**	-										
3 Tenure	.30	3.25	.33**	-.22**	-									
4 Burnout	.00	0.97	-.18**	.04	-.04	(.88)								
5 Job Sat	.53	0.90	-.08	.09	-.10	-.44**	(.83)							
6 Org Cmm	.97	0.97	-.05	.01	-.07	-.42**	.64**	(.83)						
7 Intention to Quit	.41	0.65	-.15*	-.06	.08	.39**	-.58**	-.56**	(.91)					
8 Cmpssn Stsfctn	.50	.48	.13*	.01	-.09	-.46**	.42**	.46**	.42**	(.90)				
9 Ctchng Frustrtn	.75	.55	.12	-.03	-.03	.21**	-.15*	.09	-.15*	.07	(.73)			
10 Ctchng Lv	.21	.69	-.01	.04	-.17**	-.03	.07	.21**	.07	.25**	.35**	(.85)		
11 Ctchng Hppnss	.66	.41	.15*	.02	-.04	-.19**	.22**	.24**	.22*	.41**	.23**	.36**	(.73)	
12 Psychlgcl Dstrss	.71	.36	-.13*	.04	.08	.60**	-.43**	-.38**	-.43	-.49**	.16*	-.07	-.33*	(.84)

Notes: *p<0.05; **p<0.01, Cmpssn Stsfctn (compassion satisfaction), Ctchng Frustrtn (Catching Frustration), Ctchng Lv (Catching Love), Ctchng Hppnss (Catching Happiness), Psychlgcl Dstrss (Psychological Distress), Org Cmm (Organisational Commitment)

Table 3

Summary of multiple linear regression analyses predicting burnout, job satisfaction, organisational commitment and intention to quit in home care workers (n=267)

	Burnout			Job Satisfaction			Organisational Commitment			Intention to Quit		
	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3
Controls												
Age	-.01*	-.01**	-.00	-.00	-.00	-.00	-.00	-.01*	-.01*	-.01*	-.00	-.01
Gender	-.10	-.21	-.19	.24	.49*	.45*	-.03	-.00	-.04	-.31	-.12	-.12
Tenure	.01	-.01	-.02	-.02	.00	.00	-.02	.01	.01	.04	.02	.02
Main effect												
Catching Love		.09	.10		.00*	.00		.02	.02		.22	-.17
Catching Happiness		.23	.19		-.03	-.00		-.05	-.03		-.07	.04
Catching Frustration		.18	2.68*		-.19	-.79		.19*	-.49		.29	.47
Compassion Satisfaction		-.62***	1.82**		.58***	1.02		.45***	1.48**		-.62***	-1.16
Psychological Distress		1.18***	6.64***		-.62***	1.75		-.37**	2.97*		.50*	-1.8
Interaction terms												
EC Frstrtn x CmpssnSt			-.35			.15			.12			.02
CmpssnSt x Psyc Distress			-.88**			-.48			-.78**			.28
EC Frstrtn x Psyc Distress			-.58			-.07			.03			.35
F	2.41	19.98	16.67	1.58	9.01	6.76	.78	9.43	8.26	2.88	5.92	4.31
Change R^2	.03	.39	.03	.02	.24	.00	.01	.27	.04	.04	.20	.25
Total $R^2change$	.03	.43	.47	.02	.26	.26	.01	.27	.31	.04	.24	.00

Notes: *p<.05*; **p<.01; ***p<.001, EC Love (Emotional Contagion Love), EC Happy (Emotional Contagion Happy), EC Frustration (Emotional Contagion Frustration), CmpssnSt (Compassion Satisfaction), Psyc Distress (Psychological Distress)

Discussion

The primary aim of the current study was to examine the role of emotional sensitivity in predicting burnout and retention variables in HCWs. Specifically, the study examined the influence of three types of felt emotions, namely catching love, frustration and happiness in HCWs. The influence of emotional sensitivity was measured with four regression models burnout, job satisfaction, organisational commitment and intention to quit. While some results supported study hypotheses and in particular the influence of catching frustration, the overall results did not reveal a causal model between emotional sensitivity, burnout and other employee retention variables.

Our results are generally in line with previous studies of exploring emotions in a health setting (Omdahl & O'Donnell, 1999) indicating that sharing positive emotions had a positive effects on employees (Barsade & O'Neill, 2014) and sharing negative emotions had a negative effect on employees (Doherty, 1997). While there are no previous studies that specifically address different facets of emotional contagion in an aged care setting, some studies contribute to understanding the results. For example, Iacovides et al. (2003), found a relationship between burnout and experiencing negative emotions in nurses and Omdahl and O'Donnell (1999) found positive effects of sharing positive emotions. Our results revealed that in relation to emotional contagion variables, only catching frustration was significant and the other two emotional contagion variables, catching love and catching happiness, were not significant. This can be explained as catching love and catching happiness are positive emotions and catching frustration was a construct developed through factor analysis which included the original items from sadness and anger subscales (Doherty, 1997). Past research in emotional contagion has generally examined the influence of catching emotions and relationships between employees and their managers, not the influence of sharing negative emotions between employees and clients.

In examining the relationship between different types of emotional contagion, the results indicate HCWs catch both positive and negative emotions. While HCWs are more prone to catching happiness and love, with higher average scores reported across the two positive constructs than in catching frustration, caution needs to be given to the effects of catching frustration and the implications this may have for HCWs when attending to clients who may be frustrated with their health status and the overall quality of life. Regression revealed catching positive emotions, namely love and happiness is not associated with burnout, job satisfaction, organisational commitment and intention to quit. Catching frustration is associated with burnout. This pattern of results suggested catching negative emotions may have implications for employers. That is, although the source of negative emotions can vary, due to a number of factors in a client's life such as finance, lack of family support, death of a loved one, new environment, being from a non-English speaking background (Muramatsu, Yin, & Hedeker, 2010) of particular concern is the high prevalence of undetected and undiagnosed mental health illness in older people which can be improved with appropriate treatment (T. E. Davison et al., 2009; Eyers et al., 2012). Not addressing the mental health needs of clients affects HCWs and affect the quality of service delivery.

Attention might turn to how to limit the effect of emotional contagion in catching negative emotions. The role of mindfulness in a workplace is a new yet important concept which until recently has attracted limited attention in the field of management (Erik Dane, 2010). Mindfulness is described as a psychological state in which an individual focuses on the present moment in time, rather than focusing on the past or future (Atkins & Parker, 2012). Erik. Dane and Brummel (2014) found in a dynamic service industry context mindfulness to be positively related to job performance and negatively related to turnover intention. These results may be useful and could be explored further in the context of paid care (Folbre, 2012), including home care context where HCWs are required to be

psychologically present at work and emotionally engage with their clients. Implementing mindfulness exercise before work may assist HCWs in predicting both distress and well-being in their clients and improve self-efficacy (Soysa & Wilcomb, 2015) in detecting emotional changes in clients. Overall, equipping HCWs with mindfulness skills may reduce the effect of emotional contagion, improve HCW interaction with clients and may improve HCW retention rates and contribute towards saving expenditure for the elderly and disabled (Tilden et al., 2012).

The limitation of the current study is that the data was cross-sectional quantitative and collated from one organisation. Future research is required in examining the role of emotional contagion in a home care setting by collecting data from clients. This will allow the bi-directional influence of emotional contagion to be examined. Further, future research may explore training HCWs in implementing mindfulness strategies for themselves, which in other studies was found to improve aged care worker knowledge on mental health (T. Davison, McCabe, Knight, & Mellor, 2012) and re-assess catching emotional contagion variables, particularly EC frustration in the home care context. Attention might turn to how to limit the effect of emotional contagion in catching negative emotions. The role of mindfulness in a workplace is a new yet important concept which until recently has attracted limited attention in the field of management (Erik Dane, 2010). Mindfulness is described as a psychological state in which an individual focuses on the present moment in time, rather than focusing on the past or future (Atkins & Parker, 2012). Erik. Dane and Brummel (2014) found in a dynamic service industry context mindfulness to be positively related to job performance and negatively related to turnover intention. These results may be useful and could be explored further in the context of paid care (Folbre, 2012), including home care context where HCWs are required to be psychologically present at work and emotionally engage with their clients. Implementing mindfulness exercise before work may assist HCWs

in predicting both distress and well-being in their clients and improve self-efficacy (Soysa & Wilcomb, 2015) in detecting emotional changes in clients. Overall, equipping HCWs with mindfulness skills may reduce the effect of emotional contagion, improve HCW interaction with clients and may improve HCW retention rates and contribute towards saving expenditure for the elderly and disabled (Tilden et al., 2012).

Conclusion

The aged care sector is characterised with high rates of turnover and low job satisfaction rates which make growing demand for services difficult to meet for ageing population. Home care services have been the answer for reducing government expenditure on residential care costs and have assisted in reducing the need for permanent nursing home accommodation, which has been welcomed by older clients. There are few previous studies on the effect of emotional contagion, and most of those that have been carried out have been examining the influence of employee and manager relationship, not sharing emotions between employees and clients in a health setting. The results make a significant contribution as they expand on previous research on emotional contagion (Doherty, 1997; Hatfield et al., 1994).

Although the literature provides theoretical arguments and quantitative evidence that employers can control emotions of their employees, studies have not conducted research in a home care setting. This study reports that as HCWs are under distal supervision they are exposed to greater environmental risks working in client homes. The findings thus suggest one mechanism through which emotional contagion may be minimised is with improved detection of health risks in older adults. This study contributes to research on home care policies by drawing attention to the organisational context in which employees perform their duties in client homes. Results indicate aspects of organisation of work and workplace environment make a significant importance to the wellbeing of workers and the impact that catching negative emotions has on the wellbeing of the workers. It is therefore important that

policies are improved in screening clients in their homes and minimising environmental risks prior to service delivery. HCWs workers may benefit from improved communication and support due to the isolating nature of their work and limited support and direct supervision from head office.

Finally, we note the role of psychological distress in HCWs and its influence on burnout, organisational commitment and intention to quit. It is important for home care providers to recognise the influence of negative emotions of HCWs on clients and how they may affect clients in a remote setting. Incorporating improved system for screening emotional needs of both clients and workers may minimise catching negative emotions. Training HCWs in mindfulness strategies may further enhance their own wellbeing, self-efficacy and improve interaction with clients.

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Conclusion to Study Three:

Study Three expands our understanding of emotions at workplace. Each of the first three studies recognises the importance of screening environmental risks for HCWs and the influence of emotional contagion. Findings from Study Two and Study Three indicate that differences exist in perception and the outcome of catching positive and negative emotions. Findings from Study Three suggest that catching positive emotions has positive effects on HCWs, but catching negative emotions has negative effects on HCWs and can lead to burnout. The first three studies examined the role of emotions in home care context and found a link between mood and psychological wellbeing. Study Four expands on those findings by suggesting a link between mental health status and self-efficacy specific to working in aged care. Further, Study Four suggests a relationship between aged care self-efficacy and trust in supervisor. Study Four examines self-efficacy in HCWs by evaluating the extent to which HCWs feel confident in decision making in relation to client needs and HCW's own perception of skills and knowledge in completing the required duties.

Introduction to Study Four:

The fourth paper in this thesis is a mixed-method study to establish the self-efficacy in home care workers and design a measure specific to working in aged care. Study Four includes interviews with HCWs, survey with residential care workers and a subsequent validity study with HCWs. Study Four provides the empirical testing of the relationships between aged care self-efficacy (ACSE), trust in supervisor and the role of training. Furthermore, the significance of different types of self-efficacy and their influence on trust in supervisor and training is examined in a setting with complex reporting systems and management hierarchy.

Chapter 5

Self-efficacy in aged care workers – designing a measure

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Ms. Julie Bajic Smith was responsible for the design of this study, collection and entry of data, analysis and write-up of this paper. Associate Professor Denise Jepsen collected the data for residential care workers and provided research supervision through all stages of the research.

Abstract

Purpose: The aged care sector is under enormous pressure to meet high demand for services and resolve the workforce supply challenge. Aged care workers face unique challenges and have complex reporting lines which may affect their self-efficacy, perception of the skills and ability to manage the workload and wellbeing. Self-efficacy in aged care is important as it determines worker's own perception of skills and capabilities to undertake the required tasks.

Design and Method: Based on literature review and 24 semi-structured interviews, a new dimension of self-efficacy specific to aged care was identified. To test the scale in the aged care context, aged care self-efficacy (ACSE) was administered to 332 residential care workers. In a concurrent validity study ACSE was administered to 269 home care workers (HCWs). ACSE was measured against generalised self-efficacy (GSE), extra-role behaviour and psychological distress.

Results: After performing exploratory factor analyses we conducted confirmatory factor analysis, a five-item ACSE convergent measure was developed predicting self-efficacy in an aged care setting. The concurrent validity study demonstrates acceptable levels of validity, reliability and no social desirability bias. Results from the validity study indicate trust in supervisor is a significant predictor of GSE and ACSE but not of extra-role behaviour and psychological distress. Further, aged care training was found to be a significant predictor of GSE but not ACSE.

Implications: This study provides a short self-report measure that can be used to explore relationship between ACSE and employee retention variables and to determine how employees feel as a group, for training purpose and peer support.

Keywords
Aged care, employee support, measures, organisational distance, self-efficacy, training

Introduction

Self-efficacy, a central component of Bandura's (1997) social cognitive theory, is defined as an individual's belief about one's own capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1997). Evidence from management studies, work psychology and educational sciences point to self-efficacy improving the understanding of employee engagement and willingness to learn (Gartmeier, Bauer, Gruber, & Heid, 2010), reducing perceived job stress (Sur & Ng, 2014) and perceived productivity, as well as improving job satisfaction and ability to cope (Staples, Hulland, & Higgins, 1999). These studies have focused mainly on generalised self-efficacy across various work settings. So far, little evidence exists on different types or components of self-efficacy in particular in paid care setting, such as the aged care sector. The purpose of this paper is to design a measure of self-efficacy in aged care workers.

The aged care sector is growing due to ageing population, increased life expectancy and longevity (World Health Organisation [WHO], 2015). However, the demand is hindered with workforce challenges facing the sector, including difficulties sourcing and retaining adequately trained workers, and the high number of workers reaching the retirement age (Radford, Shacklock, & Bradley, 2015). Aged care is the most common type of paid care work. Apart from meeting the physical and emotional needs of care recipient, aged care workers engage in interpersonal interactions to enhance the intellectual capabilities of care recipients (Folbre, 2012; Lamberton, Leana, & Williams, 2015). Duties are performed in a residential setting (known as residential care) or in an older person's home (known as home care), depending on the older person's level of health, finance and geographical location. Across both settings, and particularly home care given the isolating nature of the context, little is understood about employee engagement, intention to stay and the influence of training in carrying out work duties.

The central assumption of self- efficacy is its origin, which according to Bandura (1997) stems from past performance, vicarious experience, verbal persuasion and emotional cues. Pursuing a similar idea, Lunenburg (2011) says the most important source of self-efficacy is past performance, as employees who have succeeded on job-related tasks are likely to have more confidence to complete similar tasks in the future (high self-efficacy) than employees who have been unsuccessful (low self-efficacy). According to Lunenburg (2011), there are three dimensions of self-efficacy including magnitude, strength and the degree to which the expectation is generalised across situations. Individuals with high levels of self-efficacy have been found to have higher motivation to perform well in training (Huang & Jao, 2016) and transfer newly learned skills to their workplace (Chiaburu & Lindsay, 2008) as well as set more challenging goals for themselves than individuals with low self-efficacy (Bandura, 1997). In workplaces, managers can boost self-efficacy through careful hiring, supportive leadership, and rewards for improvement (Lunenburg, 2011).

Self-efficacy is a multidimensional construct involving perceptions of one's self and abilities (Chiaburu & Lindsay, 2008; Gist & Mitchell, 1992; Judge & Bono, 2001; Staples et al., 1999). Self-efficacy is based on the principal assumption that psychological procedures serve as means of creating and strengthening expectations of personal efficacy. Bandura (1997) argues that efficacy expectations are distinguished from response-outcome expectations as they are guided by the individual's behaviour. One of the most-used measures for self-efficacy is generalised self-efficacy (GSE) scale which was developed by Schwarzer (1995), who proposed that self-efficacy can be regarded as a positive resistance resource factor which facilitates goal-setting, effort investment, persistence in the face of barriers and recovery from setbacks. Recent studies challenge Schwarzer's (1995) concept and suggest self-efficacy overlaps with other constructs. For example, Zhou and Kam (2016) demonstrated that hope and self-efficacy are two measures of the same unidimensional

construct. Totawar and Nambudiri (2014) demonstrate self-efficacy is related to one's mood and propose a four-quadrant framework identifying the role of hedonic and utilitarian motivation as moderators of mood and GSE relationship. These studies highlight an important aspect of GSE, which is that of self-perception and the influence of an individual's mood on their self-efficacy.

The role of an individual's mood in relation to their perceived self-efficacy has been of fundamental interest for management researchers (Sur & Ng, 2014), although the causality of this relationship has not been agreed (Totawar & Nambudiri, 2014). Individuals who are depressed are known to become self-critical, have negative opinion about themselves (Beck, 1976) and lack accurate perception of their abilities (Judge & Bono, 2001). A meta-analysis by Faragher, Cass, and Cooper (2005) concluded that individual's psychological barriers not only affected their perception of self-efficacy but were also found to be associated with low levels of job satisfaction and led to burnout. The interactions between psychological outcomes and job satisfaction suggest job satisfaction is an important factor influencing the health of workers. An increase in an individual's mood, wellbeing and increased perception of abilities are all adaptive functions of positive emotions which may prevent prolonged negative affect occurring. Thus stress management policies and training may serve as emotional buffers against the effect of negative daily experiences, over time enhancing employee's emotional and physical wellbeing and minimising the risk of burnout. This study will examine the influence of mood by examining mental health status of aged care workers and its relationship to worker self-efficacy, as employee's wellbeing may influence the level of self-efficacy to conduct their duties.

The influence of poor mental health in clients on the aged care workforce has not been studied and may provide better understanding of how workers overcome the on-the-job challenges of supporting the elderly who may have undetected mental illness. Numerous

studies have demonstrated that older adults are prone to depression (Alexopoulos, 2005; Baldwin & Wild, 2004) particularly if their physical health is compromised (Beekman, Copeland, & Prince, 1999; Beyondblue, 2009) and they have limited support network (Kvelde et al., 2013). Mental illness in older people is often undetected by health professionals due to comorbidities associated with declining physical health (Eyers, Parker, & Brodaty, 2012). Training aged care workers to detect emotional changes in older people is not mandatory but when delivered is effective by increasing employee knowledge on mental illness and increased escalation of concerns to medical professionals (McCabe, Russo, Mellor, Davison, & George, 2008; Mellor, Davison, McCabe, & George, 2008).

Emotional contagion theory suggests that positive and negative emotions are exchanged between individuals through an automatic and fast fleeting process (Hatfield, Cacioppo, & Rapson, 1994). In an aged care setting, employees may be exposed to and therefore automatically catch negative emotions from their elderly and frail clients who are experiencing poor health. Aged care workers may not recognise that the symptoms experienced by the older person may be symptoms of a mental health condition and require a medical intervention. The consequence of repeated exposure to negative stimuli, lack of escalation of concerns about client welfare, limited knowledge about mental illness as well as poor practices in handling workplace errors (Gartmeier et al., 2010) may affect the workers and their perceived self-efficacy in completing duties.

Findings on employee attitudes in the aged care sector are mixed. Most research has been conducted in a residential care setting, where employees have consistent reporting lines and face-to-face contact with peers and supervisors (Community Services and Health Industry Skills Council [CSHISC], 2014). Roberts, Nolet, and Bowers (2013) conducted a meta-analysis of 20 studies on consistent assignment i.e., being allocated to support the same clients on each shift, and found significant discrepancies in how consistent assignment was

defined, measured and linked to outcomes. It is unclear whether this discrepancy is a result of the research design, distance in organisations or barriers in conducting research in aged care settings.

A wider issue for research in the home care sector is gaining access to the workforce, measuring employee attitudes and assessing workplace relations. Accessing workers who are geographically isolated and under distal supervision arrangements, particularly in a home care setting, is particularly difficult as these workers travel to different locations and deliver the services in clients' homes during the course of their shifts (Broadbent, 2014). In diverse organisational settings and in virtual organisations, geographical isolation was found to play a critical role in influencing remote work effectiveness, perceived productivity, job satisfaction, and ability to cope (Staples et al., 1999). Other types of distance in organisations including organisational, structural and functional distances (Napier & Ferris, 1993) may affect attitudes of aged care workers, however little research exists despite the fact that role theory is underpinned by our understanding of workplace dynamics (Graen, 1976). Research is required to better understand the role of geographical and organisational distance in determining self-efficacy in aged care workers and in particular in those under distal supervision arrangements.

One of the key strategies suggested to improve self-efficacy of employees is with training (Staples et al., 1999). Training participants' cognitions, including training self-efficacy and training instrumentality, can be powerful and impact motivation to learn and transfer knowledge (Chiaburu & Lindsay, 2008). Similarly, on-the-job training has been found to be effective, such as in the case of recognising mental health needs of older clients (McCabe et al., 2008). However, training programs are effective only if the knowledge taught and practice during instructions is transferred to the workplace with established and well maintained policies and practices to facilitate newly taught skills (Chiaburu & Lindsay,

2008). Research is required to understand the role of training in aged care and determining self-efficacy of the workforce.

There is a growing literature on aged care which is predominantly focused on team dynamics, job satisfaction and intention to quit which are largely measured in a residential setting. Researchers have not yet explored the role of self-efficacy in aged care workers. The specific aspects of working in an aged care setting and measuring worker self-efficacy need to be explored, particularly considering that aged care workers are employed in two distinct environments. Residential and home care settings are characterised with complex supervision arrangements, commonly grouped into clinical support and administration. It is important to assess the role of supervision in examining self-efficacy in this population.

One of the most widely used self-efficacy measures in management studies is Schwarzer's (1995) generalised self-efficacy scale (GSE). For example, Judge and Bono (2001) measured the relationship between self-esteem, GSE, locus of control and emotional stability and found these traits are among the best dispositional predictors of job satisfaction and job performance. GSE was found to be useful in assessing self-efficacy, however it does not specifically relate to the aged care setting. Thus, despite the insights gained from studies on self-efficacy, a measure to address the specific challenges faced in the aged care sector is needed.

Purpose of the Research

The aged care sector is under pressure to meet high demand for services and resolve the workforce supply challenges (King, Svensson, & Wei, 2016). Aged care workers face unique on-the-job challenges and have complex reporting lines (Kaine, 2012). Measuring work performance in an aged care setting often relies on assessing the quality of service provided in the prescribed duties as well as those outside of the role. Completing duties outside of

prescribed duties has been studied extensively in organisational behaviour literature and while it is not formally specified in the job description or formally rewarded it encompasses performing services for clients that are beyond "the checklist" (Lamberton et al., 2015).

The purpose of this research is to develop an aged care self-efficacy (ACSE) measure, which is distinct from generalised self-efficacy (GSE) and is valid, reliable, and easy to administer across large samples. The characteristics of ACSE address the specific environmental setting relevant to the aged care sector including making independent assessment of client needs, reflecting on the training and support received and the overall self-efficacy as an aged care worker. The participants in this study were aged care workers, including home care workers (HCWs) who deliver personal care and social support to elderly clients or those with disabilities who live in their own homes. In Study 1, based on 24 interviews, challenges faced by HCWs were identified which assisted in the initial development of scale items. In Study 2 survey items were created, analysed and tested in residential care workers (RCWs). In Study 3 the scale was refined and validated in HCW population. In Table 1, a summary of the research studies is outlined.

Table 1
Summary of Research Studies

	Purpose of research	Method	Sample
Study 1	Development of initial scale items	Qualitative: Semi-structured interviews, off worksite	24 home care workers
Study 2	Quantitative analysis of initial set of scale items developed through literature research and qualitative study	Quantitative: online survey	332 residential care workers
Study 3	Scale refinement and validation	Quantitative: online survey	269 home care workers

Methods

Study One: Initial Item Development

The purpose of this study was to develop and refine items for the Aged Care Self-Efficacy scale (ACSE). The sample was home care workers (HCWs) who deliver personal care and social support to elderly clients or those with disabilities living in their own homes. According to the Australian Skills Quality Authority (2013), Certificate III in Home and Community Care is a compulsory competency-based course completed in six months. Training includes a classroom theory component and/or blended online modules and practical work experience (120 hours). The program covers seven compulsory topics including individualised support, recognising healthy body systems and safe work practices. Optional units include dementia and palliative care (National College Australia, 2016).

Twenty four HCWs from one Australian organisation participated in the interviews after they received an email invitation from an internal human resource representative. Participants' mean age was 52 years. HCWs characteristics are presented in Table 2 and demographic profile in Table 3. Eighteen HCWs participated in face to face interviews and six in telephone interviews. HCWs signed individual consent forms and were reimbursed with an AU$25 gift voucher for approximately one hour of their time. Other results from the wider study have been reported elsewhere (Bajic Smith & Jepsen, 2016).

Table 2
Characteristics of HCWs (n = 24)

		Count	%
Gender	Male	2	8.3
	Female	22	91.6
Employment status	Full-time (permanent)	1	4.1
	Part-time (permanent)	10	41.6
	Casual	13	54.2
Education	Junior high school	7	29.2
	High school	9	37.5
	Some college	7	29.2
	University – Undergraduate	0	
	University – Postgraduate	1	4.1
Company tenure	Less than 1 year	1	4.1
	1-2 years	11	45.85
	3-5 years	9	37.5
	6-10 years	3	12.5

Table 3
Demographic profile of HCWs

Interview	Age (yrs)	Tenure (yrs)	Region	Highest level of education
1	55	5	Metropolitan 1	Trade
2	38	5	Metropolitan 1	Senior high
3	47	3	Metropolitan 1	Senior high
4	56	4	Metropolitan 1	Senior high
5	21	1	Metropolitan 1	Senior high
6	35	2	Metropolitan 1	Junior high
7	57	9	Rural	Junior high
8	72	7	Rural	Junior high
9	54	3	Rural	Junior high
10	62	3	Rural	Senior high
11	64	9	Rural	Bachelor Degree
12	56	5	Rural	Junior high
13	54	2	West Coast	Senior high
14	63	1	West Coast	Junior high
15	65	2	Metropolitan 2	Senior high
16	50	2	Metropolitan 2	Senior High
17	47	1	Metropolitan 2	Junior high
18	61	1	Metropolitan 2	Junior high
19	60	1	Metropolitan 2	Trade
20	63	3	Metropolitan 2	Junior high
21	48	2	West Coast	Postgraduate
22	48	4	West Coast	Junior High
23	42	1	West Coast	Senior high
24	34	1	West Coast	Senior high

The interviews followed a semi-structured interview plan with open questions. Discussion was oriented toward self-efficacy in conducting on-the-job decision making, confidence and the frequency in escalation of concerns to office managers and confidence in detecting emotional changes in clients and implementing strategies to reassure emotionally distressed clients. For example, participants reported various level of confidence in contacting office managers about issues in client homes, emotionally supporting clients and detecting when a client required additional service hours. Some HCWs reported that they spent additional time with clients in order to complete all the set tasks and that they were responsible for not being able to work faster. Interviews were recorded and transcribed verbatim by the researcher. Data was imported into NVivo10 (NVivo, 2002) to assist with qualitative data analysis (Saldana, 2009). Analyses began with open coding, categorizing chunks of data, followed by a refinement process based on deeper interpretation of meaning (Bazeley, 2013).

Results

A number of topics emerged during the interviews which were groups according to themes. A theme was defined after 20 codes were detected on the same topic. The codes were prioritised in the number of references made by the participants during the interviews, as patterns were forming around re-emerging themes. To ensure internal validity, the data was given a unique code representing each of the key themes from the interviews (Gibbert & Ruigrok, 2010). The interviews revealed ten key themes relating to self-efficacy theory from which six were selected as the highest codes and patterns, as outlined in Table 4. Interviews with HCWs confirmed the common themes of isolation and distal supervision in home care setting found in literature review e.g., Broadbent (2014), with HCWs reporting they worked remotely with no face-to-face contact with peers or supervisors. We will now report the findings from each of the themes.

Table 4
Coding Topics

Code	Topic
Code 1	Overcoming client difficulties
Code 2	Detecting when a client required additional service hours
Code 3	Escalation of client difficulties to management
Code 4	Reassuring emotionally distressed clients
Code 5	Declining shifts with clients who have greater support needs than HCW training
Code 6	Acknowledging training as a contributor to being an excellent HCW

Code 1. HCWs confirmed a number of their clients presented with difficulties with finance, grief and loss, reduced mobility, symptoms of pain and mental health illness. HCWs described how they made decisions about client welfare during the course of their shift, including determining if a client concern could be resolved or if it required input from the supervisor. Escalation of client concerns to management was reportedly conducted at the conclusion of the shift with a phone call to the office or feedback form submitted electronically. HCWs reported receiving inconsistent support from management in resolving on-the-job client issues, with some stating they did not receive any support and others indicating the issue was quickly resolved. HCWs reported varied willingness and readiness to engage management in problem-solving issues, with some HCWs reporting little contact with office management.

Code 2. Most HCWs reported they perceived their clients requiring more hours than were allocated during their assessment and that it was easy for them to recognise when a client required additional support hours. Several HCWs reported spending additional time with their clients to complete the set tasks and taking on the responsibility for overtime, not reporting it to the office or their peers. HCWs attributed overtime to ensuring they completed their task

correctly and in line with the needs of the client, by focusing on the delivery of person-centred care (Kitwood, 1997) which encourages workers to work together with clients in achieving goals as opposed to completing the tasks on behalf of the older person. HCWs reported rarely notifying managers if they spent more time with a client, and staying beyond their rostered hours.

Code 3. HCWs reported frequently encountering on-the-job concerns and how they decided if the issues should be escalated to office managers. HCWs reported calling the office or emailing office managers to raise concerns:

> *"Being in client homes is a challenge but it is also about empowerment away from the office. It's just you and the client. So you've got the responsibility of looking after the client, providing duty of care and then you've also got the need to rely upon good communication from the office" Participant #19.*

Code 4. HCWs reported that a number of their clients become emotionally distressed during shifts. HCWs used terms such as "lonely", "sad" and "abandoned" when describing the circumstances of their clients and their emotional wellbeing status saying their personal knowledge and experience improved their ability to detect emotional changes in clients:

> *"If they seemed to me to be very distressed or anxious, my first thing would be try and engage them in conversation and see if you can find the problem"* Participant #18.

Code 5. Several HCWs reported being allocated to support clients who had greater behavioural or physical support needs than their training. In particular, HCWs reported supporting non ambulant clients and difficulties using a hoist, which some HCWs reported was beyond their level of training. HCWs stated that at times they asked office managers to not be sent back to the client while other HCWs stated that they continued to service the client, particularly if they worked with another HCW.

> *"There was a client who was a prime candidate for a residential care facility as she couldn't mobilise, vocalise and weighed 160 kg. It was very difficult as a HCW to service that client. Eventually the service was withdrawn as it wasn't viable. She was just too high care for what we are able to do in the time given." Participant #22.*

Code 6. HCWs reported their initial training assisted them in building confidence in the workplace. Further, most HCWs referred to "life experience" when describing additional set of skills that improved their on-the-job confidence and enjoying the social aspect of monthly meetings:

> *"We have monthly meetings but I play around and read things on the internet. I read up on the client before I go in so I'm more aware of it. So this is where I get to the point where I go 'Shut up, you sound like a know it all' ". Participant #12.*

The interviews conducted in Study One assisted in development of an aged care self-efficacy (ACSE) scale. To ensure rigorous criteria, each of the six themes emerging from the interviews were converted into one unique question. The six questions are in Table 5. To review the reliability of the ACSE, we conducted the subsequent quantitative studies.

Table 5
Preliminary Aged Care Self Efficacy (ACSE) Items

1. My training has taught me how to handle the problems my aged clients face
2. It is easy for me to detect when a client requires more service hours
3. When a client faces difficulties, I am confident in escalating them to management
4. I feel confident in reassuring emotionally distressed clients
5. I decline shifts with clients who have greater support needs than my skills and training
6. Thanks to my training, I am an excellent aged care worker

Study Two: Preliminary Item Analysis and Scale Validation

Method. An online survey (Qualtrics) was used to collect the data. Respondents were workers from a non-religious charitable institution that manages around 20 eldercare homes and employs 1229 workers. Respondents were predominantly employed in the direct care parts of the business with smaller representation from other parts of the business including catering, building and administration. Ethics approval was received from the university and surveys were distributed online to employees. Participation was voluntary and conducted in work hours. Paper survey packages were distributed to employees in each residential village and handed to each employee by their manager. An incentive of $3 was paid to a nominated

charity for each response. Completed surveys were returned direct to the researchers in a pre-paid envelope. In total 372 responses were received. Data was exported to SPSS Version 21.0 for analysis. The six aged care self-efficacy (ACSE) items and GSE items were included as part of a wider study on aged care employee attitudes

Analysis and Results

Cronbach's alpha reliability of the ACSE scale indicated an acceptable level of reliability (α = .76) when one of the six items was removed *("I decline shifts with clients who have greater support needs than my skills and training")*. An exploratory factor analysis using five ACSE and three GSE items with principal axis approach and a varimax rotation resulted in two distinct factors. Five ACSE items were identified as Factor 1, including item 5 which had a low loading, and three items that should be retained for GSE as Factor 2. All the items are presented in Table 6 and full factor analysis is in Appendix Three.

Table 6
Loadings in KMO Extractor Rotation on self-efficacy items

	Factor 1 ACSE	Factor 2 GSE
My training has taught me how to handle the problems my aged clients face	.579	
It is easy for me to detect when a client requires more service hours	.804	
When a client faces difficulties, I am confident in escalating them to management	.775	
I feel confident in reassuring emotionally distressed clients	.772	
Thanks to my training, I am an excellent aged care worker	.312	
When facing difficult tasks, I am certain that I will accomplish them		.769
In general, I think that I can obtain outcomes that are important to me		.823
I believe I can succeed at most any endeavour to which I set my mind		.837

Study Three: Concurrent validation study

Although individuals with low mood are found to experience low self-efficacy (Totawar & Nambudiri, 2014), it is unclear whether training and trust in supervisor play a role in self-

efficacy. This study investigates the influence of training and trust in supervisor in an aged care setting by measuring self-efficacy in an aged care setting using the aged care self-efficacy (ACSE) scale. The study aims to distinguish the role of generalised self-efficacy (GSE), aged care self-efficacy (ACSE) and wellbeing outcomes in HCWs.

To investigate the research questions, the following hypotheses were proposed:

Hypothesis 1. Aged care training is related to ACSE

Hypothesis 2. Trust in supervisor is related to ACSE.

Hypothesis 3. Aged care training and trust in supervisor are related to GSE

Hypothesis 4. Aged care training is a significant predictor of extra–role behaviour

Hypothesis 5. Trust in supervisor is a predictor of psychological wellbeing.

Method. Ethics approval was received from the university, organisational consent was obtained and email invitation to participate was sent to 1280 home care workers. The participating organisation is a private national home care provider which delivers services to 16,000 elderly people in Australia. Participants were invited to enter a draw to win one of nine AU$100 gift cards (one gift card per geographical region) at completion of the survey. In total 292 HCWs responded and 269 valid responses were used after 23 respondents were removed due to missing data. The data collected with Qualtrics was exported to SPSS Version 21.0 (IBM).

Measures

Control Variables. Following prior self-efficacy research, a number of individual-level attributes were controlled for. Participants' age and organisational tenure was coded in years. The self-confidence measure, assessing individual's perceived level of self-worth, was derived from Tafarodi and Swann (2001) by developing a unidimensional measure on self-competence and self-control.

Aged Care Training. Participants indicated their highest level of training specific to aged care with responses coded: *Certificate III in Home and Community Care* or *Certificate III in Aged Care*, *Certificate IV in Home and Community Care* or *Certificate IV in Aged Care*, *Diploma in Community Services Coordinator*, *university undergraduate* and *university postgraduate*.

Trust in Supervisor. The six item Cook and Wall (1980) trust in supervisor scale was used, forming an index that describes an overall trust in immediate supervisor. The responses include seven points, ranging from (1) *strongly disagree* to (7) *strongly agree* with higher scores indicating greater trust in supervisor. The scale consists of single statements including confidence that supervisor would treat fairly, not take advantage by deceiving workers and loyalty displayed towards the supervisor. The scale has a good reliability ($\alpha = .78$).

Generalised Self-Efficacy. The 10 item Schwarzer (1995) self-efficacy measure was used, which assesses the extent to which one believes in their own ability to achieve a goal or complete tasks. The item "If someone opposes me, I can find the means and ways to get what I want" was removed as it did not load at above .3. The responses include four points ranging from (1) not true at all to (4) completely true with higher scores indicating greater generalised self-efficacy. The scale consists of single statements including "It is easy for me to stick to my aims and accomplish my goals", "I am confident that I could deal efficiently with unexpected events" and "I can resolve most problems if I invest the necessary effort". The scale has excellent reliability ($\alpha = .92$)

Aged Care Self-Efficacy. The aged care self-efficacy (ACSE) items derived from semi-structured interviews, as described in Study One and Study Two. The scale includes six items ranging from (1) not true at all to (4) completely true. Five items are outlined in Table 7 which demonstrated factor loading of above .5. The scale has a good reliability ($\alpha = .82$).

Table 7

Factor Analysis of ACSE in Home Care Workers

Item	ACSE
My training has taught me how to handle the problems my aged clients face	.712
It is easy for me to detect when a client requires more service hours	.583
When a client faces difficulties, I am confident in escalating them to management	.633
I feel confident in reassuring emotionally distressed clients	.620
Thanks to my training, I am an excellent aged care worker	.564

Extra-Role Behaviour. The three item sub-scale developed by Lamberton et al. (2015) and includes items such as "Doing my job well means doing things that are not necessarily in my job description", "I do many 'extra things' for my clients, even if my employer doesn't tell me to" and "Job requires a lot more than it says in the job description". The response choice ranges from *strongly disagree* (1) to *strongly agree* (5) with higher scores indicating greater willingness to do extra tasks. The scale has a good reliability ($\alpha = .81$).

Psychological Distress. The Kessler et al. (2002) Depression Scale (K10) is a 10 item scale used to screen for psychological distress. The stem is "about how often did you feel" with the questions including items such as "nervous", "depressed", "feel that everything is an effort". Responses are coded from none of the time (0) to all of the time (4) with higher scores indicating greater psychological distress. The scale has excellent reliability ($\alpha =. 91$).

Results

Participants had average age of 50 years (M = 50, SD = 11.23, range from 19 to 79) and employed with the organisation for 3.3 years (M = 3.29, SD 3.25). Training in aged care correlated with tenure ($r = .205$, $p < .01$) and ACSE correlated significantly with trust in supervisor ($r = .360$, $p <. 01$) and GSE ($r = .699$, $p < .01$). Further details of scale means, standard deviations, Cronbach alpha reliabilities and inter-correlations can be found in Table 8. The hypothesis were tested using a hierarchical multiple regression analysis to predict

ACSE, GSE, extra-role behaviour and psychological distress with trust in supervisor and aged care training.

Four hierarchical multiple regression models were conducted, as outlined in Table 9. Model 1 contains only the control variables (age, tenure and self-confidence). Together these variables were a significant predictor of ACSE, (F (3, 244) = 4.50, p = .004), with an adjusted R^2 = .04. Aged care training and trust in supervisor were entered as predictors in the second step. The model adding each of the independent predictors was significant, (F (5, 182) = 7.3, p <.001), adjusted R^2 = 1.47, however aged care training was not a significant predictor of ACSE B = .18, t (.293) = .351, p = .77. This was contrary to the first hypothesis that aged care training is related to ACSE.

To test the second hypothesis, trust in supervisor was added to the model, however it was not found to be a significant predictor of ACSE. Finally, the interaction between aged care training and trust in supervisor were entered into the regression. However, when the interactions between each of the independent predictors and ACSE were entered into the regression, there was no significant change in variance, F (6, 182) = 6.14, p = .436, adjusted R^2 = .145, and therefore the interaction between aged care training and trust in supervisor is not significant.

In Model 2, generalised self-efficacy (GSE) was assessed as an outcome variable. As in Model 1, age, tenure and self-confidence were entered into the regression in the first step as independent variables. Together these variables were a significant predictor of GSE, (F (3, 245) = 11.45, p <.001, adjusted R^2 = .113). Aged care training and trust in supervisor were entered as predictors in the second step. The model adding each of the independent predictors was significant, (F (5, 181) = 8.88, p <.001 adjusted R^2 = 1. 79), which confirmed hypothesis 3. The interaction between aged care training and trust in supervisor was entered into the

regression and there was no significant change in variance, (F (6, 181) = 7.75, p = .172), adjusted R^2 = .183.

In Model 3, extra-role behaviour was the outcome variable, and was only significant in step 1, when controls were entered (F (3, 247) = 2.80, p =040, adjusted R^2 = .021). There was no significant change in variance when training in aged care and trust in supervisor were added, (F (5, 185) = 2.63, p = .842, adjusted R^2= . 042). Hypothesis 4 was not supported.

In Model 4, psychological distress was the outcome variable, which was only significant in step 1, when controls were entered (F (3, 243) = 18.67, p <.001, adjusted R^2 = .179) with no significant variance with predictors aged care training and trust in supervisor (F (5, 180) = 10.67, p = .484, adjusted R^2 = .212). Therefore, hypothesis 5 was not supported.

Table 8

Scale means, standard deviations, reliabilities and inter-correlations, ACSE (aged care self-efficacy), GSE (generalised self-efficacy)

	M	SD	1	2	3	4	5	6	7	8	9
1 Age	50.62	11.23	-								
2 Tenure	3.29	3.25	.33**	-							
3 Aged Care Training	1.33	.66	.04	.21**	-						
4 Self-Confidence	2.00	.88	-.10	-.03	-.09	(.90)					
5 Trust in Supervisor	5.52	.94	-.06	-.15*	-.02	-.26**	(.78)				
6 Psychological Distress	1.55	.54	-.27**	-.08	.05	.33**	-.15*	(.91)			
7 ACSE	3.28	.56	.06	.06	.03	-.22**	.36**	-.19**	(.82)		
8 GSE	3.06	.53	-.03	-.08	.15*	-.32**	.34**	-.18**	.69**	(.92)	
9 Extra-Role Behaviour	3.62	.79	.16*	.02	.02	-.01	.00	.09	.08	.13*	(.81)

Notes: *p<0.05; **p<0.01

Table 9
Aged Care Training and Empathetic Care Regressed on ACSE, SE, Self-Liking and Competence and Two-Way Interactions (N = 269)

	ACSE			GSE			Extra-Role Behaviour			Psychological Distress		
	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3
Controls												
Age	.001	.004	.004	-.003	-.002	-.002	.013**	.019**	.019**	-.011***	-.012**	-.012**
Tenure	.007	.006	.008	.012	-.013	-.015	-.009	-.030	-.031	.001	.005	.006
Self-Confidence	-.140**	.089*	.089*	-.207***	-.162**	-.160***	-.028	-.034	.035	.217***	.257***	.267***
Main effect												
Trust in Supervisor		.230***	.163		.151**	.259**		.039	.118		.031	-.009
Aged care training		.018	.266		.34*	.584		.024	.431		-.059	-.035
Interaction terms												
Aged care training x Trust in supervisor			.050			-.080			-.070			-.017
F	4.5	7.26	6.14	11.45	8.88	7.75	2.80	2.63	2.28	18.67	10.67	8.86
Change R^2	.053	.114	.003	.124	.085	.008	.033	.002	.003	.189	.006	.000
Total $R^2 change$	.053	.170	.173	.124	.202	.210	.033	.068	.071	.189	.234	.234

Notes: *p<.05*; **p<.01; ***p<.001

Discussion

The aim of these three studies was to develop and validate a measure of self-efficacy for aged care workers. Further, in Study Three we examined the relationship between trust in supervisor and aged care training as a predictor of aged care self-efficacy (ACSE). Aged care self-efficacy (ACSE) a five-item measure was shown to be distinct from generalised self-efficacy (GSE). ACSE appears to be a valid measure of self-efficacy for aged care workers in residential and home care setting. The magnitude of the relationship between ACSE and trust in supervisor was low to moderate (.36) indicating that there could be other factors which contribute towards self-efficacy in aged care workers, such as personality traits (Barrick, Mount, & Li, 2013). Higher scores in ACSE related to greater ability to undertake job tasks independently and make decisions about client care.

Although further research is required to examine the specific contributors towards ACSE, these findings suggest that organisations need to consider the structure and organisation of supervision. By strengthening organisational policies, modelling consistent practices and support to subordinates, leaders can provide an opportunity for improved self-efficacy in subordinates. Regular training and organisational support will assist in building stronger and more resilient workforce.

As expected, ACSE had a high relationship with GSE (.69), however factor analysis revealed the two scales are distinct. Our findings suggest that both types of self-efficacy are important in aged care workforce, particularly in predicting self-confidence, trust in supervisor and psychological distress. Workers who are psychologically well are likely to have good self-confidence and engage in a holistic care culture (Ng, Fong, & Wang, 2011). Psychological wellbeing has further been found to improve job satisfaction and reduce burnout and compassion fatigue (Hunsaker, Chen, Maughan, & Heaston, 2015).

The relatively large contribution that employee wellbeing contributes to self-efficacy suggests an opportunity to rethink self-efficacy theory, particularly with regard to measuring intricate factors such as self-confidence, self-esteem and psychological distress. Research on measuring self-efficacy has moved from the broad psychological evaluation of individual's traits in daily life to measuring the influence of self-confidence in workplace settings (Lunenburg, 2011). The transition between measuring general population and employees was usually handled with the use of college students e.g., Zhou and Kam (2016) found hope and self-efficacy items measured the same construct.

Measuring the attitudes of aged care workers is important in particular when assessing the influence of training on ACSE and GSE rather than measuring the attitudes of general population. One justification is the importance of evaluating the influence of aged care training. For example, our research has shown that training is a predictor of GSE in aged care workers. To become an aged care worker specific training is required. In Australia, Certificate III and IV in Aged Care or Community Care is a prerequisite (National College Australia, 2016). However, there are various types of training including tertiary university degrees, trade colleges and less formal selective short-term programs with varying level of difficulty and duration. Our study exclusively examined the influence of compulsory aged care sector training and did not assess the influence of ongoing learning, including on-the-job training, external and quarterly group training sessions delivered by the organisation. This interpretation fits with existing research demonstrating on-the-job training in residential aged care setting was beneficial and improved employee skills (Mellor et al., 2008). Similarly, Staples et al. (1999) demonstrated on-the-job training assisted in determining self-efficacy of remote workers. Future research is required to assess influence of all types of training in aged care.

Extra-role behaviour measures the service beyond "the checklist" and is mostly reflective of the qualitative tasks performed (Lamberton et al., 2015). Our research showed that aged care training and trust in supervisor did not predict extra-role behaviour, as predicted. It is possible that the skills required to perform extra-role behaviours are not taught in the compulsory aged care training and that participants gained those skills through other sources, such as previous employment, on-the-job training and self-initiated training. Alternatively, it is possible that those skills are gained from observing interactions that peers and supervisors have with clients and modelling that behaviour.

Interestingly, we did not find any significance in aged care training and trust in supervisor in predicting psychological distress in HCWs, as predicted. This aspect of our study only assessed HCWs these findings are limited to home care setting and cannot be generalised across both environments. It is possible that there are other workplace stressors which affect employees' psychological state, lead to burnout and other outcomes such as job satisfaction (Faragher et al., 2005). Future research could use a more representative sample from the wider aged care community and include both home care and residential employees.

Several limitations of the present study should be noted. First, data was collected as self-report for variables under investigation. Participants were asked to indicate their agreement with a number of employment-related measures and a psychological measure on distress. However, stress is not a static phenomenon and may not be a representative of participants' general lives. Second, data was collected at one point in time, using a cross-sectional design. However, this is relatively common practice for management studies. Replication of these results using longitudinal design would give a more accurate assessment and allow for causality to be determined. Third, generalisability of results could be limited since the dataset is specific to two organisations. Thus, the findings from this study should be replicated in other aged care organisations. Last, future research may include all types of

training (e.g., self-initiated and compulsory ongoing learning) in assessing self-efficacy in the aged care sector. Future research should also investigate more directly the link between each type of training and self-efficacy outcomes.

These findings have important implications for research and for practice. First, ACSE can be incorporated into studies on employee engagement in an aged care setting, and more specifically home care environment which is complex and context specific as it relies on management's ability to promote a supportive internal context (Jenkins & Delbridge, 2013). Findings from the ACSE measure can assist in determining the effectiveness of training and internal improvement for support systems for aged care workers across residential and home care setting. Findings can further assist in minimising workplace errors when making decisions about older client care (Gartmeier et al., 2010). The five item ACSE measure can be used by aged care employers for recruitment and ongoing performance review of employees to determine training and development needs, identify employees suitable for leadership roles as well as recognise employees who may be stressed and require additional support systems (Lunenburg, 2011).

In summary, these results provide insight into self-efficacy in the aged care sector using both ACSE and GSE measures. The findings suggest that ACSE is a valid measure to assess self-efficacy for aged care workers. Training in aged care and trust in supervisor are important predictors of self-efficacy, however they did not predict extra-role behaviour and psychological distress. These findings have implications for theoretical and workplace models of both generalised and specific self-efficacy.

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Conclusion to Study IV:

Study IV's results extend the findings from the earlier three studies which indicate the importance of training and organisational support for HCWs. More specifically, Study IV provides the empirical testing of the aged care self-efficacy (ACSE) scale which differs from generalised self-efficacy (GSE) scale. Results indicate that ACSE is a valid measure. Trust in supervisor is a significant predictor of both types of self-efficacy but not of extra-role behaviour and psychological distress. Further, aged care training was found to be a significant predictor of GSE but not ACSE. Results from the validity study indicate trust in supervisor is a significant predictor of GSE and ACSE but not of extra-role behaviour and psychological distress. Further, aged care training was found to be a significant predictor of GSE but not ACSE.

Chapter 6

General Discussion

Overview

Research on emotions has shown that sharing positive emotions in a health setting underpins the quality of service delivery and promotes empathetic care (Lamberton, Leana, & Williams, 2015), compassion satisfaction (Hunsaker, Chen, Maughan, & Heaston, 2015) and person-centred care (Kitwood, 1997). Sharing negative emotions may lead to burnout, reduced job satisfaction and increase employees' intention to quit (Gascon et al., 2013). However, there are mixed results and lack of research in influence of emotional sensitivity in the aged care workforce and specifically how emotional sensitivity affects home care workers (HCWs). Therefore, the current thesis sought to examine the mechanisms of emotional contagion and emotional sensitivity in HCWs. We firstly reviewed the organisational factors from the perspective of office managers, observations and review of internal documents. Second we empirically investigated a proposed mechanisms in emotional sensitivity by conducting a multi-method study on the emotional and psychological wellbeing in HCWs. In this chapter the findings from each of the four empirical papers will be discussed. Then, a summary of the theoretical and organisational implications of these results, limitations of the current research, and recommendations for future research will be presented.

Environmental Risks in Home Care (Chapter 2)

The first aim of this thesis was to review the home care environment from the perspective of office managers. Review of internal documents, telephone interactions between office-based managers and HCWs was conducted prior to semi-structured interviews. Findings from Chapter Two study showed that office-based managers were physically removed from the home care environment with many managers reporting not having regular face-to-face contact with HCWs and even less direct contact with clients. A review of internal documents revealed a stringent process for new client assessment, including background information on client health status and preference for service delivery

times as well as government regulation and expectation on service delivery standards and timeframe. Assessment information was limited to the physical status of clients and screening and recording client mental health status was not evident. Client mental health status was considered confidential and irrelevant to the delivery of home care services. The structured component of the interviews consisted of an operational overview of the organisation including job design of office managers, environmental context, training and support available for HCWs. Findings revealed office managers rely on distal supervision of HCWs with phone calls and emails as the main method of communication. HCWs were predominantly employed on a casual basis with many reporting other commitments outside of the organisation. The emergent themes in the interviewed included examples of compromises to HCW safety and environmental risks in client homes. Finally, the emergent themes revealed the organisational focus on retaining clients and minimising client complaints.

This is a first study to assess workplace risks for HCWs from the perspective of office managers. The study demonstrates the unique challenges of working in a home care environment and the unique challenges of organisational factors which cannot be generalised to residential setting. Further this study demonstrates the importance of supervision and support, particularly when exposed to clients with environmental risks, such as risk of falls, limited support network and unaddressed emotional support needs. Although previous research has addressed the risks and protective factors associated with emotional needs of older adults receiving care services (Bhar & Brown, 2012; Davison, McCabe, Mellor, Karantzas, & George, 2009; Kvelde et al., 2013), most studies were conducted in a residential care setting. These results confirm the usefulness of collecting data from multiple sources and environments, including conducting interviews, review of internal organisational documents and interactions between office staff. The internal documents in this thesis suggest that mental health status of clients is not screened, queried and does not form part of a risk

assessment prior to commencing service delivery in the client home. Therefore, an audit of internal documents was a good supplement to the interviews, strengthened the conclusions and provided a potential check for response biases that can occur with interviews.

Emotional Sensitivity in Home Care (Chapter 3 and Chapter 4)

Chapter Three presented a review of emotional sensitivity mechanisms in home care services. The review drew on the emotional contagion theory of Hatfield et al. (1994). Using a semi-structured methodology, interviews were conducted with HCWs. The structured component of the interviews included themes on the nature of interactions between HCWs and their clients. Interviewees were asked if during their shifts clients displayed both positive and negative emotions and what effect client emotions had on the HCWs. Previously research established that sharing positive emotions and companionate love existed between aged care workers and older adults which improved client health outcomes and job satisfaction in aged care workers (Barsade & O'Neill, 2014). Previous research further established the risk to personal safety for HCWs when supporting clients in their own homes (Fazzone, Barloon, McConnell, & Chitty, 2000) and witnessing mistreatment of older adults in their own homes by family members (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009). However, previous research did not examine the influence of negative emotions and emotional contagion between clients and HCWs. These two studies exclusively examined the influence of emotion sharing from the perspective of HCWs. Clients were not included in the study and this is an important area which future researchers may need to address.

In Chapter Three HCW described the home care context which is characterised with isolation, limited peer contact and distal supervision and support. HCWs described how they completed caring duties and overcame challenges with organising their work, such as rostering and scheduling leave. Consistent with previous findings, participants reported that their clients had complex support needs, emotional distress and possibly mental illness, which

was unconfirmed as HCWs did not have access to client health records. HCWs reported a strong trend of sharing positive emotions with clients who were in a good mood during their interaction. HCWs reported that clients who were in a negative mood had a negative effect on their wellbeing, with several HCWs describing compassion fatigue when supporting depressed clients. Several HCWs reported witnessing passive suicidality in clients and those concerns were mainly escalated to office managers. HCWs reported requesting not to be scheduled to see clients who were severely depressed.

A key finding from Chapter three was the prevalence of self-reported mental illness in HCWs. HCWs stated that they did not disclose their mental health status to their employer however several HCWs reported sharing their own mental health status with their clients. HCWs reported experiencing depression which in their opinion enabled them to detect emotional changes in clients and offer emotional support. Most HCWs reported not having any training in mental health. Several HCWs reported spending additional time with clients after the conclusion of their shift and not informing their managers about this arrangement. HCWs appeared to breach professional boundaries which they perceived improved their ability to perform HCW duties and form a bond with clients. A closer investigation revealed the overtime interaction with clients contributed towards bidirectional emotional contagion in that clients who were in a good mood were exposed to HCWs who were experiencing personal difficulties and challenges and using client contact time for their own emotional needs. HCWs further described constraints in communication with office managers which contributed towards breaches in professional boundaries and the lack of escalation of client concerns.

Chapter Four sought to measure emotional contagion in HCWs with a quantitative study by investigating the relationship between emotional contagion and burnout. A survey was administered to HCWs which revealed that emotional contagion was present particularly

in catching frustration. The findings aligned with previous research examining the positive influence of emotional contagion (Omdahl & O'Donnell, 1999). Further, the study demonstrated the influence of HCWs catching frustration and its influence on burnout and intention to quit. Although being highly susceptible to catching frustration did not predict job satisfaction or organisational commitment, there is a strong evidence on the negative influence of catching frustration.

Aged Care Self-Efficacy (Chapter 5)

Chapter Five broadened the scope of the research in self-efficacy in HCWs. This was achieved by conducting three studies in developing the aged care self-efficacy measure (ACSE). Study One included semi-structured interviews with HCWs which assisted in the initial construction of the ACSE measure. Study Two included the development of the scale and testing with residential care workers. In Study Three testing of the ACSE measure was conducted with HCWs in a model which was predicted with trust in supervisor and training. Other predicted outcomes included conducting duties outside of set requirements (extra-role) and experiencing psychological distress. Results revealed that trust in supervisor predicted both generalised self-efficacy (GSE) and ACSE in HCWs but aged care training only predicted GSE. Experiencing trust in supervisor and the level of aged care training did not predict completing extra-role duties and experiencing psychological distress. It could be argued that high trust in supervisor and higher aged care training contributes to both ACSE and GSE in HCWs, however conclusions cannot be reached about the direction of the relationship as the interaction between trust in supervisor and aged care training was not significant. As the sample consisted of HCWs who work remotely without direct supervision the influence of isolation needs to be considered when determining both ACSE and GSE in this population sample. Previous research e.g., Staples, Hulland, and Higgins (1999) demonstrated that training assisted in determining self-efficacy of remote workers. However,

this study only considered the compulsory training in aged care and did not consider the influence of self-initiated training and on-the-job training. It is possible that other types of training, as well as the nature of training (i.e., self-directed versus mandatory) influence GSE and ACSE in aged care workers. The study did not find any relationship between experiencing psychological distress, having high trust in supervisor and aged care training. It is possible that there are other workplace stressors which affect aged care workers psychological state, leading to burnout and the intention to quit (Faragher, Cass, & Cooper, 2005).

Implications for Theory

Overall findings from the four papers presented in this thesis support the presence of emotion contagion in HCWs. In Chapter Two, we found that home care clients had complex support needs and were prone to poor mental health outcomes, which presented an occupational risk to HCWs. Research has suggested that the home care environment can present risks for HCWs, who may be exposed to aggressive clients (Gascon et al., 2013) or witness a client being mistreated (Biggs et al., 2009). Environmental risks may contribute towards increased stress, burnout and reduced job satisfaction, leading to absenteeism. Previous studies had not examined the relationship of environmental risks and retention in home care setting. In study 2, HCWs reported catching both positive and negative emotions from their clients. HCWs reported that catching positive emotions improved their mood and increased their job satisfaction. However, HCWs reported that catching negative emotions deteriorated their mood, affected their job satisfaction and at times resulted in HCWs requesting to not be sent back to support clients who displayed a negative mood. HCWs reported compassion fatigue in supporting elderly clients with poor mental health. Recent evidence has shown that low level of manager support is a significant predictor of higher levels of burnout and compassion fatigue while a high level of manager support contributed

to a higher level of compassion satisfaction (Hunsaker et al., 2015). HCWs self-reported prevalence of mental illness, which contributed towards their job satisfaction, detection of emotional changes in clients and the frequency of communication with office managers.

These findings are consistent with the emotional contagion theory (Hatfield et al., 1994). The influence of face to face contact between HCWs and their clients in context of emotional contagion theory indicates that individuals 'catch' emotions in an automatic fast fleeting process (Hatfield et al., 1994). Our findings suggest that HCWs are susceptible to catching both positive and negative emotions from their clients. Catching positive emotions improves compassion satisfaction (Hunsaker et al., 2015), catching negative emotions affects organisational commitment and causes burnout. It could be interpreted that in remote work negative emotions in clients lead to negative interactions and therefore affect perceived organisational support and trust in supervisor (Podsakoff, MacKenzie, Moorman, & Fetter, 1990). Alternatively, distal environment allows clients and HCWs to be more open with each other about their emotions without a need to conform to institutionalised setting. Either way, interpersonal interactions have their own benefits and challenges that must be adapted to. The present findings support the literature which advocates better screening of mental health in older people and referral for treatment (Australian Institute of Health and Welfare [AIHW], 2013; Davison et al., 2009; Huang & Carpenter, 2011), rather than associating depression as normal part of the ageing process (Pettigrew, Donovan, Pescud, Boldy, & Newton, 2010).

When considering the influence of emotional contagion in home care settings it is important to acknowledge the influence of interpersonal interactions. As discussed earlier in the thesis, jobs which include emotional labour generally have face-to-face contact with the public, require the worker to produce an emotional state in the customer and allow the employer to exercise some control over the emotional life of employees (Hochschild, 1983).

It could be interpreted that HCWs identify too closely with their work and the emotions displayed by their clients in a home care context. Alternatively, the home care environment reduces the influence of employer and their ability to control over the emotional life of employees, as there is no face to face interaction between the managers and HCWs.

Affective events theory is underlined by a belief that human beings are emotional and that their behaviour is guided by emotion (Weiss & Cropanzano, 1996). The theory suggests that environmental conditions are recognised as 'hassles and uplifts' and the accumulation of those events were seen to result in either positive or negative affect states. It could be argued that the effects of workplace environment affect HCWs. The role of affective events theory has not previously been explored in a home care setting.

Implications for Practice

A key finding from this thesis is the influence of catching and sharing negative emotions between HCWs and clients. That is, while catching of both positive and negative emotions was expected, the occupational risks from undetected mental illness in clients as well as the prevalence of mental illness in HCWs was not expected. Assessment of mental health status of the clients and screening employee mental health is not conducted as part of home care services. HCWs have not been trained in detecting and reporting to office managers any changes in client mental health status. This is an important finding which demonstrates the factors which contribute to job satisfaction in HCWs, and potentially cause a safety risk, are unique to the home care environment and may not be relevant in a residential setting. Therefore, selecting appropriate safety measures to reduce occupational and environmental risks for HCWs is crucial, as it highlights the current theoretical models of emotional labour are applicable in the paid care environment.

Research conducted in the aged care sector has only in the 21st century started to focus on measuring the emotional status of aged care workers. Job satisfaction is the gold standard measure in management studies (Hebson, Rubery, & Grimshaw, 2015; Karasek, 1979; Wright & Cropanzano, 2000), and is increasingly replaced with psychological outcomes including burnout (Gascon et al., 2013), compassion fatigue (Hunsaker et al., 2015) and intention to leave (Rosen, Stiehl, Mittal, & Leana, 2011). There is still some debate whether, and to what extent emotional engagement between care givers and care recipients plays a role in employee retention strategies (Barsade & O'Neill, 2014; Folbre, 2012; Howes, Leana, & Smith, 2012). Lopez (2006) argued that emotional labour and organised emotional care are distinguished by the presence or absence of organisational feeling rules and affective requirements. Consequently, recommendations have been suggested for organisations to be plotted on a continuum with emotional labour at the coercive end and organised emotional care at the other end (Lopez, 2006). While this argument may stand for residential care organisations, recent evidence suggests the home care context is distinct from residential care and that perceived organisational support in distal context can improve employee retention strategies (Hunsaker et al., 2015). Our results also suggest that HCWs can benefit from training in recognising emotional changes in clients (Davison et al., 2009) and escalating concerns to management.

The findings from Chapters Two to Five highlight the need for improved communication between HCWs and office managers. HCWs reported difficulties in maintain regular contact with office managers. These findings lend support for the effectiveness of teamwork and supervision in improving communication and minimising associated occupational risks (Petitta & Naughton, 2015). Further, the findings highlight trust in supervisor and the role of perceived organisational support in a distal context and provide an

opportunity for improved internal protocols and ongoing training for home care workers on how to identify, respond to and report incidents in the home care setting.

Another issue that may be important to consider in this context is the role of training HCWs. During the interviews, HCWs reported poor knowledge of mental illness and training in recognising emotional needs in their clients. These findings were not dissimilar to earlier research on HCWs knowledge in recognising psychological conditions in older adults (Davison et al., 2009). Practically, in the context of home care environment it might then be useful to run workshops for HCWs on mental health and signs and symptoms to recognise in their clients and how to escalate concerns to management. Improved screening of mental illness in clients may reduce catching negative emotions from clients and improve the interaction between HCWs and clients. Further, detection of emotional changes in clients may improve their physical activity levels and the level of support required during the delivery of home care services.

Finally, findings from Chapter Five suggest that there are unique characteristics to working in aged care environment that contribute towards greater self-efficacy. Thus, aged care workers are likely to have specific knowledge and training which affects their self-efficacy and ability to initiate and complete work related tasks. This is important to acknowledge in order to target training appropriately, for example mindfulness training (Dane & Brummel, 2014; Soysa & Wilcomb, 2015). With significant staff shortages in the aged care sector, organisations need to be aware of specific and effective training requirements to improve worker job performance and intention to leave the organisation. Although the content of training may differ across different organisations, results from the current studies imply that same self-efficacy mechanisms underlie worker skill sets. This suggests the unique characteristics of aged care self-efficacy should be implemented across both residential and home care environments.

Limitation of the current thesis and future research directions

The overall aim of the thesis was to examine the factors which contribute towards the emotional and psychological wellbeing in HCWs. The results demonstrated that interactions with clients affect HCWs, in that positive emotions in clients have a positive effect on HCWs and that negative emotions in clients have a negative effect on the HCWs. However, given that this is the first study to investigate the influence of exchanging emotions between clients and HCWs, future research is needed to replicate and extend the current findings.

Chapters Two and Three examined the current state of evidence regarding emotional contagion in a home care setting. In order to overcome the perceived limitation of interviews, the research design was supplemented with substantial quantitative analysis with two surveys administered to a home care organisation and a residential care organisation. The interview data contributed to the development of survey items used for this thesis.

One of the largest limitations is that clients were not interviewed to assess if they were susceptible to catching emotions from HCWs. This important element would have allowed us to test the emotional contagion more holistically from both the receiver and sender's point of view. Another limitation is that data was mainly collected from a single home care organisation. Although the research attempted to get a representation of the organisation by including employees from across the country, the results are limiting the generalisability. Further, the validation study in Chapter Five was collected using data from one residential aged care organisation. Another limitation is that home care clients were not interviewed and their input, either in person or through a review of complaints and compliments received by the organisation, would have allowed for an input from a client's perspective on how emotions between HCWs and clients are managed in a home care context.

In line with the aforementioned limitation, though the empirical papers investigated the effects of important elements of emotional and psychological wellbeing in HCWs, there are many other factors thought to contribute to workers wellbeing. Both employee and organisational factors could be further examined, for example, the leadership aspect of the HCW-manager relationship, the impact of leader and member exchange e.g., Brunetto, Farr-Wharton, and Shacklock (2010), teamwork, educational skills, job performance and supervision. Additionally the effect of specific employer initiatives such as mindfulness training, as proposed in Chapter Four, could be explored.

A further limitation of the thesis is that the data reflects a single point in time, thus limiting the opportunity to explore a longitudinal dimension. Systematically observing the relationship between HCWs and management in a variety of interactions, in person and over the phone, may indicate the types of behaviours that are fundamental to emotional and psychological wellbeing in general, potentially allowing for enhanced employee outcome. As always (Totawar & Nambudiri, 2014), causality can not be implied from any cross-sectional studies.

Conclusion

Although the aged care workforce has high rates of turnover, it is unclear which factors account for this. By assessing the impact of organisational factors, interviewing officer managers and HCWs as well as conducting two large scale surveys in home care and residential setting, this thesis makes several important contributions to the understanding of attitudes of aged care workers. Most HCWs appear to be satisfied caring for older adults and working independently in client homes. However, the prevalence of undetected and undiagnosed risks in client homes, particularly mental illness and the lack of HCW knowledge about mental illness needs to be considered. Improved internal processes for client induction, screening mental illness, training HCW in recognising emotional changes in

clients and escalating concerns needs to be considered. Future research is required to explore the role of emotional contagion in home care setting further. This can be achieved by collecting data from clients and therefore examining both the sender and receiver of emotional exchange. Future research is required to investigate the casual pathway between emotions in residential care clients and escalation of concerns by residential care workers to understand the mechanism driving increased job satisfaction strategies and contributors to staff turnover rates in aged care workers. The final recommendation is for home care providers to assist the workforce to build resilience by offering regular training, support, opportunity for peer network and improved policies and practices on supporting HCWs who work under distal supervision arrangements.

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Appendix

Appendix One

CHC30212Certificate III in Aged Care

Course Structure

Course Units

CHCAC318B	Work effectively with older people
CHCAC319A	Provide support to people living with dementia
CHCCS411C	Work effectively in the community sector
CHCAC317A	Support older people to maintain their independence
CHCICS301B	Provide support to meet personal care needs
CHCICS302B	Participate in the implementation of individualised plans
CHCICS303A	Support individual health and emotional well being
CHCWHS312A	Follow WHS safety procedures for direct care work
CHCPA301B	Deliver care services using a palliative approach
HLTAP301B	Recognise healthy body systems in a health care context

Elective Units

CHCMH301C	Work effectively in mental health
HLTHIR403C	Work effectively with culturally diverse clients and co-workers
CHCAC417A	Implement interventions with older people at risk of falls
HLTIN301C	Comply with infection control policies and procedures
	Medication unit available as an elective

CHC40108 CERTIFICATE IV in Aged Care

Course Structure

The Certificate IV in Aged Care (CHC40108) is made up of 15 units: 10 core units and 5 elective units

Course Units

CHCAC412B	Provide services to older people with complex needs
CHCAC416A	Facilitate support responsive to the specific nature of dementia
CHCAC417A	Implement interventions with older people at risk of falls
CHCAD401D	Advocate for clients
CHCCS400C	Work within a relevant legal and ethical framework
CHCICS401B	Facilitate support for personal care needs
CHCICS402B	Facilitate individualised plans
CHCINF403E	Coordinate information systems
CHCNET404B	Facilitate links with other services
CHCORG406C	Supervise work

Elective Units

CHCWHS312A	Follow WHS procedures for direct care work
HLTHIR403C	Work effectively with culturally diverse clients and co-workers
CHCICS410A	Support relationships with carers and families
CHCCOM403A	Use targeted communication skills to build relationships
CHCMH402B	Apply understanding of mental health issues and recovery processes
	Medication unit available as an elective

CHC33015: Certificate III in Individual Support (Home and Community)

Course Structure

Core Units

CHCDIV001	Work with diverse people
CHCCCS015	Provide individualised support
CHCCCS023	Support independence and well being
CHCCOM005	Communicate and work in health or community services
CHCLEG001	Work legally and ethically
HLTAAP001	Recognise healthy body systems
HLTWHS002	Follow safe work practices for direct client care

Elective Units

CHCCCS025	Support relationships with carers and families
CHCHCS001	Provide home and community support services
CHCCCS011	Meet personal support needs
CHCAGE001	Facilitate the empowerment of older people
CHCPAL001	Deliver care services using a palliative approach
CHCAGE005	Provide support to people living with dementia

CHC40212: Certificate IV in Home and Community Care

Course Structure

Core Units

CHCAC416A	Facilitate support responsive to the specific nature of dementia
CHCCS411C	Work effectively in the community sector
CHCHC401B	Coordinate and monitor home based support
CHCICS402B	Facilitate individualised plans
CHCWHS312A	Follow WHS safety procedures for direct care work
HLTHIR403C	Work effectively with culturally diverse clients and co-worker

Elective Units

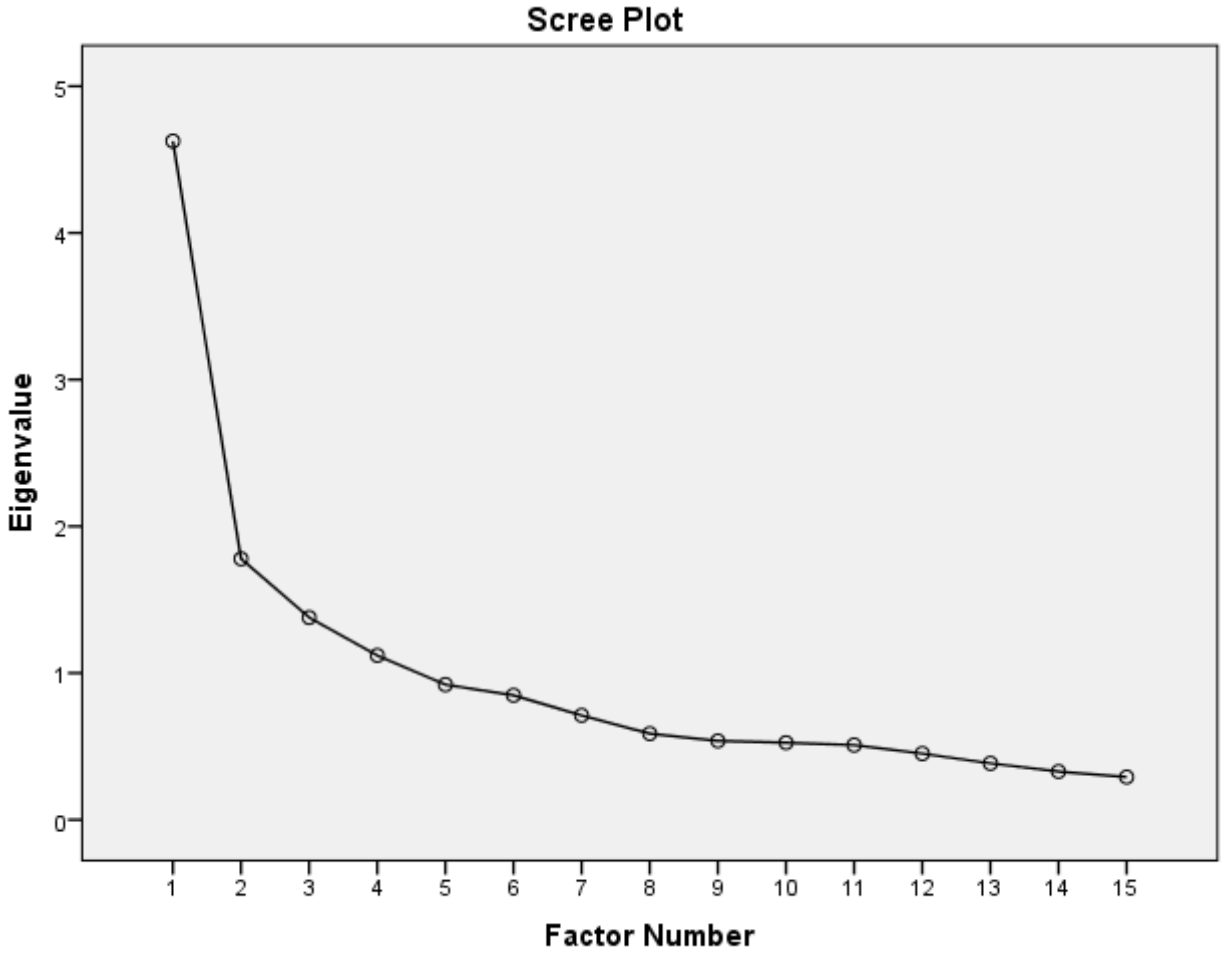
CHCICS401B	Facilitate support for personal care needs
CHCMH411A	Work with people with mental health issues
CHCCOM403A	Use targeted communication skills to build relationships
CHCORG423C	Maintain quality service delivery
CHCNET404B	Facilitate links with other services
CHCORG406C	Supervise work
CHCICS407B	Support positive lifestyle
CHCCS422B	Respond holistically to client issues and refer appropriately
CHCICS403A	Conduct individual assessment

Appendix Two Factor Analysis

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.626	30.839	30.839	4.116	27.441	27.441	1.994	13.294	13.294
2	1.779	11.858	42.697	1.278	8.518	35.960	1.982	13.214	26.508
3	1.379	9.193	51.890	.910	6.068	42.027	1.772	11.814	38.322
4	1.120	7.467	59.357	.582	3.881	45.909	1.138	7.587	45.909
5	.921	6.141	65.499						
6	.848	5.656	71.155						
7	.711	4.743	75.898						
8	.587	3.915	79.812						
9	.538	3.584	83.396						
10	.526	3.505	86.901						
11	.509	3.395	90.296						
12	.451	3.007	93.303						
13	.385	2.565	95.868						
14	.329	2.191	98.059						
15	.291	1.941	100.000						

Extraction Method: Principal Axis Factoring.


Scree Plot
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0
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11
12
13
14
15
Factor Number

Rotated Factor Matrix[a]

	Factor			
	1	2	3	4
If someone I'm talking with begins to cry, I get teary-eyed				.583
Being with a happy persons picks me up when I'm feeling down			.658	
When someone smiles warmly at me, I smile back and feel warm inside			.579	
I get filled with sorrow when people talk about the death of their loved ones			.321	
I clench my jaws and my shoulders get tight when I see the angry faces on the news		.554		
When I look into the eyes of the one I love, my mind is filled with thoughts of romance	.748			
It irritates me to be around angry people		.579		
Watching the fearful faces of victims on the news makes me try to imagine how they might be feeling		.344		
I melt when the one I love holds me close	.762			
I tense when overhearing an angry quarrel		.624		
Being around happy people fills my mind with happy thoughts			.765	
I sense my body responding when the one I love touches me	.776			
I notice myself getting tense when I'm around people who are stressed out		.657		
I cry at sad movies				.674
Listening to the shrill screams of a terrified child in a dentist's waiting room makes me feel nervous		.384		.339

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.[a]

a. Rotation converged in 6 iterations.

Factor Transformation Matrix

Factor	1	2	3	4
1	.550	.547	.519	.358
2	-.585	.671	-.315	.330
3	-.566	-.295	.716	.282
4	.188	-.404	-.344	.827

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.791
Bartlett's Test of Sphericity	Approx. Chi-Square	1151.181
	df	28
	Sig.	.000

Communalities

	Initial	Extraction
My training has taught me how to handle the problems my aged clients face	.305	.340
It is easy for me to detect when a client requires more service hours	.517	.651
When a client faces difficulties, I am confident in escalating them to management	.497	.611
I feel confident in reassuring emotionally distressed clients	.509	.605
Thanks to my training, I am an excellent aged care worker	.097	.110
When facing difficult tasks, I am certain that I will accomplish them	.505	.604
In general, I think that I can obtain outcomes that are important to me	.552	.684
I believe I can succeed at most any endeavour to which I set my mind	.582	.729

Appendix Three

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.170	39.620	39.620	2.760	34.497	34.497	2.323	29.031	29.031
2	1.940	24.246	63.866	1.573	19.668	54.165	2.011	25.134	54.165
3	.868	10.852	74.718						
4	.642	8.031	82.749						
5	.390	4.871	87.620						
6	.363	4.543	92.163						
7	.340	4.249	96.412						
8	.287	3.588	100.000						

Extraction Method: Principal Axis Factoring.

Factor Matrix[a]

	Factor	
	1	2
My training has taught me how to handle the problems my aged clients face	.500	
It is easy for me to detect when a client requires more service hours	.683	-.430
When a client faces difficulties, I am confident in escalating them to management	.677	-.390
I feel confident in reassuring emotionally distressed clients	.669	-.397
Thanks to my training, I am an excellent aged care worker	.315	
When facing difficult tasks, I am certain that I will accomplish them	.558	.541
In general, I think that I can obtain outcomes that are important to me	.562	.607
I believe I can succeed at most any endeavour to which I set my mind	.640	.565

Extraction Method: Principal Axis Factoring.

a. 2 factors extracted. 7 iterations required.

Rotated Factor Matrix[a]

	Factor	
	1	2
My training has taught me how to handle the problems my aged clients face	.579	
It is easy for me to detect when a client requires more service hours	.804	
When a client faces difficulties, I am confident in escalating them to management	.775	
I feel confident in reassuring emotionally distressed clients	.772	
Thanks to my training, I am an excellent aged care worker	.312	
When facing difficult tasks, I am certain that I will accomplish them		.769
In general, I think that I can obtain outcomes that are important to me		.823
I believe I can succeed at most any endeavour to which I set my mind		.837

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Factor Transformation Matrix

Factor	1	2
1	.795	.607
2	-.607	.795

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.

MACQUARIE UNIVERSITY

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Email ethics.secretariat@mq.edu.au

28 October 2014

Dr Denise Jepsen
Department of Marketing and Management
Faculty of Business and Economics
MACQUARIE UNIVERSITY
NSW 2109

Dear Dr Jepsen

Reference No: 5201400778

Title: *Workplace implications of depression in older clients*

Thank you for submitting the above application for ethical and scientific review. Your application was considered by the Macquarie University Human Research Ethics Committee (HREC (Human Sciences & Humanities)) at its meeting on 29 October 2014 at which further information was requested to be reviewed by the HREC (Human Sciences and Humanities) Executive.

The requested information was received with correspondence on 3 October 2014.

The HREC (Human Sciences and Humanities) Executive considered your responses at its meeting held on 14 October 2014. Additional information was requested and was requested to reviewed by the Ethics Secretariat. The requested information was received on 22 October 2014

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted at:

- Macquarie University

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007 – Updated March 2014) (the *National Statement*).

Details of this approval are as follows:

Approval Date: 23 October 2014

The following documentation has been reviewed and approved by the HREC (Human Sciences & Humanities):

Documents reviewed	Version no.	Date
Macquarie University Ethics Application Form	2	Received 3/10/2014
Correspondence from Miss Julie Bajic responding to the issues raised by the HREC (Human Sciences and Humanities)		Received 3/10/2014 & 22/10/2014

MQ Participant Information and Consent Form (PICF) - Organisational Consent Letter – (Organisation Copy)	1
MQ Participant Information and Consent Form (PICF) - Organisational Consent Letter (Researcher Copy)	1
MQ PICF- Interview Information (Participant Copy)	1
MQ PICF - Interview Information (Researcher Copy)	1
MQ PICF - Employee Survey Information Sheet (Participant Copy)	1
MQ PICF - Employee Survey Information Sheet (Researcher Copy)	1
MQ PICF - Manager Survey Information Sheet (Participant Copy)	1
MQ PICF - Manager Survey Information Sheet – (Researcher Copy)	1
Signed PICF – Kincare (Organisation Copy & Researcher Copy)	1
Draft Interview Questions (Home Care Workers)	
Draft Employee Survey Questions	1
Draft Manager Questions	

This letter constitutes ethical and scientific approval only.

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the *National Statement,* which is available at the following website:

http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC (Human Sciences and Humanities) Terms of Reference and Standard Operating Procedures are available from the Research Office website at:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics

The HREC (Human Sciences and Humanities) wishes you every success in your research.

Yours sincerely

Dr Karolyn White
Director, Research Ethics & Integrity,
Chair, Human Research Ethics Committee (Human Sciences and Humanities)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

Home Care Worker Interviews

Preliminary Questions
☐ Completed Consent Form
☐ Completed Demographics
☐ Recorder ON

"Thank you for taking part in the study. The reason I am interested in speaking with you to better understand the pressures on HCWs in recognising changes in clients and escalating them appropriately".

I will be taking notes and the information used will assist in finalising the survey which will be distributed to all KinCare's HCWs in February 2015.

Have you heard anything about the research?

****

What is your **role**?

What **responsibilities** does it include?

What are the **biggest challenges** working in your role as a home care worker?

What percentages of your clients speak English?

Apart from meeting physical health needs, what other needs do you need to consider in a client?

Do your clients have **mental health conditions**?

Which is the most prevalent type of a mental health condition?

Are you informed if a client has a mental health condition?
Who informs you?

What percentage of your clients do you estimate have depression?

What are the **advantage(s)** of identifying depression in a client?

How does this detection benefit you in your role?

To what extent are you able to detect depression in a client?

To what extent are you able to detect anxiety in a client?

If your client appeared sad, would you inform your supervisor?

If your client appeared anxious, would you inform your supervisor?
Has your employer informed you of policies and procedures to report poor mental health in a client?

How confident in these systems?

What are the key issues in detecting poor emotional status in clients and referring them for treatment?

Have you received any mental health training from your current or previous employer which would assist you to note emotional changes in your clients?

Are you confident in differentiating symptoms of mental health condition(s) such as anxiety from normal symptoms of stress?

Are you confident in differentiating symptoms of mental health condition(s) such as depression from neurological condition(s) e.g., dementia?

If a client that you talk to begins to cry, how does it affect you?

What impact does being with a happy client have on you when you are feeling down?

Do you notice any physical changes in you when you are around people who are stressed out?

Summary of key issues

Clarifying any points of uncertainty and ambiguity

Factors Associated with Older Client Wellbeing and Employee Job Satisfaction

Survey Information and Consent Form

You are invited to participate in a study of the impact of client depression on the aged-care workforce. The purpose of the study is to investigate the attitudes of aged-care workers towards mental health conditions. We are interested in understanding the impact of poor mental health in clients on the workers and their overall job satisfaction. Your participation is entirely voluntary and has no bearing on your employment status or work performance.

The study is being conducted by Dr Denise Jepsen and Julie Bajic both of Macquarie University. This study is being conducted to meet the requirements for the degree of a PhD in Business for Julie Bajic.

All information, organisational or personal details gathered in the course of the study are confidential. Your employer has supplied us with de-identified employee demographics that allow us to determine the representativeness of our research. No individual or organisation will be identified in any publication of the results. Only the primary researcher and supervisors will have access to the raw data. Publication of results will only include de-identifiable aggregated data. De-identified data may be used for future publications and studies.

The survey will take approximately 20 minutes to complete and you may choose to go into a draw to win one of nine $100 Coles Group & Myer Gift Cards. If you decide to participate, you are free to withdraw from further participation in the research at any time without having to give a reason and without consequence. Once the research has been completed, aggregated results and research findings will be available via email from Julie.Bajic@mq.edu.au. If you wish to participate in a longitudinal study we ask that you provide your employee identification number so that you can be re-surveyed in 12-18 months. The purpose of that study is to measure how employee attitudes towards mental health in older adults change over time.

Return of the survey will be regarded as consent to use the information for research purposes. In returning the completed survey participants acknowledge that they have read and understood the above information statement. If you have any questions please contact either Dr Denise Jepsen (Ph 9850 4805) or Julie Bajic (0422 819 282).

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics and Integrity (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Some questions are awkwardly worded, others may seem repetitive at times, and some questions are relevant mostly to home care workers and may not apply to all employees. Please try to answer all questions that relate to you and skip those questions that do not relate to your role. When answering the questions, please refer to your employment and main role at Organisation Y.

If you have any problems which may be related to your involvement in the project (for example, feelings of distress) the following support networks are available for you to contact:

Organisation Y Employee Assistance Program: Please contact your HR Department
Life Line: Crisis Counselling 13 11 14 www.lifeline.org.au
beyondblue: Resources on depression and anxiety 1300 224 636 beyondblue.org.au

If you would like to complete the survey online, please go to: http://bit.ly/1E4wIRN

If you are **not** completing the survey online, please return the completed printed survey to:

Reply Paid 63448
Ms Julie Bajic
C/o Dr Denise Jepsen
Faculty of Business & Economics
Macquarie University NSW 2109

Q1 Generally speaking, our mental health refers to our state of mind and our ability to cope with the everyday things that are going on around us. These questions relate to your understanding of mental health conditions. Which of the following conditions are mental health conditions and, in your opinion, can be treated and cured? Please do not spend too much time on any question and answer to the best of your understanding (check all that apply):

- ☐ Adjustment Disorder
- ☐ Alzheimer's Disorder
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Vascular Dementia
- ☐ Schizophrenia

Q2 What percentage of your current clients has symptoms or diagnoses of depression and/or anxiety? (E.g. 50% or 80%) _____

Q3 Please indicate how much you agree with each of the following statements

	Strong Disagree-ment	*Disagree-ment*	*Agreement*	*Strong Agreement*
Older people who complain of feeling down are often just looking for attention	❍	❍	❍	❍
Older people may actually be depressed even though they do not report feeling unhappy	❍	❍	❍	❍
Depression is a normal reaction to the death of an older person's partner	❍	❍	❍	❍
Depression is a normal reaction to the changes of old age	❍	❍	❍	❍
Older people who talk of feeling that life is not worth living should be taken seriously	❍	❍	❍	❍
Difficulty in concentrating, restlessness and feeling overly guilty about things are all symptoms of depression	❍	❍	❍	❍
Most older people who have to sell their home and move into residential care will become depressed	❍	❍	❍	❍
In most cases there is little that can be done to help an older person with depression	❍	❍	❍	❍
Sleep problems, loss of interest in things previously enjoyed and tiredness are all symptoms of depression	❍	❍	❍	❍
If a person you are caring for tells you that s/he is depressed, it is best to leave them alone; talking about it might make things worse	❍	❍	❍	❍

Q4 Read each question and indicate the answer which best applies to you. Please answer each question very carefully. There are no right or wrong answers, so try very hard to be completely honest in your answers.

	Never	*Rarely*	*Sometimes*	*Always*
If someone I'm talking with begins to cry, I get teary-eyed	❍	❍	❍	❍
Being with a happy person picks me up when I'm feeling down	❍	❍	❍	❍
When someone smiles warmly at me, I smile back and feel warm inside	❍	❍	❍	❍
I get filled with sorrow when people talk about the death of their loved ones	❍	❍	❍	❍
I clench my jaws and my shoulders get tight when I see the angry faces on the news	❍	❍	❍	❍
When I look into the eyes of the one I love, my mind is filled with thoughts of romance	❍	❍	❍	❍
It irritates me to be around angry people	❍	❍	❍	❍
Watching the fearful faces of victims on the news makes me try to imagine how they might be feeling	❍	❍	❍	❍
I melt when the one I love holds me close	❍	❍	❍	❍
I tense when overhearing an angry quarrel	❍	❍	❍	❍
Being around happy people fills my mind with happy thoughts	❍	❍	❍	❍
I sense my body responding when the one I love touches me	❍	❍	❍	❍
I notice myself getting tense when I'm around people who are stressed out	❍	❍	❍	❍
I cry at sad movies	❍	❍	❍	❍
Listening to the shrill screams of a terrified child in a dentist's waiting room makes me feel nervous	❍	❍	❍	❍

Q5 Please rate your agreement with these statements:

	Strongly Disagree	-	-	-	*Strongly Agree*
I feel courageous in my work…I am willing to ask clients and families direct questions about their care requirements	❍	❍	❍	❍	❍
I have an emotional connection with our clients and their families…they are able to share their feelings with me	❍	❍	❍	❍	❍

I am curious about our clients' reactions to our care and work practices	❍	❍	❍	❍	❍
I tend to collaborate with clients, their families and other staff in caring for our clients	❍	❍	❍	❍	❍
I tend to compromise in my care of our clients, through "give and take"	❍	❍	❍	❍	❍
I tend to celebrate with others when something works well in caring for our clients	❍	❍	❍	❍	❍

Q6 Please indicate to what extent you agree with the following statements

	Not true at all	*Somewhat true*	*Mostly true*	*Completely true*
I can always manage to solve difficult problems if I try hard enough.	❍	❍	❍	❍
If someone opposes me, I can find the means and ways to get what I want.	❍	❍	❍	❍
It is easy for me to stick to my aims and accomplish my goals.	❍	❍	❍	❍
I am confident that I could deal efficiently with unexpected events.	❍	❍	❍	❍
Thanks to my resourcefulness, I know how to handle unforeseen situations.	❍	❍	❍	❍
I can solve most problems if I invest the necessary effort.	❍	❍	❍	❍
I can remain calm when facing difficulties because I can rely on my coping abilities	❍	❍	❍	❍
When I am confronted with a problem, I can usually find several solutions.	❍	❍	❍	❍
If I am in trouble, I can usually think of a solution	❍	❍	❍	❍
I can usually handle whatever comes my way	❍	❍	❍	❍
My training has taught me how to handle the problems my aged clients face	❍	❍	❍	❍
It is easy for me to detect when a client requires more service hours	❍	❍	❍	❍
When a client faces difficulties, I am confident in escalating them to management	❍	❍	❍	❍
I feel confident in reassuring emotionally distressed clients	❍	❍	❍	❍
I decline shifts with clients who have greater support needs than my skills and training	❍	❍	❍	❍
Thanks to my training, I am an excellent aged care worker	❍	❍	❍	❍

Q7 Please read each statement and tick an option which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

	Did not apply to me at all	*Applied to me to some degree, or some of the time*	*Applied to me considerable degree, or a good part of time*	*Applied to me very much, or most of the time*
I found it hard to wind down	❍	❍	❍	❍
I was aware of dryness of my mouth	❍	❍	❍	❍
I couldn't seem to experience any positive feeling at all	❍	❍	❍	❍
I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	❍	❍	❍	❍
I found it difficult to work up the initiative to do things	❍	❍	❍	❍
I tended to over-react to situations	❍	❍	❍	❍
I experienced trembling (e.g., in the hands)	❍	❍	❍	❍
I felt that I was using a lot of nervous energy	❍	❍	❍	❍
I was worried about situations in which I might panic and make a fool of myself	❍	❍	❍	❍
I felt that I had nothing to look forward to	❍	❍	❍	❍
I found myself getting agitated	❍	❍	❍	❍
I found it difficult to relax	❍	❍	❍	❍
I felt down-hearted and blue	❍	❍	❍	❍
I was intolerant of anything that kept me from getting on with what I was doing	❍	❍	❍	❍
I felt I was close to panic	❍	❍	❍	❍
I was unable to become enthusiastic about anything	❍	❍	❍	❍
I felt I wasn't worth much as a person	❍	❍	❍	❍
I felt that I was rather touchy	❍	❍	❍	❍
I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	❍	❍	❍	❍
I felt scared without any good reason	❍	❍	❍	❍
I felt that life was meaningless	❍	❍	❍	❍

Q8 I experience compassion:

	Never	-	-	-	*Nearly all the time*
On the job	❍	❍	❍	❍	❍
From my supervisor	❍	❍	❍	❍	❍
From my co-workers	❍	❍	❍	❍	❍

Q9 Please tell us about your shifts:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am normally assigned to work with the same clients most shifts	❍	❍	❍	❍	❍
I prefer to work with the same clients for most of my shifts	❍	❍	❍	❍	❍
I prefer to work with a variety of clients for most of my shifts	❍	❍	❍	❍	❍
If I had a choice, I would ask to work with the same client every opportunity	❍	❍	❍	❍	❍
I am happy to work in most areas, with most of Organisation Y clients	❍	❍	❍	❍	❍

Q10 We would like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions simply by indicating the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions. Have you recently:

	Not at all	Occasionally	Frequently	Much more than usual
Been able to concentrate on whatever you are doing?	❍	❍	❍	❍

Q11	Not at all	Occasionally	Frequently	Much more than usual
Lost much sleep over worry?	❍	❍	❍	❍
Felt constantly under strain?	❍	❍	❍	❍
Felt you couldn't overcome your difficulties?	❍	❍	❍	❍
Been feeling unhappy and depressed?	❍	❍	❍	❍
Been losing confidence in yourself?	❍	❍	❍	❍
Been thinking of yourself as a worthless person?	❍	❍	❍	❍

Q12	More so than usual	Same as usual	Less useful than usual	Much less
Felt that you are playing a useful part in things?	❍	❍	❍	❍
Felt capable of making decisions about things?	❍	❍	❍	❍
Been able to enjoy your normal day-to-day activities?	❍	❍	❍	❍
Been able to face up to your problems?	❍	❍	❍	❍
Been feeling reasonably happy, all things considered?	❍	❍	❍	❍

Q13 Compassion fatigue: When you care for aged clients you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a carer. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	Never	Rarely	Sometimes	Often	Very Often
I get satisfaction from being able to care for aged care clients	❍	❍	❍	❍	❍
I feel invigorated after working with those I care for	❍	❍	❍	❍	❍
I like my work as a carer	❍	❍	❍	❍	❍
I am pleased with how I am able to keep up with aged care techniques and protocols	❍	❍	❍	❍	❍
My work makes me feel satisfied	❍	❍	❍	❍	❍
I have happy thoughts and feelings about those I care for and how I could help them	❍	❍	❍	❍	❍
I believe I can make a difference through my work	❍	❍	❍	❍	❍
I am proud of what I can do to help	❍	❍	❍	❍	❍
I have thoughts that I am a "success" as a carer	❍	❍	❍	❍	❍
I am happy that I chose to do this work	❍	❍	❍	❍	❍

Q14 About this organisation:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would recommend this organisation to my family and friends	❍	❍	❍	❍	❍
If I had to receive home care one day in the future, I think I would be happy to receive care from Organisation Y	❍	❍	❍	❍	❍

Q15 Please rate your agreement with the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Doing my job well means doing things that are not necessarily in my job description	❍	❍	❍	❍	❍

I do many "extra things" for my clients, even if my employer doesn't tell me to	❍	❍	❍	❍	❍
It would be hard to measure a lot of things I do for my clients	❍	❍	❍	❍	❍
This job requires a lot more than it says in the job description	❍	❍	❍	❍	❍
I help my clients feel better when they are down	❍	❍	❍	❍	❍
Sometimes you just have to give a client a hug when he or she is feeling down	❍	❍	❍	❍	❍
My client's emotional state is just as important as their physical state	❍	❍	❍	❍	❍
Part of my job is to get to know pretty much everything about the people I care for	❍	❍	❍	❍	❍
My clients would find it difficult if another care worker were assigned to them instead of me	❍	❍	❍	❍	❍
I know what my clients' lives were like before they became unwell	❍	❍	❍	❍	❍

Q16 My manager/s and supervisor/s:

	Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
Usually seem to set goals for what they want to achieve	❍	❍	❍	❍	❍
Make decisions about workplace issues based on evidence	❍	❍	❍	❍	❍
Tend to use evidence when implementing a new way of doing things	❍	❍	❍	❍	❍
Tell me about the evidence for implementing a new way of doing things	❍	❍	❍	❍	❍
Ask me for feedback for my opinion after implementing a new way of doing things	❍	❍	❍	❍	❍
Involve me in research on workplace issues	❍	❍	❍	❍	❍
Give me/us the information on the success (or otherwise) of a trial or a new way of working	❍	❍	❍	❍	❍
Like to evaluate the success of a new way of working	❍	❍	❍	❍	❍
Share their experiences of workplace trials, changes, and new implementations with other supervisors and managers	❍	❍	❍	❍	❍
Use clinical and scientific evidence in making decisions	❍	❍	❍	❍	❍
Share clinical and scientific evidence with me	❍	❍	❍	❍	❍
Use organisational facts and metrics in making decisions	❍	❍	❍	❍	❍
Share organisational facts and metrics with me	❍	❍	❍	❍	❍

Q17 Please indicate how much you agree with the following statements

	Never	*Rarely*	*Sometimes*	*Often*	*Extremely Often*
To what extent does your job require your working fast?	❍	❍	❍	❍	❍
To what extent does your job require your working hard?	❍	❍	❍	❍	❍
To what extent does your job require a great deal of work to be done?	❍	❍	❍	❍	❍
To what extent is there not enough time for you to do your job?	❍	❍	❍	❍	❍
To what extent is there excessive work in your job?	❍	❍	❍	❍	❍
To what extent do you feel there is not enough time for you to finish your work?	❍	❍	❍	❍	❍
To what extent are you faced with conflicting demands on your job?	❍	❍	❍	❍	❍
To what extent is high skill level required?	❍	❍	❍	❍	❍
To what extent are you required to learn new things?	❍	❍	❍	❍	❍
To what extent is your work non-repetitious?	❍	❍	❍	❍	❍
To what extent does your job require creativity?	❍	❍	❍	❍	❍
To what extent do you have the freedom to decide how to organise your work?	❍	❍	❍	❍	❍
To what extent do you have control over what happens on your job?	❍	❍	❍	❍	❍
To what extent does your job allow you to make a lot of your own decisions?	❍	❍	❍	❍	❍
To what extent are you assisted in making your own decisions?	❍	❍	❍	❍	❍

Q18 Now think of the expectations you have had of Organisation Y

	Strongly Disagree	*Disagree*	*Neither*	*Agree*	*Strongly Agree*
Almost all promises made by Organisation Y when I started have been kept so far	❍	❍	❍	❍	❍
I feel Organisation Y has come through in fulfilling the promises made to me when I was hired	❍	❍	❍	❍	❍
So far Organisation Y has done an excellent job of fulfilling its promises to me	❍	❍	❍	❍	❍
I have not received anything promised to me in exchange for my contributions	❍	❍	❍	❍	❍
Organisation Y has broken many of its promises to me even though I've upheld my side of the deal	❍	❍	❍	❍	❍
I feel a great deal of anger towards Organisation Y	❍	❍	❍	❍	❍
I feel betrayed by Organisation Y	❍	❍	❍	❍	❍
I feel Organisation Y has violated the contract between us	❍	❍	❍	❍	❍
I feel extremely frustrated by how I have been treated by Organisation Y	❍	❍	❍	❍	❍

Q19 To what extent do you believe your obligations to Organisation Y include the following:

	Very high	-	-	-	Not at all
Working extra hours	❍	❍	❍	❍	❍
Loyalty	❍	❍	❍	❍	❍
Volunteering to do non-required tasks on the job	❍	❍	❍	❍	❍
Giving advance notice if taking a job elsewhere	❍	❍	❍	❍	❍
Willingness to accept a transfer	❍	❍	❍	❍	❍
Refusal to support the organisation's competitors	❍	❍	❍	❍	❍
Protection of proprietary information	❍	❍	❍	❍	❍
Spending a minimum of two years at the organisation	❍	❍	❍	❍	❍

Q20 These items concern your general thoughts and feelings about yourself. Please indicate the extent to which you agree or disagree with each item:

	Strongly Agree	-	-	-	Strongly Disagree
I tend to devalue myself	❍	❍	❍	❍	❍
I am highly effective at the things I do	❍	❍	❍	❍	❍
I am very comfortable with myself	❍	❍	❍	❍	❍
I am almost always able to accomplish what I try for	❍	❍	❍	❍	❍
I am secure in my sense of self-worth	❍	❍	❍	❍	❍
It is sometimes unpleasant for me to think about myself	❍	❍	❍	❍	❍
I have a negative attitude toward myself	❍	❍	❍	❍	❍
At times, I find it difficult to achieve the things that are important to me	❍	❍	❍	❍	❍
I feel great about who I am	❍	❍	❍	❍	❍
I sometimes deal poorly with challenges	❍	❍	❍	❍	❍
I never doubt my personal worth	❍	❍	❍	❍	❍
I perform very well at many things	❍	❍	❍	❍	❍
I sometimes fail to fulfil my goals	❍	❍	❍	❍	❍
I am very talented	❍	❍	❍	❍	❍
I do not have enough respect for myself	❍	❍	❍	❍	❍
I wish I were more skilful in my activities	❍	❍	❍	❍	❍

Q21 To what extent do you believe Organisation Y is obliged to provide you with the following:

	Very high	-	-	-	Not at all
Rapid advancement	❍	❍	❍	❍	❍
High pay	❍	❍	❍	❍	❍
Pay based on current level of performance	❍	❍	❍	❍	❍
Training	❍	❍	❍	❍	❍
Long-term job security	❍	❍	❍	❍	❍
Career development	❍	❍	❍	❍	❍
Support for personal problems	❍	❍	❍	❍	❍

Q22 Please indicate to what extent you agree with the following statements

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
This job denies me any chance to use personal initiative in carrying out the work	❍	❍	❍	❍	❍
My judgment about client care is often questioned by other home care personnel at Organisation Y	❍	❍	❍	❍	❍
Organisation Y has so many rules that I can't get my job done	❍	❍	❍	❍	❍
I often have to care for clients in ways that are against my best judgment	❍	❍	❍	❍	❍
The people I work with take a personal interest in me	❍	❍	❍	❍	❍
My co-workers appreciate my efforts	❍	❍	❍	❍	❍
In general, the people I work with are excellent home care workers	❍	❍	❍	❍	❍
I have a strong feeling of trust in the people I work with	❍	❍	❍	❍	❍

Q23 The following questions ask about your personality and work, family and other commitments

	This does not describe me at all	This mostly does not describe me	This describes me somewhat	This describes me mostly	This describes me very well

I hope to find a greater purpose to my life that suits who I am	❍	❍	❍	❍	❍
I hunger for greater spiritual growth in my life	❍	❍	❍	❍	❍
I have discovered that crises in life offer perspectives in ways that daily living does not	❍	❍	❍	❍	❍
If I could follow my dream right now, I would	❍	❍	❍	❍	❍
I want to have an impact and leave my signature on what I accomplish in life	❍	❍	❍	❍	❍
If necessary, I would give up my work to settle problematic family issues or concerns	❍	❍	❍	❍	❍
I constantly arrange my work around my family needs	❍	❍	❍	❍	❍
My work is meaningless if I cannot take the time to be with my family	❍	❍	❍	❍	❍
Achieving balance between work and family is life's holy grail	❍	❍	❍	❍	❍
Nothing matters more to me right now than balancing work with my family responsibilities	❍	❍	❍	❍	❍
I continually look for new challenges in everything I do	❍	❍	❍	❍	❍
I view setbacks not as "problems" to be overcome but as "challenges" that require solutions	❍	❍	❍	❍	❍
Added work responsibilities don't worry me	❍	❍	❍	❍	❍
Most people describe me as being very goal directed	❍	❍	❍	❍	❍
I thrive on work challenges and turn work problems into opportunities for change	❍	❍	❍	❍	❍

Q24 **Please indicate how much you agree with the following statements about your relationship with your key Care Co-ordinator at Organisation Y**

	Never	*Rarely*	*Sometimes*	*Often*	*All of the time*
I usually know where I stand with my Care Co-ordinator	❍	❍	❍	❍	❍
My Care Co-ordinator has enough confidence in me that he/she would defend and justify my decisions if I was not present to do so	❍	❍	❍	❍	❍
My working relationship with my Care Co-ordinator is effective	❍	❍	❍	❍	❍
My Care Co-ordinator understands my problems and needs	❍	❍	❍	❍	❍
I can count on my manager to "bail me out", even at his or her own expense, when I really need it	❍	❍	❍	❍	❍
My Care Co-ordinator recognises my potential.	❍	❍	❍	❍	❍
Regardless of how much my Care Co-Ordinator has built into his or her position, my Care Co-ordinator would be personally inclined to use his/her power to help me solve problems in my work	❍	❍	❍	❍	❍

Q25 **Please indicate how much you agree with the following statements about your relationship with your key Program Manager at Organisation Y**

	Never	*Rarely*	*Sometimes*	*Often*	*All of the time*
I usually know where I stand with my Program Manager	❍	❍	❍	❍	❍
My Program Manager has enough confidence in me that he/she would defend and justify my decisions if I was not present to do so	❍	❍	❍	❍	❍
My working relationship with my Program Manager is effective	❍	❍	❍	❍	❍
My Program Manager understands my problems and needs	❍	❍	❍	❍	❍
I can count on my manager to "bail me out", even at his or her own expense, when I really need it	❍	❍	❍	❍	❍
My Program Manager recognises my potential.	❍	❍	❍	❍	❍
Regardless of how much my Program Manager has built into his or her position, my Program Manager would be personally inclined to use his/her power to help me solve problems in my work	❍	❍	❍	❍	❍

Q26 **Please indicate your agreement with these statements regarding your commitment to Organisation Y**

	Strongly Dis-agree	*Disagree*	*Neither*	*Agree*	*Strongly Agree*
I would be very happy to spend the rest of my career with Organisation Y	❍	❍	❍	❍	❍
I enjoy discussing Organisation Y with people outside of it	❍	❍	❍	❍	❍
I really feel as if Organisation Y's problems are my own	❍	❍	❍	❍	❍
I think that I could easily become as attached to another organisation as I am to Organisation Y	❍	❍	❍	❍	❍
I feel like "part of the family" at Organisation Y	❍	❍	❍	❍	❍
I feel "emotionally attached" to Organisation Y	❍	❍	❍	❍	❍
Organisation Y has a great deal of personal meaning for me	❍	❍	❍	❍	❍
I do feel a strong sense of belonging to Organisation Y	❍	❍	❍	❍	❍

Q27 Please indicate:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
About how often did you feel tired out for no good reason?	❍	❍	❍	❍	❍
About how often did you feel nervous?	❍	❍	❍	❍	❍
About how often did you feel so nervous that nothing could calm you down?	❍	❍	❍	❍	❍
About how often did you feel hopeless?	❍	❍	❍	❍	❍
About how often did you feel restless or fidgety?	❍	❍	❍	❍	❍
About how often did you feel so restless you could not sit still?	❍	❍	❍	❍	❍
About how often did you feel depressed?	❍	❍	❍	❍	❍
About how often did you feel that everything is an effort?	❍	❍	❍	❍	❍
About how often did you feel so sad that nothing could cheer you up?	❍	❍	❍	❍	❍
About how often did you feel worthless?	❍	❍	❍	❍	❍

Q28 Please indicate how satisfied or dissatisfied you feel with each of these features of your main job at Organisation Y

	Extremely Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Neither	Somewhat Satisfied	Satisfied
I am satisfied with the nature of the work that I perform	❍	❍	❍	❍	❍	❍
I am satisfied with the person that supervisors me	❍	❍	❍	❍	❍	❍
I am satisfied with my relations to others in the organisation that I work with, such as my co- workers and peers	❍	❍	❍	❍	❍	❍
I am satisfied with the pay that I receive	❍	❍	❍	❍	❍	❍
I am satisfied with the opportunities that exist in the organisation for advancement and promotion	❍	❍	❍	❍	❍	❍
Considering everything, I am satisfied with my job	❍	❍	❍	❍	❍	❍

Q29 Please rate your performance at Organisation Y

	Unsatisfactory	Mostly Unsatisfactory	Somewhat Unsatisfactory	Neither	Somewhat Satisfactory	Mostly Satisfactory	Excellent
My ability to perform core job tasks	❍	❍	❍	❍	❍	❍	❍
My judgment when performing core job tasks	❍	❍	❍	❍	❍	❍	❍
My accuracy when performing core job tasks	❍	❍	❍	❍	❍	❍	❍
My knowledge of core job tasks	❍	❍	❍	❍	❍	❍	❍
My creativity when performing core job tasks	❍	❍	❍	❍	❍	❍	❍

Q30 Please indicate how much you agree with each of the following statements about Organisation Y

	Strongly Disagree	Disagree	Somewhat Disagree	Neither	Somewhat Agree	Agree	Strongly Agree
I feel quite confident that my Care Co-ordinator will always try and treat me fairly	❍	❍	❍	❍	❍	❍	❍
My Care Co-ordinator would never try to gain an advantage by deceiving workers	❍	❍	❍	❍	❍	❍	❍
I have complete faith in the integrity of my Care Co-ordinator	❍	❍	❍	❍	❍	❍	❍
I feel a strong loyalty to my Care Co-ordinator	❍	❍	❍	❍	❍	❍	❍
I would support my Care Co-ordinator in almost any emergency	❍	❍	❍	❍	❍	❍	❍
I have a divided sense of loyalty toward my Care Co-ordinator	❍	❍	❍	❍	❍	❍	❍

Q31 Please indicate how much you agree with each of the following statements about Organisation Y

	Strongly Disagree	Disagree	Somewhat Disagree	Neither	Somewhat Agree	Agree	Strongly Agree
I feel quite confident that my Program Manager will always try and treat me fairly	❍	❍	❍	❍	❍	❍	❍
My Program Manager would never try to gain an advantage by deceiving workers	❍	❍	❍	❍	❍	❍	❍
I have complete faith in the integrity of my Program Manager	❍	❍	❍	❍	❍	❍	❍
I feel a strong loyalty to my Program Manager	❍	❍	❍	❍	❍	❍	❍
I would support my Program Manager in almost any emergency	❍	❍	❍	❍	❍	❍	❍

Q32 Please indicate how much you agree with each of the following statements about Organisation Y

	Strongly Disagree	Disagree	Somewhat Disagree	Neither	Somewhat Agree	Agree	Strongly Agree
Management shows very little concern for me	❍	❍	❍	❍	❍	❍	❍
Management cares about my general satisfaction at work	❍	❍	❍	❍	❍	❍	❍
Management really care about my well-being	❍	❍	❍	❍	❍	❍	❍
Management strongly considers my goals and values	❍	❍	❍	❍	❍	❍	❍
Management cares about my opinions	❍	❍	❍	❍	❍	❍	❍
Even if I did the best job possible, management would fail to notice	❍	❍	❍	❍	❍	❍	❍
Management takes pride in my accomplishments at work	❍	❍	❍	❍	❍	❍	❍
Management is willing to extend itself in order to help me perform my job to the best of my ability	❍	❍	❍	❍	❍	❍	❍
Help is available from management when I have a problem	❍	❍	❍	❍	❍	❍	❍

Q33 Please rate your performance at work

	Strongly Disagree	Disagree	Somewhat Disagree	Neither	Somewhat Agree	Agree	Strongly Agree
My quantity of work is higher than average	❍	❍	❍	❍	❍	❍	❍
The quality of my work is much higher than average	❍	❍	❍	❍	❍	❍	❍
My efficiency is much higher than average	❍	❍	❍	❍	❍	❍	❍
My work quality standards are much higher than this job's formal standards	❍	❍	❍	❍	❍	❍	❍
I strive for higher quality work than required	❍	❍	❍	❍	❍	❍	❍

Q34 Please read each of the following statements carefully and decide if you ever feel this way about your job. If you have never had this feeling, mark 'never'. If you have had this feeling, indicate how often you feel it.

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel emotionally drained from my work	❍	❍	❍	❍	❍	❍	❍
I feel used up at the end of the workday	❍	❍	❍	❍	❍	❍	❍
I feel fatigued when I get up in the morning and have to face another day on the job	❍	❍	❍	❍	❍	❍	❍
I can easily understand how my clients feel about things	❍	❍	❍	❍	❍	❍	❍
I feel I treat some clients as if they were impersonal objects	❍	❍	❍	❍	❍	❍	❍
Working with people all day is really a strain for me	❍	❍	❍	❍	❍	❍	❍
I deal very effectively with the problems of my clients	❍	❍	❍	❍	❍	❍	❍
I feel burned out from my work	❍	❍	❍	❍	❍	❍	❍
I feel I'm positively influencing other people's lives through my work	❍	❍	❍	❍	❍	❍	❍
I've become more callous toward people since I took this job	❍	❍	❍	❍	❍	❍	❍
I worry that this job is hardening me emotionally	❍	❍	❍	❍	❍	❍	❍
I feel very energetic	❍	❍	❍	❍	❍	❍	❍
I feel frustrated by my job	❍	❍	❍	❍	❍	❍	❍
I feel I'm working too hard on my job	❍	❍	❍	❍	❍	❍	❍
I don't really care what happens to some clients	❍	❍	❍	❍	❍	❍	❍
Working with people directly puts too much stress on me	❍	❍	❍	❍	❍	❍	❍
I can easily create a relaxed atmosphere with my clients	❍	❍	❍	❍	❍	❍	❍
I have accomplished many worthwhile things in this job	❍	❍	❍	❍	❍	❍	❍
I feel like I'm at the end of my rope	❍	❍	❍	❍	❍	❍	❍
In my work, I deal with emotional problems very calmly	❍	❍	❍	❍	❍	❍	❍
I feel clients blame me for some of their problems	❍	❍	❍	❍	❍	❍	❍

Q35 Please tell us one strategy you were taught by Organisation Y in how to promote emotional wellbeing of your clients

Q36 Please tell us how depression and anxiety in clients has any impact on your at work

Q37 **Please tell us how depression and anxiety in clients has any personal impact on you**

Q38 **Please tell us any other comments you wish about your work, the emotional wellbeing of your clients and escalating your concerns, that you would like us to know**

Demographics:

Your gender:

Q39 ❍ Male ❍ Female

Q40 The year you were born (e.g., 1974) _____

Q41 Country of birth: _____

Q42 Do you speak a language other than English? ❍ Yes ❍ No

Q43 If yes, please specify which other language(s) you speak _____

Q44 Are you matched with clients based on your fluency in their native language? ❍Yes ❍No ❍Sometimes ❍Rarely

Q45 Is Organisation Y your first employer in the aged care industry? ❍ Yes ❍ No

Q46 Tenure with Organisation Y in months or years e.g. (3 years, 5 years) _____

Q47 Tenure in the aged care industry in months or years e.g. (7 years, 2 years) _____

Q48 Do you currently work for more than one employer? ❍ Yes ❍ No

Q49 **Relationship status:**

❍ Single (never married) ❍ Divorced ❍ Widowed ❍ Long-term partner (married or de-facto)

Q50 **Organisation Y employment type**

❍ Casual ❍ Part-Time (permanent) ❍ Full time (permanent) ❍ Fixed Term

Q51 **Please identify your role in the organisation structure:**

❍ Senior Management
❍ Care Co-ordinator
❍ Program Manager
❍ Office Staff (Support Functions e.g. IT, HR, Finance, Admin, Operations)
❍ Home Care Worker
❍ Registered Nurse/EEN/EN
❍ Allied Health Worker

Q52 **Workplace Location (where you deliver most of your work)**

❍ **NSW – West**: Nepean, Cumberland Prospect, South West Sydney, Central West
❍ **NSW – Coast**: Illawarra, Inner West, South East Sydney, Central Coast, Hunter, Northern Sydney
❍ **NSW – Northern Coast**: Mid North Coast and Far North Coast
❍ ACT
❍ QLD
❍ SA
❍ WA
❍ TAS
❍ VIC

Q53 **What is the highest level of education you have successfully completed?**

❍ Below Year 9
❍ School Certificate (Year 10)
❍ Higher School Certificate (Year 12)
❍ Trade or Technical Course or Certificate – Certificate III
❍ Trade or Technical Course or Certificate – Certificate IV
❍ University – Undergraduate

Q54 **What training specific to aged care have you successfully completed? Tick all that apply**

❍ Certificate III in Home and Community Care
❍ Certificate III in Aged Care
❍ Certificate IV in Home and Community Care
❍ Certificate IV in Aged Care
❍ Diploma in Diploma in Community Services Coordination
❍ University – Undergraduate
❍ University – Post graduate

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Q55 How many hours of formal training in mental health have you received (E.g. 1 day = 8 hours, 1 week = 40 hours)? Please specify_____

Q56 Which of the following types of mental health training have you received? Tick all that apply

❍ Classroom
❍ Online
❍ On-the-job
❍ Self-Directed

Q57 **We are keen to know how many Organisation Y employees have a mental health condition, so we can help managers to be more sensitive and respond appropriately to those needs. We want to reassure you that this information will NOT be linked to any other item in this survey and will be reported strictly as a summary. Please indicate if, in the last three years, you have suffered from any of the following mental health conditions, whether formally diagnosed or not:**

☐ Depression
☐ Anxiety, stress or panic disorder
☐ Schizophrenia
☐ Obsessive compulsive disorder
☐ Bipolar Disorder
☐ Anorexia, bulimia or other eating disorder
☐ Alcohol/substance abuse or dependence
☐ Post-traumatic stress disorder (PTSD)
☐ Insomnia or other sleep or wake disorder
☐ Other, not listed

Q58 **Optional and important** - please create a unique code as an employee number so that we can match any future survey responses with this response. Please use your initials and date of birth as the unique code.

For example, John Smith who was born on 7 April 1970 would be
JS07041970_____

Thank you for taking the time to complete our survey. Your participation is greatly appreciated.

Optional - to be in the draw to win one of nine $100 Coles Group & Myers Gift Cards please enter your Organisation Y email address. This information will be separated from your other responses, will only be used for the prize draw and will never be used to identify you.

E.g. john.smith@Organisation Y.com.au

_____@Organisation Y.com.au

Optional Questions

Q58 **Please indicate your agreement with each of the following statements about your career:**

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
I am satisfied with the success I have achieved in my carer	❍	❍	❍	❍	❍
I am satisfied with the progress I have made toward meeting my overall career goals	❍	❍	❍	❍	❍
I am satisfied with the progress I have made toward meeting my goals for income	❍	❍	❍	❍	❍
I am satisfied with the progress I have made toward meeting my goals for advancement	❍	❍	❍	❍	❍
I am satisfied with the progress I have made toward meeting my goals for the development of new skills	❍	❍	❍	❍	❍

Q59 **The following section is asking you questions about your future career choices**

	Strongly Disagree	*Disagree*	*Neither*	*Agree*	*Strongly Agree*
There is a good chance that I will leave this job in the next year or so	❍	❍	❍	❍	❍
I frequently think of quitting this job	❍	❍	❍	❍	❍
I will probably look for a new job in the next year	❍	❍	❍	❍	❍

Q60 **After working in a field for a while, many people shift to another job for any of a variety of reasons: pay, satisfaction, opportunity for growth, shut-down, etc. When the shift is a change in field, not just working for another employer in the same field, it is commonly called a 'career change'. Following are five statements which represent various stages in career change. Choose the one that best describes your current status: (Please tick ONE only)**

I am not considering making a career change	❍
I am considering whether to make a career change.	❍
I plan to make a career change and am choosing a field to change to.	❍
I have selected a new field and am trying to get started in it.	❍
I have recently made a change and am settling down in the new field	❍

Q61 **Please rate your agreement with these statements:**

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
I plan to retire from the workforce in the next five years	❍	❍	❍	❍	❍
I plan to retire from the workforce in the next two years	❍	❍	❍	❍	❍
When I retire, I plan to do some part time work still	❍	❍	❍	❍	❍
When I retire, I would be happy to still do my current job, but part time or fewer hours than I work now	❍	❍	❍	❍	❍

Q62 **Please describe your carer and dependent responsibilities. Please write the number of dependents or individuals that you currently care for in each category. A carer is defined as a person who, through family relationship or friendship, looks after an individual with a disability or chronic illness. A dependent is someone who relies upon your financial support:**

❍ Children-Infants _____

❍ Children – School age _____

❍ Children – Adults _____

❍ Parents _____

❍ Spouse's Parents _____

❍ Grandchildren _____

❍ Other _____

❍ N/A _____

Thank you so much for completing these extra survey items.
The survey is now finished.