Identifying Strategies to Alleviate Aged-Care Worker Burnout: A Study from Two Aged-Care Facilities in Sydney

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A Thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Professional Studies

Central Queensland University

2014

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Abstract

This thesis identifies strategies that will help alleviate the burnout experienced among aged-care workers in Sydney. Specifically, the study investigates the factors contributing to burnout in the human services sector with particular application to two aged-care facilities.Burnout among carers has been a major concern for many years in health care fields. Previous studies of the issue have generally focused on examining the causes of burnout and the associated consequences. However, there seems a lack of studies which suggest interventions for the alleviation of burnout. The literature in this field has identified ten factors pre-disposing carers to burnout in the aged-care industry. In this study the factors are categorised into three major groups: fixed, moderate and non-fixed factors.

To gather data to achieve the research goals, a qualitative interview approach was employed. Data was elicited from twenty-five survey participants grouped as follows: ten assistant nurses, eight nurses, three facility managers and four relatives of those in care. Participants were selected from the Canterbury Domain Principal Aged Care facility and the Frank Vickery Lodge of the Wesley Mission at Sylvania. A version of the Copenhagen Burnout Inventory was adapted and used as a verification tool for interviews completed by those participating in the study.

Major factors identified as influencing burnout among aged-care workers included: problems with facility staffing, the lack of ethics (or otherwise described as a breach of duty of care), and the unrealistic expectations of relatives. Recommendations arising from the study findings include: a review of training for aged-care workers, promotion of the professionalism of the aged-care profession, regulation with regard to the staff-resident ratio, and synergistic collaboration between relatives and staff.

There are significant challenges to the development and maintenance of a healthy aged-care workforce in Australia. Although the data in this study is generated by small cohorts from only two sites, the strategies identified might be applied to those sites and have wider application potential for the well-being of aged-care workers in other aged-care facilities.

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Abbreviations and Acronyms

ABS	Australian Bureau of Statistics
ACIC	Aged Care Industry Council
ACSA	Aged and Community Services Australia
AIHW	Australian Institute of Health and Welfare
AiN	Assistant in Nursing
CBI	Copenhagen Burnout Inventory
DADHC	Department of Ageing, Disability and Home Care
EN	Enrolled Nurses
EEN	Endorsed Enrolled Nurses
NHHRC	National Health and Hospitals Reform Commission
PCA	Personal Care Assistant
PCW	Personal Care Worker
RN	Registered Nurses
SCARC	Senate Community Affairs References Committee

Acknowledgements

I feel very proud to have completed this research at this stage of my life and as a second language writer. It has proven to be an extremely enjoyable exercise on the one hand and an excruciatingly painful journey on the other.

I owe a deep debt of gratitude to the following people for their help and support. My academic supervisor, Dr. John Rule, for his constructive criticism, truly devoted support, and endless patience with my writing. Certainly, he played the most important role in assisting my climb to the Doctoral summit. Without him, this project would not have been possible. My gratitude also extends to Dr Clive Graham, for his invaluable suggestions and kind guidance and to Mrs Corlette Todd, industry supervisor, for her constant compliments and interest in my research. Special thanks also go to the participants in this study.

I am greatly indebted to Dr Ned Munroop and Professor Arun Aggarwal for their generosity and encouraging comments whenever I cried out for help. I will never forget their supports.

Special thanks must go to my wife, Lorna, for her endless support, and my most beautiful two children for their long-suffering patience during my candidature. I must also express my gratitude to my family back in Madagascar and Mauritius, especially to my mother, and to my uncles, my mother in-law, my deceased grand-mother and father in-law who have always encouraged my scholarly achievements.

Author's Declaration

I Lovasoa N. Andriamora declare that:

I. This thesis comprises only my original work towards the Doctor of Professional Studies degree
II. Due acknowledgement has been made in the text to all other material used
III. The thesis does not exceed the word length for this degree
IV. No part of this work has been used for the award of another degree
V. This thesis meets the Central Queensland Human Research Ethics Committee (HREC) requirements for the conduct of research

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Chapter 1 – Introduction

1.1 Overview of the study

This thesis explores the causes of burnout among residential aged-care workers at two aged-care facilities. Theories concerning burnout in other human services are also explored for their applicability to the aged-care industry. The aim of the research is to develop strategies that contribute to alleviating residential aged-care worker burnout. To this end, two key research questions and sub-questions have been developed:

1) What are the known factors contributing to burnout in the human services sector?

a) To what extent do general factors contribute to aged-care worker burnout?

b) What perceptions do aged-care workers have of these factors?

c) What are some additional factors contributing to burnout among aged-care workers?

2) What can be done to alleviate aged-care worker burnout?

a) What do aged-care workers suggest in order to reduce burnout in the aged-care industry?

b) Who should be responsible for implementing the strategies?

c) What current resources are provided within the industry to address and manage burnout?

It should be kept in mind that a complex phenomenon such as burnout is not curable with simple recommendations. Rather, a thorough investigation

of causes and resources in a certain setting can bring about a meaningful strategy to alleviate burnout.

The thesis complies with the requirements of the Doctor of Professional Studies degree in that it:

i) Employs transdisciplinary, Mode-2 applied knowledge production as opposed to mono-disciplinary, Mode-1 theoretical knowledge production (Gibbons et al. 2009; Nowotny, Scott & Gibbons 2002);

ii) Focuses on the creative use of knowledge and skills and problem solving;

iii) Shifts from the dominant focus of 'research' and 'theory' and is concerned with industry-based problems faced by working professionals; and

iv) Requires a shift from knowledge as 'illumination' (power to describe the world) to knowledge in application (the value of knowledge to impact performance) (CQUniversity 2009).

Pohl et al. (2008) defines trans-disciplinary research (TR) as an emerging field of research in the knowledge society. It relates science and policy in addressing issues such as public health, socio-cultural change, new technologies, global and local environmental concerns.

The TR is needed when knowledge about a socially relevant problem field is uncertain, when the description and explanation of the genesis and possible further development of such problem fields may create complexity, when the concrete nature of problems is disputed, and when there is a great deal at stake for those affected by problems and involved in dealing with them. Trans-disciplinary research deals with problems in such a way that it

can: a) grasp the complexity of problems; b) take into account the diversity of social reality around the problem; c) link abstract and case specific knowledge; and d) develop knowledge and practices that promote what is perceived to be the common good (Graham & Brien 2010; Pohl & Hirsch Hadorn 2008).

Nicolescu (2002) argues that trans-disciplinarity concerns transgressing and dissolving boundaries because it involves an integrated system of problem analysis across, between and beyond, multiple disciplines. In line with Nicolescu, Graham and Brien (2010) assert that trans-disciplinarity is about unifying different forms of knowledge for solving problems which are concrete, identified and structured questions within problem fields. The trans-disciplinary research process mainly consists of problem identification, problem analysis and bringing solutions which are achieved in the form of a real-world experiment (Pohl & Hirsch Hadorn 2008. Trans-disciplinarity is an integral component of Mode 2 knowledge production (Gibbons et al. 2009).

Nowotny, Scott and Gibbons (2002) argue that a shift in knowledge production from academically-based Mode 1 knowledge production towards a novel Mode 2 system is crucial in contemporary society. Mode 2 is 'socially distributed, with research capacity beyond traditional academic institutions' (Ferlie & Wood 2003, p. 51).According to Nowotny, Scott and Gibbons (2002) and Gibbons et al. (2009) the main characteristics of Mode 2 knowledge production can be summarised as follows:

a) Knowledge is generated within the context of an application describing the environment in which problems arise.

b) Mode 2 is trans-disciplinary, implying that a range of theoretical

perspectives are gathered for the purpose of solving problems.

c) Mode 2 knowledge can be developed in a much greater diversity of sites and is not exclusive to university knowledge production. It is heterogeneous.

d) Mode 2 is highly interactive and reflexive.

e) Mode 2 involves a novel form of quality control referred to as 'the agora'. This term encapsulates the idea that the value of knowledge must be socially accountable in the context of application and available for a broad group of stakeholders (Buser & Jensen 2010; Gibbons et al. 2009; Nowotny, Scott and Gibbons 2002).

Mode 2 knowledge production aims to investigate and solve a wide range of problems that involve specific, immediate practical concerns. It aims to promote innovative application that is appropriate to a current and specific industry context (Taylor 2006).

The thesis is divided into seven chapters. A brief description of the contents of each chapter is presented below:

Chapter 1 contextualises the research topic and provides a rationale for the research. While the current study was being undertaken, it was well publicised in the media that aged-care workers were facing a crisis related to stress and burnout. This chapter provides basic demographic data about aged-care workers and explains how background societal influences and trends can affect aged-care workers' well-being in Australia. Accordingly, this chapter serves to highlight the pertinent pressures currently faced by aged-care workers.

Chapter 2 presents an overview of the literature that has influenced this study. It describes the historical development of the burnout concept in human services and identifies the known factors contributing to burnout in the human services sector. Various theoretical models about burnout are explored. The chapter concludes by identifying some of the limitations and gaps in the existing knowledge and proposes a framework for describing the pre-disposing factors contributing to burnout by categorising them into fixed, moderate and non-fixed factors.

Chapter 3 describes the research methodology which involves semi-structured interviews with twenty-five research participants comprising assistant nurses, registered nurses, and managers from either the Frank Vickery Lodge Nursing Home or Canterbury Domain Principal Nursing Home. This chapter also describes in further detail the method and procedures used in the collection of data, and its analysis.

Chapter 4 presents the main findings from the interview data. It also analyses the data derived from the interviews referring to the proposed framework and concepts derived from the literature review in Chapter 2.

Chapter 5 provides a synthesis of the main themes derived from the analysis. This forms the basis of the recommendations in Chapter 6.

Chapter 6 concludes the thesis in the form of recommended strategies to alleviate aged-care worker burnout. The strategies point out that aged-care worker burnout must not be seen as an individual problem, but as an occupational problem for which the organisation, the government and other stakeholders are all responsible. This chapter also considers the extent to

which the thesis was successful in achieving its aims and discusses limitations and specific research objectives.

Chapter 7 is a reflection of the journey undertaken by the researcher. This reflection provides information relevant to building and researching the thesis topic**.** This is a standard format for the Doctor of Professional Studies degree.

1.2 Definitions and Explanation of Terms

1.2.1 Burnout

Despite the difficulty in finding a standard definition, there has been a wide variety of opinions about what constitutes burnout. The most commonly accepted definition of burnout is the three-component conceptualisation proposed as a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity'. (Maslach, Jackson & Leiter 1996, p. 4). Chapter 2 will take stock of the existing empirical knowledge regarding burnout.

1.2.2 Discourse Analysis

In this thesis, the term 'discourse' refers to the usage of a series of related statements and practices drawn from interview transcriptions. Therefore, discourses are regarded as patterns of ways of representing the aged-care phenomena in language. They provide the contextual meaning of

language and shape the meaning by which aged-care workers' practices and terms are understood. Words and actions are understood by the context in which aged-care workers perform their caring duties (Brunton & Beaman 2000; Hardy, Palmer & Phillips 2000; Seibold 2006).

1.2.3 Assistant Nurses/Registered Nurses

An assistant nurse–also called a personal care assistant (PCA), an assistant in nursing (AiN), or a personal care worker (PCW)–is a care provider who works primarily within the community and aged-care sector. A personal caretaker is neither regulated nor registered and cannot be described as a nurse, and the level of care provided by the personal caretaker is similar to that which would normally be provided by a responsible family member (Nesvadba 2003). AiNs are the carers who provide the majority of day-to-day care in any aged-care facilities.

A registered nurse (RN) is defined as 'a person with appropriate educational preparation who is registered and licensed under the Nursing Act 1992 to practice nursing' (Nesvadba 2003, p. 6; Nursing Act 1992 (NSW)). The RN is responsible for the provision of nursing, the supervision of enrolled nurses and personal carers, and the delegation of decisions.

1.2.4 Strategies

The term strategies refer to a plan of action designed to achieve a long-term or overall aim. They include policy direction and practical recommendations.

1.3 Research Background

1.3.1 The nature of the aged-care profession

It is recognised that the nature of aged-care work in Australia is rapidly changing. Providing care for older people in residential aged-care settings is perceived as demanding and challenging (Edvardsson et al. 2011). Burnout has been found to occur among individuals who work with people in emotionally charged situations making aged-care workers especially vulnerable (Altun 2002). Aged-care workers' principal mission is oriented towards nurturing and caring for residents. In addition to providing personal care, they also comfort residents with loneliness, pain, incapacity, death and disease (Duquette et al. 1994). Aged-care workers deal with older adults with multiple diagnoses who often present complex problems and require advanced personal and nursing care (Fläckman 2008). They are employed to provide health, personal and rehabilitation care services. The increased workload seen in today's residential facilities has been discussed by several authors (Bellis 2010; Ford 2008; Hickman et al. 2007; Phillips et al. 2007; Robinson & Cubit 2007). Aged-care workers are constantly exposed to

stressful situations that form the breeding ground for burnout. This thesis investigates these stressful situations and proposes ways to alleviate burnout among aged-care workers.

Among those working in aged care, personal carers and nurse's aides make up the largest group, with registered nurses numbering only a few (Martin & King 2008). As stated above, these caregivers provide care that is complex and personal. As older people often present complex problems and require high levels of nursing care, the consequence today is a considerably increased workload in aged-care facilities (Fläckman 2008). In an aged-care facility, a worker is called to perform various tasks starting from basic support to higher order levels of care. As well as these responsibilities, there are other ad-hoc activities such as training attendance, meetings, and paperwork. These peripheral activities can add to the exhaustion experienced by aged-care workers. In addition to these various activities, several more general factors have been found to influence aged-care workers' well-being; for instance, the nature of the profession, decision making and institutional factors such as staffing, and instability in leadership (Fläckman 2008).

The aged-care profession is demanding and requires a great deal of dedication and commitment. Many carers quit as a result of the conditions they are subjected to and their inability to cope with the changing landscape of the work (Institute of Health and Welfare 2004b; Woods 2010). Dealing with old people is often cumbersome and requires both patience and determination. Aspects of the work such as bathing, showering and dressing are perceived as particularly unattractive by many, and these aspects contribute to burnout among caretakers (Scott 2009). These are the reasons

why few young people wish to enter the industry and why so many carers leave it (Senate Community Affairs References Committee 2005).

An additional difficulty faced by aged-care workers in their daily life is related to decision making. Caregivers in aged care face decision-making difficulties in their everyday work. While Zwijsen, Niemeijer and Hertogh (2011) argue that ethical debate –in terms of practical decision making – appears not to be a priority in residential elder care, ethical difficulties may lead to a troubled conscience and stress, contributing to burnout (Dreyer, Ford & Nortvedt 2011; Juthberg et al. 2010; Rees, King & Schmitz 2009).

Issues related to the human services workforce have also become key challenges for the aged-care industry: workforce shortages, workforce feminisation, the ageing workforce, workforce planning and innovation. The aged-care workforce displays more casual employment at low levels than any comparable segment of the workforce (Martin 2007). Staffing instability is a key challenge for the aged-care industry. Turnover rates amongst aged-care workers are quite high (Martin 2007). Aged-care workers frequently resign as a result of the conditions they are subjected to and their inability to cope with the changing landscape of the job (Institute of Health and Welfare 2004a; Richardson & Martin 2004). The residential aged-care industry faces significant challenges in terms of attracting and sustaining a competent and stable workforce, mainly due to expected labour shortages in this sector (Boldy, Chou & Lee 2004; Edvardsson et al. 2011; Vernooij-Dassen 2009). By developing strategies to alleviate aged-care worker burnout, this thesis aims to contribute to an understanding not only of the retention of aged-care

workers, but also of the reasons why stress and burnout might relate to workforce instability.

1.3.2 Burnout in human services and aged care

The issue of burnout has become the focus of extensive investigation in the human services sphere (Alexander & Hegarty 2000; Dempsey & Arthur 2002; Schaufeli, Leiter & Maslach 2009). Accordingly, burnout has been examined in a variety of human service workforces including child care workers, nurses and social workers (Gray & Schubert 2009; Skirrow & Hatton 2007). However, it appears that less attention has been paid to this phenomenon within the aged-care context in Australia, and particularly in New South Wales.

Many scholars point out that the lack of relevant research to guide planning and decision-making regarding the alleviation of aged-care worker burnout is a significant issue (Dodd et al. 2008; Hastings, Horne & Mitchell 2004; Pilo 2006). Few studies have considered the alleviation of aged-care worker burnout (Devereux, Hastings & Noone 2009; William & Rose 2007). According to Devereux, Hastings and Noone (2009), this may be because no comprehensive theoretical framework has so far been developed to explain aged-care and disability-workers' burnout.

It is recognised that burnout is a significant problem for workers in the aged-care industry. Spooner-Lane and Patton (2003) assert that aged-care workers are particularly vulnerable to burnout. Shanafelt (2006) also reported that 90% of the caregivers had some degree of burnout. Vashon's study (2009) confirmed that the burden among caregivers for the 'old disabled' was

extremely high and research conducted in Europe and in Australia supports this concern (Baillie & Gallagher 2011; Borritz et al. 2006; Duffy, Oyebode & Allen 2009). European studies suggest that approximately 60% of residential carers experience burnout (Devereux et al. 2008; Pilo 2006; Skirrow & Hatton 2007). A German study concludes that alleviating carers' burnout should be 'an important part of risk management in the disability and aged care services' (Kowalski et al. 2009, p. 471). Other studies report that 45% of residential care nurses have burnout levels that exceed the standards for healthcare (Braithwaite 2008; Funderburk 2008).

In Australia, there is strong evidence that working in aged-care services can be extremely stressful (Productivity Commission 2008b). During the television program, the *7PM project*, an aged-care worker described her routines as follows:

We're short of staff; constantly running around trying to get things done. Every morning shift we each have ten residents and six hours. That's about thirty-six minutes per person. In that time we have to ensure each resident is fed breakfast, morning tea, and lunch. They need to be showered, dressed. We have to tidy up after both the resident and ourselves, including making the bed and taking the old clothes/lines to the skips and putting away any rubbish etc…This doesn't include the running around we have to do getting ready for each person, such as fetching equipment (hoists, wheelchairs). And we get paid less than a cashier at McDonalds, yet have a heavy emotional and physical toll unknown I think to people who have not worked in aged care! (*7PM project* 2011)

In New South Wales, high levels of burnout due to difficult relationships between carers, excessive sleepovers, and inadequate rosters have been noted (Carers NSW 2010) and respondents in a study by Patton and Goddard (2006) report that carers experience high levels of emotional exhaustion. According to Hegney et al. (2005), residential aged-care workers have the highest level of stress reported in the disability workplace. Areport from the Department of Health and Aged Care (2002) asserts that other major causes of stress and burnout among aged-care nurses are associated with inappropriate recruitment and retention methods. A study by Martin (2007) confirms that turnover rates among aged-care workers have increased as a result of burnout derived from poor retention strategies. Aged-care nursing retention and attrition presents real challenges for both the Government and service providers in Australia. Cooper and Mitchell (2006) argue that the motivation of nurses in long-term care homes is reduced by de-personalisation and emotional exhaustion leading to depression, long periods of absence, and high turnover.

Staff burnout has been shown to have an impact on patient satisfaction, quality of care (Juthberg et al. 2010; Vahey et al. 2004) and patient health outcomes (Jansen & Murphy 2009). Carers' burnout may impede their ability to deal with clients' needs and challenging behaviours (Devereux et al. 2008). In a survey conducted by Todd and Watts (2005) of 25 nursing staff and 26 psychologists, burnout was found to be associated with low willingness to help, low optimism and negative emotional responses to clients' behaviour.

A study commissioned by the Commonwealth Department of Health and Aged Care concluded that minimising aged-care worker burnout is one of the most important solutions to the attrition of residential aged-care nurses (Department of Health and Aged Care 2002). The importance of reducing aged-care worker burnout for the sake of the health and quality of life of the carers themselves is evident (Benson & Maigrath 2005; Department of Health and Ageing 2009; Productivity Commission 2008a). Horin (2010) reports on a study conducted in Melbourne showing that aged-care workers are more stressed and fatigued and have less job satisfaction than three years ago. Nurses and personal care staff complained about appetite change, clients' behaviour, and unattractiveness of the job, fatigue, headaches, backache and trouble sleeping and these are generally the signs of caregivers' burnout (Richardson & Martin 2004). Though the study was conducted in Melbourne, the NSW Nurses' Association asserts that the results are relevant to NSW (Horin 2010).

Few earlier empirical studies have explored the implications of these facts in developing strategies to alleviate aged-care worker burnout. This makes it significant to carry out a research for this thesis.

1.3.3 Policy directions

The Department of Ageing, Disability and Home Care (DADHC) (2008) affirms that prevention and alleviation of carer burnout is an important issue requiring serious consideration in New South Wales. Aged-care policy makers need to be aware that the sense of conflict and frustration that personal carers and nurses experience could be correlated with emotional exhaustion and

burnout (Martin & King 2008). When the Productivity Commission Report (2011) was released, no recommendations regarding minimum staff ratios for aged care were included. It would seem that more information is required to enhance aged-care policy in relation to residential carers.

It is anticipated that the research for this thesis might contribute to the development of relevant policies for the Department of Ageing Disability and Home Care, policy-makers and aged-care service providers in order to alleviate burnout among aged-care staff.

1.3.4 An ageing population

Over the next forty years, population ageing and growing diversity among older people, in terms of their care needs and affluence, are expected to pose a number of challenges for Australia's aged-care system. For example, the ageing of Australia's population will give rise to a significant increase in the number of older Australians with dementia or other disabling conditions, with important implications for the aged-care workforce (Institute of Health and Welfare 2004a; Productivity Commission 2008b). Approximately 5 to 7% of elderly persons are in residential aged care in Australia, and the probability that a person will require 'residential care' increases with age (Institute of Health and Welfare 2005).

According to Ingram (2013), nursing-home admissions have increased, but this upward trend in admissions has been accompanied by significant decline in the number of available beds. At the same time, there has been a decrease in the number of qualified staff in residential care over the past two decades (Martin and King 2008). The National Health and Hospitals Reform

Commission (NHHRC) acknowledged that there is an urgent need to secure the aged-care workforce because the number of aged-care workers will need to triple by 2050 to care for more than 3.6 million elderly persons (Productivity Commission 2011). The Nursing Federation (2009) predicts that there will be a 56% increase to about 250,000 residents in residential aged care by 2020. However, estimates suggest that the total number of staff working in residential aged care will only increase by around 14% by 2020 (Edvardsson et al. 2011). A number of other studies attest to the worsening staff shortages in the aged-care industry (Brown 2010; Productivity Commission 2008a, 2011; Yates & Laverty 2011). There is also a high turnover among aged-care workers due to stress, fatigue and burnout issues (Fenech 2011; Horin 2010; Patrick & Lavery 2007). In addition, trends suggest that skilled workers are being increasingly replaced by unskilled staff in the residential aged-care workforce (Nursing Federation 2009; IBIS Care 2007). These trends are evident in Australia where less skilled workers are being employed. Such a change is due to the fact that unskilled and less skilled workers demand less wages (The formal *aged care workforce* n.d.). Similar projections are observed in countries such the United States, China and New Zealand (Beverly et al. 2010; Chen, Song & Chui 2010; McDanielle, James & Veledar 2011; Spies and Schneider 2003). Therefore, considering the welfare of an increasing aged population, it becomes imperative to alleviate aged-care workers' burnout.

1.3.5 Increase in demand for aged services

Among the aged population, those over 80 years have increased the most. There are currently 4.5 million 'baby boomers' (born between 1946 and 1964) who will move into the space currently occupied by 2.5 million people (Drape 2010). The aged population (aged 65 years and above) is predicted to reach 22% (5 million) by the year 2051, double that of 1991, which was 11% or 1.9 million (Bureau of Statistics 2008). It is projected that the NSW population will increase from almost 6.8 million people in 2006 to almost 8.3 million people in 2031. A significant proportion of the increase will be aged 65 years and above (Bureau of Statistics 2008). Aged people will make up 22% of the population in 2030.

There will also be a significant rise in the number of 'very old' people, with the number of people in NSW aged 100 years or older expected to increase from 1,000 in 2008 (now) to 6,500 by 2026, and 8,200 by 2031 (Department of Ageing, Disability and Home Care 2008). The overall population has, and will continue to have, the largest number of people aged 65 years and above. The period between 2006 and 2031, is expected to see an increase in total population by almost 1 million people, including an increase in the number of people aged 65 years and above from 527,700 to 963,900 i.e., an increase from 12% to 18% of the population (Productivity Commission 2008b).

Better healthcare services have led to declined fertility, increased life span and longevity (Woods 2010). Such an image of the aged-care workers has increased their demand (Productivity Commission 2008b). If nothing is done to face the results of this trend, there will be further shortages of aged-

care workers, probably even higher workloads, and consequently even higher levels of burnout.

An additional concern is that aged-care workers are mostly females (Joinson 2007; Keidel 2008). It is projected that the number female aged-care workers will decline in coming years due to their age factor (they will become old) (Martin 2007). In the future, aged-care providers will seek replacements for a growing number of retiring female workers (Productivity Commission 2008b; Richardson & Martin 2004). This will occur at a time when growth in the effective labour supply is expected to be lower than population growth. Demographic trends will be compounded by difficulties in retaining personnel and by an insufficient number of young people choosing educational programmes and careers in eldercare. Consequently, workloads are expected to increase resulting in high levels of burnout among aged-care workers. Demand for aged-care services will increase significantly. Studies by Arevalo-Flechas (2008), the Productivity Commission (2002) and Martin (2007) urge research to be undertaken concerning aged-care workers' well-being. This thesis aims to respond to these urgings.

1.3.6 Dementia care: an added complexity in current times

A particularly challenging aspect of demographic shift is the projected increase in dementia accompanying the ageing population. Access Economics (2009) estimates that the number of people with dementia will increase from around 220,000 to over 730,000 between 2007 and 2050. This will have significant implications for the demand for, work conditions and welfare of aged-care workers. Further, the burden of caring for older people

with dementia is a well-reported phenomenon for aged-care workers in residential facilities (Edvardsson et al. 2011; Zimmerman et al. 2005). Research suggests that dementia care could be the main cause of carers' burnout because of heavy patient care needs and challenging behaviours associated with the condition (Almberg, Graftstorm & Winblab 1997; Duffy, Oyebode and Allen 2009; Productivity Commission 2008b; Zimmerman et al. 2005).

Several issues have been identified in residential care of people with dementia that might contribute to carer burnout. One issue is that measures taken to provide physical care and safety might be resisted by the patient. Another is related to the conflicts arising from communication barriers as aged-care workers often express their concerns to managers about their understanding of the person's core needs (Edberg et al. 2008; Noone & Hastings 2010), and this has the potential for conflict with management or the relatives of those in care. An additional concern is the distress arising from the desire to alleviate patient suffering and to enhance their quality of life even when it is obvious that very little that is effective can be done. Other patterns of behaviour increasing burnout among dementia caregivers include: aggression, self-injury, screaming, yelling and constant moaning by residents (Rodney 2000; Skovdahl, Kihlgren & Kihlgren 2003). Rodney (2000) finds that resident aggression is related to an increase in residential caregiver burnout and that even perceiving the possibility of aggressive behaviour can be a source of stress. However, the level of burnout each staff member experiences appeared to be determined by several variables including: the level of knowledge about the effects of dementia, the extent to which nurses

understand the causes of the behaviour, and attitudes to care (Bird et al. 2007). It is therefore important and timely to find out how the changing nature of aged-care impacts the well-being of aged-care staff and whether they perceive this to contribute to burnout.

1.3.7 Government policy directions

The Government has a vital role to play with aged-care work both in the funding and regulation of the industry. The government is the chief funder of the aged-care industry in Australia. The Treasury's projections suggest there will be strong growth in high care residential places in the coming years (Council of Governments 2008; Treasury 2009). The Treasury report estimates that the Government expenditure on aged care will increase 'from 0.8% of GDP in 2006–2007 to around 2.0% in 2046–2047' (Treasury 2007, p. 210). The report also observes that spending on aged care will account for much of the projected rise in overall budget spending in the next four decades.

A report commissioned by the Aged Care Industry Council (ACIC) predicts a capital funding shortfall of $5.7 billion between 2008 and 2020for high care placements in the future (PricewaterhouseCoopers 2007). This funding issue will have a direct impact on the well-being of paid aged-care workers. Several studies have indicated that there is a correlation between pay, job satisfaction and burnout (Edvardsson et al. 2011; Fenech 2011; Tuckett et al. 2009). The low levels of funding provided by the Federal Government for aged care has drawn criticism from the Aged Care Association of Australia:

…if a country should be judged on how it treats its elderly it should also be judged on how it treats the staff who provide the compassion, care and devotion to provide the highest quality of service within very limited resources. (Young 2009, p. 1)

The role of the government as the regulator of aged care in Australia may also be problematic. Research by the Productivity Commission (2008a) suggests that the regulatory system is fragmented and difficult to access and navigate, reflecting the existence of multiple programs, combined with the involvement of multiple government departments and agencies across different tiers of the government. Government determines how many aged-care places are provided, where these places are located, the appropriate mix of services, the prices of these services, and how they are modified in response to changing community expectations. The Commission finds that competition and price play little role in signalling to providers the changing patterns of demand and the need to adjust decision-making accordingly (including the need for new investment). This fragmentation is seen as a barrier to improving service interfaces within the aged-care system, and between the aged-care system and the welfare of the aged-care workforce (Productivity Commission 2008b).

Immigration is a further area in which government decisions may have a major impact on burnout among aged-care workers. A large proportion of staff in the aged-care industry is from overseas. These overseas workers, including nurses, students and welfare workers, have filled labour shortages (Aged and Community Services Australia 2008). Unfortunately, aged-care workers are not on any Skilled Occupation List, making them extremely

difficult to sponsor in their own right. The recent Government announcement (shift from 'bigger Australia to sustainable Australia') might also impact the aged-care workforce (Aged and Community Services Australia 2011). Changes to Australia's immigration policies could significantly reduce the number of overseas workers.

The Government faces four key challenges to impact aged-care worker burnout:

i. To build an effective workforce with the necessary flexibility to provide appropriate care for older Australians in an environment where caring activities will face immense pressure for workers given the anticipated slowdown in workforce growth;

ii. To review and establish a system for upgrading the skills base and training opportunities involving aged-care workforce requirements and development options for the reform of regulatory and funding arrangements, policy settings, regulations, funding and subsidies;

iii. To adapt the aged-care sector and its workforce to changes in consumer needs and preferences; and

iv. To consider structural reform options (a blueprint for reform over the next 20 years which is not constrained by the existing system) (Productivity Commission 2011).

If the Government fails to address these issues, the aged-care workforce is likely to be characterised by frustration and extremely high levels of burnout due to job dissatisfaction, work overload and other related

concerns. The significance of the research of this thesis is predicated on reducing this potential for burnout.

To summarise, current trends indicate that the challenge to reduce aged-care worker burnout is an enormously difficult and complex task. This thesis therefore aims to identify strategies that take these trends into consideration.

1.4 Contribution to the research area

The research for this thesis aims to contribute to existing knowledge in the field of aged-care worker burnout by way of theoretical, empirical and methodological contributions.

There are several reasons for studying burnout. Burnout is a component of Workplace Health and Safety arising from the increasing complexities of Western society. The guidelines for residential aged-care facilities in Australia emphasise the importance of stress management and positive coping strategies for nursing homes (Productivity Commission 2011). However, as noted above, there have been limited studies carried out on strategies to alleviate burnout of aged-care workers (Edvardsson et al. 2001; Senate Community Affairs References Committee 2005). While some studies show a trend towards increased levels of burnout among nurses, few studies have examined in depth the reality of burnout among aged-care staff. It is anticipated that the research for this thesis will expand current knowledge of burnout to the aged-care industry such that the findings will contribute to the development of appropriate burnout-reduction strategies that may be used in residential care facilities.

In terms of a methodological contribution, the majority of previous research has relied on quantitative data to determine factors contributing to burnout (Hastings, Horne & Mitchell 2004; Hayes 2010; Jenull-Schiefer, Salem & Brunner 2010). In this thesis, aged-care worker' perceptions are considered to generate information of individual work experiences with the elderly in residential care as distinct from the quantitative data of previous studies (Jenull-Schiefer et al. 2007; McGrath, Reed & Boore2003).

1.5 Summary

With consideration of the rationale for undertaking the research topic of this thesis detailed above, the following Chapter 2 provides an in-depth review of the literature underpinning the research questions moving toward the development of an evaluative framework with which to undertake the qualitative research employed in the research methodology outlined in Chapter 3.

Chapter 2 – Literature Review

The purpose of this chapter is to review existing knowledge about burnout. The literature review can be categorised into two main sections: literature related to burnout in general and literature related to burnout in nursing specifically. The first section examines the burnout concept from Freudenberger's construct to the recognised psychological syndrome, as it is known today. The second section focuses on literature pertaining to burnout in particular in the fields of nursing and aged care. The review charts the development of the burnout concepts in human services and provides basic definitions, descriptions and an account of the ways burnout is currently understood and measured. More specific examination of the concept in the nursing and caring profession identify potential pre-disposing factors contributing to burnout in human services and in the aged-care industry. The chapter concludes by identifying some of the limitations and gaps in the existing knowledge and proposes a framework describing the pre-disposing factors contributing to burnout by categorising them into fixed, moderate and non-fixed factors.

2.1 Burnout: General Context

2.1.1 Historical development

The term 'burnout' comes from the language of aerospace in the 1950s, when it was used to describe the exhaustion of fuel in rockets and nuclear reactors. There was no allusion to human behavioural issues as part of the burnout definition during this period of time (Minter 2009).The burnout

concept emerged in human services as an extension of this concept of exhaustion of energy. The concept was developed from observation rather than theory. In the 1950s, Elliot Jacques conducted a study into social defence against anxiety (Jacques 1955). Isabel Menzies later applied it to the study of social systems in the nursing service of a general hospital. Menzies (1960) led a case study in nursing with the aim of developing defences against the anxiety that comes with change. The defence mechanisms that Menzies and Jacques described from in-depth interviews and observations closely resemble the symptoms of what was twenty years later labelled 'burnout'. The terms used were depersonalisation, anxiety, denial, and detachment (Bloom & Farragher 2010; Engelbrecht 2006; Jacques 1955; Menzies 1960). The phenomenon of burnout had been present long before the expression was coined to describe the phenomenon. It is notable that initially, burnout was not an idea derived from specific instances. On the contrary, it was considered to be related to human society.

The first few empirical articles about burnout were published in the mid-1970s in the United States. The significance of these articles was that they provided the initial description of the burnout phenomenon, and showed that this psychological syndrome was relatively common among human services professionals (Freudenberger 1974; Maslach 1976). Burnout was initially relevant to the effect of stress occurring among people. The concept was then examined in the context of human services, such as health care, social work and teaching (Maslach, Schaufeli & Leiter 2001; Schaufeli, Leiter and Maslach 2009). The literature acknowledges that the concept of burnout was introduced in 1974 by Herbert Freudenberger and popularised by Maslach

and her colleagues (Hayes 2010; Maslach & Leiter 1997; Williams 2007). Freudenberger's publication on staff burnout in 1974 is referred to as 'the starting point for the broader recognition of burnout' (Engelbrecht 2006, p. 26).

Freudenberger, a psychiatrist employed in a health care agency, was the first to note that many of the workers with whom he was working experienced a gradual emotional depletion. He noticed that health care workers at free clinics often suffered from chronic fatigue, emotional exhaustion and 'an increased distancing from their patients' (Canter & Freudenberger 2001, p. 1172). Freudenberger observed that those particularly susceptible to burnout were more likely to be committed to their jobs in clinics and therapeutic communities. He argued that long work hours, job pressures, job monotony and lack of organisational and social support can cause burnout (Hayes 2010). At the same time, Maslach, a social psychologist, was studying people's emotions on the job. Maslach interviewed human service professionals and started to realise that the emotional stress inherent in human services occupations could be harmful. When Maslach presented the results of her research to an attorney, she was told that poverty lawyers called this phenomenon 'burnout'. Maslach and her colleagues subsequently adopted this term and they discovered that interviewees immediately recognised it (Maslach & Jackson 1986; Maslach & Leiter 1997). The difference between the Freudenberger and Maslach concepts is that while Freudenberger based his model of burnout relative to the psychology of the individual, Maslach approached the study of burnout using a perspective involving environmental and individual factors. For example, Maslach (1998a) stated that the organisational environments for human service jobs are

shaped by various political, social and economic factors that result in work settings that are high in demands and low in resources. This is particularly relevant to nurses working in the aged-care industry.

During the next phase of the 1980s, the work on burnout entered a more constructive and empirical period. Many books and articles were written about burnout, in which authors described their working models, and presented various forms of corroborative evidence (e.g. questionnaire data, clinical case studies). Standardised measures of burnout were also developed providing researchers with more precise definitions and methodological tools for studying the concept.

Recently, researchers began to recognise that burnout occurred in a wide range of human service workforces. These included drug and alcohol counsellors (Duraisingam et al. 2007), child care workers (Seti 2007), teachers (Pillay, Goddard & Wills 2005), social workers (Schwartz, Tiamiyu & Dwyer 2007), police officers (Ivie & Garland 2010), correctional officers (Carlson & Thomas 2007), nurses (McVicar 2003), and disability services (Innstrand, Espnes & Mykletun 2004; William & Rose 2007). The literature also demonstrates that the phenomenon of burnout extends to advertising and sales work. Low et al. (2000) analysed burnout among marketing personnel and concluded that salesperson performance is strongly affected by burnout. Low et al. (2000) point out that 55% to 60% of marketing people believe that burnout has affected many colleagues as a result of work pressure and high sales quotas.

According to Schaufeli and Salanova (2007), the burnout research focus has shifted from exhaustion to disengagement in the twenty-first

century. In their research, key disengagement factors were found to include team conflicts, long hours of work, poor rates of pay, low job satisfaction, lack of quality care, personal emotion, morale, workload, and dealing with death and dying. These disengagement factors are related to the factors contributing to burnout in human services. In the context of the aged-care industry, these factors can be classified into three main categories: intrinsic, extrinsic and social factors (Tuckett et al. 2009). Intrinsic work values refer to the degree to which aged-care workers value immaterial aspects of their job such as morale, image of nursing, and emotional attachment to residents. Material or instrumental work aspects such as remuneration, working conditions, and paperwork are described as extrinsic factors. Social factors include the degree to which aged-care workers find it important to have a good relationship with their co-workers and the management.

In summary, burnout is not a new phenomenon. As Schaufeli and Enzmann (1998) state, it has its roots in the past. The development of burnout as a psychological notion took place along three lines. Initially, in the pioneer phase, Freudenberger developed a clinical approach which was characterised by merely describing symptoms of the burnout syndrome. Much of the work during that pioneer phase consisted of personal experiences or narratives based on specific programs (Freudenberger 1974, 1977; Maslach & Pines 1977; Pines & Maslach 1980). In the second empirical phase, social psychologists studied burnout more systematically, using standardised measures. They popularised the concept and legitimised its credibility. Finally, contemporary researchers have seen burnout as a psychological rather than emotional concept, and have adopted new language to describe the burnout

phenomenon. The following section will elaborate the three avenues of definitions and measurements of burnout. Alternative theoretical models will also be examined.

2.1.2 Searching for a definition of burnout

2.1.2.1 The pioneers' definitions

Definitions of burnout have evolved over the years. Freudenberger (1974) provided the first definition of burnout in a psychological context, describing it as becoming exhausted, wearing out, and failing in response to excessive demands. According to Hayes (2010), Freudenberger stated in 1974 that burnout was accompanied by a feeling of exhaustion and fatigue in combination with the presence of different physical symptoms, such as headaches, gastrointestinal disturbances, sleeplessness, and shortness of breath. Workers who experienced burnout also looked and seemed depressed. In 1978, Hargreaves provided a further definition of burnout. He described it as being a more extreme result of long-term stress leading to total exhaustion, apathy, alienation from work and withdrawal into a number of defensive strategies. In 1980, Freudenberger equated burnout with stress; connected burnout with an endless list of adverse health and well-being variables; and suggested it is caused by the relentless pursuit of success (Burke, Shearer & Deszca 1984).

In 1981, Pines, Aronson and Kafry proposed another definition of burnout according to which it is a condition of bodily, emotional, and psychological fatigue that results due to involvement in situations that need emotional participation and extend over a long period. It was the first time the

word ‘exhaustion’ appeared and was linked to the concept of burnout. The authors revised their definition in 1998 and presented a slightly broader description, including physical symptoms as well and arguing that burnout is not restricted only to human services. They describe burnout as a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding. They argued that burnout can also be a state of physical exhaustion caused by long-term involvement in emotionally demanding situations. Physical exhaustion is characterised by weakness, low energy, and a wide variety of psychosomatic complaints (Pines & Aronson 1998).

Another distinct definition by Freudenberger and Richelson (1980) described burnout in terms of chronic fatigue, depression and frustration typically engendered by commitment to undertakings that did not realise the person’s ambitions and expected results or rewards. Although this description incorporates some elements of burnout, it is problematic because there is a difference between depression and chronic fatigue. Chronic fatigue is described as tiredness, lethargy, impairment of one’s activity, along with a general depletion of energy resources (Benson & Maigrath 2005; Cooper, Dewe & O’Driscoll 2001). These features may be precursors to burnout. Burnout encompasses emotional (as well as physical and cognitive) exhaustion mainly emanating from dealing with ‘people issues’. On the other hand, chronic fatigue may simply be caused by work overload.

It has been argued that depression and burnout need to be understood as distinct. Maslach and Jackson (1986) found burnout to be distinct from, but related to, depression and frustration. Subsequent analysis by Leiter and

Durup (1994) also found that burnout is a problem that is specific to the work context, in contrast to depression that tends to pervade every domain of a person's life. Dewe, O'Driscoll and Cooper (2010, p.4) also argue that this definition 'confounds burnout with variables which are normally considered as distinct from, although related to, burnout, especially depression and chronic fatigue'. Burnout is generally perceived as job specific and situation specific, as opposed to depression which is general and contextual.

Other definitions used during the pioneering period were provided by Perlman and Hartman (1982) and Cordes and Dougherty (1993). These definitions of burnout included workplace aspects such as failure, exhaustion, loss of creativity and commitment to work, estrangement from clients and colleagues, and inappropriate attitude toward clients and self. Blase (1982) also defined burnout as a type of chronic response to the cumulative long-term negative impact on work stress. This definition seems to be appropriate in that it views burnout as the end result of unmanaged work stress and not a symptom of work stress (Altun 2002; Arthur 2004).

Stress and burnout are generally perceived as the product of a complex transaction between individual needs and resources and the various demands within an individual's immediate environments. Brill (1984) argued that burnout is, in fact, a response to prolonged job stress i.e., when the demands at the workplace, exceed an individual's resources. According to Brill, while stress is related to an adaptation process that is temporary and is accompanied by mental symptoms, burnout refers to a breakdown in adaptation accompanied by chronic malfunctioning. This longer time perspective is also implied in its terminology: burning out (depleting one's

resources) is a long-term process. Subsequently, Eltzion (1987) defined burnout as a latent process of psychological erosion resulting from prolonged exposure to stress. In other words, stress is a generic term that refers to the temporary adaptation process that is accompanied by mental symptoms; burnout, on the other hand, can be viewed as the concluding phase in collapse in acclimatisation, which is a result of disparity between demands and available resources (hence the work pressure). Burnout includes the development of dysfunctional attitudes and behaviours towards recipients and the job; whereas stress is not necessarily accompanied by such attitudes and behaviours (Garrosa et al. 2008).

Overall, these early definitions suggest that burnout is a pattern of responses that develop as a result of prolonged exposure to stressors at work. These definitions also suggest that burnout may be a greater problem in occupations where employees are more interactive with other people (e.g. clients, patients, colleagues, and other related parties) rather than dealing with things and information (Maslach, Schaufeli & Leiter 2001).

However, the definitions lacked a common and precise description of burnout as a process, and none described a clear model of the burnout process phenomenon. The definitions also failed to differentiate stress, illness and burnout. The following section will present a definition of burnout proposed by Maslach and various colleagues, and consider at least three competing models derived from the Maslach collegiate description of burnout as a process.

2.1.2.2 Maslach's definition: burnout as a process

Christina Maslach (1976) studied two hundred professionals in the health and social services sector by surveying professionals in the field, collecting responses to questionnaires and undertaking interviews. She found that the professionals were often unable to cope with emotional stress at work and that burnout was a common result. Maslach then assumed that burnout is a sequential process that starts with emotional exhaustion resulting from the emotional demands of dealing with clients. Maslach, Jackson and Leiter (1996) defined burnout as a work-related syndrome consisting of three dimensions that occur among individuals who work with people: emotional exhaustion, depersonalisation, and reduced personal accomplishment. According to Maslach and Leiter (2008), while emotional exhaustion represents the basic individual stress component of burnout, depersonalisation captures a dimension of interpersonal relations, and reduced personal accomplishment reflects a dimension of self-evaluation. This description has become the most commonly accepted. Schaufeli and Enzmann (1998) and Maslach and Leiter (2008) have carried on with this description which defines burnout as 'as a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity' (Maslach, Jackson & Leiter 1996, p.4). There are three dimensions to the burnout process as described by Maslach and colleagues.

The first dimension, emotional exhaustion is the start of a sequential process of burnout. It refers to feelings of depleted emotional resources. It is characterised by a lack of energy and a feeling that one's emotional resources

are used up (Cordes & Dougherty 1993). In other words, workers feel drained without any source of replenishment. They lack enough energy to face another day or another conflict or another person in need. Maslach, Jackson & Leiter (1996) also argue that emotional exhaustion involves feelings of being emotionally over-extended and exhausted by one's work. It has been the most extensively studied factor in the burnout literature (Spooner-Lane & Patton 2003). This exhaustion occurs as a result of deep frustration and tension because the worker realises that he/she cannot continue to deliver services, or be responsible for clients, as they had in the past. Maslach (1998b) also cites the major sources of this exhaustion as work overload and personal conflict at work.

The second component, depersonalisation, is related to an interpersonal dimension. Depersonalisation refers to negative, cynical attitudes towards the recipient of one's services, or excessively detached responses to other people. Maslach, Jackson and Leiter (1996) defined depersonalisation as the development of impersonal and unfeeling attitudes towards recipients of one's service, care or treatment. It could also be a loss of idealism where workers may display an emotional callousness, and they may be cynical to co-workers, clients, and the organisation (Schaufeli et al. 2002). Maslach (1998a) argues that depersonalisation usually develops in response to the overload of emotional exhaustion. The point is that although a certain degree of psychological and physical distance may be beneficial when dealing with a stressful situation, too much detachment may result in the individual developing negative attitudes towards self or clients. The risk here is that the detachment can turn into dehumanisation. Visible symptoms of

depersonalisation include impaired and distorted perceptions of oneself, of others and one's environment, loss of motivation, use of derogatory or abstract language, intellectualisation of the situation, and strict compartmentalisation of professional lives (Prinz et al. 2012).

According to Maslach, Jackson & Leiter (1996), the final component of burnout involves feelings of reduced personal accomplishment. It generally refers to a decline in feelings of competence and productivity at work. It is characterised by a tendency to evaluate one's own work effort negatively, with feelings of low self-esteem in the work situation. A decrease in individual performance can be attributed to a conviction that an employee can no longer offer appropriate services to patients and other related parties (Salmela-Aro, Nataanen & Nurmi 2004). In other words, the worker reaches a stage where he or she experiences a decline in his or her feelings of job competence and in his or her interaction with people.

In summary, burnout can be viewed as a process including different stages. Generally, job stressors result in psychological fatigue and subsequent loss of personal identity and a decreased level of performance. Burnout can be defined as feelings of exhaustion, a cynical attitude towards the job or people involved in the job and through a reduced personal accomplishment. Opposed to the general perception of pioneers in this field, burnout also exists beyond the various professions. The next section will present three models of burnout which are built upon the three-dimensional concept proposed by Maslach and her colleagues.

2.1.3 Theoretical models derived from Maslach's definition

Despite the continued debate related to Maslach's definition, there has been an underlying consensus about the three core dimensions of burnout experience – emotional exhaustion, depersonalised and reduced personal accomplishment –described by Maslach, Schaufeli & Leiter (2001). Maslach (1998a) states that upon these three dimensions, the development of models of burnout could still evolve and that the development of any model of burnout should be more of a 'grass-roots, bottom-up process, rather than a top-down derivation form a scholarly theory' (p.69).

The next section will present three popular models built upon the three-dimensional concept proposed by Maslach, Schaufeli & Leiter (2001). These models do not have any major differences except their degree of emphasising the significance of specific kinds of aspects in the progress of burnout. They have been also used as guides for many research investigations related to burnout (Whitehead 2001).

2.1.3.1 Cherniss Model of Burnout

Cherniss (1980) defined burnout as negative personal changes which occur overtime in helping professionals because of an imbalance between resources and demands. In 1980, Cherniss and his associates interviewed 28 human services professionals in four fields (mental health, poverty law, public health nursing, and high school teachers). Participants were interviewed several times over one to two years. The variables in the model were distilled from interviews with these professionals. This model proposes that particular work setting characteristics along with individual interpersonal approaches

determine various types of stressor sources. Some sources of stress and the resulting distress can be dealt with either adequately, by active problem solving, or inadequately, by developing negative attitudes. The Cherniss model proposes eight critical factors in human services work settings that could contribute to stress and burnout. These include: poor orientation process, a high work load, stimulation, a narrow scope of client contact, lack of autonomy, incompatible institutional goals, poor leadership and management practices and social isolation. In addition to these factors, the model also distinguishes three kinds of personal factors which are mainly related to the individual's life outside the work. These three factors include career orientation, demands outside of work and a lack of stable, close and available network of family and friends (Cherniss 1980). Finally, Cherniss (1980) also mentioned seven attitude changes that are typical for burnout: energy depletion, emotional detachment, loss of idealism, increased indifference, work alienation, reduced aspirations and increased self-interest.

The Cherniss model is illustrated in Figure 1 below.

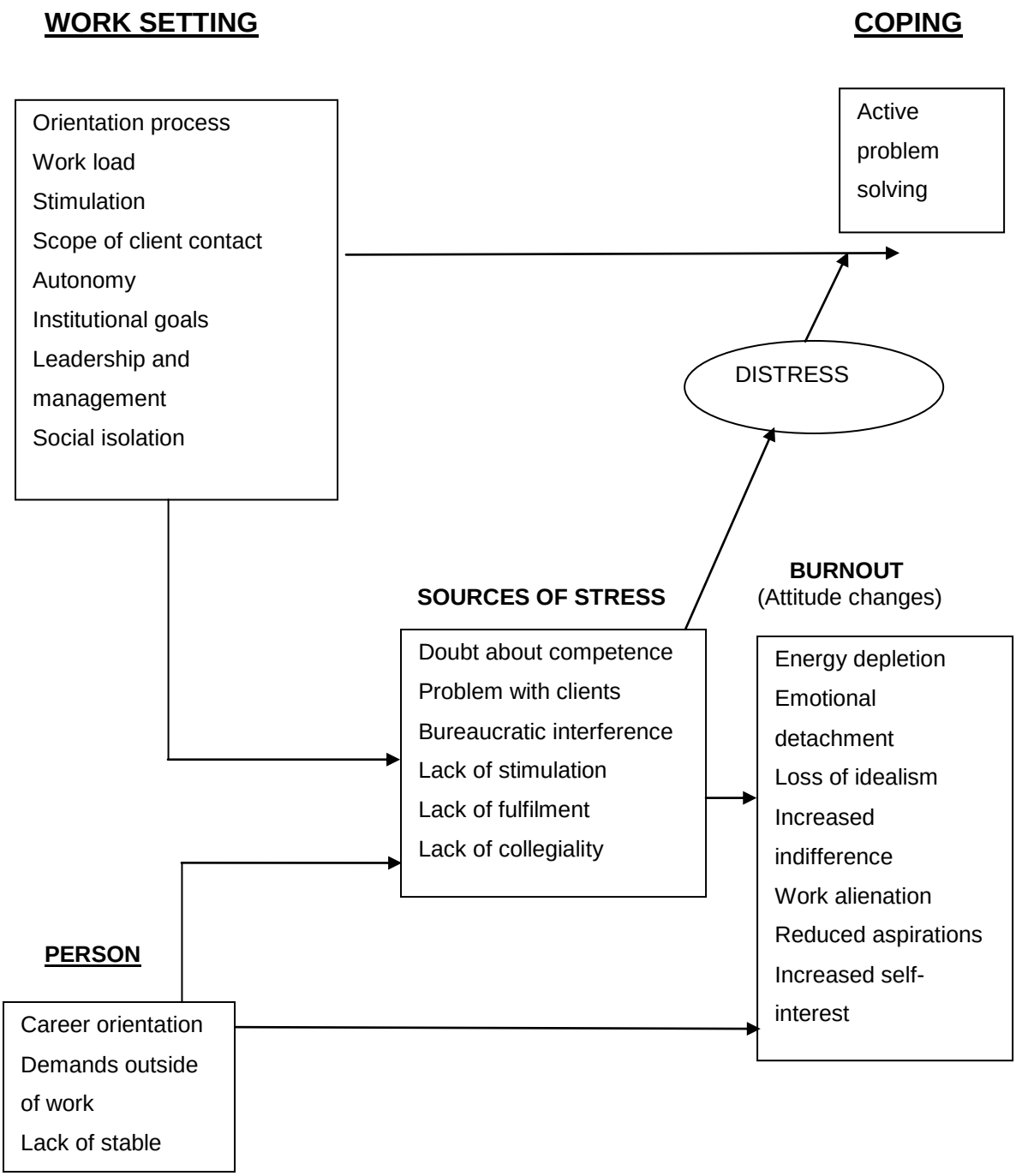


Figure 1: The Cherniss Model of Burnout

2.1.3.2 Golembiewski and Munzenrider Model of Burnout

An alternative model of the burnout process was developed by Golembiewski and Munzenrider (1988) who considered it to be a powerful function that passes through six stages during its progress. Golembiewski and Munzenrider (1988) and Golembiewski et al. (1996) argue that burnout is triggered by job stressors or situations (e.g. bureaucratic structures and cultures, role conflict, workload) and lead in turn to physical symptoms, reduced productivity and decreased performance. Although Golembiewski and Munzenrider agree with the three dimensional nature of burnout as proposed by Maslach, they updated the literature by providing a rather more strongly modified process of burnout (Schaufeli & Enzmann 1998). They argue that in human service settings, the burnout process starts with depersonalisation, followed by a lack of personal accomplishment and emotional exhaustion. As depersonalisation deepens and one's sense of accomplishment diminishes, work stress may surpass one's ability to cope, leading to emotional exhaustion (Spooner-Lane & Patton 2003). In other words, depersonalisation, the first manifestation of burnout, has the effect of impairing personal performance and, as a result, the individual's sense of personal capability and accomplishment on the job also diminishes. Reduced personal accomplishment then becomes the second phase in the burnout process. Finally, depersonalisation and the diminished sense of achievement lead to the development of emotional exhaustion as the tension associated with depersonalisation and reduced personal accomplishment surpasses the individual's coping ability. In Golembiewski and Munzenrider's model, emotional exhaustion is the end phase of the burnout process.

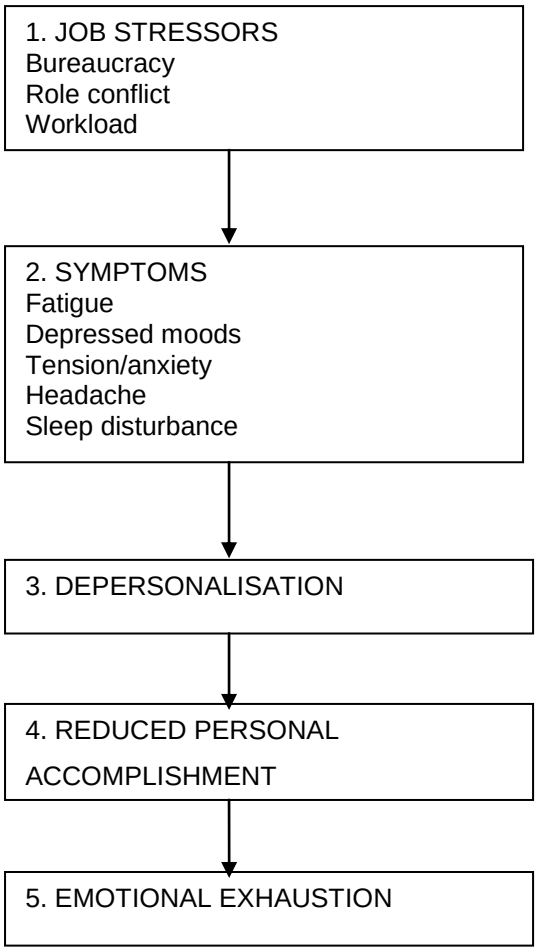


Figure 2: Golembiewski and Munzenrider's Model of Burnout

Golembiewski and Munzenrider's model has been criticised by researchers (Ashforth & Lee 1997; Spooner-Lane & Patton 2003), because they failed to articulate a detailed theoretical rationale for the sequence model. They did not make it clear how and why depersonalisation develops since according to Maslach, Schaufeli & Leiter 2001), depersonalisation is argued to be a 'means (albeit futile) of staunching the flow of emotional energy, of coping with growing exhaustion' (Spooner-Lane & Patton 2003, p. 51). Second, emotional exhaustion often arises from unrealistic desires to solveclients' problems. Indeed, the more idealistic the service provider, the

greater the risk of burnout. In the Golembiewski and Munzenrider model, the provider is already retreating from a commitment to his or her clients through depersonalisation and low personal accomplishment. It is not then clear why emotional exhaustion would develop at this point rather than earlier.

2.1.3.3 Leiter's Model of Burnout

Critical reviews of the Golembiewski and Munzenrider model prompted Leiter (1993) to conduct a series of studies. He speculated that personal accomplishment follows an independent but parallel process to emotional exhaustion and depersonalisation. During his studies, Leiter (1993) distinguished between quantitative job demands (workload, time pressure), qualitative job demands (role conflict, interpersonal conflict) and lack of resources (lack of support, lack of opportunities for personal development, lack of empowerment). Leiter (1993) proposed that job demands are associated with emotional exhaustion, whereas resources are related to depersonalisation and reduced personal accomplishment. The results of the study largely confirmed Leiter's speculations. It was found that some demanding aspects of the work environment lead to exhaustion, which in turn contributes to increased depersonalisation. On the other hand, the presence or absence of resources influences personal accomplishment.

In Leiter's model, contrary to Maslach's description, personal accomplishment seems to develop rather independently from the two other dimensional components of burnout –emotional exhaustion and depersonalisation. The model indicates that reduced personal accomplishment develops in parallel with emotional exhaustion and

depersonalisation, provided that resources are lacking. Leiter's model was confirmed by Lee and Ashford (1996) who asserted that while emotional exhaustion is particularly associated with various job demands (e.g. workload, work pressure, unmet expectation, stressful work situations), declining personal accomplishment is related to lack of resources. Depersonalisation then appears to be related to both job demands as well as lack of resources. This work, directing attention to the lack of resources, is an important addition to the knowledge about burnout.

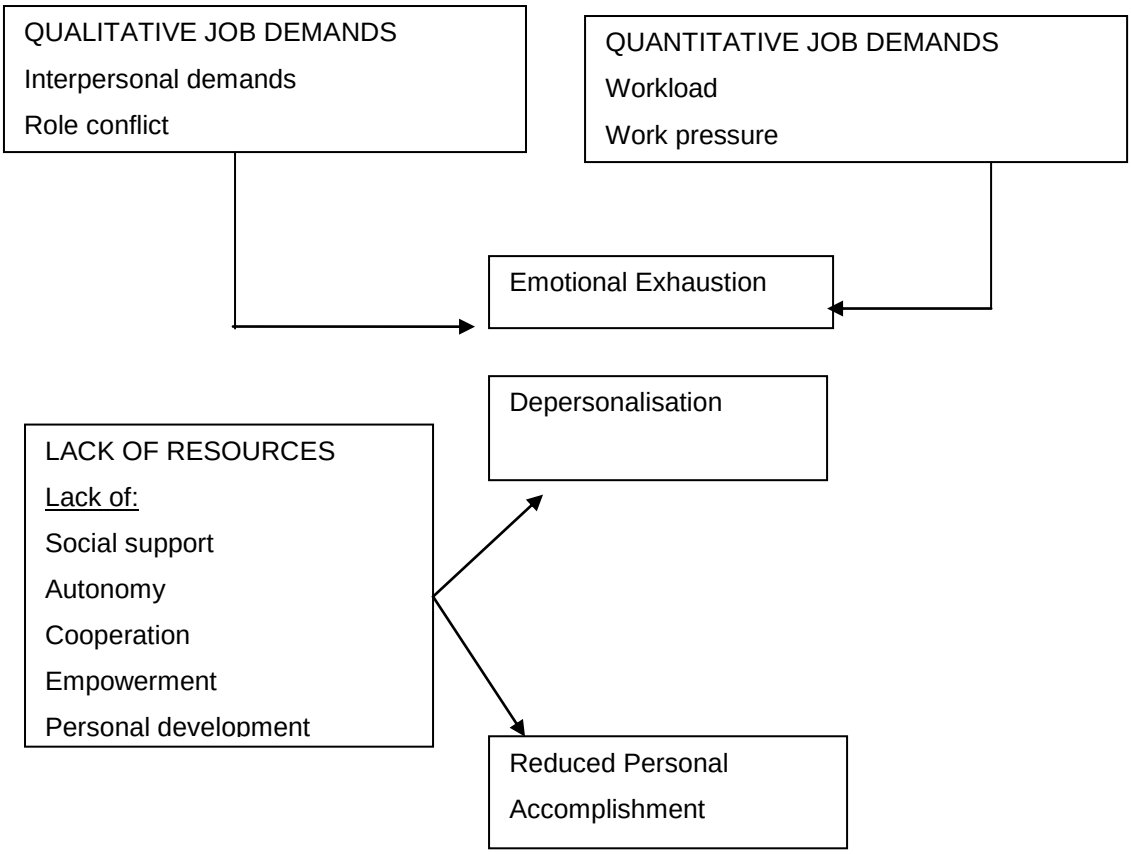


Figure 3: Leiter's Model of Burnout

In contrast to the original Maslach (1998a) model, which proposed an entirely internal model in which emotional exhaustion triggered the whole burnout syndrome, Leiter (1993) suggests that the relationship between emotional exhaustion and personal accomplishment exists externally to individuals (Spooner-Lane & Patton 2003). It exists within their social context, in the personal conflict among co-workers and service recipients, in the pressure of emotional demands and is affected by lack of resources.

In summary, the three models discussed in this section have asserted that burnout is a process and the three components of burnout influence one another over time. It may be that there is no strict order in which these three dimensions affect each other (Houkes et al. 2011). The present thesis asserts that burnout consists of three related, but empirically distinct components – emotional exhaustion, depersonalisation and personal accomplishment.

Maslach's definition of burnout relates to the psychological syndrome that is common among human service professionals where workers generally lose their self-identity. Burnout theory by Golembiewski and Munzenrider suggests that such loss of self-identity cold lead to emotional exhaustion and decrease in performance. Further, Maslach's theory suggests that the organisational environments for human service jobs are shaped by various political, social and economic factors that result in work settings that are high in demands and low in resources. Theories by Cherniss and Leiter also suggest similar traits; Cherniss suggested that burnout among workers was a result of an imbalance between resources and demands; Leiter also suggested lack of resources as the reason for burnouts. Even though there has been various shifts and changes overtime, earlier models and definitions

have always been incorporated into later models and definitions. It can even be argued that the definitions provided by the pioneers seem to be relative to the modern times as well.

The following section will include some of the most prominent definitions of burnout in contemporary times. It will also describe the conditions in which burnout is likely to develop. The last part of this section will discuss how contemporary researchers have articulated more clearly the difference between stress and burnout.

2.1.4 Contemporary descriptions of burnout

Over the last few years, researchers have agreed that stressors leading to burnout in human services can also be found in other occupations (Burisch 2006; Demerouti et al. 2000). It is commonly acknowledged that people in the twenty-first century are vulnerable to burnout (Cho, Laschinger & Wong 2006; Gellert & Kuipers 2008; Losa Iglesias, Vallejo & Fuentes 2009). The nature of work life and the broad cultural context within which work occurs seem to be the deciding factors. Bakker and Demerouti (2007) argue that a persistent imbalance of demands over resources creates a huge volume of pressure on contemporary idealistic professionals. In other words, burnout results from psychological exhaustion resulting from attempting to apply insufficient resources to increasingly demanding tasks.

2.1.4.1 Some contemporary definitions

Demerouti et al. (2000) describe burnout as a specific kind of occupational stress-reaction, as a result of the demanding and emotionally charged relationships between caregivers and their recipients. Another way of describing burnout is as a state of physical, emotional and mental exhaustion caused by long periods in emotionally demanding situations (Chen & McMurray 2001; Halbesleben et al. 2008).

Schaufeli et al. (2002) formulated a working definition of burnout that is characterised by the core indicator, exhaustion, which is accompanied by four general symptoms: distress, a sense of reduced effectiveness, decreased motivation, and dysfunctional attitudes and behaviours at work. These symptoms typically develop gradually. Schaufeli, Leiter and Maslach (2009) offer an alternative definition of burnout as a state of physical, emotional and mental exhaustion resulting from long-term involvement in emotionally demanding work situations. Winwood and Lushington (2006) characterised burnout as a chronic depletion of an individual's energetic resources, including physical fatigue, emotional exhaustion and cognitive weariness as a reaction to long-time exposure to stress at work.

In some countries, the concept of burnout has been replaced by a new, more general diagnosis, called 'the exhaustion syndrome' (De Silva, Hewage & Fonseka 2009; Schaufeli, Leiter & Maslach 2009; Spooner-Lane & Patton 2003). The exhaustion syndrome is characterised by mental exhaustion and reduced endurance as a result of identifiable stress factors for at least six months. The stress factors can be identified both in and outside of work situations.

According to these definitions, emotional exhaustion seems to be the core symptom of burnout. Burnout has been implicated in the reduction in quality of care, absenteeism and job turnover (Altun 2002; Gillepsie & Melby 2003). Taris (2006) argues that this symptom leads to significantly impaired functioning on the job. Ultimately, this compromised standard of care impacts the effectiveness and success of health services (Akroyd and Adams 2002).

Other perspectives on the causes of burnout have also emerged that focus more on changing value systems and expectations. According to Schaufeli, Leiter and Maslach (2009) the twenty-first century workforce expects a much more varied career than their counterparts a generation previously, and few are ready to make a life-long commitment. Employees in the twenty-first century are 'less willing to put aside their personal inclinations for the good of the company' (p. 215). They view organisational missions, visions and values with scepticism and may be more interested in maximising personal advantage than developing an ongoing relationship with clients (Schaufeli, Leiter & Maslach 2009). Therefore, the 'exhaustion-only' view has been greatly questioned by researchers and practitioners (Demerouti, Mostert & Bakker 2010; Kristensen et al. 2005; Lewig et al. 2007). Schaufeli and Salanova (2007) argue that the burnout concept has shifted from exhaustion to disengagement in the twenty-first century. It is theorised that work engagement is the positive antithesis of burnout. This concept is important for this study because aged-care workers provide care for human beings and require a high level of job engagement in order to be effective.

The definition of burnout may vary according to its context and with the intention of those using the term (Schaufeli, Leiter & Maslach 2009). Although

the three-dimensional definition that is described in Maslach's theory has achieved almost universal acceptance in research, it is important to consider other contexts. For example, in relation to the perspective of disengagement, studies have indicated stress and burnout as a reason for nurses having low job commitment or even leaving aged care (Department of Health and Aged Care 2002; Hsu et al. 2007; Perry et al. 2003). An Australian study conducted among aged-care nurses, Tuckett et al. (2009) reported that most aged-care nurses are planning to leave nursing in the near future due to burnout and fatigue. It seems that aged-care nurses are undervalued for the work they do and they are gradually becoming a rare breed (Department of Health and Aged Care 2002; Edvardsson et al. 2011; Fussell, McInerney & Patterson 2009; Senate Community Affairs References Committee 2005).

Gerontological nursing is still an unpopular specialty (Mukoro 2011). A recent study shows that the annual rate of staff turnover in residential aged care is as high as 96%, and job disengagement has been identified as one of the key reasons why aged-care workers leave their employment (Vernooij-Dassen 2009). Zimmerman et al. (2005) have observed that in the beginning of their aged-care career, staff exhibit high ambitions and positive attitudes, however these attitudes become significantly less visible after just few years. Martin (2007) also affirmed that aged-care workers job satisfaction appears to be consistently a little lower than for comparable sectors of the whole Australian workforce.

In Table 1, selected definitions are listed chronologically according to year of publication. This list is not comprehensive but it summarises the most frequently cited definitions of burnout in the literature

Decades	Definitions
1970s	Becoming exhausted, wearing out, and failing in response toexcessive demands (Freudenberger 1974).
	To fail, wear out, or become exhausted by making excessive demands on energy, strengths or resources.
1980s	An imbalance between resources and demands (Cherniss 1980).
	A state of fatigue or frustration, brought about by devotion to a cause (Freudenberger & Richelson 1980).
	A state of emotional and mental exhaustion due to long-terminvolvement in situations that are emotionally demanding (Pines, Aronson & Kafry 1981).
	A syndrome of 'emotional exhaustion and cynicism thatthat occurs frequently among individuals who do 'people-work' (Maslach & Jackson 1986).
	A negative affective state caused by recurring stress (Kahil 1998).
1990s	A progressive disillusion, with related symptoms diminishing one'sself-esteem (Gold & Roth 1993).
	Manifests itself in the form of cynical detachment and exhaustion.
	Represents erosion in values, dignity, spirit, and will (Maslach & Leiter 1997).
	A malady that spreads gradually and continuously overtime, putting people into a downward spiral from which it is hard to recover.
	A persistent work related state of mind in 'normal' individuals that is primarily characterised by exhaustion.
	Results from a misfit between intentions and reality (Schaufeli & Enzmann 1998).
2000s	Unmanagedwork stress (Davies & Farmer 2001).
	A special form of psychological stress, emerging when a significant investment of time and energy does not lead to the gaining of new resources (Hobfol in Borritz et al 2006, p. 105).
	A state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding (Schaufeli & Greenglass 2001).
	Physiological and psychological fatigueand exhaustion, which is attributed to specific domains: personal, work-related or client-related (Kristensen et al. 2005).
	Negative emotion leading to decrease in productivity (Espeland 2006).
	A chronic depletion of an individual's energetic resources,including physical fatigue, emotional exhaustion and cognitive weariness (Winwood & Lushington 2006)
	Indifference, which is a lack of concern, interest and enthusiasm in work-related tasks (Montero-Marin et al. 2011).

Table 1: Listing of common definitions of burnout from the literature

2.1.4.2 The process of burnout

Contemporary researchers agree that burnout does not occur 'overnight'. It is rather the result of a slow process that may last even for years. However, there is little agreement on how burnout develops and which stages are included (Bursich 2006). Although most researchers agree that burnout follows a process of stages, almost every author presumes a different

stage order. Some researchers still agree with Maslach and colleagues by asserting that burnout usually starts with emotional exhaustion. High levels of emotional exhaustion consequently lead to a withdrawal from the people/clients/patients/customers the employees work with and also from their job in general (Taris et al. 2005). On the other hand, several researchers claim that emotional exhaustion and depersonalisation develop serially rather than in parallel and have different antecedents (Demerouti et al. 2000; Demerouti et al. 2007; Edvardsson et al. 2011). For example, according to Demerouti et al. (2000, p. 458) 'the development of burnout follows two processes'. The first process is related to job demands which lead to exhaustion. The second process is related to lack of resources which in the end lead to disengagement from work. This second process is linked to the above mentioned argument that the burnout concept has shifted from exhaustion to disengagement. If resources are not functional in meeting job demands, withdrawal behaviour from work will occur. Consequently, withdrawal behaviour leads to disengagement which refers to distancing oneself from one's work, and thus experience negative attitudes toward the work object (Demerouti, Mostert & Bakker 2010).

It is important to note that many contemporary authors perceive the third component of burnout, reduced personal accomplishment, rather incidental in the process and not a core dimension of burnout (Burisch 2006; Demerouti, Mostert & Bakker 2010; Edvardsson et al. 2011). Burisch (2006) and Korunka et al. (2010) propose the basic aspect of the burnout process in terms of the following stages:

Stage 1: High workload, high level of job stress, high job expectations

- Job demands exceed job resources;
- The job does not fulfil one's expectations.

Stage 2: Physical/emotional exhaustion

- Chronic exhaustion: sleep disturbance, susceptibility to headaches;
- Emotional exhaustion and fatigue

Stage 3: Depersonalisation/Cynicism

- Apathy, depression, boredom;
- A negative attitude toward the job, clients or patients;
- Withdrawal from the job, the problems; a reduced work effort.

Stage 4: Despair/Aversion

- Aversion to oneself, to other people (sometimes to everything);
- Feelings of guilt and insufficiency.

In summary, contemporary authors view burnout as a process including different stages. Usually job stressors lead to physical/emotional exhaustion, followed by depersonalisation and a cynical attitude toward the job. The burnout process often ends with aversion to oneself and feeling of despair.

2.1.4.3 Burnout and stress

As mentioned earlier, the pioneers failed to differentiate stress from burnout; burnout has been often mistaken for stress. Accordingly, over the

last few decades, numerous studies have been conducted in order to clarify the nature of burnout and to identify what does not constitute burnout. Specifically, stress is a generic term that 'refers to the temporary adaptation process that is accompanied by mental and physical symptoms (Spooner-Lane & Patton 2003, p. 48). In contrast, burnout can be considered as a final stage in a breakdown in adaption that results from the long-term imbalance of demands and resources, thus from prolonged job stress (Brill 1984). Burisch (2006) argued that burnout includes the development of dysfunctional behaviours towards recipients, whereas job stress is not necessarily accompanied by such behaviours. This assertion has been supported by Maslach, Schaufeli and Leiter (2001) and Mealer et al. (2009) who showed that burnout can be distinguished from job-related distress, and that emotions associated with stress are over-reactive, whereas those associated with burnout are more blunted. Burnout is a unique, multi-dimensional, chronic stress reaction that goes beyond the experience of mere exhaustion. Burnout, on the other hand, is caused mainly by interpersonal and emotional stressors in the workplace and is characterised by different reactions (e.g., exhaustion). (Maslach, Schaufeli & Leiter 2001).

In summary, stress and burnout may not be distinguished on the basis of symptoms, but only on the basis of the process (Schaufeli et al. 2002). Overall, researchers agree that burnout is a pattern of responses that develops as a result of prolonged exposure to stressors at work. Stress produces only emergency actions and hyperactivity, whereas burnout, on the other hand, produces helplessness (Mealer et al. 2009). In the following, a list of symptoms is introduced, approaches to the measurement of burnout are

discussed, and specific literature pertaining to burnout in the nursing profession is considered.

2.1.5 Symptoms of burnout

Schaufeli and Enzmann (1998) provide a comprehensive list of more than 120 symptoms of burnout (see Table 2). These symptoms are far from being specific for burnout and refer to a rather broad range of symptoms. Nevertheless, the description of symptoms is the first step towards a practice concept of a phenomenon.

Schaufeli and Enzmann (1998) summarise the following problems in regard to burnout symptoms:

- Most symptoms result from uncontrolled observations rather than from empirical studies;
- Symptoms listed are rather indefinite;
- Throughout the process of development of burnout, symptoms may reverse from one polar opposite to the other, e.g. over- or under-involvement;
- Different patterns of burnout are assumed, reflecting different groupings of symptoms.

On the other hand, Schaufeli and Taris (2005) recommend looking for the smallest number of core symptoms that reflect theoretical meaning and are sufficient to characterise burnout.

	Affective & Physical	Cognitive	Behavioural	Motivational
Personal	depressed mood, tearfulness emotional exhaustion changing moods, decreased emotional control undefined fears, Increased tension headaches,nausea dizziness, restlessness pains, sexual problems sleep disturbances (insomnia, nightmares) sudden loss or gain of weight loss of appetite pre-menstrual tension missed menstrual cycles, chronic fatigue, physical exhaustion,	helplessness, loss of meaning and hope, fear of going crazy feeling of powerlessness feelings of being trapped sense of failure feelings of insufficiency poor self-esteem suicidal ideas suicidal ideas inability to concentrate forgetfulness difficulty with complex tasks rigidity and schematic thinking, difficulties in decision making daydreaming fantasising intellectualisation loneliness	hyperactivity, impulsivity procrastination, increased consumption of: caffeine, tobacco,alcohol high risk-taking behaviours increased accidents abandonment of recreational activities	loss of zeal, loss of idealism disillusionment, resignation, disappointment, boredom, demoralisation
Interpersonal	irritability, being oversensitive lessened emotional empathy with recipients Increased anger	cynical and dehumanising negativism lessened cognitive	violent outbursts, aggressive behaviour aggressiveness interpersonal, marital	loss of interest, indifference using recipients to meet personal and social needs,

	Affective & Physical	Cognitive	Behavioural	Motivational
		empathy withrecipients, stereotyping of recipients, labelling derogatory ways, 'blaming the victim', 'martyrdom', hostility, suspicion, projection, paranoia	and family conflicts, Isolation and withdrawal, detachment responding torecipients in a mechanical manner overbonding from other staff, sick humour aimed at recipients' expression of hopelessness, helplessness jealousy, compartmentalisation	Over-involvement
Organisational	job dissatisfaction	cynicism about work feelings of not being appreciated, distrust in management and peers Increased sick-leave	reduced effectiveness poor work performance, declining productivity, absenteeism, theft, resistance to change, being over-dependent frequent clock watching 'going by the book	loss of work motivation, dampening of work initiative

Table 2: List of symptoms of burnout (Schafeli & Enzmann 1998, p. 21–24)

2.1.6 Measurements

Though this present study is not about measuring burnout, it is important to present ways to measure burnout because they are usually designed based on specific burnout definitions. There are three main tools for the measurement of burnout. The Maslach Burnout Inventory (MBI) has become the dominant tool in burnout research. The MBI assesses three aspects of the burnout manifestation: a feeling of emotional exhaustion, depersonalisation (cynical attitudes towards one's clients), and low personal accomplishment. Higher scores on emotional exhaustion and depersonalisation coupled with lower scores on personal accomplishment indicate burnout (Maslach & Jackson 1981). The MBI consists of 22 items divided into three subscales to measure each aspect of the burnout syndrome (nine items for emotional exhaustion; five items for depersonalisation; and eight items for personal accomplishment, assessing feelings of achievement).

However, three alternative versions of MBI have recently been developed. These new versions reflect the evolution of research about burnout in non-human services. Halbesleben and Demerouti (2005) describe these new versions as variations on the original MBI, for use with human service jobs, a version developed for educational occupations, and the MBI-General Services Scale that is intended for occupations without a significant human service component. Despite the development of new burnout measurement tools, Poghosyan, Aiken and Sloane (2009) recently evaluated the applicability of the original MBI in different occupations and argue that it still performs across contexts. Hayes (2010, p. 159) also asserts that the MBI

‘can be used with confidence internationally to determine effectiveness of burnout reduction interventions.’

In 2002, a group of German scholars developed the Oldenburg Burnout Inventory (OLBI) as an alternative to the MBI. Demerouti et al. (2002) discuss the shortcomings of the MBI, arguing that the MBI is restricted to human service professions and that its structure is limited because of the ‘one-sided wording of the items’ (p. 299). Accordingly, they proposed the OLBI, which has been developed for use in different kinds of occupations. It measures only two elements: exhaustion and disengagement (Demerouti et al. 2000). The exhaustion items are generic measurements of emotional, physical and cognitive strain as a long-term consequence of prolonged exposure to work stressors. Disengagement in the OLBI refers to ‘distancing oneself from one’s work, and to the negative attitudes towards the work object’ (Demerouti et al. 2000, p. 456). The OLBI was originally constructed and validated by German scholars. Few English studies have used it, largely because of a lack of certainty that the translation would be reliable and valid (Hayes 2010).

Another tool is the Copenhagen Burnout Inventory (CBI) developed by Kristensen et al. (2005). Along with Bakker, Demerouti and Verbeke (2004), Kristensen et al. (2005) argue that burnout primarily consists of exhaustion. The depersonalisation and reduced personal accomplishment are thus secondary phenomena. The CBI is composed of three scales: personal burnout relates to normal physical or mental exhaustion which applies to everyone; work-related burnout pertains to symptoms of exhaustion related to work and applies to everyone in the workforce; and client-centred burnout

pertains to exhaustion linked to caring responsibilities and applies to caregivers in human service work such as teachers, nurses, and caregivers (Kristensen et al. 2005). The CBI was specifically developed for burnout studies in human services; it has been used in a study investigating burnout among dentists (Winwood & Winefield 2004). Borritz et al. (2006) discussed the burnout concept by adapting the CBI to people who work with clients. Their study demonstrates that the CBI is an appropriate tool for burnout study among carers and nurses. The present study used an adapted version of the CBI as a verification tool for the data from the interviews. CBI questionnaires were distributed to participants before the interviews. Chapter 3 will provide further details in relation to the use of CBI for this research.

2.2 Burnout in Nursing

As mentioned at the beginning of this chapter, more specific examinations of the concept in the nursing and caring profession identify potential pre-disposing factors contributing to burnout in the human services and in the aged-care industry. Accordingly, the following section will examine the literature pertaining to burnout in nurses from the point of view of its relation to the research topic. The notion of burnout among nurses is regarded in the literature as an occupational hazard exhibiting complex and multi-disciplinary characteristics (Jennings 2008; Kanste, Kyngas & Nikkila 2007).

Several researchers (Adali & Priami 2001; Greenglass, Burke & Fiksenbaum 2001; Kirkaldy & Martin 2001) have concluded that nurses have a high risk of burnout. It could therefore be assumed that the prevalence of

burnout in aged-care nursing is high. Burnout is defined by the nursing literature as 'the index of the dislocation between what people are and what they have to do' (Mantzoukas & Gouva 2010, p. 230). Such a dislocation creates an erosion of values and dignity leading to depletion of personal resources and energy, leaving nurses with negative feelings (Gillepsie & Melby 2003; Laschinger & Leiter 2006).

Burnout is believed to originate from nursing work itself as much as from the characteristics of the worker and the work environment (Koivula, Paunonen & Laippala 2000; Spooner-Lane & Patton 2003). However, findings regarding the exact work-related factors contributing to burnout in nursing have been inconsistent. This may be because studies have described burnout in different ways. Some studies have analysed burnout as a uni-dimensional concept that is emotional exhaustion (e.g. Duquette et al.1994; Gouva et al. 2009) whereas other studies have investigated burnout as a two component syndrome – emotional exhaustion and depersonalisation (e.g. Augusto-Landa et al. 2008; Demerouti et al. 2000; Geary 2008)).

Moreover, studies have been conducted on different nursing groups working in a variety of contexts such as general hospital, mental health, and aged care. The literature search reveals that there is some evidence to suggest that there are three main stressors contributing to burnout among nurses. These include workplace stressors, job role stressors and personal stressors. The next section will explore these stressors.

2.2.1 Workplace factors

The literature consistently reveals that certain workplace factors such as exposure to death and a dying person, clients with dementia, and high workload have an enormous impact on nurses. The first two empirical studies (Jenkins & Ostchega 1986; Tpof & Dillon 1988) that identified workplace stressors as contributing factors to nursing burnout were noted by Duquette et al. (1994) in a comprehensive review on burnout in the nursing profession. Further, the stressful environment along with the constant state of alertness creates conditions of physical and mental exhaustion for the nurses that lead to burnout sensations (Duquette et al. 1994). These two studies (Jenkins & Ostchega and Tpof & Dillon) revealed that the most significant predictors of burnout among nurses are heavy workload and conflict with co-workers.

Demerouti et al. (2000) investigated the influence of workplace environment on burnout using a sample of 109 nurses. The results of the investigation reveal that demanding patients, high workload, time pressures and problems with the shift work schedule were related to emotional exhaustion which is considered to be the core component of burnout. These findings are consistent with Ashforth and Lee's (1996) findings in which emotional exhaustion was most strongly related to workplace stressors.

While examining the relationship between job-specific stressors and burnout among 510 psychiatric nurses, Kilfedder et al. (2001) also concluded that emotional exhaustion is associated with workplace stressors.

Payne (2001) examined nursing stressors as determinants of burnout in 39 female hospice nurses. The study revealed that death and dying and

conflict with staff are associated with emotional exhaustion. On the other hand, perceived imbalance between investments and outcomes in relationships with patients contributed to depersonalisation and reduced personal accomplishment.

A study conducted by Augusto-Landa et al. (2008) showed that the common occupational stressors among nurses were 'poor staffing, workload, demanding aspects of work, death and suffering, followed by insufficient training, uncertainty regarding treatment, problems with hierarchy, lack of support, problems between the nursing staff', and a lack of knowledge about how to operate and manage specialised machines (p. 260).

In a Swedish study, Hansen, Sverke and Naswa (2009) found workplace stressors such as poor staffing, mandatory overtime for high census, lack of materials to complete required tasks, and unrealistic workload have been shown to contribute to burnout. While workload is believed to contribute to burnout to a great extent, the literature also identifies certain factors influencing workload and how the overall quality of the work environment is perceived by the nurse. The Mediation Model of Burnout was proposed as a way to link six key areas of a nurse's work life – workload, control, reward, community, fairness and values –to outcomes such as job satisfaction and turnover (Hayes 2010; Leiter 2005). According to the model, control has consequences for workload, reward, community and fairness; those who have successfully 'shaped their workload, rewards, social interactions, and institutional justice are more likely to develop an environment consistent with their values' (Hayes 2010, p. 161). Incongruities or disparities

in these six areas of nursing work life are therefore predictive of burnout (Leiter & Maslach 2004).

Another work-related stressor discussed in the nursing literature has to do with nursing leadership. Nurses who have the necessary support in their workplace feel psychologically empowered with a sense of competence and control that enables them to perform their job effectively (Laschinger et al. 2003). Nurses, who feel empowered and supported, have been able to derive a deeper sense of accomplishment from their work, thereby buffering against full burnout syndrome (Hochwalder 2008; Leiter & Laschinger 2006). In other words, higher levels of empowerment are related to lower levels of burnout; adequate support is therefore critical to enable nurses to grow in their careers and provide good quality care without experiencing chronic exhaustion from the inherent responsibilities of nursing practice.

A series of other studies have also identified that the nature of the nursing profession can significantly increase the level of workplace stress which has negative impacts on nurses' well-being (Gouva et al. 2009; Morita & Wada 2007; Pedrini et al. 2009). Several studies (Cottrell 2001; Demerouti et al. 2000; Humpel, Caputi & Martin 2001) found that nursing professionals are the group most prone to burnout because of work-related stressors such as contact with suffering and death, conflicts with peers, lack of preparedness to deal with the emotional needs of patients and their families, uncertainty about the effectiveness of treatment, tiredness and fatigue, fear being negligent, and night work. Indeed, the nursing profession includes involvement with individual situations and human suffering along with the use

of empathy as a caring technique. This exposure to human suffering places nurses at higher risk of workplace stress and burnout (Cameron & Brownie 2009). This also is aggravated by the well-known staff-shortage issue (Buerhaus et al. 2007; Demerouti et al. 2000; Jennings 2008; Winwood & Lushington 2006).

It is extensively reported in the literature that the exhaustion caused by over-exposure to stressful environments can induce dysfunctional behaviours, diminishment of nurses' ability to cope with work demands, and even malpractice (Gillepsie & Melby 2003; Laschinger & Leiter 2006; Winwood & Lushington 2006). Gillepsie and Melby (2003) assert that stress and burnout have far-reaching effects both for nurses in their clinical practice and personal lives. They also affirm that 'if nurses continue to work in their current environment without issues being tackled, then burnout will result' (p.848).

2.2.2 Job-role factors

According to Pilo (2006), as role pressures increase, nurses experience stress and end up burning out. Role conflict and role ambiguity are frequently studied as sources of stress in the nursing literature. They have also been identified as playing an important role in the development of burnout. Role conflict refers to 'incompatible or mutually competing expectations or demands', and role ambiguity is a lack of clarity and predictability regarding role expectations (Hayes 2010, p. 162). Based on a study among nurses in Hungary, Pilo (2006) determined that role conflict was a factor contributing positively to Maslach's three components of burnout. This

finding has been reiterated by Acker (2003) in his study of burnout among mental health service workers. Furthermore, Lake (2002) affirms that work environment characteristics usually account for more than 50% of the explained variance in burnout with the majority of this variance being explained by the factor of role conflict.

In a study of 102 nursing professionals, Gil-Monte, Valcarcel and Zornova (1995) found a significant positive relationship between role conflict and emotional exhaustion and depersonalisation. Other studies have also demonstrated that there is significant relationship between role conflict and emotional exhaustion (Jackson, Schwab & Schuler 1986; Lake 2002; Pilo 2006). This positive relationship between role conflict and emotional exhaustion could be because nursing work requires sympathy, affection, and warmth, together with objectivity and assertiveness. The consequent effort for dealing with this intra-role conflict could result in emotional exhaustion. Furthermore, the positive relationship between the second component of burnout, depersonalisation, has also been replicated in other studies (Celik 2013; Jawahar, Stone & Kisamore 2007; Hollet-Haudebert, Mulki & Fournier 2011). Depersonalisation is a defence mechanism developed by nurses to cope with conflicting demands.

When it comes to role ambiguity, Tunc and Kutanis (2009) found a significant positive relationship between personal accomplishment and role ambiguity. It seems that role ambiguity is a silent stressor when it comes to emotional exhaustion. However, role ambiguity contributes to personal accomplishment because although the role of nurse may seem clear, there

are considerable uncertainties regarding how to carry out this role. For example, nurses may feel uncertain about how to become involved with patients and how to deal with various problems of patients, and may experience insecurities about whether they are doing their job correctly (Spooner-Lane & Patton 2003).

In summary, it is evident from the literature reviewed that both role ambiguity and role conflict have a part in the development of burnout. Both have been identified as factors contributing positively to Maslach's three components of burnout. This is important in relation to the current research because it helps to construct the evaluative framework.

2.2.3 Individual factors

During the 1990s, researchers argued that individual factors have little influence on burnout among nurses. For example, no relationship has been found between burnout and marital status (Ackerley et al. 1988; Kandolin 1993), ethnic background (LeCroy & Rank 1998; Raquepaw & Miller 1989) or level of education (Leiter & Harvie 1996). Only age and length of nursing experience were suggested and appeared to contribute to burnout among nurses (Duquette et al. 1994).

Since the older nurses have been in the profession for quite some time, they have already developed some sort of personal involvement with patients and as such, they do not face any excessive demands from them. On the contrary, the newer nurses have to face and fulfil the demands of their

patients (Robinson et al. 2012). In the same study, older nurses reported less personal accomplishment. This finding suggests that although practical experience may guard against emotional exhaustion, it does not enhance one's sense of personal experience. This has been confirmed by Chen and McMurray (2001) and Patrick and Lavery (2007) who found younger nurses the most prone to emotional exhaustion. Other studies have reported contrasting findings in terms of years of experience. For example, Yousefy and Ghassemi (2006) also reported findings which revealed significant positive correlation between years of experience or longer duration of service and emotional exhaustion. Losa Iglesias, Vallejo and Fuentes (2009) also found that being older than 30 years was associated with a nurse's vulnerability to burnout syndrome.

A number of studies examine the relationship between burnout components and other variables relating to individual nurses. For example, based on a sample of intensive care nurses, Chen and McMurray (2001) found that separated and divorced nurses were the most prone to emotional exhaustion. Sahraian et al. (2008) found single nurses to be more emotionally exhausted. Several personality traits have also been studied in an attempt to discover which types of people may be at greater risk for experiencing burnout. For example, Maslach, Schaufeli and Leiter (2001) identified personality type, locus of control, and attitude as important factors in potential burnout. Nurses with greater hardiness and strong personality have a feeling of control in life, an optimistic outlook; consequently, they use direct-active coping behaviours (changing stressors or finding positive aspects in the situation) and were less likely to suffer from burnout. In other words, those

who are prone to burn out cope with stressors in a rather passive and defensive way, whereas active and confrontational coping is associated with less burnout.

Other personality traits may influence the likelihood of burnout. The emotional exhaustion and depersonalisation of burnout appears to be linked to 'Type A' personality behaviour characterised by competitiveness, misplaced extrovertism, time-pressured life style, hostility, and an excessive need for control (Maslach et al. 2001). In addition, personality characteristics such as perfectionism and over-involvement with clients have also been identified by Sherman (2004) as contributing to burnout. Finally, the educational level has also been identified as a potential factor for developing burnout (Chen & McMurray 2001; Patrick & Lavery 2007; Yousefy & Ghassemi 2006).

These burnout factors also apply to aged-care nurses. The context in which aged-care nurses work is usually intense and emotionally charged (McVicar 2003; Winwood & Lushington 2006). Karlsson, Ekman and Fagerberg (2009) point out that registered nurses especially those who are working in residential elder care, experience burnout due to a job role expecting them to be everywhere and to know everything, while working in an environment in which they feel invisible and underestimated. The aged-care work environment is also characterised by nurses' lack of authority and limited decision-making capacities, by super-stressful organisational demands, and by violent and aggressive behaviours (Bekker, Croon & Bressers 2005; Patrick & Lavery 2007). Coupled with extended working hours and physical

work demands, such as lifting and carrying heavy objects, the work environment becomes heavy and highly demanding. There is also a feeling of frustration if there is no relief to take over the responsibility of providing nursing. Lack of time also creates burnout among nurses. For example, one study found that nurses sometimes did not even have a chance to take a break for lunch and that their manager expected them to only give priority to important duties (Karlsson, Ekman & Fagerberg 2009). Cristina, Noelia and Benito (2007) argued that the highest stress levels among residential-care workers are related to job demands. Unrealistic workload has been frequently reported as a casual factor for anxiety and decreased job satisfaction in aged-care nurses (Aiken et al. 2002).

There is evidence that the context in which aged-care nurses work is intense and emotionally charged (Gouva et al. 2009; Tuckett et al. 2009). The concept of caring is also manifest in aged-care nurses' language as they describe their workplace, the residents, their relatives and themselves. The concept of caring is evident in residential aged-care facilities because the residents are central to the business of any facilities. Carers and nurses are often required to go beyond what is written in their job description (Tuckett et al. 2009).

There is a limited amount of up-to-date empirical information available in relation to the aged-care worker burnout. It seems that less attention has been paid to the burnout phenomenon within the aged-care industry. Raikkonen, Perala & Kahanpaa (2007) investigated the relationship between care quality and staffing in the aged-care industry in Finland. The study found

out that aged-care workers, who perceived staffing levels as inadequate, had lower perceptions of their own professional skills and the quality of care. These findings echo those of Maslach, Jackson and Leiter (1996), who found that lower perceptions of one's own professional skills leads to burnout. The study only reports the findings and discusses staffing issues; it does not suggest any further solutions.

More recently, Juthberg et al. (2010) conducted a study of patterns of perceptions of stress of conscience and burnout in relation to registered nurses and nursing assistants in municipal residential care of older people. The paper also discusses the ethical dilemmas that aged-care nurses face in their workplace. Juthberg et al. (2010) assert that care providers in elder care face ethical difficulties in their everyday provision of care for older people may be ethically challenged; meeting the residents' demands while aged-care workers experience heavy workload, lack of resources, a mismatch between their ideals and the reality of care creates 'stress of conscience' (p.1709). Juthberg et al. (2010) will be referred to in later sections of the thesis to establish a clear understanding of ethics in the aged-care industry. This arises because the importance of ethical dilemmas as a factor in burnout is a major finding of this research and it will be discussed in Chapters 4 and 5. Stress related to a troubled conscience has been found to be a major factor contributing to the burnout phenomenon. However, Juthberg et al. (2010) affirm that very little is known about how to reduce burnout among residential aged-care nurses. Another study by Jenull-Schiefer, Salem and Brunner (2010) comprises a lengthy discussion of the complexity of aged-care work, but does not address aged-care worker burnout.

2.3 Gap in the literature

The burnout concept has been the subject of academic discourse for approximately three and a half decades. Although some of these studies are both relevant and provide interesting discussions, none of these studies are specific to the aged-care worker burnout. The review of the literature indicates that the burnout phenomenon, within the aged-care industry, is not understood to any great extent. There is still a need to develop a theoretical framework specifically in relation to the aged-care industry. The dearth of empirical evidence in relation to aged-care worker burnout is evident despite the volume of anecdotal literature that is available on nursing burnout and in reports noted earlier.

After conducting an extensive literature search, it is obvious that a significant gap in knowledge exists in today's literature pertaining to the aged-care worker burnout phenomenon and an appropriate method to alleviate it. This thesis is expected to help fill that gap. When it comes to the aspect of caring, two major problems with research on burnout and caring exist: the lack of research on the link between the two and the lack of robust methods of research utilised to study the relationships between the two concepts (Peery 2007). Further, the literature focusing on geriatric workers' burnout is very weak. A limited amount of up-to date empirical information is available in relation to aged-care worker burnout.

Another important aspect neglected in burnout research so far is the question of prevention of burnout. The majority of the literature examines the

general causes and consequences of burnout in various disciplines, but not interventions to alleviate it. Indeed, the literature is extremely limited in research related to interventions to alleviate burnout. Some studies would only conclude that thinking about prevention of burnout only brings the question of complexity of the issue into sight (Kalimo et al. 2003). They argue that finding ways to prevent burnout is complex because it 'should include both enhancement of the possibilities for developing the employees' personal resources and improvement of the social processes at work' (Kalimo et al. 2003, p. 120). It should be kept in mind that a complex phenomenon such as burnout is not curable with simple recommendations. Rather, a thorough investigation of causes and resources in a certain setting can bring about a meaningful strategy to alleviate burnout. This study aims at understanding the factors that promote burnout among employees and to develop strategies to address them.

Burnout of aged-care workers is an ethical issue that should be attended to immediately because its prevalence decreases the carer's interest towards patients and organisation. Caring for its employees is an organisation's prime responsibility. Their wellbeing should be of great concern as they are the ones who increase or decrease the image of an organisation. Moreover, taking care of patients is also an ethical issue because they put faith in the healthcare facility that they have chosen for their treatment. If the staff members are not satisfied and face a burnout, the patients will not get proper attention and treatment. Ethical issues consist of (but not limited to) having the required resources to meet the patients' demands. Fewer resources would lead to excess workload that might result in a burnout.

2.4 A framework developed from literature

As mentioned in the introduction to this chapter, the final part of this literature review focuses on the ten significant factors related to the research topic. They have been identified from the literature search and analysis. These factors, which the researcher identified and categorised, using information from the literature review, were used as the basis for developing interview questions for assistant nurses and nurses. The factors also helped during the development of the adaptation of the CBI questionnaire for use in this study, and guided the analysis of the research findings in Chapter 5.

These factors are classified into three categories. The non-fixed factors relate to situations that can be changed or managed by site management and government interventions. The non-fixed factors comprise the different components of the work environment such as staffing and pressure, job workload and job resources, lack of reciprocity, role ambiguity, and ethics. The moderating factors are those that largely depend on workers' attitudes and include individual factors and staff training. The fixed factors have to do with situations that are difficult or impossible to change because they occur as the result of pre-existing social structures and conditions, and include client behaviours, the nature of the aged-care profession with its workplace practices and projected trends.

2.4.1 Non-fixed issues

Staffing and pressure

A common theme discussed in the literature is poor staffing. Poor staffing leads to an excess of overtime, misunderstandings between staff, fatigue and inadequate support. Poor-staffing is the main source of the burden of time-pressure for caregivers and nurses. The staff-resident ratio is a very complex matter to address because it depends on various factors. As mentioned in Chapter 1, when the Productivity Commission' Draft Report was published recently, no recommendations of minimum staff ratios for aged care were provided.

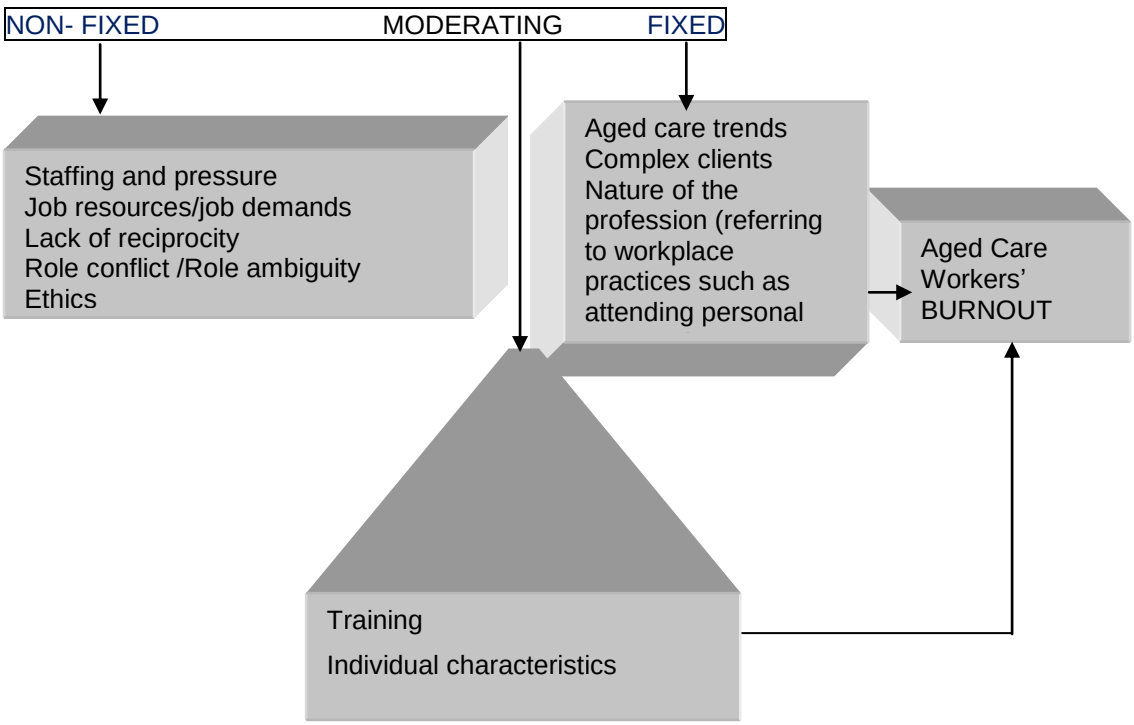


Figure 4: Burnout factors identified through literature review

Job resources and job demands

Another frequently cited theme is job demands. These are working conditions that potentially lead to burnout, and include issues related to the physical workload, cognitive workload, patient contact, environmental conditions and shift-work. Inadequate job resources also have the potential to induce stress-reactions among workers. Such job resources include performance feedback, participation in decision making, rewards, and the degree of organisational support provided.

Lack of reciprocity

In the context of this research, reciprocity refers to the feeling experienced by caregivers that they invest more in the relationships with clients than they receive. Relevant issues include management support, access to necessary resources, opportunity to grow, and remuneration packages. Schaufeli, Leiter and Maslach (2009) found that burnout is related to a lack of reciprocity at the organisational level, such that when a nurse feels that he/she invests more in the organisation than he/she receives, he/she tends to burn out. Schaufeli, Leiter and Maslach (2009) also found that people engaged in direct resident care demonstrated significantly greater levels of burnout than other occupations with less focus on human inter-relationships.

Laschinger and Leiter (2006) also examine the consequences of lack of reciprocity. In addition to doing psychologically engaging work which depletes cognitive, emotional, and physical resources, the nurse does not feel rewarded or appreciated. Consequently, there is a perception of imbalance with respect to the demands of the job and what a nurse receives from it. This

imbalance eventually results in a chronic depletion of energy. When nurses are in a state of balance, they can easily renew these resources through rest, learning, social support and successful experiences.

Role ambiguity, role conflict and ethics

The literature shows that role conflict and role ambiguity play a part in the development of burnout. Role conflict refers to incompatible or mutually competing expectations or demands, and role ambiguity is a lack of clarity regarding role expectations. These factors are likely to form a crucial subject of inquiry for this research into aged-care worker burnout. Finally, as discussed in the previous chapter, ethics play a vital role when it comes to aged-care duties.

2.4.2 Moderating factors

Training and individual characteristics are here called ‘moderating variables’ because they can moderate the relationship between the Non-Fixed issues and the criterion variable. These two variables seem to influence how caregivers respond to the work environment. Individual factors refer to the level of education attained, age, experience, marital status, locus of control, personality characteristics such as perfectionism or over-involvement, and expectations about the job. Training generally refers to on-job training.

2.4.3 Fixed issues

The three fixed terms (trends, complex clients, and nature of the profession) are also identified as predisposing factors in aged-care worker

burnout. They occur as the consequence of pre-existing social structures and conditions that are almost impossible to reverse. The aim of this proposed research is to ascertain whether solutions to manage these fixed themes can be suggested.

2.5 Summary

This chapter provided an overview of the relevant literature pertaining to burnout and its prevalence in nursing. It is apparent from this review that there is still no universally accepted definition of burnout. Accordingly, this research was undertaken to further study the concept of burnout among aged-care workers.

The review of literature reveals that the concept of burnout has been the object of debate for over thirty-five years. However, few empirical studies into aged-care worker burnout were found. The literature search helped to identify, construct and categorise some predisposing factors of burnout. It also helped to construct a specific and unique conceptual framework for the proposed thesis. Ten themes have been identified and categorised for convenience under three headings. The non-fixed themes include the different components of the work environment, such as staffing and pressure, job workload and job resources, lack of reciprocity, role ambiguity, and ethics. The second category includes moderating themes such as staff training and caregivers' individual factors. Finally, behaviour, the nature of the aged-care job, and projected trends form the fixed issues. These themes guide the research methodology and the analysis of the research outcomes detailed in

Chapter 5. Having outlined the theoretical literature of burnout, the next chapter provides an overview of the research process explaining the research paradigm, methodology and procedures.

This thesis adopts the most commonly accepted definition of burnout which is represented by the three-component conceptualisation proposed by Maslach and colleagues, as it appears most closely related to the research topic and the research context. Maslach's definition relates to the psychological syndrome that is relatively common among human services professionals; like the aged-care workers on whom this research is based. Also, Maslach suggested that the organisational environments for human service jobs are shaped by various political, social and economic factors that result in work settings that are high in demands and low in resources; this again relates to the aged-care workers. Considering these suggestions, Maslach's definition of burnout was selected for this thesis.

Chapter 3 – Methodology

This chapter describes the research methodology of the thesis and details the steps taken to ensure that the research adequately meets principles of academic rigour. This chapter presents a detailed analysis of the procedure for data collection, selection of the participants and the sites of data collection. In the literature review it was identified that there is a lack of ongoing qualitative research in the area of burnout among aged-care nurses. The research methods selected for this study are appropriate in addressing that gap.

Data was collected through interviews with nurses, assistant nurses, managers, and relatives of people in aged care. An adapted version of the Copenhagen Burnout Inventory (CBI) was used as a prompt sheet and completed by nurses, assistant nurses, and managers. During the data analysis, the completed CBI was also used as a verification tool. The data was examined using a discourse analysis technique, details of which are provided at the end of this chapter.

3.1 An adapted version of Copenhagen burnout Inventory (CBI)

In the questionnaire, burnout is defined in two ways. First, it is defined as a state of prolonged physical and psychological exhaustion. Second, it also has something to do with the phenomenon defined as a loss of energy and interest in one's job. The data from the CBI is used as a verification tool for the data from the interviews. An adapted version for the project entitled "Identifying strategies to alleviate aged care workers' burnout" was used for the research. This version was divided into four segments, as under:

Part one: Personal burnout

Definition: Personal burnout is a state of prolonged physical and psychological exhaustion.

The questions included in this segment are as below:

1. How often you are physically exhausted?

Always / often / sometimes / seldom / almost never

2. How often you are emotional exhausted?

Always / often / sometimes / seldom / almost never

3. How often do you think, “I can’t take this anymore?” (You want to quit)

Always / often / sometimes / seldom / almost never

4. Do you control several aspects of my job (time-table, the way I do my work, etc...)?

Always / often / sometimes / seldom / almost never

5. Do you feel worn out at the end of the working day?

Always / often / sometimes / seldom / almost never

6 . Do you have enough energy for family and friends during leisure time?

Always / often / sometimes / seldom / almost never

Part two: Work burnout

Definition: Personal burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person’s work.

The questions included in this segment are as below:

1. Is your work emotionally exhausting?

To a very high degree / to a high degree / somewhat / to a low degree

2. Do you feel burnout because of your work?

To a very high degree / to a high degree / somewhat / to a low degree

3. Do work pressure and staffing issues make you feel burnout?

To a very high degree / to a high degree / somewhat / to a low degree

4. Do you feel worn out at the end of the working day?

Always / often / sometimes / seldom / almost never

5. Are you exhausted in the morning at the thought of another day at work?

Always / often / sometimes / seldom / almost never

6. Are the roles expectations in your workplace clear to you?

Always / often / sometimes / seldom / almost never

Part three: Client related burnout

Definition: Client related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients.

The questions included in this segment are as below:

1. Do you find it hard to work with clients?

To a very high degree / to a high degree / somewhat / to a low degree

2. Do you find the nature of job can make you burnout?

To a very high degree / to a high degree / somewhat / to a low degree

3. Do you feel that you give more than you get back when you work with clients?

To a very high degree / to a high degree / somewhat / to a low degree

4. Do you sometimes wonder how long you will be able to continue working with clients?

Always / often / sometimes / seldom / almost never

Part four: Predisposing factors

The specific questions included in this segment are displayed below:

1. Please rate the importance of the following factors:

Workplace factors that may make you feel exhausting

-Role conflict

To a very high degree/to a high degree/somewhat/to a low degree

-Clients' behaviour

To a very high degree/to a high degree/somewhat/to a low degree

-Role ambiguity

To a very high degree/to a high degree/somewhat/to a low degree

-Insufficient management support

To a very high degree/to a high degree/somewhat/to a low degree

-Insufficient workmate's support

To a very high degree/to a high degree/somewhat/to a low degree

-Increase of clients' number

To a very high degree/to a high degree/somewhat/to a low degree

-Change in clients' needs

To a very high degree/to a high degree/somewhat/to a low degree

2. Please state the extent to which you agree with the following suggestions:

Burnout can be alleviated through:

-Training

Strongly agree / partially agree / agree / disagree

-Management support

Strongly agree / partially agree / agree / disagree

-Structured work conditions (for e.g. structured shift rosters, structured tasks...)

Strongly agree / partially agree / agree / disagree

-Use of technology

Strongly agree / partially agree / agree / disagree

-Regular respite programs

Strongly agree / partially agree / agree / disagree

3.2 The research paradigm

The research of this thesis emphasises the meaning-making of social actors. Meanings are trans-behavioural in the sense that they do more than describe behaviour (Cohen 2000; Krauss 2005). Hence, an interpretivist paradigm is selected for the setting of the research. Within the interpretative paradigm, meaning is understood as subjective. In this study the subjective experiences of various social actors is explored.

Though the interpretivist paradigm has been criticised for lack of rigour (Cavana et al 2001; Denscombe 2002), its main advantage is the formulation of approaches to research in which data related to the individual's perception of social issues is considered. Meanings are the cognitive categories that make up one's view of reality and with which actions are defined and interpreted by the researcher. Examples given in the following sections demonstrate how important meaning-making is for this study. Aged-care workers' experiences generate and enriche meanings, while the meanings provide explanation and guidance for the study (Chen 2001). Applying an interpretive paradigm allows for the interpretation of the "*how*-and sometimes *why*-participants construct meanings and actions in specific situations" (Charmaz, 2006, p. 130).

3.3 Qualitative research

Employing qualitative research methods for data gathering and

analysis has become an accepted research approach, especially over the past two decades (Cavana et al 2001; Strauss & Corbin 2006). 'Qualitative researchers stress the socially constructed nature of reality....They seek answers to questions that stress how social experience is created and given meaning' (Denzin & Lincoln 1998, p. 8). In contrast to quantitative inquiry where representations of the world are symbolized numerically, qualitative inquiry offers representations of the world which are primarily linguistic (Krauss 2005) (see Table 3). Qualitative researchers aim to study motivation, behaviour and one's struggles in context and might even go so far as to contend that it is the interpretation of the context that is the essential process to be studied (Gallan 2008).

Features	**Qualitative research**	**Quantitative research**
Purpose	To achieve a qualitative understanding of the underlying reasons and motivations.	To quantify collected primary data and make simpler the results from the sample to the population of interest.
Sample size	Small number of non-representative cases needs to be considered.	Large number of non-representative cases needs to be dealt with.
Data collection process	It needs to follow unstructured questionnaire to collect data.	At the same time, it must be structured and would be based on the content of the questionnaire.
Data analysis method	However, it has to be non statistical because it is helpful for descriptive thesis.	This method is more statistical and the researcher has the opportunity to select data analysis method.
Result	This method widens the primary understanding.	In contrast, quantitative approach recommends a final course of action consisting with fields.

Table 3: Qualitative vs. Quantitative Research

This research is a qualitative study using semi-structured interviews to study aged-care workers' daily life in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meaning people bring to them. Crowe (2005) and Krauss (2005) assert that the qualitative approach allows researchers to grasp the point of view of the research participants. In qualitative research, Gallan (2008, p. 246) points out, 'the firsthand interaction with people in their daily lives can lead to a better understanding of their motivations, struggles and behaviours'. It also makes the study contextual and reflective. The main benefit to be obtained from this qualitative study is to gain knowledge about residential aged-care workers' roles in their workplace. Such experiences of aged-care workers help to understand the reasons and circumstances that lead to burnout.

Additionally, qualitative research allows the investigation of complex phenomenon such as burnout in a different way to quantitative research as it enables richer data to be developed about a complex matter (Gordon et al., 2005). Qualitative research approaches are well documented as being valuable when investigating fields of human interaction (Creswell 2003; Denzin & Lincoln 2000; Lamnek 2005; Seale 1999). For this reason, a qualitative research approach helps to investigate the underlying reasons that lead to burnout. The interpretative nature of qualitative research is its strength and challenge at the same time (Lamnek 2005). Findings, results, knowledge interpretations and meaning are dependent on the context and must be understood as interpretations of reality. This does not imply that outcomes from qualitative investigations are arbitrary, they are just not normative. That

is, they do not follow any particular norms. The challenging part is to transform, integrate and translate interpretative knowledge into new contexts.

Researchers, who are engaged in studying the workplace culture, are usually confronted with a large set of varied and complex views concerning the selection of appropriate information gathering methods that might generate new methods to counter burnout (Whitehead 2001). This complexity can be explained by the fact that there are different forms of knowledge and systems for representing and understanding reality. Choosing the research method for this study requires careful consideration of the various schools of thought that characterise the conduct of research in the field of burnout.

This type of investigation allows for the subtleties of human experience to float to the surface. Attention to subtle and, at times, nebulous, experience requires the researcher to “sustain a fair amount of ambiguity” through flexibility and openness towards the data (Stauss & Corbin, 2006, p. 5). By maintaining a “beginners mind, a mind that is willing to see everything as if for the first time” the qualitative researcher supports a methodology which is ideal for explorative research of a new, or relatively new, social experience (Creswell 2003, p.5)

The qualitative inquiry of this study offers a high level of internal validity as the participants and researcher co-create data while they explore the causes of burnout among aged care workers. Though it may not be possible to generalise the outcomes of the study, the applicability to the reader’s personal experience is a goal. Such applicability allows readers of the study and future researchers to identify pieces of the data that may create an interest or spark the development of questions within the contexts of their

own lives or future research.

Hence, it is contended that qualitative research is an appropriate tool for the study of burnout among aged care workers. It gives the actual opinion of employees who have experienced burnout during their career. The aforementioned data (of CBI) clearly depicts that there are instances of burnout among employees. The gathered information might be of help to the concerned authorities to improve the working conditions of their employees.

3.4 Sampling and Participants

Sampling is the process of selecting a sufficient number of participants from the population so that by studying the sample, and understanding the properties or characteristics of the sample subjects, it is possible to generalise the properties or characteristics of the group of participants (Cavana et al 2001). Deciding on a sample size for qualitative inquiry can be difficult as there are no definite rules to follow. However, Powell (2009, p. 78) asserts that qualitative researcher usually 'works with small samples of people, nested in their context and studied in-depth'. The smaller the sample, the more detailed, intense, and sophisticated the process is in exploring psychological reality (Davies 2007). Hill et al. (2005) and Lamnek 2005) recommend employing 20-30 interview participants, with fewer participants needed when it comes to an interpretive research or when the group of participants is particularly homogenous.

The focus of qualitative research is on depth and richness of information, rather than on the sheer number of participants (Jones 2002).

Determining an appropriate sample size in qualitative research also depends on ‘what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be done in the available time’ (Patton 1990, p. 184). Hence, purposive sampling is employed as the sampling strategy for this study. This is because it is important to obtain information from specific target groups. The purposive sample involves personal carers, nurses, and managers because they provide information about the possible causes of burnout among aged-care workers. The study thus seeks the views of diverse workers within the aged carer industry and relatives of residents in order to identify potential strategies to address burnout.

In order to avoid researcher bias, managers from the Wesley Mission Frank Vickery Lodge and the Canterbury Nursing Domain Principal Group selected participants volunteer for the project. Managers of the Wesley Mission Frank Vickery Lodge and the Canterbury Nursing Domain Principal also provided a list of relatives who regularly visit their next of kin for the researcher to contact and arrange interviews with their consent.

The group of ten personal carers represent the growth sector of the residential aged-care workforce since 2003 (as illustrated in Figure 5). A personal caretaker, also called a personal care assistant (PCA), an assistant in nursing (AIN), or a personal care worker (PCW), works primarily within the community and aged-care sector. A personal caretaker is neither regulated nor registered and cannot be described as a nurse. The level of care provided by the personal caretaker is similar to that which would normally be provided

by a responsible family member (Nesvadba 2003). The carers who provide the majority of day-to-day care in any aged-care facilities are personal carers. In the nursing home industry, personal caretaker tasks involve feeding, showering, and dressing aged residents. The Institute of Health and Welfare (2011) found that the number of personal carers in the labour force (that is, employed or looking for work) increased by 14.2% between 2005 and 2009. According to Martin and King (2008), they make up nearly 60% of all direct carers in residential aged-care facilities. Additionally, the Nursing Federation reveals that 44.5% of those who have left aged care are personal carers, allegedly due to poor staff-to-resident ratios and negative working environments (Productivity Commission 2011). Thus, the inclusion of personal caretakers in this study is significant.

The group of eight residential aged-care nurses, enrolled nurses and registered nurses are selected because they work closely with assistant nurses. They comprise about 21% of aged-care workers in Australia (Figure 6). For the sake of clarity, in this study, a registered nurse (RN) is defined as ‘a person with appropriate educational preparation who is registered and licensed under the Nursing Act 1992 to practice nursing’ (Nesvadba 2003, p. 6). The RN is responsible for the provision of nursing, the supervision of enrolled nurses and personal carers, and delegation decisions. The enrolled nurse (EN) has appropriate educational preparation and is also licensed under the *Nursing Act* 1992 to practice nursing ‘under the direct or indirect supervision of a Registered Nurse’ (p. 7). The endorsed enrolled nurse (EEN) is typically an advanced-practice EN with qualifications to administer certain medications.

Total employees, 2003 and 2007

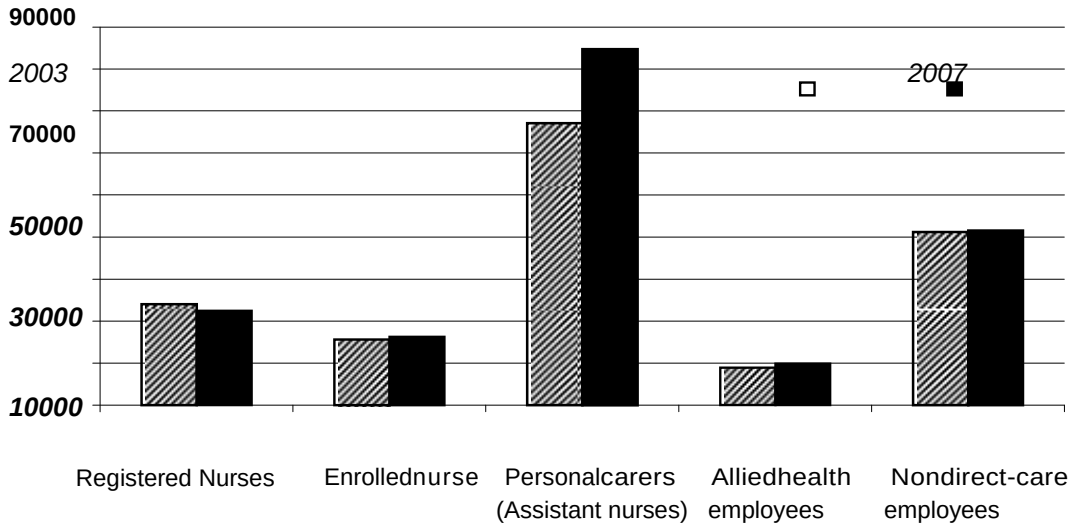


Figure 5: Residential aged-care employment

Occupation	Employees (No.)	%	Full-time equivalent (No.)	%	Employees (No.)	%	Full-time equivalent(No.)
Registered nurses	24,019	21.0	16,265	21.4	22,399	16.8	13,247
Enrolled nurses	15,604	13.1	10,945	14.4	16,293	12.2	9,856
Asst. Nurses	**67,143**	**58.5**	**42,943**	**56.5**	**84,746**	**63.6**	**50,542**
Allied healthemployees	8,895	7.4	5,776	7.6	9,875	7.4	5,204
Total number	**115,661**	**100**	**75,929**	**100**	**136,313**	**100**	**78,849**

Full-time equivalent data is only available for employees engaged in direct care activities, not all employees.

Figure 6: Aged care employees (Residential aged-care employees engaged in direct care – 2003 and 2007 (Martin & King, 2008, p. 11)

The group of managers and care coordinators design and monitor the work environment in residential care and their perceptions assist an understanding of aged-care worker burnout.

The group of four residents' relatives is relevant because they contribute direct input into the nature of the care being given. As the research method employs discourse analysis, the small sample size is not problematic given that a sufficient number of research participants were interviewed to generate data for analysis.

Group	**Participants (No.)**
Assistant Nurses	10
Nurses	8
Managers	3
Relatives	4

Table 4: Number of participants in each category

Participants were divided into two major groups, as shown in table 4 above: assistant nurses (10) and registered nurses (8) (group 1) and care-coordinators/managers (3) and relatives (4) (group 2). Two different open-ended interview questionnaires were used. These are tabled below in tables 5 and 6. The interview questions allow participants to provide detailed information related to their work experiences and to potential and actual burnout.

Personal burnout

a. Can you give me a brief summary or overview of your aged care personal carer/nurse career?

What brought you here?
How long have you been at this residential facility?

b. Some people might classify this as an 'unattractive job'. Do you think this is reasonable?

c. What motivates you to work in aged care?

d. What would encourage you to stay working in aged care for the rest of your working life?

e. What factors would force you to leave aged care and choose another career?

Training factors

a. Do you have the opportunity to learn new things through your work?
b. Can you use your skills or expertise in your work? To what extent?

Work-related burnout

a. What are the good things about working in aged care?
b. Are there any stressful things about working in aged care? That you would like to talk about?

What happened?

- What did you do?
- How did you feel?
- How did you deal with your feelings?

Could you tell me some stories ..."

c. What degree of influence do you have over the way you do your work?
d. Do you get help and support from your colleagues?

Staffing and pressures

a. How would you describe your workload: flows easily or tends to pile up? Could you please elaborate?

b. How would you describe your time allocation: plenty of time or not enough?

Could you please elaborate?

c. Does your work require that you remember a lot of things? Please elaborate.

Job resources/ job demands

a. How would you describe your work environment: able to state your feelings or unable to state your feelings? Please elaborate.

b. Would you say your work is emotionally demanding or detached? Please elaborate.

Lack of reciprocity

a. How would you describe your work with clients: do you feel that you give more than you get back or do you feel clients treat you fairly? Please elaborate.

b. Does your superior talk with you about how you carry out your work? Please elaborate.

Role conflicts

a. Do you know exactly which areas are your responsibilities?

b. Do you sometimes have to do things which you think ought to be done in a different way? Please elaborate

c. How would you describe co-operation between your colleagues at work?

Client-related burnout

a. What are your main sources of support? To whom do you talk?
b. How would you describe your current approach to work: high energy and interest or waning energy and interest? Please elaborate

Global questions

In your opinion, what causes burnout among some aged care workers?

Have you any ideas how this might be alleviated? Who can help?

Table 5: Interview questions for nurses and assistant nurses

1) It is extensively reported in the literature that overexposure to stressful experiences can increase burnout. To what extent is that claim true for aged care workers? Do they experience 'stressful experiences'? Could you please give some examples?

2) Why do you always have lack of staff for this industry? Is it because people are not interested in the job or?

3) Is caring for the elderly a health risk? Would you say your work is emotionally demanding or detached? Please elaborate.

4) Aged care workers espouse individualised care; to what extent does this nature of the job create 'emotional exhaustion' to aged care workers?

5) How are the structures and supports in place? Do they enable aged care workers to be successful in their responsibilities in a way that is consistent with their professional values and standards? Could you please give some more details? (Staff ratio, training, etc.…)

6) What sort of additional training and resources do we need to help aged care workers assume their duties with minimum "stress and emotional exhaustion"?

7) Do you think the Government has a role to play in the reduction of aged care workers burnout? If so, in what ways might this be achieved?

8) Do you think certain personality traits may predispose aged care workers to workplace burnout?

9) In your opinion, what causes burnout among some aged care workers?

10) Have you any ideas how this might be alleviated? Who can help?

Table 6: Interview questions for managers and relatives

Data collection took place between November 2011 and January 2012. The relationships between the research questions, the instruments for data collection, and the participants are shown below in Table 7. Table 7 also shows the link between the main research questions and the data gathering strategies. Further the CBI questionnaire also tested the validity of the theoretical framework, which was formulated through the literature review (Figure 4, page 73)

Research questions	**Instruments for data collection**	**Participants**
What causes burnout among aged-care residential carers?	Document review Semi-structured interview (backed up by a burnout questionnaire)	Assistant nurses Nurses Managers
How might this be alleviated?	Document review Semi-structured interview and Copenhagen Burnout Inventory	Assistant nurses Nurses Managers

Table 7: Research questions and data gathering strategies

3.5 Data collection procedures

The diagram below (Figure 7) details of the data collection procedure. It has two phases. Phase 1 involves preliminary data collection. It includes negotiating site entry, selection of participants, and further literature analysis. It aims to identify some specific theoretical problems related to the residential aged-care workers' role. Phase 2 commences with the semi-structured interviews, aimed at establishing the validity of the factors related to

residential aged-care workers' burnout. The CBI questionnaire was completed in Phase 2.

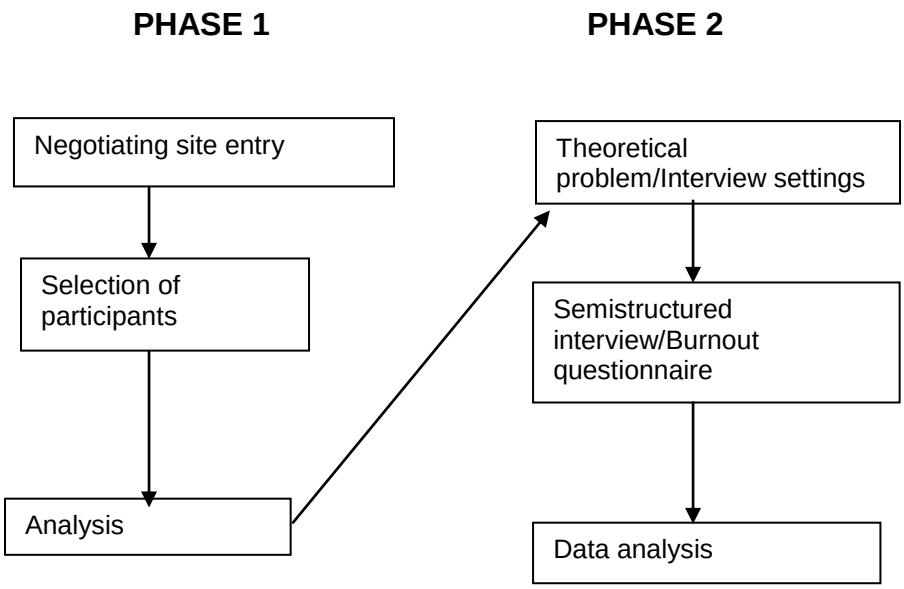


Figure 7: Data collection procedures

3.6 Data analysis

For carrying out the data analysis, the collected information is categorised according to themes. Thematic analysis of data is then employed. This is consistent with qualitative data analysis which involves 'describing phenomena, classifying them and seeing how concepts are interrelated' (Dey 1993, p.30).

When the themes are identified, discourse analysis is undertaken, a method which emphasises how responses and conversations are used to make meaning (Gulbrium & Holstein 2003). The following section and Figure 8 describe how discourse and discourse analysis are used in this study. In

this thesis, the term ‘discourse’ refers to a series of related statements and practices drawn from the interview transcriptions. Discourses are regarded as patterns representing aged-care phenomena in language. They provide the contextual meaning of language and shape the meaning by which aged-care worker practices and terms are understood: that is, in the context aged-care workers perform their caring duties.

Literature suggests that discourse analysis is gaining a place as a relevant method in social and nursing research (Crowe 2005; Crowe & Carlyle 2003; Halford & Leonard 2003). Lundgren (2011) asserts that gerontological discourse views ageing and caring for the aged as biographical processes that involve a continual storying of personal experience; this storying of personal experience is well suited to my study. Generating initial codes and derived themes are shown below:

Group	Participant number	Codes
Nurses and Assistant nurses	4, 11, 13, 14, 16, 23, 24, 25, 26, 28,	Cooperation Duty Ethics Teamwork Colleagues Physical exhaustion Self-relying Hard work Frustration Trust Staff shortage
Managers and relatives	3, 5, 6, 7, 8, 10,	Relatives

	12, 15, 18, 19, 20, 21, 22,	Patients Working hours Staff-patient ratio Workload Responsibilities Emotional exhaustion Culture Demands Needs Stress

Derived Theme	Codes
Ethics	Cooperation Duty Physical exhaustion Culture Emotional exhaustion Trust
Staffing issues	Colleagues Staff shortage Saff-patient ratio Working hours
Relatives and their expectations	Patients, demands, needs
Training quality	Self-relying, responsibilities, hard work, teamwork, workload, frustration, stress

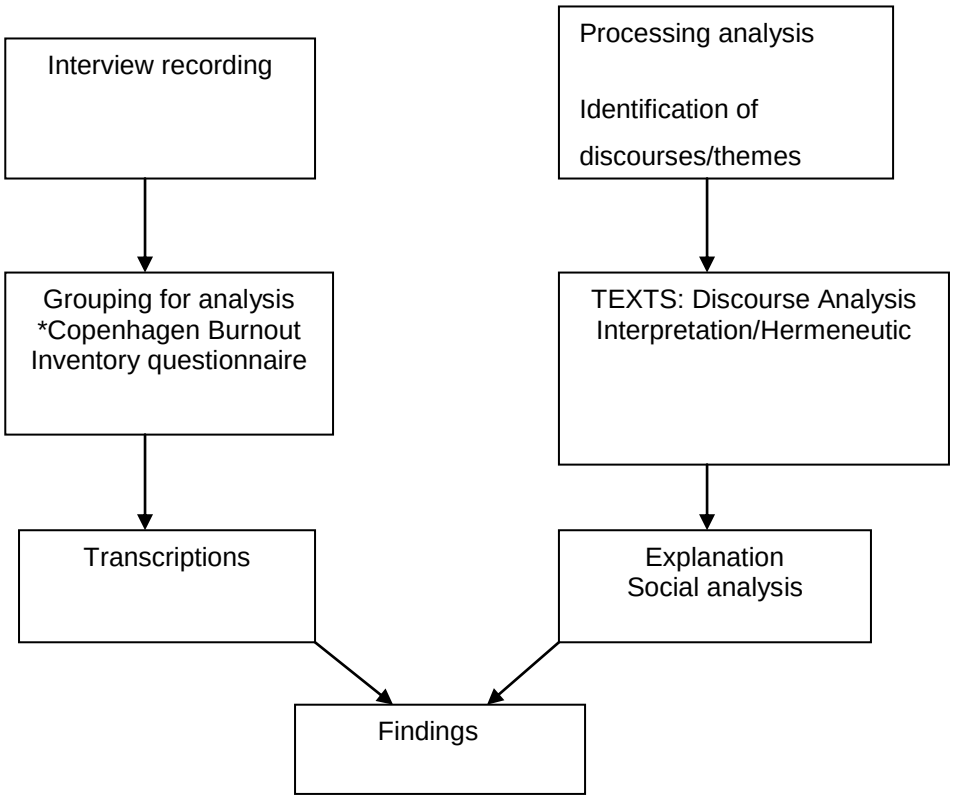


Figure 8: Data analysis: discourse analysis

3.7 Ethics and accountability

The ethical considerations of the research comply with the requirements of the Australian Government National Statement on Ethical Conduct in Human Research (Australian Government 2013). The Australian Government National Statement on Ethical Conduct in Human Research assumes a deontological approach such that the end cannot justify the means (Cavana et al. 2001). In order to ensure the disclosure of accurate and realistic data from the subjects, the researcher established clear accountability. This includes explaining:

- The nature and purpose of the study;
- The subject's right to withdraw from the project at any time;

- A guarantee of confidentiality and privacy;
- How the data would be analysed and what would happen afterwards;
- How data will be reported and published;
- That ethical clearance from the CQ University Human Research and Ethics Committee had been obtained.

3.8 Conclusion

Thus, it is contended that methodology described above is appropriate to research burnout among aged-care workers in the selected locations. Chapter 4 tables the outcomes of the research undertaken.

Chapter 4 – Results

4.1 Introduction

This chapter presents the findings of the interviews undertaken consistent with the research methodology tabled in Chapter 3 and with the potential to inform the underpinning research questions presented in Chapter 1:

i. What are the known factors contributing to burnout?

ii. What do aged-care workers generally consider to be the causes of burnout?

iii. What are the main issues to be considered in the development and the implementation of strategies to alleviate aged-care workers' burnout?

iv. What do aged-care workers suggest in order to reduce burnout in the aged-care industry?

It will be recalled that four cohorts participated in this study: ten assistant nurses, eight nurses, three managers and four relatives of those in care. Results are presented separately for each cohort in two sections. The first section presents the results related to the research question which aims to investigate the causes of burnout among aged-care workers. The second section introduces the results in relation to aged-care workers' suggestions for the alleviation of burnout. Interview responses are tabled in Appendices 7–10).

With regard to the causes of burnout, three main themes are identified, namely, ethics of care, staffing issues and relatives' interventions and expectations. The data analysis revealed two potential strategies to alleviate aged-care worker burnout: government review of training packages and

promotion of the aged-care profession. Participants advocated a review of the content of TAFE and other industry education and training courses in aged-care work to focus in part on issues which may reduce burnout in the aged-care industry. They suggested that the training packages should address issues such teamwork, ethics, stress management and cultural awareness and be not only technical-focused packages. Management support and the creation of a strong workplace culture were also seen as ways to alleviate burnout among aged-care workers. Details will follow and a summary will be presented along with the findings from the CBI questionnaires at the end of this Chapter (Tables 10, 11, 12 and 13).

4.2 Assistant nurses: Findings

4.2.1 Assistant Nurses – Causes of burnout

Ten assistant nurses participated in this study. Table 8 below details the demographic characteristics of these assistant nurses. One had one year of experience as an assistant nurse, six have had between two to four years of experience, two had between five to ten years of experience, and one had being working as a personal caretaker in the industry for thirty years.

Gender	Experience (years)
F	1
M	2
M	3
F	4
F	4
F	4
F	4
F	6
F	10
F	30

Table 8: Demographic characteristics of assistant nurses

While ten themes have been identified during the literature search, the information emerging from the assistant nurses' interviews reveals multiple causes contributing to aged-care workers' burnout. The researcher has identified three main themes, namely work ethics, staffing issues, and relatives' expectations. The other themes may be considered as sub-themes of these over-arching themes (see Table 9).

Themes	Related factors
Work Ethics	Ethics Cultural differences Teamwork Management Indifference Training
Staffing Issues	Staff Shortage Workload Staff quality Resident-staff ratio Rostering Time Language barrier Empathy
Relatives' Expectations	

Table 9: Findings from theme analysis – Assistant nurses

4.2.1.1 Ethics and aged-care workers' burnout

A key finding of this research is that a major cause of burnout is associated with ethics. Generally, ethics is a branch of philosophy that deals with the study of what is good and bad, right and wrong, and includes values, principles, and theories (Dreyer, Ford & Nortvedt 2011; Robertson & Walter 2007).

In the residential aged-care context, ethics could be understood as principles related to respect for residents such as: no intimidation, no lying to

families, no infantilisation, and no treachery (Baillie & Gallagher 2011; Department of Education, Science and Training 2002; Sormunen et al. 2007; Tuckett 2012). A lack of ethics of care can also be defined as a breach of duty of care. In this research, ethics is related to the way aged-care workers perform their duties. As mentioned earlier, Juthberg et al. (2010) argued that in order to meet residents' demands, aged-care workers need mutual support. Without mutual support, providing care for older people may be ethically challenging. All ten assistant nurses who participated in this study made reference to this issue. Fifteen direct references to ethics from seven assistant nurses' interviews were identified during the coding of interview transcripts. On the other hand, NVivo 9 detected sixty references. Direct references relate to comments or answers where the words ethics, ethics of care, or inappropriate care occur.

If 6.25% is assumed as the average norm for each factor, ethical references double this norm. According to NVivo 9, the coverage for 'ethics' is 12.57%. Five participants made references to ethical issues on more than seven occasions during the interviews. Even if the question concerned client-related or role-related conflict, some interviewees would always refer or return to ethical concerns as defined in this research.

There are different ways in which individual participants convey ethical concerns. When assistant nurses were asked about how they would describe co-operation between colleagues at work, they gave the following answers.

You know some members of staff are not cooperative. Some don't even do the minimum. No way to go beyond that, so sometimes you better rely on yourself. (Participant 11)

Participant 11 is correct in his/her perception because work has to be done whether or not any support is received.

It is hard to expect others to do the job as you do it. Some are not co-operative; some are just – how can I say? Some do not do their work appropriately – they have no notion of what we called duty of care or ethics. They just do the minimum and leave the rest for you. (Participant 14)

This happens because likewise participant 14, other workers also might be under the effect of burnout and as such, they do not perform their job sincerely.

We do practice teamwork. Some colleagues are good, but others you cannot rely on them; maybe they do not really understand that it is about "caring for people". Do you understand what I mean? Some staff members are not reliable; not because they don't know what to do but they just don't do it and let others do it. For example, yesterday a staff simply lied and asserted that she made the bed whereas she didn't do it. Isn't that frustrating? You come in, you have your own duties, but you also need to complete what others don't. Every day, there are similar issues like that; at the end you feel exhausted. (Participant 26)

In situations like this, one ought to get frustrated. The reason for such frustration might be different. Like for instance, the person might think that when the other person is getting the same emoluments, why he is not performing his duties. It is quite possible that the person would perform his duties up to a certain extent and then he also would start neglecting them.

It depends… we work in a teamwork if you are rostered with good staff then good on you; if you are rostered with others, unfortunately, who do not

have the notion of duty of care, then you better rely on yourself. (Participant 28)

There is a dearth of sincere employees and even these employees, after seeing the way others work, get discouraged and experience burnout.

Words and phrases with similar meanings such as 'not co-operative', 'unreliable', 'breach of duty of care' occur in each answer. They also all convey the unethical attitudes of some aged-care workers when it comes to performing duties and tasks. These attitudes create frustration and thwart all notions of teamwork since sometimes it becomes preferable to rely on oneself. The lack of 'ethics of care' also might increase the workload of other staff. For example, two participants made the following remarks related to the inappropriate care performed by others:

And at the end of the day, we're the ones that have to work doubly as hard and the residents are the ones that are missing out. So at some point everyone needs to pull their head in and just work hard. (Participant 23)

Sometimes you, you know, I'm sure people feel like they do more than what others do, not because they have more duties or overcommitted but just because others just don't perform their duties appropriately; they don't care. (Participant 26)

This situation might increase the workload and is a likely cause of psychological and physical exhaustion.

One participant asserts that unethical staff '*tell lies to get out of any trouble while they neglect their basic duties such showering or making residents' beds'* (Participant 23). The participant made the following comments with regard to this issue:

Well, I just think apart from the business, just being able to – like we've got a list of things we've got to do. Some staff members do not do things properly, or they might have difficulty with a resident, and things aren't done and someone else has got to do it. I don't have to go back and check. A lot of the time there's no other word for it but lie. (Participant 23)

This comment reveals how heavy the workload in the aged-care profession is. Inappropriate care not only increases other carers' workloads, but also encourages the unethical carer to get out of the situation by lying. Such attitudes are likely to cause anger, frustration, depression and eventually burnout amongst other carers.

Inappropriate care performed by incompetent or lazy staff is identified as one of the main causes of burnout among aged-care workers. A question may be asked: Why do some aged-care staff members lack the notion of ethics of care? The interview analysis provides some reasons behind this attitude. Six participants think that there are various understandings of care because of cultural differences. One participant asserted: *'the problem is the cultural difference; it is hard to expect others to do the job as you do it'* (Participant 14). These cultural issues could be related to the approach to care and the understanding of appropriate care.

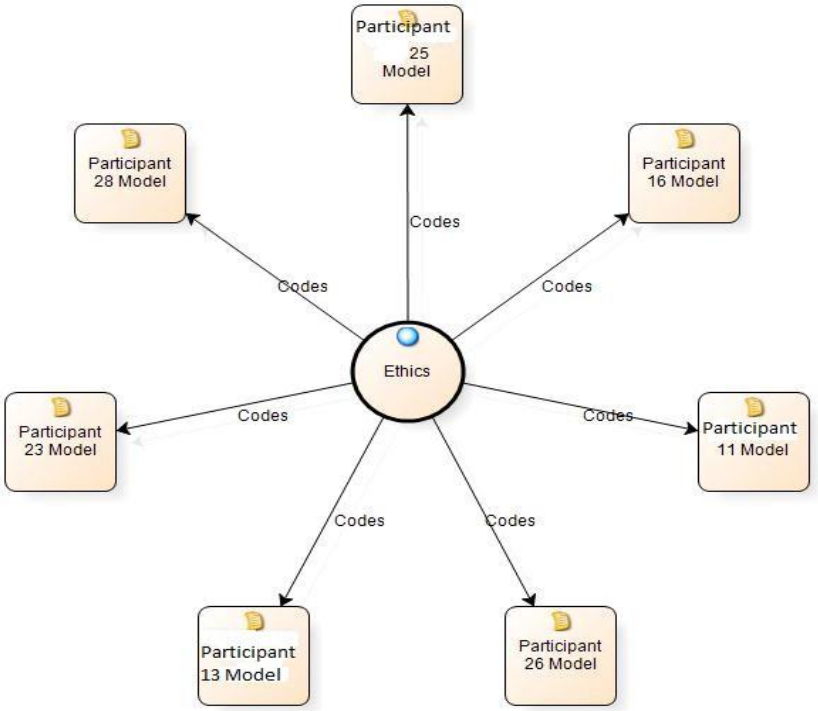


Figure 9: Seven participants making direct references to ethics

Francis et al. (2008) note that Australia receives a large number of overseas health-care workers. To exemplify, during the course of this research the caring work in the two aged-care facilities under study is performed by assistant nurses from a diversity of cultural backgrounds. When asked during interview if they received support from colleagues, two participants replied:

There is always someone to help if needed. But a large proportion of staff come from overseas which creates its own cultural difficulties within facilities where you have many residents who need culturally appropriate care. I think the standards are different. For some people making a bed means just flip the bed sheets; there is no need to change it or wash it. I think that's the way they do it in their country. When you explain, they hardly understand what you mean. (Participant 13)

People from different backgrounds work together, and it is about 'caring'; I think we need some training about culture and work ethics. Of course, I do not expect others to clean exactly as I clean for example but I think there is a minimum standard ….Do you see what I mean? (Participant 26)

Studies have also reported that personal values, education, tradition and belief could determine carers' perceptions of care (Bassett 2002; Tuckett et al. 2009). For example, a participant stated that between himself and another fellow-country assistant nurse, there is a difference in their respective caste; according to the other's cultural tradition, a man should never assist a woman in showering or toileting. Consequently, that nurse would often find ways to avoid providing care to female residents and would leave the duties to work colleagues. It can also derive from a country's respective perception of the nature of profession. For example, Francis et al. (2008) report in their study the experience of an Indian nurse who so often used the words 'I don't do that'. This is because in her country a nurse should not undertake duties related to residents' personal hygiene.

Additionally, the lack of ethics is not assisted by management lassitude, inefficient complaint handling procedures and inappropriate training programs. Apparently, management finds it hard to deal with ethical complaints from workers. One participant points out that so often managers would just adopt a take it easy attitude because they might be scared of losing staff.

You know, when things – like there was actually an incident on Friday that really frustrated me. I was busy doing something myself and I walked

past another personal care staff who was not doing anything. And I asked her to help a resident because the resident needed help. And she said yes. And then I asked her a few minutes later again to help her because she still wasn't helping her, and she said, 'I don't need to help her. She's fine on her own.' And the resident wasn't fine on her own…. But in that incident, instead of sitting down with the person and saying, 'What you did was wrong', the girls tend to sit down and have a little bit of a talk about it, have a bit of a bitch about it, and nothing actually gets done from that. It is like, 'Oh, well, we've heard your side. Let's hear her side and then that's it.' It's not – you know, you'll tell management – like I've told management and I've told people, but you know nothing's happened to it. People have asked me this morning, 'Oh, what happened on Friday? What happened?''Nothing happened. She didn't do her job. That's what happened. There's nothing to talk about. She didn't follow a procedure. That's my problem.' (Participant 23)

An interviewee made the following remark whilst talking about complaint procedures:

In this type of industry, it's not just, 'Oh, we faxed that thing late. Oh, we didn't e-mail them.' It is people's lives. It's a big deal. That's how I feel about it. So if you can't trust people with basic things like she told me she made the bed, but she didn't. Well, what can you trust them with? Do you know what I mean? It makes the whole job very stressful and it makes everyone have to run around and do it twice over because we're not sure who's doing things properly. Do you know what I mean? That's the – I think that's one of the biggest things. (Participant 4)

There is an apparent awareness among assistant nurses that it is very important that management review the way they handle ethical complaints.

It was also stated that the inappropriateness of the training offered internally or by registered training organisations is one of the reasons for the lack of ethics of care which contributes to burnout among aged-care workers. Generally, participants referred to the formal training leading to Certificate III in Aged Care and the in-house training delivered by Registered Nurses or registered training organisations. All participants pointed out that these training sessions are all about the know-how, and have nothing to do with ethics. In other words, courses or training offered to aged-care assistant nurses are only pertinent to what they are doing on a daily basis (Participant 4 and Participant 16).

One participant asserted that training is too generic and that they do not solve the teamwork problem they encounter everyday (Participant 24). They are generally related to workplace health and safety, fire, documentation and manual handling. Therefore, according to assistant nurses who participated in this study, the lack of training related to ethics and teamwork caused a lack of understanding of the ethics of care among aged-care workers.

As depicted in figure 10, the main causes of inappropriate care are cultural differences, management attitude and the nature of training being provided. Owing to a diverse work culture among organisations, staff members are from different nations. It is human tendency to favour people from same culture. This can be witnessed in all walks of life where a multicultural atmosphere is prevalent. People tend to make groups with others

of similar culture. There is a feeling of affection among them. So, the first thing that patients do after getting hospitalised is to search for employees from their own culture so that they can get the best possible care. In such situations, the nurse or other healthcare professional is unable to offer similar care to other patients who are from different cultures.

Management's attitude also plays a crucial role in the performance of nurses and other staff members. It is quite possible that due to some business restrictions, management might not be able to provide the requisite facilities to its employees. The employees can get disgruntled and perform low. They are ought to be demoralised that will ultimately hamper their performance.

The nature of training provided to staff members should be conducive to providing excellent care, irrespective of culture. They should be taught the importance of a patient and the consequences that might occur due to bad care. Mouth publicity can make or damage the image of any organisation. If the staff is appropriately trained to provide better healthcare facilities, the patients will spread good words and the image is bound to increase.

Team work is very crucial for the success of any organisation but when the staff members do not work as required, there is a lack of such team work and the overall performance goes down. There is wide spread mistrust among the employees and the organisational culture is in jeopardy. Staff members desist from cooperating each other and as a result, jobs are not completed or even if they are completed, there is always a lack of satisfaction on both the sides (patient as well as staff members).

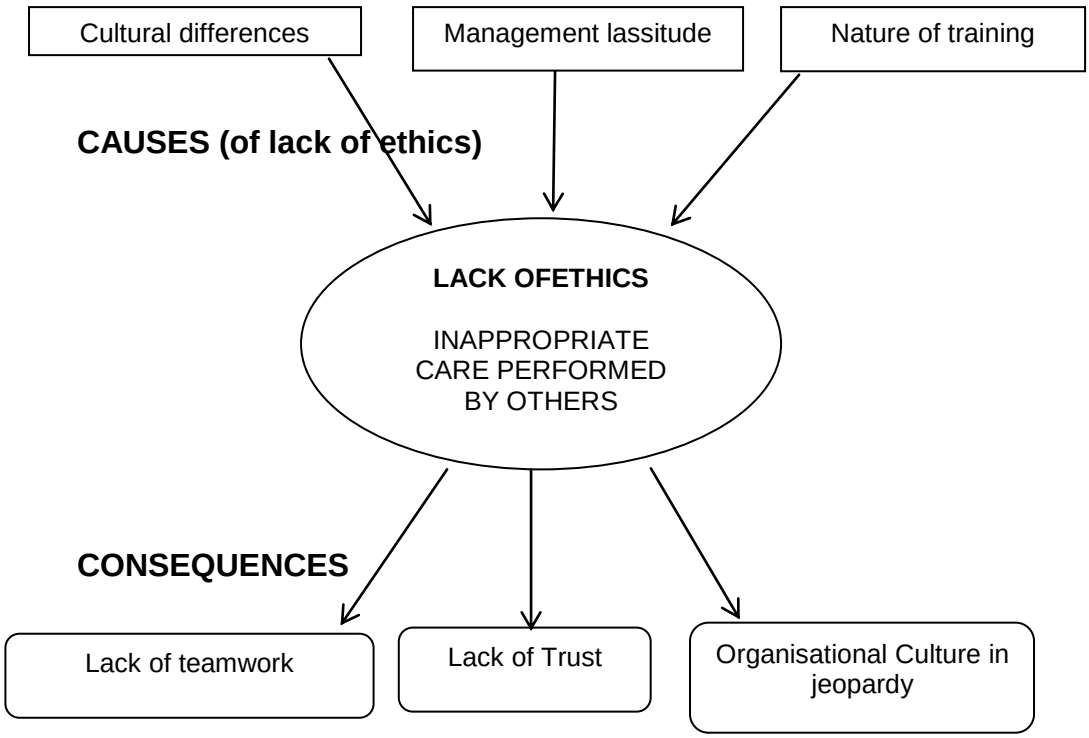


Figure 10: Causes and consequences of inappropriate care performed by others

From the interviews with assistant nurses it could be argued that the overarching factor contributing to burnout among aged-care workers is related to ethics –inappropriate care performed by colleagues. This is generally caused by cultural differences, management lassitude and the nature of training provided. As a result, the notion of teamwork cannot be applied as it should be. Further, management lassitude and lies destroy trust within the residential facility; organisational culture is in jeopardy because people do not see the need to report or challenge unethical behaviour.

4.2.1.2 Staffing issues

The second theme identified during the analysis of data from assistant nurses' interview transcripts has to do with staffing issues. This is not surprising because several studies identified in the literature review suggested that staffing issues are a factor contributing to burnout among various human services industry (Hayes 2010; Jenull-Schiefer, Salem & Brunner 2010; Pilo 2006). According to the assistant nurses, staff shortages are also a key factor leading to burnout. This is because the lack of staff increases the workload. It has also great impact on the staff-resident ratio, the time allocated for each resident and the roster calendar. Nine participants made references to this staffing issue. When asked about the stressful aspects of working in aged care, seven participants asserted that the lack of staff is one of the problems. Some of the responses follow:

Yes. It's not to do with the, with the, the care that – it's staff, staffing issues. Yeah. Not enough staff. (Participant 4)

Staff because it's … and they do not replace much staff and if it's short then it brings burnout and much stress. Staff also, everybody is not the same. They do not cope with each other. (Participant 24)

Basically, it is staff shortage. It can also be stressful when you see a resident that you're particularly close to that's deteriorating really fast. And you know that, you know, you're limited in what you can do. So! Yeah. I think that's about it. (Participant 28)

Yeah, it is staff shortage because you're short-staffed. You don't, can't give the quality care to the residents that you need to. Therefore, you will run off your feet and you can't do everything you need to. (Participant 26)

It may not be surprising that staff shortage is a major issue in the aged-care industry because studies have revealed that staff retention in this industry has become very challenging over the last few decades; the workforce is becoming older and young people seem not to be attracted to the aged-care profession (Nursing Federation 2009; Edvardsson et al. 2011; Martin 2007; Richardson & Martin 2004).

The consequences of staff shortages on assistant nurses' work are numerous, including increased workload, unmet residents' needs, roster problems, and working long hours. For example, three assistant nurses describe the workload due to staff shortage as follows:

One carer is in charge of 4 to 6 residents, so you see time is always a problem. One resident wants for example to talk to you while you give the medication, but you cannot because you have to bring the other one to the toilet (laughter). Residents' needs are not met because of time. (Participant 11)

You have 6 to 8 residents to take care of within less than 2 hours. You have to know and remember their individual plans: medications, likes and dislikes. (Participant 16)

Time is always a problem especially in the morning when one nurse provides care for 5 to 6 residents. (Participant 26)

In addition, one participant thought the system is abusive toward staff and residents. The participant was adamant that the staff-resident ratio is the source of all factors leading to burnout in the aged-care industry:

You have 6 to 8 residents to take care of within less than 2 hrs in the morning…. I feel being abused by the system, taking advantage of, you know,

work hard, work like a dog, no support. And then just work! And I felt – because it was to give clients individual care. I did not have time to give them individual care. It felt more like a production line. We just, you know (pause). No time to sit and communicate and interact with the client. (Participant 16)

Those words used by the assistant nurse indicate frustration and disappointment, which are major factors in burnout and matches the findings of Imai (2010) in a study of mental health nurses' burnout. The busyness of the workplace due to staff shortage was also mentioned by two assistant nurses. Relatives also observed that aged-care workers are always busy, as if they do not have time even for a tea break. An assistant nurse made the following comment to a question related to the workplace environment:

'I think it's just busy. I think it's just really busy. You're always doing something. I think that's probably the main cause of burnout'. (Participant 23)

4.2.1.3 Relatives and their expectations

The third theme identified during the analysis of data from the assistant nurses' interview transcripts has to do with relatives, their expectations and interventions in the strict sense of the word. There appears to be a disagreement or misunderstanding between assistant nurses and some relatives with regard to the concept of caring. The relatives have their own expectations; on the other hand those who are in charge of the care also have their own ways of performing their jobs. The conflicts are real, and the comments from assistant nurses help to understand why relatives' attitudes could contribute to aged-care workers' burnout. Eight assistant nurses made references to relatives as a factor contributing to burnout in their workplaces.

It seems that the assistant nurses perceived residents' family to be in competition with them. It is hard to know to what extent this perception could be true because it might be that family members experience a range of emotions regarding the fact that their relative is institutionalised and the care staff members misinterpret these emotions. Further, it is hard for relatives who are used to looking after elderly persons in their homes to give up involvement when they move to a nursing home (Westin, Ohrn & Danielson 2009). One participant made the following comment when asked whether their work is emotionally demanding:

It is definitely emotionally demanding, especially when the relatives come in with their unrealistic expectations and they start telling you what to do with their dad or mum. Oh My God. (Participant 23)

Here, the interviewee points out that residents' relatives are telling or commanding them about what to do. Here, the context or circumstance in which such intervention or involvement takes place is not known, but as Haut et al. (2010) note, next of kin are typically very concerned about their relatives' well-being. Consequently, they would like to check everything such as ward door locking, bedroom door locking, sleeping bags and bedrails. Small issues could become magnified and develop into arguments and misunderstanding. Given the number of direct references made – approximately fifteen according to NVivo 9 – it seems that such situations occur often.

Second, assistant nurses perceive residents' next of kin as demanding and time-consuming. Here again, it is hard to determine to what degree relatives could be demanding; they may just feel a need to receive information

from staff, in particular about their resident's daily life, or they would like to be involved in care. On the other hand, a study related to staff and family relationships in end-of-life nursing home care reveals that about 8% of next of kin are 'often' or 'sometimes' not totally happy with how staff handle this kind of situation – i.e. end-of life nursing (Gjerberg, Førde & Bjørndal 2011). Here are some comments from assistant nurses when asked about the causes of burnout among aged-care workers:

Residents' relatives! They can bring in a lot of stress with unrealistic demands. (Participant 13)

It is demanding especially if there have been a lot of changes in terms of residents' needs and also the unrealistic expectations of relatives. Sometimes, after a relative's visit, you feel exhausted as if you do not know anything about your job; they know all. (Participant 24)

Sometimes the residents are good but the relatives sometimes are mean and demanding making your work emotionally draining. (Participant 28)

To summarise, assistant nurses identified ethics related to inappropriate care performed by other care staff, staffing issues related to staff shortage, and residents' next of kin unrealistic expectations and involvement as the main factors contributing to burnout among aged-care workers. The following section will discuss some strategies proposed by the same group in order to alleviate aged-care workers' burnout.

4.2.2 Assistant Nurses: Alleviation of burnout

Overall, the ten assistant nurses who participated in this study suggested multiple ways to alleviate aged-care workers' burnout. However,

the most cited approaches are the leveraging of training, increasing staff numbers, and the creation of a strong organisational culture. It is surprising to find that while relatives' involvement was mentioned as a major factor contributing to burnout; only one participant suggested a solution addressing this, which is meeting with relatives in order to clarify expectations.

Eight participants thought that there is a need to review the training offered to potential aged-care workers and those already in the workforce. Several aspects of training have been mentioned such as ethical training and cultural training. According to Participant 4, *'trainings are too generic, address only common issues related to the works, and they could do some ethical, stress management training'*. Second, six assistant nurses believed that adding more care staff would help to alleviate aged-care workers' burnout. This view could be expected, since discussions related to staffing issues in any residential aged-care facilities abound in the literature and many reports. One participant pointed out *that 'wherever you go, whoever you may ask, resolving staff shortage would always be given as an answer to that question' (Participant 24)*. Four participants mentioned something related to organisational culture. They suggested that finding ways to increase trust levels among aged-care workers would greatly decrease the experience of burnout. For example, Participant 23 made the following comments in response to the question about how aged-care workers' burnout could be alleviated:

I think if we all could actually fully rely on each other and trust what we say to be true, and then I think that would really help. Do you know what I mean? So I know that when you tell me that that room is done, I know that it's

done. I don't have to go back and check that room and find that you actually haven't made the bed, her towels are dirty, and she hasn't been showered, which happens a lot.

Another participant commented about an organisation having a strong culture where care staff can openly express their frustrations in order to improve quality care:

We need to have another way you can express your frustration and your disappointment, and for them to take into account and try to rectify the situation. But you didn't get all that support. It was very, very minimum support. (Participant 16)

4.3 Nurses/registered nurses: Findings

Eight nurses participated in this research. All have more than five years of experience as nurses in a residential aged-care facility. There was only one male, who has been working in the aged-care industry for nine years. Two nurses have been working as nurses for more than thirty years; one has worked for twenty years.

4.3.1 Causes of burnout

Nurses reported a combination of factors contributing to burnout among aged-care workers. Themes around staff shortages, ethical issues, relatives and training quality were evident in the data from the nurses.

4.3.1.1 Staff Shortages

Seven nurses of the eight asserted that the lack of staff is one of the major causes of burnout in any aged-care facility. According to NVivo 9, there were 68 references related to staff shortage in the interview texts. This lack of staff brought to light other factors such as increased workload, long hours, low staff quality, absence of teamwork, increasing paperwork, and shift roster problems (see figure 11 below). Five participants asserted that staff shortage is the most significant factor in increasing workloads. For example, one participant gave the following answer when asked about the possible causes of burnout among aged-care workers:

Staff shortage has great impact on the nurse to patient ratio– the resident to nurse ratio. It could be she has nine residents. One nurse for six residents, one nurse! And they all need to be showered, things like that. Yeah, nurse to resident ratio is quite big. It's different from the hospital where someone is in charge of four and one nurse. But where I work we might find is six residents, seven residents, eight residents per one nurse. And most of them, they want to be fed. They want to have showers. They cannot move on their own. They need wheelchairs. By the end of the day, you will be so tired for sure. (Participant 5)

Another participant affirms:

Look! Lack of staff increases the workload. Once – this is the, the main thing is once you – you know, you work, say, for example, with me I'm working 10 hours. Yeah. Four days, 10 hours. (Participant 8)

According to Participant 8, it is the lack of staff which makes them work long hours. This is may be because staff shortages have a great impact on shift rosters.

One Registered Nurse also comments that because of staff shortage she is now doing the work that was done by three people twenty years ago (Participant 20).

Another participant has compared the staff-resident ratio between various sections. The participant affirms that in some sections, a Registered Nurse may be in charge of twenty eight residents, whereas in other sections one may have only fifteen. This is because the staff shortage in some sections is higher than in others. This comment still confirms that staff shortage increases workload, and also affects the staff-resident ratio:

Oh, the workload is unmanageable. Twenty years ago, three people did the work that I do. (Participant 20)

Well, right now where I work, well, because I am probably – I am working the section with the most number of residents. So! Of course if I'm going to compare, if I'm going to compare it with the other RN on the other section. He or she only has half of what I have. So definitely I feel like I'm at the worst position. Like, I am more burnout than him or her. And it's not really based on the experience but just based on where you're assigned. Yeah. Because, and we're also – they're, in this section, which I have about 28 residents. If I was doing the other side, they only have 14 or 16 residents. (Participant 21)

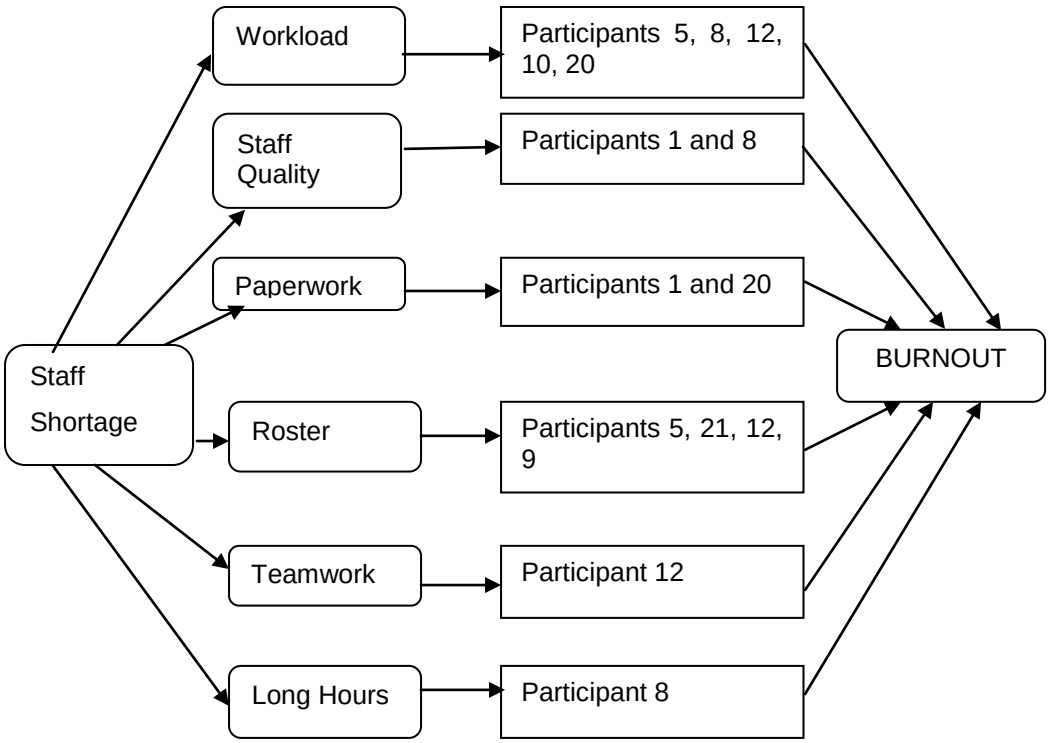


Figure 11: Staff shortage and other factors

4.3.1.2 Ethical issues

Six nurses of the eight attributed issues related to ethics as contributing factors to burnout among aged-care workers. These issues include the unreliability of workmates, lack of the notion of duty of care from other staff, inappropriate care performed by others. In other words, the repetitive absence of ethical understanding would bring frustrations, might increase other workload; and the final outcome would be exhaustion and burnout.

Extracts of some comments are shown below.

I work on a roster basis and I do have good work mates but some staff members are truly complaining about others' attitudes. They do not have any notion of duty of care and responsibility. It is really frustrating because at the end you feel exhausted just thinking of the way some staff perform their duties

as if they have no conscience. It is sad we live in a world of just my pay; and the problem that other staff members have to complete what the unethical ones didn't do. (Participant 8)

(Laughter) It depends, some are good, and others don't even want to shower properly the residents. It depends on the person. I don't know. (Participant 10)

I do not know in general but in my roster team we're fantastic. I do though hear some complaints from other staff…about others' attitudes and lack of sense of responsibilities. (Participant 12)

It depends but inappropriate cares performed by others are really annoying and creates stress and emotional exhaustion; and you don't know how to deal with it. It is most of the time a personal or cultural problem. (Participant 20)

But you know some staff members are not cooperative. Sometimes you wonder why some have come here as if they do not like the job. *(Participant 20)*

4.3.1.3 Relatives

The other main factor contributing to burnout according to nurses is associated with relatives, especially relatives' expectations and interventions. Again six of the eight participants identified relatives as a burnout contributing factor. As well, NVivo 9 identified forty three references related to relatives inside the interview texts for nurses. The result is also meaningful in that the comments for the six nurses revolve around the same issues which are relatives' unrealistic expectations and demands. It is also important to note

that these six nurses have all been working in the aged-care industry for more than six years; and they all have interacted with different residents' relatives.

Extracts of some comments are shown below.

Secondly, you know, when relatives complain. That makes it stress about, you know, working in aged care. Yeah. They don't appreciate what you're doing. (Participant 8)

It is very demanding. In fact, the relatives are very demanding. They sometimes interfere too much as if we don't know anything. (Participant 9)

The most stressful thing is interaction with their relatives. They (the relatives) are sometimes very demanding. Dealing with the family, they have their own expectations. (Participant 10)

Residents' relatives! It doesn't matter how hard they [the jobs] are, we don't mind to do them but if they need big issue … small thing happens and then the family is coming in, it really become stressful. Here, that is the most stressful thing in the aged care … already there is a lot of stress with the workload. (Participant 12)

Relatives! They create more stress than any other part of the job. They are demanding. They want a champagne service for beer price. They expect their person to be given – a lot of them, I mean, there's only a percentage of them, a percentage of relatives. But probably say ten percent of relatives they expect their person to be number one priority, to be serviced like they're – they want something, they expect it like that. They have no compassion for anyone else. They have no compassion for the staff. What they want, they want it now and they expect it now. They, rather than being grateful for the care they get, complain. They contact the Complaints Investigation Scheme

and complain about the most stupidest and ridiculous things, the relatives. (Participant 20)

It is very demanding especially when the relatives come in. They become your supervisors. (Participant 21)

4.3.1.4 Training quality

Another factor identified by nurses as contributing to aged-care workers' burnout is related to the nature of training they receive. Two major issues were mentioned. The first issue has to do with the Certificate III or IV in Aged Care; the second one has to with in-house training. Two participants pointed out that the way the Certificate III in aged care is delivered seems to be one of the reasons why aged-care workers are not prepared for the challenge of the job and experience burnout so quickly. According to these two participants, aged-care workers face two main challenges: the nature of the profession itself and residents' challenging behaviour. Certificate III in Aged care is a real problem because *'there are no hands on, you need those hands on at all times in the aged-care industry' (Participant 20).* Participant 20 also added:

The Certificate is also delivered online, in fast track way; how can you really prepare people to work in this caring industry online and in five weeks? How can they be ready to deal with making the bed, showering residents? How can they cope with residents with dementia online (laughter)? That's why when they come in, they are quickly get burnout.'

When it comes to the in-house training, four participants pointed out that they receive generic training related to fire and Workplace Health and

Safety. They asserted that they do not receive any stress or burnout-related training. This issue was also mentioned by eight assistant nurses. Participants 8, 12, 20 and 21 pointed out that training is too generic and does not address any stress and burnout management. Participants 1 and 8 argued that the Certificate III in Aged Care does not address any practical preparation for the workplace challenges. These situations have an impact on staff quality and lead to burnout (Figure 12).

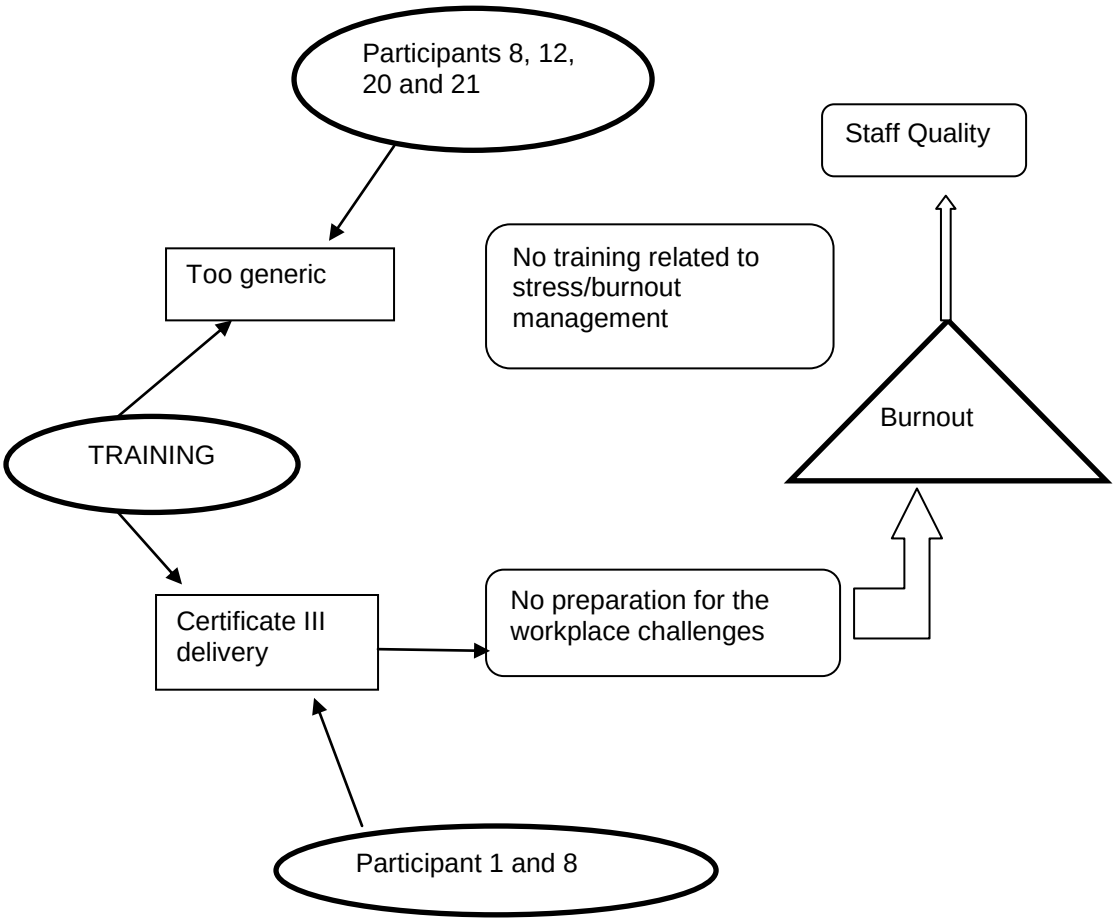


Figure 12: Training issue: factor contributing to burnout

4.3.2 Alleviation of burnout

The eight nurses were also asked how aged-care workers' burnout might be alleviated. Two main suggestions emerged from their interviews. These include a review of training programs and increased management support. Four participants advocate a review of the way certificate courses in aged-care work are delivered as one way to reduce burnout in the aged-care industry. They suggested that the training packages should address issues such as teamwork, ethics, stress management and cultural awareness and not only be technical-focused packages (Figure 13). Participants also talked about increased management support in terms of the staffing issue, equal division of jobs and the promotion of an aged-care profession as solutions to aged-care workers' burnout (Figure 13).

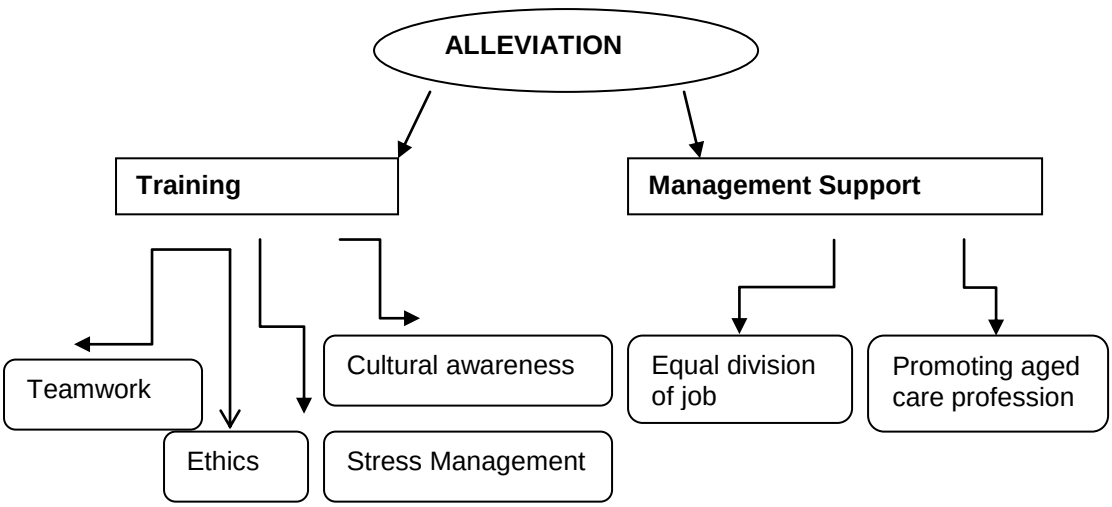


Figure 13: Nurses: suggestions for alleviation

4.4 Managers: Findings

Three managers participated in this study. They were all women and have at least ten years of experience in the industry. Two of them have been working in the aged-care industry for more than twenty years, whereas the third one have been working in disability services for ten years as a coordinator and has moved into aged-care four years previously. The length of experience and work-place based knowledge of these managers has been a very important contribution to this study. They are important participants in the study, with valuable contributions to make in identifying strategies to alleviate aged-care workers' burnout.

4.4.1 Causes of burnout

From the interview, four major areas of theme around burnout have been identified. These include staffing issues, ethical issues, relatives and unprofessional control (Figure 14). Staffing issues include staff shortage, staff quality, and heavy workload and language barriers. Below are samples of the interview text which demonstrate the ways in which managers talked about burnout.

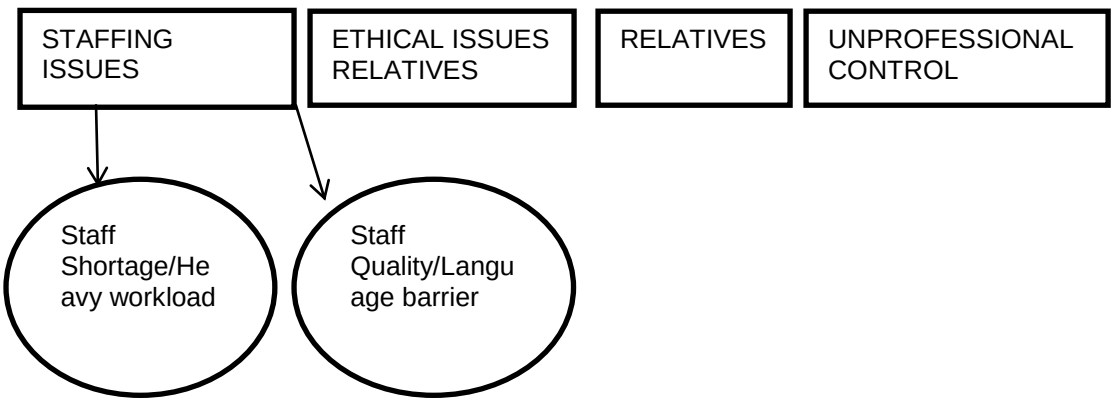


Figure 14: Causes of aged-care workers burnout: Interviews with managers

The figure is a consolidation of respondent reviews from the questionnaire for managers.

Staffing issues

Apart from the staffing issues, there is workload that is quite heavy. Mornings are very heavy. We could do with more, especially when they don't arrive for the shifts in the morning and you have, say, 30 showers to do and you've got about four staff, three staff. It's a bit hair-raising. (Participant 3)

Well, first of all, it would have to be the budget. It's absolutely, trying to have enough staff, not causing them burnout, and, but still get the care done. It's, like, it's getting worse. It's getting worse. I didn't think it would, but that's very stressful. So outside the budget, it's extremely stressful, because, you know, if you go out of the budget, then – the other stressful thing is getting staff, because we pay. Again, we pay less money than they do in the hospital. Why would people want to come and work here? So we get – I hate to say this – but we probably get the dregs of what's left over of working elsewhere where they get more money. Now by saying that, I mean, we've got fantastic staff and I really respect them. But they're not, you know, that's some of the reason. So that's very stressful, because you're also getting people who are probably not well-educated. We get a lot of non-English speaking background people because you come to a nursing home; you know they always get a job, because there are hundreds of jobs going. And so we get a lot of that. That's very stressful. It's stressful for me, because I get complaints from the

residents and relatives saying, 'He can't speak English.' It's stressful for the rest of the staff because…. (Participant 7)

Oh, the workload is unmanageable because of staff shortage and quality. I think everywhere you go, you will have similar answer. (Participant 15)

Ethics

Yeah. There is always something frustrating: residents' illness, change of routines, inadequate care performed by colleagues. You need to manage all of these usually by yourself. We do provide training, recruit Certificate III holders but above all it's all about love and care first. If you don't have these attributes, you perform without duty of care notion. (Participant 3)

I received a number of complaints from staff regarding the way others do their job. Some staff would spend an hour showering a resident only in order to avoid another resident or just to kill the time and leave other duties. I mean delicate duties. You see what I mean to others. Similar attitudes are very common. We need to promote and enforce Code of ethics. The problem is that the control system in place in this industry is not totally enforced. We focus more on fire and OHS …! First of all, it's about caring! On the other hand, we are also busy … the coordinators or managers. (Participant 7)

I think interpersonal skills and teamwork. I think we need more training on duty of care, about the caring profession itself. For example, we hear or receive a lot of complaints…usually verbal about how other staff members do their works. I think this a serious matter but more intrinsic value. You see what I mean. (Participant 15)

Relatives

Relative! They bring a lot of stress leading to exhaustion in …. They expect their person to be number one priority, to be serviced like they're – they want something, they expect it like that. Some clearly tell you how you should do your work. They follow you wherever you go. But others are nice, like the Greek community, the wife comes in, just stays with the husband for a while, and goes. But others, they are really mean and expect a lot. (Participant 3)

Unprofessional control

Another thing! The paperwork and bureaucratic control! Oh my God, you would not have imagined. I think the system is still too bureaucratic and very highly regulated. I am not saying it's bad but just sometimes unprofessional because our first job is to manage the facility. Those who come to check should just do it and not always interrupting us. (Participant 7)

The constant changing and the constant inspections are just crazy. I would have – like I might have, I've got a diary, right. Most days it's [unintelligible] I got staff appraisals and I've got relative resident, you know, interviews. And I've got all sorts of things to do. And then suddenly a team will turn up and say, 'We're going to do an inspection today.' Now I have no comeback. I can never say, 'I can't do it today. I've got too much on.' I have to make the time. And that's so stressful and so unprofessional. I just find that incredibly unprofessional. So, you know, the accreditation team just goes, 'Bang.' And why would they do that, unless they want to catch you doing whatever? I just, I don't know. And I suppose the other, other stressful thing is that they, they do catch you on stupid things that you think, 'Oh, for heaven's

sake.' Because we didn't write something down, then, you know, the whole place looks as if you've let down. And it's a let-down. And the board asks you why. And it's extremely stressful. Gosh, you've started me, haven't you? Anyway, there are a whole lot of other things. (Participant 15)

4.4.2 Alleviation of burnout

Several themes have been derived from managers' interviews when it comes to their point of views related to the alleviation of aged-care workers' burnout. These include better and more consistent management support, review of training delivery and the nature of training itself, human resource planning, pay rise, promotion of the aged-care profession.

Participants 3 and 15 mentioned almost all of these during their respective interviews:

R: Have you any ideas how this might be alleviated? Who can help?

P: *I think in any workplace, people should be given opportunities to try different jobs in a workplace.*

Well, if someone's been in a job as a care worker role for, you know, five years, and have done a lot of training, there's probably a very good chance that they would have some skills that would give, that would be, and they'd be able to do other jobs within the organization. They might be able to step up into an acting position. It is about human resource planning. (Participant 3)

I think equal pay would definitely be one thing that I think would make my job a lot easier. I feel that if all of the staff members are paid more, we'd

get better quality people. I don't think that will ever happen, but I think that will be good. Participant 15

We need to review the training. The program and the way we deliver it. The fast track ten days is not working, absolutely not. Further, include ethics, cultural issues, and interpersonal skills in the packages (Training). Participant 15

Also, recognising that these people do a valuable job, and possibly by paying them more would allow them to work for less hours and spread it all out a bit (Pay). Participant 3

To summarise, managers suggest the review of training packages related to the aged-care service and management support, as strategies to alleviate burnout among aged-care workers.

4.5 Relatives: Findings

Four individuals who had a close family member in the two nursing homes where this study was conducted were interviewed. NVivo 9 identified twelve factors contributing to burnout among aged-care workers. However, it is possible to say here as well that there are a set of themes around staffing issues, client's behaviour, emotional issues and residents' families. The four participants mentioned staffing issues as having great impacts on workload, time and working hours. Three participants thought that burnout among aged-care workers is due to low pay, which would result in low job satisfaction and disengagement. Two participants asserted that clients' behaviour could be one of the main contributors to burnout among aged-care workers. Finally,

two interviewees presented other relatives' expectations as a factor contributing to burnout among aged-care workers. In other words, these two participants acknowledged that relatives' expectations and demands contribute to burnout in the aged-care industry.

Staffing and nature of the profession

The job is definitely stressful because its nature is very complex, but they have chosen to do it. (Participant 19)

It must be because they have to take care of different people with different expectations, different care needs but I see the main cause is lack of staff. (Participant 19)

Absolutely, I think so. I notice that they are always busy when I come there. (Participant 6)

It is absolutely. It is a huge responsibility. I think they all work very hard and they're always busy and there's always something to do, you don't ever see anybody sitting around doing nothing. They're all always helping somebody, filling out forms, doing things. They seem to be very busy always. Oh, very busy, very busy. Yeah. They have a lot to do and I notice there is not enough staff. (Participant 22)

They are always busy and by 'they' I mean everyone. During the last couple of days, I have driven them mad because I've been there all the time and every time I have asked for something, I have got it. Whenever I have said, "Can mum do this?" "Yes, she can". "Can you do this?" "Yes, we can". And it has been done. So I've got absolutely no complaints. And I think they work very hard and they probably don't get paid enough for it. As I said, they

are always busy. I think the workload is too much but the number of staff members is not enough. (Participant 22)

In relation to staffing, the following are the comments of a relative who is also a RN in another aged-care facility:

Well, not in the section where my father is. But I work in aged care myself. And for me, I say yes. I don't work here, but I work in aged care.

I have got too much to do but too little time. I am a RN.

The time and the workload are the problem. Too many things to do. I put a patient and what they have to do is fine. But I work in hard care, and it's full on. I've always, yes. And all of these are due to two main causes: lack of staff and the quality of staff in the aged-care industry. The industry just – often – recruits anyone and it creates a lot of frustrations for those who really love to care for older people… some are there only because they don't find jobs! Well, yes and no. We really need more staff. But you won't get it because you need, you know, the government. We need to get more money from the government. And they just show accreditation. (Participant 18)

The second factor contributing to burnout among aged-care workers according to relatives has to do with the residents' challenging behaviour. One participant did not hesitate to mention residents' behaviours as the first cause of burnout in geriatric care.

Oh, not a doubt. Yes. They have residents with challenging behaviours, which is obviously quite stressful to sort out at times. They do certainly have – they do have education in managing challenging behaviours, but in reality it is

just hard ….I've seen some residents really aggressive and demanding. I wonder how these nurses and carers can still cope with. I would get mad. (Participant 6)

The third is related to emotions. Two relatives who participated in this study pointed out that the aged-care workers have to exercise a high level of emotional intelligence, and because of that they may experience burnout easily.

I should imagine they would, because they're dealing with sad cases all the time. I– I should imagine they would have stress because they, they're dealing with, you know, people who are stressed themselves. I mean, elderly people, most of them don't want to be there. They'd rather be living in their own house, on their own, doing their own thing and being healthy. And they're not. (Participant 22)

I guess it's just you're giving a lot of yourself, you know, because emotionally sometimes. Knowing that people that are possibly at the end of their – the end of their life. The emotions that they and their families are feeling can sometimes get on their nerves.

And you are sort of in the middle between the family and the person.

Also I don't think the aged-care industry is very well paid.

So people have to probably sometimes work longer hours.

Or different – and work different jobs just to be able to kind of live. (Participant 6)

Finally, two relatives acknowledged that other relatives' expectations are also factors contributing to burnout among aged-care workers.

By being understanding, not having too many demands, and being of helping nature, relatives can be of great relief. On the other hand, the relatives also feel that even though they are not staying with us, we care for them. So it is just important to clarify expectations, I guess. (Participant 22)

Well, some relatives have unrealistic expectations. Some and others don't, of course. But it is, when you're dealing with relatives with unreal…. This can happen, too. But when you're dealing with relatives with unrealistic expectations, that's very stressful and it leads to emotional exhaustions easily. So you're trying to help them at the same time you're trying to help the patient come quiet. And, you know, and that can cause stress.

Okay. She was pushing it in the room. There were two in the room. And she was going to get the person near the window, put her back in the bed. She's a nice lady. (Participant 18)

Suggestions from relatives to alleviate burnout among aged-care workers included:

- Promotion of the aged-care profession (make society more aware of the increasing number of old people and the need for aged-care workers);
- Increasing staff numbers;
- Increasing aged-care nurses and carers' pay;

- Reviewing training packages (review the nature of training provided in order to help aged-care workers cope with clients' behaviour and manage emotional intelligence);
- Taking advantage of technology (reducing paperwork, using technological devices to control medications and to help in caring);
- Creating synergy between nurses/carers and relatives.

This last suggestion (creating synergy between nurses/carers and relatives) is the most prevalent one in that all the four relatives mentioned it. The finding reveals that relatives believe that regular meetings between them and aged-care assistant nurses/nurses and coordinators would help to clarify expectations and reduce aged-care workers' burnout.

4.6 The CBI questionnaire: Findings

This study also used an adapted version of the Copenhagen Burnout Inventory questionnaire. The questionnaire was given to each participant, excepting the relatives, before the interview took place. Twenty one participants completed the adapted version of the CBI questionnaire (ten assistant nurses, eight nurses and three managers). Most of participants circled 'Agree' next to the statement that 'insufficient support from co-workers' is a factor contributing to burnout among aged-care workers. This is followed by 'insufficient management support', where sixteen participants circled 'Agree', while four circled 'Somewhat'. 'Change in clients' needs' was also identified as a factor contributing to burnout, with seventeen participants

circling ‘Agree’, while three circled ‘Somewhat’. Table 10 and Figure 15 present some other factors and the number of participants who agreed.

Predisposing factors	**Agree**	**Somewhat Agree**	**Not Really Agree**
Role conflict	10	9	2
Clients’ behaviour	13	6	2
Role ambiguity	10	8	3
Insufficient Management Support	16	4	1
Insufficient Workmates Support Clients’ number increase	20 8	0 9	1 4
Change in clients’ needs	17	3	1

Table 10: Causes of burnout: CBI questionnaires

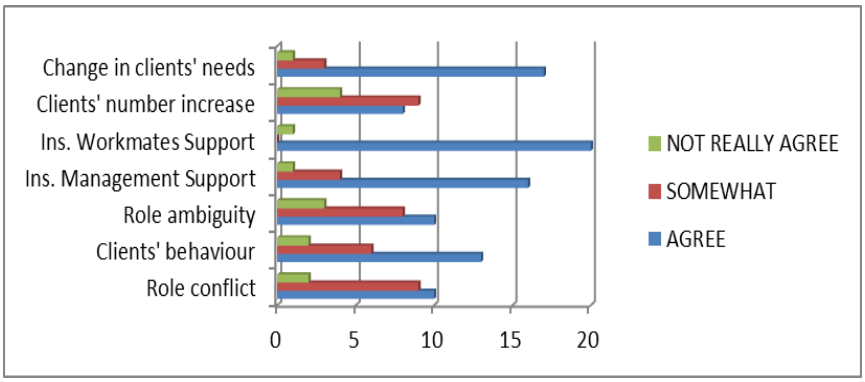


Figure 15: Causes of burnout: CBI questionnaires

4.7 Summary

Table 11 summarises the major factors contributing to burnout among aged-care workers. Ethics is identified by assistant nurses, nurses and

managers as one factor (blue shaded area). All four groups of participants identify staffing issues and relatives as additional (red and green shaded areas). Almost all participants believe that a review of the government training packages and promotion of the aged-care profession would alleviate burnout (blue and red shaded areas in Table 12) along with better management support (by nurses and assistant nurses (yellow shaded areas), structured work conditions and the use of assistive technology.

Causes / Group	**Assistant Nurses**	**Nurses**	**Managers**	**Relatives**
Ethics				
Staffing				
Relatives				
Cultural Differences				
Training Quality				
Unprofessional Control				
Emotional Control				
Clients' Behaviour				

Table 11 : Causes of burnout: Summary

Alleviation Group	Assistant Nurses	Nurses	Managers	Relatives
Review of Government Training Packages				
Add Staff / Promote Aged-Care Profession				
Creating Strong Workplace Culture				
Better Management Support				
Human Resource Planning				
Pay Rise				
Assistive Technology				
Meeting Nurses / Relatives				

Table 12: Summary- Strategies to alleviate burnout

Alleviation Strategies	Agree	Somewhat Agree	Not Really Agree
Review of Government Training Packages	20	0	1
Better Management Support	17	4	0
Structured Work Conditions	18	3	0
Use of Assistive Technology	16	5	0
Respite program for carers	11	5	5
Meeting with relatives	2	0	0
Appropriate aged-care workers recruitment strategy	3	0	0

Table 13 : CBI- Strategies to alleviate burnout

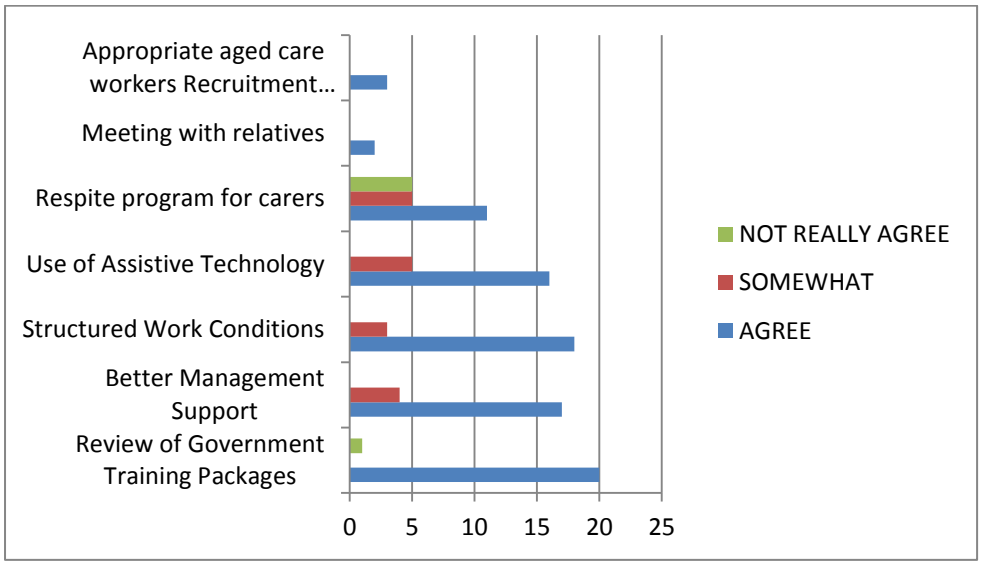


Figure 16: Strategies to alleviate burnout: CBI questionnaires

Chapter 4 has presented the participants' responses to the interview questions. The key outcomes pertaining to inappropriate care are:

1. Lack of ethics among the staff members
2. Staffing issues: Shortage of efficient staff members.
3. Behaviour of relatives
4. Cultural differences
5. Quality of the training
6. Management problems: ineffective control or supervision
7. Lack of emotional control

Chapter 5 synthesizes the key outcomes presented above towards recommendations relevant to the alleviation of burnout in the aged-care industry.

Chapter 5 –Synthesis

5.1 Introduction

This study explored factors contributing to burnout among aged-care workers. An important additional aim of this study was to identify strategies to alleviate burnout and to develop a more effective means of assisting aged-care workers to perform their duties in a safe working environment. This chapter uses the literature review material, synthesises the findings presented in Chapter 4 and analyses the emerging themes from the data and the other factors contributing to burnout as outlined in the literature review in Chapter 2.

5.2 Significance of the findings

The current study extends an understanding of the burnout phenomenon among aged-care workers. Although this study is not about measuring the level of burnout among aged-care workers, the findings provide further support for the multidimensionality of burnout and insights into various factors that contribute to its development.

First, the findings demonstrated support for the assertions of previous researchers (e.g. Burisch 2006; Cottrell 2001; Leiter 1993; Maslach et al. 1996) that burnout is not a one-dimensional concept and the factors contributing to burnout vary from profession to profession. Although a number of studies have been conducted in order to identify the causes of burnout, but most of them do not make the reader understand the actual reasons. While in other professions, job-demands and job-role factors are considered to be the main causes of burnout, this study shows that is not necessarily the case in

the aged-care profession. Taking into consideration previous models of burnout and the present study's findings, a tentative model of burnout among aged-care workers has been devised (see Figure 17). This conceptual model is based on the burnout-coping theoretical framework of Storm and Rothmann (2003). It could be inferred from the tentative conceptual model that there are three main factors contributing to burnout among aged-care workers. All other themes can be considered as subsidiary and related to these three main factors.

The aim of an aged-care facility is to provide appropriate care for its residents. However, having great buildings or beautiful accessories is not the main asset. The main asset is its people, especially those who work closely with residents, giving them personal care and supporting them in their daily activities. These are the assistant nurses, nurses and coordinators. Consequently, their welfare and well-being are very important. This study aims to find ways in which aged-care workers can perform their caring duties with minimum exhaustion and burnout. In Chapter 2, theories from literature were identified in order to develop a framework for the study. During this literature search ten major themes were identified. These include staffing, job demands, lack of reciprocity, role conflict, ethics, training, individual characteristics, pay, aged-care trends, client's behaviour and the nature of the aged-care profession.

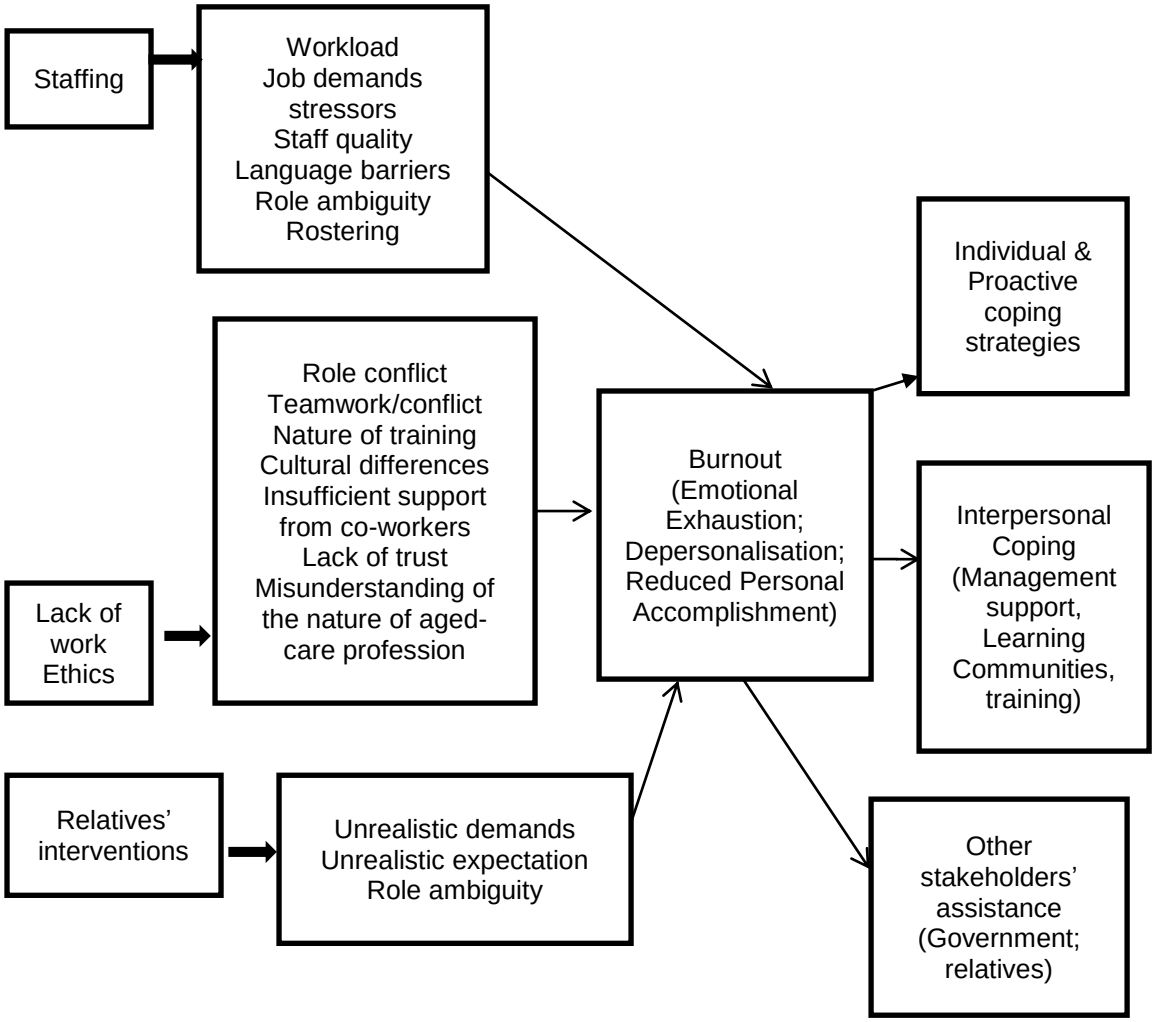


Figure 17: A tentative conceptual model of burnout among aged-care workers

It has also been discovered that there is definite lag in the literature and current academic curricula across Australia regarding the well-being of aged-care workers. The focus is much more on policy development rather than on the aged-care system as a whole. This in itself remains a threat given the trends in aged care with regard to the increasing aged population and the lack of interest in the aged-care profession. It would be very hard to encourage people to enter the profession if the interest is only on policies and

neglects those who are delivering the services (Tuckett et al. 2009). The findings from this research can generate theories which could help to understand the reality in the aged-care industry. For example, looking into some themes in the findings, a number of questions may arise. Someone even said that if this is the case, from the standpoint of a lack of ethics, it would be scary to be placed, or to place a loved one, in a nursing home. This kind of reaction would encourage policy-makers, managers and academics to look into the system more deeply and consider change in preparing people to work in the aged-care industry.

5.3 Two emerging themes from the questionnaire

Before discussing the overarching themes from an analysis of the data from the interviews, it is important to briefly discuss the findings from the CBI questionnaire. This is because it will help to synthesise the major findings along with the data collected during the interviews. It will reveal congruency in the findings; in other words, what a participant 'circled' in the CBI questionnaire matches what he/she said during the interview.

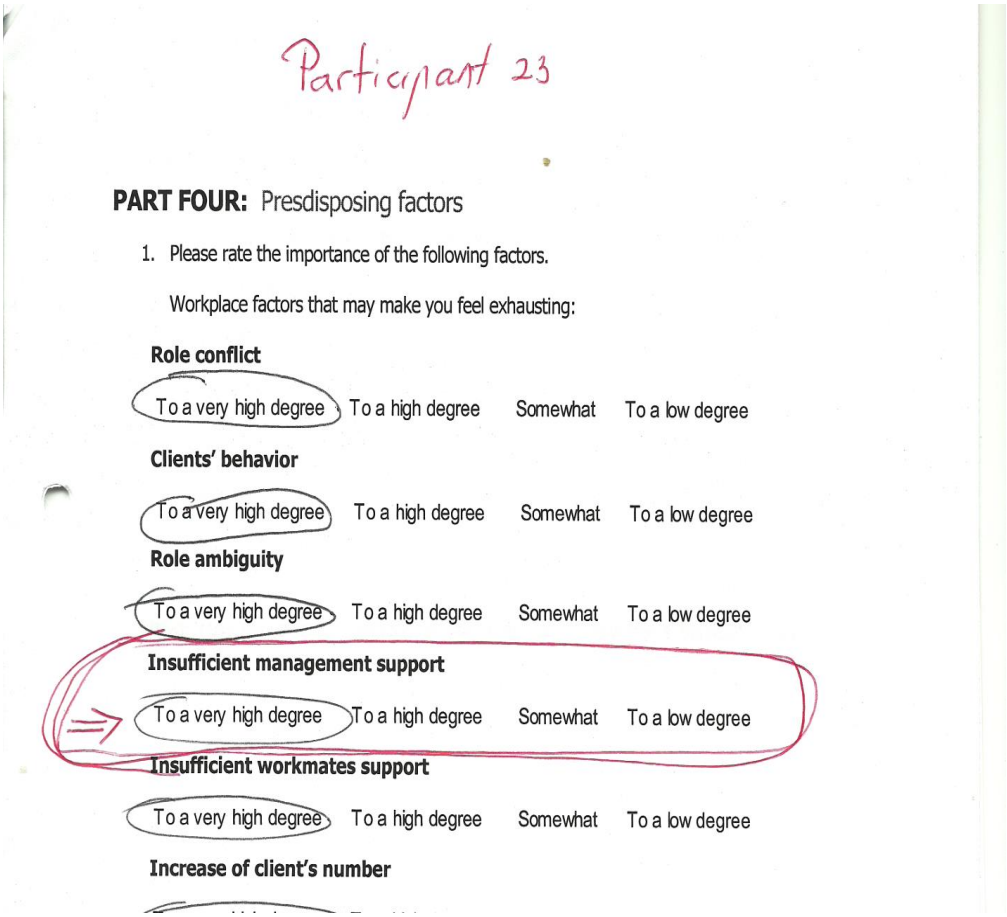
Findings from the adapted version of The CBI questionnaires tend to confirm what have been discussed in the literature. For example, based on the literature, clients' behaviour is one of the major factors causing burnout in the aged-care industry (Institute of Health and Welfare 2004a; Bottrill & Mort 2003). Thirteen participants of twenty-one confirmed this view. There are many comments from participants about role conflict/ambiguity (Bekker et al. 2005; Patrick & Lavery 2007). Ten of twenty-one participants assert that role

ambiguity can cause burnout among geriatric nurses. The majority of participants also agreed that the trend in aged care is indeed one of the factors contributing to burnout among aged-care workers. These trends include the change in clients' needs and an increase in client numbers. The results tend to confirm what have been identified as factors leading to burnout in the literature. This may be because when Kristensen et al. (2005) presented the CBI, they defined burnout as exhaustion and fatigue, and that the CBI was designed based on previous research related to work-related and client-related burnout. Role ambiguity, role conflict, increase in clients' needs, and client behaviours, are all factors contributing to exhaustion.

On the other hand, two new themes have emerged from the general question asked at the end of the questionnaire. That question was: 'in your opinion, what causes burnout among aged-care workers?' These two themes were articulated as insufficient support from work colleagues and insufficient support from management.

Insufficient support from work colleagues is a concept which is closely related to 'ethics/breach of duty of care'. In other words, ethics become an overarching theme because the findings from assistant nurses, nurses and managers' interviews confirmed this perception. Insufficient management support was also mentioned by sixteen participants to be reason for burnout. However, the findings from the interviews in relation to the causes of burnout do not provide any obvious indications related to this concept. Only, when considering alleviation as a concept, did some assistant nurses and nurses suggest that management support was one way to alleviate aged-care worker

burnout. Though some assistant nurses and nurses circled ‘insufficient support from management’ in their questionnaire; they did not mention it during the interviews, but they returned to it when it comes to alleviation. For example, Participant 23 – an assistant nurse – clearly encircled ‘to a very high degree’ for insufficient management support in the CBI questionnaire (see figure 18). However, that participant didn’t mention it at all during the interviews related to causes of burnout; when it comes to suggestions to alleviate burnout, the participant returned to the concept of management support which was encircled in the questionnaire.



Participant 23

PART FOUR: Presdisposing factors

1. Please rate the importance of the following factors.

Workplace factors that may make you feel exhausting:

Role conflict

To a very high degree | To a high degree | Somewhat | To a low degree

Clients' behavior

To a very high degree | To a high degree | Somewhat | To a low degree

Role ambiguity

To a very high degree | To a high degree | Somewhat | To a low degree

Insufficient management support

To a very high degree | To a high degree | Somewhat | To a low degree

Insufficient workmates support

To a very high degree | To a high degree | Somewhat | To a low degree

Increase of client's number

Part of answers related to 'alleviation from Participant 23

I really think for me – like I could be wrong. I don't know. But I've been in management for a lot in my previous industry. And I know that industries are very different, but management's the same. You need to learn how to actually manage someone properly. Not micromanage, not bitch behind people's backs. Actually do something. Management needs to be proactive and act. Whenever someone came to me about an issue, I would deal with it straight away. If I couldn't deal with it straight it away, it would be, like, as soon as possible. Not the next day. Not the next week. It would be straight away, because that's when you need to deal with the problem. That's me.

Figure 18: Example from one CBI Questionnaire

Despite the fact that insufficient support from management is not an overarching theme in the findings, it can create some implications with regard to alleviating burnout among aged-care workers.

5.4 Emerging Discourses and Implications

This current research revealed three main themes that have been considered as the main factors contributing to burnout among aged-care workers. These include staffing issues, ethical issues and relatives' expectations. The following section will provide an integration and interpretation of these three themes.

5.4.1 Staffing issues

This section discusses themes related to staffing issues such as staff quality, language barriers, and cultural differences. The Aged and Community Services Australia Federation recognises that workforce shortage is one of the main issues confronting the aged- and community-care sector (Aged and Community Services Australia 2011). According to the findings of this study, other factors contributing to burnout – such as heavy workload, resident-staff ratio, and unstructured rosters – are mainly the result of staff shortages. The interviews all reveal that one nurse is usually in charge of at least five residents. This would increase stress, fatigue, and exhaustion. It can even lead to unethical practices due to the duties involved and resultant lack of control. Staff shortages are reported to have compounded the low morale

experienced, and overworked nurses express their inability to provide quality resident care, thereby reducing their own estimation of personal professional effectiveness and self-esteem (Department of Health and Aged Care 2002; Lapane & Hughes 2007).

Another concept related to the staffing issue is staff quality. The findings of this study reveal that staff quality is an important issue leading to burnout in the aged-care industry. Three major themes have emerged. The first is related to the fact that aged-care facilities seem to have difficulties in recruiting well-trained and knowledgeable workers. According to participant 15, one of the reasons is that trained workers leave and go elsewhere for better pay:

Hard to recruit and retain good workers because the pay here is terrible; they don't get that great pay either. It's terrible pay. You know? I mean if you're feeling like you're really putting your heart and soul into something every day, we try to think that they, most of them genuinely thought they get 50% of what they should get. Pay them well.

The second concept is language barrier. People from non-English-speaking countries come to seek work in the aged-care industry (Aged and Community Services Australia 2011). The result is that language barriers have become an issue between workers, managers, and residents. Participant 7 pointed out

In my opinion, the reason for people from non-English speaking countries coming to seek work in aged-care industry lies within the non-English speaking people who are already settled there. These people face a

language barrier when they have to avail any health care facility. It is quite possible that in order to remove such barriers, people from non-English speaking countries are being encouraged to take up the aged-care work.

We get a lot of non-English speaking background people because you come to a nursing home; you know they always get a job, because there are hundreds of jobs going. And so we get a lot of that. That's very stressful. It's stressful for me, because I get complaints from the residents and relatives saying, "He can't speak English". It's stressful for the rest of the staff.

Arising from the various backgrounds of the workers, cultural differences have become an important issue because different expectations and different perceptions of the rights of those in care create misunderstanding, consequently resulting in frustration, then ultimately leading to exhaustion and burnout. For example:

The problem is the cultural difference; it is hard to expect others to do the job as you do it. (Participant 14)

Staff have different cultural background; some have come from countries where there are no social structures; they have seen a nursing home for the first time here, so what can you really expect, they are still in the process of understanding. The impact of that on daily works, personal; care, and communication with family is beyond description (Participant 25)

These staffing issues (shortage and quality) can bring along several implications for practice that should be scrutinised. In addition, some

participants had problem with the management as well. Participants in this research confirmed this issue when some of them said:

I try to communicate my frustration to the management, but they don't seem to care very much. (Participant 16)

I want to talk to managers, but it seems they are busy and do not understand. (Participant 26)

You know, you'll tell management – like I've told management and I've told people, but you know, nothing's happened to it. People have asked me this morning, "Oh, what happened on Friday? What happened?" Nothing happened. She didn't do her job. That's what happened. There's nothing to talk about. She didn't follow a procedure. That's my problem. (Participant 23)

Staffing Levels

It is recognised that staff shortage is one of the major causes of burnout among aged-care workers. However, interventions addressing this issue are very limited. Research usually focuses on regulations for providers and consumers. Even the Productivity Commission (2011) ignores this key issue; overall the report ignores key workforce issues. Appropriate staffing levels in the aged-care sector need to be examined and proposed. It is also important to regulate the staff-resident ratio.

Training packages

There is a need for the aged-care sector to develop, in collaboration with education and training providers, a review of training packages and

programs addressing not only competencies but training, which prepares potential aged-care workers to understand and assimilate within the workplace environment. These programs should prepare nurses and assistant nurses to deal with cultural differences and language barriers. Units dealing with how to work effectively with culturally diverse clients and co-workers should be compulsory. It may also be necessary to develop an executive training program for managers, which will better equip them to provide guidance to staff with regard to cultural differences.

Management support

It has also been suggested by interviewees that management support would play a vital role in terms of career planning. Aged-care facilities have an urgent need of improvement in the approach of management, especially when formulating policies for human resources is concerned. It is necessary for the aged care sector to develop and implement a program to improve management capability, particularly in the area of Human Resources, in all levels of staff, and Executive Officers.

Some participants reported that a significant number of nurses find working in a single area for long periods repetitive, and this leads to burnout. To overcome this, strategies need to be developed to increase the variety of work settings. These may include:

- rotating staff between nursing home areas and acute areas;
- working together across the different areas in smaller homes;

- providing nurses with training in other areas, to provide variation for nurses working in one area for long periods;
- Using teams to provide care to residents.

Recruitment and retention

There is a need for new and more considered strategies for the recruitment and retention of aged-care workers. Retention, typically measured by the annual staff turnover rate, has been identified as a national problem in the aged-care sector. As such, it is imperative for aged-care facilities to have a cooperative work atmosphere. It is crucial for the aged care sector to develop a strategy to promote the creation of a supportive work environment in aged care facilities

For example, further research related to the creation of supportive work environments needs to be commissioned.

Promotion of the aged-care profession

As suggested by participants, it is important to promote the aged-care profession, which would involve improving the image of the aged-care profession. This is one of the main strategies suggested by participants, although it is not entirely clear what they envisage. However, some suggestions as to how the aged-care profession can be promoted are as follows:

- National media campaigns to raise the profile of aged-care nursing and show that this area of nursing is important and interesting;
- Funding a program on television about nurses in aged care;

- Positive reporting about aged care in the press;
- Promoting nursing as a career in high schools in order to encourage young people to enter the profession;
- A professional association to promote aged care and lobby governments;
- Promoting a general positive image of aged care; identifying and promoting the diversity of practices for nurses within aged care, to raise interest and the profile of the profession;
- Employing strong leaders in aged care to lead education programs for nurses and instil more confidence and positive attitudes in aged-care nurses.

Organisational culture

Aged-care providers are to be encouraged to create a strong organisational culture that aged-care workers must embrace. This would greatly help in addressing some factors that create a burnout-predisposing culture, such as cultural differences and language barriers.

5.4.2 Ethics/Breach of duty of care

In the context of this research, ethics are related to the way aged-care workers perform their duties. It is closely linked to the notion of duty of care. An ethical attitude in the context of caring is grounded in the understanding of what ought to be done (McDanielle, James & Veledar 2011). Another definition is that ethics can be perceived as an abuse in this context because,

according to the survey findings, it seems there is a repeated lack of an appropriate action occurring within the relationships between staff, where there is an expectation of trust, which causes frustration in others or in older persons. Ethics is also about evaluating caregivers' attitudes, values, and beliefs and how social context influences their interactions with co-workers and aged people (Wityk 2009). Self-awareness of personal issues and stress influences the aged-care workers' perceptions of their roles. Individual ethics contributes a lot to the general ethical concept. Findings point out that the lack of a work ethic is an overarching theme identified by assistant nurses, nurses, and managers, contributing to exhaustion among aged-care workers.

Unethical and unprofessional practices were discussed by almost all participants. The quality of nursing care is essential to the residents' and workers' well-being. Disregard for ethical principles may also lead to institutional violence or physical or psychological violence between staff or between residents and staff (Buzgova & Ivanova 2011). However, this study demonstrated that breaches of duty of care might increase the workload of other carers, bringing frustration and finally leading to exhaustion. There are several reasons why an aged-care worker might breach the duty of care and act unethically. One of these is understaffing. Being short-staffed, aged-care workers might be unable to undertake nursing care appropriately: although this is no excuse for the violation of ethical principles and the responsibility for duty of care. Another reason could be clients' characteristics. Bellis (2010) asserts that there is a significant relationship between violation of ethical principles and clients' personalities. This could be related to unrealistic

demands, leading the carer to just avoid a particular client and leave him/her to others.

Employees participating in unethical attitudes and abuse are more often dissatisfied with their working conditions, do not feel sufficiently motivated by their managers, and consider their job stressful or very stressful. Another possible reason for aged-care workers to engage in unethical care may be related to a lack of knowledge about ageing. Knowledge about ageing and attitudes toward older patients may be related to, and significantly influence, the carers' attitudes toward the quality of care. Studies revealed that nurses with a higher level of professional education had more positive attitudes toward older people (Department of Health and Aged Care 2001; Malmedal, Hammervold & Saveman 2009; World Health Organization 2002).

When it comes to implications, there are various points that need consideration.

Duty of care: standard and guidelines

This study has shown that breaches of duty of care seem to be part of everyday life in residential aged-care facilities. This has a significant impact on the carers' well-being since they do not feel supported by work colleagues. They become frustrated and carry the load that others have left; they become exhausted. There is a need for increasing standards in the control process, including more regular checking processes of staff performance. Ethical codes should be communicated in order to guide the carer in difficult situations, as well as the obligation to report matters related to a breach of

duty of care. Provision of training on standards and improvements in the quality of care is also crucial.

Management support: ethics and complaints handling

Reflecting on the findings from this study, it is important for management to set the ethical tone of the working environment and sustain it over time. For example, providing clear statements of the mission and aims, consistency in personnel policies, enhancing the relationships between supervisors and subordinates(the latter including the support of supervisors for staff), and providing access to discussions of an ethical nature regarding practice, have all been reported as ways to improve organisational ethics and solve cultural problems. Studies have shown that for people working to provide care for older people, it may be ethically challenging to perform their duties appropriately when there is a mismatch between their ideals, the reality of care, and the organisational culture (Park & Kim 2009; Rashid, Sambasivan & Johari 2003; Rees, King & Schmitz 2009; Venturato, Kellett & Windsor 2007).

Ethical environments in aged-care facilities have been associated with providers' abilities to attain their stated care goals or work effectiveness. Sites with positive ethical environments have been regarded by employees as desirable places in which to work. As such, the aged-care facilities ought to adopt such strategies that favour a work environment that is conducive to mutual cooperation and is based on ethics. The aged care sector needs to develop a strategy to promote the creation of a supportive work environment in aged care facilities

When it comes to complaints related to the duty of care, management needs to be proactive and make sure follow-ups are conducted regarding complaints made about inappropriate care performed by others.

Training packages

It is recommended that a new unit should be included in the CHC30208 – Certificate II in Aged Care to cater for ethics in the age-care sector. In business studies, there is a subject called business ethics; it is not an elective subject. However, there is no such ethics course in the aged-care curriculum. In this regard, it is important to make 'aged-care ethics' explicit. It should not be a chapter in a unit, but a full unit. In collaboration with the industry, training providers, and the National Quality Council, further research needs to be commissioned so that a unit of study such as this can be developed, designed and become part of the curriculum in aged-care study.

5.4.3 Relatives

The four groups of participants (assistant nurses, nurses, managers, and relatives) pointed out that the relatives of residents have a role to play in contributing to burnout among aged-care workers. Contrary to Weman, Kihlgren and Fagerberg (2004) and Weman and Fagerberg (2006), who showed that nurses saw residents' next of kin as a resource, this study showed that relatives' interventions are sources of burnout. Their unrealistic

expectations and demands are usually cited as a source of frustration, fatigue, and emotional exhaustion.

There are various reasons for this. First of all, when people are choosing a care home for their older relative or a spouse, they may spend weeks or months making phone calls, reading literature, searching the Internet, or simply listening to personal recommendations from friends and family, because they feel responsible for their older relatives. When the older family member is placed in an aged-care facility, relatives turn out to be more willing to help in the care than the staff may have anticipated. When family caregivers feel that they have no control or have lost control and are not being heard, small issues have the potential to become magnified and develop into problems. The relatives' interferences can also be caused by the approach and attitudes of the nursing staff. Another reason for the unrealistic demands of a resident's next of kin may be because their relatives expressed anxiety or concerns about the management or the quality of care. As one interviewee said, they would always listen to what their family is saying even if he/she suffers from severe dementia. Nursing homes are busy places; nevertheless, relatives feel the need to receive spontaneous information from the staff, in particular about their residents' daily lives.

Two major implications need to be scrutinised and the suggestions will have to be adopted at a facility level.

Customer service attitude

The way that staff and care home managers treat their residents and relatives will affect future business. It is important to help the staff develop a

positive customer service-focused attitude in order to assure relatives that the facility has a high value and orientation. The staff should be prepared to be understanding, with the ability to be organised and to communicate at all levels. They need to be encouraged to display and develop a customer service-oriented attitude so that the facility enjoys a great reputation, which can give assurance to relatives. This depends on how deep the values and culture of the aged-care facility are inculcated in the employees' minds. Further, aged-care providers should always remind nurses that they have a special responsibility to abide by the Nursing and Midwifery Code of Professional Conduct.

Synergy between staff and residents' relatives

As suggested by relatives who participated in this study, management needs to organise regular meetings between their staff and the residents' relatives. The four relatives who participated in this study were adamant with regard to this point. Relatives feel the need to talk to carers in order to clarify expectations, to explore residents' needs, and to discuss to what degree they can be a resource and how they can be helpful. On the other hand, the meeting would also allow the staff in nursing homes to discover and recognise various opportunities for encounters with relatives. This study indicates that both the staff and relatives are important in the lives of residents, and therefore it is beneficial for all to meet and discuss issues related to the caring for their older families.

5.5 Summary

Aged-care worker burnout is part of growing social and organisational constructs created over long periods of time. Aged-care stakeholders all have some responsibilities to alleviate aged-care workers' burnout. This implication could be addressed at three levels: the government, the aged-care sector, and the facility. The government needs to establish parity in salaries within the nursing profession. A clearer system of promotions with recognition of qualifications should also be put in place. On the other hand the aged-care sector needs to review the policies with the government in order to improve the staff-resident ratio in the aged-care industry. It should also develop a number of activities designed to improve support for the staff. For example, it is important to provide a counselling service for staff members, for work-related or personal problems; to move staff from one area to another to avoid burnout; to develop flexible rostering dependent on personal needs; and to have regular team meetings to discuss and resolve issues.

Chapter 6 –Conclusion

The aim of this study was to identify strategies to alleviate aged-care workers' burnout. A key motivation was to develop and to suggest a more effective means of assisting aged-care nurses, aged-care facilities, and the government to manage the well-being of aged-care workers. This final chapter provides an overview of the research and findings. The chapter also outlines recommendations arising from the findings. The final section discusses the limitations of the study, suggests directions for further research, and finishes with some concluding remarks.

6.1 Overview of the main findings

Three major factors contributing to burnout among aged-care workers have been identified. They include lack of work ethics, staffing issues, and relatives' interferences and expectations. Personal carers, nurses, and managers have pointed out that a breach of duty of care is the main cause of burnout among aged-care workers. Breach of duty of care is related to the lack of work ethics in the process of caring. Staffing issues have also been expressed as a cause of burnout among aged-care workers. Staffing issues are related to the staff-resident ratio and staff quality. On a number of occasions, low staffing levels and the quality of staff in aged-care facilities were mentioned by participants. Finally, relatives' interferences accompanied by unrealistic expectations and excessive demands are sources of burnout among aged-care workers. Other factors, such as cultural differences,

insufficient support from the management, and unprofessional control, were also identified as sources of burnout.

The CBI questionnaire revealed that 20 of 21 participants thought that insufficient support from work colleagues was a major cause of burnout in the aged-care industry. Other significant factors include some of those identified through the literature review and supported through interview data, such as role conflicts and clients' behaviours. No significant relationships were found between burnout in the aged-care industry and income sources or personality. This is consistent with the research of Schaufeli and Salanova (2007), indicating that personality and social-biographical background do not play important roles in burnout.

Reviewing the training packages and their delivery, promoting the aged-care profession, better management support, structured work conditions, and the use of assistive technology have been suggested as ways to alleviate burnout among aged-care workers.

6.2 Recommendations for the alleviation of burnout

Burnout is a complex phenomenon that cannot be remedied with simple recommendations (Engelbrecht 2006). Aged-care workers would experience less burnout if they could improve their sense of coherence and meaning in work. Leiter and Maslach (2009) argued that the loss of meaning related to work is a substantial cause of burnout. The findings of this study suggest that the organisational leadership and measured involvement of relatives could reduce burnout and assist aged-care workers in the quest for

work and ethical meaning. In this study, proposed interventions or strategies to alleviate aged-care worker burnout have been directed at three levels: the individual, the management and the Government.

6.2.1 Recommendations to aged-care workers

One way aged-care workers can ensure a positive and an ethical work environment is by supporting each other. Alleviating burnout and its effects can be mitigated by addressing the situation and seeking help; this has been already empirically tested as having a negative relationship with work burnout (Leiter 2005). Aged-care workers can unite to create support structures and mentor groups are aimed at the general welfare of co-workers. Aged-care workers can take a pro-active approach to supporting each other in their daily practices. Workers involved in such a support structure can create a wide-environment focus on preventing burnout and in creating a positive work climate (Rodney 2000; Shanafelt 2006). Botwinik (2007) suggested the best line of defence against the development of burnout is to have others who face the same conflict to be support mentors. Aged-care workers must work hand-in-hand to implement and develop a comprehensive, multilevel and cohesive structure, in which nurses and assistant nurses work in a cooperative and collaborative fashion to successfully provide ethical, customer-focused care to residents.

On an individual level, a supportive family is important in alleviating burnout, through ‘conversation and sharing’. Gjerberg, Førde and Bjørndal (2011) argued that a good family relationship can act as a buffer against

burnout generated in the workplace. Creagan (2004) also found that long-term commitment in a relationship can act as a defence against modern day stressors.

When asked, 'What are your main sources of support? Whom do you talk to?', a number of participants asserted that they talk to their husband or partner when they feel exhausted emotionally:

My partner, my husband or my colleagues! Also, colleagues at work!…We've all usually got the same complaint, and it's good to be able to sound off to each other. (Participant 4)

Even if it is about work, and given an option between family and managers, I would talk to my family when I am tired because everyone at work is busy, even the managers. (Participant 11)

Well, like I said, I try to communicate my frustration to the management, but they don't seem to care very much; so, I talk to my wife, she at least would listen. (Participant 16)

Engelbrecht (2006) emphasises the necessity to unwind from work in order to cope with work stress. Aged-care workers could develop personal strategies in order to alleviate burnout. Suggested strategies from the research findings would indicate that trying to mitigate adverse personal and work conditions would be more fruitful than trying to find external solutions. From the research it could be suggested that focusing on the job rather than on a person, such as an unethical co-worker could be a useful strategy. None of the participants suggested changing jobs or locations as strategies to

alleviate burnout. The evidence from this study's findings indicates that trying to control the internal environment and trying to mitigate the adverse working conditions would be more fruitful than trying to address some issues outside one's scope of control.

Positive interactions with the relatives of those in care could also mitigate burnout. Aged-care workers can adopt customer service-oriented attitudes instead of focusing on relatives' interferences. This could be achieved through training, personal development, and continuous improvement. Ranasinghe (2007) argued that the aged-care sector needs to change from practising an endless auditing concept to a quality concept, which is about considering relatives as customers. Most problems in aged care are found in the processes and attitudes, not in people (Ranasinghe 2007). This can be achieved in any aged-care facility that develops a learning culture.

Last but not least, it would mean taking control of the environment, especially dealing with co-workers who do not have a clear understanding of work ethics, finding meaning at work, setting limits, having a mentor, and reviewing personal values.

6.2.2 Recommendations to management

Managers need to understand how organisational design and context can affect workers' morale and emotional conditions. Studies reported that managers usually fail to see that organisational factors can cause burnout,

and their lack of understanding perpetuates the problem (Moore 2000; Sutherland 2004).

According to Malone (2004) managers in any residential care facility must be responsible for creating a healthy work climate for all aged-care workers. Aged-care workers need to feel like they are valued stakeholders and their needs are being met with equity and a sense of urgency. One of the managers who participated in this study argued that mangers or administrators in aged-care facilities carry a plethora of pressure on their shoulders when it comes to the need to develop and support nurses and assistant nurses in growing and achieving as professionals. Managers serve as coaches and support mentors for aged-care workers and serve as the medium between co-workers The more supportive and understanding administrators are with carers or nurses, the less likely those aged-care workers will experience stress (Smith 2003). Managers must provide support for assistant nurses and nurses in a very collegial manner whereby the workers are treated equally and their voices are respected and heard especially when they report incidents or unethical attitudes for the improvement of service and care delivery. This collegial respect and support will relieve stress, eliminate emotional exhaustion, and prevent burnout from becoming an issue. Managers can greatly influence the decline of emotional exhaustion and stress among aged-care workers by providing support and creating trust. Administration support of aged-care workers in the prevention of burnout relies on the core values, morals, and ethics of the mentor.

When it comes to training, managers need to know the specific needs of their staff and what professional development would best benefit individuals. If professional development needs are met, emotional exhaustion and depersonalisation are less likely to be experienced (Dick & Wagner 2001).

Another recommendation for managers is related to a 'system thinking approach'. The systems thinking approach calls for a true collaboration in which staff are included in the decision-making process (Senge et al. 2010). This is important because one of the assistant nurses who participated in this study pointed out that because team meetings are sometimes not held properly, mangers make decisions related to carers' duties without proper consultation with direct carers, and it creates an unsafe and unhealthy environment.

The systems thinking approach validates and affirms carers as part of the residential facility community and validates their professionalism. Any administrator would gain respect and support from using a systems thinking approach; this will directly translate to aged-care workers having confidence in the leadership of the site. Assistant nurses and nurses must feel they are a major part of the overall structure and decision-making process. The more important they are and feel, the less likely they will be affected by emotional exhaustion (Skirrow & Hatton 2007).

It may also be necessary to foster Professional Learning Communities among aged-care workers. According to Honey, Gunn and North (2004), Professional Learning Communities offer nurses the opportunity to support

each other in the development of best and ethical practices. Learning Communities would offer aged-care workers the support structure of weekly professional development meetings focused on duty of care, best practices, and accountability (Honey, Gunn & North 2004). Allan, Smith and Lorentzon (2008) stated that learning communities are the most effective strategy for assistant nurses and nurses to make a difference in their own personal and professional development. This development could translate into self-confidence and skills building and perhaps result in effective and motivated nurses who are well prepared to cope with the challenges related to their caring duties.

To summarise, managers need to:

- Establish positive workplace practices by demonstrating to their staff a balanced perspective, valuing staff feedback, providing clear work expectations and reasonable assignment of duties;
- Promote a culture of 'collegiality' and trust in which the relationships between staff are mutually supportive;
- Provide clear administrative policies and procedures in terms of work ethics and relevant work objectives. Regular performance feedback and performance appraisal should also take place;
- Communicate realistic expectations to staff. Provide clear expectations for all aged-care workers so that all understand and fulfil their responsibilities toward co-workers and residents in care. Set up systems that encourage open communication at all levels and back to the management team;

- Conduct ‘Training Needs Analysis’ at least yearly and provide appropriate training for aged-care workers in the areas of planning, work ethics, social value roles, grievances, and interpersonal communications;
- Use staff development days or team meetings to share values, goals and to explore problems of role conflicts, interpersonal relationships and so on. External trainers or speakers could be utilised for some ‘hot’ topics on occasion;
- Set up a mentor system to support aged-care workers by more experienced nurses who have a clear understanding of the aged-care profession.

Finally, when immediate managers recognise the burnout syndrome in an employee, they need to act decisively. It is important for management to:

- Offer support;
- Review shift rosters and offer a flexible work arrangement;
- Recommend alignment with the culture and values of the facility;
- Manage performance;
- Market employee value;
- Offer development opportunities;
- Recognise the individual;
- Communicate and assess effectiveness;
- Give more latitude in decision-making;

- Improve leadership qualities;
- Increase job control through reorganization. (Malach-Pines & Oreniya 2001; Malone 2004; Schaufeli et al. 2007; Smith 2003; Sutherland 2004; Voydanoff 2005)

As mentioned earlier, burnout is a complex phenomenon and cannot be alleviated with simple recommendations. Long-term preventive interventions will depend on the organisation's commitment and the manager's willingness to identify factors contributing to burnout, then work to adopt processes to alleviate burnout among aged-care workers.

6.2.3 Recommendations to the government

A proactive approach by the government to embark on intervention strategies to reduce burnout among aged-care workers is crucial. Developing a 'Framework Agreement on Aged-Care Work', which stipulates the aged-care staff-resident ratio, working-time arrangement, and working conditions and environment would significantly reduce burnout among aged-care workers. It would also be useful if there was a Framework Agreement on risk assessment and prevention strategies.

It is also important to promote the aged-care profession to mitigate staff shortages. This might also entail a review of the training packages and courses required for the aged-care industry. This study recommends the

inclusion of courses on ethics, cultural differences, and a review of these concepts in relation to duty of care in the training packages.

It appears that current training programs have not provided an adequately prepared aged-care workforce to deliver the appropriate care to this cohort of consumers. Consequently, those who try to do their best would be likely to experience burnout. With an ageing workforce and an ageing population creative measures are required to address this concerning issue. By addressing the education deficits in aged-care nursing, staff quality can be improved. This would require the bringing together of key stakeholders, that is Registered Training Organisations, TAFE, the University sector, government bodies, industry partners and other professional groups. Such an undertaking would provide aged-care workers or students with the skills and knowledge necessary in the delivery of quality care to people living in aged-care facilities.

6.3 Strengths and limitations

The present research was designed with the aim of identifying strategies to alleviate aged-care worker burnout. In order to achieve that aim, it sought to identify the main factors contributing to burnout among aged-care workers. This thesis has accomplished these aims and has contributed to knowledge about burnout among aged-care workers. It advances the view that staffing issues, unethical attitudes, and unrealistic relatives' expectations contribute to burnout among aged-care workers.

The choice of an interpretative methodology to explore the causes of burnout among aged-care workers is a major strength of this study. This methodology allowed for analyses that helped refine a theoretical evaluative framework and its application to the aged-care industry. The study confirmed that while a qualitative approach was more time consuming, it enabled the researcher to elicit aged-care workers' feelings and opinions about burnout.

Another feature of the research was the willingness of the staff from the two sites to participate in the study. This willingness contributed to a good response during the data collection process and considerable detail emerged in the responses given in interviews. Clearly participants were eager to tell their stories, affirming the importance of this study.

The criterion of trustworthiness or objectivity was also met due to two major factors. First, participants had the opportunity to complete the CBI questionnaire by simply circling the degree to which they agreed with some known factors contributing to burnout. This helped the researcher to easily analyse and synthesise the major findings along with the data collected during the interviews. It revealed if the findings were congruent with reality; in other words, that is, what a participant 'circled' in the CBI questionnaire matched what he/she said during the interview. Second, the researcher was careful about the way interview questions were read out. This included tone of voice, manner, gestures and being mindful not to 'lead' respondents.

An additional strength of this study was the inclusion of participants from various cultural backgrounds. Data collected on these caregivers allowed for cultural comparisons not previously reported in the literature.

Another strength was the inclusion of managers and relatives among the participants. It allowed the researcher to consider opinions related to aged-care worker burnout from those who are not directly caring for residents, but they have some inputs to the residents' lives.

The ability of the researcher to interview all participants in English was also an advantage for this study. This avoided the need to translate transcripts. The findings were reported in English, avoiding completely the cultural, contextual loss of meaning often caused by translation. The complete avoidance of interpreters and translators facilitated the acquisition of the perspective of the participants by the researcher.

Despite these strengths, the present study had some limitations. It may not be possible to generalise and apply the findings to the overall aged-care sector and caution should be taken when interpreting the research findings in relation to the quality of care in aged-care facilities in Australia. Although a number of ethical concerns have been mentioned, this certainly does not mean that ethics and duty of care are totally absent in those facilities or other facilities. On the contrary, the existence of staff members who feel exhaustion, due to carrying double loads, conveys the sense that some very dedicated people are working in aged-care facilities.

The findings of this research might provide an impetus for further investigations. Further research could address the limitations mentioned above by using a larger sample and include more sites. More studies also need to be conducted in order to refine the theory and determine which sections of the training packages for CHC30208 need a review in order to

address some of the issues found during this research. It is also recommended that further research be conducted to address the lack of aged-care studies investigating ethical practice and duty of care in aged care. Finally, to date, the amount of research related to aged-care workers' well-being is very limited and this study has added to the body of knowledge about the experiences of aged-care workers. This study could be replicated at more sites and generate more evidence to assist aged-care workforce development.

6.4 Conclusion

In conclusion, the present study further contributed to our understanding of burnout among a small sample of aged-care workers. Although there can be few doubts about the significance of burnout in the aged-care industry, the findings suggest that reducing burnout among aged-care workers deserves more attention. This study has identified some of the key contributors to aged-care worker burnout. Three main themes would be worthy of consideration and also of future research. The most immediate concern for aged-care workers and relatives is related to staffing issues. Overall, participants see staff shortage and staff quality as the main factor contributing to burnout among aged-care burnout. Another concern is associated with the lack of work ethics. It is a significant factor because it makes work conditions, work environment and interpersonal relationships difficult to manage. Finally, relatives' interferences are also considered as a factor contributing to burnout among aged-care workers.

The findings also suggest that burnout must be tacked by individual and organisation-based preventive strategies. This study has provided some useful strategies that could go some way to alleviating burnout among aged-care workers. The assumption that the purpose of Mode-2 research is to propose solutions to practical problems through direct contact with practical problem situations (Gibbons et al. 2009) was validated in this study. Aged-care nurses' burnout must not be seen as an individual problem, but as an organisational and occupational problem for which the aged-care industry in general and other stakeholders such as residents' relatives and the Government, are all responsible.

The findings from this study indicate that the work environment needs to be improved and it is not just about aged-care employees adjusting to the problem. This study confirms the argument by Maslach and Leiter (1997, p. 9), wherein they warned against the tendency to blame the victim and asserted that 'burnout does not result from a depressive personality, or a general weakness. It is not caused by failure of character or a lack of ambition. It is not a personality defect or a clinical syndrome. It is an occupational problem'. The main benefit of these strategies will be the attainment of healthy aged-care facility environments and in demonstrating that the responsibility for helping aged-care workers to avoid burnout is jointly that of the individual aged-care worker, management, government bodies and communities.

Chapter 7 – Personal Reflections

7.1 Introduction

The purpose of this chapter is to allow the researcher to reflect on his personal experiences whilst conducting this research. Undertaking this doctorate program has been a challenging undertaking in terms of time, effort and having to balance work commitments and family around study and research. However, it has been a period of learning and professional growth. It has also been a fulfilling exercise in terms of understanding the rigours around what is required to complete a doctorate. This chapter is divided into five sections: personal pleas, reflection on the workshops, impact of the project on me, impact of the project on my work, and conclusion. This reflection is written in the first-person.

7.2 Personal pleas: Contribution and reasons

This study makes an important contribution to the theoretical uncertainty and areas of dispute concerning the causes of aged-care worker burnout.

The importance of this study is also highlighted by my own personal and professional experience. Having worked as chaplain, support worker and social educator for intellectually disabled and aged people in for three years, I have observed how stressful and challenging this kind of social profession is. A number of work colleagues have complained about their emotional exhaustion and decrease in motivation.

The high levels of burnout among aged-care workers and the evidence of its impact on the health and quality of life of both workers and patients underpin the significance of this study. It is crucial to develop practical methodologies to alleviate carers' burnout in aged-care services in NSW. It is also in the employers' direct interest to reduce carers' burnout, given the association between staff burnout, sickness, absenteeism and turnover. This study might therefore help employers to develop policies in relation to stress management and thus address the issues outlined above.

My research brings a significant contribution to the issues identified above. It proposes interventions to alleviate carers' burnout which might not only improve the carers' performance, but also improve the quality of work performance with respect to residents. Given that the well-being of aged-care workers has implications for the quality of life of staff and clients, this research topic is important and of immediate practical concern.

7.3 Reflection on the workshops

The CU55 Doctor of Professional Studies course is a three-year full-time higher degree doctorate requiring the completion of a major thesis. The program is context based, driven by solving a current workplace issue and acknowledge the workplace as a location of knowledge production (CQUniversity 2009). During the first year, candidates are required to attend six workshops: Critical Foresight, Creating Futures, Futuring, Market Positioning, Net Solutions and Working in the Knowledge Society.

The first workshop –Critical foresight – was about exploring the concepts of Mode 2 knowledge production and Mode 2 society. It helped me to understand the nature of applied research and to delineate the project topic. Moreover, this workshop assisted me to think about my research aims in terms of Mode 2 knowledge production which focuses on the application of knowledge and must provide a solution to a need in a specific professional setting (Ferlie & Wood 2003).

The second workshop –Critical Foresight –explored the concept of trans-disciplinarity. Dr. C. Graham took us through theoretical concepts – from Piaget (1970) to Nicolescu (2009). Three trend lines were discussed during this workshop. These included: the quest for systematic integration of knowledge, Mode-2 Trans-disciplinarity and Mode-2 research emergence. This workshop assisted me to redefine my research objective and eventually influence the way I wrote the introductory and literature review chapters.

The third workshop –Futuring – was an interesting workshop in that we were asked to develop scenarios about the potential of your proposed research topic by using policy documents, articles and literature. It assisted me to identify and reference the key driving forces behind my research topic. These scenarios were not intended to be predictions but rather a source of insight into possible future trends which may inform the research topic. This course embedded in my mind the role of critical and creative thinking in problem solving.

The fourth workshop – Market positioning – could be identified as a ‘literature review’ in that it helped me to define the gap in the literature and

also to define who would benefit from my proposed research topic and how they might benefit. This course assisted me to identify relevant gaps in theory and practice in relation to my research topic. A tentative framework resulted from this course.

The fifth workshop – Net Solutions – introduced me to various research paradigms and research methods. It explained the difference in assumptions and approaches between the qualitative and quantitative research. This workshop assisted me in developing a research method appropriate for my research topic and question. The conclusion was that qualitative research would be the most suitable methodology for my research topic.

Finally, the 'Working in the Knowledge Society' workshop prepared me for the National Research Ethics Application in order to obtain approval for my project from the CQ University Human Research Ethics Committee. During this course, I also wrote a Colloquium paper which was presented before the panel in May 2011. The colloquium helped me to narrow my research focus to be more manageable. The colloquium panel provided valuable helpful feedback regarding the sampling of participants and the data analysis process.

Completion of these workshops was a major milestone in the development of my thesis. It gave me confidence in my ability to undertake the research, and encouragement for the tasks ahead. After submitting my NEAF application, I obtained approval in September 2011 and started to collect data from November 2011. Overall, these workshops were useful in that they assisted me to understand the difference between the traditional,

purely academic, research and applied research. These workshops introduced me to what I should know before undertaking the real research program and they were helpful.

7.4 Impact of this project on myself

From 2008 to mid-2011, I worked as a disability support worker. Combining my work experience and my master's degree in human resource development, my first choice was a topic related to training packages for disability workers. However, I realised that it was going to be difficult to conduct such research given the dearth of literature about training packages for disability workers. After a discussion with Dr Clive Graham, I spoke to one of my work colleagues and asked him about possible topics to be researched. During our conversation, I picked up something that my work colleague said: 'Stress and burnout will kill us here slowly'. That day, after my shift, I immediately went on Google Search and started to do a quick search on burnout. A few days later, I met another friend, one who has been working in the aged-care industry for several years. I asked for her thoughts about a study that would identify strategies to alleviate burnout. She was so excited and provided a positive response. According to her, aged-care workers experience more burnout than any other workers in the aged and disability services sectors. Since my mind was engaged in the trans-disciplinary nature that the research topic should have, these three conversations led me to choose the present topic. Being a community living manager now and having undertaken this project, I have become more critical and reflexive about what

kind of support and training the organisation should organise. This study has enabled me to be more critically engaged in staff management. That attitudinal change would not have occurred if I had not undertaken this doctorate and did not have an open mind as to where the research might lead.

These consultations have created an intellectual property that will grow in value as it is kept up-to-date with evolving trends in the coming years. Additionally, an orientation to learning is one of the most important conditions that support high-performance work practices within an organisation (McShane, Olekalns & Travaglione 2013). Learners could be compared to people going on a holiday trip. They have spent a certain amount of money and have done some planning related to the activities to be undertaken. However, when asked about their reflections on the trip, they have much more to tell than the trip itself. During my research, I have realised that the 'trip' provided more surprises than I thought possible. For example, after collecting and analysing a body of data, I have come to conclude that ethical values also need to be re-emphasised in the non-profit world. The trip has also brought some debate within a specific group of colleagues because while conducting my research, I have been able to share some points with the people I work with, which in turn have multiplied the number of discussions I was to have with superiors, peers, and subordinates and which have in turn increased my network of contacts.

I do remember that one of the main objectives of a doctor of professional studies is to reach out to the 'agora'.

I have closed my eyes for a moment and tried to utter the word ‘research’ to myself. I wanted to know what images this word conjures up for me. The first image that came up was a kind of a laboratory with scientists at work with test tubes; then I also visualised someone collecting data to study the impact of some new theories or new systems. In the context of my thesis, I have seen ‘research’ as the process of thoroughly studying and analysing the situational factors surrounding a problem in order to seek out solutions. This is because the concept of trans-disciplinarity deals with research problems and organisations that are defined by complex and heterogeneous domains (Nicolescu 2002). I have discovered that the nature of knowledge does not respect institutional boundaries; its acquisition is transgressive, and any stakeholders within a specific industry could be considered as sources of information.

During my journey of learning, I discovered that my understanding of a thesis grew to the extent that today Icon tell what I have learned since this process started. I can even affirm that I am now no longer the same person who started this journey of learning.

My journey could be summarised by reflecting on three major changes that took place:

- Focus on thoroughness and details;
- Continuous learning in terms of writing skills;
- Professional development.

Focus on thoroughness and details

As I mentioned earlier, research is a thorough study and analysis of the situational factors surrounding a problem in order to seek out solutions. I remember, when I first sat in our first doctorate class for a workshop, I thought that the work would only consist of taking some time to write a thesis and submitting it. At the end of that first weekend of the workshop, I started to realise it would be more complicated than just writing. The whole process has taught me to improve my ability to look into details, which is one of the requirements of any managerial profession.

The doctoral program forced me to read beneath the surface and took me out of my own comfort zone. The program comprises five assignments that would set up the foundation of the research. The first assignment question, ‘Complete a written rationale for undertaking the proposed topic of study’, forced me to find a language to define my own thinking.

It became more difficult with the third assignment, and by the fourth assignment, where I had to develop scenarios and start a literature search, I could no longer hide behind a pre-conceived mentality; I had to define what I wanted to say. A very important change occurred during the literature search, when I came across articles that helped me to design my own theoretical framework, which would guide me through the methodology design and data analysis. The literature search introduced a number of key influencers into my thought process. These are key influencers that made me understand that there are no prescribed patterns but that new patterns could occur or may even flow from existing patterns.

I have been working in management for most of my 17 year career – from religious to corporate organisations. Over this time, I have developed reasonably firm ideas about how people learn and how to bring about solutions to a problem. I have observed that people within an organisation usually provide solutions to a specific problem through a quick consultation or a board meeting. They usually learn by traditional approaches rather than by scholarly approaches. The result of this is that true learning rarely occurred. This thesis has helped me to adopt a new approach to problem solving, where learning has to be linked to a change. In other words, if no change occurs, no true learning has taken place. Of course, it is not always possible to bring change or to find answers, but as long as we keep on searching for answers, we are building knowledge, which will eventually bring some solutions. Through a single research, it would not be possible to find radical solutions to a problem; but through the knowledge gained from the study, each researcher is participating in building the coral reefs that will one day be the solution (Cavana, Delahaye & Sekaran 2001).

Continuous Learning

I arrived in Australia in 2008 with very little knowledge of English as a language. I barely spoke, and needless to say, I could not write. I do remember, I sat down in a human resource management class, and when I saw the requirements for the first assignment – with 2,500 words – I went home and said to my wife I would not be able to make it, that I would have to attend an English class first. I soon realised that I needed help. Accordingly, I went to see the student support services and met Dr. Susan Lee. I attended

twenty-four workshops on how to write academically. I have always used the techniques and followed the guidelines she has provided for my assignments. When I started the doctorate program, I was not really scared of the assignments, but I knew that writing a large document would be a great challenge for me. I had a very personal idea of how to do things differently, and hopefully better, but I was not sure how to structure and articulate my ideas. The continuous learning in which I have been engaged through reading, through Dr. John Rule's supervision and Dr. Susan Lee's proofreading process, has assisted me not only in discovering legitimate explanations for my personal ideas; it also taught me the language needed to articulate these ideas. I have understood the concept of language to the extent that today I can explain what I was unable to explain before I started the doctoral program. The research program gave me invaluable experience in applied action research.

The next challenge for me is to prepare articles for publications. I have actually started to draft a paper, but I soon realised how painful it could be and that more courage and skills will be needed.

7.5 Impact of this project on my work

As well as developing my own critical reflexivity, I have been able to share this with the people I work with. It has widened my thinking into all areas of training programs, grievances, and staff management. This in turn has multiplied the number of discussions I had with superiors, peers, and subordinates and which has in turn increased my network of contacts. I have

also been given the privilege to present part of my research finding – ethics and duty of care – during a staff conference in. My presentation has led to a long debate among workers in that they still discuss and ask question about it when I visit community houses.

The topic has even become a focus of discussion at board level, which continues at the time of writing. Though I have not published any of my studies yet, I do feel that, to some degree, the findings from this study could have potential impacts in relation to the way aged-care workers are trained and supported. The discipline of undertaking academic research has altered the way I approach work-related issues and investigations today.

Professional growth

As mentioned earlier, it took me a while to articulate a clear study topic. My topic did not specifically grow out of my involvement with community services since I have only been involved in community services since 2008. Before this, I worked in religious and human resources roles. However, I have always developed my thoughts about how to reduce stress and burnout. When I started working in the community services profession, I became deeply concerned by the apprenticeship approach that widely prevailed. The type of training that is provided does not practically address daily problems encountered by care workers. When an issue occurs, the answer usually is to either blame or provide quick-fix solutions or just ignore.

At the start of the doctoral program, I wanted to just apply theories related to burnout to the aged-care industry. This is because the concept of burnout is popular among various disciplines already. Further, I was not

confident that I possessed the language ability to explain what I wanted to do, nor could I express the reason why I should pursue a particular approach. I soon realised during the literature search that it would be more complex than I thought because the aged-care industry has its own particularities, and I would have to do a thorough analysis based on the appropriate methodology and analysis.

When I met my industry supervisor for the first time to discuss the project, she was so excited and told me that the topic is indeed well-chosen and could be of great value for not only aged care but also for the whole range of services under Ageing, Disability and Home Care. One of the managers at the Canterbury Domain Principal Aged Care said that the topic is timely and appropriate because managers have difficulty approaching such a practical issue as staff burnout.

My journey eventually took shape; my own understanding of a theoretical framework emerged. Today, I can talk with confidence about what I have found, and I am keen to tell others what I have learned.

7.6 Conclusion

Academic research may not always be held in high esteem in community services, especially in the aged-care industry. Many supervisors or team leaders in the industry may not even hold postgraduate degrees, and I am not sure if there is a strong commitment from providers to support doctoral studies. Mostly, budgets are allocated for training, not for research. I am

proud of myself in attempting to bring academic knowledge into the human services sphere. I have no doubt I made and will make a difference by suggesting solutions from an applied research perspective on how to look after the well-being of aged-care workers.

On a personal and professional level, one of the most obvious impacts of this study was the degree to which it added to my understanding of staff concerns within the aged-care industry; concerns could also be extended to the frontline workers in the human services sphere. The following points stand out to me as insights that impact my current and future works. They have significance for anyone working in the human services field.

1. Support workers or carers do have serious concerns in relation to their work practices and well-being, but seldom do they have an opportunity to voice them.

I have learned that asking aged-care workers to share their narratives in terms of burnout gives me a much deeper understanding of their desires to be heard. These narratives also provide great case studies for future publications and staff development workshops.

2. Given a high level of trust and a sense of value, research participants are willing to give precious time for research, also sharing highly personal experiences normally kept private.

Seeing the participants in this study respond with such enthusiasm has challenged me to share the findings of the study and use my access to the

aged and disability services to bring some contributions in terms of staff management or staff development programs.

3. Managers and relatives seem tounderstand the struggles, stress, and burnout aged-care workers may face. However, they also seem to be powerless in the face of such situations.

The findings of this research could be used by stakeholders, including policymakers, to review policies and regulations. This may help in regulating the staff-resident ratio. I feel the responsibility to begin writing and making presentations on this point to alert others to its significance.

4. Aged-care workers often do not understand the picture of their development.

The findings of this research also reveal that aged-care workers tend to focus on issues such as staffing and inappropriate care performed by others. These are present in reality, as the findings show. However, there is a need to encourage aged-care workers to help themselves to focus on their development, rather than just their daily routines and tasks.

5. I tend to believe that the three main issues found during this study are also present in other sectors, such as the disability sector or the community living services sector.

I am challenged to explore whether the insights revealed in this study can also be relevant to other industries in the human services sphere. The search could be continuous and never ending because other findings may be interesting.

Solving workplace problems allows the staff to bring value that others recognise, and it gradually builds the confidence needed to find solutions for staff burnout. Being proactive is an important attribute since expecting or waiting for others to work on solutions first could create more exhaustion. Key elements include seeing how to define the problem, taking the initiative (even without being asked), being sensitive to the people involved, and being able to engage those people so that they support the solution.

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Appendices

Appendix 1: Mode 2 and the research topic

This section discusses the scope of this study in relation to the five characteristics of Mode 2 research described by Nowotny, Scott and Gibbons (2002), providing the theoretical structure upon which the Doctor of Professional Studies course was formulated, and for which this thesis has been written. These characteristics include knowledge production in the context of application, transdisciplinarity, heterogeneity, social accountability and the 'Agora'. The following demonstrates how this study aimed at alleviating residential aged-care worker burnout is compatible with Mode 2 knowledge production within the Doctor of Professional Studies program guidelines.

Context of application

This research aims to identify strategies to alleviate aged-care worker burnout. Consequently, it attempts to suggest solutions to a problem arising directly from a social workplace which is the aged-care industry service. Additionally, these problems are shaped by a diverse set of social demands including competitiveness, quality care, Occupational Health and Safety policies and clients' family expectations (AIHW 2004a). In other words, this research aims at solving relevant field and real world problems and is thus aligned with the Mode 2 knowledge production system (Nowotny, Scott and Gibbons 2002).Further, the transformation of research participants' tacit to explicit experience is required in order to identify the causes of burnout

among aged-care workers. Niedderer and Reilly (2007) point out that experimental and tacit knowledge are very important in a creative social work practice. This transformation of tacit to explicit knowledge is a key feature of Mode 2 knowledge production (Nowotny, Scott and Gibbons 2002). The results of my research are intended to be useful to the aged-care industry, policy-makers, and residential carers and my research is based on 'knowledge-guided practice' as described byGray (2008) and Grayand Schubert (2009).

Transdisciplinarity

Klein et al. (2001, p. 4) assert 'the core idea of transdisciplinary is different disciplines working jointly with practitioners to solve a real-world problem'.The research attempts to solve a real world problem as it engages nurses, managers, caregivers, and residents' relatives who share an interest in relation to quality of care within the aged-care industry sphere andI draw upon a range of disciplinary categories to do this. This study is transdisciplinary in that it involves aspects of the social work, psychology, nursing, and management disciplines (Gray & Schubert 2009). Indeed, a number of social work researchers contend that social work research in itself constitutes the 'gold standard of Mode 2 knowledge production' (Gray 2008, p. 5). Accordingly, the shape of the solution proposed by this research must be beyond any single contributing discipline. Additionally, this is qualitative researchrelying on multiple sources of evidence. Denzinand Lincoln (2003) argue that such research can work as a transdisciplinary exploration allowing

the researcher to cut cross the humanities and the social sciences. This feature of qualitative research makes it highly suitable for Mode 2 research.

Heterogeneity

Participants in this thesis represent different categories of carers working at two aged-care facilities in Sydney.The heterogeneity of the participants' roles and their various experiences contribute to the Mode 2 nature of this thesis. The heterogeneity of participants provides diverse viewpoints which are necessary for the knowledge production and transfer. The research process is seen as a knowledge transfer system. This implies a multiplication and social diffusion of the research topic within the research field. Non-academic dissemination of knowledge is an aim of this study, even if that aim is not immediately realised during the project.

Social accountability and Reflexivity

Residential carers' burnout cannot be alleviated by using scientific and technical policies alone. Carers' burnout is influenced by diverse circumstances and experiences. According to Gray and Schubert (2009, p. 8), any research within such a context requires 'reflexivity and high level of social accountability'. This research about residential carers' burnout cannotsucceed without deep reflection and consultation with actors involved. Nowotny, Scott and Gibbons (2002, p. 232) have argued that Mode 2 should be understood 'in terms that are both more reflexive and more realistic' than previous understandings of the nature of research. Mode 2 research should thus be a

response to the needs of both science and society. In striving to address a social need in an accountable manner, this research qualifies as Mode 2 knowledge production. It seeks to meet the demandfor socially relevant knowledge (Gibbons et al. 2009). I note also that my own work experience leads me to a set of research questions about burnout in aged-care services. This research is thus a kind of dialogue process, a conversation between researcher and research participants.

The Agora

Another significant characteristic of the Mode 2 system is related to the concept of ‘agora’ (Gibbons et al. 2009, p. 257, 260). The term agora is an ancient Greek word for a gathering place for commercial, political, and social interaction and discussion; in today’s context, it can be understood as incorporating both the business market and society or the community in general (Nowotny, Scott & Gibbons 2002). During the Mode 2 research process, science is required to enter the Agora, which is a key source of innovation. My engagement in industry and with industry actors, through conducting this study, shows how I have engaged with a particular ‘agora’ to produce relevant, community-based knowledge.

Appendix 2: Ethical clearance

CQUniversity
AUSTRALIA

Secretary Human Research Ethics Committee

Ph: 07 49232603

Fax: 0749232600

Email: ethics@cqu.edu.au

20September2011

Mr Lovasoa Andriamora
4 Harcourt Avenue
Campsie NSW 2194

Dear Nr Andriamora

HUMAN RESEARCH ETHICS COMMITFEE APPROVAL: PROJECT H11/OS-136, ***IDENTIFYING STRATEGIES TO REDUCE AGED CARE WORKERS BURNOUT: A STUDY FROM TWO AGED CARE FACILITIES IN SYDNEY***

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC *Australian Code for the Responsible Conduct of Research.* This is available at http://www.nhmrc.gov.au/publications/synopses/files/r39.pdf.

On 30 August 2011, the committee met and considered your application. The project was assessed as being greater than low risk, as defined in the National Statement. On 14 September 2011, the committee acknowledged compliance with the conditions placed upon ethical conditional approval for your research *Identifying strategies to reduce aged care workers burnout A study from two aged care facilities in Sydney* (Project Number H11/08-136).

The period of ethics approval will be from 20 September 2011 to 1October 2012. The approval number is H11/08-136; please quote this number in all dealings with the Committee. HREC

wishes you well with the undertaking of the project and looks forward to receiving the final report and statement of findings.

The standard conditions of approval for this thesis are that:

(a) you conduct the thesis strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. *(A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event)*

(c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

(d) you provide the Human Research Ethics Committee with a written "Annual Report" on each anniversary date of approval (for projects of greater than 12 months) and "Final Report" by no later than one (1) month after the approval expiry date, or upon submission of your thesis (Psychology honours students only)

(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)

(e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project

(f) if the thesis is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee is committed to supporting researchers in achieving positive research outcomes through sound ethical thesiss. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Ethics and Compliance Officer or myself.

Yours sincerely,
Redacted text

Dr Tania Signal
Acting Chair, Human Research Ethics Committee

Cc: Dr John Rule, Mrs Corlette Todd (supervisors) Project file

Application Category: A

Appendix 3: Request to conduct the research

Lovasoa N. Andriamora
4 Harcourt Avenue, Campsie NSW 2194
mobile: 0424 813 731email: l.andriamora@cqumail.com
July 14, 2011

Mrs Corlette Todd
Wesley Mission, Vickery Lodge
Centre Manager
101 Port Hacking Road
Sylvania NSW 2224

Dear Madam

PERMISSION TO CONDUCT RESEARCH

I am writing to request permission to conduct a research study among aged care workers employed at Vickery Lodge, including professional nurses, assistant nurses, and care coordinators. It is envisaged that, should permission be granted, approximately four professional nurses, eight assistant nurses and three care coordinators will be interviewed. The project is a requirement for a Doctorate degree at Central Queensland University Sydney under the supervision of Dr. John Rule.

The purpose of the study is to investigate the major causes of burnout among aged care workers and to propose solutions to alleviate this problem. Permission has been granted to proceed with the intended topic by the University's academic panel.

Potential participants will be approached individually to obtain their voluntary informed consent to participate. The research approach will be qualitative in nature. Interviews will be audio-taped with the permission of participants. I undertake to ensure the anonymity of the participants by omitting the use of names during the interviews and in the reports. Confidentiality will be ensured by erasure of the taped material on completion of the study. Access to transcriptions of the taped material will be limited to myself, my supervisors, and an independent coder, who will help with the analysis of data. Participants will have the right to withdraw from participation at any

time should they wish to do so. The findings of this study will be made available to you on its completion.

Thanking you in advance for your cooperation,

Yours faithfully,

Mr. Lovasoa N. Andriamora

Please find enclosed:

- Academic panel Colloquium Report
- Indicative interview

Appendix 4: Letters of approval

DOMAIN PRINCIPAL GROUP
Australia's Leading Aged Care Provider

12th August 2011

Lovasoa Andriamora

4 Harcourt Avenue

CAMPSIE NSW 2194

Dear Lovasoa,

Thnak you for your letter requesting permission to conduct a research study among aged care workers employed at Canterbury District Nursing Home.

I writ to advise that I am happy to grant this permission and look forward to working with you.

Yours faithfully,

Redacted text

Susan Yasina
Acting Manager

Domain Principal Group

Canterbury District Nursing Home
Telephone- 02 9789 3821 Fax 02 97181615
Email canterbury@domainprincipal.com.au www.domainprincipal.com.au
DAC Finance Pty Ltd - ABN 28 129 420 444 Principal Healthcare Finance No. 3 Pty Ltd – ABN 38 090 007 999

101 Port Hacking Road, PH. (02) 9522 2997
Sylvania NSW 2224

Monday 8th August 2011

Lovasoa Andriamora
4 Harcourt Avenue,
Campsie NSW 2194
l.andriamora@cqumail.com

Re: PERMISSION TO CONDUCT RESEARCH

Dear Lovasoa,

Thank you for your letter requesting permission to conduct a research study among aged care workers employed at Vickery Lodge.

I write to advise that I am happy to grant this permission and look forward to working with you.

Yours Sincerely,

Redacted text

Corlette Todd
Centre Manager
Vickery Lodge

Appendix 5: Invitation to participate

Dear (name of participant),

My name is Lovasoa Andriamora (Lova) and I am a researcher for CQUniveristy Sydney.

I would like to invite you to participate in a thesis entitled 'Methodology to alleviate aged care worker burnout in New South Wales'. This research aims to investigate and propose solutions to aged care worker burnout in Sydney. You have been identified as a suitable participant, and we would value the opportunity to include you in the project if you are willing to volunteer to do so.

Participation in the project will involve a one-to one interview lasting approximately forty five minutes. The interview will be confidential, and your comments will not be reported in any way that might identify you. The interview questions will be general and involve no personal discomfort. You may also choose not to answer any of the interview questions and you may withdraw from the research at any time without providing a reason. During our interview, I will ask you some questions about your past experiences with and ideas about aged care worker burnout. I will take some notes of your responses, and I will make an audio recording of the interview so that I can have a record of everything that we both say. The notes and recordings will be stored securely and will not be released to anybody not directly involved in the thesis.

I sincerely hope that you will agree to give me forty five minutes of your time for this project.

Yours sincerely,

Lovasoa Andriamora

*Please find enclosed: Letter of consent, Letter of authorisation, indicative interview questions, and Letter of approval from CQUniversity Ethics Committee

Appendix 6: Consent Form

Research Consent Form

'**Methodology to alleviate aged care worker burnout in New South Wales'**
Researcher: Lovasoa N. Andriamora - CQUniversity Sydney
Supervisor: Dr. John Rule

1) Introduction
You are invited to participate in a research study entitled 'methodology to alleviate aged-care worker's burnout in New South Wales'. Taking part in this research is entirely voluntary.
2) Why is this study being done?
The research focuses on aged-care worker burnout. It aims to explore the major causes of burnout among aged-care caregivers in Sydney.It also aims to develop methodologies for alleviating aged-care worker burnout.A total of 38 participants will be asked to take part in this study.
3) What is involved in this study?
If you choose to take part in this study, you will share your experiences during an interview. The total amount of time you will spend in connection with this study is approximately forty five minutes.
4) What are the risks of participating in this study?
There are no physical risks associated with this study. Every effort will be made to keep your information confidential. You may refuse to answer any of the questions and you may end your participation in this study at any time.
5) How will my privacy be protected?
When the results of this research study are reported, the people who participated in this study will not be named or identified in any way. All interview data will be stored securely.

If you agree to participate in this study, please sign below:

I understand the information printed on this form. I have discussed this study, its risks and potential benefits, and my other choices with the researcher. My questions so far have been answered. My signature below indicates my willingness to participate in this study and my understanding that I can withdraw at any time.

| --- | --- | --- |
| Participant's Name (printed) | Signature | Date |

| --- | --- | --- |
| The researcher | Signature | Date |

Appendix 7: Sample of interview responses: Assistant nurses

INTERVIEWS: ASSISTANT NURSES

R: Researcher
P: Participant

Personal burnout

R: Can you give me a brief summary or overview of your aged-care personal carer/nurse career?

P4: Four years now.

P11: 6 years now…hmm. Maybe more than six years, maybe.

P13: 4years.

P14: 4years.

P16: 2 years, before I worked as disability support worker in a residential facility.

P23: Almost 1 year.

P24: I am an international student. I am here for three years now.

P25: I have been here for four months, but I did 3 years in the high care. I left because it is too hard. I feel like I gave too much of myself. Too much for me

P26: Ten years now. Yeah. I started in high care nursing home work. So I'm now doing low care, which is much more pleasant than high care.

P28: 38 years

R: Some people might classify this as an 'unattractive job'. Do you think this is reasonable?

P4: No, I don't think so. I don't agree. I wouldn't agree. I'm, I actually enjoy what I, what I do. It's rewarding.

P11: Sometimes yes…maybe when you have violent residents or work in dementia and disability section. I work in low care so for me it's ok.

P13: Yes. It could be, but it's also a good job. You take care of people, you make people clean, happy.

P16: Yeah the job description may not be attractive: showering, cleaning etc. …but it is a noble job.

P4: Oh, just knowing that you've made one of the residents a better, like made their day be better for them. Yeah.

P23: No. It is a job, a very rewarding job. You bring joy to people's lives.

P24: Yes and No. It depends on your values. I mean the reason why you work here.

P25: Sometimes yes but if you know your job and you love people it is a good job.

P26: May be when you have violent residents or work in dementia and disability section. I work in low care so for me it's ok.

P28: Sometimes yes maybe when you have violent residents or work in dementia and disability section. I work in low care so for me it's ok.

R: What motivates you to work in aged care?

P4: They might like the curtains pulled to the left rather than to the right and it's those little things that make their day happier. Being able to do that and get to know them and their relatives well, that's the pleasure of it.

P11: It's my way of giving to these elderly people the kind of love and support I would have given my mum. She passed away back home and it was my sister in law who looked after her. When I work, I think of her.

P13: Interest in old people! Knowing you can make them smile and make their day slightly easier, that's a very rewarding part of it. Being able to do that and get to know them and their relatives well, that's the pleasure of it.

P14: Making difference in people's lives and also I have relatives in other nursing home.

P16: I just have an interest in humanitarian work.

P23: It is a secure job and also an interest in older adults.

P24: Interest in old people and have a job.

P26: It is a secure job and also an interest in older adults. Because I like aged-care nursing and I decided to give it a go and I never regretted it.

P28: It is about making differences in people's lives. They are old.

R: What would encourage you to stay working in aged care for the rest of your working life?

P4: Job security.

P11: As I said it is secure employment also I already have the experience. Positive interaction with residents and colleagues.

P13: Good work environment, friendship with colleagues.

P16: I do not have the intention to stay in the aged care, as a personal carer' for the rest of my life but for now it is a personal experience with older adults.

P24: Interest in old people and have a job.

R: What factors would force you to leave aged care and choose another career?

P4: Family issues.

P11: May be personal illness.

P 13: Family obligation, personal illness.

P16: I am exactly leaving next year…moving to Queensland….and if there is another opportunity over there, then we'll see.

P23: I've only done few training. The thing is that everybody knows, everyone knows the people that—I'm not saying I'm perfect. I'm not just trying to sit here and say everybody else is bad. But I think everybody has an understanding and knows the people that struggle with their jobs and don't really do the right thing a lot of the time. But everyone knows, but nothing gets done. So I don't know how much training will help with that. Anyway, I may because of Irresponsible workmates, personal illness, moving

P24: Family obligation, personal illness.

P25: Family obligation, change in my heatlh conditions.

P26: It's hard to say. I mean, there's a lot of things that could, that could, you know? In every job, in every job you have. You know? But with aged care—I do. I enjoy it. That's what I know. I know aged care.

P28: May be personal illness.

Current Training factors

R: Do you have the opportunity to learn new things through your work?

P4: We do receive a lot of training, but not in regards to, not in regards to keep like just stress levels. It is more stuff that's pertinent to what we're doing on a, on a daily basis. They don't deal with your personal stress and burnout

P11: P: Yeah, more training. More, more knowledge. Like we have a, just like a lecture today about the residents' care. So if we get more training and more knowledge. Yes a lot of training, but not dealing with stress…staff stress. We receive training about OH&S, Manual handling but not really about managing personal issues or stress that may have impacts on our job.

P13: Not about stress management actually, a lot of training but about the job.

P14:Oh yes, mainly learning about people, but we receive trainings related to the work we do

P16: Training sessions are much more about OH&S, fire, documentations, and they are repeated all along the year.

P23: I've only done few training. The thing is that everybody knows, everyone knows the people that – I'm not saying I'm perfect. I'm not just trying to sit here and say everybody else is bad. But I think everybody has an understanding and knows the people that struggle with their jobs and don't really do the right thing a lot of the time. But everyone knows, but nothing gets done. So I don't know how much training will help with that.

P24: OH&S training, manual handling. General training…fire training and that's all.

P25:No. We have general training: OH&S training, manual handling, fire training and that's all.

P26: We receive training about the know-how OH& S, Manual handling but not much about psychological and teamwork issues.

P28: Yeah, more training. More, more knowledge. Like we have a, just like a lecture today about the residents' care. So if we get more training and more knowledge. Is that what you're talking about?

Work-related burnout

R: What are the good things about working in aged care?

P4: You do good and help people.

P11: Stressful? Do your job and we didn't get that appreciation from the residents or the staff or the relatives, isn't it, it is the main thing. You're doing your job. You're trying your best, but nobody appreciate it. It really stressed things.

Also, Residents' relatives. When the family is coming in, it really become stressful. That is the most stressful thing in the aged care, already there is a lot of stress with the workload.

P13: Positive interaction with residents and colleagues.

P24: Positive interaction with residents and colleagues.

R: Are there any stressful things about working in aged care? That you would like to talk about?

P4: Yes. It's not to do with the, with the, the care that – it's staff, staffing issues. Yeah. Not enough staff.

P11: Yeah, to some degree!

But you know some staff are not cooperative…some just do the minimum or just what is written…no way to go beyond that. So sometimes you better rely on yourself.

P13: Residents' relatives. They can bring in a lot of stress with unrealistic demands. Secondly, attitudes of some workmates!

R: What do you mean?

P13: Some are not reliable not because they do not know what to do but they do not have any work ethics as we always say.

P14: Lack of teamwork and residents' relatives. They can bring in a lot of stress with unrealistic demands.

P16: Oh, for sure. There's huge factor involved in getting stress level of working in residential care. There are a few things involved definitely, for sure.

Well, I recall working in the residential home a little after, at least seven clients. Again, the training was totally inappropriate. I recall there was about only, like, a couple of buddy shifts and just, you know, walking around with the one who was waiting for the day. And then you're left on your own, no

support, to get on with the work. It was very, very challenging and very stressful.

P23: So for me, I'd have to say the staff and the management are the hardest things about here. The residents are part of the job. You know? You deal with that. But the staff and how things are run and how people do things sometimes make it really stressful, I think.

R: What do you mean by management?

P23: Well, some of the staff—I don't, there's a big, there's a lack of we don't know, nobody seems to work very well together. When we're together in a room and we have our meetings and our hand-overs, it seems to run well. But on our own, you know simple things like asking someone to do something or asking for help, it doesn't, it doesn't really happen. So—

R: Why is that? People are busy or a lack of structure?

P23: Sometimes it's because people are busy. But, yeah. There's a lack of structure and teamwork. You know, when things – like there was actually an incident on Friday that really frustrated me. I was busy doing something myself and I walked past another personal care staff who was not doing anything. And I asked her to help a resident because the resident needed help. And she said yes. And then I asked her a few minutes later again to help her because she still wasn't helping her, and she said, 'I don't need to help her. She's fine on her own'. And the resident was not fine on her own. But we just had to leave it, because she didn't want to go and help her. So in that situation, instead of – I documented it and told the people I should have told about it. But in that incident, instead of sitting down with the person and saying, 'What you did was wrong', the girls tend to sit down and have a little bit of a talk about it, have a bit of a bitch about it, and nothing actually gets done from that. It is like, 'Oh, well, we've heard your side. Let's hear her side and then that's it'. It's not—

I just find sometimes people, you know, in my opinion you need to help a resident no matter what you're doing or whatever. You need to try and help them. If you can't help them, get somebody else to. And in that situation, they shouldn't have been bitching and talking about it. They should have been, that shouldn't happen again. Let's move on. A simple thing like that. I think, you know, people get bored and want to create drama and stuff like that. And, you know, you'll tell management – like I've told management and I've told people, but you know, nothing's happened to it. People have asked me this morning, 'Oh, what happened on Friday? What happened?''Nothing happened. She didn't do her job. That's what happened. There's nothing to talk about. She didn't follow a procedure. That's my problem'.

P24: Staff because it's … and they do not replace much staff and if it's short then it brings burnout and much stress.Staff also, everybody is not the same. They do not cope with each other.

P25 : When we are short of staff.

R: What else a part from staffing issue?

P25: Low care residents are much easier but in the high care it is stressful. I feel stressed when some; not with residents actually, residents are alright, we

know that they…how they gonna be. But I think the environment gets upset when staff is short or some staff may be …not cope with each other. Yeah, that's the main thing. A lack of communication.So, some sort of ethical issue and teamwork also.

P26: Probably when staff are unreliable. Like not turning up. Things like that. No teamwork. Sometimes—

Sometimes not having the facilities to – like for example, if a resident comes. He has a low care. And then they tend to progress to high care, then we don't have the facilities or the staff to give them quality care. So that can be frustrating. Having said that, they do get assist. And, you know, to be high care. And I, but we move them onto nursing homes or somewhere more suitable.

R: So it's staffing.

P: Yeah, it's a lot of things. Like I said, staff that don't turn up to work, that is one thing, you know, because you're short-staffed. You don't, can't give the quality care to the residents that you need to. Therefore, you will be run off your feet and you can't do everything you need to. And I think it's like that everywhere in hospitals and everything like that. So.

P28: There can be, like if you get too many sick people at any one time and you haven't got the staff to accommodate it. Sure.

Basically, it is staff shortage It can also be stressful when you see a resident that you're particularly close to that's deteriorating really fast. And you know that, you know, you're limited in what you can do. So, yeah. I think that's about it.

R: Do you get help and support from your colleagues?

P13: There is always someone to help if neede*d. But* a large proportion of staff come from overseas which creates its own cultural difficulties within facilities where you have many Australians residents who need culturally appropriate care. And I think we are asked to do things beyond our level of skill. I have only Certificate II but I do a lot of things: doing reports, write a lot.

P16: That's the trouble. No. There was, there was no support, because you've got your buddy shift for a couple of shifts, and then they're gone. And then you're in charge of the seven guys all by yourself.

P23: Yeah to some degree!!!

But you know some staff are not cooperative…some just do the minimum or just what is written…no way to go beyond that…so sometimes you better rely on yourself.

P26: Some staff are not reliable. If you want to be happy, just do it yourself.

Staffing and pressures

R: How would you describe your workload: flows easily or tends to pile up? Could you please elaborate.

P4: Oh, that's a, that's a daily, like a daily routine. Yeah. And that'd be a question that you, you could ask me every day, and the answer would probably be different every day.

Yeah, yeah.Some days goes, some days flow really well, and others, days not, not quite so well. It's usually because we've had a, we've, we've had an incident or we're having staffing issues.

P11: Of course it is. Of course it is Yeah, yeah. Even you have my weaknesses. See, look. And, yeah. Not enough help and there's all this stress. A heavy job. I can tell you it's really heavy.

P13: It will always be hard mentally and physically.

P14: Nursing is always heavy. It will always be hard mentally and physically.

P16: The duties as soon as you walk into the ward, you have to wake them all up. Usually they're still in bed. Okay? And then you have to shower them one by one, and each one have their own, shall we say, special requirement in terms of what shampoo to use or what lotion to use on their body. You have to check the file to make sure you give the appropriate treatment. And some of them, you know, they don't like showering. So it's going to be very stressful. They are fighting with you in the shower. And others, they've got their bag with them. You know? You got to make sure you secure the bag and empty it and so on. And the kicking and punching while you're trying to shower them and you've got to shave them and you've got to brush their teeth. And you've got to do that, like, within, like, an hour and then you have to dress them. And the funny, if I could say funny is, you can rely on yourself sometimes.

Very, very heavy. I am sometimes totally disgusted. Working in residential home where you've got to look after 6 whole clients, and you've got to time faculties, it's just too much, too stressful.

P23: Usually it does. Usually it does. Sometimes you, you know, I'm sure people feel like they do more than what others do, as in all job roles. But usually it all flows quite well. It's kind of stressful when it's hard and, like, it's full-on. But I work quite well under that. So.

P24: It is always up and down. It doesn't flow easily because we're getting new staff every time, some of them are not really educated like what they need to do, some of them have not got Certificate 3 and not training to do this kind of job. It is actually about teamwork. Do you see what I mean? Mostly depends on the teamwork. It is not about IQ or physical thing. We really need teamwork, low care and—

R: But are you doing actually?

P24: Helping residents, giving them their medications, and helping them in dressings, showering, eye drop—

P25: Hmm, we need more staff. Some staff are brand new, they are not educated, do not know much about this job. A big issue. Then it comes on our

head like …Yeah, in the high care is a bit different. Sometimes it is physical. Assessing residents, giving them their medications, and helping them in dressings, showering.

P26: It can flow easily. I have worked in places where it's a lot, a lot of workload. I have worked in places where you don't even get tea break. Yes, which I don't think is right. But you're there – maybe there for one week, I find it very good. I think it's, it's consistent, but it's sufficient. It's, you know, I'm able to give quality care. So I'm happy with my job.

P26: It fluctuates. Like sometimes you can have a good run and you've got residents that are, only need assistance. And then you can have a run where people have to have everything done for them. So, yeah. It fluctuates. But it does sort of flow. You know?

R: How would you describe your time allocation: plenty of time or not enough? Could you please elaborate.

P13: Time is always a problem, especially in the morning you have to provide full care for 4 to 6 residents.

P16: It's a very high care, because they can't dress themselves. Then you have to undress them. What I used to do is I took care of one by one. Shower one quickly, dress them quickly, take the next one quickly. It's very stressful, because you have to get them all ready, and then you have to take two of them down to the dining room. Fortunately, there was some staff there who was serving the breakfast. And then you've got the other two. And then you've got the others. And then you're to take all the medication down and you have to make sure you give the right medication. And sometimes they're not enough support in the kitchen, so you have to get the breakfast for your guys. Talk about stress. And that's not the end. So once they're all ready, and then you've got to get them down to the Centre and then you've got to rush back, and then you've got to do all the beds. And if they wet their beds, you've got to clean the beds. And that's all within two hours.

P14: You have 6 to 8 residents to take care of within less than 2 hrs. You have to know and remember their individual plans: medications, likes and dislikes.

P24: Clients' needs are not met unfortunately; lack of time.

P26: Time is always a problem especially in the morning when one nurse provides care for 5 to 6 residents.

P28: Time is really a source of burnout. We are always in a rush in the morning particularly.

<u>Job resources/job demands</u>

R: How would you describe your work environment: able to state your feelings or unable to state your feelings? Please elaborate.

P4: I like my work environment.

P11: Dealing with difficult residents is a real problem. Sometimes you are not able to decide by yourself because of various regulations but allowing us to make decisions in day to day running of the facilities would be good.

P13: I talk to my family when I feel exhausted!

P14: I talk to my family when I am tired, not really there everyone one is busy there. Everyone is burnout to some degree. Even the managers!

P16: It is emotionally draining…time, residents' needs, and relatives' expectations. Sometimes you feel yourself unable to really help.

P24: I talk to my family everyone at work is burnout to some degree.

P25: I talk to my family and managers one is busy there…everyone is burnout to some degree. Even the managers!

P26: You do, but that's the reason for your work. You're here for them, for the residents, whatever they need. You know, some people are more—how can you say—they need more attention than others. But that's why we work there. You know? To help them.

R: Would you say your work is emotionally demanding or detached? Please elaborate.

P11: It is emotionally demanding of course, you deal with human being and sometimes you have to understand them and meet their expectations, which is not always an easy task.

P12: Of course, it is emotionally demanding.

P23: It is definitely emotionally demanding, especially when the relatives come in with their unrealistic expectations and they start telling you what to do with their dad or mum…oh My God.

P24: It is demanding, especially there have been lot of changes in term of residents' needs and also the unrealistic expectations of relatives. Sometimes, after a relative's visit, you feel exhausted since as if you do not know anything about your job, they know all.

P28: It is. You know. Sometimes the residents are good but the relatives sometimes are mean and demanding making your work emotionally draining.

<u>Lack of reciprocity</u>

R: How would you describe your work with clients: do you feel that you give more than you get back or do you feel clients treat you fairly? Please elaborate.

P4: I think that they treat me fairly generally, they're, that they, they do have, some of the clients do have high expectations, and not always able to meet them.

P11: I give it to you more. I can tell you, yeah. We give it to them a good service. I already tell you good things. But we just get less, less. I think the

nurses do. I think they give more than they get back in terms of pay everything. However,they respond to you. They are very wonderful."

P13: I think aged-care nurses give more than they get back in terms of pay…everything

P14: I think the nurses do. Honestly, I have been an assistant nurse too. I think they give more than they get back in terms of pay everything

P16: Oh, for sure. I feel being abused by the system, taking advantage of, you know, work hard, work like a dog, no support. And then just work. And I felt—because it was to give clients individual care. I did not have time to give them individual care. It felt more like a production line. We just, you know, di dididi. No time to sit and communicate and interact with the client. So totally, totally unhappy environment.

P23: Oh, definitely. Yeah, of course. But you know, most of them are, most of them have dementia. There's nothing you can do about that. They've got dementia. So you can't expect that they're going to give you a whole lot back, or they're going to be responsive or, you know, or anything like that. Some of them are just old. A lot of them are in pain. A lot of them have worked their entire lives and I think they deserve to be a little bit naggy sometimes. So you just deal with that. The residents are not the difficult part about this job, I don't think.

R: It's the management and the staffing

P23: I think it's everything else. Yeah. Because we all know that when we come to work, you know, it's going to be hard. You're going to have to shower people and toilet people and, you know, help them with everything sometimes. And that's part of the job. That's fine. That's all fine. But when you don't have the adequate, I suppose, like support, that's when it makes it difficult, I think.

P24: Yes. Do you mean we give more and we get less? In the high care, there is too much physical job, lot of difficult clients, but here it is too much paperwork. In the low care, we do not have lifts in the high care, residents can hit you.

P25: I've been working only four months but I was in the high care before in the high care, I felt really like that. I am doing a lot but not giving. When I was in the nursing home for high care, I used to feel like that every day, too much physical job. Here there is also burnout but not necessarily with the residents. I used to push a big bed, used lift…residents are very demanding, they got dementia.

P26: You do, but that's the reason for your work. You're here for them, for the residents, whatever they need. You know, some people are more – how can you say – they need more attention than others. But that's why we work there. You know? To help them.

P28: Well, I don't think you do it to get anything back. You do it because it's what you want to do. Residents ok but the relatives… Oh, some of them do. Some of the relations, they're really good. They will listen if we ask for anything. You know? They'll give you the shoes or underwear or whatnot. Then you have others that are on your back all the time demanding that their

mother or their father, you know, if they need this, that, and the other. So, yeah. Yes. Restricted in what you can do. I don't think so much burnout. But it, it can bring a bit of stress with it. Like I lost a resident just a few weeks ago that I was particularly close to and it upset me. It didn't stress me, but it upset me. But if it happens regularly, it makes you burnout.

R: Does your superior talk with you about how you carry out your work? Please elaborate.

P11: We receive training in fact you come to work, the first day may be a bit stressful and then you follow the routines. If there is any specific situations, you gotta ask for her.

R: For example?

P11: A resident may just refuse to take medications or just refuse you to shower them.

<u>Role conflicts</u>

R: Do you know exactly which areas are your responsibilities?

P4: Pretty well, yes. There are some routines.

P11: Yes.

P13: Yes, there are individual plan for each client.

P14: When you are new, you could be very stressed, but then you learn and you know—

P16: Yes, you follow the Individual plan.

P23: We do practice teamwork. Some colleagues are good, but others you cannot rely on them, may be they do not really understand that it is about 'caring for people'. Do you understand what I mean? Even making the bed, others are not good at it (laughter).

P26: Yes. You know the residents, you know their likes and dislikes and routines.

R: Do you sometimes have to do things which you think ought to be done in a different way? Please elaborate.

P11: Of course, you sometimes have to just follow the regulations and policies but you know the biggest issue is not resident, it is the way some workmates perform their duties. Sometimes you just wonder: why is she/he here? They are supposed to help but anyway. The collaboration between colleagues is sometimes a problem.

P13: I would love more time to talk to residents. Even when you are giving out the medications, the residents want to tell you things but you just don't have time. It would give you a better understanding of the residents and facilitate your jobs……reduce stress and burnout (Laughter).

P14: Sometimes ok. The problem is the cultural differences, it is hard to expect others to do the job as you do it. Some are not cooperative and they just do the minimum.

Client-related burnout

R: What are your main sources of support? To whom do you talk?

P4: My partner. But my, my husband or my colleagues.Colleagues at work. We usually, but usually, like we've all usually got the same complaint, and it's good to be able to sound off to each other.

P11: My family…or manager if it is about the work. I talk to my family when I amtired not really there…everyone is busy there.

P13: My family.

R: How would you describe your current approach to work: high energy and interest or waning energy and interest? Please elaborate.

P11: I love my job. I am now doing a Cert IV and if an opportunity occurs for a higher position then I will not say No. But for now, It's Ok, I am full of energy.

P16: Well, like I said, I try to communicate my frustration to the management, but they don't seem to care very much. And I did request that I didn't want to work here anymore, and I wanted to move after a few weeks. I couldn't cope.

P23: I try and talk to Colette because personally I find, we don't really, I don't, we have a supervisor, a PC supervisor, but I'm not really sure where I stand with her. So I tell Colette because like I said before, a lot of the time people, instead of keeping it confidential and me passing on information, it gets passed on because that's just what they do. And I don't, I find that unacceptable. I don't care what age you are. I don't like that. So Yeah. So I usually try and go to Colette (the manager).

P28: It depends we work in a teamwork if you are rostered with good staff then good on you; if you are rostered with others, unfortunately, who do not have the notion of duty of care, then you better rely on yourself.

Global questions

R: In your opinion, what causes burnout among some aged-care workers?

P4: I suppose it's just the routine repetitiveness of, of the, of the job. Yeah. And it's mentally, it's mentally fatiguing. Like keeping track of what's, what needs doing. It is not a physical fatigue, then. It's here, psychological.

P11*:* Lack of staff, residents' relatives.It has to be cooperative with the co-workers and listening and understanding with each other. And, like, job– it has to be done more reliable and easy for the staff. Isn't it?

P13: Lack of staff, residents' relatives, lack of work ethics from carers.

P14: Lack of staff, residents' relatives.

P16: I would say some of the factors involving, but one is lack of appropriate training in the first place.

R: But they provide trainings a lot of trainings.

P16: Not really. The only training I had there, with all due respect, was a buddy shift. That's all. And if the buddy shift didn't know their job properly, then I had no, you know, no other training. I would just put [unintelligible] into that environment. And with all due respect, I did have some training out of the office, but it's not the same as when you're in the field actually working with the clients. Then you see the real, real, real, real, real challenge. So really, the main issue is no proper supervision, no proper buddy shift system. It's not ongoing. It should be ongoing. It should be monitored on a regular basis. That's too short. And the other thing is, I've heard management, when we had management meetings, they didn't seem to care too much. They didn't listen. They felt that, 'Oh, you're a new staff. What are you complaining about? There is all this stuff. They've been here for years. They're happy. Why are you complaining?' And when you try to put a suggestion forward, they just brush it aside. Because while I was there, I remember I made a few suggestions. They did take one or two into account to improve the system. But the [unintelligible], they just totally, they just didn't so much trust themselves. You know?

P23: I think it's just busy. I think it's just really busy. You're always doing something. You know? Every day you've got the same routine. You do the same thing every day. But every day something different might happen. You know? Like yesterday, you know, a resident might be fine. Today she might not be feeling that well. So it's going to take you, you know, an extra five minutes to get her up. Or she might not want to get up and she might want a tray for breakfast. And you might have to organise that. So along with, you know, finishing all the things you've got to do before breakfast, you've got to get there. Like if you do medication, for example. Like I'm on the medication shift today. I've got to do so many showers first before 8:00. Then I've got the medication trolley. I've got to take that around to the dining room. Start that. I've got four people asking me random questions in the kitchen. I've got staff coming up to me. They're going, 'Where's this resident? Where's that resident?' Then I remember that she wants a tray. I've got a tray over there. Like, there's just a lot of stuff to do at once. I think that's probably the main cause of burnout.

Yeah, I start at 6:00 am and finish at 2:30pm.

R: Okay. And that's the most for everyone?

P23: Well, for me I generally do during the day. So yes. I either do 6:00 till 2:30 or 6:30 till 3:00, which is fine. I don't like working less than eight hours. Eight hours is good because eight hours is barely enough time to fit in everything you've got to do anyway. So I don't have a problem doing the eight hours. That's fine.

P24: Sometimes, you do yourself the best and some residents are not happy. They may complain to another staff, and the family. The family complains. Even though, some of them got dementia, not really bad but some of them got dementia, they (the family and staff) will listen to them better than us. They do

not listen to us, they listen to them. And they said this has done this, this has done that

P25: A part from the staffing issue. When some residents are…we are trying our best to give them comfortable, make them comfortable but they are not happy. And sometimes, you now, I am trying my best of what I can do. When family complains! Family always listens to their relatives even if they've got dementia. Families are sometimes really nut us. Also, staff have different culture. This a big issue too.

P26: People from different background work together, and it is about 'caring', I think we need some training about culture and work ethics. Of course, I do not expect others to clean exactly as I clean for example but I think there is a minimum standard. Do you see what I mean? It could be a heavy workload; a lot of stress could be studies as well as trying to juggle work.

But I have also worked with people that do study and I just think it's hard to balance it. Yeah. But I do know that nurses do get very burnt out. So, yeah.

P26: I think it is repetitiveness can have something to do with it. You know? Where if you've got all full-on residents and not a break with some that are a little bit self-sufficient, and also if you can have a conversation with some of them, it helps. It's hard to try and figure out what is wrong with a person when they can't talk or can't explain or whatever.

R: Have you any ideas how this might be alleviated? Who can help?

P4: I think we could do with some stress management training or stress managementprocess, just so – other than what we, what, as I said, other than just sounding off to each other.

P11: Adding more staff, having more structured roster, fill up positions!

P13: We need to be focused on the task lists. It needs to be clear. Further, everyone doing its job correctly will really help. Also attract younger people to the sector, there is a need for adequate pay and better staffing levels.

Relatives also need to be…expectations need to be clarified. Do you understand what I mean?

A meeting with them could be useful.

P14: It actually depends on the situation for what I see. You've got heavy section and light section, sometimes it's not balanced but everyone is doing an excellent job, but it creates stress and some frustration sometimes. Extra nurse…Adding more staff, fill up positions!!!

P16: If during the training they give you appropriate information about each individual client, so you know everything about the client, about their behaviour. Because what tends to happen in this environment is you're put on the wall. There's a file. Read it. And that's it. So you've got to read the file, and then you work with the clients right off. You see? You do not have time to discuss it with the management. You don't have a chance to sit down, go through each case individually, and to make us aware of the behavioural issues we're going to face, and how to handle them and so on, as opposed to

be confronting where you do not have to handle the situation, the issues. And so that would be a great help, some proper, proper training and be more supportive in the field. In other words, not just a quick—

R: You mean the management board meeting?

P16: Well, the actual working with the clients. Not just, like, one or two shifts. But you're at three, four buddy shift for a few days so you can really get the hang of it. And you feel much more confident in yourself. So that would be a great help. And the third one is to have another way you can express your frustration and your disappointment, and for them to take into account and try to rectify the situation. But you didn't get all that support. It was very, very minimum support.

P23: Well, I just think apart from the busyness, just being able to – like we've got, we've got a list of things we've got to do. Like for example, in the morning, like, there's a list of showers that we all do. And certain people do certain showers. Sometimes some showers aren't done. Some staff do not do things properly, or they might have difficulty with a resident, and things aren't done and someone else has got to go do it. I think things like that. They carry on through the day. So if residents aren't done properly in the morning, they're not showered properly, then the beds aren't made properly. Then they don't have this. They don't have that. Things don't get done properly during the day. I think if we all could actually fully rely on each other and trust what we say to be true, then I think that would really help. Do you know what I mean? So I know that when you tell me that that room is done, I know that it's done. I don't have to go back and check that room and find that you actually haven't made the bed, her towels are dirty, and she hasn't been showered, which happens a lot. A lot of the time people – there's no other word for it but lie. They lie about it to get out of it or for whatever reason. And that makes—

I really think for me – like I could be wrong. I don't know. But I've been in management for a lot in my previous industry. And I know that industries are very different, but management's the same. You need to learn how to actually manage someone properly. Not micromanage, not bitch behind people's backs. Actually do something. Whenever someone came to me about an issue, I would deal with it straight away. If I couldn't deal with it straight it away, it would be, like, as soon as possible. Not the next day. Not the next week. It would be straight away, because that's when you need to deal with the problem. That's me. So I—

R: I read an article on that a few weeks about this ethical practice in the aged-care industry.

P23: It's really difficult. And the thing is is that, you know, I wouldn't say that none of us get along. We do. We all get along very well. But when it comes to people not doing their job properly or not doing tasks properly, there isn't anything that happens with that. If you try and say something, that person will get angry at you. That person will then go have a wince to their supervisor. And it will become a big bitch fest. It doesn't actually get solved. It doesn't, you know, instead of that person saying, 'Listen. All you have to do is do your job. Like don't sit here and explain to me why you didn't do it or why that person yelled at you or whatever it is. Just do it'. There's none of that. There's

no repercussion. There's no, nothing happens when you do something wrong. And in this type of industry, it's not just, 'Oh, we faxed that thing late. Oh, we didn't e-mail them'. It's people's lives. It's a big deal. That's how I feel about it. So if you can't trust people with basic things like she told me she made the bed, but she didn't. Well, what can you trust them with? Do you know what I mean? It makes the whole job very stressful and it makes everyone have to run around and do it twice over because we're not sure who's doing things properly. Do you know what I mean? That's the – I think that's one of the biggest things.

I think we could have, like, a, you know, a casual type of meeting where we sat down and went through people's roles and actually explained it. A team meeting.Like we don't have to be best friends. I don't believe that we're going to have a team bonding session and we're all going to be best friends. It doesn't happen because we're all different people. But we need to be able to bond and have a trust and understanding so that we can work together and actually get stuff done. We need to be able to – do you know what I mean? So when I say, 'Can you go and do that?' I'm not going to get someone to yell at me and say, 'She doesn't need my help'. That's unacceptable. I don't care what anybody says. It's unacceptable. And that's the things, they're the things that aren't, they're not getting looked after. And if they are getting looked after, it's after the date has happened. So by then, the person doesn't even remember what's going on because she's had that much drama through her day and she's been that busy. Nobody remembers and you can't really give a repercussion to someone when it's, like, two weeks later. You can't talk to them in. You know what I mean? You've got to say it straight away. That's what I think. And it's not about people, like, getting in trouble. It's just about pulling people up. Because once you do that, once you don't do that, people realise it and they keep getting away with it. And they're untouchable. No one says anything. We all know what's going on and everyone talks between us, although no one actually does anything about it. And at the end of the day, we're the ones that have to work doubly as hard and the residents are the ones that are missing out. So at some point everyone needs to pull their head in and just work hard. Because working physically hard doesn't just cut it. You've just got to work smart and you've got to do the job properly. Then we won't be burnt out as much. I think. I could be wrong.

P24: More staff, educated staff and proper environment to work, staff not bad-mouthing about each other like saying this to another and that thing to another and you speak good in front of me and if you do not see me you would starting about me. Yeah, a bit of respect, do your duties well, be fair etc… it is, it is. It is really an issue and it's in this industry. And multicultural as well. People are different culture, different countries and if they don't know how to speak in English, they can't answer what they are asked for and they cannot handle the resident, residents are very demanding and if you don't know how to answer them properly it is gonna be another problem too. It is gonna be stress on you too because you will think you cannot do anything and they thing you cannot do anything too.

P25: More staff is number one. It will reduce burnout. Also, no back-biting. That's everywhere. A bit of duty of care…Yeah it is, it is. It is really an issue and it's in this workplace I thing. Yeah. You know what to do this but a person

interferes. Oh no, you need to know more because you are not from here, you've been here only few years or something like that. So every time, you are realising this Ok. I need to know more (laughing)…the culture, the job.

P26: Management. Management could help. Maybe the Union could do something to help us nurses. Put something in place to make sure that we're all getting a good rest and, you know, we've got sufficient staff and, and things like that. The proper equipment to do our jobs properly. Yeah, just—

The use of some tools also is very helpful: Lifting devices, yes. Pelican belts.Sliding sheets. Because a lot of these residents can't move themselves, so we're doing everything

P: Yes. More staff.More equipment. Maybe one week off every couple of months. Yeah. Just so you can sort of just chill-out a little bit. But I think basically it's staffing and everywhere is the same. At the moment we're okay in the shifts that I do. Like, we, we are coping really well. But that's my shift. I can't say that for the other shifts.

R: When you say 'equipment', do you mean the…

P28: Yeah. Lifters and, you know that sort of stuff. At the moment we don't require them. But if we do, it's nice to know they would be there. And like for palliative care, which we've only done twice since I've been here anyway, I think a little bit of further education in palliative care might be useful if this is the way we're going, which we are, because it's aging in place and palliative. So, yeah. I think a little bit more education on palliative care.

Appendix 8: Sample of interview responses: Nurses

INTERVIEWS: NURSES

R: Researcher
P: Participant

Personal burnout

R: Can you give me a brief summary or overview of your aged-care personal carer/nurse career?

P1: I am an RN.I have been working in this industry for 35 years.

P5: 4 years. I am an RN.

P8: 20 years.

P9: 6 years.

P10: 8 years.

P12: 7years now…physio-assistant now.

P20: I've been a Carer, RN, Care Manager….38 years now.

P21: 9 years…I am an RN

R: Some people might classify this as an 'unattractive job'. Do you think this is *reasonable?*

P1: No. Every day is different, as a job is returned by people's response in different ways for everybody to nurse with. So that means that you are not doing the same thing over and over again and people's attitudes change from one day to the next; so you may have.Clients, clients' attitudes and responses are different every day.

P5: Yes if you just think of cleaning up, you might think so, but there are a lot of satisfactions.

P9: No. I would not agree. I see it as a privilege rather than a job. You take care of people.

P10: I don't know, maybe they think of the dressing, toileting but I love my job.

P12: Sometimesyes.

P20: It can be but it is not a dirty job. No.

P21: Sometimes yes. It may be when you have violent residents or work in the dementia and disability section.

R: What motivates you to work in aged care?

P1: It is a job. To help and make a difference in their lives… Interest in older people,interaction with residents.

P10: I already know the job, I like it.

P20: It is a secure job and also an interest in older adults.

R: What would encourage you to stay working in aged care for the rest of your working life?

P1: I left for 6 years…just tired with the bureaucracy. Then I came back. Now I just want to work and go home!

P5: Family issues.

P8: It is a secure job.I already have the experience in working in aged care.

P9: Interest in old people. Interaction with residents, management support, job security.

P12: Family obligation, personal illness.

P20: Never thought about that actually. There was a time I took a few years break, but then I have returned.

P21: As I said it is secure employment. Also, I already have the experience.

Current Training factors

R: Do you have the opportunity to learn new things through your work?

P1: We are over-trained. But nothing about stress or stress management.

P8: Once, once you've been taught the basic things like, you know, how to get it, you're really okay. But because some people then – when you're not being taught the basics things and they want to teach you that enough. No! You really have to teach them the basic things and get to because, yeah, it's, to me, it's very stressful education.

P5: Absolutely, we use my skills and the practical things that I've learnt.

P8: Yeah, we do receive a lot of training about how to do our job.

P10: It is interesting to know the residents, interact with their relatives though they – the relatives – are sometimes very demanding.

P12: Yes. A lot of training, butsometimes the same things repeat OH&S, Fire.

P20: Yes sure training related to the know-how and the experience you get also are very helpful.

P21: Yes but due to the ever-changing clients' needs and conditions, the family interference, you become sometimes powerless.

Work-related burnout

R: Are there any stressful things about working in aged care? That you would like to talk about?

P1: There is a lot of stress. Stressful things! You might just say the wrong thing once and the client cries or lashes out attitude or hits you. Your

response is to stay him back, say five…give it five…Try someone. I mean go and nurse someone else, then come back and try again because they might not be in the frame of mind for you to work with at the time. So you could always go do a different job and come back.

And leave them to space…hmmm

R: So you're talking about clients' behaviour?

P1: Clients' behaviour!

R: Is that the most challenging circumstance in aged care or…

P1: The most. It's very very challenging in aged care because of the different dementia, their agitations, schizophrenia, and all that you get it all in one go and that's where the lock up wards come and everything else so that you can see, segregate that kind of clients in one area and the other clients in the other area. You can always return after one client is becoming very agitated. You can always come back to that, you leave him the last or you go and do the first. The easier one the first and leave them to last to start with. That is one thing but there are others like heavy workload. Can you imagine sometimes I care for 7 people and I have to finish assisting them before 8am. In addition, hmm, when some staff do not complete their duties correctly, you are like doubling. I tell sometimes when I come to work here in the morning, I wonder what will I see again. Some people leave clients with their bed wet or even full of faeces. Sorry but you have had enough…exhausted!

P5: What can I say? Maybe with what like challenging behaviours where the residents have got that aggressive behaviour. And especially and when this resident is aggressive to other residents and might cause injury to other resident, that's when you'll be so stressed out, because you don't know what is going to happen next. Also when you have to do what other staff did not do during their shift. That is very frustrating.

P5: There's a lot. Okay. The most thing – gee. The most thing when it stress you – gee. When you have to complete tasks that are not supposed to be yours. For example, some staff do not like showering clients, they leave it for you…gee

R: So, it's the (nature) of the job?

P5: No. It is when others do not care. Secondly, you know, when relatives' complain. That makes it stress about, you know, working in aged care. Yeah. They don't appreciate what you're doing. It's, you know, when residents are getting very aggressive, physically aggressive.

Staff is big problem. And then it's very – yeah. You know, each year I just wish they'd put people in the government to see how it's very hard.

P8: What is the most stressful? Surely, it's the staffing. It's the staffing.

R: Not enough staff?

P8: Yeah, it's – normally, it's not, normally it's not. But also the quality of people coming to work. Some just here for money, they have no idea of what it is.

P10: Most stressful things is actually looking after the residents. That's the most stressful thing to do because, you know, you are dealing with people. These are people that have their own way of thinking. They have their behaviours so that's a stressful thing, too, in this care. Looking after the resident, apart from, of course, the environment, as well.

R: What do you mean by the environment?

P10: I mean like it's a stressful – you start from the resident. So from the resident you extend to the family. So you're dealing – you're not only dealing with the resident. You're also dealing with the family. And then when there's a problem you are dealing with the management. You are dealing with a spouse. So that's the environment. Then my God dealing with staff! You could fight with everyone every day, reminding them their task lists.

But anyway the most stressful thing is, of course, looking after the resident. Dealing with the family, with the resident, because these are people who have their own – these are human individuals, you know?

P12: Teamwork. Sometimes the teamwork is not applied.

Also, residents' relatives. It doesn't matter how hard they (the jobs) are, we don't mind to do them but if they need big issue. Small thing happens and then the family is coming in, it really become stressful. Here, that is the most stressful thing in aged care…already there is a lot of stress with the workload.

P20: Relatives. They create more stress than any other part of the job. They are demanding. They want a champagne service for beer price. They expect their person to be given – a lot of them, I mean, there's only a percentage of them, a percentage of relatives. But probably say ten percent of relatives they expect their person to be number one priority, to be serviced like they're – they want something, they expect it like that. They have no compassion for anyone else. They have no compassion for the staff. What they want, they want it now and they expect it now. They, rather than being grateful for the care they get, they complain. They contact the Complaints Investigation Scheme and complain about the most stupid, ridiculous things, the relatives. Without a doubt.

P21: For me, I guess it's a combination, really, because, you know, dealing with people who don't really necessarily understand or comprehend what you want them to do. Then you're trying to communicate. And then, plus, they're not physically agile. They're limited, really, in terms of their physical. So, let's see. So you have to feel, you can only do so much with them. So, yeah. It's stressful, you know, dealing, conversing with the residents, trying to explain all these things and then, you know all the physical aspects of the job.

R: Do you get help and support from your colleagues?

P1: Yes. There is always someone to help, but it depends on the circumstances.

P9: It is a teamwork, so we support each other even if some workers are just doing what they can do but it's like that.

P20: Yeah, to some degree! But you know some staff are not cooperative. Sometimes you wonder why some have come here as if they do not like the job.

Staffing and pressures

R: How would you describe your workload: flows easily or tends to pile up? Could you please elaborate.

P1: No. If you do your time and motion, it will just flow in the time spins because you get a half an hour per client to do what you have to do like dressing and everything. And you get fifteen minutes to feed and things like that. If you flow in with it, it runs perfectly. If you have a problem, you always go back, you leave it and go back to it when you get that more time to just handle it.Anyway, it's plenty of time if you've got it in to practice, but if you are a very unorganised person, it's never enough time. But there is always someone else to help you. To be a nurse is a 24/7 job because you are either studying or you are doing nursing. There is no turn off brackets if you are a nurse of 35 years. There is new improved things that you've gotta keep learning, keep your knowledge up.. You must keep up with the new techniques and that's where your burnout comes in.

R: So do you mean that those who have experienced burnout are disorganised persons?

P1: Disorganised people are very much burnout…in aged care, in nursing full stop because you have to do your time and motion with every client and you have to stick to it.

R: But do they provide some sort of training?

P1: You get every bit of training that you actually need, you get overtrained. Then you've gotta put it into practice, and the practice is not enough time where the brain work of organising it and teaching you is all there, but trying to put into practise people can't do that.

P5: Oh, it is heavy, but finally we managed to make the targets. Then it's quite heavy, but as long as you plan what you're going to do by the end of the day, you'll see whether you have achieved the goal. Then you know that we are somewhere. Maybe if you don't plan and there are a lot of workers who can say, 'I'm always busy. I don't have time to spare'.

P8: Very heavy.Mentally stressed.Yeah, because the ratio is 1:6. It is definitely demanding.

P9: Yeah, with the work I do, yeah, I am given plenty enough time with what I do.But then observing this one is. But with what I do if I have enough time.It's just giving out medications and doing the dressing. In the morning, it is very heavy because you provide care for 4 to 6 residents.

P10: It's heavy. Very heavy, actually, because sometimes, you know, right now it's six nurses. I mean six residents to one nurse. That ratio is really heavy. Especially, yeah. It's very heavy. Looking at the ratio, it's really heavy. Six residents to one nurse is heavy.

P12: Needless to comment, 4 to 6 residents for you.Some heavy, some not heavy It's all mixed up because nursing will be heavy anyway. Nursing is always heavy. Sometimes when you get a good section, but it will always be hard mentally and physically.

P20: Oh, the workload is unmanageable. Twenty years ago, three people did the work that I do. And so the workload is unmanageable. But I don't worry about it. I just keep prioritising. Eventually, eventually things will get to the top of the priority list. I can't be bothered stressing about it. I'm too old now. I just want to work and go home. Work and go home. And I get all the top priority stuff done. That's all that matters to me.

P21: Well, right now where I work, well, because I am probably – I am working the section with the most number of residents. So of course if I'm going to compare, if I'm going to compare it with the other RN on the other section. He or she only has half of what I have. So definitely I feel like I'm at the worst position. Like I'm more tired than him or her. And it's not really based on the experience but just based on where you're assigned. Yeah. Because, and we're also – they're, in this section, which I have about 28 residents. If I was doing the other side, they only have 14 or 16 residents.

Job resources/job demands

R: Would you say your work is emotionally demanding or detached? Please elaborate.

P1: Very much, is very demanding because its concentration, you need the outside world outside, its onlyyour concentrating on six to ten clients or twenty clients in that ward and its very demanding because your brain is just all focused on them .

Very demanding! You have to deal with all, the residents, almost disabled! The relatives, the boss.

P5: I am in charge of the facility as an RN, and it is very demanding.

P9: It is very demanding. In fact, the relatives are very demanding. They sometimes interfere too much as if we don't know anything.

P10: It is very demanding. You need sometimes break.

P20: It depends but inappropriate cares performed by others are really annoying and creates stress and emotional exhaustion; and you don't know how to deal with it. It is most of the time a personal or cultural problem.

P21: It is very demanding especially when the relatives come in. They become your supervisors.

Lack of reciprocity

R: How would you describe your work with clients: do you feel that you give more than you get back or do you feel clients treat you fairly? Please elaborate.

P1: No, you always give more than what you get but there's always a smile that comes or a thank you now and then or something and that rewards you in everything.

P12: I talk to my family when I am tired.

P21: Yeah. Yeah, definitely.Definitely. Because, like, sometimes, you know, you work there although you're working, like, on a fixed roster or shift. Sometimes you're still there an hour or so after you're done just to finish on, like, your reports because you weren't able to do itbecause part of our job is, aside from the physical or giving medications or giving of – we do document everything.

R: Is that useful to alleviate some sort of stress and fatigue?

P1: It does, just that smile or just that thank you is, relieves you, that's a hundred percent payback.

R: Let's guess you have a fatigue of burnout, have you experienced it I don't know but what could be the main source of support; to whom can you talk?

P1: Oh, you do burnout a lot especially if its reputation in work, repetition in work. So your biggest support worker is your supervisor and from there you can go on from there to counselling or whatever else you need, but that supervisor re-arranges everything so that you're not burned out, she sees that your burning out she will get step in and do something but she is very capable of letting you know that she thinks you're burning out but you can go to her at 24/7 and tell her that you're burning out she'll find other.

P5: Yeah. We work very hard. We work very hard. We go extra mile, but it's okay. Of course, we just need to help residents,

P8: I think nurses do but you chose to do it,

P9: It is good, we work on a roster basis; you know the residents their likes and dislikes. You follow the routines.

P10: Of course. Yes. Yeah, because it's always been an issue actually with aged care. It's always been an issue that we don't get paid much as compared to people who are working in a shop in the retail industry. And looking – and if you compare the job you are dealing with people. They're just really – they're still dealing with customers, you know.

Role conflicts

R: Do you know exactly which areas are your responsibilities?

P1: Yes…

P9: Yes as I said it is about routinesand following the plans.

P10: There is no problem about that. I know what to do, where to start**.**

R: How would you describe co-operation between your colleagues at work?

P1: Cant' really say. It depends, some are reliable, others are not.

P8: I work on a roster basis and I do have good work mates but some staff are truly complaining about others' attitudes. They do not have any notion of duty of care and responsibility.

P9: Some are good, but I think the cultural differences play a role. Sometimes, the expectations are not clarified and that creates misunderstanding, gossip and frustrations.

P12: I do not know in general but in my roster team we're fantastic. I do though hear some complaints from other staff, about others' attitudes and lack of sense of responsibilities.

P21: Co-operation! Sometimes you better do your job and not rely on others because everyone has her own standard. You cannot expect someone to do to the job as you do it.

Client-related burnout

R: What are your main sources of support? To whom do you talk?

P1: Definitely, you usually work two on two. What happen is if that person becomes agitated so much that you cannot work, you go to the next client and leave him to last. You bring in the registered nurse and she will sedate them or give you another option to deal with them.

P5: My partner. But my, my husband or my colleagues.Colleagues at work.We usually, but usually, like we've all usually got the same complaint, and it's good to be able to sound off to each other

P8: When something happen you just go out for a while so you can sit down for some…. It's all in me. If something happen I just walk out, sit out, refresh a little bit.

P9: Well, it's always my family. I couldn't, not here.Yes, family. Not I don't know in the workplace no.

I also Yeah, I always have a break yearly and when I use my holiday. Get away for a while.

P10: Main sources – main source of support sometimes when we go for our break. It's just like a stress de-briefing with your co-workers. You just have to – ah, I really had a bad day today. For me, that's how I do it. And when I am stressed with one I just walk away. Otherwise, I will be more burned out when I stay with it. Yeah.

P21: Well, definitely, I don't really talk a lot with my peers, because we're on a roster shift. So the minute I'm off, I want to go home and rest. The only person I can speak with, perhaps, would be my family. This is some (unintelligible), I speak with my wife. 'I'm so tired'. You know? 'I don't want to be bothered'.

Global questions

R: In your opinion, what causes burnout among some aged-care workers? You have already cited some important facts but ….

P1: Yeah ok umm.Your burn out is the same job over and over again the same times and.What you need to do is, you need to do is every second day go to a different ward for a different category of aged care.

If you're rostered to one job it's up to you to, to talk to your manager, talk to your you need to rotate Ok, you need to rotate to in other ward, you can't just be 24/7 in one ward that's why you have burnouts.

R: So… is that about thestructure of work conditions that's all

P1: That's about your structure work because now you can only work in a ward up to three days at a time and then they put you into a different ward Ok and that's to cut down the burnouts.There is there's a lot of high (unintelligible) high needs for us because you can walk into any ward and you think as soon as you walk in this ward, I know what's wrong with this one,that one, that one and you put it into your brain straightaway, you read their scenario very quickly, you go over their case history very quickly and you put it into structure but you need to size it up before you walk in, size your client up and see, and then you're already prepared for an emergency of whatever else that goes on.

P5: Maybe the nurse to patient ratio. The resident to nurse ratio.It could be she has nine residents.

R: One nurse?

P5: The one nurse for six residents, one nurse. And they all need to be showered, things like that. Yeah, nurse to resident ratio is quite big. It's different from the hospital where someone is [unintelligible] four and one nurse. But where I work we might find is six residents, seven residents, eight residents per one nurse.And most of them, they want to be fed. They want to have showers. They cannot move on their own. They need wheelchairs. By the end of the day, they will be so tired for sure.

P8: Look. It's just the workload. Once – this is the, the main thing is once you – you know, you work, say, for example, with me I'm working 10 hours. Yeah. Four days, 10 hours. And then you really need to take your break. When you have given three days you really need to take three days and have a –And have a rest. You really need to have a rest. Because if you don't have a rest and you really need to have your break during your 10 hours because it's a lot. The workload is really … and it makes you stressed. You're wearing this fatigue. So with me, I always take my six months – work six months and I take a break. Yeah. That's whatwith me.This is my… I take…After six months I have to take my break because it is….

P12: Lack of staff, residents' relatives.

P20: Most companies I work for don't provide any sort of support. But where I work has an Employees Assistance Scheme.And it's a team of psychologists.We all have access to it if we – and it can, we can use them for personal problems or work-related problems. And it's a matter of just ringing up and saying, 'I work for the employer at one of their Sydney facilities'. And that's all we have to say. And we get assistance to their care.

R: What about staff ratio?

P20: Well, see, we don't have a problem with that there, because lately we have very generous staffing. I mean, a lot of places do. I mean, I was talking to a nurse this morning, and she's the only registered nurse for 44 people. You know? We have three registered nurses for 68 people. You know? They have about 25, 26 each. That's a manageable workload. But a lot of places, the staffing is an issue. It doesn't, no. We've got good, we've got industry recommended staffing right here.

P21: Well, sometimes some of the stress is, of course, from outside when assessors or accreditors come in, or people from head office, they come in, demand a lot of things, ask you to do this and that. You know? You're asked, you try to become, like, on top of everything. So you become really more stressed.But other than that, because of the regular, like, I get used to it, what management does or asks from us. You get to prioritise and manage it, manage your time to fit in all those things. But, you know, extra-curricular activities coming from outside, that's what's stressful, really.

R: Have you any ideas how this might be alleviated?Who can help?

P1: Well for the burn out to be alleviated is to cut down the amount of clients that you do have to care of.

R: So it's a staff ratio

P1: Staff ratio its, it cuts down and the study that goes with it, there's just so much study , there's no stop time after you finish work you gotta go home and still study.

R: Study; what do you mean by study?

P1:Well you upgrade every three months don't you. Oh, yeah you gotta keep upgrading on with time all the time, you gotta do assignments and things like that after you finish your nursing, so you're not turning off, you're in that add air bracket , at air bracket should be work structure, when you go home it's your home time to turn off from work. It is part of the training and the continuous learningbut there's too much you said

There's too much and not enough relaxation away from the job and then to come back, if you're going to do that you've got to take a week of just studying but go to work and sit in the classroom and study it take it home yeah and they've to rost you… roster you that you get two days of a fortnight or something to just go to work and do that studying. So that you've got time at home and time at work; and that's keep your brain active that way; instead of taking at home and trying to do you stuff household thing and study. There is no leave way, that's way burnout comes out quickly.

P5: Well, we try our best to like to increase the number of nurses, but at the same time, when you increase the number of nurses, you go out of budget, also.

So, it's playing with the figures and the – with the staff also at the same time. Of (unintelligible) or what's pending, and to have adequate number of staff on duty, also, because if you don't have adequate staff on duty, it's not good, also.

They have to be happy at the same time, although their workload is heavy anyway.

The nurse's workload is just too heavy. Like we don't have to put scheduled staff on duty just to be enough written stuff for the resident to get quality care, also.

So we try our best, but anyway at end of the day, they will be tired. For example, We have one RN on night duty with four nurses, two down, two up.

P8: Share the workload. And staff. You really need to have staff there. Yeah, because if you don't have staff the level staff in aged care is not very good. Say, for example, like we in the men's section it's two in the morning for 17 people.

R: Wow. Two for 17?

P8: Yes. In the morning. Then another one comes at 9:00 o'clock, so we are really stressed. If something … they're walking around. They're aggressive. You know? [side comment]

Yeah. It's the workload. You're given the workload and the workload is there for you and there is not enough staff. Of course you're just going to ….P9: Add more staff.Yes, and then probably, you know equal division of the job, the work. And then probably – because probably – you see them very tired. That's why they become really stressful and they bully one another. So!

P10: One step that the government should look into is looking at the ratio for the nurses. Looking after six – six is really too much. It's really heavy.

Really. So that's the first thing that probably would really help remove all these. For us not to be burned out because… And, apart from that, of course, the support system from the management. That's another thing.

There is a support system that probably – it is something that really helps a lot and also the teamwork. People working. How they work together. It's very important when … it is one aspect that's really good help with the stress.

P12: It actually depends on the situation…for what I see. You've got heavy section and light section, sometimes it's not balance but everyone is doing an excellent job, but it creates stress and some frustration sometimes. It is important to add extra nurses, adding more staff.

P20: Well, I, personally I think there's a great difficulty because we are obliged to function according to various legislation. We are obliged to look after staff, according to Occupational Health and Safety legislation. And yet the company says the customer is always right. So you have a staff member being abused by a relative. If you intervene in that and the relative complains, then the customer's right. So it causes this great, you know – conflicts.

P21: Well, for our work, well, in each care … because there's always, they put a limit to the number of workers. Some of, some facilities would have their own formula for the number of staff working. So, well, of course the more people sharing the workload. Yeah. And more staff. That's really, that's got to help. But if that can't be then the rostering is also going to be helpful, because sometimes, in my case, I do morning, then I do afternoon shift, which is … morning you come, you come to work at 6:00 and go home at 3:00. And then

in the afternoon, you come at 3:00 you finish at 11:00 in the evening. And sometimes because I'm in charge and, this for example, I go home half past 11:00. And sometimes, like I said, you do some reports, you write some things. You finish after 11:30. So by that time … and then the following Wednesday, I'm on morning shift again. So 6:00. So my sleep, it's not, you know, it's adding on the burnout. If it was, like, a fixed all mornings, then your body's going to adjust, perhaps. Or afternoons. But because of the rotating roster, it adds a lot to the burnout, like you said.

Appendix 9: Sample of interview responses: Managers

INTERVIEWS: MANAGERS

R: Researcher P: Participant

R: It is extensively reported in the literature that overexposure to stressful experiences can increase burnout. To what extent is that claim true for aged-care workers? Do they experience 'stressful experiences'?Could you please give some examples?

P3: Yeah.Yeah.Definitely. Yeah.They manage a lot of incidents, like if a resident has a fall or has a medical emergency.They have to cope with that and send them to hospital.They also have to cope with when a resident dies or passes away.And they are the first line of care, so they're the ones that will often find the residents or need to call an ambulance, so that can be very stressful for them. Yes, for example Lack of staff. Uh-hmm. And we get maybe one or two ringing in. That leaves four on the floor for 60-old residents. Also staffing, I notice the younger generation, they're not interested in this kind of jobs (pause) making it difficult for those already in the workforce not to be stressed etc…

P7: Is it one thing, or can I tell you a hundred?

Well, first of all, it would have to be the budget. It's absolutely, trying to have enough staff, not causing them burnout, and, but still get the care done. It's, like, it's getting worse. It's getting worse. I didn't think it would, but that's very stressful. So outside the budget, it's extremely stressful, because, you know, if you go out of the budget, then … the other stressful thing is getting staff, because we pay. Again, we pay less money than they do in the hospital. Why would people want to come and work here? So we get – I hate to say this – but we probably get the dregs of what's left over of working elsewhere where they get more money. Now by saying that, I mean, we've got fantastic staff and I really respect them. But they're not, you know, that's some of the reason. So that's very stressful, because you're also getting people who are probably not well-educated. We get a lot of non-English speaking background people because you come to a nursing home. You know they always get a job, because there are hundreds of jobs going. And so we get a lot of that. That's very stressful. It's stressful for me, because I get complaints from the residents and relatives saying, 'He can't speak English'. It's stressful for the rest of the staff because—

R: The language barriers?

P7: The language barriers. Yes, yes. That was stressful things. The constant changing and the constant inspections are just crazy. I would have – like I might have, I've got a diary, right. Most days it's [unintelligible] I got staff appraisals and I've got relative resident, you know, interviews. And I've got all sorts of things to do. And then suddenly a team will turn up and say, 'We're going to do an inspection today'. Now I have no comeback. I can never say, 'I

can't do it today. I've got too much on'. I have to make the time. And that's so stressful. And so unprofessional. I just find that incredibly unprofessional. So, you know, the accreditation team just goes, 'Bang'. And why would they do that, unless they want to catch you doing whatever? I just, I don't know. And I suppose the other, other stressful thing is that they, they do catch you on stupid things that you think, 'Oh, for heaven's sake'. Because we didn't write something down, then, you know, the whole place looks as if you've let down. And it's a letdown. And the board asks you why. And it's extremely stressful. Gosh, you've started me, haven't you? Anyway, there's a whole other things.

P15: Of course they do. Well, you know, the job within itself is that you're in a caring professional, profession. And you're in a helping profession. So that brings all kinds of stresses to it. The fact that you're going into people who need help or in a vulnerable situation, they could be experiencing health conditions or family conditions – you know, family stresses – financial stresses as well, because of the situation of the family member. So they're coming in, and unfortunately, when you are coming into help people, you sometimes get that stress put onto you, because they'll start talking about all their problems. And even though you're not there for that reason, they can't help but to, you know, unleash some of those stressful feelings. So that in itself is very difficult, I think, for care workers.

R: Is caring for the elderly a health risk? Would you say your work is emotionally demanding or detached? Please elaborate.

P3: Very demanding and detached.Yeah and so we'll be short staffed for days and they'll be run off their feet.And it can be very hard when you're short staffed and when you've got residents that have high care needs – residents that aren't well.

P7: Because some people ask for, you know lots. They want you to spend an hour showering them and they want special diets and they want – not just diets, but, you know, special food, because they don't like the food. And you do. You go, 'I have it backwards'. And often those people will continue with complaints. They just seem to go on and on. But I don't know about feeling that I don't get anything back, because actually a lot of the clients and a lot of relatives are really very supportive and very nice. So, it's just occasionally.

P15: Well, I guess, I guess. It is very emotionally demanding.As a coordinator, I experience that as well, because my role is to coordinate the services.And more often I'm getting a lot of, you know, a lot of, you know, carers that are just so stressed out and so isolated from the normal day-to-day life because they're caring for someone on a 24-hour basis. That they just, they need to talk about it. And they get very impatient and, yeah, they just want things to change for them. They want things to be different and better. But unfortunately, you can't do that. You can only just support them in the way that your job allows you to. So of course they do.

R: And what could be their sources of support?

P: Well, some of them have support in the fact that they have extended family members. But even if they have extended family members, the role of the 24-hour carer – like if you go to a person that's caring [unintelligible] for 24-hours,

there's a part for that. Like, they might have three or four sons and daughters that can help them sometimes, but that doesn't mean that they get a very good break from their role. You know? They might get an hour or two to race down the shops or go into the hairdresser or something. But you know, the fact is that they're responsible for 24-hours for that person. You know? And they're probably experiencing terrible sleep. And they're probably, you know, and they're probably not getting a lot of sleep and they're probably just not getting the freedom to live their own life. You know? But that, in a way, imprisoned 24-hour carers, I'm talking about. Because they really don't have the scope.

I had a carer who recently went down to South Australia for her grandchild's birth. While she was there, her husband went into a facility. He fell five times. She was there her husband went into a facility. He fell five times. She was fine each time. Of course while she's trying to experience the joy of the birth of a grandchild, and have some rest finally from the caring role, she still had the phone calls and the worry and concern that her husband's gone into a facility and he's falling and hurting himself. So even when they're away on a holiday, they're never really fully relieved of that responsibility.

Yeah, as far as care workers go. There's, what they're seeing is for short periods of time. So it's not as – you know, when you're, like a 24-hour care worker. [Unintelligible] care workers coming in and helping services, yes, they see people who are suffering. They see people who are limited in their lives. You know? They see people who are under financial stress. It depends on what area they work in. Some of the homes they go into are dilapidated and falling down around them. You know? There are some carers who are abandoned really by their families. So they get very, you know, involved in the fact that this person hasn't got anyone really to care for them. They're supposed to, but they don't really. Do you know what I mean? I had a client recently that, you know, I had to go to the Guardianship Board because I would know people being neglected by their children. And the care workers were emailing me every day. And I was so upset with what was happening to this client, because this client was possibly being neglected, and they were totally powerless to do anything about it.

Apart from report it to me. And then I had to do my bit what I had to do. But that didn't take away from the fact that every day they were going to see this person who was blind, demented, living alone, urinating all over her floors, sleeping under her kitchen table because she couldn't find a way back to her bed. Being locked in the bathroom because she couldn't find a way out of the bathroom. They had to deal with that when they were going into see her. They find her in the bathroom crying out. They couldn't get her out of the bath – she couldn't get out of the bathroom. They had to calm her and care for her and this went on for months. So those care workers, you know. They were quite rightly upset, outraged, really hurt about what they were seeing about this client. So.

R: How are the structures and supports in place? Do they enable aged-care workers to be successful in their responsibilities in a way that is

consistent with their professional values and standards?Could you please give some more details? (Staff ratio, training, etc….)

P3: We do get a lot of training. We really do. It's one of the reasons that you don't have the staff to go around. That's when you start to panic, you know, and rush.

We have a lot of training throughout the year covering different types of things they might face.

R: Who – who offers their training?

P3: We do it at a centre level.We run like through our registered nurse.

We get people to come into the centre and run training. About – say dementia or different types of…and we also send them to external training, like Certificate 3 and 4 in aged care.We send them through those programs.We also offer support just from their supervisors, and we have an employee support program through Wesley Mission that all our staff can access.

Staff ratio – yeah.Sometimes it can hard be hard to recruit people in aged care. We have a lot of training. Yes. Some of them deal with the way we should assume our responsibilities, but they do not help in reducing the stress on us.

P7: I think, I think our support of each other is quite evident. I'm probably a bit different. Lots of [unintelligible] are. I do actually go on the floor and actually talk with the staff most days. And we have handouts. And I'm usually there. Not every day, but I try to be there. And I encourage the girls to, you know—

R: Talk to each other?

P7: Well, yes. To unload all of their frustrations 'n that. So I guess that's, yeah. Their support is with each other, because I don't know that we get much support from anybody else really.

P15: Well, yeah. We do. Of course we do. We have, you know, we have an Employees Assistance Program like every organisation has, I would think. Like the counselling and things like that for anything that is, you know, that if they think they are starting to burn out, they have got an Employees Assistance Program that they can tap into as far as counselling and all of that. But on a day-to-day basis, they have, you know, team leaders that they can talk to. You know? So they've got directly, they go to the director for the team—

R: So the management support is …

Absolutely. They've got a team leader. They've got a coordinator. So they go into a situation, I would, I would advise—

I can only help by offering them some sort of words of comfort, allowing them to talk things through. Meeting with them if they would like to talk about it further.Following up.Making sure how they're only a couple of days top, although that's more the team leader's role, not really so much my role as a coordinator.And then referring them for other sort of services.Taking, removing them from that particular service if there is a service that they're being stressed out or the carer is being particularly difficult or demanding or

abusive in any way. We immediately remove them from the service. Absolutely. They're not to receive any kind of abuse at all.

R: What sort of additional training and resources do we need to help aged-care workers to assume their duties with minimum 'stress and emotional exhaustion'?

P3:Stress management training! AndJust to keep training them.To give them as much information on how to deal with things.Giving them more knowledge of aged care…of diseases they have to see, as well as having plenty of staff.I know they can get very stressed when there is not enough staff and they're already…

P7: Stress management, cultural issues and ethics.

P15: I guess, you know, like recognising stress-related behaviours. You know? I mean from [unintelligible] industry, they've done training where they, you know, recognise the need to look after yourself. You know? Living a healthy life. Because if you, if you're living a healthy life and you're getting the things that you need, you're more likely to cope, you know, with your, the stresses of your job. So minimising, you know – you can have the stressful life in your home life and then go to work and deal with stressful situations. Something's got to give eventually. We all burnout in one way or another. Something will suffer, whether it's your family or whether it's your work.

So it's really recognising, training and recognising stresses. You know? Organizing a healthy life, balance, taking time, you know? Making sure you take time for leave, annual leave and all that sort of stuff. I mean, really, to be honest, I think that most people who go into this sort of job, it's because they're that way inclined. They're just the caring kind of people. They just want to help people. And it's really up to them as individuals to be empowered with their – the knowledge they need to look after themselves as a, you know… Yeah. Eating well and sleeping well and, you know all that stuff.

R: Do you think the Government has a role to play in the reduction of aged-care workers burnout?If so, in what ways might this be achieved?

P3: I guess more funding, more support training programs.

P7: More funding (laughter) and also promoting the aged-care career. There will be a huge problem within a few years in terms of staff.

P15: The staff-resident ratio. Needs to be regulated.

R: Do you think certain personality traits may predispose aged-care workers to workplace burnout?

P3: Yeah, there is always something frustrating. Residents' illness, change of routines, Inadequate care performed by colleagues. You need to manage all of these, usually by yourself

P15: Yes but it can be managed through experience. Those who have just entered the industry are always 'burnout'.

R: In your opinion, what causes burnout among some aged-care workers?

P3: Apart from the staffing issues? Okay. Workload.The workload.Too heavy… high tech, too. Yeah. Mornings are very heavy. We could do with more, especially when they don't arrive for the shifts in the morning and you have, say, 30 showers to do and you've got about four staff, three staff. It's a bit hair-raising.

P15: I'm not sure. Being short staffed. Having a lot of responsibility and not feeling like they have enough time in the day to do everything.

R: Okay. So it's all about staffing issues.

P15: I think staff's a huge thing.

R: And do you think that if it's addressed it may alleviate the burnout?

P15: To an extent, I think. I think there's always going to be a lot of challenges.

It's not easy work. It's very challenging and risky? Yeah. It's challenging and they're dealing ,,, it's a lot of emotional…when you see someone go from being quite active and healthy and you watch them deteriorate, and then they either move to a nursing home or they pass away. They get – like they get very – they bond with the residents and it's hard for them.

R: That's a very good point. It involves some sort of relationships developing.

P15: It's so – yeah, you get emotionally attached and then it's hard.

R: And if that, if that happened, what, what, what can we do to help a person just for…?

P15: Yeah. We have a chaplain that comes every week and he's always, he always offers to talk with anyone if someone's passed away or if they need support. And we do often have sort of debriefs – group debriefs, when something's happened. I think staff's a huge thing.

And pay. Like they don't get that great pay either. It's terrible pay. You know? I mean if you're feeling like you're really putting your heart and soul into something every day, we try to think that they, most of them genuinely thought they get 50% of the [unintelligible]. Pay them well. You know?

R: Have you any ideas how this might be alleviated?Who can help?

P7: I think first of all, we have to have fair pay. I absolutely. I think that if we had … no. I had an RN yesterday. I could only pay her $32-something an hour, but where she was working when she was in the public, and she was getting $37. And she will be doing similar things. They weren't, you know, it wasn't she was doing psychiatric kind of nursing. It wasn't anything technical. You know? Intensive care or anything. It was just ordinary. And I think, I think equal pay would be definitely one thing that I think would make my job a lot easier. In saying that, I think for the RN's and the lower [unintelligible], I

suppose all of the staff, if they were paid more, we'd get better quality people, I think. I don't think that will ever happen, but I think—

P15: I think in any workplace, people should be given opportunities to try different jobs in a workplace. So, you know, if someone's been—

Well, if someone's been in a job as a care worker role for, you know, five years, and have done a lot of training, there's probably a very good chance that they would have some skills that would give, that would be, they are able to do other jobs within the organisation. They might be able to step up into an acting position or—

R: Career planning.

P15: Yeah. Absolutely. Yeah. Yeah. Giving people opportunities to try different things if they want. I mean, I'm going to point right now. I work for a program. Each program – no, I'm with a package care program. [Unintelligible] and all of my clients are high care needs clients. I've got 26 of them. Okay? All high care needs. A lot of my other colleagues, there's 18 of us, six of us are in the high care. Twelve of us are in low care clients. Okay? I'm burning out after 15 months in the high care because of the demands of my job at the moment. And because I also have some things happening with my daughter.All right? My manager is recognising that and I'm saying to her, 'I need some time out from my role. I really need some time out from my role'. So they're planning to put me over to the low care for a while to give me a bit of a breather and to peel off the crisis kind of stuff that I'm dealing with every day pretty well. So, you know, you need to help managers that recognise that in people. And, you know, if the [unintelligible] doesn't recognise it themselves, you need to help.

R: So we are still talking about management support?

P15: It is. But it's also up to the individual to also recognise that, you know – I mean, it's not good to be in any job, I don't think, forever. You know? It's not good for the client to be the same client forever either. I think it's always good to bring in a fresh and a new and the new ideas and the newly trained and the newly educated and all of that at any time. Because, you know, we can only – no one ever has the answers to everything. It's always going to be a, you know, approached by a team, isn't it?

Appendix 10: Sample of interview responses: Relatives

INTERVIEWS RESIDENTS' RELATIVES

R: Researcher P: Participant

R: It is extensively reported in the literature that overexposure to stressful experiences can increase burnout. To what extent is that claim true for aged-care workers? Do they experience 'stressful experiences'? Could you please give some examples?

P6: Oh, not a doubt. Yes.They sometimes have residents with challenging behaviours, which is obviously quite stressful to sort out at times.

P18: Well, not in the section where my father is. But I work in aged care myself. And for me, I say yes. I don't work here, but I work in aged care.

Because I've got too much to do and too little time. I hardly get, get through my … I'm an RN.

The time and the workload are the problem. Too many things to do and I work in hard care, and it's full on..

P19: I don't know, to be honest. Well, we are here to tell them what our relatives need.But in turn we expect them to do that, to, to meet the needs of the residents.

P22: I should imagine they would, because they're dealing with sad cases all the time. And, and my mother's only just moved in there this week.So I haven't had a lot of contact with them.So I might not be very helpful to you. But I – I should imagine they would have stress because they, they're dealing with, you know, people who are stressed themselves.I mean, elderly people, most of them don't want to be there.They'd rather be living in their own house, on their own, doing their own thing and being healthy. And they're not. So.

R: Is caring for the elderly a health risk? Would you say your work is emotionally demanding or detached? Please elaborate.

P6: Absolutely, I think so. I notice that they are always busy when I come there.

P18: Obviously, they have to use all these hoists and wheelchair but that's their job. When I visit my dad there, I always hear someone moaning, crying, dementia could be! And it's stressful to perform your duties with such a noise.

P19: It must be because they have to take care of different people with different expectations, different care needs. The job is definitely stressful because its nature is very complex, but they have chosen to do it

P22: It is absolutely. It is a huge responsibility.

R: How are the structures and supports in place? Do they enable aged-care workers to be successful in their responsibilities in a way that is

consistent with their professional values and standards? Could you please give some more details? (Staff ratio, training, etc….)

P6: They do have – they do have education in managing challenging behaviours, just for example. Or different aspects, say, when people have lost someone, loss and grief and that kind of thing because you do get emotionally – people who are emotionally upset with a lot of things, as well.

P18: Well, yes and no. We really need more staff. But you won't get it because you need, you know, the government. We need to get more money from the government. And they just show accreditation, blah, blah, blah. Yeah. Yeah.

P19: I don't know. We don't know what support the staff have. Our only contact is we see them occasionally when they're, when we visit. That's it. We visit our relative. And as far as I can see, there's either not enough staff or they're not doing … I don't know. They're maybe not trained as much as they used to be. I don't know.

P22: Well, I have, I probably haven't. See, I'm probably not going to be very helpful to you, because I haven't been here long enough.But I mean, I think they all work very hard and they're always busy and there's always, you don't ever see anybody sitting around doing nothing. They're all always helping somebody, filling out forms, doing things. They seem to be very busy always. Oh, very busy. Very busy. Yeah.

R: That's an observation, which is important.

P22: They are always busy. Everybody. And it doesn't … every time I, and I have probably driven them mad the last couple of days because I've been all the time. But I've been … and every time I'm asked for something, I've got it. You know? Whenever I've said, 'Can mum do this?''Yes, she can.''Can you do this?''Yes, we can.' And it's been done. So I've got absolutely no complaints. And I think they work very hard and they probably don't get paid enough for it.

R: What sort of additional training and resources do we need to help aged-care workers assume their duties with minimum 'stress and emotional exhaustion'?

P6: Maybe, about how to work together with us. I do understand, we have different expectations but we can help each other.

P18: Maybe it is important to organise a meeting for carers and relatives in order to clarify expectations for each other…But surely, they must have got training on how to do their job.

P19: Would be good to have meeting together and have a discussion about how we can help each other. I mean relatives and the staff.

P22: Maybe how to work in a team, how to take advantage of the technology.

R: Do you think the Government has a role to play in the reduction of aged-care workers burnout? If so, in what ways might this be achieved?

P6: Of course, it is a Government funded industry. The Government need to find ways to attract people to enter it. Pay! I fear that without reform, there will not be enough nurses and carers to provide it and the pressures will intensify.

P18: Injecting more people in the industry; giving incentives like they have done for nursing. It is time to do so for the aged care if not within few years there will bea great problem.

P19: More pay, make people realise the importance of this industry in our society. At the end of the day, we will all get old.

R: Do you think certain personality traits may predispose aged-care workers to workplace burnout?

P6: Absolutely, people, nurses need to manage well their emotions.

P18: Maybe. If they cannot control their emotions.

P22: Yes, but it is important to know yourself before entering any profession, specially this one. It requires love and patience.

R: In your opinion, what causes burnout among some aged-care workers?

P6: I guess it's just you're giving a lot of yourself, you know, because emotionally sometimes. Knowing that people that are possibly at the end of their – the end of their life. That emotional – the emotions that they are feeling and the family are feeling it sometimes can get to you. And you are sort of in the middle between the family and the person. Also I don't think the aged-care industry is very well paid. So people have to probably sometimes work longer hours. Or different – and work different jobs just to be able to kind of live.

P18: I see lack of nursing and assistant nursing staff.

P19: Well, you'd have to point out why they're burned out and why they're stressed and then address those issues. I see lack of staff.

P22 As I said, they are always busy. I think the workload and also not enough staff.

R: Have you any ideas how this might be alleviated? Who can help?

P6: Well, there is. As I mentioned before there is training.Well, there's a possibility like someone – that you might be able to work something out like perhaps recognising the work that they do. It's only – there's only going to be more and more of an ageing population in this area.

P18: Well, the environment's fine. Or for me, where I work, I would like an office where I don't have as much noise, because it is right, I've got relatives going past. I've got patients going past with dementia. And relatives to take after now. And a patient can take another half-an-hour just walking past. And staff and so I would like an office where I can close the door and do paper work. Also, well, some relatives have unrealistic expectations. Some. And others don't, of course. But it is, when you're dealing with relatives with unreal

…. This can happen, too. But when you're dealing with relatives with unrealistic expectations, that's very stressful. So you're trying to help them at the same time you're trying to help the patient become quiet. And, you know, and that can cause stress. Like the other day a nurse – not here – had a – you know what the [unintelligible] are?

Okay. She was pushing it in the room. There were two in the room. And she was going to get the person near the window, put her back in the bed. She's a nice lady. Okay? She accidentally, she knocked a clock off the wall, and it broke on the floor and the other resident – the daughter was there. And she just went hysterical. And the nurse was upset because she was hysterical. The relatives were blaming the nurse. The nurse tried to say it was an accident, and the nurse was hyperventilating. I had to send her home because she was so stressed, the nurse. Because the relative was being – well, she, she just had so much anger in her. She probably had other issues. Yeah. But she took it out. Yes. But still.

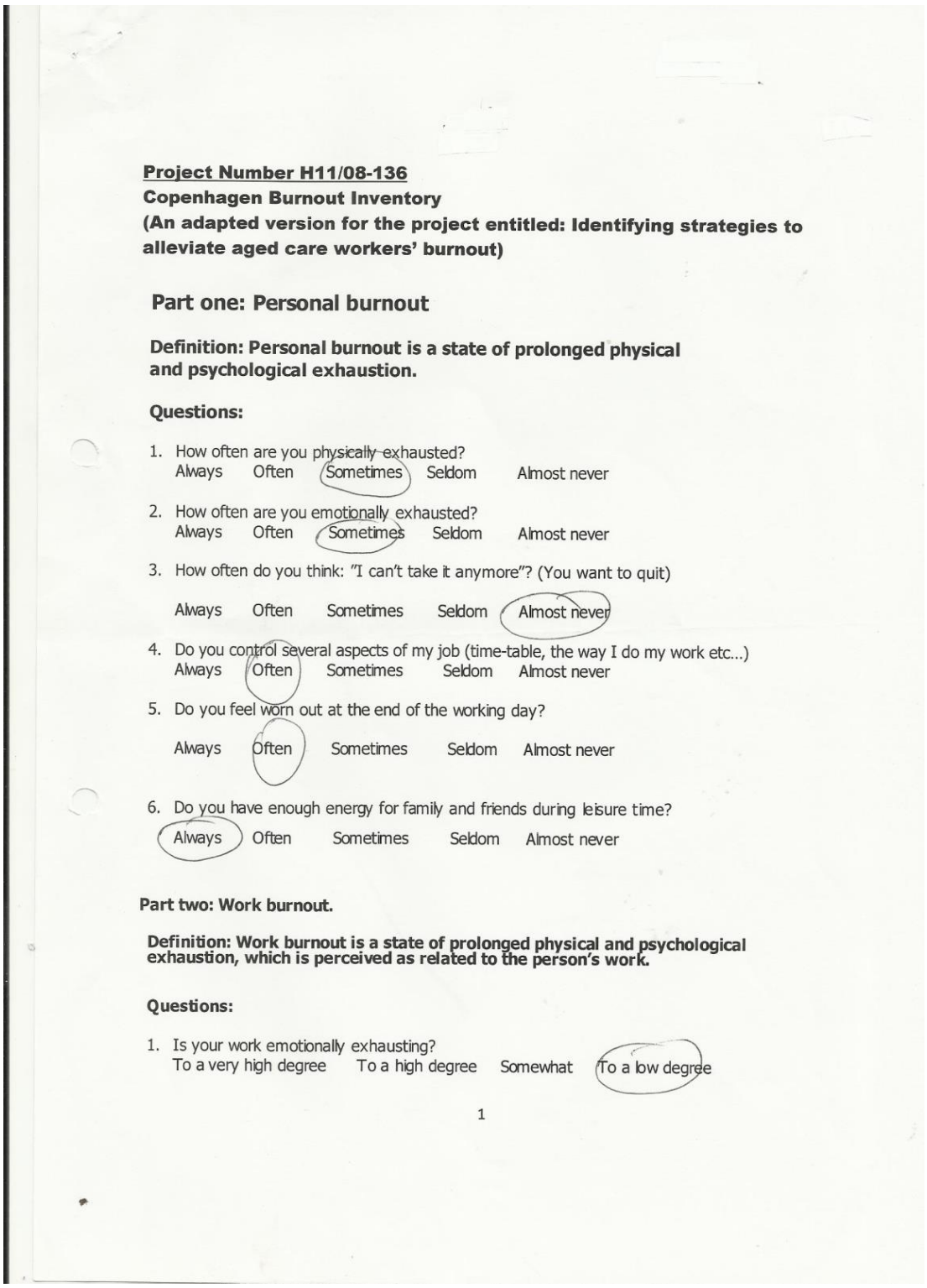
P19: Add more staff and may be work more closely with us. There might be some responsibilities we can share. We do usually meet with the clinical manager, we liaise with her. She is the one who is between us and the nurses. Her interventions…

P22: I guess pay them for what they do. That would be, you know, if they felt like they were being appreciated with monetary values, that would be a big, that would, that would really, you know, help stress. And supplying more people to help them so they're not understaffed. I should imagine that would be, that would be helpful, yeah. More, more, more staff. Appreciate them with the monetary side of it. Those, those would have to be the two major things, surely.

And the relatives, I think they, they can by being, by being understanding and not putting too much, many demands on and helping out with their, their relative whenever they can. You know? Doing, doing their bit. I think that would be … On the other hand, relatives also think that they are still caring for him/her even though he/she's not living with them. So it is just important to clarify expectations Iguess…

Appendix 11: Sample of Copenhagen Burnout Inventory

(An adapted version for the project entitled: Identifying strategies to alleviate aged-care workers' burnout).



Project Number H11/08-136

Copenhagen Burnout Inventory

(An adapted version for the project entitled: Identifying strategies to alleviate aged care workers' burnout)

Part one: Personal burnout

Definition: Personal burnout is a state of prolonged physical and psychological exhaustion.

Questions:

1. How often are you physically exhausted?
   Always Often Sometimes Seldom Almost never
2. How often are you emotionally exhausted?
   Always Often Sometimes Seldom Almost never
3. How often do you think: "I can't take it anymore"? (You want to quit)
   Always Often Sometimes Seldom Almost never
4. Do you control several aspects of my job (time-table, the way I do my work etc...)
   Always Often Sometimes Seldom Almost never
5. Do you feel worn out at the end of the working day?
   Always Often Sometimes Seldom Almost never
6. Do you have enough energy for family and friends during leisure time?
   Always Often Sometimes Seldom Almost never

Part two: Work burnout.

Definition: Work burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work.

Questions:

1. Is your work emotionally exhausting?
   To a very high degree To a high degree Somewhat To a low degree

1

2. Do you feel burnt out because of your work?
To a very high degree To a high degree Somewhat To a low degree

2. Do work pressure and staffing issues make you feel burnout?

To a very high degree To a high degree Somewhat To a low degree

4. Do you feel worn out at the end of the working day?

Always Often Sometimes Seldom Almost never

5. Are you exhausted in the morning at the thought of another day at work?

Always Often Sometimes Seldom Almost never

6. Are the role expectations in your workplace clear to you?

Always Often Sometimes Seldom Almost never

Part three: Client-related burnout

Definition: Client-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients*.

***Clients are aged people in the residential facility.**

Questions:

1. Do you find it hard to work with clients?

To a very high degree To a high degree Somewhat To a low degree

2. Do you find the nature of this job can make you burnout?

To a very high degree To a high degree Somewhat To a low degree

3. Do you feel that you give more than you get back when you work with clients?

To a very high degree To a high degree Somewhat To a low degree

4. Do you sometimes wonder how long you will be able to continue working with clients?

Always Often Sometimes Seldom Almost never

PART FOUR: Presdisposing factors

1. Please rate the importance of the following factors.

   Workplace factors that may make you feel exhausting:

Role conflict

To a very high degree To a high degree Somewhat To a low degree

Clients' behavior

To a very high degree To a high degree Somewhat To a low degree

Role ambiguity

To a very high degree To a high degree Somewhat To a low degree

Insufficient management support

To a very high degree To a high degree Somewhat To a low degree

Insufficient workmates support

To a very high degree To a high degree Somewhat To a low degree

Increase of client's number

To a very high degree To a high degree Somewhat To a low degree

Change in clients' needs

To a very high degree To a high degree Somewhat To a low degree

2. Please state the extent to which you agree with the following suggestions.

Burnout can be alleviated through:

Training

Strongly agree Partly agree Agree Disagree

Management support

Strongly agree Partly agree Agree Disagree

Structured work conditions (ex: structured shift rosters, structured tasks...)

Strongly agree Partly agree Agree Disagree

Use of technology

Strongly agree Partly agree Agree Disagree

Regular respite programs

Strongly agree Partly agree Agree Disagree

If you have any other suggestions for alleviating aged care workers' burnout, please write below:

_____

_____