DISCUSSION PAPER AND RECOMMENDATIONS, DECEMBER 2020

GUIDING PRINCIPLES SUPPORT HUB

MACQUARIE University

SINGLE SITE EMPLOYMENT DURING COVID-19 IN RESIDENTIAL AGED CARE FACILITIES, A MULTI-STAKEHOLDER PERSPECTIVE

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Citation: Jepsen, D. and Barker, T., COVID-19 reveals: Multi-stakeholder perspectives on single site employment Guiding Principles in Residential Aged Care Facilities, Discussion and Roadmap, Aged & Community Services Association, December 2020.

Acknowledgements: This research was commissioned in October 2020 by Aged and Community Services Australia (ACSA) on behalf of the sector-led consortium. Professor Denise Jepsen and Toni Barker thank Dr Kate Booth for her literature review skills, and all who participated in the study, providing their time, opinions and ideas generously. We thank, also, members of the Support Hub Advisory Group including their project manager Glenys Webby.

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Abbreviations used in this report

ACSA	Aged and Community Services Australia
AHP	Allied health professional
AHHPC	Australian Health Protection Principal Committee
ANMF	Australian Nursing and Midwives Federation
ASU	Australian Services Union
CALD	Culturally and linguistically diverse
DHHS	Department of Health and Human Services
HR	Human resources
HSU	Health Services Union
HWU	Health Workers Union
LASA	Leading Age Services Australia
MJH	Multiple jobholding
PBI	Public Benevolent Institution
PCW	Personal care worker
PPE	Personal protective equipment
PSRAC	Victorian public sector RAC services
RAC	Residential aged care
RACF	Residential aged care facility, home, site, or village
SSE-GP	Single Site Employment Guiding Principles
WHS	Work health and safety
24/7	24 hrs a day/7 day a week

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SECTION 1

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Executive summary

The COVID-19 crisis that rocked the residential aged care (RAC) sector in 2020 impacted all stakeholders as they pivoted at short notice, adapting to rapidly changing conditions to protect vulnerable residents. The Australian and Victorian Governments along with sector representatives responded to increasing COVID-19 case numbers in Victoria by funding urgent and voluntary implementation of Single Site Employment – Guiding Principles (SSE-GP) in the two Victorian COVID-19 hotspots of metropolitan Melbourne and Mitchell Shire for RAC employees with multiple jobs. This funding resulted in a sector-led collaboration of residents, employees, providers, unions, peak bodies and governments.

This paper presents observations, opinions, learnings, suggestions and recommendations from our 70+ interviews with stakeholders in October and November 2020, a review of the relevant literature and a scan of international RAC sector human resource (HR) practices during COVID-19. As expected, there are both similar and different experiences across and within stakeholder groups. Variations in interpreting and applying the SSE-GP are likely due to stakeholders who were learning, implementing, problem solving and seeking advice on the new program at a particularly hectic time. It was difficult for some interviewees to separate SSE-GP from some persistent and already-known policy and practice weaknesses, so some important HR observations are included.

This paper is intended to help the sector to rapidly and effectively ramp up for future COVID-19 or other highly infectious situations, and to prompt policy and decision making discussion with governments and other stakeholders both in Australia and internationally. It is also intended to assist in identifying further research and collaboration opportunities to effect change and assist sector performance.

Despite otherwise diverging opinions, there were three instances of almost universal agreement within and across stakeholder groups:

- First, there was strong agreement that along with many other interventions, SSE-GP was successful at reducing resident and employee cross-infection in and across RACFs. The sector supports SSE-GP implementation as further COVID-19 hotspots are identified or declared. ***Most interviewees support SSE-GP on a voluntary and funded basis in a pandemic*** with some adjustments for timing, depth and breadth of coverage, single site versus single employer flexibility, and clearer communications.
- Second, ***the sector did not support single site employment outside pandemics*** given legal rights on restricting an individual's employment and/or earning capacity. However, many interviewed stakeholders expressed their desire to reduce part time employment and multiple job holding (MJH) providing an individual's rights to work and earn as they see fit are respected and provider operational needs are met.

- Third, ***preparedness is key***. Employers need to be ready to move early and swiftly in COVID-19 and other highly infectious situations. Readiness includes maintaining workplace health and safety registers for MJH employees, training in contact tracing and diary maintenance, and upskilling in work and home risk assessment. The Support Hub needs to be maintained and updated as processes, practices and resources evolve as we learn and adapt. Resources may include recorded webinars on SSE implementation and cessation, sample MJH questionnaires and templates, tips and tools to encourage MJH disclosure (e.g., employee privacy and data use considerations) and useful links such as online contact tracing course options. It may be useful to identify higher and lower risk MJH locations around Australia, as other regional or metropolitan locations may have different MJH profiles to Victoria.

Although we conducted fewer employee interviews than anticipated, their feedback was useful to identify their SSE-GP experiences and reasons for ***part-time and multiple jobs,*** and further employee research is encouraged. Other themes and observations include:

- A deeper understanding of the ***occurrence of MJH and its relationship to the high level of part time employmen***t, if any, and worker fatigue, absenteeism, turnover and rostering challenges along with impacts on sector attraction and retention is recommended. A reduced need for MJH is likely to reduce the need for SSE and could favourably impact other HR sector challenges. Further research is proposed.
- Further ***job design research, sharing, and collaboration*** may assist with broader sector-wide HR challenges such as career pathing and understanding the role, status, responsibilities and value of personal care work and how roles change over time.
- ***Opportunities for greater transparency*** and the use of more standardised ***HR metrics*** in decision making and planning were noted in several interviews.
- The degree of impact of SSE-GP on ***resident centred and clinical care*** was unclear. Some anecdotal feedback suggested favourable impacts and others noted it was too early to tell until more robust evidence was available. Given SSE-GP was one of many infection control initiatives it may not be possible to isolate specific benefits. Beyond impacts on employee-resident relationships, clinical experts could advise on impacts such as resident falls, skin tears, influenza and gastroenteritis.
- Several ***RAC providers outside Victoria*** told us how frightening the Victorian experience was for all providers. Many initiated COVID-19 risk minimisation strategies proactively to protect residents and staff. Initiatives included single site practices where there were disparate health directions, where no disease was evident and where no government funding applied. Beyond SSE-GP shifts costs, significant costs and wages included extra cleaning shifts, cleaning materials and waste management, emergency food supplies and PPE expenditure. Further data would be useful here.
- Staff retention at all levels is a risk factor to be continually monitored. The sector tends to focus on front line service delivery staff, however those in ***management roles*** may be at ***flight risk*** due to burnout and pose a potentially large skill deficit.
- When required and with the necessary funding, the sector was able to quickly and effectively collaborate and deliver a positive outcome in Victoria in a difficult operating environment. The sector now has this knowledge foundation to effect further change.

(signed) Professor Denise Jepsen and Toni Barker, December 2020.

Introduction to SSE-GP in Australian Residential Aged Care

Australian Residential Aged Care (RAC) Stakeholders

Key *stakeholders in the Australian aged care system referred to in this report include:*

- ***Care recipients and their families:*** Residents and their families are arguably the most important stakeholders in this research, which focuses on services supporting them during the second wave COVID-19 outbreak in Victoria, Australia. The Australian Government Institute of Health and Welfare found in June 2018 that around 59% of Australians accessing RAC are aged 85 or older.
- ***Service providers*****:** Across Australia at 30 June 2019, there were 873 organisations providing short and long-term stays, respite and permanent bed services in 2,717 RACFs, villages, or long-term care homes. Of the 213,397 RAC places, 56,500 (26%) were in Victorian RACFs. More than half those places in metropolitan Melbourne are in facilities with more than 100 beds.

  Under Commonwealth legislation (*Aged Care Act 1997*), aged care providers are responsible and accountable for providing quality care that complies with the Aged Care Quality Standards set out in the Quality of Care Principles 2014.

  Providers may have one or many RAC facilities and may offer RAC services alone, or RAC as part of a wider mix of services including home or community care, disability, or other services. There are two broad types of RAC providers:

  - **Non-government:** These are either for-profit or non-profit:
    - **For-profit providers:** Some are small privately owned facilities, and some are larger, others listed on the Australian Stock Exchange may pay a dividend to their shareholders. Together they operate around 30,000 mostly metropolitan places in Melbourne.
    - **Non-profit providers:** Generally community organisations or faith-based charities, operate around 55% of Australian RACFs, including over 21,000 places in Victoria.
  - **Public:** There are around 180 Victorian public sector RAC services (PSRACs) across 5133 places operated by the Victorian Government public health service for those with complex and specialised needs.
- ***Employees*****:** There were around 366,000 aged care workers in Australia in 2016. Around 87% of the 154,000 RAC direct care workforce were female (Mavromaras et al., 2017).
- ***Government*****:** The Australian Department of Health has responsibility for advising, developing and implementing aged care policy, funding and administration. The Aged Care Quality and Safety Commission has responsibility for aged care regulation. Each State Government has responsibility for health care delivery and managing public health emergencies.

- ***Peak bodies*:** Most providers are members of one or more peak bodies who provide support, often including member services and employment relations advice. The peak bodies and recognised provider advocates are:
  - Aged & Community Services Australia (ACSA)
  - Leading Age Services Australia (LASA); and
  - Faith-based advocates: Anglicare, BaptCare, Catholic Health, UnitingCare Australia.
  - The Aged Care Guild: Active during the research investigation phase, disbanded 2020.
- ***Unions*:** Three unions that service aged care sector employees in Victoria are:
  - Australian Nursing and Midwives Federation (ANMF)
  - Health Services Union (Health Workers Union in Victoria), and
  - Australian Services Union.
- ***Other stakeholders:*** Further RAC sector stakeholders include academics, advocates, agency or labour hire providers, gerontologists, general practitioners, health economists and other experts, specialists and subcontractors.

Single Site Employment and Guiding Principles (SSE-GPs)

Underpinning Single Site employment were a set of Guiding Principles and the establishment of a Support Hub to assist aged care providers implement Single Site employment. The release of the Guiding Principles was an innovative and collaborative sector-led, government-supported solution to the pandemic outbreak.

The Guiding Principles (full copy in the Appendix) were designed to minimise the risk of residential aged care workers unintentionally transmitting COVID-19 by working across multiple sites and, by extension, reducing the overall risk of outbreak at any given site:

1. Every effort will be made to ensure workers are supported, paid their usual income, not disadvantaged, and have choice over their place of employment;
2. There will be no diminishing impact to the consumer's right to make informed choices about care and services;
3. Implementation of risk management practices and workforce practices will be practical, and providers will have access to avenues of support; and
4. Recommendations will promote sustainable and safe rostering, employment and workplace practices to minimise disruption to any one provider.

The Guiding Principles released on 22nd July 2020 detailed the objectives, scope and initial timeframe and how the Guiding Principles would be operationalised, such as that the primary site would be where the employee worked the most hours. The document details practical implementation, worker protections and consumer rights.

Although providers from NSW, SA and QLD were interviewed as part of the study to gather their experience and comments, this report does not evaluate or compare the differences between the varied approaches taken across state governments:

- Despite the SSE-GP guiding principles only applying to two specific Victorian local government areas, many RAC providers in Victoria and elsewhere outside those areas implemented single site employment practices similar to the SSE-GP at their own direction and expense.
- PSRAC required all Victorian services to implement SSE until Feb 2021 which was beyond the hotspot declaration timeline for Melbourne and Mitchell Shire.
- SSE practices were introduced by state governments in South Australia and Queensland despite no COVID-19 outbreaks at the time.

The Support Hub

To support providers to introduce the SSE-GPs, the federal Department of Health funded the establishment of the Support Hub. The Support Hub was auspiced by ACSA and co-managed by the peak bodies and unions through an Advisory Committee. The Advisory Committee and the Working Group were two regular meeting forums supporting and maintaining the SSE-GPs, each with union and peak body representatives.

Providers and other stakeholders could call the Support Hub Hotline for advice and download information, resources and other materials from the online information platform. Correspondence templates were developed for providers and employees, such as to document work hours across providers and formalise leave of absence arrangements with secondary employers.

A brief survey of Support Hub use in September 2020 showed strong SSE-GP engagement, a willingness to continue SSE-GP into the longer term, intention to apply for grant funding and a wide disparity in organisations with the number of employees working in more than one site. Barriers to implementation and recommendations for further support were included in that report and extended where appropriate in this report.

Peak Bodies' Role in SSE-GP

The peak bodies and sector stakeholders co-created a mentorship model to assist providers maintain their residents and employees' safety. Support using partners' capability included:

- Direct communication channels to providers to circulate information, policy, resources and toolkits;
- Deep sector touch points to understand members' challenges, advocate for change and for more effective solutions and escalate providers to the support network;
- Expert, sector-specific resources to support implementation of the guidelines; and
- A channel for feedback and data collection to evaluate impact and opportunities for continuous improvement.

Timeline of Victorian RAC COVID-19 "second wave"

The following timeline summarises the Victorian COVID-19 second wave context and highlights SSE-GP actions taken by the Australian and Victorian Governments.

***March 2020*:** The first COVID-19 wave in Sydney included infections at RACFs BaptistCare's Dorothy Henderson Lodge in Macquarie Park (March 2020), Opal Care Bankstown and Quakers Hill (March 2020) and Newmarch House in Kingswood (April 2020). These outbreaks demonstrated the devastating impact of RACF infections.

***Late May 2020*:** Australia's second wave of COVID-19 infections in Victoria in late May 2020, were linked to family outbreaks caused by community transmission as a security guard in a Melbourne quarantine hotel became infected.

***June 2020*:** The Commonwealth and Victorian Governments attempted various community infection control strategies in Victoria, however COVID-19 infections continued to increase.

***July 2020*:** In early July the Victorian Government confirmed a new COVID-19 case of a RAC worker, and within 24 hours another five cases were linked to RAC services in both metropolitan Melbourne and the Mitchell Shire. One week later this increased to 40 new cases and by the end of July there were 769 reported active cases across 60 RACFs.

Through July it was observed that some RAC outbreaks were associated with staff working in multiple RACFs. Resident and staff infections were increasing rapidly. Measures were considered to limit workers to working at only one site as a further means of infection control and protecting elderly and vulnerable residents. The Victorian Aged Care Response Centre (VACRC), representing both Australian and Victorian government agencies, was established to mitigate further COVID-19 spread in RACFs.

On 15 July the sector-led voluntary SSE-GPs were ***introduced to the pandemic hotspots of metropolitan Melbourne and Mitchell Shire*** to help reduce COVID-19 transmission in RACFs during the high-risk pandemic period. The guiding principles also applied to public sector RACFs operated by the Victorian Government in the hotspot areas of metropolitan Melbourne and Mitchell. The Support Hub was established at this time.

The transition period was two weeks with the goal of 27 July for new rosters to be implemented. The initial finish date was 25 September 2020. The SSE-GP were then amended on 7 September 2020 to finish on 26 October 2020. On 14 October 2020 a second extension was announced with an end date of 30 November 2020.

On 8 July 2020 the Victorian Government introduced stay at home or lockdown restrictions for metropolitan Melbourne and Mitchell Shire, for up to six weeks. Lockdowns were later tightened and extended to further reduce COVID-19 community spread.

***August 2020*:** SSE-GPs were bedded down in early August 2020. Employees were rapidly screened and surveyed to determine those with secondary RAC employment. Providers liaised with workers and each other to determine transition arrangements. Providers, peak bodies and unions worked out SSE-GP implementation issues such as the workplace health and safety hazard of employees who had been working excessive hours with two or more employers, funding entitlements for casual employees and employees who may not have disclosed a secondary employer.

A triage system was introduced to the Support Hub to ensure support requests were prioritised and addressed.

The Victorian Department of Health and Human Services (DHHS) announced further funding so that irrespective of location, SSE-GP practices would apply to all public sector RACFs in Victoria. DHHS later announced funding for out-of-pocket expenses would continue until end of February 2021.

***September 2020*:** At the end of September there were 645 Australian RAC deaths, 63 Victorian RACFs with 139 resident and 66 staff COVID-19 cases active. The outbreak was starting to show signs of slowing with 205 RACFs out of 216 with resolved outbreaks. The last new RAC active COVID-19 case was identified on 26 September 2020.

October 2020: By 30 October 2020 there were 678 Australian RAC deaths, no active resident cases and two active staff cases.

By 27 October 2020 some restrictions in the metropolitan Melbourne and Mitchell Shire lockdown areas were starting to relax.

November 2020: The SSE-GPs for Australian Government funded providers ceased on 30 November, in line with the Australian Health Protection Principal Committee conditions for de-escalation. Total Australian RAC deaths was unchanged at 678, there were no active resident cases and four active staff cases. There were 11 RACFs under enhanced surveillance following an outbreak, and 216 out of 217 RACFs had resolved outbreaks.

***December 2020*:** At 4 December there were no new RAC deaths and all 217 RACF outbreaks were resolved. Early in the outbreak there were a high number of resident deaths in a small number of RACFs, while later in October and November the 33 deaths were spread among a larger number of facilities. There had been 2,236 RAC staff COVID-19 cases. The large number of unwell and quarantining staff had a significant impact on staff availability during the second wave and the requirement for an interstate surge workforce.

International Scan

We conducted a scan of HR practices in RACFs internationally in October 2020. Using the Cranet (www.cranet.org) network of HR scholars, we invited the representative scholar to tell us about any innovative HR practices they heard had been used in RACFs in their countries in response to COVID-19. We received responses from 21 countries. This is an anecdotal review of practices, many of which will have changed as the number of COVID-19 cases increases and countries experience their second or third wave.

Results summary. The scan demonstrated a variety of HR responses to reducing COVID-19 community transmission in RACFs around the world. Example practices include either voluntary or compulsory SSE-GP (e.g., Canada, England, Greece, Ireland, Lithuania, Turkey), cohorting teams two weeks on, two weeks off (Croatia), transporting staff to and from work (Croatia), daily staff testing (Greece), staff sleeping at RACFs (Hungary), reserve corps (Iceland), compressed working month (Lithuania), increased wages (Lithuania, Poland), medical error forgiveness (Poland), zoned workplace (Slovenia) and increased training (Slovenia).

Belgium	Focus of relatively new government appears to be on hospitals and PPE; no new RAC practices noted.
Brazil	Aged care generally informal rather than formal, normally in homes rather than institutions.
Canada	Regulations and programs vary by province. Single site orders implemented in some areas.
Croatia	Employees work in just one facility in A or B team, each team working two weeks on and two weeks off. In April 2020, isolation with separate accommodation was recommended for 7 or 14-day shift employees, with daily testing and transport organised to and from work.
England	Given evidence of asymptomatic transmission, it was initially strongly recommended for RACFs to restrict staff movement, including ensuring staff work in only one RACF wherever possible. In late October, legislation was due to ban carers from working in more than one home with employees signing an “exclusive contract”. This sparked concerns that some providers would struggle to sufficiently care for their residents, and others may need to close entirely due to staff shortages.
Germany	The government and Robert-Koch-Institute (RKI) make recommendations about how to handle COVID-19. Typically for German federalism, each German state is responsible for whether and how they implement those recommendations.
Greece	Greek employees were advised to keep employment only at one facility, but this was not obligatory. Each employee cares for specific residents and meals are provided in residents’ rooms. In case of a COVID-19 incident, all staff are tested every day for two weeks. Staff complete a daily survey, like a diary, of their social interactions.
Hong Kong	Learned from SARS in 2003 that elders in group homes were five times more likely to be infected than the general public, so instituted rapid COVID-19 response.
Hungary	Stopped all temporary or contract workers, normally an important workforce. Some nurses in smaller RACFs in the first wave slept at facilities rather than going home after their shifts.
Iceland	Not common in Iceland to work in more than one location. As some facilities, especially in regional areas, had problems with staffing, authorities established what could be called reserve corps where experienced employees would be called in to take (paid) shifts.
Indonesia	Although there are aged care centres in large cities, mostly in small towns the elderly are cared for by their families. Some towns may have Christian or church related missions. There is a growing need for long term care.

Ireland	Public nursing staff could voluntarily redeploy to a nursing home in pairs as a last resort providing their reporting lines to their existing manager continued. Media links on the impact of COVID 19 in nursing homes in Ireland demonstrate some zoning to limit movement around the centres, staff shortages due to "cocooning" staff, and consideration for separate accommodation for some staff. Screening and reporting processes ensured symptomatic staff did not come on duty, nor if staff were living with others in another healthcare setting that was affected by COVID-19. Low staff numbers made this risky, some were unable to zone with a single nurse in contact with all residents especially for medications administration. There were also issues around timing of Garda (children & vulnerable care) vetting and agency staff availability. Initial proposals tabled would have seen section 39 employees who work for government-funded bodies but not recognised as state employees moved from their standard work sites into nursing homes. The proposals never appeared to materialise maybe because the pandemic had not reached the height where such action was required, or as a result of trade union pressure.
Italy	In Italy there are around two million caregivers, about 850,000 on a regular contract, the others in the informal economy. Two settings: Small/medium facilities where carers are directly employed on a single site with full-time engagement, or facilities owned by large private companies where care is often provided by specialized long term care service companies. In this case carers work in more than one facility. At 9 Nov 2020, there were no national schemes for caregivers, who have been excluded from restricted or banned activities. A Prime Ministerial decree divided the country into three macro areas with different levels of restrictions, with caregivers allowed everywhere, including "red" areas.
Lithuania	During the spring lockdown the Ministry of Health recommended a key voluntary measure for medical staff with more than one job to only work at one place at a time. With resistance from health care providers this measure was amended to a compressed working month model (working more hours per day to compress four weeks work into three) to try to minimise movement between facilities. There were a few instances where a higher hourly rate was offered to attract carers into roles that were otherwise filled by infected staff.
Nepal	No innovative HR practices known to address aged care issues during COVID-19.
Philippines	Nursing homes are new for Filipino families. No reports on COVID-19 conditions.
Poland	Medical personnel are excused from nondeliberate medical mistakes and not obligated, but are paid 200% additional wage for working only in one place (i.e., COVID-19 hospital).
Slovenia	RACF employees have fixed or indefinite-term employment relationships, and it is not customary to have other jobs on the side. At first they worked in several departments in one facility. The government required facilities to have three spaces – white zone (healthy residents with no COVID-19), grey zone (residents waiting for test results) and red zones (residents with COVID-19), which many facilities could not provide. Ministry of Health organised professional staff training for RACFs without enough knowledge and experience.
Spain	Most professions dealing with elder care contracts are full-time, there are few cases of part-time contracts. No special measures like Australia's SSE-GP are known.
Sweden	In several regions with union support, Sweden aims to provide full-time elder care work. As most staff work for a big public employer, or bigger private actors which are tax-financed, many move from one site to another to get a full-time contract. With COVID-19, mobility of healthcare employees (teams visiting patients and older people) has been a strategy.
Turkey	Turkey has single site employment for aged care facilities.

Conclusion. There are three key messages from this review. First, although SSE-GP has been used in many other countries, it is not the only HR response, as some countries have implemented stricter practices to deal with their COVID-19 outbreaks. Second, further lessons are likely to emerge from a future comprehensive review of international practices that may also consider clinical conditions. Third, HR practices implemented in the pandemic have not been static, rather they are likely to have evolved to deal with changing circumstances such as local infection rates, health care systems, labour markets, and political and economic conditions.

Literature review

Beyond the Royal Commission into Aged Care Quality and Safety, due to report in February 2021, the Australian aged care workforce has been heavily reviewed through seminal reports such as:

- Future of Australia's aged care sector workforce, Senate Community Affairs References Committee, 2017
- 2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, Department of Health, Mavromaras, Knight, Isherwood, Crettenden, Flavel, Karmel, Moskos, Smith, Walton & Wei, 2017
- A Matter of Care, Australia's Aged Care Workforce Strategy, Aged Care Strategy Taskforce, 2018, Professor John Pollaers OAM
- Advisory report on Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018, House of Representatives Standing Committee on Health, Aged Care and Sport, 2018.

The Royal Commission into Aged Care Quality and Safety Background Paper 8 concludes that governments have not been able to resolve the underlying problems articulated in the reviews and inquiries that make remarkably similar recommendations.

This broad-reaching rapid review of the scholarly literature examines single site employment guiding principles (SSE-GP) practices in aged care and some of the staffing and HR issues that emerged in the SSE-GP study. Each of these topics appeared to have at least some impact on SSE-GP implementation in the early interviews and so warranted scholarly investigation. The review aimed to surface evidence on employment conditions in Australian and international RACFs to inform discussion and stimulate engagement and future policy formulation. The review starts by examining the limited recent research on SSE-GP and then moves to the literature on multiple jobholding, migrant employees, consistent assignment, staffing, employment relations, salary sacrificing, rostering and patching, and agency use.

Inclusion/exclusion criteria. Searches were conducted in October 2020 and restricted to academic peer-reviewed papers published in English between January 1950 and October 2020. Papers were included if they concerned employment conditions in residential aged care. While aged care bears similarities to hospital and disability environments, we excluded most studies exclusively concerned with those environments.

Searching relevant literature. We searched for conceptual and empirical papers in the following databases: APAIS, PubMed, Scopus, Wiley, Web of Science, ScienceDirect, JSTOR, Taylor & Francis, Sage, Springer, Informit, HeinOnline, Emerald Management, Emerald Insight Health and Social Care, and EBSCOHost. We searched the Australasian Journal on Ageing, Australian Health Review and The Gerontologist. Where possible, searches were restricted to business, economy, health, humanities, management, psychology and social sciences.

Searches used initially broad search terms of “aged care” OR “nursing home” OR “long term care”; AND “employment” OR “staff” in the full text of articles. Further terms were identified and adopted during the literature search (e.g., “consistent assignment”, “staffing”, “secondary employment”, “moonlighting”, “multiple job holding,” “non-compete”, “underemployment”, “human resources”, “absenteeism”, and “industrial relations”). We reviewed reference lists from papers identified as key to the topics of interest and papers that cited those key papers.

Selecting relevant literature. Two researchers independently reviewed the resulting abstracts to identify the most relevant papers, which were then retrieved for closer review. Due to space restrictions, only the most relevant results are included here.

Single site employment in pandemic

At November 2020, four studies highlight the importance of SSE-GP for staff in RACFs. The first two studies present data from the USA and the UK supporting the use of SSE-GP while the next two studies present advice on managing when SSE-GP is not possible and which facilities may be more likely to benefit from SSE-GP.

A USA Centre for Disease Control and Prevention report (Chen, Chevalier, & Long, 2020) identified that staff working in multiple nursing homes were likely to be a source of COVID-19 spread to other facilities. Geolocation data from 50 million smartphones showed that 5.1% of facility visitors of at least one hour also visited another facility during the 11-week study, even after COVID-19 visitor restrictions were imposed. They estimated facilities share people movement connections with an average of seven other facilities. Multivariate regressions comparing demographically, and geographically similar nursing homes suggest 49% of COVID-19 cases in USA RACF residents are attributable to staff movement between facilities.

In a study of six London facilities, a three-fold higher risk of COVID-19 infection was found among staff working across different facilities than those working in the same facility (Ladhani et al., 2020). As local infection clusters were found between staff only, including those staff with minimal resident contact, the authors advised that staff should be encouraged and incentivised to work in single facilities with limited movement across multiple facilities. Further, infection control should be extended for all contacts, including those between staff, whilst on facility premises (Ladhani et al., 2020).

Out of Harvard Medical School, Yurkofsky and Ouslander (2020) offer practical advice addressing the tensions between workforce shortages, desire for flexibility, and infection control. The authors note “clusters of infections have been blind to the quality of the nursing home; even the best-prepared, highest-quality, and most well-resourced facilities have had tragic clusters of infections with high mortality rates” (Yurkofsky & Ouslander, 2020). They recommend those who work in multiple facilities should be repeatedly tested and limit work to a single facility per day where possible, otherwise they should change clothes and wash their hands and face between shifts (Yurkofsky & Ouslander, 2020).

The Canadian aged care sector had been challenged by staff shortages before the pandemic, so their SSE-GP order posed additional challenges to staff assignment at both facility and provincial or regional health care system level, risking an abrupt decrease in staffing. Public non-profit and private for-profit homes had significantly higher proportions of care aides working at multiple facilities compared with voluntary non-profit (e.g., faith based) homes (31%, 27% vs 18.8%) (Duan et al., 2020).

Further studies have examined cohorts of residents and staff in Ireland (Health Information and Quality Authority, 2020) and patient recovery and rehabilitation issues in Australia and New Zealand (Faux, Eagar, Cameron, & Poulos, 2020). A French study found the practice of voluntary staff self-confinement with residents may help protect nursing home residents from mortality related to COVID-19 and residents and staff from COVID-19 infection (Belmin et al., 2020). Finally, a report into COVID-19 infections among healthcare workers at the Royal Melbourne Hospital in July-August 2020, the largest institutional outbreak in Australia at September 2020, describes a multimodal containment approach including the use of dedicated 'COVID-19 teams' to minimise staff moving between wards (Buising et al., 2020).

Multiple jobholding

As SSE-GP is likely to reduce COVID cross-infection where staff work in more than one job, we now turn to literature regarding secondary employment. Holding a second or third job, called multiple jobholding (MJH) in the scholarly literature, is strongly linked to underemployment in the Australian labour market. Around 11% of underemployed, 9% of part-time and 7% of full-time workers hold multiple jobs (Wilkins & Lass, 2018), with estimates of non-English speaking background migrant health and personal care assistants' MJH substantially higher at 21% (Charlesworth & Isherwood, 2020).

Many aged care staff hold a second job, which is often also in aged care. Canada recently reported 24% of care aides work at more than one facility (Duan et al., 2020), while just 9% of Australian RAC staff (where survey respondents were selected by managers) hold a second job, most of which are also in aged care (Mavromaras et al., 2016).

An integrative systematic review (Campion, Caza, & Moss, 2020) is timely in synthesising the latest thinking on the complex MJH phenomenon. MJH is characterised as a critical management inconsistency as it is seen as either *depleting* via push-based motivation (e.g., financial need) or *enriching* via a pull-based motivation (e.g., psychological fulfilment). Of the three categories of motivation for MJH, financial motivation was most reported over career development and psychological fulfilment, a finding supported in an aged care setting (Dill, Morgan, & Marshall, 2013).

In contrast to research on financial and career outcomes which have some positive impacts for workers, how MJH affects performance remains contentious (Campion et al., 2020) as no differences have been found between multiple and single job holders on objective performance-related measures, failing to fully support the depletion perspective (Arcuri, Gunn, & Lester, 1987; Bell & Roach, 1990; Bennett, Carson, Carson, & Blum, 1994; Jamal, Baba, & Riviére, 1998). It is unclear whether this finding extends to all types of work, particularly the physically and emotionally taxing direct care work in aged care.

Jobs with more surface acting (e.g., service work) negatively affect workers, compounding over multiple jobs (Walsh et al., 2016). Whether MJH is personally depleting or enriching results in mixed findings regarding work-life conflict, psychological wellbeing, and attitudes to work, but there is stronger evidence of depletion of physical wellbeing (reduced sleep, increased work-life conflict leading to headaches, fatigue, insomnia, less frequent exercise) from MJH (Campion et al., 2020), who conclude:

> *It is reasonable for managers to be concerned about whether a MJH employee will perform worse, but HR policies restricting this practice will likely not prevent these potential repercussions. It is important for researchers to take a deeper look at the relationship between HR MJH policies and outcomes for both parties. (Campion et al., 2020, p. 167)*

Despite sizable but varying estimates of MJH and research across disciplines (e.g., management, economics, sociology, health and medicine), our understanding of MJH remains limited (Campion et al., 2020). Research is needed on the boundary conditions, experiences, and outcomes of MJH, particularly the individual (e.g., gender, race, social class), the job type, the MJH socioeconomic context, sustainability, successful MJH self-management, organisational-level concerns such as human resource policies, manager awareness of MJH, and advantages and disadvantages of having an MJH workforce.

The above MJH studies refer only to paid second jobs, and do not consider the unpaid informal, double or triple duty caregiver roles of dependent children or older adults that should also be considered in infection control investigations (Van Houtven, DePasquale, & Coe, 2020).

Migrant workers

Migrants make up a significant proportion of the Australian aged care workforce (Charlesworth & Isherwood, 2020), with a growing trend between 2006 and 2011 towards foreign-born workers in the sector (Negin, Coffman, Connell, & Short, 2016). With respect to motivation for MJH, migrant care workers from non-English speaking (NESB) countries are most likely to be employed on a casual basis, underemployed, and seeking more work hours, with around 50% of NESB personal care assistants (PCWs) wanting more hours compared with 34% of Australian born peers and 28% of English-speaking background PCWs (Charlesworth & Isherwood, 2020).

Migrant aged care workers in Australia are overwhelmingly permanent residents, rather than temporary migrants compared to many European studies (e.g., Hussein & Manthorpe, 2014; Jönson & Giertz, 2013). Temporary visas are more likely to be associated with casual employment and underemployment for NESB aged care workers (Charlesworth & Isherwood, 2020). There is a relatively low level of government employment for NESB PCWs, who are also less likely to work for small or medium-sized employers (Charlesworth & Isherwood, 2020).

Both Australian and New Zealand migration pathways present regulatory challenges in worker protection and citizenship claims (Howe, Charlesworth, & Brennan, 2019). Research from New Zealand clusters RAC migrant worker issues around the three themes of communication and language barriers, racism by residents, families and managers, and underemployment of tertiary qualified migrant care workers (Ngocha-Chaderopa & Boon, 2016). A recent systematic review (Chen, Xiao, Han, Meyer, & Muller, 2020) collated the challenges and opportunities presented by a multicultural aged care workforce, finding workers' awareness of cultural diversity varies and knowledge of each other's cultural background is limited despite links between cultural skills, teamwork and team cohesion. Teamwork was found to be linked to enhanced care outcomes for residents, but as fostering teamwork is challenging, there are opportunities for better cross-cultural leadership and management (Chen et al., 2020).

Consistent assignment

Stable staffing has been long recognised as important to consumer or person-centred care. The aged care literature refers to continuity of care, or resident-staff stability as consistent assignment. Rather than the traditional practice of rotating care assignments, consistent assignment involves care staff working with the same residents almost every shift they are on duty (Caspar, Brassolotto, & Cooke, 2020; Castle, 2013). Consistent assignment of nursing staff to residents is a key practice in transforming traditional institutional culture to a home like culture, where residents receive person-centred care according to their individual preferences and routines (Roberts, Nolet, & Bowers, 2015).

Consistent assignment has been promoted extensively in the US (Brennan, Lemke, Schutte, & SooHoo, 2017) with some states including consistent assignment among facilities' target goals in pay for performance programs (Roberts et al., 2015). In home care, consistent assignment has been linked to reduced hospital re-admissions (David & Kim, 2018). Rahman et al. (2009) found the gerontology literature widely endorses consistent assignment for residents and staff.

Facilities with consistent assignment tend to have significantly fewer deficiency citations or compliance breaches (Castle, 2011). Some residents report feeling 'known', which increases comfort, trust, and ease in the care work relationship (Caspar et al., 2020). Consistent assignment advocates emphasise human dignity, arguing that intimate care should be provided by a small group of staff with whom the resident has a long-term relationship, "rather than a rotating cast of strangers" (Slaugh & Scheller-Wolf, 2020, p. 2). Relationship quality is crucial to care work as staff consistent assignment is said to strengthen staff-resident and staff-family member relationships (Caspar et al., 2020). High consistent assignment rates are associated with stable care team membership, staff input for case assignments, better unit functioning with lower absenteeism and fewer complaints about workload fairness (Lemke, Brennan, SooHoo, & Schutte, 2017). Facilities with consistent assignment have significantly lower rates of turnover (Castle, 2013).

Despite favourable reports about the benefits of consistent assignment and its promotion as a cornerstone of the person-centred care model, research reports are mixed with sometimes contradictory findings (Rahman et al., 2009). There is some concern that consistent assignment studies are small and not methodologically rigorous, disputing strong links between consistent assignment and quality (Roberts et al., 2015). Further, there appears to be a research gap in linking the consistent assignment practice definitively with quality outcomes for both residents and staff (Rahman et al., 2009; Roberts, Nolet, & Bowers, 2019). It was found that “contrary to conventional wisdom, more stability in staff–resident assignment was related to worse staff ratings of residents’ quality of life’” (Zimmerman et al., 2005, p. 144), and consistent assignment had no effect on how the research observers rated residents’ quality of life or residents’ own quality of life rating.

Care workers’ experiences of staff assignment practices are diverse. The key benefit of consistent assignment has been in being able to get to know each other well and form meaningful relationships (Caspar et al., 2020). Despite these benefits, small studies have indicated care aides gradually becoming overwhelmed by the work, feeling confined by consistent assignments, burnout and isolated from colleagues and other residents (Andersen & Spiers, 2015). Unintended consequences of consistent assignment include decreasing staff experience of supportive teamwork, reducing the exchange of individualised resident care information and negatively impacting staff ability and desire to care for each other as well as the residents (Caspar et al., 2020). The same study identified staff experiences of closeness with residents served to heighten their grief when the resident died. In that study, staff felt unacknowledged and unsupported in handling their grief, leading to staff expressing a need to protect themselves from grief by reverting to rotating assignment. Suggestions for managing these unintended consequences include considering organisational systems which reduce staff isolation and support teamwork, staff involvement, grief support and increased staff peer communication (Caspar et al., 2020). Further, increased interprofessional collaboration in implementing consistent assignment to increase staff perceptions of empowerment, given empowerment has been found to be significantly associated with care workers’ ability to provide person-centred care, is recommended (Caspar & O'Rourke, 2008).

Consistent assignment has been inconsistently conceptualised and operationalised (Roberts et al., 2015). Studies are said to have methodological limitations (e.g., a lack of control and statistical analyses of group differences in experimental-level studies, small sample sizes, lack of attention to confounds in multicomponent interventions, and outcomes that were not theoretically linked). Although consistent assignment of service delivery is logical, the supporting evidence is not yet convincing: we do not yet know “how, when, why, where, and for whom consistent assignment is effective” (Roberts et al., 2015, p. 445). Further research on implementing consistent assignment is needed.

No consistent assignment research appears to have been conducted in Australia.

Staffing

Australians are remaining in their own homes for longer, with residential aged care less a lifestyle choice than a necessary choice when living at home is no longer viable. On admission, residents tend to be highly fragile with complex care needs (Eagar, Westera, & Kobel, 2020). Funding and staffing have not kept up with increasingly complex needs.

Quality in aged care is a difficult concept to capture directly, and measures tend to focus on residents' clinical outcomes (Spilsbury, Hewitt, Stirk, & Bowman, 2011). Organisational factors such as ratio of registered nurses to total staffing levels, the use of agency staff, staff turnover rates, and consistency in staffing also have an impact on quality (Eagar et al., 2020; Howe, 2010), as do staff training and experience, care organisation and management (Spilsbury et al., 2011). Over 150 studies in systematic reviews confirm a "strong positive impact of nurse staffing on both care process and outcome measures" (Harrington, Schnelle, McGregor, & Simmons, 2016). RACFs are more likely to experience quality concerns when staffing falls below a certain level (Eagar et al., 2019; Eagar et al., 2020). In their submission to the Australian Royal Commission into Aged Care Quality and Safety, Eagar and colleagues applied a star rating system used in the US by the Centers for Medicare and Medicaid Services, and identified:

> *"More than half of all Australian aged care residents (57.6%) are in RACFs that have inadequate (one or two stars) staffing levels. A little over a quarter (27.0%) are in RACFs that have three stars, 14.1% of residents are in RACFs with four stars, and 1.3% are in RACFs with five stars, which we consider best practice" (Eagar et al., 2020, p. 508).*

The increase in average staffing needed to bring Australian RACFs to three stars is 37%, and 49% to five stars as proposed in the AN-ACC funding model (Eagar et al., 2019; Eagar et al., 2020; McNamee et al., 2019).

Employment relations

Residential aged care work is characterised by physically and emotionally demanding work, which is undervalued and low paid, a key barrier to a sustainable workforce (Kaine & Ravenswood, 2013). Unions and the Fair Work Ombudsman have undertaken limited enforcement activity but invisibility (also a theme in work by Daly and Armstrong (2016)) presents significant employment relations challenges (Charlesworth & Howe, 2018). Caring work pays less than other occupations after controlling for worker education, experience, occupation, and industry characteristics (England, Budig, & Folbre, 2002). Addressing the intersection of unequal pay and gendered disadvantage in RACFs is being pursued through activism and coalitions of unions, employers, industrial relations and human rights bodies (Charlesworth & Heap, 2020). It appears there may be numerous challenges to effective enforcement of employment standards for precarious or vulnerable workers in Australia where aged care is described as a gendered industry characterised by restricted government funding, low wages, non-standard employment, and low unionisation and collective representation.

Kaine (2012) argues that the traditional regulation of wages and conditions in Australia through industrial instruments such as awards and collective bargaining agreements has failed to produce adequate or sustainable outcomes, which is concerning given projected sector growth forecasts. Sector-wide funding constraints and low pay exacerbates labour supply issues. Kaine argues for integration of labour standards and outcomes into RACF accreditation standards. The role of organised labour in combating previous epidemics has been noted, when union pressure is said to have led to employers protecting workers from infection by offering free vaccination and protective equipment (Muraskin, 1995). The most common barrier to influenza outbreak management in Australian RACFs is scepticism towards staff flu vaccination (Huhtinen, Quinn, Hess, Najjar, & Gupta, 2019).

Rostering and patching

Three studies of rostering in RACFs provide substantial clues to staffing operations. First, Kossek and colleagues (2016) studied how schedulers fill holes to schedule workers in RACFs, engaging in rule-bound interpretation to avoid role expansion. Recognising the three-way relationship between resident, employee and employer interests combined with the unpredictable nature of double or triple care duties of the female-dominated direct care workforce with high turnover, work scheduling is described as an "ongoing, ever-changing and improvised organisational process" (Kossek et al., 2016, p. 234). Rather than chaos, they found improvised and organised patterns of schedule patching.

Four types of schedulers were identified based on the priority given to organisational, resident or employee needs: enforcers, patient-focused schedulers, employee-focused schedulers, and balancers. Variations in job crafting not only create meaningful work but also manage conflicting demands and to mediate among the competing labour interests of workers, clients, and employers (Kossek, Piszczek, McAlpine, Hammer, & Burke, 2016).

Second, taking this work further to investigate the period after a roster is scheduled, patching or 'plugging holes' in work schedules involves varying degrees of improvisation and formalisation. Approaches include 'share the pain', 'work life needs', or 'reverse status rotation'. Suggestions made links between improvised work-life scheduling and lower rates of pressure ulcers (Kossek, Rosokha, & Leana, 2020). Of particular interest to residential aged care facility managers is the reverse-status-rotation finding that

> *"If there is an employee callout, managers, as the highest rank, were required to come in to cover other lower-level employees' jobs, even if not under their direct supervision. Thus, a manager must become a frontline worker when needed… Although the length of on-call rotation varied across facilities (7 days a week every 5 weeks, one weekend every 8 weeks, or 1 week a month), this reverse-status-rotation was common. At all facilities, managers were expected to be readily available even off work. Facility C unit manager explained, "Once we [managers] go home, we [have] to keep the phones on . . . and be ready for any calls, in case anything is to happen."*

Third, a rostering data study from the resident perspective of "inconsistency" (number of different caregivers) found optimal assignment by prioritising part-time workers to their home units, while assigning full-time workers flexibly (Slaugh & Scheller-Wolf, 2020).

Literature review conclusion and future research

This review found there is good research on aged care SSE-GP related workforce issues. Unsurprisingly given COVID-19 is the first pandemic in a hundred years, there appears to be no literature on the results or effects of single-site employment practices in controlling infection. Those studies may exist in the medical or health literature that was not included in this review. It is possible that countries with other severe infection outbreaks such as Ebola virus disease may have used SSE-GP practices but it has not yet been documented in management literature.

There is literature across a broad range of disciplines to inform discussions on multiple jobholding. Important research relevant to the aged care sector that is missing is an understanding of the boundary effects of multiple jobholding. First, we do not know which employees, jobs or roles are likely to be impacted by multiple jobholding. We do not know whether the second job held by a PCW is a depleting or enriching activity. How might that effect change for nurses, perhaps at different career stages where an early or late career nurse may thrive in an acute setting and simply make up income in the aged care setting, or perhaps the reverse is true? Should employers be pleased or concerned to find their catering staff working in a second job?

Second, we do not know the effect of different types of multiple jobholding. Does having *any* second job impair or enhance performance? Does a second job either in or outside the sector enrich or deplete the carer? Perhaps “RAC+RAC” second jobs have a different effect on workplace performance than “RAC+non-RAC” second jobs, and that may vary by role (e.g., nurses, carers, catering). Should RAC employers encourage or discourage their catering staff to moonlight in a five-star restaurant?

Third, we do not know how many hours of multiple jobholding will impact employee performance. Employers’ workplace health and safety concerns in aged care are triggered industrially at 38 hours a week, however from an employee’s perspective there may be a higher threshold before concerns need to be raised. Understanding these levels will help employers set policies around disclosure and maintain a healthy and productive workforce and workplace.

The migrant workforce is often disadvantaged, and multiple jobholding is particularly important in this community that often seeks more working hours. A closer understanding of their needs is important. Research on the relatively low take up of Public Benevolent Institution (PBI) salary sacrificing would be useful to better understand why many in the sector do not take advantage of this financial benefit and determine if migrant workers are less able to participate in this benefit.

Consistent assignment is often acclaimed as the way forward for residential aged care, and there is good evidence from residents and families to support that model of care. Research is needed to understand the impact of consistent assignment on staff, particularly carers who must manage their emotions, and are required to manage their residents' emotions. It is important to be able to identify which staff are, or are not, able to cope with these often highly personal resident relationships. There may be thresholds at which an optimum balance could be appropriate, such as working four but not five days a week with an assigned resident cohort. There is no research on how carers in RAC settings may adapt and manage their behaviour and emotions over time.

Staffing levels in residential aged care have been well studied by specialists, and the Royal Commission into Aged Care Quality and Safety is expected to make recommendations on wages, agency staffing and other workforce issues in its final report.

Employment relations research would be strengthened by a greater understanding of union penetration and activity in the sector, given the importance of unions in advancing wage and conditions in the sector.

Finally, a better understanding of the sector's rostering principles and practices may lead to opportunities to reduce the need and prevalence of MJH and may assist in managing absenteeism. Studies using archive or historical data from past rosters or tracking future rosters perhaps under experimental conditions could inform a discussion on part or full-time employment preferences.

More broadly than the above topics directly related to SSE-GP, HR management in aged care is relatively under-researched, especially in Australia (Cooke & Bartram, 2015). Challenges vary from one facility or organisation to the next (Farr-Wharton & Shearman, 2017), so broad strategies addressing management or care issues may not be as effective as targeted local initiatives. A secondary set of references are provided for those seeking further studies on retention, turnover, burnout, culture or high-performance work teams. Readers are also referred to the seminal Australian aged care workforce reports listed at the start of this review and the reports of the Royal Commission into Aged Care Quality and Safety.

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GUIDING PRINCIPLES SUPPORT HUB

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SECTION 2

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Findings: Stakeholder perspectives

This section reports views on the impacts of implementing SSE-GP. Responses describe impacts from employees, unions, allied health, peaks and advocates.

Employee perspective

Advertisements for interview volunteers to participate in this research were placed on the Support Hub and distributed to providers and unions. Out of 30 invitations sent to employees who volunteered, just 12 participated in interviews. These results therefore provide a glimpse into understanding SSE-GP from the employee perspective.

The interviews in five non-profit and five for-profit Victorian facilities were nurses, personal care workers (PCWs), office managers, leisure assistants and team leaders. Of the three who started as PCWs, two were now studying nursing, and one completed a nursing qualification several years ago. Most interviewees, but not all, held two jobs. All but one with a second job said that prior to COVID-19 their employer was aware they worked at another RACF. They said some staff had been hesitant to disclose they had multiple jobs, for fear of losing either of their jobs or extra shifts.

Reasons interviewees gave for holding more than one job included low pay, job security and shift flexibility. Most said they would prefer to work full-time with one employer rather than work in two jobs. A few said one full-time job would not give them enough income so they would always need two or more jobs unless the hourly rate was higher.

Employees reported many positive effects of SSE-GP, including:

1. ***Infection control***: All employees agreed SSE-GP assisted in minimising infection and lowering the risk of infection in their facilities.
2. ***Guaranteed income***: It was seen as positive that the Australian Government stepped in and funded this scheme, so no workers were worse off.
3. ***Multiple jobholder awareness***: SSE-GP increased awareness around the number of staff working across multiple employers, which can now be managed from a WHS, worker fatigue and risk perspective. Employees were hopeful the increased awareness would lead to increased consideration of the benefits of full-time work.
4. ***Increased consistency of care***: SSE-GP resulted in increased consistency of care for residents. Staff were able to get to know residents better because they were spending more time with them.

There appears to have been some inconsistency in how providers approached payments under the SSE-GP guidelines, which were said to be open to interpretation especially where “excessive” hours were worked across two jobs. Employees reported several negative effects of SSE-GP, including:

1. ***Financial disadvantage***: Several employees said they were worse off financially as a result of SSE-GP practices. They said their primary employer told them additional shifts were available, but funding was not. One employee said he was worse off by around $1000 a fortnight, and another by around $200 a fortnight because they used to work additional shifts that were no longer available.
2. ***Financial disadvantage, excessive hours***: Most providers gave employees who previously worked “excessive” hours 76 hours a fortnight and did not offer or require additional hours they felt was a WHS risk. Rather, they gave them higher penalty rate shifts where feasible and topped up their pay for the unworked hours, so the employee was not financially disadvantaged. Other providers continued to roster and require staff to work above what might be acceptable additional hours, e.g., up to 14 hour shifts on a repeated basis to be able to earn their pre-SSE-GP 130 hours per fortnight.
3. All staff interviewed who reported an outcome that did not align with the principles were given information by the researchers on how to have their situation addressed.

Union perspective

The unions stated their position that employees cannot be forced to break an employment contract with one employer at the behest of another. Also that SSE-GP was not required beyond a COVID-19 infection control strategy and it would be difficult to extend SSE-GP beyond a public health disaster response, especially given low wages in the sector.

The unions’ supported the SSE-GP as the existing COVID-19 situation in Greater Melbourne and Mitchell Shire required an extreme response and agreed it was necessary to try to prevent further COVID-19 transmission for members, residents and the broader community. Some hesitation was noted around the SSE-GP seemingly assuming all workers were positive. It was noted the success of the SSE-GP were in part successful due to employee goodwill such as employees working beyond the scope of their normal job classification where they were trained and supported to do so during the crisis.

Positive feedback of SSE-GP from the Union perspective included:

1. ***Infection control***: SSE-GP resulted in identifying poor infection control practices and knowledge in the sector, reduced resident and employee infections.
2. ***Identified workforce gaps***: SSE-GP resulted in identifying the absence of a surge workforce in a pandemic, an important lesson for the Government and sector.
3. ***Context for communication***: The Guiding Principles provided context for the purpose of the SSE-GP practice, gave useful information on how to implement the practices, and was helpful to be able to communicate with workers.

4. ***Details settled***: Although rolled out at short notice, the scheme settled over time as providers, employees, unions, peaks and government learned and refined the details and complexities of the SSE-GP scheme.
5. ***Support Hub***: The Support Hub was helpful to centralise and coordinate responses to employee queries and to assist with consistent interpretation.
6. ***Funding welcomed***: The funding designed to protect workers from loss of income from their second job was welcome, especially compared with Queensland where funding was not provided and South Australia where although mandatory no funding applied because no outbreak was evident.
7. ***Certainty in work conditions***: Under SSE-GP conditions, more routine work was available for employees, which gave many workers increased certainty in their working conditions.
8. ***Continuity of care***: Unions said many employees reported they were pleased to be able to get to know their residents better by working in just one facility.

Opportunities for improvement reported by the unions included:

1. ***Infection control***: Unions said SSE-GP should be used as a last line of defence. Other infection control should be in place before staff are restricted. SSE-GP assumes that employees are infected and may not act responsibly. Further, although SSE-GP helped control infection across sites, it was not a feature of infection control within sites. Many RACF staff were infected with COVID-19 from contact with a resident or worker from within their facility.
2. ***Limited funding***: The SSE-GP funding was limited and did not include those working in second jobs outside RAC who may have continued working in the community. SSE-GP was available only in declared hotspots so for people on the border there was no entitlement which created difficulty.
3. ***Timing to commence and conclude:*** Unions noted time issues at the start and the end of the SSE-GP period. At the start, there was insufficient time for planning between creating and implementing SSE-GP. The short extension notice beyond the original end date put pressure on providers and created confusion for employees. It would have been preferred for the end date to be aligned with the Victorian PSRAC state government system.
4. ***Coercion:*** Prior to SSE-GP, some providers had urged employees to work at a single provider, rather than a single site. Some employees were asked for signed statutory declarations regarding their second jobs, some were asked to work non-regular hours or shifts that impacted on family commitments, some were told they would be on a different roster when they returned, some were told they needed to take leave or resign. The unions said some employees were stood down if they admitted to a second job.
5. ***Loss of wages****:* Unions noted they had been contacted by workers to assist in instances where they were experiencing loss of hours and pay as their pre COVID-19 evening and other penalty shifts were not always available and they were unable to accept alternate shifts offered because of personal or family reasons.

6. ***Delayed worker payments***: Unions reported that administering and applying for the grants appeared to be not simple or straightforward, rather that it appeared to be complex. Some employer payments were given in a lump sum, such as six weeks, however workers' bills continued on a regular weekly or fortnightly schedule, so some workers experienced extreme financial stress on those occasions.
7. ***Inconsistent interstate conditions***: SSE-GP was implemented differently: in Queensland SSE was recommended, with no funding provided and in South Australia SSE was mandated but limited to carers only with no funding attached for a set time period, causing confusion, loss of income and financial stress.
8. ***Classification flexibility***: Unions reported some workers were asked to work outside their usual classification and were not happy about this change in conditions. Some union representatives reported they adopted a more flexible approach and attitude than they may have in non-pandemic circumstances, such as when they supported a worker to be flexible to work outside their classification (PCW, cleaning, kitchen hand, other) in COVID-19 conditions, providing they were trained, and it was safe to do so.
9. ***Workload***: Unions reported that some workers said their facilities had low staffing levels and the workers did not want to work there as their primary job.
10. ***Facility managers***: Unions said there was frustration when some facility managers who did not understand fully how SSE-GP worked, and this was further complicated by reports of communication breakdowns between some human resources departments and facility managers.
11. ***Centrelink*** could have provided more support to workers.
12. ***Computing access***: Unions reported a general expectation that workers could check websites for information or access forms to be completed, however most RAC workers do not have easy and full access to a computer, and many are unable to use their mobile phones during their work shifts. Rather, having access to information at the workplace or by text would have been useful supplements to websites.

Further union comments not specifically related to SSE-GP included:

- Well paid and secure work with good conditions are required. The low pay rates, especially compared with public sector, need reviewing. Flexible part time employment is similar to, but not quite casual, as hours are often tenuous and subject to change.
- The high level of multiple jobholding reflects the mix of insecure work and low wages.
- More transparency is needed in aged care regarding publishing staffing issues such as number of care minutes, staff-resident ratios and how government funding is spent.
- Four-to-six-week roster notifications would better allow workers to plan their lives.
- The unions noted that staff may need some retraining in the recovery phase as policy and practices may have changed at their second job while they were at their primary SSE-GP job. They cautioned providers to consult on any roster changes as they were already hearing stories of workers having changed rosters on return, despite a commitment that no one was to be worse off.

Allied health perspective

Allied health professionals (AHPs) in this context refers to physiotherapists, occupational therapists and speech therapists.

Most AHPs work through a contract or agency model for multiple providers across different facilities or multiple sites for one provider on a regular basis. During the SSE-GP some providers either temporarily ceased or significantly reduced delivery of AHP services to help minimise traffic at facilities and thereby further reduce transmission risks. AHP RAC agency work reportedly was indirectly impacted by SSE-GP by some providers' decision to reduce traffic at their facilities. AHPs were redirected to other tasks such as updating policies and procedures so employment contracts could be maintained, and allied health services could recommence immediately once the outbreak was managed. They reported wanting to retain their talent and avoid full recruitment induction after the outbreak passed and wished to be able to quickly honour their original client contracts. They reported they were not eligible to claim funding for this period despite having incurred significant out of pocket expenses for wages as an indirect and unexpected possible consequence of the SSE-GP.

Positives reported by AHPs included:

- ***Telehealth benefits in regional areas*:** While in-person services may have reduced in metropolitan Melbourne, AHP use in regional areas may have increased through telehealth.

Opportunities for improvement reported by AHPs included:

- ***Essential services not delivered*:** AHPs were regarded as essential services for resident care, yet some providers temporarily paused this service to minimise COVID-19 transmission risk, rather than a direct result of SSE-GP.
- ***Reduced treatments may increase fragility*:** There is a risk that reduced physiotherapy services may lead to increased fragility in some residents.
- ***Future clinical outcomes*:** AHPs were concerned about potential impacts on future clinical outcomes. They expressed concern that data may indicate an increase in trips, slips and falls from when therapy was reduced and mobility was restricted (e.g., eating in own room, not dining rooms, and absence of day trips).

Peaks and advocates' perspectives

Workplace health and safety: Peak bodies said SSE-GP highlighted the broader issues around worker fatigue that now need to be addressed and managed to ensure workers are fit for work, and that both workers and residents are safe. The peaks recognised their role in supporting the sector with tools to assess risk more broadly in their workplaces.

Communication: SSE-GP highlighted to peaks that they could improve their communication with the sector. Although they received favourable feedback on their webinars, there had been much confusion around applying SSE-GP and how to apply for grants in the first few weeks. They said providers sometimes received conflicting information and messages did not always get through.

Throughout the pandemic there has been opportunities to advocate with one voice, rather than the many channels and voices of the sector. Adding to communication challenges were often conflicting information and direction on related matters from multiple government departments e.g., Defence Force, Health Department, Aged Care Quality and Safety Commission and the Victorian Department of Health and Human Services.

Collaboration: The Support Hub Advisory Committee provided a quick and early opportunity for peaks, unions and government to work collaboratively.

Coverage: Further consideration to SSE-GP depth and breadth might be useful. For example, multiple job holding impacts on roles outside RAC such as in the disability sector, home care, hotel quarantine, abattoirs and public hospitals. RAC employees with shared living arrangements may mean one RAC worker with two or more RAC jobs may live with another RAC worker with two RAC jobs, posing transmission risks for the sector.

Timing*:* Some peaks noted a stronger voice was required to ensure implementation and extension timing that were more mindful of operational restraints given legalities of pay periods and posting of rosters. Although the award provides minimum terms for these, there is wide variation in providers' enterprise agreements that need to be honoured.

Single employer SSE-GP: Consideration should be given to single employer rather than single site practices as many providers wish to share their own staff between their own quality-consistent facilities in a pandemic.

Funding: Peaks were supportive of SSE-GP in COVID-19 hotspots, provided it was funded and providers and workers would not be out of pocket. The allocation of funding by the Department of Health was regarded as positive for the sector. Longer term, SSE- GP was not regarded as financially viable but there may be aspects of SSE-GP to keep or further develop. For example, peaks may facilitate processes to assist providers to determine the feasibility of converting part time employees with second jobs into full-time employment, if both employers and employees see that as a better way of working.

Voluntary or mandatory: Peaks said it does not make sense to mandate SSE-GP when labour supply is low, and is not likely to be fully implementable. It could be useful to later review the differences in SSE-GP outcomes and impact in Victoria and South Australia.

Training: Peaks said they work to support their providers to find best ways to communicate with staff. This is multi-dimensional as it needs to cover how to build trust, what channels staff prefer, and content such as cultural and linguistic diversity (CALD), financial literacy and building rapport with residents. Peaks said all carers would benefit from dementia training to help identify impacts on those residents' judgement and behaviour. Peaks said dementia support capability training is essential in a pandemic as residents tend to be more alarmed and may demonstrate more unusual behaviours due to changed routines and less visits. More practical and standardised infection control training is a priority.

Provider perspectives

We interviewed 35 providers in Victoria and around Australia, some having had COVID-19 outbreaks but most preparing for a potential outbreak. Most interviewees had extensive (20+ years) experience in the sector. Interviewees were mostly Chief Executive Officers, facility managers, or in human resources roles. This section gives their views by topic.

Providers commented on the following areas that worked well:

1. ***Multiple jobholder awareness:*** Providers were often surprised to see how many staff had second jobs, and how many hours they worked in that second job. Although concerned about hours worked in a second job and whether staff had disclosed their secondary employment in the past, they were pleased their PCWs were able to maintain their income without needing to work excessive hours, so their quality of life improved. One provider noted they would prefer staff work more hours just for them but recognised this may be challenging.
2. ***Fatigue risk awareness:*** Providers often said they were relieved to now know how many workers were working over 76 hours a fortnight. Those workers were being questioned and if determined to be unsafe, the worker was not to attend additional shifts and would not be worse off financially.
3. ***Improved staff relationships and communication:*** SSE-GP seemed to lead to a more collegial workforce in many facilities and staff communication appeared to improve because with SSE-GP there were fewer staff to communicate with. There was high agreement by providers that SSE-GP was good for relationships. Staff were able to get to know each other better and provide support during uncertain times, which they said built stronger working relationships and teamwork. SSE-GP was said to have a positive effect on staff wellbeing.
4. ***Staff recognition:*** SSE-GP was said to be beneficial to residents as staff were rostered to the same residents more often and care was therefore more consistent, with staff getting to know families better. Staff received more appreciation and recognition from families than prior to the pandemic, with one provider reporting six to eight compliments per month compared with one per month in the past.
5. ***Quality control:*** Providers said with SSE-GP they had more control over standards and procedures, communications and training, which they thought was positive for infection control. One provider noted SSE-GP helped them avoid several near misses with staff who had previously been working for another provider where there were subsequent Covid-19 outbreaks.
6. ***Reduced sick leave:*** One provider said they saw reduced sick leave during SSE-GP.

***Mixed views on infection control*:** While there was strong agreement SSE-GP had favourably contributed to controlling infection, some providers said that impact was minimal. Some said infection control came best from cohorting staff and residents, daily temperature screening and declarations, infection control training and contact tracing. Providers were mindful that resident clinical care continued to be the priority and was separate from infection control. Some providers said it was too early to tell, current evidence was anecdotal and more robust data collection and analysis may be useful.

Providers commented on the following areas that did not work so well:

7. ***SSE-GP scope***

- ***SSE-GP funding not broad, deep, or sharp enough:*** Providers said SSE-GP funding was welcome and they could not have implemented SSE-GP without the funding. However, the funding only went part way in supporting control of full community transmission of COVID-19. They said SSE-GP applied to RACF workers but not agency, allied health or medical officers. They said SSE-GP applied only to second jobs at other RACFs, not other high-risk second jobs or sectors such as community, disability and health services, security or abattoirs and medical officers. Providers said SSE-GP did not apply to workers whose partners or other household members were engaged in high-risk employment. Some providers said funding these gaps may have further reduced the risk of infection.
- ***SSE-GP only one of many measures:*** There were many other infection control strategies in place when SSE-GP was implemented, including COVID-19 testing, temperature checks, PPE use, cohorting residents and staff in facility wings where possible, and increased cleaning, hand washing, and waste management. Beyond RAC, Melbourne was in full lockdown with mandated restrictions including mask-wearing, non-essential workers not attending workplaces, schools closed, heavily restricted gatherings such as weddings and funerals, no visitors to homes, and one exercise period per day within a restricted range. The number of infection control variables in place make it difficult to determine the specific effect of SSE-GP on infection control in metropolitan Melbourne and Mitchell Shire.

8. ***SSE-GP rostering pressures***

- ***Rapid introduction:*** Providers said the fast implementation and resultant challenge in interpreting the Guiding Principles in the first four to six weeks was a stressful time for both providers and employees. One example was a provider with a large workforce in multiple facilities who reported a lot of stress when they heard they needed SSE-GP to be ready within 72 hours. Another provider said their HR staff made “hundreds of calls in 48 hours” to determine who was working in which facility and who would be their primary employer. Another said that SSE-GP came in when they had already lost half of their workforce, so it was even more difficult to lose staff to another provider.
- ***No time to implement SSE-GP during an active outbreak:*** Facilities in a COVID-19 outbreak said when they were in crisis mode they did not have time or resources to shift focus from resident care to SSE-GP. Needing 120% to 150% of regular staffing requirements to effectively manage outbreak conditions, some said they were forced to use agency or surge staff to supplement their own staffing, which added to the complexity. Their priority was on providing residents with meals and medications, with PPE as their major infection control.
- ***Short notice on extension:*** It was consistently noted that more notice was needed when SSE-GP was extended. With rosters posted two to four weeks ahead, the short notice made it challenging to align the rostering changes needed.

- ***Increased workload:*** COVID-19 conditions require more work with less staff. Providers said that working with PPE takes longer and needs 1.2 to 1.5 times the workforce to allow time to correctly follow procedures to put on and take off PPE (donning and doffing). Some providers said the only option was to request a surge workforce and there was sometimes a shortage in that workforce.
- ***Reduced staffing and surge workforce:*** Some providers lost a significant component of their workforce in a short time for a variety of reasons. Staff unable to work may have been infected themselves, were waiting on test results, had transmission concerns for their own health, were home schooling, were quarantining as close contacts of an infected resident or staff member/s, or, directly related to SSE-GP, chose their other employer to be their primary employer. In addition, several providers reported staff productivity slowed given PPE and other infection control measures which were estimated to reduce a worker's productivity by 20% or more. The cumulative effect of reduced staffing may have applied additional pressure to an already short-staffed sector. Some providers asked remaining staff to work additional hours outside their regular roster.
- ***Carer shortage:*** There was already a shortage of carers and difficulty attracting carers to the sector prior to COVID-19 shrinking the workforce further. Some staff stopped work to reduce risk to their own compromised health or the frail or elderly living with them. Staff were off work for days waiting on test results, or for two weeks of self-quarantine if they or a close contact were COVID-19 positive.
- ***Reduced working visa travellers:*** One provider said their workforce was further reduced by the lack of international visitors. Because interstate and international borders were closed, there were fewer travellers who would have been employed previously on working holiday visas. This temporary pool of workers was not available to supplement lost SSE-GP workers.
- ***Fear of losing staff after SSE-GP:*** A few providers expressed concerns they may lose staff to other providers if they do not come back after SSE-GP. They saw this perception of increased risk as yet another challenge, given they struggle to recruit staff even without COVID-19.

9. ***Rostering difficulties:*** Many providers found it difficult to manage the practicalities of ensuring workers were not financially disadvantaged, which involved factoring in requirements of various industrial instruments (enterprise agreements, modern awards) and payroll periods when preparing new rosters. One provider said it was difficult when they were unable to roster workers where they were needed because they needed to maintain worker earnings. If they could not give them work, they would have to pay workers as the funding guidelines were prescriptive. In some instances, they had too many workers on some shifts and not enough on another shift. Providers previously rostering across multiple sites to meet staff shift preferences and operational needs were unable to provide the same shifts at the one site under SSE-GP conditions. SSE-GP was not regarded as sustainable in the longer term as it imposes too much restriction on rostering, which comes with additional costs. SSE-GP was said to be “a constant juggling act”. Most providers said SSE could not be implemented longer term for structural workplace reasons in additional to any legal issues relating to individual’s work rights.
10. ***Backfilling rosters:*** Providers expressed difficulty with backfilling roles at short notice due to absenteeism and struggling to fill short shifts on rosters. Backfilling shifts was required to manage roster variations despite master schedules and workload being fairly static in the sector. A small number of providers said sick leave and part time work arrangements were related. For example, an employee may take a casual or penalty shift with employer B over a day shift with employer A because it earns them more income in this low paying sector. To take the penalty shift they may need to call in sick to employer A. In another example an employee working 120 hours across two facilities to pay a mortgage and raise a family may get tired and need more sick days to rest and recover.
11. ***Regional and remote providers*** advised they would struggle with implementing SSE-GP without backup staff. Many staff work across two locations in their local town or area. One regional provider told us he had already informed his local health district that in an outbreak he would not be able to staff his facility and would either transfer all residents to the local hospital or require an incoming surge or agency workforce.

Second jobs and register

Multiple jobholding registers: Providers were asked if they had maintained a register of workers with two or more jobs (multiple jobholding, or MJH) prior to COVID-19. Only two providers had previously recorded second jobs since workers’ compensation claims revealed working with a second employer may have contributed to the workers’ injuries.

Register timing and types: There was variation in timing of worker registers. Some providers surveyed staff early in the pandemic in March and April 2020, and were aware of second jobs before SSE-GP was released, but most compiled their register after they were released. One provider noted the enormity of preparing their register, with just 48 hours to contact more than 1200 staff, then contacting other providers to help facilitate decisions around primary employer and obtaining payslips for evidence. One said they had not had time to register their workers’ second jobs during their COVID-19 outbreaks when resident care had been the priority but were now collecting that data.

Providers' registers varied: Most providers registered just those staff with a second job that was also in RAC. Few recorded whether second jobs were in a RAC, hospital, or some other high-risk role such as security or cleaning in hotel quarantine or abattoirs.

Number of staff with multiple jobs: Reports estimated around 9% of Australian (Mavromaras et al., 2016) and 24% of Canadian (Duan et al., 2020) RACF staff held second jobs. Most providers said while they had been aware some staff had other roles, they were surprised how many had multiple jobs, as this information has not previously been sought. Even those who had surveyed their staff earlier in the year were surprised by how many more declared a second job later when SSE-GP was implemented – an observation explained as workers' fears of disclosing their secondary employment.

Although all providers were asked how many of their workers had multiple jobs (MJH), either as a percentage or a number, many were unable to say. Responses ranged from 2% to 58% of the workforce. Because registers varied by provider, some providers knew how many workers had a second job, some knew how many had second jobs only in RACFs, some knew how many workers chose another RACF as their primary employer, and some providers had data on all those categories.

Most acknowledged that outside COVID-19 SSE-GP requirements, MJH needs to be addressed from a WHS perspective particularly with respect to infection control, worker fatigue and long hours worked. However, all providers said it would be unfair to try to limit workers' ability to earn extra income from multiple jobs in the future. It was recognised that MJH needs to be managed but that workers have the right to earn what they need.

Centralised register: Several providers and others expressed support for a centralised register of employee MJHs in relation to COVID-19. Further, that beyond COVID-19, worker MJH registration be included as a requirement in the Aged Care Quality Standards with a commitment to ensure both fatigue and infection control issues were managed.

Guiding Principles Support Hub

The Guiding Principles Support Hub was used by around half the interviewed providers in metropolitan Melbourne and Mitchell Shire, although others in their organisations (e.g., HR or finance teams) may have accessed the Hub without the interviewee's knowledge. Alternative sources of HR advice reported were outsourcing to employment law firms, providers' own HR, finance or other management teams, and direct contact with their peak body.

The Support Hub was said to be useful with good information, straightforward and helpful:

> *Having the Hub was fantastic, having somewhere to go to was brilliant, the advice we received on six occasions… was really good solid advice.*

The major use of the Hub was to seek advice on staffing, especially how to schedule, pay and later claim funding for those employees working more than 76 hours a fortnight, both to ensure the employee was not disadvantaged and to check they were interpreting the Guiding Principles correctly. Providers sought clarity on the legality of requiring employees to not work in a second job, and compulsory staff COVID-19 testing. Downloading Hub templates and advice on worker documentation, work permits, and staff communication was particularly welcomed, as was being able to watch webinar recordings.

SSE-GP funding applications

Most providers had not yet applied for Government funding as it was not required until end of June 2021. They planned to wait until SSE-GP ended and make a single consolidated application. One provider had already applied for the funding and another said they would not apply for funding because it was not “worth their while” to do so.

HR interviewees said they were not concerned about the funding application, as their finance teams would do that. Some smaller providers without dedicated functional supports were concerned about the complexity of funding applications. Most had been too busy managing COVID-19 outbreaks to finalise their data, some were waiting to see if the rules changed, and one said they were waiting to see if sick leave would be covered.

Plans and support for SSE-GP after COVID-19

All providers said they would have concerns operating an SSE-GP model outside a pandemic because it was not reasonable to restrict a worker’s choice on where they work. One provider said they would be attempting to offer full-time rather than part time roles to carers in the future and that more staff in full-time roles would likely result in fewer staff with second jobs.

Single employer: Some larger multi-site providers said they preferred the notion of “single employer” rather than “single site”, given many staff work across a number of their own sites. They said they know their business, risks and controls well and trust their consistent standards. They would prefer to retain that business model and flexibility during a pandemic, given they can continually assess their risks and hazards and make appropriate changes if needed. Staff working across multiple sites not only assists with scheduling and rostering of frontline staff, but also provides learning and succession planning opportunities and allows for specialist roles to be shared across sites.

Cross training: Some smaller providers referred to the cross-training opportunities that accompany second jobs, especially nurses working in acute care who bring broader current clinical skills, knowledge and expertise into their facilities. They rely on this outside knowledge being brought into their facility and would be reluctant to lose that.

Support required after SSE-GP: Providers commented about transitioning to the "new" business as usual. First, a staggered transition out of SSE-GP practices would be preferred rather than a fixed date. A one-month transition period would allow a streamlined alignment with rosters and pay periods. Next, some providers were concerned staff may have difficulty settling back into the culture and values of their organisation after being away for an extended period, and staff re-induction may be required given some processes and policies may have changed while staff were away.

Some providers expect some staff would resign and not return if they preferred the new primary employer or found other roles, and other providers with decreased occupancy were reviewing their master rosters and resourcing needs to see if the same capacity was needed going forward.

Communication channels: Providers were keen to have just one voice or channel with consistent messaging rather than receiving multiple updates and sometimes apparently conflicting instructions from government and other parties and would welcome a government website with a date driven repository of information and resources so providers can locate documents easily.

Voluntary or mandatory SSE-GP

Most providers said where there is a risk of community transmission in a COVID-19 pandemic, SSE-GP would help with RAC infection control and should be implemented. One interviewee said no provider CEO would refuse SSE-GP:

> *"We were kidding ourselves that it was voluntary in Victoria. We need to stop pretending. It needs to happen to protect vulnerable people."*

All but one provider said SSE-GP should be voluntary as it was not reasonable or legal to restrict an individual's earning capacity. Furthermore, any move to SSE-GP should be well planned with longer and more realistic timeframes. Most providers said funding was required to ensure employees could continue to meet their obligations.

Mandatory SSE-GP could be difficult and potentially damaging in regional and remote locations. Two regional providers expressed concern around mandatory SSE-GP because their local labour supply was already short. If SSE-GP were implemented in the longer term, they would be concerned their current staff may resign. They would then have trouble recruiting new staff if there were restrictions on employees holding second jobs.

Staff fatigue and potential workers compensation

Providers reminded us of the impact of this difficult time on their care staff, not just residents. Most providers told us that SSE-GP had tired and fatigued so many of their employees. They said their staff had withstood many changes and were close to burnout. One provider said there was no immediate opportunity “to lower our expectations of them to accommodate this widespread burnout”.

Another provider said their workers compensation claims had increased in 2020, given the enormous toll on carers. They said increased resident social care in uncertain times took an emotional toll on employees. They explained that beyond the changed routines, social isolation and other difficulties of the general population in lockdown, many staff grieved their much-loved residents lost to the disease, feared catching COVID-19 themselves, and were drained from learning new ways of operating and strict PPE requirements.

Other findings

Several further topics arose in the interviews that either impacted SSE-GP or appeared to have a significant impact on the sector and were worthy of mention.

Evidence quality: Some providers were concerned there was little governance associated with SSE-GP. They said an employee who was receiving wages from them as the primary employer may have continued to work in their second job or found a third job. As a trust-based system, there was no centralised record, registration or other source for providers to ensure their employees were only working the one job.

Differences in Victorian and South Australian implementation: Differences in approaches between Victoria and South Australia were noted by interviewees. South Australian employees were reported to have lost income due to SSE-GP and unintended consequences resulted. One provider noted the inconsistency between Victoria’s voluntary SSE-GP compared with South Australia’s compulsory health direction where despite no COVID-19 at the time, and with no funding to support it, it was against the law to work for a second provider.

Provider profiles: turnover, employment status, PBI rates

SSE-GP employer changes: Although we asked, most providers did not know how many employees chose another site as their primary employer or how many chose them as the primary employer, saying they had not had the chance to analyse their workforce data.

Employee turnover: Most (75%) providers gave their turnover statistics, sometimes with full-time staff and sometimes only frontline workers. Turnover ranged from “basically very low, just retirements” up to 33%, with the majority from 15 to 25%, and an 18.2% average.

Employment status: Most providers estimated their workforce employment status profile, reporting 65 to 70% part time employees, 20 to 25% casual and the balance largely administrative and management roles. Three providers were outside that range. The first reported 85% part-time, 5% casual and 10% full-time, the second provider outside the standard range reported 55% part-time, 35% casual and 10% full-time, and the last reported 45% part-time and 65% full-time.

PBI salary sacrificing rates: To determine potential impact of Public Benevolent Institution (PBI) salary sacrificing on choice of primary provider for employees with multiple jobholding, non-profit providers were asked their PBI take up rate. Results were mixed. Several providers did not know their take up rates. Three providers had low take-up rates. One rate was “basically nil”, another estimated “around 15%” and the third said around 30% of their staff took advantage of this benefit. Most PBI take up rates, however, were between 40 and 60%. Two providers estimated 70 and 74% take up rates respectively, and two more estimated their PBI take up at around 90%. The first of these providers said their staff took up the option due to a strong education program, ease of use, and the support available to employees. The other provider explained their 85 to 90% take up was actively promoted with “many” employee sessions from their superannuation and financial literacy supplier. This provider said they may have had employees who also had PBI salary sacrifice with other employers. Most providers said take up is significantly higher in management and administrative roles than in front line roles. One private provider said salary sacrificing should be available to all employees in the sector, not just Australian Charities and Not-for-profits Commission approved organisations.

Providers generally reported that despite broad education programs, some staff are still cautious about trusting others (potentially such as the tax office) with either knowing or accessing their finances. Some staff are reluctant to prepare what appears to be complex paperwork, and others decline the benefit due to Centrelink or rental assistance payments.

It was speculated that non-profit providers may be prioritised as primary SSE-GP employers given PBI status allows those employees to sacrifice part of their salary for financial benefit. There was only small evidence of employees who prioritised working for a non-profit over their for-profit provider, however that could be a result of the limited range of worker interviews. There was, however, a general knowledge that salary sacrifice forgone under SSE-GP conditions could be “caught up” once a worker returned to their PBI provider. Most providers knew employees could catch up missed amounts when they returned to the PBI employer, however because those employees tend to be on a low wage and would need to contribute additional funds, that catch up plan was not likely to be a practical option.

Long service leave: It was speculated that employees may have been concerned about the impact of SSE-GP on their entitlements such as long service leave (LSL), given Victorian RACFs have portable LSL. LSL was referred to by few interviewees. One small provider said their staff had thought they were at risk of losing long service leave under SSE-GP conditions but were reassured they would not.

Research methodology

The research consists of the following studies:

1. Stakeholder interviews

Two researchers conducted 74 interviews between 23rd October and 30th November 2020. Zoom, Microsoft Teams or phone interviews with RAC employees, representatives from advocacy organisations, government, peak bodies, providers, unions, as well as academics and other experts in aged care, health economics and human resources lasted 25 to 60 minutes. Organisational interviewees were largely nominated by the Support Hub Advisory Committee and invited to participate by email. Providers were invited by their peak bodies, and employees were invited to volunteer by providers, unions and Support Hub notices. We thank all individuals and organisations who gave their time to participate in this research. Individual and organisation names have been withheld following feedback from the Advisory Committee to ensure confidentiality. Table 1 lists the interviews by stakeholder category. The interview guide, adapted for each stakeholder type, is in the Appendix. The study was approved by Macquarie University Human Ethics Committee. Residents and families were not interviewed.

Providers: Representatives from 35 providers were interviewed, including 14 with COVID-19 outbreaks, and 21 with no outbreak. Interviewees were from a mix of small, medium and large providers in roles including CEOs, facility managers, finance, human resources, operations managers and quality assurance. Non-profit, for-profit and public providers in Victoria, New South Wales, Queensland, Tasmania and South Australia were included.

Employees: Despite requests to encourage interviews, we received just 30 enquiries to which we responded with interview invitations. We conducted 12 employee interviews.

2. International human resource academics

Cranet is a global network of senior HR scholars, with one representative in each of more than 40 countries. They were emailed in early October 2020 to ask about any innovative employment practices they heard had been used in RACFs in their countries. Their responses and observations, many of which will have changed as the number of COVID-19 cases increases and countries experience their second or third wave, are listed.

3. Literature review

A literature review was conducted to review global SSE-GP practices and issues arising in the interviews, focussing on issues relevant to SSE-GP rather than broader workforce issues addressed in past reports. The literature review and extra readings are listed. To maintain focus on SSE-GP, literature on staffing ratios, workforce casualisation generally and the gig economy were excluded from the review.

Further contributions

Australian and international gerontologists' contributions. Australian and international gerontologist associations and the Global Ageing Network were invited by email to tell us their views on SSE-GP. Unsurprisingly given the pandemic, few responses were received. The responses we did receive are integrated into this report.

Australian academics scan. A group of leading Australian human resources academics, 16 members of the Australian Human Resources Institute's Advisory Research Panel, were invited by email to inform the discussion on SSE-GP practices. Advice from group members informed and have been integrated into this report.

Table 1: Number of interviews conducted in each stakeholder category

Interviewee category	Interviews
Academics & Advocates	6
Employees	12
Government	7
Labour hire & registered training org	3
Peak body representatives	7
Providers	35
No outbreak	21
Non-Profit	18
ACT	1
NSW	2
QLD	4
SA	2
TAS	1
Victoria	6
National	2
For Profit	3
Victoria	3
Outbreak	14
Non-Profit	9
Victoria	7
National	4
For Profit	5
Victoria	1
National	4
Unions	3
Total	74

Limitations

As with all research, there are limitations to be highlighted and the results of this study should be interpreted with caution. First, the lack of input from aged care residents and their families is recognised as an important omission, a decision made early in the project, given the nature of that data collection at a potentially difficult time. Second, the short time frame and high level of activity in RAC facilities at the time of the study means these results are not claimed to be representative of the sector either in Australia or internationally. Rather, they provide a good early investigation on which future studies may build. Third, information from providers was often a best or educated guesstimate, as some were still collecting relevant data, and most had not analysed what data they had. Fourth, the small sample of employee interviews and the bias that most had second jobs are both potentially problematic and may skew the results. A future census stratified, or randomly sampled study of providers and employees would give more reliable and robust results.

GUIDING PRINCIPLES SUPPORT HUB

MACQUARIE University

SECTION 3

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Discussion points: Strategic workforce issues

A number of issues arose from the multiple perspectives on SSE-GP that are worthy of further integrated discussion. Some of these issues, already evident prior to COVID-19, were exaggerated or became more obvious under SSE-GP conditions. Because SSE-GP was one of many infection control measures it is unlikely that its specific and direct effect on controlling COVID-19 infection in Australian RACs will ever be isolated. Its effect on highlighting the following workforce issues, however, is clear. This section addresses issues directly or indirectly raised during the SSE-GP research interviews and represents an integrated range of views, opinions and interpretations that may prompt reflection, further discussion and possible further research.

SSE-GP impact on quality of resident care

Stakeholders offered their views on the impact of SSE-GP on resident care, and how they felt person-centred or clinical care may have changed with SSE-GP. Most stakeholders reported improved continuity of care and personal care. Responses regarding clinical care were mixed, depending on whether the facility had had a COVID-19 outbreak and how many staff were impacted by SSE-GP. Some providers were confident there was no change in resident clinical care, but others said it was too early to determine if care quality had changed, preferring to wait for data before commenting.

Positive observations regarding clinical care included:

Infection control: Most providers agreed that SSE-GP was another tool that helped control infection by reducing COVID-19 community transmission from staff to residents, reducing COVID-19 transmission between staff who previously would have attended more than one facility, and reducing influenza infections and gastrointestinal infections.

Continuity of care: All stakeholders reported improved continuity of care as fewer staff worked more hours in a single facility resulting in improved:

1. ***Resident knowledge:*** Employees developed better personal and clinical understanding of residents in that facility.
2. ***Productivity:*** A stable workforce that knows their residents and care plans better can get through the workload faster than when working across multiple sites.
3. ***Clinical care:*** Expert clinicians told us that as continuity of care increases, so too does clinical care, as carers are more likely to notice changes in residents' physical and cognitive functioning and clinical signs.
4. ***Personal care:*** Carers provided extra personal, emotional and social support to residents who were often restricted to their rooms, unable to receive family visits or participate in bus trips or other group activities. Staff-resident relationships were reported as stronger in many instances.
5. ***Communication:*** Communication between management and staff was said to have improved by several providers with a more consistent and stable workforce, which had a positive effect on residents.

Technology skill development: Carers learned new skills and used technology (such as facetime family visits) that will continue to improve service delivery beyond the pandemic.

There were aspects of SSE-GP that negatively impacted on resident care as experienced local employees chose other facilities as their primary employer.

Initial clinical care: Short term crisis management was required in facilities with an infection or outbreak, with significant losses of staff to another employer, or those who lost up to 90% of their workforce at short notice due to quarantining requirements. It is likely some immediate clinical care needs were not met during these early emergency periods when staff were unable to be replaced promptly. One provider was concerned there may have been an increase in psychotropic medications in RAC over the COVID-19 period, given new staff and staff wearing PPE masks and aprons is likely to lead to reduced sense of safety and increased dementia-related behaviours.

Reduced productivity and learning curve: A few providers said many of the early replacement workforce had a steep learning curve on arrival. They were not familiar with the facility's clinical policies and practices, nor the residents, their care needs or their preferences. Productivity was reduced while they learned policies and procedures.

Exhausted staff caring for residents: Several providers said staff became exhausted not just from providing extra supports to residents, but also from increased use of PPE, managing their SSE-GP work-life schedules, their own families in lockdown, fear for their own health and other issues.

Strategic projects delayed: Several providers said SSE-GP placed pressure on staff not just in the front line, but strategic and back-of-house operations also. Some larger programs planned for rollout in 2020 were put on hold when staff were diverted to manage the outbreak, holding back potential improvements in clinical care. One provider outside greater Melbourne and Mitchell Shire said they held back a long-term resident pain management program they had planned to roll out in 2020 so they could manage COVID-19 risks. It is possible providers implementing SSE-GP and managing outbreaks delayed other programs also.

Reduced allied health treatments: SSE-GP was sometimes applied to allied health practitioners, when they were employees. Fewer allied health treatments, especially physiotherapy, may lead to resident deterioration in mobility, loss of balance and reduced strength. Although slips, trips and falls may have reduced with less movement during confinement, there is an increased risk of those injuries in the medium and longer term. Clinical data later may provide evidence of this effect.

Multiple jobholding and work hours congruence

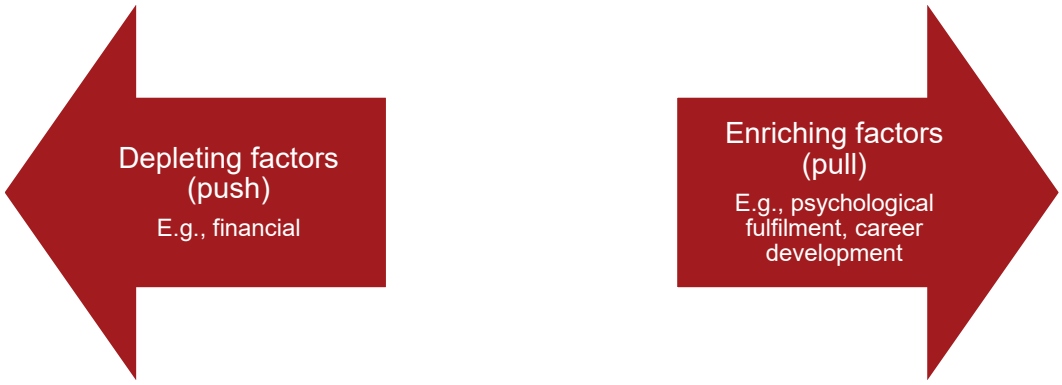
Most providers reported surprise at learning the number of employees with second or more jobs in their organisations. In contrast, employees mostly reported their employers were aware of other jobs they held. Further research is needed to understand this difference in understanding. It may be that local supervisors and site managers were aware of MJH and head office staff we interviewed were not as aware.

In terms of work hour congruence most employees said the main reason they work multiple jobs was because they needed the equivalent or more of one full time job to meet their financial commitments. One employee preferred multiple employers for security in case one job was discontinued. A few employees said studying part time and holding multiple jobs fitted with their shift preferences. Employees said in most instances that if a full-time job were available and allowed them to meet their financial commitments then they would prefer this arrangement over multiple jobholding. Given the small number of employee interviews, more research is needed to understand differences of work hour congruence across different roles and employees.

Motivation for multiple jobholding: Multiple jobholding (MJH) may either deplete or enrich an employee (Campion, Caza & Moss, 2020). Depletion occurs when an employee is motivated or pushed to work a second job, such as financial need. Enrichment occurs when an employee is pulled to work the second job, such as seeking career development or psychological fulfilment, as shown in Figure 1.

Some employees prefer to work in a second job that gives them variety and learning opportunities, such as nurses who prefer a mix of shifts in both acute and aged care environments. According to the model, these employees are enriched by their second jobs. However, financial motivation is a stronger motivation for a second job than either career development or psychological fulfilment (Dill, Morgan, & Marshall, 2013). Most multiple jobholders in aged care appear to be motivated by depleting factors.

Figure 1: Multiple jobholding motivation (Campion, Caza & Moss, 2020)



Consistent with the finding that MJH is linked to underemployment in the Australian job market (Wilkins & Lass, 2018), the main reason interviewed employees held two jobs was because both were part time jobs. They needed shifts from two jobs to generate a full-time income to meet their financial commitments, which included a mortgage or rent, raising children, vehicle costs and groceries. None said the extra income was for holidays or luxury items.

Some employees said they would prefer a full-time job with one employer rather than working two jobs. Two said that one full-time job would still not provide enough income so unless the hourly rate was higher, they would always need two or more jobs.

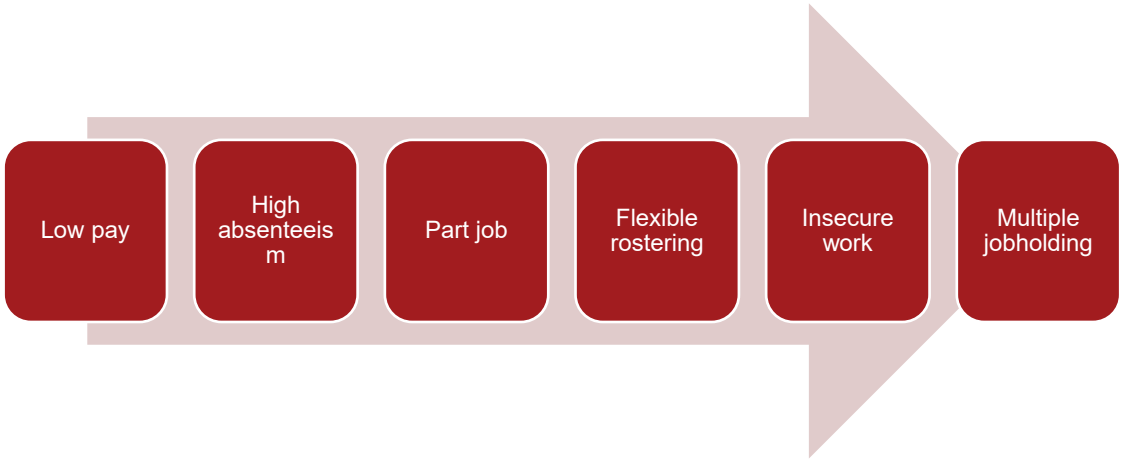
Performance and multiple jobholding: As noted above, although providers knew of some staff with second jobs, most providers said they were surprised at how many staff had second jobs they did not know about. This lack of impact on the workplace may reflect the mixed research results on how MJH affects performance, especially in service work (Walsh et al., 2016). MJH results in physical rather than psychological wellbeing being more clearly depleted (Campion et al., 2020). Providers' concerns on quality of resident care when serviced by overworked staff, and the risk of physically tired employees being more vulnerable to work injuries appear to be justified. Research on this topic is required.

Low salary encourages MJH: RAC work is long recognised as undervalued and low paid, a key barrier to a sustainable workforce (Kaine & Ravenswood, 2013). A proposed model in Figure 2 shows how low pay in RAC leads to MJH. To start, low pay (box 1) may lead to high absenteeism (box 2) as employees try to maximise their income with better shifts in second jobs. High absenteeism encourages providers' preference to offer and schedule part time work (box 3). The part time roles being used to backfill absenteeism result in uneven and inconsistent work from flexible rostering (box 4). Flexible rostering gives employees a sense of insecurity (box 5) that can be addressed by holding a second job (MJH, box 6). Research is required to test this model in Australian aged care to validate the claim that secure and well-paid work with good conditions is likely to result in a more stable, skilled and reliable 24/7 workforce.

MJH may also be related to other HR practices referred to in the interviews such as part time employment, absenteeism and rostering practices. The following graphic highlights these possible relationships. Further research that that informs these topics is included below along with a profile that highlights a number of different workforces noted whilst interviewing stakeholders. Also noted are the possible impacts of SSE-GP and consistent assignment. Further research is recommended across these topics to ascertain any significant causal relationships which may aid in sector change programs and improve resident care outcomes and employee atraction, retention and commitment and satisfaction. Some of these issues may be sector wide and others may be provider specific only.

In relation to part time employment, nearly all providers said they had a high level of part time employment in service delivery roles. Most full-time roles were clerical, administration or management and described as Monday to Friday or 9 am to 5 pm roles. One provider recently introduced an option to offer full time roles to new employees, while several providers have been converting some of their casual employees to part time employment since March 2020 when COVID-19 was first reported in Australia. Providers reported that some employees prefer part time, some prefer full time and some prefer casual work.

Figure 2: Possible causal multiple jobholding path in residential aged care



Attraction of part time jobs: The part time nature of vacancies in this sector is likely to be one of the major disincentives to choose this work, and along with low pay, a primary reason the sector has trouble attracting staff. Entry-level part time employees in hospitality and retail tend to be young, often students, without families or mortgages. However, more mature employees who are more likely to have family and mortgage responsibilities are also more likely to seek the stability, security and income of a full-time job.

Further, the extra physical and mental effort required to schedule, attend and perform in multiple jobs, and the cognitive load of forming and maintaining relationships and psychological contracts with two sets of employers, and the divided attention of two sets of residents and their care needs, is potentially significant. The extra cognitive effort associated with MJH may be a contributing cause of the sector's reported high absenteeism and may contribute to other poor workforce outcomes.

SSE-GP and continuity of care: Whether worked full or part time, continuity of care, stable staffing or consistent assignment is recognised as an important practice in providing a home-like culture (Roberts, Nolet & Bowers, 2015), improving quality of care (Castle, 2011) and reducing staff turnover (Castle, 2013).

While no studies have yet directly addressed MJH and consistent assignment, an implication could be drawn that SSE-GP makes consistent assignment easier to achieve because staff are more available to the primary facility. Multiple stakeholders suggested SSE-GP could strengthen staff commitment and create a more consistent workplace culture. There is a risk that potential negative aspects of consistent assignment may be accentuated where SSE-GP does not allow staff to take a physical and mental break from caring for the same residents. Further research is required to identify unintended consequences such as reduced resident information exchange (Caspar et al., 2020) and PCWs feeling confined or overwhelmed by the work, becoming burned out and being isolated from colleagues and other residents (Andersen & Spiers, 2015).

Multiple aged care workforces: The RAC workforce is generally spoken as a single workforce, yet at least six distinct workforce profiles became apparent in this study:

Figure 3: Profile model of multiple aged care workforces

1. First, those *content to work part-time*. Frequently women with young children, often the second income earner in their household, juggling children and partner's work, or part and full-time local and international students, around 20 to 30 hours/week is sufficient.
2. Second, those who *seek a full-time income*. Both men and women who require a full-time income but are unable to find a full-time job in aged care. They make up a full-time income by working two jobs, either one part time and one casual, or both part time jobs. They may seek to maximise their income with penalty shifts or overtime.
3. Third, those who *require more than a full-time income*. Many providers discovered employees working more than 100 hours/fortnight. These men and women might work double shifts across two facilities, sometimes with just half an hour between shifts. Providers see these employees at risk of fatigue or injury, while employees see an opportunity to maximise their income and would probably continue to work two jobs even if one were full time. Although these stories were sometimes extraordinary, most providers had only a few employees in this category.
4. Fourth, the *temporary workforce of casuals* who make up part of the pool of the emergency or surge workforce. These workers were sometimes new to the sector and sometimes already working elsewhere but with insufficient or uncertain hours needed to supplement or backup their primary employment. Most but not all indicated preferring permanent over casual work.
5. Fifth, the permanent workforce of carers, administration, accounts, finance, human resources, IT, marketing, and other functional or overhead full-time staff.
6. Finally, when all the other backups are not available, the *facility manager* workforce who already work more than full-time. This is the workforce where the longer they have worked in the sector and worked their way up the career ladder to management, the more they are required to backfill for junior staff at a moment's notice. Technically known as reverse-status-rotation patching (Kossek 2016), this workforce is exhausted and at risk of high turnover as increasing pressures are placed on them.

As noted previously, further research is encouraged specifically to confirm this or other profiles and determine the prevalence, preferences, attitudes and behaviours that are particular to each segment. This nuanced information on each workforce segment is likely to be able to support providers to improve attraction and retention in the sector and reduce employee turnover.

Further research may also reveal where part time employment is useful or not to employees, residents and providers and in which roles and for which types of workers it is most attractive. It may help to understand if the prevalence of part time employment occurs in other areas of Australia, and any relationships between part time employment and other HR metrics to determine which are serving us well and which we need to reconsider. It may be useful to effecting change in the sector and future decision making and managing pandemic situations because less part time employment may result in less MJH which would reduce the need for SSE-GP in the future.

Scheduling and rostering

Rostering or scheduling management: SSE-GP was reported to have put extra pressure on rostering and scheduling. Providers told us of the ongoing, ever-changing improvised rostering known in the sector (Kossek et al., 2016) as master rosters gradually erode and schedulers seek to balance organisational, residents, and employee needs. Most providers said either the facility manager or an administrator was responsible for backfilling cancelled shifts, called “patching” in the scholarly literature (Kossek, Rosokha, & Leana, 2020). All providers reported using some sort of electronic rostering or scheduling systems. A few providers had centralised rostering and patching, sometimes with extended hours.

Rostering notice: Most providers said they posted their rosters with two weeks’ notice, the minimum required in most employment contracts. Unions highlight the planning difficulties associated with just two weeks’ notice and call for rosters to be posted four to six weeks ahead. The most stressful aspect reported by past RAC employees (Mavromaras, 2016) was the unanticipated changes in work patterns at short notice. Employees find it difficult to manage home commitments when work commitments are not confirmed early. More rostering notice, wherever possible, may assist in minimising short notice labour disruptions. Further research is recommended to unpack and identify any causal relationships that may exist.

Flexible staffing not needed for operations: Several reasons were provided for the high proportion of part time roles:

- Part time roles are an historical artefact of this sector;
- Part time roles provide flexibility to increase or decrease hours quickly in a 24/7 business with unexpected rostering changes;
- Some employees require flexibility and choice around shift times (e.g., for study or carer responsibilities), so providing part time work is sometimes important;
- Part time roles cost less than overtime. It makes more sense to have up to two times the capacity on the floor for the same cost as paying overtime.

However, beyond unplanned last-minute absences, most providers said staffing needs are relatively stable when occupancy rates are stable. Master rosters were reported to only be updated periodically or annually as part of annual budgeting processes.

Prior to COVID-19, occupancy rates were reasonably predictable, with some ongoing decline noted in overall occupancy across the sector. This may mean occupancy rates are not driving the need for operational flexibility potentially perceived from the high number of part time jobs in the sector. Further understanding could be useful to determine drivers and relationships between part time employment and unplanned absenteeism.

We do also note that occupancy rates are not the only consideration in rostering and allocation of staff and that staff allocations are adjusted daily dependant on fluctuating resident needs and in consideration of staff skill and competency mixes, for example. Some residents have more stable needs on any given day or week and some have fluctuating needs on any given day or week. The needs change day by day if not hour by hour in some circumstances and any necessary staffing needs are addressed by site managers.

Unplanned absenteeism: All providers said their rosters change after posting due to unplanned absenteeism, often with many changes. One provider said up to 20% of their staff might call in sick on any day, and others reported similar absenteeism. Unlike other sectors that can manage with staff shortages, these cancelled shifts in residential aged care must be backfilled.

Absenteeism management: Most providers said staff tend to cancel shifts by phone or text to the facility administration person. One manager reporting very low absenteeism required all cancellations to be by phone to her only. Providers with centralised rostering and backfilling took cancelled shift calls centrally also.

High absenteeism due to MJH sick or personal leave: In a sliding scale up to 20 days/year, Victorian enterprise agreements appear to have sick/personal leave above the national employment standards entitlements of 10 to 15 days/year. The extra entitlement allows aged care staff to stay home if at risk of influenza or gastro. However, some providers speculated that sick leave also supports employees to take on a second job. An example employee who is entitled to 20 days sick leave and 20 days annual leave per year from each of employers A and B has a total of 80 days (11.4 weeks) leave per year. They could work at job A while on annual or personal leave at job B, or accept extra shifts at job B to suit their needs, and call in sick with job A.

The hidden cost of high employee turnover: The constant need to attract and recruit new part-time employees is perhaps a vicious cycle based on a myth. From the interview sample a small number of providers have low staff turnover (below 10%), while most have high (15%~) or very high (20-30%) turnover. Direct and indirect costs associated with staff turnover is generally estimated at 30 to 40% of the worker's annual salary. If the part time nature of the work results in higher employee turnover, then the supposed cost savings of part time employment is not realised but instead is spent in direct and indirect recruitment and employment costs. These costs include extra casual shifts for unplanned absenteeism, the advertising, interviewing and other recruitment costs, onboarding and training costs of new recruits, and the strain, burnout and ultimately often the resignations of facility management who are frequently required to backfill for absenteeism. An increase in full time and/or decreased part time PCW roles may result in care that is higher in quality and safety. Providers may test this theory by converting their employees to full-time contracts and assessing changes in turnover and other important indicators.

Job design, MJH and employment relations

When discussing managing employees under SSE-GP conditions with providers, sharing employees across facilities or departments, cohorting, organising of work and the range of other factors associated with SSE-GP were discussed, the following issues emerged:

Restriction of employment: The most frequently raised issue was the legality of restricting an employees' capacity to earn – many providers had sought legal advice and were told it was not possible outside of declared emergency conditions.

Multi-skilling supporting cohorting: While larger multi-site providers often share staff across sites for operational efficiency, learning and development or succession planning, few employees cross departments within the one site such as working between caring, catering and laundry. Other than in household models of care, multi-skilled roles are normally restricted to carer and either leisure or administrative roles, but not cleaning, catering or maintenance. The COVID-19 pandemic has demonstrated the advantage of cohorting residents and staff where it was physically possible. Where possible, multi-skilled staff working across departments in one wing reduces traffic and improves infection control.

Job design flexibility: A few providers said they would like to more easily redesign jobs. An example is the provider wanting to create a quasi-carer-clinical role with clinical, caring and family communication responsibilities for certain residents. This type of role gives residents high care continuity and requires a higher skill level than current PCW roles but does not require full nursing skills. This hybrid-type role could be an important component in a career ladder either for the provider or the sector but is not currently allowed in their agreement. Many smaller providers do not have the time and employee relations expertise to manage this.

Most providers said they were not prepared for managing MJH. A few had guidelines on potential conflicts of interest or MJH in their code of conduct policies. A few had "moonlighting"-type clauses in their enterprise agreements and letters of offer, but said they were not likely to be enforceable. Two providers preferred to proactively speak with employees about perceived excessive work hours from a workplace health and safety perspective, citing impacts on both resident safety and concerns about employee fatigue and wellbeing.

It is possible that COVID-19 conditions provide a context where multiple jobholding puts residents and staff safety at risk, so MJH must be disclosed and managed appropriately.

Future of residential aged care: Senior Counsel at the Royal Commission into Aged Care Quality and Safety recently recommended that residential aged care move to smaller, rather than larger facilities. This move is likely to spur further new models of care and job design changes. Additional issues to be considered when looking at job design include:

- How closely do newer models of care and the resulting workforce organisational design required sit with the Award job classifications? How much flexibility is available in current Awards or enterprise agreements to change job design to adapt to new or different models of care?
- To what extent is the Award job classification structure automatically transferred to enterprise agreements without considering job redesign?
- Are individual flexibility agreements (IFAs) used in the sector with employees who would benefit from the flexibility offered by those instruments?
- Providers may wish to trial a new role for a few months. Providers can introduce proposed new roles into their enterprise agreements without being required to continue with those roles into the next three or four-year term of the agreement by using project roles, fixed term roles or salaried rather than EBA options.
- Job design changes may be challenging for some providers depending on the industrial instruments under which employees are engaged and their other resources. Job analysis, re-design and mapping plus negotiating or amending enterprise agreements can be time consuming and expensive even for highly skilled operators. How do providers, particularly smaller providers who may not have the skill and experience, manage? To what extent are enterprise agreement templates provided by unions and peak bodies flexible, or do clauses need to be tailored?

Migrant workforce

A small number of advocates and providers noted the migrant make-up of the RAC workforce and the sector's reliance on this group to do this important work. The literature review also noted the sector's migrant workers as a further key topic to understand the RAC workforce as well as potential impacts on SSE-GP and broader strategic issues such as MJH, part time employment and absenteeism.

Due to declining participation of Australian citizens and permanent residents, migrants make up a significant (Charlesworth & Isherwood, 2020) and growing (Negin, Coffman, Connell, & Short, 2016) proportion of the Australian aged care workforce. The sector is highly dependent on the permanent migrant and temporary visa workforces who are overseas born and from culturally and linguistically diverse (CALD) backgrounds. Migrants may work in any part of residential aged care, including nursing, carers, laundry, kitchen, maintenance and lifestyle roles.

As around 21% of non-English speaking background migrant health and PCWs hold multiple jobs (Charlesworth & Isherwood, 2020), SSE-GP is likely to have had an impact on migrant employees in the sector.

It is suggested migrants on temporary visas in RAC are more vulnerable than most (Charlesworth & Isherwood, 2020), with limited pathways to permanent residency, limited hours of work, poor understanding of workplace entitlements, potential for exploitation, inadequate training and support, and often experiencing racism or discrimination from other employees, care recipients and/or their families. The increasing reliance on the temporary migrant workforce has been described as of concern as whilst they have the same employment rights and protections as others, migrants on temporary visas may not always have the skills, knowledge and confidence to access these rights and protections, and may be fearful of real or imagined risks of ongoing employment, citizenship or permanent visa status.

With respect to workplace absenteeism, migrants are sometimes more vulnerable to absences due to reduced family, community or network support for child or elder care. Providers told us that temporary and permanent visa holders tended to take their home country national holidays off work, frequently as unplanned absences that created roster backfilling difficulties. Some providers noted recurring patterns each year however most did not proactively manage those periods.

Others have recommended staff on student visas should be able to work more than the 20 hour limit when there is a staff shortage, a visa restriction that was relaxed as part of the federal Government's pandemic response. International student visa interviewees said they frequently shared housing with other students working in aged care. This represents a tight network of shared information about where a second job might be available

It was suggested by one stakeholder that the often low PCW wages in the RAC sector may need to increase significantly if migrants were not available for this work. It was said that many Australians would not accept the current lower wages.

More research on migrant RAC workers would be very useful given they make up so much of the workforce. This research could be useful for attraction and retention strategies, broader workforce interest groups and sector policy makers.

Broad view of voluntary or mandatory future of SSE-GP

Stakeholders were asked whether they thought SSE-GP should be mandatory or voluntary.

There was a strong view that SSE-GP should be voluntary for both employees and providers: Cooperation is preferred over coercion. Both providers and employees are expected to be mature enough to make responsible decisions when funding is available.

However, there was a strong counter view that SSE-GP should be mandatory with funding to ensure consistency and no disadvantage: Unions highlight that in contrast to what they saw as ad hoc compliance in Victoria, mandated and funded SSE-GP requires providers to implement the practices consistently, and employees are unlikely to be disadvantaged.

Concerns were expressed about the potential for SSE-GP to be implemented long term:

- *Reduced workforce attraction and retention:* If the ability to earn a living wage through multiple jobholding was not possible, it would be reasonable to expect few employees to be attracted into a sector where a part time job could not be supplemented. Many current RAC staff would be likely to leave the sector for retail, hospitality or other employment if additional income were not possible. Both registered nurses and carers would be impacted, and existing shortages would be made worse.
- *Learning opportunities through second jobs:* Especially smaller providers sometimes use secondary acute care employment as supplementary learning opportunities for their staff and as part of an employee retention strategy. Registered nurses particularly gain clinical exposure, training and knowledge they use and share with others. The two roles combined provide employment variety and hence reduces staff turnover.
- *SSE-GP impact on provider capacity:* During a community outbreak, already low staff levels are amplified when staff are lost to another primary employer. The potential for low and inadequate resident care should be recognised when agency staff are also in short supply, even though they can engage in multisite employment under SSE-GP. There must be enough employees in the system to manage when implementing SSE-GP practices. The sector already has skill shortages and difficulty attracting staff.
- *Single-employer employment:* Rather than single-site employment, some providers have suggested single-employer employment (SEE) in the event of a COVID-19 outbreak. Larger multi-site operators were keen to return to their previous practices of sharing staff across their sites as part of skill development, learning and succession planning strategies. They have confidence in their infection control standards in facilities and should be able to share employees amongst their facilities.
- *Sharing employees in geographical zones:* Rather than single site or single employer, it was also suggested there may be an opportunity for zones or hub-like employment, where employees are restricted to work in RACs in a single geographical area. This could be particularly helpful in regional and remote areas.
- *SSE-GP in regional and rural locations:* Some providers noted a difference in regional and rural locations whereby an unintended negative consequence of longer term single site employment may result in retention issues. This could be further complicated with difficulties attracting workers to the sector in a limited job market.

Workforce stress and wellbeing

The following general comments were noted in relation to stress and wellbeing and seen as important to include in this report.

SSE-GP was a financial and psychological burden: Administrative, finance, payroll, HR and other staff were re-directed or hired for SSE-GP activities such as planning and collecting employee data on second jobs, identifying primary employer, seeking evidence of hours in second jobs, collecting rostering and payroll data, preparing grant funding applications, staff communications broadly and individual correspondence such as leave of absence confirmations, management and employee queries.

Management stress: SSE-GP was seen as yet another impost on management. Managers with or without outbreaks worked under extreme conditions for many months. They attended daily executive group meetings to prepare for COVID-19 in their facility. They dealt with new and emerging issues in fields that were contested even by scientists. They dealt with constant news, discussions and preparations for worst case scenarios where residents lives were at stake. Some said they and their staff were vilified by those outside the sector. They have arranged training for staff in skills such as infection control, risk assessment, contact tracing, concierge and purchasing. They have dealt with ambiguous guidelines and sometimes contradictory information. They have dealt with extra calls from residents' families, the media, local and state government regulators and others.

Small providers without a head office function to research, prepare, implement and advise on clinical governance, HR, finance, supply chain or communications have added complexity in each of those functions to their already-full facility management tasks. All these activities are required while operating their business-as-usual model of care. On the other hand, large providers have these issues compounded over many facilities and geographies. They have responsibilities for even greater numbers of staff, residents and families. Their head office staff have been sent to facilities to help out in ways they never imagined. They have spent long evenings and weekends contacting or training staff, searching for PPE or other equipment, and otherwise preparing for an outbreak.

Background and context

This section provides broad background and context for readers not familiar with Australian aged care and employment conditions.

Victoria, Australia

Victoria is in south east Australia, geographically the second smallest state in Australia. A federated state with around 6.4 million people, its capital is Australia's second largest city, Melbourne. Australia's second wave of COVID-19 was in both metropolitan Melbourne and Mitchell Shire, about one hour drive north of Melbourne city.

Australian Residential Aged Care COVID-19 Authorities

The ultimate authority for Australia's Aged Care COVID-19 response is the National Community Cabinet comprising Commonwealth, State and Territory representatives. The National Community Cabinet is supported by the Australian Health Protection Principal Committee (AHHPC), comprising all senior state health representatives. Each State has jurisdiction for its own area and the national collective is a collaborative decision-making body. The AHPPC advisory groups developed aged care statements and guidelines for national implementation, and new guidelines to support the delivery of services in the metropolitan Melbourne and Mitchell Shire COVID-19 outbreak areas.

The Aged Care Quality and Safety Commission is central to the Australian RAC sector. Their role is to protect and enhance the safety, health, wellbeing and quality of life of people receiving Australian Government funded aged care. They accredit providers, assess and monitor services, conduct investigations, educate and promote quality standards and best practice, determine compliance requirements and resolve complaints. They developed resources for aged care in a COVID-19 environment.

Employment Law Landscape

The legislation that determines employment for most employees in Australia is the Fair Work Act 2009 (Cth). This is supported by other federal, state and territory legislation, industrial instruments and common law. The Fair Work Act 2009 provides 10 minimum national employment standards (NES) such as personal/carer's leave, parental leave and notice of termination and redundancy pay.

Further details about the Fair Work Act 2009, NES, modern awards and enterprise agreements are available at www.fairwork.gov.au.

Government Welfare and COVID-19 Support Payments

An overview of some payments available to RAC employees and others are outlined below.

Aged Care Support Program: Two funding grants were available to help aged care providers manage the financial impact of COVID-19. Details regarding these grants is available at https://www.health.gov.au/news/financial-support-for-aged-care-providers-directly-impacted-by-covid-19

Aged Care Workforce Retention Bonus Payment: This Australian Government payment encouraged those working in RAC providing direct contact with residents (nurses, AHW, PCWs) to stay in the sector. Each of three payments between July and December 2020 depended on hours worked with a maximum payment of $800.

Pandemic Leave Disaster Payment – Victoria: The Australian Government Pandemic Leave Disaster Payment is a lump sum payment to eligible employees directed to self-isolate, quarantine or care for someone with COVID-19 and have no other income. Eligible participants receive $1,500 for each 14-day period they are unable to work.

COVID-19 Test Isolation Payment: Eligible Victorian workers can apply for this $450 COVID-19 Test Isolation Payment for financial support while self-isolating to wait for results of a coronavirus test. This payment is funded by the Victorian Government.

Economic Support Payments During 2020/21: The Economic Support Payments were four payments to Australians on government support (e.g., age or disability pension), part of the Australian Government's COVID-19 stimulus package. Payments were $750 each in April and July 2020, and $250 each in December 2020 and March 2021.

JobSeeker: This Australian Government funded welfare payment is available to eligible Australians aged 22+ who are currently unemployed or unable to perform full work-related duties due to temporary injury or illness. As an example, a single parent of one child will receive $862, whilst partnered individuals can receive $760.80 each per fortnight. Payment amounts decrease for each dollar earned in paid employment.

In addition to JobSeeker benefits, eligible Australians may have also received the Coronavirus Supplement. The fortnightly supplement was $550 until 25 September 2020, reducing to $250 until 31 December 2020 and to $150 until 31 March 2021. Eligible Australians are exempt from normally compulsory mutual obligation requirements to actively demonstrate attempts to find work to continue receiving payments. This benefit is funded by the Australian Government.

Australian Royal Commission into Aged Care Quality and Safety

A Royal Commission into Aged Care Quality and Safety commenced in Australia in October 2018. The final report is due for release at the end of February 2021. The Royal Commission into Aged Care Quality and Safety as a part of its work, investigated the Sydney COVID-19 outbreaks at BaptistCare's Dorothy Henderson Lodge and Newmarch House as noted above and prepared a special report called the Royal Commission into Aged Care Quality and Safety, Aged care and COVID-19: a special report dated September 2020.

Further information on Australian aged care

The following links provide further information on Australian aged care.

https://www.aihw.gov.au/reports/australias-welfare/aged-care

https://www.gen-agedcaredata.gov.au/Topics/Services-and-places-in-aged-

https://www2.health.vic.gov.au/

Melbourne aged care is facing a coronavirus catastrophe. This is how it happened https://www.abc.net.au/news/2020-07-29/victoria-coronavirus-aged-care-outbreaks-timeline/12498532

https://supporthub.agedservicesworkforce.com.au/wp-content/uploads/2020/09/Guiding-Principles-Updated-7-September-2020.pdf

https://www.health.gov.au/resources/collections/COVID-19-outbreaks-in-australian-residential-aged-care-facilities

https://agedcare.royalcommission.gov.au/publications/aged-care-and-COVID-19-special-report

www.health.gov.au

https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc.

www.agedcarequality.gov.au.

Recommendations

Key SSE-GP recommendations

1. *Continuous readiness, centralised communications*: Given its success as a communication vehicle, the Support Hub should be in a state of continuous readiness to be stood up when the Commonwealth designates hotspot areas. It should promote SSE-GP for consistent interpretation and application, continue to improve resources, host a central repository for communications and register all queries, complaints and feedback.
2. *Timing*: Given its impact as risk mitigation for infection control, rather than waiting, SSE-GP should be implemented on a voluntary and funded basis immediately after a hotspot has been identified or designated by the Commonwealth. Maximum notice should be given to end dates.
3. *Scope*: SSE-GP could be further improved with a "single employer" option rather than only "single site". Consider SSE-GP funding of contracted and agency AHPs, including possibly broader roles and responsibilities for AHPs to assist PCWs and nurses. Consider the roles that families might be able to undertake in a hotspot during an outbreak.
4. *Employee register*: Providers could be asked to demonstrate their continuous readiness by developing and maintaining a standardised register of MJH employees, both in and outside RAC, including employees with compromised health and higher risk living arrangements or other activities. Providers to train employees in contact self-tracing skills and the importance of maintaining a regularly updated self-managed risk diary.
5. *Research*: Research is required to collect clinical and non-clinical data relating to the impact of SSE-GP on both resident-centred and clinical care (e.g. falls, skins tears, influenza and gastro, mental health, dementia-related behaviours and psychotropic medications), employee productivity and wellbeing (e.g. absenteeism, workers compensation), on MJH incidence around Australia to identify risks and create guidelines and resources for targeted mitigation strategies, on the drivers and motivators of part-time employment in the sector, from both provider and employee perspectives and any relationships with MJH, wages, absenteeism, turnover and quality of care. Research is also required on the best way of organising tasks, roles and responsibilities in job design for career pathing, care quality and employee satisfaction and productivity, and on wage differences across the sector and roles (e.g., public/private, nursing/caring/catering) and impact on employee attraction, absenteeism or retention.
6. *HR metrics, transparency and rostering*: Although not directly SSE-GP related, development of standardised HR metrics will assist future sector workforce analysis, decision making and planning. Developing, promoting and improving sector transparency (e.g., compliments and complaints, HR metrics, occupancy rates, care minutes, staff-resident ratios) will improve sector reputation, and providers giving employees minimum four week roster notification may improve absenteeism over the longer term.

Proposed considerations for further development

Maintaining a firm focus on RACF residents and provider viability, the following tables outline the researchers' brainstorming approach to identify solutions to issues raised at interviews. These activities are a suggested starting point for stakeholders to collaborate and build on.

The SSE-GP Preparation and Operations and HR columns recommendations include preparing, implementing and transitioning out of SSE-GP, while strategic recommendations are longer term. Expert and specialist views are incorporated generally. Because neither peak bodies nor unions have full coverage of all providers and employees, government may be more appropriate for sector-wide recommendations.

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Employees	Positive response to SSE-GP		► Providers to be proactive in staff communications. Talk, build preferences into rosters to maximise labour use ► Providers to ask MJH staff if wanting full time job, increased hours, or prefer to stay with two employers	► Research on RAC career paths available and projected
Employees, Unions	Inconsistent SSE-GP implementation – lost wages	► Sector to promote clear guidelines on implementation for supernumerary and shifts allocation ► Providers to review processes relating to implementation to ensure that the principle of no staff disadvantage is maintained.		
Employee	Reluctance to disclose	► Providers to develop and communicate to all staff their clear guidelines around workers in other employment and the reasons why this is important to disclose.	► Providers to develop a positive and safe culture of open disclosure, remove fear of disclosure	

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Unions, providers, peaks	Insufficient surge workforce	► Government to continue to implement funding for SSE-GP when a Commonwealth Government hotspot is declared to reduce staff or resident infection and to reduce need for surge workforce ► Government, peaks and providers to consider how residents' family members can be supported to continue to have an active role supporting their loved one during COVID -19 such as reading, helping their loved ones, or facilitating e-visits which would lighten the employee load ► Sector to consider how to better promote AHPs availability and benefit to workforce such as assist with meals, dressing, bed-chair transfers, recording keeping, showering etc.		
Unions, AHPs, providers, peaks	Limited SSE-GP scope	► All stakeholders to promote access to allied health services with staff as part of workforce or agency during SSE-GP ► Sector to consider the risks of other high-risk roles, e.g., community services, disability services hotel quarantine, hospitals, abattoirs and consider pathways for SSE and funding access, ► Providers to assess care workers household living arrangement risks, e.g., PCW living with PCW or other high risk, or employees who may have a high-risk vulnerable person living with them		
Unions, providers, peaks	SSE-GP readiness, timing, start and finish	► Government to provide maximum notice of transition out of SSE-GP with minimum agreed to fit with rosters and pay periods when transitioning to and from SSE-GP as short notice of SSE-GPs extensions creates much difficulty and rework for rostering teams and employees ► Providers to be ready to implement SSE-GP and consistent with ACQSC recommendation also – Providers to prepare workforce to expect changes under outbreak conditions, e.g., directions already prepared and consulted – Providers to plan for possible change in leadership style, resident, staff cohorting – Providers to train employees in infection control risk assessment, develop in-house contact tracing and self-contact tracing skills – Providers to prepare emergency response e.g., assign roles and responsibilities for updating MJH data, roster changes, payroll evidence and changes, employee travel permits		

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
		► Providers to prepare for increased capability/capacity needed under a COVID-19 outbreak with full PPE conditions ► Providers to scenario plan for COVID-19 outbreak conditions for rostering that may be impacted by MJH, leave, other planned and unplanned absences with permanent and casual staff at risk, unwell, isolating or otherwise not available ► Providers to prepare fast track induction for new employees or surge workforce under COVID-19 conditions ► Support Hub to ensure plain English materials for CALD workforce ► Support Hub with Peaks advice to continue to develop SSE-GP templates for provider use: survey, letters, staff contact details ► Support Hub or Peaks to develop SSE-GP templates for fast-tracking induction ► Providers to conduct risk analysis of staff profile to identify SSE-GP-critical roles or personnel ► Providers to prepare master roster for COVID-19 outbreaks with extra shifts and roles required (e.g., concierge, cleaning) ► Unions to encourage employees to participate in SSE-GP preparations, close contacts and second job disclosures as workplace health and safety issue ► Support Hub, peaks and unions to prepare SSE-GP standard operating procedures which outline in more detail steps required in preparing, implementation and ceasing SSE-GP and handling of grievances to minimise any inconsistency in interpretation of the SSE-GP across providers, unions and states. This could include expanding the video library and further just-in-time- webinars and strong marketing and promotion to all providers using a variety of communication channels		
Unions	Coercion	► Unions and peaks to work collaboratively to address any issue of coercion and in corporate awareness with providers and employees via materials and resources such as operating procedures, videos and webinars ► Sector to consider incentives for positive engagement and experiences with SSE-GP and how to address infringements		

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Unions	Late wages payments	► Providers to prioritise employee wages to be paid in accordance with GP SSE and access early funding if need be, respecting the principle that no employee should be disadvantaged		
Unions	Inconsistent national practices	► Sector including Commonwealth and State governments work to develop a consistent approach to voluntary but highly recommended and funded SSE-GP		
Unions	Computing access	► Providers to provide information on SSE-GP to staff in alternate forms, e.g., text, WeChat, direct to mobile phones ► Unions to review and ensure there is the capability to respond to all forms (text, phone, email, webform) of enquiries from all employees including non-union members		
Unions	Roster notification		► Providers to review giving more than two weeks' notice of publishing rosters as part of enterprise agreements (i.e., outside of COVID-19) to support work life balance	
Unions	Re-entry	► Providers to prepare re-entry mini-induction ► Providers to be reminded that rostering changes require employee consultation ► Providers to consider welcome and reengagement for returning staff		

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Allied health	Telehealth			► Providers to consider job scoping and training for telehealth aides across range of clinical conditions ► Metropolitan providers to investigate and prepare for telehealth implementation beyond existing resources ► Sector to review different telehealth models used during COVID-19 in metropolitan and rural areas and advocate for continuation

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Providers, peaks	MJH register	► Support Hub, peaks and unions to advise providers on standardised format for collecting MJH data ► Providers to record employees' second jobs, nature of the job and industry, hours worked ► Providers to record employees' householders' high-risk jobs ► Providers to maintain accurate information on appropriate frequency	► Providers to assess WHS risk for MJH employees related to COVID-19 transmission and fatigue ► Providers commence discussions with employees to address employee and resident risks ► Providers to review recruitment, induction and other practices, policies and procedures to ensure clarity around collecting and managing this data	► Government to incorporate MJH register requirement in Aged Care Quality Standards ► Research on levels and motivation for MJH in RAC ► Research on fatigue management in RAC ► Research on attraction of part Vs full-time jobs in RAC ► Research on MJH effect on RAC productivity ► Peaks and unions to support providers and employees on rights and responsibilities around MJH disclosure ► Research required on MJH impact on consistent assignment
Providers	Improved staff relationships, communication and quality control		► Providers to consider reviewing workforce profiles, identifying opportunities and value in increasing proportion of full-time roles	► Research to understand the reasons for and impacts of part time employment on continuity of care, productivity, and other workplace factors
Providers	Rostering difficulties	► Providers and workers to review SSE-GP roster arrangements after two weeks to adjust for any over or under capacity issues and continue regular communication with staff over the SSE-GP period	► Update rostering software if needed	► Research on RAC rostering practices as a potential key driver

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Providers	Absenteeism		► Peaks to develop tools to support providers with high absenteeism	► Research on levels, causes and impacts of absenteeism in RAC
Providers	Regional & remote	► Providers in regional and remote areas to develop plans and liaise with local health authorities on workforce implications under future COVID-19 outbreak conditions ► Sector to review SSE-GP guidelines to consider application of SSE-GP provisions for regional and remote providers, to be prepared in the instance that these are required		► Government representatives and sector as appropriate determine regional risk profiles across Australia for future SSE-GP
Providers	Shift refusals	► Sector to review incidence and reasons where RAC employees refused shifts under SSE-GP conditions and what options/action/impact resulted		
Providers	HR metrics			► Peaks to advocate for development of guidelines for calculating HR metrics, provide coaching and support to use those metrics to support workplace change ► Research required on employee turnover in the sector to identify key drivers of hidden costs
Providers	Support Hub	► Peaks to seek Support Hub user feedback and maintain and update this service for future needs as/if required and to maximise use of the Support Hub with all providers to promote consistency in application and interpretation of the SSE-GPs ► Government to extend Support Hub as triage service for RAC employees, involving logging, monitoring and tracking calls, and forward to unions for resolution. Support Hub promoted to employees through SSE-GP advisory template letter		

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Providers	COVID-19 testing	► Peaks, unions to review drug and alcohol testing practices in other sectors with view to recommending compulsory staff COVID-19 testing for employees continuing in a second job	► Develop policy and implementation program for COVID-19 testing	
Providers	SSE-GP funding	► Peaks to collect and analyse providers' SSE-GP costs, funded and unfunded out of pocket and incidentals for future reference		
Providers, peaks	Single employer Vs SSE-GP	► Sector to consider single site employment options for providers with multiple sites and option of single organisation approach to SSE with allocation of employees across sites		
Providers	Regional hub	► Sector to consider establishment of regional RAC employment hubs to allocate resources locally in remote and regional areas affected by SSE-GP		
Providers	Mandatory SSE-GP	► Sector to consider risks of future mandatory SSE-GP impacts where nursing staff may nominate acute care over RAC roles ► Sector to consider risks of future mandatory implementation that may result in staff losses to other sectors, especially regional locations with existing staff shortages and advocate accordingly ► Full funding of any future mandatory SSE-GP implementation is recommended		
Providers, peaks	Information channels	► Peaks to outline the roles, responsibilities and limitations of governments and statutory authorities likely to communicate directly with providers during an SSE-GP emergency, so providers can clarify and prioritise communications ► Peaks to continue co-ordinating consistent messaging communications during SSE-GP		
Providers	Governance	► Peaks and unions to review communication materials to incorporate measures to support employees and providers with information to optimise alignment with SSE-GP and limit the risk of employee disadvantage or ineligible funding claims by employers ► Support Hub Advisory Group to consider closer engagement with the Aged Care Quality and Safety Commission		► Sector to provide funding to fast track attraction and development initiatives for facility managers to provide buffer for current burnt-out management at flight risk

Source	Issue	SSE-GP Preparation recommendations	Operations & HR recommendations	Strategic recommendations
Providers	PBI status			► Research on reasons for low PBI salary sacrificing take-up
Providers, peaks	Clinical care	► Providers to train all staff in dementia care in preparation for SSE-GP conditions that could result in increased dementia-related behaviours		► Research to distinguish SSE-GP from other infection control measures
Unions, providers	Employee wellbeing	► Providers to increase communication about psychological wellbeing of staff during and after SSE-GP, provide extra supports and advocate for appropriate continued EAP and health support		
Providers, peaks	Job design		► Peaks to provide educational materials and shared stories on Australian RAC innovative job designs ► Peaks to provide education on how to implement job design	

Appendix: SSE-GP Guiding Principles

Guiding Principles for residential aged care – keeping Victorian residents and workers safe

Date of document: 22 July 2020

The safety of residents and workers in residential aged care is the highest priority. These principles are designed to minimise the potential risk of workers unintentionally transmitting COVID-19 by working across multiple sites and, by extension, reducing the overall risk of outbreak at any given site and also reducing the health risk for individual residents and workers in Victorian aged care homes, located in hotspots.

Objectives

To keep residents and workers located in hotspots in Victoria protected from the risks of acquiring COVID-19 in residential aged care facilities.

To have Victorian aged care workers based with one residential aged care facility only during this high risk pandemic period.

To reduce the risk of aged care workers unintentionally transmitting COVID-19 by working across multiple sites.

Scope

The principles apply to permanent and casual residential aged care workers who work in a hotspot in Victoria and will apply if the worker has multiple employers.

The principles do not apply to contractors, the emergency workforce and agency staff.

Guiding Principles

1. Every effort will be made to ensure workers are supported, paid their usual income, not disadvantaged and have choice over their place of employment[1];
2. There will be no diminishing impact to the consumer's right to make informed choices about care and services;
3. Implementation of risk management practices and workforce practices will be practical, and providers will have access to avenues of support; and
4. Recommendations will promote sustainable and safe rostering, employment and workplace practices to minimise disruption to any one provider.

Timeframe

The changes are intended to be started as soon as practicable. Employers should aim to commence implementing roster changes from Monday 27 July 2020.

[1] No disadvantage to workers with respect exercising their workplace rights.

The changes will initially be for a fixed term of 8 weeks from Monday 27 July until 25 September 2020 and may be extended if required as a result of the pandemic and advice from the Commonwealth and Victorian Governments.

These principles initially apply in Victoria only, but may be adopted in other States and Territories as needed.

Stakeholder engagement

Stakeholder engagement has and will be continued throughout the fixed term period and any extension. The Guiding Principles have been met with a constructive and cooperative approach from the sector, sector peaks, industrial bodies and Governments, and the initiative to find a solution has been welcomed.

Implementation

Worker protection:

1. Any changes during this fixed term period will be implemented with a specific focus on not disadvantaging workers.
2. Workers will continue to be protected by safe working conditions (including the provision of appropriate PPE and hand hygiene products).
3. Workers who elect to work at a single-site must have the security of their additional jobs and their accrued entitlements and continuity of service maintained during this period, subject to relevant legislation.
4. Workers who elect to work at a single-site will be able to access annual leave or long service leave entitlements accrued at their additional job(s) during this period.
5. Workers who elect to work at a single-site within the Guidelines will be recognised to be exercising a workplace right, reflecting the intent of these Principles to minimise the risk to health and safety.

Practical implementation:

Any employee who requests unpaid single-site leave to work at a second provider must be granted that leave. The guidelines will include:

1. The employer must hold the employee's position for a minimum of eight weeks for the agreed period of single-site leave;
2. The employee must notify the employer in writing, if the employee elects to extend the single-site leave period;
3. The employee's primary and additional employment must be with an approved residential aged care provider;
4. The additional employer(s) have a right to request evidence of the employee's elected primary job (evidence may be in the form of an employment agreement, letter of offer, pay slip or statement of service from the employer) – the employee may choose to redact personal information (including pay rates) from such documents;
5. Employees will continue to be allowed to access their annual leave and long service leave entitlements only via their usual leave application and approval channels;
6. Personal and annual leave will not continue to accrue with additional employer(s) during this period if the employee is taking unpaid leave (although personal and

annual leave **will** continue to accrue if the employee is taking paid leave); [see s.22 of the FW Act]

7. Continuity of service is protected (including for redundancy purposes) and long service leave will continue to accrue; and
8. As a result of taking this leave, the employee will not be disadvantaged in the future with respect to progression, development, learning and other opportunities in the workplace.

Provider support:

9. Providers will continue to have access to Government support through the Aged Care Support Program, access to PPE, and support to boost an emergency workforce.
10. Providers without sufficient internal resources will have access to practical tools to support them in complying with the Principles. Providers will access support via the member services of their elected Peak Body which will serve as a support hub.
11. Providers will work cooperatively to stabilise the workforce and prevent disadvantage to any one provider.

Support hub:

12. Peak Bodies will be engaged to serve as support hubs to provide guidance, tools and advice to employers to assist them in implementing these guidelines.
13. An Advisory Committee will be led by Peak Bodies and will include representatives from Government, Unions, AQSC, and other sector representatives.
14. The support hub will promote regional and state collaboration to facilitate access to resources, expertise and intelligence for smaller providers who may require support to adapt to the new scheme, including through support to adopt new payroll and other HR processes.

Support from providers, peak bodies, industrial bodies and Governments

An effective workforce pandemic response will require generous and open collaboration between providers, peak bodies and industrial bodies, with support from Governments. A regional cooperative approach to a temporary single-site solution is critical.

Providers will be required to:

- Adhere to the guidelines to preserve the safety of their consumers and their workers;
- Act reasonably and in accordance with the guidelines and workplace laws;
- As far as reasonably practicable, employers will take steps to mitigate the risk of worker fatigue;
- Contribute to the regional solution through participation in facilitated conversations, providing due consideration to other local providers, and considering how the aged care workforce is best utilised and mobilised for the benefit of the sector;
- Contribute resources and expertise, where this is possible and safe, to support smaller providers or providers where an outbreak has occurred; and
- Provide employees with extra shifts, where operational requirements allow, to make up for shifts they have foregone with their other employer(s).

The **peak bodies** will provide strong mentorship of providers to assist them to maintain the safety of their consumers and workers. Peak bodies have the capacity to offer:

- Direct communications channels to providers to circulate information, policy, resources and toolkits;
- Deep sector touch points to understand the challenges of members, advocate for change for more effective solutions and escalate providers to the support network;
- Expert, sector-specific resources to support implementation of the guidelines; and
- A channel for feedback and data collection to evaluate impact and opportunities for continuous improvement.

The **unions** representing aged care workers will continue to represent member interests and ensure that members are provided with accurate information and support to guide their decisions, mindful of the primary obligation of the Principles to ensure resident and worker safety. Such unions have the capacity to offer:

- Direct communications channels to their members to circulate information and support;
- Deep sector touch points to understand the challenges of workers, advocate for change for more effective solutions and escalate worker issues to providers and governments;
- A channel for feedback and data collection to evaluate impact and opportunities for continuous improvement.

To enable aged care providers to implement the principles, support from **governments** will be provided in the form of funding to:

- Residential providers to ensure aged care employers can cover costs to enable employees to work at a single site; and
- Funding to facilitate the establishment of a hub which will support providers to implement these principles.

Appendix: Interview guide

Residential Aged Care COVID-19 Single Site Employment Practices Study 2020

Interview protocol – ADAPTED ACCORDING TO INTERVIEWEE ROLE

ALL: Introduction:

1. Do you consent to this interview being electronically recorded so we can ensure accuracy in our recollection? I will also take notes.
2. Please can you return the Participant Information and Consent Sheet by email?
3. We will be including your organisational name as part of our report. Do you wish to have your name and job title included also?

ALL: Demographics:

4. Please confirm your name, role, job title, organisation.
5. How long have you been in that role at that organisation? In the aged care sector?

Provider demographics:

6. How many RACFs do you operate? In which states/territories?
7. What operations does your parent organisation have other than residential aged care (e.g., home care, community care, disability, other)?
8. Are you for-profit, non-profit or a Government employer?

PROVIDERS/EMPLOYEES: Org/Provider employee details:

9. Approximately how many employees are in your facility/organisation/membership?
10. Approximate percentage of full/part, casual employees in your facility/organisation/ membership? Do you use agency staff for unplanned absenteeism etc?
11. If your organisation is a NFP with PBI status, what percentage of employees salary sacrifice? If yes, what is the split of take up of salary sacrifice between corporate and management compared to front line service delivery roles?
12. What is your employee turnover/retention?
13. If you have had a COVID-19 outbreak at your RACF, please tell us briefly about that.

ALL: Single-site employment content

14. How familiar are you with the COVID-19 Single Site Employment (SSE-GP) practices?
15. To what extent are you familiar with the Guiding Principles for those practices?
16. Please explain the impact of Guiding Principles on your organisation/members.
17. To what extent have those impacts been positive or negative? In what way are those impacts positive? In what way are those impacts negative?
18. Did you have an SSE-GP policy before COVID-19 came along?

19. Will you be considering a change to multiple site employment or SSE-GP practices in the near future? Why or why not? If not, are you considering an SSE-GP policy going forward?
20. Do you keep a WHS or other register of any employees with multiple jobs?

ALL: Future of SSE-GP

21. What specific benefits do you see that single-site practices have on employees?
22. What disadvantages do you see those practices might have for employees?
23. What other comments or observations would you make regarding these practices?

Clinical impact:

24. Has patient centred care changed? Improved, decreased or remained the same?
25. What impacts do you think SSE-GP practices may have on resident's clinical care? In what ways, and why might that be?
26. To what extent have single-site practices been successful in controlling infection?

SSE-GP future and bureaucracy:

27. To what extent would you wish to see an extension of the SSE-GP practices beyond COVID-19 crises? Why, or why not?
28. What do you see as the major barriers or obstacles to implementing SSE-GP practices outside a COVID-19 crisis?
29. Please comment on administration and applying for funding of Government grants for the Guiding Principles in terms of interpreting, collecting and collating data.
30. Do you believe SSE-GP practices should be mandatory or voluntary? Why/why not?
31. What ongoing support do you think may be required for SSE-GP beyond 30th November?
32. Do you see any benefits of agency/labour hire and allied health professionals being included in SSE-GP practices and the Guiding Principles for Victoria?

Employees (remind employees this is confidential, will be de-identified and used to further understand employee situations):

33. Do you now, or did you before COVID-19 have more than one job?
34. If yes, was it in aged care or outside aged care?
35. How many hours extra is it per week?
36. Have you disclosed this other role to each of your employers?
37. Why have you taken up extra roles? Is it for financial reasons or for career development reasons or because you enjoy the variety etc.?
38. Would you prefer to have only one employer?
39. What are advantages/disadvantages of a single employer?

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