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Single-site employment (multiple jobholding) in residential aged care: A response to COVID-19 with wider workforce lessons

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Abstract

Objective: This study aimed to capture stakeholder views and issues arising from the implementation of the innovative single-site employment guiding principles (SSE-GP) that the Australian Government, in consultation with the sector, introduced into hot spot residential aged care facilities (RACFs) in July 2020 in response to COVID-19.

Methods: Interviews with 74 stakeholders around Australia were conducted in October–November 2020. Provider interviews included employees and managerial and human resources staff in profit and non-profit services who did, and did not, have COVID-19 outbreaks. Sector interviews included representatives from peak bodies, unions, government, academics, advocates, labour hire and registered training organisations.

Results: There was broad but not total agreement on SSE-GP's effectiveness. Beyond specific SSE-GP feedback, six strategic workforce issues were identified. The quality of resident care was mixed, sometimes improved and sometimes diminished. The extent of employees' multiple jobholding surprised many providers, and rostering and unplanned absenteeism are a substantial strain for both providers and employees. Innovative work practices are often difficult for smaller providers lacking employment relations specialists. Future SSE-GP is seen by larger providers as voluntary and organisation- rather than facility-specific, and unions saw only mandated SSE-GP as appropriate for future outbreaks. Last, all staff, management and executives had additional stress that placed their well-being at risk.

Conclusions: Although SSE-GP revealed new and existing weaknesses in the Australian RACF workforce, the broad industry consultation and collaboration demonstrated that the sector can meet COVID-19's urgent and complex challenges. The experience provided lessons for further workforce challenges that remain to be addressed.

KEYWORDS

change management, COVID-19, human resources, infection control, residential aged care, workforce

1 | INTRODUCTION

Nurses, personal care workers, allied health and related staff provide essential services attending directly to residents' clinical, personal and daily needs in residential aged care facilities (RACFs). While this workforce has always been alert to infection control given the potential for influenza and gastric outbreaks, the contagion and fatality rates of COVID-19 were an unprecedented danger to residents. In Australia's second wave between July and November 2020, there were 648 COVID-19 deaths in Victorian RACFs.[1] The potential for rapid COVID-19 spread put RACFs on alert nationally.

As an urgent response to managing COVID-19 in RACFs in metropolitan Melbourne and adjoining Mitchell Shire, service providers, unions, peak bodies and governments consulted and collaborated to develop and introduce the innovative single-site employment guiding principles (SSE-GP), online support hub and hotline in July 2020. As staff working in more than one home had been seen as a key factor in COVID-19 transmission,[2] the principles encouraged employees in declared hot spots to nominate and work in only one RACF and to ensure those employees were not financially disadvantaged. Providers' additional SSE-GP-related workforce expenses were funded by the Australian Government, other than public sector RACFs that the Victorian State Government covered. While SSE-GP was voluntary, not mandated, for both providers and employees, most providers were motivated to adopt the principles.

Beyond staff working across RACFs, implementing SSE-GP drew attention to several other aspects of residential aged care workforce management. This paper focusses on six strategic workforce issues drawn from a full report on SSE-GP learnings presented to stakeholders.[3] In recognising the critical relationships between workforce management and resident care quality,[4] these six strategic workforce issues complement the extensive coverage of residents' direct experience recounted in the special report on COVID-19 in aged care presented in the Royal Commission on Quality and Safety in Aged Care.[5]

Policy Impact

This study found that government and industry can work together on difficult, urgent and complex aged care issues in which all parties have responsibilities. This demonstrates future aged care workforce issues can be addressed from multiple stakeholder perspectives when parties are willing.

Practice Impact

The study highlights a number of workforce issues that service providers could review to improve operational effectiveness, person-centred care and employee satisfaction and commitment. Reviews could be conducted on workplace profiles and employment status, rostering and absenteeism practices and well-being of all employees, including management and executives, as well as direct care staff.

2 | METHODS

The authors were commissioned by Aged and Community Services Australia on behalf of the sector-led consortium comprising the Guild, Leading Age Services Australia, Health Services Union, Health Workers Union, Australian Nursing and Midwives Federation, and the Australian Department of Health to research and report on stakeholder experiences with SSE-GP implementation. The study, approved by Macquarie University Human Ethics Committee (Ref: 52020917021943), was conducted in October–November 2020. The SSE-GP had been in place for around 3 months, Melbourne and Mitchell Shire were in lockdown, and other cities went into lockdown as COVID-19 outbreaks occurred. The report included a rapid review of the local and international literature on human resources (HR) practices in RACFs and international HR practices under COVID-19 conditions. The 74 interviews of 25–60 min were conducted remotely. Nominated by the Advisory Committee and invited to participate by email from the researchers, seven interviews were conducted with representatives from government, unions, and peak bodies, and six interviews were conducted with representatives from advocacy organisations and other recognised experts in aged care, health economics and HR. Encouraged to volunteer by their peak bodies and formally invited to participate by email from the researchers, 35 interviews were conducted with management representatives (CEOs, HR, operational or care managers) of provider organisations. Fourteen of these had experienced a COVID-19 outbreak (nine non-profit and five for-profit). Invited by providers, unions and support hub notices, just 12 front-line personal care workers volunteered and were interviewed, due largely to the workplace conditions and short time frame.

Given the pace and urgency of the research and interviewees' workplace demands, both researchers attended most interviews to ensure completeness and comprehensive note-taking, and to enable discussion and reflection on findings during and after data collection. The iterative

data collection included checks in later interviews on information provided in earlier interviews.

To ensure accurate recollection, interviews (with three exceptions) were audio- or video-recorded, depending on the technology available, and transcribed. Transcripts were stored in NVivo[6] where codes were developed for each main interviewee type. Initial coding by one researcher and check coding by the other enabled interview responses to be compiled and compared for thematic analysis.[7] Themes were identified at an explicit, surface data level of meaning. While particular themes of analytic interest were identified deductively (quality of resident care, multiple jobholding and the future of SSE-GP), further themes emerged inductively from patterns recurring in all or most interviews (scheduling and rostering, job design and employment relations, and workforce stress and wellbeing). For example, the code 'Staff rostering' contained 109 references from 63 interview files. Interviews were classified and results cross-checked for relevant potential moderators such as provider status (size, profit/non-profit or outbreak), and interviewee rank, occupation and sex.

3 | STRATEGIC WORKFORCE ISSUES

Beyond specific SSE-GP feedback, many of the issues arising were evident prior to COVID-19 but became more obvious or amplified under SSE-GP conditions. Although some different issues were raised by interviewees, there was high commonality across different stakeholder perspectives. A few divergent issues are flagged.

3.1 | SSE-GP impact on quality of resident care

Providers reported positive outcomes from improved continuity of care as fewer staff worked more hours in a single home and so developed better personal and clinical knowledge and understanding of those residents. Most also reported improved personal care, as staff were more likely to notice changes in residents' functioning and provided extra personal, emotional and social support to residents who were often restricted to their rooms. Staff–resident relationships were often stronger, and communication between management and staff improved with a more consistent and stable workforce, with positive effects on residents. Care workers learned new skills and used technology such as FaceTime family visits that will continue beyond the pandemic.

Reports regarding clinical care were mixed, depending on whether the facility had a COVID-19 outbreak and how many staff were impacted by SSE-GP. Some providers were confident there was no change in clinical care, but others said it was too early to know, preferring to wait for data before commenting. Most providers agreed SSE-GP was another tool that helped control infection by reducing COVID-19, influenza and gastrointestinal infection transmission from staff to residents and between staff who worked across multiple homes.

Negative impacts on resident care were also reported as employees chose just one RACF as their primary worksite. Short-term crisis management was required in facilities with an infection or outbreak, and significant staff losses occurred at short notice due to staff isolating or quarantining requirements. It is likely some immediate clinical care needs were not met during these early emergency periods. Productivity was reduced when early replacement workforces unfamiliar with the residents or the facility's clinical policies and practices faced steep learning curves. Two interviewees said that fewer allied health treatments, especially physiotherapy, could lead to resident deterioration. Strategic projects were delayed as SSE-GP placed pressure on staff not just in the front line, but executive, management and back-of-house operations.

3.2 | Multiple jobholding

Many providers said they were surprised at the number of employees with second or more jobs, called multiple jobholding (MJH). Around nine per cent of the RACF workforce reported MJH in 2016[8] (not reported in 2020).[9] Yet, the range of MJH reported was from two per cent in a single-site provider up to 58% in a larger multisite provider. Most providers estimated their MJH reporting as they did not have formal policies requiring MJH declaration or approval. Only three referred to MJH, 'moonlighting' or conflict of interest in their workplace policies and practices, collective agreements or letters of offer. They said they were unsure if they were enforceable. From a workforce health and safety perspective, they said as MJH may put residents and staff at risk, it should be disclosed and managed appropriately.

Almost all employees, however, said their employers were aware of their second jobs as they had informally declared them prior to the COVID-19 pandemic. They said the main reason they had a second job was that they needed to generate a full-time income to meet their regular financial commitments and so they worked two part-time jobs. Other reasons included security in case one job was discontinued, and fitting into study commitments. Most said they would prefer one full-time job rather than two part-time jobs, but unless the hourly rate was higher, they would always need multiple jobs.

3.3 | Scheduling and rostering

Single-site employment guiding principles put extra pressure on rostering and scheduling. Providers reported ongoing, ever-changing, improvised rostering as posted rosters gradually eroded and schedulers resorted to 'patching'[10] to balance organisational, resident and employee needs.

While most providers said they posted rosters with two weeks' minimum notice, unions highlighted planning difficulties and called for four to six weeks' notice. Research supports this, as unanticipated changes in work patterns at short notice are one of the most stressful aspects of aged care work.[8]

Some providers gave several reasons for high proportions of part-time roles relating to flexible staffing needed on operational grounds, but not all appear to be supported. For example, some cited the need to increase or decrease hours quickly in a 24/7 business with unexpected rostering changes. However, other providers said staffing needs are relatively stable when occupancy rates are stable, and master rosters were only updated periodically or as part of annual budgeting processes. All providers said their rosters change after posting, often with many changes when unplanned absenteeism could reach as high as 20%. Absenteeism was managed in different ways: most staff cancelled shifts by phone or text to an administrator, but two providers with centralised rostering and backfilling took cancel calls centrally. One manager who reported very low absenteeism required all cancellations by phone to her only.

Another part of the federal government's response to COVID-19 was to allow staff on the international student visas to work more than the 20 hour limit that normally applied. Several providers called for relaxing this visa restriction for wider workforce shortage situations.

3.4 | Job design and employment relations

Although SSE-GP was voluntary for both providers and employees, an issue provider raised frequently was the legality of potentially restricting an employee's capacity to earn if employees did not voluntarily follow the guidelines. Three providers, concerned their employees may continue to hold multiple jobs, sought employment relations legal advice but were yet to resolve the issue.

A second issue raised frequently was multiskilling to support cohorting, or consistent assignment[11] of the same staff to the same group of residents. While larger multisite providers often share staff across sites for operational efficiency, learning and development or succession planning, few employees cross departments (e.g. caring, catering, laundry) within a site. The pandemic demonstrated the advantage of cohorting where possible to reduce traffic and improve infection control.

Third, several large multisite providers said they would like to more easily redesign jobs to enable greater flexibility. One said that creating a quasi-carer clinical role with clinical, caring and family communication responsibilities for certain residents requires a higher skill level than current carer roles but not full nursing skills, and could create high care continuity. They said this hybrid-type role could be an important component in a career ladder.

3.5 | Voluntary or mandatory future of SSE-GP

With respect to the future of SSE-GP, there was a strong view among providers and employees that SSE-GP should be voluntary. Cooperation was preferred to coercion, with both providers and employees expected to be mature enough to make responsible decisions when funding is available. However, unions expressed a strong preference for mandatory SSE-GP with attached funding. In contrast to what they saw as ad hoc compliance, unions emphasised that mandated and funded SSE-GP required providers to implement practices consistently to ensure that employees were not disadvantaged.

Providers expressed concerns about potential long-term SSE-GP implementation. They said that workforce attraction and retention would be adversely affected if the ability to earn a living wage through MJH was not possible. They said current staff could leave the sector and existing shortages would be made worse, especially in regions with workforce shortages in other sectors. Three smaller providers who sometimes used secondary acute care employment for supplementary learning and part of their employee retention strategy said that learning opportunities from many second jobs would be lost. Three regional providers told us their registered nurses, particularly, gain clinical exposure, training and knowledge that they used and shared with others. Alternatives proposed for the future include single *employer* rather than single *site* employment and restricting employee sharing to defined geographic areas.

3.6 | Workforce stress and well-being

The most widespread impact of SSE-GP on stress and well-being reported was frontline staff exhaustion from providing extra support to residents and managing their changed SSE-GP work–life schedules, beyond the

increased use of personal protective equipment (PPE) and fears for their own and their families' health in lockdown. Further, financial and psychological burdens occurred where management, administrative, finance, payroll, HR and other backroom staff were hired or redirected for SSE-GP activities, where additional workloads included planning and collecting employee data on second jobs, identifying primary employers, seeking evidence of hours in second jobs, collecting rostering and payroll data, and preparing grant funding applications, staff communications and individual correspondence such as leave of absence confirmations and employee queries.

Second, SSE-GP was seen as another burden on managers working under extremely stressful conditions for many months, irrespective of whether their facilities had outbreaks. These impacts affected both small providers who had to absorb the extra activities while delivering their usual service, and large providers for whom resident, staff and fiscal responsibilities were extended to multiple sites.

4 | IMPLICATIONS

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 RACFs will ever be isolated. SSE-GP's effect on highlighting several workforce issues, however, provides some insights into approaches that might be applied in addressing other critical aspects of workforce management in a nationally collaborative and consistent manner. Notwithstanding the exceptional circumstances in which SSE-GP was introduced in Victoria and later adopted more widely, we speculate that findings from this innovation have implications for translation into workforce management practice more generally and over the longer term.

The first is that major interventions are best integrated with other measures to gain optimum outcomes. In situations less urgent than COVID-19, multiple stakeholders collaborating and co-designing strategies that incorporate complementary measures are likely to achieve better outcomes than single-source imposed measures. The SSE-GP Support Hub's critical role suggests a central dedicated contact point providing prompt consistent information, advice, referral, monitoring and issues-tracking could be critical to other sectorwide initiatives, perhaps such as minimising the use of restraints.[12]

The second implication arises around employee MJH prevalence, declaration and registration, the costs and benefits of MJH to both providers (including absenteeism, rostering) and employees (including fatigue, turnover, commitment), and the optimum proportions of casual, fixed and part- or full-time employees. Understanding MJH is fundamental to better workforce planning and management. We note that prior research shows providers' concerns about the quality of resident care when staff were overworked and risks of physically tired employees being more vulnerable to work injuries appear justified.[13] Further, employees require extra physical and mental effort to schedule, attend and perform in multiple jobs. The extra 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 may contribute to the sector's reported high absenteeism and other poor workforce outcomes.[14] While several stakeholders said SSE-GP could strengthen staff commitment and workplace culture, further research is required to assess the 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.[15]

Further, we speculate that part-time hours and pay appear to encourage MJH for some of the multiple employee profiles we observed (Table 1) and pose a barrier to a sustainable workforce as a 'vicious cycle' may develop. The MJH fatigue and shift maximising may lead to high absenteeism, when providers may be prompted to offer and schedule part-time work. Flexible rostering of those part-timers to backfill absenteeism may result in uneven and inconsistent work. Those part-timers' increasing sense of insecurity prompts them to hold a second job. Beyond all these effects on HR practices, the supposed cost savings of part-time work compared to paying overtime for fewer workers may not be realised, but instead incur direct and indirect recruitment, onboarding and other turnover employment costs.

Third, it may be that the voice of personal care workers needs stronger representation in negotiations over initiatives affecting their work. As the largest and most diverse part of the residential care workforce and closest to residents, it could be useful to understand how their voice is heard regarding residents' views and concerns, their pay and conditions, and initiatives to advance their skills, roles and career pathways.

Fourth, while the burgeoning literature on international experience of COVID in aged care reports a wide range of approaches, direct cross-national applications are limited by differences in aged care systems. An exception is between Australia and New Zealand: although COVID-19 has had much less effect on aged care in New Zealand, similarities in the structure of the aged care sector, in workforces and working conditions,[16] mean these

TABLE 1 Summary profile of six aged care workforce segments observed

Staff profile	Description, examples
Permanent full time: Standard roles	Includes administration, accounts, clinical, facilities, finance, human resources, IT, marketing and other functional or overhead staff. Some direct carers and nursing staff may include lifestyle, catering and laundry. Usually work a standard 76 h/fortnight.
Permanent full time: Facility management	Already working more than full time, when no other backups are available, are required to backfill for care staff at short notice.
Permanent part time: Contented part-timers	Frequently women with young children, often second household income, and others for whom 16 to 24 h/week is sufficient.
Permanent part time: Seeking full time	Unable to find a full-time aged care job, works two jobs to make a full income. Possibly seeks penalty shifts and overtime to maximise their income.
Permanent part time: Seeking more than full time	A few work more than 100 h/fortnight, perhaps double shifts across two homes with 30 min between shifts. Providers see these employees at risk of fatigue or injury, while employees see the opportunity to maximise their income. Many would continue to work two jobs even if one were full time.
Casuals	Part of the pool of emergency or surge workforce may work elsewhere but with insufficient or uncertain hours, or new to the sector, they need to create, supplement or backup primary employment. Most prefer permanent over casual work.

findings are likely to apply there in managing any future epidemics, and more widely.

Finally, rather than the traditional view of a single workforce, the study found a broader perspective of the RACF workforce to be segmented and diverse. A comprehensive survey of all categories of workers would give a more in-depth account than was reported in the 2020 Aged Care Workforce Census.[8] Building on previous surveys, new questions on MJH, COVID-19 experiences, part- and full-time employment, and manager stress and well-being could be included for both managers and direct care staff, and would enable comparison of perceptions. Standardised HR and workforce management metrics could generate key indicators of this dimension of quality of care.

With the help of SSE-GP to minimise COVID-19 spread, almost all (93%) outbreaks in the July-to-November 2020 wave occurred in just 10% of Melbourne RACFs.[1] The shared success of the SSE-GP development, collaboration and implementation demonstrates a model for addressing the sector's future challenges.

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CONFLICTS OF INTEREST

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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