Senior manager leadership competencies to promote and protect Australian residential aged care quality of care.

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Abstract

The Australian population is rapidly ageing, placing increased service demand on residential aged care facilities. Concurrently, longstanding concerns about the quality and safety of aged care services have emerged with the 2020/21 Royal Commission into Aged Care Quality and Safety describing the national system designed to care for older Australians as "neglectful" and "woefully inadequate". The same commission reported that leadership competencies and strategies required by managers to promote quality of care were poorly defined compared to international residential aged care services and other Australian mainstream health care organisations. This PhD drew on the *Skills Approach to Leadership Theory* and applied the interpretive descriptive methodology to identify the critical knowledge, human, technical and conceptual skills required by senior managers in Australian residential aged care settings to promote quality of care. Senior managers play an important role in promoting and protecting quality of care, but globally and in Australia, there remain significant gaps in knowledge regarding the specific competencies and skills required of leaders in the clinically and administratively complex setting of residential aged care.

Drawing on in-depth interviews with residential aged care senior managers (n=19) operating in regional, rural and remote northern Queensland, and Australian aged care industry and academic experts (n=12), this PhD qualitatively examined the challenges faced by regional, rural and remote senior managers in contemporary Australian residential aged care facilities; and from the perspective of managers, provider and consumer advocates and other experts inductively identified the knowledge, skills and traits necessary to protect quality of care in this complex service environment. Bringing the qualitative findings together, a framework synthesis subsequently mapped the identified competencies against those listed in leadership frameworks from other sectors, producing an empirically-grounded (preliminary) leadership competency framework for residential aged care senior managers, the Residential Aged Care Senior Manager Quality Framework (RCSM-QF). The framework comprises two key elements: personal qualities and leadership skills, with the latter comprising five domains, including: i) culture and environment; ii) stakeholder relations; iii) clinical and aged care expertise; iv) asset management; and iv) disaster and change management.

Findings from this PhD give voice to the experiences and perspectives of frontline residential aged care senior managers regarding the challenging structural environment in which they work, including chronic underfunding and an inadequate national regulatory regime; and add to the evidence base regarding the crucial business, communication, and clinical skills needed to deliver on quality of care in those settings. By combining data from interviews with frontline senior managers and Australian aged care industry experts, the PhD delivers much-needed empirical evidence of the different types and combinations of skills and competencies needed by aged care senior managers and consolidates

these into a preliminary leadership framework that, once validated may assist in the recruitment, appraisal and professional development of competent senior managers nationally. This work thus not only addresses key gaps in the literature and evidence base regarding senior management competencies but represents an important and timely first step in responding to Royal Commission recommendations to strengthen leadership in the sector.

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Abbreviations

AAG	Australian Association of Gerontology
ABF	Activity-Based Funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AN-ACC	Australian National Aged Care Classification
ASGS	Australian Statistical Geography Standard
CEO	Chief Executive Officer
CHSP	Commonwealth Home Support Program
DoH	Department of Health
DON	Director of Nursing
FP	For-profit
HCPs	Home Care Programs
HLA	Healthcare Leadership Alliance
ID	Interpretive Description
IOM	Institute of Medicine
IPEC	Interprofessional Education Collaborative
JCU	James Cook University
LEADs	Leads self, Engages others, Achieves outcomes, Drives innovation and Shapes systems
MMAT	Mixed Methods Appraisal Tool
NCHL	National Centre for Healthcare Leadership
NFP	Non for profit
NHA	Nursing Home Administrator
NHMRC	National Health and Medical Research Council
NHPF	National Health Performance Framework
NQPHN	Northern Queensland Primary Health Network
OECD	Organisation for Economic Co-operation and Development
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines
QoC	Quality of care
RAC	Residential Aged Care
RCSM-QF	Residential Aged Care Senior Manager Quality Framework
SDG	Sustainable Development Goals

Chapter 1
Introduction

This introduction provides a brief background on the aged care sector in Australia and the context for my programme of research. It positions my work in the evidence base, provides an overview of the thesis, summarises the chapters and describes the significance of this work.

1.1 Background

Australia's population is ageing, with the proportion of people aged 65 years or over projected to increase from 16 % (2018) to 23 % in 2066 (Australian Bureau of Statistics, 2021). In line with national ageing trends, the demand for Australian residential aged care services is also increasing (Khadka et al., 2019), and there have been ongoing concerns about the quality and safety of that care (Caughey et al., 2020). Indeed, the recent Royal Commission into Aged Care Quality and Safety described a "cruel and harmful" national aged care system comprising services that were "neglectful" and "woefully inadequate" (Royal Commission into Aged Care Quality and Safety, 2019). The leadership of these services, including that provided by residential aged care senior management teams, was described as "lacking", and leadership responsibilities and accountabilities for promoting quality of care were found to be "poorly defined" (Royal Commission into Aged Care Quality and Safety, 2021). Accordingly, the Commission *Final Report* recommended that professional development and continuous learning activities be formed to enhance the competence and confidence of aged care leaders for improved quality of care.

The senior manager role and quality of care

Spanning multiple healthcare settings, including residential aged care, senior managers play an important role in promoting and protecting quality of care (Parand, Dopson, Renz, & Vincent, 2014). In the context of acute hospital services, Bradley et al., (2013) reported that competent senior managers positively influence quality of care by forming effective relationships and personally engaging with clinical staff (Bradley et al., 2013). In addition, senior managers are responsible for promoting an organisational culture that aligns with a vision for continuous quality improvement and procuring and allocating the resources required for better health-related outcomes (e.g., contemporary healthcare technologies) (Braithwaite, Herkes, Ludlow, Testa, & Lamprell, 2017). Managers also play a critical role in evaluating the quality-of-service delivery by monitoring and providing feedback to clinical staff against quality-of-care performance indicators (A. Burgess, van Diggele, Roberts, & Mellis, 2020). In residential aged care facilities, senior managers, including Directors of Nursing (DONs) and Chief Executive Officers (CEOs), are primarily responsible for the day-to-day linking of governance, operations management, and service delivery, including as interpreters and initiators of policies that influence quality of care (Dingley, Daugherty, Derieg, & Persing, 2008). They also

direct, monitor, and lead a diverse team of aged care employees in developing and implementing strategies to achieve quality health-related outcomes for older care recipients (Bombard et al., 2018).

Leadership competencies for high-quality care

The ability of senior managers to promote high-quality care depends significantly (although not entirely) on the leadership competencies (abilities, behaviours, knowledge and skills) they possess (Sonmez Cakir & Adiguzel, 2020). Herd, Adams-Pope, Bowers and Sims (2015) found that American hospital leaders, including senior managers [executives] who influence high-quality care, often possess the ability to establish a workplace culture of connection and purpose; a thorough understanding of the healthcare landscape in which they operate [knowledge], and the skills to successfully plan and implement change aimed at improving health-related outcomes (Herd, Adams-Pope, Bowers, & Sims, 2016). Furthermore, healthcare leaders who promote quality of care often possess the skills to form effective working relationships with clinical staff, the care recipient, and their families (Bombard et al., 2018; Moudatsou, Stavropoulou, Philalithis, & Koukouli, 2020). For example, a systematic review by Cummings et al. (2010) exploring leadership styles to promote healthcare organisational outcomes, reported that senior nursing managers with relationship management and communication skills, including effective active listing techniques and the ability to engage appropriately with employee concerns, were more likely to motivate clinical staff resulting in a higher quality of care (Cummings et al., 2010). Managers with proficient communication skills also promote team collaboration, with clinical staff assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions, to formulate and carry out plans for improved quality of care (O'Daniel & Rosenstein, 2008).

Empirical evidence also points to a range of relational, technical, and administrative leadership competencies that influence residential aged care and quality of care (Siegel, Leo, Young, & Castle, 2014; Zonneveld, Pittens, & Minkman, 2021). In American nursing homes (residential aged care facilities), Directors of Nursing with effective communication skills and participatory management practices were founds to enhance staff engagement with quality improvement initiatives (Zonneveld et al., 2021). Furthermore, managers who can form therapeutic and compassionate relationships with residents and their families are more likely to influence improved healthcare outcomes within their respective organisations (O'Toole, Bamberry, & Montague, 2021). In the context of Australian residential aged care facilities, O'Toole, Bamberry, & Montague (2021) pointed to a range of technical and administrative skills required by managers across multiple facility levels and managerial roles (e.g., frontline, middle and senior managers). Competencies include a manager's ability to successfully implement an organisational strategic vision for quality improvement, manage finances and budgets for appropriate resource allocation, and successfully implement change for quality

improvement within the industry and their respective organisations (O'Toole et al., 2021). Asante, Zúñiga & Favez (2021) found that Swiss residential aged care senior managers who possess basic clinical knowledge and skills often plan and implement episodes of care that appropriately meet the complex healthcare needs of older care recipients(Asante, Zúñiga, & Favez, 2021).

1.2 Statement of the problem

In Australia, there is now growing recognition of the need to better understand the skills and knowledge required by senior managers to address aged care quality concerns, many of which are amplified in regional, remote and rural communities (Savy, Warburton, & Hodgkin, 2017). In 2018, The Royal Commission into Aged Care Quality and Safety was established following more than 5,000 submissions detailing inadequate care and safety breaches in the Australian aged care sector (Royal Commission into Aged Care Quality and Safety, 2019). The Commission's *Final Report – Care, Dignity and Respect* comprised 148 recommendations to "remedy" Australia's "broken" aged care system (Royal Commission into Aged Care Quality and Safety, 2021). With reported concerns regarding the competence of aged care leaders, including residential aged care senior managers, it was recommended that leadership personnel possess professional qualifications, managerial competencies, and high-level experience to better execute their roles and responsibilities (Royal Commission into Aged Care Quality and Safety, 2021). It was further suggested that organisations, including education providers, plan to manage and support staff leadership training, professional development and continuous learning for improved and sustained quality of care (Royal Commission into Aged Care Quality and Safety, 2021).

Existing studies have generated some knowledge regarding leadership requirements for aged care services globally, although evidence gaps still exist. Seminal work by Jeon, Merlyn, and Chenoweth (2010) and Zonneveld, Pittens, and Minkman (2021), explored literature on leadership and its link to quality residential aged care. These foundational reviews identified the important link between positive leadership *practices* (including leadership styles and behaviours) and patient satisfaction in the aged care sector, and concurrently, reduced adverse events and high-quality of care. (Jeon, Merlyn, and Chenoweth, 2010; Zonneveld, Pittens, and Minkman, 2021). More focussed explorations of leadership *competencies* required of senior managers in residential aged care specifically, however, remains a gap. To my knowledge, no review has yet sought to identify studies specifically focused on the leadership competencies of residential aged care senior managers for quality of care in the Australian setting. This is significant given the (increasingly well recognised) role that senior managers play in balancing the challenges of a complex regulatory, clinical and relational environment.

With empirical evidence of *which* leadership competencies are required by senior managers in Australian residential aged care still elusive, there also remains an absence of empirically based competency models or frameworks that could inform the development of training curricula or guide the formation of professional development activities specific to residential aged care senior managers. Seminal work in the domain of Australian aged care leadership was conducted by Jeon et al (2015) in validating a clinical leadership framework, the Aged care *Clinical* Leadership Qualities Framework (ACLQF), for middle (mainly clinical) managers in a mixture of aged care services including community-based and residential aged care (Jeon et al., 2015). In 2014, Aged & Community Services Australia (ACSA) developed the Australian Aged Care Leadership Capability Framework. While this framework reflected an important step forward, its inclusion of different leadership levels (frontline, middle- and senior managers) and multiple service types (residential, acute and community aged care provider organisations) meant it was necessarily general in nature. Specificity concerning the multi-faceted and demanding nature of residential aged care facilities (Aged and Community Services Australia, 2014) is absent from that framework. Furthermore, the ACSA framework describes leadership capabilities (statements of behaviours, skills, knowledge that affect an outcome), but not competencies (a measure or index of how well a person performs that capability) and does not explicitly link these to promoting quality of care.

Against the backdrop of an ageing population, increasing demand for Australian residential aged care services and concurrent concerns regarding the quality of that care, there is a clear need to understand which types and combinations of competencies are required by senior managers to provide effective leadership in these facilities. With a view to grounding the inquiry in the knowledge and experiences of senior managers themselves, this PhD sought to identify the challenges faced by Australian residential aged care senior managers in delivering high-quality residential aged care and the leadership competencies required to address these concerns. Part of this programme of work took a 'remote and regional' focus to recognise the additional challenges associated with service leadership in more geographically remote locations. Building on this knowledge, this research aimed to develop an empirically based, preliminary leadership competency framework to assist the recruitment, appraisal and development of competent senior managers within the Australian residential aged care setting.

1.3 Thesis Aim and Objectives

Aim: *To characterise the leadership competencies required by senior managers to promote and protect quality of care within Australian residential aged care facilities.*

Objectives:

1. Determine and discuss the prevailing challenges towards ensuring quality of care in Australian residential aged care facilities.
2. Identify and synthesise senior manager leadership competencies influencing high-quality residential aged care in Australia.
3. Develop a preliminary aged care quality framework mapping senior management leadership competencies that may enhance quality of care in Australian residential aged care facilities.

1.4 Thesis Outline

This PhD utilises an interpretive description methodology to qualitatively explore senior managers' knowledge, human, technical and conceptual skills that promote high-quality residential aged care in Australia. The thesis is organised into nine chapters, four of which are peer-reviewed journal publications reformatted into 'chapters' per University requirements. Below is a summary of the chapters in this thesis:

Chapter 2 is a literature review examining current knowledge regarding senior manager leadership characteristics and quality of care in residential aged care facilities. The literature review was initially conducted in 2018 and published in the *International Journal of Healthcare Management* on 11 December 2019 (Appendix 1). The chapter presented in the thesis represents an updated version of the published paper, including a refined and updated search strategy to include relevant literature from January 2019 through May 2022.

Chapter 3 describes the context of the study, including the formal structures of Australia's aged care system, the services available, funding models, and regulatory and legislative environments. Current and projected challenges facing the Australian aged care sector are described.

Chapter 4 is an unpublished methods chapter that details the research design, philosophical principles, theoretical and conceptual bases, data collection and analysis methods, and ethical aspects of the PhD. Qualitative data collection involved in-depth interviews with residential aged care senior managers operating in regional, rural and remote northern Queensland facilities and Australian aged care industry experts. Subsequently, a framework synthesis mapped reported leadership competencies against pre-existing leadership frameworks in related fields.

Chapter 5 is a (reformatted) published manuscript that addresses objective 1. It reports the challenges experienced by residential aged care senior managers operating in regional, rural and remote

Queensland and maps these against concerns for quality of care. The chapter gives voice to senior managers' experiences in the context of a significantly dysfunctional national aged care system, highlighting their critical role in addressing resource, regulatory, finance and recruitment challenges. This chapter was published in the journal *Societies and Humanities Open* on 21 June 2022. A copy of this manuscript is presented in - Appendix 2).

Chapter 6 is a (reformatted) published manuscript and addresses objective 2. This chapter is an exploration of the senior manager's leadership competencies required to address the challenges reported in the previous chapter (Chapter 5), alongside other structural elements contributing to residential aged care quality vis-à-vis the perceptions of Australian aged care senior managers. This chapter qualitatively explores the leadership competencies that a group of Australian residential aged care senior managers perceived as critical for promoting quality of care within regional, rural, and remote facility settings. It was published in the journal *BMC Health Services Research* on 18 May 2022 (a copy of this manuscript is presented in - Appendix 3).

Chapter 7 is a (reformatted) published manuscript that addresses objectives 1 and 2. The chapter extends on the new knowledge presented in chapters 5 and 6 to qualitatively explore the views of Australian aged care industry experts regarding which senior management leadership competencies are necessary to deliver and strengthen the quality of care in residential aged care, to improve understanding of the professional development needs of leaders in the sector. Enhancing the analytical generalisability of these empirical findings, industry experts were recruited from national organisations, across various locations and jurisdictions, including academics, primary health network representatives, and provider and consumer advocates. Empirical findings from this chapter were published in the *BMC Health Services Research* journal on 8 May 2022 (a copy of this manuscript is presented in - Appendix 4).

Chapter 8 comprises a synthesis of the results from chapters 5 – 7, but the focus of the chapter is on describing the development of the Residential Aged Care Senior Manager Quality Framework [RCSM-QF), a preliminary leadership competency framework specific to the Australian residential aged care setting (objective 3). To my knowledge, the preliminary RCSM-QF is the first that maps Australian senior manager competencies to residential aged care and quality of care. The framework design comprised multiple methods, which increased the robustness of the findings and allowed for triangulation and cross-validation using different sources: a literature review, in-depth interviews, and existing senior-management focused leadership frameworks.

Chapter 9 provides a synthesis of the main study findings offered from each empirical chapter in the context of relative strengths and limitations. The chapter addresses the potential implications of this programme of work for future practice, policy, and research in the Australian aged care sector. A list of references for the thesis and appendices noted throughout the chapters are then presented.

Chapter 2
Literature review

2.1 Chapter Introduction

This chapter synthesises and critiques the current knowledge regarding senior manager leadership characteristics and quality of care in residential aged care facilities. The chapter is based on a review initially conducted in 2018 and published in the *International Journal of Healthcare Management* (Appendix 1.) but subsequently refined through the inclusion of new key search terms (adding leadership competenc*' or skill* or personal qualit*) and updated to include a search of literature from January 2019 through to May 2022.

A systematic scoping review was conducted to map the literature on senior managers' skills, competencies and leadership styles in residential aged care facilities. Of the 20 articles included, most were from the United States and none from low and middle-income countries. Findings indicate that there is limited evidence of a link between senior management leadership styles, behaviours and competencies and the quality of residential aged care. The discussion considers the implications of the state of the evidence on senior management characteristics in residential aged care settings in this thesis and the field more broadly.

2.2 Background

Emerging concerns in residential aged care

Globally, population ageing is accelerating (United Nations, 2018). In 2017, there were approximately 962 million individuals aged 60 years and over; by 2050, this figure is expected to reach 2.1 billion (Schultz, André, & Sjøvold, 2016; United Nations, 2018). The concurrent rise of complex co-morbidities among aged populations, including dementia, depression and multiple chronic non-communicable diseases, have well-recognised implications for mainstream health systems (Royal Commission into Aged Care Quality and Safety, 2019). Yet there has been only relatively recent recognition of the impact of these forces on the systems and residential aged care facilities internationally (Lin, Otsubo, Sasaki, & Imanaka, 2016).

In many countries' residential aged care sector, increasing population pressure now runs concurrent to concerns about financial viability (Borotkanics et al., 2016; StewartBrown, 2018). For example, in 2017/18 in Australia, 974 Australian aged care facilities were surveyed, with 45.1% recording an operating loss (Borotkanics et al., 2016). A study of residential aged care providers in the Netherlands in 2014/15 showed that 30% had profitability of less than zero, an increase of 9% from 12 months prior (OECD, 2019). These figures indicate the trend in several (primarily high-income) (OECD, 2019).

Financial losses can result in lower staffing levels and the employment of inadequately skilled healthcare professionals to administer healthcare services to a particularly vulnerable population (Australian Nursing Federation, 2019). Like hospitals, residential aged care research has demonstrated clear links between nurse staffing levels, funding allocations and the quality of care delivered in aged care homes (Australian Nursing Federation, 2019). Failure to treat residents adequately in the residential aged care setting or their home leads to adverse and potentially fatal health outcomes for residents and costly admissions for hospital care and broader community health care organisations (Australian Nursing Federation, 2019).

Concurrent with concerns about financial performance, concerns about poor residential aged care, quality of care, have been on the rise in OECD countries over the past decade (OECD, 2019). In 2013, the European Commission issued a report noting that few EU countries systematically measured whether residential aged care was safe, effective, and met care recipients' needs (OECD, 2019). In the United Kingdom, between 2014 – 2016, the Care Quality Commission, an independent regulator, rated a fifth (21%) of providers as "inadequate" or "requires improvement" (Studies, 2013). In Australia, a Royal Commission into Aged Care Quality and Safety was established in October 2018 (Royal Commission into Aged Care Quality and Safety, 2019) following receipt of more than 5,000

submissions detailing incidences of inadequate care and safety breaches in the Australian aged care sector (Royal Commission into Aged Care Quality and Safety, 2019).

Quality of care and the role of senior management

A residential aged care facility is a special-purpose facility that typically provides longer-term accommodation and other support to frail and aged residents, including assistance with day-to-day living and frequent healthcare for complex needs (Royal Commission into Aged Care Quality and Safety, 2019). Daily operations within these facilities are typically managed by a senior management team comprising of a director of nursing (DON), a nursing home administrator (NHA), and, depending on the organisation, a medical director (Aged Care Workforce Strategy Taskforce, 2018) (Aged Care Workforce Strategy Taskforce, 2018). In the context of global growth in the ageing population and projected increases in demand for residential aged care, the clinical complexity and financial acumen required to deliver and sustain high-quality services for such a high-need population presents distinct challenges. Despite this, the influence of senior management leadership characteristics on quality of care in the residential aged care sector is poorly understood (Australian Nursing Federation, 2019).

The purpose of this review is to scope the literature and synthesise current knowledge concerning the following:

1. Senior management personnel's educational and professional attributes that influence quality of care in residential aged care facilities.
2. Specific senior management leadership styles, behaviours and competencies that influence quality of care delivery in residential aged care facilities.
3. Proactive strategies that senior management personnel employ to prepare for the future social, healthcare, workforce and operational challenges facing residential aged care facilities.

Quality of care (QoC) is defined as the degree to which healthcare and social services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Castle & Decker, 2011). Recognising the multi-faceted nature of quality, the Institute of Medicine's (IOM) six key domains of quality of healthcare were used as a conceptual point of reference. Those quality domains are: i) safety; ii) effectiveness; iii) patient-centeredness; iv) timeliness; v) efficiency; and vi) equity (Nakrem, Vinsnes, Harkless, Paulsen, & Seim, 2009).

2.3 Methods

A systematic approach was used to undertake the scoping review, based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA). A scoping review provides a comprehensive map of research literature (Pham et al., 2014). This involves specifying the research question, identifying relevant studies, selecting the studies, charting the data using thematic analysis, collating, summarising, and reporting the results (Armstrong, Hall, Doyle, & Waters, 2011). The process enabled the identification of gaps in the current literature and describe the need for future research concerning the research topic (Daudt, van Mossel, & Scott, 2013). It was anticipated that a scoping review would contribute to the knowledge base, informing research, practice, and policy implications to prepare senior management personnel for ensuring quality of care in residential aged care facilities.

Original Search strategy (Jan.1989 – Dec.2018)

Before the formal development of a search strategy, a scoping search was completed to ensure that all relevant terms were included. The following keywords were involved in the search: 'nursing home* or 'long-term care' or 'residential care' or 'assisted living' or 'aged care home' or 'home for the aged' or 'residential aged care facilit*''; 'manage*' or 'health facility administrator' or 'leadership'; and 'delivery of health care'. CINAHL, Medline PubMed, Informit, Medline Ovid and PsychInfo databases were searched for literature relating to the research topic. Subsequently, a search confined to peer-reviewed journals was carried out using Google Scholar and OneSearch version 2.0, which searches the James Cook University (JCU) library catalogue (Tropic at), over 90% of JCU's journal articles, Libguides, eBooks, the eJournal portal, and ResearchOnline@JCU. Searches were finalised on 14 December 2018.

Extended and updated search strategy (Jan. 1989 - May 2022)

Following the original scoping review finalised in December 2018, a second comprehensive review of the recent literature was conducted, from January 1989 to May 2022. The initial inclusion and exclusion criteria were used, but the search terms differed slightly. The search included keywords from the previous search strategy and additional terms to identify peer-reviewed literature exploring the link between residential aged care senior manager leadership competencies [leadership skills and personal qualities] and quality of care. The following keywords were used: 'nursing home* or long-term care or residential care or assisted living or aged care home or 'home for the aged' or 'residential aged care facilit*'; 'manage* or 'health facility administrator' or 'leadership'; 'delivery of health care' or 'quality of care'; 'leadership competenc*' or 'skill*' or 'personal qualit*'. The new search terms were included to reflect a conceptualisation of residential aged care leadership and quality of care that was refined during the course of the PhD. Five hundred and ninety-three peer-reviewed

publications were identified using the updated search terms. Using the same eligibility process outlined during the original search strategy, the manuscript title and abstract were reviewed for relevance to the inclusion and exclusion criteria and overarching research question (Dawes & Topp, 2019). This produced six new publications for inclusion. Two focused on senior manager leadership styles and behaviours and quality of care. One explored the link between management tenure and quality, and another sought to understand the connection between senior manager level of higher education attainment and quality of care. Another two publications examining senior manager leadership competencies that influence quality of care were identified (Table 1.)

Inclusion criteria

According to a series of established criteria, all candidate literature was subject to independent title, abstract, and full-text review by the authors (Figure 1). In line with PRISMA guidelines, inclusion and exclusion criteria were developed and applied (Table 1).

Table 1. Scoping Review Inclusion and Exclusion criteria

Inclusion	Exclusion
Research published between Jan. 1989 – May 2022 in a peer-reviewed journal in English. This date range was applied to capture an extended period of development following the initial scoping search and to ensure the inclusion of several clusters of publications relevant to the review's focus. Peer-reviewed journal articles describing an association between managerial characteristics (including leadership styles, leadership competencies or behaviours) and quality of care in residential aged care facilities. Peer-reviewed articles that examine senior management roles include Director of Nursing, Nursing Home Administrator or Chief Executive Officer. Study settings that include for-profit or non-for-profit residential aged care facilities. These facilities are defined as those that provide in-house assistance with day-to-day living, intensive forms of care, and contribution towards independent living, to frail and aged residents who can no longer live at home or in another community-based dwelling. Both quantitative and qualitative research articles were included for analysis. Peer-reviewed articles from all countries were included for analysis.	Peer-reviewed journal articles not written in the English language. Journal articles that do not directly associate managerial characteristics (including leadership styles, competencies and behaviours) with health care quality in residential aged care facilities). Research studies that were not conducted in residential aged care facilities. For example, research completed within community health care organisations, hospital institutions or an individual's community residence were excluded from the analysis. Studies that describe the managerial characteristics relating to aged care roles that are not specific to Director of Nursing, Nursing Home Administrator or Chief Executive Officers (roles including medical directors, middle managers, frontline managers, governing board representatives and clinical care staff were not included for analysis).

Figure 1. Original PRISMA Flow Diagram (Jan. 1989 – Dec. 2018)

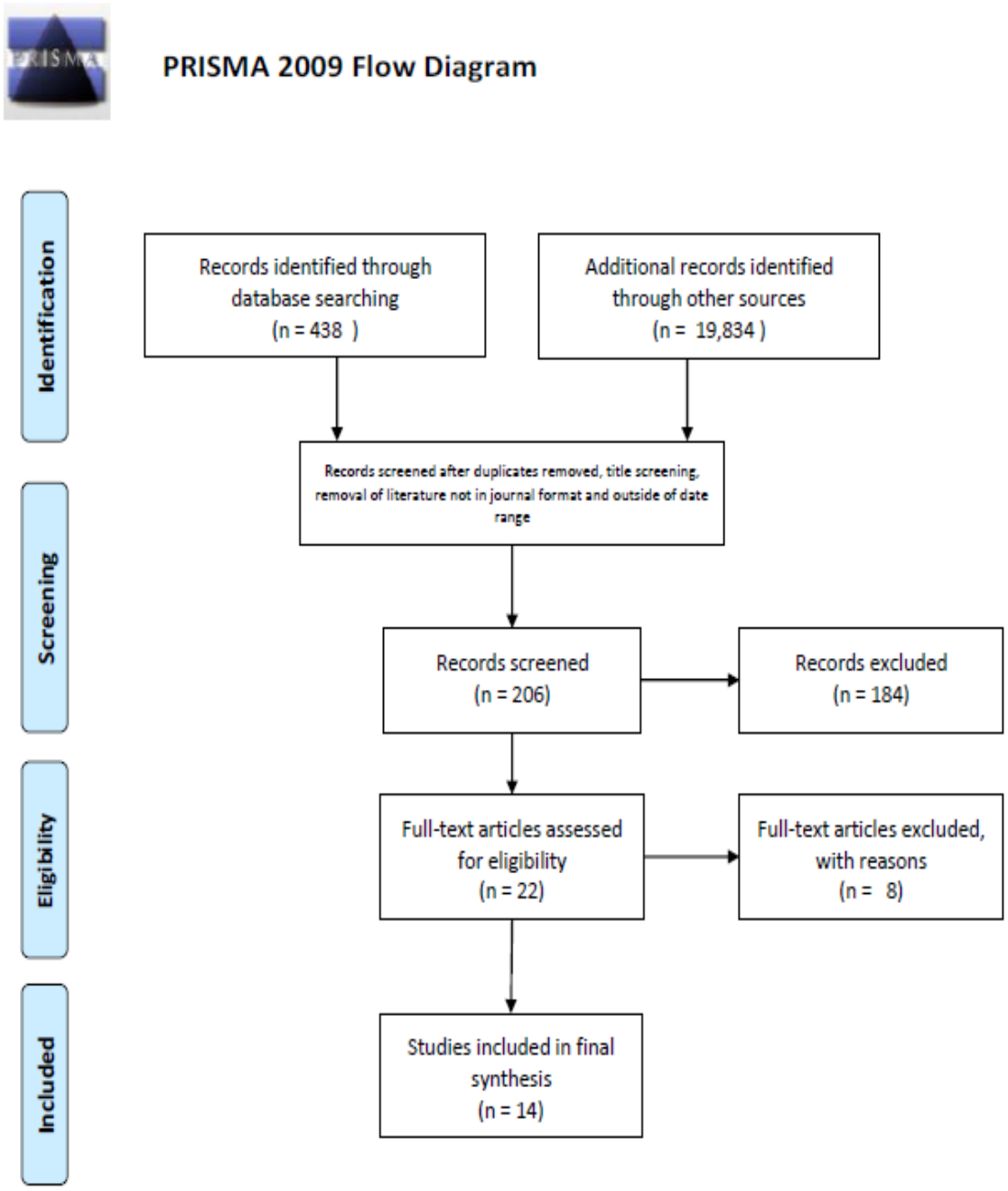
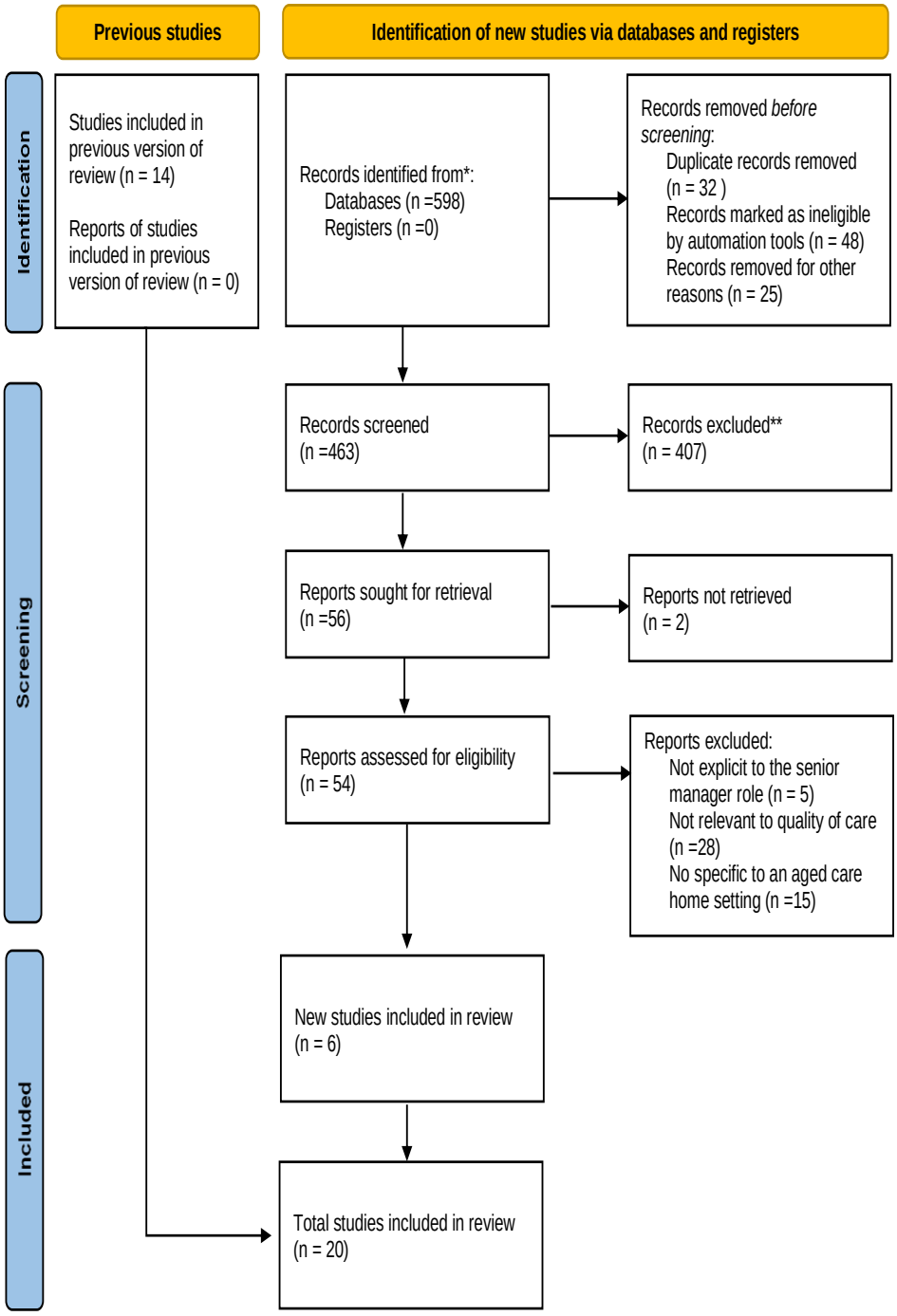


Figure 2. Extended and updated PRISMA Flow Diagram (Jan. 2019 – May 2022)



Data extraction

Critical appraisal and thematic analysis were undertaken (Whittemore & Knafl, 2005). Guided by the study objectives, thematic analysis was employed to determine patterned meaning across the dataset (Haracz, Ryan, Hazelton, & James, 2013). The following process was tailored to ensure that a thorough thematic analysis was achieved: i) data familiarisation; ii) data theme search; iii) theme review; iv) theme definition; and v) data tabulation (Braun & Clarke, 2006). The analysis was conducted to collate common themes derived from the research question.

Given the presence of qualitative and mixed-method journal articles, the Mixed Methods Appraisal Tool (MMAT) was used to evaluate the research studies critically. The MMAT guidelines assisted the authors in determining the quality of each article. All literature that met the eligibility criteria was included in the data analysis regardless of methodological rigour. Limitations derived from applying the critical appraisal tool were included as part of the findings (Table 2). Specifically, the: i) breadth of articles; ii) depth of information; iii) relevance of data concerning the research topic; and iv) gaps in the form of relevant questions to guide further research recommendations were assessed. The appraisal process allowed the authors to determine inconsistencies within single pieces of work and with research compiled by other authors.

Limitations

Studies included in this review utilised different quality indicators to define senior management leadership characteristics that influence quality of care in residential aged care facilities. This limitation may impact the consistency of review findings. Also, it is possible that articles contributed by experts in the field were not included in this review. As part of the extended and updated review, this limitation was addressed by extending the search strategy to include additional terms relevant to the research question and eligibility criteria. However, if alternative words and forms were used, a different result may have been obtained. Moreover, research studies were restricted to peer-reviewed journal articles and did not include grey literature. Finally, only those studies written in the English language were included for review. No non-English publications were located in the process of the search; however, it is possible these were missed due to search terms and the use of predominantly English-language scientific databases.

Table 2: Scoping Review Included Articles (Jan. 1989 – Dec. 2018)

Study	Study coverage, facility chain affiliation and profit status.	Research Method	Study Purpose	Study Identified Findings (thematic)	Senior management characteristics and quality of care	Methodological quality criteria (MMAT 2018)
(Castle, 2001)	United States of America - FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine the association between turnover of nursing home administrators and five important quality of care outcomes.	i)NHA turnover influences several quality outcomes (Pressure Ulcers, catheterisation, psychoactive drugs and quality of care deficiencies.	Management tenure and quality of care	i) Relevant sampling strategies utilised ii) Sample is representative of the target population. iii) Measurements are valid and reliable. iv) Low risk of nonresponse bias. v) Appropriate statistical analysis relevant to the research question.
(Castle & Fogel, 2002)	United States of America - FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine administrator professional associations and quality of care in aged care homes.	i)Characteristics of Medicare and Medicaid-certified Nursing and professional affiliation of the administrator ii) Quality indicators and NHA professional associations iii)Health-related deficiencies and turnover	Role preparedness and quality of care.	i) Relevant multiple sampling strategies utilised ii) Sample is representative of the target population. iii) Measurements are valid and reliable. iv) Low risk of a nonresponse bias v) Appropriate statistical analysis relevant to the research question.
(Donoghue & Castle, 2009)	United States of America - FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine the associations between nursing home administrator (NHA) leadership style and staff turnover.	i)Consensus managers and impacts on staff turnover (linked to the quality of care) ii)Shareholder managers and association with turnover (linked to the quality of care)	Leadership style and quality of care	i) Relevant multiple sampling strategies utilised ii) Sample is representative of the target population. iii) Measurements are valid and reliable. No evidence of questionnaire pre-testing. iv) Low risk of a nonresponse bias v) Appropriate statistical analysis relevant to the research question.

(Keays, Wister, & Gutman, 2009)	United States of America - FP and NFP organisations included	Quantitative; Questionnaire and secondary data reviews.	To examine administrator and facility-related predictors of quality of care in aged care homes.	i) Administrator education and experience as a predictor for quality of care. ii)Association between administrator salary and quality of care. iii) Characteristics of facility and quality of care. iv)Administrator effort and quality of care.	Role preparedness and quality of care.	i) Relevant multiple sampling strategies utilised (probability, stratified sampling) ii) Sample is representative of the target population. iii) Measurements are valid and reliable. No evidence of questionnaire pre-testing. iv) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
(Castle & Lin, 2010)	United States of America – FP and NFP organisations included.	Quantitative: Questionnaire and secondary data reviews.	To determine the association between administrators' education and the quality of nursing home care.	i) Turnover of Nursing Home Administrators and quality of care ii) Turnover of Director of Nursing and quality of care iii)Staffing levels and quality of care iv)Use of agency staff and quality of care	Managerial tenure and quality of care.	i) Relevant multiple sampling strategies utilised (probability, stratified sampling) ii) Sample is representative of the target population. iii) Unable to determine whether measurements are valid and reliable. No evidence of questionnaire pre-testing. iv) Low risk of a nonresponse bias v) Appropriate statistical analysis relevant to the research question.
(Castle & Decker, 2011)	United States of America - FP and NFP organisations included	Quantitative: Survey and primary data reviews.	To examine the association of Nursing Home Administrator (NHA) leadership style and Director of Nursing (DON) leadership style with quality of care.	i)Variables describing NHA and DON leadership styles and association with quality of care. ii) Senior management and organisational effectiveness.	Leadership styles and quality of care.	i)Relevant multiple sampling strategies utilised (probability, stratified sampling) ii) Sample is representative of the target population. iii) Measurements are valid and reliable. No evidence of questionnaire pre-testing. iv) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
(Krause, 2012)	United States of America - FP and NFP organisations included	Quantitative; Questionnaire and secondary data reviews.	To examine the association between the Directors of nursing managerial characteristics and quality of care.	i) Job tenure and quality of care. ii) DON experience and quality of care.	Managerial tenure and quality of care.	i)Relevant multiple sampling strategies utilised (probability, stratified sampling) ii) Sample is representative of the target population. iii) Measurements are valid and reliable. No evidence of questionnaire pre-testing. iv) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.

(Siegel et al., 2014)	United States of America - Medicaid and Medicare dual-certified facilities included for analysis.	Quantitative: Questionnaire and statistical data analysis.	To explore NHAs' self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation.	i) Administrator preparedness. ii) Education, training and experience to support role preparedness. iii) Education, training and experience requirements.	Role preparedness and quality of care.	i)Relevant multiple sampling strategies utilised (probability, stratified sampling) ii) Sample is not representative of the target population. Only five states selected iii) Unable to determine whether measurements are valid and reliable. The choice of measurements is justified but not entirely representative of the research question. iv) Risk of nonresponse bias (Long questionnaire duration – 18.7 % response rate). v) Appropriate statistical analysis relevant to the research question.
(S. R. Hunt, Corazzini, & Anderson, 2014)	United States of America – NFP and non-chain affiliated aged care homes excluded.	Qualitative: Semi-structured/ in-depth interviews, observations and document reviews.	This study examined how nurse management turnover impacts system capacity to produce high-quality care	i)Description of turnover trajectory ii)Administrative turnover and care system management iii)Nursing staff turnover and patient care iv)Positive emergent behaviours	Managerial tenure and quality of care	i)Appropriate qualitative approach utilised ii)Adequate data collection methods iii)Findings are accurately derived from the data (cross-case analysis) iv) The data sufficiently substantiate the interpretation of results. v) Adequate coherence between qualitative data sources, collection, analysis and interpretation.
(Trinkoff et al., 2015)	United States of America - FP and NFP organisations included	Quantitative. Questionnaire and secondary data reviews.	To examine associations of education and certification among NHAs and DONs with resident outcomes.	i) Management level of education and resident outcomes. ii) Management certification and level of resident outcomes. iii) Nursing home characteristics and outcomes.	Role preparedness and quality of care.	i)Relevant multiple sampling strategies utilised (multistage, stratified sampling) ii) Sample is representative of the target population. iii) Unable to determine whether measurements are valid and reliable. The choice of measurements is justified but not entirely representative of the research question. iv)Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.

(Castle, Furnier, Ferguson-Rome, Olson, & Johs-Artisensi, 2015)	United States of America - FP and NFP organisations included.	Quantitative: Questionnaire and secondary data reviews.	To determine the association between administrators' education and the quality of nursing home care.	i) Descriptive demographic characteristics of long-term care administrators (including education and licensure) and association with quality of care.	Role preparedness and quality of care.	i)Relevant multiple sampling strategies utilised (Probability sampling) ii) Not able to ascertain whether the sample is representative of the target population. iii) Unable to determine whether measurements are valid and reliable. No evidence of pre-testing of the questionnaire. Measurements are not justified. iv)Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
(McKinney, Corazzini, Anderson, Sloane, & Castle, 2016),	United States of America - FP and NFP organisations included	Quantitative. Questionnaire and secondary data reviews.	To examine the effects of DON leadership style, including behaviours that facilitate the exchange of information between diverse people on care quality domains through the lens of complexity science.	i) Complexity leadership patterns and aged care home deficiencies. ii) DON quit intentions and aged care home deficiencies.	Leadership style and quality of care.	i)Relevant sampling strategy utilised (Probability sampling) ii) Not able to ascertain whether the sample is representative of the target population. iii) Unable to determine whether measurements are valid and reliable. No evidence of pre-testing of the questionnaire. iv)Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
Havig (Havig & Hollister, 2018)	Norway – Private and FP aged care homes excluded.	Qualitative: Semi structures interviews, observations and document reviews.	This study examined how, or through which processes or mechanisms, the: [1] use of workgroups and [2] active leadership are associated with high quality of care in Norwegian nursing homewards.	i)The use of workgroups to foster quality of care in aged care homes. ii)The role of active leadership in fostering the development quality.	Leadership style and quality of care	i)Appropriate qualitative approach utilised ii)Adequate data collection methods (Potential research bias) iii)Findings are accurately derived from the data (cross-case analysis) iv) Interpretation of results is not sufficiently substantiated by the data (No use of quotes from interviews, No coding analysis provided) v) Satisfactory coherence between qualitative data sources, collection, analysis and interpretation.
(Backman, Sjögren, Lindkvist, Lövheim, & Edvardsson, 2017)	Sweden – Facility affiliation and profit status not specified	Quantitative	To identify characteristics of highly rated leadership in nursing homes.	i) Specific characteristics of highly rated leadership in aged care homes. ii) Units specific to leadership behaviours.	Leadership styles and quality of care.	i)Relevant sampling strategy utilised (Probability sampling) ii) Not able to ascertain whether the sample is representative of the target population. iii)Measurements are valid and reliable

						iv)Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.

Table 3. – Extended and updated review articles (Jan. 2019 – May 2022)

Study	Study coverage,	Research Method	Study Purpose	Study Identified Findings (thematic)	Senior management characteristics and quality of care
(Asante et al., 2021)	Swiss aged care homes	Qualitative – semi-structured interviews	Examine how managers of top-quality nursing homes define, develop and maintain high-quality of care.	i)Leading with commitment ii)Creating appropriate framework conditions iii)Working together for quality of care	Leadership style and behaviours
(Bourgeault et al., 2021)	Canada	Qualitative	Explore the role that leadership plays in enabling the conditions for high-quality long-term care	i)Developing coalitions ii)Achieving results iii)Leading self iv)Engaging others	Leadership style and behaviours
(Amirkhanyan, An, Hawks, & Meier, 2019)	United States of America	Quantitative – surveys	Investigate the linear and nonlinear effects of job tenure on organisational performance and explores how administrators' job tenure can moderate the relationship between three critical managerial strategies—innovative management, participatory management, and external management—and performance	i)Experience and performance ii)Tenure and quality performance iii)Management style and quality	Management tenure
(Holle, Sundean, Dellefield, Wong, & Lopez, 2019)	United States of America	Quantitative – surveys	To understand the interest in advancing education, researchers surveyed SNF DONs in Connecticut to examine their beliefs about academic education's the DON education on resident outcomes.	i)Limited personal or professional incentives to complete a bachelor's degree ii)Link between higher-level tertiary education and quality of care;	Role preparedness
(Anderson, Issel, & McDaniel Jr, 2003)	United States of America	Quantitative – surveys	To test complexity hypotheses about the relationship between management practices (communication openness, decision making, relationship-oriented leadership, and formalisation) and resident outcomes	Each management practice understudy had an impact on resident outcomes	Leadership competencies
(Siegel, Zisberg, Bakerjian, & Zysberg, 2017)	United States of America	Mixed – methods, Interviews and survey	To present the development and preliminary validation of an instrument to measure nursing home administrators' self-efficacy in nursing home quality of care.	i)Presentation of various subscales involving leadership competencies to influence quality residential aged care, including: -Knowledge -Leadership -Financial -Working with other leaders -Working with the general workforce	Leadership competencies

2.4 Results

Of the 14 articles included in the original review (Dawes and Topp 2019), 12 (85%) were studies conducted in the United States of America, one (7%) in Sweden and one (7%) in Norway. Twelve articles employed qualitative and 12 quantitative research methodologies. Five (35.7%) examined aged care senior management leadership styles, while four (28.6%) articles explored the relationship between senior management tenure and quality of care. Five (35.7%) papers focused on the role preparedness of senior management personnel. Key findings within these broad categories will be elaborated on in the following section and summarised in Table's 2, 3 and 4.

Six additional articles were identified for inclusion in the extended and updated review (January 1989 – May 2022) (Table 3). Two (33%) focused on senior manager leadership styles and behaviours and quality of care. One (17 %) explored the link between management tenure and quality, and one (17%) sought to understand the connection between senior manager level of higher education attainment and quality of care. Another two publications (33%) examining senior manager leadership competencies that influence quality of care were identified.

Leadership style

Five publications (Castle and Decker, 2011; Donoghue and Castle, 2009; McKinney, Corazzini, Sloane and Anderson, 2016; Havig and Hollister, 2018; Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017) explored the influence of senior management leadership styles (including leadership behaviours) on quality of care in residential aged care facilities. One explored the characteristics of highly rated leadership behaviours in Swedish facilities (profit status not specified) (Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017), one examined the influence of active leadership in for-profit Norwegian residential aged care facilities (Havig and Hollister, 2018) and three examined the association of senior management leadership styles in the United States of America (for-profit and not-for-profit) (Castle and Decker, 2011; Donoghue and Castle, 2009; McKinney, Corazzini, Sloane and Anderson, 2016). One study examined NHA leadership styles (Donoghue & Castle, 2009), one study explored DON leadership styles (McKinney, Crazing and Anderson, 2016), and three looked at senior management leadership styles and behaviours across a combination of senior management roles (DON and NHA) (Castle and Decker, 2011; Havig and Hollister, 2018; Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017). Two key clusters of findings emerged concerning leadership styles from this group of five articles. One related to the types of senior management leadership behaviours highly rated by non-managerial staff. The second was related to the impact of senior management leadership styles on quality of care in residential aged care facilities.

Backman et al. (2017) identified highly-rated leadership behaviours in Swedish residential aged care facilities (Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017). Namely, the manager experiments with new ideas, controls work closely, relies on subordinates, coaches, gives direct feedback and handles conflicts constructively (Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017). This study also revealed that contextual and operational factors (including staffing characteristics and chain affiliation) are associated with senior management leadership ratings (Backman, Sjögren, Lövheim, Edvardsson and Lindkvist, 2017).

Four articles examined the relationship between leadership styles and quality of care in residential aged care facilities (Castle and Decker, 2011; Donoghue and Castle, 2009; McKinney, Corazzini, Anderson, Sloane, & Castle, 2016; Havig and Hollister, 2018). Castle and Decker (2011) examined NHA and DON leadership styles in non-for-profit and for-profit residential aged care facilities. The Bonoma–Slevin leadership model categorises leaders into four styles: consensus manager, consultative autocrat, shareholder manager and autocrat (Castle and Decker, 2011). Castle and Decker's (2011) results indicated that the consensus manager leadership style positively correlates with the quality of care delivered in residential aged care facilities. Castle and Decker (2011) also suggest that consensus leaders allow employees to offer input which encourages team decision-making and enhances organisational performance (including care quality) (Castle and Decker, 2011). Regarding the IOM Domains of Health Care Quality, Castle and Decker's assessment measured the delivery of i) safe and ii) effective health care services using the Nursing Home Compare Quality Measure and 5 – Star rating scores. Donoghue and Castle (2009) presented similar findings earlier, applying the Bonoma–Slevin leadership model. Donoghue and Castle (2009) concluded that consensus managers were associated with the lowest staff turnover levels, enhancing the standard of care in residential aged care facilities (Castle and Decker, 2011). The Online Survey Certification, Reporting database, and Area Resource File extracted the facilities' organisational and local economic characteristics.

A general linear model was used to evaluate the impact of the NHA leadership style, the contributing organisational factors, and regional economic characteristics on staff turnover and care quality within each facility (Castle and Decker, 2011). Additionally, Donoghue and Castle's findings revealed that "shareholder managers", who neither seek input when making a decision nor provide staff with relevant information for making decisions on their own, are associated with the highest turnover levels, which can disrupt organisational performance and result in the provision of substandard quality of care (Castle and Decker, 2011).

McKinney et al. (2016) examined the effects of DON leadership style on care quality domains through the lens of complexity science; where leadership information is explored through inputs of various agents (including managers, residents and family members) (McKinney, Corazzini, Anderson, Sloane, & Castle, 2016). Findings from this study revealed that DONs using complexity leadership approaches, including regular staff interactions and shared decision-making processes, enabled better care outcomes (McKinney, Corazzini, Anderson, Sloane, & Castle, 2016). Quality indicators that were deemed DON sensitive included resident behaviours/facility practices, quality of life, nursing services, and quality of care. Logistic regression procedures estimated associations between variables (McKinney, Corazzini, Anderson, Sloane, & Castle, 2016). Regarding the IOM quality domains, this study evaluated the provision of i) safe, ii) effective, and iii) timely health care across 609 nursing homes in the United States. The authors recommend DONs utilise complex leadership approaches to enhance and maintain quality of care in residential aged care settings (McKinney, Corazzini, Anderson, Sloane, & Castle, 2016). Havig and Hollister's (2018) work also suggests that residential aged care leaders who employ "active" leadership styles, or styles that enhance the relationship between leader and staff, will optimise components of the work environment (including the standard of aged care delivery) (Havig and Hollister, 2018).

Their analyses led to a ranking of participating nursing home wards as measured by quantitative data from i) surveys of relatives, ii) surveys of care workers, and iii) rankings by the field observer. Evaluation of care quality tended to be defined concerning the IOM quality domains, i) safety, ii) effectiveness, and iii) patient-centeredness across 22 residential aged care facilities in Norway (Havig and Hollister, 2018).

Leadership style: Extended and updated review to May 2022.

Two papers (Bourgeault et al., 2021; Asanta, Zuniga & Favez, 2021) published between January 2019 and May 2022 further support the link between a senior manager's leadership style (and other behaviours) and quality of care. One examined how high-performing organisations' managers develop and maintain quality in Swiss residential aged care facilities. Another explored the role of leadership in enabling conditions for quality of care in Canadian for-profit and non-profit facilities. Unlike previous studies that primarily examined a link between senior management leadership styles and quality of care, these more recent studies focused more on the leadership behaviours that senior managers exhibit to promote high-quality residential aged care.

Through conducting formal and informal interviews with residential aged care managers and staff, Bourgeault et al. (2021) found that senior managers who model positive behaviours they want to see

exhibited by staff were more likely to influence quality resident care. Bourgeault et al. (2021) also described the importance of senior managers engaging staff by distributing leadership responsibilities during times of change. For example, it was found that a manager's ability to partner with communities and key stakeholders to design and enact new quality systems was linked to increased quality of care. Unlike studies found in the previous search (1989-2018), however, Bourgeault et al. (2021) used the 'Leads self, Engages others, Achieves outcomes, Drives innovation and Shapes systems' (LEADs) framework to guide data analysis. This approach allowed the authors to move beyond a broad association of leadership style and quality of care to look more specifically at leadership behaviours.

Similar to the approach used by Bourgeault et al. (2021), Asanta, Zuniga & Favez (2021) used qualitative research methods to examine Swiss senior managers' perceptions of leadership on residential aged care, quality of care. The authors found that managers in high-performing facilities lead with a high commitment to person-centred care. In line with findings from Bourgeault et al. (2021) and studies included in the original review, Asanta, Zuniga & Favez (2021) also describe high-performing managers as those who strongly emphasised the need for co-creating vision and goals toward improving quality of care.

Management tenure

Four articles (Castle, 2001; Castle and Lin, 2011; Krause, 2012; Hunt, Corazzini and Anderson, 2014; Castle, 2006) described the relationship between senior management employment tenure and quality of care in residential aged care facilities. All four studies were conducted in for-profit and non-for-profit aged care homes in the United States of America. Two articles explored NHA turnover (Castle and Lin, 2011; Castle, 2006), one examined the influence of DON employment tenure (Krause, 2012), and one study examined the link between DON turnover, non-managerial staff turnover and the provision of care (Hunt, Corazzini and Anderson, 2014). All four articles concluded that the turnover of administrators in aged care homes has an important influence on the quality of care which tended to be defined in relation to IOM quality domains i) safety, ii) effectiveness and iii) timeliness of health care delivery (Castle, 2001)

Castle and Lin (2011) explored the direct and indirect relationships between senior management turnover and quality of care in the residential aged care setting (Castle and Lin, 2011). Findings suggest that NHA turnover can influence the safety and efficiency domains through increased (resident) pain ratings, higher incidences of pressure sores, and physical restraints (Castle and Lin, 2011). Counter-intuitively, the same study found DON turnover is associated with reduced rates of depression and reduced incidence of delirium for short-stay residents in residential aged care facilities (Castle and Lin, 2011). Hunt, Corazzini and Anderson (2014) suggested that higher DON tenure is related to higher staff retention, lower turnover

and increased quality of care as measured by a complex adaptive systems theory to identify emergent relationships between nursing management turnover, staff turnover, and health care outcomes (Hunt, Corazzini and Anderson, 2014). Furthermore, Krause (2012) found that residential aged care facilities with longer DON employment tenure increased quality ratings (Krause, 2012). Krause also found that past career experience and tenure in the current job were not equivalent in their effect on quality of care. Based on a questionnaire completed by 823 DONs in both for-profit and non-profit aged care homes, the authors suggested that DON's current job tenure, but not experience, is associated with quality of care as there may be a "learning curve" that is unique to individual aged care homes and that experience in other residential aged care facilities may have little bearing on current performance (Krause, 2012),

Drawing on data from a survey of 420 aged care facilities and the 1999 Online Survey, Certification and Reporting System, Castle (2001) examined the association between NHA turnover and five 'safety-oriented quality of care outcomes, including the formation of pressure ulcers and frequency of psychoactive drug administration. In residential aged care facilities that were not chain affiliated, the authors concluded that NHA turnover is associated with a higher proportion of residents who are restrained, catheterised, have pressure ulcers, and administered psychoactive drugs (Castle, 2001). These results are consistent with those later reported by Castle and Lin (2011). They suggested that overall, the organisational disruption resulting from NHA turnover negatively impacts quality through the domains of efficiency and safety of care in residential aged care facilities (Castle and Lin, 2011).

Management tenure: Extended and updated review to May 2022.

Only one new paper was identified that described the link between management tenure and quality of care in the extended and updated review. In 2020, Amirikayan et al. (2019) investigated the linear and nonlinear effects of management job tenure on quality of care and resident health outcomes. Like previous studies exploring this topic, the authors employed archival performance indicators and surveyed nursing home managers to explain this link. Similar to previous research (Trinkoff, Lerner, Storr, Han, Johantgen and Gartrell, 2015; Seigel, Leo, Young and Castle, 2014), the authors found that more experienced managers were better able to manage environmental factors influencing the quality-of-care domains, including safety and timeliness of care. They also demonstrated senior managers with longer employment tenure as having more ability to distribute power internally to achieve better health care outcomes for older care recipients.

Role preparedness

Five articles (Castle and Fogel, 2002; Keays, Wister and Gutman, 2009; Siegel, Leo and Young, 2014; Trinkoff et al., 2015; Castle et al., 2015) described the influence of senior management role preparedness and quality of care in residential aged care facilities with a focus on i) safe, ii) effective, and iii) efficient care quality domains. All the studies were conducted in non-for-profit and for-profit facilities in the United States of America. Four articles explored the role preparedness of NHAs (Castle and Fogel, 2002; Keays, Wister and Gutman, 2009; Siegel, Leo and Young, 2014; Castle et al., 2015), and one article examined the readiness of NHAs and DONs (Trinkoff et al., 2015). Three key findings emerged, including the relationship between a professional association and senior management performance, senior management educational attainment and NHA's self-rated job preparedness and person-job fit when transitioning into a senior management role.

Castle and Fogel (2002) compared the influence (on care quality) of NHAs with professional associations to those that did not (Castle and Fogel, 2002). Findings revealed that professional membership and certification in the study population influenced higher quality of care. These findings are supported by both Keays, Wister & Gutman (2009) and Trinkoff et al. (2015), whose studies suggested that aged care homes led by DONs with at least a bachelor's degree produced better quality outcomes, including reduced (resident) pain ratings and decreased rates of catheterisation. Keays, Wister & Gutman (2009) present findings from a questionnaire applied to a sample of 302 administrators, suggesting that the higher the level of education attained by the administrator, the better the quality of care for residents. Castle et al. (2015) examined the association between administrators' education attainment, state training requirements and quality of care (mainly measured in safety) in residential aged care facilities. Findings demonstrated some positive relationship between the education level of administrators and five quality indicators, including the incidence of restraint use, catheter use, inadequate pain management and residents with pressure ulcers (Castle et al., 2015). The higher the educational attainment of NHA's, the lower the incidence of poor-quality outcomes in residential aged care facilities.

Siegel et al. (2014) explored NHA's self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation for transitioning into a senior management role. From a sample of NHAs (n=175) randomly recruited from nursing homes in the United States of America, the authors noted that only 30% of participants reported feeling adequately prepared when transitioning into their first senior management role. Findings also revealed that NHAs preferred formalised training methods to develop entry-level competencies, with a lower preference for on-the-job

training and self-directed study. Preferred approaches to training included administrator-in-training, bachelor's degree programs, and mentoring. Siegel and colleagues noted that more research is required to identify specific teaching/learning practices and on-the-job training that maximise the NHAs' preparation to meet their job demands (Siegel, Leo and Young, 2014).

Role preparedness: Extended and updated review to May 2022.

The extended and updated review identified a single additional publication by Holle et al. (2019), which explored the link between senior manager role-preparedness and quality of care in residential aged care facilities. This study sought to understand the interest in advancing education by surveying residential aged care Directors of Nursing (DONs); to examine their beliefs about academic advancement and the impact of DON education on resident outcomes. Interestingly, most DONs (72 %) with a diploma or certificate level education did not believe that achieving a bachelor's degree would enhance their capacity to provide high-quality care. This was particularly relevant for DONs who were nearing retirement. The authors concluded that alternatives to advanced tertiary education, such as short-course interventions teaching targeted skills to enhance resident outcomes, should be viewed as a substitute approach to DONs completing tertiary-level degrees. Aside from the paper by Holle et al. (2019), literature concerning senior manager role preparedness and quality of care has been consistent for some years. Studies primarily describe a link between a senior manager's level of educational attainment, professional association affiliation, and quality of care.

Leadership competencies and quality of care

Leadership competencies constitute a potentially significant area of study relevant to the questions posed by this thesis. To extend and strengthen the original published review, which did not include senior manager leadership competencies and residential aged care, quality of care, I ran an additional search targeting literature focused on this link for the dates January 1989 – May 2022, identifying two eligible papers. Anderson, Issel & McDaniel (2003) explored the relationship between resident outcomes and senior manager leadership skills in United States nursing homes, including a manager's ability to communicate effectively and make decisions that promote high-quality care. In this study, effective deployment of these skills was found to reduce a resident's aggressive behaviour and the need to employ chemical or physical restraints. Anderson, Issel and McDaniel (2003) also found that longer DON tenure and increased aged care experience were linked to better resident outcomes and higher quality of care. This finding was similar to other studies examining the impact of senior management tenure on quality of care that were not included in this review (Trinkoff, Lerner, Storr, Han, Johantgen and Gartrell, 2015; Seigel, Leo, Young and Castle, 2014),

The second identified paper (Siegal, Zisbergm, Bakerjian & Zysberg, 2017) examined a range of senior manager leadership competencies required to improve quality of care, again in residential aged care facilities in the United States. The authors applied a mixed-methods cross-sectional study design to develop and test a nursing home administrator quality improvement self-efficacy scale to identify administrators with higher/lower chances of successfully implementing strategies to enhance care. The instrument included various subscales with leadership skills and knowledge to improve quality of care, including communication and decision-making capabilities. The authors concluded that the self–efficacy tool could be used to identify a senior manager's professional development needs and inform directions for in-house training and professional mentoring to promote quality of care.

Table 4. Thematic Analysis: Senior management factors, leadership styles and quality of care in residential aged care facilities.

Theme	Sub-theme	Definition	Description
Leadership style	Highly rated leadership styles	Leadership and management characteristics are perceived as effective by aged care home staff.	Includes i) Top five rated leadership and management behaviours perceived by all nursing home staff. ii) Contextual and operational factors are associated with high leadership ratings.
	Senior management leadership styles	DON and NHA methods of providing direction, motivating people and implementing plans.	Includes: The Bonoma-Slevin model categorises four leadership styles and associates them with five quality indicators.
Role preparedness	Professional association	Methods whereby individuals seek to further a particular profession, the interests of individuals engaged in that profession and the public interest.	Includes General facility characteristics, NHA professional association and quality of care in aged care homes.
	Educational attainment	The highest degree was completed using three categories: Master's degree or higher, Bachelor's degree, and associate degree or less.	Includes Educational background and level of senior management personnel and the association with quality of care in aged care homes.
	Self–rated preparedness.	Perceptions of senior management personnel regarding the degree to which they are prepared to assume their professional role.	Includes: self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation towards transitioning into a senior management role.
Management tenure	NHA turnover and quality of care	The association between NHA turnover and quality of care in an aged care home.	Includes NHA turnover, length of employment and quality of care indicators.

	DON turnover and quality of care	The association between DON turnover and quality of care in an aged care home.	Includes DON turnover, length of employment and quality of care.
	The influence of senior management on staff turnover and quality of care	The link between DON, staff turnover and quality of care	Includes: Direct and indirect relationships among senior management turnover, the number of staff, the types of staff, and specific quality indicators.
Leadership competencies	Leadership skills and quality of care	The link between leant skills and quality of care	Includes: Skills, decision-making and communication skills that influence residence outcomes and a self-efficacy scale to identify leadership skills that positively impact the quality of care.

2.5 Discussion

The 2030 Agenda for Sustainable Development maps an action plan to achieve sustainable development while ensuring the human rights of all people (United Nations, 2018). It calls for leaving "no one behind" while ensuring that the Sustainable Development Goals (SDGs) are met for all segments of society, with a particular focus on the most vulnerable—including older populations (United Nations, 2018). This review provides an important update on the state of evidence regarding senior management characteristics that influence quality of care in residential aged care facilities. The original review revealed only 14 articles globally, using a systematic search method to investigate this critical issue. The vast majority of articles (n=12; 85%) were conducted in the United States of America, and none related to aged care facilities in low and middle-income countries. In the context of projections for rapid growth in the proportion of older persons in high and middle-income countries (United Nations, 2018) and increased reliance on aged care homes to provide basic and complex care (Royal Commission into Aged Care Quality and Safety, 2019), this absence of empirical evidence is concerning.

Notwithstanding the limited geographic scope and varied methodologies used by studies in this review, evidence was found relating to three themes relevant to the question: *what are the characteristics of senior management personnel that influence care quality in aged care homes*? These were: i) a link – albeit still poorly defined - between leadership styles, competencies and behaviours and residential aged care, quality of care; ii) that senior management role preparedness constitutes a likely challenge to delivering quality of care; and iii) that senior management tenure constitutes a likely challenge to delivering quality of care in a residential aged care facility.

Attributes of effective senior management in mainstream health services (hospitals or primary healthcare organisations), and the impact these attributes have on quality of care, have been well researched in high and middle-income countries (Castle, 2006). But services provided in residential aged care facilities vary considerably from those delivered in mainstream healthcare institutions. Residential aged care facilities are often not recognised as part of a 'mainstream' health system, have substantially different funding models, and, consequently, require management with varying combinations of expertise and leadership competencies. For example, residential aged care senior managers provide leadership to facilitate the delivery of custodial care, activities of daily living support, quality nursing and allied health care, a range of political acumen and the management of finance (and other assets) (Sfantou et al., 2017). In contrast, hospital managers lead a range of complex acute healthcare services, including emergency medical care, diagnostic testing, intensive treatment and surgery and a business model that must take account of both public and private (insurance or out-of-pocket) financing (Rinfret, Laplante, Lagacé, Deschamps, & Privé, 2020). The distinction in client profile and service type, therefore, suggests the need for a more advanced examination of senior management characteristics that influence quality of care in residential aged care facilities.

Findings from this review provide some, but not sufficiently high-quality, evidence acknowledging a link between senior managers' leadership styles (and behaviours) and quality of care (Castle & Fogel, 2002). While most studies used valid and reliable measurements, it was found that many studies defined quality of care in relation to clinical 'safety' and 'efficiency' while other well-recognised domains (Agency for Health Care Research and Quality, 2019) of quality, including patient-centeredness, equity and effectiveness, were largely overlooked. Specifically, there is a lack of evidence that explores leadership and its influence on client well-being and psychological outcomes.

Most articles examining the link between leadership and quality of care utilised the Bonoma –Slevin Leadership Model to categorise leaders into four styles. Findings suggest that the consensus leadership style is most influential in ensuring high-performing health services in residential aged care facilities. The consensus approach is linked to increased resident satisfaction, higher employee satisfaction, and lower staff turnover rates (Castle and Fogel, 2002). Alternative styles and behaviours may be represented in other conceptual leadership models that influence the quality of care in residential aged care facilities and have not been described in this review. Furthermore, while a mixture of non-profit and for-profit residential aged care facilities were sampled to explore this theme, studies were specific to the context of Scandinavian countries or the United States, which may impact the application of these findings to other national/ sub-national settings.

While much has been written about 'role preparedness' for senior health managers in the broader context of national and global health care systems (A. M. Mosadeghrad, 2014), however, much of this evidence remains inconclusive – deriving from methodologically weak studies - or poorly defined in the context of residential aged care. All of the studies analysed in this review were specific to the geographical context of aged care homes in the United States of America, which may impact the relevance of these findings in aged care settings elsewhere. Siegel et al. (2014) found that only 30% of individuals felt adequately prepared when transitioning into a senior management role for the first time. Although there is little consensus regarding the set of basic knowledge and skills required, there is an accord that academic improvement and professional development are necessary to support competent managerial performance in a complex and dynamic environment such as aged care (Royal Commission into Aged Care Quality and Safety, 2019). Yet a majority of work on this theme has focused on the residential aged care administrator's knowledge gap regarding the role preparedness for other senior management positions that influence quality of care in this setting.

A third theme emerging from this review is the relationship between management tenure and quality of care in residential aged care facilities. Again, this evidence is highly context-specific to the United States, limiting its applicability to other national/sub-national settings where organisational, regulatory, political, demographic and cultural factors differ. Findings suggest that NHA turnover can influence increased (resident) pain ratings, higher incidences of pressure sores and the use of physical restraints (Keays et al., 2009). This reflects studies of mainstream healthcare settings (e.g., hospitals) where shortened management tenure is viewed as a major threat to the long-term success of various quality improvements (Slipicevic & Masic, 2012). Mosadeghrad, Ferdosi, and Hosseini-Nejhad (2013) recommend that successful quality of care management needs supportive and committed leadership (Mosadeghrad, Ferdosi, Afshar, & Hosseini-Nejhad, 2013). Senior management stability encourages long-term planning and commitment to pursuing long-term objectives, including enhancing quality of care (Slipicevic and Masic, 2012). However, strategies to successfully identify a senior manager's intention to leave during the recruitment process are yet to be determined.

Since the original literature review was published in 2019, an intense public inquiry concerning the quality and safety of aged care services in Australia has completed. Indeed, between 2019 and 2021, a Royal Commission into Aged Care Quality and Safety found multiple factors, including leadership by managers in Australian residential aged care facilities, as lacking and contributing to substandard quality of care. Inadequate leadership has also been linked to multiple episodes of unsafe care whereby a resident

has been harmed (Royal Commission into Aged Care Quality and Safety, 2021). However, existing leadership competency and professional development frameworks for aged care senior managers detail little in terms of skill development to enhance quality of care in this setting (Dawes & Topp, 2022). Notwithstanding these accounts, the updated literature review identified no new peer-reviewed research examining the link between senior manager characteristics and Australian residential aged care quality. Reflecting the original literature search completed in December 2018, four of the six articles identified inn the extended review comprised were conducted in the United States of America, one in Switzerland and another in Canada.

Role preparedness, with a specific focus on a senior manager's type and level of educational attainment, remains a topic of some interest in the context of residential aged care quality globally (Keays, Wister and Gutman, (2009); Siegal et al., 2014; Trinkoff et al., 2015). In the Canadian residential aged care facility setting, Bourgelant et al. (2022) found that although senior manager engagement with tertiary training courses is not always required, individuals should regularly engage with targeted training designed to enhance the knowledge and skills needed to promote quality of care. Recently in Australia, a lack of education and formal qualification of those in leadership positions, including senior managers, has been linked to substandard quality of care in residential aged care (Aged Care Workforce Strategy Taskforce, 2018). Echoing such findings, Burgess et al. (2018) found that one of the primary difficulties faced by the Australian aged care industry is the lack of suitably qualified applicants to fill leadership positions (J. Burgess, Connell, Nankervis, Dhakal, & Fitzgerald, 2018). Correspondingly, The Royal Commission heard that the education and training available for the Australian aged care workforce, including leadership and management personnel, is 'patchy', and there is no defined career path for staff who occupy a majority of these roles (Royal Commission into Aged Care Quality and Safety, 2021). Subsequently, the Commission Final Report provided recommendations to revise the competency and accreditation requirements for all job grades, including senior managers, ensuring the delivery of focused education and training that builds the required skills and knowledge to promote and protect the quality of Australian residential aged care (Royal Commission into Aged Care Quality and Safety, 2021).

Despite the need to better understand senior managers' human, technical and conceptual skills and knowledge for high–quality care, very few (n=2) papers exploring this topic were identified in this literature review. Both articles examined a refined set of senior manager leadership competencies, emphasising senior managers' communication and decision-making abilities to deliver high-quality care. A leader's ability to communicate with multiple stakeholders for quality of care has been extensively explored in mainstream organisations (Sfantou, 2017). In the context of Australian public hospitals, for

example, Brown (2020) found that several key components of communication, including open communication, effective questioning and clear, logical narratives in reporting, are all shown to influence quality of care (Brown, 2020). Moreover, the ability of leaders to create an environment of open communication by modelling appropriate behaviour, setting expectations, and investing in support systems within the organisation's structure is recognised as promoting the delivery of safe, high-quality care in acute health care settings (Merlino, 2017). While a manager's ability to communicate and manage relationships is important in promoting quality of care, existing and well-applied health care, leadership competency frameworks suggest additional leadership competencies are required to influence quality performance. The Health Care Leadership Alliance (HLA) Competency Directory, specifies 232 competencies common to a range of health professions participating in its development, as well as another 68 competencies that were specific to particular disciplines within healthcare management (Healthcare Leadership Alliance, 2017). In comparison, only two papers examining a refined set of communication and relationship management competencies were identified in this literature review, demonstrating a need for further research on leadership skills, knowledge and personal qualities in the Australian residential aged care setting.

Conclusion

Drawing on local and international best practices, further research to develop a set of domains aimed at recruiting and retaining competent and confident senior managers who influence high-quality care in residential aged care facilities would have positive implications for management practices in the context of the global aged care sector. However, to achieve this, several critical questions require urgent attention. First, detailed national- and sub-national research is needed to identify the current and future challenges concerning the structural barriers and enablers of care quality in aged care homes, with specific attention to the role of financing and regulatory arrangements that impact management decisions. Second, research is needed to better identify the leadership competencies of senior management personnel who, under appropriate conditions, can positively influence high-quality healthcare in residential aged care facilities. Third, there is a need to document positive exemplars of professional development strategies and organisational and system-wide enablers (e.g., policies, incentives, career structures) that have been shown to enhance the preparedness, recruitment and retention of senior managers who positively influence high-quality of care in residential aged care facilities.

2.6 Chapter Summary

This review provides an important update on the state of evidence regarding senior management characteristics that influence residential aged care, quality of care. The original search completed in December 2018 that identified 14 articles globally, revealed some evidence, albeit not sufficiently high-quality, of a link between senior managers' leadership styles (and behaviours) and quality of care. Moreover, much has been written about 'role preparedness' for senior health managers in the broader context of national and global health care systems; however, much of this evidence remains inconclusive and poorly defined in residential aged care globally. A third theme emerging from the original review is the relationship between management tenure and the delivery of quality healthcare services in residential aged care facilities. Senior management stability encourages long-term planning and commitment to pursuing long-term objectives, including those to enhance quality of care. However, strategies to successfully identify a senior manager's intention to leave during the recruitment process are yet to be determined.

The subsequent and extended review (to May 2022) identified six other peer-reviewed articles using the original criteria for eligibility. The search included keywords from the previous search strategy and additional terms to identify peer-reviewed literature exploring residential aged care senior manager leadership competencies and quality of care. With themes from the original findings (2018) similar to results generated from the updated and extended recent search, there is a notable and continued evidence gap concerning the optimal mix of senior management leadership competencies required to deliver quality of care in different national and sub-national aged care settings, including Australia. Therefore, further research is needed to identify and map senior manager leadership characteristics, including leadership competencies, that positively influence residential aged care, quality of care.

Before outlining the specific objectives and methods used to frame this PhD (Chapter 4), it is necessary to understand the setting of the Australian aged care system. This is described in Chapter 3.

Chapter 3

Background

3.1 Chapter Introduction

In this chapter, I describe the context of the PhD, including Australia's population ageing profile, and the social and economic engagement of those aged 65 years and over. I also introduce the formal structures of Australia's aged care system, including the services available, funding and regulatory environments. The chapter concludes by summarising the current and forecasted challenges facing the Australian aged care sector, concentrating on findings from the recent Royal Commission into Aged Care Quality and Safety *Interim* and *Final* reports. Information compiled within this chapter was collected via a comprehensive desk search and drew on my experiences working as a clinician in a northern Queensland residential aged care facility.

3.2 Population ageing in Australia

Australia's population is ageing, with the proportion of people aged 65 years or over projected to increase from 16 % (2018) to 23 % in 2066 (Australian Bureau of Statistics, 2021). This growth is partly due to increased life expectancies across the nation (Australian Institute of Health and Welfare, 2021a). In 2016, for example, a 65-year-old female could expect to live another 22 years and 65-year-old male another 20 years - 7 years longer for both sexes than 50 years ago (Australian Institute of Health and Welfare, 2021). Australia's combined life expectancy is higher than most other countries and ranks seventh globally (Australian Institute of Health and Welfare, 2021). There is, however, an emergent global concern regarding the future policy challenges to inform the leadership and governance of retirement support, healthcare, intergenerational relationships and aged care (Kendig, McDonald, & Piggott, 2016) (as the proportion of those 65 years and over continues to grow. Concurrent with the trend of population ageing, the predicted demographic profile of older Australians is expected to change (Burkett, Martin-Khan, Scott, Samanta, & Gray, 2017). In 2017, approximately 2.2 million Australians were aged 65–74 years, and 13% (497,000) were aged 85 years and over (Australian Institute of Health and Welfare, 2021). By 2047, it is predicted there will be 3.4 million people aged 65–74 years in Australia (Australian Institute of Health and Welfare, 2021). People aged 75–84 years will account for 35% (2.6 million) of the population, and 1 in 5 older people will be aged 85 and over (Australian Institute of Health and Welfare, 2021).

3.2.1 Social and economic engagement of older Australians

Those aged 65 and over contribute to society by participating in family and community life: including volunteering at local organisations and caring for younger family members (Australian Institute of Health and Welfare, 2021b). Older Australians also play an essential role in supporting the national economy through their continued engagement in the workforce (Australian Human Rights Comission, 2019). In 2020, 1 in 8 older Australians were employed, and 25 % of the population aged 65 years and over had volunteered in the previous 12-month period (Australian Institute of Health and Welfare, 2021). It is anticipated that the employment rate will likely increase as sentiments and intentions regarding retirement continue to evolve with economic and social reform globally (OECD, 2019). With the retirement age recently increased to 67 years (from 65), many Australians are also working to an older age (OECD, 2021) and currently, Australia has 13 % of its workforce aged 65 years and over, compared with 8 % in 2006 (Australian Institute of Health and Welfare, 2020a). Although there remains some doubt about the immediate health effects of employment among older generations, there is growing evidence suggesting that longer-term employment could benefit the psychosocial wellbeing of older adults (Staudinger, Finkelstein, Calvo, & Sivaramakrishnan, 2016).

3.3 The organisation of aged care services in Australia

The Australian Productivity Commission describes aged care as a range of services provided to older people who have diminished capacity to care for themselves because of physical and psychological disability or frailty (Australian Government Productivity Comission, 2021). In Australia, aged care includes: i) entry-level community-based care at home; ii) higher levels of care at home (Home Care Packages Program) and when living at home is not an option; iii) permanent residential aged care within a specialised facility (Australian Institute of Health and Welfare, 2020), 2021). These three approaches to care are the largest by the number of users across Australia (Australian Institute of Health and Welfare, 2021).

In 2018, 1.3 million Australians received social and health care services within the Australian aged care sector (Australian Institute of Health and Welfare, 2021). These services are mostly funded and regulated by the Australian Government; however, state and territory governments manage some public residential aged care facilities (Australian Government Department of Health [DoH], 2021). While Australian aged care services have been traditionally associated with residential care, recent evidence shows that a majority of older Australians select to remain in their home, connected to family and community for as long as they are physically and psychologically able (Australian Institute of Health and Welfare, 2021). To support individuals to stay at home for longer, home support and home care packages are designed to provide care that many require to maintain their independent living (DoH, 2021). In 2021, 77 % of individuals receiving aged care services in Australia received support in their home or other community-based settings (Australian Institute of Health and Welfare, 2020), 2021). In comparison, a small proportion (7%) of older Australians accessed residential care at any time (Australian Institute of Health and Welfare, 2021).

3.3.1 My Aged Care

By 2050, more than 3.5 million Australians are expected to access an aged care service (SeroInstitute, 2022). With this increased service demand, Australia's aged care system faces the challenge of delivering high-quality care and is predisposed to ongoing reform, altering the availability and viability of some aged care services (Royal Commission into Aged Care Quality and Safety, 2021). This ongoing transition often confuses older Australians attempting to access an aged care service for the first time (Royal Commission into Aged Care Quality and Safety, 2019).

The Federal Government established the *My Aged Care* portal in 2013 (Health Direct Australia, 2022). This online service aims to assist older Australians in navigating the Australian aged care system and

finding the necessary information to connect with an aged care provider (Health Direct Australia, 2022). The portal is also designed to align its service with more comprehensive reforms across the aged care sector, acting as the "gateway" for consumers accessing the Australian aged care system (DoH, 2021). While the *My Aged Care* portal is designed to streamline access to services for consumers, qualitative market research conducted by the Australia Medical Association (AMA) determined that the service has complicated consumer access and caused delays in consumer access to support and medical care (Australian Medical Association, 2019). The AMA, therefore, suggests that additional collaboration with General Practitioners and other health care practitioners is required to link older Australians with relevant services within a safe and reduced timeframe (Australian Medical Association, 2019).

Public criticism of the *My Aged Care* portal was also heard during the Royal Commission into Aged Care Quality and Safety. The *Interim Report* (2019), for example, detailed various accounts of older Australians and carers having to directly contact multiple aged care services to identify whether or not there were spaces available. The Commission also heard that the *My Aged Care* service often did not provide information regarding the quality of services or detail regarding whether services were delivered on their proposed promises (Royal Commission into Aged Care Quality and Safety, 2019). These findings suggest new processes may be required to facilitate an individual's transition into the aged care system and ensure that detailed information regarding the availability and performance of aged care providers is readily available to aid the decision-making process for provider selection (Royal Commission into Aged Care Quality and Safety, 2021).

3.3.2 Commonwealth Home Support Program

Two programs provide health and aged care services to older Australians in their homes, including the Commonwealth Home Support Program (CHSP) and the Home Care Packages Programme (Australian Government Department of Health [DoH], 2022). In 2015, The CHSP was designed to link older Australians to mobile health, social and domestic services to continue to live independently and safely at home. It was established under the *Australian Government's Better Ageing – Promoting Independent Living Program*, a budget for investment in 'wellness' and 'reablement' for older Australians (DoH, 2022). Under this program, 'wellness' is described as a broad approach that aims to promote independence by building on a client's strengths and capability (Australian Association of Gerontology, 2019), whereas 'reablement' intends to promote a client's independence through time-limited interventions that increase an individual's capacity to resume daily activities such as shopping (Australian Government Department of Social Services, 2015). In 2020, the Australian government contributed $2.5 billion to providers who service 783,043 older Australians accessing the CHSP program (DoH, 2021).

The CHSP trial, delivering wellness and reablement services to older Australians is due to conclude in 2023 (DoH, 2022).

3.3.3 Home care packages

Home Care Packages (HCPs) were introduced in 1992 as an alternative to residential aged care (Australian Government MyAgedCare, 2022). HCPs aim to provide a structured approach so that older Australians can receive necessary care based on their current level of physical and psychological functioning and social supports available at their community-dwelling (DoH, 2021). The Federal Government subsidises four levels of care. Level 1 supports people with basic care needs. Level 2 supports people with low care needs (formerly Community Aged Care Packages) (DoH, 2021). Level 3 supports intermediate care needs, and Level 4 helps people with high care needs (once Extended Aged Care at Home and Extended Aged Care at Home Dementia packages) (DoH, 2021). To access a home care package, individuals are first assessed by an Aged Care Assessment Team (ACAT), which determines eligibility for the services provided under the program (DoH, 2021). An ACAT team usually consists of a nurse, social worker, doctor and occupational therapist to assess the eligibility of an older Australian who has applied for assistance. Once the service commences, the Federal Government provides a subsidy to an approved home care provider (DoH, 2021). The consumer or their carer will typically coordinate the care package and elect their service provider to ensure their individual needs are met (DoH, 2021).

3.3.4 Residential aged care

Residential aged care provides health care services and accommodation for older people who cannot continue living independently in their homes (Australian Government Department of Health, 2022c). Typical services may include: i) accommodation; ii) personal care assistance; iii) clinical care; and iv) social care activities, including recreational activities and emotional support. As of June 2021, 335,889 people were accessing a residential aged care service (permanent or respist care), an increase of 889 residents over the previous 12-month period (Australian Institute of Health and Welfare, 2021). The typical length of stay at a residential aged care facility was 34.4 months, and the average age on entry was 82.3 years for men and 84.6 years for women (Australian Institute of Health and Welfare, 2021).

In Australia, residential aged care providers span various sectors, including religious, charitable, community, for-profit and government organisations (Scott, Webb, & Sorrentino, 2014) and facilities are often classified concerning their profit status. For example, a facility may be classified as a for-profit (FP) or business whose primary goal is financial gain (Nowy, Wicker, Feiler, & Breuer, 2015). Alternatively,

a residential aged care facility may be a non-for-profit (NFP) organisation or one that focuses on other priorities aside from revenue generation (Australian Institute of Health and Welfare, 2020). Regardless of an organisation's profit status or chain affiliation, all subsidised residential aged care providers must be approved under the *Aged Care Act 1997*, which stipulates that all services must be consumer-centred and delivered per the resident's care needs (Australian Government Department of Health, 2020).

3.4 Aged care regulation in Australia

In Australia, aged care regulations and legislations aim to maintain and enhance the health and wellbeing of older Australians by stipulating directives for the provision of quality and safe services (Australian Government Department of Health, 2022b). At a national level, the Aged Care Quality and Safety Commission is one of the Department of Health portfolios developed to protect and improve the safety, health, well-being, and quality of life of those receiving Australian-funded aged care (DoH, 2022). Among the Commission's many functions, it regulates aged care providers to ensure that organisations who receive federal government subsidies to fund their services are approved by the DoH and demonstrate the delivery of quality services in line with the overarching *Aged Care Act 1997* (DoH, 2022).

3.4.1 The Aged Care Act 1997

The *Aged Care Act 1997* outlines the requirements for approved Australian Government-funded aged care services (DoH, 2020). It stipulates the processes that guide the allocation of aged care places, the approval and classification of care recipients, responsibilities of approved providers, subsidies and supplements paid by the Australian Government (DoH, 2020). The overarching aim of the Act is to provide funding for Australian aged care services that consider the quality of care, type of care and level of care provided to older Australians (DoH, 2020). It was also developed to protect aged care recipients' health and well-being and provide respite for full-time carers and family members. Seventeen principles sit under the *Aged Care Act 1997* and are established to achieve the overarching objectives (DoH, 2020). The principles are wide-ranging and include directives that guide complaints and resolution processes, the delivery of services that rely on federal government subsidies and those that outline national service benchmarking standards, including the Aged Care Quality Standards (DoH, 2020).

3.4.2 Quality of Care Principles – 2014

The *Quality of Care Principles (2014)* are formed under the *Aged Care Act 1997* (DoH, 2022). The principles serve two main objectives: i) to specify the care and services that an approved residential care service provider must provide to comply with the industry; and ii) to describe provider responsibilities

against the *Aged Care Quality Standards* (DoH, 2022). The *Aged Care Quality Standards* were implemented in July 2019 (My Aged Care, 2019). The Standards focus on consumer-centred outcomes and were developed to reflect the level of care that the public expects from organisations providing aged care services in Australia (DoH, 2022). A summary of each standard is provided in Table 5. below (DoH, 2022)

Table 5. Aged Care Quality Standards

Standard	Brief description
1. Consumer dignity and choice	Standard 1 is a foundation Standard that reflects seven essential concepts. These concepts recognise the importance of a consumer's sense of self. They also highlight the importance of the consumer acting independently, making their own choices, and participating in their community.
2. Ongoing assessment and planning with consumers	Standard 2 describes what organisations must do to plan care and services with consumers. The scheduled maintenance and services should meet each consumer's needs, goals and preferences and optimise their health and well-being.
3. Personal care and clinical care	Standard 3 applies to all services delivering personal and clinical care specified in the *Quality-of-Care Principles*, *2014*.
4. Services and supports for daily living	Standard 4 outlines services support for daily living and aims to help consumers live as independently as possible and enjoy life.
5. Organisation's service environment	Standard 5 applies to the physical service environment the organisation provides for residential care. It does not apply to home care services where the consumer's home environment.
6. Feedback and complaints	Standard 6 requires an organisation to have a system to resolve complaints. The system must be accessible, confidential, prompt and fair.
7. Human resources	Standard 7 requires an organisation to have and use a skilled and qualified workforce to deliver and manage safe, respectful, and quality care and services.
8. Organisational governance	Standard 8 intends to hold the governing body responsible for the organisation and the delivery of safe and quality care and services.

Adapted from (Aged Care Quality and Safety Comission, 2022)

The *Aged Care Quality Standards (2019)* replaced the four Accreditation Standards or 'old Standards', which were: i) management systems, staffing and organisational development; ii) health and personal care; iii) care recipient lifestyle; and iv) physical environment and safe systems (Aged Care Quality and Safety Comission, 2022). A reported limitation of the 'old standards' is they were outdated and did not reflect older Australians' current and future needs (Culturally Directed Care Solutions, 2022). In addition, the old Accreditation Standards were described by some consumer advocates as 'provider focused' and 'task orientated' without fostering a partnership with consumers in the planning and implementation of their care (Blundell, 2012). Therefore, the *Aged Care Quality Standards* (2019) were formed around a consumer-centred and directed model of care to give older Australians greater control and direction of

their health, quality of life and wellbeing. They aim to ensure quality and safe aged care services to older Australian adults (Aged Care Quality and Safety Commission, 2022).

3.4.3 Users Rights Principles (2014)

The User Rights Principles (2014) also fall under the *Aged Care Act 1997*. Part A of this official document specifies the responsibilities of an approved residential care service provider concerning care, recipients, to whom the provider provides, or is to provide, residential care (DoH, 2020). It includes directives concerning the information providers should give to older adults about the services they receive, and the facility access that persons acting for care recipients, including consumer advocates or community visitors, may have to the organisation. Part B includes the *Charter of Aged Care Rights*, which describes care recipients' rights to Australian government-funded aged care services (DoH, 2020).

The *Charter of Aged Care Rights* was updated in 2019 to replace and streamline the existing four Charters for residential care, home care, short-term restorative care (in a residential setting) and short-term restorative care (in a home setting) (DoH, 2020). The redevelopment followed feedback from the social sector that the old Charter was unclear and care recipients were unaware of their human rights when receiving care (Royal Commission into Aged Care Quality and Safety, 2019). The new Charter stipulates 14 rights for care recipients accessing services, including residential aged care. These include the rights of consumers to i) receive safe and high-quality services; ii) live without abuse and neglect; and iii) have control over; and iv) make decisions about, the personal aspects of my daily life, financial affairs and possessions (DoH, 202).

3.4.4 Aged Care Quality and Safety Commission Act 2018

The Aged Care Quality and Safety Commission Act, 2018 directs the Aged Care Quality and Safety Commission (Commission), which is responsible for assisting the Aged Care Quality and Safety Commissioner (Commissioner) with its roles and responsibilities (DoH, 2020). The key objectives of the *Aged Care Quality and Safety Commission Act 2018* are to: i) protect and enhance the quality of life and safety of the consumer; ii) promote public confidence and trust regarding the delivery of aged care services; and iii) promote the engagement of aged care consumers with evidence-based quality processes (DoH, 2020). The rules covered under this legislation lead to performance assessments of each aged care provider. This process is administrated by the Aged Care Quality and Safety Commission and guided by the Aged Care Quality Standards (2019).

3.4.5 Australian aged care Workforce Strategy

The Australian Aged Care Workforce Strategy was developed in 2018 in consultation with individuals and interest groups, including aged care consumers, peak consumer and provider advocacy bodies and aged care providers (Aged Care Workforce Strategy Taskforce, 2018). The strategy aims to grow and sustain the Australian aged care workforce and ensure it can provide services that meet older Australians' current and future care social and health care needs (DoH, 2020).

The Strategy comprises 14 strategic actions, focusing on adjusting negative opinions about aging and promoting the aged care workforce as an attractive option for skilled professionals (Aged Care Workforce Strategy Taskforce, 2018). Action areas describe approaches to defining new career pathways, including mandatory workforce accreditation requirements and the emergence of new roles based on integrated and living well models of care (DoH, 2020). They also include recruitment and retention strategies for various positions across the aged care sector. One is the development of well-organised work-integrated learning opportunities for younger individuals (Aged Care Workforce Strategy Taskforce, 2018). Recognising workforce issues in rural and remote areas, the *Australian Aged Care Workforce Strategy* recommends establishing a remote accord to address the workforce challenges in isolated Australian communities (DoH, 2020).

3.5 Aged care financing in Australia

Australian aged-care services are jointly funded by state and Commonwealth governments, non-government organisations (charities or religious groups), and consumers and their families (Australian Government Productivity Commission, 2021). In 2020–21, governments (federal, state, territory and local) spent over $21 billion on aged care, up from $19.9 billion in 2019-20 (Aged Care Financing Authority, 2021). Over half of this expenditure was for residential aged care services, costing $13.4 billion, a slight increase from the previous reporting period. Government expenditure for aged care services is predicted to increase to over $27 billion by 2023-24 (Aged Care Financing Authority, 2021). Although funding is increasing annually, most aged care services continue to operate at a loss, substantially impacting a provider’s ability to promote and protect quality of care (Aged Care Financing Authority, 2021). In the reporting period 2020-21, for example, collectively, residential care providers reported an overall loss of $736 million, compared with $264 million in 2019-20. These figures are predicted by leading sector analysts, including StewartBrown, to worsen in the immediate future as population ageing and increased service demand continues to transpire (StewartBrown, 2021b).

3.5.1 The Aged Care Funding Instrument (ACFI)

The government subsidy funded to an aged care provider is based on assessing care recipient needs (Australian Government Department of Health, 2022a). The Aged Care Funding Instrument (ACFI) was implemented in 2008 to allocate funding around the three criteria areas said to differentiate relative care needs among older Australians, including i) activities of daily living; ii) behaviour; and iii) complex health care requirements (DoH, 2022). Each consumer is classified as requiring low, medium or high care in each of these domains (DoH, 2022). Once an individual is assessed using the framework, the service provider completes an ACFI Application and is determined by Services Australia, which then assigns a care classification based on the care recipient's level of need (DoH, 2022). If an individual's status changes over any of the three criteria, an ACFI reappraisal is completed to reassess for reclassification of funding. Under the 2021-22 ACFI rates, the highest subsidy provided under the Funding Instrument is $225.60 per day for those with the highest care needs (high in all three domains) (DoH, 2022).

Recent support for aged care funding reform was heard before the Royal Commission where provider and care recipient accounts suggested that ACFI does not effectively consider all requirements that ensure adequate care for older Australians (Royal Commission into Aged Care Quality and Safety 2019). It was reported, for example, that younger people in residential aged care receive less support than they would otherwise be receiving in the community (Royal Commission into Aged Care Quality and Safety, 2019). Additionally, consumer advocates reported that the current funding allocation model does not directly focus on the drivers of care costs or discriminate enough between the care requirements of each care recipient, given that each person is only assessed against three broad criteria (Royal Commission into Aged Care Quality and Safety, 2019).

3.5.2 The Australian National Aged Care Classification (AN-ACC)

The Australian National Aged Care Classification (AN-ACC) funding system was designed to address weaknesses identified in the current Aged Care Funding Instrument (ACFI) (DoH, 2022). The model is similar to the activity-based funding (ABF) system in place nationally across the broader health system (VicHealth, 2022). Moreover, the AN-ACC design principles are based on future population growth and ageing trends (Eagar et al., 2020). They aim to enhance the accuracy and consistency of the assessment process and reduce the administrative burden on aged care providers (DoH, 2020). Under the AN-ACC funding model, the subsidies payable to homes for the care of residents incorporate three components i) a base care tariff (for the fixed care component); ii) a variable payment (for the individual care needs of the resident as determined by the resident's AN-ACC class; and iii) a one-off adjustment payment for residents when a resident enters residential aged care (Eagar et al., 2020). The current AN-ACC trial

commenced in 2019. In October 2020, a report on the trial determined the assessment tool as fit for purpose, with the new model to be implemented into Australian residential aged care facilities in October 2022.

3.6 Current and future challenges for the Australian aged care sector

In Australia, Royal Commissions are the utmost form of review on matters of public significance (Australian Law Reform Commission, 2022). The Royal Commission into Aged Care Quality and Safety was established on 9 October 2018 (Australian Government, 2019), following the acknowledgement of more than 5,000 submissions detailing incidents of inadequate care and safety breaches in the Australian aged care sector (Australian Government, 2019). The commission conducted various public forums and onsite observations to hear from aged care consumers, their families and a range of service providers. This review aimed to determine the extent of concerns regarding quality and safety across the Australian aged care sector and how best to meet the challenges and the opportunities of delivering aged care in the future.

The commission *Interim Report* was released in October 2019. The report outlined various systemic issues within the Australian aged care system and described the provision of many services across the sector as "woefully inadequate" meaning that many consumers were having their fundamental human rights denied (Royal Commission into Aged Care Quality and Safety, 2019). The report also detailed that the system relied on a regulatory model that does not provide an "incentive" for home care and residential aged care providers to improve (Royal Commission into Aged Care Quality and Safety, 2019). A further priority issue was that the aged care workforce is under immense pressure, with a proportion of health service providers lacking critical knowledge and skills to deal with the often-complex health needs of older generations (Royal Commission into Aged Care Quality and Safety, 2019).

The *Final Report* was released in March 2021. It described several systemic issues which impacted a provider's capacity to deliver high-quality and safe care and that stem from the design and operation of the aged care system (Royal Commission into Aged Care Quality and Safety, 2021). These included "flawed" national payment models, variable provider governance and behaviour, an absence of leadership and management among aged care providers, and poor access to health care due to issues with navigating the system and limited resources such as skills health practitioners and administrators (Royal Commission into Aged Care Quality and Safety, 2021). Both Commissioners who led the inquiry proposed that the purpose of the aged care system should be to ensure that older people have an entitlement to high-quality aged care and support and that they must receive it (Royal Commission into Aged Care Quality and

Safety, 2021) and 148 recommendations were reported as a mechanism to “remedy” the broken system. Recommendations were grouped under 26 different topics and included regulatory and financial reform aimed at enhancing provider governance structures and workforce development (Royal Commission into Aged Care Quality and Safety, 2021).

3.7 Chapter summary

This chapter provides insights into the context of the programme of work conducted for this PhD. The aged care system in Australia is highly centralised, with little formal authority in the hands of state or local governments. Although regulations and strategic directives exist, the regulatory model has been found to not provide an "incentive" for home care and residential aged care providers to improve. The Aged Care Funding Instrument (ACFI) has been described as a flawed model that has created financial hardship for many aged care services over an extended period. ACFI also does little to support the attraction and retention of skilled and experienced personnel who can promote and protect quality of care. These systemic factors, coupled with ongoing incidences of substandard care and poor leadership and governance structures at the facility level, flag the need for an alternative approach to improving the quality of residential aged care. Within that broader eco-system, aged care senior managers clearly play a critical role in planning and implementing this change. The remainder of this thesis will focus on the role of residential aged care senior managers in addressing quality of care concerns. Specifically, the knowledge, human, technical and conceptual skills that senior managers require to promote residential aged care will be qualitatively explored and synthesised.

Chapter 4
Methodology and Methods

4.1 Chapter Introduction

This chapter details the methodology and methods used to develop this PhD, which aims to characterise the leadership competencies required by senior managers to influence quality of care in Australian residential aged care facilities. The chapter covers research design, philosophical principles, theoretical and conceptual bases, data collection and analysis methods and the ethical aspects relating to the current project.

4.2 Ontological assumptions and epistemological approach

"Good, sound research projects begin with straightforward, uncomplicated thoughts that are easy to read and understand." ― John W. Creswell

The current project is multidisciplinary and focuses on the intersection of leadership studies, gerontology and health services research. Leadership studies is a multidisciplinary academic field that focuses on leadership in organisational contexts and human life (Asrar-ul-Haq & Anwar, 2018), while the field of gerontology research is concerned with the physical aspects of ageing and the mental, social, and societal implications involved with the ageing process (Southern New Hampshire University, 2022). Health services research is a multidisciplinary field of scientific investigation that studies how financing systems, social factors, organisational structures, health technologies and personal behaviours, including those employed by leadership personnel, affect the quality and cost of health care (Lohr & Steinwachs, 2002). Applied health services research provides evidence and tools to make health care affordable, safe, effective, equitable, accessible, and patient-centred (Lohr & Steinwachs, 2002). Products stemming from health services research enable providers and care recipients to make better decisions and can be used to inform policy at multiple levels (Lohr & Steinwachs, 2002). Collectively, insight into each of these research fields allowed me to explore and consider the leadership competencies required by Australian senior residential aged care managers to promote high-quality care.

Research is about creating new knowledge and using existing knowledge in a new and creative way to generate new ideas, methodologies and understandings (Australian Research Council, 2022). A straightforward, uncomplicated research design promotes efficient and successful functioning, whereas a flawed design can lead to many potential issues, including an unfulfilled research aim (Thomas & Hodges, 2010). To avoid this scenario, a rigorous strategy should include developing a structured and realistic plan to achieve the study aim (J. L. Johnson, Adkins, & Chauvin, 2020). Creswell (2009) describes three aspects of research design that facilitate this planning process and enhance the validity of the study findings: i) philosophical perspectives, ii) instruments for enquiry and iii) specific methods or procedures used to translate research into practice (Catalano & Creswell, 2013).

A research philosophy provides the researcher with general principles for theoretical thinking (Spirkin, 1975). There are two core facets of philosophy commonly described in health and social sciences. The first is ontology: what actually exists in the world about which humans can acquire knowledge (Guest, Namey, & Mitchell, 2013). The second is epistemology (i.e., the study of knowledge), which in qualitative research is as diverse and complex as the various disciplines that employ qualitative methods

(Guest, Namey & Mitchell, 2013). Stemming from ontology and epistemology are philosophical perspectives or the researchers' generalised views of the world, which form beliefs that guide action (Lincoln & Guba, 1990; Spirkin, 1975).

This project adopts a relativist ontology by accepting there is no absolute truth, only the truths that a particular individual or culture happen to believe (Levers, 2013). As a senior aged care clinician, this ontology represents my learnt knowledge and perspectives, which I employ to understand better the social and cultural factors that influence quality of care in Australian residential aged care facilities. Social constructivism, which aligns with a relativist ontology, is an epistemology that views human learning as constructed and knowledge as shaped by the cultural, historical, political, and social norms that operate within that context and time (Vygotsky & Cole, 1978). Social constructivists, therefore, view reality as constructed through human activity and that individuals in society construct the properties of their surrounding environments (Kukla, 2013). Social constructivists also consider knowledge and learning as human products, influenced by social processes (Ernest, 1999; Gredler, 1997; Kim, 2001) and create meaning via their interactions with each other and their environment (Kim, 2001).

Social constructivism shaped the development of this PhD project and the overarching question: *What leadership competencies are required by Australian residential aged care senior managers to promote and protect quality of care?* The social constructivist perspective meant paying close attention to the social processes that influence the residential aged care senior manager role because, at its core, this role is relational and rooted in social interaction that should, ideally, produce better health outcomes for vulnerable members of society. Social constructivism also influenced my exploration of senior manager interactions with the social and structural factors that influence the quality of residential aged care. I was then able to analyse these experiences and insights to construct new knowledge and meaning of the leadership competencies senior managers require to interact with factors influencing quality of care within their respective organisations.

4.3 Interpretive description: A generic qualitative methodology

Interpretive description is a recently developed qualitative research methodology aligned with a constructivist orientation to inquiry and is described as a practice and action-based methodology seeking to discover and understand a phenomenon (Thorne, 2016). The methodology posits that people utilise "what they see, hear, and feel" to make sense of social experiences and circumstances (Thorne, 2016). Interpretive description also seeks to understand how people interpret, construct, or make meaning from their world and experiences, like many qualitative methodologies grounded in relativist ontology

(Merriam, 2002). Epistemologically too, interpretive description aligns well with social constructivism as it focuses on how people create their worlds, and new knowledge and interpret their experiences (Merriam & Grenier, 2019).

The interpretive description methodology has been applied across many settings and professional fields since its inception (Hunt, 2009), including those in other health disciplines, education, leadership and management sciences. In 2013, for example, Björkdahl, Palmstierna, and Hansebo (2010) used interpretive description to describe nurses' approaches to care in acute psychiatric care units in Sweden (Björkdahl, Palmstierna, & Hansebo, 2010). Of relevance to residential aged care and the focus of this PhD, Edwards, McClement, & Read (2013) employed an interpretive description approach to explore long-term care [residential aged care] nurses' experiences of moral distress (Edwards, McClement, & Read, 2013). More recently, Swiss researchers used interpretive description to examine quality of care in Swiss residential aged care facilities; investigating how managers of top-quality nursing homes define, develop and maintain high-quality care within their respective organisations (Asante, Zuniha & Favez, 2021).

Interpretive description was used in the current project because it aligned with my relativist ontology and social constructivist perspective while offering an action-oriented approach suitable for health services research. Since interpretive description preferences qualitative methods for exploring the experiences and opinions of interview participants (Thorne, 2016), such as Australian residential aged care senior managers and industry experts, it is flexible to the integration of inter-disciplinary theoretical concepts and propositions (Hunt, 2009). These theoretical concepts, which are described later in this chapter, presented a logical explanation of the challenges that influence residential aged care, quality of care, and allowed a deeper exploration of how managers interact with these forces to promote better health outcomes for older care recipients. As a practice of action-based methodology (Thorne, 2016), interpretive description guided the synthesis and mapping of the leadership competencies required by senior managers to address and manage the reported structural factors and facility-level challenges influencing quality of care.

Methodology limitations

Criticism of interpretive description exists within the literature. Thorne and colleagues (2004) offered the first when they addressed concerns over blurred distinctions between qualitative approaches and a perceived lack of epistemological and methodological grounding in interpretive description (Kahlke, 2014). Furthermore, in articulating a non-categorical method of study such as interpretive description,

there are risks such as those of "method slurring" (Baker, Wuest, & Stern, 1992; Morse, Morse, & Tylko, 1989), which refers to an assorted and irrational use of techniques from incompatible methodological traditions (Kahlke, 2014). While method slurring can create congruence issues, interpretive description may actually alleviate these concerns by intentionally building a new generic research framework, including epistemology, methodology, and methods (Kahlke, 2014). The researcher can then select approaches that will work together to answer the research question (Kahlke, 2014). Critics of interpretive description also point to a dearth of literature contextualising the methodology (Hunt, 2009). Most information on interpretive description methodology, for example, has been supplied by Thorne and colleagues (Maheu & Thorne, 2008; Thorne, 2016; Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Kirkham, & O'Flynn-Magee, 2004). Interpretive description, however, offers an approach to unearth novel and interesting questions that can arise in the "in-between" methodological spaces yet to be explored (Thorne, 2008). As a result, many researchers across multiple disciplines, including health care, the social sciences, leadership studies, education and management sciences, are employing the methodology to achieve a deeper understanding of social phenomena relevant to their discipline (Kahlke, 2014; Hunt, 2009, Thorne, 2016).

4.4 Literature review and theoretical underpinnings

This section will detail the literature review findings and theoretical underpinnings that shaped the research question, data collection and analysis. The literature review, presented in Chapter 2 and entitled *'Senior management characteristics that influence care quality in aged care homes: A global scoping review'*, identified significant gaps in knowledge around senior management characteristics that promote quality of care in residential aged care settings. Nonetheless, review findings did flag a potential link between senior manager professional characteristics and the quality of residential aged care. The results show a connection between senior managers' leadership styles (and behaviours) and quality of care. Moreover, an individual's role preparedness before transitioning into a senior management position is linked to the quality of care delivered. Another theme that emerged from the review was the relationship between management tenure and the delivery of quality healthcare in aged care homes. Finally, it was found that a range of social and environmental factors such as regulation, finances, organisational structural and systemic variances across the different state and international jurisdictions influence the prevailing challenges towards ensuring high-quality care. These external factors, mean that senior managers require certain leadership competencies to deliver high-quality health care within their respective organisations. Such factors have been documented in the larger body of literature on senior management in distinctive mainstream (e.g., hospital) healthcare settings.

4.4.1 Leadership theory

Leadership theories explain how and why certain people become leaders (Benmira et al., 2016). They focus on the traits and behaviours that people can adopt to increase their leadership capabilities and help to explain how leaders harness and develop these characteristics (Northouse, 2021). While several leadership theories date back to the 1800s, a few are more well-known and used to explore the field of leadership studies and health services research. These include the 'great man' theory, situational theory, relationship theory, and the *Skills Approach to Leadership Theory* (Katz 1956), which possesses concepts and propositions used to explore the role of residential aged care senior managers in this PhD.

Situational and relationship theories focus on examining a leader's context, including their interactions with others and the surrounding environment in which they operate (Benmira et al., 2016). Situational leadership posits that different situations demand different kinds of leadership depending on the desired outcome (Graeff, 1997). This theory is commonly used in designing organisational leadership training and development courses to support current and aspiring leaders in forming the characteristics required when responding to dynamic situations or environments (Northouse, 2021). Relationship theories are also commonly used in leadership development; however, they are more focussed on the ability of leaders to interact with others to optimise an output or results (Al-Sawai, 2013). There are certain advantages to situational and relational leadership abilities. For example, within an organisational context, employees generally feel more confident around leaders who possess well-developed relational skills and can respond appropriately to various contexts (Xu, 2017). However, a limitation of leadership theories focussing on relational and situational characteristics is that they are limited in describing the innate leadership skills, personal qualities, traits, and other attributes leaders require to perform successfully (Northouse, 2021).

The great man theory of leadership, sometimes called the trait theory, focuses primarily on identifying high-performing leaders' innate qualities and characteristics (Halaychik, 2016). Unlike situational and relationship theories, the 'great man' theory does not consider relational or contextual factors influencing leadership development and believes that 'great' leaders are born with inherent leadership abilities (Northouse, 2021). Several critics argue against propositions of the 'great man' theory and suggest that leaders are shaped by the environment in which they exist. Sociologist Herbert Spence, for example, postulated that leaders were products of the society in which they lived and are not born with a set of developed innate abilities allowing them to lead successfully (Vilkinas, Murray, & Chua, 2020). Spector (2016) also queried whether leaders are born or, similar to Spence, are a product of their experiences and

external surroundings. In addition, it was suggested that not all people who possess natural leadership qualities become great leaders (Spector, 2016).

The skills approach leadership theory also takes a leader-centred perspective on leadership like the great man theory (Lussier & Achua, 2015). In the skills approach, however, thinking is shifted from focusing on personality characteristics, which usually are viewed as innate and primarily fixed, to emphasising skills and abilities that can be learned and developed (Northouse, 2021). Although personality certainly plays an integral role in leadership, the skills approach suggests that knowledge and abilities are needed for effective leadership (Northouse, 2021). The three primary skills required by leaders to accomplish their goals, according to this theory, are technical, human, and conceptual (Lussier and Achua, 2022). Technical skill refers to knowledge about and proficiency in a specific type of work or activity, while human skill is knowledge about and the ability to work with people (Powell et al., 2017). Conceptual skills are the ability to work with ideas and concepts (Powell et al., 2017). Where technical skills deal with objects and processes, and human skills deal with people, conceptual skills involve the ability to work with ideas (Powell et al., 2017).

The *Skills Approach to Leadership Theory* was used to inform data collection and analysis within the current project as it presents concepts and propositions that provide a logical, systematic, and coherent approach to exploring and better understanding senior managers' competencies that promote residential aged care, quality of care. For example, I examined senior managers' technical skills to better understand the competencies required to lead administrative, regulatory and clinical aspects of Australian residential aged care facilities. I also considered the human skills required by managers to create a workplace culture and physical environment conducive to high-quality care. Other relational and human focussed skills included the ability of senior managers to address barriers to staff recruitment and retention, a well-reported challenge linked to residential aged care, quality of care. Finally, I explored the conceptual leadership skills required by managers to promote quality of care by examining the leadership competencies required to recognise and manage a range of structural factors that influence the quality of residential aged care. These include current regulatory and funding arrangements specific to the Australian aged care system.

4.5 Aims

The PhD aims to contribute to leadership studies, gerontology, and health services research by characterising the competencies required by senior managers to promote and protect quality of care within Australian residential aged care facilities.

4.5.1 Objectives

1. Determine and discuss the prevailing challenges towards ensuring quality of care in Australian residential aged care facilities.
2. Identify and synthesise senior manager leadership competencies that influence high-quality residential aged care in Australia.
3. Develop a preliminary quality framework mapping senior management leadership competencies that may enhance quality of care in Australian residential aged care facilities.

4.5.2 Guiding research questions

1. What are the prevailing challenges towards maintaining or improving quality of care within an Australian residential aged care facility?
2. What leadership competencies are required by senior managers to influence high-quality health care in Australian residential aged care facilities?
3. What leadership competencies and professional development opportunities are required to prepare professionals transitioning into a residential aged care facility senior management role?

4.6 Methods

For the findings to be credible, the research process must have a research aim consistent with the epistemological view and an interpretation of data that sensibly stems from the research objectives (Austin & Sutton, 2014). To strengthen the credibility and rigour of this project, nine principles to evaluate each qualitative approach were used to guide the research design, data collection and analysis (Forero et al., 2018; J. L. Johnson et al., 2020; Morse & Chung, 2003). The following sections describe each principle in turn and the methods used in this PhD to reflect that principle. Both the principles and these methods are summarised below and elaborated upon in subsequent sections of this chapter.

Table 6. Summary of methods to ensure methodological quality and rigour

Research Phase	Principles for Ensuring Quality and Rigour	Methods used in this Study
DESIGN	**Guiding conceptual and theoretical frameworks**	A conceptual framework was developed and guided by the 'skills approach leadership theory' (Katz 1956), the National Health Performance Framework (2019), Aged Care Quality Standards (2019) and Institute of Medicine – Quality Dimensions (2016). The conceptual framework was continuously updated as insights were gathered during data collection and analysis.
DATA COLLECTION	**Justified site and participant selection**	Interviews with senior managers were conducted within the Northern Queensland Primary Health Network region to explore the structural factors and likely challenges influencing quality of care within remote, rural and inner regional northern Queensland communities. Interviews with industry experts were conducted across multiple professional roles and jurisdictions to broaden the scope of expertise at the national level.
	Purposeful sampling	*Interviews* - Senior managers in high-performing residential aged care facilities, in northern Queensland. 19 interviews were conducted with senior managers in this location. *Interviews* – Industry experts provided an 'information-rich' view of the structural factors that exist and may influence the quality of Australian residential aged care facilities. 12 interviews were conducted with industry experts across various professional roles and organisations. Industry experts are defined here as those who contribute to or advise regarding the delivery of residential aged care services in Australia.
	Thick description	The meaningfulness of each detail was observed during each interview and documented to ensure an accurate interpretation of each interaction. Memoing was also completed as a reflective activity where I considered the concepts and relationships taking place within each interview setting
	Multiple methods	In-depth, semi-structured interviews were conducted with senior managers and industry experts. An existing leadership competency framework data extraction was performed and compared against the interview data. A framework synthesis was conducted to collectively analyse findings across the interviews and competency extraction process.
ANALYSIS	**Reflexivity**	The researcher completed a reflexive journal detailing informal observations and interpretations throughout the data collection process. These research perspectives, positions, values and beliefs are reported in manuscripts linked to the study and included within this thesis.
	Triangulation	Triangulation of data collected from semi-structured interviews, existing framework review and the literature review (chapter 2).

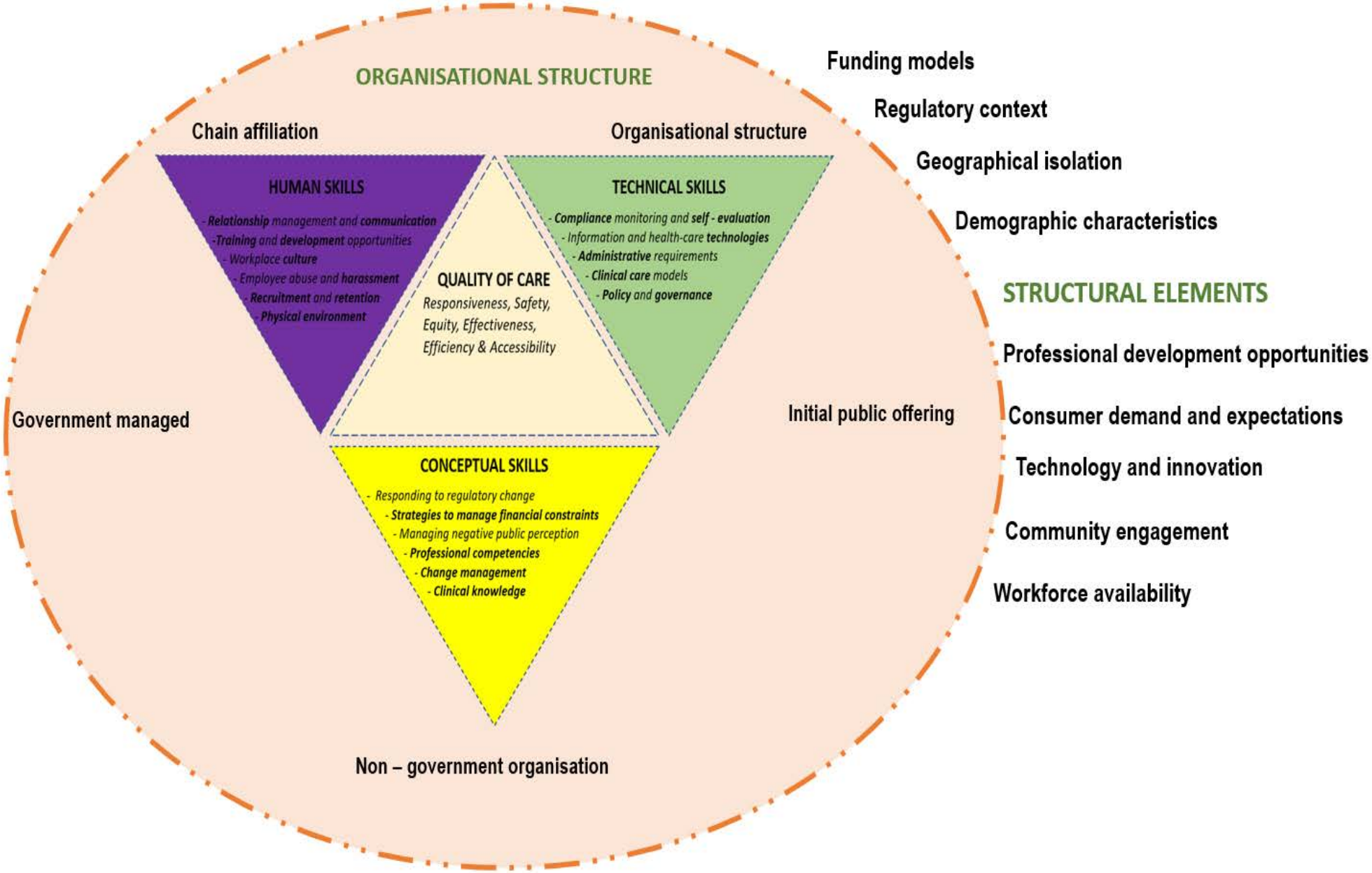
	Peer debriefing and support	The advisory panel reviewed transcribed interviews verbatim. Frequent contact between the researcher and the advisory board was maintained during each study phase.
	Respondent validation	Initial interview transcripts were sent to each participant to reduce the prospect of error and misinterpretation.

4.6.1 Developing a conceptual framework

A conceptual framework is a justification for why a given study should be conducted, and (Reeves, Albert, Kuper, & Hodges, 2008)describes the state of known knowledge. The framework assists the researcher to identify gaps in their understanding of a phenomenon or problem; and outlines the methodological underpinnings of the research project (Varpio, Paradis, Uijtdehaage, & Young, 2020). In this PhD, initial framework development drew on a synthesis of the existing literature (chapter 2) and a summary of the relevant conceptual designs and regulatory requirements used to develop and evaluate the quality of aged care services. These included the National Health Performance Framework (NHPF) (2019) and Institute of Medicine (IOM) Quality Dimensions (Australian Institute of Health and Welfare, 2020b; Institute of Medicine, 2022). I also incorporated elements of the *Skills Approach to Leadership Theory* (Kratz, 1956) to conceptualise potential human, technical and conceptual leadership factors influencing quality of care in Australian residential aged care facilities. As the programme of work progressed, I frequently updated the original conceptual design with insights obtained from interviews and following review of existing health-related leadership competency frameworks.

A practical conceptual framework should explain why the research is conducted in the selected context (Varpio, Paradis, Uijtdehaage, & Young, 2020). The context of this PhD is focused on five (5) primary domains, including the technical, human, and conceptual skills of residential aged care senior managers, quality of care dimensions and the structural factors that influence the operations of Australian residential aged care facilities (Figure 3). This thesis conceptualises that each of these domains is interdependent and affects residential aged care, quality of care. The six quality-of-care dimensions (efficiency, effectiveness, safety, responsiveness, equity, and accessibility) were extracted from both the IOM Quality Dimensions and NHPF to inform the leadership competencies required by senior management personnel to promote and protect quality of care (project objective 2). These dimensions informed the design of a preliminary leadership competency framework aimed at assisting the recruitment, development and retention of confident and competent Australian senior managers who promote high-quality care residential aged care (project objective 3).

Figure 3. Conceptual Framework



4.6.2 Data collection

Depending on the question explored and the depth and detail wanted, interpretive description enables the use of various data collection methods, including interviews, participant observation and documentary reviews (Kahlke, 2014). Three principles were used to guide and strengthen the rigour of data collection processes, including justified site and participant selection, the incorporation of multiple qualitative research methods, and purposive sampling techniques.

Purposive sampling

Sampling may be convenient, theoretical, or purposive when employing a qualitative interpretive description methodology (Thorne, 2016). Thorne (2008) acknowledged that the idea of representation within sampling is complicated and that a study can never represent anything other than what it is. Thorne (2008) therefore, urged researchers to accept that although the sample will not be meaningfully representative, it will reflect a certain kind of perspective built from an auditable set of angles of vision whose nature and boundaries we can acknowledge and address. A purposive sampling approach was used here whereby residential aged care senior managers and Australian aged care industry experts were intentionally selected to understand better the central phenomenon - competencies required by senior managers to influence quality of care in the Australian residential aged care setting. This approach helped to ensure that participants were 'information-rich' (Patton, 1990) and well-positioned to describe the challenges influencing quality of care, and the leadership competencies required by senior managers to address these concerns.

4.6.2.1 Phase 1: Qualitative interviewing

Interviewing is a valuable data collection strategy for addressing "experience-type" questions (Braun & Clarke, 2006) that allow for further probing or clarification (Johnson, Turner, & Iwata, 2003). There are three types of research interviews: structured, semi-structured and unstructured (Gill, Stewart, Treasure, & Chadwick, 2008).

In this PhD, semi-structured interviews with two different participant groups were used: i) northern Queensland residential aged care senior managers, and ii) Australian aged care industry experts and academics. By adopting this interview style, I was able to obtain an insight into the human experience of each residential aged care facility senior manager concerning the challenges of leading a quality residential aged care service and further enabled me to explore the perceptions of industry experts regarding the role of structural; economic and regulatory contexts that influence quality of care. Across both participant groups, semi-structured interviews allowed in-depth description and open-ended

discussion regarding the leadership competencies required by senior managers to promote and protect factors contributing to high-quality care.

Interviews: Residential aged care senior managers

Interviews were conducted with 19 senior managers employed within for-profit or non-for-profit residential aged care facilities in the Northern Queensland Primary Health Network (NQPHN) region (Figure 4). The NQPHN region contains various degrees of geographical remoteness, including inner and outer regional, rural and remote localities (Northern Queensland Primary Health Network [NQPHN], 2022). The area comprises for-profit, not-for-profit, chain affiliated, and non-chain affiliated residential aged care organisations. Chain affiliated residential aged care facilities form part of a broader organisation, usually consisting of multiple facilities in different locations (Nowy et al., 2015). Non-chain-related facilities are standalone, independently owned and managed organisations (Nowy et al., 2015). The inclusion of these different types of residential aged care facilities enabled the consideration of potential differences in the experiences of senior managers working under various organisational and funding structures and across various areas of geographical remoteness. A consciously 'remote and regional' focus also allowed exploration of the unique challenges and structural factors associated with service delivery in more geographically remote areas.

Figure 4. Northern Queensland Primary Health Network Region - Study locations

Note: Source: (Adapted from Northern Queensland Primary Health Network website, 2018)

Recruitment

GEN Aged Care Data (Australian Institute of Health and Welfare, 2021) was used to obtain a list of senior managers who operated in 'high performing', non-government residential aged care facilities within the NQPHN region. 'High performing' residential aged care facilities were those that obtained the maximum score (44/44) against the accreditation standards, as assessed by the Aged Care Quality and Safety Commission. Recruitment was conducted using a combination of email with phone follow-up and was conducted face to face and over the phone between December 2019 and January 2020. All participants agreed to the interview being audio-recorded and transcribed and were provided with a copy

of the transcription as an opportunity to correct or remove data before the analysis. Table 7. provides a further breakdown of interviews according to residential aged care facility profit status, geographical location, chain- affiliation and participant employment position.

The final interview guide (Appendix 5) included multiple open-ended questions that were developed with the guidance of conceptual and theoretical frameworks. The interview context was informed by my own experience, working as an occupational therapist in a northern Queensland residential aged care facility. The final interview guide comprised four major themes. The first theme was focused on the prevailing challenges associated with providing high-quality care in Australian residential care facilities. The second interview theme focused on the specific quality of care dimensions relevant to and prioritised within residential aged care facilities. The third theme focused on participants' perceived role preparedness when transitioning into a senior management role for the first time. The fourth theme explored the leadership characteristics of senior management personnel who influence high-quality healthcare while outlining any professional development strategies that may affect the degree of health care provided in a residential care facility.

Table 7. Description of senior manager participants based on professional role, qualifications and Australian Statistical Geography Standard (ASGS) category

Participant	Professional Role	Qualification/s	Remoteness (ASRG)Category
1	CEO	Registered Nurse Diploma of Business & Human Resources	2
2	Facility Manager	Registered Nurse (UK) Management short course (over ten years ago	2
3	CEO	Certificate in Business and Hospitality Financial cadetship	4
4	Clinical Care Coordinator	Registered Nurse	3
5	Senior Administration Officer	Certificate IV Administration	2
6	Director of Nursing	Registered Nurse	4
7	Residential Facility Manager	Registered Nurse Industry accreditation short courses	2
8	Facility Manager	Business short courses – no formal qualification reported	3
9	General Manager	No formal qualification	3
10	Director of Care	Emergency Nurse (NZ) Bachelor of Geography and Social Policy	4
11	Clinical Care Manager	Registered Nurse	4
12	Clinical Care Manager	Registered Nurse	4
13	Clinical Care Manager	Registered Nurse (UK) Dip. Leadership and Management	2
14	Facility Manager	Dip. Management Bachelor of Business	2

15	Clinical Operations Manager	Registered Nurse	2
16	Facility Manager	Registered Nurse	4
17	Director of Nursing	Registered Nurse	2
18	Facility Manager	Bachelor of Hospitality	2
19	Facility Manager	Registered Nurse	5

Interviews: Australian aged care industry experts

Although senior managers provided critical frontline perceptions of the challenges to promoting quality of care within the northern Queensland context, I recognised the importance of broadening my line of enquiry to a group of participants spanning multiple jurisdictions and professional roles. Therefore, 12 interviews were conducted with industry experts who engage with stakeholders across multiple levels of the Australian aged care system and inform sector-wide policy development and governance arrangements.

Recruitment

Australian aged care industry experts engage with stakeholders across multiple levels of the Australian aged care system and inform sector-wide policy development and governance arrangements (South Australian Council of Social Service, 2011). The PhD identified three major groupings of industry representatives including, peak advocacy bodies, primary health network representatives and aged care researchers. First, 'peak advocates' included participants who work for national peak provider and consumer advocacy bodies that provide support, advocacy, and policy development services for their members (South Australian Council of Social Service, 2011). Primary Health network representatives are employed by statutory bodies funded by the Australian federal government and possess skills and knowledge to evaluate and monitor the effectiveness of health services against local population health needs, including those provided in residential aged care (Russel & Dawda, 2019). Aged care researchers aim to improve understanding of and produce evidence, tools, and resources to improve the aged care sector's health, policies, and services. Like peak body advocates, aged care researchers tend to engage with a variety of stakeholders to explore or develop knowledge to inform national policy or implementation (National Ageing Research Institute, 2022).

Using a combination of aged care industry experience and a comprehensive desk search, I developed a list of eligible individuals and organisations using public contact information, including Primary Health Network organisations, Department of Health government websites, national research institutes and Australian University websites. Participants were then emailed an invitation for involvement and followed up by phone if a response had not been received in two weeks. The interview guide (Appendix

6) canvassed the role of the industry expert, their perceived link (if any) between senior managers and quality residential aged care, current and potential challenges associated with delivering high-quality residential aged care, and the leadership skills required to address these concerns. All participants provided written informed consent and agreed to audio-recorded and transcribed interviews. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data before the analysis. Table 8. provides a further breakdown of interviews according to residential aged care participant employment position and organisation type.

Table 8. Description of industry expert participants based on professional role and organisation type

Participant ID	Position	Organisation Type	Government affiliation (if applicable)
1	Chief Executive Officer (CEO)	Provider advocacy	
2	National Policy and Advocacy Manager	Provider advocacy	
3	Chair of Board – Non–Executive Director	Consumer advocacy	Aged Care Advisory group
4	Chief Executive Officer (CEO)	Consumer advocacy	Aged Care Advisory group
5	Chief Executive Officer (CEO)	Provider advocacy	
6	Senior Policy and Engagement Officer	Provider advocacy	
7	Professor – Academic	Research Institution	National Aged Care Advisory committee
8	Queensland State Manager	Provider advocacy	
9	Program Director	Research Institution	
10	Executive Director	Provider advocacy	
11	Project Manager – Aged Care	Primary Health Network	
12	President	Consumer advocacy	

4.6.2.2 Phase 2. Existing competency framework review and extraction

In phase 2 of data collection, I extracted leadership competencies from existing health and aged care leadership competency frameworks. First, I defined a search strategy that included the definition of five key terms: *competency*, *competence*, *competency list*, *domains of competence*, and *competency framework* (Englander et al., 2013). Using PubMed, CINAHL, Medline PubMed, Informit, Medline Ovid, Google, and Web sites of selected health care organisations, I then conducted a global search for published competency frameworks representing health and aged care leadership competencies. A framework was eligible for inclusion if it: i) included competencies relating to the senior manager role; ii) was a methodological framework and reported the approach used for developing that framework was presented, iii) was written in English, and iv) published in the last 20 years in peer-reviewed or grey literature (2011 onwards) (Table 9).

Table 9. Included leadership competency frameworks for data extraction

Model/ Framework	Intended audience	Purpose of model
HLA Competency Directory, established: 2005, updated: 2011	Health care executives	Identify competencies necessary across diverse professional roles within health care management and find common competencies among alliance members
NCHL Health Leadership Competency Model established: version 2.1 (2006), updated: version 3.0 (2018)	Interprofessional, academic and clinical sector learners	To: i) Improve the health status of the entire country through effective health leadership; ii) establish core competencies for health leaders at all levels of the career cycle; and iii) strengthen the practice of health leaders with academic research.
IPEC Core Competencies for ICP, established: 2010, updated: 2016	Interprofessional health disciplines—academic and clinical Environments	To identify collaborative practice domains and improve communication amongst health professionals.
NSW Health Leadership and Management Framework, established: in 2020	New South Wales health system executives	To provide an evidence-based structure to support leadership and management development for the NSW public health.
Vic Health CEO Leadership capability framework, established: 2019.	Victorian health system Chief Executive Officers	To support the identification, development and management of CEO talent across the Victorian health system.
Master Health Service Management Competency Framework, established: 2016.	Health care executives	To inform employers and policymakers of the competencies they should consider when employing, leading, and managing health service managers.
Australian, Aged Care Leadership Capability Framework, established 2014	Australian aged care leaders	Describes the knowledge, skills and abilities that underpin leadership required by leaders across aged care.

4.6.3 Data Analysis

There is no prescriptive method for analysing data within an interpretive description methodology (Thorne, 2008). Researchers should, however, use inductive analytical approaches that allow structure and meaning to be given to the data to develop new understandings (Thorne, 2016, 2008; Thorne et al., 1997). Data collection and analysis generally occur concurrently with the researcher constantly reflecting

and asking questions such as: 'why is this here?', 'why not something else?', 'what does this mean?' (Thorne, 2008; Thorne et al., 2016). Analytically, it allows the researcher to structure their process to unearth applied practices that are fundamentally important to the discipline or content and relevant to the research question about the audience towards which it is projected (Thorne, 2016).

Data immersion and familiarisation

In this PhD, the first phase of analysis was concurrent with interviews across both participant groups. Handwritten memos were collated immediately after each participant interaction to ensure that I could maintain a reflexive stance concerning the research situation, participants and documents under study. These field notes provided summaries of evidence relating to individual interactions with senior managers and industry experts. I also documented my initial impressions when entering each residential aged care facility to interview senior managers, including the perceived interactions between residents and staff members within the facility. Furthermore, I noted factors that contributed to the ambience in each facility, including the lighting, cleanliness and design of the internal and external communal environments. By routinely completing this activity, I found that the interplay between myself as the researcher and informal data compiled via memoing was crucial to the generation of knowledge and depth of my experience within each residential aged care facility that I visited (Birks, Chapman, & Francis, 2008).

After completing each interview, individuals were emailed a copy of the transcription verbatim to ensure that my understanding corresponded with those of the participants from whom those data were derived. I also re-read the transcriptions multiple times to achieve thorough data immersion. Respondent validation also occurred via telephone, where I contacted individual participants to inquire further about a specific detail noted in the transcribed text. I used this technique to clarify any misunderstandings when re-reading transcribed verbatim. During informal meetings, the collated memos stating informal observations and the researcher's perceptions were shared and discussed with my supervisory panel.

Initial code generation and thematic analysis

Once all interviews with senior managers and industry experts were transcribed, the discussions, memos and transcripts were imported into NVivo 12™. The initial coding process was then completed, whereby I read each of the transcripts and assigned the text to broad code names for further reference. Following initial coding, each theme was reviewed, defined, and named based on the newly developed conceptual framework. Codes relating to leadership competencies and residential aged care, quality of care included relationship management and communication skills, interpreting and responding to regulatory change.

Once coding was complete, data from each interview was transcribed verbatim and analysed using a blended deductive and inductive analysis. Inductive analysis is a process of coding the data without trying to fit it into a pre-existing coding frame or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven (Braun & Clarke, 2006). In the current project, I employed inductive thematic analysis to explore the data and identify themes that industry experts and senior managers reported regarding challenges to promoting quality residential aged care and the competencies required to address these concerns. Following this inductive phase, deductive thematic analysis was employed and driven by the Australian National Health Performance Framework (Australian Institute of Health and Welfare, 2020b), IOM Quality Dimensions, and the new conceptual framework described earlier in this chapter. These frameworks allowed a better exploration of how the structural factors and facility-level challenges linked to quality of care within the Australian residential aged care context. The deductive approach also considered senior managers' leadership skills and knowledge influenced individual quality dimensions within existing theoretical frameworks.

Constant comparison

Interpretive description employs various verification strategies, such as concurrent data collection and constant comparative analysis (Thorne, 2008). After the data for each participant group had been analysed separately, a constant comparison was conducted to assess any similarities or differences regarding the leadership competencies that influence quality of care, as reported by residential aged care senior managers and Australian aged care industry experts. During this process I carefully reflected on participant positionality (why might certain themes or competencies be described by one participant or group of participants but not another? How/do different participants understand and frame leadership differently? And what additional information or experiential knowledge does each participant bring in identifying important competencies?). A comprehensive list of leadership competencies reported across both participant groups was collated and labelled ‘RCSM-QF 0.1’.

A second comparative analysis was then conducted between the RCSM-QF 0.1 and existing health-related leadership competency frameworks. This comparison aimed to identify additional leadership competencies that interview participants did not report during Phase 1 of data collection. Throughout this iterative process, new competencies were added to the RCSM-QFV 0.1. The findings from this phase are comprehensively detailed in chapter 8.

Framework synthesis

A framework synthesis guided the analysis and triangulation of in-depth interview data and new data derived from the existing health-related leadership competency framework. Framework synthesis starts deductively from pre-set aims and objectives – to extract and synthesise findings (Barnett-Page & Thomas, 2009). Firstly, I immersed myself with the raw data from the literature review and in-depth interviews by re-reading interview transcripts and reviewing recurrent themes. I noted the potential challenges to the quality of care posed by political and regulatory requirements directly linked to residential aged care service provision. Next, an inductive thematic approach was employed to determine the human, technical and conceptual skills and knowledge that influence the quality of Australian residential aged care from both the literature review and in-depth interview data. This inductive approach was applied across all data to extract relevant leadership skills and quality themes. Specific leadership skills and personal qualities linked to residential aged care quality of care were extracted from the inductive themes generated from the indexing phase. Once an association between themes was determined, leadership skills and personal qualities were grouped under overarching leadership competency domains. A comprehensive description of the framework synthesis is presented in chapter 8.

4.7 Ethical Aspects of the Research

To ensure the ethical treatment of all human research participants, this study was based on five principles: researcher reflexivity, research merit and integrity, respect for human beings, justice and beneficence as described by the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (2007). Ethics approval for the interviews conducted with senior managers was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019. An amendment was approved in December 2020 to facilitate interviews with Australian industry experts.

Researcher reflexivity and positionality

Positionality is the researcher being aware of their 'political emotions' concerning the context, both socially and politically, of the project (Holmes, 2020). According to Petray (2012), political emotions are "those related to our sense of power over ourselves and our environments as we pursue those goals, ideals and activities that give our life a meaning" (Petray, 2012). Thus, political emotions will differ from person to person, given that social realities and identities also vary from person to person (Petray, 2012). To this end, I acknowledge my reality, and therefore my positionality, not only as a researcher, but as a white, Australian, middle-class, well-educated male, and aged care clinician. Throughout this research, I

have kept my positionality in mind from the initial proposal to the ethics process, to the formulation of the semi-structured interview questions, to the data analysis.

An important consideration has been my role as a practitioner-researcher throughout this study. Clinically, I was a senior occupational therapist who has worked in residential aged care for 18 months. During this period, I was dismayed at witnessing the substandard level of care provided to care recipients and inadequate leadership conveyed to address these concerns. These experiences and an internal quest for social justice drove my passion for developing this exploratory project. I recognise, however, that this positionality may have predisposed me to interpret and analyse specific issues in certain ways. Reed and Procter (1995) also talk about practitioner-researchers "being part of the world that they are researching in a way that an academic researcher cannot be" (Reed & Procter, 1995). Whilst acknowledging that the role brings distinct advantages, for example, a practitioner who is involved in both research and clinical practice can facilitate an "interactive flow of ideas" (Yanos & Ziedonis, 2006) between the two domains, they also highlight the risk of ethical conflict. I have employed various strategies across each phase of the data collection, analysis and thesis formation to ensure ethical principles were adhered to and the robustness of research and validity of findings was assured. These considerations are highlighted within the ethical principles below.

Research merit and integrity

This PhD was designed in response to well-reported instances of substandard quality of care and safety breaches within Australian residential aged care facilities. Research of merit must be well justified, meet relevant quality criteria and be conducted by persons or teams with sufficient experience and competence (Australian Council for International Development, 2020). This programme of work aimed to contribute to the evidence base and practice toolkit of the residential aged care sector in order to help strengthen health care services for residents living in Australian residential aged care facilities. To achieve this goal, I sought to map the core leadership competencies required by senior managers to influence high-quality health care within their respective organisations. This work has been guided by researchers with experience in the Australian residential aged care sector and expertise in health systems research. Also, the design, planning, implementation and analysis of the project findings meet the *Effective and Ethical Research and Evaluation* (Table 10.) criteria to ensure the merit and integrity of the research design, planning, analysis and reporting in this PhD.

Table 10. Research merit & Integrity: Self–Assessment Checklist

Research design	Are the methodology and analysis appropriate to the context, and what is being investigated?	Given a lack of depth of evidence, exploratory qualitative research methods were used to explore the opinions and experiences of senior managers and industry experts regarding the competencies required for high-quality residential aged care; framework synthesis enabled results to be combined with systematic review findings.
	Does the research design involve local partners at all stages?	Senior manages and industry experts were consulted in the design of the project; and involved key informants to the studies reported in Chapters 5,6,7.
Planning	Do researchers have the relevant expertise to conduct the research?	The Candidate (ND) has industry-experience in residential aged care and exploratory qualitative research; primary supervisor (ST) is a health systems and services research methods expert; secondary and external supervisors have expertise in the Australian health sector, and aged care leadership (internationally) respectively.
Implementation	Have researchers received training, information and assistance related to addressing ethical issues?	All researchers have completed relevant training to address common ethical issues as per mandatory modules developed by James Cook University.
	Will the data be collected and secured safely?	All data is stored within the James Cook University *Research Data and Information Management* archive.
	Is there a plan for how the findings will be disseminated and used? Is there a plan for how the findings will be disseminated and used?	Data are published or being prepared for publication in peer-reviewed journals, conference presentations and a PhD thesis. Further dissemination and validation of the framework will be undertaken post-PhD.
Dissemination and use	Will this research be presented in diverse places (e.g., academic or other conferences), distributed via diverse formats (academic flyers, verbal communications and community meetings) and contribute to the body of knowledge on this topic?	Yes, this research has been presented in academic conferences and was distributed by academic flyers to contribute to the body of knowledge on this topic.

Note: Adapted from (Australian Council for International Development, 2020)

Research integrity is secured by research commitment to a genuine search for knowledge and understanding (National Research Council, 2002). Integrity also encompasses dissemination and communication of results to research participants and, more broadly, in ways that permit scrutiny, contribute to knowledge, and preserve and protect the trust participants place in researchers (Australian Council for International Development, 2020). This research has developed my knowledge and skills

leadership studies, gerontology and health services research. The findings derived from the current project will aim to assist the recruitment, appraisal and development of competent senior managers within the increasingly complex Australian residential aged care setting.

Justice

Justice is generally described concerning equity: a fair process for recruitment of research participants; no unfair burden of participation on particular groups; and equitable distribution of and access to the benefits of the involvement in research (Australian Council for International Development, 2020). In the current project, participants were purposively sampled to achieve the aim and objectives relating to the research design. The methods for assuring the quality and rigor of this project are described earlier in this chapter, and the inclusion and exclusion criteria for participant recruitment were set to align with the overarching study aim. This process was fair and clearly stated in the original Human Research Application to ensure that participants were not coerced or exploited.

Before each interview, participants were invited to sight and explain the ethics approval of the James Cook University Human Research Ethics Committee. Letters of approval from the University Human Research Ethics Committee are attached (Appendix 7). These approval letters covered all the study phases conducted.

Beneficence

Beneficence is defined as an act of charity, mercy, and kindness with a strong connotation of doing good to others, including moral obligation (Kinsinger, 2021). It requires that all professionals and researchers have the foundational moral imperative of doing right (Kinsinger, 2021). This PhD project presented a low negligible risk to participants in causing stress, harm, or foreseeable inconvenience. It is anticipated that the Australian residential aged care sector will experience the benefits of this research.

Respect for autonomy

Respect calls on every one of us to respect the intrinsic dignity of all other people (Dillon, 2003). Each participant was contacted via telephone or email to provide an initial invitation to engage with the project to ensure utmost respect and autonomy. I provided a description of the study design, including the study context, aim and data collection techniques. Those who agreed to participate in the study were sent the study *Information Sheet* and *Consent Form* (Appendix 8) via email and encouraged to be in contact regarding any queries or concerns about their participation. Each interview was scheduled with individual participants at a time, date and location that suited them. Participants were informed that their

participation in interviews was confidential, voluntary and anonymous and that they could withdraw from the study at any time without prejudice. Where anonymity was potentially compromised through each interview, analysis was conducted with text omission that de-identified that participant.

Conflict of interest and consent

A conflict of interest exists where there is a divergence between the individual interests of a person and their professional responsibilities. An independent observer might reasonably conclude that the professional actions of that person are unduly influenced by their interests (Schünemann et al., 2009). I have worked as an occupational therapist in a residential aged care facility in northern Queensland. This facility was omitted from the project to avoid any undue influences that could have arisen throughout the interviews.

Informed consent is an essential part of all research endeavours that involve human participants so the human rights of research participants must be protected (Byrne, 2001). In this project, the provision of complete information and informed consent was guaranteed in a series of steps.

1. In advance of each interview, individuals were provided with a *Consent Form* and *Information Sheet* via email. Before the interview commenced, the researcher reviewed the project aims and processes to ensure that each participant understood the aims of the project and how their data was to be used.
2. When it has been established that the participant comprehended and fully consented to be part of the project, this was recorded on the *Consent Form*.

4.8 Chapter Summary

In this chapter, the rationale behind the chosen methodology (interpretative description) was described and located within a broadly social constructivist approach. The chapter discussed theoretical and personal assumptions shaping the design, described data collection methods and analysis processes. Finally, this chapter outlined multiple principles that guided the evaluation and credibility of this PhD which included specific ethical considerations. The next chapter will describe empirical findings generated through qualitative data analysis.

Chapter 5
Findings 1: Challenges to managing quality of care in northern Queensland residential aged care facilities

5.1 Chapter Introduction

Australian aged care senior managers face a range of challenges in promoting and protecting quality of care. This chapter presents the findings of an exploratory qualitative study conducted with residential aged care senior managers operating within the Northern Queensland Primary Health Network (NQPHN) region. The study sought to identify leadership challenges relating to quality of care from the perspective of current senior managers.

This chapter first provides background to current and well-reported quality concerns within the Australian residential aged care sector. Quality of care is defined, and roles and responsibilities of senior managers in residential aged care facilities are described and compared against similar roles in mainstream healthcare organisations. Next, I describe the study setting, recruitment process and qualitative methods to address the study aim. 19 semi-structured interviews were conducted with senior managers in 14 residential aged care facilities in northern Queensland. Thematic analysis combined inductive identification of managerial challenges and a mapping exercise to locate these encounters against health system quality dimensions in the Australian National Health Performance Framework (NHPF).

Findings from this study were published in the journal *Social Sciences and Humanities Open* on 21 June 2022. A copy of this manuscript is presented in Appendix 2.

5.2 Background

With aged populations growing globally, demand for residential aged care facilities is increasing in many countries (Australian Institute of Health and Welfare, 2021a). Australia is no exception, with the proportion of people aged 65 years or over projected to increase from 15% (in 2017) to 23% in 2066 (Australian Institute of Health and Welfare, 2021a). Depending on the context, residential aged care may be referred to as 'aged care', 'long-term care', 'skilled nursing facilities' or 'nursing home care' (Cleland, Hutchinson, Khadka, Milte, & Ratcliffe, 2021). These facilities provide accommodation and personal care, access to healthcare, and social and emotional support to older persons who can no longer reside independently within a community-dwelling (Woolford, Joyce, & Polacsek, 2022).

Quality of healthcare in residential aged care is a long-standing concern internationally and in Australia (Australian Institute of Health and Welfare, 2021). Indeed, in 2019, the shortcomings of Australian aged care services were made public as part of the Royal Commission into Aged Care Quality and Safety, in which the national system designed to care for older Australians was described as "woefully inadequate" (Royal Commission into Aged Care Quality and Safety, 2019). The *Royal Commission into Aged Care Quality and Safety - Interim Report* described numerous incidences of neglect and substandard clinical services, resulting in significant harm and premature loss of life (Caughey et al., 2020). Even before the Commission, consumers reported concern regarding the limited skill set of staff, turnover, and low staffing ratios, each linked to reduced care quality and safety in the residential aged care settings (Royal Commission into Aged Care Quality and Safety, 2019).

High-quality care is indicative of care that is accessible, continuous, effective, and safe, as well as responsive (to clients' needs and expectations), efficient and sustainable (Castle & Decker, 2011). Both structural contexts – including political, economic and technological – and agential factors – such as choices and decisions by a chain or facility-level managers and providers – shape the design, delivery and accountability of residential aged care health services (Kruk et al., 2018). Organisational and management sciences literature and studies from medical sociology in particular point to the impact of leadership and direction on quality of care (Figueroa, Harrison, Chauhan, & Meyer, 2019).

Traditionally, residential aged care daily operations are controlled by the senior management team, which generally includes the director of nursing (DON), the Chief Executive Officer (CEO), and, depending on the facility, a clinical care director (Royal Commission into Aged Care Quality and Safety, 2019). The title and responsibilities of each senior management role may differ depending on the facility's profit and chain affiliation status. Parand et al. (2014) note, however, that senior managers play an essential and

prominent role in determining quality of care by balancing sometimes competing legal, financial, and moral obligations and consumer and regulatory expectations at the facility level (Parand et al., 2014). As is the case in many health services, the challenge presented, and skills required to balance these considerations are often heightened in facilities located in more geographically isolated areas (Caughey et al., 2020).

Despite the increasing attention directed at quality problems in Australian Residential aged care facilities, and the critical role and responsibilities of aged care senior management teams vis-à-vis that quality, little research has been conducted in Australia to understand facility-based senior managers' experiences or perceived challenges to delivering high-quality care. In a scoping review of the international literature focused on senior management leadership to promote quality in residential aged care, Dawes and Topp (2019) identified 14 studies, the majority of which (n=12) reported on residential aged care in the United States of America and only two including a qualitative exploration of senior managers' experiences or concerns regarding factors influencing care quality (Dawes & Topp, 2021). In one narrative synthesis, Jeon, Merlyn, and Chenoweth (2010) sought to examine the issues associated with, and progress made, in residential aged care leadership and management. While findings demonstrate the influence of staff productivity and workplace culture on health-related outcomes, multiple studies found as part of this review maintained a largely U.S.- centric focus and scanned managerial roles across multiple organisational levels rather than senior managers specifically (Jeon, Merlyn, & Chenoweth, 2010). An original qualitative research study by Savvy, Warbuton and Hodgkin (2017) additionally examined service managers' experiences of the challenges of providing aged care services in rural Australia (Savy et al., 2017). Key findings included issues with staff recruitment and retention and their impact on quality of care (Savvy, Warbuton & Hodgkin, 2017), however, the study was specific to the context of community-based services and did not consider the residential aged care setting.

With a view to addressing a gap in the literature regarding the experiences of senior managers to promote quality in the increasingly complex environment of Australian residential aged care, the present study aimed to explore the experiences, challenges and solutions adopted by senior managers in 14 Australian residential aged care facilities. The study took a consciously 'remote and regional' focus to recognise the additional challenges associated with service delivery in more geographically remote areas and the importance of managing the quality of care to all aged care residents.

5.3 Methods

Study Setting

The study was conducted across the Northern Queensland Primary Health Network (NQPHN) region (Figure. 1) (Northern Queensland Primary Health Network, 2020). The NQPHN region contains various degrees of geographical remoteness, including inner and outer regional, rural and remote localities (NQPHN, 2020). Facilities are located in Modified Monash categories 2 – 7 (Department of Health [DoH], 2020) (with 7 equivalent to 'very remote') and include for-profit, not-for-profit, chain affiliated and non-chain affiliated facilities. Chain-affiliated residential aged care facilities form part of a broader organisation, usually consisting of multiple facilities in different locations. Non-chain-related facilities are standalone, independently owned, and managed organisations (Royal Commission into Aged Care Quality and Safety, 2019). The inclusion of these different types of residential aged care facilities enabled exploration of potential differences in the experiences of senior managers working under other organisational and funding structures.

Figure 1. Northern Queensland Primary Health Network Region - Study locations

Note: Source: (Adapted from Northern Queensland Primary Health Network website, 2020)

Study design and conceptual framework

From the perspective of senior managers, an exploratory qualitative study was conducted to understand the challenges of delivering high-quality health care in regional, rural and remote residential aged care facilities. Qualitative methods were deemed appropriate in that they support examining individual participants' underlying reasons, opinions, and motivations (Austin & Sutton, 2014). In-depth interviews were conducted (IDIs) using probes such as 'why', 'how' and 'what' to gain a deeper understanding of participants' views and experiences regarding the challenges of managing care quality.

As a reference to the quality domains relevant to health service delivery in residential aged care facilities, we were guided by the Australian National Health Performance Framework (2019), which supports benchmarking for health system improvement and facilitates the use of data at facility level quality benchmarking purposes (Australian Institute of Health and Welfare, 2020b).

The National Health Performance Framework (NHPF) provides a non-hierarchical conceptual framework to understand and evaluate the health of Australians and the health system (Australian Institute of Health and Welfare, 2020b). The framework has 14 health dimensions grouped under three domains: health status, determinants of health, and health system performance. *Domain 3 – Health system performance* comprises six sub-dimensions utilised to evaluate health care service performance (Table 11). Five of these sub-dimensions have quality indicators specific to service provision within Residential aged care facilities. These indicators can assist in assessing residential aged care, quality of care, and whether the care provided delivers value for money (Australian Institute of Health and Welfare, 2020b).

Issues surrounding quality of care, as described in the Royal Commission into Aged Care Quality and Safety – *Interim Report,* and prior industry experience of one author (ND) provided the investigator team with additional insights regarding the broader and systemic issues influencing care quality in Australian residential aged care facilities.

Table 11. Health system performance sub-dimensions and quality indicators (Adapted from Australia Institute of Health and Welfare, 2020)

Domain 3 – Health system performance		
Sub-dimension	**Description**	**Quality indicators relevant to residential age care services**
Accessibility	People can obtain health care at the right place and time irrespective of income, physical location and cultural background.	Residential and community aged care places per 1,000 population aged 70+ years (and Aboriginal and Torres Strait Islander people aged 50–69 years), *Source National Health Care Agreement, 2021 Pg.26.* Aged care assessments completed. *Source: National Healthcare Agreement, 2021: Pg. 54.* Residential and community aged care services per 1,000 population aged 70+ years. *Source: National Healthcare Agreement, 2021. Pg.49.*
Continuity	Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.	This sub-dimension has no specific quality indicator relevant to health care services provided within residential aged care facilities.
Appropriateness	Care/intervention/action provided is relevant to the client's needs and based on established standards. Care, intervention or action achieves the desired outcome.	PI 06–Life expectancy, *Source: National Healthcare Agreement, 2021. Pg.6.*
Efficiency	Achieving desired results with cost-effective use of resources. The capacity of the system to sustain workforce and infrastructure, innovate and respond to emerging needs.	Full-time equivalent employed health practitioners per 1,000 population (by age group), *Source: National Healthcare Agreement, 2021: Pg 33.*
Effectiveness	Service is client orientated. Clients are treated with dignity and confidentiality and encouraged to participate in choices related to their care.	Patient satisfaction/experience. *Source: National Healthcare Agreement, 2021 Pg. 32*
Safety	The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.	Falls in residential aged care resulting in patient harm and treated in hospital, 2012 Health, *Source: National Healthcare Agreement: Retired 25/06/2013*

Site Selection

Site selection was purposive and designed to represent 'high-performing' residential aged care facilities across different areas of geographical remoteness in northern Queensland. The study focuses on 'high-performing' residential aged care facilities to explore the mechanisms employed by senior management teams who positively influence quality health care outcomes within their respective facilities. This insight could assist in determining management strategies that address quality of care concerns across the broader Australian aged care sector.

First, a comprehensive list of Queensland aged care service providers was sourced from the Australian Institute of Health and Welfare – *GEN Aged Care Data* (Australian Institute of Health and Welfare, 2021a). Facilities classified as a multi-purpose service, or a home care service were excluded as they did not align with the definition of a residential aged care facility. Due to the time-intensive governance requirements imposed on research in government facilities, it was not possible to include these facilities in this study; however, future research is planned to address this gap. To be classified as 'high performing', the facility must have obtained the maximum score (44//44) during the most recent site audit conducted by the Aged Care Quality and Safety Commission. Purposive targeting of invitations to 'high performing' residential aged care facilities in the NQPHN ensured representation of different geographic and facility (chain, FP, NFP) statuses.

Recruitment

Recruitment was conducted using a combination of email with phone follow-ups. ND emailed all potential participants (n=42) using public access contact information. The initial email included a copy of the study *Information Sheet*, which provided each prospective participant with detail of the study purpose, the role and experience of the first author and interviewer (ND) as an aged care occupational therapist and current PhD candidate. To be included in the study, participants were: i) aged 18 years and above; ii) in a senior management role; iii) employed at a RACF that was not government-owned or operated and iv) employed within the NQPHN region.

Overall, a response rate of 48 % was achieved with 19 in-depth interviews conducted by ND between December 2019 and January 2020, face to face (n=18) and via telephone (n=2). Generally, the duration of each interview was between 30 and 45 minutes and each face-to-face discussion occurred with the participant within the residential aged care facility in which they operated. The interview guide canvassed the role of the senior manager, the processes through which quality of care improvement processes was devised and evaluated, and the challenges associated with delivering high-quality health care in the northern Queensland setting. Interview questions and exploratory probes were piloted for acceptability and focus and to ensure that each question elicited responses with the intended focus on the challenges and solutions adopted by senior managers to manage quality of care. All participants provided written informed consent and agreed to the interview being audio-recorded and transcribed. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data before the analysis.

Data management and analysis

Inductive thematic analysis was conducted, and data was managed using QSR International Pty Ltd. (2018) *NVivo* (Version *12*) (Zamawe, 2015). To identify major and minor themes, the following steps were taken: i) handwritten memos were collated immediately after each interview to ensure that a

reflexive stance was maintained concerning the research situation, participants and documents under study; ii) familiarisation through careful and repeated reading of transcripts and research memos, noting emergent themes; iii) each participant was emailed a copy of the transcribed verbatim to ensure that the investigators records corresponded with those of the participants from whom those data were derived. Three participants (n=3) provided feedback regarding the interview content, which was considered during the subsequent stages of analysis; and iv) open coding was conducted in which codes were created based on identified themes. Codes were assigned to specific sections of transcripts and verified by the co-author (ST) to enhance the precision and consistency of the coding process; vi) the development of facility descriptions, which included an account of each interview and discussed the findings relevant to the residential aged care organisational structure, profit status, policy and regulatory directives, facility geographical location and the role and each senior manager and other participants and vi) data display using matrices including summary tables (Braun and Clarke, 2006).

Ethics and consent

Ethical clearance was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019.

Limitations

This study did not include residential aged care facilities owned and managed by government organisations. This is a potential limitation as the unique regulatory and funding structures influencing the senior management role in government organisations are not represented in the study findings. In addition, 'lower-performing' institutions or those that did not obtain the maximum Audit score against the Accreditation standards were not eligible for participation. As a result, overall, the findings are likely to be, if anything, a conservative representation of challenges experienced in the broader residential aged care sector.

5.4 Results

Overview

In this section, findings are organised to reflect major themes relating to residential aged care senior managers' experiences supporting health care quality. The themes are not simply a list of challenges but rather incorporate data relating to both *challenges* and senior managers' *responses* to those challenges in pursuit of high-quality care. The three themes include i) staff recruitment, retention, and development; ii) resourcing and regulatory requirements; and iii) geographic isolation. Within each of these themes, the influence of challenges across the six quality-relevant sub-dimensions of the NHPF were mapped.

5.4.1 Staff recruitment, retention, and development

Barriers to recruitment and retention

All participants described challenges to recruiting, supporting and retaining competent employees at northern Queensland residential aged care facilities. Senior managers also experienced recruitment competition from mainstream health care services that often provide higher pay rates, flexible working arrangements and more career progression opportunities.

"Aged care pay isn't fantastic. We are up against other facilities and community organisation that do pay a lot more money. We're possibly the second job for many of our employees and trying to get staff to dedicate themselves to us is a real challenge." ***Senior Administration Officer, MM2, Chain affiliated RACF – Participant 5.***

Negative public perceptions

Negative perceptions about working in aged care, in part driven by negative findings of Australia's recent Royal Commission into Aged Care Quality and Safety, have made the sector less desirable as a career option for nurses and other health care practitioners. As one senior manager observed:

"Of course, the stress levels are higher because of the media and the Royal Commission that just bombard everyone. So, you've got this outlook of the family that comes because the Royal Commission and the media is just sweeping everything up" ***Director of Nursing, MM4, Non–chain affiliated RACF – Participant 18.***

Recruitment competition and working conditions can result in high levels of staff turnover. Staff turnover is linked to the NHPF sub-dimension (SD) *Continuity of Care* as it can interrupt the provision of coordinated care in a facility over time. Moreover, as reported by one senior manager, staff turnover contributes directly to the loss of revenue through costs associated with recruiting and training new employees. Some (n=7) senior managers reported that staff turnover resulted in higher clinical workloads and employee burnout. Three senior managers said that low staffing levels resulted in substandard service provision and increased frustration for residents and their families.

"I tell everybody when they walk in here, families and residents alike, we run on the smell of an oily rag. If we cannot do something for you straight away, then we will tell you why. And if we can't do it at all, we'll look for the next best thing." ***General Manager, MM4, Chain affiliated RACF – Participant 14.***

On occasions, managers reported having to explain to families that a resident could not be sufficiently cared for and that the "second best" would have to suffice as a result. Low staffing levels resulting in substandard care quality is linked to SD - *Efficiency and Sustainability* as an example of when a health care system does not possess the capacity to sustain workforce-staffing ratios to respond to consumer expectations and care needs adequately. Reduced staffing levels are also linked to SD - *Accessibility* as residents have a reduced opportunity to access the care that they require at the right time.

Recruitment and development in geographically isolated areas

Participants described social and geographical barriers to recruiting given the region's relative isolation and limited numbers of suitably qualified and experienced aged care workforce. Due to poor staffing ratios and challenges with recruiting and retaining skilled (qualified) workers, rural and remote residential aged care facilities employ several individuals who do not possess formal healthcare qualifications or work experience in the Australian aged care sector. Compounding the lack of skilled workers, three senior managers operating in isolated areas (MM 5 & 6) reported limited and expensive access to accredited training programs to upskill personnel. Employees lacking clinical knowledge and skill proficiency are less likely to recognise and deliver client-orientated care (SD – *Responsiveness*) that aligns with established aged care treatment standards (*SD – Effectiveness*). Limited training opportunities for residential aged care facilities with a high proportion of unskilled staff were reported to compromise care quality and resident safety (SD – *Safety*).

"So, our biggest issue is getting qualified support people. Most people do not have a university degree. Most of them, particularly the workers on the floor, other than the registered staff and allied health left school at 14, 15 and have little idea of what the residents need." ***Facility Manager, MM5, Chain affiliated RACF – Participant 7.***

Senior managers operating in rural and remote areas reported difficulty accessing 'online' training packages due to poor internet connectivity and dated IT infrastructure to provide ongoing professional development opportunities.

"So there's not only challenges of getting people to deliver the training, there are additional challenges of even getting online to do training due to all of our internet problems" ***Facility Manager, MM6, Chain affiliated RACF – Participant 12.***

External service providers and international sponsorship

For some managers (n=5) in outer regional and rural localities, one solution to staffing shortages was to employ external agency staff. This strategy was reported to help improve staffing ratios (SD – *Continuity of Care*) and introduced other challenges. Agency staff were expensive to hire, and reliance on these external and high-turnover providers made it difficult for residents to develop rapport (SD – *Continuity of Care*). However, in more rural localities, participants described how agency staff were scarce and difficult to recruit, particularly skilled professionals. As a result, two senior managers reported relying on video-link for most assessments and treatment interventions.

"So, I've worked in smaller regional towns, which has been really difficult. I've done things like speech therapy assessments over FaceTime, which is not best practice and can affect the quality of care delivered and the practitioner – patient relationship." ***Facility Manager, MM6, Chain affiliated RACF – Participant 12.***

International visa sponsorship was another expensive but medium-term solution to increasing staff, especially nursing and allied health professionals. Several senior managers noted the benefits of being able to source international staff, including lower turnover than agency staff, but still described

challenges. These included written and verbal communication barriers (among international staff who spoke English as a second language), which reduced individuals' capacity to recognise, address, and document residents' expressed needs (SD- *Responsiveness*).

"Look, we've got a lot of staff here that are sponsored. English is their second language, which poses some concerns around communication and providing ongoing quality care." ***Facility Manager, MM5, Non-chain affiliated RACF – Participant 13.***

Senior managers (n=3) also noted that employees who migrated to Australia were particularly susceptible to verbal abuse and harassment from RACF residents. This situation was described as traumatising for the providers, risking conflict, resulting in an unsafe situation for both the resident and staff member (SD – *Safety*). Such competition also increased the chance of the staff member ceasing to work with an individual, the facility or even the sector as a whole (SD – *Continuity of Care*). One senior manager observed that racism was a likely contributor.

"But it becomes increasingly difficult when they're [employees] being abused by residents and families. I think the clientele that we have in our aged care facilities - some within that generation can be bit racist" ***Facility Manager, MM2, Non–chain affiliated RACF – Participant 6.***

4.4.2 Resources and regulatory requirements

Fiscal resourcing constraints

A majority of senior managers (n=15) interviewed in this study described their facility as experiencing recent financial hardship. Some reported they are often required to reduce staff hours, increasing the workload of those rostered to work and limiting the frequency of resident care (SD – *Accessibility*).

"It's a really hard balancing act at the moment because all facilities are struggling financially and trying to provide as much care as we possibly can with funding we get" ***Director of Nursing, MM2, Chain affiliated RACF – Participant 9.***

A majority of interviewees (n=11) characterised Australia's current aged care funding model (ACFI) as inadequate and inaccurate, inhibiting the provision of high-quality services across the sector but particularly affecting the viability and sustainability of smaller facilities in rural and regional locations (SD – *Efficiency and sustainability*).

"I don't understand how a lot of providers can provide quality health care in the dollars that are set by the department under the ACFI model." ***Chief Executive Officer, MM2, Non–Chain Affiliated RACF – Participant 10.***

"The reality is you're not going to get a five-star gold service, paying 50 bucks a day, or whatever it is, the two just aren't going to come together." ***General Manager, MM4, Chain affiliated RACF – Participant 6.***

Changes to regulatory requirements

Many senior managers (n=14) reflected on challenges related to the introduction of the new Aged Care Quality Standards in July 2019, which signaled a regulatory away from task-orientated care

towards the consumer-centred model. The new *Aged Care Quality Standards* reshaped the way that many facilities were required to deliver their health care services as well as consumer perceptions about care delivery (SD – *Responsiveness*)

"Because of the new standards. People are saying, "Well that's my choice." And so that expectation is rising, especially with the royal commission." ***Facility Manager, MM2, chain affiliated RACF – Participant 11.***

More than two-thirds of the study participants (n=13) reported challenges associated with the new standards. Some said that the expectations of the new *Aged Care Quality Standards* (2019) were not clearly stated or well understood, undermining efforts to shift to more client-oriented approaches across facilities (SD – *Effectiveness*) (SD – *Responsiveness*). Lack of guidance regarding the standards meant that senior management teams in different residential aged care facilities interpreted standards differently and developed various non-standardised internal care structures. One senior manager described how this had profound implications for some residential aged care facilities that were previously assessed as "high performing" but failed when reassessed against the new standards.

"So, we got reassessed under the new standards in the last week of July (2019) and we got absolutely hammered. The report was about 88 pages long and as far as my perspective, not very professionally written and with little recommendation regarding how we can improve." ***Facility Manager, MM2 – Chain affiliated RACF – Participant 8.***

Several managers (n=2) described how embedding the new standards into routine operations was a stressful and intimidating process for which they received little support. Some participants (n=4) observed that limited education materials were provided to assist the regulatory transition. Five senior managers specifically described challenges to educating staff regarding the new standards and shifting their facility-wide approach to care.

"There's so much unsettledness out there when the quality agency turns up. Because different - we're all just getting our heads around the other standards and now they've changed it." ***Facility Manager, MM4, Chain affiliated RACF – Participant 17.***

Reflecting a particular challenge for regional and remote facilities that were chain affiliated, two senior managers described how internal policies and regulations developed to transition chain-affiliated services to the new Standards had been devised mainly concerning the metropolitan experience and failed to engage with the unique practices and processes required to deliver high-quality care in outer regional/ rural areas (SD – *Effectiveness*).

The increased administrative and documentation requirements to satisfy quality compliance under the new *Aged Care Quality Standards* were noted to reduce the amount of time available for (already limited) health care practitioners to complete care interventions. This, in turn, influenced

practitioners' time to attend to resident needs, sometimes undermining the quality and safety of interventions provided (SD – Effectiveness & SD – Safety)

"My fear when I'm dealing with the quality is it takes those nurses away from giving that bedside care and that hands-on care because we're more caught up at the moment with documentation." ***Facility Manager, MM2 – Chain affiliated RACF – Participant 2.***

Senior managers also described how the new *Aged Care Quality Standards* had increased the number of consumers and their families requesting additional services. While supportive in principle of these demands, senior managers observed that with no other resources, these requests and quality standards were often unable to be met due to resourcing constraints (SD – *Effectiveness*).

"It's becoming increasingly difficult to keep up quality and the expectations that the general public have of aged care compared to the funding and resources that we get." ***General Manager, MM4 – Chain affiliated RACF- Participant 14.***

The challenges brought by complex and expensive information technology systems were linked to, but distinct from administrative requirements, paradoxically designed to help meet residential aged care facilities' administrative and regulatory demands. Participants broadly acknowledged that generic information technology systems were designed in part to support quality compliance processes. Yet several noted that, in the context of vastly different profiles (chain, for-profit, not-for-profit) of Australian residential aged care facilities, the inability to tailor such information systems resulted in a considerable (downstream) administrative burden. Three senior managers described the pressure to ensure regulatory compliance by adopting new information systems, which had created an additional unfunded workload for already stretched staff (SD – Effectiveness). As one participant observed, moreover, despite these information system changes, in some cases, there are no programs available to satisfy the current quality criteria.

"There's no off the shelf product that's actually meeting the standards that we're aware of, as they are, as they have emerged and then all off sudden, there's another two or three to be added to that list" ***Facility Manager, MM2 – Non – chain affiliated RACF - Participant 4.***

The mismatch between heightened consumer expectations in line with Royal Commission recommendations increased the administrative workload associated with the *Aged Care Quality Standards*. Several participants described the largely static human and financial resources as contributing to a highly stressful work environment. One senior manager reported that increased stress had resulted in a large exodus of senior managers from the industry and high staff turnover, further interrupting the coordination of services across facilities (SD – *Effectiveness and SD – Continuity of Care*).

"The complaints are rising, the expectations are rising, the administrative burden is rising, and it's becoming an extremely stressful environment for senior managers." ***Chief Executive Officer (CEO), MM2, Non–chain affiliated RACF – Participant 1.***

5.4.3 Geographic location

Previous sections have described some impacts of geographic isolation on residential aged care senior managers' experiences, including the difficulties in recruiting and retaining skilled professionals. Here we briefly report several other distinctive challenges related to geographic location and technology.

Access to technology

Senior managers (n=2) operating in isolated areas reported that the increasing reliance within the residential aged care sector on information technology (IT) was a challenge for outer regional and rural facilities. Often, internet connections were poor, resulting in a facility having no access to IT platforms – and thus essential quality assurance systems - for an extended period. Similar challenges with internet connectivity and speed were described as magnifying challenges in accessing training and professional development opportunities between rural and metropolitan localities.

"Our internet access isn't great, so there's not a lot of Telehealth type of training that we can do, because we're constantly cutting out, or those sorts of things; even though we've upgraded, it's still not perfect." ***Facility Manager, MM5, Non-Chain affiliated RACF – Participant 7.***

Managing natural disasters

Geographic location was described as pertinent to the quality of care, with some areas more prone to environmental disasters and cut off from essential services. One senior manager reflected that outer regional northern Queensland areas are prone to natural disasters, influencing service access and continuity at a residential aged care facility. Very isolated residential aged care facilities are often cut off for long periods because of flooding and subsequent damage to connecting inroads. This adds another element of planning and management to ensure that all resources, including food and health care infrastructure, are available to support ongoing and high-quality service provision (SD – *Efficiency and Sustainability*). It also determines the type and access to external services during a disaster (SD – *Accessibility*).

"I've never lived in north Queensland, then I had about two floods, two cut-offs, and I've worked in a flood –, but not as a manager at that time. When a natural disaster hits, it can be a very overwhelming time for the residents and staff, and we need to be prepared for that." ***Facility Manager, MM6, Chain affiliated RACF – Participant 12.***

5.5 Discussion

Drawing on interviews with 19 individuals across 14 facilities in remote, rural and regional locations, this study addresses a gap in the literature vis-à-vis the challenges experienced by senior managers in delivering high-quality health care in Australian residential aged care facilities. While all participants recognised the importance of health care quality, they described multiple and overlapping challenges to effectively delivering on that goal. Many challenges were a product of forces external to the

facility, including well-known and sector-wide challenges such as chronic underfunding and struggles with recruiting and retaining skilled health professionals (Royal Commission into Aged Care Quality and Safety, 2019). Participants also reported difficulties not previously well documented, such as interpreting and responding to regulatory directives. Although managers reported strategies to mitigate barriers to quality, many of these strategies presented challenges of their own.

Study findings provide further evidence of technological and fiscal resource constraints as barriers to quality residential aged care (Royal Commission into Aged Care Quality and Safety, 2019). Participants, particularly those working in the most isolated areas, described challenges to accessing reliable IT infrastructure, including unstable internet that resulted in temporary interruptions to software systems, including those required to fulfil mandatory reporting. A majority of managers also emphasised how the "flawed" and "inadequate" funding model (ACFI) placed critical limitations on their capacity to hire both sufficient numbers *and* appropriately skilled health workers. Moreover, interview data highlights the interaction between these well-known funding constraints and the particular challenges of recruiting experienced professionals in regional and rural locations, where intense competition for the same limited pool of skilled health workers from better funded and often more flexible mainstream health services (A. Burgess et al., 2020; Community Affairs References Committee, 2020).

Despite the recent formation of voluntary-industry codes and other regulatory directives to counter workforce concerns, many residential aged care facilities are challenged to interpret and respond to such requirements (Hodgkin, Warburton, Savy, & Moore, 2017). The current study found the communications from commissioning bodies around new regulatory expectations to be unsupportive and non-transparent. Participants' accounts also emphasised the importance of adequately resourcing and supporting the facility-level implementation of new regulatory directives and the unintended consequences of not doing so. Such findings align with reports from governing bodies, including the Australian Government Department of Health, who described the Australian aged care system as lacking fundamental transparency while highlighting that available support providers to enact new regulatory requirements were limited (Royal Commission into Aged Care Quality and Safety, 2019). Notwithstanding these concerns, well-reported and ongoing issues around skilled workforce shortages, it is observed that directives, including the Aged Care Workforce Strategy (2018), do not stipulate the resources or knowledge required by managers to embed, often complex strategic actions within their facilities. Moreover, directives rarely detail recommendations to curb current systemic issues that detract from aged care roles being a desirable career option despite intense competition from other health care sectors (Hodgkin, Warburton, Savy and Moore, 2017).

Another important study finding relates to the quality challenges of introducing the new *Aged Care Standards (2019)*. Organised under the *Quality of Care Principles (2014),* the new Standards were devised to highlight the core rights of central importance for consumers who access an aged care service, with directives to increase the quality of care through a person-centred lens (Department of Health, 2020). Findings highlighted the paradoxically negative impacts of these evidence-based and person-centred standards. Senior managers struggled to adjust workplace routines, administrative systems, and professional development strategies to meet the revised audit requirements without additional funding and limited sector- or facility-level guidance. This issue has not yet been reported in-depth to the authors' knowledge. Rather than promoting quality as intended, senior managers described residential aged care facilities as being largely unsupported in the process of transitioning operations to meet the new *Aged Care Standards*. Consequently, study participants described redirecting their own time and staff into guideline interpretation, system, re-designing and intensive audit requirements at the expense of already limited resources for direct monitoring of client services. These findings provide insight into revelations from the 2019 Royal Commission, which described the Australian aged care regulatory regime as 'unfit for its purpose' and lacking the ability to 'adequately deter poor practices' (Royal Commission into Aged Care Quality and Safety, 2021). Indeed, as part of the Commission's Final Report (2021), several recommendations targeted regulatory reform, including the establishment of an Aged Care Safety and Quality Authority responsible for devising a new overarching *Aged Care Act 1997* with transparent quality standards that are easier for providers to interpret and embed within their respective facilities (Royal Commission into Aged Care Quality and Safety, 2021).

Notwithstanding the variety of challenges highlighted by study participants, our findings did reveal ongoing efforts to manage and mitigate these in several ways. For example, several residential aged care facilities utilise external agency staff despite their expense to address skilled worker shortages. In addition, some facilities sponsor international staff, whose levels of English proficiency and lack of familiarity with the Australian aged care system have quality implications. This strategy resembles those employed by mainstream healthcare organisations, particularly those located in isolated areas that have trouble recruiting experienced healthcare personnel (Community Affairs References Committee, 2014). residential aged care senior managers also reported their awareness of managing the complex relationships between clients and providers – many of whom come from different cultural and linguistic backgrounds – in ways that protected both clients and providers and ensured high-quality performance. In this sense, the capabilities of residential aged care senior managers were noted to be an essential contributing factor to quality by providing a positive work environment and organisational culture more broadly (Howe, Charlesworth and Brennan, 2019)

Maintaining and developing a competent aged care workforce in light of regulatory challenges technological and fiscal resourcing constraints is critical and requires senior managers with the capacity to focus on job quality, employee satisfaction and employment conditions (Hart, 2019). Yet the compounding, primarily structural, challenges reported by senior managers in this study shine a spotlight on the high-stress work environment of residential aged care senior managers. Several participants described their perception of recently increased turnover among senior personnel. Just as in general staff, a high turnover of senior managers is likely to have negative quality impacts (Royal Commission into Aged Care Quality and Safety, 2019). With this in mind, further research is urgently needed to understand the various competencies required and professional pathways to ensure residential aged care senior managers can achieve personal and professional resilience and successfully deliver high-quality care in this complex environment.

5.6 Chapter Summary

As outlined in Chapter 4, a specific objective of this PhD was to:

- Determine and discuss the prevailing challenges towards ensuring quality of care in Australian residential aged care facilities.

Quality of care is critical to the wellbeing of those receiving a health care service and highly relevant to residential aged care recipients who require frequent and often complex health care interventions. This chapter improves understanding of the challenges experienced by senior management teams in delivering quality of care in regional and remote Australian residential aged care facilities, mapping those challenges against NHPF sub-dimensions of service performance. Findings demonstrate how sector-wide challenges such as chronic underfunding and poorly supported regulatory reform have intersected with location-specific issues such as geographic isolation and skilled workforce shortages to compound the challenge of delivering high-quality care across all NHPF sub-dimensions. Findings also reveal the critical role senior managers play in developing 'work arounds' to maintain quality of care in the short term in the face of such chronic and structural challenges. Work to address macro-level constraints and better understand the leadership skills and knowledge [competencies] required by residential aged care managers to cope with these issues successfully remain urgent priorities.

Chapter 6 reflects on these reported challenges and explores the leadership skill requirements of senior managers to address these concerns. Data from the same data set of semi-structured interviews with senior managers, are analysed to examine frontline perspectives regarding leadership skills critical and explicit to providing high-quality care. In doing so, the forthcoming chapter seeks to build the evidence base and better characterise and understand the future professional development needs of Australian residential aged care senior managers.

Chapter 6
Findings 2: A qualitative study of senior management perspectives on the leadership skills required in regional and rural Australian residential aged care facilities

6.1 Chapter Introduction

This chapter brings new knowledge regarding the leadership competencies that a group of residential aged care senior managers perceived as critical to promoting quality of care, while considering the social and structural interactions that often occur in challenging regional, rural, and remote locations. Data were acquired from 19 semi-structured interviews with northern Queensland residential aged care senior managers, and thematic analysis was used, including inductive identification of the leadership skills and strategies employed to promote quality of care. Findings from this chapter were published in *BMC Health Services Research* on 18 May 2022 (a copy of this manuscript is presented in Appendix 3).The publication represents a distinct piece of work intended to contribute to the exploration of senior managers' beliefs and perceptions regarding the skills required and explicit to promoting quality residential aged care in Australia.

6.2 Background

Compared with other nations, Australians are living longer than expected (Jeon et al., 2015). By 2057 it is projected there will be 8.8 million older people in Australia (22% of the population), and by 2097 approximately 25% of the population will be aged 65 years or over (Australian Institute of Health and Welfare, 2021). With extended longevity often accompanied by increasing health issues, population ageing is expected to increase the demand for residential aged care (Khadka, 2019).

As in many countries, residential aged care facilities in Australia face increasing service demand that runs concurrently with concerns about financial viability, workforce shortages, and associated quality of care (Australian Nursing Federation, 2019; Lin, Otsubo, Sasaki N and Imanaka, 2016). Recently, shortcomings of some aged care organisations and multiple incidences of substandard care were made public as part of a Royal Commission into Aged Care Quality and Safety (Royal Commission into Aged Care Quality and Safety, 2019). The *Final Report* highlighted that Australia's residential aged care sector faces many structural challenges (Royal Commission into Aged Care Quality and Safety, 2019). First, the national aged care funding instrument is considered a "flawed" model, resulting in chronic underfunding and financial hardship for most aged care providers (Royal Commission into Aged Care Quality and Safety, 2019). In the 2021/22 financial year, over half of the Australian residential aged care facilities recorded an operating loss (StewartBrown, 2021a). This situation influences facilities' capacity to recruit and retain sufficient and appropriately skilled staff (Royal Commission into Aged Care Quality and Safety, 2019). Research pre-dating the Royal Commission has also demonstrated how these widespread resourcing challenges were exacerbated in rural and regional areas where competition with better-paid mainstream health services (e.g., hospital and family medicine practices) makes it difficult for residential aged care facilities to recruit from a limited pool of skilled providers (Community Affairs References Committee, 2020). Resourcing constraints also limit the ability to access or update information technologies, subsequently reducing reporting accuracy and access to accredited virtual training opportunities (Alotaibi & Federico, 2017)

Notwithstanding the significant structural challenges to residential aged care facilities in Australia, the Royal Commission report also noted that leadership skills and strategies employed by residential aged care senior managers were lacking in comparison to other Australian mainstream health care organisations as well as international aged care services (Royal Commission into Aged Care Quality and Safety, 2021). Effective leadership and a manager's ability to provide strategic direction are regarded by Anderson, Issel and McDaniel (2013) as important factors in promoting quality in healthcare settings. Previous work has demonstrated how leadership is a process; that entails influence; within a group setting or context and involves achieving goals that reflect a shared vision (Hunt, 2004). Empirical research in healthcare settings has also demonstrated that the personal attributes of leaders are linked to increased quality of care via their effects on employee job

satisfaction and patient engagement (Caughey et al., 2020) and, specific to aged care, through the empowerment of older persons to make informed decisions regarding their care (Royal Commission into Aged Care Quality and Safety, 2021).

While the leadership of residential aged care services may be viewed through multiple lens' (Cummings et al., 2010), a skills perspective has often been employed to identify and describe the skills, knowledge and personal qualities required by managers to promote quality of care in healthcare settings (Gray-Miceli, 2008; Northouse, 2021). Overall, leadership competencies can be understood as the cumulative leadership skills, knowledge and personal qualities that have the potential to influence quality of care (Gray-Miceli, 2008). However, although substantial research has been conducted on leadership skills in mainstream healthcare organisations (Northouse, 2021; Sfantou et al., 2014) comparatively little is known about the leadership skills or combinations of skills required in residential aged care facilities (Jeon, Simpson, Chenoweth, Cunich, & Kendig, 2013; Jeon et al., 2010). In examining the issues and the progress made in leadership relevant to the residential aged care workforce, Jeon (2010) found the stability of leadership tenure promoted staff job satisfaction and employee retention, two factors linked to high-quality care. Research has also demonstrated the link between leadership styles and factors influencing the quality of care, including staffing levels and workforce culture in residential aged (Havig, Skogstad, Kjekshus, & Romøren, 2011). However, most research exploring the role of leadership in promoting the quality of residential aged care has been conducted in the United States of America. None focuses explicitly on senior management skills in the Australian residential aged care sector (Dawes & Topp, 2021).

This knowledge gap is notable because although mainstream healthcare organisations and residential aged care facilities share some standard features, they also differ in several critical ways relevant to their leadership profile (Aged Care Workforce Strategy Taskforce, 2018). Clients' purpose for attending and length of stay, the nature of clinical services delivered, the attendant organisational structures and staff skills mix required (Dawes and Topp, 2021) and the broader financial and regulatory context differ in residential aged care compared with mainstream hospital settings (Australian Institute of Health and Welfare, 2018). For example, senior managers of residential aged care facilities may be responsible for clinical care responsibilities, but also and concurrently, for institutional governance and risk operations, finance and asset performance, ethical conduct issues, people development, inter-professional collaboration and a range of commercial and political acumen (Aged Care Workforce Strategy Taskforce, 2018). Indeed, residential aged care senior managers may require different types and combinations of leadership skills to achieve high-quality service outcomes as compared to their mainstream healthcare organisation counterparts (Agency for health care Research and Quality, 2019).

Against the backdrop of an ageing Australian population, the observation of limited leadership skills in residential aged care facilities by the Royal Commission, and considering the scarce empirical research conducted on leadership in this setting, there is a need for a closer examination of the leadership skill requirements of senior management in Australian residential aged care facilities. The current study aimed to qualitatively explore senior managers' perspectives about which leadership skills are critical to providing high-quality care.

6.3 Methods

Study design

This study was exploratory, as with a few notable exceptions, there is little empirical evidence regarding how leadership does or should influence the quality of Australian residential aged care services (Jeon et al., 2015). Qualitative methods were appropriate to capture senior managers' expressed beliefs, values, feelings, and motivations regarding important leadership skills required in residential aged care facilities (Braun and Clarke, 2013). In-depth interviews (IDIs) were conducted to understand participants' views and experiences regarding the leadership competencies that influence the quality of care in residential aged care facilities.

Study Setting

Participants were included from aged care facilities located within the region covered by Northern Queensland Primary Health Network (NQPHN) (Northern Queensland Primary Health Network [NQPHN], 2018) (Figure. 1). Spanning an area of 510,000km^2, approximately twice the land size of the United Kingdom (UK), this tropical environment is home to about 700,000 people (NQPHN, 2018). Most of the population is located within the regional centers of Cairns, Townsville, and Mackay, while approximately 8% of inhabitants live in remote and very remote areas. The Australian Statistical Geography Standard (ASGS) distinguishes five classes of relative remoteness across Australia (Australian Bureau of Statistics, 2022). The NQPHN region contains various degrees of geographical remoteness, including inner and outer regional and remote localities (ASGS 2 – 5). Facilities eligible for recruitment were in ASGS categories 2 – 5 and included for-profit and not-for-profit organisations.

Figure 1. Northern Queensland Primary Health Network Region - Study locations

Note: Source: (Adapted from Northern Queensland Primary Health Network website, 2020)

Site Selection and participant recruitment

Site selection was conducted using GEN Aged Care Data (Australian Institute of Health and Welfare, 2021) to obtain a list of 'high performing', non-government residential aged care facilities within the NQPHN region. 'High performing' residential aged care facilities obtained the maximum score (44/44) against the Accreditation standards and were assessed by the Aged Care Quality and Safety Commission in 2019. Targeting of 'high performing' facilities was taken to ensure a 'strengths-based' approach to understanding how and in what ways leadership by senior management positively influenced quality of care.

From the final 14 selected sites, a purposive sampling approach was used to select and recruit individual participants. Purposive sampling accounted for participants' current role and relevant

experience within the sector to ensure critical reflection on the link between senior manager leadership skills and quality residential aged care in northern Queensland. Selection was designed to achieve a spread of roles (e.g., CEO, Director of Nursing, and other administrative leadership roles).

Recruitment was conducted using a combination of email with phone follow-ups. Overall, 19 in-depth interviews (Table 7.) Individual IDIs were conducted over the phone with residential aged care managers between December 2019 and January 2020. All participants agreed to the audio-recorded and transcribed interview and were provided with a copy of the transcription as an opportunity to correct or remove data before the analysis.

Table 7. Description of senior manager participants based on professional role, qualifications and Australian Statistical Geography Standard (ASGS) category

Participant	Professional Role	Qualification/s	ASRG Category
1	CEO	Registered Nurse Diploma of Business & Human Resources	2
2	Facility Manager	Registered Nurse (UK) Management short course (over ten years ago	2
3	CEO	Certificate in Business and Hospitality Financial cadetship	4
4	Clinical Care Coordinator	Registered Nurse	3
5	Senior Administration Officer	Certificate IV Administration	2
6	Director of Nursing	Registered Nurse	4
7	Residential Facility Manager	Registered Nurse Industry accreditation short courses	2
8	Facility Manager	Business short courses – no formal qualification reported	3
9	General Manager	No formal qualification	3
10	Director of Care	Emergency Nurse (NZ) Bachelor of Geography and Social Policy	4
11	Clinical Care Manager	Registered Nurse	4
12	Clinical Care Manager	Registered Nurse	4
13	Clinical Care Manager	Registered Nurse (UK) Dip. Leadership and Management	2
14	Facility Manager	Dip. Management Bachelor of Business	2
15	Clinical Operations Manager	Registered Nurse	2
16	Facility Manager	Registered Nurse	4
17	Director of Nursing	Registered Nurse	2
18	Facility Manager	Bachelor of Hospitality	2
19	Facility Manager	Registered Nurse	5

Data management and analysis

A range of approaches were conducted to ensure the rigour and credibility of the study findings. Handwritten memos were collated immediately after each interview to maintain a reflexive stance about the research and participants. The data from each interview was transcribed verbatim into

separate documents and then checked by the authors for accuracy against the original recording. ND assigned a unique identifier to each transcript denoting the service location: inner and outer regional, remote and remote very localities (ASGS 2 – 5); the participant's managerial title; and the interview number for that service location and position title. Each participant was emailed a copy of the transcript for checking.

Thematic analysis was conducted using *NVivo v12* software (Woolf and Silver, 2017). Open coding was performed, where codes were created based on identified topics and assigned to specific sections of transcripts (Grandy, Mills, Durepos, & Wiebe, 2010). Coding was guided by the study's exploratory and involved assigning text from across the dataset to a label (Nowell, Norris, White, & Moules, 2017)

6.4 Results

Overview

Findings of reported leadership skills are presented under five inductively identified domains: i) communication and relationship management; ii) stewardship; iii) professional development; iv) knowledge of the healthcare environment; and v) information technology (IT) and finance. Domains and the leadership skills that fall within them are referred to as 'domains' and 'skills', respectively to improve clarity. Participants were purposefully grouped into two categories to explore potential differences between the leadership skills described by those with a health qualification (n=13) and those without a health qualification (n=6).

6.4.1 Communication and relationship management

'Communication and relationship management' skills included a leader's ability to communicate clearly and concisely with internal and external stakeholders, share clinical and industry-related knowledge and employ effective complaint management processes within the facility. Most study participants strongly emphasised relationship management and communication skills; however, skills, including the ability to negotiate with external stakeholders, were less of a focus.

Participants with a formal health qualification reported that a manager's ability to build and nurture collaborative relationships with residents, staff and external providers was important to promote a facility's level of quality performance.

"So, when you are dealing with the various stakeholders, trying to be a bit more collaborative as opposed to directive. This can be an effective way to develop rapport and longstanding relationships"
Clinical Care Coordinator, Regional Facility, ID4.

Among health-qualified participants, an essential skill was senior managers' ability to share knowledge and build working relationships with other residential aged care facilities. Participants described how this helped design and implement processes that influenced the quality of residential aged care services. Interestingly, senior managers with health qualifications (but not those without) also stressed networking and collaboration with other organisations as important for high-quality care.

"As organisations, big or small, we [senior managers] need to collaborate and share our knowledge. We do not do that very well. We do have a regional facility management group meeting, and we talk. We talk to things that could help with raising quality within our facilities" ***Clinical Operations Manager, Regional Facility, ID15. Participant 7.***

As an important mechanism for developing positive residential aged care stakeholder relationships, almost all participants with a formal health qualification recommended that senior managers develop the skills to foster trust and rapport with residents and their families. The need for managers to effectively address resident complaints was strongly emphasised as a mechanism to ensure quality of care, as described by one participant.

"Your ability to manage complaints is important. It drives positive clinical care outcomes, and it helps you to effectively negotiate with service providers to come in to look after your community in a way that the community expects" ***Facility Manager, Regional Facility, ID7.***

To sustain relationships with staff, participants with health qualifications noted that senior managers needed effective interpersonal skills such as active listening techniques to enhance teamwork across all levels of the facility, as reported by this CEO, who possessed both nursing and business qualifications:

"The first thing that comes to mind is being able to listen. I think that is a key thing in terms of managing and caring for people. So, I am open to listening to people. I've certainly learned to be more patient and take in what is happening around me before making a decision that could impact the way that care is carried out" ***CEO, Regional Facility, ID1. Participant 1.***

A manager's ability to build and nurture collaborative relationships with residents, staff, and external providers was emphasised by both health-qualified and non-health qualified participants as essential to promoting a facility's level of quality performance. As one qualified health practitioner reported:

"You have to understand people, relationships and what drives them. This helps you to pick up how you can get the best out of them. For the residents, you have to understand their story and what they need from you as the provider" ***Clinical Care Coordinator, Rural Facility, ID3.***

6.4.2 Stewardship

'Stewardship' skills encapsulated the ability of senior managers to inspire organisational change and create a positive organisational culture that celebrates the diversity of staff and residents.

When considering the impact of organisational change, senior managers with and without health qualifications spoke to the importance of interpreting industry regulations that influence health service

delivery in the residential aged care sector, particularly during regulatory and legislative change. Among health-qualified managers, one CEO and one Facility Manager particularly emphasised the importance of senior managers having the skills and knowledge to comprehend and monitor legal and regulatory standards that influence quality of care.

"Above all, you need to be aware of and fully understand the frameworks and policies that dictate the way your organisation operates. Without this, you don't know where to start when planning for quality compliance" ***Facility Manager, Regional Facility, ID22.***

"Managers need to be familiar with the legislation or the accreditation, all of the regulatory compliance issues that go with this unique type of industry [residential aged care]" ***CEO, Regional Facility, ID2.***

One Director of Nursing further emphasised the importance of managers being able to interpret regulatory environments and then educate staff and residents regarding quality compliance to ensure high-quality performance across the facility.

"Another really important skill is being able to educate patient care team members and the resident on the legislative and regulatory processes and methods for influencing both during daily operations" ***Director of Nursing, Rural Facility, ID6.***

Drawing attention to recent regulatory changes in Australia, including the introduction of the new *Aged Care Quality Standards*, several health-qualified participants reflected on the way senior managers needed the skills to serve as a "change agent" to assist staff and residents in understanding reasons for change and to effectively manage resistance to change.

"Sometimes there are people who have worked in this industry for 30 or 40 years and say this is the way they've always done it and they're not going to change, and so then your conversation has to be probably a bit more directive around, well, actually, it needs to change. You need to be a vessel to filter messages around change and make sure that actions follow" ***Facility Manager, Rural Facility, ID19.***

"So, my advice to a new manager is just very comfortable to listen, observe, sit back and understand, and get to know what you're dealing with. Without this insight, you will struggle to manage resistance to change" ***Facility Manager, Regional Facility, ID8.***

To minimise employee resistance to change, one Facility Manager with a tertiary Business qualification emphasised that skills to promote a collaborative approach to decision-making processes were necessary for empowering staff at all levels of the facility to help embrace and champion change.

"I always aim to be motivating; a motivational leader that staff can follow and be inspired by, particularly when the message of change is on the table" ***Facility Manager, Regional Facility, ID18.***

The ability of senior managers to develop and lead a positive organisational culture was reported across both participant categories as a contributing factor to quality of care. Linking positive organisational culture to high-quality outcomes across the facility, for example, one participant noted:

"Culture is critical, and something I always bang on about here is that you can walk into a workplace and within five minutes you can actually have a pretty good idea of what the quality of care would be like" ***Facility Manager, Regional Facility, ID7.***

The same Facility Manager also reported that the residential aged care leadership team should possess the skills to define diversity within its facility.

"So, part of my role is I do some social profiling of our consumers and of our staff, trying to get to know who they are as a community. So, I definitely do try and orientate them to the different cultures and what's important. It helps everyone to feel connected to each other" ***Facility Manager, Regional Facility, ID7.***

6.4.3 Professional development

'Professional development' skills identified by study participants included the ability of a senior manager to create working environments that promoted the accountability of internal and external services to the delivery of quality health care. Skills strongly emphasised by both participant categories within this domain included mentoring junior staff to participate in opportunities for continuing professional development and lifelong learning. Participants with formal health qualifications additionally emphasised skills relating to promoting staff accountability for residential aged care quality of performance.

To promote and sustain quality performance, health-qualified senior managers in this study emphasised the importance of skills to create and foster leadership teams to establish a professional work environment where both internal staff and external health care providers were responsible and accountable. A Clinical Care Coordinator operating in an inner regional residential aged care facility additionally noted that skills to design reward and positive feedback mechanisms were essential to effective leadership.

"Managers need to devise strategies so that each department is accountable for the health care they provide. This way, you are making everyone, regardless of their professional role, accountable for his or her actions. Regularly rewarding and showcasing high-quality performance is really important" ***Clinical Care Coordinator, Regional Facility, ID4.***

The capacity of senior managers to mentor junior staff and seek mentorship from respected colleagues was specified by both participant categories as an essential residential aged care leadership skill.

"And I guess accessing mentoring is also important. Accessing other managers, who are really high performers and working ways to integrate this into your routine, can only help professional development" ***Facility Manager, Rural Facility, ID7.***

Of the qualified health practitioners interviewed, three Facility Managers reported that skills to mentor and coach junior managers to deliver sustained care quality within a facility were important. Relatedly, participants with and without formal health qualifications described the self-awareness and opportunity of senior managers to actively seek mentorship from respected colleagues as an important skill within a residential aged care facility.

"Accessing mentoring was also important. Accessing other managers, and looking at, developing through them". ***General Manager, Regional Facility, ID9.***

6.4.4 Knowledge of the healthcare environment

Skills linked to a manager's understanding of the health care system and environment in which they operate were categorised under 'Knowledge of the health care environment' and were primarily referenced by participants with a formal health qualification. Four participants, spanning different managerial roles and geographic areas of remoteness, suggested that senior managers require health knowledge to understand and interpret the scope of practice for the multiple and varied health care professions working within a residential aged care facility.

"Every manager should have basic clinical skills that you can continue to build on in whichever direction you need to through education and other avenues. Overall, you need to know that your staff are meant to be doing to ensure a safe, quality service" ***Facility Manager, Remote Facility – ID19.***

One Director of Nursing also reported that senior managers required a developed knowledge and understanding of assessing and observing clinical interventions.

"So, your clinical assessment and observation skills need to be really on the ball if quality is to prevail" ***Director of Nursing, Regional Facility, ID17.***

One Facility Manager mentioned the importance that senior managers know how to assess quality and safety performance, noting it was important to reward positive behaviours for staff who promote safe and quality health care practices.

"I always go back, and I compliment them, and I do that often in front of the team at handover, saying this was really good in regard to your safety documentation. You were clear. So, my compliments are also very specific" ***Clinical Care Coordinator, Regional Facility, ID4.***

Of note, throughout most participant interviews, service quality was predominantly framed concerning general business operations rather than health care quality per se.

6.4.5 Information technology and finance

Interviewees across both participant categories recommended residential aged care senior managers develop the knowledge and skills to promote the use of IT platforms within their facilities. Strategies included residential management teams employing innovative IT to deliver staff education regarding resident quality outcomes. IT was also reported as an approach to support the successful integration of regulations, including the new *Aged Care Quality Standards*. Two managers in inner regional residential aged care facilities reported that education contributed to increased knowledge across the facility and a greater opportunity for high-quality care.

"Yeah so it's about having information systems. So, it's important to have a structure where we have a forum where they concentrate on different topics to enhance the skills and knowledge or out staff across multiple areas" ***Facility Manager, Regional Facility, ID16.***

The ability of a senior manager to encourage the use of IT platforms was also linked to increased residential aged care efficiency and accuracy with documentation and quality reporting requirements, as emphasised by one General Manager who did not possess a health qualification.

"Senior managers must be aware of IT that can support quality reporting and compliance in line with its unique organisational profile. Senior managers must have knowledge regarding the operation of RACF IT platforms" ***Facility Manager, General Manager, Regional Facility, ID9.***

Another participant with a tertiary qualification in Business and management experience within the hospitality industry strongly emphasised the importance of recognising finance's role in quality improvement programs. This participant reflected that senior managers should have the skills to effectively oversee the residential aged care financial position and ensure that appropriate resources are available to support high-quality care.

"If you want to see quality outcomes, you need to know how to budget for quality staff, technology and other resources. Quality health care costs money" ***Facility Manager, General Manager, Regional Facility, ID18.***

6.5 Discussion

Drawing on interviews with 19 individuals across 14 facilities in northern Australia, this study brings new knowledge regarding the leadership skills that a group of Australian residential aged care senior managers perceived as critical for promoting quality of care is often challenging in regional, rural, and remote facility settings. Five domains of skills were identified by participants, including i) communication and relationship management skills; ii) stewardship skills; iii) professional development skills; iv) knowledge of the health care environment; and v) information technology and finance skills.

Overall, it was found that participants emphasised communication and relationship management skills. Participants noted that senior managers' ability to develop and nurture stakeholder collaborations, particularly those with clients' families, regulatory bodies, and external service providers, was essential given the challenging resourcing environment in which many facilities operated. Communication and relationship management skills were also crucial to workforce recruitment and retention in the face of resource shortages. Although often focused on health services rather than residential aged care, other studies have similarly identified effective staff communication strategies as an important leadership skill. Focusing on rural settings, for example, Lehmann et al. (2005) showed that staff communication strategies often improve levels of employee job satisfaction (Lehmann, Dieleman, & Martineau, 2008). Moreover, the authors described the formation of mutual manager-employee relationships to enhance the quality of teamwork and self-reported employee well-being levels within a residential aged care facility (van Stenis, Van Wingerden, & Kolkhuis Tanke, 2017).

Relatedly, stewardship skills, such as the ability to competently interpret and translate the increasingly complex regulatory requirements of the Australian aged care sector into facility-level strategies and operations, were noted as necessary. While drawing attention to the importance of understanding the unique regulatory requirements of the aged care sector, these findings broadly align with the known extent of stewardship skills in mainstream healthcare. In a study involving health care managers in Swedish hospitals, for example, Andreessen et al. (2016) suggest that senior managers play an important role in supporting organisational change and should possess the knowledge to inspire new approaches to enhance quality of care (Andreasson, Eriksson, & Dellve, 2016). Moreover, health care leaders contribute to strategic directions by participating in senior-level decision-making about patient flow and staffing, quality improvement activities, and continuous learning opportunities to improve overall care delivery (Wong & Cummings, 2007).

Findings from the current study support the importance of senior managers' having adequate health knowledge to influence the quality of clinical care, with a sub-set of participants reflecting on the importance of health knowledge for designing and overseeing efficient, effective and consumer-centred clinical care. Participants with formal health qualifications reported knowledge of health professional scope of practice as necessary for assessing and monitoring the quality performance of staff. Such findings align with previous research in mainstream settings showing effective clinical leadership is linked to various functions (Joseph & Huber, 2015), such as achieving regulatory objectives and timely care delivery (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). In mainstream and residential aged care settings, clinical knowledge is important to a manager's capacity to form and enact quality-improvement systems (Boyatzis, 1991). To monitor compliance within these systems, however, the current study also pointed to the importance of leadership skills to engage

with and promote contemporary IT platforms to enhance the accuracy and efficiency of quality reporting.

Interestingly, differences in emphasis on leadership skills emerged between health-qualified and non-health qualified participants. The importance of leadership skills in change management and strategic planning, for example, was particularly emphasised by those with tertiary business qualifications but not by those with health qualifications. Likewise, those with formal business education only reported financial management skills, including a manager's ability to recognise the role of finance in quality improvement programs. Conversely, participants without formal health qualifications did not mention health and health environment knowledge as critical skills. Such findings may indicate how particular professional backgrounds equip individuals with some, but not all, skills required to deliver leadership across the spectrum of residential aged care operations. With growing awareness of the range of clinical and business-related leadership skills likely necessary in this domain (Royal Commission into Aged Care Quality and Safety. 2021; Caughey et al., 2020), these findings emphasise the need for further work to establish a framework of leadership competencies for aged care and to better understand the differentiated professional development needs of those with health and non-health backgrounds (Royal Commission into Aged Care Quality and Safety, 2019).

Although findings from the current study provide an important first step in addressing the evidence gap relating to leadership skills required by senior management personnel in Australia's residential aged care facilities, we recognise that they are not comprehensive. Due to resource constraints, this study was not able to include residential aged care facilities owned and managed by the government. This is a potential limitation as the unique regulatory and funding structures influencing the senior management role in government organisations are not represented in the study findings. Also, the focus on high-performing aged care facilities may have limited the scope of study findings. Future research, including lower-performing facilities, may broaden the category of themes identified in the current study and further enhance public discussion of leadership skills that influence the quality of residential aged care across a broader range of organisations. It is also acknowledged that selected participants were from residential aged care facilities in northern Queensland. No participants managed facilities in major cities (ASGS-1). The inclusion of such localities may have allowed additional exploration and comparison of the leadership challenges to quality of care across multiple areas of geographical remoteness, broadening the generalisability of study findings.

6.6 Chapter Summary

As outlined in Chapter 4, a specific objective of this PhD was to:

- Identify and synthesise senior manager leadership competencies influencing high-quality residential aged care in Australia.

This chapter contributes to addressing the above objective through an exploration of senior managers' perspectives on leadership skills required to promote high-quality care, considered in the context including those relevant to regional, rural and remote residential aged care facilities.

Findings demonstrate that senior managers view communication and relationship management skills and the ability to strategically plan and manage change as critical to promoting quality of care. Participants with different professional qualifications often emphasised certain leadership skills but did not mention others. For example, only those with formal health qualifications linked health knowledge and clinical skills to increased quality of care. Moreover, leadership skills in change management, strategic planning and finance were predominantly emphasised by those with tertiary business qualifications but not by those with healthcare degrees.

With ongoing challenges impacting the quality of residential aged care in Australia, more work is needed to identify sector-wide views of the leadership competencies required to prepare residential aged care senior managers, to address quality of care concerns. Chapter 7 aims to capture these industry perspectives by presenting findings from interviews with a range of aged care industry experts.

Chapter 7
Findings 3: Senior manager competencies for quality residential aged care: An Australian industry perspective

7.1 Chapter Introduction

Documented poor quality and standards of care in Australia's residential aged care sector have highlighted a need to better understand the role and competencies required by residential aged senior managers to address these concerns. In chapter 6, senior managers' perspectives concerning the leadership skills critical and explicit to providing high-quality care were examined. The current chapter extends on these findings by further exploring perspectives on senior management competencies among Australian aged care industry experts, including academics, primary health network representatives, consumer and provider advocates.

Drawing on 12 in-depth key informant interviews, findings from this chapter highlight five major domains of senior management leadership competencies viewed as necessary for residential aged care senior managers to influence high-quality care. Respectively these include: i) workforce development and retention, ii) governance and business acumen; iii) health systems knowledge; iv) stewardship; and v) responding to regulatory and political contexts. Skills particularly emphasised by industry experts were those required to recruit and retain a skilled workforce, manage relationships, and promote a positive organisational culture and employee wellbeing. Findings from this chapter were published in *BMC Health Services Research* on 8 May 2022 (a copy of this manuscript is presented in Appendix 5).

7.2 Background

The global population is rapidly ageing (United Nations, 2018). In 2020, there will be approximately 980 million individuals aged 60 years and over; by 2050, this figure is expected to reach 2.1 billion (United Nations, 2018). Australia is no exception, with approximately 25% of the population projected to be 65 years and over by 2057 (Australian Institute of Health and Welfare, 2021). As the proportion of Australia's aged population increases, there has been a concurrent rise in demand for residential aged care, capable of delivering high-quality services to older persons with complex co-morbidities such as multiple chronic non-communicable diseases and dementia (Australian Institute of Health and Welfare, 2018). Yet, the inadequacies of Australian residential aged care services made public as part of the Royal Commission into Aged Care Quality and Safety demonstrated numerous incidences of neglect and substandard clinical services (Royal Commission into Aged Care Quality and Safety, 2021). The same Commission identified leadership skills and strategies required by managers to promote quality of care as lacking compared to international residential aged care services and other Australian mainstream healthcare organisations (Royal Commission into Aged Care Quality and Safety, 2021).

Leadership is considered a foundation stone for improving healthcare quality (Oldland, Botti, Hutchinson, & Redley, 2020) and includes identifying priorities and providing strategic direction to multiple actors within the health system (Cummins et al., 2010). Effective health leadership fosters a culture of continual learning and improvement, ensuring that care recipients are at the centre of care planning and delivery and where staff are supported to provide safe, effective and compassionate care (Cummins et al., 2010). Xing, Song and Yan (2020) also suggest the personal qualities of healthcare leaders are linked to increased quality through the effects they have on staff wellbeing and patient engagement (Xing, Song, & Yan, 2020) and the empowerment of care recipients to make informed decisions regarding their own care (Fitzpatrick, Modic, Van Dyk, & Hancock, 2016). Leadership that promotes and enables patient engagement improves quality of care, produces better health outcomes, and often reduces healthcare costs (Fitzpatrick, Modic, Van Dyk and Hancock, 2016).

While leadership is conceptualised in many ways, most frameworks recognise four central characteristics (Northouse, 2021). Respectively, these include: i) leadership is a process; ii) involves different forms of influence; iii) occurs in groups; and iv) involves clear vision and a common goal. In healthcare, a *skills perspective* (approach) to leadership is often adopted (Northouse, 2021) with a view to strengthening the quality outcomes of an organisation by recognising the abilities required to lead quality performance (Mumford, 2006). While healthcare leadership is a broad term with a diverse range of applications (Coleman & Briggs, 2002), the *skills perspective* can be used to identify and describe the competencies (knowledge and skills) that managers require to influence high-quality care across multiple healthcare settings, including residential aged care (United Nations, 2018). Here, we define a leadership competency as an expected level of performance that results from integrating

knowledge, skills, abilities, and judgment and recognises such attributes as integral to influencing quality performance (Heinen et al., 2019).

Substantial research has been conducted around leadership skills in mainstream healthcare organisations (Heinen, van Oostveen, Peters, Vermeulen, & Huis, 2019), yet comparatively little is known about the skills or combinations of skills required in the distinctive setting of residential aged care (Smith & Stevens, 2013). It is important to recognise that the demands of, and thus skills required by, managers in residential aged care services may differ from other healthcare organisations. The continuous nature and complexity of clinical services required by residential aged care residents (Royal Commission into Aged Care Quality and Safety, 2019); specific regulatory requirements associated with the residential aged care sector, and facility-level business operations that must accommodate both clinical and broader lifestyle considerations (Royal Commission into Aged Care Quality and Safety, 2019), all highlight the need for leadership capabilities that include (a combination of) skills distinct from those required in non-residential mainstream healthcare organisations (Smith & Stevens, 2013). With the demand for residential aged care services increasing in Australia and concurrent concerns regarding the quality of that care (Australian Institute of Health and Welfare, 2018)), there is a clear need to understand which types and combinations of skills are required by managers to provide effective leadership in this complex landscape.

The *Australian Aged Care Leadership Capability Framework* was developed by Aged and Community Services Australia [ACSA] in 2014. This framework is behaviourally based, and the capabilities are illustrated by a set of indicative behaviours appropriate to multiple levels of leadership, including frontline, middle and senior management roles (Aged and Community Services, Australia, 2014). The design of the framework is indicative of an intent to provide broad guidance to leadership across a range of aged care agencies and acute, community and residential aged care facilities (Aged and Community Services, Australia, 2014). However, the *Australian Aged Care Leadership Capability Framework* (2014) makes no specific mention of the senior manager role, nor the competencies linked to this leadership responsibility and high-quality care, beyond mention of the capability of 'person-centred focus'. Indeed, to the author's knowledge, no sector-specific skills or leadership competency frameworks focusing on the professional development and attainment of competencies required by RAC senior managers to promote quality of care have been produced in Australia. Moreover, few studies have explored the topic in-depth.

Recent reviews of the literature have synthesised evidence concerning the role of leadership in promoting quality of care in residential aged care globally. In a scoping review of the literature that focused on senior management leadership to promote quality of care in residential aged care, Dawes and Topp (2021), for example, found 14 studies, the majority of which focused on leadership styles,

not competencies; and the majority of which (n=12) reported on RAC in the United States of America (Dawes & Topp, 2021). Moreover, Jeon, Merlyn, and Chenoweth (2010); and Zonneveld, Pittens, and Minkman (2021) explored the role of leadership across multiple organisational levels, with findings demonstrating a link between positive leadership practices, patient satisfaction, increased workplace culture and quality of care (Jeon, Merlyn, and Chenoweth, 2010; Zonneveld, Pittens, and Minkman, 2021). Most recently, an original research study by O'Toole, Bamberry and Montague (2021) examined the perceptions of leadership by senior managers and identified the crucial requirements for successful leadership within the Australian residential aged care industry (O'Toole, Bamberry & Montague, 2021). Findings clearly demonstrated recognition among senior managers that effective leadership skills are required to successfully deliver quality care and resident satisfaction but reported leadership competencies were again considered across multiple organisational levels with none linked explicitly to the senior manager role (O'Toole, Bamberry & Montague, 2021).

With a view to addressing the gap in current knowledge regarding the combination of competencies required by residential aged care managers in Australia, this study aimed to qualitatively explore the views of a range of aged care industry experts regarding the senior management leadership skills and knowledge necessary to ensure the quality of care.

7.3 Methods

Study design

From the perspective of Australian aged care industry experts, an exploratory qualitative study was conducted to understand the leadership skills and strategies required by residential aged care senior managers to influence the high quality of care. For the purpose of the current study, Australian aged care industry experts are those in a professional role: an academic, primary health network representative, consumer or provider advocate.

Qualitative methods support the examination of individual participants' underlying reasons, opinions, and motivations. In-depth interviews (IDIs) were conducted using probes such as 'why', 'how' and 'what' to gain a deeper understanding of participants' views and experiences regarding the senior manager leadership skills that influence the quality of care in Australian residential aged care facilities.

Study Setting

The current study was completed with representatives who contribute to or advise regarding the delivery of aged care services in Australia. Examples of different 'levels' of aged care include: i) entry-level community-based care at home; ii) higher levels of care at home (Home Care Packages Program); and when living at home is not an option iii) residential aged care (Department of Health [DoH], 2021). This study focused specifically on the role of senior managers in providing quality of care in the Australian residential aged care setting. Residential aged care provides healthcare services and accommodation for older persons who cannot continue living independently in their own homes (Scott, Webb and Sorrentino, 2014).

In Australia, residential aged care providers can span a range of different sectors, including religious, charitable, community, for-profit and government organisations (Scott, Webb and Sorrentino, 2014). Typical services may include accommodation, personal care assistance, clinical care and a range of social care activities, including recreational activities and emotional support. Approximately 250,000 older Australians received permanent residential aged care at some time during the financial year 2019/2020 (Australian Institute of Health and Welfare, 2021).

Participant recruitment

Industry representatives [experts] engage with stakeholders across multiple levels of the Australian aged care system and inform sector-wide policy development and governance arrangements (South Australian Council of Social Service, 2021). Three major groupings of industry representatives were identified. First are those who work for national peak advocacy bodies that provide support, advocacy, and policy development services for their members (J. Hunt, 2013). Peak advocacy bodies offer a mechanism for collating and representing the experiences of a heterogeneous membership on issues relating to consumer and labour protections, quality of care and aged care regulation (South Australian Council of Social Service, 2021).

The second group of industry experts include those working for primary health networks (PHNs) statutory bodies funded by Australia's federal government (Russel and Dawda, 2019). By conducting population needs assessments and commissioning services, PHNs aim to improve healthcare efficiency and effectiveness (particularly for those at risk of poor health outcomes, including older persons) and enhance the coordination of health services at local, regional, and national levels (Russel and Dawda, 2019). PHN representatives possess the skills and knowledge to evaluate and monitor the effectiveness of health services against local population health needs, including those provided in residential aged care (DoH, 2022). They also offer education and training to develop workforce skills to influence quality performance positively and are thus well-positioned to describe the link between

senior manager leadership skills and quality of care delivered by Australian aged care services (DoH, 2022).

The third group of experts are aged care researchers who aim to improve understanding of and produce evidence, tools and resources to improve health and policies and services in the aged care sector (National Ageing Research Institute, 2022). Like peak body advocates, aged care researchers tend to engage with a variety of stakeholders to explore or develop knowledge to inform national policy or implementation (South Australian Council of Social Service, 2021; National Ageing Research Institute, 2022), including the skills required to develop leadership training programs for managers to drive best practice at national and facility levels (Coleman & Briggs, 2002).

Purposive sampling was used to identify and select information-rich participants from the three expert groupings described earlier, with knowledge of and experience working within the Australian aged care sector. Participant selection was deliberate, and aged care industry experts were recognised as possessing specific knowledge of the health service needs of older persons in Australia and capable of reflecting critically on the link between senior manager leadership skills and quality residential aged care. Snowball sampling was employed to incorporate eligible participants who may have been missed during initial recruitment. Two additional interviewees were recruited using this technique. To be included in the study, participants were required to: i) be 18 years and above and ii) be either an aged care researcher, primary health network representative, consumer or provider advocate.

Using a combination of aged care industry experience and a comprehensive desk search, the first author (ND) developed a list of eligible individuals and residential aged care facilities using public access contact information, including Primary Health Network organisations, Department of Health government websites, national research institutes and Australian University websites. Participants were then emailed an invitation for involvement. Participants were also deemed eligible for participation if they represented national government committees, including the National Aged Care Advisory Council and Aged Care Sector Committee. Both government committees support aged care policy development and implementation.

Overall, 12 in-depth interviews were conducted by ND between December 2020 and February 2021 via video conferencing (n=11) and telephone (n=1). Interviews were conducted with provider advocates (n=6), consumer advocates (n=3), researchers (n=2) and primary health network (PHN) representatives who are involved in commissioning Australian aged care services (n=1) (Table 8). One participant who was an aged care academic also represented the National Aged Care Advisory committee, while two consumer advocates were members of the Aged Care Advisory group.

The interview guide canvassed the role of the industry expert, their perceived link (if any) between senior managers and residential aged care quality of care, current and potential challenges associated with delivering high-quality residential aged care, and the leadership skills required to address these concerns. All participants provided written informed consent and agreed to the interview being audio-recorded and transcribed. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data before the analysis.

Data management and analysis

Abductive, thematic analysis incorporated coding derived from existing leadership skills frameworks and inductively identified themes. To identify major and minor themes, the following steps were taken: i) handwritten memos were collated immediately after each interview to ensure that a reflexive stance was maintained concerning the research situation, participants and documents under study; ii) familiarisation through careful and repeated reading of transcripts and research memos, noting emergent themes; iii) each participant was emailed a copy of the transcribed verbatim to ensure that the investigator's record corresponded with those of the participants from whom those data were derived; iv) open coding in which codes were created based on identified themes, codes were assigned to specific sections of transcripts; and v) data display using matrices including summary tables.

7.4 Results

Overview

Findings from this qualitative analysis are presented under five inductively identified skill domains, including: i) workforce development and retention; ii) governance and business acumen; iii) health systems knowledge; iv) stewardship; and v) responding to regulatory and political contexts. In the following sections, these overarching domains and the more specific leadership skills they encompass are referred to simply as 'domains' and 'skills' respectively to improve clarity. Interview participants are identified only by generic labels (as outlined in Table 8.) of 'consumer advocate', 'provider advocate', 'primary healthcare network representative' or 'academic'

7.4.1 Workforce development and retention

Skills in this domain included a manager's ability to develop a workforce with an appropriate balance of clinical skills across the facility. To achieve this optimal skill mix, a manager's ability to recruit healthcare personnel across key service areas, with the knowledge to service a range of complex co-morbidities and psychosocial needs specific to an older demographic, was reported by most participants as critical to the quality of care.

A leader's ability to choose, recruit, and retain key people across the core health services areas is important to delivering quality care. ***Consumer advocate – ID4***

Critical to supporting recruitment and retention, five participants comprising both provider and consumer advocates also noted the importance of human resource management skills, including the ability to negotiate with staff and being compassionate to an employee's needs within and outside of the workplace.

Human resource management is so essential to making quality healthcare occur. ***Provider advocate - ID2***

Alongside these more technically oriented skills, most participants, including primary health network representatives, consumers and provider advocates, collectively highlighted the importance of a senior manager's relational skills. Critical amongst these was the ability to nurture and build relationships with staff, communication skills, and peer support networks. The ability of senior managers to develop rapport and trusting relationships with staff, for example, was described as promoting open channels of communication among interprofessional teams and thus promoting high-quality care.

So, it's being personable and being able to develop that rapport with your staff so that they trust you and they feel like they can come to see you to discuss anything regarding the healthcare services that they are responsible for providing. ***Provider advocate - ID2***

Another participant emphasised the importance of a manager's ability to employ communication skills involving empathy and active listening techniques as essential to creating therapeutic relationships with residents and their families and positively influencing care quality.

I think every person who works in aged care, whether they're a leader or not, needs to have good communication skills to be able to engage therapeutically with residents, and so communication skills involve imparting empathy and involve listening. ***(Researcher – ID9)***

External to the facilities, a manager's ability to build and nurture peer support networks with other residential aged care facilities, to share expertise around business models that promote quality of care, improve business knowledge, and receive peer mentorship, was also emphasised as an important leadership skill by four provider advocates:

People should start to build collaborations across other [aged care] facilities… so that they can bring in top-quality people. ***Provider advocate – ID5***

Make sure that you've got a good peer network around you that you reach out for that support. ***Provider advocate – ID8***

7.4.2 Governance and business acumen

The ability of senior managers to create a governance structure to delineate power and define management roles in an organisation was linked to the quality of care. Participants viewed this skill as a strategy for managers to set rules, procedures, and other informational guidelines for quality improvement. Researchers, primary health network representatives, providers and consumer advocates reported skills under this domain and linked these to quality of care.

A provider advocate emphasised that senior managers should possess the knowledge to develop an organisational structure that provides executives and managers with the opportunity to make informed decisions regarding healthcare delivery.

The organisational structure must be designed by managers so that they can support themselves … to free up their time to make the best decisions for their healthcare services ***Provider advocate – ID10***

A consumer advocate emphasised the importance of senior managers possessing the skills to successfully lead the operational aspects of a residential aged care facility that are linked to service provisions, such as compliance management and management of resources.

Again, leaders need to be committed to older Australians and be able to smoothly run high-level operations to positively influence the quality of their service ***Consumer advocate and Aged Care Advisory group member – ID4***

Critical to supporting the sustainability and quality of residential aged care services, several consumer and provider advocates also noted the importance of a manager's business skills, such as financial management, human resource, and people management skills, as a factor contributing to the quality of care. As reported by this provider advocate:

So, there are significant financial management, sales significant clinical skills and significant human resources skills, and people management skills that are required ***Provider advocate – ID2***

The capacity of a senior manager to be strategic in planning operations was also emphasised as an important leadership skill for residential aged care in Australia. As described by the provider advocate below, such skills were linked to effective planning to meet challenges and identify opportunities for handling the increasingly complex political, regulatory and clinical landscape of residential aged care in Australia:

I think being strategic as well. So, looking at opportunities and, as you were talking about before, innovation, thinking outside the square to get the best possible care for the resident. ***Provider advocate – ID6***

7.4.3 Health systems knowledge

Several study participants noted skills and strategies associated with a manager's understanding of the healthcare system and clinical environment. External to their specific facility, interviewees linked quality performance to the ability of senior managers to recognise the variations between mainstream healthcare organisations and residential aged care service provision. Five participants, who were researchers, provider and consumer advocates, reported skills under this domain.

One researcher described that the quality of residential aged care should be focused on maintaining an older person's quality of life, which required a unique set of leadership skills:

So it is important to recognise the differences between acute care, where the focus is on diagnosis and treatment, and aged care, where the focus is more about quality of life. It takes very different managerial skills to effectively manage each context, and those who lead these organisations need to recognise this. ***Researcher and National Aged Care Advisory Committee member– ID7***

In addition to providing oversight to the clinical aspects of residential aged care, study participants across all expert categories suggested that senior managers should themselves possess clinical knowledge and skills to successfully embed quality healthcare practices within the facility. Clinical skills included managers' ability to recognise effective clinical care models that address the healthcare needs of an older demographic and the ability to recognise clinical outcomes to care.

I think a problem where we separate residents' needs into biomedical needs, clinical needs and social needs and accommodation needs …. We need a consistent model of care that focuses solely on caring for the individual ***Researcher – ID9***

You must have a keen eye towards resident outcomes, and I would be as broad as to say clinical quality outcomes and customer experience outcomes, all of these clinical attributes are important for a manager to possess and be aware of ***Provider advocate – ID 10***

One researcher suggested that if senior managers did not possess a sound level of clinical knowledge, then residents' needs could be missed or neglected.

So, I think the fact that we now have many leaders who don't have any healthcare background has put us in a situation where residents' clinical care needs are often missed and neglected. ***Researcher National Aged Care Advisory Committee member – ID7***

7.4.4 Stewardship

'Stewardship' encompassed leadership skills to create a positive workplace culture through creating a physical environment that encouraged employee wellbeing, promoting team cohesiveness, and helping team members overcome negative industry perceptions.

The ability of a senior manager to create a physical environment that encouraged employee wellbeing was linked by study participants to positive workplace culture and high-quality care. The skills to promote such a physical environment included the ability to develop a workspace that encourages

employee and resident comfort, with one consumer advocate describing the links to employee job satisfaction and retention and resident quality of life:

Coming to work at a place that is comfortable each day will only improve employee performance to delivering quality care ***Consumer advocate Aged Care Advisory group member – ID4***

Leadership skills to promote team cohesiveness were also linked to increased workplace culture and organisational quality.

If you have a good leader, you could be working in a positive and cohesive team even though; the situation around you feels quite dire ***Provider advocate – ID1***

Additionally, and potentially specific to the Australian context, participants reported the importance of stewardship skills to overcome negative public perceptions regarding residential aged care (in light of negative accounts heard during the recent *Royal Commission into Aged Care Quality and Safety*). The capacity to manage such perceptions were also linked to promoting a positive organisational culture and staff retention.

I think probably the biggest challenge is the negativity within the media for the bad cases and the lack of media interest in a good case. So, it is more difficult for them to get and retain staff because of that ***Consumer advocate Aged Care Advisory group member – ID4***

7.4.5 Responding to regulatory and political contexts

'Responding to regulatory and political contexts' included the leadership skills required by senior managers to successfully interpret and respond to Australian aged care regulatory change. As part of this study, researchers, provider and consumer advocates reported skills under this domain and linked them to quality of care.

Two provider advocates suggested that while the current aged care regulatory environment can be challenging to interpret, senior managers need to be proactive to lead residential aged care regulatory compliance. This process was described as senior managers initiating partnerships between regulators and their facilities to ensure a joint approach to regulatory compliance.

Providers do need to look at themselves and see how they contribute to improving the overall situation … which would suggest more of a partnership-based approach between regulator and provider rather than a compliance-focused approach of seeking out and punishing wrongdoing ***Provider advocate – ID2***

In addition to forming external relationships with regulatory authorities, some participants emphasised that senior managers further develop their lateral thinking skills to assist in interpreting and responding to the evolving aged care regulatory and political context. This includes the ability to

recognise and interpret regulatory reform and successfully translate this change to residential aged care operations to sustain quality healthcare delivery.

So, I think those external factors require a leader to be adaptable, to be mobile, to be a lateral thinker and responsive to the regulatory and political surroundings to be effective for health service delivery
Consumer advocate – ID12

7.5 Discussion

Quality of care in Australian residential aged care has been identified as lacking, and the Royal Commission pointed to leadership as a key area requiring improvement (Royal Commission into Aged Care Quality and Safety, 2019). To date, however, evidence regarding the types and combinations of leadership skills required in residential aged care is limited (Dawes and Topp, 2021). Drawing on and triangulating the perspectives of experts from provider and consumer peak advocacy bodies, Primary Health Networks and aged care research institutions, this study highlighted five major domains of leadership skill likely required by Australian residential aged care senior managers to influence quality of care, respectively: i) workforce development and retention; ii) governance and business acumen; iii) health systems knowledge; iv) stewardship; and v) responding to regulatory and political contexts. Skills particularly emphasised by participants were those required to recruit and retain a skilled workforce, manage relationships, and promote a positive organisational culture and employee wellbeing. Such skills are intuitively important and noted elsewhere to be central in mainstream healthcare leadership (Figueroa et al., 2019; Mannion & Davies, 2018). However, the emphasis on these skills as part of the current study also reflects the specific context and several macro-through-micro level challenges of the Australian residential aged care sector, including regulatory change ongoing human resourcing challenges Community Affairs Reference Committee, 2014), and longstanding issues with work culture and morale (Low et al., 2015).

Findings from the current study demonstrated industry experts' perception of a strong link between a manager's relational skills and residential aged care quality. These abilities included communication techniques that enable the formation of partnerships and therapeutic relationships with care recipients, their families and other immediate caregivers. Previous studies have shown the importance of effective communication with older people as a critical aspect of care quality, with ineffective communication skills often leading to care recipients feeling inadequate, disempowered and helpless (Jack, Ridley, & Turner, 2021). In the current context of Australian residential aged care, in which documented challenges to skilled workforce retention (Royal Commission into Aged Care Quality and Safety, 2021; Community Affairs Reference Committee, 2014), ongoing regulatory reform (Charlesworth & Howe, 2018) and workplace culture (Low et al., 2010), have been recently discussed, industry experts linked the skill of partnering with care recipients, to influencing improved clinical outcomes and increased levels of health literacy. Specific to acute healthcare settings, research

has also demonstrated that, from a quality-of-care perspective, the ability of managers to develop proficient communication skills, including active listening techniques, often increases the accessibility and appropriateness of healthcare for older persons (Berman & Chutka, 2016).

Participants from the current study reported that senior managers' knowledge regarding the design and implementation of clinical care models and other innovations was important to achieving quality residential aged care. Study participants further stressed that effective senior managers required clinical knowledge and skills to address older persons' unique and diverse healthcare needs. Such findings are likely to partially reflect concerns about widespread lack of regulatory compliance and poor quality of clinical care in the Australian residential aged care sector, as documented in the 2021 Royal Commission (Royal Commission into Aged Care Quality and Safety, 2021). Although primarily located in mainstream healthcare organisations, previous studies have also described a connection between a manager's health systems knowledge, clinical skillset, and quality of care. For example, Parand (2014) & Andreasson et al. (2017) found that effective managers who positively influence care quality possess a range of technical skills, including knowledge about treatments and technologies, healthcare services, and the healthcare environment in which the service is situated. In addition, Australian health agencies, including the Agency for Clinical Innovation, affirm that a health service manager is central to designing and implementing innovative clinical care models in promoting quality performance (New South Wales Agency for Clinical Innovation, 2021).

An intuitive but important finding from this study was the emphasis placed by participants on managers' skills to recruit and retain a workforce with a diverse skill set. Karan et al. (2021) describes human resources for health as a core building block for the quality of services across multiple settings, and previous research has also found that investment in more diverse staff and skill-mix can result in improved quality of care, quality of life, and employee job satisfaction (Karan et al., 2021; Koopmans, Damen, & Wagner, 2018). Braithwaite, Herkes, Ludlow, Testa & Lampree (2017) found a balanced practitioner skill mix and healthier organisational culture to positively influence healthcare outcomes, such as reduced mortality rates and increased quality of life (Braithwaite et al., 2017).

Although much of this empirical work to date has been specific to mainstream healthcare organisations, participants from the current study confirmed the importance of these leadership skills in residential aged care settings too, additionally reporting skills required to enhance workforce capacity and development, such as the ability to promote a positive organisational culture and safe physical environment that supports employee wellbeing and fosters job satisfaction. As with knowledge of clinical skills, the emphasis placed by participants – particularly provider advocates – on such skills is likely influenced by the current Australian context in which low pay (Community Affairs Reference Committee, 2014), challenges to workforce recruitment and retention (Isherwood,

Mavromaras, Moskos, & Wei, 2018) and weak morale (Hodgkin et al., 2017) have all been documented.

Combined, the findings highlight modern residential aged care senior managers' complex and multi-dimensional leadership skills. Balancing a need for business and human resource understanding with clinical expertise and relational skills implies the potential need for highly targeted professional development frameworks and support packages if industry-wide strengthening in leadership is to occur in the future. This study is the first building block in that effort.

As with most studies, the current study's design is subject to limitations. Firstly, purposive sampling was used to recruit interview participants from three categories of experts (peak bodies, PHNs, and researchers); however, not all participants were able to interview due to scheduling or other issues. As a result, half the study participants were provider advocates, whose primary focus is to support the viability and sustainability of aged care service providers (South Australian Council of Social Service, 2011); of these experts are potentially less likely to consider the resident experience and personalised healthcare needs. Conversely, consumer advocates play an important role in advocating for the older person and speaking on behalf of that individual in a way that best represents their interests (Aged Care Quality and Safety Comission, 2018). With an intense focus on older Australians' individualised healthcare needs, consumer advocates may have less understanding of the structural elements that adversely influence residential aged care quality and the leadership competencies required. Finally, although 31 Australian PHNs represent jurisdictions defined by geographical scope, our study only included PHN representatives from North Queensland and thus likely reflected some concerns specific to that region.

While acknowledging these limitations of representation and standpoint, purposive sampling was deliberately used to ensure representation of all types of expertise in some form. Close attention was paid to the positionality of each expert during analysis which included systematic triangulation of data from different experts. Further work will be essential to broaden and deepen understanding of the field, nonetheless, the current findings constitute an important contribution to the field by delivering a starting point for mapping key leadership skills required by Australian residential aged care senior managers.

7.6 Summary

As outlined in Chapter 4, a specific objective of this PhD was to:

- Identify and synthesise senior manager leadership competencies that influence high-quality residential aged care.

Combined with Chapter 6, the findings and discussion in this chapter (7) provide additional insights to address this objective. Findings demonstrated that aged care industry experts view a range of technical, relational and administrative skills as critical to ensuring service quality. Similar to the perspectives of frontline senior managers, industry experts strongly emphasised communication and relationship management skills and the ability of senior managers to create a positive organisational culture as required for high-quality of care. There were, however, certain competencies that were emphasised by industry experts and not by senior managers. For example, the skills and knowledge required by managers to recruit and retain a well-balanced clinical workforce within an organisation was strongly emphasised by a majority of industry experts.

With ongoing concerns and challenges to quality of care, more work is needed to prepare senior management personnel with the appropriate skills to positively lead quality Australian residential aged care services. In this context, the lack of any professional development framework to guide the acquisition or updating of those competencies is a concern. Chapter 8 seeks to contribute to future efforts by producing a preliminary leadership competency framework, focussing explicitly on the knowledge, human, technical and conceptual skills required by aged care senior managers to promote residential aged care, quality of care.

Chapter 8
Findings 4: A framework synthesis of senior manager leadership competencies to promote and protect quality residential aged care in Australia

8.1 Chapter Introduction

Quality of care within Australian residential aged care facilities has been identified as lacking, and leadership is reported as a key area requiring improvement. To date, however, evidence regarding sector-specific leadership competencies needed by Australian residential aged care senior managers to promote high–quality care is limited. In a complex and often politically charged sector, the absence of leadership frameworks that describe the professional development and competency requirements of senior managers is notable. In chapters 6 and 7, in-depth interviews examined the views of senior managers and aged care industry experts regarding which senior management leadership competencies are necessary to deliver and strengthen the quality of residential aged care services in Australia. The current chapter synthesises these empirical findings with those from a synthetic review of existing leadership frameworks in health or aged care-related fields.

To set the scene the current chapter first considers the roles and benefits of a national aged care quality leadership competency framework to support the recruitment, development and retention of competent and confident senior managers in the Australian setting. Second, the chapter describes the process of data extraction and synthesis to underpin the development of the Residential Aged Care Senior Manager Quality Framework (RCSM-QF), a preliminary leadership competency framework. Finally, the RCSM-QF competency domains are presented and discussed.

8.2 Background

Leadership is critical to promoting and protecting quality residential aged care (Castle, 2011). Influential leaders play an important role in promoting employee wellbeing and resident engagement (Xing et al., 2020), which empowers care recipients to make informed decisions regarding their care, resulting in better health outcomes and increased service efficiency (Fitzpatrick et al., 2016). Considering the continuous nature and complexity of clinical services required by residential aged care residents; and the unique political, financial and regulatory requirements associated with the Australian residential aged care sector (Australian Institute of Health and Welfare, 2018), it is important to recognise that the demands of, and thus competencies required by residential aged care managers differ from other mainstream health care organisations and indeed other international residential aged care services (Aged Care Workforce Strategy Taskforce, 2018). Yet, there remains limited evidence to elucidate the combinations of leadership competencies required by Australian residential aged care senior management teams, including sector-specific frameworks describing leadership competencies related to aged care quality (Dawes & Topp, 2021; 2022).

The *Australian Aged Care Leadership Capability Framework* was developed in 2014 by Aged and Community Services Australia [ACSA] (Aged and Community Services Australia, 2014). The framework describes leadership capabilities across several domains, including self-development and business acumen, but does not provide a specific focus on the skills or personal qualities linked to quality of care beyond recognising the capability of 'person-centred focus' (Aged and Community Services Australia, 2014). Furthermore, the ACSA framework applies to leaders across multiple organisational levels and various aged care settings, including acute community services, without explicitly focusing on residential aged care. Recent reviews of the literature also point to limited evidence mapping senior manager leadership competencies to quality of care in residential aged care organisations (Aged and Community Services Australia, 2014). The literature review presented in chapter 2 revealed only 20 articles globally, with some evidence acknowledging a link between management tenure, role preparedness and leadership styles and competencies of senior managers and quality of care, with few exploring the topic in Australian setting (Dawes and Topp, 2019).

Building on foundational work recognising the importance of leadership in the Australia aged care leadership sector (Jeon et al., 2015; Jeon et al., 2015; Jeon et al., 2013; O'Toole, Bamberry, & Montague, 2021) , previous chapters have presented novel empirical evidence highlighting the views and experiences of senior managers and industry experts respectively, regarding challenges experienced by senior managers in promoting high-quality residential aged care. These included: barriers to recruiting and retaining a skilled and experienced workforce, particularly in geographically isolated areas, fiscal resourcing constraints and obscurities to interpreting and responding to poorly communicated regulatory directives. Notwithstanding these concerns, findings revealed ongoing

efforts by senior managers to manage and mitigate these in several ways. For example, some residential aged care facilities sponsored international staff or utilised external agency staff, despite their expense, to address skilled worker shortages. Yet, despite these efforts to manage the quality-of-care issues at the facility level, concerns remain, and the Royal Commission recently pointed to leadership as a key area requiring improvement (Royal Commission into Aged Care Quality and Safety, 2019).

With current and anticipated challenges to residential aged care quality, work is needed to prepare senior management personnel with the appropriate skills to strengthen Australia's evolving aged care sector (Richardson & Stanford, 2021). Findings from previous chapters again provide new evidence that helps to address this knowledge gap, with senior managers and Australian aged care industry experts articulating a range of technical, relational, and administrative skills as critical to ensuring health service quality. Participants also stressed clinical knowledge and skills as important senior manager leadership competencies needed to address older persons' unique and diverse health care needs. While these findings constitute an important contribution to the field by providing a starting point for mapping key leadership skills required by Australian residential aged care senior managers, skills and personal qualities are yet to be synthesised across participant groups and considered against pre-existing competency frameworks in aged care and health-related fields, globally.

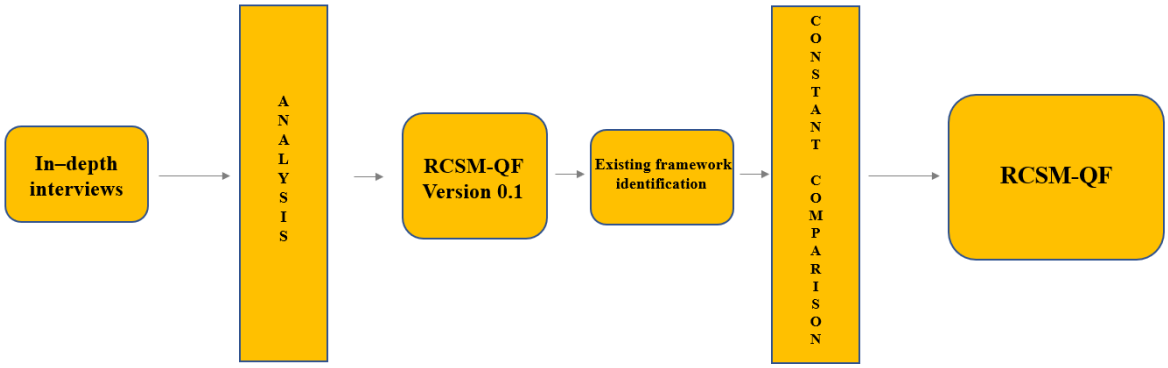
Developing a national aged care quality leadership competency framework provides a tool that may support a positive change to residential aged care quality if political will and resourcing were available (Czabanowska et al., 2012). For example, to strengthen continuing professional development opportunities, a quality-focused competency framework could inform sector-specific strategies preparing senior managers to mitigate the multiple and overlapping challenges to promoting quality of care (Thistlethwaite et al., 2014). Additionally, a preliminary framework mapping the critical skills required to lead quality residential aged care may support organisations to make informed decisions when recruiting senior managers within the sector (Keijser et al., 2019). While developing a fully validated framework lies beyond the scope of this PhD, this final empirical chapter makes an essential contribution to future efforts by producing a preliminary framework that draws on a synthesis of published evidence and the new empirical findings from chapter 6 and 7 of this PhD. Below, I describe the methods used to develop the preliminary Australian aged care quality leadership framework, including how leadership competencies were acquired and synthesised.

8.3 Methods

Methods and analysis

The following research methods were used to develop the preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF): i) in-depth interview analysis and comparison; ii) existing framework data extraction; and iii) a framework synthesis.

Figure 5. RCSM-QF development process



Methodological appropriateness and quality

This chapter aimed to synthesise leadership skills, knowledge and personal qualities required by Australian residential aged care managers into an overarching leadership competency framework. The main data sources comprised: i) evidence synthesised from the original and updated literature review presented in chapter 2; ii) findings from in-depth interviews with Australian residential aged care senior managers and industry experts in chapters 6 and 7; and ii) analysis of existing leadership competency frameworks in related fields. The choice to review existing international health care and Australian aged care leadership frameworks following the completion of inductive thematic analysis in previous phases (Phase 1) was deliberate. The approach to data collection/extraction, analysis and subsequent findings across each phase is summarised below.

Phase 1: In-depth interview analysis and comparison

*An in-depth description of the recruitment and interview approaches for senior manager and industry expert participant groups is presented in Chapters 4, 6 and 7.

Thirty-one in-depth interviews (IDIs) were conducted with participants representing two participant groups. As detailed in previous chapters, the first participant group (n=19) comprised residential aged care (RAC) senior managers from ‘high performing’ RAC facilities located in the Northern Queensland Primary Health Network (NQPHN). The second group included Australian aged care

industry experts (n=12) who contribute to or advise regarding delivering aged care services in Australia.

Inductive thematic analysis

Firstly, an inductive thematic analysis of the data relating to the senior manager and industry expert participant groups was conducted. The data from each group were analysed separately, which allowed me to establish patterns and look for correspondence between the personal qualities and leadership skills reported by participants working within and external to Australian residential aged care organisations. To identify major and minor themes, I took the following steps: i) handwritten memos were collated immediately after each interview to ensure that a reflexive stance was maintained concerning the research situation, participants and documents under study; ii) familiarisation through careful and repeated reading of transcripts and research memos, noting emergent themes; iii) each participant was emailed a copy of the transcribed verbatim to ensure that the investigator's record corresponded with those of the participants from whom those data were derived; and iv) open coding in which codes were created based on identified themes, codes were assigned to specific sections of transcripts (Edelman et al., 2020).

Comparative analysis

Subsequently, a comparative analysis of interviews across both participant groups was conducted. This analysis method allowed me to assess any similarities or differences regarding the personal qualities and leadership skills that influence the quality of care, as reported by RAC senior managers and Australian aged care industry experts. A series of comparative questions were devised to guide the analysis (List 2.)

List 2. Comparative analysis question guide:

1. What do senior managers report regarding leadership skills and personal qualities influencing quality of care (themes) and what do industry experts have to say about the same themes?

2. Which themes appear in one group but not in the other group and vice versa?

3. Reflect on why do both groups view issues similarly or differently.

4. What nuances, additional detail or new information does the other group supply about the group of our interest?

Note Source: Adapted from (Englander et al., 2013)

A reference list of foundational competency domains and leadership skills was formed following in-depth comparison between groups. This reference list was named the Residential Aged Care Senior Manager Quality Framework – Version 0.1 (*RCSM-QF 0.1*). This list included the leadership skills

and personal qualities inductively derived from the interview data. Eight discrete domains were formed, which comprised 29 leadership competencies (Table 13.)

Phase 2: Existing framework review and extraction

Identification of frameworks for extraction

Review and data extraction for existing leadership competency frameworks started with a search for and identification of candidate frameworks. Five key terms were defined —*competency*, *competence*, *competency list*, *domains of competence*, and *competency framework* (Englander et al., 2013)—based on both published definitions (List 2.) and my experience as a residential aged care occupational therapist. Using PubMed, CINAHL, Medline PubMed, Informit, Medline Ovid, Google, and Web sites of selected health care organisations, a search for published competency frameworks representing health and aged care leadership competencies was conducted. Frameworks were eligible for inclusion if: i) a methodological framework and reported approach was described for developing that framework was presented; ii) the framework was written in English; and iii) published in the last 20 years in peer-reviewed or grey literature (2002 onwards). Additionally, frameworks were only included for extraction if they included competencies relating to the senior manager role. Table 12. summarises the frameworks included for extraction, including the organisation of leadership competencies and overarching domains.

List 1. Definitions of Key Leadership Competency Concepts

- ***Competency framework:*** *"An organised and structured representation of a set of interrelated and purposeful competencies."*
- ***Domains of competence:*** *Broad distinguishable areas of competence that in the aggregate constitute a general descriptive framework for a profession. (Authors' definition)*
- ***Competency list****: The delineation of the specific competencies within a competency framework.*
- ***Competence****: "The array of abilities [knowledge, skills, and attitudes, or KSA] across multiple domains or aspects of performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training. Competence is multi-dimensional and dynamic. It changes with time, experience, and setting."*
- ***Competency:*** *"An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition."*

Note Source: Adapted from (Englander et al., 2013)

Table 12. Included leadership competency frameworks for extraction and RCSM-QF alignment

Model/ Framework	Intended audience	Purpose of model	Competencies	Organisation of competencies	Alignment with RCSM-QF domains	
HLA Competency Directory, established: 2005, updated: 2017. (Healthcare Leadership Alliance, 2017)	Health care executives	Identify competencies important across diverse professional roles within health care management and find common competencies among alliance members	802	**Five domains with clusters** Leadership-centred domain Professionalism Communication and relationship management Knowledge of the health care environment Business skills and knowledge	**RCSM-QF domain**	**Existing framework domain**
					Culture and environment	✓
					Stakeholder relations	✓
					Clinical and aged care expertise	✓
					Asset management	✓
					Disaster and change management	✓
NCHL Health Leadership Competency Model established: version 2.1 (2006), updated: version 3.0 (2018). (National Center for Healthcare Leadership, 2006)	Interprofessional, academic and clinical sector learners	1. Improve the health status of the entire country through effective health leadership 2. Establish core competencies for health leaders at all levels of the career cycle 3. Strengthen the practice of health leaders with academic research	28	**Four action domains** Boundary spanning Execution Relations Transformation **Three enabling domains** Values Health system awareness Self-aware and self-develop	**New framework domains**	**Existing framework domains**
					Culture and environment	
					Stakeholder relations	✓
					Clinical and aged care expertise	✓
					Asset management	
					Disaster and change management	✓
IPEC Core Competencies for ICP, established: 2010, updated: 2016. (Interprofessional Education Collaborative, 2022)	Interprofessional health disciplines—academic and clinical environments	To identify collaborative practice domains and improve communication amongst health professionals	No leadership domain yet leadership skills and behaviours referenced in each core domain	**Four practice domains** Ethics and values Roles and responsibilities Communication Teams and teamwork	**New framework domain**	**Existing framework domain**
					Culture and environment	✓
					Stakeholder relations	✓
					Clinical and aged care expertise	
					Asset management	

					Disaster and change management	
NSW Health Leadership and Management Framework, established: in 2020. (New South Wales Government, 2022)	New South Wales health system executives	To provide an evidence-based structure to support leadership and management development for the NSW public health	27	**Six leadership and management domains** Achieving outcomes Developing and leading self Engaging people and building relationships Partnering and collaborating across boundaries Transforming the system Managing for now and the future	**New framework domain**	**Existing framework domain**
					Culture and environment	
					Stakeholder relations	✓
					Clinical and aged care expertise	✓
					Asset management	✓
					Disaster and change management	✓
Vic Health CEO Leadership capability framework, established: 2019. (Vic. Health, 2019)	Victorian health system Chief Executive Officers	To support the identification, development and management of CEO talent across the Victorian health system	14	**Personal qualities, leadership capability and behaviour domains** Personal qualities **Leadership domains** Shaping the future Cultivating relationships Delivering service quality Activating operational excellence	**New framework domain**	**Existing framework domain**
					Culture and environment	
					Stakeholder relations	✓
					Clinical and aged care expertise	✓
					Asset management	
					Disaster and change management	
Master Health Service Management Competency Framework, established: 2016. (Australasian College of Health Service Management, 2020)	Health care executives	To inform employers and policymakers of the competencies they should consider when employing, leading, and managing health service managers.	86	**Five competency domains** Leadership Health and health care environment Business skills Communications and relationship management skills Professional responsibility	**New framework domain**	**Existing framework domain**
					Culture and environment	✓
					Stakeholder relations	✓
					Clinical and aged care expertise	✓
					Asset management	✓

					Disaster and change management	
Australian, Aged Care Leadership Capability Framework, established in 2014. (Aged and Community Services Australia, 2014)	Australian aged care leaders	Describes the knowledge, skills and abilities that underpin leadership required by leaders across aged care.	34	**Five leadership domains** Self Others Purpose Business Change	**New framework domain**	**Existing framework domain**
					Social responsibility	
					Stakeholder relations	✓
					Clinical and aged care expertise	
					Asset management	
					Disaster and change management	✓

Data extraction

Following the framework identification, a comparative analysis was conducted to compare existing frameworks against the reference list (RCSM-QF 0.1) developed from inductive analysis of the interview data. This analysis aimed to identify additional leadership skills, knowledge or personal qualities that interview participants did not report during Phase 1. Throughout this iterative process, new (n=10) competencies were added to the RCSM-QF 0.1.

Phase 3: Framework Synthesis

In Phase 3, I used framework synthesis to collate and collectively analyse findings from Phases 1 and 2; to determine residential aged care leadership competencies that promote quality of care. Framework synthesis starts deductively from pre-set aims and objectives – to extract and synthesise findings (Barnett-Page & Thomas, 2009). The synthetic product can be expressed in a chart or framework for each critical dimension identified (Iliffe et al., 2015). The four stages of the framework approach applied in the current project included: i) familiarisation; ii) identifying a thematic framework; iii) indexing; and iv) mapping and interpretation (Iliffe et al., 2015).

Familiarisation- I immersed myself with the raw data from the literature review, in-depth interviews and pre-existing frameworks by re-reading interview transcripts and reviewing recurrent themes. *Identifying a thematic framework* – An inductive thematic approach was employed to determine the leadership skills and personal qualities that influence the quality of Australian residential aged care from the literature, in-depth interview data and pre-existing competency framework extraction process. *Indexing* – The inductive approach was applied across all data to extract relevant leadership skills and quality themes. *Charting and interpretation* – Specific leadership skills and personal attributes linked to RAC quality of care were extracted from the inductive themes generated from the indexing phase. Once an association between themes was determined, leadership skills and personal qualities were grouped under overarching leadership competency domains.

Next, I drafted an initial conceptual version of the framework based on the collection of domains and their underlying content (leadership skills, knowledge and personal qualities). This was done to ensure that all the themes identified from the literature, interviews and official document reviews were accounted for and retrievable in the text. Inductive findings were then compared against existing leadership competency frameworks to expose additional leadership skills, knowledge and personal qualities that influence quality of care. Subsequently, after discussion and intermittent editing of successive versions, the preliminary RCSM-QF was designed by two researchers, including myself and primary advisor for this PhD project (ST).

8.4 Results

8.4.1 Phase 1 – In-depth interview comparison

*An in-depth description of the Results relating to the in-depth interviews is presented in Chapters 6 and 7 but are re-presented here with explicit consideration for the broad domains and specific skills and qualities relevant to the RCSM-QF.

Participants reported leadership skills under eight inductively identified domains which consisted of 53 leadership skills and five personal qualities linked to quality of care. It was found that participants who were senior managers emphasised skills relating to the communication and relationship management domain more than the knowledge of health and the healthcare environment in which they operated. In comparison, we found that industry experts emphasised the skills required to recruit and retain a competent health care workforce and manage relationships with key stakeholders to support and maintain their subordinates (Table 13).

Both groups emphasised leadership skills relating to managing relationships. Senior managers emphasised the skills needed to communicate and form relationships with stakeholders, including the care recipient, their families, and health care providers external to the organisation. Industry experts focused on relationship management skills to support and maintain a confident and competent residential aged care workforce. Both participant groups highlighted the importance of practical communication skills to develop trust and rapport with key internal and external stakeholders.

Industry experts reported skills specific to creating a positive organisational culture, including developing team cohesiveness and creating a physical work environment enhancing employee "comfort" at work. In comparison, senior managers focused more on the stewardship required to lead and manage change positively. Knowledge of the health care environment formed a leadership requirement that both participant groups strongly emphasised. Industry experts tended to focus more on the ability of managers to operate at a health systems level to recognise and implement clinical care models. On the other hand, residential aged care senior managers focused more on the essential clinical knowledge required by leaders to effectively serve an older demographic's health care needs.

Senior managers, but not industry experts, reported leadership skills under the Professional Development domain. This included the ability of residential aged care managers to promote staff and external provider accountability for health care quality. While few senior managers emphasised the importance of understanding and responding to regulatory, political and legislative contexts, Industry experts strongly recommended that residential aged care senior managers develop the competencies to network and engage with sector representative committees to guide the enactment of regulatory change within their respective organisations. The two participant groups also differed in their articulation of leadership skills required for residential aged care resource management. Industry experts tended to focus more on skills needed to utilise and integrate information technologies (IT)

that support quality of care provision. In contrast, senior managers emphasised business acumen skills including the ability to employ effective financial management techniques.

After cross-analysis, five overarching leadership domains and skills reported by both participant groups were created to reflect the leadership domains and skills. This integration formed the foundational competency domain and leadership skill reference list (RCSM-QF 0.1), used to compare the leadership skills and personal qualities extracted from data in Phases 1 and 2.

Table 13. In-depth interview analysis and comparison

Senior Managers		**Industry Experts**	
Domain	**Leadership skills**	**Domain**	**Leadership skills**
Communication and relationship management	-Nurtures and maintains resident relations -Communicates effectively with stakeholders -Partners with other aged care providers	**Workforce development and retention**	-Creates a balanced clinical workforce -Human resource management -Employee relational skills -Peer support networks -Communication skills
Stewardship	-Manages resistance to change -Leads change -Demonstrates a commitment to developing others	**Stewardship**	-Creates a physical environment for quality care -Creates a sustainable physical environment -Promotes team cohesiveness
Knowledge of the health care environment	-Demonstrates basic clinical knowledge -Recognizes service variations	**Health systems knowledge**	-Develops appropriate clinical care systems -Demonstrates basic knowledge of the health care system -Understands the regulatory and legislative environment
Professional development	- Recognises and values diversity - Encourages socialisation	**Responding to regulatory and political contexts**	-Partners with regulatory authorities -Engages with sector representative committees
Governance and business acumen	-Engages technology for staff communication -Creates and controls budgets -Demonstrates basic information technology skills -Uses contemporary software for reporting	**Information technology and finance**	-Understands financial management -Demonstrates problem-solving skills

8.4.2 Phase 2 – Existing framework data extraction

Of the existing leadership competency frameworks examined, four were domestic, and three were international. Six of the seven were frameworks that applied to mainstream health care organisations, while only the *Australian Aged Care Leadership Capability Framework (2014)* related directly to

aged care leadership capabilities in the Australian context. All frameworks consisted of leadership skills, knowledge and personal qualities linked to at least two of the preliminary Residential Aged Care Senior Manager Quality Framework (*RCSM-QF)* domains. A majority of these competencies related to the *RCSM-QF* – 'clinical and aged care expertise' domain (n=5), whereas only three described leadership skills linked to the *RCSM-QF* – 'culture and environment domain' (*HLA Competency Directory, IPEC Core Competencies* and *Master Health Service Management Competency Framework*).

Following comparison between existing frameworks and the foundational competency domain and leadership skill reference (RCSM-QF 0.1), additional leadership competencies were extracted and included in the final framework synthesis and development.

8.4.3 Phase 3. Framework Synthesis - Synthetic output

The Residential Aged Care Senior Manager Quality Framework (RCSM-QF) comprises two key elements: personal qualities and leadership skills. Leadership skills are broken down into five domains, including: i) culture and environment; ii) stakeholder relations; iii) clinical and aged care expertise; iv) asset management; and iv) disaster and change management. Below I elaborate on each domain and the overall preliminary RCSM-QF framework.

Figure 6. The preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF)

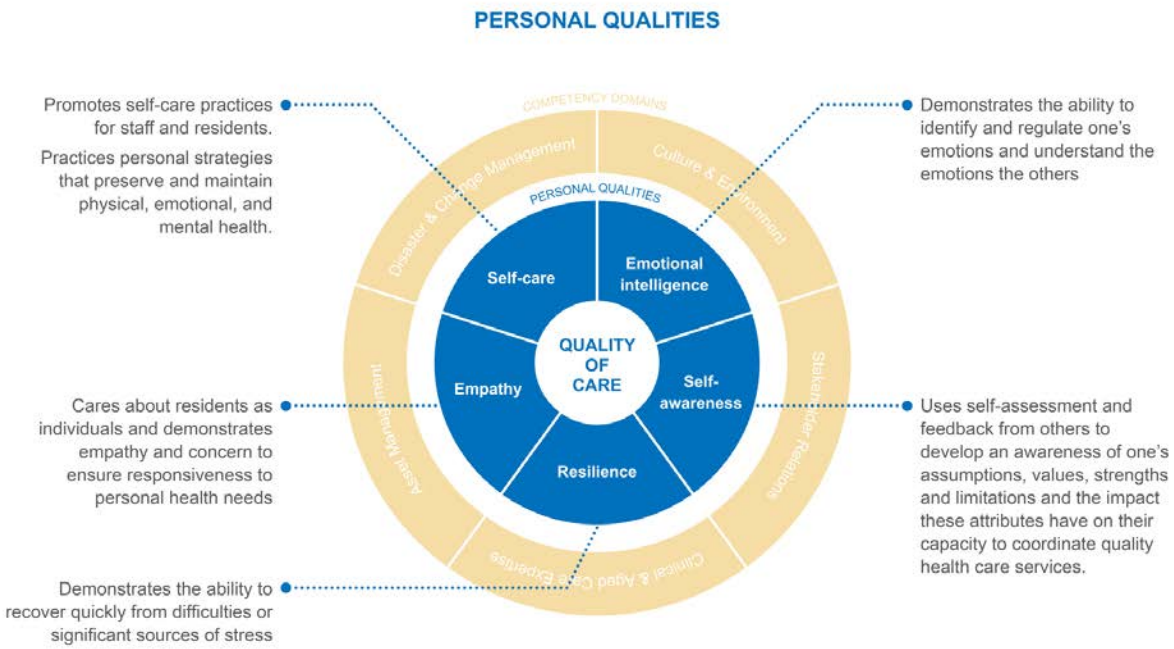
Source: Authors own figure

Personal Qualities

Australian residential aged care senior manager 'personal qualities' refer to leaders' attributes (or traits) such as personality characteristics, competencies, and values – that are reported to positively influence quality care in Australian residential aged care facilities. Personal qualities consist of five primary traits including: i) emotional intelligence; ii) self-awareness; iii) resilience; iv) empathy; and v) self-care.

Most leadership attributes under the 'personal qualities' domain were identified during the in-depth interview data, with one – 'demonstrates resilience' extracted from the *HLA Competency Domain*. Senior managers also regarded the development of 'professional resilience' as a critical personal quality linked to quality of care. Moreover, managers emphasised the importance of residential aged care senior managers developing the ability to 'display emotional intelligence and 'empathy' to care recipients, their families, and colleagues. Industry experts also reported 'emotional intelligence' as an essential managerial trait to lead quality health care services for older persons.

Figure 7. Senior manager's personal qualities that influence high-quality residential aged care.



Source: Authors own figure

Leadership skills

Leadership skills refer to the human, technical and conceptual skills and knowledge required by Australian aged care senior managers to promote quality of care. Skills are categorised across five domains, including: i) culture and environment; ii) stakeholder relations; iii) clinical and aged care expertise; iv) asset management; and v) disaster and change management. In the following sections, these overarching domains, related subdomains, and the more specific leadership skills they encompass are referred to simply as ‘domains’ and ‘skills’, respectively, to improve clarity.

Culture and Environment

‘Culture and Environment’ encompasses a series of skills influencing organisational decision-making and behaviour in the broader community and environment. This domain is broken into three sub-domains: i) influences organisational climate; ii) prioritises individual wellbeing; and iii) physical environment. Leadership skills include the ability of residential aged care senior managers to encourage resident-employee socialisation, promote fairness and equality, and create a safe and sustainable physical work environment (Table. 14).

Leadership skills specific to ‘Culture and Environment’ were derived from existing leadership competency frameworks and in-depth interviews with senior managers and industry experts. Senior managers, in particular, emphasised skills required to promote an organisational climate (atmosphere) conducive to high-quality care. Examples includes a manager’s ability to recognise and value care recipients' socio-economic, religious and cultural diversity and encourage socialisation between staff and residents within the facility. Under the ‘influences organisational climate’ subdomain, skills to enhance organisational culture for high-quality residential aged care were also included, such as recognising the preference of population groups when planning and administering episodes of care. Industry experts focused more on the skills required to construct a physical work environment that promoted employee and resident wellbeing. This included the ability of managers to create a safe and sustainable workplace for employees to attend. Most industry experts linked this leadership skill to benefiting resident health outcomes and quality of life.

Table 14. Skill Domain 1: Culture and Environment

SKILL DOMAN 1: CULTURE AND ENVIRONMENT	
Competency	**Description**
Subdomain	**1.1. Influences Organisational Climate**
Recognises and values diversity	1.1.1. Recognises and values the social differences among staff, residents, and communities.
Values of an inclusive workplace culture	1.1.2. Values and promotes an inclusive workplace culture that encourages high-quality care.
Encourages socialisation	1.1.3. Encourages meaningful socialisation between staff and residents to promote psychosocial and emotional wellbeing.
Engages the wider community	1.1.4. Engages the wider community to connect residents with the external social environment.
Fosters trust and respect	1.1.5. Fosters an organisational climate that promotes trust and respect for staff, residents, and external stakeholders.
Promotes accountability for care quality	1.1.6. Promotes and monitors internal and external health practitioners' accountability for providing high-quality care.
Understands social responsibility	1.1.7. Understands and considers the organisation's impact on the broader community and environment.
Recognises the preferences of population groups	1.1.8. Recognises the health care preferences of majority and minority communities regarding organisational practices for older residents receiving care.
Sub-domain	**1.2. Prioritises individual wellbeing**
Promotes fairness and equality	1.2.1. Responds to abuse and harassment towards staff, residents, and external stakeholders.
Encourages quality performance	1.2.2. Encourages and acknowledges employee performance resulting in high-quality health care outcomes.
Subdomain	**1.3. The physical environment**
Creates a physical environment for quality care	1.3.1. Creates a physical/ built environment that promotes residents' and staff's physical, emotional, and psychological wellbeing.
Creates a safe workplace	1.3.2. Creates ergonomically sound work environments to prevent staff injury and fatigue.

Stakeholder Relations

The leadership domain 'Stakeholder Relations' refers to the ability of managers to create and maintain effective relationships with internal and external stakeholders. This skill can be broken down into four subdomains: i) managing internal relations; ii) communication techniques; iii) managing external relations, and iv) conflict management. Leadership skills include a manager's ability to communicate effectively with external stakeholders and establish and maintain these relationships.

Leadership skills spanning the four related sub-domains were derived from in-depth interviews with senior managers and industry experts. In addition, skills were considered across existing leadership competency frameworks, including the *Vic. Health CEO Leadership Capability Framework*, *NCHL Health Leadership Competency Model* and *HLA Competency Directory*. Senior managers strongly emphasised competencies to form and maintain external relations for high-quality care. These included coordinating external health care services and partnering with other residential aged care providers to share ideas to enhance quality.

Industry experts emphasised skills under the 'manages external relations' and 'communication techniques' subdomains. Industry expert participants viewed skills such as partnering with regulatory authorities and engaging with sector representative committees as essential for managers to interpret and respond to regulatory directives. Additional 'stakeholder relations' skills, including the ability of senior managers to enact problem-solving skills and deliver clear business communications, were extracted from existing leadership frameworks as both were linked to high-quality care.

Table 15. Skill Domain 2: Stakeholder relations

SKILL DOMAN 2: STAKEHOLDER RELATIONS	
Competency	**Description**
Subdomain	**2.1. Manages internal relations**
Manages collaborative decision-making processes	2.1.1. Manages collaborative decision-making processes for health care delivery, involving staff, residents, and relevant stakeholders external to the organisation.
Promotes team cohesiveness	2.1.2. Promotes teamwork and team cohesiveness across all levels of the organisation
Nurtures and maintains resident relations	2.1.3. Nurtures and maintains personal relationships with residents and their families.
Encourages staff participation in performance evaluation	2.1.4. Encourages the participation of staff in evaluating organisational quality performance
Promotes the sharing of opinions	2.1.5. Promotes feedback and the sharing of opinions to improve service quality by staff, residents, and external stakeholders.
Manages resident satisfaction	2.1.6. Develops and applies tools that measure the resident experience for continuous quality improvement
Subdomain	**2.2. Communication techniques**
Develops transparent communication strategies	2.2.1. Develops and implements organisational communications strategies that are timely and transparent for staff and residents.
Communicates effectively with stakeholders	2.2.2. Demonstrates effective communication strategies, including active listening when communicating with staff, residents, and external stakeholders.
Provides constructive feedback	2.2.3. Provides constructive feedback to staff as a method of maintaining or improving the quality of care
Recognises non–verbal communications	2.2.4. Recognises and utilises non-verbal forms of communication to interpret and convey information to staff effectively, residents, and external stakeholders.
Delivers comprehensive business communications	2.2.5. Prepares and delivers business communications, including meeting agendas, presentations, business reports and project communication plans to summarise and promote quality of care.
Subdomain	**2.3. Manages external relations**
Coordinates external providers	2.3.1. Coordinates and monitors the quality performance of external service providers, including contract health care practitioners and equipment suppliers.
Responds to negative public opinion	2.3.3. Interprets and effectively responds to negative public opinion regarding the quality and safety of residential aged care.
Partners with other aged care providers	2.3.4. Partners and networks with other aged care service providers to share strategies and professional development opportunities to enhance the quality of care.
Partners with regulatory authorities	2.3.5. Partners with industry regulators to monitor and implement quality compliance requirements in line with regulatory developments.
Engages with sector representative committees	2.3.6. Engages with representative aged care sector committees to advocate the challenges experienced by providers to deliver quality.
Subdomain	**2.4. Conflict management**

Demonstrates problem-solving skills	2.4.1. Demonstrates problem-solving skills to address adverse conflict scenarios between staff, residents and external stakeholders.
Manages conflict	2.4.2. Manages conflict through mediation, negotiation, and other dispute resolution techniques.

Clinical and Aged Care Expertise

'Clinical and Aged Care Expertise' refers to the clinical knowledge required by managers to develop a quality focussed aged care system. This domain includes three subdomains: i) workforce development; ii) clinical and health service knowledge; and iii) aged care knowledge. Leadership skills include creating a balanced clinical workforce, developing and implementing clinical care models, and understanding the political and social environment influencing the quality of residential aged care services in Australia.

Like previous domains, most competencies linked to 'clinical and aged care expertise' were acquired from in-depth interviews with senior managers and industry experts. It was found that industry experts described macro-level skills required to promote quality of care, including the ability to understand and respond to the complex aged care political, social and regulatory environments. Clinical skills, including developing effective clinical care models tailored to the unique health needs of older persons, were also strongly emphasised.

Industry experts and senior managers reported skills to develop the residential aged care workforce and retain competent staff. Senior managers reported the skill to recognise the professional scope of practice for each health practitioner within the facility as important to ensure a balanced mix of clinical skills across the organisation. Senior managers reported skills under the 'aged care knowledge' subdomain, recognising the distinct service variations between aged care and mainstream health care operations. Moreover, most senior manager participants strongly emphasised the importance of knowledge to understand and respond to complex aged care regulatory and legislative contexts. With staff recruitment and retention forming a recurrent theme across this PhD and posing a significant challenge to the quality of residential aged care in Australia, an additional competency, 'creating innovative recruitment strategies', was extracted from the *NSW Health Leadership and Management Framework*

Table 16. Skill Domain 3: Clinical and Aged Care Expertise

SKILL DOMAN 3: CLINICAL AND AGED CARE EXPERTISE	
Competency	**Description**
Subdomain	**3.1. Workforce development**
Creates a balanced clinical workforce	3.1.1. Forms a residential aged care workforce with an appropriate balance of clinical skills that reflect older persons' unique health care needs.
Develops and coordinates innovative professional development opportunities	3.1.2. Develops and coordinates innovative internal training opportunities to upskill health care practitioners and personal care workers.
Encourages staff participation in quality evaluation	3.1.3. Encourages staff participation with health care quality auditing and reporting activities.
Promotes staff retention	3.1.4. Promotes the retention of qualified and experienced health staff who influence high-quality residential aged care.
Creates innovative recruitment strategies	3.1.5. Creates innovative strategies to recruit qualified health care practitioners with residential aged care experience.
Recognises professional scope of practice	3.1.6. Recognises the scope of practice for each health care discipline providing services within the residential aged care organisation.
Subdomain	**3.2. Clinical and health systems knowledge**
Develops appropriate clinical care systems	3.2.1. Develops clinical care systems that align with external quality guidelines and best-practice strategies to care for older persons.
Promotes resident-centred care	3.2.2. Promotes clinical care practices that are resident centred.
Demonstrates basic clinical knowledge	3.2.3. Demonstrates basic clinical knowledge regarding health and the health care needs of older persons
Demonstrates basic knowledge of the Australian health care system	3.2.4. Demonstrates basic knowledge of the broader Australian health care system and its influence on residential aged care quality.
Develops clinical care models	3.2.5. Develops and implements clinical care models that serve the needs of older persons receiving care.
Uses self–regulation for quality improvement	3.2.6. Encourages self–regulation, incorporating relevant quality indicators that inform quality improvement activities.
Uses data to manage risk factors	3.2.7. Uses organisational, community, national and global public health data for surveillance and control of threats to older persons.
Responds to diverse health care needs	3.2.8. Creates initiatives and approaches to reflect of diverse health needs of the resident population.
Subdomain	**3.3. Aged care knowledge**
Understands the regulatory and legislative environment	3.3.1. Understands the regulatory and legislative context of the Australian aged care system.
Recognises service variations	3.3.2. Recognise the variations that occur between mainstream and aged care service delivery and the influence these determinants have on service delivery
Understands organisational variations	3.3.3. Recognises the influence of organisational type and geographical location on the quality of residential aged care.
Understands systemic challenges	3.3.4. Understands the broader challenges influencing the Australian aged care system and the quality of residential aged care.
Advocates for systemic change	3.3.5. Advocates as an agent for change to address systemic challenges to quality of care in the Australian aged care sector.
Understands the political and social environment	3.3.6. Understands and considers external factors (social, technical and economic) on residential aged care quality.

Asset Management

The 'Asset Management' domain included two leadership subdomains: i) financial management; and ii) information technology. Participants who were senior managers mostly emphasised skills linked to the financial management subdomain, such as a manager's ability to understand the link between

financial status and residential aged care quality. Likewise, industry experts reported that finance management skills, including a manager's ability to create and control budgets, are critical to enhancing service efficiency and effectiveness. With the integration of health and information technologies expected to increase in many aged care settings, additional competencies, including senior managers' ability to plan for technological advancements, were extracted from existing competency frameworks, including the *HLA Competency Directory*.

Table. 17. Skill Domain 4: Asset Management

SKILL DOMAN 4: ASSET MANAGEMENT	
Competency	**Description**
Subdomain	**4.1. Financial management**
Understands financial management	4.1.1. Develops an administrative arrangement that promotes and sustains financial performance to support high-quality residential aged care.
Creates and controls budgets	4.1.2. Creates and controls organisational and departmental budgets that enable high-quality care.
Manages resourcing constraints	4.1.3. Manages resourcing constraints and effectively coordinates resources of the organisation to ensure optimal health care outcomes for older care recipients.
Recognises external funding opportunities	4.1.4. Recognises and successfully obtains external funding to improve the quality of residential aged care services
Uses financial principles	4.1.5. Understands and effectively uses critical accounting principles and financial tools to measure performance against the quality of residential aged care provided.
Advocates for funding provisions	4.1.6. Advocates for external change agents to secure additional government funding for residential aged care providers.
Understands finance and quality	4.1.7. Recognises the role of finance in maintaining and promoting quality of care.
Subdomain	**4.2. Information technology**
Engages technology for staff communication	4.2.1. Engages contemporary technologies to support efficient and transparent staff communications.
Uses e-technology for change awareness	4.2.2. Uses e-technologies to create awareness and educate staff and residents regarding an organisational change to enhance care quality.
Uses contemporary software for reporting	4.2.3. Engages contemporary software to promote quality reporting accuracy, timeliness, and transparency.
Promotes digital literacy	4.2.4. Promotes the safe and effective exploration and incorporation of effective digital health care technologies that optimise residential aged care and quality of care.
Uses e–technology for professional development	4.2.5. Develops and coordinates relevant professional development opportunities for staff via contemporary information technologies.
Plans for technological advancements	4.2.6. Evaluates existing and emerging technologies in planning the technical direction to support organisational strategy for improved quality of care.
Demonstrates basic information technology skills	4.2.7. Demonstrates basic competency in e-mail, common word processing, spreadsheet, and aged care quality reporting systems.

Disaster and Change Management

'Disaster and Change Management' refers to a residential aged care aged care senior manager's ability to lead self, engage others, drive innovation, and positively shape systems that promote quality of care. Leadership skills relevant to this domain included a manager's capacity to lead change and demonstrate a commitment to self-care. Under the 'Disaster and Change Management' domain, only

managers living and working in rural and remote northern Queensland localities reported leadership competencies required to plan for and manage natural disasters so that quality of care is not significantly compromised. Senior managers and industry experts strongly emphasised the skills needed to lead and manage resistance to change. Industry experts also emphasised the importance of managers leading by example and demonstrating strategies to self–care. No competencies were extracted from existing competent frameworks under the 'Disaster and Change Management' domain.

Table 18. Skill Domain 5: Disaster and Change Management

SKILL DOMAN 5: DISASTER AND CHANGE MANAGEMENT	
Competency	**Description**
Subdomain	**Stewardship**
Disaster management	5.1.1. Devises and manages operations to promote and protect quality of care during natural and manmade disasters
Leads change	5.1.2. Competently leads organisational change aimed at improving quality of care.
Manages resistance to change	5.1.3. Understands and responds to factors contributing to staff and resident resistance to change
Responds to leadership limitations	5.1.4. Responds to evidence-based leadership limitations emphasised through public hearings, e.g., the Royal Commission into Aged Care Quality and Safety.
Exhibits leadership skills for quality care	5.1.5. Exhibits the core aspects of organisational leadership that promote and protect the quality of residential aged care
Demonstrates a commitment to developing others	5.1.6. Provides mentoring to junior staff, including junior or aspiring residential aged care managers.
Demonstrates a commitment to developing self	5.1.7. Explores continuing professional development opportunities and actively seeks guidance from mentors.

8.5 Discussion

With increasing recognition of quality and safety issues in Australian residential aged care facilities (Cumming et al., 2010), there is an urgent need to better understand the senior manager competencies required to deliver on the spectrum of leadership functions that promote high-quality care. The lack of any sector-specific professional development or competency framework to guide the acquisition of these required skills is a concern. Synthesising evidence from existing leadership competency frameworks in related fields, and in-depth interviews with senior managers and aged care industry experts, this chapter describes the formation of a preliminary leadership competency framework that maps the competencies required by Australian residential aged care senior managers to promote and protect quality of care. The Residential Aged Care Senior Manager Quality Framework (RCSM-QF) comprises two key elements: i) personal qualities and ii) leadership skills. Leadership skills are broken down into five domains: i) culture and environment; ii) stakeholder relations; iii) clinical and aged care expertise; iv) asset management; and iv) disaster and change management. Findings demonstrate that competencies reported by senior managers and industry experts applied to each of the five domains, as did the leadership competencies extracted from existing leadership frameworks,

including the ‘New South Wales (NSW) Health Leadership and Management Framework’ and ‘HLA Competency Directory.

This chapter involved a targeted review and analysis of global leadership competency frameworks in aged care and health-related fields. Many of the frameworks were tailored to management roles in mainstream international healthcare organisations (HLA Competency Directory, 2010; IPEC Competencies for ICP,2016; NCHL Health Leadership Competency Model, 2018), with one focused on leadership in the Australian aged care context (Australian Aged Care Leadership Capability Framework, 2014). While most frameworks described a least one aspect of leadership linked to quality of care, many considered leadership roles across multiple organisational levels, with few refined to the senior manager role. For example, the ‘New South Wales Health Leadership and Management Framework’ describes the ‘core’ management capabilities required when providing acute health care services (New South Wales [NSW] Health, 2015). The framework broadly focuses on the skills needed by leaders at various levels, including executives, middle managers, and clinicians who participate in management-orientated work (New South Wales [NSW] Health, 2015). In comparison, the Australian Aged Care Leadership Capability Framework (2014) described leadership capabilities specific to the Australian aged care setting (Aged and Community Services Australian [ACSA], 2014). Similar to the NSW Health Leadership and Management Framework and others from mainstream health care organisations, however, the ACSA framework considers leadership behaviours appropriate to multiple leadership levels, including frontline, middle and senior management roles (Aged and Community Services Australian [ACSA], 2014). It makes no specific mention of the senior manager role, nor the competencies linked to this leadership responsibility and high-quality care, beyond recognising the capability of ‘person-centred focus’. The framework connects with leadership capabilities across a range of aged care operations, including acute community services, without explicitly focusing on residential aged care.

To my knowledge, the preliminary ‘Residential Aged Care Senior Manager Quality Framework’ (RCSM-QF) is the first that maps Australian senior manager competencies to residential aged care, and quality of care. The framework design comprised multiple methods, which increased the robustness of the findings and allowed for triangulation and cross-validation using different sources: a literature review, in-depth interviews, and existing leadership frameworks (Johnson, 2017). Interviews with Australian residential aged care senior managers provided knowledge and understanding of the challenges encountered when leading a residential aged care facility. Moreover, Australian aged care industry experts possessed macro-level and systemic insights into the structural: political, economic and regulatory contexts that influence a senior manager's capacity to influence high-quality care within their respective organisations. Both participant groups provided informed opinions regarding the leadership competencies required to assess and negotiate these structural factors and reported

challenges to delivering a quality residential aged care service. The analysis of existing leadership competency frameworks allowed the triangulation with work on leadership in different but related industries (e.g., mainstream healthcare settings) and strengthened the robustness of findings. The inclusion of frameworks tailored to health care organisations outside of Australia provided an exploration of competencies relevant to aged care and leadership practices, globally.

Although findings from the current chapter provide an important first step in addressing the evidence gap relating to sector-specific leadership competencies required by Australian senior managers to promote quality residential aged care, it is recognised that they are not comprehensive. The preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF) has not been applied or tested in the Australian residential aged care setting. Therefore, the competencies described are not yet empirically validated, and the accuracy and relevance (Netland, Espelid, & Mughal, 2007)of the RCSM-QF for describing the leadership competencies required by senior managers are not confirmed. It is recognised that content validation of the RCSM-QF is necessary to ensure that the framework accurately reflects the skills and personal qualities required by Australian residential aged care senior managers to promote quality of care (Netland, Espelid & Mughal, 2007). This additional required work to validate the RCSM-QF, lies beyond the scope of this PhD whose primarily aim was to create new knowledge and understanding of the senior management leadership competencies that promote quality of care in a sector where no professional development or leadership competency framework to guide the attainment of these qualities currently exists.

8.6 Chapter Summary

As outlined in Chapter 4, a specific objective of this project was to

- Develop a preliminary aged care quality framework mapping senior management leadership competencies that may enhance quality of care in Australian residential aged care facilities.

This chapter involved a synthetic review and analysis of senior management-relevant leadership competency frameworks in aged care and health-related fields, globally. Many of the frameworks were tailored to management roles in mainstream international healthcare organisations (HLA Competency Directory, 2010; IPEC Competencies for ICP,2016; NCHL Health Leadership Competency Model, 2018), with one focused on leadership in the Australian aged care context (Australian Aged Care Leadership Capability Framework, 2014). While most frameworks described a least one aspect of leadership linked to quality of care, many considered leadership roles across multiple organisational levels, with few refined to focus specifically on the senior manager role.

This chapter subsequently presented the Residential Aged Care Senior Manager Quality Framework (RCSM-QF), a preliminary competency framework specific to the Australian residential aged care setting. The RCSM-QF maps senior managers' human, technical and conceptual skills and knowledge to quality of care and consists of five domains: disaster and change management, asset management, clinical and aged care expertise, stakeholder relations, and culture and environment. To my knowledge, the RCSM-QF is the first preliminary framework that identifies and maps senior manager leadership competencies to quality of care; however, the accuracy and relevance of the framework have not been applied or tested in the Australian residential aged care setting. The following Discussion chapter (the final chapter of this thesis) will discuss future research considerations to validate the framework's content. Furthermore, potential practical implications of the RCSM-QF for developing and upskilling current Australian residential aged care senior managers and those aspiring to transition into the role for the first time, will be discussed. An overview of the main findings presented in this thesis will be presented, in the context of relative strengths and limitations, and potential implications of the programme of work described herein for future practice, policy, and research in the Australian aged care sector.

Chapter 9
Discussion and Conclusion

9.1 Chapter Introduction

Senior managers play a critical role in the planning and delivery of services for older Australians receiving residential aged care. Attending to the distinctive features of a residential aged care facility, including the complex and frequent nature of clinical services for an older demographic and the broader financial and regulatory context specific to the Australian aged care system, the combinations of leadership competencies required by residential aged care senior managers to promote quality of care are unique. During the recent Royal Commission, however, the quality of residential aged care facilities was identified as lacking, with evidence pointing to leadership as a critical area requiring improvement (Royal Commission into Aged Care Quality and Safety, 2019). Notwithstanding these concerns, there has been limited empirical evidence regarding the challenges Australian senior managers face in promoting quality of care, the coping mechanisms employed to address these concerns, and the types and combinations of leadership competencies required to lead quality residential aged care services. Furthermore, to date, and to the best of my knowledge no appropriately tailored senior management leadership competency framework to guide the acquisition or updating of those skills has been developed.

This PhD contributes to knowledge and builds the evidence base by examining the perceptions and experiences of frontline senior managers regarding the challenges faced in promoting quality of care, focusing on outer regional, rural, and remote areas of northern Queensland (Chapter 5 – objective 1). Drawing on the *Skills Approach to Leadership Theory* (Katz, 1956), findings in Chapters 6 and 7 (objective 2) then provided new evidence of the senior managers' human, technical and conceptual skills required to address these concerns, drawing on the experiences and strategic insights of senior managers themselves, and Australian aged care industry experts. In Chapter 8, these empirically identified leadership competencies were compared with those extracted from pre-existing senior-management-relevant leadership frameworks and consolidated to form a preliminary overarching competency framework – the Residential Aged Care Senior Manager Quality Framework (RCSM-QF), thereby addressing objective 3. To my knowledge, the RCSM-QF is the first preliminary leadership competency framework that explicitly identifies the leadership competencies required by senior managers to promote quality of care in the Australian residential aged care setting.

This final discussion chapter synthesises and discusses the main empirical findings from Chapters 5, 6, 7 and 8 in the context of Australia's residential aged care system. It concludes by discussing the current project's strengths and limitations and describes future research opportunities.

9.2 A 'broken' national aged care system

The Australian aged care system has been described as "inadequate" and "neglectful", with many older care recipients having their fundamental human rights denied (Royal Commission into Aged Care Quality and Safety, 2019). Accordingly, multiple reported incidents of substandard and unsafe healthcare practices have resulted in unnecessary harm and, on some occasions, premature loss of life (Grattan Institute, 2020). Contributing to these concerns, senior managers who are primarily responsible for leading residential aged care operations face several challenges, many of which inhibit their ability to promote quality of care within their respective organisations. Well-reported challenges include chronic underfunding, a regulatory regime that is "unfit for purpose" and skilled workforce shortages (Royal Commission into Aged Care Quality and Safety, 2019).

Findings from Chapter 5 gave voice to the experiences and perspectives of frontline outer regional, rural and remote senior managers regarding the impact of structural challenges on human and financial resources and, ultimately, the quality of Australian residential aged care services. Chapter 7 reported that a majority of industry experts viewed the national payment model, the Aged Care Funding Instrument (ACFI), a tool used by aged care providers to calculate and claim care subsidies, as inadequate and inaccurate. Both senior managers and industry experts reported that ACFI does not discriminate sufficiently between resident care needs and associated costs, leaving a large proportion (32%) of Australian residential aged care facilities that experience financial hardship (StewartBrown, 2021). These funding constraints have implications for a residential aged care facility's capacity to invest in contemporary healthcare technologies and quality reporting software required to deliver efficient and accurately documented episodes of care. Furthermore, chronic underfunding is a barrier to recruiting and retaining skilled healthcare practitioners, who often seek better-paid positions and more flexible working arrangements within mainstream healthcare organisations.

Given recent and longstanding concerns of chronic underfunding for Australian residential aged care providers, researchers at the Australian Health Services Research Institute were engaged by the Australian Government to design a new funding model to more appropriately capture the care needs of residents in aged care and the relative costs of providing care (Department of Health [DoH], 2022). Coinciding with the commencement of this PhD, The Australian National Aged Care Classification (AN-ACC) has been piloted in Australia since 2019 (DoH, 2022). It will replace the current ACFI tool in October 2022 (DoH, 2022). Assessment under AN-ACC differs considerably from the ACFI (DoH, 2022). The primary modification is that assessment is undertaken by an independent, skilled workforce external to the residential aged care facility (DoH, 2022). Under the ACFI scheme, providers conduct initial funding assessments, and reporting a resident's care needs is often higher than required to access more funding to deliver care. The AN-ACC may allow a more accurate

payment to providers that better reflect the healthcare requirements of its resident population. In addition, with the AN-ACC described as being focused on maximising funding relevant to the context of the facility (DoH, 2022), including its location and size, the new payment model may also assist residential providers in geographically isolated areas to remain financially viable and allow more significant investment in resources, including contemporary health technologies used to promote high-quality care.

Chapters 5, 6 and 7 also spoke to other structural factors impacting residential aged care quality, including an Australian aged care regulatory environment with guidelines that were difficult to interpret and often poorly communicated by national regulatory authorities. In Chapter 7, provider advocates described a lack of educational resources and other mechanisms to support senior managers in embedding new directives within their respective organisations. Such findings align with reports from the Australian Government Department of Health, describing Australian aged care regulation as difficult for providers to interpret while highlighting that available support to enact new regulatory directives is limited (DoH, 2020). In Chapter 5, senior managers reported increased time spent by staff, including skilled practitioners, interpreting new regulatory guidelines, re-designing clinical systems, and developing intensive audit requirements to satisfy regulatory expectations at the expense of patient-centred care. Counter-productively, it was also reported that increased administrative demands resulted in incidences where treatment was delayed or forgone, which has an evident and detrimental effect on the health and well-being of older care recipients.

The Royal Commission described the Australian aged care regulatory regime as lacking the ability to "adequately deter poor practices" and monitor the "quality of clinical care". (Royal Commission into Aged Care Quality and Safety, 2019). It was also reported that leaders across multiple service types (e.g., community, residential and acute aged care) experience difficulties interpreting regulatory guidelines that influence quality of care. Subsequently, the Commission *Final Report*, detailed several recommendations for regulatory reform across the Australian aged care sector. This included forming an Australian Aged Care Commission, which, as part of its many proposed functions, would support the capacity building of providers to interpret better and successfully embed new regulatory directives within their respective organisations (Royal Commission into Aged Care Quality and Safety, 2021).

The current project provided an improved understanding of senior managers' needs for better capacity-building initiatives to construe and act upon regulatory expectations. Many participants who were senior managers, for example, reported difficulties interpreting and responding to recently formed regulatory guidelines, including the Aged Care Quality Standards (2019). These experiences were particularly acute in more geographically isolated areas, where senior managers indicated a disconnect between policy formation at the national level and the geographical and structural realities

that determine the quality of residential aged care services in outer regional, rural and remote areas of northern Queensland. As well, these frontline perspectives provide further evidence that supports the proposed formation of a second new regulatory body, the Aged Care Advisory Council, comprising experts from multiple aspects of the aged care system, including people receiving aged care and representatives of the aged care workforce in geographically isolated areas (Royal Commission into Aged Care Quality and Safety, 2021). As per the Commission's recommendation, the proposed function of the Aged Care Advisory Council would be as an interface between residential aged care providers and national decision-makers to provide advice on aged care policy development and service arrangements influencing the quality of residential aged care across multiple geographical areas of remoteness (Royal Commission into Aged Care Quality and Safety, 2021).

In many cases, underfunding and poor regulatory oversight have contributed to longstanding workforce shortages, with many residential aged care providers unable to compete with remuneration and professional development opportunities provided by mainstream healthcare services. Correspondingly, as the Australian population continues to grow and age, it is predicted that there will be relatively fewer skilled healthcare workers to draw on to meet the growing demand for aged care services (Hodgkin, 2016). Recently, the National Aged Care Workforce Census and Survey (2020) described a decline in the proportion of registered nurses in the residential aged care workforce, from 15% (2016) to 11% (2020) (Department of Health, 2021). During the same period, the proportion of residential aged care workers who were personal care workers and did not possess a tertiary healthcare qualification increased from 58% to approximately 70% (Department of Health, 2021).

Qualitative findings presented in Chapter 5 provided a critical perspective on these human resource challenges, demonstrating how negative public perception and stigma towards Australian aged care services, in part-fuelled by the Royal Commission's findings, contribute to difficulties in recruiting and retaining staff. Indeed, the Chapter 5 findings provided unique insights into the experiences of senior managers operating within rural and remote locations that demonstrate a perfect storm of financial hardship and the geographic implications of a limited skilled health workforce driving and embedding a human resource crisis in aged care facilities in regional, rural and remote areas of the country.

Notwithstanding workforce challenges highlighted by study participants and other sources, this chapter also demonstrates ongoing efforts by residential aged care senior managers to manage and mitigate these concerns. Some worked with their organisations to sponsor international staff, although lower levels of English proficiency and lack of familiarity with the Australian aged care system often presented new quality complications. Several managers also reported using external agency staff to address skilled worker shortages despite their expense. While such workarounds demonstrated senior

managers' efforts to address workforce challenges, recent evidence describes that the employment of "non-standard", temporary and agency staff can adversely affect workforce stability, efficiency, and continuity of care (Dickenson, 2021). The Commission's *Interim Report* also described many agency staff as having little motivation or interest in working in the Australian aged care setting, resulting in substandard and unsafe care being delivered (Royal Commission into Aged Care Quality and Safety, 2019). Such findings are a reminder of key conclusions of Wilson and McDonald (2015), who noted that health worker motivation is an important but complex influence on the quality performance of a healthcare organisation and describe low worker motivation as having a negative impact on service delivery, efficiency, equity and quality of care (Thi Hoai Thu, Wilson, & McDonald, 2015).

9.3 Leadership requirements in an increasingly complex setting

Set against the challenges outlined above, attracting and developing aged care leaders who promote quality and safe care within their organisations was a key recommendation of the Royal Commission (*Recommendation: 89*). Yet, findings from the literature review (chapter 2) established a lack of empirical evidence regarding the knowledge, human, technical and conceptual skills required to achieve this goal in Australia and internationally. Chapters 6 and 7 thus reported on two qualitative studies that addressed this knowledge gap, drawing out the experiences and perceptions of two groups – senior managers and industry experts, respectively – regarding the types and combinations of skills required by residential aged care senior managers to promote quality of care within their respective organisations. Findings demonstrated that different study respondents identified some but not other skills and competencies, tending to emphasise skills most relevant to their own experience. For example, health-qualified senior managers emphasised knowledge of clinical quality, while provider advocates spoke more emphatically about the relational and administrative skills required. By combining data from these different types of respondents, this PhD contributes to the literature and the evidence regarding the totality of skills and competencies needed by aged care senior managers to improve quality of care. These skills encompass clinical health and team and client management skills, business acumen, and strategic skills to negotiate the regulatory and resourcing terrain of aged care in Australia.

While these findings are an important first step to understanding the leadership needs of Australian residential aged care senior managers to promote quality of care, there remains an absence of leadership competency frameworks to guide the acquisition or development of these skills.
A leadership competency framework is central to managing healthcare leaders' and managers' selection, ongoing performance, and professional development (Wooten & James, 2008). It is a tool that can be used by human resource professionals or senior management to determine and measure the competencies an employee needs to perform their job effectively (Society for Human Resource

Management, 2022). In the context of healthcare organisations, formal competency frameworks have many advantages in that they "include a broad range of knowledge, attitudes, and observable patterns of behaviour which together account for the ability to deliver a specified professional service" (McGaghie et al., 1978) and can be applied to a range of professions and career levels or stages. Leadership competency frameworks can also inform the development of curricula and assessments in the education and training of health professionals and leadership teams (Clark & Armit, 2010). In the late 1970s, for example, the World Health Organisation published a paper entitled *Competency-based Curriculum Development in Medical Education* (McGaghie et al., 1978), which described the evolution of medical curriculum from being centred on individual clinical disciplines or subjects through to a more integrated model and eventually to competency-based.

Despite the recognised importance of competency frameworks to identify and develop competent and confident healthcare leaders, there remains an absence of empirically based leadership frameworks relevant to the critical senior management role and quality of care in the Australian residential aged care setting. While the current Aged Care Leadership Capability Framework (2014) does describe capabilities for Australian aged care leaders, it is not specific to: i) the Australian residential aged care context, ii) the senior manager role; and iii) it defines few capabilities that directly influence quality of care. Moreover, the framework is dated, and substantial reform and other developments within the Australian aged care sector have occurred since its publication in 2014. This includes the introduction of the Aged Care Quality Standards in 2019 and the recent Commission findings (2021), which confirmed ongoing concerns regarding the quality and safety of residential aged care in Australia. Currently, peak bodies, educators and residential aged care providers have no access to a framework specific to the role of senior managers, whose role – as demonstrated - requires a mix of clinical, business and communications skills. In the context of the industry-wide challenges described earlier, the absence of a guiding framework is a potentially limiting factor concerning efforts to recruit competent and confident senior managers with the skills required to promote quality of care; efforts to prepare and conduct training and development to upskill residential aged care senior managers; and efforts to determine the competencies needed to support leadership succession planning or career progression opportunities for current managers.

Lack of transparency and consistency regarding the responsibilities and accountabilities of aged care leaders, including residential aged care senior managers, have been documented (Royal Commission into Aged Care Quality and Safety, 2021). The Royal Commission recommended that aged care leaders possess the relevant professional qualifications, knowledge and skills, or high-level experience in a management role. Moreover, it was proposed that Australian aged care providers have specific indicators to assess the quality performance of leadership and management personnel; and that a plan to manage and support leadership training, including professional development and continuous

learning, be devised and implemented (Royal Commission into Aged Care Quality and Safety, 2021). In that context, developing an empirically based leadership competency framework could assist in forming solutions to these recommendations by guiding the development of evidence-based professional development activities, including a curriculum for professional qualifications aimed at enhancing the competence and confidence of aspiring senior managers within the Australian residential aged care setting.

9.4 The preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF)

Combining the empirical findings from Chapters 6 and 7 and cross-referencing these with a synthesis of global leadership competency frameworks in health or aged care settings, Chapter 8 makes a novel contribution to the field by producing a preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF) (Figure 6). This original and empirically grounded competency framework consolidates Australian senior managers' skills and personal qualities to promote and protect quality of care in the residential aged care setting. Leadership skills defined within the RCSM-QF were grouped into five domains: i) social responsibility; ii) relationship management; iii) clinical and aged care knowledge; iv) resource management; and v) stewardship.

Figure 6. The preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF)

Source: Authors own figure

Once validated, the competencies defined and described by the preliminary RCSM-QF could provide a practical tool to form a professional development infrastructure for Australian residential aged care senior managers. Within this infrastructure, the framework would define and describe the specific skills, behaviours, knowledge, and experience needed by aspiring and current senior managers to lead a quality residential aged care service. Additionally, the framework could inform the development of quality indicators to assess and monitor the performance of senior managers within their current roles (Posthuma & Campion, 2008). RCSM-QF competencies could also assist residential aged care organisations in establishing a consistent promotion criterion that incorporates demonstrated excellence by senior managers who consistently lead high-quality healthcare operations within their respective organisations (Morgeson, Campion, & Levashina, 2009).

In line with the Commission's recommendation to devise and support a plan for aged care leadership development (Royal Commission into Aged Care Quality and Safety, 2019), the RCSM-QF makes a contribution to the literature and field by providing an initial set of skills and personal qualities that could inform the development of future courses or qualifications to develop aspiring residential aged care, senior managers. For current managers, the RCSM-QF framework may provide a valuable tool for self-reflection (Ruben, 2019) to identify knowledge and skill gaps and to guide the planning of future training and other career progression opportunities (Esser, Kahrens, Mouzughi, & Eomois, 2018). While still requiring testing and validation, the tool addresses the issue of professional 'blindness' that comes with being either a health or business professional – demonstrated in the differing emphasis placed on specific skills sets founds among interviews reported in Chapters 6 and 7; reminds both managers and the sector more broadly of the complex combinations of skills required to manage these important settings – flagging personal and institutional professional development needs; and provides a basis for the strengthening of professional development offerings in the industry – including through identifying areas of weakness in the professional curriculum. Over time this could inform revisions to pre-service as well as in-service curricula (Jais, Yahaya, & Ghani, 2020).

9.5 Strengths and limitations of the project

Methodology

The findings presented in this thesis should be considered in the context of several limitations. Firstly, there are certain limitations related to the study design and methods. One limitation is the constraint posed by my professional background as an aged care occupational therapist. This includes 18 months of working within a residential aged care facility in northern Queensland, which may have predisposed me to understand and analyse specific issues in certain ways. However, this professional experience and expertise also provided advantages, including a deeper understanding of the challenges influencing quality of care within the northern Queensland residential aged care setting and

knowledge of the structural factors that shape the delivery of aged care services in Australia. It ensured that deep industry knowledge and the ability to forge trusting relationships were linked to a personal motivation to see improvements in the sector.

As noted in Chapter 5, selecting senior managers from 'high performing' residential aged care facilities in northern Queensland was purposive. Due to resource constraints, this study did not include senior managers who operated in residential aged care facilities owned and managed by government departments, including Queensland Health. This is a potential limitation as the regulatory and funding structures influencing the senior management role in government organisations are not explicitly represented in the study findings, which may impact on the generalisabilty of the findings presented in this thesis to these settings. Recent evidence does suggest, however, that there are likely commonalities between government-owned and non-government facilities, which to some extent, may moderate the potential impact on generalisability. For example, similarities include the clients' purpose for attending and length of stay, the nature of clinical services delivered, the attendant organisational structures and the staff skills mix required (Cosh, Fu, & Hughes, 2012). The inclusion of lower-performing organisations, however, may have broadened the category of challenges identified and further enhanced public discussion of leadership competencies required to influence the quality of residential aged care across a broader range of organisations.

It is also acknowledged that none of the senior managers included in the current study resided in major cities. The inclusion of senior managers who operate in more densely populated settings may have allowed additional comparison of the challenges faced by leaders in promoting quality of care across a wider expanse of geographical remoteness. This decision was largely a pragmatic response to the high levels of anxiety and distrust of external operators at the time of data collection due to the concurrent negative findings emerging from the Royal Commission. Despite these potential limitations, however, concentration on 'high-performing' facilities in regional, rural and remote communities did allow for a 'strengths-based' approach to better understand how and in what ways leadership by senior management was positively influencing the quality of care. Given wide-ranging disparities between health-related outcomes between older populations in outer regional, rural and remote areas and major cities (Australian Institute of Health and Welfare, 2021), the site selection and participant recruitment of senior managers from geographically isolated areas allowed for a deeper exploration of the particular challenges, vis-à-vis staff recruitment and mix, affecting service delivery within these geographically, demographically and electorally marginalised locations.

As noted in chapters 6 and 7, a purposive sampling approach was also employed to recruit Australian aged care industry experts, defined in this thesis as those who were either academics with residential aged care expertise, national peak consumer or provider advocates; or a primary health network

representative (PHN). Out of 12 industry experts interviewed, six participants were provider advocates whose primary professional focus is to support the viability and sustainability of aged care service providers. Therefore, 50% of industry expert participants in this study were focused on the provider (versus resident) experience, potentially skewing insights towards provider concerns. Although Australian aged care industry experts were recruited from national organisations and across various locations and jurisdictions, PHN representative participants were only from northern Queensland and thus likely reflected some concerns specific to that region.

While acknowledging these limitations of representation and standpoint across both the senior manager and industry expert participant groups, purposive sampling was deliberately used to ensure representation of expertise in some form. During the participant analysis, close attention was paid to the role and location of each senior manager and industry expert across the major groupings, including triangulation of data from participants operating in different contexts. While further work is essential to broaden and deepen understanding within the field, the findings presented in this thesis delivered an important starting point for mapping key leadership competencies required by Australian residential aged care senior managers to promote high-quality care.

Applicability

The approach to identifying and mapping senior manager leadership competencies influencing quality of care was specific to the Australian residential aged care context and focused on higher-performing northern Queensland facilities. Since every context is unique, it could be argued that the challenges to quality of care and leadership competencies reported are specific to the experiences of senior managers operating within this region. Following interviews with senior managers, I sought to mitigate this limitation in subsequent phases of data collection. First, recruiting industry experts from national organisations was deliberate considering their representation of operating in various jurisdictions and organisations across Australia. Second, as part of the framework synthesis, both international and domestic leadership frameworks were deliberately included to compare and identify potential leadership competencies linked to the quality of residential aged care in Australia and similar organisations globally. Finally, as mentioned previously, the RCSM-QF is yet to be applied and tested within the Australian residential aged care setting. Future research opportunities to address this limitation will be described in the next section of this chapter.

9.6 Future research

Although findings from the current study provide an important first step in addressing the evidence gap relating to sector-specific leadership competencies required by Australian senior managers to promote quality residential aged care, they are not comprehensive. The preliminary Residential Aged

Care Senior Manager – Quality Framework, for example, has not been applied or tested in the Australian residential aged care setting. Therefore, the competencies described are not yet empirically validated, and the accuracy and relevance of the RCSM-QF for describing the leadership competencies required by senior managers across all of Australia are not yet confirmed. Although the model was developed through an extensive review of the literature and based on the input of Australian industry experts and residential aged care senior managers, I recognise that content validation of the RCSM-QF is necessary to ensure that the framework accurately reflects the knowledge, skills and personal qualities required by Australian residential aged care senior managers to promote quality of care.

Considering the methods used and findings presented in this thesis, future research for content validity evidence could be obtained quantitatively and qualitatively by asking those with knowledge of and experience working within the Australian aged care sector regarding the feasibility and appropriateness of RCSM-QF competencies within the residential aged care setting. The advantage of a quantitative approach is that questions could be disseminated broadly to identify whether current information in the framework is inaccurate, irrelevant or not important. Moreover, data collected through a large-scale survey, for example, could allow for differences across demographic and residential aged care organisational characteristics, including government and non-government-managed facilities, to be further explored and evaluated. Qualitatively, focus groups could accompany quantitative research methods by capitalising on communication between research participants to generate data that further describes the feasibility and acceptability of the RCSM-QF within the Australian residential aged care setting. In situations where focus groups prove less effective in recruiting eligible participants for personal or logistical reasons, pre-identified key stakeholders, including residential aged care senior managers and industry experts in Australia and abroad, could be invited to participate in semi-structured interviews instead to evaluate the baseline feasibility of implementing the RCSM-QF. The proposed incorporation of multiple methods is expected to improve the robustness of content validation by allowing triangulation and cross-validation across various qualitative and quantitative sources.

9.7 Conclusion

This PhD gave voice to the experiences and perspectives of frontline outer regional, rural and remote senior managers regarding the impact of structural challenges on human and financial resources and, ultimately, the quality of Australian residential aged care services. Reported challenges included a national regulatory regime described as ‘unfit for purpose’ and chronic underfunding, resulting in skilled workforce shortages. These experiences were particularly acute in more geographically isolated areas. To address these concerns, this thesis explored the knowledge, human, technical and

conceptual skills [competencies] required by senior managers to promote quality of care; vis à vis the perceptions of residential aged care senior managers and Australian aged care industry experts spanning multiple locations and professional roles. Findings demonstrate that Australian senior managers require various technical and administrative skills, aged care, and clinical expertise to positively influence residential aged care and quality of care. Both participant groups strongly emphasised the ability to develop and maintain relationships with internal and external stakeholders and create a workplace culture and physical environment that supports employee and resident wellbeing as core competencies in senior managers, that are linked to high-quality care.

In the absence of a leadership competency framework that explicitly consolidates, defines and describes the competencies senior managers require to promote quality of care in residential aged care facilities, this thesis included a framework synthesis of the leadership competencies reported by study participants and those within existing frameworks in healthcare-related fields. The synthetic product is the preliminary Residential Aged Care Senior Manager Quality Framework (RCSM-QF), which defines senior manager leadership skills and personal qualities linked to high-quality residential aged care spanning five domains, including culture and environment, stakeholder relations, clinical and aged care expertise, asset management and disaster and change management. Although the RCSM-QF is yet to be applied or tested in the Australian residential aged care setting, once refined and validated, it may provide a practical tool to assist the recruitment, appraisal and development of competent senior managers within this increasingly complex setting.

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Appendices

Appendix 1: Peer-Reviewed Publication – 'Senior management characteristics that influence care quality in aged care homes: A global scoping review'

Dawes N and Topp S (2021) Senior management characteristics that influence care quality in aged care homes: a global scoping review. International Journal of Healthcare Management, 14 (3). pp. 731-743

Abstract

By 2050 the number of older persons is expected to double with figures reaching nearly 2.1 billion worldwide. This projection will challenge every nation's ability to provide the leadership required to reform and develop systems of care for the aged. The purpose of this review is to explore senior management characteristics that impact the performance of healthcare delivery systems in aged care homes. A systematic approach was used to search, extract and synthesise the literature. Both thematic analyses and critical appraisal were undertaken to identify prominent themes and evaluate the quality of each article. Of the 14 articles included in this review, 12 (85%) were from the United States and none from low- and middle-income countries. Findings from this review indicate that senior management characteristics influence the quality of care in aged care homes. There is some limited evidence of a link between senior management leadership styles (and behaviours) and the quality of health care delivery in aged care homes. Further research to determine the prevailing healthcare challenges concerning care quality in aged care homes is recommended to contribute to the evidence-based literature in the context of the Australian aged care sector.

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Senior management characteristics that influence care quality in aged care homes: A global scoping review

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ABSTRACT

By 2050 the number of older persons is expected to double with figures reaching nearly 2.1 billion worldwide. This projection will challenge every nation's ability to provide the leadership required to reform and develop systems of care for the aged. The purpose of this review is to explore senior management characteristics that impact the performance of healthcare delivery systems in aged care homes. A systematic approach was used to search, extract and synthesise the literature. Both thematic analyses and critical appraisal were undertaken to identify prominent themes and evaluate the quality of each article. Of the 14 articles included in this review, 12 (85%) were from the United States and none from low and middle income countries. Findings from this review indicate that senior management characteristics influence the quality of care in aged care homes. There is some limited evidence of a link between senior management leadership styles (and behaviours) and the quality of health care delivery in aged care homes. Further research to determine the prevailing healthcare challenges concerning care quality in aged care homes is recommended to contribute to the evidence-based literature in the context of the Australian aged care sector.

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Residential aged care; age care homes; management; quality; health care

Background

Emerging concerns in residential aged care

Globally, the rate of population ageing is accelerating. In 2017, there were approximately 962 million individuals aged 60 years and over and by 2050 this figure is expected to reach 2.1 billion [1,2]. The concurrent rise of complex co-morbidities among aged populations including dementia, depression and multiple chronic non-communicable diseases have well-recognised implications for mainstream health systems [3]. Yet there has been only relatively recent recognition of the impact of these forces on the systems and facilities of residential aged care internationally [4].

In the residential aged care sector in many countries, increasing population pressure now runs concurrent to concerns about financial viability [5,6]. In 2017/18 in Australia, for example, 974 Australian aged care facilities were surveyed with 45.1% recording an operating loss [5]. A study of aged care providers in the Netherlands in 2014/15, showed 30% had a profitability of less than zero, an increase of 9% from 12 months prior [7]. These figures are indicative of the trends in a number of (mostly high income) countries [7].

Financial losses can result in lower staffing levels and the employment of inadequately skilled health care professionals to administer health care services to a particularly vulnerable population [8]. Just as with hospitals, residential aged care research has demonstrated clear links between nurse staffing levels, funding allocations and the quality of care delivered in aged care homes [8]. Failure to treat residents adequately in the residential aged care setting or in their home leads to adverse and potentially fatal health outcomes for residents, costly admissions for hospital care and wider community health care organisations [8].

Concurrent to concerns about financial performance, concerns about poor residential aged care quality have been on the rise in OECD countries over the past decade [9]. In 2013 the European Commission issued a report noting that few European Union (EU) countries systematically measured whether residential aged care was safe, effective, and meeting the needs of care recipients [10]. In the United Kingdom between 2014–2016 the Care Quality Commission, an independent regulator, rated a fifth (21%) of providers as 'inadequate' or 'requires improvement' (10). In Australia, a Royal Commission into Aged Care Quality and Safety was established in October 2018 [11] following receipt of more than 5,000 submissions detailing incidences of inadequate care and/or safety breaches in the Australian aged care sector [11].

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Quality of care and the role of senior management

An aged care home is a special-purpose facility that provides typically longer term accommodation and other types of support to frail and aged residents, including assistance with day-to-day living and frequent healthcare for complex needs [12]. Daily operations within residential aged care facilities are typically managed by a senior management team comprising of a director of nursing (DON), nursing home administrator (NHA), and depending on the organisation, a medical director [13]. Against the backdrop of global growth in the aging population and projected increases in demand for residential aged care, the clinical complexity and financial acumen required to deliver and sustain high quality services for such a high-need population present distinctive challenges. Despite this, the influence of senior management attributes on care quality in the residential aged care sector is as-yet poorly understood [8].

Recognising this, we sought to scope the literature and synthesise current knowledge with regards to the:

1. Educational and professional attributes of senior management personnel that influence the quality of care in aged care homes.
2. Specific senior management leadership styles and/or behaviours that influence the quality of care delivery in aged care homes.
3. Proactive strategies that senior management personnel employ to prepare for the social, healthcare, workforce and operational challenges facing aged care homes into the future.

We defined quality of care (QoC) as the degree to which healthcare and social services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge [14]. Recognising the multifaceted nature of quality, we used, the Institute of Medicine's (IOM) six key domains of quality of healthcare as a conceptual points of reference. Those quality domains being: i) safety; ii) effectiveness; iii) patient-centeredness; iv) timeliness; v) efficiency; and vi) equity [15].

Method

A systematic approach using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA) was used to undertake a scoping review. A scoping review provides a broad map of research literature [16]. This involves specifying the research question, identifying relevant studies, selecting the studies, charting the data using thematic analysis, collating, summarising and reporting the results [17]. The process enabled the authors to identify gaps in the current literature and describe the need for future research in relation to the research topic [18]. It is anticipated that a scoping review will contribute to the knowledge base, informing research, practice, and policy implications to prepare senior management personnel towards ensuring quality care delivery in aged care homes.

Search strategy

Prior to the formal development of a search strategy, a scoping search was completed to ensure that all relevant terms were included. The following key words were involved in the search: 'nursing home* or long term care or residential care or assisted living or aged care home or home for the aged or residential aged care facilit*'; 'manage* or health facility administrator or 'leadership'; and 'delivery of health care'. CINAHL, Medline PubMed, Informit, Medline Ovid and PsychInfo databases were searched for literature relating to the research topic. Subsequently, a search confined to peer reviewed journals was carried out using Google Scholar and OneSearch version 2.0 which searches the James Cook University (JCU) library catalogue (Tropic at), over 90% of JCU's journal articles, Libguides, eBooks, the eJournal portal, and ResearchOnline@JCU. Searches were finalised on 14 December 2018.

Inclusion criteria

All candidate literature was subject to independent title, abstract, and finally full-text review by the authors according to a series of established criteria (Figure 1). In line with PRISMA guidelines, inclusion and exclusion criteria were developed and applied (Table 1).

Data extraction

Both critical appraisal and thematic analysis were undertaken [19]. Guided by the study objectives, thematic analysis was employed to determine patterned meaning across the dataset [20]. The following process was tailored to ensure that a thorough thematic analysis was achieved: i) data familiarisation; ii) data theme search; iii) theme review; iv) theme definition and; v) data tabulation. The analysis was conducted to collate common themes derived from the research question.

Given the presence of qualitative and mixed method journal articles, the Mixed Methods Appraisal Tool (MMAT), were used to critically evaluate the research studies. The MMAT guidelines assisted the authors to determine the quality of each article. All literature that met the eligibility criteria was included in the data analysis regardless of methodological rigor. Limitations derived from the application of the critical appraisal tool were included as part of the findings (Table 2). Specifically the: i) breadth of articles; ii)

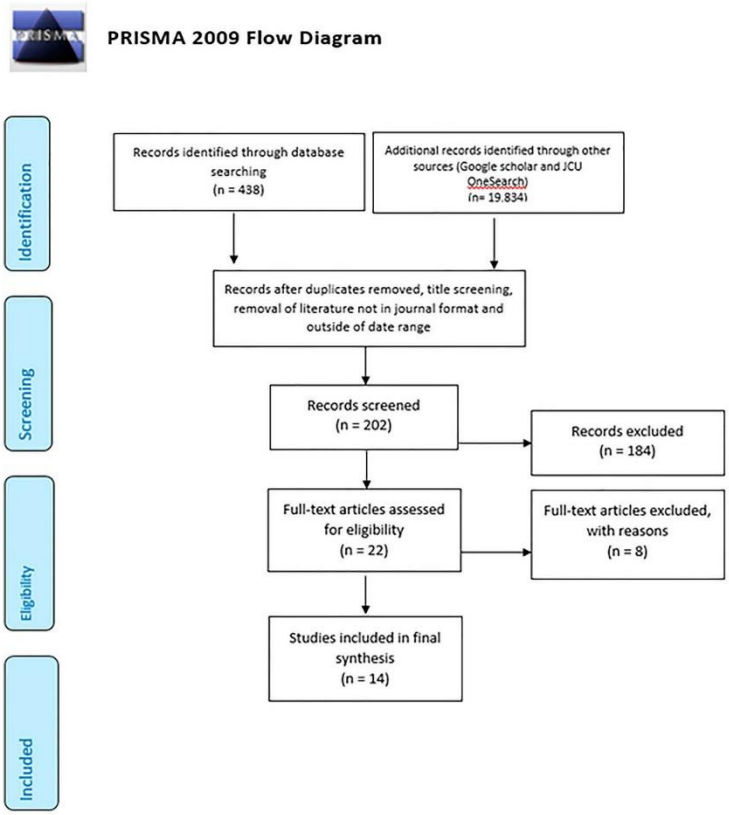

Figure 1. Literature search flow chart.

Table 1. Inclusion/ exclusion criteria.

Inclusion	Exclusion
Research published between Jan. 1989 – Jan. 2019 in a peer-reviewed journal, in English. This date range was applied to capture an extended period of developments following the initial scoping search and to ensure inclusion of several clusters of publications relevant to the review's focus.	Peer reviewed journal articles not written in the English language.
Peer reviewed journal articles that describe an association between managerial characteristics (including leadership styles or behaviours) and quality of care in aged care homes.	Journal articles that do not directly associate managerial characteristics (including leadership styles or behaviours) with the quality of health care in aged care homes.
Peer reviewed articles that examine senior management roles including director of nursing, nursing home administrator or Chief Executive Officer.	Research studies that were not conducted in aged care homes. For example, research completed within community health care organisations, hospital institutions or an individual's community residence were excluded for analysis.
Study settings that include for-profit or non-for-profit aged care homes. These facilities are defined as those that provide in house assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents who can no longer live at home or in other community based dwelling.	Studies that describe the managerial characteristics relating to aged care roles that are not specific to director of nursing, nursing home administrator or Chief Executive Officers (roles including medical directors, middle managers, frontline managers, governing board representatives and / or clinical care staff were not included for analysis).
Both quantitative and qualitative research articles were included for analysis.	
Peer reviewed articles from all countries were included for analysis.	

depth of information; iii) relevance of data in relation to the research topic and; iv) gaps in the form of relevant questions to guide further research recommendations were assessed. The appraisal process allowed the authors to determine inconsistencies, both within single pieces of work and with research compiled by other authors.

Limitations

Studies included in this review utilised different quality indicators to define senior management characteristics that influence the quality of care in aged care homes. This is a potential limitation of this review which may impact on the consistency of its findings. Also, it

is possible that articles contributed to by experts in the field were not included in this review as they were not able to be identified as a contribution of the terms included in the search strategy or part of a wider study but not discussed as a focal topic. The authors tried to make the search terms as inclusive as possible. However, if alternative words and forms were used, a different result may have been obtained. Moreover, research studies were restricted to peer reviewed journal articles and did not include grey literature. Finally, only those studies written in the English language were included for review. Therefore this review may potentially miss studies that are written in other languages

Results

Of the 14 articles included in this review, 12 (85%) were studies conducted in the United States of America, one (7%) in Sweden and one (7%) in Norway. Two articles employed qualitative, and 12 quantitative research methodologies. In total, five (35.7%) examined aged care senior management leadership styles while four (28.6%) articles explored the relationship between senior management tenure and quality of care. Five (35.7%) papers focussed on role preparedness of senior management personnel. Key findings within these broad categories will be elaborated in the following section and are summarised in Table 2.

Leadership style

Five articles [13,23,31–33] explored the influence of senior management leadership styles (including leadership behaviours) on the quality of care provided in aged care homes. One explored the characteristics of highly rated leadership behaviours in Swedish aged care homes (profit status not specified) [33], one examined the influence of active leadership in for-profit Norwegian aged care homes [32] and three examined the association of senior management leadership styles in the United States of America (for-profit and non-for-profit) [13,23,31]. One study examined NHA leadership styles [23], one study explored DON leadership styles [31] and three looked at senior management leadership styles and behaviours across a combination of senior management roles (DON and NHA) [13,32,33]. Two key clusters of findings emerged in relation to leadership styles from this group of five articles. One related to the types of senior management leadership behaviours that were highly rated by non-managerial staff; and the second related to the impact of senior management leadership styles on quality of care in aged-care facilities.

Backman et al. (2017) identified characteristics of highly rated leadership behaviours in Swedish aged care homes [33]. Five behaviours of highly rated leadership were identified. Namely, that the manager experiments with new ideas; controls work closely; relies on subordinates; coaches and gives direct feedback; and handles conflicts constructively [33]. Findings from this study also revealed that contextual and operational factors (including staffing characteristics and chain affiliation) are associated with senior management leadership ratings [33].

Four articles examined the relationship between leadership styles and quality of care in aged care homes [13,23,31,32]. Castle and Decker (2011) examined NHA and DON leadership styles in non-for-profit and for-profit aged care facilities. The Bonoma – Slevin leadership model was applied to categorise leaders into four styles; consensus manager, consultative autocrat, shareholder manager and autocrat [13]. Castle and Decker's (2011) results indicated that the consensus manager leadership style has a positive association with the quality of care delivered in aged care homes. Castle and Decker (2011) suggest that consensus leaders allow employees to offer input which encourages team decision making and enhances organisational performance (including care quality) [13]. With reference to the IOM Domains of Health Care Quality, Castle and Decker's assessment measured the delivery of i) safe and ii) effective health care services using the Nursing Home Compare Quality Measure and 5 – Star rating scores. Similar findings were earlier presented by Donoghue and Castle (2009) who also applied the Bonoma – Slevin leadership model. Donoghue and Castle (2009) concluded that consensus managers were associated with the lowest staff turnover levels, in turn enhancing the standard of care in an aged care facilities [23]. The Online Survey Certification, Reporting database and Area Resource File were utilised to extract organisational and local economic characteristics of the facilities. A general linear model was used to evaluate the impact of the NHA leadership style, the contributing organisational factors, and local economic characteristics on staff turnover and care quality within each facility [23]. Additionally, Donoghue and Castle's findings revealed that 'shareholder managers', who neither seek input when making a decision nor provide staff with relevant information for making decisions on their own, are associated with the highest turnover levels which can disrupt organisational performance and result in the provision of substandard care [23].

McKinney et al. (2016) examined the effects of DON leadership style on care quality domains through the lens of complexity science; where leadership information is explored through inputs of various agents (including managers, residents and family members) [31]. Findings from this study revealed that DONs using complexity leadership approaches, including regular staff interactions and shared decision-making processes, enabled better care outcomes [31].Quality indicators that were deemed DON sensitive included

Table 2. Included articles.

Study	Study coverage, facility chain affiliation and profit status.	Research Method	Study Purpose	Study Identified Findings (thematic)	Senior management characteristics and quality of care	Methodological quality criteria (MMAT 2018)
Castle (2001) [20]	United States of America – FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine the association between turnover of nursing home administrators and five important quality of care outcomes.	1) NHA turnover influences a number of quality outcomes (Pressure Ulcers, catheterisation, psychoactive drugs and quality of care deficiencies.	Management tenure and quality of care.	1) Relevant sampling strategies utilised 2) Sample is representative of target population. 3) Measurements are valid and reliable. 4) Low risk of nonresponse bias. 5) Appropriate statistical analysis relevant to the research question.
Castle and Fogel (2002) [21]	United States of America – FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine administrator professional associations and quality of care in aged care homes.	1) Characteristics of Medicare and Medicaid-Certified Nursing and professional affiliation of the administrator 2) Quality indicators and NHA professional associations 3) iii)Health related deficiencies and turnover	Role preparedness and quality of care.	1) Relevant multiple sampling strategies utilised 2) Sample is representative of target population. 3) Measurements are valid and reliable. 4) Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.
Donoghue and Castle (2009) [22]	United States of America – FP and NFP organisations included	Quantitative: Questionnaire and secondary data reviews.	To examine the associations between nursing home administrator (NHA) leadership style and staff turnover.	1) Consensus managers and impacts on staff turnover (linked to quality of care) 2) Shareholder managers and association with turnover (linked to quality of care)	Leadership style and quality of care.	1) Relevant multiple sampling strategies utilised 2) Sample is representative of target population. 3) Measurements are valid and reliable. No evidence of questionnaire pre-testing. 4) Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.
Keays, Wister and Gutman (2009) [23]	United States of America – FP and NFP organisations included	Quantitative; Questionnaire and secondary data reviews.	To examine administrator and facility related predictors of quality of care in aged care homes.	1) Administrator education and experience as a predictor for quality of care. 2) Association between administrator salary and quality of care. 3) Characteristics of facility and quality of care. 4) Administrator effort and quality of care.	Role preparedness and quality of care.	1) Relevant multiple sampling strategies utilised (probability, stratified sampling) 2) Sample is representative of target population. 3) Measurements are valid and reliable. No evidence of questionnaire pre-testing. 4) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
Castle and Lin (2010) [24]	United States of America – FP and NFP organisations included.	Quantitative: Questionnaire and secondary data reviews.	To determine the association between administrators education and quality of nursing home care.	1) Turnover of Nursing Home Administrators and quality of care 2) Turnover of Director of Nursing and quality of care 3) Staffing levels and quality of care 4) Use of agency staff and quality of care	Managerial tenure and quality of care.	1) Relevant multiple sampling strategies utilised (probability, stratified sampling) 2) Sample is representative of target population. 3) Unable to determine whether measurements are valid and reliable. No evidence of questionnaire pre-testing. 4) Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.

(*Continued*)

Table 2. Continued.

Study	Study coverage, facility chain affiliation and profit status.	Research Method	Study Purpose	Study Identified Findings (thematic)	Senior management characteristics and quality of care	Methodological quality criteria (MMAT 2018)
Castle and Decker (2011) [12]	United States of America – FP and NFP organisations included	Quantitative: Survey and primary data reviews.	To examine the association of Nursing Home Administrator (NHA) leadership style and Director of Nursing (DON) leadership style with quality of care.	1) Variables describing NHA and DON leadership styles and association with quality of care. 2) Senior management and organisational effectiveness.	Leadership styles and quality of care.	i)Relevant multiple sampling strategies utilised (probability, stratified sampling) 2) Sample is representative of target population. 3) Measurements are valid and reliable. No evidence of questionnaire pre-testing. 4) iv) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
Krause (2012) [25]	United States of America – FP and NFP organisations included	Quantitative; Questionnaire and secondary data reviews.	To examine the association between the Directors of nursing managerial characteristics and quality of care.	1) Job tenure and quality of care. 2) DON past experience and quality of care.	Managerial tenure and quality of care.	1) i)Relevant multiple sampling strategies utilised (probability, stratified sampling) 2) Sample is representative of target population. 3) Measurements are valid and reliable. No evidence of questionnaire pre-testing. 4) Low risk of nonresponse bias v) Appropriate statistical analysis relevant to the research question.
Seigel, Leo, Young and Castle (2014) [26]	United States of America – Medicaid and Medicare dual-certified facilities included for analysis.	Quantitative: Questionnaire and statistical data analysis.	To explore NHAs' self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation.	1) Administrator preparedness. 2) Education, training and experience to support role preparedness. 3) Education, training and experience requirements.	Role preparedness and quality of care.	1) i)Relevant multiple sampling strategies utilised (probability, stratified sampling) 2) Sample is not representative of target population. Only five states selected 3) Unable to determine whether measurements are valid and reliable. Choice of measurements justified but not entirely representative of research question. 4) Risk of nonresponse bias (Long questionnaire duration – 18.7% response rate). 5) Appropriate statistical analysis relevant to the research question.
Hunt, Corazzini and Anderson (2014) [27]	United States of America – NFP and non – chain affiliated aged care homes excluded.	Qualitative: Semi structured/ in depth interviews, observations and document reviews.	This study examined how nurse management turnover impacts system capacity to produce high quality care	1) Description of turnover trajectory 2) Administrative turnover and care system management 3) Nursing staff turnover and patient care 4) Positive emergent behaviours	Managerial tenure and quality of care.	1) Appropriate qualitative approach utilised 2) Adequate data collection methods 3) Findings are accurately derived from the data (cross-case analysis) 4) Interpretation of results is sufficiently substantiated by the data. 5) v) Adequate coherence between qualitative data sources, collection, analysis and interpretation.
Trinkoff, Lerner, Storr, Han, Johantgen and Gartrell (2015) [28]	United States of America – FP and NFP organisations included	Quantitative. Questionnaire and secondary data reviews.	To examine associations of education and certification among NHAs and DONs with resident outcomes.	1) Management level of education and resident outcomes. 2) Management certification and level of resident outcomes. 3) Nursing home characteristics and outcomes.	Role preparedness and quality of care.	1) i)Relevant multiple sampling strategies utilised (multistage, stratified sampling) 2) Sample is representative of target population. 3) Unable to determine whether measurements are valid and reliable. Choice of measurements justified but not entirely representative of research question. 4) iv)Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.

(*Continued*)

Table 2. Continued.

Study	Study coverage, facility chain affiliation and profit status.	Research Method	Study Purpose	Study Identified Findings (thematic)	Senior management characteristics and quality of care	Methodological quality criteria (MMAT 2018)
Castle, Furnier, Ferguson-Rome, Olson and Johns-Artisensi (2015) [29]	United States of America – FP and NFP organisations included.	Quantitative: Questionnaire and secondary data reviews.	To determine the association between administrators education and quality of nursing home care.	1) Descriptive demographic characteristics of long-term care administrators (including education and licensure) and association with quality of care.	Role preparedness and quality of care.	1) Relevant multiple sampling strategies utilised (Probability sampling) 2) Not able to ascertain whether sample is representative of target population. 3) Unable to determine whether measurements are valid and reliable. No evidence of pre-testing of questionnaire. Measurements not justified. 4) Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.
McKinney, Corrazini, Anderson, Sloane and Castle (2016) [30]	United States of America – FP and NFP organisations included	Quantitative. Questionnaire and secondary data reviews.	To examine the effects of DON leadership style including behaviours that facilitate the exchange of information between diverse people on care quality domains through the lens of complexity science.	1) Complexity leadership patterns and aged care home deficiencies. 2) DON quit intentions and aged care home deficiencies.	Leadership style and quality of care.	1) Relevant sampling strategy utilised (Probability sampling) 2) Not able to ascertain whether sample is representative of target population. 3) Unable to determine whether measurements are valid and reliable. No evidence of pre-testing of questionnaire. 4) iv)Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.
Havig and Hollister (2017) [31]	Norway – Private and FP aged care homes excluded.	Qualitative: Semi structures interviews, observations and document reviews.	This study examined how, or through which processes or mechanisms, the: [1] use of work groups, and [2] active leadership are associated with high quality of care in Norwegian nursing home wards.	1) The use of work groups to foster quality of care in aged care homes. 2) The role of active leadership in fostering the development quality.	Leadership style and quality of care.	1) Appropriate qualitative approach utilised 2) Adequate data collection methods (Potential research bias) 3) Findings are accurately derived from the data (cross-case analysis) 4) Interpretation of results is not sufficiently substantiated by the data (No use of quotes from interviews, No coding analysis provided) 5) Satisfactory coherence between qualitative data sources, collection, analysis and interpretation.
Backman, Sjogren, Lindkvist, Lovheim and Edvardsson (2017) [32]	Sweden – Facility affiliation and profit status not specified	Quantitative	To identify characteristics of highly rated leadership in nursing homes.	1) Specific characteristics of highly rated leadership in aged care homes. 2) Units specific to leadership behaviours.	Leadership styles and quality of care.	1) Relevant sampling strategy utilised (Probability sampling) 2) Not able to ascertain whether sample is representative of target population. 3) Measurements are valid and reliable 4) Low risk of nonresponse bias 5) Appropriate statistical analysis relevant to the research question.

all facility survey deficiencies in the domains of resident behaviours/facility practices, quality of life, nursing services, and quality of care. Logistic regression procedures estimated associations between variables [31]. With reference to the IOM quality domains, this study evaluated the provision of i) safe, ii) effective and iii) timely health care across 609 nursing homes in the United States. The authors recommend DON's to utilise complexity leadership approaches as a method of enhancing and maintaining care quality in the aged care setting [31]. Havig and Hollister's (2017) work also suggests that aged care leaders who employ 'active' leadership styles, or styles that enhance the relationship between leader and staff, will optimise components of the work environment (including the standard of health care delivery) [32]. Analyses led to a ranking of participating nursing home wards as measured by quantitative data from: i) surveys of relatives, ii) surveys of care workers, and iii) rankings by the field observer. Evaluation of care quality tended to be defined in relation to the IOM quality domains, i) safety, ii) effectiveness and iii) patient centeredness across 22 nursing homes in Norway [32].

Management tenure

Four articles [21,25,26,28] described the relationship between senior management employment tenure and quality of care in aged care homes. All four studies were conducted in for-profit and non-for-profit aged care homes in the United States of America. Two articles explored NHA turnover [25,34], one examined the influence of DON employment tenure [26] and one study examined the link between DON turnover, non-managerial staff turnover and the provision of care [28]. All four articles concluded that the turnover of administrators in aged care homes has an important influence on the quality of care which tended to be defined in relation to IOM quality domains including i) safety, ii) effectiveness and iii) timeliness of health care delivery [21].

Castle and Lin (2011) explored the direct and indirect relationships between senior management turnover and quality of aged care [25]. Findings suggest that NHA turnover can influence the safety and efficiency domains, through increased (resident) pain ratings, higher incidences of pressure sores and the use of physical restraints [25]. Counter-intuitively, the same study found DON turnover is associated with reduced rates of depression and reduced incidence of delirium for short-stay residents in aged care homes [25]. Hunt, Corazzini and Anderson (2014), suggested that higher DON tenure is related to higher staff retention, lower turnover and increased quality of care as measured by a complex adaptive systems theory to identify emergent relationships between nursing management turnover, staff turnover, and health care outcomes [28]. Krause (2012) found that aged care homes with longer DON employment tenure tended to have increased quality ratings [26]. Krause also found that past career experience, and tenure in current job were not equivalent in terms of their effect on care quality. Based on a questionnaire taken by 823 DONs in both for profit and non – profit aged care homes, the authors suggest that DON current job tenure, but not past experience, is associated with quality of care as there may be a 'learning curve' that is unique to individual aged care homes and that past experience in other aged care homes may have little bearing on current performance [26].

Drawing on data from a survey of 420 aged care facility and the 1999 On-line Survey, Certification and Reporting System, Castle (2001) examined the association between NHA turnover and five 'safety' oriented quality of care outcomes including the formation of pressure ulcers and frequency of psychoactive drug administration. In aged care homes that were not chain affiliated, the authors concluded that NHA turnover is associated with a higher proportion of residents who are restrained, catheterised, have pressure ulcers and who are administered psychoactive drugs [21]. These results are consistent with those later reported by Castle and Lin (2011) who suggested that overall, the organisational disruption resulting from NHA turnover has a negative impact on quality through the domains of efficiency and safety of care in aged care homes [25].

Role preparedness

Five articles [22,24,27,29,30] described the influence of senior management role preparedness and quality of care delivery in aged care homes with a focus on i) safe, ii) effective and iii) efficient care quality domains. All of the studies were conducted in non-for-profit and for-profit aged care homes in the United States of America. Four articles explored role preparedness of NHAs [22,24,27,30] and one article examined the preparedness of NHAs and DONs (29). Three key findings emerged including the relationship between professional association and senior management performance, senior management educational attainment and NHA's self-rated level of job preparedness and person-job fit when transitioning into a senior management role.

Castle and Fogel (2002) compared the influence (on care quality) of NHAs with and without professional associations to those that did not [22]. Findings revealed that, in the study population, professional membership and certification influenced higher quality of care. These findings are supported by both Keays, Wister & Gutman (2009) and Trinkoff et al. (2015) whose studies suggest that aged care homes led by DONs with at least a Bachelor degree produced better

quality outcomes including reduced (resident) pain ratings and decreased rates of catheterisation. Keays, Wister & Gutman (2009) present findings from a questionnaire applied to a sample of 302 administrators suggesting that the higher the level of education attained by the administrator the better the quality of care for residents. Castle et al. (2015) examined the association between administrators' education attainment, state training requirements and care quality (measured largely in terms of safety) in aged care homes. Findings demonstrated some positive relationship between the education level of administrators and five quality indicators including the incidence of restraint use, catheter use, inadequate pain management and residents with pressure ulcers [30]. That is, the higher the educational attainment of NHA's, the lower the incidence of poor quality outcomes in aged care homes.

Siegel et al (2014) explored NHAs' self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation towards transitioning into a senior management role. From a sample of NHAs (n = 175) randomly recruited from nursing homes in the United States of America, the authors noted that only 30% of participants reported feeling adequately prepared when transitioning into their first senior management role. Findings also revealed that NHA's preferred formalised training methods to develop their entry-level competencies, with a lower preference for on-the-job training and self-directed study. Preferred approaches to training included administrator-in-training, bachelor's degree programmes, and mentoring. Siegel and colleagues noted that more research is required to identify specific teaching/learning practices and on-the-job training that maximize the NHAs' preparation to meet their job demands [27]. Table 3.

Discussion

This review provides an important update on the state of evidence regarding senior management characteristics that influence care quality in aged care homes. Using a systematic search method, the research findings revealed only 14 articles globally, investigating this important issue. The vast majority of articles (n = 12; 85%) were conducted in the United States of America and none related to aged care facilities in low and middle-income countries. In the context of projections for rapid growth in the proportion of older persons in high and middle income countries [1], and increased reliance on aged care homes to provide basic and complex care [3],this dearth of empirical evidence is concerning.

Notwithstanding the limited geographic scope and varied methodologies used by studies in this review, we found evidence relating to three themes relevant to the question: *what are the characteristics of senior management personnel that influence care quality in aged care homes*? These were: i) a link – albeit still poorly defined – between leadership styles (and behaviours) and care quality in aged care facilities; ii) that

Table 3. Thematic Analysis: Senior management factors, leadership styles and quality of care in aged care homes.

Theme	Sub-theme	Definition	Description
Leadership style	Highly rated leadership styles [32]	Leadership and management characteristics perceived as effective by aged care home staff.	Includes: 1) Top five rated leadership and management behaviours as perceived by all nursing home staff. 2) Contextual and operational factors are associated with high leadership ratings.
	Senior management leadership styles [12,22,30,31].	DON and NHA methods of providing direction, motivating people and implementing plans.	Includes: The Bonoma-Slevin model categorising four leadership styles and associating with five quality indicators.
Role preparedness	Professional association [21]	Methods whereby individual seek to further a particular profession, the interests of individuals engaged in that profession and the public interest.	Includes: General facility characteristics, NHA professional association and quality of care in aged care homes.
	Educational attainment [23,28,29]	The highest degree completed using three categories: Master's degree or higher, Bachelor's degree, and Associate's degree or less.	Includes: Educational background and level of senior management personnel and the association with quality of care in aged care homes.
	Self – rated preparedness [26]	Perceptions of senior management personnel regarding the degree to which they are prepared to assume their professional role.	Includes: self-assessed person-job fit based on NHAs' self-rated preparedness and the importance of the activities that supported their preparation towards transitioning into a senior management role.
Management tenure	NHA turnover and quality of care [20,24]	The association between NHA turnover and quality of care in an aged care home.	Includes: NHA turnover, length of employment and quality of care indicators.
	DON turnover and quality of care [24,25]	The association between DON turnover and quality of care in an aged care home.	Includes: DON turnover, length of employment and quality of care.
	The influence of senior management on staff turnover and quality of care [27]	The link between DON, staff turnover and quality of care	Includes: Direct and indirect relationships among senior management turnover, the number of staff, the types of staff, and specific quality indicators.

senior management role preparedness constitutes a likely challenge to delivering care quality; and iii) that senior management tenure constitutes a likely challenge to delivering quality healthcare in an aged care home.

Attributes of effective senior management in mainstream health services (hospitals or primary healthcare organisations), and the impact that these attributes have on care quality, have been well researched in high and middle income countries [35]. But services provided in aged care homes vary considerably to those delivered in mainstream healthcare institutions. Aged care facilities are often not recognised as part of a 'mainstream' health system; have substantially different funding models; and as a consequence require management with different combinations of expertise and leadership capabilities. For example, aged care senior managers provide leadership to facilitate the delivery of custodial care, activities of daily living support, quality nursing and allied health care, a range of political acumen and the management of finance (and other assets) [36]. In contrast, hospital managers lead a range of complex acute healthcare services including emergency medical care, diagnostic testing, intensive treatment and/ or surgery and a business model that must take account of both public and private (insurance or out of pocket) financing [37]. The distinction in client profile and service type suggests the need for a more refined examination of senior management characteristics that influence quality of care in aged care homes.

Findings from this review provide some, but not sufficiently high quality evidence acknowledging a link between the leadership styles (and behaviours) of senior managers and care quality [23]. While a majority of studies used measurements that are valid and reliable, we found the most studies defined quality in relation to clinical 'safety' and 'efficiency' while other well-recognised domains [16] of quality including patient-centeredness, equity and effectiveness were largely overlooked. Specifically, there is a paucity of evidence that explores leadership and its influence on client well-being and psychological outcomes.

A majority of articles examining the link between leadership and care quality utilised the Bonoma – Slevin Leadership Model to categorise leaders into four styles. Findings suggest that the consensus leadership style is most influential towards ensuring a high performing health services in aged care homes. The consensus approach is linked to increased resident satisfaction, higher employee satisfaction and lower rates of staff turnover [23,38]. There may be alternative styles and behaviours represented in other conceptual leadership models that influence the quality of healthcare delivered in aged care homes and have not been represented in this review. Furthermore, while a mixture of non-profit and for-profit nursing homes were sampled to explore this theme, studies were specific to the context of Scandinavian countries or the United States which may impact the application of these findings to other national/ sub-national settings.

While much has been written about 'role preparedness' for senior health managers in the broader context of national and global health care systems, however, much of this evidence remains inconclusive – deriving from methodologically weak studies – or poorly defined in the context of aged care [39]. All of the studies analysed in this review were specific to the geographical context of aged care homes in the United States of America, which may impact the relevance of these findings in aged care settings elsewhere. The findings affirm that United States health leaders and managers feel ill prepared through their formal education for a career as a senior manager in aged care [39]. Siegel et al. (2014) found that only 30% of individuals felt adequately prepared when transitioning into a senior management role for the first time. Although there is a little consensus regarding the set of basic competences and skills required, there is accord that academic improvement and professional development is necessary to support competent managerial performance in a complex and dynamic environment such as aged care [39]. Yet a majority of work on this theme has focussed on role preparedness of nursing home administrator's knowledge gap regarding the role preparedness for other senior management positions that influence care quality in this setting.

A third theme emerging from this review is the relationship between management tenure and delivery of quality healthcare in aged care homes. Again, this evidence is highly context-specific to the United States limiting its applicability to other national/sub-national settings where organisational, regulatory, political, demographic and cultural factors differ. Findings suggest that NHA turnover can influence increased (resident) pain ratings, higher incidences of pressure sores and the use of physical restraints [25]. This is reflective from studies of mainstream healthcare settings (e.g. hospitals) where shortened management tenure is viewed as a major threat to the long-term success of various quality improvements [40]. Mosadeghrad, Ferdosi, Hosseini-Nejhad (2013) recommend that successful quality management needs supportive and committed leadership. Senior management stability encourages long-term planning and commitment towards pursuing long-term objectives including those to enhance care quality [40]. However, strategies to successfully identify a senior manager's intention to leave during the recruitment process are yet to be determined.

Implication for healthcare management practices

Upon entering an aged care home older individuals and their families have the right to expect they will not be placed in danger or at risk of injury when seeking and receiving healthcare. They also have the right to expect that those providing their care and treatment will act in ways that will ensure their safety and wellbeing during the course of their care and treatment. In recent years, however, there has been increasing recognition that the quality of care is not as it ought to be and that the public's entitlements and expectations in this regard are not always being met (Kohn et al 2000, Committee on Quality Health Care in America 2001, Page 2004). The 2030 Agenda for Sustainable Development maps an action plan to achieve sustainable development while ensuring the human rights of all people [1]. It calls for leaving 'no one behind' while ensuring that the Sustainable Development Goals (SDGs) are met for all segments of society, with a particular focus on the most vulnerable – including older populations [1].

Our review highlights a dearth literature and general evidence gap in relation to the optimal mix of senior management leadership capabilities that will deliver quality of care in different national and sub-national aged care settings [41]. While the attributes of effective senior managers and their impact on care quality have been explored in mainstream health services, still relatively little is known about these attributes in aged care services. Further, existing leadership capability and professional development frameworks for aged care senior managers, detail little in terms of skill development to enhance care quality in this setting.

Drawing on both local and international best practice, further research to develop a set of domains aimed at recruiting and retaining competent and confident senior managers who influence high quality care in aged care homes would have positive implications for management practices in the context of the global aged care sector. To achieve such, however, a number of key questions require urgent attention.

First, detailed national – and sub-national research is needed to identify the current and future challenges concerning the structural barriers and enablers of care quality in aged care homes, with specific attention to the role of financing and regulatory arrangements that impact management decisions. Second, research is needed to better identify the professional attributes of senior management personnel who, under appropriate conditions, can positively influence high quality healthcare in aged care homes. Third, there is a need to document positive exemplars of) professional development strategies and organisational and system-wide enablers (e.g. policies, incentives, career structures) that have been shown to enhance the preparedness, recruitment and retention of senior managers who positively influence high quality healthcare in aged care homes.

Conclusion

This review provides an important update on the state of evidence regarding senior management characteristics that influence care quality in aged care homes. Using a systematic search method, the research findings revealed 14 articles globally, investigating this important issue. Findings from this review provide some, but not sufficiently high quality evidence acknowledging a link between the leadership styles (and behaviours) of senior managers and care quality. Much has been written about 'role preparedness' for senior health managers in the broader context of national and global health care systems, however much of this evidence remains inconclusive and poorly defined in the context of aged care. A third theme emerging from this review is the relationship between management tenure and delivery of quality healthcare in aged care homes. Senior management stability encourages long-term planning and commitment towards pursuing long-term objectives including those to enhance care quality. However strategies to successfully identify a senior manager's intention to leave during the recruitment process are yet to be determined.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Associate Professor ***Stephanie Topp*** has substantial expertise and experience working as a health systems practitioner and researcher. Associate Professor has investigated methods towards enhancing health care service delivery and governance strategies associated with a variety of health care organisations in OECD and lower income countries. This experience enhances discussions around the aged care system – including leadership, management and governance factors that might impact on the quality of care (health care delivery) in aged care homes.

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Appendix 2: Peer-Review Publication – 'Challenges to managing quality of care in northern Queensland residential aged care facilities'

Dawes, N., & Topp, S. M. (2022). Challenges to managing quality of care in northern Queensland residential aged care facilities. Social Sciences & Humanities Open, 6(1)

Abstract

Background

Senior management teams in residential aged care facilities (RACFs) face a range of challenges in providing quality health care services. With increasing attention directed at quality problems in Australian RACFs, there is an urgent need to better understand the experiences of this crucial cadre. This qualitative study sought to identify challenges from the perspective of current senior managers in residential aged care (RAC) organisations and map their influence on the quality of health care provided within.

Methods

19 semi-structured interviews were conducted with senior managers in 14 RACFs in northern Queensland, Australia. Thematic analysis was used, combining inductive identification of managerial challenges and a mapping exercise to locate these encounters against health system quality dimensions in the Australian National Health Performance Framework (NHPF).

Results

Reported challenges to promoting and sustaining quality health care within RACFs included barriers to recruiting and retaining skilled staff, service constraints resulting from geographical isolation, limited access to quality fiscal resources, and a recent change to regulatory and administrative requirements. Identified challenges touch on all sub-dimensions of the NHPF.

Conclusion

Several forces, many structural, currently challenge quality health care services in northern Queensland RACFs. Senior management teams come under substantial pressure and are developing short-term solutions to protect quality in the face of often chronic and structural challenges. Alongside work to address macro-level issues, more work is needed to understand the personal and professional attributes of senior managers who are successful in positively influencing facility-level quality issues.

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Regular Article

Challenges to managing quality of care in northern Queensland residential aged care facilities

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ABSTRACT

Background: Senior management teams in residential aged care facilities (RACFs) face a range of challenges in providing quality health care services. With increasing attention directed at quality problems in Australian RACFs, there is an urgent need to better understand the experiences of this crucial cadre. This qualitative study sought to identify challenges from the perspective of current senior managers in residential aged care (RAC) organisations and map their influence on the quality of health care provided within.

Methods: 20 semi-structured interviews were conducted with senior managers in 14 RACFs in northern Queensland, Australia. Thematic analysis was used, combining inductive identification of managerial challenges and a mapping exercise to locate these encounters against health system quality dimensions in the Australian National Health Performance Framework (NHPF).

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1. Introduction

With aged populations growing globally, demand for residential aged care facilities is increasing in many countries (Australian Bureau of Statistics, 2020). Australia is no exception, with the proportion of people aged 65 years or over projected to increase from 15% (2017) to 23% in 2066 (Australian Bureau of Statistics, 2020). Depending on the context, residential aged care may be referred to as 'aged care', 'long-term care', 'skilled nursing facilities' or 'nursing home care' (Cleland et al., 2021). These facilities provide accommodation and personal care, access to healthcare, and social and emotional support to older persons who can no longer reside independently within a community dwelling (Woolford et al., 2022).

Quality of care in residential aged care is a long-standing concern internationally and in Australia (Australian Institute of Health and Welfare, 2019). Indeed, in 2019, the shortcomings of Australian aged care services were made public as part of the *Royal Commission into Aged Care Quality and Safety*, in which the national system designed to care for older Australians was described as "woefully inadequate". [5(p12)] The *Royal Commission into Aged Care Quality and Safety - Interim Report* described numerous incidences of neglect and substandard clinical services, resulting in significant harm and premature loss of life (Caughey et al., 2020). Even before the Commission, consumers reported concern regarding the limited skill set of staff, turnover, and low staffing ratios, each linked to reduced care quality and safety in the residential aged care settings (Royal Commission into Aged Care, 2020).

High-quality care is indicative of care that is accessible, continuous, effective, and safe, as well as responsive (to clients' needs and expectations), efficient and sustainable (Castle & Decker, 2011). Both structural contexts – including political, economic and technological – and

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agential factors – such as choices and decisions by a chain or facility-level managers and providers – shape the design, delivery and accountability of RAC health services (Kruk et al., 2018). Organisational and management sciences literature and studies from medical sociology in particular point to the impact of leadership and direction on quality of care (Figueroa et al., 2019).

Traditionally RACF's daily operations are controlled by the senior management team, which generally includes the director of nursing (DON), the Chief Executive Officer (CEO), and, depending on the organisation, a clinical care director (Royal Commission into Aged Care, 2020). The title and responsibilities of each senior management role may differ depending on the facility's profit and chain affiliation status. Parand et al. (2014) (Parand et al., 2014) note, however, that senior managers play an essential and prominent role in determining the quality of care by balancing sometimes competing legal, financial, and moral obligations and consumer and regulatory expectations at the facility level (Cameron, 2011; Dawes & Topp, 2019). As is the case in many health services, the challenge presented, and skills required to balance these considerations is often heightened in facilities located in more geographically isolated areas (Caughey et al., 2020).

Despite the increasing attention directed at quality problems in Australian RACFs, and the critical role and responsibilities of aged care senior management teams vis-à-vis that quality, little research has been conducted in Australia to understand facility-based senior managers' experiences or perceived challenges to delivering high-quality care. In a scoping review of the international literature focused on senior management leadership to promote quality in residential aged care, Dawes and Topp (2019), identified 14 studies, the majority of which (n = 12) reported on RAC in the United States of America (U.S) and only two including a qualitative exploration of senior managers' experiences or concerns regarding factors influencing care quality (Dawes & Topp, 2019). In one narrative synthesis, Jeon et al. (2010) sought to examine the issues associated with, and progress made, in residential aged care leadership and management. While findings demonstrate the influence of staff productivity and workplace culture on health-related outcomes, the study maintained a largely U.S.- centric focus and scanned managerial roles across multiple organisational levels rather than senior managers specifically (2010) (Jeon et al., 2010). An original qualitative research study by Savvy, Warbuton and Hodgkin (2017) additionally examined service managers' experiences of the challenges of providing aged care services in rural Australia (Hodgkin et al., 2017a). Key findings included issues with staff recruitment and retention and their impact on quality of care (Savvy, Warbuton and Hodgkin, 2017), however, the study was specific to the context of community-based services and did not consider the residential aged care setting (Hodgkin et al., 2017a).

With a view to addressing a gap in the literature regarding the experiences of senior managers to promote quality in the increasingly complex Australian residential aged care setting, this study aimed to explore the experiences, challenges and solutions adopted by senior managers in 14 Australian RACFs. The study took a consciously 'remote and regional' focus to recognise the additional challenges associated with service delivery in more geographically remote areas and the importance of managing the quality of care to all aged care residents. Findings forms part of a broader project that aims to enhance knowledge and evidence of what is needed to improve management practice for quality of care within Australian RACFs in the future.

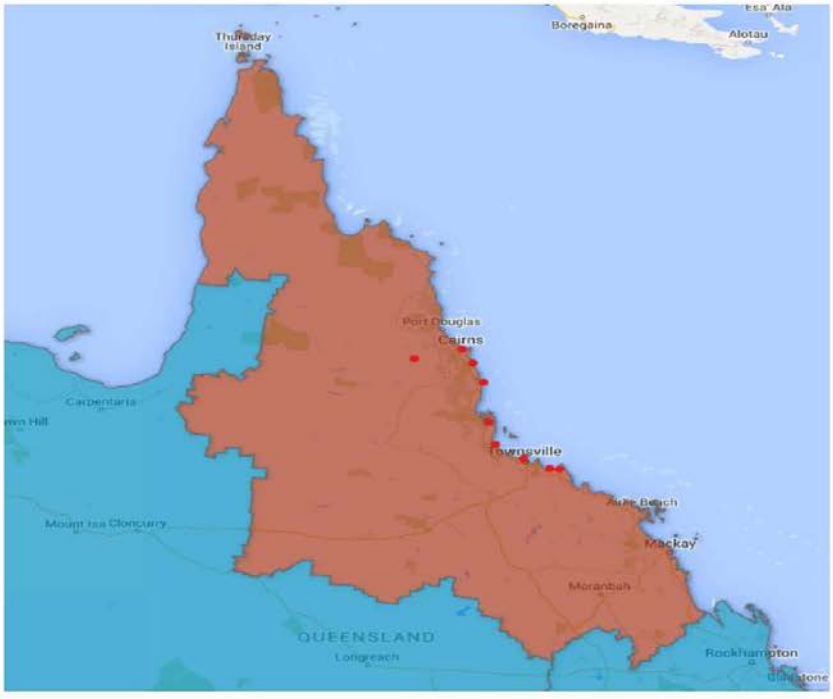

Fig. 1. Northern Queensland Primary Health Network Region - Study locations
Note: Source: (Adapted from Northern Queensland Primary Health Network website, 2020).

2. Methods

2.1. Study setting

The study was conducted across the Northern Queensland Primary Health Network (NQPHN) region (Fig. 1). (Northern Queensland Primary Health Network, 2020) The NQPHN region contains various degrees of geographical remoteness, including inner and outer regional, rural and remote localities (Hodgkin et al., 2017a). Facilities are located in Modified Monash categories 2–7[16] (with 7 equivalent to 'very remote') and include for-profit, not-for-profit, chain affiliated and non-chain affiliated organisations. Chain affiliated RACFs form part of a broader organisation, usually consisting of multiple facilities in different locations. Non-chain related facilities are standalone, independently owned, and managed organisations (Royal Commission into Aged Care, 2020). Inclusion of these different types of RACFs enabled exploration of potential differences in the experiences of senior managers working under other organisational and funding structures.

2.2. Study design and conceptual framework

From the perspective of senior managers, we conducted an exploratory qualitative study seeking to understand the challenges of delivering high-quality health care in regional, rural and remote RACFs. Qualitative methods were deemed appropriate in that they support examining individual participants' underlying reasons, opinions, and motivations (Austin & Sutton, 2014). We conducted in-depth interviews (IDIs) using probes such as 'why', 'how' and 'what' to gain a deeper understanding of participants' views and experiences regarding the challenges of managing care quality.

As a reference to the quality domains relevant to health service delivery in RACFs, we were guided by the Australian National Health Performance Framework (2019), which supports benchmarking for health system improvement and facilitates the use of data at facility level quality benchmarking purposes (Australian Institute of Health and Welfare, 2020).

The National Health Performance Framework (NHPF) provides a non-hierarchical conceptual framework to understand and evaluate the health of Australians and the health system (Australian Institute of Health and Welfare, 2020). The framework has 14 health dimensions grouped under three domains: health status, determinants of health, and health system performance. *Domain 3 – Health system performance* comprises six sub-dimensions utilised to evaluate health care service performance (Table 1). Five of these sub-dimensions have quality indicators specific to service provision within RACFs. These indicators can assist in assessing the residential aged care, quality of care, and whether the care provided delivers value for money (Australian Institute of Health and Welfare, 2020).

Issues surrounding quality of care, as described in the Royal Commission into Aged Care Quality and Safety – *Interim report*, and prior industry experience of one author (ND) provided the investigator team with additional insights regarding the broader and systemic issues influencing care quality in Australian RACFs.

2.3. Site selection

Site selection was purposive and designed to represent 'high-performing' RACFs across different areas of geographical remoteness in northern Queensland. The study focuses on 'high-performing' RACFs to explore the mechanisms employed by senior management teams who positively influence quality health care outcomes within their respective organisations. This insight could assist in determining management strategies that address quality issues across the broader Australian aged care sector.

First, a comprehensive list of Queensland aged care service providers was sourced from the Australian Institute of Health and Welfare – *GEN Aged Care Data* (Woolford et al., 2022). Organisations classified as multi-purpose service or a home care service were excluded as they did not align with the definition of a RACF. Due to the time-intensive governance requirements imposed on research in government facilities, it was not possible to include these facilities in this study; however, future research is planned to address this gap. To be classified as 'high performing', the facility must have obtained the maximum score (44//44) during the most recent site audit conducted by the Aged Care Quality, and Safety Commission (Caughey et al., 2020). Purposive targeting of invitations to 'high performing' RACFs in the NQPHN ensured representation of different geographic and organisational (chain, FP, NFP) status.

Table 1
Health system performance sub-dimensions and quality indicators (Adapted from Australia Institute of Health and Welfare, 2020) (Australian Institute of Health and Welfare, 2020).

Domain 3 – Health system performance		
Sub-dimension	Description	Quality indicators relevant to residential age care services
Accessibility	People can obtain health care at the right place and time irrespective of income, physical location and cultural background.	Residential and community aged care places per 1000 population aged 70+ years (and Aboriginal and Torres Strait Islander people aged 50–69 years), *Source National Health Care Agreement, 2021 Pg.26.* Aged care assessments completed. *Source: National Healthcare Agreement, 2021: Pg. 54.* Residential and community aged care services per 1000 population aged 70+ years. *Source: National Healthcare Agreement, 2021. Pg.49.*
Continuity of Care	Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.	This sub-dimension has no specific quality indicator relevant to health care services provided within residential aged care facilities.
Effectiveness	Care/intervention/action provided is relevant to the client's needs and based on established standards. Care, intervention, or action achieves the desired outcome.	PI 06–Life expectancy, *Source: National Healthcare Agreement, 2021. Pg.6.*
Efficiency & Sustainability	Achieving desired results with cost-effective use of resources. The capacity of the system to sustain workforce and infrastructure, innovate and respond to emerging needs.	Full-time equivalent employed health practitioners per 1,000 population (by age group), Source: National Healthcare Agreement, 2021: Pg 33.
Responsiveness	Service is client orientated. Clients are treated with dignity and confidentiality and encouraged to participate in choices related to their care.	Patient satisfaction/experience. Source: National Healthcare Agreement, 2021 Pg. 32
Safety	The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.	Falls in residential aged care resulting in patient harm and treated in hospital, 2012 Health, *Source: National Healthcare Agreement: Retired June 25, 2013*

2.4. Recruitment

Recruitment was conducted using a combination of email with phone follow-ups. The first author emailed all potential participants (n = 42) using public access contact information. The initial email included a

copy of the study 'Information Sheet', which provided each prospective participant with detail of the study purpose, the role and experience of the first author and interviewer (ND) as an aged care occupational therapist and current PhD candidate. To be included in the study, participants were: i) aged 18 years and above; ii) in a senior management role; iii) employed at a RACF that was not government-owned or operated and iv) employed within the NQPHN region.

Overall, a response rate of 48% was achieved with 20 in-depth interviews conducted by the first author (ND) between December 2019 and January 2020, face to face (n = 18) and via telephone (n = 2). Generally, the duration of each interview was between 30 and 45 min and each face-to-face discussion occurred with the participant within the residential aged care facility in which they operated. The interview guide (Appendix 1) canvassed the role of the senior manager, the processes through which care quality improvement processes were devised and evaluated, and the challenges associated with delivering high-quality health care in the northern Queensland setting. Interview questions and exploratory probes were piloted for acceptability and focus and to ensure that each question elicited responses with the intended focus on the challenges and solutions adopted by senior managers to manage quality of care. All participants provided written informed consent and agreed to the interview being audio-recorded and transcribed. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data before the analysis.

2.5. Data management and analysis

Inductive thematic analysis was conducted, and data was managed using QSR International Pty Ltd. (2018) *NVivo* (Version *12*) (Zamawe, 2015). To identify major and minor themes, we took the following steps: i) handwritten memos were collated immediately after each interview to ensure that a reflexive stance was maintained concerning the research situation, participants and documents under study; ii) familiarisation through careful and repeated reading of transcripts and research memos, noting emergent themes; iii) each participant was emailed a copy of the transcribed verbatim to ensure that the investigators records corresponded with those of the participants from whom those data were derived. Three participants (n = 3) provided feedback regarding the interview content, which was considered during the subsequent stages of analysis; iv) open coding was conducted in which codes were created based on identified themes. Codes were assigned to specific sections of transcripts and verified by the co-author (ST) to enhance the precision and consistency of the coding process; vi) the development of organisational descriptions, which included an account of each interview and discussed the findings relevant to the RACF organisational structure, profit status, policy and regulatory directives, facility geographical location and the role and each senior manager and other participants and vi) data display using matrices including summary tables (Braun & Clarke, 2006).

2.6. Ethics and consent

Ethical clearance was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019.

3. Findings

3.1. Overview

In this section, findings are organised to reflect major themes relating to RACF senior managers' experiences supporting quality of care. The themes are not simply a list of challenges but rather incorporate data relating to both *challenges* and senior managers' *responses* to those challenges in pursuit of high-quality care. The three themes include i) staff recruitment, retention, and development; ii) resourcing and regulatory requirements; and iii) geographic isolation. Within each of these themes, we map the influence of challenges across the six quality-relevant sub-dimensions of the NHPF.

3.2. Staff recruitment, retention, and development

3.2.1. Barriers to recruitment and retention

All participants described challenges to recruiting, supporting and retaining competent employees at northern Queensland RACFs. Senior managers also experienced recruitment competition from mainstream health care services that often provide higher pay rates, flexible working arrangements and more career progression opportunities.

> "Aged care pay isn't fantastic. We are up against other facilities and community organisation that do pay a lot more money. We're possibly the second job for many of our employees and trying to get staff to dedicate themselves to us is a real challenge." *Senior Administration Officer, MM2, Chain affiliated RACF – Participant 5.*

3.2.2. Negative public perceptions

Negative perceptions about working in aged care, in part driven by negative findings of Australia's current Royal Commission into Aged Care Quality and Safety, have made the sector less desirable as a career option for nurses and other health care practitioners. As one senior manager observed:

> "Of course, the stress levels are higher because of the media and the Royal Commission that just bombard everyone. So, you've got this outlook of the family that comes because the Royal Commission and the media is just sweeping everything up" *Director of Nursing, MM4, Non – chain affiliated RACF – Participant 18.*

Recruitment competition and working conditions can result in high levels of staff turnover. Staff turnover is linked to the NHPF sub-dimension (SD) *Continuity of Care* as it can interrupt the provision of coordinated care in an organisation over time. Moreover, as reported by one senior manager, staff turnover contributes directly to the loss of revenue through costs associated with recruiting and training new employees. Some senior managers reported that staff turnover resulted in higher clinical workloads and RACF employee burnout. Three senior managers said that low staffing levels resulted in substandard service provision and increased frustration for residents and their families.

> "I tell everybody when they walk in here, families and residents alike, we run on the smell of an oily rag. If we cannot do something for you straight away, then we will tell you why. And if we can't do it at all, we'll look for the next best thing." *General Manager, MM4, Chain affiliated RACF – Participant 14.*

On occasions, managers reported having to explain to families that a resident could not be sufficiently cared for and that the "second best" would have to suffice as a result. Low staffing levels resulting in sub-standard care quality is linked to SD - *Efficiency and Sustainability* as an example of when a health care system does not possess the capacity to sustain workforce-staffing ratios to respond to consumer expectations and care needs adequately. Reduced staffing levels are also linked to SD – *Accessibility*, as residents have a reduced opportunity to access the care that they require at the right time.

3.2.3. Recruitment and development in geographically isolated areas

Participants described social and geographical barriers to recruiting given the region's relative isolation and limited numbers of suitably qualified and experienced aged care workforce. Due to poor staffing ratios and challenges with recruiting and retaining skilled (qualified) workers, rural and remote RACFs employ several individuals who do not possess formal healthcare qualifications or work experience in the Australian aged care sector. Compounding the lack of skilled workers, three senior managers operating in isolated areas (MM 5 & 6) reported

limited and expensive access to accredited training programs to upskill personnel. Employees lacking clinical knowledge and skill proficiency are less likely to recognise and deliver client-orientated care (SD – *Responsiveness*) that aligns with established aged care treatment standards (*SD – Effectiveness*). Limited training opportunities for RACFs with a high proportion of unskilled staff were reported to compromise care quality and resident safety (SD – *Safety*).

> "So, our biggest issue is getting qualified support people. Most people do not have a university degree. Most of them, particularly the workers on the floor, other than the registered staff and allied health left school at 14, 15 and have little idea of what the residents need." *Facility Manager, MM5, Chain affiliated RACF – Participant 7.*

Senior managers operating in rural and remote areas reported difficulty accessing 'online' training packages due to poor internet connectivity and dated IT infrastructure to provide ongoing professional development opportunities.

> "So there's not only challenges of getting people to deliver the training, there are additional challenges of even getting online to do training due to all of our internet problems" *Facility Manager, MM6, Chain affiliated RACF – Participant 12.*

3.2.4. External service providers and international sponsorship

For some managers in 'outer regional' and 'rural' localities, one solution to staffing shortages was to employ external agency staff. This strategy was reported to help improve staffing ratios (SD – *Continuity of Care*) however introduced other challenges. Agency staff were expensive to hire, and reliance on these external and high-turnover providers made it difficult for residents to develop rapport (SD – *Continuity of Care*). Although, in more rural localities, participants described how agency staff were scarce and difficult to recruit, particularly skilled professionals. As a result, two senior managers reported relying on video-link for most assessments and treatment interventions.

> "So, I've worked in smaller regional towns, which has been really difficult. I've done things like speech therapy assessments over FaceTime, which is not best practice and can affect the quality of care delivered and the practitioner – patient relationship." *Facility Manager, MM6, Chain affiliated RACF – Participant 12.*

International visa sponsorship was another expensive but medium-term solution to increasing staff, especially nursing and allied health professionals. Several senior managers noted the benefits of being able to source international staff, including lower turnover than agency staff, but still described challenges. These included written and verbal communication barriers (among international staff who spoke English as a second language), which reduced individuals' capacity to recognise, address, and document residents' expressed needs (SD- *Responsiveness*).

> "Look, we've got a lot of staff here that are sponsored. English is their second language, which poses some concerns around communication and providing ongoing quality care." *Facility Manager, MM5, Non - chain affiliated RACF – Participant 13.*

Senior managers also noted that employees who migrated to Australia were particularly susceptible to verbal abuse and harassment from RACF residents. This situation was described as traumatising for the providers, risking conflict, resulting in an unsafe situation for both the resident and staff member (SD – *Safety*). Such competition also increased the chance of the staff member ceasing to work with an individual, the organisation or even the sector as a whole (SD – *Continuity of Care*). One senior manager observed that racism was a likely contributor.

> "But it becomes increasingly difficult when they're [employees] being abused by residents and families. I think the clientele that we have in our aged care facilities - some within that generation can be bit racist" *Facility Manager, MM2, Non – chain affiliated RACF – Participant 6.*

3.3. Resources and regulatory requirements

3.3.1. Fiscal resourcing constraints

Most senior managers interviewed in this study described their facility as experiencing recent financial hardship. Some reported they are often required to reduce staff hours, increasing the workload of those rostered to work and limiting the frequency of resident care (SD – *Accessibility*).

> "It's a really hard balancing act at the moment because all facilities are struggling financially and trying to provide as much care as we possibly can with funding we get" *Director of Nursing, MM2, Chain affiliated RACF – Participant 9.*

Most interviewees characterised Australia's current aged care national payment model (ACFI) as inadequate and inaccurate, inhibiting the provision of high-quality services across the sector but particularly affecting the viability and sustainability of smaller facilities in rural and regional locations (SD – *Efficiency and sustainability*).

> "I don't understand how a lot of providers can provide quality health care in the dollars that are set by the department under the ACFI model." *Chief Executive Officer, MM2, Non – Chain Affiliated RACF – Participant 10.*

> "The reality is you're not going to get a five star gold service, paying 50 bucks a day, or whatever it is, the two just aren't going to come together." *General Manager, MM4, Chain affiliated RACF – Participant 6.*

3.3.2. Changes to regulatory requirements

Many senior managers reflected on challenges related to the introduction of the Aged Care Standards in July 2019, which signalled a regulatory shift away from task-orientated care towards the consumer-centred model. The new Quality Standards reshaped how many organisations were required to deliver their health care services and consumer perceptions about care delivery (SD – *Responsiveness*).

> "Because of the new standards. People are saying, "Well that's my choice." And so that expectation is rising, especially with the royal commission." *Facility Manager, MM2, chain affiliated RACF – Participant 11.*

More than two-thirds of the study participants reported challenges associated with the new standards. Some said that the expectations of the new Aged Care Standards (2019) were not clearly stated or well understood, undermining efforts to shift to more client-oriented approaches across facilities (SD – *Effectiveness*) (SD – *Responsiveness*). Lack of guidance regarding the standards meant that senior management teams in different RACFs interpreted standards differently and developed various non-standardised internal care structures. One senior manager described how this had profound implications for some RACFs that had previously been assessed as 'high performing' but failed when reassessed against the new standards.

> "So, we got reassessed under the new standards in the last week of July (2019) and we got absolutely hammered. The report was about 88 pages long and as far as my perspective, not very professionally written and with little recommendation regarding how we can improve." *Facility Manager, MM2 –Chain affiliated RACF – Participant 8.*

Two managers described how embedding the new standards into routine operations was a stressful and intimidating process for which they received little support. Some participants observed that limited education materials were provided to assist the regulatory transition.

Five senior managers specifically described challenges to educating staff regarding the new standards and shifting their facility-wide approach to care.

> "There's so much unsettledness out there when the quality agency turns up. Because different - we're all just getting our heads around the other standards and now they've changed it." *Facility Manager, MM4, Chain affiliated RACF – Participant 17.*

Reflecting a particular challenge for regional and remote facilities that were chain affiliated, two senior managers described how internal policies and regulations developed to transition chain affiliated services to the new Standards had been devised mainly concerning the metropolitan experience and failed to engage with the unique practices and processes required to deliver high-quality care in outer regional/rural areas (SD – *Effectiveness*).

The increased administrative and documentation requirements required to satisfy quality compliance under the Aged Care Standards was noted to reduce the amount of time available for (already limited) health care practitioners to complete care interventions. This, in turn, influenced practitioners' time to attend to resident needs, sometimes undermining the quality and safety of interventions provided (SD – Effectiveness & SD – Safety)

> "My fear when I'm dealing with the quality is it takes those nurses away from giving that bedside care and that hands-on care because we're more caught up at the moment with documentation." *Facility Manager, MM2 – Chain affiliated RACF – Participant 2.*

Senior managers also described how the Aged Care Standards had increased the number of consumers and their families requesting additional services. While supportive in principle of these demands, senior managers observed that with no other resources, these requests and quality standards were often unable to be met due to resourcing constraints (SD – *Effectiveness*).

> "It's becoming increasingly difficult to keep up quality and the expectations that the general public have of aged care compared to the funding and resources that we get." *General Manager, MM4 – Chain affiliated RACF- Participant 14.*

The challenges brought by complex and expensive information technology systems were linked to, but distinct from administrative requirements, paradoxically designed to help meet RACFs administrative and regulatory demands. Participants broadly acknowledged that generic information technology systems were designed in part to support quality compliance processes. Yet several noted that, in the context of vastly different organisational profiles (chain, for-profit, not-for-profit) of Australian RACFs, the inability to tailor such information systems resulted in a considerable (downstream) administrative burden. Three senior managers described the pressure to ensure regulatory compliance by adopting new information systems, which had created an additional unfunded workload for already stretched staff (SD – Effectiveness). As one participant observed, moreover, despite these information system changes, in some cases, there are no programs available to satisfy the current quality criteria.

> "There's no off the shelf product that's actually meeting the standards that we're aware of, as they are, as they have emerged and then all off sudden, there's another two or three to be added to that list" *Facility Manager, MM2 – Non – chain affiliated RACF - Participant 4.*

The mismatch between heightened consumer expectations in line with Royal Commission findings and recommendations increased the administrative workload associated with the Aged Care Standards. Several participants described the largely static human and financial resources as contributing to a highly stressful work environment. One senior manager reported that increased stress had resulted in a large exodus of senior managers from the industry and high staff turnover, further interrupting the coordination of services across facilities (SD – *Effectiveness and SD – Continuity of Care*).

> "The complaints are rising, the expectations are rising, the administrative burden is rising, and it's becoming an extremely stressful environment for senior managers." *Chief Executive Officer (CEO), MM2, Non – chain affiliated organisation – Participant 1.*

3.3.3. Geographic location

Previous sections have described some impacts of geographic isolation on RACF senior managers' experiences, including the difficulties in recruiting and retaining skilled professionals. Here we briefly report several other distinctive challenges related to geographic location and technology.

3.3.3.1. Access to technology. Senior managers operating in isolated areas reported that the increasing reliance within the RAC sector on information technology (IT) was a challenge for facilities in outer regional and rural locations. Often, internet connections were poor, resulting in a facility having no access to IT platforms – and thus essential quality assurance systems - for an extended period. Similar challenges with internet connectivity and speed were described as magnifying challenges in accessing training and professional development opportunities between rural and metropolitan localities.

> "Our internet access isn't great, so there's not a lot of Telehealth type of training that we can do, because we're constantly cutting out, or those sorts of things; even though we've upgraded, it's still not perfect." *Facility Manager, MM5, Non - Chain affiliated RACF – Participant 7.*

3.3.3.2. Managing natural disasters. Geographic location was described as pertinent to the quality of care, with some areas more prone to environmental disasters and cut off from essential services. One senior manager reflected that outer regional northern Queensland areas are prone to natural disasters, influencing service access and continuity at a RACF. Very isolated RACF facilities are often cut off for long periods because of flooding and subsequent damage to connecting inroads. This adds another element of planning and management to ensure that all resources, including food and health care infrastructure, is available to support ongoing and high-quality service provision (SD – *Efficiency and Sustainability*). It also determines the type and access to external services during a disaster (SD – *Accessibility*).

> "I've never lived in north Queensland, then I had about two floods, two cut-offs, and I've worked in a flood –, but not as a manager at that time. When a natural disaster hits, it can be a very overwhelming time for the residents and staff, and we need to be prepared for that." *Facility Manager, MM6, Chain affiliated RACF – Participant 12.*

4. Discussion

Drawing on interviews with 20 individuals across 14 facilities in remote, rural and regional locations, this study addresses a gap in the literature vis-à-vis the challenges experienced by senior managers in delivering high-quality health care in Australian RACFs. While all participants recognised the importance of health care quality, they described multiple and overlapping challenges to effectively delivering on that goal. Many challenges were a product of forces external to the facility, including well-known and sector-wide challenges such as chronic underfunding and struggles with recruitment and retention of skilled health professionals (Caughey et al., 2020). Participants also reported difficulties not previously well documented, such as interpreting and responding to regulatory directives. Although managers reported strategies to mitigate barriers to quality, many of these strategies presented challenges of their own.

Study findings provide further evidence of technological and fiscal resource constraints as barriers to quality residential aged care (Caughey et al., 2020). Participants, particularly those working in the most isolated areas, described challenges to accessing reliable IT infrastructure, including unstable internet that resulted in temporary interruptions to software systems, including those required to fulfil mandatory reporting. A majority of managers also emphasised how the "flawed" and "inadequate" national payment model (ACFI) placed critical limitations on their capacity to hire both sufficient numbers *and* appropriately skilled health workers. Moreover, interview data highlights the interaction between these well-known funding constraints and the particular challenges of recruiting experienced professionals in regional and rural locations, where intense competition for the same limited pool of skilled health workers from better funded and often more flexible mainstream health services (Burgess et al., 2020; Community Affairs References Committee, 2020).

Despite the recent formation of voluntary-industry codes and other regulatory directives to counter workforce concerns, many RACFs are challenged to interpret and respond to such requirements (Hodgkin et al., 2017b). The current study found the communications from commissioning bodies around new regulatory expectations to be unsupportive and non-transparent. Participants' accounts also emphasised the critical importance of adequately resourcing and supporting the facility-level implementation of new regulatory directives and the unintended consequences of not doing so. Such findings align with reports from governing bodies, including the Australian Government Department of Health, who described the Australian aged care system as lacking fundamental transparency while highlighting that available support providers to enact new regulatory requirements were limited (Caughey et al., 2020). Notwithstanding these concerns, well-reported and ongoing issues around skilled workforce shortages, it is observed that directives, including the Aged Care Workforce Strategy (2018), do not stipulate the resources or knowledge required by managers to embed, often complex strategic actions within their facilities. Moreover, directives rarely detail recommendations to curb current systemic issues that detract from aged care roles being a desirable career option despite intense competition from other health care sectors (Hodgkin et al., 2017b).

Another important study finding relates to the quality challenges of introducing the Aged Care Quality Standards (2019). Organised under the Quality of Care Principles (2014), the Aged Care Quality Standards were devised to highlight the core rights of central importance for consumers who access an aged care service, with directives to increase the quality of care through a person-centred lens (Australian Government Department of Health, 2020). Findings highlighted the paradoxically negative impacts of these evidence-based and person-centred standards, as senior managers struggled to adjust workplace routines, administrative systems, and professional development strategies to meet the revised audit requirements without additional funding and limited sector guidance. Consequently, study participants described redirecting their own time and staff into guideline interpretation, system re-design, and intensive audit requirements at the expense of direct monitoring of client services. These findings provide insight into revelations from the 2019 Royal Commission, which described the Australian aged care regulatory regime as 'unfit for its purpose' and lacking the ability to 'adequately deter poor practices' (Royal Commission into Aged Care, 2020). Indeed, as part of the Commission's Final Report (2021), several recommendations targeted regulatory reform, including the establishment of an 'Aged Care Safety and Quality Authority' responsible for devising a new overarching Aged Care Act with transparent quality standards that are easier for providers to interpret and embed within their respective organisations (Royal Commission into Aged Care, 2022).

Notwithstanding the variety of challenges highlighted by study participants, our findings did reveal ongoing efforts to manage and mitigate these in several ways. For example, several RACFs utilise external agency staff despite their expense to address skilled worker shortages. In addition, some organisations sponsor international staff, whose levels of English proficiency and lack of familiarity with the Australian aged care system have quality implications. This strategy resembles those employed by mainstream healthcare organisations, particularly those located in isolated areas that have trouble recruiting experienced healthcare personnel (Burgess et al., 2020). RACF senior managers also reported their awareness of managing the complex relationships between clients and providers – many of whom come from different cultural and linguistic backgrounds – in ways that protected both clients and providers and ensured high-quality of care. In this sense, the capabilities of RACF senior managers were noted to be an essential contributing factor to quality through providing a positive work environment and organisational culture more broadly (Howe et al., 2019).

Maintaining and developing a competent aged care workforce in light of regulatory challenges technological and fiscal resourcing constraints is critical and requires senior managers with the capacity to focus on job quality, employee satisfaction and employment conditions (Hart et al., 2020). Yet, the compounding, primarily structural, challenges reported by senior managers in this study shine a spotlight on the high-stress work environment of RACF senior managers, with several participants describing their perception of recently increased turnover among senior personnel. Just as in general staff, a high turnover of senior managers is likely to have negative quality impacts (Caughey et al., 2020). With this in mind, further research is urgently needed to understand the various competencies required and professional pathways to ensure RACF senior managers can achieve personal and professional resilience and successfully deliver high-quality care in this complex environment.

4.1. Limitations

This study did not include residential aged care facilities owned and managed by government organisations. This is a potential limitation as the unique regulatory and funding structures influencing the senior management role in government organisations are not represented in the study findings. In addition, 'lower-performing' institutions or those that did not obtain the maximum Audit score against the Accreditation standards were not eligible for participation. As a result, overall, the findings are likely to be, if anything, a conservative representation of challenges experienced in the broader residential aged care sector.

5. Conclusion

Quality of care is critical to the wellbeing of those receiving a health care service and highly relevant to residential aged care clients who require frequent and often complex health care interventions. This study improves understanding of the challenges experienced by senior management teams in delivering quality of care in regional and remote Australian RACFs, mapping those challenges against NHPF subdimensions of service performance. Findings demonstrate how sector-wide challenges such as chronic underfunding and poorly supported regulatory reform have intersected with location-specific issues such as geographic isolation and skilled workforce shortages to compound the challenge of delivering high-quality care – across all NHPF subdimensions. Findings also reveal the critical role senior management play in developing 'work arounds' to maintain quality of care in the short term in the face of such chronic and structural challenges. Work to address macro-level constraints and better understand the professional attributes required by RACF managers to cope with these issues successfully remain urgent priorities.

Consent for publication

All participants provided verbal and/or written consent for data to be

published.

Availability of data and materials

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

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Credit statement

Nathan Dawes: Conceptualization, Methodology, Data curation, Analysis, Writing- Original draft preparation. Stephanie M Topp: Supervision, Methodology, Analysis, Reviewing and Editing.

Declaration of competing interest

The authors reported no potential conflict of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssaho.2022.100300.

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Appendix 3: Peer-Reviewed Publication – 'A qualitative study of senior management perspectives on the leadership skills required in regional and rural Australian residential aged care facilities'

Dawes N and Topp S (2022) A qualitative study of senior management perspectives on the leadership skills required in regional and rural Australian residential aged care facilities. BMC Health Services Research, 22.

Abstract

Background

With increasing recognition of the quality and safety issues in residential aged care, there is an urgent need to better understand what skills senior managers require to deliver on the spectrum of leadership functions in residential aged care facilities. This qualitative study sought to explore the leadership skills that positively influence the quality of care within Australian residential aged care facilities and better understand the professional development needs of senior managers to positively influence care within these complex environments.

Methods

We conducted semi-structured interviews with 19 senior managers purposively recruited from 14 high-performing non-government residential aged care facilities of varying geographical remoteness in northern Queensland, Australia. Participants held a range of professional roles, including Chief Executive Officer, Director of Nursing and Facility Manager, and had various professional qualifications. We used inductive thematic analysis to identify and categorise senior managers' perspectives on leadership skills and related strategies to promote quality of care.

Results

Senior managers reported leadership skills in five major domains: i) communication and relationship management, ii) stewardship, iii) professional development, iv) health care knowledge and v) information technology and finance. Most participants highlighted communication and relationship management skills and responding to regulatory change as influential to residential aged care quality performance. Interestingly, participants with different professional backgrounds often emphasised some skills but not others.

Conclusions

Participants identified a broad range of skills and strategies required by senior managers in Australian residential aged care facilities. Identifying different skills by differently trained individuals suggests more work is needed to understand and develop sector-specific professional development approaches to better prepare individuals to lead in this complex service environment.

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BMC Health Services Research

RESEARCH Open Access

A qualitative study of senior management perspectives on the leadership skills required in regional and rural Australian residential aged care facilities

Nathan Dawes* and Stephanie M. Topp

Abstract

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Methods: We conducted semi-structured interviews with 19 senior managers purposively recruited from 14 high-performing non-government residential aged care facilities of varying geographical remoteness in northern Queensland, Australia. Participants held a range of professional roles, including Chief Executive Officer, Director of Nursing and Facility Manager, and had various professional qualifications. We used inductive thematic analysis to identify and categorise senior managers' perspectives on the leadership skills and related strategies to promote quality of care.

Results: Senior managers reported leadership skills in five major domains: i) communication and relationship management, ii) stewardship, iii) professional development, iv) health care knowledge and v) information technology and finance. Most participants highlighted communication and relationship management skills and responding to regulatory change as influential to residential aged care quality performance. Participants with different professional backgrounds often emphasised different skills.

Conclusions: Participants identified a broad range of skills and strategies required by senior managers in Australian residential aged care facilities. Identifying different skills by differently trained individuals suggests more work is needed to understand and develop sector-specific professional development approaches to better prepare individuals to lead in this complex service environment.

Keywords: Leadership, Management, Skills, Quality of care, Residential aged care

Background

Compared with other nations, Australians are living longer than expected [1]. By 2057, it is projected there will be 8.8 million older people in Australia (22% of the population), and by 2097 approximately 25% of the population will be aged 65 years or over [2]. With extended longevity often accompanied by increasing health issues,

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population ageing is expected to increase demand for residential aged care [3].

As in many countries, residential aged care organisations in Australia face increasing service demand that runs concurrent with concerns about financial viability, workforce shortages, and associated quality of care [4, 5]. Recently, shortcomings of some aged care organisations and multiple incidences of substandard care were made public as part of a Royal Commission into Aged Care Quality and Safety [6]. The report highlighted that Australia's residential aged care sector faces many structural challenges. First, the national aged care funding instrument is regarded as a "flawed" model, resulting in chronic underfunding and financial hardship for a majority of aged care organisations [6]. In the 2021/22 financial year, over half of the Australian residential aged care facilities recorded an operating loss [7]. This situation influences facilities' capacity to recruit and retain sufficient and appropriately skilled staff [6]. Research pre-dating the Royal Commission has also demonstrated how these widespread resourcing challenges were exacerbated in rural and regional areas where competition with better paid 'mainstream' health services (e.g. hospital and family medicine practices) make it difficult for residential aged care facilities to recruit from a limited pool of skilled providers [8]. Resourcing constraints also limit the ability to access or update information technologies, subsequently reducing reporting accuracy and access to accredited virtual training opportunities [9].

In addition to these significant structural challenges to residential aged care organisations in Australia, the Royal Commission report also noted that leadership skills and strategies employed by residential aged care senior managers were lacking compared to other Australian mainstream health care organisations and international aged care services [10]. Effective leadership, together with a manager's ability to provide strategic direction, is regarded by Anderson, Issel and McDaniel (2013) [11] as important in promoting quality in healthcare settings. Previous work has demonstrated how leadership is a process, that entails influence within a group setting or context, and involves achieving goals that reflect a common vision [12]. Empirical research in healthcare settings has also demonstrated that the personal attributes of leaders are linked to increased quality of care via their effects on employee job satisfaction and patient engagement [13], and, specific to aged care, through the empowerment of older persons to make informed decisions regarding their own care [10].

While the leadership of residential aged care services may be viewed through multiple lens [14], a skills perspective has often been employed to identify and describe the skills, knowledge and personal qualities required by managers to promote quality performance in healthcare settings [15, 16]. Overall, leadership competencies can be understood as the cumulative leadership skills, knowledge and personal qualities that have the potential to influence quality of care [16]. Although substantial research has been conducted around leadership skills in mainstream healthcare organisations [15, 17], comparatively little is known about the leadership skills or combinations of skills required in the distinctive settings of residential aged care facilities [18, 19]. In examining the issues and the progress made in leadership relevant to the residential aged care workforce, Jeon (2010) reported leadership and management promoted staff job satisfaction and employee retention, two factors linked to high-quality care. Research has also demonstrated the link between leadership styles and factors influencing quality of care, including staffing levels and workforce culture in residential aged care [20]. However, a majority of research exploring the role of leadership in promoting the quality of residential aged care has been conducted in the United States of America. None focuses explicitly on senior management skills in the Australian residential aged care sector [21].

This knowledge gap is notable because although mainstream healthcare organisations and residential aged care facilities share some common features, they also differ in a number of critical ways relevant to their leadership profile [22]. Clients' purpose for attending and length of stay, the nature of clinical services delivered, the attendant organisational structures and staff skills mix required [21], and the broader financial and regulatory context differ in residential aged care compared with mainstream hospital settings [2]. Attending to these factors, the role, skills and personal qualities required by residential aged care senior managers are therefore potentially unique compared with other health settings. For example, senior managers of residential aged care facilities may be responsible for clinical care responsibilities but also and concurrently for institutional governance and risk operations, finance and asset performance, ethical conduct issues, people development, inter-professional collaboration and a range of commercial and political acumen [22]. Indeed residential aged care senior managers may require different types and combinations of leadership skills to achieve high-quality service outcomes as compared to their mainstream healthcare organisation counterparts [23].

Against the backdrop of an aging Australian population, the observation of limited leadership skills in residential aged care facilities by the Royal Commission, and considering the scarce empirical research conducted on leadership skills in this setting, there is a need for a closer examination of the leadership skill requirements of senior management in Australian residential aged care

facilities. The current study aimed to qualitatively explore senior managers' perspectives about which leadership skills are critical to providing high-quality care. In doing so, we aim to build the evidence base and better characterise and support this critical leadership group's future professional development needs.

Methods

Study design

This study was exploratory, as with a few notable exceptions, there is little empirical evidence regarding how leadership does or should influence the quality of Australian residential aged care services [1, 19]. Qualitative methods were deemed appropriate to capture senior managers' expressed beliefs, values, feelings, and motivations regarding important leadership skills required in residential aged care facilities [18]. We conducted in-depth interviews (IDIs) to gain a deeper understanding of participants' views and experiences regarding the leadership competencies that influence quality of care in residential aged care facilities (Additional file 1).

Fig. 1 Northern Queensland Primary Health Network Region [24] - Study locations

Study setting

Participants were included from aged care facilities in the region covered by Northern Queensland Primary Health Network (NQPHN) [24] (Fig. 1). Spanning an area of 510,000 km2, approximately twice the land size of the United Kingdom (UK), this tropical environment is home to approximately 700,000 people [24]. Most of the population is located within the regional centres of Cairns, Townsville, and Mackay, while approximately 8% of inhabitants live in remote and very remote areas. The Australian Statistical Geography Standard (ASGS) distinguishes five classes of relative remoteness across Australia (Australian Bureau of Statistics, 2019) [25]. The NQPHN region contains various degrees of geographical remoteness, including inner and outer regional, remote and very remote localities (ASGS 2 – 5). Facilities eligible for recruitment were in ASGS categories 2 – 5 and included for-profit and not-for-profit organisations.

Site selection and participant recruitment

Site selection was conducted using GEN Aged Care Data [26] to obtain a list of 'high performing', non-government residential aged care facilities within the NQPHN region. 'High performing' residential aged care facilities obtained the maximum score (44/44) against the Accreditation standards and as assessed by the Aged Care Quality and Safety Commission in 2019. Targeting of 'high performing' facilities was taken to ensure a 'strengths based' approach to understanding how and in what ways leadership by senior management was positively influencing quality of care.

From the final 14 selected sites, a purposive sampling approach was used to select and recruit individual participants. Purposive sampling took account of participants' current role and relevant experience within the sector to ensure critical reflection on the link between senior manager leadership skills and quality residential aged care in northern Queensland. Selection was designed to achieve a spread of roles (e.g. CEO, Director of Nursing, other administrative leadership roles).

Recruitment was conducted using a combination of email with phone follow-ups. Overall, 19 in-depth interviews (Table 1) were conducted face to face or over the phone with residential aged care managers between December 2019 and January 2020. All participants

Table 1 Description of participants based on professional role, qualifications and ASRG category

Participant	Professional Role	Qualification/s	ASRG Category
1	CEO	Registered Nurse Diploma of Business & Human Resources	2
2	Facility Manager	Registered Nurse Management short course (over 10 years ago	2
3	CEO	Certificate in Business and Hospitality Financial cadetship	4
4	Clinical Care Coordinator	Registered Nurse	3
5	Senior Administration Officer	Certificate IV Administration	2
6	Director of Nursing	Registered Nurse	4
7	Residential Facility Manager	Registered Nurse Industry accreditation short courses	2
8	Facility Manager	Business short courses – no formal qualification reported	3
9	General Manager	No formal qualification	3
10	Director of Care	Emergency Nurse Bachelor of Geography and Social Policy	4
11	Clinical Care Manager	Registered Nurse	4
12	Clinical Care Manager	Registered Nurse	4
13	Clinical Care Manager	Registered Nurse Dip. Leadership and Management	2
14	Facility Manager	Dip. Management Bachelor of Business	2
15	Clinical Operations Manager	Registered Nurse	2
16	Facility Manager	Registered Nurse	4
17	Director of Nursing	Registered Nurse	2
18	Facility Manager	Bachelor of Hospitality	2
19	Facility Manager	Registered Nurse	5

agreed to the interview being audio-recorded, transcribed and were provided with a copy of the transcription as an opportunity to correct or remove data before the analysis.

Data management and analysis

A range of approaches were conducted to ensure the rigour and credibility of the study findings. Handwritten memos were collated immediately after each interview to ensure a reflexive stance was maintained in relation to the research and participants. The data from each interview was transcribed verbatim into separate documents and then checked by the authors for accuracy against the original recording. ND assigned a unique identifier to each transcript denoting the service location: inner and outer regional, remote and remote very localities (ASGS 2 – 5); the participant's managerial title; and the interview number for that service location and position title. Each participant was emailed a copy of the transcript for checking.

Thematic analysis was conducted using NVivo v12 software [27]. Open coding was performed, where codes were created based on identified topics and assigned to specific sections of transcripts [28]. Coding was guided by the study's exploratory and involved giving text from across the dataset to a label [29].

Results

Overview

We present our findings of reported leadership skills under five inductively identified domains i) communication and relationship management, ii) stewardship, iii) professional development, iv) knowledge of the healthcare environment, and v) information technology (IT) and finance. Domains and the leadership skills that fall within them are referred to as 'domains' and 'skills,' respectively to improve clarity. Participants were purposefully grouped into two categories to explore potential differences between the leadership skills described by those with a health qualification ($n=13$) and those without a health qualification ($n=6$).

Communication and relationship management

'Communication and relationship management' skills included a leader's ability to communicate clearly and concisely with internal and external stakeholders, share clinical and industry-related knowledge and employ effective complaint management processes within the organisation. Most study participants strongly emphasised relationship management and communication skills, however skills, including the ability to negotiate with external stakeholders, were less of a focus.

Participants with a formal health qualification reported that a manager's ability to build and nurture collaborative relationships with residents, staff, and external providers was important to promote an organisation's quality performance.

> *"So, when you are dealing with the various stakeholders, trying to be a bit more collaborative as opposed to directive. This can be an effective way to developing rapport and longstanding relationships." Clinical Care Coordinator, Regional Facility, ID4.*

Among health-qualified participants, a key skill was senior managers' ability to share knowledge and build working relationships with other residential aged care facilities. Participants described how this helped design and implement processes that influenced the quality of residential aged care services. Interestingly, senior managers with a health qualification (but not those without) additionally stressed the importance of networking and collaboration with other organisations.

> *"As organisations, big or small, we [senior managers] need to collaborate and share our knowledge. We do not do that very well. We do have a regional facility management group meeting, and we talk. We talk to things that could help with raising quality within our facilities." Clinical Operations Manager, Regional Facility, ID15.*

As an important mechanism for developing positive residential aged care stakeholder relationships, almost all participants with a formal health qualification recommended that senior managers develop the skills to foster trust and rapport with residents and their families. The need for managers to effectively address resident complaints was strongly emphasised as a mechanism to ensure quality of care, as described by one participant:

> *"Your ability to manage complaints is important. It drives positive clinical care outcomes, and it helps to you to effectively negotiate with service providers to come in to look after your community in a way that the community expects." Facility Manager, Regional Facility, ID7.*

To sustain relationships with staff, participants with health qualifications noted that senior managers needed effective interpersonal skills such as active listening techniques to enhance teamwork across all levels of the organisation, as reported by this CEO, who possessed both nursing and business qualifications:

> *"The first thing that comes to mind is being able to listen. I think that is a key thing in terms of managing and caring for people. So, I am opened to lis-*

tening to people. I've certainly learned to be more patient and take in what is happening around me before making a decision that could impact the way that care is carried out." CEO, Regional Facility, ID1.

A manager's ability to build and nurture collaborative relationships with residents, staff, and external providers was emphasised by both health-qualified and non-health qualified participants as important to promoting an organisation's quality performance. As one qualified health practitioner reported:

"You have to understand people, relationships and what drives them. This helps you to pick up how you can get the best out of them. For the residents, you have to understand their story and what they need from you as the provider." Clinical Care Coordinator, Rural Facility, ID3.

Stewardship

'Stewardship' skills encapsulated the ability of senior managers to inspire organisational change and create a positive organisational culture that celebrates the diversity of staff and residents.

When considering the impact of organisational change, both senior managers with and without health qualifications spoke to the importance of interpreting industry regulations that influence health service delivery in the residential aged care sector, particularly during regulatory and legislative change. Among health-qualified managers, one CEO and one Facility Manager particularly emphasised the importance of senior managers having the skills and knowledge to comprehend and monitor legal and regulatory standards to influence quality of care.

"Above all, you need to be aware of and fully understand the frameworks and policies that dictate the way your organisation operates. Without this, you don't know where to start when planning for quality compliance." Facility Manager, Regional Facility, ID22.

"Managers need to be familiar with the legislation or the accreditation, all of the regulatory compliance issues that go with this unique type of industry [residential aged care]." CEO, Regional Facility, ID2.

One Director of Nursing further emphasised the importance of managers being able to interpret regulatory environments and then educate staff and residents regarding quality compliance to ensure quality performance across the organisation.

"Another really important skill is being able to educate patient care team members and the resident on the legislative and regulatory processes and methods for influencing both during daily operations." Director of Nursing, Rural Facility, ID6.

Drawing attention to recent regulatory changes in Australia, including the introduction of the new Aged Care Quality Standards, several health-qualified participants reflected on the way senior managers needed the skills to serve as a 'change agent' to assist staff and residents in understanding reasons for change and to manage resistance to change effectively.

"Sometimes there are people who have worked in this industry for 30 or 40 years and [who] say this is the way they've always done it and they're not going to change, and so then your conversation has to be probably a bit more directive around, well, actually, it needs to change. You need to be a vessel to filter messages around change and make sure that actions follow." Facility Manager, Rural Facility, ID19.

"So, my advice to a new manager is just very comfortable to listen, observe, sit back and understand, and get to know what you're actually dealing with. Without this insight, you will struggle to manage resistance to change." Facility Manager, Regional Facility, ID8.

To minimise employee resistance, one Facility Manager with a tertiary Business qualification emphasised that skills to promote a collaborative approach to decision-making processes were necessary for empowering staff at all levels of the organisation to help embrace and champion change.

"I always aim to be motivating; a motivational leader that staff can follow and be inspired by, particularly when the message of change is on the table." Facility Manager, Regional Facility, ID18.

The ability of senior managers to develop and lead a positive organisational culture was reported across both participant categories as a contributing factor to quality of care. Linking positive organisational culture to high-quality outcomes across the organisation, for example, one participant noted:

"Culture is critical, and something I always bang on about here is that you can walk into a workplace and within five minutes you can actually have a pretty good idea of what the quality of care would be like." Facility Manager, Regional Facility, ID7.

The same Facility Manager also reported that the residential aged care leadership team should possess the skills to define diversity within its organisation.

"So, part of my role is I do some social profiling of our consumers and of our staff, trying to get to know who they are as a community. So, I definitely do try and orientate them to the different cultures and what's important. It helps everyone to feel connected to each other." Facility Manager, Regional Facility, ID7.

Professional development

'Professional development' skills identified by study participants included the ability of a senior manager to create working environments that promoted the accountability of internal and external services to the delivery of quality health care. Skills that were strongly emphasised by both participant categories within this domain included those of mentoring junior staff to participate in opportunities for continuing professional development and lifelong learning. Participants with formal health qualifications additionally emphasised skills relating to promoting staff accountability for residential aged care quality of performance.

"Managers need to devise strategies so that each department is accountable for the health care they provide. This way you are making everyone, regardless of their professional role, accountable for his or her actions. Regularly rewarding and showcasing high quality performance is really important." Clinical Care Coordinator, Regional Facility, ID4.

To promote and sustain quality performance, health-qualified senior managers in this study emphasised the importance of skills to create and foster leadership teams to establish a professional work environment where both internal staff and external health care providers were responsible and accountable. A Clinical Care Coordinator operating in an inner regional residential aged care facility additionally noted that skills to design rewards, and positive feedback mechanisms, were an important part of effective leadership.

The capacity of senior managers to mentor junior staff and seek mentorship from respected colleagues was specified by both participant categories as an important residential aged care leadership skill.

"And I guess accessing mentoring is also important. Accessing other managers, who are really high performers and working ways to integrate this into your routine, can only help professional development." Facility Manager, Rural Facility, ID7.

Of the qualified health practitioners interviewed, three Facility Managers reported that skills to mentor and coach junior managers to deliver sustained care quality within an organisation were important. Relatedly, participants with and without formal health qualifications described the self-awareness and opportunity of senior managers to actively seek mentorship from respected colleagues as an important skill within a residential aged care facility.

"Accessing mentoring was also important. Accessing other managers, and looking at, developing through them." General Manager, Regional Facility, ID9.

Knowledge of the healthcare environment

Skills linked to a manager's understanding of competencies that influence qualitythe health care system and environment in which they operate were categorised under 'Knowledge of the health care environment' and were primarily referenced by participants who possessed a formal health qualification. Four participants, spanning different managerial roles and geographic areas of remoteness, suggested that senior managers require health knowledge to understand and interpret the scope of practice for the multiple and varied health care professions working within a residential aged care facility.

"Every manager should have basic clinical skills that you can continue to build on in whichever direction you need to through education and other avenues. Overall, you need to know what your staff are meant to be doing to ensure a safe, quality service." Facility Manager, Rural Facility, ID 19.

One Director of Nursing also reported that senior managers required a developed knowledge and understanding of how to assess and observe clinical interventions.

"So, your clinical assessment and observation skills need to be really on the ball if quality is to prevail." Director of Nursing, Regional Facility, ID17.

One Facility Manager mentioned the importance that senior managers have the knowledge to assess quality and safety performance, noting it was necessary to reward positive behaviours for staff who promote safe and quality health care practices.

"I always go back, and I complement them, and I do that often in front of the team at handover, saying this was really good in regard to your safety documentation. You were clear. So, my compliments are also very specific." Clinical Care Coordinator, Regional Facility, ID4.

Of note, throughout most participant interviews, service quality was predominantly framed in relation to general business operations rather than quality of health care per se.

Information technology and finance

Interviewees across both participant categories recommended residential aged care senior managers develop the knowledge and skills to promote the use of IT platforms within their organisations. Strategies included residential management teams employing innovative IT to deliver staff education regarding resident quality outcomes. IT was also reported as an approach to support the successful integration of regulations, including the new Aged Care Standards. Two managers located in inner regional residential aged care facilities reported that education contributed to increased knowledge across the organisation and a greater opportunity for high-quality care to be achieved.

> *"Yeah so it's about having information systems. So, it's important to have a structure where we have a forum where they concentrate on different topics to enhance the skills and knowledge or out staff across multiple areas." Facility Manager, Regional Facility, ID16.*

The ability of a senior manager to encourage the use of IT platforms was also linked to increased residential aged care efficiency and accuracy with documentation and quality reporting requirements, as emphasised by one General Manager who did not possess a health qualification.

> *"Senior managers must be aware of IT that can support quality reporting and compliance in line with its unique organisational profile. Senior managers must have knowledge regarding the operation of RACF IT platforms." Facility Manager, General Manager, Regional Facility, ID9.*

Another participant who possessed a tertiary qualification in Business and management experience within the hospitality industry strongly emphasised the importance of recognising finance's role in quality improvement programs. This participant reflected that senior managers should possess the skills to effectively oversee the residential aged care financial position and ensure that appropriate resources are available to support high quality care.

> *"If you want to see quality outcomes, you need to know how to budget for quality staff, technology and other resources. Quality health care costs money." Facility Manager, General Manager, Regional Facility, ID18.*

Discussion

Drawing on interviews with 19 individuals across 14 facilities in northern Australia, this study brings new knowledge regarding the leadership skills that Australian residential aged care senior managers perceived to be critical for promoting quality of care in often challenging regional, rural, and remote facility settings. Five domains of skills were identified by participants, including i) communication and relationship management skills; ii) stewardship skills; iii) professional development skills; iv) knowledge of the health care environment; and v) information technology and finance skills.

Overall, we found that participants emphasised communication and relationship management skills. Participants noted that senior managers' ability to develop and nurture stakeholder collaborations, particularly those with clients' families, regulatory bodies, and external service providers, was essential given the challenging resourcing environment in which many facilities operated. Communication and relationship management skills were also essential for workforce recruitment and retention in the face of resource shortages. Although often focused on health services generally rather than residential aged care, other studies have similarly identified effective staff communication strategies as an important leadership skill. Focusing on rural settings, for example, Lehmann et al. (2005) and Moosavi et al. (2020) showed that staff communication strategies often improve levels of employee job satisfaction [30, 31]. Moreover, the authors described the formation of mutual manager-employee relationships to enhance teamwork and self-reported employee well-being levels within an organisation [32].

Relatedly, stewardship skills, such as the ability to competently interpret and translate the increasingly complex regulatory requirements of the Australian aged care sector into facility-level strategies and operations, were noted as important. These findings draw attention to the importance of understanding the unique regulatory requirements of the aged care sector, and align with what is known about the importance of stewardship skills in mainstream healthcare. In a study involving healthcare managers in Swedish hospitals, for example, Andreessen et al. (2016) suggest that senior managers play an important role in supporting organisational change and should possess the knowledge to inspire new approaches to quality care [33]. Moreover, health care leaders contribute to strategic directions through their participation in senior-level decision-making about patient flow and staffing, quality improvement activities, and continuous learning opportunities to improve overall care delivery [34].

Findings from the current study support the importance of residential aged care senior managers' having adequate health knowledge to influence quality of clinical care, with a sub-set of participants reflecting on the importance of health knowledge for designing and overseeing efficient, effective and client-centred

clinical care. Participants with formal health qualifications reported knowledge of health professional scope of practice as important for assessing and monitoring the quality performance of staff. Such findings align with previous research in mainstream settings showing effective clinical leadership is linked to various functions [35] such as the achievement of regulatory objectives and timely care delivery [36]. In both mainstream and residential aged care settings, clinical knowledge is important to a manager's capacity to form and enact quality-improvement systems [37]. To monitor compliance within these systems; however, findings from the current study additionally pointed to the importance of leadership skills to engage with and promote contemporary IT platforms as a strategy to enhance the accuracy and efficiency of quality reporting.

Interestingly, we found differences in emphasis on leadership skills between health qualified, and non-health qualified participants. The importance of leadership skills in the area of change management and strategic planning, for example, were emphasised by those with tertiary business qualifications but not by those with health qualifications. Likewise, financial management skills, including a manager's ability to recognise the role of finance in quality improvement programs, were only reported by those with a formal business education. Conversely, participants without formal health qualifications did not mention health and health environment knowledge as critical skills. Such findings may indicate how particular professional backgrounds equip individuals with some, but not all, skills required to deliver leadership across the spectrum of residential aged care operations. With growing awareness of the range of clinical and business-related leadership skills likely necessary in this domain [10, 13], these findings emphasise the need for further work to establish a framework of leadership competencies for aged care and better understand the differentiated professional development needs of those with health and non-health backgrounds [6].

Although findings from the current study provide an important first step in addressing the evidence gap relating to leadership skills required by senior management personnel in Australia's residential aged care facilities, we recognise that they are not comprehensive. Due to resource constraints, this study was not able to include residential aged care facilities owned and managed by government. This is a potential limitation as the unique regulatory and funding structures influencing the senior management role in government organisations are not represented in the study findings. Also, the focus on high performing aged care facilities may have limited the scope of study findings. Future research, including lower-performing organisations may broaden the category of themes identified in the current study and further enhance public discussion of leadership skills that influence the quality of residential aged care across a broader range of organisations. We also acknowledge that selected participants were from residential aged care facilities in northern Queensland. No participants managed facilities in major cities (ASGS-1), and the inclusion of such localities may have allowed additional exploration and comparison of the leadership challenges to quality care across multiple areas of geographical remoteness, broadening the generalisability of study findings.

Conclusion

To better understand the optimal skill–mix of managers who lead Australian aged care services, the Royal Commission into Aged Care Quality and Safety - Final Report recommends that aged care leadership accountabilities and professional development strategies be better defined. This recommendation includes that residential aged care senior managers possess professional qualifications or high-level experience in management roles while receiving the continuous learning required to positively influence the quality of residential aged care within an increasingly complex health care environment. Yet, understanding of the critical skills needed by senior managers in Australian residential aged care is limited. In this study, we aimed to reduce this evidence gap and explore senior managers' perspectives about which leadership skills are required to deliver high quality care in regional, rural and remote area residential aged care facilities.

Our findings demonstrate that senior managers view communication and relationship management skills and the ability to strategically plan and manage change as critical to ensuring service quality. Participants with different professional qualifications often emphasised certain leadership skills but did not mention others. For example, only those with formal health qualifications linked health knowledge and clinical skills to increased quality of care. Building on these important findings, further research is required to explore leadership skills and quality of care in government-owned residential aged care facilities to enhance the generalisability of research findings in this area. With ongoing concerns and challenges to residential aged care quality of care, more work is needed to identify sector-specific professional development strategies that prepare residential aged care senior management personnel with the appropriate skills to positively lead quality care within an increasingly complex environment.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-022-08049-4.

Additional file 1.

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Authors' contributions
ND was responsible for collecting and interpreting the participant data. ND and ST were both responsible for data analysis. ND conducted the primary manuscript draft. ND and ST both completed subsequent manuscript revisions. Both authors read and approved the final manuscript.

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Availability of data and materials
The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethical clearance was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019. All methods were carried out in accordance with relevant guidelines and regulations. Informed consent was obtained from all subjects.

Consent for publication
All participants provided verbal and/ or written consent for data to be published.

Competing interests
No potential conflict of interest was reported by the authors

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Publisher's Note

Appendix 4: Peer-Review Publication – 'Senior manager competencies for quality residential aged care: An Australian industry perspective'

Dawes N and Topp S (2022) Senior manager leadership competencies for quality residential aged care: an Australian industry perspective. BMC Health Services Research, 22.

Abstract

Background

Documented poor quality and standards of care in Australia's residential aged care (RAC) sector have highlighted a need to better understand the role of and skills required by RAC senior management personnel to address these concerns. This study examined which senior management leadership skills and personal qualities are necessary to deliver and strengthen the quality of RAC, with the aim of improving understanding of the professional development needs of leaders in the sector.

Methods

We conducted 12 in-depth interviews with Australian aged care industry experts, including academics, and representatives from the primary health network, consumer, and provider advocate groups. Abductive, thematic analysis incorporated coding derived from existing leadership skills frameworks as well as inductively identified themes.

Results

Identified leadership skills were grouped into five domains including i) workforce development and retention, ii) governance and business acumen; iii) health systems knowledge; iv) stewardship and v) responding to regulatory and political contexts. Skills particularly emphasised by participants were those required to recruit and retain a skilled workforce, manage relationships, and promote a positive organisational culture and employee wellbeing.

Conclusions

RAC senior managers require a complex mix of business, human resource management, and clinical skills to deliver quality care in Australia's complex RAC setting. The lack of any professional development framework to guide the acquisition or updating of those skills is a concern.

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BMC Health Services Research

RESEARCH Open Access

Senior manager leadership competencies for quality residential aged care: an Australian industry perspective

Nathan Dawes* and S. M. Topp

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Keywords: Leadership, Management, Skills, Residential aged care, Industry experts

Background

The global population is rapidly ageing [1]. In 2020, there were approximately 980 million individuals aged 60 years and over and by 2050 this figure is expected to reach 2.1 billion [1]. Australia is no exception, with approximately 25% of the population projected to be 65 years and over by 2057 [2]. As the proportion of Australia's aged population increases, there has been a concurrent rise in demand for residential aged care (RAC), care that is capable of delivering high-quality services to older persons with complex co-morbidities such as multiple chronic non-communicable diseases and dementia [2]. Yet, the inadequacies of Australian RAC services made public as part of the *Royal Commission into Aged Care Quality and Safety*, demonstrated numerous incidences of neglect and substandard clinical services [3]. The same commission identified leadership skills and strategies required by managers to promote quality of care as lacking, by comparison to international RAC services and

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other Australian mainstream health care organisations [3].

Leadership is considered a foundation stone for improving health care quality [4] and includes the ability to identify priorities and provide strategic direction to multiple actors within the health system [5]. Effective health leadership supports and fosters a culture of continual learning and improvement; a culture that ensures care recipients are at the centre of care planning and delivery and where staff are supported to provide safe, effective and compassionate care [5]. Xing, Song and Yan (2020) also suggest the personal qualities of health care leaders are linked to increased quality through the effects they have on staff wellbeing and patient engagement [6], and the empowerment of care recipients to make informed decisions regarding their own care [7]. Leadership that promotes and enables patient engagement contributes to improving quality of care, producing better health outcomes and often reduces health care costs [7].

While leadership is conceptualised in many ways, most frameworks recognise four central characteristics [8]. Respectively, these include i) leadership is a process, ii) involves different forms of influence, iii) occurs in groups and iv) involves clear vision and a common goal [8]. In health care, a *skills perspective* (approach) to leadership is often adopted [8], with a view to strengthening the quality outcomes of an organisation by recognising the abilities required to lead quality performance [9]. While health care leadership is a broad term, with a diverse range of applications [10], the *skills perspective* can be used to identify and describe the competencies (knowledge and skills) that are required by managers to influence high-quality care across multiple health care settings, including residential aged care [1]. Here, we define a leadership competency as an expected level of performance that results from an integration of knowledge, skills, abilities and judgment and recognise such attributes as integral to influencing quality [11]. Extending this definition, leadership attitudes and behaviours can also be considered important leadership characteristics that contribute to high-quality care [12].

Although the term leadership competency is used interchangeably with other related concepts including leadership traits, capabilities and attributes, it is important to acknowledge that the definition and application of each term differ [13]. Traits are ingrained behaviours that are mostly permanent and difficult to change [14], whereas attributes are usually understood to be specific behaviours learned as part of external experiences [15]. Leadership competencies are a way of measuring how well an individual does certain things, taking into consideration knowledge, skills and attributes [16]. Competency differs from capability. Whereas capability may be defined as having the ability to do something (with improved capability arising from the improvement of skills), "competence" references the degree of skill in the task's performance [17]. Improved capabilities may lead to competence [18].

Substantial research has been conducted around leadership skills in mainstream health care organisations [11]; yet comparatively little is known about the skills or combinations of skills required in the distinctive setting of residential aged care [18]. It is therefore important to recognise that the demands of, and thus skills required by, managers in residential aged care services may differ from other health care organisations. The continuous nature and complexity of clinical services required by RAC residents [19]; specific regulatory requirements associated with the RAC sector, and facility-level business operations that must accommodate both clinical and broader lifestyle considerations [19], all highlight the need for leadership capabilities that include (a combination of) skills distinct from those required in non-residential mainstream healthcare organisations [18]. With the demand for residential aged care services increasing in Australia and concurrent concerns regarding the quality of that care [2], there is a clear need to understand which types and combinations of skills are required by senior managers to provide effective leadership in this complex landscape.

The Australian Aged Care Leadership Capability Framework was developed by Aged and Community Services Australia [ACSA] in 2014. This framework is behaviorally based, and the capabilities are illustrated by a set of indicative behaviours appropriate to multiple levels of leadership, including frontline, middle and senior management roles [20]. The design of the framework is indicative of an intent to provide broad guidance to leadership across a range of aged care agencies, acute, community and residential aged care provider organisations [20]. However, the Australian Aged Care Leadership Capability Framework (2014) makes no specific mention of the senior manager role, nor the competencies linked to this leadership responsibility and high-quality care, beyond mention of the capability of 'person-centred focus.' Indeed, to the author's knowledge, no sector-specific skills or leadership competency frameworks focusing on the professional development and attainment of competencies required by RAC senior managers to promote quality of care has been produced in Australia. Moreover, few studies have explored the topic in-depth.

Recent reviews of the literature have synthesised evidence concerning the role of leadership in promoting quality of care in residential aged care, globally. In a scoping review of the literature that focused on senior management leadership to promote quality of care in

residential aged care, Dawes and Topp (2019), for example, found 14 studies, the majority of which focused on leadership styles, not competencies; and the majority of which ($n=12$) reported on RAC in the United States of America [21]. Moreover, Jeon, Merlyn, and Chenoweth (2010); and Zonneveld, Pittens, and Minkman (2021) each explored the role of leadership across multiple organisational levels, with findings that focussed on leadership behaviours connected to certain leadership styles including relationship-oriented, task-oriented and context-dependent leadership [22, 23]. Most recently, an original research study by O'Toole, Bamberry and Montague (2021) examined the perceptions of leadership by senior managers and identified the crucial requirements for successful leadership within the Australian residential aged care industry [24]. Findings clearly demonstrated recognition among senior managers that effective leadership skills are required to successfully deliver quality care and resident satisfaction (O'Toole, Bamberry and Montague, 2021) but reported leadership competencies were again considered across multiple organisational levels with none specifically linked to the senior manager role [24].

With a view to addressing the gap in current knowledge regarding the combination of skills required by residential aged care senior managers in Australia, this study aimed to qualitatively explore the views of a range of aged care industry experts regarding the senior management leadership competencies required to ensure quality of care.

Methods

Study design

We conducted an exploratory qualitative study to understand, from the perspective of Australian aged care industry experts, the leadership competencies required by Australian RAC senior managers to influence high-quality care. For the purpose of the current study, Australian aged care industry experts are those in a professional role that is either an aged care researcher, primary health network representative, consumer or provider advocate.

Qualitative methods support the examination of underlying reasons, opinions, and motivations of individual participants. We conducted in-depth interviews (IDIs) using probes such as 'why', 'how' and 'what' to gain a deeper understanding of participants' views and experiences regarding the senior manager leadership skills that influence quality of care in Australian RAC organisations.

Study setting

The current study was completed with representatives who contribute to or advise regarding the delivery of aged care services in Australia. Examples of different 'levels' of aged care include: i) entry-level community-based care at home; ii) higher levels of care at home (Home Care Packages Program), and when living at home is not an option iii) residential aged care [25]. This study focused specifically on the role of senior managers in providing quality care in the Australian residential aged care setting. Residential aged care provides health care services and accommodation for older people who are unable to continue living independently in their own homes [26].

In Australia, residential aged care providers can span a range of different sectors including religious, charitable, community, for-profit and government organisations [26]. Typical services may include accommodation, personal care assistance, clinical care and a range of social care activities including recreational activities and emotional support. Approximately 250,000 older Australians received permanent residential aged care at some time during the financial year 2019/2020 [27].

Participant recruitment

Industry representatives [experts] engage with stakeholders across multiple levels of the Australian aged care system and inform sector-wide policy development and governance arrangements [28]. We identified three major groupings of industry representatives. First, those who work for national peak advocacy bodies that provide support, advocacy, and policy development services for their members [29]. Peak advocacy bodies provide a mechanism for collating and representing the experiences of a heterogeneous membership, on issues relating to consumer and labour protections, quality of care and aged care regulation [28].

The second group of industry experts include those working for primary health networks (PHNs) statutory bodies funded by Australia's federal government [30]. By conducting population needs assessments and commissioning services, PHNs aim to improve health care efficiency and effectiveness (particularly for those at risk of poor health outcomes including older care recipients) and enhance the coordination of health services at local, regional and national levels [30]. PHN representatives possess the skills and knowledge to evaluate and monitor the effectiveness of health services against local population health needs, including those provided in RAC [31]. They also provide education and training aimed at developing workforce skills to positively influence quality performance and are thus well-positioned to describe the link between senior manager leadership skills and quality of care delivered by Australian aged care services [31].

The third group of experts are aged care researchers who aim to improve understanding of, and produce evidence, tools and resources to improve, health and policies and services in the aged care sector [32]. Like peak

body advocates, aged care researchers tend to engage with a variety of stakeholders with a view to exploring or developing knowledge to inform national policy or implementation [28, 32] including the skills required to develop leadership training programs for managers to drive best practice at national and facility levels [10].

Purposive sampling was used to identify and select information-rich participants from the three expert groupings described earlier, with knowledge of and experience working within the Australian aged care sector. Participant selection was deliberate and aged care industry experts were recognised as possessing specific knowledge of health service needs of older persons in Australia and capable of reflecting critically on the link between senior manager leadership skills and quality RAC. Snowball sampling was employed to incorporate eligible participants who may have been missed during initial recruitment. Two additional interviewees were recruited using this technique. To be included in the study, participants were required to: i) be aged 18 years and above and ii) be either an aged care researcher, primary health network representative, consumer or provider advocate.

Using a combination of aged care industry experience and a comprehensive desk search, the first author (ND) developed a list of eligible individuals and organisations using public access contact information including Primary Health Network organisations, Department of Health government websites, national research institutes and Australian University websites. Participants were then emailed an invitation for involvement. Participants were also deemed as eligible for participation if they represented national government committees including the National Aged Care Advisory Council and Aged Care Sector Committee. Both government committees support aged care policy development and implementation.

Overall, 12 in-depth interviews were conducted by ND between December 2020 and February 2021, via video conferencing ($n=11$) and telephone ($n=1$). Interviews were conducted with provider advocates ($n=6$), consumer advocates ($n=3$) researchers ($n=2$) and primary health network (PHN) representatives who are involved in commissioning Australian aged care services ($n=1$) (Table 1). One participant who was an aged care Researcher also represented the National Aged Care Advisory committee, while two consumer advocates were members of the Aged Care Advisory group.

The interview guide canvassed the role of the industry expert, their perceived link (if any) between senior managers and RAC quality of care, current and potential challenges associated with delivering high-quality RAC, and the leadership skills required to address these concerns. All participants provided written informed consent and agreed to the interview being audio-recorded and transcribed. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data prior to the analysis.

Data management and analysis

Abductive, thematic analysis incorporated coding derived from existing leadership skills frameworks as well as inductively identified themes. To identify major and minor themes, we took the following steps: i) handwritten memos were collated immediately after each interview to ensure that a reflexive stance was maintained in relation to the research situation, participants and documents under study; ii) familiarisation through careful and repeated reading of transcripts and research memos, noting emergent themes; iii) each individual participant was emailed a copy of the transcribed verbatim to ensure that the investigators records corresponded with those of

Table 1 Description of participants based on professional role and organisation type

Participant ID	Position	Organisation Type	Government affiliation
1	Chief Executive Officer (CEO)	Provider advocacy	
2	National Policy and Advocacy Manager	Provider advocacy	
3	Chair of Board – Non – Executive Director	Consumer advocacy	Aged Care Advisory group
4	Chief Executive Officer (CEO)	Consumer advocacy	Aged Care Advisory group
5	Chief Executive Officer (CEO)	Provider advocacy	
6	Senior Policy and Engagement Officer	Provider advocacy	
7	Professor – Academic	Research Institution	National Aged Care Advisory committee
8	Queensland State Manager	Provider advocacy	
9	Program Director	Research Institution	
10	Executive Director	Provider advocacy	
11	Project Manager – Aged Care	Primary Health Network	
12	President	Consumer advocacy	

the participants from whom those data were derived; iv) open coding in which codes were created based on identified themes, codes were assigned to specific sections of transcripts; v) data display using matrices including summary tables.

Results

Overview

We present findings from this qualitative analysis under five inductively identified skill domains including i) workforce development and retention, ii) governance and business acumen; iii) health systems knowledge; iv) stewardship and v) responding to regulatory and political contexts. In the following sections, these overarching domains, and the more specific leadership skills they encompass are referred to simply as 'domains' and 'skills' respectively to improve clarity. Interview participants are identified only by generic labels (as outlined in Table 1) of 'consumer advocate', 'provider advocate', 'Primary Healthcare Network' or 'Researcher'.

Workforce development and retention

Skills in this domain included a manager's ability to develop a workforce with an appropriate balance of clinical skills across the organisation. To achieve this optimal skill mix, a manager's ability to recruit health care personnel across key service areas, with the knowledge to service a range of complex co-morbidities and psychosocial needs specific to an older demographic, was reported by a majority of participants as critical to quality of care.

> *The ability of a leader to choose, recruit and retain key people across the core health services areas is so important to delivering quality care***Consumer advocate – ID4**

Critical to being able to support recruitment and retention, five participants comprising both provider and consumer advocates, additionally noted the importance of human resource management skills; including the ability to negotiate with staff and being compassionate to an employee's needs within and outside of the workplace.

> *Human resource management is so essential to making quality health care occur.***Provider advocate - ID2**

Alongside these more technically oriented skills, a majority of participants including primary health network representatives, consumer and provider advocates, collectively highlighted the importance of a senior manager's relational skills. Key amongst these was the ability to nurture and build relationships with staff, communication skills and building peer support networks. The ability of senior managers to develop rapport and trusting relationships with staff, for example, was described as promoting open channels of communication among interprofessional teams and thus promoting high-quality care.

> *So, it's being personable and being able to develop that rapport with your staff so that they trust you and they feel like they can come to see you to discuss anything regarding the health care services that they are responsible for providing.***Provider advocate - ID2**

Another participant emphasised the importance of a manager's ability to employ communication skills involving empathy and active listening techniques, as essential to creating therapeutic relationships with residents and their families and to positively influencing care quality.

> *I think every person who works in aged care, whether they're a leader or not, needs to have good communication skills in order to be able to engage in a therapeutic manner with residents, and so communication skills involve imparting empathy and involve listening.***(Researcher – ID9)**

External to the organisation, a manager's ability to build and nurture peer support networks with other RACFs, to share expertise around business models that promote quality of care, improve business knowledge, and receive peer mentorship, was also emphasised as an important leadership skill by four provider advocates:

> *People should start to build collaborations across other [aged care] organizations ... so that they can bring in really top-quality people.***Provider advocate – ID5**

> *Make sure that you've got a good peer network around you that you reach out for that support.***Provider advocate – ID8**

Governance and business acumen

The ability of senior managers to create a governance structure to delineate power and define management roles in an organisation, was linked to quality of care. Participants viewed this skill as a strategy for managers to set rules, procedures, and other informational guidelines to quality improvement. Researchers, primary health network representatives, provider and consumer advocates reported skills under this domain and linked these to quality of care.

A provider advocate emphasised that senior managers should possess the knowledge to develop an organisational structure that provides executives and managers

the opportunity to make informed decisions regarding health care delivery.

> *The organisational structure must be designed by managers so that they can support themselves ... to free up their time to make the best decisions for their health care services**Provider advocate – ID10***

A consumer advocate emphasised the importance of senior managers possessing the skills to successfully lead the operational aspects of an organisation that are linked to service provision, such as compliance management and management of resources.

> *Again, leaders need to be committed to older Australians and be able to smoothly run high level operations in order to positively influence the quality of their service**Consumer advocate and Aged Care Advisory group member – ID4***

Critical to being able to support the sustainability and quality of RAC health care services, several consumer and provider advocates additionally noted the importance of a manager's business skills such as financial management, human resource, and people management skills, as a factor contributing to quality of care. As reported by this provider advocate:

> *So, there's significant financial management, sales significant clinical skills and significant human resources skills, and people management skills that are required**Provider advocate – ID2***

The capacity of a senior manager to be strategic in planning operations was also emphasised as an important leadership skill for RAC in Australia. As described by the provider advocate below, such skills were linked to effective planning to meet challenges and identify opportunities for handling the increasingly complex political, regulatory and clinical landscape of RAC in Australia:

> *I think being strategic as well. So looking at opportunities and, as you were talking about before, innovation, thinking outside the square to get the best possible care for the resident.**Provider advocate – ID6***

Health system knowledge

Skills and strategies associated with a manager's understanding of the health care system and clinical environment were noted by a number of study participants. External to their specific facility, interviewees linked quality performance to the ability of senior managers to recognise the variations between mainstream health care organisations and RAC service provision. Five participants, who were researchers, provider and consumer advocates reported skills under this domain.

One researcher described that the quality of RAC should be focused on maintaining an older person's quality of life, which required a unique set of leadership skills:

> *So it is important to recognize the differences between acute care where the focus is on diagnosis and treatment, and aged care, where the focus is more about quality of life. It takes very different managerial skills to effectively manage each context and those who lead these organization's need to recognise this.**Researcher and National Aged Care Advisory Committee member– ID7***

In addition to providing oversight to the clinical aspects of RAC, study participants across all expert categories suggested that senior managers should themselves possess clinical knowledge and skills to successfully embed quality health care practices within the organisation. Clinical skills included managers' ability to recognise effective clinical care models that address the health care needs of an older demographic and the ability to recognise clinical outcomes to care.

> *I think a problem where we separate out residents needs into biomedical needs, clinical needs and social needs and accommodation needs .... We need a consistent model of care that focuses solely on caring for the individual**Researcher – ID9***

> *You must have a keen eye towards resident outcomes, and I would be as broad as to say clinical quality outcomes and customer experience outcomes, all of these clinical attributes are important for a manger to possess and be aware of**Provider advocate – ID 10***

One researcher suggested that if senior managers did not possess a sound level of clinical knowledge, then residents' needs could be missed or neglected.

> *So, I think the fact that we now have a lot of leaders who don't have any healthcare background has put us in a situation where resident's clinical care needs often missed and neglected.**(Researcher National Aged Care Advisory Committee member – ID7)***

Stewardship

'Stewardship' encompassed leadership skills to create a positive workplace culture through creating a physical environment that encouraged employee wellbeing; promoting team cohesiveness; and helping team members overcome negative industry perceptions.

The ability of a senior manager to create a physical environment that encouraged employee wellbeing, was linked by study participants to positive workplace culture

and high-quality care. The skills to promote such a physical environment included the ability to develop a workspace that promotes employee and resident comfort, with one consumer advocate describing the links to employee job satisfaction and retention and resident quality of life:

> *Coming to work at a place that is comfortable each day will only improve employee performance to delivering quality care***Consumer advocate Aged Care Advisory group member – ID4**

Leadership skills to promote team cohesiveness were also linked to increased workplace culture and organisational quality performance.

> *If you have a good leader, you could be working in a positive and cohesive team even though; the situation around you feels quite dire***Provider advocate – ID1**

Additionally, and potentially specific to the Australian context, participants reported the importance of stewardship skills to overcome negative public perceptions regarding RAC (in light of negative accounts heard during the recent *Royal Commission into Aged Care Quality and Safety*). The capacity to manage such perceptions were also linked to promoting a positive organisational culture and staff retention.

> *I think probably the biggest challenge is the negativity within the media for the bad cases and the lack of media interest in a good case. So, it is more difficult for them to get and retain staff because of that***Consumer advocate Aged Care Advisory group member – ID4**

Responding to regulatory and political contexts

'Responding to regulatory and political contexts' included the leadership skills required by senior managers to successfully interpret and respond to Australian aged care regulatory change. Researchers, provider and consumer advocates interviewed as part of this study reported skills under this domain and linked them to quality of care.

Two provider advocates suggested that while the current aged care regulatory environment can be difficult to interpret, that senior managers need to be proactive to lead RAC regulatory compliance. This process was described as senior managers initiating partnerships between regulators and their organisation to ensure a joint approach to regulatory compliance.

> *Providers do need to actually look at themselves and see how they contribute to improving the overall situation ... which would suggest more of a partnership-based approach between regulator and provider rather than a compliance focused approach of seeking out and punishing wrongdoing***Provider advocate – ID2**

In addition to forming external relationships with regulatory authorities, some participants emphasised that senior managers further develop their lateral thinking skills to assist in interpreting and responding to the evolving aged care regulatory and political context. This includes the ability to recognise and interpret regulatory reform and to successfully translate this change to RAC operations in order to sustain quality health care delivery.

> *So, I think those external factors really require a leader to be really adaptable, to be mobile, to be a lateral thinker and responsive to the regulatory and political surroundings, in order to be effective for health service delivery***Consumer advocate – ID12**

Discussion

Quality of care in Australian RAC has been identified as lacking, and the Royal Commission pointed to leadership as a key area requiring improvement [19]. To date, however, evidence regarding the types and combinations of leadership skills required by senior managers who lead RAC is limited [21]. Drawing on and triangulating the perspectives of experts from provider and consumer peak advocacy bodies, Primary Health Networks and aged care researchers, this study highlighted five major domains of leadership skills likely required by Australian RAC senior managers to influence quality of care, respectively: i) workforce development and retention, ii) governance and business acumen; iii) health systems knowledge; iv) stewardship and v) responding to regulatory and political contexts. Skills particularly emphasised by participants were those required to recruit and retain a skilled workforce, manage relationships, and promote a positive organisational culture and employee wellbeing. Such skills are intuitively important and noted elsewhere to be central in mainstream healthcare leadership [33, 34]. However, the emphasis on these skills as part of the current study also reflects the specific context and a number of macro-through-micro level challenges of the Australian RAC sector, including regulatory change [35] ongoing human resourcing challenges [36], and longstanding issues with work culture and morale [37].

Findings from the current study demonstrated industry experts' perception of a strong link between a manager's relational skills and RAC quality. These abilities included communication techniques that enable the formation of partnerships and therapeutic relationships with care recipients, their families and other immediate caregivers. Previous studies have shown the importance

of effective communication with older people as a critical aspect of care quality, with ineffective communication skills often leading to older care recipients feeling inadequate, disempowered and helpless [38]. In the current context of Australian RAC, in which documented challenges to skilled workforce retention [3, 36], ongoing regulatory reform [35] and workplace culture [37] have been recently discussed, industry experts, linked the skill of partnering with care recipients, to influencing improved clinical outcomes and increased levels of health literacy. Specific to acute health care settings, research has also demonstrated that, from a quality-of-care perspective, the ability of managers to develop proficient communication skills, including active listening techniques often increases the accessibility and appropriateness of healthcare for older individuals [39].

Participants from the current study reported that senior managers' knowledge regarding the design and implementation of clinical care models and other innovations, was important to achieving quality RAC. Study participants further stressed that effective senior managers required clinical knowledge and skills to address the unique and diverse health care needs of older persons. Such findings are likely to at least partially reflect concerns about widespread lack of regulatory compliance and poor quality of clinical care in the Australian RAC sector, as documented in the 2021 Royal Commission [3]. Previous studies, although mostly located in mainstream health care organisations, have also described a connection between a manager's health systems knowledge, clinical skillset and quality of care. For example, Parand (2014) & Andreasson et al. (2017) both found that effective managers who positively influence care quality possess a range of technical skills including knowledge about treatments and technologies, health care services, and the health care environment in which the service is situated [40, 41]. In addition, Australian health agencies including the Agency for Clinical Innovation, affirm that a health service manager is central to the design and implementation of innovative clinical care models in promoting quality performance [42].

An intuitive but important finding from this study was the emphasis placed by participants on managers' skills to recruit and retain a workforce with a diverse skill-set. Karan et al. (2021) describe human resources for health as a core building block for the quality of services across multiple settings [43] and previous research has also found that investment in more diverse staff and skill-mix can result in improved quality of care, quality of life, and employee job satisfaction [44]. A balanced practitioner skill-mix and healthier organisational culture was found by Braithwaite, Herkes, Ludlow, Testa & Lampree (2017) to positively influence health care outcomes, such as reduced mortality rates and increased quality of life [45].

Although much of this empirical work to date has been specific to mainstream health care organisations, participants from the current study confirmed the importance of these leadership skills in RAC settings too, additionally reporting skills required to enhance workforce capacity and development, such as the ability to promote a positive organisational culture and safe physical environment that supports employee wellbeing and promotes job satisfaction. As with knowledge of clinical skills, the emphasis placed by participants – particularly provider advocates – on such skills is likely influenced by the current Australian context in which low pay [46], challenges to workforce recruitment and retention [46] and weak morale [47] have all been documented.

Combined, the findings highlight the complex and multi-dimensional leadership skills required by modern RAC senior managers. Balancing a need for business and human resource acumen, with clinical expertise and relational skills implies the potential need for highly targeted professional development frameworks and support packages if industry-wide strengthening in leadership is to occur into the future. This study is the first building block in that effort.

As with the majority of studies, the design of the current study is subject to limitations. Firstly, purposive sampling was used to recruit interview participants from three categories of experts (peak bodies, PHNs, and researchers), however not all participants were able to interview due to scheduling or other issues. As a result, half the study participants were provider advocates, whose primary focus is to support the viability and sustainability of aged care service providers [28]; these experts are potentially less likely to consider the resident experience and personalised health care needs. Conversely, consumer advocates play an important role in advocating for the older person and speaking on behalf of that individual in a way that best represents their interests [48]. With an intense focus on the individualised health care needs of older Australians, consumer advocates may have less understanding of the structural elements that adversely influence RAC quality, and the leadership competencies required. Finally, although 31 Australian PHNs represent jurisdictions defined by geographical scope, our study only included PHN representatives from North Queensland and thus likely reflected some concerns specific to that region.

While acknowledging these limitations of representation and standpoint, the use of purposive sampling was deliberately used to ensure representation of all types of expertise in some form. Close attention was paid to the positionality of each expert during analysis which

included systematic triangulation of data from different experts. Further work will be important to broaden and deepen understanding of the field, nonetheless, the current findings constitute an important contribution to the field by delivering a starting point for mapping key leadership skills required by Australian RAC senior managers.

Conclusion

With the demand for residential aged care in Australia increasing and concurrent concerns regarding the quality of that care, a better understanding of the leadership skills required to optimise quality performance is urgently required. The lack of any professional development framework to guide acquisition or updating of those skills is a concern; and overall, there remains a poorly defined link between quality of care and leadership in the context of Australian RAC. This study aimed to reduce this evidence gap and examine the senior management leadership skills necessary to deliver and strengthen the quality of RAC. Findings demonstrated that aged care industry experts view a range of technical, relational and administrative skills as critical to ensuring service quality. However, with ongoing concerns and challenges to RAC quality of care, more work is needed to prepare senior management personnel with the appropriate skills to positively lead quality care within Australia's evolving RAC setting.

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Authors' contributions
ND was responsible for collecting and interpreting the participant data. ND and ST were both responsible for data analysis. ND conducted the primary manuscript draft. ND and ST both completed subsequent manuscript revisions. Both authors read and approved the final manuscript.

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Availability of data and materials
The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethical clearance was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019. All participants provided written informed consent and agreed to the interview being audio recorded and transcribed. Each participant was provided with a copy of the interview transcription and an opportunity to correct or remove data prior to the analysis. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication
All participants provided verbal and/ or written consent for data to be published.

Competing interests
No potential conflict of interest was reported by the authors.

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Publisher's Note

Appendix 5: Interview Guide – Residential aged care senior managers

1. Thank you for agreeing to chat with me, could you introduce yourself and your role in this organisation?
2. How long have you been in the role, and how did you come to be in this position?
3. Can you describe the senior management structure in this organisation / facility?
4. How is your role different from other senior management positions in this organisation?
5. Among the senior management staff, whose role would you say is most concerned with ensuring quality of health care?
    a. Why? How
6. When you think about ensuring quality of health care in a home/facility like this, what quality of care aspects do you feel it's important to consider?
   ALLOW respondent to answer – consider probes below, but be careful *not* to lead.
    a. Effectiveness
    b. Safety
    c. Accessibility
    d. Equity
    e. Responsiveness
    f. Efficiency
7. Do you or your colleagues use any quality frameworks to evaluate quality?
8. What are the main strategies you, and your colleagues use to maintain or improve quality of health care in this facility?
9. Thinking specifically about this home/facility, what do you see as the challenges to maintaining and improving quality of health for residents?
   ALLOW respondent to answer – use below as follow-up probes "*What about…"*
    a. Finances / business model
    b. Leadership (education/experience/tenure of senior management + board)
    c. Number of staff (staffing ratio)
    d. Staff capabilities (training)
    e. Space (infrastructure)
    f. Team work and work culture (internal)
10. [If it hasn't come up already] What are the key pieces of policy or regulation that influence quality of care in aged care homes in this region?
11. Do you think these challenges are the same as those experienced in a mainstream health service, such as a hospital, or are there differences?
12. Thinking back to when you started this role, do you think you were well prepared to handle the challenges associated with quality of care that we just discussed? (please explain)
13. If you could have had more preparation or professional development before taking on your leadership role, in what areas would you have liked to have been upskilled?
14. Considering the increased pressure on aged-care homes from population ageing and complex-co-morbidities, what do you think are the key features or characteristics required of senior management team to protect and promote quality of care?
15. And, relatedly, what organizational and policy settings are needed to better protect and promote quality of care in homes/facilities like this?

Appendix 6: Interview Guide – Australian aged care industry experts

1. Thank you for agreeing to chat with me, could you introduce yourself and your role in this organisation?
2. How long have you been in the role, and how did you come to be in this position?
3. Within your current role, have you ever been involved in assisting aged care providers to ensuring quality and safe health care practices? (please explain)
4. When you think about ensuring quality of health care, what aspects do you feel are most important to consider?

ALLOW respondent to answer – consider probes below, but be careful *not* to lead.

a. Effectiveness
b. Safety
c. Accessibility
d. Equity
e. Responsiveness
f. Efficiency

5. Is there a link between the senior management personnel and the quality of care provided within a residential aged care facility?
6. Are you aware of any quality frameworks or improvement strategies that residential aged care facilities utilise to evaluate quality?
7. At a national and/ or sub-national level, have any quality frameworks or improvement strategies been introduced to support providers since the commencement of COVID – 19?
8. What are the key pieces of policy or regulation that influence quality of care in Australian residential aged care facilities?
9. And, relatedly what organizational - policy and regulatory settings are needed to better protect and promote quality of care in Australian RACFs?
10. What do you perceive are the greatest challenges to maintaining and improving the quality of health care within Australian residential aged care organizations?
    a. Finances / business model
    b. Leadership (education/experience/tenure of senior management + board)
    c. Number of staff (staffing ratio)
    d. Staff capabilities (training)
    e. Space (infrastructure)
    f. Team work and work culture (internal)
    g. COVID - 19
11. Do you feel that the current senior manager professional development opportunities and educational materials available to aged care senior managers are adequate to enhance service quality?
12. Considering the increased pressure on aged-care homes from population aging and complex-co-morbidities, what do you think are the key features or characteristics required of senior management team to protect and promote quality of care?

Appendix 7: James Cook University Human Research Ethics Committee – Letters of Approval

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Appendix 8: Interviewee Participant Information Sheet and Consent Form

INFORMATION SHEET

PROJECT TITLE: A Professional Development Framework to recruit, support and retain competent aged care senior managers who influence high quality healthcare.

Dear Sir/ Madam,

You are invited to take part in a research project about senior management capabilities that enhance care quality in for-profit and non-for-profit aged care homes. The study is being conducted by Nathan Dawes (PhD candidate), Dr Stephanie Topp (Primary supervisor) and Dr Kerrianne Watt (Secondary supervisor). This project forms part of Nathan's Doctor of Philosophy (PhD) qualification within the College of Public Health Medical and Veterinary Sciences at James Cook University.

PROJECT SIGNIFICANCE

By 2050, the number of older persons is expected to double with figures reaching nearly 2.1 billion worldwide (United Nations [UN], 2015). This situation will challenge many countries ability to deliver quality healthcare for the aged. There is a paucity of literature on what constitutes the best mix of senior management leadership capabilities or evidence regarding how to achieve these characteristics while retaining a focus to ensuring the delivery of high quality health care in aged care homes, particularly since the beginning of COVID-19. This project seeks to identify the key challenges to recruiting, supporting and retaining competent and confident aged care senior managers. Evidence will assist the development of a Professional Development Framework that prepares senior managers to positivity influence the delivery of high quality healthcare in aged care homes.

DESCRIPTION OF INVOVEMENT

If you agree to be involved in the study, you will be invited to be interviewed. The interview, with your consent, will be audio-taped, and should only take 30 – 45 minutes of your time. The interview will be scheduled using telephone or secured web based communication platforms such as Zoom. You will be asked questions that seek to describe and analyse the adequacy of current senior management professional; developmental strategies that address different dimensions of care quality. In addition, we hope to identify and describe the professional attributes of senior management personal who influence high quality health care and whether or not these characteristics have altered or developed further since the beginning of the current pandemic.

We would also like to analyse the feasibility, acceptability and appropriateness of implementing a recently developed Professional Development Framework into Queensland aged care homes. This Professional Development Framework aims to provide a set of domains and overarching principles to recruit, support and retain competent and confidence senior managers who influence high quality care in aged care homes.

Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice. There are no anticipated risks associated with participating in this interview. Your responses and contact details will be strictly confidential/anonymous. The de-identified data from the study will be used in research publications including journal articles and a PhD articles. If you know of others that might be interested in this study, can you please pass on this information sheet to them so they may contact me to volunteer for the study?

If you have any questions about the study, please contact – Mr Nathan Dawes or Dr Stephanie Topp

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