OPTIMISING THE RESIDENTIAL AGED CARE WORKFORCE: LEADERSHIP & MANAGEMENT STUDY

**Yun-Hee Jeon
Teri Merlyn
Emily Sansoni
Nicholas Glasgow**

November 2008

ANU COLLEGE OF MEDICINE, BIOLOGY & ENVIRONMENT

Australian Primary Health Care Research Institute (APHCRI)
ANU College of Medicine, Biology and Environment
Building 62, Cnr Mills and Eggleston Roads
The Australian National University
Canberra ACT 0200

T: +61 2 6125 0766
F: +61 2 6125 2254
E: aphcri@anu.edu.au
W: www.anu.edu.au/aphcri

TABLE OF CONTENTS

LIST OF FIGURES

INTRODUCTION

> If I were going to leave the [aged care] provider with one message it would be 'Work with your supervisors. Many of our supervisors are just dropped into this position; they need to understand how to coach and mentor. This is not about command and control; it's about coaching and nurturing your staff'. ..//.. It [this message] is true for all industries, but the fact of the matter is many industries have actually applied these techniques. Aged care is coming very late. (Dr Robyn Stone)[1]

Aged care faces a potential crisis in terms of meeting present and future workforce demand in Australia. As concerns over the consequences of an ageing population are growing, the recruitment and retention of the aged care workforce has been the focus of national and international debates in academic, political and industry arenas.[2-4] Creating a supportive work environment is one of the key strategies to improve staff retention in residential aged care.[5] The supportive work environment means providing a context within which staff have "adequate supervision, access to professional and emotional support, the establishment of systems that provide feedback to staff (such as regular staff appraisal), and the presence of strong professional leadership" (p.55).[5] On the other hand, the lack of a supportive work environment, including limited career progression and inadequate staffing and skill mix in residential aged care, is a significant impediment in retaining staff and a cause of low staff morale and self esteem.[6] Evidence also suggests correlations between effective leadership and management and staff productivity and care quality.[7, 8, 9]

Much has been written about the impact of leadership and management on the staff experience. However, little is known about how this relationship is explained within the Australian residential aged care context in terms of staff turnover and their intention to leave or to stay, and ultimately the quality of the care residents receive. Much less is known about what systems and policies are in place to facilitate effective leadership and management in this arena. We begin our report with the socio-political and economic factors which influence health policy.

This report is the result of a systematic narrative review of the black and grey literature that aimed to: examine what is known about the issues of leadership and management for the residential aged care workforce; and develop relevant policy options and strategies to improve leadership and management within the social, economical, and political context of Australian residential aged care.

CONTEXT

AGEING POPULATION

Across the western world, chronic diseases and multi-morbidity accompany longer life spans.[10] In 2004–05 more than 80 per cent of Australians aged 65 years old and over had three or more long-term conditions.[11] Dementia is becoming more common and it is currently estimated that there are 24.3 million people with dementia worldwide.[12] The number of Australians with dementia was around 220,000 in 2007 and it is estimated that by 2050, 730,000 will suffer from dementia.[13] The recent national report highlights the increasing level of care needed by people in residential care. The

percentage of residents requiring high care (according to residential classification scale, RCS, Level 1-4) increased from 58% to 70% between 1998 and 2007.[14] Fifty-four per cent of the 156,549 people in residential aged care settings at 30 June 2007 were aged 85 years or older with 27% aged 90 years or more.[15] Of more concern to the aged care sector is the population of people over 85 years old, the fastest growing age group and the main users of residential care. They are predicted to reach between six-to-nine per cent of the total population.[15, 16] Baby boomers now moving towards the 65 year-old elderly demographic confront an aged care sector already struggling to provide quality residential care to an increasingly frail population.[3] People from culturally and linguistically diverse (CALD) backgrounds are of particular concern in terms of their access to and utilisation of health care services. Over one third (35 per cent) of older people in Australia were born overseas with 61 per cent coming from a non-English speaking country.[16]

AGED CARE WORKFORCE ISSUES

In 2005 people employed in the Australian aged care sector consisted of 1.3 per cent of the workforce and ninth in total employment making it a major contributor to the economy.[17] The aged care sector shares many workforce issues common to the wider nursing sector and competes with the acute and primary health care sectors for a shrinking pool of qualified nurses.[3, 18] However, as it employs a majority of personal carers who may or may not be vocationally trained, there are also concerns unique to that sector, in particular the registered nurse (RN) staffing ratios, or skill-mix. According to the latest national survey of the Australian residential aged care workforce, in 2007 64 per cent of care staff in residential aged care facilities (RACFs) were personal carers, a five per cent increase in this workforce demographic over four years.[19] A balanced skill-mix, in levels of experience and knowledge, has been found essential for effective teambuilding[17, 20] and when that balance is not achieved, staff job dissatisfaction occurs.[21, 22] Recent United States studies suggest that greater RN staffing ratios are associated with better resident outcomes,[23, 24] whilst poor skill-mix is linked to higher error rates and iatrogenic deaths of residents.[25]

The traditional culture of custodial care that incurred perceptions of low status work is currently challenged from more humanistic and higher skilled models of aged care. However, effecting lasting change in institutional culture is complex and the sector remains fraught with gender-based preconceptions that work to maintain perceptions of low status.[21] The actuality of aged care's lower status is reinforced by fewer resources and lower wages compared to other nursing sectors such as acute or community care nursing.[6, 18, 22, 26] Such persistent inequities, along with perceived documentation and administrative burden associated with accreditation,[27] produce higher levels of staff dissatisfaction, burnout and turnover,[18, 21, 22] which impacts on the quality of the care and resident outcomes.[28] These contribute significantly to the challenges associated with staff recruitment and retention in residential care settings[5, 6, 21] that the management of RACFs are expected to overcome.

Whilst perceptions may be recalcitrant, in practice residential aged care has gone from a parochial service for 'nice little old ladies' to demandingly complex clients requiring sophisticated knowledge and expertise.[18, 21, 29] Such complex care demands require that the direct care workforce—the majority of which are assistants in nursing (AINs) or Personal Care Assistants (PCAs) whose clinical knowledge and skills in complex care

needs are limited—undertake perennial up-skilling as care methods and workplace safety practices evolve.[2, 30] Combined with the need for developments in information technology support, this demand for care and technological expertise is set to increase.[2, 29, 31] Such complexity places a greater emphasis on the quality of clinical and organisational leadership capabilities, still found in short supply across the profession.[20, 28] In 2005 the National Aged Workforce Committee identified the importance of developing and sustaining workplace leadership and management in order to support 'competent, effective and innovative teams,' [17] but there has been little movement on its recommendations.

Diminishing student nurse enrolments, an ageing workforce and qualified nurse shortages are international concerns and have been reported with numerous recommendations, often.[3, 17, 18, 21, 29] However, these reports have yet to translate into significantly improved conditions or higher remuneration. Such endemic problems diminish the sector's appeal in staff recruitment and render retention more difficult, as "*Current subsidy rates preclude all aged care providers from paying rates that are competitive with the rest of the health care system.*" (p.4)[2]

Whilst the Productivity Commission report acknowledges this as a serious issue for future recruitment in a highly competitive market, it also notes the need to moderate costs in the face of growing demand by broadening the training and scope of practice for qualified nurses.[3] However pragmatic as such a recommendation may be, it comes into conflict with the cacophony of complaints at already overstretched workloads that are central to much nurse dissatisfaction.[18, 21, 22, 26]

Aged care staff struggle constantly with negative status perceptions that are both internalised and external.[26] Pearson et al. suggest internalised perceptions may be as much to do with ageism and status consciousness within the sector itself.[6] Baby boomers who are likely to hold strong views on independence and autonomy tend to rate aged care facilities poorly.[3] Yet when leadership is sufficiently strong and flexible to engage families with the loved one's care planning and participate in residential life, such prejudice tends to abate.[28].Alzheimer's Australia now recommends RACF managers actively accommodate the involvement of families.[32] Furthermore, studies show negative attitudes toward various aspects of aged care affect nursing students who feel aged care nursing is not valued by peers, negatively influencing their choice of employment and the morale of those working in aged care.[33, 34]

CULTURAL DIVERSITY IN AGED CARE

Similar to other countries with high levels of immigration and multiethnic populations, the Australian aged care workforce provides services to a growing CALD client group.[16] Cultural differences have shown to create difficulties in health care delivery, the leadership of which remains essentially mono-cultural. Australia trains and employs increasing numbers of overseas nurses, and those who experience difficulties with English literacy tend to gravitate to aged care because it is perceived to have less stringent requirements for language fluency.[35] These demographic streams converging in aged care create additional complexity for an already overburdened leadership.

Demand for cultural sensitivities will compound the aforementioned pressures in aged care, placing additional burdens on staff without training in CALD client needs, the lack of which can lead to unnecessary client distress and negative health outcomes.[36] Whilst both clients and direct care staff are increasingly diverse, the persistence of white

Anglo-Saxon or European management is evident in aged care staff demographics.[37] Such a racially based status differential can produce cultural insularity in the leadership, encouraging cultural stereotyping amongst care staff. As the Australian aged care sector caters for an ever more diverse community it will be essential that its leadership is educated in CALD sensibilities and the issue is included in workforce training programs with CALD staff encouraged to aspire to leadership positions.

ACCESS TO PRIMARY CARE FOR RESIDENTS

Residential aged care services in Australia outsource medical or clinical care from external service providers, such as general practitioners (GPs), specialists, allied health service professionals, community health teams, or dentists. Whilst a significant proportion of residents in aged care facilities have dementia and/or chronic illness, often accompanied by multi-morbidities and requiring complex care management, access to primary care and timely access to GPs has been problematic.[2, 30] Shortages of GPs in the wider Australian health care system may be one reason for this problem, however there are other barriers contributing to this issue. In a submission to the National Health and Hospitals Reform Commission, Aged and Community Services Australia (ACSA) identified key issues associated with the lack of access to GP services including: 1) Insufficient remuneration or incentives for seeing patients in RACFs to cover their costs; 2) Lack of consulting rooms or equipment for GPs in RACFs; 3) Failure of aged care staff to attend to visiting GPs; and 4) GPs delaying completion of the paperwork to substantiate funding claims, and consequently less funding being received by the aged care service (p. 5).[30] Aged Care Association Australia (ACAA) shares the same concerns in the policy direction paper. The paper also points out GPs' lack of confidence in treating the very old and communication barriers between GPs and RACFs in terms of coordinating consultation times.[2]

GPs are engaged in comprehensive medical assessments, care planning and case conferencing, which are largely subsidised through the Medicare Benefits Schedule (MBS).[38] The latest report of the BEACH study (a continuous national study of general practice activity) indicates about 18 per cent of GP participants had at least one RACF consultation.[38] Problems managed at RACF consultations differed considerably from those managed at general practice encounters. In order to address the lack of access to GPs for residents of aged care facilities and facilitate collaboration between GPs and allied health service providers to improve care quality, the Australian Government introduced the Aged Care GP Panels Initiative in 2004. The Panels Initiative appeared to have some success in reducing the problems in a limited manner, and has recently been replaced by the Aged Care Access Initiative to facilitate its uptake.[39] However, with chronic and complex care needs and dementia the most frequently managed condition by GPs in RACFs (33 times higher than the usual dementia management rate in general practice), the need for further provision of education and resources to address the problems is indicated.[38]

AGED CARE POLICY, REGULATION AND FUNDING

The clamour for change in care practices and anticipated growth in the aged care sector produced the Aged Care Act 1997 and Quality of Care Standards 1997 with the Resident Classification Scale (RCS) as its funding assessment tool. Over the next decade, this funding system's power to sanction was felt to be punitive by some and

regarded by many as diverting valuable time from care delivery.[40] Aged care has become perhaps the most stringently regulated sector, with government setting bed numbers by an allocation system and controlling quality standards through the Aged Care Standards and Accreditation Agency Ltd.[2, 29] ('The Agency' hereafter)

The Agency aims to support the aged care industry to meet the care standards and promote care quality while ensuring the industry's compliance with minimum standards through the accreditation process.[41] However, a recent report commissioned by the Department of Health and Ageing on the evaluation of the impact of accreditation on care quality concludes that:

> The compliance regime is fundamental to the ultimate success of accreditation in maintaining national improvement in the minimum standards of care and driving quality improvement. ..//.. in the absence of a meaningful financial sanction, it would be highly likely that some providers would assess the cost of complying with their regulatory responsibilities as higher than the cost of avoiding them. (p. xviii)[27]

Since 1997 the 'ageing in place' policy has seen resident characteristics in low care facilities become more diverse, necessitating further changes in service and funding arrangements.[42] This policy allows residents to progress from low care to high care in the one facility, depending on the facility's available resources to service higher needs. Since that time, previously low care facilities needed to develop appropriate accommodation, employ higher skilled staff and conduct culture change programs to adjust staff to both new care models and the more diverse needs of residents.

The federal government's regulation of the aged care industry through the bed allocation system restricts bed numbers to approved providers funded on the basis of care required, as assessed by the Aged Care Funding Instrument (ACFI).[3] The ACFI came into effect on July 1 2008 to replace the earlier funding assessment tool, the Residential Classification Scale (RCS), which was unpopular largely due to its complex, time consuming and resource intensive system.[43] The ACFI system increases subsidy rates per high care bed and simplifies the classification procedures, by no longer using ongoing care documentation as evidence to support funding claim.[44] The effectiveness of this new system is yet to be seen.

The increased demand on aged care services over the past decade has seen the sector struggling with a persistent funding shortfall of $513m. per annum between 1997 and 2006.[29] In 2007 the federal government responded to the 2004 Hogan review of aged care pricing with increases in bed allocations and funding for more training positions and aged care nursing scholarships.[45] However, these increases fell short of Hogan's recommendations as they failed to address "strategic issues bearing upon the implementation of policies to secure efficiencies and quality outcomes in aged care" (p.104).[31] The 2008 Productivity Commission report[3] questions whether, given the sector's fragmentation and multiple government departments at multi-tiered levels overlapping in a diverse array of programs, it is possible to genuinely assess needs and services. Yet assessment is essential for the provision of services and perhaps a more reflexive funding system might be developed.

SIGNIFICANCE OF THE STUDY

There are a number of Australian Government initiatives currently available to encourage development of leadership and management in aged care, through awards and additional funding/programs for education and training. Key initiatives include the Bringing Nurses back into the Workforce program; the Aged Care Nursing Scholarship Scheme and the provision of postgraduate scholarships for community aged care nurses; the Support for Aged Care Training Program targeting rural and regional areas; dementia-related education and training; and the Community Aged Care Workforce Development and the Better Skills for Better Care programs. However, the focus of these programs/initiatives has been rewarding a limited number of managers or facilities for their excellence, or towards training and education for staff involved in direct care and supervision. None of the initiatives provide a systematic and strategic direction for the development of leadership and management roles for middle managers. Details of these initiatives are included in Appendix 1.

The recent report prepared by the Aged Care Workforce Committee[46], *the National Aged Care Workforce Strategy*, provided a strategic approach that focused on the need for long-term structural reform in the Australian sector. The findings of the present study are highly significant and timely for this agenda and will fill gaps, in particular the third objective of developing sustainable workforce leadership and effective management. The *Strategy* identified actions to be taken and key participants to be involved to achieve desired outcomes for this objective; the majority of these actions are yet to be followed-up. This review has systematically explored one of the most pressing issues and debates as presented in the literature and via the views of stakeholders consulted. It is intended that the outcomes will help the residential aged care industry build its workforce capacity through evidence informed policy options that enable managers to provide leadership and effective management. This is fundamental to the provision of quality care for older people in RACFs by enhancing staff competency, morale and job satisfaction through consistent empowerment and supervision.

AIM AND RESEARCH QUESTION

The aim of this study is to provide options, strategies and recommendations for the enhancement of workforce leadership and management within the residential aged care sector to promote and maintain best practice.

The core research question for the study is 'What policy and system solutions are necessary to build capacity for sustainable workforce leadership and effective management in residential aged care?'

DEFINITIONS AND SCOPE OF THE REVIEW

Leadership and management: Evidence suggests the debate on leadership versus management and their relationship to each other is ongoing and further work needs to be done. Some argue that leadership is part of the management function, or vice versa, while others believe they are different. A systematic review of research in health services leadership for the NHS found much confusion between the constructs of leadership and of management, with 'old management programmes being repackaged as leadership'.[47] The authors argue that whilst management can be prescribed, leadership is about building social capital and some of its elements need to be

recognised as 'emergent' (i.e. emerging organically out of facilitative environments) rather than prescribable.[47] While the present study was not designed to unravel the definition of leadership and management, a distinction of the two made in a position paper for the American Health Care Administrators appears relevant to the study, which refers to leadership as an external focus with future vision, where management's internal focus is on immediate needs.[48] With this distinction in mind, those systems and protocols within which leadership manages the human and material resources under its charge are the testing grounds of an individual's leadership capability and management skills. In this review we accept there are overlapping factors between leadership and management and the prescribed and emergent capabilities required by each, while recognising different elements between the two concepts, and treat both as equally important and integral to the creation of an enabling and supportive environment to optimise workforce capacity. "Leadership and management should be integrated and complementary" (p.13), so that leadership is reflected in management roles at all levels.[49]

Residential aged care workforce: Workers who provide or manage the care of older people who are in RACFs. These include RNs (general and specialist, e.g. in gerontology, mental health or palliative care), enrolled nurses (ENs), nurse practitioners (NPs), nurse managers, nurse educators, care workers and allied health workers. The RAC workforce also includes a range of health professionals who are not direct employees of a RACF, including medical practitioners, pharmacists and allied health professionals (p. xi).[46]

Types of leaders/managers: Terminologies and their definitions describing managers vary in the literature. Borrill et al.[50] make distinctions between senior management and immediate management. Senior management is referred to the person responsible for setting the strategic direction for the organisation and immediate management is referred to the person responsible for line management and staff supervision.[50] Most literature uses 'executive management' as somewhat equivalent to 'senior management' while 'middle management' is equivalent to 'immediate management'. For this review, middle management is situated in between the two categories (senior and immediate) and at times crosses between the two types of roles depending on the way each individual organisation is structured. Leadership in this report includes clinical leadership and managerial leadership as middle management. Target populations include administrative, managerial and supervisory positions, such as directors or assistant directors of nursing or care managers whose roles involve assessment of residents' health, development of treatment plans and supervision of other nursing staff or care workers as well as human resource management.

METHODS

The present study utilised the systematic literature review and a narrative synthesis approach to produce evidence for developing policy solutions and decision making. Mays, Pope and Popay[51] provide a framework for this type of review, called 'decision support', that is sensitive to a particular context and time, and involves a process of combining existing research evidence with expert opinions in the field of inquiry. The following four steps are not necessarily linear, but rather are interwoven throughout the study.

SEARCH OF RELEVANT LITERATURE

SEARCH TERMS AND SELECTION CRITERIA

<u>Search terms:</u> the leadership related terms were combined with the health service related terms using the 'AND' operator. 'Leadership', 'leaders', 'management', 'managers', 'workforce', 'organisational development', 'organisational theory', 'organisational structure', 'organisational behaviour', or 'change theory' <u>AND</u> 'health', 'health services', 'health care', 'residential aged care', 'nursing homes', 'nursing education' or 'long-term care'.

<u>Inclusion criteria</u>: materials that discussed the provision of effective workforce leadership and management in health care with a particular focus on residential aged care settings, in terms of theoretical and conceptual elements, organisational culture, organisational development, policy guidelines, influencing factors (barriers and facilitators), leadership development, and effective leadership models or programs.

<u>Exclusion criteria</u>: materials that focussed on disease/illness management, clinical pathways, clinical management, service delivery models, models of care, patient care management, or care practice that focused largely on residents' health and well-being outcomes. However, if the materials discussed both clinical management and workforce issues at the same time they were not excluded. Materials not in English and theses/dissertations were excluded.

SEARCH SOURCES

A set of comprehensive literature searches were conducted using both black and grey literature, including: electronic databases, hand searching of specialist journals, Google, specific health and aged care industry sites, snowballing (i.e. scanning of reference lists from identified studies, in particular those renowned as seminal studies) and using suggestions from experts in the field. Detailed search sources and the number of references obtained from each search source are included in Appendix 2.

APPRAISAL OF STUDIES

From the original 4484 references identified, 1047 were selected for further review following a review of their titles, and their abstracts if necessary (Tier 2). Of these, 280 were determined to be not relevant or duplicated (Tier 3). Two members of the team, independently selecting potentially relevant papers for further reading, agreed in 87 per cent of the cases (based on a title and abstract review).

The most relevant papers were classified into each of the three categories (Tier 4):
Q1: Leadership and management issues related to health care, other than aged care, e.g., acute, sub-acute, community and primary health care (n=428)
Q2: Leadership and management issues related to aged care, residential aged care, nursing homes or long-term care (n=226)
Q3: Leadership models, programs or theories/ frameworks (n=113)

After further examination of abstracts, 104 were excluded from further review as they were focusing on clinical/disease management while leadership was a mere supplementary issue, resulting in 663 papers for review. To ensure recency of this review and manage a large volume of papers to be reviewed within a timeframe, we

excluded papers published before 1997 and included only systematic reviews for the Q1 category (Tier 5). Once the full-text of the remaining 305 papers was reviewed, 158 papers were deemed appropriate for in-depth examinations and were included in summary sheets (Tier 6). Each of these remaining papers were examined in terms of relevance to the topic, degree of confidence for methodology, the depth of information and particular insights into the study (Tier 7). This led to 153 papers being included in the final report. This process is illustrated in the figure below (Figure 1). Tiers 4-7 were initially conducted by the second and third author and the first author verified their relevance and appropriateness for inclusion/exclusion in the review. The summary sheets of the final research papers are attached at the end of this report.

QUALITY OF STUDIES

Initially the National Institute for Health and Clinical Excellence (NICE) Guidelines[52] was employed to rate the quality of evidence, which would then feed into the selection process of the final papers for the review. However, it quickly became apparent this approach would not be appropriate. There was a dearth of research using a rigorous experimental design such as a randomised controlled trial, meta-analysis and systematic review of RCTs. All of the studies on the effectiveness of leadership and management programs/models within the health care setting were found to be descriptive and observational designs in nature, exploring correlations between styles or quality of leadership/management and staff outcomes such as turnover, intention to leave, job satisfaction and stress. Therefore, the review team chose to take an inclusive approach in the selection process that reflects the diversity of research in the field of leadership and management. This approach proved to be useful in examining the complex issue of the aged care workforce.[4] Given a paucity of research conducted in the Australian aged care setting it was deemed appropriate to include all relevant Australian studies in this review.
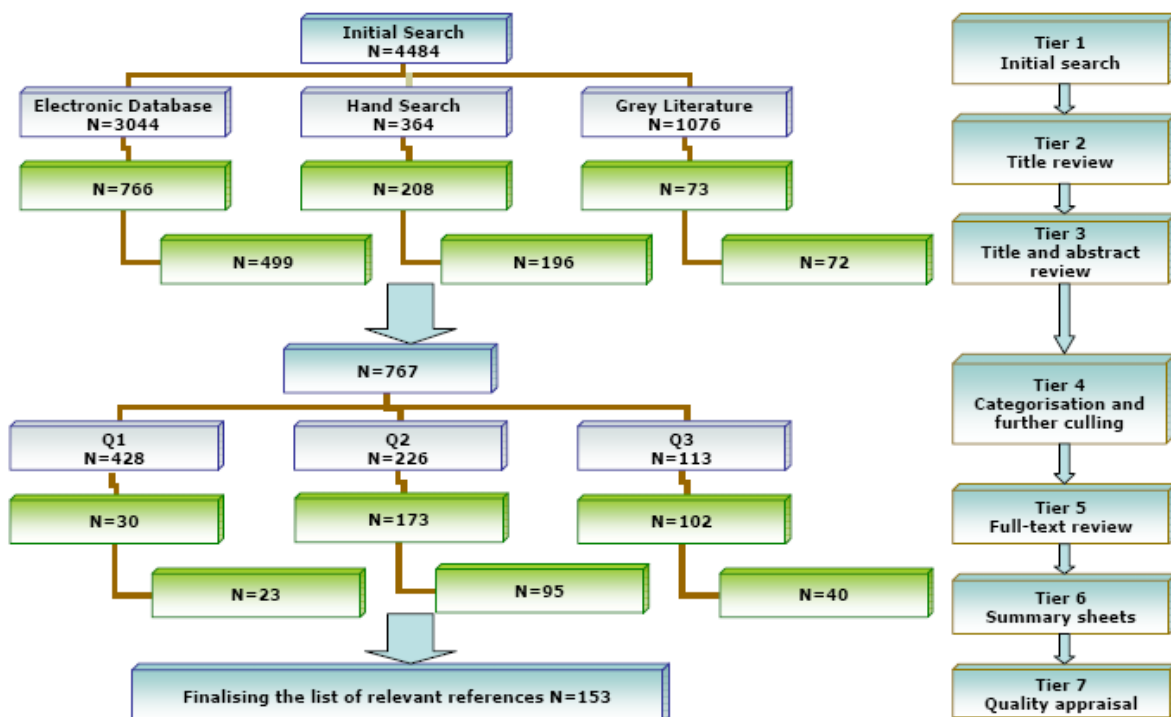

Figure 1   Selection process   [9]

TYPES OF PAPERS

The literature is highly diverse and, of the final 153 articles included in the following sections, individual nursing leadership was the focus of 28 papers, with a further 30 papers on executive and broader health care leadership issues. Individual leadership skills are a key factor in many other studies, as would be expected in an era of change. However the most substantial number of studies (n=100) had a focus on, or outcomes that pointed to, the leadership of organisational management systems.

In such complex environments of high staff mobility and vulnerable clientele, experimental studies are rare (n=3), as the majority of studies are in the observational, descriptive, cross-sectional, triangulated (n=63) and qualitative (n=25) range of design. Government and organisational reports, policy, position statements and educational curriculum comprise a solid section (n=39), with critical theory, opinion and synthesis (n=24) and literature reviews (n=12) making up the remainder.

The US is represented by the greatest number of articles (n=68), particularly those focused in aged care (n=47), with three on acute nursing leadership. The UK is next, with material focused more on general health care leadership (n=23) and acute/primary nursing (n=10) and fewer in aged care (n=6). Canada's is a mostly government and peak body discourse focused on wider nursing leadership issues (n=13) with some studies in aged care (n=7) and one in acute nursing. The Australian selection (n=22), much of it in aged care (n=19) with three in more general health care issues, is mostly comprised of government, educational and peak body documents. Otherwise, New Zealand is represented by two reports with marginal bearing on health care leadership, Sweden has two in aged care and one in acute/primary and Finland has one in each.

CONSULTATIONS

THE REFERENCE GROUP

Reference group members came from key government and non-government organisations for aged care and dementia within Australia. They included senior managers/policy advisors from the Department of Health and Ageing, ACT Health, the Aged Care Standards & Accreditation Agency, Alzheimer's Australia and the Australian General Practice Network. Representatives from two peak bodies were consulted: Aged & Community Services Australia and Aged Care Association Australia. There were also representatives from major aged care industries (e.g. Catholic Health Australia, Baptist Community Services, and Uniting Care), one professional body (Geriaction) as well as academics/researchers. The group provided expert advice in the direction and conduct of the methods and actions proposed and in the development of outcomes from the literature reviews at various stages of the study. Two reference group teleconferences were held in December 2007 and April 2008. Face-to-face meetings were held in Sydney and Canberra in August 2008. The Terms of Reference and membership are included in Appendix 3.

INTERNATIONAL LINKAGE AND EXCHANGE

Face-to-face meetings were conducted with experts in the United Kingdom, including senior academics and managers who were directly or indirectly involved in leadership

and management development or research. The purpose of the meetings was threefold: to develop international linkages with other researchers, academics and service providers who have expert leadership and management knowledge in the field of residential aged care; to exchange information with each other while sharing key findings of this study; and to test out policy recommendations. During the meetings with the international experts new references were suggested for inclusion in the study, however they confirmed that the key findings and recommendations from the preliminary report were valid in light of the existing literature and relevant to the international context. They were also very supportive of the idea of an urgent need to develop a leadership and management program that is residential aged care specific in Australia. Some emphasised the importance of conducting needs analysis of the program in the aged care sector to inform the development and implementation process of the program. The list of participants is included in Appendix 4.

DIALOGUES WITH MIDDLE MANAGEMENT

A forum was held with 11 directors of care and care managers from RACFs in the ACT in September 2008. Similar to the reference group, management participants were asked to verify the key findings and recommendations and provide additional viewpoints and suggestions. It was found they generally agreed with the information presented. (We were unable to conduct discussions with care staff because of the resource and time limitation issues)

SYNTHESIS AND INTERPRETATION

A synthesis founded on research documents was guided by the following review questions designed to answer the key research question.

1. What does the literature tell us about leadership and management in relation to the residential aged care workforce?

2. What are the essential characteristics and the influencing factors (e.g., individual, policy and system related) necessary to sustain effective workforce leadership and effective management?

3. What are the best models in developing sustainable workforce leadership and effective management in residential aged care?

Findings from the literature review were analysed and integrated with the other information (consultations) to produce evidence for developing policy solutions and decision making in terms of sustainable leadership and effective management within the RAC workforce. We took an analytical step to identify potential policy responses using the Buse et al.'s approach.[53] This approach considers four key domains in developing and analysing policy: 'actors' (individuals, groups and organisations, 'key stakeholders' that are influenced by and influence policy development), 'context' (systemic factors – both national and international socio-political and economic factors by which health policy is influenced), 'content' (substance of a particular policy which details its constituent parts, particular policy elements operating at micro, meso or macro levels) and 'process' (cycle of developing, communicating, implementing and evaluating policy).

RESULTS AND DISCUSSION

1. WHAT DOES THE LITERATURE TELL US ABOUT LEADERSHIP AND MANAGEMENT?

IMPACT OF LEADERSHIP AND MANAGEMENT

Stability of managerial leadership and staff job satisfaction and retention: Nursing leadership has become a target research variable shown to be a significant factor for outcomes in just about every dimension of the sector, with stability of tenure a central factor.[54-57] One review seeking to identify the nursing leadership attributes most conducive to healthy workplace environments concluded that the leader's stability was central to their ability to nurture and support staff.[56] Facility management leadership that is better educated and more stable is likely to be more innovative.[58] In a comparison of staff connectivity in four nursing homes, a coherent, stable leadership with strong staffing tenure of ten years induced more collaborative teams conducting interactive care planning and delivering high quality care.[55] The stability of leadership tenure corresponds with strong teamwork, which has shown to be a key factor in effective management of resources and positive outcomes for both staff and patients.[37, 59-63] Another study found more positive perceptions of senior management associated with higher job satisfaction and lower levels of intention to leave.[50]

Turnover of top management, NHAs and DONs has been strongly associated with RN and LPN (licensed practical nurse) turnover,[64, 65] whilst leadership style was found to have a dramatic effect on nurses' motivation for continuing professional development and noted as a key factor in the generativity of leadership.[65] A strong association is also found between DON turnover and RN turnover, with instability in the administrative climate impacting on LVN (licensed vocational nurse) turnover.[66] Overall, this study found the contextual factors created by senior management, in particular those of managed, meaningful change protocols, stable leadership and a reward culture of openness and accuracy, to be the most productive of greater staffing stability.[66]

Bringing about a successful change and a positive culture: When innovative programs are successful and research projects have significant outcomes, good leadership and effective management is often indicated in a variety of positive outcomes.[67, 68] In one particular nursing home an integrated culture change program was deemed successful, due to its participative and holistic practice of leadership.[68] Conversely, lack of leadership, most often manifesting as ineffective and/or insufficient supervision and resources, is seen to be fundamental to the failure of numerous innovative change staff programs and quality improvement research.[55, 67, 69, 70] A Canadian report on a sector-wide culture change initiative shows inadequate leadership can present an intractable obstacle with most nursing home administrators (NHAs), leaving DONs and RNs ill prepared for the tasks required.[67] Similarly, another large, multi-level survey found many NHAs and DONs underqualified and unprepared for their supervisory responsibilities.[54]

Leadership emerges as a key factor in improvements on a wide variety of variables.[23, 61, 62, 69-71] A clinical leadership Person-Centred Care (PCC) training program conducted in 80 of the UK's NHS Trusts found positive improvements in both staff and patient

outcomes.[71] The WIN A STEP UP (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance), workforce development interventions engaging both care assistants and managers from 18 nursing homes in the US, reported increases in job satisfaction, morale and care outcomes.[61] These positive results were reflected in staff, reported as growing in confidence through increased clinical skills and perceived recognition and reward.[61]

The nurse manager has a key leadership role in communicating long-term vision, generating overall staff satisfaction and building organisational commitment. The role of the nurse manager in nursing homes has emerged as a key driver in a healthy workplace culture.[66, 72, 73] Organisational investment in this position through training and supportive systems is recommended in a number of studies.[74-77] However, over the past decade this position has decreased in number while the role has increased in span of control and responsibility.[25]

Staff productivity and unit performance: Staff productivity and unit performance benefit from good leadership practices, which are conducive to healthy work environments that reduce absenteeism and increase productivity.[7] The WIN A STEP UP program found significant improvements in both care quality and performance.[61] Another leadership program found 42 per cent of participants cited improved line staff productivity and 67 per cent cited improved organisational performance as outcomes.[78] One study confirming the centrality of leadership in productivity found that 20 per cent of leadership activity has a direct, positive effect on nurse productivity, with an increase of five per cent boosting productivity by 3.4 per cent.[8] This is supported in a literature review that found strong links between developmental organisational culture and higher staff performance, with job satisfaction positively correlated with performance and negatively correlated with turnover.[79] Another literature review of leadership style and organisational culture found when both are positive leads to increased productivity and reduced occupational stress.[7]

When provided with sufficient structural and psychological support, the nursing home RN experiences a greater sense of empowerment and organisational commitment.[80] However, many RNs are insufficiently supported by their managerial leadership and are unprepared for the supervisory responsibilities of aged care, either in their training or the role description.[81] Inadequate leadership preparation and the role's stressors mean direct care staff remain poorly supervised, contributing to persistently high burnout, absenteeism and turnover that drives care quality down,[24, 55, 82] staffing costs up and diminishes the sector's recruitment appeal.[83] Yet at the same time, leadership roles have diminished across the nursing profession[84, 85] and aged care nurse roles have become increasingly managerial, distanced from the intrinsic rewards of bedside care and from the care staff that deliver it.[86] A reduction in workload, with clerical support to diminish paperwork and increase bedside time, training to prepare for the challenges of leading change and a system of reward and recognition is recommended to improve perceptions of status and meaning.[86]

Care quality and resident outcomes: A review of empirical research linking nurse leadership directly with patient outcomes found no such studies, with care quality only an indirect outcome of other variables—changes in the work environment or nursing practice influencing patient care—that suggest an association.[87] The authors found significant associations between positive leadership practices and increased patient

satisfaction and reduced adverse events, such as behaviour problems, restraint use, complications of immobility, fractures, patient falls, and medication errors.[87]

The nurse manager has emerged as the leadership linchpin for both acute and residential health care organisations.[25, 66, 67, 73, 74, 88] Yet, a widespread loss of trust in the nurse managers' role has been reported, resulting from the shift of emphasis from care to efficiency. Reductions in clinical nurse leadership positions and a decline in their executive power, combined with the increase in responsibilities has produced chronic overload with increased errors.[25] In this report, the high turnover of administrators is considered the result of continuous crisis management, mostly related to turnover and absenteeism. The authors recommend system-wide changes, with reinstatement of nursing leadership positions, significantly increased staffing levels, a core knowledge and aptitude test for new administrators and support for leadership development at all levels. [25] One study that examined the relationship between management practices and resident outcomes found stable, experienced Directors of Nursing (DONs) with effective communication patterns and participatory management practices facilitated self-organising systems which also produced better resident outcomes.[72]

The aged care RN often plays a key leadership role, impacting on those who provide direct care and the quality of care delivered.[23, 64, 70, 89, 90] Higher RN ratios in nursing homes have been found to have positive impacts on resident outcomes of pressure sores and urinary tract infections (UTIs).[23] Another nursing home study found each RN proportionate loss per full-time/100 beds increased risks of infection by more than 30 per cent and hospitalisation by over 80 per cent.[70] RN turnover and poor supervision are both linked to direct care workers turnover.[90] Indeed, poor and inconsistent leadership is seen as central to many nursing home problems, indicating the need for leadership skills training for both senior management and supervisory staff.[90]

COST IMPLICATIONS OF LEADERSHIP AND MANAGEMENT

The factor of cost is not always made explicit in outcome variables, nevertheless the association of poor leadership with costly issues such as lower quality outcomes[23, 24, 55, 91-94] and staff turnover[54, 64, 66, 90, 95-97] is irrefutable. Notably, these dimensions are rarely separable, the lower quality outcomes that indicate poor care associated with higher staff dissatisfaction,[7, 85, 86] which is often linked to turnover.[55, 59-61, 69] In turn, the cost of each turnover involves separation, recruitment, induction and training costs, further leaching resources from care. Estimations of the costs of turnover vary, ranging from $10-60k per RN to $42k for a surgical ward nurse and $64k for a specialty nurse.[98] A multi-centre Canadian-Australian study estimated Australian RN turnover at between $16,634 and $19,663.[99] The Australian Baptist Community Services aged care turnover averages 32.2 per cent, with the costs of one high care manager at $29.7k and overall turnover for 1998-2000 running at $4.65m.[100] Two studies directly show that investing in good leadership practices is cost-effective, with increased retention and improved quality outcomes.[91, 101]

Baer[90] cites poor leadership as the main cause of turnover, the average cost of which for a 120-bed facility is between $258-387k or more, whilst an annual leadership training program might cost the equivalent of the loss of 1-2 CNAs. Factors or issues leadership had the power to change attributed to 40 per cent of nurses' reasons to leave. Some of which related to organisational issues while others were the province of

culture, linked more to the conduct of individual leadership.[74] Similarly, the dynamics of disempowerment and dissatisfaction in aged care RNs, ENs and AINs have been identified, in part, as individual leadership and organisational leadership.[26] In this study, a lack of effective teamwork, emotional support and communication can be clearly identified as a failure of individual leadership characteristics. Other issues cited, such as unsuitable new hires, inadequate staffing ratios and perceived exploitation are likely to be the precinct of organisational leadership.[26]

Unstable leadership is costly to research, evident in an innovative culture change leadership program for NHAs and DONs, where they failed to complete follow-up data due to participant turnover.[59] Many participants attempting to apply what they had learned, reported diminished enthusiasm as obstacles mounted or the organisational ground changed beneath their feet.

The circular relationship of the high costs of poor leadership and unhealthy work environments can be seen in staff dissatisfaction, absenteeism and turnover, ultimately producing reduced care quality and its associated costs, in human lives and specific physical outcomes such as adverse resident events,[55] urinary tract infections and pressure sores.[23, 25, 102] A study of administration costs found higher expenditure on leadership resources resulted in lower turnover and better care quality, concluding it was cheaper all round to spend upfront on staff support and resources rather than pay for the consequences of not doing so.[101]

2. WHAT ARE THE ESSENTIAL CHARACTERISTICS NECESSARY TO SUSTAIN EFFECTIVE WORKFORCE LEADERSHIP AND MANAGEMENT?

COMMUNICATION AND FLEXIBILITY

Communication is a characteristic synonymous with leadership, especially in two-way mode where proficiency in both conveying information and listening and responding is facilitated between leadership and followership. Respectful, considerate communication was found to be a key attribute in perceptions of effective leadership common to both nursing home staff and their nurse supervisors,[103] as evident in the participatory communication by the leadership of the four successful Special Care Unit (SCU) projects.[104] The ability to listen is considered an essential factor of responsive communication.[56, 103, 105-109] Communication is considered a highly desirable capability, both for individual leaders[7, 54, 57, 71, 74, 75, 88, 103, 110-112] and in organisational leadership, where protocols for the open flow of information are considered essential to instil a sense of empowerment and meaningful engagement.[7, 25, 28, 66, 68, 91, 113-115]

In an era of change, it is perhaps to be expected that **flexibility** is also a key leadership characteristic, arising with lesser or greater emphasis in a large number of studies, applying to both individual and organisational leadership. It is a characteristic to be desired, with problem solving a key leadership attribute[8, 56, 65, 103, 116, 117] indicating a reflexive responsiveness to both staff and circumstances.[67, 96, 118-121] It is also a highly recommended organisational characteristic, particularly when applied to human resource (HR) practices and care procedures.[24, 55, 85, 94, 107, 122-124] From the research, these two characteristics appear to be the common pillars upon which all other leadership characteristics build.

OTHER INDIVIDUAL LEADERSHIP ATTRIBUTES

The essential attributes of leadership, identified in virtually every staff consultative study are a hands-on accessibility and professional expertise in nurturing respect, recognition and team building, along with effective communication.[118, 125-127] An individual's leadership style has found to have a dramatic effect on other nurses' motivation for continuing professional development.[65] CNAs were found to value the quality of their teamwork and respect **an accessible, hands-on leadership with a can-do attitude** that saw themselves as part of the team.[125] Finnish nurses respond best to an interactive and rewarding leadership.[127] A comparison of 'emerging workforce' and 'senior nurses' perceptions of desirable leadership found much commonality with honesty—leading both—followed in diverse order by: motivational, receptive and positive, communicative, team player, approachable with good people skills, knowledgeable and supportive.[126] Leadership is perceived as effective when it is: empowering and expert, consultative and accessible, flexible, responsive and supportive.[56]

Marquis et al.[28] found **an ethical ethos**, in the primacy of care and the equal rights of all to recognition and respect, as the most important factor in staff, family and resident satisfaction, leading to minimal agency use. Similarly, Stanley[109] found an alignment between a **passion** for high quality care and personal and professional **authenticity** as what makes work meaningful to the care team and central to effective nursing leadership. Nowhere is the personal experience of a good leader more highly valued than to a member of a team, and a 'hands-on' approach to leadership is appreciated by all.[81, 85, 102, 104, 109, 125, 128, 129] **Visibility** is an important quality of senior leadership, the actual presence of Nurse Administrators on the practice floor found to have a positive effect on nurse productivity.[8] Maintaining the nurse manager's 'line of sight' to the bedside is also considered an essential component of leadership transmission.[75] The effective nurse manager **acts as mentor and role model**, providing esteem and empowerment to staff on their watch and inculcating a culture of generativity.[76] Leaders who inspire others are more likely to model values and ethics that are congruent in their personal manner and professional practice[57, 67, 71, 79, 116, 122, 128, 130-132] and these are aligned with the organisational values and expectations they transmit.[28, 59, 69, 76, 105, 109, 133]

To inspire others and encourage aspiration, an individual leader requires a range of personal qualities, some of which will be emergent whilst others are learned by example and in training.[47] Key personal leadership attributes of **openness**, **enthusiasm**, **respect** and **consideration** combined with professional skills of accessibility/visibility, communication, role modelling, mentoring and supervision are reflected in the variety of similar terms used by staff to describe the sort of leadership needed.[56, 103, 104, 125] Other highly desirable attributes of individual leaders are a **nurturing, supportive** style,[24, 75, 126, 134] **emotional intelligence**[56, 57, 88, 106, 107] and **political astuteness**,[71, 96, 106, 111, 119, 120, 135] all of which contribute to peer and organisational networking.[71, 106, 119, 120, 129, 135-141] A **positive attitude** is also considered a generally desirable leadership attribute,[7, 28, 103, 126, 142] and found to produce more satisfied staff and patients and less staff turnover for the nurse manager.[143]

Collaboration and team-building practices are central to good nursing leadership, but these characteristics are not necessarily innate for many in leadership roles[54, 81, 120, 138] and often need to be learned. To be an effective team builder, leaders need not

only those personal attributes identified above, but highly developed skills in **self-management and self-awareness**,[84, 116, 119] presenting a calm, professional expertise,[48, 56, 57, 63, 75, 84, 103, 126, 144, 145] mentoring[8, 24, 56, 120, 130, 136, 143, 146] and delivering clinical supervision.[83, 104, 122, 146] The lack of collaborative leadership preparation in nurse training is evidenced in sequential reports on the pilot of an NHS needs-led, clinical leadership-training package, which found senior nurses disinclined to think of themselves as team members.[120, 138] This study found ward nurses under-prepared for leadership and its responsibilities, concluding that a significant proportion of the nursing workforce was working well below optimal capacities.

In all, the recent flurry of research in nursing leadership has revealed a mostly ad hoc situation, with effective leadership more a combination of natural ability, individual professional ambition and good fortune than deliberate planning in many countries. At the same time, nursing leadership has emerged as a central factor to many of the problems besieging the sector. The search is on to find the best ways of identifying and developing promising individuals as leaders and educational curricula to build leadership competencies in all nurses. A key study to identify essential nurse manager leadership characteristics determined that, whilst mission-driven, ardour and attunement are dispositional traits to be fostered, self-regulation, identification, generativity, **boundary clarity**, **reflection**, changeability and an affirmative framework are all eminently teachable. [75]

ORGANISATIONAL LEADERSHIP ATTRIBUTES

An organisation that provides coherent, cohesive structural and psychological frameworks, within which the layers of leadership function efficiently, has been found central to high care quality, positive staffing outcomes and successful interventions.[28, 55, 68, 76, 110, 134, 137, 147-150] Good organisational leadership, directed by the boards, provides resources that enable perceptions of structural empowerment - in that middle managers feel confident they have sufficient resources at their disposal - to ensure the delivery of high quality care and sufficient support for their staff.[150] DeCicco et al. define **structural empowerment** as the material framework by which all resources are distributed, and psychological empowerment as the cultural framework, within which formal and informal protocols are conducted, the establishment of both seen as the responsibility of executive leadership.[150]

An example of the effective practice of structural and psychological empowerment is Scott and Caress's report on a successful leadership and shared governance intervention with Christie Hospital in the UK.[149] The executive appointed a Nursing Development Coordinator to lead the project, provided the role with structural empowerment to spend an entire year developing a 'culture of permission' (i.e. **psychological empowerment**) in which to grow a shared governance framework. Staff volunteering for leadership roles were provided with skills training, their councils supported with facilitation, time and, most importantly, a responsive management. An earlier shared governance project with design and executive support similarities had equally positive outcomes.[134]

An essential function of organisational leadership in change and quality improvement programs is to manipulate culture. Key characteristics of effective change are identified as **clear vision and direction**, where there is **coherence between rhetoric and action** transmitted in frequent, copious and interactive communications

that induce trust, confidence and participation.[107] Alignment of organisational and individual values and expectations that prioritise care quality is essential to the creation of an organisational culture of excellence. This is a key characteristic of organisational leadership central to the success of Tasmania's Adards nursing home in Australia.[123] Incongruence within a facility's organisational leadership induces competing values and reduces staff capacity for the conduct of effective quality improvement programs.[151]

Coherent leadership is seen to cascade, its flow facilitated by effective management providing structural empowerment with organising power and sufficient resources for everyday services and support for interventions.[68, 148, 150] An organisation that provides its leadership with sufficient resources to empower their efforts will inspire greater leadership potential, and so attract and retain a more skilled leadership who feel and inspire higher organisational commitment.[57, 74, 150] Change interventions are seen to be successful when supported by a philosophically coherent leadership and management.[28, 55, 68, 148] Similarly, whilst some facilities experienced problems with the 1997 Aged Care Act and funding changes, leaders who interpreted the implementation with a holistic consideration for staff and resident needs were able to produce positive outcomes.[40] Indeed, Australian facilities adapting to the ageing in place policy found only by conducting culture change programs that developed and maintained staff organisational vision could they effect the changes required.[42]

Without **philosophical cohesion and sufficient resources**, administrative leadership tends to instability and fails to provide effective management procedures that endow structural empowerment, hence restricting leadership capacity at the point of care delivery to achieve desirable quality outcomes for both staff and patients.[66, 95, 101, 152] Higher full time equivalent (FTE) administration hours have been linked to improved nursing home care outcomes and non-health related deficiencies.[152] A comparison of 1,014 Texan nursing homes found higher administrative costs indicative of well-resourced administration leadership, strongly associated with lower staffing turnover and translating into lower staffing costs overall.[101]

Two sequential studies sought to identify the essential characteristics of the nurse manager role through intensive interviews with thirty high-performing nurse managers: the first focusing on personal factors and the second specifying supportive organisational factors.[75, 76] These studies support a nurse manager role model that emphasises the importance of a clear position description supported by an organisational culture of learning and excellence that maintains the role's 'line of sight' to the bedside. This study locates nurse executive leadership as instrumental in creating an organisational culture of learning and opportunity to encourage excellence, elicit respect and provide cohesive meaning and generativity.

Organisational leadership support is cited as the top factor in the effectiveness of educational development for practice and cultural change, with pervasive understaffing and insufficient resources as the primary constraints on staff confidence in most change programs.[153] **Open, inclusive organisational leadership** was pivotal in one successful change program by providing full authority to the change leader and effective response to staff input.[110] Many of these characteristics were evident in a comparison of eight rural nursing homes with new SCU projects.[104] The leadership of four of the facilities conducted consultative, participative programs that inculcated staff ownership and as a consequence had few problems, whilst the top-down leadership of the remainder endured frequent complications. The successful programs practiced

vigilant, continuous communication that reinforced organisational vision and expectations, and supported staff commitment through persistent clinical supervision, clear role description and informed autonomy. An inquiry into teamwork in health care services[154] concluded multidisciplinary teams were the way of the future for best practices in health care, but required a cohesive, supportive organisational framework in which to operate successfully.

Key elements of organisational leadership are identified as **a learning culture of educational opportunity and mobility**, in which risk-taking is encouraged, transparency and accessibility are practiced and the nurse manager is seen as the 'prime driver' of a culture of regard.[76] A comparison of nursing homes with good, average and poor resident outcomes found those with good outcomes commonly used consultative procedures with consistency in multidisciplinary teamwork, multi-level communication and assessment processes, and were ultimately more cost-effective.[91] This study identified the administrator as the initiator of the organisational values and expectations that determined the coherence of good facilities. On examination it was found that many nursing homes claiming to have a quality improvement program did not have the organisational leadership in place to actually implement these programs in practice.[105] Another study of nursing homes claiming a policy of 'high-involvement work practices' found similar discrepancies between leadership rhetoric and implementation.[22] An examination of a failed quality improvement program demonstrates the corrosive effects of inconsistent, incongruent organisational leadership, even when initiated with the best of intentions.[91]

Organisational leadership in HR practices, such as **regular and effective performance appraisal and career development**, is found to play a strong role in positive perceptions of senior management, better work-life balance and organisational commitment.[50] There also needs to be **career pathways** to which nurses can aspire, as found in a Canadian review of the causes of nurse shortages where reductions in nursing leadership roles and correspondingly fewer career opportunities were significant contributors to the attrition of nurses and failure in recruitment.[85] A survey evaluation of the British NHS Skills for Care program found when organisational leadership provided training opportunities and career development it produced significant improvements in recruitment and retention.[155] With the need for organisational support in mind, the successful LEAP (Learn, Empower, Achieve, Produce) program assesses participating facilities for their readiness to support staff with necessary resources to fulfil the program's career development planning requirements.[156]

Administrative support is a key issue for the facilitation of leadership, freeing up nurses in senior positions to allow time for leadership engagement to take place. One study of NHS HR development suggests some administrative duties have devolved to nursing staff and need to be resumed by HR clerical staff.[102] Onerous paperwork and bureaucracy is a constant, widespread complaint of nurses, but the increasingly managerial nature of the RN in aged care has emerged as a particular cause of dissatisfaction and a number of studies have recommended increased clerical support staff.[86, 129, 157] As noted earlier, the loss of leadership visibility on the floor has a detrimental effect on the attractiveness of leadership roles and a number of studies advocate organisational support for a higher leadership presence.[75, 76, 86] Given the competing pressures of increasing consumer demand with concomitant quality

improvements and the need to constrain costs, the development of technological support systems for aged care is considered essential.[2, 3, 37, 55, 85, 94, 158]

POLICY ELEMENTS

The importance of career development,[6, 17, 61, 68, 73, 124, 134, 139, 150, 156, 159] and in many cases dissatisfaction with the lack of career opportunities,[7, 18, 21, 22, 25, 37, 62, 77, 85, 102, 130, 160] are central to staffing and leadership issues in all care settings. Perhaps the most critical policy factors in nurse staffing and leadership issues are: a) The attractiveness of leadership positions, in the quality of support and appropriate rewards to incite aspiration, and b) Sufficient leadership positions for the development of viable career pathways that have leadership as a goal. These were key cost cutting victims of the 1990s restructuring across health sectors in most western nations[84, 85, 161] and have subsequently been found essential to policies aimed at attracting and keeping better quality people in nursing careers. These issues were changed at government policy level then, and can only be redressed by legislation and funding targeted at reinstituting leadership roles with appropriate salaries and training provision.

Clinical supervision has emerged an important policy factor, both for change, quality improvement programs[81, 83, 104, 131] and in practice and professional development.[85, 122, 146, 162, 163] As discussed earlier, this capability cannot be dependent on innate talent and left to individual inclination. It is a necessary professional skill that requires systematic organisational policy. Specifications for both training in clinical supervisory skills[162, 163] and adequate time[83, 85, 104] to conduct the practice of clinical supervision need to be articulated in policy. Likewise with the broader supervisory skills of leadership, for which a minority demonstrate natural facility and inclusion in education and training has emerged as an urgent issue for policy.[37, 56, 60, 61, 77, 95, 103, 104, 126, 144]

At both government and peak body levels, the importance of and access to **education and training for leadership and management development** needs to be clearly articulated in policy, which should be based on competencies and their quality framework.[164] The UK made leadership skills central to the curricula of its social service training program, *Skills for Care*, prescribing equal access to consistent, relevant continuing professional development that is transferable across organisations with a common language and systems.[121] Likewise, the NHS Leadership Qualities Framework[165-167] and *Leadership at the Point of Care* program[168] are evidence of recognition of the importance of leadership. The Canadian government has recently set leadership training as an important factor in the improvement of nursing as a career choice.[85, 94, 140] At an organisational level, leadership training is central to the successful LEAP program, for which facilities need to prove they have policy in place to support staff career development before committing to the program.[156]

Congruent organisational policy that provides systematic leadership protocols proved an essential factor for successful outcomes in the Canadian government's resident centred care culture change program, for which the leadership competencies of many nurse leaders proved inadequate to the task.[67] It is equally important there be State policy in place that provides adequate leadership roles with well-defined position descriptions and succession protocols for managers to aspire to.[85] Kilty[169] reviewed leadership education available to nurses for the Canadian Nurses Association, finding a number of university and international offerings with only one Canadian leadership institute, concluding that a National Leadership Centre was essential to coordinate

stakeholders, establish a national framework and lobby for funding to increase leadership roles and take better care of existing leaders.[169] Dickson et al. carried this further, articulating a competency framework,[135] which was subject to scrutiny and further comment by peak bodies.[170]

Developing and working with multidisciplinary teams is increasingly considered optimal care provision and the collaborative skills involved are essential components of the leadership capacity spectrum,[94, 107, 135, 140, 146, 149, 154, 164, 171, 172] but this is yet to translate into formal policy for many organisations. The leadership competencies developed by Calhoun et al. cite the development of **effective interdisciplinary teams** as an essential leadership competency.[164] However, change at policy level is necessary for the practice to advance.[154]

The responsibility for choosing **an optimal skill-mix in** developing an effective team remains the province of an individual leader[154] and a matter for the policy of individual facilities. Skill-mix, which in aged care means primarily the ratio of qualified nurses to unqualified staff, has emerged an important factor in both care quality[24, 25, 91, 93, 152] and staff satisfaction[21, 74, 93] so it remains an important issue for organisational policy. A decrease of some 4,603 RNs and ENs in Australia between 2002 and 2005 has seen aged care facilities substituting more nurse positions with care assistants,[3] both reducing leadership positions and further diminishing the skill-mix. Recommendations for optimal skill-mix are all very good, but if qualified nurses are simply not available, then no staffing ratio policy is going to survive.

A clearly articulated, comprehensive HR policy that provides structural and psychological empowerment for organisational congruence has previously shown to be essential. The coalface of HR policy is in the hiring process, a procedure that Cohen[133] advises is best approached in matchmaking mode to ensure the new hire is compatible with both organisational values and the team with whom they will be working.[133] Compatibility has shown to be essential for staff satisfaction and team development.[81, 144] The *Skills for Care* program in the UK provides training for the nursing home RN to engage with new care staff hires, ensuring organisational policies and procedures are manifested in the hiring process and reinforced by contract, with six supervisory sessions yearly to support learning and development.[121] The LEAP program also uses contracts, and sets the 'three R's of retention' as 'relationships, respect and recognition'.[156]

An effective, articulated, integrated communication policy has emerged as essential for overall organisational efficacy, in the transmission of values, expectations and meaning.[28, 54, 66, 69, 111, 113, 115, 139, 150] Whilst communication is an essential competency in all leadership training,[56, 57, 71, 75, 78, 102, 103, 125, 172] consistency is too important to leave to individuals, and formal protocols need to be established in the organisational framework. Systematic, consistent and clear communication from and with management was found to be a key factor in the success of change and quality improvement programs[59, 67, 68, 70, 107, 110, 120, 130, 134, 139, 147, 156] and a factor in ensuring quality outcomes.[55, 72, 91, 173] Organisational policy that ensures a two-way flow of information is essential for staff support, to maintain teams and networking,[63, 81, 85, 88, 109, 112, 114, 158, 174] sustain clinical performance[128, 162] and generate staff satisfaction.[26, 74]

INFLUENCING FACTORS OF LEADERSHIP

A variety of factors have been found to facilitate the development and practice of leadership, and whilst these skills may be individual, their practice can be facilitated or constrained by organisational systems. Perhaps the most immediate facilitator of leadership is the **practice of transmission, or generativity,** where leaders inspire others through the model they embody on the practice floor[75, 76, 109, 119, 128, 129, 132, 139] and encourage aspiration through mentoring.[63, 75, 136]

For leadership to facilitate an all-important sense of meaningful work, all the above attributes of individual and organisational leadership must cohere in the congruence of organisational and individual values and expectations that Mackoff terms a **'culture of meaning'**.[75, 76] Indeed, the ability to inculcate a sense of meaning in the work and workplace relationships has emerged as an important facilitator of leadership.[56, 66, 109, 135, 150, 175] An established 'learning organisation' ethos facilitates existing leadership with supportive resources and fosters aspiring leaders through the provision of opportunities for personal and professional development.[17, 24, 25, 68, 76, 163, 176, 177] The glue that coheres these factors, facilitating the impetus to achieve best practice for current and aspiring leaders, is the 'culture of excellence' that is the hallmark of good leadership and magnet status.[48, 75, 76, 132]

Perhaps the most critical barrier emerging from the research is the sheer **pressure of workload on existing leaders**, which constrains all leadership behaviours and diminishes both transmission and aspiration. This pressure occurs at all leadership levels, with health care CEOs finding time and accessibility major impediments in undertaking leadership development.[178] The factors of this workload barrier are complex and need to be teased out. The restructuring of health systems in the 1990s saw the rationalisation of nursing leadership roles, reducing the number of positions and increasing span of control,[84, 85, 95, 143] increasing responsibilities for which many nurses remain ill-equipped.[86] In aged care, this combines with the work's increased complexity to render the RN's role increasingly managerial, burdened with paperwork and with less time for hands-on, supervisory and care activity.[37, 74, 103]

The development and transmission of leadership is restricted by the widespread **scarcity of resources** in health care, which is further exacerbated in the aged care sector. This places additional barriers on the effective conduct of leadership,[67, 86, 103, 144] limiting the effectiveness of change programs[61, 105, 137, 179] and contributing to dissatisfaction and turnover.[66, 101, 104, 125, 157] Turnover amongst nursing managers is a barrier to the development and practice of leadership, with turnover at higher levels frequently linked to the turnover of lower leadership positions.[55, 65, 66, 101, 116, 130]

Most current leadership theory and research findings favour **the collaborative, participative approach of flatter management** as opposed to an authoritarian, top-down leadership style.[28, 54, 59, 104, 136, 139, 144, 149, 154] However, as Oandasan et al. points out, there are systemic organisational and cultural barriers to this practice, requiring significant changes to facilitate implementation.[154] Whilst there is considerable advocacy for the PCC model and more recently the Relationship-Centred Care (RCC) approach,[180, 181] which ideally extends its approach to staff management and family, many facilities continue to struggle to change their medical-custodial care culture, which holds little appeal or potential advancement for aspiring leaders.[6, 59, 144]

The persistence of this traditional model has much to do with the aforementioned lack of resources, at the core of which is poor staffing ratios, low wages and lack of respect,[37, 101, 130, 136, 157, 163] which encourage the intransigence of perceptions of the aged care sector's low status.[86] Likewise, an overloaded leadership lacks the most precious resource of all: the time to provide the positive feedback and recognition necessary to encourage leadership transmission.[62, 113, 150] Lack of sufficient resources also reduces what career opportunities an organisation offers, limiting leadership pathways.[6, 7, 17, 21, 28, 85, 132]

3. WHAT ARE THE BEST MODELS IN DEVELOPING SUSTAINABLE WORKFORCE LEADERSHIP AND EFFECTIVE MANAGEMENT IN RESIDENTIAL AGED CARE?

Rigorous, experimental research in nursing leadership theory and models for education, training and development is rare in the literature, and entirely absent for aged care, so it is not possible to provide evidence-based recommendations for 'best models.' In general, research in nursing leadership is relatively recent and initially borrowed much of its theory from models of professional development, with an understandable preference for change management. An exhaustive review of empirical studies on health care leadership found a sector struggling to adapt these models to a more complex and very different cultural and professional environment.[57] In this review, the development of sustainable, effective nursing leadership and management was located in collaborative, communicative and flexible approaches, informed by systematic communication protocols and procedures, which were associated with the spectrum of staffing variables across job satisfaction, retention and recruitment.[57] However, health care leadership transmission discourse remains trapped in frameworks unsuited to health care, resulting in much of the leadership activity going 'under the radar,' unsupported and unrewarded.[136]

Pressure for change in health care is intense, none more so than in aged care, and nursing leadership discourse is working towards models suited to the sector's unique workplace environments. The most common 'borrowed' theoretical construct in preparing nursing leadership for change has been the transformational model of a visionary, charismatic and dynamic leader, frequently linked to a transactional approach, based on reinforcement and reward.[118] The review by Pearson et al. found support for this model in higher staff and patient satisfaction and improved quality of life.[56] Use of the transformational approach in change programs makes literal sense, as Deutschman found, with only highly innovative and assertive leadership able to implement and sustain effective change.[130] Likewise, Dana and Olsen found the transformational leader essential for change programs, but cautioned that its appropriateness is limited to the early stages of change, after which some more grounded style is preferable.[48]

However, the literature is 'littered' with diffuse applications of the term 'transformational', its contradictory use evident in Page where it is linked with participative, non-hierarchical management[25] and others who use the term generically, for its promise of much needed change.[56, 63, 74, 97, 120, 127, 129, 172, 174, 175, 177, 182] Gilmartin and D'Aunno found upper management tends to exercise transformational leadership amongst themselves despite poor receptivity, they surmise due to nurses' professional

egalitarianism, but less so with lower echelons who actually respond better to its dynamism.[57] Hartley and Hinksman suggest the model's roots in American individualism may not be universally applicable[47] and Stanley argues the creative ethos of the transformational model is not appropriate to nursing, where 'doing' has priority over 'creating'.[109] Overall, as a style it may well be the transformational model has its place in generating change and suits some individuals and situations more than others, but is best when drawn from a repertoire of useful leadership styles.[128, 149]

The sections above identified an array of studies with some focus on the development of sustainable leadership, all of which identify common conditions, characteristics and attributes that comprise an organic model of leadership development and facilitation. For leadership to be sustainable, solid evidence shows the essential role of organisational policies linked to and congruent with leadership development programs[47] provides necessary resources for structural and psychological empowerment.[150] Mackoff et al. describe a model for an organisational culture that facilitates sustainable leadership with five dimensions of engagement in cultures of Learning, Regard, Meaning, Generativity and Excellence, providing a framework that is universally applicable across health care settings.[76]

In their recommendations on organisational changes to support sustainable staffing in aged care, Ellis et al. advocate a shared governance model that disperses leadership and encourages autonomous work teams in recognition of the complexity of conditions in that sector.[94] Pearson et al. cite an experimental, shared governance SCU study that found greater staff satisfaction, improved perceptions of leadership and lower absenteeism.[56] Whilst sufficient resources, including increased staffing and wages, are top of the list to improve aged care staffing sustainability for DeCicco et al.[150], shared governance is their recommended leadership model.[150] Successful shared governance, culture change programs in the UK hospitals, Christie[149] and Leicester[134], add support for this model, as do Buchanan et al., who suggest shared governance allows opportunities for wider leadership transmission and is worthy of further research.[136]

Achieving the status of 'magnet hospital' indicates best-practice management policies that support nursing leadership to sustain a culture of excellence and learning in which professional autonomy and personal development are nurtured, making the organisation an 'Employer of Choice'[132]. This construct, which began in acute hospitals but quickly extended to aged care, has become an inspirational goal for organisations, but requires a whole organisation change and simply adopting 'high involvement work practices' is insufficient.[183] The Wellspring model, which develops multidisciplinary teams with the sharing of resources and data between an alliance of facilities[184] and the Eden Alternative, a community environment design[185] are exemplars of leadership development, in that both facilitate non-hierarchical leadership in self-managed teams.

LEADERSHIP DEVELOPMENT APPROACHES

There is strong evidence that sustainable leadership is dependent upon the personal, immediate experience of good leaders, its transmission through both informal role modelling[48, 56, 75, 103, 105, 107, 108, 116, 128, 130, 144, 156, 186] and formal generative procedures.[63, 75, 136, 171] During their careers, all nurses will receive and deliver formal and/or informal mentoring, making this an essential competency[8, 69, 76-78, 85, 104, 120, 122, 130, 138, 140, 146, 150, 151, 156, 187] and fundamental to the transmission of leadership. Most nurses will need to learn these competencies and the aforementioned learning culture that incorporates

continuing professional development opportunities is a key organisational leadership development strategy.[6, 17, 38, 56, 63, 88, 127, 141, 169] In a UK study of the Leadership Practices Inventory (LPI) in Nursing Development Units (NDUs), conceived as centres of nursing excellence, innovation and leadership development, NDU nurses were found to produce significantly higher scores in three of the five domains of exemplary leadership practice, and higher overall leadership with a higher level of congruence between self and observer evaluations.[188]

Supervisory mentoring is regarded an important leadership competency,[71, 138, 159, 169] found essential for succession planning and generativity.[75, 76, 85, 140] In comparison with coaching, which is coach-driven, mentoring is usually mentee-driven and has more significant outcomes.[159, 189] Yet, relative effectiveness may be dependent on style and context, since coaching of clinical leaders has been found to be cost effective, leading to greater staff retention.[190] For formal mentoring, the matching of mentor and mentee for relevant expertise and personal and professional compatibility is important for success, and competency in mentoring can also be disturbingly uncommon, even amongst senior nurses and administrators.[54, 67, 187] Mentoring is frequently twinned with supervision, and often linked to the individual leadership attribute of 'nurturing'.[24, 75, 76, 84, 103, 126, 134]

Systematic clinical supervision has been found to produce improved attitudes for aged care and dementia nurses[83, 122, 131, 146] —an essential constant for a learning organisation[163] and core activity of nurse leadership[71, 85, 104, 120, 138, 162] and administrators.[162] Poorly planned clinical supervision has been found to act as a deterrent to aged care for nursing students.[146] Clinical supervision is also associated with action learning in two clinical leadership programs that encourage leadership transmission through cascade learning.[120, 138] Action learning is a common strategy for workplace learning, using 360° feedback[74] for constructive leadership in shared governance,[136] collaborative leadership and networking training,[141] and is central to the UK's leadership programs.[71, 121]

FORMAL LEADERSHIP PROGRAMS

Across comparative national health systems, leadership development has only recently emerged as a critical issue in its own right, most remaining integrated in professional development offerings and the availability of formal programs focusing on leadership development is patchy. Appendix 6 provides brief descriptions of the programs identified in this section.

- Perhaps the only country to have responded with a comprehensive, national staff training and development program is **the UK** through, for example, its *Clinical Leadership Development Programme*[71, 120, 138] and *Skills for Care*.[155, 191, 192] **The Skills for Care Leadership and Management program** issues a series of intensive articulated curriculum modules called 'products' that address each dimension of social care leadership practice.[155, 191, 192]

  The UK's Royal College of Nursing Clinical Leadership Programme provides sustainable leadership development throughout which the patient remains the constant reference point for all behaviours and procedures, providing an ethically congruent model of practice[71] synonymous with the move to PCC in aged care.

The UK's NHS Modernisation Leadership Centre provides **a Leadership Qualities Framework (LQF)** that guides a series of initiatives in 3 modes: Setting the Direction, Delivering the Service, and Personal Qualities.[119] These initiatives provide clearly articulated program objectives for target group levels, with expectations, aims, benefits and previous outcomes. The program content and authority are clearly described, giving adequate notification of timeframes and location, with a caution to assess participant readiness and learning styles. The latter are accommodated with a variety of educational and training strategies that allow flexibility in delivery and assessment.

- Despite the formation of **a US National Leadership Centre** and the issuing of leadership competencies in 2004,[164] when Reinhard and Reinhard explored the leadership landscape in 2006 they found very little for nursing and aged care specific programs rarer still in the US.[77] There were four universities offering advanced long-term care (LTC) leadership curricula, one gerontological specialist internship, leadership as a feature of Continuous Quality Improvement programs, **the Pioneer Network** and the LEAP program.[77]

  The LEAP PCC culture change program in Illinois is an exemplar of comprehensive, formal aged care-specific leadership programs.[156] This perennial culture change program with leadership development at its core is the collaboration between Rush University, Mather Lifeways and the Life Services Network. Participating facilities are first assessed for organisational readiness, then a manager and staff educator attend a Train the Trainer workshop in the implementation of two LEAP Modules: 1. Essential Nurse Roles – articulating leadership roles and responsibilities for all nurses; 2. Heart of Care – training all care staff in PCC practice for residents, families and staff, with a focus on career development and peer mentoring.

  The WIN A STEP UP program demonstrates successful outcomes for improving some of the residential aged care workforce challenges such as staff job performance, care quality and teamwork. Whilst aiming at improving the working situation of nursing assistants who are key training participants, the program also includes 'Coaching Supervision' for improving nurses' supervisory and active listening skills.

- Between 2005 and 2007, various **Canadian** health authorities issued reports on an emerging national crisis in nurse leadership and staffing.[85, 135, 169] In 2005 Kilty reported to the Canadian Nurses Association on leadership development for nurses, finding no national framework and those programs on offer largely atheoretical.[169] University leadership components were primarily management focused and available only in the third or fourth year; otherwise there was just one dedicated institute, the remainder of programs mostly arbitrary and self-evaluated. Priest et al. reported serious staffing shortfalls and an absence of government strategy in Canada.[85] The report recommends returning resources to improve conditions and argue there is an urgent need to increase base qualifications and reinstate nurse leadership positions lost in earlier restructuring. In 2007, Dickson and colleagues consulted the national health leadership widely, with specific policy recommendations for the establishment of a common framework and language for health care leadership and identifying essential leadership domains.[135] There are no

further reports on implementation, but it is likely these recommendations will manifest in a coordinated leadership development program.

- **Australian** education and training in health care leadership is at a similar stage to Canada, except there is no stand-alone nursing leadership institute and the national discourse is not as developed. Most Australian university nursing schools have some leadership dimensions embedded in the general curriculum, but few leadership-specific courses. Recently several nursing schools in Australia (Flinders University and University of Western Sydney for example) have started offering postgraduate degrees in the aged care specific management.

South Australia is a stand-out, with the Royal Adelaide Hospital hosting the UK's Royal College of Nursing, SA Chapter offering **the Clinical Leadership Programme in Australia**.[193, 194] However, this Clinical Leadership program was designed for staff from acute and community health care settings. Deakin University School of Nursing offers annual Leadership in Nursing awards to recognise and develop emerging leaders. There are also non-degree management courses offered through vocational training organisations such as a health management course, which is a generic program, and Certificate IV in aged care, which targets frontline managers or supervisors who do not necessarily hold a management position.

SUMMARY OF KEY FINDINGS

Strong, effective leadership and management promotes staff job satisfaction and retention, high care quality, the well-being of care recipients and reduces associated costs.

The essential individual attributes of leadership are a hands-on accessibility and professional expertise in nurturing respect, recognition and team building, along with effective communication and flexibility. However, successful leadership outcomes depend on good organisational leadership that enables leaders to feel confident they have sufficient resources at their disposal to ensure the delivery of high quality care and sufficient support for their staff, for example adequate skill mix of staff, clear HR practices and communication policies, administrative support, attractive incentives/rewards and career pathways.

A paucity of work has been done in Australia in terms of leadership and management development in the aged care sector. The initial search of literature indicates most studies have been acute care setting oriented and overseas based, largely from the UK and North America. Theory development in aged care leadership research is limited, resulting in attempts to source a suitable model from general management discourse. Currently models are being sourced from the management field, of which the transformational model appears to have the most evidential support so far. Further theory development in aged care leadership research is needed.

Middle managers and leaders working in aged care have limited opportunities to prepare for these roles and lack clear, congruent guidelines to support them in the roles' responsibilities. Although desired leadership attributes and core competencies are listed in a number of papers, these are generic and there is little in the way of hard evidence for these knowledge and skill sets or how best to develop the effective leadership and management necessary for the future of aged care. Key performance indicators to assess leadership and management skills do not exist.

Few effective clinical leadership programs exist in the health and social care arenas, for example, the Royal College of Nursing Clinical Leadership Programme and the Skills for Care Leadership and Management program in the UK. The US LEAP program is perhaps the only aged care specific program with a leadership development focus that showed increases in work empowerment, perceived organisational climate, job satisfaction, and work effectiveness. The relevance of these to the Australian aged care sector and how best effective leadership and management can be developed for the aged care sector in Australia are unknown.

In much of the literature reviewed here, the constructs of leadership and management merge under the term of nursing or clinical leadership and when management is mentioned the two are often twinned and few articles differentiate between them. Perhaps this is due to the disruption of traditional leadership hierarchies in health care in the sector's restructuring and the loss of leadership roles, inducing a sense of loss and perceived need to revise nursing leadership. When management training is identified specifically, it is often for administrative health care staff than nurses. Yet nursing leaders engage with activities that fall under the rubric of management, requiring management-specific competencies. Whilst it is not often articulated as such, organisational management has emerged central to many of the sector's concerns. Together, these factors highlight the need for a clearly defined aged care management component in leadership education and training.

Strengthening of leadership and management skills in the residential care sector is critical in ensuring adequate care quality and health and well-being of those who receive and provide the care. However, focusing on an individual leadership and management development cannot be a panacea to bring successful and positive outcomes, and any endeavour to improve leadership and management is likely to fail without organisational leadership and appropriate policy that guarantees philosophical cohesion, coherent psychological and structural frameworks, physical and environmental support (e.g., adequate financial, physical and administrative resources, staffing ratios and skill-mix, remuneration, and staff training and development). Onus is on aged care industries as a whole and various levels of Governments through establishment of relevant regulation, legislation and funding, and their concerted efforts.

POLICY IMPLICATIONS AND OPTIONS

The findings of this study have highlighted the following:

- There is an urgent need for a nationwide and focused effort to develop sector-appropriate models/programs for leadership and management congruent with the philosophy of 'Person Centred Care' and the characteristics of the aged care workforce.

- Organisational policy needs to establish coherent frameworks that support leaders and managers through structural and psychological empowerment, enabling them to achieve best practice in team work and quality care.

- Attention must be given to building evidence informed policy for the development of leadership and management skills for the aged care workforce to inform both organisations and educational curriculum development.

- A needs assessment for leadership and management programs in combination with mapping of the Australian aged care workforce is urgent.

- Development of a leadership and management quality framework together with theory development in aged care leadership research would underpin sound leadership and management programs.

- Leadership and management skills for aged care should extend beyond the RAC workforce to include community aged care.

- The aged care sector's increased complexity is a significant stress factor in the workplace environment and the underlying principle of any new policy should be to diminish rather than increase stress.

- Shared funding and accountability among the Australian Government, State and Territory Governments and the aged care industry is necessary to support the development of leadership and management skills in the aged care sector.

AGED CARE LEADERSHIP AND MANAGEMENT STRATEGY

A national strategy that promotes a common approach to aged care leadership and management development at both government and aged care industry level is necessary. Under this strategy the importance of and access to education and training for leadership and management development can be clearly articulated in relevant policy, in terms of education and training; regulation, legislation and accreditation; incentives, remuneration and reward; and national minimum dataset.

EDUCATION AND TRAINING

It is important leadership and management skills of residential aged care workers be improved. This review has shown leadership and management skills are associated with increased job satisfaction, retention and intention to stay, perceived unit performance, perceived improvement in the work environment, peer cohesion, organisational commitment, productivity, reduced turnover and intention to leave, and reduced absenteeism. Thus good leadership and management skills are central to organisational development and change. Four key issues should be considered:

Development of Aged Care Specific Leadership and Management Qualities Framework: A leadership and management qualities framework (LaMQF) will be an important tool in developing or evaluating activities that aim to ensure effective leadership and management are in place to provide quality care. The framework should encompass both leadership and management qualities (with a clear delineation of the skills, attitudes and knowledge for the two concepts), and include sets of competencies for key domains as well as key performance indicators for a systematic evaluation. The existing literature provides limited evidence in terms of specific skills and knowledge required for the delivery of effective management in aged care. Key skill sets of the effective management identified in this review include capabilities to address cultural diversity, performance management of junior staff, information and technology management, and working with a multidisciplinary team or those from outside the RACF.

Development of a leadership and management course: Currently there is inadequate preparation for middle management leadership roles. A nationwide

curriculum should be developed based on the qualities framework mentioned above, and be a RAC specific, affordable and accessible program. The program however, should allow for flexibility based on organisational uniqueness and its context. Given the clearly identified time constraints of current leadership, flexibility needs to also apply to module design and accessibility to encourage take-up.

Establishment of a partnership approach: The development of the leadership and management framework and program should take place in collaboration with policy/decision makers, aged care industry representatives, an accreditation body, consumers/carers, tertiary and vocational education and training organisations. This includes peak bodies such as Aged Care Services Australia (ACSA), Aged Care Association Australia (ACAA) and the Community Services and Health Industry Skills Council (CSHISC). Collaborative action will facilitate and ensure consistent approach to the issue, dissemination and implementation of the framework and the program.

Establishment of an aged care leadership and management centre: The centre should focus on developing, identifying and disseminating effective educational and training programs and best practices for improving leadership and supervisory skills among people in a managerial position (e.g., RAC managers, directors of nursing, charge nurses and team leaders). This centre should provide a hub for peer networking and mentoring, building further leadership transmission.

REGULATION, LEGISLATION AND ACCREDITATION

It is recommended that job requirements in terms of qualifications and experience be instated, as care workers need to be qualified in aged care. However, requirements should depend on the individual's roles and responsibilities where, if one is a director of care nursing, qualifications are more important, but if they're an executive manager this might not be necessary. Increasingly, middle management in RAC have no nursing qualifications. It is therefore important an experienced clinical nurse with the relevant qualifications always be available in the RACF.

The supply of the right workforce for the right job, with clear delineation of scope of practice, appropriate workload and skill mix, and maximum utilisation of the workforce should be ensured so middle management can be supported in their practice. Currently, RACFs are assessed against the Accreditation Standards. Standard 1 deals with Management systems, staffing and organisational development and is assessed with reference to expected outcomes. There are guidelines for the Agency's specified areas, which might be extended to include those policies and systems in place that ensure cohesive leadership support. However, there is no means by which the effectiveness of individual leadership or an organisation's ability to support its leadership might be formally assessed. An important proviso is that any assessment of these capacities would be best framed as supportive and developmental rather than punitive.

INCENTIVES, REMUNERATION AND REWARD

Career paths for nurses and other care staff into administration and senior management need to be made available so the senior levels of management are occupied by people who understand the floor environment. Development of relevant policies guiding the notion of providing attractive career paths and succession planning

should be in place. Increased incentives, remuneration and reward are recommended along with further promotion of career pathways, integration of nurse leader succession planning into organisational culture, and movement between the different leadership levels. Also, recognition of leadership and management development programs completed at university could provide further encouragement. The image of the RAC industry needs to be modernised and made more appealing. Wage parity between acute and non-acute care would help with this.

NATIONAL MINIMUM DATASET

Understanding the nature and characteristics of the aged care workforce is important in developing the leadership and management qualities framework and the leadership and management development program. It is recommended a national minimum dataset (MDS) be set up so there is ongoing data collection detailing types of managers, their diversity and the qualifications they hold, pay and remuneration, and turnover and retention. The data, analysis and synthesis obtained from the MDS will inform further improvement of the framework and the program. In order to be able to conduct complex and systematic workforce planning and ongoing comprehensive monitoring of the workforce, the establishment of the MDS is necessary.

GLOSSARY

360 degree feedback	A leadership evaluation process which involves the systematic collection of performance data on an individual (the participant), gathered from a variety of useful sources (the raters) in a confidential manner.
ACSAA	Aged Care Standards and Accreditation Agency Ltd.
ACAA	Aged Care Association Australia
ACSA	Aged and Community Services Australia
Absenteeism	Unscheduled absence from work
ACFI	Aged Care Funding Instrument; a means of allocating Australian Government subsidy to residential aged care providers.
Action learning	An approach to learning based on individuals working on real problems that are capable of having action taken on them. The process is reflexive and the individual needs to be able to identify the problem, own it, identify steps necessary to resolve it, implement them and analyse the effects, making necessary changes. This is often done with a group of colleagues who are 'comrades in adversity'. These colleagues may share the same problem, work in the same or another organisation or may have very different problems.
Aged Care Access Initiative	Replaces the aged care GP panels initiative; aims to improve access to primary care services for residents of Commonwealth-funded aged care facilities, through payments to GPs and allied health professionals.
Aged Care Act	The principle legislation that regulates the residential aged care program from 1 October 1997. The Act covers residential aged care (including former nursing homes and hostels), flexible care (including former multi-purpose services and nursing home options), and community aged care packages.
Ageing in place	A policy designed to allow, in those facilities which could offer appropriate accommodation and care, residents to remain in the same environment as their care needs increase.
AIHW	Australian Institute of Health and Welfare

BEACH study	Bettering the Evaluation And Care of Health. The BEACH[©] program continuously collects information about the clinical activities in general practice in Australia including characteristics of the GPs; patients seen; reasons people seek medical care; problems managed, and for each problem managed. The BEACH database includes currently includes about 900,000 GP-patient encounter records. (07/07) It uses a cross-sectional, paper based data collection system developed and validated over 30 years at the University of Sydney. Data generated is used by researchers, government, industry and non-government organisations.
Black literature	Material that is published in regular accessible journals, often through electronic databases.
CALD	Culturally and Linguistically Diverse
CAP	Conditional Adjustment Payment
Change management	The process of developing a planned approach to change the cultural environment and work practices and protocols of an organisation. The objective is to make the best of the shared efforts of all people involved in the change.
CHSRF	Canadian Health Service Research Foundation
CNA	Certified Nursing Assistant
CNC	Clinical Nurse Consultant
CSHISC	The Community Services & Health Industry Skills Council is the recognised peak national body providing advice on the training and skills development needs of the community services and health workforce to government and industry. The role of CSHIC involves developing competencies and training packages for the community services and health workforce.
GP	General Practitioner
Grey literature	Material that is not published in regular accessible journals, and does not show up on databases (e.g., conference proceedings, unpublished theses, etc.). It also refers to publications issued by government, academia, business, and industry, in both print and electronic formats, but not controlled by commercial publishing interests, and where publishing is not the primary business activity of the organisation.

High care	High level residential aged care includes accommodation and related services, personal care services and nursing care and equipment. Residents classified as 1–4 according to the Resident Classification Scale are considered high care.
HR	Human Resources
LEAP	Learn, Empower, Achieve, Produce
Low care	Low level residential aged care includes the provision of suitable accommodation and related services, such as laundry, meals and cleaning, and personal care services, such as assistance with bathing, dressing and toileting; residents classified as RCS 5–8 comprise the low care category.
Magnet theory	'Employers of Choice' due to a Culture of Excellence and Learning with less hierarchy, more autonomy, supportive supervision and colleagues.,.
NHA	Nursing Home Administrator
NHS	National Health Service (UK)
NMDS-SC	National Minimum Dataset for Social Care; An initiative developed to address the lack of workforce data in social care, it is gathering data from the workforce in the private and voluntary sectors.
NP	Nurse Practitioner
NUM	**Nursing Unit Manager**
Organisational development	The process of conducting overviews, interviews, analyses and any other assessments required to determine the overall structure and function of an organisation. The purpose of this review is generally to determine where problem areas may exist and then to suggest changes.
PCC	Person Centred Care is a humanistic approach to care that places the individual person at the centre of the care process. PCC recognises the need to value and treat the person as an individual, to view the world from the person's perspective and to create a positive psychosocial environment.
RCC	**Relationship Centred Care** is underpinned by individual person's six 'senses', and acknowledges the subjective and perceptual

	nature of the key determinants of care for older people, families and staff. Focus of this care framework is not only the person who receives care, but others such as staff and families, and their interactions with each other.
RACF	Residential Aged Care Facility
RCS	Resident Classification Scale; a nationally consistent instrument which assesses a care recipient's care needs. This scale has 8 classification levels ranging from low to high care, with each level having a specified subsidy level which is paid to the provider for providing the required care to the care recipient.
SCU	Special Care Unit, usually sited in a RACF to accommodate residents with dementia and other cognitive disorders.
Shared governance	A generic term describing any model of participative management or 'shared accountability' or a process through which all members of a group, community or organisation are encouraged to share in the process of decision making. It is based on the principles that the success of an organisation is dependant on the legitimate involvement of members in the planning and decision making processes of that organisation.
Skill mix	Skill-mix refers to: mix of posts, grades or occupations in an organisation; the mix of employees in a post; combination of skills or competencies available or needed for each job within the organisation; or alternatively, it may refer to the combinations of activities that comprise each role, rather than the combination of different job titles; a mix of skills or competencies possessed by an individual; the ratio of senior to junior grade staff within a single discipline; or a mix of different types of staff within a multidisciplinary team.
Span of control	The number of people overseen and reporting to the manager
Structural empowerment	Power is defined as the ability to mobilise resources and 'get things done'. Employee's perceptions of power within the workplace result from having access to organisational structures (i.e. formal/informal power structure,

	information, resources, support and opportunities) that are empowering.
Succession planning	The process of identifying and preparing suitable employees through mentoring and training to replace current leaders and managers within an organisation before their terms expire.
Staff turnover	The ratio of the number of workers that had to be replaced in a given time period to the average number of workers; or, the number of workers that have quit within a given time period, usually one year, in relation to the total number of workers on the payroll for that period.
Work environment/work climate	The prevailing workplace atmosphere as experienced by employees often influenced by supervisor support, resource and policy adequacy, workload, team work, and autonomy or sense of control over their work as well as physical comfort.

Leadership Models and Theories

Distributed/Dispersed Leadership	A collective leadership approach to care in which individual attributes and acts are facilitated to occur opportunistically across a broad range of work situations and at all staffing levels. This is a flatter style of management facilitating shared leadership between leaders and followers and different leadership groups and work teams.
Contingent/Situational Leadership	Proposes that an effective leadership requires a repertoire of leadership styles, which are applied as appropriate in response to the context and situation.
Congruent Leadership	Focuses on the leader's personal authenticity and integrity and how that is integrated within the organisational ethos. Promotes a sense of trust and meaningful work practice and integrity of principles, values, vision and practice at all levels.
Hierarchical Leadership	Vertical organisational structure commonly applied to the medical, or 'traditional' model of care.

Shared Governance	A more formal, integrated approach to distributed leadership, which establishes multidisciplinary communities of collective practice that manage localised responsibilities and are facilitated and overseen by coordinators. These units collaborate and network with others within the organisation.
Transactional Leadership	In transactional leadership, leader-follower relationships are based on a series of reward and censure exchanges or interactions between leader and followers.
Transformational Leadership	Proposes a dynamic, inspirational leadership that transmits a vision and ambition to their followers in order to achieve beyond normal expectations. Developed as a model for change agents and professional and business leaders and become popular for change in health care organisations.

Additional notes on care staff titles and aged care settings [4]

The term 'nurse' is used in a number of ways in the literature and the status of the position is denoted through the common use of acronyms within this literature review.

A **licensed** nurse is one who has successfully achieved an approved program of tertiary level study that is recognised by the Nurse Register authority of the country or state/territory in which the award was granted. Acronyms used to denote qualified nurses throughout the literature include:

RN   Registered Nurse
EN   Enrolled Nurse
LPN   Licensed Practical Nurse (USA)
LN   Licensed Nurse (USA), often meaning RNs and LPNs
DON   Director of Nursing
APN   Advanced Practice Nurse

A direct care worker may/or may not have achieved a nationally recognised vocational qualification (often Certificate III). While not acknowledged by Nurse Register authorities, the qualification may be approved by the government and/or the aged care industry in each country. Acronyms used to denote unlicensed nurses throughout the literature include:

AIN   Assistant in Nursing
CNA/NA Nurse Assistant/nurse aid
PCA   Personal Care Assistant

The residential aged care sector is variously described in the literature in the following ways:

LTC   Long Term Care
NH   Nursing Home

RAC   Residential Aged Care

The older person receiving care and treatment is generally referred to in the literature as follows:

Patient   Person receiving care and treatment in the acute care sector (hospital), or by a doctor or other health professional in their rooms or clinic

Resident Person receiving care and treatment in the residential aged care sector (nursing home or hostel)

Client   Person receiving care and treatment in the community sector (generally their own home)

APPENDIX 1 CURRENT AUSTRALIAN GOVERNMENT INITIATIVES

WORKFORCE INITIATIVES

While the training and education of the aged care workforce is seen by the government to be largely the responsibility of aged care service providers, the Australian Government has supported the aged care workforce in various ways. Since 2002, the Australian Government has allocated over $229 million for workforce initiatives designed to increase overall staff supply, to provide additional training opportunities for existing staff and to create better career paths for care workers.[195]

Currently, the Australian Government's aged care workforce initiatives include: the Bringing Nurses back into the Workforce program which supports the return of 7,750 nurses to hospitals and 1,000 nurses to residential aged care homes; providing scholarships to encourage more people to enter or re-enter aged care nursing through the Aged Care Nursing Scholarship Scheme; and the provision of postgraduate scholarships to assist community aged care nurses to gain higher qualifications in home-based aged care. A further 1,400 aged care workers in rural and regional areas will be offered places for further training under a new round of the Support for Aged Care Training Program; and training places will be provided for aged care workers to access dementia-related education and training.[196]

BETTER SKILLS FOR BETTER CARE PROGRAM

Through the Community Aged Care Workforce Development and the Better Skills for Better Care programs, the Department of Health and Ageing has also funded 7,700 new training places over four years in aged and community care at a cost of $41 million. A total of 2,700 community training places and up to 5,000 RAC training places will be made available, including places for Certificate IV in Service Coordination and Certificate IV in Aged Care Work and Community Services. The Certificate IV in Service Coordination involves preparation for frontline management roles.[196] However, the focus of these programs has been towards nursing and care staff involved in direct care and supervision, rather than leadership and management roles for middle managers.

THE 'CONDITIONAL ADJUSTMENT PAYMENT' (CAP)

The 'Conditional Adjustment Payment' (CAP) was one of the key measures in the Australian Government's 2004 Budget package – Investing in Australia's Aged Care: More Places, Better Care. The aim of the CAP is to improve the quality, accessibility and sustainability of the aged care sector to better meet the needs of the ageing population. The measures aim to provide better training opportunities to staff of RAC services and provide aged care residents and potential residents with better information on an aged care provider's services.[197] The CAP was intended to provide medium term financial assistance to providers while encouraging them to become more efficient through improved management practices. RAC providers are eligible to receive the CAP if they give their staff information and opportunities regarding workforce training; make audited general purpose financial reports available each year to residents, potential residents, their representatives and any person or agency

authorised by the Secretary of the Department; take part in a periodic workforce census; and provide periodic reports to the Department of their compliance with each of these three conditions.[197] CAP is providing $877.8 million over four years in additional funding to the residential aged care industry and increased the average annual payment per resident by approximately $2,000 in 2007-08. This is in addition to the usual annual indexation of subsidies.[197]

MINISTER'S AWARDS FOR EXCELLENCE AND THE PEAK ORGANISATIONS AWARDS

'Leadership and Management' is included as a category in the Minister's Awards for Excellence and the Peak Organisations Awards. This gives individuals and aged care facilities recognition and support in view of their achievements. The organisational winners in the Information Technology and Training and Staff Development categories receive $10,000 to spend on approved activities. Individual winners in the Leadership and Management, Professional Development and Aged Care Lifestyle categories each share $10,000 with their employing organisations. The awards seek to both recognise and reward the pursuit of a culture of professional excellence in the aged care industry.[198]

THE AGED CARE STANDARDS AND ACCREDITATION AGENCY LTD.

The Aged Care Standards and Accreditation Agency Ltd. also provides various educational courses, conferences, seminars and packages focusing on leadership and management issues, and a number of ACSAA's standards address issues related to leadership and management. Of the Accreditation Standard's assessment modules,[199] module 8 on staffing levels, qualifications and skills, is the most relevant to this study. During an assessment, AACSAA interviews staff, residents and relatives about their experiences of care and services in the home, and corroborates this information with care planning documentation.[200]

Staffing levels, qualifications and skills are expected to be at a standard which ensures residents' individual needs are met and the physical environment is safe and comfortable. Management should demonstrate improvements relating to the way in which the home deals with staffing management systems including staffing types, staff credentials, leadership, staff knowledge and skills, training and competencies, and staff communication. Staff members are interviewed about processes involved in recruitment and the monitoring of staff qualifications; as well as competency assessments, performance appraisals and an education calendar including monitoring for attendance at compulsory sessions.[199] Competencies (knowledge, skills) should be set out for all roles in the home, and the home should ensure that staff and management have the required knowledge and skills (albeit by encouraging staff to take personal responsibility for their professional development). Education and training needs are to be reviewed on a regular basis in relation to all roles, and education (including informal) should be planned and provided for all staff and management.[199] However, there is still no explicit requirement for qualifications, and this module is directed more towards care workers rather than those in management roles.

APPENDIX 2 SEARCH SOURCES AND INITIAL RESULTS

Search sources

Electronic databases	Hand searching	Grey literature (Websites)
Medline PsycINFO CINAHL PubMed Web of Science APAFT (Australian Public Affairs) Cochrane library CENTRAL (Cochrane Central Register of Controlled Trials) EMBASE (the Elsevier Science Journals Collection) EBM Reviews Internurse Wilson Art Abstracts Intute: Health and Life Sciences via OMNI	The Gerontologist Journal of Gerontological Nursing Australasian Journal on Ageing Journal of Health Services Research and Policy Journal of Nursing Management JONA: Journal of Nursing Administration Canadian Journal of Nursing Leadership The Australian Health Review	NYAM (New York Academy of Medicine) AIHW (Australian Institute of Health and Welfare) NIH (National Institute of Health), NHS Institute for Innovation and Improvement NHS (National Health Services) EHMA (European Health Management Association) CHSRF (Canadian Health Services Research Foundation) Skills for Care Commission for Social Care Inspection The Care Services Improvement Partnership

Number of references by source and tier

Sources	Tier 1	Tier 2	Tier 3
Electronic database	3044	766	499
Hand search	285	129	122
Relevant references	79	79	74
Grey literature	1076	73	72
Total	4484	1047	767

APPENDIX 3 TERMS OF REFERENCE

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE   ANU THE AUSTRALIAN NATIONAL UNIVERSITY

**Optimising Residential Aged Care Workforce: Leadership and Management Study
(RAC: LAM)**
Sub-title: Developing Sustainable Workforce Leadership and Effective Management in Residential Aged Care

RAC: LAM Reference Group

TERMS OF REFERENCE

Date: 26 November, 2007

Preamble:
The aim of this study is to conduct a literature review and develop policy options and strategies designed to enhance effective workforce leadership and management within the residential aged care sector. The core research question for the proposed study is 'What policy and system options are necessary to build capacity for sustainable workforce leadership and effective management in residential aged care?'

Goals:

1. Advise on issues concerning the project scope.

2. Advise on a conceptual framework for the literature review and its relevance to and application in Australian residential aged care settings, as informed by the Consultation Paper prepared by the research team, and suggest possible sources of literature including 'grey' literature and unpublished / in press papers.

3. Advise on options, strategies and potential recommendations for best practice for use in the Australian Health Care context, as informed by the Consultation Paper prepared by the research team.

4. Advise on the conclusions and policy options to be included in the final report.

Actions:

1. Review, provide feedback, and discuss:

    the most common and salient issues in delivering effective leadership and management in residential aged care settings;

    recommendations for the standard search terms and strategies used in a literature review prepared by the research team;

    the inclusion and exclusion criteria for the literature review;

    general directions and issues for implementation and appropriate use of options

2. Participate in regular consultation with the research team over the course of the project.

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

Membership:

Representatives from key government and non government organisations for aged care and dementia within Australia, including:

- **Alzheimer's Australia**
- **Commonwealth Department of Health & Ageing Aged Care Workforce Section**
- **Aged and Community Services Australia (ACSA)**
- **Australian General Practice Network (AGPN)**
- **Aged Care Nursing Research, University of Tasmania**
- **Aged Care Association Australia**
- **Geriaction**
- **Aged Care Standards and Accreditation Agency Ltd**
- **Catholic Health Australia**
- **Uniting Care Australia**
- **Baptist Care Australia**
- **ACT Health**

Chair:

Dr Yun-Hee Jeon

Research Team:

Dr Yun-Hee Jeon
Professor Nicholas Glasgow
Research Assistants: Dr Teri Merlyn and Ms Emily Sansoni
Australian Primary Health Care Research Institute (APHCRI), the Australian National University

Responsibilities:

Members:
1. Participate in two teleconferences and one face-to-face meeting, between December 2007 and August 2008, as outlined in the Actions 1 and 2 listed (above)
2. Participate in two individual consultations via email between meetings with the research team when necessary. This includes a review of the final draft to be circulated November 2008

Chair:
1. Produce relevant materials for review by the members two weeks prior to the Meetings
2. Convene and chair the Reference Group meetings two times during the research project
3. Facilitate group discussions based on all work undertaken in the project

Secretary:
1. Set the dates for the meetings, in consultation with members and the Chair
2. Provide members and the Chair with an agenda two weeks prior to the Meetings
3. Arrange and advise members of teleconferencing arrangements for meetings
4. Prepare Minutes of the meetings, have signed off by the Chair and send copies to all members within two weeks of meetings

2   Version 7. 01/08/2008

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

5. Manage travel arrangements and re-imbursement incurred for attending the meeting. Covered costs include economy airfares from and to Canberra and incidentals such as cab charges.

Conduct of the Meetings:

Frequency:	Three meetings between December 2007 and August 2008
Dates:	**Meeting 1** – Teleconference on Wednesday12 December 2007.
	Meeting 2 – Teleconference on Monday 21 April 2008.
	Meeting 3 – Fact-to-face meeting on Wednesday 27 August 2008.
	Time for Meeting 3: 1.00-4.00pm, Tea and lunch provided
	Venue for Meeting 3: Board room, The John Curtin School of Medical Research (JCSMR)

Project Timeframe: December 2007 – November 2008

Output:

- Final report (1:3:25 format) to APHCRI containing sets of options, strategies and options for the development of policies necessary for ensuring sustainable workforce leadership and effective management within the residential aged care sector. The report will be made available in APHCRI Website, inviting feedback from others.
- Submission of papers to refereed journals
- Conference presentations

Acknowledgement:

The research team would like to acknowledge individual names and affiliations of the reference group members in the final report, but will do so only with the individual members' wish to be included in the acknowledgement.

APPENDIX 4 ADDITIONAL PARTICIPANTS

Australia

- Christine Duffield, Professor of Nursing and Health Services Management Centre for Health Services Management University of Technology, Sydney, NSW

- Patrick Crookes, National Coordinator for Dementia Study Centre and Dean, Faculty of Health & Behavioural Sciences, and Head, School of Nursing, Midwifery & Indigenous Health, University of Wollongong, NSW

- Jannie Overduin, DON/Site Manager, St Basil's Homes, St Peters Aged Care Facility, SA

- Laurann Yen, Visiting Fellow, The Menzies Centre for Health Policy and APHCRI, The ANU, ACT

UK

- Pauline Ford, Adviser in Nursing Older People, and Anne Benson, Clinical Leadership Program Facilitator, Royal College of Nursing Learning & Development Institute, London

- Kim Rutter, Publicity and Promotions Manager, Social Care Institute for Excellence, London

- Professor Dame Catherine Elcoat DBE, Director of Patient Care, NHS East Midlands

- Professor Tony Warnes, Professor of Social Gerontology, Sheffield Institute for Studies on Ageing (SISA), The University of Sheffield

- Professor Mike Nolan, Professor of Gerontological Nursing, SISA, The University of Sheffield

- Professor Stuart Parker, Professor of Health Care for Older People and Director, SISA, The University of Sheffield

- Dr Susan Nancarrow, Research Fellow, School of Health and Related Research, The University of Sheffield

- Professor Jon Glasby, Professor of Health and Social Care, Co-Director of Health Services and Management Centre

- Liz Heaven, Regional Development Officer, Skills for Care, Skills for Care West Midlands

- Mr Andrew Shaw, HR Director for Residential Care, Care UK

- Professor Julienne Meyer, My Home Life Program Director, Centre for Care Home Studies, The City University

APPENDIX 5 NOTES DURING CONSULTATIONS

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE   **ANU** THE AUSTRALIAN NATIONAL UNIVERSITY

**Optimising Residential Aged Care Workforce:
Leadership and Management Study (RAC: LAM)**

Notes from the RAC: LAM reference group meetings

Dates and time:
Sydney: Friday, August 22, 2008, 1:00-3:30pm
Canberra: Wednesday, August 27, 2008, 1:00-3:30pm

Venues:
Sydney: Australian Health Policy Institute, Victor Coppleson Building - D02, University of Sydney
Canberra: Board Room, John Curtin School of Medical Research, Australian National University

Chair: Yun-Hee Jeon

Prior to the meetings a summary report had been circulated to the members. Based on this summary report, Yun-Hee Jeon provided a brief progress report and asked the members to comment on the following: the process of the review; key findings; and potential policy options.

All participants unanimously agreed that leadership development is one of the top priorities in addressing the workforce and care quality issues in the residential aged care sector in Australia.

KEY FINDINGS

Comments made:

- Leadership models and theories:
    - Rather than thinking about leadership models or theories, the three most important things when evaluating a nursing home are: quality of the middle management staff, the use of a team approach to management, and an outcomes approach to the care they're delivering. If these three things are present, then good residential aged care can be delivered
    - There are elements from all of those theories that could be relevant to aged care
    - Magnet hospital model and practice development are good examples of leadership development
- Structural empowerment:
    - Leadership is made much more difficult by the limited infrastructure within facilities to support good leadership. Leaders are spending their time avoiding crises and problems rather than applying what they've learned about effective leadership and realising their potential as leaders. Thus we need to look at developing infrastructure in residential aged care that will facilitate good leadership, rather than requiring leaders to spend all their time reacting to problems
    - Infrastructure that supports and facilitates changes will allow leadership programs to move beyond short-term impact
    - It would help if the organisation was open to changes that are consistent with what the staff members have learnt at training programs (i.e. structural sources of empowerment); provides further justification for this kind of work with a focus on policy level and infrastructure
- Leadership training programs:
    - A problem with leadership training programs is that people attend them for a couple of days, but when they come back to reality it all falls apart

16/12/2008   1

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE · THE AUSTRALIAN NATIONAL UNIVERSITY

- o They realise they can't implement these skills in the current environment, so they leave for another environment where they can
- Nursing education and training:
  - o Important to change the culture of communication and social interaction earlier on in nurse education
  - o Role models in nursing education are heavily dominated by acute care settings, and nurses should be educated in settings other than hospitals
  - o Not many nursing homes are well prepared for taking on students and being a role model
  - o Teaching nursing homes could create a higher profile leading to more specialisation in this area
- Change of nursing home image:
  - o The issue of status and the perception of this being an undesirable area to work in was a significant issue in the literature
  - o Being able to develop longer-term relationships with patients and families should be stressed as a positive of nursing in aged care
  - o Lifestyle benefits such as the fact that many nursing homes are situated in nice locations on the coast and there are opportunities for nurses to work part-time
  - o Aged and Community Services Australia (ACSA) has done some work on the image of aged care
- The University of Wollongong (UoW) offers a post-graduate course for leadership and management (not aged care specific). South Eastern Sydney and Illawarra Area Health Service has been offering a clinical leadership course for their employees. A UoW PhD student is examining antecedents of leadership development among nursing students
- Australian Policy Context – Funding issues:
  - o One statement should be corrected as funding is not based on the Australian Aged Care Standards and Accreditation
  - o Accreditation is part of the overall regulatory framework, and approved providers must meet accreditation to receive funding. However they must also meet other requirements such as certification, user rights principles, prudential arrangements etc. It is the Department of Health and Ageing who manages and imposes sanctions on homes, not the Agency. As such the Department regulates the industry as it has the power to allocate beds, determine who can be an 'approved provider', approve or restrict funds paid to homes etc.
- Australian Policy Context – Documentation issues:
  - o Documentation issues should be separated from funding issues
  - o Under the accreditation, Expected Outcome 1.5 Planning and leadership is the only time documentation requirements are specified as required for the Accreditation Standards. Complaints from the industry about 'excessive documentation requirements' often put Accreditation documentation in the same category as documentation required for funding such as RCS and ACFI. Aside from the documentation required for 1.5, the Agency expects documentation as part of the quality management system to reach a level consistent with providing high quality care. *This expected outcome requires that "the organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service")*
- Policies in place to facilitate leadership development:
  - o Acknowledge that through the Agency Education initiatives, the Government is active in this area. Leadership and management are recurring themes in the Agency education products such as Better Practice conferences, Governance and Accreditation Toolkit, Seminars and Courses

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

THE AUSTRALIAN NATIONAL UNIVERSITY

POLICY OPTIONS

Suggestions and comments made

- Clinical Leadership Program:
    - Clinical leadership program has been offered by SA Health for their employees. JO completed the clinical leadership program three years ago and thought it would be extremely beneficial to make such a program available for residential aged care staff
    - NSW Health once offered the RCN (UK) Clinical Leadership Program for their employees but it was discontinued after one 12 month cohort, and replaced by the Clinical Excellence Commission. The government doesn't see leadership training as something that would result in cost effective outcomes. However, when you consider patient outcomes and reduced staff turnover, it actually saves money
    - The cost to the government would not be that significant compared to its overall outlays
- Leadership and management development course with a nationwide curriculum that is a residential aged care specific, affordable and accessible program, and also allows for flexibility based on organisational uniqueness is required
- Scholarships:
    - Graduate scholarship programs would be more appropriate than lower-skilled incentives
    - Aged Care Australia, Summit Health and Baptist Community Services have scholarships and awards that target managers
    - Productivity places are available in the VET system
- Leadership and management strategy:
    - We need a national approach to address the leadership issues, some form of strategy
    - The UK Social Care sector has developed leadership and management strategies for social care workers, requirements for care managers, a national MDS specifically to address workforce, and programs on skills development of leadership and management
- Existing leadership programs:
    - Look at the leadership and management course specific to health care that has been developed by the AGPN with the UNE
    - The residential aged care industry might not be ready to commit to long-term initiatives like that, as residential aged care workers feel that they had already completed their education and would prefer specific professional development programs to target the skills they lack
    - A generic management program/ qualification would be more useful than an aged-care specific one but we'd need to make the link between generic models and their applicability to aged care
- Shared responsibility:
    - Important principle that needs to be addressed by the government because if they are going to implement changes, then managers in residential aged care are going to have to manage these changes. Thus organisations will need support and government assistance due to the huge amount of pressure on the viability of these services
- National Minimum Dataset:
    - Census on the aged care workforce is completed every three years. Rather than developing a whole new MDS, modify the current census

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

THE AUSTRALIAN NATIONAL UNIVERSITY

- o The government should use evidence-based policy rather than implementing untested policies. Need to take stock and look at the aged care act, the system, funding, accreditation and consumer needs and then form a picture based on this information
- It is time to take stock and act to address the leadership issues in aged care
- It's time to develop and implement leadership programs for the aged care workforce
- More innovative and flexible models to develop leadership and management skills of the residential aged care workforce are needed, e.g. Summit Health Care 12 Month Graduate Program for Management in Australia
- Regarding the provision of a competency framework, differentiate between 'competencies' and 'capabilities', where Health Canada thought 'capabilities' was a more appropriate term for nursing
- In terms of awards, managers should be handing out the awards to their staff as this shows more leadership than receiving awards themselves. Add this point to the discussion on awards
- Conditional adjustment payment should be removed from the slide on the current policies in place, as it is not relevant to leadership and management development
- Specific qualifications or experiential requirements for RACF managers:
  - o Care managers should be RNs, but regional managers need not be
  - o There shouldn't be a rule saying that managers of aged care facilities should be RNs, but there must be sufficient numbers and experienced nurses who are able to provide clinical supervision
  - o We do not know enough to say that the manger has to be an RN

Suggestions made for the structure of the report:
- Emphasis on research is wrong. We need action and investment in people based on the best practice research that already exists. Research option might give readers of the report (i.e. government and bureaucrats) the excuse to do nothing
- Rather than making research a headline, it could be seen as a fundamental strategy to enhance the status of aged care
- Investment should be put as the main heading under which to collect the other policy options. The presentation of the options should be such that there is no "wriggle room" for the government to do nothing
- The report should emphasise the fact that residential aged care workers are fundamental people to the health industry, and yet they are provided with so little support
- The report should emphasise how leadership and management are important in producing good care outcomes, highlight residential aged care workers in a more positive way, look at policy options with an emphasis on investment and develop an umbrella strategy with concerted efforts for all the sectors
- The report needs to be explicit about which group is in mind for the material being written (e.g. clinicians vs. CEOs)

Suggestions made for the content of the report:
- The effect of the size of the organisation should be discussed because residential aged care is usually organised into small units, where the leaders are one or two people supervising everyone else. Acts as a barrier due to lack of support, monitoring and opportunities to interface. Problem of being a clinical manager and a general manager at the same time – a larger organisation could have separate people for these roles
- Include a broad statement saying that when frontline managers are able to provide input on the strategic direction of the organisation, the result is change management which provides an environment and culture that enables the development of clinical skills and clinical management

16/12/2008

4

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE — THE AUSTRALIAN NATIONAL UNIVERSITY

- 'Wide span of control' concept could be expanded to cover the number of people the manager has accountability for as well as the number and type of tasks. Leaders working in a small organisation might have a greater variety of activities that they are responsible for compared to a large organisation where there is more specialisation of tasks
- Change "wide span of control" to the "number of people a leader or manager has to supervise" or "staff supervision"
- Mention that the well-being of staff is affected by all policies, protocols and information available within the organisation (e.g. IT policies, workplace health and safety etc), and not just by HR policy, and that in order to lead effectively in residential aged care, a leader needs access to all the policies and protocols
- The time pressures in the industry are so great that it makes it hard to implement all the learning and theory from leadership courses.
- Look more closely on what staff time is being spent doing and the key performance indicators (KPIs) used to judge their performance – KPIs can actually undermine the capacity of staff to perform their job (e.g. 50% of is time spent writing notes that no one reads or uses)
- Other barriers to effective leadership that should be included are stifling government regulation and the inability of funding to provide wage parity. YHJ has addressed these in other areas of the study but will include them here also.
- Lack of management training and support across the industry should be included as another barrier
- The report should look at leadership from the perspective of the consumer (i.e. what are consumers looking for in leadership). Staff have low self esteem because they don't feel highly regarded by the community, while the community actually regards staff very highly and sees management as very important
- The role of the boards should be addressed because it can affect the leadership role greatly (e.g. the leadership role can be very difficult if the board doesn't want to try anything new and restricts funding). Needs a discussion of boards and how they also need to lift their game – could be another topic for further research
- Ethics should also be mentioned as a key characteristic of leadership

Suggestions for further research
- Comparisons of leadership and management policies between different countries (U.K, USA, Scandinavian countries, Canada, etc.) could be useful for future research
- Needs to consider looking beyond the residential aged care workforce (it should be aged and community care workforce)
- Mapping of the Australian residential aged care workforce and needs analysis. However, it was also suggested that we have already enough information to develop leadership and management programs (More comprehensive database for the residential aged care workforce
- The problem with current research is that it looks at leadership and management on a short-term basis, and this makes it hard to capture real outcomes
- Need to consider the characteristics of people who are led (and not just the leaders) when developing leadership and management programs and research

PLAN
- YHJ proposed for a further study looking at establishing evidence for the best leadership and management model suitable for the aged and community care services in Australia (NHMRC partnership grants 2008). Most members agreed it is important to move beyond the current study and in principal are willing to be partners for the proposal. YHJ will keep the members informed of the progress of this proposal.

16/12/2008

5

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE THE AUSTRALIAN NATIONAL UNIVERSITY

- Penultimate draft to be provided in November, feedback is desired from reference group members
- Further consultations: YHJ will hold a seminar with a group of care managers / directors of nursing in the ACT region and meet with experts from England to discuss the study findings and policy options.

NOTES FROM ADDITIONAL MEETINGS
Department of Health and Ageing held on 7 October 2008
- Current policy on leadership and management focuses on the effects of not having clinical leadership (e.g. failing the health standards), and if the standards are not met then a complaint is usually made. However, there is no policy or mechanism that looks at the process of or ensuring individual leadership and management skills
- If the terms, quality and environment of employment were appropriate, people would go back to work in aged care
- The Aged Care Act 1997 is a social model, where a nursing home is viewed as a home, rather than a form of healthcare. This has the implication that health professionals aren't necessary, which is wrong, because people go to nursing homes because of health issues
- It is important to look at the outcomes of not having leadership
- SH emphasised the lack of clinical leadership, where there is evidence from people that work in the industry that there is not enough clinical leadership present

Forum with directors or nursing / care managers working in residential care facilities within the ACT, held on 4 September 2008

Specific qualifications or experiential requirements
- The report should discuss the lack of department policy on registration requirements for nurses in aged care despite the unions, the UK and Queensland health all having registered nurse requirements
- Requirements should depend on the job, where if one is a director of care they should have nursing qualifications, but if they're a CEO this might not be necessary
- Strict requirements for qualifications could preclude alternative structures and models. For example, people can have really good management skills without being an RN while others have clinical skills. A team structure (instead of a hierarchical structure) that utilises both of these forms of experience could be useful
- A clinical supervisor with the relevant qualifications should be present in the nursing home. Currently, many of the carers working in nursing homes are not qualified

Policies in place to facilitate leadership development:
- The report needs to emphasise that there is no input from policy makers in terms of leadership and management within these organisations. Their focus is more on process and compliance issues instead of how to get aged care the leadership and management skills it needs

Australian Policy Context – Funding issues:
- Funding arrangements are welfare based rather than business focussed. A business focussed system could be more economically viable and attract more workforce and managers. It would be based more on the perspective of the consumer and what they can afford to pay, and government support would supplement this. By looking at business imperatives, the focus would shift to the viability of the service. The report should mention this issue
- Government funding could be supplemented by other sources but people shouldn't have to sell their house to go into a nursing home. Maybe people could contribute towards their own care drawing on funds they've built up over time, rather than leaving it to the next generation

- People who will come in to nursing homes in the future will have had less opportunity to own their own home, therefore they won't have the assets to pay a bond or sell their home to do it. There has been a huge growth in transient people throughout the national community. There are also a lot more divorcees with no capital or property, and women that have came into the workforce later who haven't had the time to build up superannuation or pay off their house. This loss of money hasn't been addressed and the funding model has not been properly re-evaluated in recent times
- One nursing home has had a 66% resident turnover in the last 12 months because people now come in later and thus die sooner after entry. This has lead to a big decrease in the average length of stay and impacts on the required skills of staff, administration and costs. The cost of residential turnover is comparable to that of staff turnover, due to having to enter a new resident, conduct another assessment, and complete more paperwork
- There is the perception that things can be done cheaper than what they can be – look at minimising cost of entry, incentives for good leadership and management with adequate training and career path opportunities
- The problem with ageing being grouped under the health system, is that resources are taken from ageing and put into health (e.g. if we need increased AINs in hospitals they are taken from aged care)

Australian policy context – documentation issues
- In the public sector RNs get increased pay for administrative work but not for clinical. Perhaps we are drawing too many RNs out of clinical work for too long, which then leads to their registration collapsing
- A system was proposed whereby if an RN's registration collapses, rather than having to go back to university to get their registration back, there could be two streams. One with normal RNs and one with former RNs that could work in aged care without having to re-obtain their full registration
- The other participants in the meeting disagreed, as it would undervalue the role of aged care workers. It was pointed out that this could contribute to the perception that aged care is at the bottom of the skills pile, where on the contrary it is much more demanding and challenging than much of the work done in hospitals. It also implies disrespect for aged care

Incentives
- Aged care lacks a regulated workforce. There are no checks and balances, which allows staff to shop through different facilities and gain employment despite the fact that they were fired from the last place or left on bad terms
- The ACT government looked at regulating but this meant increased costs due to increased wages. It would help but it's difficult because of the competition with acute care for the workforce. Staff members leave for the public and acute sectors because there is better pay
- Need incentives and remuneration to attract and retain workers, where for example, if you work at the one place for a certain number of years you get a bonus. Funded training could also be beneficial
- Other incentives could be provided for certain qualifications, for example if they're registered with a certificate 3 then they get a bonus

Leadership training programs
- YHJ asked the meeting whether they would be interested in doing a training program as part of a research project. Some said they would be interested and felt their staff would benefit from such a program.

16/12/2008   7

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE   THE AUSTRALIAN NATIONAL UNIVERSITY

Notes from the trip to England (22 September – 3 October 2008)

The purpose of the trip was to: develop international linkages with other researchers, academics and policy makers/service providers who have expert knowledge and experience in the field of residential aged care in the UK; exchange information with each other while sharing the key findings of the RAC_LAM study with them; and test out policy recommendations. The following is a list of the organisations that YHJ visited.

- Royal College of Nursing Learning & Development Institute, London
- Social Care Institute for Excellence, London
- NHS East Midlands
- Sheffield Institute for Studies on Ageing (SISA), The University of Sheffield
- Sheffield Hallam University
- Health Services and Management Centre, The University of Birmingham
- Skills for Care West Midlands
- Care UK
- Centre for Care Home Studies, The City University

All of the people that YHJ met showed strong support for the study and its findings. They were also very supportive of the idea of extending the study to develop a leadership and management program that is residential aged care specific in Australia. Some of them also emphasised the importance of conducting needs analysis of the program in the aged care sector to inform the development and implementation process of the program. The idea of applying for the NHMRC partnership grant using action research was well received. Most of them also indicated their willingness to participate in the proposed study as a member of the international advisory group.

APPENDIX 6 FORMAL LEADERSHIP PROGRAMS

Skills for Care Leadership and Management Strategy (UK)

The Skills for Care Leadership and Management strategy issues a series of curriculum modules called 'products' that address each dimension of social care leadership practice and enable managers to implement the recommendations.[191] The products address each of the following areas:

o Statement of what leaders and managers in social care do (Product 1)

o Whole systems model and person management specification (Product 2)

o Mapping of leadership and management standards (Product 3)

o National signposting links (Product 4)

o Continuing professional development (Product 5)

o Manage effective supervision (Product 6)

o Evaluation of leadership and management development (Product 7)

The aim is for these products to link up the different stages of the learning cycle, which involves the identification of learning needs, commission learning and qualifications, deliver learning and qualifications, and the evaluation of learning activities.[49] The strategy is based on a whole systems model that integrates individual and organisational needs. It can be applied to all leaders and managers and any size of organisation. The strategy is based on the approach that leadership and management can be integrated and seen as a continuum, where leaders benefit from management skills and vice versa.[49]

Further information on the Skills for Care Leadership and Management Strategy is available at:
http://www.skillsforcare.org.uk/developing_skills/leadership_and_management/leadership_and_management_strategy.aspx

Royal College of Nursing Clinical Leadership Programme (UK)

The Royal College of Nursing (RCN) offers a range of leadership and team development programmes that are available to members and health care organisations. These include the award winning and internationally renowned RCN Clinical Leadership Programme.[201]

The Clinical Leadership Programme (CLP) was designed specifically to create patient-centred clinical leaders, capable of developing effective team relationships that enable the delivery of client-focused care. The CLP development framework represents key areas that clinical leaders need to develop, in order to enhance their leadership capabilities and become more patient-centred clinical leaders.[71] These areas are:

o Learning to manage self

o Effective relationships within teams

o Developing a consistent patient focus on care

o Networking

o Political awareness

The types of interventions used to support the learning of participants include 360-degree review, personal development planning, mentorship, one-to-ones with local facilitators, action learning, needs led and intervention workshops, patient stories and observations of care, shadowing, teambuilding and networking.[71]

Further information on the RCN Clinical Leadership Programme is available at:

http://www.rcn.org.uk/development/practice/leadership

NHS Modernisation Leadership Centre's Leadership Qualities Framework (UK)

The Leadership Qualities Framework (LQF) has been developed specifically for the NHS and describes the qualities expected of existing and aspiring leaders both now and in the future. The framework can be used across the NHS to underpin leadership development, for individuals, teams and organisations.[202] The development opportunities offered by the Leadership Centre (LC) are based on the LQF, with each initiative tailored to address one or more of the dimensions in the LQF. This includes 15 qualities arranged into three main dimensions:[119, 203]

o Personal qualities

o Setting the direction

o Delivering the service

LC initiatives develop the skills, competencies and capacity of staff in a range of ways, including individually tailored development activities and whole-system programs. The initiatives seek to provide participants with a knowledge base, identify appropriate leadership activities and challenges, reflect on the complexity of the political context and/or meet the needs of multiple stakeholders.[119]

Further information on the Leadership Qualities Framework is available at:

http://www.nhsleadershipqualities.nhs.uk/

Gerontological Specialist Internship (US)

The North Carolina Centre for Nursing offers an intensive one-week leadership seminar, known as the Institute for Nursing Excellence (INE), to registered nurses working full-time in North Carolina. The INE is an annual professional development program that recognises and rewards excellent direct care RNs. It is for direct care nurses with high potential to be nurse managers and leaders in long-term care settings. Although not specifically targeted at long-term care nurses, the director is a gerontology specialist and actively seeks out long-term care nurses as both fellows and faculty. Participants are exposed to leaders from across the US, providing opportunities to network with peers over the week. This state-funded program aims to enhance the ability for nurses to be role models and leaders.[77, 204] The stated purposes of the INE are to:[204]

o   Reward outstanding registered nurses

o   Encourage outstanding nurses to remain in the profession

o   Increase the leadership capacity of excellent nurses

o   Enhance nurses ability to be role-models

o   Enhance ability to attract other individuals into nursing

Further information on the Institute for Nursing Excellence is available at:

http://www.nccenterfornursing.org/recruitmentandretention/institute/ine.htm

Continuous Quality Improvement Programs (US)

Two programs in the Reinhard study[77] incorporated continuous quality improvement. The Visiting Nurse Associations of America (VNAA) Curriculum for Homecare Advances in Management and Practice (CHAMP) aims to influence ages and adopt philosophies and practices of continuous quality improvement in home-based care. In terms of RAC, Wellspring Innovative Solutions, Inc. focuses on culture change and organisation development, with the view that nursing staff play a major role in the implementation of change initiatives. Wellspring education modules are used to train staff, and cover resident-directed care concepts, staff empowerment, and clinical issues. While the initial training lasts two days, staff are engaged in process quality improvement initiatives for the next six months. The leadership model stresses staff empowerment, data-based decision processes and accountability.

Further information on Wellspring is available at: www.wellspringis.org

Pioneer Network (US)

The Pioneer Network Professional Study Pathways program is an off-site, two-day seminar focusing on the person-centred model for culture change. Programs are tailored for specific levels of staff, and the audience usually includes CEOs, CFOs, DONs, administrators, activities professionals, social workers, department heads, nurses and direct care workers. Organisations are encouraged to send 'teams', to provide a greater platform for change. There are five 'pathways' which teams can choose from to receive training that meets their development needs:

o   Leading culture change

o   Becoming a learning organisation

o   Creating communities that make life worth living

o   Navigating the culture change journey

o   Using a multi-stakeholder approach.[77]

Further information on the Pioneer Network is available at:
http://www.pioneernetwork.net/

LEAP Program (US)

LEAP aims to empower staff, improve staff retention and promote quality improvement through use of the person-centred care model. It is a train-the-trainer program which applies the Gallup School of Management Model for leadership and staff development. Nurses are taught about leadership, person-centred care, communications, supervisory skills and mentoring.[77]

The goals of the program are contained in the LEAP acronym:

o Learn how to build strong relationships among nurses, residents and families

o Empower nursing staff and create structures for advancement

o Achieve staff development and retention goals

o Produce measurable outcomes

Core components of the program include: training programs delivered by staff from the organisation implementing the program; series of organisational and individual assessment tools to identify the level of readiness for change; separate training modules designed exclusively for either nurses or certified nurse assistants (CNAs) that are delivered over several weeks; development of a career ladder program; a CNA mentoring component; and cost implementation tracking to evaluate program results.[77]

Further information on the LEAP program is available at:

http://www.matherlifeways.com/re_leap_3.asp

WIN A STEP UP (US)

WIN A STEP UP stands for 'Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance' and is a workforce development intervention aimed at reducing staff turnover and improving the working situation of nursing assistants in North Carolina's nursing homes. The program is a partnership between the North Carolina Department of Health and Human Services and the University of North Carolina Institute on Aging. The program consists of a 30-hour curriculum that focuses on:[61]

o Clinical and interpersonal topics

o Infection control

o Team work

o Dementia care

This program also has a focus on aged care leadership development for nursing assistants and engages their nurse managers in intensive evaluative procedures. The program requires commitments from the nursing assistants, the nursing home and the program staff (e.g. nursing assistant agrees to attend the classes and remain employed at the facility for an agreed upon amount of time). To improve relationships between the nurse supervisor and the nursing assistants, there is supplementary training for nursing assistant supervisors available. Coaching Supervision is a two-day training course designed to teach nurse supervisors active listening, problem-solving skills and to foster an environment of mutual respect.[61]

Further information on WIN A STEP UP is available at:

http://www.aging.unc.edu/research/winastepup/index.html

Clinical Leadership Programme in Australia

Designed, developed and supported by the UK Royal College of Nursing, this program has been available to South Australian Nurses and Midwives since 2003.[194] The introduction and ongoing provision of the program for South Australian nurses is supported by funding from the Department of Health, through the Office of the Chief Nurse.[193] CLP aims to achieve safe, quality person-centred care by assisting health professionals to develop consumer/client-centred leadership strategies that enable them to deal with the day-to-day realities of practice.[193]. The CLP is a structured program delivered over 12 months.[193]

The theoretical basis of the Programme involves:

o   Learning to manage self

o   Building, developing and managing effective relationships

o   Focusing on the person receiving care

o   Networking

o   Increasing political awareness

The components of the program include action learning, patient focussed interventions, 360 degree feedback and one-to-one coaching and mentoring.[193]

Further information on the Clinical Leadership Programme in Australia is available at:

http://www.clinicalleadership.com/

University Programs (Australia)

The Deakin University School of Nursing in partnership with Health Super offers the annual Leadership in Nursing Awards to recognise nurses who have contributed to the profession and benefited the public by improving health service delivery, capacity and/or policy. These awards create awareness of the achievements of leaders in nursing, setting a standard to which future leaders in nursing may aspire. The awards also build leadership through research and education, mentoring and role modelling.[205]

Further information on the Leadership in Nursing Awards is available at:

http://www.deakin.edu.au/hmnbs/nursing/awards/index.php

The Australian Catholic University in association with Catholic Health Australia, offers a Graduate Certificate in Leadership and Catholic Culture. It is designed to prepare leaders for Catholic health and aged care. Topics covered within the Graduate Certificate include:

o   Catholic ethos and health care

o   Ethics in a faith-based context

o   Catholic social thought

o Leadership and health care

The four units are completed over 2 years, or units can be offered intensively over five days in a residential program.

Further information on the Graduate Certificate is available at:

http://www.cha.org.au/site.php?id=729

In order to address the need for a more strategic and focused approach to competency development for aged care managers, the Health Management Department and the Applied Gerontology group at Flinders University have designed the Graduate Certificate in Aged Care Administration. The program can be completed in 12 or 18 months and covers:

o Managing people and organisations in health and aged care

o Health care financial management

o Introduction to social gerontology

o Demography and epidemiology of ageing

o Psychological dimensions of ageing

Further information on this graduate certificate is available at:

http://som.flinders.edu.au/FUSA/DHM/default.htm

Non-University Programs (Australia)

The Certificate IV in Aged Ware Work targets frontline managers or supervisors who do not necessarily hold a management position. Its purpose is in line with Baptist Community Services' (BCS) aim to develop a suitable qualified workforce specifically for aged care. BCS identified the need for a career pathway for aged care workers and the need to retain specialised aged care workers within the industry. BCS operates as a registered training organisation and also offers qualifications in: Certificate IV in Business (Frontline Management) and Certificate III in Aged Care Work.[206]

Further information is available from the Baptist Community Services website:

http://www.bcs.org.au/pages/content.asp?plid=4

The Certificate IV in Aged Care Work as well as the other certificates is also available through TAFE:

http://www.tafe.vic.gov.au/tafecourses/search/Courses/Detail.asp?ID=5688&AllRegions=yes

Diploma of Business (Frontline Management) is also available through registered training organisations, for example, TAFE, BCS and Pathways Health & Education Consultants Pty Ltd. The diploma is designed to improve management knowledge and skills, allowing workers to better perform their role as an effective and efficient

frontline manager. One can either obtain the full diploma or attain competency in individual skills sets such as:

o Leadership

o Quality Management

o Staff Education and Development

o Change Management

o Human Resource Management

o OH&S and Risk Management

The full diploma consists of 11 workshops that run from March to December. It is a management delivery strategy, which places learning within an organisation and links management performance to the achievement of quality business outcomes that are customer focused. Pathways Health and Education Consultants has taken this framework and the learning competencies of the Diploma of Business (Frontline Management) and focused the outcomes in accordance with the health care industry, including RAC.[207]

Further information on the Diploma of Business (Frontline Management) is available at:

http://phec.com.au/joom2/index.php?option=com_frontpage&Itemid=1

REFERENCES

1.   Stone R. *Executive Director of the Institute for the Future of Ageing in the United States*: ABC Radio National 2; 2 October 2008.
2.   Aged Care Association Australia. *Aged care Australia: Strategic policy solutions.* Curtin: Aged Care Association Australia; 2007.
3.   Productivity Commission. *Trends in aged care services: some implications.* Canberra: Commission Research Paper; 2008.
4.   Chenoweth L, Merlyn T, Jeon Y-H. *Waiting for nurse Godot. What factors attract and retain nurses in aged and dementia care: A systematic literature review*: Primary Dementia Collaborative Research Centre; 2008.
5.   Pearson A, Nay R, Koch S, et al. *Recruitment and Retention of Nurses in Residential Aged Care, Final Report* 2002.
6.   Pearson A, Nay R, Koch S, Ward C, Andrews C, Tucker A. *Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*: National Review of Nursing Education, Department of Education, Science and Training; 2001.
7.   Clegg A. Occupational stress in nursing: a review of the literature. *Journal of Nursing Management.* 2001;9(2):101-106.
8.   Fox RT, Fox DH, Wells PJ. Performance of first-line management functions on productivity of hospital unit personnel. *Journal of Nursing Administration.* 1999;29(9):12-18.
9.   Meyer J. Keeping the workforce fit for purpose. In: Meyer J, ed. *My Home Life: Quality of life in care homes - A review of the literature*. London: Help the Aged; 2007:124-141.
10.   Nolte E, McKee M, eds. *Caring for people with chronic conditions: A health system perspective*. Berkshire, England: McGraw Hill Open University Press; 2008.
11.   Australian Institute of Health and Welfare. *Chronic Diseases and Associated Risk Factors. Cat. no. PHE 81.* Canberra: AIHW; 2006.
12.   Department of Health. *Transforming the Quality of Dementia Care Consultation on a National Dementia Strategy*: Department of Health; 2008.
13.   Access Economics Pty Limited. *Dementia estimates and projections: Australian States and Territories.* Canberra: Report for Alzheimer's Australia; February 2005.
14.   Australian Institute of Health and Welfare. *Residential aged care in Australia 2005-06: A Statistical Overview*: Ageing and Aged Care Unit; 2007.
15.   Australian Institute of Health and Welfare. *Residential aged care in Australia 2006-07: A statistical overview.* Canberra: AIHW; 2008.
16.   Australian Institute of Health and Welfare. *Older Australia at a glance: 4th edition. Cat. no. AGE 52.* Canberra: AIHW; 2007.
17.   Department of Health and Ageing. *Aged Care Workforce Committee*: Department of Health and Ageing; 2005.
18.   Hegney D, Eley R, Plank A, Buikstra E, Parker V. Workforce issues in nursing in Queensland: 2001 and 2004. *Journal of Clinical Nursing.* 2006;15(12):1521-1530.
19.   Martin B, King D. *Who carers for older Australians?: A picture of the residential and community based aged care workforce 2007.* Barton ACT: National Institute of Labour Studies, Flinders University; Australian Government Department of Health and Ageing; 2008.

20. Pearson A, Schultz T, Conroy-Hiller T. Developing clinical leaders in Australian aged care homes. . *International Journal of Evidence-Based Healthcare.* 2006 2006;4(1).

21. Eley R, Hegney D, Buikstra E, Fallon T, Plank A, Parker V. Aged care nursing in Queensland - the nurses' view. *Journal of Clinical Nursing.* 2007;16(5):860-872.

22. Stack S. Beyond Performance Indicators: A Case Study in Aged Care. *Australian Bulletin of Labour.* 2003;29(2):143-161.

23. Konetzka RT, Stearns SC, Park J. The Staffing-Outcomes Relationship in Nursing Homes. *Health Services Research.* 2008;43(3):1025-1042.

24. Akinci F, Krolikowski D. Nurse staffing levels and quality of care in Northeastern Pennsylvania nursing homes. *Applied Nursing Research.* 2005;18(3):130-137.

25. Page A. *Keeping patients safe: transforming the work environment of nurses* Washington D.C.: National Academies Press; 2004.

26. Moyle W, Skinner J, Rowe G, Gork C. Views of job satisfaction and dissatisfaction in Australian long-term care. *Journal of Clinical Nursing.* Mar 2003;12(2):168-176.

27. Department of Health and Ageing. *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes: Final Report.* Canberra: Department of Health and Ageing; 2007.

28. Marquis R, Freegard H, Hoogland L. Cultures that support caregiver retention in residential aged care. *Geriaction.* 2004;22(1):3-12.

29. Hogan WP. *The Organisation of Residential Aged Care for an Ageing Population*: The Centre for Independent Studies; 2007.

30. Aged and Community Services Australia. Caring for an ageing population: Submission to the National Health and Hospitals Reform Commission. In: ACSA, ed; 2008.

31. Hogan WP. Outcomes from the Aged Care Review. *Australasian Journal on Ageing.* 2007;26(3):104-108.

32. Alzheimer's Australia. *Quality Dementia Care Standards: A Guide to Practice for Managers in Residential Aged Care Facilities*: Alzheimer's Australia; 2007.

33. Happell B. Nursing home employment for nursing students: valuable experience or a harsh deterrent? *Journal of Advanced Nursing.* 2002;39(6):529-536.

34. Cheek J, Ballantyne A, Jones J, Roder-Allen G, Kitto S. Ensuring excellence: an investigation of the issues that impact on the registered nurse providing residential care to older Australians. *International Journal of Nursing Studies.* 2003;9:103-111.

35. Jeon Y-H, Chenoweth L. Working with a culturally and linguistically diverse (CALD) group of nurses. *Collegian.* 2007;14(1):16-22.

36. Chenoweth L, Jeon Y-H, Goff M, Burke C. Cultural competency and nursing care: An Australian perspective. *International Nuring Review.* 2006;53(1):34-40.

37. Institute for the Future of Aging Services. *The Long-Term Care Workforce: Can the Crisis be Fixed?*: Institute for the Future of Aging Services; 2007.

38. O'Halloran J, Britt H, Valenti L. General practitioner consultations at residential aged-care facilities. *MJA.* 2007;187(2):88-91.

39. Department of Health and Ageing. *Aged Care Access Initiative program guidelines*: Department of Health and Ageing; 2008.

40. Jeong SY-S, Keatinge D. Innovative leadership and management in a nursing home. *Journal of Nursing Management.* 2004;12(6):445-451.

41. Department of Health and Ageing. *A literature review and description of the regulatory framework*: Department of Health and Ageing; 2005.

42. Department of Health and Ageing. *Ageing in place: A guide for providers of residential aged care.* Canberra: Department of Health and Ageing; 2002.
43. Aged Care Standards and Accreditation Agency. *Accreditation Standards*: Aged Care Standards and Accreditation Agency; 2008.
44. Department of Health and Ageing. About the Aged Care Funding Instrument; http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-aboutacfi.htm. Accessed 20 November, 2008.
45. Australian Government. *Final response to the review of pricing arrangements in residential aged care*: Australian Government; 2007.
46. Aged Care Workforce Committee. *National Aged Care Workforce Strategy.* Canberra: Department of Health and Ageing; 2005.
47. Hartley J, Hinksman B. *Leadership Development: A systematic review of the literature*: NHS Leadership Centre; 2003.
48. Dana B, Olson D. *Effective Leadership in Long Term Care: The Need and the Opportunity*: American College of Health Care Administrators; 2007.
49. Skills for Care. *Leadership & Management: A strategy for the social care workforce*: Skills for Care; 2006.
50. Borrill C, West M, Dawson J. *The relationship between leadership, people management, staff satisfaction and intentions to leave.* Aston University: Aston Business School; 2005.
51. Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research and Policy.* 2005;10(Suppl.1):6-20.
52. National Institute for Health and Clinical Excellence. *The NICE Guidelines Manual*. London: National Institute for Health and Clinical Excellence; 2006.
53. Buse K, Mays N, Walt G. *Making health policy*. England: Open University Press; 2005.
54. Forbes-Thompson S, Gajewski B, Scott-Cawiezell J, Dunton N. An exploration of nursing home organizational processes. *Western Journal of Nursing Research.* 2006;28:935-954.
55. Colon-Emeric C, Lekan-Rutledge D, Utley-Smith Q, et al. Connection, Regulation, and Care Plan Innovation: A Case Study of Four Nursing Homes. *Health Care Management Review* 2006;31(4):337-346.
56. Pearson A, Laschinger H, Porritt K, Jordan Z, Tucker D, Long L. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. *International Journal of Evidence-based Healthcare.* 2007;5:208-253.
57. Gilmartin MJ, D'Aunno TA. Leadership research in healthcare: A review and roadmap. *The Academy of Management Annals.* 2007;1(1):387-438.
58. Castle NG, Banaszak-Holl J. Top management team characteristics and innovation in nursing homes. *Gerontologist.* 1997;37(5):572-580.
59. Deutschman M. Interventions to nurture excellence in the nursing home culture. *Journal of Gerontological Nursing.* 2001;27(8):37-43.
60. Zimmerman S, Gruber-Baldini AL, Hebel JR, Sloane PD, Magaziner J. Nursing home facility risk factors for infection and hospitalization: importance of registered nurse turnover, administration, and social factors. *Journal of the American Geriatrics Society.* 2002;50(12):1987-1995.

61.   Konrad T, Morgan J. *STEP UP NOW for Better Jobs and Better Care: The Evaluation of a Workforce Intervention for Direct Care Workers*: Institute for the Future of Aging Services; 2002.

62.   Singh D, Schwab R. Predicting Turnover and Retention in Nursing Home Administrators. *The Gerontologist.* 2000;40:310-319.

63.   Pollard KC, Ross K, Means R. Nurse leadership, interprofessionalism and the modernization agenda. *Br J Nurs.* 2005;14(6):339-344.

64.   Castle NG. Turnover begets turnover. *Gerontologist.* Apr 2005;45(2):186-195.

65.   Hughes E. Nurses' perceptions of continuing professional development. *Nursing Standard.* 2005;19(43):41-49.

66.   Anderson R, Corazzini K, McDaniel R. Complexity Science and the Dynamics of Climate and Communication: Reducing Nursing Home Turnover. *The Gerontologist.* 2004;44(3):378-388.

67.   Gnaedinger N. Changes in long-term care for elderly people with dementia: a report from the front lines in British Columbia, Canada. *Journal of Social Work in Long-Term Care.* 2003;2:355-371.

68.   Pitkala KH, Niemi M, Suomivuori L. Development of a geriatric team: A staff development educational process in a nursing home. *Educational Gerontology* 2003;29(2):117-128.

69.   Deutschman M. What you hear when you listen to staff. *Nursing Homes Long Term Care Management.* 2000;49(6):37-38.

70.   Mentes JC, Tripp-Reimer T. Barriers and facilitators in nursing home intervention research. *Western Journal of Nursing Research.* 2002;24(8):918-936.

71.   Large S, Macleod A, Cunningham G, Kitson A. *RCN Clinical Leadership Programme Transforming Clinical Leaders to become Agents of Positive Change.* London: RCN Institute; 2005.

72.   Anderson RA, Issel LM, McDaniel Jr RR. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nursing Research.* 2003;52(1):12-21.

73.   Aroian JF, Patsdaughter CA, Wyszynski ME. DONs in long-term care facilities: contemporary roles, current credentials, and educational needs. *Nursing Economics.* 2000;18(3):149-156.

74.   Gagnon S, Rithchie J, Lynch A, et al. *Job Satisfaction and Retention of Nursing Staff: The Impact of Nurse Management Leadership.* Toronto, Ontario: Canadian Health Services Research Foundation; 2006.

75.   Mackoff BL, Triolo PK. Why Do Nurse Managers Stay? Building a Model of Engagement: Part 2, Cultures of Engagement. *Journal of Nursing Administration.* 2008;38(4):166-171.

76.   Mackoff BL, Triolo PK. Why Do Nurse Managers Stay? Building a Model of Engagement: Part 1, Dimensions of Engagement. *Journal of Nursing Administration.* 2008;38(3):118-124.

77.   Reinhard S, Reinhard T. *Scanning the Field*: Institute for the Future of Aging Services; 2006.

78.   Woltring C, Constantine W, Schwartze L. Does Leadership Training Make a Difference? The CDC/UC Public Health Leadership Institute 1991-1999. *Journal of Public Health Management Practice.* 2003;9(2):103-122.

79.   Michie S, West MA. Managing people and performance: an evidence based framework applied to health service organizations. *International Journal of Management Reviews.* 2004;5-6(2):91-111.

80. Wagner SE. Staff Retention: From "satisfied" to "engaged". *Nursing Management.* 2006;37(3):24.

81. Schirm V, Albanese T, Garland TN, Gipson G, Blackmon DJ. Caregiving in Nursing Homes: Views of Licensed Nurses and Nursing Assistants. *Clin Nurs Res.* 2000;9(3):280-297.

82. Muntaner C, Li Y, Xue X, O'Campo P, Chung HJ, Eaton WW. Work organization, area labor-market characteristics, and depression among U.S. nursing home workers: a cross-classified multilevel analysis. *International Journal of Occupational and Environmental Health.* 2004;10(4):392-400.

83. Hallberg I, Norberg A. Strain among nurses and their emotional reactions during 1 year of systematic clinical supervision combined with the implementation of individualized care in dementia nursing. *Journal of Advanced Nursing.* 1993;18(12):1860-1875.

84. Finlay N, James C, Irwin J. Nursing education changes and reduced standards of quality care. *Br J Nurs.* 2006;15(13):700-702.

85. Priest A. *What's Ailing our Nurses? A Discussion of the Major Issues Affecting Nursing Human Resources in Canada.* Ontario: Canadian Health Services Research Foundation; 2006.

86. Venturato L, Kellett U, Windsor C. Nurses' experiences of practice and political reform in long-term aged care in Australia: implications for the retention of nursing personnel. *Journal of Nursing Management.* 2007;15(1):4-11.

87. Wong CA, Cummings GG. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management.* 2007;15(5):508-521.

88. Duffield C. A Master Class for nursing unit managers: an Australian example. *Journal of Nursing Management.* 2005;13(1):68-73.

89. Leiter MP, Spence Laschinger HK. Relationships of Work and Practice Environment to Professional Burnout: Testing a Causal Model. *Nursing Research.* 2006;55(2):137-146.

90. Baer JE. The cost of inadequate leadership. *Nursing Homes Long Term Care Management.* 2006;55(9):60.

91. Rantz MJ, Hicks L, Grando V, et al. Nursing Home Quality, Cost, Staffing, and Staff Mix. *Gerontologist.* 2004;44 (1):24-38.

92. Thompson S, Dunton N, Gajewski B, et al. *Kansas nursing facility project evaluation year 3*: Kansas Department on Aging; 2006.

93. Konetzka RT, Yi D, Norton EC, Kilpatrick KE. Effects of Medicare payment changes on nursing home staffing and deficiencies. *Health Serv Res.* 2004;39(3):463-488.

94. Ellis J, Priest A, MacPhee M, McCutcheon AS, on behalf of CHSRF and partners. *Staffing For Safety: A Synthesis of the Evidence on Nurse Staffing and Patient Safety*: Canadian Health Services Research Foundation; 2006.

95. Brannon D, Zinn J, Mor V, Davis J. An Exploration of Job, Organizational, and Environmental Factors Associated With High and Low Nursing Assistant Turnover. *The Gerontologist.* 2002;42:159-168.

96. Gaughan A. Effective leadership behavior: leading "the third way" from a primary care group perspective. *Journal of Management in Medicine.* 2001;15(1):67-94.

97. Coomber B, Barriball KL. Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: a review of the research literature. *International Journal of Nursing Studies.* 2007;44(2):297-314.

98. Hayes LJ, O'Brien-Pallas L, Duffield C, et al. Nurse turnover: A literature review. *International Journal of Nursing Studies.* 2006;43:237-263.

99. O'Brien-Pallas L, Griffin P, Shamian J, et al. The impact of nurse turnover on patient, nurse, and system outcomes: a pilot study and focus for a multicenter international study. *Policy, Politics, & Nursing Practice.* 2006;7(3):169-179.

100. Hilder D. *The cost to BCS of employee turnover*: Baptist Community Services; 2001.

101. Kash RA, Castle NG, Phillips CD. Nursing home spending, staffing, and turnover. *Health Care Management Review.* 2007;32(3):253-262.

102. Miller L, Broughton A, Tamkin P, Reilly P, Regan J. *Human resources, organisational development and workforce development in the NHS: A review of recent research.* Brighton: Institute for Employment Studies; 2007.

103. McGillis Hall L, McGilton KS, Krejci J, et al. Enhancing the quality of supportive supervisory behavior in long-term care facilities. *Journal of Nursing Administration.* 2005;35(4):181-187.

104. Morgan DG, Stewart NJ, D'Arcy C, Cammer AL. Creating and sustaining dementia special care units in rural nursing homes: the critical role of nursing leadership. *Canadian Journal of Nursing Leadership.* 2005;18(2):74-99.

105. Bond GE, Fiedler FE. A comparison of leadership vs. renovation in changing staff values. *Nursing Economics.* 1999;17:37-43.

106. Chambers N, Tyrer J. What kind of leaders do we need in our care homes? *Nursing & Residential Care.* 2003;5:389-391.

107. Gibson DE, Barsade SG. Managing organizational culture change: the case of long-term care. *Journal of Social Work in Long-Term Care.* 2003:11-34.

108. Laurent CL. A nursing theory for nursing leadership. *Journal of Nursing Management.* 2000;8(2):83-87.

109. Stanley D. In command of care: Toward the theory of congruent leadership. *Journal of Research in Nursing.* 2006;11(2):132-144.

110. Brooker DJ, Woolley RJ. Enriching opportunities for people living with dementia: the development of a blueprint for a sustainable activity-based model. *Aging & Mental Health.* 2007;11(4):371-383.

111. Morjikian RL, Kimball B, Joynt J. Leading change: the nurse executive's role in implementing new care delivery models. *Journal of Nursing Administration.* 2007;37(9):399-404.

112. Mickan S, Rodger S. Characteristics of effective teams: a literature review. *Australian Health Review.* 2000;23(3):201-208.

113. Scott-Cawiezell J, Main D, Vojir C, et al. Linking Nursing Home Working Conditions to Organizational Performance. *Health Care Management Review,* 2005;30(4):372-380.

114. Wicke D, Coppin R, Payne S. Teamworking in nursing homes. *Journal of Advanced Nursing.* 2004;45(2):197-204.

115. Scott-Cawiezell J, Schenkman M, Moore L, et al. Exploring nursing home staff's perceptions of communication and leadership to facilitate quality improvement. *Journal of Nursing Care Quality.* 2004;19(3):242-252.

116. Scalzi CC, Evans LK, Barstow A, Hostvedt K. Barriers and Enablers to Changing Organizational Culture in Nursing Homes. *Nursing Administration Quarterly.* 2006;30(4):368-372.

117. Weir R, Stewart L, Browne G, et al. The efficacy and effectiveness of process consultation in improving staff morale and absenteeism. *Medical Care.* 1997;35(4):334-353.
118. Moiden N. Leadership in the elderly care home sector. *Nursing Management (Harrow).* 2002;9(8):24-28.
119. Larsen L, Cummins J, Brown H, Ajmal T, Beers H, Lee J. *Learning from Evaluation: Summary of reports of evaluation of leadership initiatives*: Office of Public Management and the NHS Leadership Centre; 2005.
120. Cunningham G, Kitson A. An evaluation of the RCN Clinical Leadership Development Programme: Part 2. *Nursing Standard.* 2000;15(13-15):34.
121. Skills for Care. *Mapping of leadership and management standards for social care, revised and expanded second edition: Leadership & Management Product 3*: Skills for Care; 2006.
122. Caldwell K, Moiden N. Followership in the elder care home sector. *Nursing Management.* 2000;7(7):12-15.
123. Cohen-Mansfield J, Bester A. Flexibility as a management principle in dementia care: the Adards example. *Gerontologist.* 2006;46(4):540-544.
124. Woodward F. *How to Achieve Effective Clinical Engagement and Leadership when Working Across Organisational Boundaries*: Guy's & St Thomas' Charity; 2007.
125. Pennington K, Scott J, Magilvy K. The role of certified nursing assistants in nursing homes. *Journal of Nursing Administration.* 2003;33(11):578-584.
126. Wieck KL, Prydun M, Walsh T. What the emerging workforce wants in its leaders. *Journal of Nursing Scholarship.* 2002;34(3):283-288.
127. Kanste O, Kyngas H, Nikkila J. The relationship between multidimensional leadership and burnout among nursing staff. *Journal of Nursing Management.* 2007;15(7):731-739.
128. Stanley D. Recognizing and defining clinical nurse leaders. *Br J Nurs.* 2006;15(2):108-111.
129. Read S, Ashman M, Scott C, Savage J. *Evaluation of the modern matron role in a sample of NHS trusts*: The Royal College of Nursing Institute and The University of Sheffield School of Nursing and Midwifery; 2004.
130. Deutschman MT. An ethnographic study of nursing home culture to define organizational realities of culture change. *Journal of Health & Human Services Administration.* 2005;28(2):246-281.
131. Berg A, Hallberg I, Norberg A. Nurses reflections about dementia care, the patients, the care and themselves in their daily caregiving. *International Journal of Nursing Studies.* 1999;35(5):271-282.
132. Scott JG, Sochalski J, Aiken L. Review of magnet hospital research: findings and implications for professional nursing practice. *Journal of Nursing Administration.* 1999;29(1):9-19.
133. Cohen KR. Playing for keeps. For a lasting relationship, apply matchmaking techniques when hiring. *Contemporary Long-Term Care.* 1999;22(2):28-30.
134. Doherty C, Hope W. Shared governance--nurses making a difference. *Journal of Nursing Management.* 2000;8(2):77-81.
135. Dickson G, Briscoe D, Fenwick S, MacLeod Z, Romilly L. *The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada*: Canadian Health Services Research Foundation; 2007.

136. Buchanan D, Caldwell R, Meyer J, Storey J, Wainwright C. Leadership transmission: a muddled metaphor? *Journal of Health Organization & Management.* 2007;21(2-3):246-258.

137. Stolee P, Esbaugh J, Aylward S, et al. Factors associated with the effectiveness of continuing education in long-term care. *Gerontologist.* 2005;45(3):399-409.

138. Cunningham G, Kitson A. An evaluation of the RCN Clinical Leadership Development Programme: Part 1. *Nursing Standard.* 2000;15(12):34.

139. Woolnough H, Faugier J. An evaluative study assessing the impact of the Leading an Empowered Organisation Programme. *Nursing Times Research.* 2002;7(6):412-427.

140. Canadian Health Services Research Foundation. *Looking Forward, Working Together: Priorities for Nursing Leadership in Canada.* Ontario: Canadian Health Services Research Foundation; 2006.

141. Setliff R, Porter J, Malison M, Frederick S, Balderson T. Strengthening the Public Health Workforce: Three CDC programs that prepare managers and leaders for the challenges of the 21st century. *Journal of Public Health Management Practice.* 2003;9(2):91-102.

142. Corrigan PW, Diwan S, Campion J, Rashid F. Transformational leadership and the mental health team. *Administration and Policy in Mental Health.* 2002;30(2):97-108.

143. Doran D, McCutcheon A, Evans M, et al. *Impact of the Manager's Span of Control on Leadership and Performance*: Canadian Health Services Research Foundation; 2004.

144. Nelson HW, Cox DM. The causes and consequences of conflict and violence in nursing homes: working toward a collaborative work culture. *Health Care Manager.* 2004;23(1):85-96.

145. Registered Nurses' Association of Ontario. *Developing and Sustaining Nursing Leadership.* Toronto: Registered Nurses' Association of Ontario; 2006.

146. Chen SL, Witucki J, Melcher P, McKibben MA. Use of nursing homes in Baccalaureate nursing education. *Nursing & Health Sciences.* 2001;3(1):57-61.

147. Scott-Cawiezell J, Vogelsmeier A, McKenney C, Rantz M, Hicks L, Zellmer D. Moving from a culture of blame to a culture of safety in the nursing home setting. *Nursing Forum.* 2006;41(3):133-140.

148. Yeatts DE, Cready C, Ray B, DeWitt A, Queen C. Self-managed work teams in nursing homes: implementing and empowering nurse aide teams. *Gerontologist.* 2004;44(2):256-261.

149. Scott L, Caress A-L. Shared governance and shared leadership: meeting the challenges of implementation. *Journal of Nursing Management.* 2005;13(1):4-12.

150. DeCicco J, Laschinger H, Kerr M. Perceptions of Empowerment and Respect: Effect on Nurses' Organizational Commitment in Nursing Homes. *Journal of Gerontological Nursing.* 2006;32(5):49.

151. Scott-Cawiezell J, Jones K, Moore L, Vojir C. Nursing home culture: a critical component in sustained improvement. *Journal of Nursing Care Quality.* 2005;20(4):341-348.

152. Castle NG, Banaszak-Holl J. The effect of administrative resources on care in nursing homes. *Journal of Applied Gerontology.* Sep 2003;22(3):405-424.

153. McConnell E, Lekan-Rutledge D, Nevidjon B, Anderson R. Complexity Theory: A Long-Term Care Specialty Practice Exemplar for the Education of Advanced Practice Nurses. *Journal of Nursing Education.* 2004;43(2):84-87.

154. Oandasan I, Baker GR, Barker K, et al. *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada*: Canadian Health Services Research Foundation; 2006.

155. Skills for Care West Midlands. *Leadership and Management (L&M) Qualification and Training Provision for the Care Sector in the West Midlands: Summary findings of a Research Report.* Birmingham: Skills for Care West Midlands; 2008.

156. Hollinger-Smith L, Ortigara A. Changing culture: creating a long-term impact for a quality long-term care workforce. *Alzheimer's Care Quarterly.* 2004;5(1):60-70.

157. Flavel J. The Aged Care Workforce: Methods to Increase Supply to Remedy Possible Shortages. *Australian Bulletin of Labour.* 2007;33(1):106-128.

158. McCutcheon SA, MacPhee M, Davidson J, Doyle-Waters M, Mason S, Winslow W. *Evaluation Of Patient Safety And Nurse Staffing*: Canadian Health Services Research Foundation; 2005.

159. Sutherland VJ, Associates. *Nurse leadership development: Innovations in mentoring and coaching - the way forward: Evaluation report*: The NHS Leadership Centre; 2005.

160. United States General Accounting Office. *Nursing workforce [electronic resource]: emerging nurse shortages due to multiple factors* United States General Accounting Office; 2001.

161. Jennings BM, Scalzi CC, Rodgers JD, Keane A. Differentiating nursing leadership and management competencies. *Nursing Outlook.* 2007;55(4):169-175.

162. Sirola-Karvinen P, Hyrkas K. Clinical supervision for nurses in administrative and leadership positions: a systematic literature review of the studies focusing on administrative clinical supervision. *Journal of Nursing Management.* 2006;14(8):601-609.

163. Timpson J. The NHS as a learning organization: aspirations beyond the rainbow? *Journal of Nursing Management.* 1998;6(5):261-274.

164. Calhoun JG, Vincent ET, Baker GR, Butler PW, Sinioris ME, Chen SL. Competency identification and modeling in healthcare leadership. *Journal of Health Administration Education.* 2004.

165. NHS Institute for Innovation and Improvement. *Leadership Qualities Framework 360 Feedback Tool: Best Practice Guide for Facilitators*: National Health Service.

166. Challinor J, Davison V, Sandford J. *Mapping of the leadership qualities framework (LQF), knowledge and skills framework (KSF), management and leadership standards*: National Health Service; 2007.

167. NHS Institute for Innovation and Improvement. Mapping of the KSF and NHS Leadership Qualities Framework. In: Overview_of_mapping.xls, ed; 2008.

168. Williams S. *Evaluation of the Leadership at the Point of Care programme: Final Evaluation Report.* Oxfordshire: Henley Management College; October 2005.

169. Kilty H. *Nursing Leadership development in Canada. A descriptive status report and analysis of leadership programs, approaches and strategies*: Canadian Nurses Association; 2005.

170. Penney C. *Report of the Canadian Health Leadership Network (CHLNet) Summit*: Canadian Health Services Research Foundation; 2007.

171. Konrad S. Innovative leadership: nurses in long-term care. *Alberta RN.* 2003;59(8):6-7.

172. Kirk H. Nurse executive director effectiveness: a systematic review of the literature. *Journal of Nursing Management.* 2008;16(3):374-381.

173. Alzheimer's Australia. *Quality Dementia Care: Practice in Residential Aged Care Facilities for all Staff*: Alzheimer's Australia; 2007.

174. McCallin A. Interdisciplinary team leadership: a revisionist approach for an old problem? *Journal of Nursing Management.* 2003;11(6):364-370.

175. Arnold KA, Turner N, Barling J, Kelloway EK, McKee MC. Transformational leadership and psychological well-being: the mediating role of meaningful work. *Journal of Occupational Health Psychology.* 2007;12(3):193-203.

176. Iles V, Sutherland K. *Organisational Change A Review for Health Care Managers, Professional and Researchers*: National Co-ordinating Centre for NHS Service Delivery and Organisation; 2001.

177. Marchionni C, Ritchie J. Organizational factors that support the implementation of a nursing Best Practice Guideline. *Journal of Nursing Management.* 2008;16(3):266-274.

178. Clarke C, Reed J, Newton J, et al. *NHS Leadership Centre: Chief Executive Development Programmes Evaluation Final Report.* UK: NHS Leadership Centre; 2004.

179. Adams-Wendling L, Lee R. Quality improvement nursing facilities: a nursing leadership perspective. *Journal of Gerontological Nursing.* 2005;31(11):36-41.

180. Nolan MR, Brown J, Davies S, Nolan J, Keady J. *The Senses Framework: Improving Care for Older People Through a Relationship-Centred Approach.* Sheffield: University of Sheffield; 2006.

181. Ryan T, Nolan M, Reid D, Enderby P. Using the Senses Framework to achieve relationship-centred dementia care services: A case example. *Dementia.* 2008;7(71):71-93.

182. Prenkert F, Ehnfors M. A measure of organizational effectiveness in nursing management in relation to transactional and transformational leadership: a study in a Swedish county hospital. *Journal of Nursing Management.* 1997;5(5):279-287.

183. Rondeau K, Wagar T. Nurse and resident satisfaction in magnet long-term care organizations: do high involvement approaches matter? *Journal of Nursing Management Issues in Collaboration in Nursing Management.* April 2006;14(3):244-250.

184. Stone R, Reinhard S, Bowers B, et al. *Evaluation of the wellspring model for improving nursing home quality*: The Commonwealth Fund; 2002.

185. MacKenzie S. Implementing the Eden Alternative in Australia. *Journal of Social Work in Long-Term Care.* 2003;2:325-338.

186. Edwards H. *Aged Care Core Component in Undergraduate Nursing Curricula*: Department of Health and Ageing; 2004.

187. Beech N, Brockbank A. Power/knowledge and psychosocial dynamics in mentoring. *Management Learning.* 1999;30(1):7-25.

188. Bowles A, Bowles NB. A comparative study of transformational leadership in nursing development units and conventional clinical settings. *Journal of Nursing Management.* 2000;8(2):69-76.

189. Sutherland VJ, Associates. *Nurse leadership development: Innovations in mentoring and coaching-the way forward-a summary*: NHS Leadership Centre; 2005.

190. McNally K, Lukens R. Leadership development - An external-internal coaching partnership. *Journal of Nursing Administration.* 2006;36(3):155-161.

191. Skills for Care. Leadership and management strategy. http://www.skillsforcare.org.uk/developing_skills/leadership_and_management/leadership_and_management_strategy.aspx. Accessed 20 November, 2008.

192. Skills for Care West Midlands. *Research briefing key findings: Key findings from employers about leadership and management training*: Skills for Care West Midlands; 2008.

193. Clinical Leadership Programme in Australia. *Clinical Leadership the difference it makes: Clinical Leaders sharing experiences of changes in practice in South Australia*: Clinical Leadership Programme in Australia; 2007.

194. Clinical Leadership Programme in Australia. *Clinical Leadership Mental Health Professionals achieving consumer centred care*: Clinical Leadership Programme in Australia; 2008.

195. Department of Health and Ageing. *Aged care in Australia*: Department of Health and Ageing; 2006.

196. Elliott J (Minister for Ageing). *Australian Government announces 7,700 extra training places for aged care workers: Preparing for our ageing population, media release.* Canberra: Parliament House; 2008.

197. Department of Health and Ageing. *Conditional Adjustment Payment (CAP). Instructions guide to CAP financial reports: requests for exemption and/or transitional arrangements application form.* Canberra: Department of Health and Ageing; 2005.

198. Department of Health and Ageing. *Minister's awards for excellence in aged care.* Canberra: Department of Health and Ageing; 2007.

199. Aged Care Standards and Accreditation Agency. *Assessment Modules*: Aged Care Standards and Accreditation Agency; 2007.

200. Aged Care Standards and Accreditation Agency. *When residential care is right for you: quality residential aged care - information about standards of accommodation and care provided by aged care homes*: Aged Care Standards and Accreditation Agency; 2003.

201. Royal College of Nursing. RCN Clinical Leadership Programme. http://www.rcn.org.uk/development/practice/leadership. Accessed 20 November, 2008.

202. NHS Institute for Innovation and Improvement. Leadership Qualities Framework. http://www.nhsleadershipqualities.nhs.uk/. Accessed 20 November, 2008.

203. NHS Institute for Innovation and Improvement. *NHS Leadership Qualities Framework*: National Health Service; 2006.

204. NC Center for Nursing. Institute for Nursing Excellence. http://www.nccenterfornursing.org/recruitmentandretention/institute/ine.htm. Accessed 24 November, 2008.

205. Deakin University School of Nursing. Deakin University Leadership in Nursing Awards. 2008; http://www.deakin.edu.au/hmnbs/nursing/awards/index.php. Accessed 20 November, 2008.

206. Baptist Community Services. Training. http://www.bcs.org.au/pages/content.asp?plid=4. Accessed 24 November, 2008.

207. Pathways Health and Education Consultants Pty Ltd. *About the Diploma of Business (Frontline Management)*: Pathways Health and Education Consultants Pty Ltd; 2008.

SUMMARY OF KEY RESEARCH REFERENCES (see Glossary for acronyms)

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Adams & Lee (2005)	USA	Mixed methods: Interviews, surveys observations	LTC - state of Quality Improvement (QI) implementation	NHs=51; DONs=48; ADONs=3;	All facilities thought they had effective QI programs but only 2 actually implementing	Essential that management see QI program as central priority, recognise cost effectiveness of QI
Akinci & Krolikowski (2005)	USA	Cross-sectional 2 database sources	LTC RN/LPN/ CNA staff levels/ratio	Counties=10; NHs=90;	Higher staff levels/ ratios significantly related to better QoC; profit-base orientation produces lower QoC & higher staffing costs	Improving workplace environment/conditions/ supervision improves QoC, retention; ethos of learning organization most effective & successful outcomes
Anderson et al. (2003)	USA	Cross-sectional testing Complexity Theory	LTC	NHs=164; DONs=164; RNs=201	Greater communication /RN engaged decision-making/relationship-oriented leadership /less formal organisation system produce better staff/resident outcome	Flatter management/good communication/greater DON stability all make for better Resident well-being & care outcomes
Anderson et al. (2004)	USA	Cross-sectional Random sample survey facility data	LTC	NHs=164/43% Total=3,449 DONs=164; RNs=244; LVNs=964 CNAs=2,317	Environment & DON instability associated with RN/LVN turnover; greater openness /communication lower LVN turnover.	Stable Nurse management is important for consistent transmission of leadership/ organisational commitment & staff retention
Aroian et al. (2000)	USA	Descriptive mailed survey	LTC DONs qualifications	DONs=274	DON role description needs clarification & minimum qualifications educational curriculum	Educational institutions to re-examine DON role & write clear curriculum for necessary capacities
Berg et al. (1998)	Sweden	Qualitative Interviews	LTC Clinical supervision	NHs=1; residents=11; Nurses=13; LENs=10; NA=1;	Caring for dementia patients creates inter-dependent lifeworlds; demands particular personality	Requires sensitive hiring to achieve right balance of team & personalities
Bond & Fiedler (1999)	USA	Triangulated Pre-post, 2 x change, 1 x control Surveys, interviews	LTC Neighbourhood model	NH=1; Units=3 (architectural change=1, culture change =1, control=1); Staff=65	Control & environment change units improved while Culture change unit deteriorated due to lack of training for change/supervisor & insufficient resources to support change	Management spent up on architectural change but didn't seem to think it need to invest same in culture change

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Borrilll et al. (2005)	UK	Cross-sectional Survey measures	NHS Trusts HR in acute & PC	Trusts=572 Staff=203,911/ 55.8%	Positive perceptions: strong link with well-structured appraisal HR; Senior leadership & work-life balance	Context differences in point of perception: Acute staff identify senior leadership as responsible & Primary Care more immediate supervisors
Bowles & Bowles (2000)	UK	Matched convenience samples Post survey – 2 studies	Hospital nurses NDU & Non-NDU	S1. Nurses=20 S2. A. Nurse Development Units (NDU) leaders=7, observers =28; B. Non-NDU leaders=7, observers =28	Non-NDUs score lower on all 5 practices of exemplary leadership	Nurse Development Units provide a focus on leadership that is productive of good leadership practice
Brannon et al. (2002)	USA	Qualitative interviews	LTC	NHs=360 DONs=288/80%	Leadership the only variable to have impact on turnover; Linera relationship between RN & NA turnover	Facilities with trained supervisors only ones to be in low turnover referent group
Brooker & Wooley (2007)	UK	Qualitative Pilot change program evaluation	LTC	Practice develop sites=4 (pop= 127); EWG=30; Focus group members=30; Locksmiths=4	Essential core role of management support & assertive/strong change agent (Locksmith)	Successful change requires engaged, supportive organisational leadership
Castle & Banaszak-Holl (1997)	USA	Cross-sectional Telephone survey, resident/census data	LTC	NHs=236; total=472 (DONs=236; NHAs=236;	Management with longer tenure/higher qualifications more likely to be innovative; chains more likely to innovate	Top management is an important factor & needs to be included in LTC research
Castle & Banaszak-Holl (2003)	USA	Cross-sectional Multiple data sources	LTC	NHs=16,055	Higher Administrative FTE hours strongly associated with lower deficiencies/high QoC; effect sizes for higher nurse staffing greater impact on QoC	Stable, well resourced administration & higher nurse staffing produces better QoC
Castle (2005)	USA	Cross-sectional, mailed survey & OSCAR data	LTC	States=5; NHs=419 (of 470)	DON/NHA turnover significantly associated with RN/LPN/CNA(less) turnover	Stable management results in stable staff; role of top management is to foster organisational commitment
Clarke et al. (2004)	UK	Triangulated surveys & 2 phases of phone interviews	NHS NLC CEO Development program	Survey=617/19% Interviews=47 Interviews=18	Improvements in CEO recognition of need to change hierarchical leadership; value of reflexive process	Important to develop CEO programs that are flexible & accessible because these roles have difficulty finding time to attend
Cohen-Mansfield & Bester (2006)	USA & Australia	Qualitative	LTC	NH=1	The Adards NH (Tas) is an exemplar of flexible organisational systems, with PCC applied to all	Ideal model of LTC Employer of choice (EOC), with flexibility key to HR/ care management in small facility with family culture

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Colon-Emeric et al. (2006)	USA	Qualitative Interviews & Observation Comparing 4 NHs	LTC	NHs=4; Staff=390; Observations =274; Encounters=69; Interviews=122	3NHs poor cohesion /communication/care planning organisation all linked to high staff turnover/low QoC; 1 NH stable leadership/ high cohesion had low turnover/high QoC	Cohesive, stable, effective organisational leadership produces higher QoC and better resident/staffing outcomes
Corrigan et al. (2002)	USA	Cross-sectional questionnaires	Mental Health Teams	Responses 70% Leaders=235 Subordinate=620	when both report high transformational qualities there is less burnout/more positive organisation culture	Leaders tend to rate self more highly than do followers but both see transformational qualities as desirable;
Cunningham & Kitson (2001)	UK	Descriptive Convenience sample	NHS Trusts Acute	Trusts=4; Senior Nurses=4; ward Sisters=24	Overall consensus on improvement in leadership skills, but leaders confidence in improvement higher than followers	Senior nurses tend not to see selves as members of teams & most had not experienced effective role models – suggesting suboptimal performance
DeCiccio et al. (2006)	Canada	Descriptive comparing acute & NH	RNs- acute & LTC	RNs=79; RPNs=75	Structural/psychological empowerment explains variance both groups; Strongest for RNs is access to information, for RPNs it is support	Access to sufficient resources/effective information protocols/ career opportunities induce stronger organisational commitment/retention
Deutschman (2000)	USA	Triangulated Surveys & focus groups	LTC	NHs=8; Focus groups=14 (NHAs /DONs/ social workers/ families/residents)	Management is fraught with stress to maintain QoC with unstable staff /inadequate resources & skills/negative staff & public attitudes	LTC facilities need to lift perceptions/be centres for research/education/training to diminish behavioural problems of residents & achieve leadership/EOC
Deutschman (2001)	USA	Qualitative Change-agent training program	LTC	NHs=7; NHAs=7; DONs=7; CNAs=7; Other staff=21	Innovative training methods well-received; participant enthusiasm for change defeated by unstable organisations	Change leadership training is only successful when it is supported with sufficient resources by organisational leadership
Deutschman (2005)	USA	Triangulated Ethnograph observations Interviews & survey	LTC	NHs=3	Only facilities with highly innovative, assertive leadership successfully implement /sustain change	Change LTC from medical model to Wellness model of care; Need responsive funding model & career development for mgmnt
Duffield (2005)	Australia	Qualitative – Delphi pilot master class	Hospital NUMs	NUMs=18 (14 completing) Hospitals=4	Developed skills for role responsibilities: effective time/people management/network	Peer networking important source of support in NUM role transition; supportive organisational resources

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Eley et al. (2007)	Australia	Cross-sectional mailed survey compared with 2001	LTC	2001 returns =424/42.4% 2004 returns =405/40.5%	Overall dissatisfaction, slight improvement in work completion/ access to training but still deteriorated stress for public sector;	Increased paperwork & poor staffing ratio/stability cause major stresses in LTC; Aging workforce of serious concern
Flavel (2007)	Australia	Cross-sectional Census & survey data	LTC	RNs=735; ENs=428; PCAs=2,171; AHs=262	PCAs desire more/ stable hours while RNs want less; suggests increased wages will not increase labour supply	A statistical assessment that fails by omission of complexity
Forbes-Thompson et al. (2006)	USA	Cross-sectional 2-phase surveys	LTC	1. NHs=101; total=55% of 3,981 (NHAs/ DONs/ADONs/ dept heads =332; RNs/LPNs /CNAs=1,872; 2. NHs=222; Both surveys: NHs=67; Admin =261, Care staff =1,463	Upper management has no minimum qualifications; many DONs under-prepared skilled for role; Care staff lower perceptions than management; higher NHA/DON turnover associated with lower perceptions of care staff on team work/communication	Need for higher minimum qualifications for upper management & better educational/career path opportunities
Fox et al. (1999)	USA	Cross-sectional Input output payroll data	Hospital	Care units=28 FTE=875 NAMs=16	Primacy of leadership 20%staff productivity Nurse Administrative Managers (NAMs) too much time operational function	Need for efficient allocation of NAM/ANAM (Assistant Nurse Administrative Manager) time; develop program for NAM management training
Gagnon et al. (2006)	Canada	Triangulated Coaching/ Action research survey/focus groups	Hospital care unit NMs	Units/NMs=11 Nurses pretest =379/42%; post=160/31%	Intention to stay linked with higher education/ better perception of NM/global satisfaction/ organisational commitment	40% of reasons for intention to leave were things organisational management could easily change
Gaughan (2001)	UK	Qualitative – Non-probability sampling Grounded Theory	Primary Care Groups (PCG)	PCG management boards =12	19 leadership themes say transformational but characteristics generic good leaders	Suggests leadership capabilities need to be developed and consistently reviewed to suit context and organisational goals
Gnaedinger et al. (2003)	Canada	Triangulated Interviews, surveys, focus groups	LTC	Interviews n=8 Survey HEU n=? Focus groups – n=30/NHs=4	LTC leadership not prepared/skilled for RCC culture change implementation	RCC principles need to apply to staff as well & leadership needs to be better educated & prepared to lead change

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Hallberg & Norberg	Sweden	Experimental/controlled	LTC - clinical supervision	EW. Nurses=19 CW. Nurse=19	EW had significant improvement on all measures for staff & residents; CW stasis	Clinical supervision for Dementia care staff improves QOC & Staff outcomes
Hegney et al. (2006)	Australia	Cross-sectional survey	Nurses Union - LTC Hospitals (Public & Private)	Nurses=1349	No change since 2001 survey; poor pay/low morale/high stress/ overwork/few career opportunities; higher stress for AC	Nurses report more satisfaction when perceive management as supportive & have sufficient resources & staffing ratios/skill-mix
Hollinger-Smith & Ortigara (2004)	USA	Descriptive Baseline/ 3/6/12mths	LTC LEAP culture change program evaluation	NHs=14; Nurses=255; CNAs=288	2-level (NMs & CNAs) have significant improvement over time & positive outcomes for staff and QoC	Important that facility is assessed for ongoing program readiness to support staff in effecting change
Hughes (2005)	UK	Cross-sectional Survey & interviews	Nurse CPD	Hospitals: Private=100; Public=100 Pilot=20, full=200; Interviews=8; NHs=13; nurses=100	All saw CPD as positive more accessible to Public than Private; only 19% sectors saw critical reflection as essential to practice; Conflict between CPD/ domestic responsibility	Indicates poor supervision & lack of leadership transmission; Evidence for dramatic effect of leadership on motivation for CPD
Jeong & Keatinge (2004)	Australia	Qualitative Observation, interviews, facility data	LTC Leadership	NH=1; Interviews=8	Adaptation to 97 Aged Care Bill caused many problems but NHs with innovative, assertive leadership managed change better	Flat management with holistic HR/high teamwork & balanced/collaborative teams with congruent values & organisational support
Kanste et al. (2007)	Finland	Cross-sectional Survey	Hospitals and health centres	Responses=601 Nurses	Transformational & Active Management by Exception both produce positive staff outcomes; only Laissez Faire did not	Nurses respond well to leadership that pays attention to them, is supportive & rewarding but do not work well with hands-off leaders.
Kash et al. (2007)	USA	Cross-sectional multiple data sources	LTC Admin costs	NHs=1,014	Expenses higher in not-for-profit, but higher admin costs=higher positive outcomes in QoC/staff retention outcomes	Higher staff benefits have positive RN recruitment & greater staff stability outcomes
Konetzka et al. (2004)	USA	Cross-sectional	LTC	National data source	Direct link established between decrease in professional nurse role &increased deficiencies & lower QoC	Cost cutting in staffing ratios actually ends up costing more in staff turnover & health care costs
Konetzka et al. (2007)	USA	Cross-sectional	LTC	National data source	Greater RN staffing significantly reduces negative patient outcomes	Minimum skill-mix of 0.63 RN HPRPD for better QoC

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Large et al. (2005)	UK	Qualitative – Interviews	NHS Trusts	NHS=80; staff=1052 Clinical leaders 360°review=134 Interviews=143 Clin. leaders=16 DONs=14;Service users=36	CNP interventions evaluation strong positive change in participant leadership capabilities; most DONs reported beneficial outcomes	Program has patient at centre of care ethos, taught observational skills & leader as change agent; improved care quality and confidence in leadership capacities.
Leiter & Spence Laschinger (2006)	Canada	Cross-sectional	Hospitals	Nurses=8,597	Confirm causal worklife model of structural relationships, links professional/environmental qualities 5 factors leadership role in workplace stressors	Staffing levels & professional relationships in direct path between nursing model of care and sense of personal accomplishment.
McGillis Hall et al. (2005)	Canada	Qualitative Focus group	LTC RN supervisors	NHs=12 (6xnot-for-profit 6xfor-profit); RN=12; RPN=18;HCA=8PSW=18	Overwhelming scope of supervisory role; poor feedback, lack of respect/courtesy due to lack of time,	Escalating pressures of complexity of high care & insufficient resources, high ratios & poor skill mix cause poor supervision
Mackenzie (2003)	Australia	Qualitative	LTC - Eden Alternative PCC Change	NHs=3 form Aged Care Group Trained Change agents n=7	Significantly improved QoC/patient/staff satisfaction/retention/ performance outcomes	Change program includes total care & workplace culture & environment; ACG shares resources
Mackoff et al. (2008)	USA	Qualitative – in-depth interviews Part 1	Hospitals	Hospitals=6 High-performing NMs=30	10 NM leadership signature behaviours; identifies teachable & dispositional elements	Role description that identifies NM as pivotal in staff retention & design educational curriculum for signature elements
McNally & Lukens (2006)	USA	Cross- sectional Program evaluation survey	Hospitals	Hospitals=3 Employee=5,000 Clinical leaders=64 response 2/3	Professional practice coaching helped all respondents become more confident as leaders.	Claims high return on $85k investment in higher retention but is specious Evaluation is conducted by coaching contractor
Mackoff et al. (2008)	USA	Qualitative – in-depth interviews Part 2	Hospitals	Hospitals n=6 High-performing NMs=30	5 signature factors of organisational culture: Learning/Regard/ Meaning/Generative/ Excellence	NM pivotal disseminator of organisational culture & leadership transmission but organisational support is essential.
Marchioni & Ritchie (2008)	Canada	Triangulated Pilot surveys & various measures	Hospital	Nurses: Medical unit =53; Surgical ward =27	Unit culture often barrier to implement BPG; most successful is culture of learning	To implement BPG needs organisational assessment/ culture change

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Marquis et al. (2004)	Australia	Qualitative Ethnographic interviews	LTC – high performing facility	NH=1; Care staff=18 (RNs=3; ENs=4; NAs=7; OTs=2	Ethos of Care; Ethical/ values congruence in PCC extended to staff/ families in extended family environment	Outsourced all non-care tasks; Compatibility of new hires with care teams & organisational values most important; primacy of care
Mentes & Tripp-Reimer (2002)	USA	Qualitative	LTC	NHs=4 Staff as RAs=8 (RNs=4 NAs=4)	Widespread lack of NH leadership acts as barrier to conducting effective research	Select better managed NHs reduces generalisability; Important to allow for facility 'warm-up' time
Morjikian et al. (2007)	USA	Qualitative Telephone interviews	Hospitals	Chief nursing officers (CNOs)	New Care Delivery models require new business plans, clear communication that articulates new goals/ objectives to all levels	Explicates importance of business expertise/HR management skills of CNOs in implementing change programs
Morgan et al. (2005)	Canada	Qualitative Interviews	LTC – new SCUs	NHs=8; DONs=10	Critical role of strong/ stable leadership that is vigilant, consistent, clear communication & facilitates collaborative practice with training & resources	The 4 NHs that practiced collaborative, participative change programs had few problems, while those with top down management had ongoing problems
Moyle et al. (2003)	Australia	Qualitative Purposive sample, focus groups & interviews	LTC	NHs=2; RNs=9; Ens=5; AINs=13	Staff gain high intrinsic satisfaction from care but struggle with low status/poor support, leadership & work conditions	Sufficient resources/better skilled supervision/careful hiring for compatibility of teams & commitment to work
Muntaner et al. (2004)	Canada & USA	Cross-sectional Mailed surveys & interviews	LTC – NA depression	NHs=49; NAs=473 of539	Deregulation of sector/ FP/higher complexity & stress/overwork/poor reward/lack of career opportunities	Stress of deregulation's reduced conditions has increased depression in direct care staff
Nelson & Cox (2004)	USA	Qualitative interviews	NH administrators	Small number of NHs n=?	Conflict arises from competing agendas poor communication stringent/punitive regulation/protocols;	Flat/holistic management & effective communication is more successful; Family engagement; Careful hiring & HR practices important
Pennington et al. (2003)	USA	Qualitative interviews	LTC	NHs=6, CNAs=12	Care staff love their work/patients; need cohesive teams with hands-on leadership	Care staff need to feel respected/supported by leadership as team member/role model

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Pitkala et al. (2008)	Finland	Qualitative PCC Culture change program	LTC	NH=1; Res=50; Staff=32 (3 teams Nurse=10; Prim nurse=19; kitchen staff=3; Consulting Physician=1)	Important attention to whole of facility/team dynamics with focus on attitude change & develop reflexive, diagnostic skills with intense communication consultation; Learning organization ethos	Small team units that can initiate/sustain own change processes & transmit congruent organisational ethics/values.
Pollard et al. (2005)	UK	Triangulated observations case conference & interviews	NHS Trusts Teams	1 Stroke Rehab;1 hospital-based mental health; 1 acute: Staff=34 Students=8 Service users=3	Effective teams rely on inter-professional collaboration/respect & non-hierarchical team structures with clear communication	Stable leadership develops high functioning networks and is key to building effective teams.
Prenkhert & Ehnfors (1997)	Sweden	Cross-sectional	Acute Hospital	Wards=13, Nurse leader=236/70% ward nurses=620	Transformational leadership is more situation contingent than expected	Hospitals are more complex environments than business where the theory was developed
Priest (2006)	Canada	NHS Research reports summary & synthesis	Nursing HR	Reports=6	Urgent reinstatement of nurse leadership positions with clerical support & 'line of sight to bedside'.	Need for increased career pathways and opportunities for further education & professional development; Foster collaborative practice
Rantz et al. (2004)	USA	Cross-sectional	LTC	NHs=92/of 433; Trained RA nurses=4	PRPD cost differences lower in good facilities than those with poor resident outcomes; Stable DON/consistent communication assoc. with better outcomes	Poor quality outcomes are more expensive than good care
Read et al. (2004)	UK	Triangulated Case studies interviews & surveys	NHS Trust Hospital modern Matron role	DON survey=414 /76%; Matron interview=131; Cases/Survey Patient? Matron =121/69%	Wide variation/diffuse role description, duty, responsibilities & working conditions; most lacking clarity & appropriate authority	Urgent need for matron role description clarity, authority & span of control 3 distinct roles suit context Primarily clinical, Primarily managerial & Mixed mode
Rondeau & Wagar (2006)	USA	Cross-sectional Mailed survey	LTC – NHs 35+beds Magnet EOC	DONs=125/43%	EOC associated higher staff/resident satisfied, supportive, progressive HIWP culture, access training opportunities	Democratic, participative, supportive workplace culture needs to support High involvement work practice (HIWP) for EOC
Scalzi et al. (2006)	USA	Triangulated 2-group mixed method descriptive	LTC	NH=3, Staff=67 (leaders=30, professional=30 care staff=28) Family=28	Striking differences in leadership style of NHs with culture change program & those not; Leader stability & exec support essential	Leadership of NHs with effective change programs significantly more stable, participative, supportive, innovative, collaborative, more career development

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Schirm et al. (2000)	USA	Qualitative focus groups	LTC Nurses & CNAs	RNs=25, LPNs=11, NAs=40	Care ethos important to both groups, but cohesive teams most important to NAs; Nurses not well trained for supervision	Hiring needs to consider team compatibility; LTC nurses need time/training for supervision
Scott-Cawiezell et al. (2004)	USA	Cross-sectional Survey	LTC NHAs	States=4; total=995 (RNs=15%, LPNs=15%, CNAs=31%; other=22%)	Disconnect/poor communication between hierarchical leadership & care staff suggest breakdown in clinical systems	Primary role of systems & policies for clear/timely/ accurate communication through to bedside to ensure clinical quality; need for connectivity
Scott-Cawiezell et al. (2005)	USA	Descriptive survey Competing values framework	LTC	NHs=31; Staff= 1,763(CNA=540RN=2 14; LPN= 218; Dept heads =153;others= 449; ?=188	Group culture more cohesive/developmental in smaller facilities; Developmental culture more participative, problem solving	Many NHs incongruent management systems; Flexible, congruent management encourages staff participation
Scott-Cawiezell et al. (2005)	USA	Triangulated survey, observations secondary data	LTC	NHs=32; Residents=2600 Response=1763 (RN=12%, CNA=31%, LPN=12% Dept. heads=9%)	Smaller facilities scored higher all performance measures/ observation; associated with better/ timely communication/ flexibility/cohesion	Smaller facilities are able to be more flexible & have better communication
Scott-Cawiezell et al. (2006)	USA	Qualitative Observation Survey,	LTC QI	NH=1	Inconsistent, punitive, hierarchical leadership prevent QI implement; Facility management thought they had a QI program but did not	Role of nurse leader central in facilitating QI programs to ensure staff participation
Singh & Schwab (2000)	USA	Cross-sectional Mailed survey	LTC NHAs	NHs=552/53%	37% NHAs will leave within 3 years, most voluntarily; stability requires organisational commitment	Sensitive hiring/HR & supervision of NHAs to build organisational trust/ commitment
Skills for Care (2008)	UK	Cross-sectional survey & employer interviews	Health care Leadership education	Employer organizations =500 Training providers=75	83% said program improved business performance; 79% recruitment/retention 84% career develop	Need for bridging program to reduce drop-out; Need for external funding to prevent smaller employers missing out
Stack (2003)	Australia	Cross-sectional	LTC	NHs=4; respond=65/24%	Failure to take account of/allow for relational aspects of care; Care workers value intrinsic satisfaction; reward/ conditions dissatisfied	Limitations in audit culture approach to accreditation of New Public Management

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Stanley (2006)	UK	Triangulated Post survey interviews 3 phases	Hospital	Pilot n=13/43% S1 N=188/22.6% S2 interview=42 S3 interview=8	Nurses identify key elements of personal congruence in clinical expertise/personal & organisational values	Importance of accessible, visible/congruent leader who explicates/models self/organisational values/ expectations.
Stolee et al. (2005)	Canada	Triangulated Delphi survey, focus group	LTC	1. NHs=34; focus grps=6;	Key role of NHAs in implementing change; Staff trained custodial model need change to new rehab model	Management needs to give full support/resources to culture change/education for programs to be effective
Stone et al. (2002)	USA	Qualitative Executive summary of interim evaluation	LTC Wellspring culture change model	Freestanding not-for-profit NHs Alliance n=11	Resource/CNP sharing overall significant QoC improvements, staff performance/satisfaction/retention outcomes	Each NH developed model in own context & variations in degree of commitment /outcomes, particularly data collection/sharing
Sutherland & Assoc. (2005)	UK	Qualitative Compared matched samples	NHS Trusts	Coaching dyads n=15 Mentoring dyads n=15	Mentoring shows more improved satisfaction & performance than coaching	Mentoring is mentee-led and more appropriate in nursing than coach-led model
Thompson et al. (2006)	USA	Cross-sectional OSCAR & MedicAid	LTC	NHs=288	Turnover rates most effective in predicting deficiency scores; FP turnover higher	Disconnect between NHA & CNA perceptions of HR policies/practices
Venturato et al. (2007)	Australia	Qualitative interviews	LTC	NHs/hostels=6 Nurses=14 DONs/clinical managers=10	Nurse role has become more managerial & intrinsic rewards of care have diminished	Nurse need clerical support to be free from paperwork & spend more bedside & supervision time
Weir et al. (1997)	Canada	RCT	Hospital NUMs paired with Consultant	Clinical Inpatient Units=13 (EG=7; CG=6)	Problem-solve mentor produced significant improvement in peer cohesion/support	More supported/confident NUMs induce more trust in staff, less absenteeism, better work environment
Wicke et al. (2004)	UK	Qualitative Focus groups	LTC	NHs=5; RNs=12	Team building Difficult due to HR/workplace management/culture	Staffing inconsistency & lack of supportive policies block team development
Wieck et al. (2002)	USA	Qualitative Delphi developed survey in 5 stages	LTC	'Emerging workforce' (18-35years) (n=108) 'Entrenched workforce' (>35 years) (n=128)	'Honest' top both lists; younger nurses prefer to be nurtured not led; want leaders with expert knowledge; not joiners ;less organisational commitment	Leadership development programs need to consider generational differences in design of curriculum

Author/s (Year)	Origin	Study design / methods	Setting	Participants / Response	Results / Factors	Comments & relevance to Australia
Woltring et al. (2003)	USA	Qualitative self-report & telephone interviews	Health care leadership education evaluation	Alumni=297 Retrospective to 8yrs	Leadership training had moderately great/ great impact on self/ organisational/personal effectiveness for approximately 70% alumni	That alumni still attributed leadership effectiveness & skills to training up to 8 yrs previous is substantial evidence for leadership training value
Woolnough & Faugier (2002)	UK	Qualitative - Interviews	National Leadership Program	Participants=109	LEO - Leading the Empowered Org. improved perceptions of skills; 20% might seek promotion, only 1 had applied matron position/successful	Poor NHS venues, crowded classes & module intensity not helpful; Did not like US style language; 80% won't seek promotion due to poor experience of existing leadership
Yeatts et al. (2004)	USA	Experimental - controlled	LTC	Pilot NH=1; teams=12 Study NHs=10; (EG=5; CG=5)	Successful when all management engaged /supportive facilitators	Management skills devolve to direct care teams when training/support is in place
Zimmerman et al. (2002)	USA	Triangulated Interviews, surveys, observations, facility data	LTC	NHs=59; New admissions =2,015	Higher rates infection/ hospitalisation related to higher RN turnover & lower QoC; higher in FP;	Higher RN/GNP ratios & stability reduces care costs & improves QoC