Valuing Support Workers.

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5.9 Form MO9: Declaration of research Thesis/Project being own work

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Solemnly and sincerely declare, in relation to the research Thesis entitled:

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Abstract

Background: The population of persons over 65 is growing exponentially correlating with a need for a sustainable workforce in aged care with support workers playing a crucial role. New Zealand is grappling with the demands of delivering aged-care services and the government is setting policies that drive organisations to improve the well-being of its workers and those they care for. There is pressure on agencies and managers to provide person-centred care within a market driven time constrained environment. Recruitment and retention of support workers has been identified as a major issue in the aged care workforce. This study was part of a wider research project with staff and students from the Schools of Physiotherapy at Otago University, Occupational Therapy at Otago Polytechnic, and Management at Otago University, collaborating in a series of qualitative studies to investigate how support workers feel valued and what capabilities they have in delivering person-centred care. The premise for this research was that identifying what promotes the support workers to feel valued and therefore enhance their well-being will in turn facilitate retainment and recruitment of this workforce.

Method: This study used descriptive qualitative inquiry and 12 participants were interviewed. Data analysis was carried out using Virginia Braun and Victoria Clarke's (2006) six stages of thematic analysis to identify the main themes of the research.

Findings: Three key themes emerged in relation to support workers experience of feeling valued: relationships, peer support and communication methods. Support workers valued their relationships with clients and their families, which was a major influencing factor in remaining in their current employment situation. Support workers valued the role they performed and having peers to support each other. However, they felt undervalued by management, agencies they worked for and society in general. Changing communication methods has meant that support workers no longer feel heard and ineffective communication has led to feelings of isolation and powerlessness. They revealed an array of capabilities that aid person-centred care: emotional intelligence, social skills, and conflict management. However, these were predominately achieved outside the care plan.

Building capability through training was valued by support workers as was regular appraisals to give feed back on performance.

Conclusion: Support workers deliver person-centred care for older people in the community and in aged care facilities. However, the quality of this care is largely due to their individual attributes: valuing older people, their role, and the relationships they form, rather than from the directives of the agency. Agency systems of client care planning, time allocation, communication and staff support have posed significant barriers rather than enabled support workers to be client centred. Information from this project indicates that support workers require more effective communication methods to enable positive feedback for themselves and their clients. It is proposed that regulation of this workforce, including equipping them with a scope of practice and a code of conduct, would provide a voice, a sense of belonging to a group and role clarification for support workers. Importantly, it would also provide clarification for the agencies which employ them, managers and others in the caring workforce.

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1   <u>Introduction</u>

1.1   <u>The background of the study</u>

Support workers have traditionally been undervalued and underpaid for the work that they do. The New Zealand Government has sought to address the issues of historical pay inequity of support workers and pay is now in alignment with training qualifications. However, feeling valued comes from more than increased pay levels, and understanding what a support worker attaches as important to their role will lead to improved retainment and recruitment (Douglas & Ravenswood, 2019). Enabling a strong support worker workforce within the health system is important because of the increasing aging population. The Government has driven policy to support the needs of the growing aging population by encouraging support workers to practise person-centred care, and by measuring the well-being of New Zealanders. Ensuring that these essential workers are well equipped for their work by identifying and utilising their capabilities will be essential to aid the policies that drive person-centred care policy. Identifying the factors that promote feeling valued, and consideration of what devalues support workers, will enable identification of what affects their well-being. The implications are that society and management of aged care facilities and community agencies should recognise the skills, capabilities and knowledge of support workers to ensure they are better supported. Understanding the welfare of these workers is crucial to enabling well-being for older people.

1.2   <u>Why this research is important</u>

New Zealand's population of older people is escalating with the number of people aged 65+ having doubled between 1988 and 2016, and is estimated to double again by 2046 (Atlas, Kerse, Rolleston, Teh, & Bacon 2017). Life expectancy (how long we will live) and health expectancy (how long we will be in good health) is on the rise. However, life expectancy outweighs health expectancy, meaning we are expected to have ten years of poor health associated with an elevation in "long-term conditions, multi-morbidity, frailty and disability" (Ministry of Health, 2018a, p. 7). With health and support needs becoming more complex,

there will be more dependency on a range of support with activities of daily living and personal cares (Leece, 2003).

How support workers in New Zealand deliver health and support needs for older people is dependent on the model of health care set by the government. New Zealand has traditionally followed a Western biomedical method of healthcare (Samuel, 2019). However, there has been a "culture change" (Andrew & Ritchie, 2017) shifting from the biomedical model of care to a social model with its focus on person-centred care (PCC). Humanistic psychologist Carl Rogers, coined the term "person-centred" (The Person-Centred Association, 2018) which focussed on the individual identifying their own health and social needs, with the proviso that as we age we should still have access and opportunities for human growth to ensure a quality of life and well-being (Andrew & Ritchie, 2017; Brownie & Nancarrow, 2013).

The essence of PCC and the concept of well-being is in alignment with how we now measure New Zealand's health and well-being success in 2019. The New Zealand government has recently incorporated measuring well-being, which influences government spending in the health sector. Indicators of well-being include reviewing health and life satisfaction, rather than just wealth or economic growth to measure a country's progress (Cohen, 2018; Samuel, 2019). When research began in 2014, measuring quality of life for people living in New Zealand relied upon the framework of Gross Domestic Product (GDP). GDP is a standard analysis of economic growth to measure a country's progress and excludes well-being indicators. Joseph Stiglitz, Amartya Sen, and Jean-Paul Fitouss led a study in 2009, to establish alternatives to GDP. They claim that non-economic factors such as well-being should be incorporated in the way we measure how well a nation is succeeding (Stiglitz, Sen, & Fitoussi, 2009).

An earlier framework proposed as an alternative to GDP was the "Capability Approach" (CA), (Sen, 1993). It had the aim to create policies designed to increase empowerment and quality of life for individuals, groups and nations (Goodpal, 2013; Leahy, 2010; Nussbaum & Sen, 2003; Robeyns, 2018; Sen, 1993). When assessing well-being, this approach is relevant for support workers and the older person. Well-being is calculated by reviewing what people

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can do, or want to do, and the freedoms by which they have choices (Sen, 1993). This links to the current research project, as the questions asked of the support workers highlights what freedoms and choices they have within their role. What support workers do aligns with questions regarding their job role and the influences on their ability to carry out their role. What they do also highlights what skills and knowledge they have. Utilising a lens of the CA for this research project has influenced the discussion of empowerment, choice, and freedoms of support workers as individuals and as a group. As described by Sen (1993), this in turn influences if support workers feel valued.

Support workers in the New Zealand context are currently influenced by policies developed by the Ministry of Health, such as the *Healthy Ageing Strategy* (Associate Minister of Health, 2016) and the *New Zealand Health Strategy 2016* (Ministry of Health, 2016). The aim of the *Healthy Ageing Strategy* is that "older people live well, age well and have a respectful end of life in age-friendly communities" (Associate Minister of Health, 2016, p. 16). These frameworks have aimed to assist support workers by transforming training opportunities, working conditions, and aid in delivering person-centred care (Associate Minister of Health, 2016, pp. 43–44). Person-centred interventions are multifaceted, consisting of the following: opportunities for relationship building between support worker and client; improving support worker empowerment; individualised care plans; improving environments and making changes to leadership and management (Brownie & Nancarrow, 2013).

At the time of this project New Zealand researchers had explored support workers' perceptions of a person-centred, restorative home-care intervention compared to the usual biomedical focus within an aged care facility. The outcome was that support workers valued working under a person-centred model of care and this aided work satisfaction and recruitment. Restorative home-care moves beyond traditional task focussed support to include a range of services that aim to improve quality of life for older people with increasing complex needs (King, Parsons, & Robinson, 2012). It was important for this research project to understand the context of what model of care the support workers were working under to review the influence on feeling valued. Support workers are one of the predominant groups supporting older people with illness and disability and can provide not only task focussed, but

restorative, and person-centred models of care (Jorgensen, Parsons, Reid, Weidenbohm. Parsons, & Jacobs, 2009).

One of the most significant issues New Zealand is going to face in the health care of the older person is the recruitment and retention of support workers and other professionals who care for the older person. Research shows there are a number of contributing factors which pose challenges for the recruitment and retention of support workers working with older people, including the following: an ageing workforce; the occupation is not deemed popular; prominent medical training in the field is lacking, all of which may further strain recruitment (Badkar & Manning, 2009; Cornwall & Davey, 2004; Fujisawa & Colombo, 2009). The New Zealand national support worker turnover from a total of 17,910 paid support workers was 29% in residential care and 39% in the community (Jorgensen et al., 2009). This high turnover of support workers correlates with adverse outcomes for older people, such as negative behaviours, greater rates of infections, pressure sores, and increased restraint use (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007). Retaining support workers can increase the quality of care and well-being of older people by improving clients mental and physical well-being (Fletcher & Lynn, 2002; Ross, Jennings, & Williams, 2017; Wells et al., 2014).

Who are support workers? In this thesis, they are referred to as paid workers who work with people in aged care residential facilities (ACRFs), or with older people in their own homes in the community. Their role is to manage a care plan that can involve personal care, household management and other tasks involved in activities of daily living (King et al., 2012). They make up 54% of the employees in the aged care sector (Salvation Army, 2017).

As the population ages, retaining and recruiting support workers is anticipated to be a worldwide issue (World Health Organization, 2016). There are many factors influencing recruitment and retention, such as insufficient pay, lack of respect, being devalued, insufficient benefits, high workload, changeable hours, and lack of opportunity for progression (Ashley, Butler & Fishwick, 2010; Brannon et al., 2007; Butler, Brennan-Ing, Wardamasky, & Ashley, 2014; Jorgensen et al., 2009). Studies in New Zealand on recruitment and retention have highlighted similar issues, such as low wages, unpredictable

hours, inadequate training, job stress, and inadequate communication and support from the agency. To improve retention and recruitment, studies suggest providing more training, increased autonomy, increased management support, consistent supervision and better career opportunities (Jorgensen et al., 2009; King et al., 2012; Roud, Keeling, & Sainsbury, 2006).

Studies on gender and care work reveal that this occupation care work is not valued by society (Banks, 2018; Bondi, 2008; Burrow, Gilmour, & Cook, 2017). New Zealand statistics (Stats NZ, 2019) reveal that 82% of support workers are predominantly female, and consistent with this, all respondents for this master's research were women. Females are classified as being the carers in society, and their emotional labour is not recognised, praised, or valued, which in-turn marginalises and stigmatises them (Banks, 2018). This lack of value affects the social identity of support workers. Social identity is influenced by the groups we belong to and the impact of others perceptions of those groups, which in-turn affects our perception of self (Tajfel, 1982). In this case the gender group, female, and the subsequent group of support workers, is affected by societal stigmatising which has been shown to have a negative impact on well-being (Ali, Hassiotis, Strydom, & King, 2012; Tajfel, 1982).

Support workers have been identified as a powerless group of workers, with several factors contributing to this (e.g., gender, high workloads, multiple jobs, being middle-aged, and low education resulting in fewer opportunities to progress their careers) (Fleming, Evans, & Chutka, 2003; King et al., 2012; Montgomery, Holley, Deichert, & Kosloski, 2005; Sheets, Black, & Kaye, 2014; Stone & Dawson, 2008; Yamada, 2002). A recent review of pay equity in this sector since this project began highlights that the empowered workers' voice is still an issue for support workers (Douglas & Ravenswood, 2019). This project gives a voice to these paid support workers.

1.3   Background and New Zealand context

1.3.1 My history leading to interest in the topic

My interest in older people was highly influenced by spending a great deal of time with my grandmother. I observed her living independently at home in a little 'granny flat', and then as she moved to live in an aged care residential facility. After this shift, she was diagnosed with Alzheimer's disease and appeared to decline rapidly in her ability to be independent. As time passed, it appeared to me, then as a teenager, that my grandmother had nothing to 'do' anymore and that this aggravated her cognitive decline.

This experience led to my first full-time job at age 17 where I worked in a rest home with residents diagnosed with dementia. I did not receive formal training on the job, but instead observed other staff and asked questions on manual handling and other skills and knowledge required to care for the residents. I was working with residents with severe dementia and observed a lack of value and care for both staff and older people.

For staff there was little support from management, no formal training, no supervision, no flexibility to work around client needs. Staff were asked to work on their own with no other paid-worker support during night shifts. Despite having no formal training, I was asked to work on my own after three weeks on the job to care for 24 residents who all required toileting during the night. The rest home had no activities or stimulation for the residents, who were made to get out of bed at 7 a.m. every morning, then showered, fed and put into a lounge chair for the day. To compensate for the lack of activities, I provided the residents with something to do. I played games, told stories in the lounge, and spent as much time one-to-one as I was allowed. I observed the positive reaction from residents, and I felt that I was delivering an excellent contribution in enhancing the residents' well-being.

After being in the position for a year, I left to work at another rest home where the residents and support worker staff were treated with respect and dignity. Respect was shown through treating residents as individuals with their own wants and needs. Residents were not forced

out of bed at a certain time; they could have their own personal items in their room, and they were provided with activities if they chose to participate. Staff were encouraged to talk to residents, form connections and ask for help from each other when needed. The atmosphere between these two residential facilities was vastly different. The first rest home felt sterile, impersonal, and staff were stressed and negative, while the latter home was warm, personal, and caring. Then, in my overseas travels, I worked as a support worker in the community, working with older people. I saw the isolation and loneliness that clients experienced, and I realised that my visits made a connection and had a positive impact on clients.

After my overseas travels, I trained to become an Occupational Therapist, and my employment included being a coordinator for an agency providing community care for people over 65. In my current position as a lecturer at Otago Polytechnic, I continued to work as a clinician in a rest home, and out in the community with older people. These experiences have influenced my attitude towards what is beneficial support for older people and the role of those who provide the care. I am passionate about the well-being of older people and feel privileged to give a voice to support workers in this project.

This research considers the importance of the support workers who assist older people in the community and aged care facilities and acknowledges that support workers are a fundamental part of the well-being of people as they age.

1.3.2 New Zealand context at the time of the study

At the time the study was conducted, the 2013-2014 census revealed around 41,940 kaiāwhina (support workers) were employed in New Zealand working as support workers for aged and disabled people (Ministry of Health, 2016). *The New Zealand Aged Care Workforce Survey* (Ravenswood, Douglas, & Teo, 2014) discussed how the aged care sector and support workers had not been given enough recognition by society; the view was that support workers were unskilled and of low value (Ravenswood & Douglas, 2019). The need for the aged care sector and support workers to gain recognition has been championed by groups such as, Public Service Association members, Human Rights Commission, Careerforce, and Health

Workforce New Zealand. *The New Zealand Aged Care Workforce Survey* indicated that the workload for support workers had increased and become emotionally and physically harder (Ravenswood et al., 2014). The New Zealand Human Rights Commission recommended that valuing support workers be discussed and held a summit to address how to achieve this (Human Rights Commission, 2012). Information from this summit indicated the need for further research in the New Zealand context (Ravenswood et al., 2014).

This theme of valuing aged care support workers was also identified following a symposium for the University Otago CARE research group (Collaboration of Aging Care Excellence) in 2013 (Hale, 2019). It was this symposium that led to the development of the current project. The School of Physiotherapy, the Department of Management at Otago University, and the School of Occupational Therapy at Otago Polytechnic, collaborated to undertake a qualitative study to investigate what being valued means to aged care support workers, and included identifying what they saw as their essential skills and knowledge. The understanding being that maintaining the health and well-being of these workers is crucial to enabling well-being for older people.

In New Zealand, older persons who require support in the community are assessed by the needs assessment and service coordination agency (NASC). Once assessed for the level of support required, this information is sent to an agency employed by the District Health Board (DHB) (Ministry of Health, 2015a). In Otago, three main nationwide agencies provide care for older people in their homes. These agencies pay support workers to deliver care, which can include any of the following activities of daily living (ADL); including personal care and or household management (King et al., 2012). The current research project was carried out in 2014, one year after the change from one provider to the DHB bulk funding of the three current agencies. The majority of community support workers had retained their positions and were divided among the three agencies, but some service coordinators lost their jobs (Goodwin, 2013).

1.3.3 Recent changes in the New Zealand context

Since 2014, there have been changes to pay equity and training opportunities for support workers in New Zealand (Douglas & Ravenswood, 2019). In 2012, an individual support worker named Kristine Bartlett lodged a claim with the Employment Relations Authority against her employer for breach of the Equal Pay Act. The claim was based on the premise that Kristine's skills, responsibilities, and experience were being undervalued compared to similar occupations held by males (National Council of Women of New Zealand, 2016). The positive result for Kristine Bartlett's case meant that support workers received $2 billion from the Government to address pay inequity in 2017 (New Zealand Nurses Organisation & E tū, 2019). Since the pay equity settlement, support workers' pay has increased and training is now aligned to pay levels. A review titled *The Value of Care: Understanding the impact of the 2017 Pay Equity Settlement on the residential aged care, home and community care and disability support sectors*, by Douglas and Ravenswood (2019), indicated that to compensate for the increased cost of employing carers, the managers of Aged Care Residential Facilities (ACRF's) and community agencies cut costs by reducing hours. This resulted in an increase of workload placed upon support workers, and a reduction in the quality of care (Douglas & Ravenswood, 2019). A report by the New Zealand Nurses' Organisation (NZNO) and E tū (2019) into aged care staffing stated there are unsafe staffing levels resulting in inadequate care for older people in aged care facilities (Douglas & Ravenswood, 2019; New Zealand Nurses Organisation & E tū, 2019). Information from the Douglas and Ravenswood (2019) report also highlighted a discrepancy between the new qualification levels and the competency of the support worker to carry out the tasks. The review highlighted the need to understand what skills and knowledge are expected of a support worker delivering person-centred care, and to establish consistency of the expectations from managers. It was apparent from the study that some managers are expecting a level four support worker to have the same proficiency as an enrolled nurse because of the similarity of pay levels (Douglas & Ravenswood, 2019).

1.4   Changes in the structure of support workers conditions

Open communication can support job satisfaction and impact on how valued support workers feel (Pullon, McKinlay, & Dew, 2009). The following information details the changes to communication methods that have applied to support workers in the current study from before, during and after the changeover of a main provider. This understanding of how the agency communicates with support workers will inform the background to the support workers' feedback on communication and feeling valued.

The change in agencies responsible for providing home help and personal care services resulted in different ways of working for support workers. The previous provider of community support had a main office locally and an office located in a suburb of Dunedin. Because of privacy concerns, the agencies and suburb will not be named in this thesis. The main office had regular meetings to discuss policies and procedures but not individual clients. The suburb office meetings provided a forum to talk over procedural duties and clients' welfare. Importantly, the suburb office provided an opportunity for support workers to voice any concerns about their clients, as a group.

The communication methods were usually face-to-face or direct phone contact to local coordinators who knew the clients. Support workers could also drop into the local office at other times to voice concerns related to clients, or clarify any rosters and paperwork required to complete the job. This information is relevant because the participants in this study often referred to the impact that the move from the old provider to the new providers had on communication. The main changes discussed resulted in less face-to-face meetings, removal of the suburb office, and the need to ring a toll-free number compared to having direct contact with a local coordinator.

Another change made by one provider in 2018 was the use of an application (app) on a smartphone device to communicate with support workers about procedural matters such as rosters. This app requires support workers to use a smartphone to report when starting and finishing a job. Meetings are still centralised in Dunedin and are focussed on procedural

matters, not about clients (NB: this may not be true in other parts of the country). For two of the three providers, if a support worker is concerned about a client, they have the option to ring a toll-free number to reach a call centre which was the situation at the time of the interviews. Support workers for the third provider can ring a local coordinator directly.

At the time the interviews for the current research project were conducted in 2014, the new providers had been operating for one year. Training, which would incorporate an orientation as well as education on skills such as catheter changes, was provided by the in-house agency if the support worker was new to the job. External training came from Careerforce, the Industry Training Organisation (ITO) for support workers, who provide NZQA-approved New Zealand Qualifications (Careerforce, 2019). According to Careerforce, there are over 12,000 support workers nationwide undertaking training each year (Careerforce, 2018). At the time of the research, there was no structure around aligning pay with training. However, consideration of previous qualifications was taken into account on starting pay rates. Time spent on orientation for new support workers appeared similar to that they received from the old provider in 2014.

New Zealand support workers at the time of the interviews in 2014 had been on the minimum wage band (Douglas & Ravenswood, 2019). With the change following the pay equity settlement for support workers in New Zealand's ACRF, and community support services, there has been an incentive to align pay with qualification. According to the Ministry of Health:

> The Act now requires employers to provide support to enable workers covered by the settlement to reach the following levels on the NZ Qualifications Authority Health and Wellbeing Certificate (or its equivalent) within the following time periods:
>
> - Level 2 NZ Certificate – within 12 months of employment,
>
> - Level 3 NZ Certificate – within three years of employment,
>
> - Level 4 NZ Certificate – within six years of employment. (Ministry of Health, 2018b)

Levels of training correlate with competencies expected of a support worker. To explore the issue of support worker understanding of what they perceive their skill and knowledge to be and their value within the workforce two main questions were explored.

1.5   Research questions

The overarching questions were as follows:

1. What contributes to support workers in the aged care sector feeling valued for the work they do?

2. What are the key attributes and skills of support workers in institutional and home-based aged care that enable person-centred care?

1.6   Conclusion

The proposition for this research project was that identifying what encourages the support workers to feel valued will improve well-being and aid in recruitment and retention of this workforce. This project will identify the participants' perspectives of what contributes to their sense of being valued (or not) as well as the knowledge and skills that they use within their role. Spanning time from 2014 to 2019, this project reviews the wider context in New Zealand of legislation, models of health care, role of agencies, and societal impact, that influence how a support worker feels valued within their role.

1.7   Outline of the thesis

Chapter one incorporates the background context as to why this research is important, the rationale for being involved, the situation at the time of the project, and the current context implications.

Chapter two will consist of a literature review that explores New Zealand's societal demographic, gender, societies views, the welfare state and market driven policy. The Capability Approach (CA) in relation to well-being and being valued will be discussed. The support worker role including training in person-centred care, the power of relationships, and recruitment and retention will be analysed.

Chapter three presents the methodology and qualitative descriptive method including ethical considerations.

Chapter four contains the data analysis and findings related to the topic.

Chapter five draws conclusions and identifies recommendations related to the topic.

2 <u>Literature review</u>

2.1 <u>Chapter overview</u>

As indicated in the introduction, New Zealand's population of older people is escalating, with both health expectancy and life expectancy rising. This impacts on the older person, support workers, and society. New Zealand must be socially and fiscally prepared to meet the demands of an increased need for support workers in aged care. Understanding what makes a support worker feel appreciated in their role has the potential to impact on their recruitment and retention. It provides the potential for the acknowledgement of skills and abilities needed to carry out this role and will validate their value in an already stretched industry. This literature review spans both the New Zealand and overseas' contexts and covers the following topics: Addressing the growing older population; Training support workers in person-centred care; Support workers role in the healthcare of older people; Capability approach in relation to support workers; gender, caring and being undervalued; emotional connection and power of care work; society's view of the older person and those who care for them; recruitment and retention of support workers; factors influencing paid support workers in New Zealand.

2.2 <u>Addressing the growing older population</u>

A search of CINAHL, ProQuest and Pubmed was conducted using the key terms: 'care for the ageing', 'support workers', 'care workers', 'capability approach', 'gender and caring', and the terms: 'value, recruitment and retention'. The majority of overseas studies were from the United Kingdom, America, Australia, and Canada (Berta, Laporte, Deber, Baumann, & Gamble, 2013; Denton, Zeytinoğlu, & Davies, 2002a; Fleming, Evans, & Chutka, 2003; Hallgrímsdóttir, Teghtsoonian, & Brown, 2008; Keefe, Knight, Martin-Matthews, & Légaré, 2011; King, 2007; Menon, 1999; Nugent, 2007; Raymond & Grenier, 2013; Sharman, McLaren, Cohen, & Ostry, 2008; Sims-Gould, Byrne, Craven, Martin-Matthews, & Keefe, 2010; Sims-Gould, Byrne, Tong, & Martin-Matthews, 2015). All studies discussed the growing older population and the need to establish good quality care, either within the home environment or in residential aged care facilities. The literature has been discussing this topic

for many years. Furukawa and Shomaker (1982) contend that providing "a good quality service to the aged has long been a problem" (Furukawa & Shomaker, 1982, p. 88) and that society's understanding of getting older has been viewed as a disease process and subsequently infused into the philosophy of health care for the elderly. A commentary reflecting the demographic changes in New Zealand society argued that the days of the biomedical model approach to health care must change to improve quality of life (Miller, Booth, & Mor, 2008).

The need for New Zealand to be collectively and socially prepared was asserted by Boston and Davey, in their book *Implications of Population Ageing: Opportunities and Risks* (2006). This book is a compilation of works that report on the issues of an ageing population, their demographics, and the impact on delivery expectations of health care. These expectations include that care is restorative, enabling, and person-centred, rather than on the biomedical model of delivering healthcare utilised in previous decades. This book outlines the implications of a revised approach which considers the demographics of an ageing population on the social and economic fabric of New Zealand society. It includes a variety of authors who provide a broad perspective. The demographics highlight that the median age will increase, deaths will exceed births, and that there will be greater social and ethnic diversity in the older population. Negative impacts of an older population are identified as higher costs, slower economic growth, shortages of skilled labour and inequality of well-being amongst older people. Positive aspects of an ageing population include economic opportunities from active older persons who will potentially spend money in the economy, supporting other family members to continue working, allowing more time to enjoy retirement, and an increase in volunteers supporting society. Several chapters in the book were influenced by the Ministry of Social Development research on population ageing (Murdoch, 2007), with the authors aiming to shape policies that affect older people in New Zealand. This book revealed the urgent need for government policy to respond to the social and economic issues arising from a growing older population (Boston & Davey, 2006).

In the article, *Rethinking The Care-Market Relationship In Care Provider Organisations,* King argues that, since the 1980s, the move from a welfare-state approach to the current

market-driven approaches to health care of the older person, are ineffective and unsustainable long-term (King, 2007). A market driven approach which is led by profit and 'efficient' service delivery, moves towards cost cutting and contracting out of services and business management practices. Market drivers force organisations to provide physical cares and home help rather than holistic care that takes psychosocial needs into account. Future generations of older people are likely to expect services that are more holistic and lead to improved quality of life. King argues that organisations could use "the norms and principles of 'bounded emotionality'" (2007, p. 200) to meet fiscal demands and provide care that improves quality of life for both support workers and older people. Bounded emotionality is a framework that allows organisations to incorporate both the rational and emotional demands of care delivery. The framework acknowledges the support workers relationship with the client and encourages a relational approach (King, 2007, p. 206). There is a recognition of the value of the support worker establishing and supporting the emotional needs of the client, suggesting that the quality of the relationships should be respected by the organisation. Research conducted by Martin, Knopoff, and Beckman (1998) concluded that utilising bounded emotionality within the workplace, supports higher work satisfaction, motivation, and retention. King claims that the implementation of the bounded emotionality framework implemented in the study conducted by Martin et el., "helped to create an organisational environment that was positive for workers, who had high levels of work-satisfaction and enthusiasm, loyalty and commitment. At an organisational level, there was greater stability in the workforce, higher levels of trust and communication, and improved efficiency in areas such as information exchange and customer service" (King, 2007, p. 207).

Recently, New Zealand policy makers have acknowledged and stated that care should be restorative and person-centred; that a person-centred approach being expected to operate within a market driven system is ineffective. One example of a policy strategy that encourages a person-centred approach within a market driven system is the *Healthy Aging Strategy* (Associate Minister of Health, 2016). It provides a framework for health and well-being for people over 65 between 2016 and 2026 (Associate Minister of Health, 2016, p. 2) and is focussed on providing restorative care, better working conditions and training for support workers. The *Healthy Aging Strategy* (Associate Minister of Health, 2016), in conjunction with the *New Zealand Health Strategy 2016* (Ministry of Health, 2016), sets out a

framework to address the burden of fiscally managing health services while creating fair health outcomes for all of society. It aims to achieve this by outlining future directions and providing a road map of actions such as utilising shared care plans, improving connections between primary care and support services delivered to people's homes, and creating a one team approach that includes professionals and carers (Associate Minister of Health, 2016, pp. 4–7). The strategy's overall aim is to give power back to the client and to shift the focus to overall well-being rather than health (Associate Minister of Health, 2016; New Zealand Productivity Commission, 2018). However, the reality of implementing this person-centred strategy with its emphasis on well-being is compromised by the fiscal frameworks that guide it, such as the Population-Based Funding Formula (PBFF) (King, 2007).

The government allocates money to District Health Boards (DHBs) through a Population-Based Funding Formula (PBFF) (Ministry of Health, 2016, pp. 25–28). PBFF was developed in NZ in 2000, under a market led ethos and has not been significantly adjusted since its inception (Centre for Health Systems, 2012). There are calls to have an independent review of the PBFF over concerns of the lack of transparency and discontent from DHBs regarding the allocation process (Chester, Penno, & Gauld, 2018). Fiscally, in 2019, the Southern District Health Board is running at a deficit of $25 million dollars and is forecast to remain in deficit for years to come (Houlahan, 2019). The impact of these funding deficits has led to health funding being discontinued or strained (Chester et al., 2018) and will continue to impact on future effective and person-centred service delivery for community and residential care of the older person.

2.3   Training support workers in person-centred care

Current New Zealand policy advocates that support workers are trained in person-centred care (Cole, 2017; Luxford, Piper, Dunbar, & Poole, 2010). Training is aimed to improve skills and knowledge for the support worker role. The *Healthy Ageing Strategy* recognises that the development of the support workforce is essential for older people living with long-term conditions either at home or in aged residential care (Associate Minister of Health, 2016). The *Kaiāwhina Workforce Action Plan: 5-Year Actions 2015-2020 – Toward the 20-year*

Vision (Workforce in Action, 2017), outlines the development of the health and disability workforce, and emphasises the implementation of a person/client centred approach for older people in conjunction with creating a career pathway, and guaranteed hours for support workers. Health Workforce NZ and Careerforce, are responsible for training support workers and offer a career pathway to study, such as a New Zealand Certificate in Health and Wellbeing (Levels 2,3,4) (Careerforce, 2019). The content of these courses covers upskilling on complex needs of older people, person-centred care, and taking a leadership role in a health and well-being setting (Careerforce, 2011, 2015).

Research has established the link between person-centred care and quality of life for older people. Ebrahimi, Dahlin-Ivanoff, Eklund, Jakobsson, and Wilhelmson (2014) utilised a binary logic regression analysis of cross-sectional data related to self-rated health of frail older people living in the community. The results indicated that psychosocial factors such as not feeling lonely and being connected with others were more important to an older person's life satisfaction than task-based care. One hundred and sixty one participants were recruited from emergency departments, with data collected through face-to-face structured interviews, and the Life Satisfaction Questionnaire (Mortenson, 2018). There was limited information on the measurement properties of the LISAT 11 but an earlier version, the LISAT 9 (which is identical but with two fewer questions), measured high for validity in Life Satisfaction questions. The LISAT 9 was developed to assess areas of life satisfaction for a variety of central nervous conditions including Parkinson's, Brain injury and Spinal cord injury (Mortenson, 2018). As participants were recruited from an emergency department and may have had a brain injury or stroke, there is little research backing this questionnaire for these specific conditions, a factor that may therefore have influenced the results. However, overall the results indicate that human contact is more important for life satisfaction for older people than home help tasks. In the context of this project it is well known that the reality of a support worker's role concentrates on personal care and home help, not on restorative psychosocial factors that impact on health and quality of life (Lawn, Westwood, Jordans, & O'Connor, 2017).

2.4   Support workers' role in the health care of the older person

Research has demonstrated that support workers can improve health outcomes for older people in relation to both medical and psychosocial issues (Fletcher & Lynn, 2002; Ross et al., 2017; Wells et al., 2014). A further study supporting this finding established that trained support workers are in the best position to create positive behaviour change in older adults by being more involved in care planning (Lawn et al., 2017). A training programme was designed and implemented to enhance knowledge, skills, and confidence of support workers to support behaviour change in clients with complex healthcare needs (Lawn et al., 2017, p. 498). Interview data indicated that support workers valued the training as it gave them better skills, enhanced teamwork and increased their satisfaction and pride in their role (Lawn et al., 2017, pp. 501–503). Support workers believed they improved their skills in risk assessment, thus motivating clients to be independent (Lawn et al., 2017, p. 505). In addition, care coordinators who worked with the support workers were also interviewed and reported that the training assisted support workers to develop enhanced communication skills including the ability to feed back change in client's health status (Lawn et al., 2017, p. 509). This research also indicated more training in mental health is required, and that care coordinators need to understand the complexities faced by support workers in their role. Despite some improvements, communication between support workers and care coordinators was still an area for development – especially for those who did not meet at an office – with more debriefs and supervision needed for support workers (Lawn et al., 2017, pp. 510–511).

In response to a shortage of nurses working in older person care (Cree, 2019; Harfield, 2019; New Zealand Aged Care Association, 2018), community support workers were trained to dispense medication to low-risk clients. A workforce model (WISE – Workforce Innovation for Safe and Effective Medicines Care) was trialled to train support workers to take on this role (Lee, Beanland, Goeman, Johnson, Thorn, Koch, & Elliot, 2015). The results indicated support workers were capable of taking on this additional task of issuing low-risk medications, pressure on community nursing resources was alleviated and the support workers valued having the extra responsibility. Although the training model was created by various stakeholders, the research was limited in only reviewing one organisation. Another concern regarding the feedback of the WISE model was when support workers were mixed with nurses in the focus groups they would have been outnumbered and potentially feel

unable to articulate their point of view openly. It has been argued that the power dynamics and hierarchy can affect a person's participation in a focus group (Devault, 2018). Data collection in the study by Yin Lee, Beanland, Goeman, Johnson, Thorn, and Koch (2015) involved one nursing organisation recording the tasks undertaken by the nurses and the support workers at each visit. This was carried out before and after implementing the WISE model, including the training in its use. Additionally, qualitative in-depth interviews were carried out with twenty-five clients, and focus groups were conducted with nurses and support workers. Out of the 57 interviewed or involved in a focus group, 50 were nurses and only seven were support workers, thus limiting their views being heard within the research.

Evidence also exists, however, that support workers are underutilised and undervalued in terms of the benefit they can have on older people's health, and the support they can provide to other healthcare professionals (Bosley & Dale, 2008; Lawn et al., 2017; Lee et al., 2015). One difficulty with support worker role expansion is nurses' perception of a threat to role territory. Not wanting their role overtaken resulted in some nurses undervaluing and undermining support workers by limiting any advanced tasks they could perform, and by withholding information on clients (Bosley & Dale, 2008). Lee et al. (2015) found that while nurses saw the benefit for their workloads and could observe the upskilling of the support workers, some were averse to losing control and delegating. Resistance from some care coordinators was also evident in terms of their unwillingness to allow support workers to contribute to the care plans for older people (Lawn et al., 2017).

The benefits of expanding the role of support workers to cover low-risk nursing duties in the care of the older person is a timely issue with both challenges and advantages. In the context of increased pressure on healthcare services because of staff shortages, increased costs, a growing older population, and increased client expectations, Sara Bosley and Jeremy Dale (2008) promote the idea of support workers conducting low-level nursing care to alleviate the workload and aid in cost reduction. In their paper, *Healthcare assistants in general practice: Practical and conceptual issues of skill-mix change*, Bosley and Dale (2008) reviewed existing roles of support workers. They found a lack of consistency with role expectations, with workers frequently conducting activities outside of their job description. The issues of

blurred role boundary can impact on client safety and quality of care, disrupt effective teamwork, and poses a risk to professional identity. The paper highlighted the need for further research into understanding the role of support workers and how their role can reduce the pressures on the healthcare system (Bosley & Dale, 2008).

2.5   The Capability Approach in relation to support workers

The well-being of support workers is important to ensure that this workforce is recruited and retained. Currently, literature indicates that support workers' well-being is being compromised by being undervalued in society and the organisations they are employed by. This can lead to role stress (Butler et al., 2013; Czuba, 2015; Elwér, Aléx, & Hammarström, 2010). In New Zealand, support workers skills and abilities are not well recognised, leading to underestimation of their role and ultimately reduced well-being (Ravenswood et al., 2014). Research relating to support workers highlights that they are a powerless, and underestimated group of workers (Hallgrímsdóttir et al., 2014). Empowerment is an essential component in supporting healthcare workers in their educational pursuits, as well as experiencing job satisfaction (Menon, 1999).

The conceptualisation of well-being has been limited to date by traditional measures, such as GDP, which is a measurement of economic performance (Chappelow, 2019). New Zealand is the first country to add social measures such as health, environment, and educational indicators to the GDP. However, further clarity is required on how these social indicators are measured (Cohen, 2018). The Capability Approach (CA) developed by Amartya Sen (1993), provides a tool that measures well-being, and has been put forward as an alternative to existing approaches, such as the GDP, as a more authentic measure of a nation's quality of life. The CA evaluates the capabilities and functioning of a person when considering their well-being. 'Capabilities' are about the person's ability to choose and act, and functioning is a term referring to a person's attainments – what the person manages to do, or be (Sen, 1993). The CA incorporates ten capabilities, and encompasses empowerment as its core focus (Nussbaum & Sen, 2003). The CA was developed as a framework to investigate quality of life, and it proposes that, "freedom to achieve well-being is a matter of what people are able to

do and to be, and thus the kind of life they are effectively able to lead" (Robeyns, 2018, p. 2). The framework also reviews the role of the person, including the tasks they perform, the choices within their roles and life, and freedoms to do what they feel is important within their role. The CA is therefore aligned with identifying and changing current support worker issues of being undervalued, limited freedoms for autonomy, and limited understanding of the boundaries of their role (Robeyns, 2018). The CA framework has the potential to advocate for support workers in recognising the skills and knowledge they bring to the workforce. The CA promotes more freedom for a support worker to have a voice in developing their role and status to enhance well-being and aid recruitment and retention (Butler, 2011).

The use of the Capability Approach in care work was debated in a paper presented by Mary Leahy (2010), at the *Annual Conference: Global Economic Crises and Feminist Rethinking of the Development Discourse*, hosted in Argentina. It was argued that although Sen's ten-capabilities approach can support equality and issues of care work, a review needs to be carried out to use the approach successfully. Leahy (2010) discusses how the current level of support by organisations and career structures for support workers is unsatisfactory. To fully consider support workers within the approach it has been argued that the development of an additional capability, called a 'Care Capability', is required (Leahy, 2010; Lewis & Giullari, 2005). 'Care Capability' refers to the promotion of social responsibilities. Leahy states: "Social responsibility includes paying taxes to fund decent support services and transfer payments as well as supporting labour laws that guarantee a living wage and proper working conditions, and supporting fair trade and environmental sustainability" (2010, p. 15).

2.6 <u>Gender, caring and being undervalued</u>

A review of the literature on gender and caring highlighted that support workers are discriminated against in policy development because of gender (Banks, 2018; Butler et al., 2013; Leahy, 2010; Lewis & Giullari, 2005; Ravenswood et al., 2014). Several studies report that support workers are undervalued, underestimated and under-resourced, three discriminatory factors which are associated with gender and cultural/minority group issues (Butler et al., 2014; Jorgensen et al., 2009; Nugent, 2007; Stacey, 2005). Susan Banks

examined the aforementioned issue in her article, *The social dynamics of devaluation in aged care context* (2018). The results of the ethnographic study discussed in this paper indicate that both support workers and their clients are undervalued by society and those who create policies affecting their lives (Banks, 2018). Organisations do not listen to clients' or support workers' opinions and do not expect workers and clients to have close relationships. Banks therefore suggests that older people and support workers "share a stigmatised and marginalised position" within the organisations who provide care, and society at large (2018, p. 167).

The issue of care work being gendered to females is connected with devaluation of care, which leads to the continuation of gender inequity (England & Lawson, 2005). A theory was drawn from psychotherapeutic approaches to view the issues of power and the emotional connection between the client and the support worker. Utilising Carl Rogers' humanistic approach, Bondi (2008) interconnects the approach through the lens of the relationship dynamics of support workers and clients. As an example, Bondi linked Rogers' view of "unconditional positive regard" (Bondi, 2008, p. 253) with the support workers respecting and viewing the client as their own person. Feminist literature is discussed as seeking, promoting and respecting the emotional elements of caring. The emotional element of good relationships is deemed to create a successful quality of care. Bondi argues that the relational, emotional connections made between workers and clients are complex and demanding, but important to work through if the outcome is "caring carers" (2008, p. 261).

Feminist perspectives within social science research have been debated. Leask (2018) reports that gender and power dynamic discrimination is a lens on research used by feminist researchers. Leask refers to Michel Foucault's work on the view that a support worker's role as "women's work" is less valued than men's roles and that "power relations" between management and workers can be complex and varied (Leask, 2018, p. 81). In a study of workplace interactions between cleaning staff in a hospital, it was found that organisations, clients, and other health professionals could enhance or diminish how a person feels about the work that they do (Leask, 2018, p. 81). Results indicated that although these support workers valued the importance of their role in the functioning of the hospital, other staff could devalue

their role in various ways. Examples include: being ignored; experiencing disgust or disdain from colleagues; not being trusted; interactions which make the job more difficult (Dutton, Debebe, & Wrzesniewski, 2012, p. 15), and being treated as though one is inadequate (Dutton et al., 2012, p. 24). This study suggested that workers who perform everyday tasks such as cleaning are commonly devalued in the workplace. Their occupation is deemed 'dirty work' (Stacey, 2005) even though such roles are essential to supporting older persons (Dutton et al., 2012). Undervaluing support workers because of the nature of the tasks they perform was also discovered by Kadri, Rapaport, Livingston, Cooper, Robertson, and Higgs (2018) during a secondary analysis of qualitative data. Their findings indicated that support workers felt unacknowledged and were not "accepted as dignified persons in their own right" (Kadri et al., 2018, p. 6).

2.7 Society's view of the older person and those who care for them

It is commonly reported that society has a negative view of older people and therefore devalues them (Faiella & Gulden, 2007; Raymond & Grenier, 2013). An analysis of ageing policies in Canada established a disparity between the aims of Canadian government policy, and the outcomes for older people (Raymond & Grenier, 2013). This analysis established that changes in policy language, which marketed older people as capable of contributing to society, had not positively changed societal views of older people. Through investigating the policies related to increased life expectancy and quality of life, Raymond and

Grenier found that older people with a disability who did not fit the ideals around social participation and usefulness, and were not engaging with activities, were deemed to be not ageing successfully by government and society (Raymond & Grenier, 2013).

Evidence of the negative views of older people was also found in an American report which identified views of older people being a burden on society and therefore their healthcare needs not worth addressing (Faiella & Gulden, 2007). The rationale for being devalued is because society sees the older person as not employed, always unwell, and not able to do or achieve anything. This affects the older person's ability to have choices and access to timely

healthcare, scenarios which Faiella and Gulden argue are medical negligence. The report suggests that several studies have indicated that older women diagnosed with breast cancer or older men with prostate cancer are not given the choices of treatment because of negative attitudes towards older people (Faiella & Gulden, 2007).

2.8 <u>Recruitment and retention of support workers</u>

Recruiting and retention of support workers is a worldwide issue (Keefe et al., 2011; King, 2007; Sims-Gould et al., 2010), with New Zealand being no exception (Human Rights Commission, 2012; Jorgensen et al., 2009b; King et al., 2012). However, support workers seek employment and remain because they value the personal connection with the client, which is the intention of person-centred care (Ashley et al., 2010; Badkar & Manning, 2009; Butler et al., 2014; Fujisawa & Colombo, 2009; Jorgensen et al., 2009; King et al., 2012). While support workers provide an essential service, their perspective on their role has not been widely researched (Goeman, Renehan, & Koch, 2016). Sims-Gould, Byrne, Craver, Martin-Matthews, and Keefe (2010), conducted a mixed-methods study that included clients, support workers and family as participants. They presented their findings in the article, *Why I Became a Home Support Worker: Recruitment in the Home Health Sector* (2010). This study sought to understand what positively influences recruitment. In particular, the interest was in why the support workers entered this role. Fifty-seven support workers who had worked five years or less were interviewed. Three key themes were identified: "caring and sharing; experience and exposure; and finances and flexibility" (Sims-Gould et al., 2010, p. 178). Under the caring and sharing theme, a major motivator for entering the profession was the ability to have a direct personal relationship with the client. Previous 'exposure' to helping others and the satisfaction of that experience promoted joining the workforce. Support workers believed that this role could be flexible around other commitments, and they appreciated the remuneration, the benefits, and training support (Sims-Gould et al., 2010, pp. 178–183). Sims-Gould et al. (2010) propose an explanation as to why support workers leave their positions; due to growing and changing workloads, the support workers' relationships with clients were being negatively affected, and less time was being spent with the client (2010, p. 186). They argued that it was important to further understand the value and scale of

the role of support workers, and suggested that areas of recruitment could come from informal carers becoming paid support workers, and from other 'people' professions such as fitness instructors (Sims-Gould et al., 2010, p 187). Other factors supporting recruitment included the ability to engage in professional development, job permanency and flexibility of work schedules.

Further findings from a systematic review on recruitment and retention of support workers is discussed in the article, *Key issues in human resource planning for home support workers in Canada* (Keefe et al., 2011). Keefe, Knight, Martin-Matthews, and Légaré, address the importance of using the support worker's knowledge and skills, while also having training available for a career pathway. Literature recommends that recruitment and retainment of support workers should be a focus at policy level, with policy being backed up by action from agencies in pursuit of boosting the workforce. This strategy should include agency-driven approaches, such as utilising social networking tools, creating a good work environment through manageable, predictable workloads, and supporting client worker relationships (Keefe et al., 2011, pp. 25–26). Keefe et al. recommend that further research on the impact of employment, education, health, and social policies related to recruitment and retainment, needs to be conducted (2011, p. 26).

In 2012, Berta, Laporte, Deber, Baumann, and Gamble (2013) conducted a study with "industry experts actively engaged in long-term care delivery and policy decision-making in Canada" (2013, p. 2). Their article, *The evolving role of health care aides in the long-term care and home and community care sectors in Canada* (Berta et al., 2013), discusses the findings gathered from the focus group discussion, conducted with six participants in managerial positions. Results from this study emulated other studies (Ashley et al., 2010; Bondi, 2008; King, 2007) identifying that personal connection is important and helps support retention. This study also revealed that the support worker role is more multifaceted than outlined in the client's care plan, with workers frequently going outside role boundaries to provide support (Berta et al., 2013, p. 3). However, the study relied on managers' perceptions and opinions, and did not incorporate support workers' views. Further study is required to

highlight what makes support workers feel valued in their role in order to support retention (Berta et al., 2013, p. 5).

2.9   <u>Factors influencing paid support workers in New Zealand</u>

Three issues dominated the New Zealand research literature regarding the influences on remaining employed as a support worker. These were the provision of training opportunities, being able to develop a personal connection with the client, and good communication between agency and support workers (George, Hale, & Angelo, 2017; Ravenswood et al., 2014). Jorgensen, Parsons, Gunderson Reid, Weidenbohm, Parsons, and Jacobs (2009) used a mixed-method design study (survey and focus groups) to explore the profile of New Zealand support workers and their training requirements. Four hundred and twenty service providers including residential, home-based and other disability support agencies responded (Jorgensen et al., 2009, p. 399). The results indicated there was a high turnover of support workers, especially in the community (39%) (Jorgensen et al., 2009, pp. 402–403). Training was one issue with providers stating that support workers were not adequately trained, and when upskilling opportunities were provided, they were poorly attended (Jorgensen et al., 2009, p. 402). This research highlighted the demographics of this group as mainly low paid, having little education, predominantly females of middle age who were deemed a vulnerable group (Jorgensen et al., 2009, p. 402), all of which correlated with current literature on the topic of support workers.

Research that investigated paid support workers' perceptions of a restorative home care intervention compared with usual home care, is discussed in the article *A restorative home came intervention in New Zealand: perceptions of paid caregivers* (King et al., 2012). King, Parsons, and Robinson found that restorative home-care training assists support workers' motivation in their role. Restorative home care involves the encouragement of independence and enhancing the quality of life of the older person (King et al., 2012, pp. 71-75). The study of King et al. (2012) included nine modules of training with increased supervision of the support workers. For each module, a review session was held that incorporated reflection, quizzes and case studies. An important aspect of the training was that it enabled the support

workers to develop individualised independence plans and goals with the older person (King et al., 2012, pp. 72–73). Data from four focus groups identified that the restorative programme was more satisfactory for support workers as it had the following qualities: firstly, the work was orientated to well-being of the clients which suited the support workers as it enhanced personal connection, and secondly, the additional support reduced the feelings of isolation in their work (King et al., 2012, p. 70). The conclusions made were that to promote recruitment and retention of support workers, better training, improved support from coordinators, more flexibility in working conditions, increased supervision and support worker involvement in care plans needs to be addressed (King et al., 2012, p. 78).

The literature points to training being positive for support workers in feeling valued (Ashley et al., 2010; Bondi, 2008; King, 2007); however, poor attendance at training is a challenge faced by the training providers (Edwards, Chapman, Forster, Gaskill, Morrison, & Sanders 2003; George et al., 2017; Ravenswood et al., 2014). The article, *Challenges associated with implementing an education program in residential aged care setting*, by Edwards, Chapman, Forster, Gaskill, Morrison, and Sanders (2003) addresses this concern. They found that attendance was an issue even when the education programme offered to support workers was a restorative method, providing care within an aged care facility, rather than a medical model (Edwards et al., 2003, p. 109). Gaining trust from those providing the education and support workers opinions of whether new learning was necessary (Edwards et al., 2003, p. 110) posed a problem which limited attendance even when strategies were organised to support attendance. Examples of strategies used to increase attendance included organising the most suitable location and time for staff, paying staff for half their attendance time, and staff who attended more frequently going into a lottery draw (Edwards et al., 2003, pp. 109–110). The positive outcomes from the education session for those who participated were the increased understanding of the importance of restorative-based care, and increased interaction between staff and residents (Edwards et al., 2003, p. 113).

Difficulties in recruiting participants for an education programme were also reported by Rodriguez, Marquett, Hinton, McBride, and Gallagher-Thompson, in their article, *The impact of education on care practices: an exploratory study of the influence of "action plans" on the*

behavior of health professionals (2010). Rodriguez et al., analysed 600 action plans developed by support workers following education sessions which were to be utilised within their practice (2010, p. 897). Support workers who completed the actions plans were contacted via email to complete a short survey regarding their use of the action plan. However, there were limited responses with only a 20% response rate indicating how or whether these action plans were used (Rodriguez et al., 2010, p. 900). The research did not clarify the demographics of those who did not respond, nor did it provide a clear rationale for the limited responses, with an admission instead that those who did respond may have had "higher motivation or commitment" (Rodriguez et al., 2010, p. 906).

Work-related stress is a significant issue among support workers who carry out care in the client's home (Denton et al., 2002a; Denton, Zeytinoğlu, Davies, & Lian, 2002b). Contributing factors include isolation from peers and supervisors, dealing with challenging clients, and feeling unsafe at times. Over time, these impacts can affect the mental health and well-being of support workers (Denton et al., 2002a). Good working environments provide support while having a positive impact on the well-being of support workers (Denton et al., 2002b). Effective communication between the organisation, agency and support worker helps maintain their mental health. To promote a good working environment, improved communication between practitioners and support workers is required (Denton et al., 2002a; Denton et al,. 2002b; Sharman et al., 2008; Tamayo, Broxson, Munsell, & Cohen, 2010; Roud et al., 2006). The COPE index assessment tool – which measures the perceptions of informal carers in terms of support, health, and wellbeing – was used with informal carers of people living with dementia in New Zealand (Roud et al., 2006). Findings indicated that a better understanding of informal carers' needs, through more regular and formalised examination, is essential. Structured interviews and questionnaires were carried out with informal carers, general practitioners, and psycho-geriatricians. Results highlighted that informal carers were undiagnosed for depressive symptoms, and general practitioners found communicating with those caring for people with dementia challenging. Informal carers were found to enjoy their role more if they were well supported with positive communication (Roud et al., 2006, p. 3). This research highlights the importance of understanding the health and well-being needs of people in caring roles, for the individuals themselves and the health professionals who support them. In correlation with paid support workers, this study highlights that effective

communication and support between all services working with the older person can assist those caring for them.

2.10 <u>Summary</u>

This literature review highlights the concerns regarding how to manage a growing older population (Boston & Davey, 2006; King, 2007; Ministry of Health, 2018a; Ministry of Health, 2018b). Research demonstrates that this has been an issue for many years, in New Zealand and abroad (Boston & Davey, 2006; Furukawa & Shomaker, 1982; Miller et al., 2008). Balancing the needs of the older person, incorporating person-centred care and the practical delivery of care by support workers, remain significant issues (Cole, 2017; Ebrahimi et al., 2014; Luxford et al., 2010). The New Zealand government has aimed to provide policy that starts to address these concerns. The *Healthy Aging Strategy*, of which the aim is to provide measures which advocate for older people and those who care for them, is one example (Associate Minister of Health, 2016). The impact for the support worker has been an increase in pay, a career pathway and training in person-centred care.

Career pathways and training are administered by Careerforce (2011, 2015, 2019), one of the education providers which supports New Zealand workers. Careerforce is training support workers in person-centred care and the management of complex needs to gratify the growing variety of health requirements of the older person. However, the literature highlights that support workers' knowledge, skills, and the complexities of the role, are currently not understood, recognised, nor utilised to aid both older people and other health professionals (Bosley & Dale, 2008; Lawn et al., 2017; Lee et al., 2015). The literature draws attention to a lack of identification and implementation of the existing and newly developed person-centred skills within the care plan that is delivered by support workers to older persons in both residential and community settings (King, 2007).

Research shows that support workers do feel valued delivering person-centred care (King, et al., 2012; Ashley et al., 2010; Badkar & Manning, 2009; Fujisawa & Colombo, 2009; Jorgensen et al., 2009). Support workers also value the personal connections they establish with the older person, with this experience being central to encouraging them to remain in

their role (Sims-Gould et al., 2010). Evidence indicates that support workers value being involved in developing care plans and having flexibility around other commitments and training; however, attendance at training is an issue (Lawn et al., 2017).

Studies clearly indicate that procurement and maintaining support workers is linked to more than improved pay (Keefe et al., 2011; Sims-Gould et al., 2010). Staff shortages and pressure in both residential aged care facilities, and in the community, indicate that it is important to identify other domains outside of pay that encourage recruitment and retention in the sector (Berta et al., 2013; Jorgensen et al., 2009; Keefe et al., 2011). The recent pay rise for support workers in New Zealand (Ministry of Health, 2018b) has improved a sense of being valued, but there are further issues that have an impact on job satisfaction (King, 2007). The literature discussed the growing need to utilise and further develop support workers' skills and knowledge in a strained industry (Chester et al., 2018). The demands are indicated by pressure on aged care facility beds increasing, a lack of nurses in care of the older person, and an increasing need for more support workers (Lawn et al., 2017).

How we evaluate what is important to an individual or society is normally measured by how much we earn. The New Zealand government is starting to look at other measures of well-being similar to the CA (Sen, 1993) to provide a measure of life satisfaction and well-being. How we evaluate a society can include examining attitudes towards its members; examples are ageism for older people, and sexism for women and support workers (Banks, 2018; Leahy, 2010). Studies indicate that our attitudes and how we treat each other does not support valuing older people and those who care for them (Banks, 2018; Dutton et al., 2012; Faiella & Gulden, 2007; Raymond & Grenier, 2013). Examples include gender inequality remaining in society (England & Lawson, 2005), hierarchical discrimination between nurses and support workers (Bosley & Dale, 2008; Lee et al., 2015), and within support workers themselves (Bosley & Dale, 2008).

3 <u>Methodology</u>

3.1 <u>Chapter overview</u>

When conducting research, a belief system "guides the investigator, not only in choices of the method but in ontologically and epistemologically fundamental ways" (Guba & Lincoln, 1994 p. 105). In this chapter, epistemology and ontology are defined and related to the research; ethics is justified by reviewing how the researcher morally conducted the research and the method is explained.

3.2 <u>Ontological and epistemological position</u>

The theoretical underpinnings of methodology, ontological and epistemological positions help clarify what knowledge the research is aiming to produce, where the researcher fits within the research and how the research was conducted. The ontological position considers the nature of reality and questions what is happening, what is the real world and what can be acknowledged about it (Guba & Lincoln, 1994). For this project, the ontological basis of the study sits in relativism. The perspective of relativism is that individuals have their own experiences and therefore there may be different interpretations of the same topic (Denzin & Lincoln, 2018). It is important in this study to acknowledge that the respondents will have a range of experiences that will inform their views and may provide differing perspectives (Guba & Lincoln, 1994). Within this project, the participants (i.e., the support workers) brought their own understandings which they shared with the researcher who also had her own experience of being in the role of a support worker. Constructivism has emerged as a model for explaining how knowledge is produced and is a form of relativism (Crookes, 2012). The constructivist paradigm accepts a worldview that believes that respondents and the researcher's realities are multifaceted, subjective and are not an exact science (Guba & Lincoln, 1994).

Epistemology is the study of knowledge: what knowledge is, and how we obtain it (Vanson, 2014). This project is gaining knowledge on what contributes to support workers feeling

valued and what they perceive their skills and knowledge to be. This information was
obtained through the lens of qualitative inquiry and a qualitative descriptive methodology.

3.3   <u>Qualitative inquiry</u>

Qualitative inquiry is used to gain new perspectives on things already known or to gain more
in-depth information (Strauss & Corbin, 1990). Denzin and Lincoln (2018), argue that in our
modern society there is an immense need to use critical qualitative inquiry to create social
justice for people who are marginalised and oppressed. As stated in the introduction, the
cohort of respondents (i.e., support workers) fit into the category of having low status because
of their gender (i.e., predominantly female workers), low socioeconomic standing and low
education. Therefore, qualitative inquiry is a suitable methodology for this research project as
it provides a voice for this group of workers.

The underlying philosophy of qualitative approaches is to represent a true account of the
participants' reports, with the researcher's responsibility being to "hear and report" (Strauss &
Corbin, 1990, p. 21). Sandelowski (2000) explains that this method aims to gather data
without the researcher coaxing the participants to respond in a predetermined way. However,
with qualitative inquiry, there is an acknowledgement that the researcher is not an impartial
bystander standing outside the research process. In this instance the researcher's own
experiences of being a support worker had given her a view that the role was relatively
powerless (Denzin & Lincoln, 2018).

An additional framework that is pertinent to this research is a feminist perspective which is
also concerned with issues of powerlessness. Poststructuralist feminists believe that
'women's work' is less valued than 'men's', and follows the work of Michel Foucault
(Foucault, 1977, 1982, 1988), who developed theories around the impact of power on
individuals and societies (Leask, 2018). Marita Leask explains that the roots of this approach
are in social injustice, where women are seen to be limited and confined by a male-dominated
society which lowers their status and choices (Leask, 2018). Feminist research is an

important contribution to social science and looks at different ways of understanding research, and the world around us. For this project, the researcher acknowledges her position as identifying with the feminist perspective, specifically those articulated by poststructuralist feminist, Judith Butler (1999). Those interviewed may be in a susceptible and disempowered position (Jorgensen et al., 2009). The poststructuralist viewpoint is each should be heard and can change their circumstances. "Poststructural scholars would argue that examination of power relations is necessary for understanding why some problems are so sedimented (solid and difficult to remedy) and how some ideas are held with more merit than others" (Tracy, 2013, p. 45). Foucault claims: "We can never be ensnared by power: we can always modify its grip in determinant positions and with a precise strategy" (Foucault, Kritzman, & Sheridan, 1988, p. 123). Power relations should be considered in research in order to understand the research obstacles, and to ensure that positive outcomes meet the needs of the support workers, rather than those already in power, such as the agency, organisation, or government policymakers (Tracy, 2013). A poststructuralist will show multiple points of view and believes the "nature of reality to be multifaceted" (Tracy, 2013, p. 48).

3.4   <u>Qualitative descriptive</u>

The qualitative descriptive methodology is often used in health research to relay the meaning participants attributed to an event that they have in common (Sandelowski, 2000). It is a useful methodology when answering the "who, what and where" of phenomena or events and provides a comprehensive summary of events in everyday terms (Sandelowski, 2000, p.339). The overarching philosophy is one of naturalistic inquiry in which the researcher aims to study a phenomenon in its normal state where the participants present themselves naturally (Sandelowski, 2000).

The methodology is appropriate for this research as the intention is to tell the participants' narratives rather than over-analyse the findings, as the findings will speak for themselves.   The data interpretation will not require conceptual or highly abstract rendering so will not require the researchers to move too far away from their data (Sandelowski, 2000). The use of qualitative description in healthcare research provides well-defined information

that can be used to develop practice. Thus, the information gained from this project has the potential to stimulate further research that can lead to changes in practice, social policy, and the well-being of the workers and those they support.

3.5   <u>Participants</u>

The sampling method for this research was purposive because the researcher wanted to talk with people who could provide information specific to the topic (Sarantakos, 2005). The participants were paid support workers providing community-based or institution-based care

Table 1. Participant Information

Participant number	Age	Community-based (CB) or, Institution-based (IB)	Time working as a support worker	Full-time or Part-time	Average number of hours per week
P119	46	CB	11 years	Part-time	20
P129	59	CB	18 years	Part-time	25
P144	56	CB	6.5 years	Part-time	18-20
P125	40	CB	10 years	Part-time	25
P158	38	IB	1 year	Part-time	22
P143	49	IB	10 years	Part- time	25
P157	54	Both	30 years	Full time	35
P104	66	CB	28 years	Part time	12
P122	39	CB	11 years	Part time	20
P120	39	IB	10 years	Part time	20
P118	57	Both	18 years	Full time	35
P117	60	IB	24 years	Full time	40

for adults over 65 years. The inclusion criteria included being able to speak English and a minimum of six-months experience working as a support worker in New Zealand. The recruitment process included advertising, by sending information sheets to rest home managers and community-based agencies in Dunedin, New Zealand. Recruitment was supported by advertisements in organisations' newsletters, and presentations delivered by researchers at staff meetings and organisations such as Age Concern. The recruitment process was a team effort by staff involved in the research from the School of Physiotherapy, at the University of Otago, the Department of Management, at the University of Otago, and the School of Occupational Therapy, at Otago Polytechnic. Participants who were interested were directed to contact the research administrator directly to organise an interview. The research administrator allocated numbers to individuals, replacing names for anonymity. Participants were recruited from three community-based organisations, and two institutional-based organisations who provide care for older people in Dunedin. There were twelve participants in total (see Table 1 for details).

3.6   Data collection method

Semi-structured interviews were used to gather in-depth information (Merriam, 2009). In qualitative research, this type of interview is a common tool to collect data and open questions in order to stimulate the respondents' own personal account, beliefs, and experiences (Creswell 2007). The research approach was positioned within a naturalistic enquiry and used open-ended questions in an interview style. The questions were developed by the team involved in the research and were based on literature collected which was then discussed, and consensus reached. Examples included changing formal terms to informal and keeping questions neutral rather than the use of leading questions that may infer that support workers do not feel valued. This approach allows the participant more control over the interview process by encouraging the telling of their own story rather than the answering of exact questions. A combination of open-ended questions followed by probes was used, with the emphasis on creating a natural flowing conversation; a social interaction that assured trust and rapport. The interviews averaged around one hour. The questions in Table 2 were used as a guide in the interviews.

Table 2. Interview Questions

Theme of question	Question asked of interviewee
1) Life as a Support Worker	*Tell me what it's like to be a support worker?*
2) Value	*What would make you feel MORE valued at work?*
3) Skills/Qualities	*What qualities in a person are needed to be a support worker*
4) Rewards/Motivation	*What is the best thing about your job?*
5) Drawbacks	*What are the drawbacks of being a support worker?*
6) Support	*What helps you feel supported to do this work?*
7) Work Conditions	*What's the environment like where you work?*
8) The decision to be a carer	*How did you decide to be a support worker?*
9) Career	*As far as careers or jobs go, where do you see yourself going in the next five years?*

Each participant was paid for their time with a supermarket voucher of $25.00. At the time of the interviews, this payment was more than their hourly rate as a support worker, and one participant commented they needed this voucher as they were broke. Payment to increase recruitment and retention is not uncommon, and for this research, it was used as an incentive and reimbursement rather than coercion or excessive inducement (Polacsek, Boardman, & McCann, 2017).

All twelve of the interviews were conducted by the main researcher. Of the 12 interviews, 4 were completed in pairs (with a member of the research team), with 8 completed by the main researcher only. The participant and researcher mutually agreed to a time and location. Each

participant was given an information sheet which outlined the aims of the study and procedure for the interview. An informed consent form was provided with the information sheet, which was discussed first with the participant, who read, asked any questions, and signed when agreed, before being interviewed. All interviews were audio-recorded with the permission of the participants. Participants filled in a demographic questionnaire at the beginning of the interview that asked for name, date of birth, ethnicity, area of work, length of time and hours worked in this role (Table 1). Questionnaires have structured responses and are a useful means of revealing any similarities and differences between the respondents (Patton, 2014).

The interviews were audio recorded and transcribed verbatim by professional transcribers and two researchers. A sample of three transcripts was checked for accuracy as part of a moderation process. After each completed interview, the researcher replayed the audio recording and wrote notes on her first impressions, observations, and own beliefs and values relevant to the information gained.

3.7   Data analysis

Data analysis is the process of searching for patterns and constancies in the data collected with the purpose of summarising the observations to answer the research questions (Tolich & Davidson, 2018). Thematic analysis was used as a "method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). This type of analysis allows for flexibility in data analysis and accepts it is not a linear process (Braun & Clarke, 2006).

The first phase of this framework is about knowing one's data. This involved the researcher starting to engage with the support workers' transcripts. Reading and rereading of the transcript material took place, and ideas were noted down. The second phase of the framework was creating initial codes. This involved reading the transcripts thoroughly to become familiar with the data, noting down ideas, and then identifying mini themes (i.e., codes) in the transcripts. This process was repeated more than once, leaving time between

each coding to compare and contrast the differences, and move towards an agreement of code topics to increase dependability (Krefting, 1991).

The broad ideas were put into code topics and discussed at a presentation symposium by independent colleagues. The main ideas brought to the symposium were the importance of the following:

- Communication in feeling valued. The initial reading showed that good communication between the agency, support worker, and the client was important to feeling valued.

- The need for acknowledgement of existing support worker skills and knowledge, as support workers felt unrecognised.

- On-the-job training, professional development, and having a career pathway were valued by support workers.

Participants at the symposium discussed the ideas presented, debated previous research linked to the topic which assisted the researcher's knowledge, and provided assurances that the analysis was consistent with issues in the research field. The researcher then had time away from the data and re-entered the analysis at the third phase of Virginia Braun and Victoria Clarke's (2006) six stages of thematic analysis, which is searching for themes.

Upon returning to the data the researcher then progressed to the creation of themes based on all the data having been coded, collated and listed (Braun & Clarke, 2006). This stage was the start of a more thorough analysis. The researcher used the process of inductive analysis, "discovering patterns, themes and categories in one's data" (Patton, 2014, p. 453). The researcher tried various ways to display the analysis, including typing up a table with the title of the idea on one side, and the narrative that related beside it. The creation of mind maps on a whiteboard was also used to explore ideas (see Appendix A). The process involved continual re-reading of the transcripts and reviewing commonalities within the data. Incorporating the ideas from the symposium, the mind maps, and the notes, twelve themes

emerged: Skills, Training, Communication, Isolation, Boundaries, Future role, Making the connection, Feeling valued, Decreased empowerment, Change over time, Other roles, Decreased humanness.

The researcher now entered the fourth phase of the data analysis. This phase incorporated reviewing the twelve initial themes and condensing these into what was manageable and appropriate for the size of the thesis. The fourth phase has two levels; the first is to review the themes developed by looking at the similarities and differences between them. This first level involved re-reading the quotes from the transcripts that related to the themes noted for any patterns between them. The second level is when patterns emerge, and a total review of the data-set has been checked for accuracy and for any missed data (Braun & Clarke, 2006). Patterns emerged that connected themes together such as "skills and training". These two themes where joined under an umbrella theme called Role expectation. Next was phase five, which clarified and put a title to the finalised themes.

Phase five is described as "defining and refining ….identifying the 'essence' of what each theme is about (as well as themes overall) and determining what aspect of the data each theme captures" (Braun & Clarke, 2006, p. 92). Four main themes were developed, these being communication with the agency, peer support, role expectations, and relationship with the client. The researcher wrote a two-page review of each theme, and verbally discussed each theme with her research supervisor. This theme-development then led to the final stage of phase six, which is the write-up of the thematic analysis. This phase is when the researcher tells the story of the data, captures and relates the evidence of what the support workers have said within the themes developed (Braun & Clarke, 2006).

The researcher was aware of the importance of the impact reflexivity has on the process. Reflexivity is about taking into account the "assumptions, positionality and the research process…which means carefully considering the research project, the approach and which one is as a researcher" (Tolich & Davidson, 2018, p. 85). As stated earlier, the researcher was interested in gender power relations. This lens influenced how the data was seen. For instance, when a respondent talked about issues related to power imbalance, the

researcher would note examples down. Conversations were held with the supervisor to review these ideas, and see if there was a bias that might have impacted on what was decided. Questions were asked as to whether or not power relationships was a subset of a theme, or should only be reflected within the discussion chapter. The outcome was that it warranted inclusion in the theme 'Peer Support' with the title 'Voiceless and Powerless'.

The researcher's role of being a support worker also impacted how the data was viewed. The researcher had experienced both being valued and not valued within her professional experience in the role. If any transcripts sparked memories of the researcher's own experience, these were discussed with her supervisor.

3.8   Trustworthiness

Trustworthiness of a research project reflects the worth and accuracy of the information gathered and presented (Krefting, 1991). Guba's model of trustworthiness in qualitative research has been used by qualitative researchers for many years as it is conceptually well developed and ensures rigour in qualitative research (Anney, 2014; Korstjens & Moser, 2018; Krefting, 1991). Five aspects of trustworthiness define Guba's model: credibility, transferability, dependability, confirmability and reflexivity (Guba & Lincoln, 1994; Krefting, 1991). The following is a discussion of these five aspects and how these were addressed in this research.

Credibility is about establishing an assurance that the findings reflect the truth (Korstjens & Moser, 2018). To enable the production of credible findings, activities such as member checks and peer debriefings "increase the likelihood of congruence between the participant constructions and the reconstructions presented" (Rodwell & Byers, 1997, p. 116). The researcher met regularly with her supervisor, and three interviews were analysed independently. From these, themes were compared with adjustments made following discussion. The researcher's supervisor was involved in the data analysis phase as described

above, which involved discussion of ways to do data analysis and checking of themes identified.

Peer debriefings and review involves discussion of the processes and findings with independent colleagues who have experience of qualitative methods and is another method of ensuring credibility (Krefting, 1991). This approach was taken in the research forums. The first was a symposium with stakeholders from the School of Physiotherapy and the Business School at Otago University, and researchers involved in the topic of caregiving, followed by an online forum with master's students for the School of Occupational Therapy at Otago Polytechnic. The researcher presented the initial analysis of the findings. Time was allocated at the end of the presentation for discussion and clarification of the initial themes (see Appendix B). Subsequently, the researcher presented a second analysis of the findings to students and supervisors who were attending a master's school at the School of Occupational Therapy at Otago Polytechnic, where discussion at the end raised questions related to the findings and the processes of the data analysis (see Appendix C).

Peer reviewers, as described by Andrew Shenton, support credibility by providing "The fresh perspective that such individuals may be able to bring may allow them to challenge assumptions made by the investigator, whose closeness to the project frequently inhibits his or her ability to view it with real detachment" (2004, p. 67).

Participants from the forum undertook a review of a transcript on an online forum meeting. The researcher submitted a one-page document that contained quotes from a transcript and notes from the researcher. A peer review of one transcript synopsis from the research was conducted. A discussion was held on the themes developed. This feedback on the themes assisted the researcher in confirming original findings and being open to new terms to explain the data (see Appendix C). Examples include support workers "going above and beyond", "emotional labour", "unsupported institutional environments", "cultural barriers" formed by societal attitudes, "interdependence" between client and support worker, and "disempowerment".

Dependability refers to the constancy of findings over a period (Anney, 2014). It has been stated that "dependability is important to trustworthiness because it establishes the research study's findings as consistent and repeatable" (Statistics Solutions, 2019). Ways of creating dependability are using an "audit trail; a code recode strategy and stepwise replication" (Anney, 2014, p. 278). An audit trail is an inspection of the inquiry process to authenticate the data, whereby a researcher justifies the research decisions and actions to reveal how the data were recorded, collected and examined (Bowen, 2009). Audio recordings of interviews with participants and the symposiums occurred. Audio records of peer reviews of the transcripts were taken, and handwritten notes from the recordings were added to types of themes (see Appendix C).

In the initial phases of the project, the use of whiteboards and markers were used to discuss ideas; these were captured as pictures using an iPad to review at a later date. As the journey continued, field notes were kept after discussions with fellow researchers and supervision sessions (see Appendix D). The use of whiteboards to capture ideas continued within supervision sessions and were recorded on paper by the researcher.

The code-recode strategy is where the researcher codes the same data more than once. If the coding results are similar, dependability in results are enhanced (Anney, 2014). The transcripts were read multiple times, and text that related to the research questions were noted and explored through the six-phase process for thematic analysis, developed by Braun and Clarke (2006).

Stepwise replication is when two or more researchers independently review the transcripts of the interviews and compare the results. If they are similar this increases dependability (Anney, 2014). Stepwise replication was achieved in this research by the postgraduate students from the School of Occupational Therapy, at Otago Polytechnic, who reviewed one transcript, the researcher's supervisor who reviewed three transcripts, and by three members of the research team who reviewed another three transcripts. Discussions were held after these reviews and similarities of ideas of themes were consistent to reveal dependability of theme outcomes. Examples include the following: Postgraduate student feedback confirmed

the themes of 'peer support' and 'communication' being dominant in the transcript; Supervisor reviews of three transcripts promoted discussion of relationships between family, client, and agency, which after discussion, was refined to the theme of 'relationship with the client', and sub-codes filtered into other themes, such as, 'communication' and 'role expectation'. Three members of the research team reviewed transcripts, and discussion relating to skills and knowledge and the importance of training became a heading within the 'role expectation' theme.

3.9 Ethics

Ethics rules and principles are required to be embedded within the research design and delivery to justify the integrity and quality of the research. These rules and principles include anonymity and confidentiality, to do no harm, and informed consent (Tolich & Davidson, 2018). This research project gained ethical approval following an ethics application to the University of Otago, Human Ethics Committee (approval 13/281) (see Appendix I), and the Ngai Tahu Research Consultation Committee (see Appendix H). Additionally, the researcher is a New Zealand-registered Occupational Therapist with a current practising certificate meeting required specifications of the Health Practitioners Competence Assurance Act 2003.

Confidentiality is maintained within research when the researcher can match a response to a particular person, but not disclose this information in the public eye. Anonymity refers to the researcher being unable to identify a response as belonging to a particular participant (Tolich & Davidson, 2018). To ensure compliance with the Privacy Act 1993 and the Health Information Privacy Code, the information collected regarding the participants' private contact details and information was kept confidential. Respondents were informed via a written letter (see Appendix E) to reassure participants that their confidentiality will be upheld including in the reporting of the findings. Participants were informed by the letter that only their assigned study number will be used as an identifying mark, and only the main researchers and students involved will have access to the data.

To support confidentiality, participants personal details were returned directly to an administrator who collated the information and created the unique study identification number. The data collected was securely stored, and only those involved in the research could gain access to it. Data obtained as a result of the research would be retained for at least five years in secure storage as per Ethics Committee requirements. Any personal information held on the participants, such as contact details, audio recordings, and their transcriptions, were kept in this secure storage.

Data from the interviews were kept confidential through the use of numbers and changing to the use of a unique number within the written thesis. Confidentiality was potentially compromised at the time of the interviews between the researcher and four of the twelve participants interviewed owing to the researcher having had a working relationship with the four participants in her past. However, the researcher acknowledged this previous connection at the time of the interview and commented on the responsibility of herself as researcher to maintain confidentiality.

An elementary ethical principle which is embedded in health research is to do no harm. Types of harm can include psychological, spiritual, and physical. Within qualitative research, researchers can explore personal and delicate confidences, and from this study, there was a potential for participants to potentially elicit emotional responses (Tolich & Davidson, 2018). A response from the University of Otago Human Ethics Committee (see Appendix F) stated the following:

> The University of Otago Human Ethics Committee was of the view that there is an assumption underpinning the qualitative survey that workers do not currently feel valued or are undervalued. This is apparent in the Information Sheet (page 9) and the advertisement (page 13). Please take care to use neutral phrasing or questions to explore how the workers feel (Letter 13/281, see Appendix F).

The researcher utilised neutral phrasing of questions and was careful to avoid the implication that was inherent in the advertisement and information sheet – that the participants would feel

undervalued. This implication could have impacted on the information collected from the interviews and potentially cause harm to the participants by implying a negative view of their role, skills and knowledge.

The recruitment of support workers from rest homes was difficult. This difficulty arose from being dependent on the management of the rest home to leave an advertisement for the study and to pass on verbally that the study existed. To encourage support workers who wanted to be involved, they were asked to contact the administrator directly and work out a time and place that worked for them to meet for the interview. This direct contact ensured that participants had anonymity from management if they wished to participate.

For this research, it was important that the participants volunteered of their own free will, and that they were fully informed about the process of the interviews and how the information would be stored. Informed consent can be defined as "the voluntary and revocable agreement of a competent individual to participate in a therapeutic and or research procedure, based on an adequate understanding of its nature, purpose and implications" (Sim, 1997, p. 60).

Participants were given an information sheet (see Appendix G) and a consent form (see Appendix E). The information sheet outlined the project aims, types of participants sought, what they were required to do, how data would be collected and stored, and information on withdrawing from the project. If the participant had any questions, they were given four contact options, and it was made clear in the information sheet they could withdraw at any stage of the process and that the results from their information would not be published.

The consent form asked the participant to read the information sheet and sign that they understood and that any questions had been answered to their satisfaction. Participants could ask for further information at any stage and the consent form identified that the research was voluntary and they could withdraw at any time; personal information would be destroyed at the conclusion of the project; and the interviews involved an open questioning technique.

3.10 __Summary__

This chapter has described the justification for the use of a qualitative descriptive inquiry as the research methodology for this project. An additional Feminist perspective lens to the project was validated because of the researcher's position and literature supporting that the participants' gender has influenced their level of empowerment. A description was provided of the processes during the ethics application, data collection, and data analysis. Trustworthiness was reflected on, incorporating Guba's model of trustworthiness in qualitative research to establish rigour within this project. A thorough review of ethics was considered, incorporating the rules and principles that were embedded for integrity and quality of this research project.

4   Findings

4.1   Communication with agency/coordinator

The following description of the recent changes to the sector that have been implemented affects communication and provides context for the interview data in this chapter. For community support workers, changes from local to nationwide providers in the Otago area prompted a change in communication methods. The provider changed from one agency to the DHB bulk funding of three nationwide agencies to provide care. Previously, if a support worker had any issues relating to a client they would ring a local number and be connected to a local coordinator who knew the client and support worker. Currently, for two of the three agencies, the support worker must ring a toll-free number which is nationwide based rather than local (one service does still provide a direct Otago contact). Most respondents indicated that they frequently leave a message on the answerphone when ringing the toll-free number.

Figure 1 Communication changes resulting from policy change
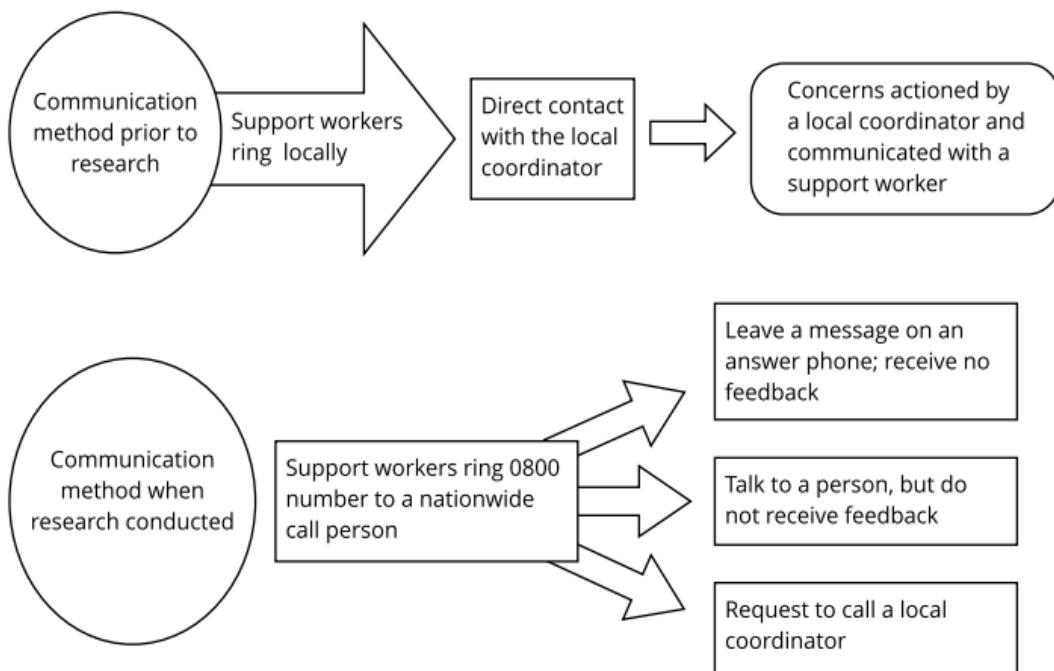
Support workers know what duties to perform by what is communicated by the agency via a care plan. These documents exist in hard-copy, based at the client's home in the community, or on file within the patients notes, at the rest home facility. For community support workers, any change to the roster is communicated via phone, text, or voice mail.

Meeting locations have become centralised and are less frequented by many responders, changing from weekly to monthly or quarterly for most community support workers. These face-to-face meetings are for support workers and agency staff to discuss organisational, administrative matters, but not to discuss clients. Most community-based participants in this project were based in one Dunedin suburb, and previously had weekly meetings where the aim was to discuss procedural processes that needed to be followed, as well as any issues arising regarding clients.

4.2   Findings theme: Communication Style

Impersonal communication was an issue. Communication was often text based rather than voice calling and respondents commented on not being able to clearly articulate what they wanted to say using this method. Participants discussed that a client's welfare and their own could be compromised if information was not fully conveyed. "*Because they approach us by text now and you can't say much in detail in a text… It's so poor [saying softly]"* (P119, 88–94). Not being able to clearly articulate their concerns regarding a client via text, as well as being unsure if their information was being actioned as there was no feedback, felt impersonal. This contrasted from previous arrangements where the person called was local and familiar with the client. As summarised by one participant who was familiar with the 'old' system:

> *… you do build up a relationship because it was the one person. Whereas if we are ringing with ### you are not quite sure who you are going to get and they are covering the whole of New Zealand… the weekend coordinator was covering the local district and she knew us all* (P125, 126).

Another participant remarked that:

> *Being a New Zealand-wide team it is not as personal as it used to be when it was*
> *Dunedin Home Support* (P129, 340). *When it was smaller you knew your care*
> *coordinator, you knew they would make the effort to go out there and do stuff but now*
> *I am finding New Zealand wide it is just not the same. That is just me personally*
> (P129, 400).

Previously, the aim of face-to-face meetings for support workers based in one suburb was to discuss clients. Support workers valued these get-togethers to voice concerns and feel heard by other peers and coordinators. The impact of limited discussions about the clients was that the support workers had less information about the client, "*I find that the biggest deficit with the hand over or changeover is the lack of information on clients… … we used to be very up with changes…*" (P122, 195).

4.2.1 Duty of care

Support workers were concerned about what happens to client information that is passed on to the agency. They are not convinced their advice will be actioned. The question around duty of care and who is responsible after ringing the toll-free number with client concerns affects the support worker's ability to feel they are doing a good job. The support workers had formed a relationship with the client and felt a responsibility to leave the client physically and mentally safe. As described by one participant, "*Well like you ring the number and they still don't answer…*" (P143, 234).

Shifting from local response to a nationwide response was considered by support workers as contributing to a misinterpretation of the day-to-day requirements of the support worker and clients. This affected the support worker's perception of how effective the service was in making sure the client received the best care. The lack of 'immediacy' was noted and the change in communication methods affected both the support worker and the client:

The support is not as immediate, well it isn't, because there's no office in #### now so that's just a fact and that's neither the fault of the new place or the old place, it's just a fact. The support's not as immediate. (P118, 315).

Conversely, a support worker who wanted to make her own choices and decisions when issues arose without consultation stated that she preferred not having an office so she can be more autonomous.

I really like not having an office here because you… you think on your feet, and I personally am the sort of person that will do that, maybe others don't but I do and I am quite happy to take the responsibility (P125, 129).

Another consequence of not having immediate support from coordinators or the agency has resulted in a shifting of responsibility. Some support workers will ring the toll-free number and either discuss their issue with the agency or the coordinator. Alternatively, they leave a message and feel their responsibility ends there. However, others would prefer a more personal approach and report to someone they know, and who knows the history and current situation of the client. *"I'll call the 0800 number and pass it on and then that's all I have to do. … The responsibility thing has perhaps been a bit lessened"* (P118, 315).

Many respondents felt there was more responsibility now to follow up to make sure a client's needs had been met to safeguard client safety.

…… the responsibility is, does seem less. I mean you've got to keep, keep pressure on yourself to make sure you keep reporting things and following them up because it would be a lot easier to just ring an 0800 number and say "So and so's depressed today." And they say, "What's their number?" And you give them their number and then, then you can think "Oh well, that's me done, don't have to think about that anymore. However, it's a person involved. It's not enough. No. (P118, 792).

It is a support worker's duty to pass on concerns about the client to the agency coordinators whose responsibility is to take action if this information is a risk to the client's welfare. The fear was that support workers concerns would either not be actioned or not actioned in a timeframe that aided the client:

…I wouldn't trust that because often you leave a message and they will get back to you and I think if it's a crisis it's too slow so I will try … our coordinator first (P112, 220).

If concerns were not heard or actioned, respondents stated feeling a lack of respect for their knowledge of the client and they worried about the client, which added stress to the role. One person noted that there were "*Some very difficult situations but um, even if I did um, voice my concerns there was nothing that was done about it, the situation wasn't resolved*" (P143, 620).

With the lack of clarity around responsibility some respondents felt the need to compensate for the agencies' communication methods by being the one who communicates with the client, even though these tasks are not perceived to be their role:

> *Well it is up to us yes… for the fact that that's not happening… and they're (co-ordinators/management) quite you know happy about us phoning clients to, um, notify them of the changes, so we shouldn't have to be doing the phoning* (P122, 155).

These perceived extra communication tasks led respondents to discuss how they are taking on more responsibilities. Support workers are not recognised when compensating for what they perceived as a lack of communication on behalf of the agency with the client. Participants expressed wanting to make sure the client is up to date with any changes.

4.2.3 Implications of current management style

Participants expressed that the coordinators are aware that there are issues with communication. The acknowledgment of who is accountable for the issues with communication can vary. One respondent indicated that accountability (has therefore) shifted amongst staff within the agency itself:

> *One office can say "Oh we think it was Auckland that did that." Or the other office can say "I think it was down Dunedin." It's… the, the responsibility seems to be a bit*

more diffuse now. [Laughs]. Which is probably just human nature, no one's real fault (P118, 315).

Some support workers commented that the negative issues related to the current communication style from the new agencies and were not the fault of the individual coordinators. They felt that the coordinators often tried their best to be considerate of individual needs such as needing time off, and were willing to listen, but they were constrained by bureaucratic processes and the impact of time limitations: "*Our coordinator values us tremendously. She gets very frustrated because her hands are tied with the system*" (P125, 229). However, not all coordinators or rest home management valued the opinion of the support worker in relation to a client's needs. Issues about whose opinions have the most influence were discussed.

> *Yes it is, it is really important, um, the new boss we sometimes feel that she doesn't know our residents and she needs to learn to actually ask us instead of taking everything that the resident says* (P158, 404).

Respondents discussed that their knowledge of the client is not asked for, and others' opinions are held with greater respect, which undermined the support worker. Management had limited time to communicate in a personal way and a comparison was drawn with the previous system which was perceived to be more responsive. Previously, the coordinator from the local provider would communicate with the client and their family when a client was admitted to hospital, and was aware of the client's condition and likely timeframe for returning home. It was noted by respondents that previously there was more communication between the coordinator and the client as to any changes that would impact on the client. With less communication happening, clients were not up to date with changes and appeared to take out their frustrations on the support worker:

> *They're doing their best but it is about the time and they're not able to get on the phone and ring the hospital and find out where clients are, or do a courtesy call if something traumatic happened and you know, see how they're doing* (P122, 156).

This limited communication by the agency with the client negatively affected the relationship between client and support worker. When rescheduling occurred that required the agency to communicate with the support worker and client, consequences of inadequate exchange of information were that the client was misinformed or not contacted, "*and it's very stressful for an elderly person to be waiting in their robe for an hour wondering if someone's going to call, or wondering if the home management person's going to turn up*" (P122, 162).

The respondents believed the client's perception of the support worker was negatively affected by the miscommunication. For example, in one instance, the client blamed the support worker for not turning up at the agreed time:

> *But you said… you've let me down… You know, you've changed the rules… she felt devalued that I had taken on somebody else that impacted on her time. You know and when a lady in her 90's is telling you that it really… It would be nice for the office to ring them and say "Hey we apologise but your carer needs to help with someone else*" (P119, 72).

Overall, communication styles have changed and support workers are concerned about the impersonal nature of the changes which in some cases appear to have resulted in the client not receiving the best care. The process of dealing with information and how this is disseminated is a work in progress for the agency, coordinators, and support workers.

4.3   Findings theme: Relationships Matter

According to the participants one of the most satisfying aspects of the role is the relationships created between the support worker, client and their family. When explaining why they became support workers participants talked about having a previous history with caring for their own parents. The skills and education gained from this past experience can now be used to benefit others.

Um, I love people and I love meeting new people. I just think it's the people, being friendly with people and um… they certainly um… make you feel valued. It doesn't matter, you know our firm it's quite impersonal now but it really doesn't matter because… for me it's about putting something back. And, um… having had a mother with dementia whose passed on, and now a father with dementia in dementia care I just feel I'm quite confident about, particularly if we get people with that particular um… condition (P122, 114).

Another example was given: "*and that's how I got into it…. because I had been caring for my father…. she gave me the job on that basis*" (P144, 435). Other participants stated they entered the job through having other caring-type roles such as looking after children or adults with disabilities. The personal connections and getting to know people were motivators: "*I enjoy it. I love going into people's homes its natural it's on their terms really…you find out more about them really*" (P122, 89). One participant said "*I think the only reason people do it is because of the people*" (P144, 233). When asked what motivated her, one participant suggested that it was "*because I am a caring person and you build relationships with these people*" (P125, 46). The attachments that are made with clients/residents were considered to be important. Being able to take time to sit and talk is important; on occasions the support worker becomes a confidante when client is going through very difficult times, such as when a terminal illness is diagnosed. On the other hand, it is rewarding when positive things happen and this is shared with the support worker:

You end up taking on board the whole lot. You know because you're there going through all the trials and tribulations and … journeys where perhaps spouses tend to duck for cover and they're not quite as you know, because they're going through their own grieving over it… one of my clients has just been diagnosed with multiple myeloma, bone marrow cancer and I was only there, well I am only there for home management but already I can see you know she's had a meltdown and it's like I'm the only one there and um… she's got quite a journey (P122, 10).

Participants were saddened when a client died or moved to a rest home. The attachment between client and support worker for some participants is not always recognised by management or the client's family:

> *Yeah and you know a lot of the, um, then there are families that come in all the time and you really get to know the families and you know when the resident passes on or whatever, yeah it… like a mourning thing* (P158, 452).

They often wanted to follow through with their clients but there is an issue around visiting clients when they are no longer under their duty of care, whether that be a hospital visit or when the client enters a rest home:

> *I have in the past gone and visited clients in rest homes, probably once or twice but I have left it there because it is not the job for me I have done them the best I could be supporting them but they have gone into the rest home for one reason and another. You just want to finalise that last little piece of goodbye before you can move on. You can get emotionally attached to your clients but you're not meant to… and when they suddenly pass away, I have known to go to client's funerals and sit there a little upset, because I have got used to my client and the way they have worked and how their family work* (P129, 205).

For some participants, however, the trust-based relationship with the client can extend to the client's family. For instance, when the family are making decisions regarding the client they may accept the support worker's advice, such as when there are decisions shifting from the community to a rest home. Relationships with family can be formed with both community support workers and rest home staff. An example given was when a client died, the family still came to visit staff and residents at the rest home because of the connections that had been made:

> *There are families that come in all the time and you really get to know the families and you know when a resident passes it is a big loss, … the family still came to see us, still came to see the other residents because it was like a big family. She came in at*

Christmas and she brought in a lot of stuff for the staff and the residents um, because as she said we were a big chunk of her life (P158, 452).

4.3.1 Depth of relationship

Participants commented that over time they get to know how to respond to the habits and routines of a client. The client appreciated these small but important touches; an example was 'pretending' to engage in gossip and a cup of tea with a client knowing that this is what the client enjoyed doing:

> *But every day we have this thing where she will come up and she'll get me by the hand and we'll walk down the hallway together and it's like she's gossiping with me… she'll say "Oh god that bloody…" and every day she takes me down to the same room, not her room, and she says "Here you sit there and I'll make you a drink"* (P117, 239).

Relationships take time to develop, and clients form trust with the support worker that enables more personal communication and opening up of a client's past history and present situation. Support workers get to know the person's likes, dislikes, schedules, and over a period, find the relationship deepens. It was reported that clients may show a variety of moods on different occasions, described as *grumpy* or *violent* and/or *depressed*. Once a relationship was established, the participants explained that they paid attention to a client's mood and found ways to alleviate their discomfort using personal touches such as sitting beside the client and holding their hand:

> *He's very very violent… and he's immobile, so he doesn't have much of a quality of life. He sits in a chair all day with his feet up and he gets fed, and occasionally he'll try to attack someone or whatever you know, but then… you go over and talk to him and sit there and you hold his hand … and he looks right at you… it's his time where he gets to communicate with someone for real so you know, and that's rewarding* (P117, 206).

As indicated in the following quote, support workers who have established a bond with a client – even though they have challenging behavioural traits – will go outside of the boundaries of their role or allocated time frames to support the client's emotional state:

> *And I grew to actually love that lady. And we're told we do not "love" our clients, but she was so grumpy and she never stopped being grumpy. But there was just something about her character and that… … and just on a thought I said "Would you like my son to come over and sing to you" because my son had a beautiful voice. And that is breaking all the rules. It was Christmas Eve and she was on her own. And she said "no no I don't want any children here…" then she said "I've been thinking about that boy of yours. You can send him over" [In a grumpy voice] … he came in and he sung her 3 songs, and she sat there and the tears just rolled down her face* (P144, 222).

4.3.2 Going beyond the call of duty

Not having enough time to complete the care plan or carry out duties was an important issue for most of the participants. They indicated that they juggled time, resulting in some clients receiving less time to make up for those that needed more:

> *I take as long as it takes to do it… the gentleman is extremely high needs… he has had his hours cut and that is creating anxiety for him and us… we just do it; well you just can't leave somebody sitting on the toilet* (P157, 155).

Another participant discussed going over the timeframe in order to help the client's distressed condition "*She said I want to die…and I sat there with her for a lot longer and had a good talk*" (P118, 137). A support worker in a rest home was allocated the task of getting three people ready for bed in thirty minutes, and was asked by the researcher if this was enough time to complete these duties: "*Not really, but we don't have much choice*" (P117, 75).

With time being an issue, and relationships deemed important, participants discussed performing roles outside of the care plan and the time they were scheduled to be at the client's home. One example was a support worker who delivers fish and chips to clients every

Saturday night in her own time. These are clients who have difficulty with transport in the community and she knows they all enjoy this, and she enjoys their company:

> *I like to do a blue cod and chip for some of my people. Um, so they sort of give, if I'm with them Thursday night I take the orders and take the money and get all their things, no Friday night, and get, and then take them on the Saturday night. Which I'm probably not, I realise I'm not meant to do but they love it. [Laughs]. They like getting fish and chips delivered* (P118, 1085).

There were many occasions when support workers went beyond the role indicated by the care plan. They are aware of the reasons for having boundaries, but acknowledged that they frequently overstep boundaries to ensure the client is well looked after and to feel they have done a good job. "*I just love being with the people and I love feeling when I walk out that I have done a good job*" (P125, 216). One participant stated she met with her clients to have lunch regularly outside of the allocated time to complete the care plan: "*I do love their company…partly it is also keeping an eye on them…partly it's also I love them as people*" (P118, 929).

For a support worker, the personal connection, understanding the client's needs and responding to these needs, are important to feel they are doing a good job. Whether a client is happy, sad, or grumpy, they pick up the emotional cues and provide person-centred care within and outside of the care plan. This person-centred care includes emotional assistance that is compensating for family that may not be able to provide the comfort that is required. Participants discussed finding closure when a client has moved to a rest home or died, by wanting to attend funerals and visit in their own time to say goodbye. Overall the depth of connection between the support worker, the client, and family, is apparent and central to their work.

4.4   <u>Findings theme: Peer Support</u>

Working and feeling a part of a team was important to participants. Whether in a rest home or in the community, being able to connect and communicate about clients was deemed necessary to provide good care. Being respected and heard, with ideas actioned by management and family, makes support workers feel valued. Older people are not respected by society, according to participants, which has inclined them to believe they are not valued for their role.

4.4.1   Isolation

Isolation from co-workers was discussed by most community support workers. The rest home support workers had other peers working alongside them so they did not feel isolated from each other; however, the most discussed feeling was isolation from management.

> *Sometimes you work with people that work good as a team and others don't and that is just something you learn to cope with… most of the girls I work with are very supportive… you never know what you're going to come up against… we have had some real laughs…and some real tears… like a family in itself* (P158, 305).

Community-based support workers were concerned about a reduction in face-to-face contact and meetings: "*I just generally do it on my own. It is a very isolating job and you don't always have a team to work with*" (P129, 286). The change to a different provider has had an impact for some:

> *Being a New Zealand wide team it is not as personal as it used to be when it was Dunedin Home Support… When it was smaller you knew your care coordinator, you knew they would make the effort to go out there and do stuff but now I am finding New Zealand wide it is just not the same… you feel kind of isolated; it is a very isolating job actually* (P129, 386).

The suburb-based support workers noted that they missed their local office and the regular weekly meetings that were focussed on discussing clients. They were concerned that the

change of providers and method of interaction had negatively affected the connection between colleagues and has had an impact on the clients:

> *When the office was out here and everything, well in my opinion then everything became much better. Um, I got to know my co-workers a lot more. We, we got to know each other, … a good relationship with your co-workers I think in this field especially if the same number of girls, or a large number of girls are caring for one person I think is really important* (P118, 415).

4.4.2 Being heard

Having a place to meet to connect with each other to feel heard and rewarded with action was considered important:

> *To hear your own ideas agreed with is a big thing for me especially you know it's hard for me to think something may be right unless I get to hear it from a few other people saying "Yeah I think that's right". Then I can relax and think it must mean something* (P118, 783).

Meetings that were dedicated to discussing clients created a place where they can voice their thoughts with peers and be a part of a team:

> *We'd meet up with each other at the other meetings here and we'd say "Oh I'm not happy about so and so. What do you think?" And if the other half dozen that work with her said "No I think she's fine," you'd think oh it's probably just me. But if you all agreed, then you could get together and think no we've got to do something about this is if we're all thinking there's something wrong, there's something wrong. We've lost a lot of that* (P118, 424).

It was felt that since the changeover staff were actively discouraged from meeting privately in order to avoid discussing clients, the support workers nevertheless felt that feeling connected was important because it made them feel they were doing a good job if they were doing the best for the clients and felt part of a team:

... we were told we weren't supposed to actually by our DNS that we're not to have private gatherings you know because inevitably clients get discussed, but honestly it's not what it's about, and um, it's just about getting together for a social time. Because we don't cross paths really with the Dunedin, um... support workers so it's not quite the same to have a total gathering. And it would be hard to coordinate as well... It's the only way we can now because we don't have weekly meetings as we did (P122, 142).

The support workers were concerned that the client was not receiving the best care because their advice is not being heard or acted on. The impact of not being heard can lead to leaving that employment: "*it's such a hard job if there's something niggling you and you can't get satisfaction from management, you're just off with the next if there's a job come up*" (P104, 658). Discussion from a respondent indicated that they separate themselves from management if they are continuously not heard, as they believe that management does not understand the day-to-day reality of the role:

it's got to a point where we really have distanced ourselves from head management, ... what would make us feel good was if she came down and actually did a day's work and seen what it is like (P117, 354).

There were examples from respondents where they were heard by registered nurses and they felt understood and supported: "*I went to the RN and spoke about it and he said right well you have got to do this... and I knew they valued me, otherwise they wouldn't bother*" (P117, 336). Alternatively, when discussing higher management, the same respondent said, "*basically the only feedback we get from head management is all negative, we're always being told off*" (P117, 345).

4.4.3 Family

The support workers discussed the interactions they had with the family of the client. If the family was making a decision regarding the client and asked for their opinion, then the support worker felt heard and respected for their knowledge of the client:

I was at a client's place and the son came in and they were talking about XX going to a day care service… and I recommended XXX… he hadn't heard of the group and then I shut up cos I thought "oh well they're family and I'm sort of an interloper" and he said "oh no no. It's really good to have you here and to have your opinion cos you know the place and you know the ladies and it is really good… I would listen to people like you and other support workers because you are involved in your holistic care… And that made me feel great (P118, 316).

4.4.4 Peer support

Peer support was discussed, with participants stating that they felt that orientation with peers is important to gain knowledge and provide a good start to their employment:

Orientation was two days where I basically followed someone around. And then when you get chucked into the deep end when you've got to do it on your own after those two days you don't know what the hell you're doing, so I think there needs to be better training for the new staff (P117, 92).

Discussion around consequences of having a limited induction meant that new support workers did not have all the information they required to understand their job. More experienced support workers would help fill the gaps of information:

'Cos I was talking to one of the newer girls the other day and she said she had a text where the text had read someone or other has had a TIA and she didn't know what that meant because I think she's been there a couple of months… (P118, 533).

Senior support workers were considered valuable as a peer support mechanism because of the information they were able to offer:

The senior caregivers are good because they all pick it up and they'll just listen for a bit and say ok, understand you've got a problem… they'll listen and say you know or, offer a bit of advice, have you tried this, why don't you try this. Yeah the senior caregivers are invaluable (P104, 597).

4.4.5 Voiceless and powerless

Participants indicated that they felt unheard when voicing concerns over the change of provider. This revealed a sense of powerlessness over the impact to both themselves and their clients. A respondent's perspective was there was a lack of consultation in discussions of the changeover to the new providers, and that clients had not been consulted:

> *When all that changeover happened… they kept on saying how they have the clients best interest… the head fellow in his suit and tie looking like he's never cleaned up someone in his life… saying people matter and I sort of thought I didn't know any clients that had been asked about this changeover. None of them have been* (P118, 808).

Because of a lack of consultation by those making the changes to the new provider, participants felt an inability to change things for the better, for themselves and their clients:

> *It means the quality of their care, the amount we're are able to do and share, the ability to make change for the better, seems our hands are tied more than the ones higher up* (P118, 740).

There was discussion from a participant that clients' opinions are also not heard or sought in regards to any complaints they may have. The participant took an advocacy role in wanting to enable the client to have a mechanism for being heard and suggested the current system is not clear enough to promote clients having a voice:

> *I don't think enough is made of complaints… there is a complaints form; all the information is given… it isn't quite pushed… I think it would make them feel more in control… clients are also low on the pecking order… so it would be good for them to have a voice* (P118, 1538).

A support worker also commented that the media has portrayed them in a negative way by not reporting on what they do well, and instead on the very small proportion of support workers who have abused their clients:

> *Bad publicity you know you see things in the paper sometimes about care worker steals money or care worker does that, but you know that's 1 out of how many? There are dedicated people who go way above and beyond… you don't get paid for that* (P144, 287).

Most respondents wanted to feel part of a group. They wanted to be heard and respected by their peers and discuss a client's issues in a safe forum to ensure that they are doing their best for the client. They wanted management to respect their knowledge and skills and to be consulted about any changes that would affect them as a group. Participants wanted society to respect older people, and in turn they believed that this respect would carry over to include their role. This role included advocacy for the older person and aiding in giving a voice, such as drawing attention to complaints forms. Powerlessness was evident for support workers through the lack of consultation with change of provider and not feeling heard when reporting client concerns or having a mechanism to discuss them as a group.

4.5   Findings theme: Support Worker Role

Discussion of the types of skills and knowledge required involved basic care and home management, to more person-centred capabilities to aid the care of the older person. Participants revealed the physical and cognitive requirements needed to perform the role including utilising intuition, training and common sense.

4.5.1 Support workers' perceptions of their role and skills

Participants revealed a variety of skills when discussing what was involved in looking after a client. This included the basic requirements of the job, such as good housekeeping. Some skills were more physically demanding and involved training, such as using a hoist when completing personal care tasks:

> *Well everyone has got to start from level two. That is our basic training, so you can't just walk off the street and be able to be in a support network, unless you have already got those skills. Our skills range* (P129, 72).

The job was considered to be very physical and required a degree of stamina and flexibility to ensure client safety:

> *There is so many things I have to remember when I am doing hoist lifting, and it is a very physical job…   I have just got to be aware of my client that she feels safe with me when I am doing this hoist lifting…* (P129, 100).

Support worker's expectations of their role also included improving the client's mood by providing company, as well as the client feeling good about having tasks around the house completed. The client would be satisfied by having meals and medications provided, being washed or showered, and the support worker leaves knowing the client is in a better state than when they arrived: "*Yes, yeah if I feel I've made a difference for them… … … It's just um… making a difference for someone and being able to express that care and look after them*" (P119, 16–254).

Participants spoke of the frequent additional tasks they completed that were not strictly part of their role. Tasks not on the care plan were numerous: sitting having a cup of tea; visiting outside of the allocated times; taking letters to the post office; collecting prescriptions; doing personal washing at their own home; lunches and pop-in visits; completing personal care tasks outside of the care plan, such as wound dressing. When conducting an interview within a support worker's own home, she remarked: "*there's a lot I do for my clients that we're actually not supposed to do… like half the washing on there belongs to one of my clients*" (P119, 145). Time pressures, however, were an obstruction for additional tasks to be completed. Support workers juggled time to ensure they did the job well, in both the rest-home setting, and out in the community.

Several participants discussed that they felt their skills were not recognised by the agency, and that it was often necessary to go beyond the care plan:

> *I was there in a capacity of home management… but you end up taking on board the whole lot… one of my clients has cancer… and it's like I'm the only one there* (P122, 9).

The skills and knowledge gained on the job, and by following one's own intuition, influenced how support workers valued themselves within the position:

> *You can see progress and see what you're doing is helping them the fact it is a medical or physical thing that you are trained to be of assistance* (P125, 58).

4.5.2 Cues and condition of client

Skills of the job require you to be alert. There is an expectation from the agency that any changes to the client need to be communicated to the agency. Cues should be noted if a person's weight changes, if they are agitated, tired or weak, and/or if there is a change in skin condition. Picking up on changes to the client was deemed a high responsibility by respondents. The agency expected this information to be passed on and some training was given; however, respondents felt that this responsibility fell heavily on their shoulders as they are often at the client's home more frequently than other professionals, and at times, family. Noticing changes in people's condition and state of mind, and the personal nature of being at the forefront of 'knowing' this client with the responsibility on the support worker, was highlighted in this response:

> *It's quite a personal job where you're quite involved with people's lives. Yes. And their health really… and we notice things perhaps, you know that somebody might have a sign of, look like they've got a urinary tract infection… … You've got to be really observant and notice changes. That's important. Um, especially people that have got dementia it's really important that you notice and um let your co-ordinators know if, you know, if there's a decline because then it becomes unsafe for them* (P144, 166).

One participant noted that you need to pick up on the cues about how the client is feeling on the day, and have an understanding of the diagnosis:

> *… everyday can be different depending on how your clients feel, whether they are in a good mood or a bad mood. So you got your challenges and it depends who you are working with, whether they have had a stroke or Parkinson's disease. So when you come in you have got to be alert, your eyes and your ears are your main tools with supporting your clients* (P117, 17).

Another discussed the basic skills and the importance of knowing how the client is feeling that day:

But for me it's not just the physical housework or the physical dressing. You know I find I chat with them and... especially when I'm showering or that, and um hear about their day and you often learn a lot about how they, how they actually are" (P143, 23).

This includes any changes in mood: "*you know if their situation changes... mood changes you are aware of those types of situations which may occur and how to deal with it*" (P143, 66).

4.5.3 Roles outside of scope of practice

Support workers commented that they were overstepping professional boundaries to complete tasks that ensured client safety:

She did say that our girls shouldn't be doing that, you should be getting a district nurse and that but that had never been put in place. And I said "Well what are we meant to do?" I said "No one's looking at it if we're not." ... I was looking at her foot and the dressing was actually well down below the wound which was oozing everywhere. And I said, "Look I know we're not, but I would like to give this a wash and just stick another bit of plaster over it." But I made sure that I asked for their permission (P118, 952).

One participant indicated that they stepped out of the parameters of the support worker role. This was due to being with the client on a more regular basis than the professionals who were not around for advice when it was needed, or to implement the intervention prescribed by a health professional:

There could be a little bit more training in some of the occupational and physiotherapy that we do... one MS client ... I have had a lot of experience in doing stretches... it is a bit like redoing the bandages that have slipped during the night, um, assessing wounds, um, and deciding whether they need any more treatment, um, assessing catheters... (P125, 139).

The participant continues…

> *Making sure the equipment is ok, um, again with this MS lady we had. I tried to get her a shower chair, the one that was sent out first was an adult one and she literally disappeared through the hole…* it *wasn't tried first of all but one of the other carers is a trained nurse and she followed it through and finally got a really good one. We were doing an awful amount of transfers from the electric chair um, and this carer set it up, she set up a system of putting the lady back onto the bed on towels after the shower and doing everything on the bed which we have followed through* (P125, 59).

Further comments about roles performed outside the support worker's job description included the following:

> *I think to some degree we are almost a kind of a social worker and um, perhaps a counsellor and um... yeah. It is hard to say really where your personality leads of and your skill takes over, you know. It is sort of, if you care about the job then you keep yourself informed about it and it can be almost a subconscious kind of thing you know keeping yourself informed about changes and medications that people are having now and the effects that they might be having and um, yeah mental well-being, physical wellbeing. It becomes, becomes, ah, um, yeah an intuitive thing to see when somebody is not on their game* (P157, 353).

The need for good communication about what you observed regarding any changes in the client, and then reporting in and referring on, was important. Knowing how to deal with death and the mental demands of clients were also requirements. Although training was provided to assist the support worker's understanding of the expectations of their role, some believe these skills often come naturally, and that some aspects cannot be taught. For instance, many respondents had times they were supporting a client through difficult life events such as terminal illness, loss, or loneliness. They said that clients relied on them at times more than family, friends or other health professionals, and support workers felt their capabilities were underestimated and that the importance of their role in handling these difficult situations was underrated: "*I don't know, it bugs me more now than it used to 'cause I think that they've, you know our lives are in people's hands*" (P144, 451), also "*general*

knowledge, a bit of um, health knowledge, knowing what's wrong with them. Knowing when to keep quiet. And referring on yes to the RNs … … , oh that's another one, sensitive about death, yes um, yeah and very very observant, pick up their mood (P104, 68–166).

The agency provides training in skills such as stoma care, administering medication and manual handling. Support workers are to complete training in these specific areas before using these skills out in practice. Based on feedback from support workers, not all are trained for these skills before applying them, and not all have read the care plans within the client's home.

4.6   Importance of the role of training

Although support workers felt that some skills and knowledge could only be gained on the job, training was valued. It supports morale, connects staff, and makes support workers feel valued for the capabilities they have obtained. Support workers expect to be trained, to increase their understanding and support for the client:

> *And so that's why training's really important. And some people say well why do we need to do this, we're just um… care workers or support workers. But you know it just helps in the job so much* (P144, 186).

A support worker indicated that training can also come from being with the client:

> *and someone can't always teach you all those things… That's how you learn. You've got to know the person before you can… yeah and that's very hard. Because you can't be trained to know a person"* (P117, 146).

Support workers who have been in the job for a long time may struggle to change their ways of doing personal care to align with the new health and safety policies. Examples include using a hoist either in a rest home or out in the community which was considered to be:

> *good for the new ones coming on because they don't know any different and it is an automatic thing for them to use a hoist and the slings and appropriate equipment. For*

us old school it gets a little more difficult… … It is just retraining yourself that you have to comply with your OSH safety things (P158, 90).

There were different opinions about a new support worker's skills and knowledge. Some felt new ones could handle the slower manual handling techniques, such as using a hoist, and were very good at what they did, but others felt they did not know the basics of common-sense household management. They did not appear to have pride in their work, or 'go the extra mile'. Going the extra mile was to perform duties that may take longer than the time frame given or the extra duties not listed on the care plan:

> *Right out the door sort of thing my time is up, watch the clock you know… whereas to me they are people not machines. If I get away half an hour later it doesn't matter, if someone needs something done I will hang around… there is a difference, you can tell the difference* (P158, 310).

New support workers were regarded as not having enough hours of training, and that their training could be compromised if they were buddied up with someone who did not have enough skills or knowledge: "*it depends on the person who's orientating you how much they teach you…*" (P117, 94).

4.7   Agency/coordinators' role of affirming support workers

Satisfaction and feeling valued can come when support workers get positive reinforcement and feedback from management and coordinators, both in the community and rest home context. They believed it was the agency's/ coordinator's role to provide positive affirmation which would make them feel appreciated. It was important for the support worker that they knew they were doing a good job, either through regular appraisals or informal feedback:

> *Well I guess, um, you know even once a week, um, the employer saying well I really appreciate the good work that you have done throughout the week and saying you have shown good initiative and that you are a really good worker but that certainly didn't occur but that would be something that would be great if they could say that* (P143, 358).

A case of positive affirmation was overheard by a support worker from her manager:

> *Um, yeah XXX is pretty good um, and I heard sometimes you pick up little things, like I heard her in the shower one morning talking to a new resident who must have been talking about me. I heard her saying that sometimes she, she couldn't come to work if I wasn't there* (P158, 222).

Being allocated roles within the service enabled a participant to feel connected and create a sense of belonging to a group. For instance, a participant said that being given a role of health and safety representative helped her to feel more valued and less isolated in their occupation, "*I get to know people… and if I wasn't involved in that, it is very isolating… you can go and work for your clients and don't really have to see anybody, and that's not that good*" (P144, 114).

Capabilities of support workers involve performing the duties of personal care such as showering, drying, dressing and home management. What was revealed in the interviews was that the support worker went beyond the basics of the care plan and performed person-centred care. The capabilities to perform person-centred care requires a strong relationship and understanding of the client and emotional intelligence to pick up the needs. Many participants went beyond what was asked for in the care plan and often crossed boundaries to perform tasks, such as changing dressings. They believed they were compensating for a system that does not immediately respond to the needs of the client, and/or family, that may not be available. By performing tasks beyond the care plan, support workers felt they were providing the best care for the client.

All participants confirmed training, both externally through Careerforce and on the job, was important and valued. It was clear that the orientation period was not sufficient and learning varied according to the trainer's ability. Overall, the participants indicated that their capabilities included emotional intelligence to pick cues on health and well-being of the client, as well as knowledge of medications and side effects beyond the remit on the care plan, such capabilities that were not recognised by their agencies, management or society. Regular appraisals to review these capabilities would enhance feeling valued.

5   <u>Discussion and conclusion</u>

5.1   <u>Chapter overview</u>

This project sought to answer the following research questions, as outlined in the introduction:

- What contributes to support workers in the aged care sector feeling valued for the work they do?

- What are the key attributes and skills of support workers in institutional and home-based aged care that enable person-centred care?

Both the literature and this project revealed that there are many facets that lead support workers to feel both valued and undervalued. Since the data was collected for this study in 2014, the New Zealand government in 2017 sought to address historical pay inequity and conditions for support workers that had led to them feeling undervalued. Although pay was not a direct theme within this research project, pay equity was considered to be a major factor in support workers feeling valued. Now that this has been addressed, it has provided an ideal opportunity to contrast the results of this study with the research that evaluates the impact of the improved pay rates.

Further changes by the New Zealand Government in 2017 was to provide alignment with pay and training levels. At the time of this research project in 2014, the skills and knowledge of support workers in enabling person-centred care appeared to be underestimated and not utilised within community care plans. A dialogue of the key qualities and impact on recent changes to training opportunities will be explored.

5.2   <u>Hierarchy and undervalued gender</u>

The issue of both hierarchy and gender within an organisation influence how support workers feel valued. Hierarchy in labour and the role of women was discussed by Émile Durkheim in his book written in 1893, *The Division of Labour in Society* (2013). This book introduced the

concept of hierarchy within occupational roles, and its influence on the individual and occupational group. Roles that are viewed as lower skilled have less status and fewer freedoms and choices. The book also reflects on women in society which, although it is based on the view of the time, still mirrors the lower status of females in the hierarchy of society (Durkheim, 2013). On the other hand, Friedrich Nietzsche, a philosopher in the 1880s, argued that society is built around hierarchy where the suffering of those with less status and fewer freedoms is part of human nature (Ansell-Pearson, 2006). Consistent with this view, research has shown that women health workers are hierarchical within their group as they do not always support each other. For instance, when orientating a new support worker, information required may be withheld and nurses may perceive support workers as a threat to role territory (Bosley & Dale, 2008). This reveals there are perceptions of hierarchy and status within the female-dominated profession that negatively influence how support workers treat each other, which in turn affect how they feel valued.

Previous research clearly states that females in the caring role are not valued by society (Banks, 2018; Butler et al., 2014; Jorgensen et al., 2009; Nugent, 2007; Ravenswood & Douglas, 2019; Stacey, 2005). Studies have indicated that the household tasks performed by support workers are deemed sullied and undignified (Dutton et al., 2012; Kadri et al., 2018). The impact of being undervalued affects the support workers by leading to increased stress in the role, reduced well-being, increased powerlessness, and less satisfaction (Butler et al., 2013; Czuba, 2015; Hallgrímsdóttir, Teghtsoonian, & Brown, 2009; Menon, 1999; Ravenswood & Douglas, 2019). Similarly, participants in this research project predominantly felt undermined by organisational and societal influences, however, felt valued because of knowing their role is important. Additionally, support workers in this research project highlighted that basic tasks are performed because the resident or client cannot complete these tasks themselves. Nonetheless, they did not feel heard by the organisation, and performed person-centred care outside of the care plan. This finding within this research project emulates another study that claims organisations do not listen to older persons' or support workers' opinions, which demoralises and affects feeling valued (Banks, 2018).

Participants of this research project also believed society undervalued the older person, which in turn, negatively influenced how society views support workers and the role they perform.

This opinion has been held in society for some time. Faiella and Gulden (2007) also support the view that society regards older people as a liability and not a priority for healthcare needs. Currently, this view remains from a New Zealand perspective; in 2017, a survey was conducted that indicated ageism is happening in New Zealand, with 40% of those over 65 stating they have fewer choices in life (Public Trust, 2018). At the same time as this disparity is continuing, in contrast, the latest NZ Colmar Brunton poll disputes that society undervalues older people by stating that the nation wants to prioritise care of the older person (Wallace, 2019).

5.3 Communication

Effective communication within an organisation is vital to assist support workers to feel valued. This research project indicated that communication methods of staff within the agency felt impersonal to the support workers. At the time of the interviews there were few opportunities for face-to-face meetings and increasingly more reliance on cell phones. The support workers were concerned that they may not be heard and, therefore, action would not be taken on the issues related to the clients. There was the potential for important issues to be overlooked, or the responses were too slow to be effective. The majority of support workers interviewed from a suburban group had no local base building to attend regular weekly meetings with coordinators. Previously, these meetings had enabled support workers to discuss concerns of clients with a group of peers. The support workers were now concerned about the impact on their clients of less communication and did not trust the toll-free number alternative. There was no feedback after ringing the toll-free number to know if their information was to be followed up.

These support workers had been used to more face-to-face communication. About the time of the research, the system had changed to an increased dependence on technology to share information. The communication needs varied from the agency to the support worker or client. The agency's use of smartphones to connect with their support worker staff provides information that can be monitored and recorded, such as rosters, arrival and departure times when visiting clients. The use of technology can be good for procedural matters such as

rosters, but is not as effective for support workers for reporting issues related to lives and care.

The issues arising from the use of technology rather than face-to-face communication are two-fold. One, is the lack of digital literacy with the predominantly older age group of support workers who prefer face-to-face contact. This is supported by a study in the UK that included 500 managers in locations where support workers used digital resources in caring for older people. The managers believed that support workers were not competent with the technology required in the caring role (Dunn, 2014). The second issue relates to the support workers feeling isolated because of a lack of face-to-face connection when the use of technology is replaced with direct modes of communication.

Isolation was a predominant theme in this research project for support workers working in the community, and the use of smartphones as a method of communicating contributed to this problem. At the time of the research there were no formalised agency-led online mechanisms to enable support workers to feel a part of a group. Support workers were turning to the social networking site Facebook to discuss how they felt about their job, but concerns were raised at one agency that this method was not creating a positive group culture (Stevens, T., 2018, November 20. Personal communication). Findings from an integrated literature review of health workers who used virtual communities to communicate found that the technology required improvement, including how to manage ethical issues such as personal information of both staff and clients (McLoughlin, Patel, O'Callaghan, & Reeves, 2018). Further issues raised are developing trust and encouraging all members to participate (McLoughlin et al., 2018). However, the use of Virtual Communities of Practice (VCoPs) can create improved well-being for the individual, can decrease social isolation, and can assist in feeling part of a group (Mairs, McNeil, McLeod, Prorok, & Stolee, 2013; McLoughlin et al., 2018; Pendry & Salvatore, 2015). VCoPs are "where members mainly use information and communication technologies (ICT) to share stories, knowledge and communications" and have been used by health workers to educate and aid teamwork (Hanisch & Churchman, 2006, p. 1). It is important to look at the conditions where virtual communities communicate effectively. One factor is having a limited number of members within the closed group so it is a more personal

gathering (Hodgkin, Horsley, & Metz, 2018). Another important factor is that a response to a person's online discussion enhances internal motivation to participate. An interesting example of an on-line forum for patient experiences is the anonymous forum set up by Care Opinion, a non-profit organisation. The purpose was to get feedback from patients in storytelling format regarding the United Kingdom, Ireland, and Australian healthcare system. Good design of a forum with built-in privacy settings develops confidence with members as they will trust who will receive the information. The Care Opinion forum counts how many "reads"

 a person's story has had which validates the contribution of the person who wrote it and lets people know which story's concerns may need following up by health staff (Hodgkin et al., 2018). This information indicates that there are proven principles that can help to ensure that people feel heard and that their views are valued when using technology.

Carers NZ have also set up a free online service for family informal carers in NZ who have a family member in hospital and or at home with a health condition and want to communicate with others regarding the patient's condition, progress and/or coordinate needs (Carers NZ, 2019). This service enables family and friends to coordinate care, receive support, share information in a social network format (Carers NZ, 2019). Thus, the use of online tools for social support and making connections for informal carers, such as online forums and video chats, have been shown to reduce social isolation and improve "social activities and intergenerational relationships" (Carretero, Stewart, & Centeno, 2015, p. 167). Buy-in to these technologies is aided by training in the use of tools, taking into account user needs, trust in where the information is stored and used, and making the tools easy to use (Carretero et al., 2015). Accordingly, this technology can be adapted as a useful tool for a paid support worker to connect as a team, and review clients they work with.

5.4   **Relationships matter**

The relationship with the client is a major driving force for people wanting to work as support workers (Ashley et al., 2010; George et al., 2017; Jorgensen et al., 2009). All support workers interviewed for this research would concur with this. They made the point that establishing and maintaining connection with the client made the job enjoyable. Another important reason

for valuing the client – support worker relationship is that being person centred assists in dealing with healthcare requirements of our ageing population, and the economic burden of chronic conditions (Health Foundation, 2016). Person-centred care benefits society economically, as studies have shown personal relationships and understanding social issues improve a person's physical and mental health with a reduction in cognitive decline, cardiovascular disease, and depression (Global Council on Brain Health, 2019; Marmot & Wilkinson, 2005). Support workers are more likely to stay in their occupation if they feel that they will be heard and they can develop a caring relationship with the client. Studies have shown that the relationship with clients/residents both stimulates people to take on a support worker's role in the first instance, and aids retainment in the role (Ashley et al., 2010; Badkar & Manning, 2009; Fujisawa & Colombo, 2009; George et al., 2017; Jorgensen et al., 2009).

In this project, support workers believed that the agency and society do not value the skills and knowledge built from the relationship they have with the client. A personal connection with a client is more likely to establish honest feedback of needs and wants, as trust has been built (Brooks, Ballinger, Nutbeam, & Adams, 2017). Utilising the knowledge the support worker has of the client to understand the changes to health and well-being, can support good care practice (King, et al., 2012). The interview data, in combination with the literature, suggests that the following principles would aid in developing a personal connection and improve respect for support workers:

- Effective communication methods for support workers to report client concerns. Examples include:

  a) direct communication between support workers and coordinators that have knowledge of the client.

  b) feedback provided to the support worker regarding the action that has taken place after client concerns have been reported.

- Greater involvement of the support worker in the care planning process.
- Support workers would like to maintain the relationship as well as attend funerals of the clients they have worked with (Gaines, Haggie, & Blanche, 2018).
- A scope of practice would provide clarity of role description and a professional body of support.

- Use Person-Centred care practice approaches in the community sector to aid valuing the relationship between client and support worker.
- Provide regular appraisals of support workers to encourage good practice and positive affirmation of work completed.
- Provide options for additional roles for support workers within the team such as health and safety representative to utilise skills and offer further leadership opportunities.

All of the above would result in a culture change of increased respect for the support workers skills and knowledge.

The support workers' perception is that their role includes looking after a client's emotional well-being, as well as physical care, and housework. They believe that doing a good job goes beyond the care plan to ensure a client is feeling positive, well, and safe. Understanding the client well enables the support worker to notice cues that would give insights to psychological and physical states. This is consistent with the agency's expectations that changes in a client's health state should be reported. However, support workers in this project felt underacknowledged regarding the observation skills they have developed, and undervalued in not receiving any feedback loops when they do declare to the agency any concerns regarding the client.

5.5 <u>Working outside the boundaries</u>

A complex issue that arises from the importance of the relationship between support workers and client is the conflict of working outside the limits of the care plan. Examples in this study included daily tasks, such as going to pick up goods and services, nursing care, and more personal arrangements that involved private get-togethers. Although there was an awareness that officially they were not allowed to do these tasks, they still felt compelled to provide the service, as they believe it is important to the client's well-being. Tasks outside of the care plan, such as prescription collections, going out for lunches, and delivering fish and chips, were not discussed with the agency. Some support workers were even putting themselves in compromising positions dealing with client's money, and performing nursing care such as wound management. This is despite Careerforce providing training in understanding

boundaries and ways of communicating when clients or their family request tasks to be performed outside of the care plan. This is not just occurring locally. Bosely and Dale (2008) also identify that support workers frequently work beyond the care plan with boundaries often being blurred. However, there is also evidence that support workers enjoy working beyond their remit with the flexibility to perform what they consider to be good care (Bosley & Dale, 2008; Hale, 2006).

One important reason for recognising tasks completed outside of the plan is the health and safety implications. The agency has a responsibility to keep support workers safe within their position. However, what the agency deems as unsafe practice may be what the client wants the support worker to do, such as wound management tasks not trained for, and handling a client's money. Being person centred means that what the client wants should be at the centre of support workers' actions. The majority of these tasks benefit the client in a way that reduces isolation and keeps people well (Ebrahimi et al., 2015). The weighing up of health and safety versus quality of care is an ongoing issue to be debated with respect to the future of supporting older people within their home and in aged-care residential facilities (ACRF).

Honouring a person's individual choice is considered a challenge in an ACRF when that choice may involve risk. Safety is more highly valued than positive spiritual and emotional consequences when assessing risk (Calkins & Brush, 2016). In 2015 a process for considering risk and residents autonomy was completed by the Rothschild task force (Calkins, Schoeneman, Brush, & Mayer, 2015). The task force comprised a variety of health professionals, advocacy, legal, and community organisations in America. The aim was to develop a process around when a resident's request in an ACRF poses a risk and what stimulated staff to consider declining the request. The task force developed a template tool of questions to review client choices, potential risks, and to weigh up positive and negative outcomes (Brush & Calkins, 2019). A study which examined using the Rothschild person-centred template tool of questions recommended that it was important to involve the support workers in planning, changing existing policies, as well as providing training in maximising client choices, and minimising risk-averse decisions (Behrens et al., 2018).

To protect the support worker and client, the agency has rules for the support worker to adhere to. This includes limitations around handling the client's money and personal items. It is clear from the research that some support workers are handling client's money, with examples of taking cash to buy fish and chips. The managing of personal items included tasks such as taking a client's washing home to dry. These examples illustrate the support worker's drive to help the client to have a better quality of life. However, it also discloses the vulnerability open to both support worker and the client to accusations of theft. One support worker revealed that a client had falsely accused her of thieving jewellery. The police were called to the support worker's house to search through her personal items, an act which she found quite distressing. The support worker in this example had not crossed the boundaries of her care plan but was still accused of theft. For those support workers who do cross boundaries, there is the potential for accusations such as those cited above. These accusations come from a vulnerable sector of society in which age-related cognitive decline can affect memory and perception of events. Therefore, the client can wrongfully accuse those who care for them (Alzheimer's Association, 2018; Murman, 2015). Alternatively, older people are open to increased financial abuse, from both family and support workers (Davey & McKendry, 2011). It is therefore important to establish some protection for those who receive and deliver care, without losing person-centeredness.

5.6 Conflict of policy and reality, and the implications on person-centred care

The New Zealand Treasury in 2018 moved to develop the Living Standards Framework (LSF) which included well-being indicators within its measure of how well New Zealand society is performing (Hall, 2019). This framework moves away from the GDP to adding well-being measures that span environmental domains, such as air quality, and occupational domains, such as knowledge and skills. Personal indicators also included in the LSF are social connections and subjective well-being (Stats NZ, 2019). The move to include well-being indicators to measure a society's success stems from the work of Sen and Nussbaum (2011), the creators of the Capability Approach. Treasury acknowledged this link to Sen's (1993) work within the original LSF working paper and the framework's design (Hall, 2019). The CA approach considers people's choices and freedoms, and how these can create happiness,

taking into account the distribution of opportunities within society that are influenced by class, gender, or age (Sen, 1993).

This research project examined issues related to the CA approach (Sen, 1993). Freedom to choose and act is a main well-being indicator of the CA approach. Studies on gender and age illustrate that support workers, and the older people they care for, have limited freedoms and choices to operate within society, which will affect feeling valued and well-being (Hallgrímsdóttir et al., 2009; Nugent, 2007; Ravenswood et al., 2014). As already identified in this study, support workers experience limitations when providing care which is person centred within the care plan and performing tasks outside of the care plan that may hold risks. This was particularly noticeable as the support workers had recently experienced a major change in the way the agencies were structured. In the consultations for this changeover, the participants expressed that they felt they had limited power and choice to advocate for themselves and their clients. This included limited choices in communication methods that would promote team culture, and feedback loops when reporting clients concerns. In relation to the New Zealand well-being indicators that incorporate facets of the CA approach, more work is required to enable a support workers freedom to choose and act in a manner that enhances well-being.

Utilising the CA approach can provide a framework to rectify the difficulties and limitations in applying person-centred care in health services (Entwistle & Watt, 2013). If healthcare focus is on cultivating a person's capabilities, it will provide genuine opportunities for people to achieve what they want to do, and be, thus improving well-being (Entwistle & Watt, 2013). This focus puts a broad perspective on how we work with people and helpfully advocates for an approach as to how staff should treat each other and their organisations. A study of care staff in an aged care facility reinforced the importance of supporting capabilities and revealed that increased autonomy led to improved confidence and self-efficacy of staff. Recognition of one's skills and knowledge, as well as trustworthy, supportive staff, improved performance and job satisfaction (McCabe, Mellor, Karantzas, Von Treuer, Davison, & O'Connor, 2017). Further exploration of applying the CA approach when working with older people and support

workers is required, but the focus of cultivating capabilities has been started by the New Zealand government, with the LSF.

David Hall, a senior researcher at AUT, reflects on Sen's capability approach in relation to LSF, and comments on the need to work on the freedoms capability for people of New Zealand (Hall, 2019). Freedom is deemed to add to well-being because it allows the opportunity to act according to one's own values and make choices to support a good life (Hall, 2019; Sen, 1993). Hall (2019) reflects on the notion that the freedom element of the LSF is unclear, as it measures achievements rather than the opportunity to achieve. In relation to support workers it opens up questions related to what support workers believe freedom of choice to be within their role for the client, and for themselves. What are the opportunities available for freedom within their role? This research project indicates a lack of opportunities for freedom for support workers. However, if given more voice in regards to developing care plans, and acting in a person centred way that is formally acknowledged, what would that look like, and how can it be measured according to the LSF? One opportunity to enable support workers to have an opportunity for freedom to act would be to more formally incorporate their ideas within the care plan. Research has shown that this increases support workers feeling value in their role, encourages person-centred care, and benefits the client (King et al., 2012).

In New Zealand, the government includes well-being indicators that are linked to Hauora (well-being). Hauora is the umbrella term for the Te Whare Tapa Whā Māori philosophy of health that is based on a wellness or holistic health model. In a traditional Māori approach, the "inclusion of taha wairua (spiritual health), the role of taha whānau (family) and the balance of taha hinengaro (mind) are as important as taha tinana (the physical manifestations of illness)" (Durie, 2017, p.1). In relation to health of the older person, the LSF well-being indicators focus on topics such as loneliness, spiritual health, and life satisfaction (Stats NZ, 2019). The role of support workers' regular contact can assist to implement this health philosophy through the task of helping people orientate to their surroundings and community, feeling as though they have a friend and connection. For support workers themselves the relevant well-being indicators relate to job satisfaction, underutilisation, job strain, experience

of discrimination, sense of belonging, and educational attainment (Stats NZ, 2019). When discussing the indicator of human capital key consultation, providers stated the importance of having "an indicator of 'self-determination/autonomy', to capture the extent to which people feel empowered and have the skills to take control of their lives"; this can include control over our working environment (Stats NZ, 2019, p. 57). This statement correlates not only with Sen's (1993) view of the importance of freedoms, but also relates to this research project that highlighted the current situation of support workers' empowerment within their role.

A paradox is apparent in the discrepancy between what is proclaimed by the government and the provision made to achieve adequate care. Support workers value person-centred care, the government policy aims for it to happen, and the needs assessors create a plan for it to happen. However, the agency care plan is limited in making it happen. Needs assessors using the International Residential Assessment Instrument (interRAI) review an older person's health with the client addressing physical, social and mental well-being and creating a plan for the agency to deliver this care. Community support agencies accept this plan, but adhere more to the physical health-related care to fulfil regulatory demands and remain fiscally sound in the market-driven environment. What is apparent is that although research finds that person-centred care can improve well-being, lessen hospital admissions, and potentially save money in the health system long term, this does not appear to be fully actioned, and the Ministry of Health recognises that the current system is economically unsustainable long term (Ministry of Health, 2019). In New Zealand, a gerontology nursing specialist, Dr Kathy Peri, advocates for a change from task-orientated care to person-centred care, and the provision of suitable training for support workers, but admits that managers need to take strong leadership in this matter. Unless they do, person-centred care will be difficult to deliver (INsite, 2018).

There is evidence that person-centred care works to improve health outcomes and make for effective health delivery, but questions are still asked regarding how it is successfully implemented in practice (Harding, Wait, & Scrutton, 2015). Research studies argue that current market-driven care delivery cannot provide successful person-centred care outcomes (King, 2007). The reason market-driven care does not work is that it deals with the physical needs but neglects the emotional, relationship element of care giving which is central to the

well-being of clients and support workers. The impact of this market-driven approach is that care work has developed "increased levels of casualization, deprofessionalization, work pressure and dissatisfaction, and as a result high rates of burnout and job diseases" (King, 2007, p. 201).

Another appropriate framework is 'Bounded Emotionality' (BE). This promises to improve the well-being of support workers and the older person they care for whilst lessening the tension between stakeholders (King, 2007; Martin et al., 1998; Medler-Liraz & Seger-Guttmann, 2018; Mumby & Putnam, 1992). BE was proposed by Dennis Mumby and Linda Putnam (1992) as an alternative to the traditional Bounded Rationality that occurs in organisations where emotions are deemed inappropriate in a work setting. The aim of BE is to respect the personal relationship between support workers and client, in a safe manner that fosters connection (Mumby & Putnam, 1992). This philosophy, of reinforcing and advocating the emotional face of care delivery, resonates with the findings of this research project: that support workers value the personal connection with the client. Studies have shown that utilising the BE approach aids retention in employees (King, 2007; Medler-Liraz & Seger-Guttmann, 2018).

The Eden Alternative (Enliven, 2018) and The Green House Project (2019) are models that have been developed to move away from institutional methods of care to more humanistic person-centred delivery for older people within ACRFs. The Eden Alternative advocates for support workers to put relationships above traditional tasks, and be involved with residents in decision-making which is achieved by changing the organisational structure from top-down to a more flattened structure, where decisions are made by direct care staff (Horton, 2005; Steiner, Eppelheimer, & DeVries, 2004). It has been noted that the traditional top-down approach does not advocate for person-centred care planning and culture (Keane, 2004). A study by Polly Yeung, Gretchen Good, Kieran O'Donoghue, Sarah Spence, and Blanka Ros (2017) reviewed the quality of life and overall satisfaction of living in a person-centred environment. Results indicated that the Eden values of person-centred philosophy (i.e., identity, growth, autonomy, security, respect, connectedness, meaning, joy) also resonated

with residents who reported high life satisfaction. The question is this: how can the values that are working well in models of ACRF's care be transposed to the community sector?

There are complexities regarding incorporating person-centred care. Concentrating on physical care is more measurable in terms of time, and less risky with concrete protocols for support workers to follow. Physical needs and psychosocial needs are seen to be separate entities, with the physical deemed to be the basic needs, such as personal cares, meals, and medication. Psychosocial needs are those considered to be outside the agency's domain of concern (Hansen, Hauge, & Bergland, 2017). There is a fear that negative health outcomes and accusations will be made of staff if the person-centred psychosocial elements of care are followed (Behrens et al., 2018). If the focus shifts, and time is spent on psychosocial rather than physical cares, there is a concern that health issues, such as increased pressure sores and hygiene-related issues, will create health problems (Hansen et al., 2017).

One study which analysed healthcare providers for those with dementia examined three approaches to person-centred care in the community (Hansen et al., 2017). This study revealed that if management understood that unmet psychosocial needs resulted in physical health problems, then both could be addressed equally within the care plan. Providers described how they met person-centred care by using one of three approaches: 1) physical need-oriented logic (physical and psychosocial needs were seen separately, with psychosocial not the domain of the agency); 2) psychosocial needs which were considered as basic needs, however, the physical needs were perceived as more essential; and 3) integrated logic whereby psychosocial needs were described as important basic needs, in line with physical needs. The first two approaches did not put person-centred care as equal to physical cares, while the third approach did. To enable the third approach to work, there was an understanding by management and staff that unmet psychosocial needs could create physical health problems. For example, reduced social contact could lead to reduced eating and malnutrition. Importance of trusted relationships, communication, and cooperation with support workers and family made it easier to conduct practical tasks and met the client's needs. The study highlighted that there is a lack of consistency in approach within healthcare providers as to who is responsible for fulfilling person-centred needs. To use an integrated

approach, the healthcare provider views psychosocial needs as basic needs and should be a part of basic care. Time is seen as an issue to perform person-centred care. Alternatively, those using the integrated approach believed time was saved because of the relationships formed, making care easier and quicker to perform.

It was clear from this research project that the majority of support workers adhered to carrying out the physical cares but did not adhere to the rigidity of the procedures set in the care plan. Evidence from this research project and other studies indicate that a support worker in the community does not have time in their care plan to focus on person-centred psychosocial issues (Turjamaa, Hartikainen, Kangasniemi, & Pietila, 2014). The underlying message from most of the individual support workers interviews was that 'care as usual' meant working outside the procedures of the care plan. These participants appeared to have a 'person' orientation. Studies have indicated that meeting the needs of psychosocial issues beyond just physical needs is providing better quality care and improved health (Hansen, et al., 2017; Ross, et al., 2017). The rationale is that for the support worker, the relationship matters, and the psychological needs of the clients also require attention. However, some support workers appeared more 'task' orientated and only focused on the physical cares and household management outlined in the care plan.

5.7   Skills and knowledge of support workers

It is clear that support workers' knowledge and skills can support the well-being of the older population (Fletcher, 2002; Ross, et al. 2017; Wells, et al., 2014). One aim of this research project was for support workers to identify their skills and knowledge. The data accentuated two types of support workers: task orientated, and person orientated. Task-orientated support workers were in the minority in this research project. They had basic skills and knowledge in physical and personal cares and were more likely to finish within the time allocated to a client. The majority of participants were person orientated and focussed on the overall quality of life for both the client and them-selves.

Participants who were person orientated used knowledge and skills beyond those taught in training and would do extra duties outside of their allocated role requirements and the care plan. An example is that some indicated that they knew about the impact of different

diagnoses and understood the side effects of medications on the client. Support workers are trained to administer some low-risk types of medications and there are protocols around this; however, further knowledge and skills around identifying side effect of medications was not noticeably taught at the time of the project (Careerforce, 2014). Therefore, person-orientated support workers would identify extra information about medication to ensure they understood changes to the client's condition and could respond appropriately to their client's needs.

Support workers realise the importance of their relationship with the client; however, this is not described as being essential by management (Keene, 2018). As shown in the review of data for this project, the issue of having time to have conversations with people and show compassion was severely limited and not encouraged. Research shows that not valuing the relationship with the client is an international concern (Berta et al., 2013; Jennings et al., 2013; Sims-Gould et al., 2010). Issues raised include management disregarding clients' concerns when a support worker is reallocated to another client in the roster (Denton et al., 2002a). The issue of the impact on clients when a support worker has changed times or shifted to another client was also revealed in this research project, with communication to the client being poor, and the change unsettling. Knowing the client well and having a good relationship assists the support workers to pick up cues if there are changes to the client's health (Lawn et al., 2017; Lester, Mead, Graham, Gask, & Reilly, 2012). Skills include noticing more in-depth cues of a client's wellbeing, such as physical health problems (e.g., deterioration of ulcers) and mental health issues (e.g., signs and symptoms of depression).

This research project indicated that person-orientated support workers felt they were performing duties that showed sincerity, self-awareness, and empathy; utilising the relationship to think ahead to determine client's needs. This finding correlates with a study conducted in the United Kingdom by Justine Schneider, Krisitian Pollock, Samantha Wilkinson, Lucy Perry-Young, Cheryl Travers, and Nicola Turner, *The subjective world of home care workers in dementia: an "order of worth" analysis* (2019), that found a key skill of support workers was utilising social skills to anticipate the client's requirements. The data analysis from this research project indicated that support workers spend their time with the clients observing how they interact and picking up on physical and mental health issues. These support workers were frustrated with time constraints, were more aware of the family

dynamics affecting the client, and felt unsupported by the agency. These findings also correlate with the study of Schneider et al. (2019) regarding support workers doing extra on top of the care plan, negotiating around family conflict, and utilising a high degree of social skills and emotional intelligence to provide good home care.

Characteristics of person-orientated support workers are in alignment with how future care should look for older people (Nolte & McKee, 2008). To provide the variety of needs of an older population, it is deemed that an integrated approach to care is better than that which is just task based (Nolte & McKee, 2008). This involves support workers having a broad range of skills and the ability to reflexively meet the needs of the older person. Support workers are responsive to being trained to create care plans as well as providing low-key nursing tasks (Lee et al., 2015). Providing an integrated approach enables the awareness the support worker has of the client to be more acknowledged within care planning, which in turn, results in better outcomes for the client and the support worker (Lawn et al., 2017).

The integrated approach does not just utilise and upskill support workers, but improves communication between all services involved in the care of the client. The World Health Organisation (WHO) defined the integrated approach as "a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency" (Gröne & Garcia-Barbero, 2001, p. 7).

The importance of good communication between all disciplines, and the flexibility of moving away from traditional silo-based services toward an integrated approach in line with person-centred care, has been discussed when working in chronic care (Nolte & McKee, 2008). This research in chronic care highlights the complexities of rolling out integrated (person-centred) care to an older population with complex needs. How this can be done effectively still requires evidence-based research. The complexities can be seen in the New Zealand context, as the new funding model for home care services utilising the interRAI Contact Assessment case-mix model of care to support aging in place is rolled out (Parsons, Rouse, Sajtos, Harrison, Parsons, & Gestro, 2018). The case-mix model refers to the range and type of

patients treated, which include ACRF residents and community clients. The inteRAI is tabling the results of assessments of functional capability and formulates the needs and services (interRaI Governance Board, 2018).

Another issue is that there is improved, consistent care quality among support workers if there is a transdisciplinary collaborative care approach in assessment and care management of older people (Molony, Kolanowski, Van Haitsma, & Rooney, 2018). With an increasing older population who have a higher percentage of chronic diseases, working in a multidisciplinary way has proven benefits. These benefits include less burnout for staff, fewer medical errors, and increased client safety (HRH Global Resource Center, 2017). The advantages of working in an integrated way also benefit the clients and family who report higher satisfaction with the health care provided (Riste, Coventry, Reilly, Bower, & Sanders, 2018). However, one of the negative implications of using an integrated approach can be the lack of transparency regarding who should take responsibility for providing the service beyond the physical health requirements (Hansen et al., 2017).

With any care approach there may be a conflict between meeting the needs of all the stakeholders. There will be pressure on agencies to deliver care in alternative ways to meet the demands (King, 2007). There are fiscal challenges in providing person-centred care, and there is limited research in conducting person-centred care in the community (Downs & Lord, 2017). Inadequate pay for support workers was an issue that was raised in the research project; however, it was not classified as a major theme related to the question of what contributes to feeling valued in their role. Nevertheless, addressing the historical pay inequity and gender discrimination with the 2017 Pay Equity Settlement has aided support workers to feel valued by the government in New Zealand (Douglas & Ravenswood, 2019). The Pay Equity Settlement was aiming to address inequity and expose the importance of their role in supporting older people in NZ (Douglas & Ravenswood, 2019).

In New Zealand, it is not the agencies that are imposing training standards and pay equity, it is the government. The impact of imposing training levels with pay equity and person-centred care from the manager's perspective is challenging (Douglas & Ravenswood, 2019).

Concerns in New Zealand from managers is that funding from the government to meet the needs of the pay equity is inadequate (Douglas & Ravenswood, 2019). Current research has highlighted that the pay equity settlement has increased recognition of the role of support workers, but not enhanced the appreciation of the support worker (Douglas & Ravenswood, 2019). The agencies are stating they need increased financial support to pay for rising costs, and support workers are still feeling undervalued by managers, as it was not the agencies that instigated the pay equity (Douglas & Ravenswood, 2019).

In order to alleviate the fiscal pressure on agencies delivering care, the New Zealand government has provided some monetary relief (Ministry of Health, 2018c). This monetary input is thus: "2.048 billion over five years by increasing funding of District Health Boards (DHBs) and the Ministry of Health: Disability Support Services (DSS). In turn DHBs and DSS are increasing their payments to providers that employ care and support workers" (Ministry of Health, 2018c, p. 3). However, a review conducted one year after the pay equity settlement by Douglas and Ravenswood (2019) has highlighted positive and negative implications. Positive impacts for community and ACRF's support workers was that the pay equity settlement was supported by both managers and support workers in addressing discrimination. Managers have noted that turnover has reduced in ACRFs and a higher calibre of applicants were noted in the community. Support workers have discussed they feel empowered by the government acknowledging the inequity and recognising qualifications. Some support workers have decreased their hours of work which has meant increased work-life balance. Overall, the support workers in the 2018 study felt a "sense of pride and appreciation that their work and skill was better recognised through the settlement" (Douglas & Ravenswood, 2019, p. 36).

There were some negative implications for support workers and managers of the pay equity a year on from implementation. Managers of ACRFs were concerned about the following: no improvement in recruitment of support workers in most areas; lack of control from managers perspective over training levels 1– 4 (e.g., some support workers paid at level 4 have less skill than those at a lower level); increased workload to administer new legislation changes and a lack of consultation in the planning and roll out; tension due to pay inequity that has been

created between other occupations such as cleaners, kitchen staff, registered and enrolled nurses; overall tension noted in regards to funding with most managers of ACRFs stating that the money was not sufficient to cover costs. One manager stated, "this Equal Pay Settlement has put us all, every single organisation that I know of... in a position where money is going to be more important than care because it is killing us" (ARM7, speaker 1 as cited in Douglas & Ravenswood, p.22).

Managers of the community sector had similar issues related to the pay equity settlement, with inadequate funding cited as a major issue to implementation. Community managers also cited issues with the training levels, and noted that qualification equivalency to the NZQA Health and Wellbeing Certificate did not always correlate with competency skill set of the support workers, an example being that a person may have social work qualifications and be deemed a level 4 support worker, but not have the skill set to perform level 4 practical duties (Douglas & Ravenswood, 2019). Lack of communication of expectations and what the legislation meant, as well as the increase in administrative time for ACRF managers, were also cited as issues. Tensions amongst staff over pay was reflected between occupations, such as cooks and cleaners, and enrolled nurses who hold legal responsibility but may only be paid 50 cents more an hour (Douglas & Ravenswood, 2019). Overall, the issue of recruiting more support workers had not improved in the community sector (Douglas & Ravenswood, 2019).

The impact of the Pay Equity Settlement on managers, and the issue with funding, has had a roll-on effect on support workers. Their perceptions one year on from pay equity is mixed depending on their level of training. Managers are now offering fewer and less guaranteed hours to level 4 support workers, and are more likely to employ a lower-level support worker. Therefore, those qualified at level 4 are stating that they are potentially earning less and are more stressed about a lack of guaranteed hours than before the settlement. Managers and support workers are stating that there is a disincentive to now train to a level 4 position (Douglas & Ravenswood, 2019).

Training was highly valued by the support workers in this study, and at this point there was no direct career pathway and no direct alignment between study and pay equity. Since the interviews for this research project were conducted, policy has changed to provide both a

career and pay alignment. However, as stated above, the changes to training and pay equity may not incentivise a support worker to further upskill. Managers, as indicated in the Douglas and Ravenswood study (2019), have stated that level 4 teaches leadership but not necessarily the skills required to do the job, and is not competency based. Support workers are now understanding that if they complete level 4 they will get fewer guaranteed hours of work. Managers have clarified that to pay a support worker at level 4 is a financial burden and may not meet the needs of clients if their skill set is not adequate (Douglas & Ravenswood, 2019).

Support workers who are employed at level 4 are being expected to carry out nursing-related tasks (Douglas & Ravenswood, 2019) to compensate for a shortage of nurses working in the elder care profession. Careerforce has expanded their level four qualification for support workers to lead to career pathways beyond caregiving and into nursing (Health Central, 2019). Studies have indicated that support workers value taking on low-level nursing duties (Lee et al., 2015). Despite this, there appears to be a current discrepancy in expectations since the pay equity settlement took effect, with managers expecting support workers to now step up to nursing tasks, whereas some support workers believe they are not trained to perform these duties (Douglas & Ravenswood, 2018). The impact of the pay equity settlement and expectation of increased skill has also affected the culture of organisations, and tensions of role boundaries has meant some negativity toward support workers. Support workers have felt pressure to perform tasks more quickly and have heavier workloads since the settlement (Douglas & Ravenswood, 2019). This is counterproductive to providing person-centred care because of having less time to form relationships.

5.8   Time for a support workers scope of practice

It has been argued that to protect both support workers and clients, a professional framework incorporating a code of conduct should be established (Wild, Szczepura, & Nelson, 2011). Boundaries of a support workers role have shifted; this research project has shown work is being conducted outside of the care plan, and current research has shown a variability in accountability, both in rest homes and in the community (Douglas & Ravenswood, 2019). Some managers are expecting level 4 support workers to be performing tasks of an enrolled

nurse, such as PEG (percutaneous endoscopic gastrostomy) feeds and bowel evacuations (Douglas & Ravenswood, 2019). In the United Kingdom, a study found that support worker staff at a higher level of training and experience believe themselves to be professionals; however, they believe others do not perceive them in this way. It was found that support workers value experience over training as they believe it is more practical. What was evident from the study is that liability is unclear for support workers and nurses if an issue arises. However, it also indicated that if the support workers workforce is to be considered a profession, then regulation through a framework which clarifies the role compared with other health professionals is required. By putting regulations in place, this will aid protection for both the support workers, other health professionals, and the client (Wild et al., 2011). Implications for introducing regulations would be the increased expense. The cost to the support worker of the annual practising certificate, and the time needed to continually prove competency, plus implementation of a board and record keeping, furthers financial expenditure (King et al., 2012).

Currently, in New Zealand, the majority of care in ACRF is performed by unregulated support workers and any scope of practice is determined by the individual employer (Shannon & McKenzie-Green, 2016). Not having a regulated scope of practice for support workers has been shown to lead to uncertainty about which tasks they are able to perform from a legal perspective and responsibility has lain with registered nurses who find it challenging under the current more complex environment (Burrow et al., 2017; Shannon & McKenzie-Green, 2016). The climate is more complex due to higher costs, high occupancy rates, higher dependency and there is no clear scope of practice for support workers' role, with managers expectations being inconsistent (Burrow et al., 2017, Douglas & Ravenswood, 2019, Shannon & McKenzie-Green, 2016).

The New Zealand Nurses Organisation had not recommended regulation owing to a potential role conflict with enrolled nurses; however, it appears that this role conflict is already happening with managers stating that a level 4 support worker may have tasks very similar to an enrolled nurse (Douglas & Ravenswood, 2019; Shannon & McKenzie-Green, 2016). The variability of the identity of a support worker because of differing titles and job descriptions leads RNs and those creating policies to struggle to develop an overall scope of practice (Burrow et al., 2017). However, overseas countries such as Australia and the United

Kingdom have sought to establish regulation by establishing scopes of practice to assist RNs in supporting support workers. The rationale for providing regulation is public safety, by implementing a national framework, educational and practice standards and a code of ethics and conduct (Shannon & McKenzie-Green, 2016). In New Zealand, an educational framework is in place; however, further development and discussion are required regarding implementing regulation for public safety, and the ability for RNs to guide support workers in their role.

Careerforce provides person-centred care training for support workers in New Zealand. Within the graduate profile of each level of the New Zealand Certificate in Health and Wellbeing, the term person-centred is applied. Graduates at level two will perform "entry level person-centred tasks and functions" while those at level four will "implement person-centred approaches to support a person with complex needs" (Douglas & Ravenswood, 2019, p. 11). This research found that there is limited evidence that person-centred approaches are being actioned in care plans in the community as support workers perform these tasks outside the care plan. Studies reveal that if a support worker is involved in the care planning, performs person-centred care, and the agency values person-centred care, there is a better outcome for support workers and client (Jorgensen et al., 2009; Lawn et al., 2017; Sims-Gould et al., 2010). According to the latest report following the pay equity settlement, support workers are still not involved in care planning and appear to have less time for person-centred care (Douglas & Ravenswood, 2019).

With the changes to pay equity and the fiscal demands placed on agencies, there is less in-house training and meetings with staff and if training is offered it must be completed in the support worker's own time (Douglas & Ravenswood, 2019). At the time of the research project, the participants clearly felt that orientation to the position was not adequate and that the colleague who taught you made an impact on your confidence, ability, and enjoyment of the role. Likewise, support workers stated that there were not enough consistent appraisals completed between the agency and support workers. The research indicated that support workers valued hearing or viewing positive comments when they were doing a good job. The impact of the fiscal constraints on the amount of time given to orientation and impact on appraisals is not revealed in the study, *The Value of Care: Understanding the impact of the*

2017 Pay Equity Settlement on the residential aged care, home and community care and disability support sectors, by Douglas and Ravenswood (2019). However, it is clear that recruitment is still an issue with the Douglas (2019) study, therefore it would be prudent to enable a positive orientation process and regular appraisals to aid retainment and feeling valued for support workers starting out in the role (Bloom, 2019; Buchanan, 2010).

This research project and current research into the impact of the pay equity indicate that it is important to have hands-on skills and knowledge when working with older people. Managers are now stating that the training for support workers is not as competency-based as it should be, and both support workers and managers are questioning the online method of training (Douglas & Ravenswood, 2019). From this research project it was clear that the tacit knowledge is gained through experience, spending time getting to know the client and willingness to observe the changes. Picking up on changes to an older person's health at the early stage is vital to prevent more complicated and costly health issues that require hospitalisation (Lunenfeld & Stratton, 2013). Evidence has shown that the more trained the support worker is, the higher level of job satisfaction they experience, resulting in better outcomes for their clients, such as lower hospital admissions for ACRF residents (Shannon & McKenzie-Green, 2016). Good mentoring and education improved relationships with colleagues and residents, which improved aspects of a support workers well-being (Lopez, White, & Carder, 2014).

As discussed, one of the major indicators of well-being is a person's ability to have freedom to make choices (Sen, 1993). Current research has indicated that the freedoms and empowerment which was intended to be provided with the pay equity settlement has resulted in fewer guaranteed hours and pressure to sign contracts to lower hours or face a casual contract. The changes since pay equity have led to support workers having less freedom by "feeling afraid to speak up because they feared retaliation through bullying or not being given available hours" (Douglas & Ravenswood, 2019, p. 39).

5.9   Limitations of the research project

One of the main limitations of the data captured was that the majority of community support workers interviewed were from one suburb. This suburb had an office base that operated differently than the main hub office. The distinction was that the suburban office had more face-to-face meetings, and the nature of these meetings were to discuss clients as well as day-to-day processes. Conversely, the main office meetings were process-driven discussions only. Nevertheless, it enabled the comparison of communication methods and responsibilities of coordinators and highlighted the importance of feeling a part of a group.

Owing to the limited geographical area, the findings regarding how agencies communicate may not be replicated to the nation as a whole. Within this research project the agency provider changeover from one to three new providers had an effect on the support workers. This impacted on the findings of how the support workers felt valued regarding the roll out of new methods of delivering care plans (less face-to-face), training, and the use of communication tools such as smartphones.

Most of the research participants appeared to be working outside the care plan, performing person-centred tasks. Those support workers who volunteered to be involved may have been those most orientated towards a client-centred approach which could have influenced the data.

5.10   Recommendations

There are several main issues arising from this research project that relate to valuing support workers. Firstly, fostering and developing caring relationships with clients that include person-centred care; the acknowledgment that support workers are going beyond the call of duty and utilising capabilities for the benefit of the client. Secondly, the importance of enabling effective communication with the agency that is associated with the aim of support workers feeling less isolated, and providing the best care for clients. Finally, the impact of government policy on coordination of care agencies, which in turn influence the role of community support workers and their ability to provide person-centred care.

Support workers value the relationship with the client and therefore work outside the care plan to facilitate person-centred care. The issue of support workers performing tasks outside the care plan, and stepping over the care plan boundaries, was discussed in this research project. Further exploration on the ramifications of this is required. It is clear that person-centred care is valuable for both the older person and the support worker – it provides them with job satisfaction. A future area of research could suggest the strategies required to allow support workers to participate in the formulation of care plans with the agency team. Cultivating the personal relationship is important, and finding clear pathways for a support worker to be strategically involved in care planning and performing person-centred care has shown to improve health outcomes and retain support workers.

The capabilities of support workers is aided by training delivered by Careerforce which provides the training for support workers, and since 2014, has aligned with the *Kaiāwhina Workforce Action Plan* (Workforce in Action, 2017) to improve the skills and knowledge of support workers. These skills and knowledge are focussed on being more person centred to correlate with the *Healthy Ageing Strategy* (Associate Minister of Health, 2016), and now, pay alignment correlates with the educational levels. Evaluation of these training courses and levels of attainment in practice, both in ACRF and in the community, is essential. Questions could include the following:

- Are the skills and knowledge gained in training being actioned to aid person-centred care?

- Do older people feel that they are being treated in a person-centred manner?

- How do support workers implement person-centred training within the care plan?

Support workers have been aided by the government to have a career pathway, and although some training is performed as a group, it was clear from this research project that a feeling of isolation is a problem for support workers. Further research investigating methods to reduce isolation and to identify the factors leading to this for support workers would be useful. Reviewing effective communication processes that alleviate isolation and promote connection as a group would be beneficial. Communication methods are changing, with the increased

use of technology such as smartphones to connect with each other. Identification of the best way to utilise technology to reduce isolation for support workers and to enhance the accuracy of information exchange is essential.

Effective communication and providing the best care is linked with which communication channels are used, and what model delivery of care is put in place. Research exploring the implementation of person-centred care models (such as the Eden alternative) within community settings in New Zealand would be beneficial. Questions could include the following:

- What does person-centred care look like in the New Zealand context?

- What person-centred care models would be appropriate in New Zealand?

In regard to effective communication channels, research could survey the following:

- Reviewing the use of the toll-free number for support workers to make a connection with the agency, and identifying feedback loops that could be put in place.

- The use of effective appraisal systems to enhance feeling valued.

- Reviewing the induction system for support workers, how much time is needed, and what skills and knowledge are required to pass on to new recruits.

There appears to be a discrepancy between policy implementation of delivering person-centred care and making support workers feel valued, and the reality of providing care. The study, *The Value of Care: Understanding the impact of the 2017 Pay Equity Settlement on the residential aged care, home and community care and disability support sectors,* provided a review one year after the pay equity agreement was actioned (Douglas & Ravenswood, 2019). A follow-up study to review whether support workers feel valued by society, the government, and other health professionals, would be useful to review where valuing and devaluing may be occurring, and why. One major issue is the conflicting perceptions and expectations of managers since the pay equity settlement has taken effect, with many believing that support workers should be completing more and higher skilled tasks. Managers have cut hours and

made it harder to maintain guaranteed hours, which has resulted in support workers being financially worse off than they were before the pay equity settlement (Douglas & Ravenswood, 2019). Therefore, an additional survey of ACRF managers and support workers, and managers of community care agencies and community support workers, would be beneficial to ascertain how support workers feel valued.

Managers of agencies are complaining that costs of delivering care are rising and there is a shortfall. In New Zealand, the present financial delivery of resources through the current business model is not meeting the needs of an aging society. Further review and study of the impact of the current funding models, and possible alternatives, are overdue. The Ministry of Health is developing frameworks around delivery of home and community support services, reviewing the Funding Model for Aged Residential Care (ARC) and reviewing the aged care contracts with Non-Government Organisations (NGOs) (Ministry of Health, 2018a). Currently, ACRFs have been deemed to have little funding negotiating power with DHBs. There is pressure on delivering care because of rising costs associated with increased wages for support workers and residents' needs (Rouse, 2019). However, further research on the impact on support workers is required if new initiatives for funding distribution changes are undertaken. Any funding model will directly impact on the role of the support worker, how they provide person-centred care, and whether they feel valued.

5.11   Concluding statement

The New Zealand Government has acknowledged that feeling valued improves your well-being. Well-being indicators are now being included in measuring how successful New Zealand is as a nation. The Capability Approach, developed by Sen (1993) and Nussbaum (2011), was utilised by the New Zealand government to form the New Zealand's Treasury Living Standards (LSF). The government is setting the standard that now encourages well-being to be acknowledged and promoted. The government is establishing standards and policies, such as the *Healthy Ageing Strategy* (Associate Minister of Health, 2016), and the *Kaiāwhina Workforce Action Plan: 5-Year Actions 2015-2020 – Toward the 20-year Vision* (Workforce in Action, 2017), to promote training in person-centred care to improve quality of life, and aim for support workers to feel good about their role.

Policies have been instigated, and Needs Assessors create plans utilising the interRAI tool that focus on function and quality of life, to create comprehensive plans that encompass client preferences. However, once these plans get to the agencies they appear to downgrade the person-centred elements and become task orientated, especially within home-based care. Reasons for this could lie within the market-driven lens that puts pressure on agencies to perform within budgetary constraints. Rising costs with growingly complex needs of older people and the implementation of bulk funding has impacted on the delivery of person-centred care services to clients.

The impact of pressure on agencies and management to deliver services has filtered down to influencing how support workers can perform their role. Time is limited for care workers to complete person-centred tasks: to do what they perceive as a good job which benefits the client and satisfies the support worker. As this role compensates for family who may not be available to support the older person, providing person-centred care is important. Relationships are an integral reason for support workers joining and staying in the occupation, and they value being useful and collaborating with the client to complete tasks that are meaningful to the client. However, there are complexities around health and safety, and how best to utilise support workers' time, skills, and knowledge.

Training and experience enhance the knowledge and skills to deliver person-centred care. Research has shown that support workers show emotional intelligence, picking up the cues around a client's mental and physical well-being. Support workers have shown they can complete low-key nursing tasks and be involved in care planning, which creates more space for time-poor nurses. How best to utilise a support worker in a fiscally tight environment, and be consistent with expectations of their role, requires further exploration. Research has shown that managers have mixed expectations of the level 4 support worker's role, with variability of the competency at this level. With the onset of pay equity alongside a career pathway, the question of developing a scope of practice to ensure consistency was discussed. The

difficulty with regulation and a scope of practice is the variability of the titles of the role, and the role expectations in different settings. However, support workers who work in ACRF and in the community could all benefit from a professional framework and a code of conduct.

A professional body can create a foundation that find ways to promote, represent, and reinforce support workers. However, there are financial costs associated with creating a regulated workforce, as well as complexities around creating a scope of practice owing to the myriad of roles for support workers in the disability sector. This project has shown support workers value good communication and feedback, but are feeling disempowered and isolated as a group. The benefits of a professional body could allow support workers to have a platform to express their needs and reduce isolation by finding mechanisms for communicating and being a part of a whole. A scope of practice specifically for those working in aged care would minimise role expectation discrepancy and establish clear boundaries for support workers. Additionally, it would provide clarity for enrolled and registered nurses, and managers. What is clear from this project and the latest survey, is that recruitment of support workers is still an issue. Support workers have benefited financially from the pay equity settlement; however, work still needs to be done in finding ways to encourage valuing this group in order to encourage retainment and enrolment. Person-centred care is encouraged by government and policy, but managers and agencies are struggling to enable the delivery of this type of care which is affecting the support workers' role. Support workers are feeling isolated, and methods of communication need to improve to enable them to feel valued for the work they do. This project has highlighted what contributes to support workers feeling valued and relates to the key qualities that enable person-centred care. Feeling valued comes from the relationship with the client, delivering person-centred care, and being included in decision-making. Effective communication includes feeling heard and actioned by the agency and managers, regular feedback, and being part of a team.

As the population ages, the need for support workers will increase and, therefore, it is vital we strive to respect and nurture the capabilities of this workforce. However, finding the best funding models and most effective communication channels that create an environment for support workers to perform person-centred care is complex. Further investigation is needed to understand how agencies and their support workers can work together to create a positive working environment that benefits those they care for.

6 <u>References</u>

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7 <u>Appendices</u>

7.2 **Appendix B: PowerPoint presentation slides for the Valuing Support Workers discussion**

Survey the best and the worst of being a support worker

- **Best**
- Appreciative bosses and clients.
- A good relationship with all staff.
- Having a good team to support you

- **Worst**
- Friction between carer's and management. Very poor pay. Lack of respect. Being told what to do rather than consulted.
- Being treated like children.
- Poor communication between carer nurses - coordinator and management. Too many chiefs
- Communication with employer

Current research project- Valuing Support Workers- Emerging ideas

- **Importance of communication in feeling valued**
- **Importance of managers understanding the skills and capabilities of support workers**
- **Importance of training and having a career pathway**

Communication

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Two types of support workers

Task orientated

○ **Do what is on the task list only**

People orientated

- Do the extras
- Get frustrated by a lack of time
- Evaluate the clients health and family dynamics. Use evaluation skills

Training and career pathway

○ Training is valued by support workers

○ Having a career pathway such as role within the agency can support feeling valued

What to do with this information?

- Communication- rethink how this is done. Grow connections. Respect that human touch is important for health. Feedback is vital.
- Respect the knowledge and capabilities of evaluation and risk assessment.
- Linked to career opportunities, create pathways job roles.

Current Themes

1)Relationships- sub theme- Communication-

- Team members
- Agency/Management
- Community
- Clients
- Family - Issues with communication create - Isolation- management/team members/clients family

2) Expectations- from agency, expectations from client, expectations from team
members about each others roles
Skills
Training/orientation "doing extra"
Stop gap
Knowledge- training
Reading people, keeping people well counsellor

What now

- Working on teasing out data related to Support worker and relationship with Client
- Write a few pages re this sub theme pulling in quotes from interviews.

The good bad and ugly

- Stop start to Masters pros and cons
- Qualitative descriptive- not changing the world
- Expectations from others
- Getting on with it.

7.3 Appendix C: Master's group review of transcript

Role worker model   Post grad review of transcript.

concepts	narrative
Narrative – Interview with a Support Worker regarding feeling valued.	
What the person enjoys about being a support worker	X describes a typical day in being a SW and discusses the set tasks that are required such as housework and personal cares. X states that "it is just magic being a SW". They continue to add later that they may be having a bad day but when they get to a client's home they immerse themselves in someone else's needs and that stops thinking about their own problems. Being there for people and being needed "I go home for the night and they are all snug and warm and beds ready, and we have wee jokes with them... I have had these clients for ten years".
X is asked about the skills required to be a SW	X discusses that empathy is required and explains an example of dealing with a lady who is quite negative in her attitudes and that X describes feeling frustrated by this person's attitude. X states she tries not to judge this person and that works though that her value systems can differ from others. X talks about the difficulties in dealing with people that want to die "...you have to control yourself and not get too upset because if you get upset your no longer any help to them and that's what your there for". Death is discussed later and X states that she has not lost anybody and that she has no understanding of what it would be like to lose someone you are close too. Patience is discussed as a skill and knowing the impact of the persons diagnosis is important an example of a client with Parkinson's who is very slow at everything they do and it requires patience to work with them. Physical skills are discussed such as being able to handle a person and knowing strategies to physically support someone who may have had a stroke. Good communication is a skill also.
Connection with family	X discusses that she is helping the families of clients also "perhaps they are able to worry a bit less because they know some is going to be there at night. Some of them have family that are quite faraway"
	who is the client
Who values you	X discusses that her co-workers value her but that with the changes to who delivers the service she is isolated away from her co-workers as they now do not meet face to face. This is discussed as having an impact on clients to as she can no longer pop into the office to talk with the coordinator if she is worried about a client. Communication between coordinators and staff has changed as you now ring an 0800 number and you get someone who does not know the client. X stated she no longer feels part of a team.
Stigma	X discusses that society does not value the older person so that is why SW are not valued " still a real stigma with older people... they say they are resistant to change....stubborn....society has created this picture of what people are like and valuing them and created a stereotype" Support workers and clients according to X are lower on the pecking order and do not have a voice to make decisions and X felt it would be good if clients had a voice and some power over their decisions
	disempowerment loss of voice bottom up approach just as impacting heavily evidence
What makes you feel valued	X talks about being listened to by management and family and acting on feedback helps to feel valued. Being spoken to fairly and being made to feel comfortable offering an opinion. Regarding family X stated, "we do have the client's best interests at heart, and that family respect that in some ways you might have more knowledge than what they do if they are busy with their lives at the time"

Handwritten margin notes:

Intrinsic value
emotional labour

Skills? required   connection respect

relieve stress

change of systems loss of team

importance of communication

value the worker

motivation

relationship impact greater than just client

Unsupport isolated environment part of team

impacted by external factors / forces
mutual relationship client / SW
Difference in values → trying to reason through this

importance of being valued

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Outside of the role	X talks about lots of jobs she has done outside of the list of duties to perform which includes spending extra time talking to clients, picking up mail, collecting fish and chips every Saturday night in her own time and taking to clients, collecting prescriptions in her own time performing tasks around the house not on the list, performing jobs like taking off and redressing bandages because the District nurse is not available to come around. "Money handling. I do an awful a lot more of that now then I used to although we are not meant to. Um cos on Saturday nights I like to do a blue cod and chip for some people. .... Friday night I take orders. I'm not meant to do but they love it (laughs) they like getting their fish and chips delivered.
extra mile in my own time (handwritten)	
Notes	
✓ *employment vocation mission* (handwritten)	

everyday living important (handwritten)

work beyond what you get paid for (handwritten)

risks (handwritten, boxed)

7.4   Appendix D: Supervision session notes

Michelle: Supervision

Date	Tasks and comments	Action
27/7/15	Discussion about the topic of the literature review; and the time line Next meeting: **Tues 4th Aug 10am** To review a presentation that is pending Then meet on **Tues 11th** I think!	Michelle to: • Decide on focus for the literature review • Draw up a time line • Analyse one interview - send same interview (not analysed) to LR along with a 2nd interview
11/8/15	Presentation done and was helpful to get feedback. Reality of timeframes - plan until end of September, then check again. Initial discussion on the themes in the 2 selected interviews. **Timeline** until end of Sept: • 18 Aug - data checking with LR using 2 interviews • 31 Aug. one page of method written • 31 Sept: analysis of all interviews; method section developed; reflective diary used to capture past experiences	Linda and Michelle to complete analysis of 2 interviews. This was completed.
2/12/15	There has been a serious delay in getting underway with this timetable.	The plan is to complete the following before Jan 18th 2016: → The analysis of 6 interviews - ready for discussion → To write the method chapter
22/2/16	Michelle is finalising teaching timetable and will then know when she has time to set aside for studying. Plan above not yet completed.	

Michelle: Supervision

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22/2/16	Michelle is finalising teaching timetable and will then know when she has time to set aside for studying. Plan above not yet completed.	

Masters Timeline (Meeting 2/7/2018 with Linda Robertson)

1) Findings Chapter	Data analysis to be completed by August 17th 2018
2) Method- Qualitative Descriptive	Writing up justifying method, what happened from my point of view, pull through literature why this method was useful to topic, how many people interviewed, include ethics by 7th September 2018.
3) Literature Review Chapter	What topics relate to my thesis by October 12th 2018.
4) Discussion Chapter	Implications. Keep a list from data analysis (Pay rise literature, "who is valued" if older people not valued then those that work for them may not be also). Potential trends discussed here such as pay rise contributing to higher costs for services and less staff, recommending more literature. By November the 9th
5) Introduction and Abstract	By 30th November

Discussed Linda being away on the following dates: 5th -20th September (contactable via email) away October 22nd- 29th.

Michelle to create fortnightly meetings via electronic diary.

7.5   Appendix E: Valuing Support Workers: Consent form for participants

VALUING SUPPORT WORKERS: CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information (such as contact details, audio-recordings) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;

4. That this project involves an open-questioning technique. This means that the general line of questioning includes asking what I think about my health and how I think my health could be improved, how I think my work as support worker/care worker could be valued, and what I think are the key attributes and skills I need to do my work. I know that the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

6. A reimbursement of a $25 grocery voucher to cover my travel costs will be offered.

7. I, as the participant: (tick one)

    ☐ I agree to participate in <u>both</u> the health checks and the interview

    ☐ I agree to participate in <u>just the health checks only</u>

    ☐ I agree to participate in <u>just the interview only</u>

I agree to take part in this project.

....
(Name of participant)   (Signature of participant)   (Date)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

7.6   Appendix F: The University of Otago Human Ethics Committee response 13/281

Mr Gary Witte
Manager, Academic Committees
17 January 2014

Dear Gary

RE: 13/281: Valuing support workers in the aged care sector

Thank your for your letter dated 16 December 2013 granting us conditional approval for the above study. The Ethics Committee had some concerns / comments about our study which we address in turn below:

- *The Committee would be grateful if you could explain the link between the physical health testing and the qualitative survey which is examining being "valued". How does the health test link to the qualitative assessment of how participants are valued?*

We agree that we have not made the link explicit in the application. We consider that assessing support workers' physical health is another way of "valuing" them - we value them enough to want find out about their physical health. We have added the following to the "brief description" of the application on page 2: "To extend the theme of valuing workers' health, the project will also include physical health checks for support workers in the aged care sector. "

Regarding the health testing, please provide assurance that trained support will be available during the Six Minute Walk Test.

Thank you for highlighting this issue. On reflection, we have decided to hold the health checks at the School of Physiotherapy under the auspices of the School of Physiotherapy's established health and safety protocols, and at times when A/P Hale or School of Physiotherapy registered physiotherapists are available to supervise. We have amended the application (page 5), the information sheet (page 10) and the advertisement (page 13) accordingly.

- *The Committee would be grateful if you could outline your procedures should any health problems be discovered during the testing. Will participants be provided with their results and advised to consult their GP?*

Thank you, this is good advice and we have included this statement in our application (page 8) and in the participant information sheet (page 10).

- *The Committee was of the view that there is an assumption underpinning the qualitative survey that workers do not currently feel valued, or are undervalued. This is apparent in the*

Information Sheet (page 9) and the advertisement (page 13). Please take care to use neutral phrasing or questions to explore how the workers feel.

Thank you for pointing this out – we have changed the wording in the information sheet (pages 9 & 10) to "how and what makes these workers feel valued", "what can be done to value support workers for the important work they do" and "how you think your work as support worker/care worker should be valued."

- **The Committee would be grateful if you could confirm that you intend to reimburse participants with $25 even if they only take part in one part of the research. From the wording in the Information Sheet, every participant will expect to receive a $25 grocery voucher.**

Yes, this is our intent – that all participants will receive this grocery voucher whether participating in one or two parts of the research.

- **Please amend item 4 of the Consent Form to ensure this is written in the first person (e.g. I, me, my etc).**

Item 4 has been amended accordingly – please see page 12.

Please see attached our amended application, which includes the amended information sheet, consent form and advertisement; the amendments are highlighted in yellow.

In our original application we indicated that we had already undertaken Māori consultation but were still awaiting feedback. We have since received this feedback and it is attached for your information. We note that the Ngāi Tahu Research Consultation Committee ask if we have considered what strategies was could use to improve "recruitment, development and training of a Māori health force in the aged care sector". We consider this to be outside the remit of this project or our job descriptions but will use the data obtained from this study to help inform such strategies. The Committee also recommended that we use the ethnicity question from the latest census, which were already (see page 14).

We hope we have satisfactorily addressed each point.

Kind regards

A/P Leigh Hale

Deputy Dean, School of Physiotherapy

7.7 Appendix G: Valuing Support Workers: Information sheet for participants

OTAGO

VALUING SUPPORT WORKERS: INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

Support workers are a vital part of the wellbeing of people as they age. Valuing and maintaining the health and wellness of this important group of workers is crucial. In this study we wish to find out about the health of support workers in institutionalised and home-based aged care, how and what makes these workers feel valued, and what the key attributes and skills of support workers are. We hope that this information will inform strategies to value and maintain the health and wellness of support workers.

Please note that we are using the term "support worker" to mean both support workers and care workers who are in paid employment as opposed to caregivers, who are not paid for the work they do.

What Type of Participants are being sought?

We wish to invite 60 support workers or care workers, who work in either community-based (30 people) or institutional-based (30 people) aged care, to participate in our study.

We have asked the organisation you work for to send this study information sheet to you. If you would like to take part in our study please contact us directly. The contact details are at the end of this information sheet. We will not tell anyone, especially not your organisation, that you have participated in our study.

There is no payment for taking part in this study but we will reimburse your travel costs with a $25 grocery voucher. We hope that the findings of this study will inform future studies investigating how the health and wellness of support workers can be optimised and maintained as well as what can be done to value support workers for the important work they do.

What will Participants be Asked to Do?

Should you agree to take part in this project, we will ask you to:
1. *Participate in a health check*, as follows:
- To complete three questionnaires about yourself, your health, your work, and what physical activity you do.

1

- We will measure your grip strength, resting heart rate and blood pressure, weight, height and waist circumference.
- We will then ask you to do:

    a. The Six Minute Walk Test. In this test we measure how far you can walk in 6 minutes along a flat surface. You are allowed to rest if necessary. Please be aware that this test carries a very small risk of causing abnormal heart responses in some people. We will ensure that the recommended safety standards are met when conducting this test.

    b. The Sit to Stand Test. This test measures how many times you can stand up fully and sit down in 30 seconds.

The health check will occur at the School of Physiotherapy. The testing will take about 30 minutes and will be conducted by two physiotherapy students from Umea University (Sweden) under the supervision of Assoc Prof Leigh Hale.

2. *We will then ask if you would like to take part in an interview. We will not interview everyone, only the first 20 people entering the study who consent to be interviewed.*

In this interview we will discuss with you what you think about your health and how you think your health could be improved, how you think your work as support worker/care worker should be valued, and what you think are the key attributes and skills you need to do your work. The interview will take about 30-60 minutes. We can hold the interview at a place that best suits you and can be held on a different day to the above health check testing. The interview will be audio-recorded and then later typed out word for word. We might need to phone you after the interview to check some information with you. The interviews will be conducted by two honours degree students from the University of Otago and the Otago Polytechnic.

As this interview involves an open-questioning technique, the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the discussion develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

Please note that you may decide to participate in both the health checks and the interviews or in one or the other. Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

What Data or Information will be Collected and What Use will be Made of it?

We will ensure that your data will be anonymous and only your study number will be on the questionnaires you complete. Data will be analysed to gain a picture of how healthy you are and how you perceive your health, value and skills. Should any health problems be discovered during the testing, we will provided you their results and advise you to consult with your GP.

Only the researchers and the students working on this project may access your data. The data collected will be securely stored in such a way that only those mentioned will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on the participants (such as contact details, audio recordings and their transcriptions) may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published in scientific journals or presented at scientific meetings, and we may present the results to community groups, such as Age Concern or the Caregiver's Society. The results of the project will also be available in the University of Otago Library (Dunedin, New Zealand). In all publications and presentations every attempt will be made to preserve your anonymity.

You are most welcome to request a copy of the results of the project should you wish. We will also let you know the results of your individual health tests.

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

Who do I contact if I wish to take part in this study?

Dr Marina Moss
University Tel: (03) 479 4979
Email: marina.moss@otago.ac.nz

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Assoc Prof Leigh Hale	**Dr Bronwyn Boon**
School of Physiotherapy University Tel: (03) 479 5425 Email: leigh.hale@otago.ac.nz	Department of Management University Tel: (03) 479 8054 Email: bronwyn.boon@otago.ac.nz
Ms Sian Griffiths	
Occupational Therapy Otago Polytechnic Tel: (03) 477 3014 Email: Sian.Griffiths@op.ac.nz	

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

7.8 Appendix H: Ngāi Tahu Research Consultation Committee response

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KĀI TAHU

Tuesday, 17 December 2013.

Associate Professor Leigh Hale,
School of Physiotherapy,
DUNEDIN.

Tēnā Koe Associate Professor Leigh Hale,

Valuing support workers in the aged care sector

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 17 December 2013 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states "Ngāi Tahu acknowledges that the consultation process outline in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of importance to Māori health.

The Committee notes and commends that ethnicity data is to be collected as part of the research project and recommends the use of the questions on self-identified ethnicity and descent, these questions are contained in the latest census.

The Committee notes the researchers have identified that the the recruitment, development and training of a Māori workforce in this area is important and asks if the researchers had considered any strategies to accomplish this.

The Committee suggests dissemination of the research findings to relevant Māori health organisations regarding this study, including Taeora Tinana, Māori Physiotherapists within the New Zealand Society of Physiotherapists.

We wish you every success in your research and The Committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 17 December 2013 to 6 June 2015.
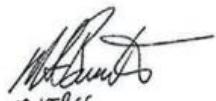
The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūnanga o Ōtākou Incorporated
Kāti Huirapa Rūnaka ki Puketeraki
Te Rūnanga o Moeraki

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KĀI TAHU

Nāhaku noa, nā

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Kaiwhakahaere Rangahau Māori
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7.9 Appendix I: The University of Otago Human Ethics Committee Final Approval Letter 13/281

Assoc. Prof. L Hale
School of Physiotherapy

20 January 2014

Dear Assoc. Prof. Hale,

I am again writing to you concerning your proposal entitled "**Valuing support workers in the aged care sector**", Ethics Committee reference number **13/281**.

Thank you for your letter of response dated 20 January 2014, and for providing your amended documentation and the letter from Ngai Tahu Research Consultation Committee.

Thank you for making the link between the health check and the theme of valuing support workers, and for incorporating this into your Information Sheet. You will now hold the health checks at the School of Physiotherapy under the supervision of either yourself or a registered Physiotherapist, to ensure the health and safety of participants. Should any problems be uncovered, you will provide results to participants and advise them to consult their GP. Thank you for amending your documentation to use more neutral language to explore the topics, and to ensure the Consent Form is written in the first person. You have also confirmed your intention to provide all participants with a grocery voucher.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor G D Baxter Dean   School of Physiotherapy