

**Hear me, see me, trust you – job burnout and disengagement of
Australian aged care workers**

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Hear me, See me, Trust you – Job Burnout and Disengagement of Australian Aged Care Employees

Introduction

This paper reports on some specific findings of a mixed-methods study that examined the effects of leadership style on organisational identification and job satisfaction of aged care employees. The qualitative findings provide evidence of organisational disengagement and job burnout in our aged care workers when thematically transcripts of semi-structured interviews exploring job satisfaction were analysed using interpretative phenomenological analysis (IPA) (Smith et al., 1999). IPA is an approach which aims to provide detailed examinations of personal lived experience with an idiographic focus (Charlick et al., 2016). This focus means that instead of producing generalization findings, it aims to offer insights into how a given person, in a given context, makes sense of a given situation.

Three themes emerged from the portion of the semi-structured interviews that enquired into participants' lived experiences relating to job satisfaction. The three streams of consciousness are a written equivalent of the participants' thought processes, reflecting their interior monologue connected to the individuals' actions and experiences (Sharron, 1985). The researcher refers to the streams of consciousness as themes. These themes emerged when data saturation became evident (Fusch & Ness, 2015). The researcher labelled these, The Context of Aged Care, Employee Engagement and Voice and Leader Behaviour were the three themes relevant to this report. Employees' engagement is a significant factor in workforce productivity (Maximo et al., 2019) and can cause job burnout and turnover intentions in the work team (Al Sabei et al., 2020). Job Burnout and Disengagement were two of the qualitative findings.

Background and Literature Review

Employee engagement and job burnout are common areas of concern for organisations and more attention and skills training for leaders is required to increase productivity and decrease turnover intentions. In Australia, it is estimated that actively disengaged employees cost the Australian economy more than \$2 billion a year (Gallup, 2021) however there is no credible evidence of the cost of a disengaged workforce specifically related to aged care in Australia. Organisations with high employee engagement experience several benefits, such as lower workforce turnover (Santhanam & Srinivas, 2019), less absenteeism (King et al., 2020), and

fewer workplace safety accidents (Haga et al., 2021). An early definition of employee engagement recognised full physical, cognitive, and emotional connection with work roles (Kahn, 1990). A more recent definition by Schaufeli (2002, p. 74) cited in Albrecht's Handbook of Employee Engagement (Albrecht, 2011) defined engagement: as "*a positive and fulfilling work-related state of mind characterised by vigour, dedication, and absorption*".

Job burnout is a state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress resulting from individual and work/life factors (Genly, 2016). It is described as a gradual process that is difficult to characterise as the signs of burnout are different for each person (Genly, 2016). As a work-related syndrome, job burnout results from prolonged exposure to emotional and interpersonal stressors (Demerouti et al., 2001; Maslach et al., 2001). Job burnout is the loss of meaning in one's work, often accompanied by mental, emotional, or physical exhaustion resulting from unresolved stress at work (Alarcon et al., 2009). It manifests itself as demotivation and detachment from work, depletion of energy levels, and even detachment in personal relationships. It is associated with individual adverse outcomes, including anxiety, depression, and other mood disorders (Hillhouse et al., 2000) and may include a general dissatisfaction with life (Alarcon et al., 2009; Hakanen & Schaufeli, 2012). From an organisational perspective, other studies have associated job burnout with increased levels of absenteeism (Schaufeli et al., 2009), diminished job performance (Bakker & Heuven, 2006), and staff turnover or intention to leave (Seibert & Kraimer, 2001).

One impact of job burnout can be lower levels of productivity (Van Steenbergen et al., 2018), a pessimistic outlook on work and life generally (Alessandri et al., 2018), and increased absenteeism associated with physical, mental, and emotional exhaustion (Genly, 2016). It is incumbent on leaders to champion a work environment that prevents burnout from occurring. Prevention involves recognising the signs of burnout in staff, with workers identified as at-risk or experiencing burnout and supporting staff through change and other stressors so that burnout may be recognised early or avoided altogether.

Job burnout is prevalent, and employee health negatively impacts performance when burnout is present in the work environment (Brown & Quick, 2013). A theoretical model proposed by Brown and Quick in 2013 supports the importance of the work environment in studying burnout, and these researchers argue that the organisation and individual employees should not ignore the employing organisation's macro-environment within which the affected individual operates (Brown & Quick, 2013).

Employee disengagement is the simultaneous withdrawal and defence of a person's preferred self in behaviours that promote a lack of connection, including physical, cognitive, and emotional absence with passive incomplete role performance (Kahn, 1990). Disengaged employees lack enthusiasm and do not expend extra effort in the workplace, are unsupportive of working in teams and can consequently negatively influence morale and, therefore, organisational performance (Kahn, 1990, p. 693).

Some studies have linked disengagement at work with job burnout (Bakker & de Vries, 2020; Basinska & Gruszczynska, 2019; Harris, 2016). Cole and colleagues undertook a meta-analysis in 2011 and found that from the 37 studies reported, there was a high degree of correlation between job disengagement and job burnout (Cole et al., 2011). Another study in 2018 found that only one in five employees exhibited high engagement levels at work, and assessed job burnout from disengagement as high (Seppala & Moeller, 2018). The costs of job burnout are high in terms of attrition and turnover of staff, placing staff engagement as a critical strategy and recognised as a key skill of leaders (Seppala & Moeller, 2018).

Ethical Approval

This research received ethical approval from the Griffith University Human Research Ethics Committee (HREC ID; MED/2017/030).

Method

An online questionnaire provided the data input for Study 1 – Quantitative. The differences in responses to three evidence-based and prior-validated tools, all using a five-point Likert scale, were recorded in a database. The results and findings reported here relate to the differences observed in the responses to questions in the MLQ5X[Short] (Bass & Avolio, 1998) measured at the factor level. The differences between leaders who self-rated and those who rated them in a 360⁰-feedback process provided the agenda for semi-structured interviews in study two, which was qualitative.

Recruitment of participants for study two came from those who had previously completed the online questionnaire in the quantitative study and was phenomenological in approach. Phenomenology focuses on studying the participants' lived experiences within their world (Creswell & Plano Clark, 2007) and is concerned with identifying, disclosing, and exploring the meaning of an individual's experience (Paley, 2014). IPA provided the method for thematically analysing the lived experiences reported by participants (Smith et al., 1999).

IPA is particularly useful for examining complex, ambiguous, and emotionally laden topics (Smith & Osborn, 2015). Thus, IPA offered a framework for the researcher to explore lived experiences to understand their personal experiences better and comprehend how they have derived meaning from them. The method provided the opportunity to explore how the participants made sense of their lived experiences in detail (Smith et al., 2009; Smith & Osborn, 2008) and focussed on the exploration of participants’ experiences, understanding, perceptions, and views (Reid et al., 2005) in an iterative and inductive cycle (Smith & Osborn, 2008).

Results and Findings

Study 1- Quantitative

The results of study 1 (n=187) demonstrated that the sample achieved was generally representative when compared to The Aged Care Workforce Study, 2016 (Mavromaras et al., 2017) in terms of characteristics of participants such as disclosed gender identity, age groups, job types, highest educational qualifications and experience working in aged care. Part of the statistical analysis of an online questionnaire determined any group differences between the leaders’ (the Leaders’ Group n =5 4) and those who rated them (the Raters’ Group n = 133).

Relevant Quantitative Findings

The following table shows the ascribed leadership styles associated with each factor of the MLQ5X[Short] (Avolio et al., 1999).

Table 1 Ascribed Leadership Style for Each Factor Contained in the MLQ5X[Short]

Factor Name	Code	Ascribed Leadership Style
Builds Trust	IIA	Transformational
Acts with Integrity	IIB	Transformational
Encourages Others	IM	Transformational
Encourages Innovative Thinking	IS	Transformational
Coaches and Develops People	IC	Transactional
Rewards Achievement	CR	Transactional
Monitors Deviations and Mistakes	MBEA	Transactional
Fights Fires	MBEP	Transactional
Avoids Involvement	LF	Laissez-faire

MLQ5X[Short] Mann-Whitney U Test Results

A Mann Whitney U test was used to compare outcomes between the two independent groups of Leaders and Raters. There were six MLQ5X[Short] factors that demonstrated significant leader-rater differences: IIA - Builds trust ($U = 3,192, p = 0.047$); IIB - Acts with integrity ($U = 3,024, p = 0.033$); IM - Encourages innovating thinking ($U = 3,004, p = 0.038$); CR - Rewards achievement ($U = 2,953, p = 0.048$); MBEA – Management by Exception – Active (Monitors deviations and mistakes) ($U = 3,392, p = 0.043$); MBEP – Management by Exception – Passive (Fights Fires) ($U = 3,403, p = 0.022$). These differences between the leaders’ and raters’ groups found in the quantitative data informed the agenda developed for the semi-structured interviews conducted in the qualitative study by constructing questions related to leaders for the leaders’ interviewees and raters for the raters’ interviews.

Study 2 – Qualitative Analysis Using Interpretive Phenomenological Analysis

The cluster map that emerged from the Interpretive Phenomenological Analysis (IPA) is shown in Figure 1., and the red circle in the figure highlights these themes. Participants demonstrated high levels of job burnout and organisational disengagement related to their perception of not being heard in the workplace and their leader’s behaviour causing issues with trust.

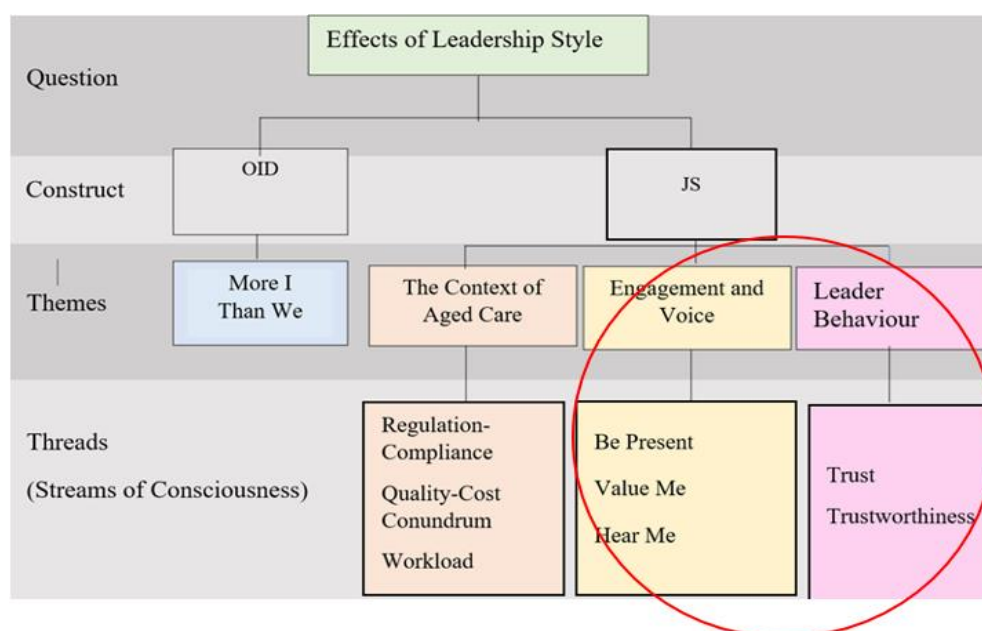


Figure 1- Thematic Analysis Cluster Map

Relevant Qualitative Findings

Regulatory System and Compliance Processes

Some leaders signalled they were experiencing job stress related to a lack of resources and the imperative to maintain regulatory compliance, including accreditation standards compliance in an environment of funding austerity and that these factors impacted negatively on innovation.

Being innovative or in any way different creates a situation in which the care service will be very visible to regulators because of the difference in the way services are provided. This leads to further review and possible compliance action, so we mostly wait for another aged care provider to innovate or change care practices before implementing the changes (L5).

We can innovate around the edges of the regulatory form and regulatory funding, so the innovation that we take pride in mostly operates outside of government funding. (L1).

Raters related various work practices and regulatory requirements and were particularly concerned with medication management practices and unregulated workers. Experiences of raters suggested that job stress led to burnout because they considered they had untenable workloads and insufficient training and development opportunities to meet their jobs' requirements. Many raters provided accounts of being placed in vulnerable and anxiety-evoking situations relating to medication administration and management.

We had a client palliating, and from my understanding as a personal care worker, [the client] was prescribed an S8 medication [dangerous drug of addiction], and I wasn't trained in it. I knew I wasn't to give it. But then, after management had their conversation, it came in that we could give S8 drugs.... I refused because; (1) I didn't know what was drawn up by someone else and what was put in there, and (2) they were S8 drugs. This caused me significant grief with my managers (R1).

After office hours, I am here on my own as an enrolled nurse. I feel very overwhelmed. There's a lot.... so, I'm basically doing what an RN would do. (R4).

The Quality-Cost Conundrum

The issues of concern differed between leaders and raters. It was apparent that the issues, although ascribed different levels of importance by the groups, were interrelated. Concern was expressed about the constant and unrelenting requirement for productivity, cost containment, and

cost reduction because the funding system is outdated and misaligned with the Federal Government's stated care outcomes.

These phenomena had a flow-on effect on the raters, who reported unreasonable workloads and work-related time pressures confounding efforts to deliver the consumer's expectations of care. These appeared to have had a deleterious effect on personal and workplace morale and the mental health of workers. Some participants expressed concern that these productivity and cost reduction measures may further reduce the quality of services offered.

Leaders described the system of aged care funding as outdated and misaligned with the Federal Government's stated desired outcomes for care. L1's experience directly pointed to the cost-quality conundrum being real and felt acutely within the sector, as indicated in many participant comments.

I think aged care is a particularly tough environment to work in, and we've often had discussions about whether or not there's a trade-off between quality and care and financial results" (L1).

The system [for] aged care funding in this country is anachronistic and based on a medical model of health rather than a social model of care. This means that much of what is required in consumer-centric environment is not provided in the aged care funding system. (L6)

The only funded package available was a Level 2 package, which attracts an annual subsidy of \$15,250. ... We had to decide to provide less care or provide the needed care for \$35,500 less than the funding entitlement (L4).

Workloads and Scope of Practice

From the raters' group, it became apparent that they experienced workloads they believed were not conducive to providing safe and high-quality care. The experiences raters recounted situations in which registered or enrolled nurses felt professionally isolated. The raters expressed feeling of being, overwhelmed by the responsibility for the level and volume of care delivered within workforce numbers that aged care workers believed to be meagre. R4, an enrolled nurse, was very concerned with staff numbers and the available skills in a large, aged care facility.

We don't have enough nurses here; there are only two or three nurses in this big community. I feel that I'm on my own, and it's a lot to take on. There is only an on-call RN for advice after hours (R4).

Additionally, raters felt that their workloads were unreasonable with insufficient staff numbers and an under-skilled workforce to meet care recipient needs and satisfy regulatory requirements.

I am often left feeling annoyed that the people that need support aren't getting it because there is no time, or the people that are seen to be leaders are using their role as just power rather than understanding how they can support the carers to support the client (R5).

Training and Development

Raters reported training over and above that which is required by regulation as those offered without cost and included staff being required to undertake the training at their own expense and time.

I went into it without any buddy shifts", an example of this company ignoring its training policies. I felt that it was all new to me. I felt extremely out of my comfort zone (R5).

I really wish I could get more training. I don't feel I get enough. I don't think they offer sufficient educational programs, only free educational programs for staff. (R4).

I was just offered training by my new clinical coordinator for palliative. It's a free course, and my employer is not paying for it. It's something that she's sourced from outside.... I want to follow through with that, but it had to be in my own time rather than paid time. (R4).

In addition to a need for increased clinical skills in the aged care sector through greater access to quality clinical training and development opportunities, the ever-present requirement to maximise revenue and contain costs may constrain funding support for staff development.

We had a lady with bilateral leg wounds that were just getting beyond my ability, so I came down and spoke to the manager...I decided I was going to ring another aged care provider, meaning we would have to split the fee provided. The GP was happy for me to ring ...they came in; they took over the wound care. I got reprimanded by my in-charge then because we should have kept it in-house. Who cares? Not me. I'd do it again (R3).

Engagement and Voice

All leaders believed that they conveyed their availability and presence to staff. However, none offered specific examples of this in practice or demonstrated ways to confirm that staff agreed that they were present.

We are a large organisation with a big footprint over a number of states, and even countries, so we have a lot of informal communication that the smaller key executives always have weekly huddles, just talking about issues. (L1).

As a manager, I've always seen my role as being able to support my people. That means that I need to make decisions and be clear about those decisions and set a vision for people. I think that all contributes to that trust relationship... Leaders must make decisions. It's how everyone gets a sense of [the] future and has confidence [that] I know what I am doing in the workplace (L4)

I think it's the being present stuff. So, you know if something happens, actually dropping everything and going. (L6).

Although leaders stated that they understood the importance of presence, which they believed demonstrated integrity and contributed to building connection and trust, they struggled to provide tangible examples of experiences that demonstrated these leadership qualities in practice. Despite the efforts of leaders to maintain a presence with their teams, raters described experiences where their leaders were not present from their perspective when they perceived they needed them. This perceived lack of presence undermined the trust so essential in the leader-follower relationship.

...they [the leaders] need to go to the villages more. I'm sure they're busy. I don't know what they do [laughs] sorry, but it would be nice to see them now and again, but then they go, "You can just email us" (R3).

[the leader] is in the office pretty much when you need him. He is easy to access. But he is not always available to assist you, but he says he is always there to talk you through any concerns you have (R5).

[Referring to the leader] She doesn't listen to the whole conversation in the meeting. She's a bit blasé sort of thing. These are people's lives (R3).

Leader Behaviour

Leader behaviour emerged as a significant issue that presented challenges to the perceived trustworthiness of leaders and some leader behaviours damaged trust in them by the follower group. Most raters identified leader credibility as an important characteristic, with some linking the possession of clinical qualifications to leader credibility.

[My previous leader] had no clinical background; [it's] very difficult to trust someone giving you information from a clinical point of view that is

not a clinician. But I'm hoping that this person will be fine. She's clinical; she's an RN. (R3).

Some leaders fulfil their promises, say they will do something, and see it through. I've seen some other leaders in my company say they will do something and not follow through. I feel annoyed that the people who need support aren't getting the support they need. Every time there's a situation, they think about themselves and not about anyone else, client or staff member. (R5).

Raters expected that their leaders would support them through prioritising safe and lawful care, even if this may have been inconvenient for the organisation. Raters related experiences where they perceived organisational policies that compromised safety had put them at risk of the scope of practice or other regulatory breaches.

I definitely feel that I'm on my own, and it's a lot to take on. Because when there's no RN on-site, there is an RN available on the phone, on-call RN for advice. ... I'm supposed to be on the floor doing things, and the on-call RN is supposed to take that call, give advice, and the person who's there is meant to follow through (R4)

Raters were asked whether they felt trusted by their leaders and had enough support and autonomy to daily work daily. Their responses highlighted a range of experiences that demonstrated how trust in their leaders could be built or undermined.

My managers identify who made the mistake and then, in my world, punish them. Yeah, I'm left on my own.... If I've made mistakes, they'll let me know straight away. (R1).

Discussion

Leaders described the problematic interface between regulatory controls and quality assessment at the corporate level impacting their licenses to provide aged care and the provision of care itself. Raters described role stress relating to the scope of practice concerns. They felt the organisation expected them to perform at a level where they believed they had not received adequate training or lacked statutory authority to undertake the expected functions. This situation is particularly related to medication management or direct supervision of unregulated workers.

Raters expressed a common concern about being placed in vulnerable and anxiety-evoking situations relating to medication administration. Raters who were licensed health professionals, predominantly nurses and unregulated care workers, raised concerns about the scope of practice

under the national law regulating health professionals. They described the dilemma for licensed nurses and unregulated care workers concerning nurses' retention and quality failures in aged care. The literature appears supportive of their concerns. (Baldwin et al., 2015; Chenoweth et al., 2010)

The participants raised serious concerns about the rigours of regulation and compliance within Australia's aged care sector. The lived experiences described system issues related to the copious amounts of legislation increasing work complexity and implementing compliance auditing for the leaders. There was a perception that the amount and types of regulation and compliance auditing confounded innovation and engendered a risk avoidance approach, causing only a task focus rather than an outcome focus. There were also numerous examples of poor relationships and mistrust in those charged with industry regulatory responsibility. Additionally, there were calls from licensed health professionals and unregulated care workers for a scope of practice for unregulated care workers is necessary.

Being present was a common thread in the leader's and raters' groups to question how they fostered trust in their follower group. All responded with strategies that described being physically present and available to staff members who reported them. The qualitative analysis showed that the raters did not perceive that many of their leaders were emotionally present even when physically present. This is in stark contrast with those in the Leaders' group who considered themselves "present" and "in the moment" with their followers. Raters' responses contradicted this view of their leaders. This led to a perception among the Raters' group that they were not heard and did not have a voice within their employing organisations. When there is a muted employee voice, there are consequences for organisations, including threats to employee psychological safety (Walumbwa & Schaubroeck, 2009), manifestations of disruptive work behaviour (Dixon-Woods et al., 2019), fraud and accounting irregularities (Frisch & Huppenbauer, 2013), and physical safety breaches because employees do not "speak up" when safety is breached (Herachwati et al., 2018; McCall, 2015). Lack of employee voice also causes staff disengagement (He et al., 2017), which places the organisation at risk. Signs of disengagement can include acquiescent, or defensive, or prosocial silence (Dyne et al., 2003), all related to the absence of employee voice.

The leader behaviour theme contained two threads, trust in leaders and trustworthiness of leaders. Trust is a party's willingness to be vulnerable to another party's actions (Schoorman et al., 2007). This illuminated the gap between leaders' intentions to act with integrity and raters' experience concerning their leader's integrity. The researcher has labelled this phenomenon as

the Intention-Experience Disparity. This disparity impacts how organisations lay the foundations for trust or distrust. Many raters' accounts described distress and the vulnerability they experienced due to their leaders' decisions and directions. Monitoring the relationship between the leader and the team member is an important prevention for employee disengagement. Fostering a culture that actively listens, provides feedback to employees, and demonstrates that their input is welcome and is given serious consideration.

To ameliorate the job burnout and disengagement findings of this research, health leaders must address the intention-experience disparity in their leadership practice. They must authentically engage with their followership in a manner that demonstrates their trustworthiness to their followership by having meaningful a meaningful presence in the workplace where their followers' concerns, and ideas are genuinely heard, valued and acted upon because there is a direct link between employee engagement and follower perception that they have a voice in the organisations in which they work.

It was evident in the analysis of transcripts of semi-structured interviews that leaders genuinely attempted to gain the trust of their follower groups, most of the followers interviewed described experiences that cast doubts about the trustworthiness of their leaders. The evidence relating to the successful implementation of employee engagement strategies include fostering self-worth (Shuck et al., 2016), continued efforts relating to team building (Slosberg et al., 2018), employee recognition and reward (Alzyoud, 2018; Osborne & Hammoud, 2017), workload equity management (Bakker & Demerouti, 2017), and the perception of substantial levels of organisational support (Meyers et al., 2018).

Conclusion

Most raters demonstrated a lack of trust in leaders based on:

1. The perception that organisational activity and financial targets were set at the expense of consumers and staff.
2. The undermining of trust in situations where non-clinician managers were involved in clinically oriented decisions.
3. A culture of blame in their employing organisation is evidenced by punitive responses to errors, undermining trust in the leadership.

Consequently, for leaders in aged care, building trust with staff through acting in a trustworthy manner is paramount. Eminent author and academic, Baroness Onora O'Neill, describes the trustworthiness of leaders as reliable, competent and honest (O'Neill, 2002), which

is a critical competency that will directly impact organisational culture and quality of care. Being trustworthy can foster trust in followers by demonstrating authenticity, and integrity, displaying ethical leadership practice and promoting equity in the work area.

Voice in the workplace means that organisational actors can express opinions, ideas, concerns, and perspectives with authenticity and without fear of consequences (Glew et al., 1995; Mowbray et al., 2015; Wilkinson, 2009). Voice in an organisation means that followers can influence decisions at work. Having influence means that leaders provide the opportunities for this while also demonstrating that they act on them. The participants' experiences illuminated a general lack of employee consultation and engagement strategies. This lack of employee voice was most evident among raters, with participants expressing they felt they had a limited ability to impact the prevailing culture in their workplace.

Each participant mentioned trust as an important concept in the leader-follower relationship. There is some overlap between this theme and the engagement and voice theme because raters in this research linked it to leader presence. Raters also tended to link being heard as an important precursor to trust. What was apparent from this research is that the followership is seeking authentic and ethical leaders. Leaders must prioritise genuinely engaging their followers. They must actively listen to contributions and concerns from their teams and act on them or provide honest feedback on why this is not possible. The leader must be perceived as always acting with integrity.

There is a demonstrable need for leadership training and development within the aged care sector. This training will provide the means for leaders to develop themselves, develop ethical leadership practices, foster positive interpersonal behaviours, and importantly, value the development of others in their work teams. It appears to come down to this being **A MATTER OF TRUST!**

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