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THE AGED CARE WORKFORCE, 2016

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Table of Contents

Glossary xiv

Executive Summary xv

1. Introduction 1

2. Finding out About the Aged Care Workforce 4

  2.1 Overview of the 2016 National Aged Care Workforce Census and Survey 4

    2.1.1 The Aged Care Workforce Research 4

    2.1.2 Research Design and Implementation 6

  2.2 Responses and Weighting used in this Report 8

    2.2.1 Residential Census and Residential Worker Survey Response Rates 8

    2.2.2 Home Care and Home Support Census and Home Care and Home Support Worker Survey Response Rates 8

    2.2.3 Weighting for Response used in the Report 9

  2.3 Interviews with Direct Care Workers 9

3. The Residential Aged Care Workforce 10

  3.1 Introduction 11

  3.2 Total Employment and Main Workforce Characteristics 11

    3.2.1 Total Employment 11

    3.2.2 Occupation 12

    3.2.3 Age and Gender 15

    3.2.4 Country of Birth 17

    3.2.5 Aboriginal and Torres Strait Islander Workforce 19

    3.2.6 Health 20

    3.2.7 Education 21

  3.3 The Main Characteristics of the Work 24

    3.3.1 Employment Arrangements and Hours Worked 24

    3.3.2 Wages 27

    3.3.3 Multiple Job Holding 28

  3.4 Career Paths 31

    3.4.1 Into Aged Care 31

    3.4.2 Into their Current Job 33

    3.4.3 Into the Future 36

  3.5 Experiences of Working in Residential Aged Care 37

    3.5.1 Job Satisfaction 37

    3.5.2 Doing the Work 38

    3.5.3 Job Demands 40

  3.6 Work-related Injury and Illness 41

  3.7 Cultural and Linguistic Diversity 44

4. The Census of Residential Facilities 48

  4.1 Introduction 49

  4.2 A Profile of Facilities 49

  4.3 Facilities' Relationships with Broader Aged Care Services 52

4.4 Ethnic Specialisation ... 53
4.5 Skill Shortages ... 54
4.6 Vacancies ... 56
4.7 Setting of Employment Conditions ... 61
4.8 Agency, Brokered and Self-employed Staff ... 61
4.9 Volunteers in Residential Aged Care ... 64
4.10 Quality Measures in Residential Aged Care ... 66
5. The Home Care and Home Support Aged Care Workforce ... 67
5.1 Introduction ... 68
5.2 Total Employment and Main Workforce Characteristics ... 68
5.2.1 Total Employment ... 68
5.2.2 Occupation ... 69
5.2.3 Age and Gender ... 72
5.2.4 Country of Birth ... 75
5.2.5 Aboriginal and Torres Strait Workforce ... 77
5.2.6 Health ... 78
5.2.7 Education ... 79
5.3 The Main Characteristics of the Work ... 83
5.3.1 Employment Arrangements and Hours Worked ... 84
5.3.2 Wages ... 86
5.3.3 Multiple Job Holding ... 87
5.3.4 Training ... 88
5.4 Career Paths ... 90
5.4.1 Into Aged Care ... 90
5.4.2 Into their Current Job ... 92
5.4.3 Into the Future ... 95
5.5 Experiences of Working in Home Care and Home Support Aged Care ... 96
5.5.1 Job Satisfaction ... 96
5.5.2 Doing the Work ... 97
5.5.3 Job Demands ... 100
5.6 Work-related Injury and Illness ... 100
5.7 Cultural and Linguistic Diversity ... 103
6. The Census of Home Care and Home Support Outlets ... 107
6.1 Introduction ... 108
6.1.1 Home Care and Home Support Aged Care Programs ... 108
6.2 A Profile of Service Outlets ... 110
6.3 Outlets' Relationships with Broader Aged Care Services ... 118
6.4 Ethnic Specialisation ... 118
6.5 Skill Shortages ... 119
6.6 Vacancies ... 121
6.7 Setting of Employment Conditions ... 126
6.8 Agency, Brokered and Self-employed Staff ... 127

6.9 Volunteers in Home Care and Home Support Aged Care 129
6.10 Quality measures in Home Care and Home Support Aged Care 131
7. Interviews with Direct Care Workers 133
7.1 The Interview Process 134
7.1.1 Sampling and Recruitment 134
7.1.2 The Interview Sample 135
7.1.2.1 New hire workers 135
7.1.2.2 Mature workers 135
7.1.2.3 General workers 136
7.2 Recruitment and Retention in the Aged Care Workforce 136
7.2.1 Pathways into Aged Care 136
7.2.2 Choosing to Work in Aged Care 137
7.2.3 Job Satisfaction 139
7.2.3.1 Positive aspects 139
7.2.3.2 Negative aspects 140
7.2.4 Retention in the Aged Care Workforce 141
7.3 Experiences of Working in Aged Care 143
7.3.1 Quality Aged Care Services 143
7.3.1.1 Characteristics of good aged care workers 143
7.3.1.2 Factors enabling aged care organisations to provide quality care 144
7.3.2 Occupational Health and Safety 146
7.3.2.1 OHS policies and procedures in the workplace 146
7.3.2.2 OHS concerns in aged care 147
7.3.3 Training and Skills 148
7.3.3.1 Aged care qualifications 148
7.3.3.2 Work-related training 149
7.3.4 Work-life Balance 150
7.4 Emergent Themes 151
7.4.1 Aged Care Reforms and Funding 151
7.4.2 Staffing Issues in Residential Care Facilities 152
7.4.3 Perceptions of Aged Care Work 153
7.5 Summary 154
7.5.1 Recruitment and Retention in the Aged Care Workforce 154
7.5.2 Experiences of Working in Aged Care 155
7.5.3 Emergent Themes 155
8. Conclusion 157
8.1 Overview of the 2016 National Aged Care Workforce Census and Survey 157
8.2 The Size and Composition of the Aged Care Workforce 158
8.3 Characteristics of the Direct Care Aged Care Workforce 160
8.4 Characteristics of Aged Care Facilities and Outlets 161
8.5 Working Arrangements and Conditions in Aged Care 162
8.6 Recruitment and Retention 163

8.7 Emerging Issues 165
References 167
Appendix 1: Weights for the National Aged Care Workforce Census and Survey 168
Appendix 2: Interview Schedule 173
Appendix 3: Additional Tables 175
Appendix 4: Questionnaires 176

List of Tables

Table 3.1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount) 12

Table 3.2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent) 13

Table 3.3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent) 13

Table 3.4: Employees not providing direct care in the residential aged care workforce, by occupation: 2012 and 2016 (per cent) 15

Table 3.5: Age distribution of the residential direct care workforce, all direct care employees and recent hires: 2003, 2007, 2012 and 2016 (per cent) 16

Table 3.6: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016 17

Table 3.7: Country of birth of the residential direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent) 18

Table 3.8: The CALD residential direct care workforce, by occupation, comparing responses from all workers and all facilities: 2016 (per cent) 18

Table 3.9: Time spent in Australia for migrant residential direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent) 19

Table 3.10: The Aboriginal and Torres Strait Islander residential direct care workforce, by occupation, comparing facility and worker responses: 2012 and 2016 (per cent) 20

Table 3.11: Self-assessed health of the residential direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent) 20

Table 3.12: Post-school qualifications completed by the residential direct care workforce, by occupation: 2016 (per cent) 22

Table 3.13: Distribution of residential facilities by proportion of Personal Care Attendants (PCAs) with Certificate-level qualifications: 2007, 2012 and 2016 (per cent) 23

Table 3.14: Specialised qualifications in ageing or aged care of the residential direct care workforce, by occupation: 2012 and 2016 (per cent) 23

Table 3.15: Current study of the residential direct care workforce, by occupation: 2012 and 2016 (per cent) 24

Table 3.16: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent) 25

Table 3.17: Work schedule of the residential direct care workforce, by occupation: 2007, 2012 and 2016 (per cent) 25

Table 3.18: Actual working hours and preferred working hours of direct care workers in the residential aged care workforce, by occupation: 2016 (per cent) 26

Table 3.19: Preferred change in working hours of the residential direct care workforce: 2003, 2007, 2012 and 2016 (per cent) 27

Table 3.20: Median weekly** earnings (gross) of the residential direct care workforce, by occupation and working hours: 2016 ($ per week) 28

Table 3.21: Prevalence of multiple job-holding among residential direct care workers, by occupation: 2012 and 2016 (per cent) 29

Table 3.22: Participation in training and/or continuing professional development (CPD) by residential aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent) 30

Table 3.23: Stated aims of training undertaken by the residential direct care workforce that undertook training during the last 12 months, by occupation: 2016 (per cent) 30

Table 3.24: Areas of training identified as most needed in the next 12 months for the residential direct care workforce, by occupation, comparing facility and worker responses: 2016 (per cent) 31

Table 3.25: Activity prior to first job in aged care of the residential direct care workforce, by occupation: 2016 (per cent) 32

Table 3.26: Age at which began working in aged care of the residential direct care workforce, by occupation: 2016 (per cent) 32

Table 3.27: Total time spent working in aged care of the residential direct care workforce, by occupation: 2016 (per cent) 33

Table 3.28: Whether had worked in aged care prior to current job of the residential direct care workforce, by occupation: 2016 (per cent) 34

Table 3.29: Whether had worked in current facility prior to obtaining current job of residential direct care workers employed in the last five years, by occupation: 2016 (per cent) 34

Table 3.30: Main reason for leaving prior aged care job of residential direct care workers with previous experience in sector, by occupation: 2016 (per cent) 35

Table 3.31: Tenure in current job of the residential direct care workforce, by occupation: 2016 (per cent) 36

Table 3.32: Proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job: 2016 (per cent) 36

Table 3.33: Expected activity in 12 months' time of the residential direct care workforce, by occupation: 2016 (per cent) 37

Table 3.34: Average scores for responses from the residential direct care workforce, to statements about job satisfaction, by occupation: 2016 (range 1–10) 38

Table 3.35: Average scores for responses from the residential direct care workforce to statements about their work, by occupation: 2016 (range 1–7) 39

Table 3.36: Responses of the residential direct care workforce to the question 'In a typical shift, how much time do you spend in direct caring?' by occupation: 2016 (per cent) 39

Table 3.37: Residential direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7) 40

Table 3.38: Residential direct care workforce assessment of the quality of workplace relationships 'between workmates/ colleagues and yourself', by occupation: 2016 (range 1–7) 40

Table 3.39: Prevalence of unusual job demands in residential facilities: 2016 (per cent) 41

Table 3.40: Types of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent) 42

Table 3.41: Causes of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent) 43

Table 3.42: Proportion of facilities with employees on Workcover (per cent) and, of these, the mean number of employees per facility on Workcover during the designated fortnight: 2016 43

Table 3.43: Fluency in a language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent) 44

Table 3.44: Use of language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent) 44

Table 3.45: Subjective assessment of English literacy for residential direct care workers most fluent in a language other than English (LOTE): 2016 (per cent) 45

Table 3.46: Distribution by proportion of personal care attendants (PCAs) from culturally and linguistically diverse backgrounds (CALD) in residential facilities: 2016 (per cent) 45

Table 3.47: Stated benefits of employing personal care attendants (PCAs) from culturally and linguistically diverse backgrounds in residential facilities: 2016 (per cent) 45

Table 3.48: Proportion of residential facilities that employ personal care attendants (PCAs) from linguistically diverse backgrounds: 2016 (per cent) 46

Table 3.49: Stated difficulties of employing personal care attendants (PCAs) who speak a language other than English in residential facilities: 2016 (per cent) 47

Table 4.1: Distribution of residential direct care workforce (per cent) by State/Territory, location, ownership type and facility type: 2003, 2007, 2012 and 2016 50

Table 4.2: Number of places* (per cent): 2007, 2012 and 2016 51

Table 4.3: Distribution of residential aged care operational places* (per cent): 2016 51

Table 4.4: Average ratio of residential direct care workers to operational places: 2012 and 2016 52

Table 4.5: Proportion of residential facilities that are part of larger provider group* or provide community aged care (per cent), by ownership type: 2016 53

Table 4.6: Proportion of residential aged care employees that work in both residential and community aged care (per cent), in facilities that provide some community aged care, by ownership type: 2016 53

Table 4.7: Residential facilities that cater for specific ethnic or cultural groups (per cent): 2016... 54

Table: 4.8: Proportion of residential facilities reporting skill shortages in 2016 (per cent), by location and occupation affected 55

Table 4.9: Proportion of residential facilities with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected 55

Table 4.10: Proportion of residential facilities with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected 56

Table 4.11: Vacancy rate (per cent of all residential facilities) and mean number of vacancies (in facilities with vacancies), by occupation: 2003, 2007, 2012 and 2016 57

Table 4.12: Weeks required for residential facilities to fill most recent vacancy, by occupation: 2016 (per cent) 57

Table 4.13: Average and median vacancy duration (weeks) for residential RNs and PCAs, by State/Territory and location: 2016 59

Table 4.14: Proportion of residential facilities giving each reason for their most recent vacancy (per cent), by occupation: 2016 60

Table 4.15: Sources of information about recruitment opportunities used by recently hired* residential direct care workers and facilities: 2016 (per cent) 60

Table 4.16: Industrial methods used by residential facilities to set employment conditions (per cent), by employee occupation: 2016 61

Table 4.17: Proportion of residential facilities (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016 62

Table 4.18: Proportion of residential facilities (per cent) using any non-PAYG RNs or PCAs in the designated fortnight, by State/Territory: 2003, 2007, 2012 and 2016 63

Table 4.19: Number of non-PAYG workers in residential facilities in the designated fortnight, by occupation: 2016 63

Table 4.20: Reasons for using non-PAYG workers in residential facilities in the designated fortnight, by type: 2016 64

Table 4.21: Total number of volunteers and volunteer hours worked in residential facilities in the designated fortnight: 2012 and 2016 64

Table 4.22: Proportion of residential facilities employing volunteer workers (per cent) in the designated fortnight, by location and ownership type: 2016 65

Table 4.23: Roles undertaken by residential facility volunteer workers (per cent): 2016 65

Table 4.24: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016 66

Table 5.1: Size of the home care and home support aged care workforce, all PAYG employees and direct care employees: 2007, 2012 and 2016 (estimated headcount) 69

Table 5.2: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent) 70

Table 5.3: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent) 70

Table 5.4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent) 72

Table 5.5: Age distribution of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent) 73

Table 5.6: Median age of the home care and home support direct care workforce, by occupation, all direct care employees and recent hires: 2012 and 2016 (number of years) 74

Table 5.7: Country of birth of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent) 75

Table 5.8: The culturally and linguistically diverse (CALD) home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent) 76

Table 5.9: Time spent in Australia of migrant home care and home support direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent) 77

Table 5.10: The Aboriginal and Torres Strait Islander home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2012 and 2016 (per cent) 78

Table 5.11: Self-assessed health of the home care and home support direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent) 79

Table 5.12: Post-school qualifications completed by the home care and home support direct care workforce, by occupation: 2016 (per cent) 81

Table 5.13: Distribution of community outlets by proportion of Community Care Workers (CCWs) with relevant Certificate-level qualifications: 2007, 2012 and 2016 (per cent) 82

Table 5.14: Specialised qualifications in ageing or aged care of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent) 83

Table 5.15: Current study of the home care and home support direct care workforce, by occupation: 2016 (per cent) 83

Table 5.16: Form of employment of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent) 84

Table 5.17: Work schedule of the home care and home support direct care workforce, by occupation: 2007, 2012 and 2016 (per cent) 85

Table 5.18: Actual working hours and preferred working hours of direct care workers in the home care and home support direct care workforce, by occupation: 2016 (per cent) 86

Table 5.19: Preferred change in working hours of the home care and home support direct care workforce: 2007, 2012 and 2016 (per cent) 86

Table 5.20: Median weekly** earnings of the home care and home support direct care workforce, by occupation and working hours: 2016 ($ per week) 87

Table 5.21: Prevalence of multiple job-holding among home care and home support direct care workers, by occupation: 2012 and 2016 (per cent) 88

Table 5.22: Participation in training and/or continuing professional development (CPD) by home care and home support aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent) 89

Table 5.23: Stated aims of training undertaken by the home care and home support direct care workforce during the last 12 months, by occupation: 2016 (per cent selecting) 89

Table 5.24: Areas of training identified as most needed in the next 12 months for the home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent) 90

Table 5.25: Activity prior to first job in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent) 91

Table 5.26: Age at which began working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent) 92

Table 5.27: Total time spent working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 92

Table 5.28: Whether had worked in aged care prior to current job of the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 93

Table 5.29: Whether had worked in current outlet prior to obtaining current job of home care and home support direct care workers employed in the last five years, by occupation: 2016 (per cent) ... 93

Table 5.30: Main reason for leaving prior aged care job of home care and home support direct care workers with previous experience in sector, by occupation: 2016 (per cent) ... 94

Table 5.31: Tenure in current job of the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 95

Table 5.32: Proportion of the home care and home support direct care workforce actively seeking work by occupation and tenure in current job: 2016 (per cent) ... 95

Table 5.33: Expected activity in 12 months of the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 96

Table 5.34: Average scores for responses from the home care and home support direct care workforce to statements about job satisfaction, by occupation: 2016 (range 1-10) ... 97

Table 5.35: Average scores for responses from the home care and home support direct care workforce to statements about their work, by occupation: 2016 (range 1-7) ... 98

Table 5.36: Responses of the home care and home support direct care workforce to the question 'In a typical shift, how much time do you spend actively caring for care recipients?', by occupation: 2016 (per cent) ... 98

Table 5.37: Distribution of the proportion of aged clients cared for by home care and home support direct care workers, by occupation: 2016 (per cent) ... 99

Table 5.38: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7) ... 99

Table 5.39: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between workmates/colleagues and yourself', by occupation: 2016 (range 1–7) ... 99

Table 5.40: Prevalence of unusual job demands in home care and home support outlets: 2016 (per cent) ... 100

Table 5.41: Types of reported work-related injuries and illnesses, comparing outlets and workers: 2016 (per cent) ... 101

Table 5.42: Causes of reported work-related injuries and illnesses, comparing outlet and worker responses: 2016 (per cent) ... 102

Table 5.43: Proportion of outlets with employees on Workcover (per cent) and, of these, the mean number of employees per outlet on Workcover during the designated fortnight: 2016 ... 102

Table 5.44: Fluency in a language other than English (LOTE) of the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 103

Table 5.45: Use of language other than English (LOTE) by the home care and home support direct care workforce, by occupation: 2016 (per cent) ... 103

Table 5.46: Subjective assessment of English literacy for home care and home support direct care workers most fluent in a language other than English (LOTE): 2016 (per cent) ... 104

Table 5.47: Distribution by proportion of community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent) ... 104

Table 5.48: Stated benefits of employing community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent) ... 105

Table 5.49: Proportion of home care and home support outlets that employ community care workers (CCWs) from CALD backgrounds: 2016 (per cent) ... 105

Table 5.50: Stated difficulties of employing community care workers (CCWs) who speak a language other than English in home care and home support outlets: 2016 (per cent) ... 106

Table 6.1: Distribution of home care and home support direct care workforce (per cent) by State/ Territory, location, and ownership type: 2007, 2012 and 2016 112

Table 6.2: Distribution of home care and home support direct care workforce (per cent) by size of outlet, by number of PAYG and direct care employees: 2007, 2012 and 2016 (per cent) 113

Table 6.3: Distribution of home care and home support outlets (per cent) between programs in the last reporting period: 2016 113

Table 6.4: Proportion of outlets offering services under each program in the last reporting period, by state, geographical location and ownership type: 2016 (per cent) 116

Table 6.5: Proportion of outlets offering services under each program in the last reporting period, (per cent) by size of outlet in number of PAYG and direct care employees: 2016 (per cent) 117

Table 6.6: Proportion of home care and home support outlets that are part of larger provider group or provide residential aged care (per cent), by ownership type: 2012 and 2016 118

Table 6.7: Proportion of home care and home support aged care employees that work in both residential and home care/home support aged care (per cent), in outlets that also provide some residential aged care, by ownership type: 2016 118

Table 6.8: Home care and home support outlets catering for specific ethnic or cultural groups: 2016 (per cent) 119

Table: 6.9: Proportion of home care and home support outlets reporting skill shortages in 2016 (per cent), by location and occupation affected 120

Table 6.10: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected 120

Table 6.11: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected 121

Table 6.12: Vacancy rate (per cent of all home care and home support outlets) and average number of vacancies (in outlets with vacancies), by occupation: 2007, 2012 and 2016 122

Table 6.13: Weeks required by home care and home support outlets to fill most recent vacancy (in outlets with vacancies), by occupation: 2016 122

Table 6.14: Average and median vacancy duration (weeks) for RNs and CCWs, by State/Territory and location: 2016 124

Table 6.15: Proportion of home care and home support outlets giving each reason for their most recent vacancy (per cent), by occupation: 2016 125

Table 6.16: Sources of information about recruitment opportunities used by recently hired* home care and home support direct care workers and outlets: 2016 (per cent) 125

Table 6.17: Industrial methods used by home care and home support outlets to set employment conditions (per cent), by employee occupation: 2016 126

Table 6.18: Allowances supplied by home care and home support outlets to employees (per cent): 2016 126

Table 6.19: Allowances supplied by home care and home support outlets to employees (per cent) by remoteness area: 2016 127

Table 6.20: Proportion of home care and home support outlets (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016 127

Table 6.21: Proportion of home care and home support outlets (per cent) using any non-PAYG RNs or CCWs in the designated fortnight, by State/Territory: 2007, 2012 and 2016 128

Table 6.22: Number of non-PAYG workers in home care and home support outlets in the designated fortnight, by occupation: 2016 128

Table 6.23: Reasons for using non-PAYG workers in home care and home support outlets in the designated fortnight, by type: 2016 129

Table 6.24: Total number of volunteers and volunteer hours worked in home care and home support outlets in the designated fortnight: 2012 and 2016 129

Table 6.25: Proportion of home care and home support outlets employing volunteer workers (per cent) in designated fortnight, by location and ownership type: 2016 130

Table 6.26: Roles undertaken by volunteer workers in home care and home support outlets (per cent): 2016 131

Table 6.27: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016 132

Table A1.1: Stratification design for residential aged care service facilities 168

Table A1.2: Weights for the residential census 169

Table A1.3: Stratification design for home care and home support service outlets 170

Table A1.4: Weights for the home care and home support outlet census 171

Table A4.2: Average number of residential direct care workforce by size of outlet (places), by number of PAYG and direct care employees: 2012 and 2016 175

Table A6.2: Average number of home care and home support direct care workforce by size of outlet, by number of PAYG and direct care employees: 2012 and 2016 175

List of Figures

Figure 3.1: Share of the occupations for the residential direct care employees (headcount and FTE, per cent) 14

Figure 3.2: Number of the occupations for the residential direct care employees (headcount and FTE) 14

Figure 3.3: Age distribution of the residential aged care workforce: 2003, 2007, 2012 and 2016 (per cent) 16

Figure 3.4: Gender distribution of the residential aged care workforce: 2016 (per cent) 17

Figure 5.1: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent) 71

Figure 5.2: Number of the occupations for the home care and home support direct care employees (headcount and FTE) 71

Figure 5.3: Age distribution of the home care and home support aged care workforce: 2007, 2012 and 2016 (per cent) 73

Figure 5.4: Gender distribution of the home care and home support aged care workforce: 2016 (per cent) 74

Glossary

ABS	Australian Bureau of Statistics
AHA	Allied Health Assistant
AH	Allied Health
AHP	Allied Health Professional
CALD	Culturally and Linguistically Diverse
CCW	Community Care Worker
CDC	Consumer Directed Care
CHSP	Commonwealth Home Support Program
CPD	Continuing and Professional Development
Direct Care	Direct Care employees provide care directly to care recipients as a core component of their work, includes occupations Nurse Practitioner, Registered Nurse, Enrolled Nurse, Community Care Workers, Allied Health Professionals, Allied Health Assistants.
DVA	Department of Veterans' Affairs programs
EN	Enrolled Nurse
HACC	Home and Community Care
HCHS	Home Care and Home Support
HCP	Home Care Packages program
IP	Innovative Pool program
LOTE	Language Other Than English
MPS	Multi-Purpose Service program
PCA	Personal Care Attendant
NACWCS	National Aged Care Workforce Census and Survey
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NDIS	National Disability Insurance Scheme
NP	Nurse Practitioner
PAYG	Employees for whom Pay As You Go (PAYG) tax is deducted by the organisation including for those on paid leave.
RN	Registered Nurse
TCP	Transition Care Program

Executive Summary

Background

This is a report on the findings of the 2016 National Aged Care Workforce Census and Survey (NACWCS) conducted by the National Institute of Labour Studies, on behalf of the Australian Department of Health. It is the fourth report in the series (previous reports were in 2003, 2007, and 2012).

Methodology

All provider organisations with aged care funding for residential facilities and home care/home support outlets, were invited to participate in the 2016 NACWCS. Over 4,500 facilities and outlets and more than 15,000 aged care workers responded.

Additional qualitative data focusing on newly-hired and mature-aged workers was obtained through in-depth interviews with a sample of 100 direct care workers.

Introduction

The aged care workforce can be viewed in a number of ways:

- PAYG/non-PAYG
- Direct care/non-direct care
- Employed/volunteer
- Residential/Home care and home support

This report focuses primarily on direct care[1], PAYG employees in both residential facilities and home care and home support outlets, although there is also limited information on PAYG non-direct care workers, and non-PAYG workers.

It also provides information on the residential facilities and home care and home support outlets as employers and businesses. Detailed information was collected on the presence, causes and consequences of skill shortages, job vacancies, the composition of the workforce including the use of agency workers and volunteers, the types of employment contracts used, prevailing industrial relations and other matters.

Where relevant, comparisons are made with the 2012 results. However, a caveat is that this report should be read in the context that since then, there have been significant changes in the aged care landscape and some reforms are continuing, with the full impact on workforce issues not yet clear.

Key quantitative findings of the 2016 NACWCS

Estimated number of PAYG aged care workers

- **366,027** (4 per cent increase since 2012)
  - 235,764 in residential facilities
  - 130,263 in home care and home support outlets

[1] Workers who provide care services to older Australians as a key part of their work.

Estimated number of PAYG aged care workers in direct care roles

- **240,317**
  - 153,854 in residential facilities (**5 per cent increase** since 2012 – converts to 3 per cent on a FTE basis)
  - 86,463 in home care and home support outlets (**7 per cent decrease** since 2012 – converts to 19 per cent on a FTE basis)

Characteristics of PAYG residential direct care workforce

- 87 per cent female
- Median age 46 years
- 70 per cent are Personal Care Attendants (PCA)
- 32 per cent born overseas
- 78 per cent employed on a permanent and part time basis
- 10 per cent of the workforce are casual or contract employees (down from 19 per cent in 2012)
- 80 per cent of workers engaged in work-related training (mostly mandatory) in the previous 12 months
- 58 per cent of workers undertook Continuing and Professional Development (CPD)

Characteristics of PAYG home care and home support direct care workforce

- 89 per cent female
- Median age 52 years
- 84 per cent are Community Care Workers (CCW)
- 23 per cent born overseas
- 75 per cent employed on a permanent and part time basis
- 14 per cent are casual or contract employees (down from 27 per cent in 2012)
- 75 per cent of workers engaged in work-related training (mostly mandatory) in the previous 12 months
- 48 per cent of workers undertook continuing and professional development (CPD)

Residential aged care facilities

- The average size of facilities has remained constant since 2012
- 52 per cent have more than 60 places
- 80 per cent belong to a larger provider group
- 53 per cent report skill shortages, most commonly for Registered Nurses (RN) (down from 76 per cent in 2012)
- An estimated 23,537 volunteers worked in residential aged care in the designated fortnight

Home Care and Home Support outlets

- Increase in size of outlets since 2012
- 28 per cent employ more than 40 PAYG workers
- 61 per cent belong to a larger provider group

- 42 per cent report skill shortages, most commonly for CCWs (down from 49 per cent in 2012)
- An estimated 44,879 volunteers worked in home care and home support in the designated fortnight

Profile of the 2016 Aged Care Workforce

General

- The aged care workforce is older than the national average, generally in good health and has high levels of post-school education and training
- Overall the direct care workforce is relatively stable, with only a small minority indicating an intention to leave the sector within 12 months
- The residential workforce is getting younger and the home care and home support workforce is getting older
- There are indications of modest under-utilisation of the workforce as a whole

Training

- A much smaller proportion of CCWs than other occupations in home care and home support undertook training or CPD, suggesting a training gap
- There is a lower level of work related training than in 2012
- Priority areas identified for future training included dementia, palliative care and (in home care and home support) mental health
- A lack of access to training for workers in regional and rural areas is evident

Skill shortages

- The incidence of skill shortages has declined considerably since 2012, particularly in residential facilities
- Shortages are more prevalent outside major cities, and vacancies are harder to fill in remote and very remote areas, especially for RNs in residential facilities

Job satisfaction

- Job satisfaction is high across all work aspects except for pay
- Home care and home support workers reported greater job satisfaction for time available to care for clients and having freedom in their work and less stress and pressure than their residential care counterparts
- In both sectors, workers reported that the most stressful aspect of their jobs was the unanticipated changes in work patterns including working longer than scheduled and variations being made to hours or location of work at short notice

Facilities and outlets

- The share of facilities and outlets offering both residential and home care and home support care has fallen since 2012 indicating that facilities/outlets are becoming increasingly specialised within their respective sectors
- The majority of residential aged care facilities are large, and outlets within the home care and home support sector appear to be getting larger

- Service provision which accounts for the diverse needs of older Australians from different ethnic and cultural groups is becoming more mainstream

Conclusion

The aged care workforce remains predominantly female, older, and in good health. It is a well-qualified and trained workforce, with good access to further work-related training. However access to this training was lower than in 2012. The direct care residential workforce is getting younger and the home care and home support one is getting older.

A considerable shift away from casual or contract employment arrangements has been seen since 2012, particularly within the home care and home support sector.

The general picture that emerges regarding working arrangements and conditions is one of improving working conditions without any major imbalances. Although there are indications of continuing modest under-utilisation of the workforce as a whole, this is not to the point of being a driving force for the deterioration of working conditions in the sector.

Negative perceptions of aged care work as an occupation of low pay and status remain. Given the need for the expansion of the aged care workforce, this issue must be addressed.

In summary, the 2016 NACWCS showed that the aged care workforce is both stable and committed. Its workers report relatively high levels of job satisfaction and a large majority wish to stay working in the sector. The overall picture that emerges is that both the retention of current workers and the attraction of new workers to the sector seem to be working well with no major bottlenecks or hurdles that the labour market could not sort out by itself and without intervention.

Emerging issues

The Productivity Commission has estimated that by 2050 the aged care workforce will need to have grown to around 980,000 workers. It is vital that the sector and its workforces are monitored in order to keep all stakeholders informed and help the design and implementation of new policies to meet this growth.

The reduction in the estimated size of the direct care workforce in the home care and home support sector, combined with the likely increase in future demand for care provided in this setting may cause concern.

The 2016 NACWCS sought to identify potential workforce competition with the disability sector. At present there appears to be very little interaction at the workforce level between the aged care and disability care sectors. However, given the full National Disability Insurance Scheme (NDIS) roll out over the next two to three years, this could have substantial impacts on the aged care workforce.

There is some concern in the home care and home support sector about the impacts of aged care reforms (particularly Consumer Directed Care) on working conditions and employment. The impact of these reforms should be closely monitored particularly in light of the unexpected decline in the estimated size of this workforce.

Responding to change, a majority of residential facilities continue to be large in scale but utilising a smaller proportion of direct care workers, while home care and home support outlets are growing in size, with the larger ones expanding their workforces at a faster rate than the smaller ones.

1. Introduction

Since the last report on the Australian aged care workforce in 2012 (King et al, 2012) and through the implementation of new government policies (Department of Health, 2017), the aged care sector has experienced considerable changes in both the demand for and the supply of its services. These changes are set to continue apace over the coming decades.

The Australian population as a whole has been getting older. About a quarter of all Australians are expected to be 65 years and older by the middle of the 21st Century (Productivity Commission 2013). The ageing of the population will be fuelled in part by a rapid expansion of the oldest-old (those aged 85 years and older and who typically have higher care needs) from less than two per cent today to between five and seven per cent. The number of people who will be requiring aged care services is therefore set to increase substantially in the decades to come. Through significant general advances in medicine and health care we are managing to keep the younger part of the retired population both healthier and more active than their parents' generation was at the same age. However, through improved longevity we are also seeing an increased incidence of age-related conditions such as dementia and Alzheimer's disease. Thus, not only is the overall number of elderly people set to rise, but the composition of the demand for aged care services, and its methods of delivery are all set to change further.

Over and above these unprecedented changes in the demography and the health of the nation, in the last decades Australians on the whole have been getting substantially richer. According to figures from the Organisation of Economic Cooperation and Development (OECD) which have been adjusted to constant 2010 prices, Australian Gross Domestic Product (GDP) per capita has risen from US$26,433 in 1985 to US$44,774 in 2015 (OECD 2017). Thus, we should not only be expecting to see a higher proportion of life spent in retirement, but also, for many Australians, a larger proportion of their lifetime income and wealth accumulated for and spent during retirement. Along with this financial empowerment, many older Australians are becoming clearer and better articulated about their future care needs and requirements. This includes expressing a stronger desire and ability to remain living in their own home and pursue an active lifestyle. Our expectation is that over time the demand for quality care services that are tailored and timed to suit these individual and family needs is set to increase to levels never exercised by past cohorts.

A new national picture of demand for aged care services is therefore emerging. This changing demand is being driven by greater absolute numbers of older people within the population, and also an increased preference to continue to live and receive supports within the home. Critically for the aged care sector, an increasing proportion of older Australians strongly feel willing, able, and empowered to make effective demands for a better and broader range of high quality care services and a fundamentally different consumer-driven method of provision.

The aged care sector has been listening, anticipating and responding to these changes in the types of services that are demanded and how they should be best be provided. Moreover, the sector is currently undergoing intense transformation as a consequence of the structural changes brought about by the recent aged care reforms. Since 2012, these reforms have reshaped the way aged care services are provided in Australia across both residential and community settings with further changes set to occur. By 2050, more than 3.5 million Australians are expected be using aged care services each year (Productivity Commission, 2011). In order to adequately provide services for these individuals, the Productivity Commission (2011) has estimated that the aged care workforce will need to quadruple in size over this time and employ around 980,000 workers. In this period of change it is of key importance that the sector and its workforces are monitored in order to keep all stakeholders informed and help the design and implementation of new policies to manage change.

The National Aged Care Workforce Census and Survey (NACWCS) is designed to provide continual and consistent information to monitor the sector and its workforces. The information in the NACWCS has been used by government and by providers of aged care services alike, the former in its efforts to design and provide a coordinated strategic approach to the sector and the latter in assisting to manage both present and future aged care workforce requirements.

The 2016 NACWCS is the fourth data collection and report commissioned by the Department of Health (DoH) and conducted by the National Institute of Labour Studies (NILS). The previous NACWCS reports were delivered in 2003, 2007 and 2012. Across this time the aged care sector has grown in size and changed in nature rapidly. The capacity of the sector and relevant stakeholders to respond appropriately to these developments, has been facilitated and enhanced through the independently generated statistical evidence about the sector itself and its workforces in the NACWCS. It is critical that both employers and employees can juxtapose evidence reflecting their own and one another's responses to change that affects both, in the knowledge that this evidence has been generated consistently over time within a broader nationally representative context. It is also critical for government to be able to rely on evidence that is manifestly both well-informed and independently produced.

This report describes the NACWCS 2016 data collection and findings in the following chapters. Chapter 2 sets the scene and offers an overview of the workings of the data collection and the reporting. It also outlines the research content and its design and implementation. The chapter firstly describes the sources of information used within the report, including the instruments and processes used to collect this data within residential facilities and home care and home support outlets - namely the *census* of employers/business units and the *survey* of a sample of their workforces. It then goes on to describe the response rates and the population weights of the data, the latter being explained in further detail in Appendix 1. Chapter 2 concludes with an outline of the qualitative module of NACWCS 2016 which focuses on recently hired and mature-aged workers in the direct care workforce.

Chapters 3 to 7 describe the data in detail and each section is preceded by a condensed list of its key findings for ease of future reference. Throughout the text we make comparisons between residential facilities and home care and home support outlets and their workforces. Where appropriate and feasible we also make comparisons across time, contrasting the new evidence found in the 2016 NACWCS with the findings previously outlined in the 2012, 2007 and 2003 reports.

Chapter 3 provides detailed information on the residential aged care workforce using responses primarily from the residential workforce survey and on occasion from the residential facilities census as well. It presents and discusses total employment within the sector and the key characteristics of the workforce. The main characteristics of aged care work itself are also discussed, including employment arrangements and wages, education and training, and the pathways that lead into and out of aged care. Chapter 3 continues by examining experiences of working in the sector (including satisfaction with the various aspects of the work) and the extent of work-related injury and illness. The chapter concludes with findings on cultural and linguistic diversity in the residential aged care sector.

Chapter 4 predominantly uses evidence from the residential aged care census to provide an overview of the key characteristics of the residential facilities themselves. It begins with a profile of facilities and examines their relationship with broader aged care services and the extent of ethnic specialisation. The chapter continues with evidence on skill shortages and vacancies, in the context of the sector's capacity to attract and retain staff in a competitive labour market. The employment arrangements of PAYG workers and the use of non-PAYG employees and volunteers are then explored. Chapter 4 concludes with a discussion of how quality is measured by employers in the residential aged care sector.

Chapters 5 and 6 essentially repeat the structure of Chapters 3 and 4, only now the information relates to the home care and home support workforces (Chapter 5) and outlets (Chapter 6).

These chapters take the opportunity to compare their findings with the corresponding results for the residential workforce and facilities.

Chapter 7 presents the findings of the in-depth interviews conducted with 100 newly hired, mature-aged and general direct care workers. A key question addressed by Chapter 7 relates to the capacity of the sector to attract and retain its workforce in the context of rapid change in the sector. This chapter offers a deeper and complementary understanding of the factors that matter for these specific sub-groups of aged care workers, including their working environment, wages, education and training, skills development and career paths. It offers invaluable deep insights of their experiences of working in aged care and on those factors that may ultimately influence their recruitment and retention outcomes.

Chapter 8 summarises and discusses the findings of the report and also identifies several emerging issues that warrant further investigation. The main text of this research is supported by a technical Appendix on the population weights that have been constructed and used in order to estimate the broader population numbers presented in the report.

2. Finding out About the Aged Care Workforce

In this chapter we describe the types of information used for this 2016 report on the aged care sector and its workforce. The information contained in this report comes from three sources.

The first and main source is the 2016 National Aged Care Workforce Census and Survey (NACWCS). The 2016 NACWCS packages of forms were sent to all provider organisations with aged care funding for residential facilities and home care/home support outlets providing specific aged care services as defined by the Australian Government Department of Health. Each package contained a census form, to be completed by the manager at the facility/outlet level, and several worker survey questionnaires, to be completed by a sample of direct care workers employed at that facility/outlet.

The second source of information comes from aged care administrative data supplied by the Department of Health with the lists of provider organisations and services which formed the basis for the census and survey sampling.

The third source of information comes from interviews with a small sample of direct care workers who in their worker survey had offered to be further contacted about their work. The overall design of the project, including census and survey design and research were conducted by the National Institute of Labour Studies (NILS) research team.

2.1 Overview of the 2016 National Aged Care Workforce Census and Survey

The census and survey packages were mailed out on 17 June 2016 with respondent completions accepted until 11 October for online completions and 27 October for hardcopy completions. Participants were asked to complete a questionnaire which was available in hard copy and online versions. I-view conducted the fieldwork and administered the process for disseminating the survey packages, collected and collated the data, and delivered the raw data files to NILS. Support to respondents for completing the questionnaires was provided by I-view via a free 1800 number. Additional support was provided by NILS and the Department where necessary and appropriate. Detailed information and guidance were also available online. NILS carried out the work necessary to prepare the data for statistical analysis and conducted that analysis. Where this was required, the surveys and the research process received approval from the ABS Statistical Clearing House and the Flinders University Ethics Committee in full compliance with the National Privacy Guidelines for survey research.

2.1.1 The Aged Care Workforce Research

The census of facilities/outlets and survey of a sample of their workforce sought information that is in its majority directly comparable with the information collected through the research conducted in 2012 and earlier in 2007 and 2003. The primary aim was to create a comprehensive profile of the direct aged care workforce in residential and community aged care settings. A further aim was to cover a broad range of sociodemographic and economic factors such as age, gender, qualification, and employment status, in a way that is directly comparable with the previous data collections. The information needed to be sufficiently detailed in order to inform strategies to further develop and build a skilled and flexible workforce. It also needed to include information about the skills and qualifications of aged care staff to reflect their readiness to meet the care needs of the rapidly growing number of consumers of the Australian aged care system.

The report therefore discusses how aspects of the workforce in residential facilities and home care and home support outlets have changed over time; how the direct care workforces in the two sectors compare with one another; and how new knowledge about the workforce might inform the direction and types of changes needed to recruit and retain direct care workers into

the future. To this purpose the NILS team strived to generate data that is comparable over time, as much as the various program changes that have been taking place will allow.

Four discrete questionnaire forms were produced to collect the data:

- Residential Census
- Home Care and Home Support Census
- Residential Worker Survey
- Home Care and Home Support Worker Survey

In line with the 2012 census of facilities/outlets, the 2016 data collection sought information about the characteristics of their PAYG direct care workforces[2], the conditions under which they are employed, their vacancy rates, and other characteristics of the organisation; management, administration and ancillary staff; their use of agency, brokered and self-employed (non-PAYG) staff; volunteers and volunteer hours; nurse practitioners; allied health assistants; the Aboriginal and Torres Strait Islander workforce; the culturally and linguistically diverse workforce; skill shortages; training; and work-related injuries and illnesses.

Information from the census was supplemented with administrative data provided by the Department of Health records, and primarily used to identify and contact the relevant organisations and their workers. For residential facilities, this administrative data included postcode, remoteness of geographical location, ownership type and the number of operational places (residential). To avoid duplication, these questions were not asked of the facilities. For the Home Care and Home Support census, only some of this information on outlets was available, so that postcode and remoteness of geographical location were additionally collected.

As in 2012, the survey of employees sought information about the characteristics of people who work in direct care roles, their career paths, their experiences of working in aged care and their intentions to stay in the sector. Specifically the worker surveys collected data on the role of the worker, working conditions (hours, form of employment, pay), career path (prior work, recruitment, intention to stay/leave), job satisfaction, demographic characteristics, training and qualifications, what workers like/dislike about their job; the balance between work and non-work responsibilities; migrant status; and proficiency in English. In 2016, as in 2012, Nurse Practitioners and Allied Health Assistants were included in the direct care workforce.

An important aspect of the NACWCS data collections is their linked employer-employee nature. The appeal of such data is that it links employer characteristics directly with employee characteristics at the micro (individual) level. Taking the potential problem of skill shortages as an example, by linking the data, we are able to know who the employers that may report skill shortages may be (that is, how they compare with other employers), and also who their employees are (that is how their employees compare with the employees of other employers). This attribute adds considerable granularity to the dataset and can be very useful for the microeconomic analysis of the labour market of the aged care sector.

In 2016, a small number of additional questions were asked of both employers and employees to capture information about new topics relevant to aged care workforce planning and development. Furthermore, in some existing questions, additional categories were added for similar reasons. The changes also reflected some updating needed for accommodating the new aged care funding packages and other changes to the aged care system within the questionnaires, and these new topic areas. Since the 2012 report, there has been significant reform to the way aged care is delivered to consumers, such as the migration to the Consumer Directed Care (CDC) model, the removal of the distinction between high-level and low-level residential care, and the introduction of the new Home Care Packages Program and the

[2] A key period for this information collected in the census is the last pay period (fortnight) in November 2015.

Commonwealth Home Support Program (CHSP). Additionally, these changes are taking place against a backdrop of an ageing population, changing client preferences including an increasing demand for formal aged care services delivered in a community setting, demand from competing sectors for the skills required in the aged care workforce, and a forecast reduction in the availability of informal (i.e. family) care. To the aged care workforce these factors and others represent significant pressures for change in the coming decades and imply the need to either expand the size of the workforce or improve its productivity, or both, whilst maintaining appropriate standards of quality. The additional questions asked reflect these factors and explored:

1. Potential competition with the disability sector: The workers surveys aimed to elicit the extent to which aged care skills are interchangeable with those used in disability support. The worker surveys asked whether aged care workers have worked in the past, are currently working alongside their aged care job, or expect to work in disability care in the future. The surveys also asked workers whether they have had any training in the area of disability support with new response categories added relating to disability skills and qualifications. These disability workforce questions were motivated by the impending expansion of the disability sector through the National Disability Insurance Scheme (NDIS), which may use people with similar qualifications and demographics as the aged care sector and result in skill shortages shared by the two sectors. In this context of judging the incidence of skill shortages, both the 2012 and 2016 NACWCS data included a suite of questions on skill shortages (their incidence, causes and responses to) similar to the ABS Business Longitudinal Database suite of questions developed by the ABS. This combination allows linking between the aged care and disability support sectors while also enabling national benchmarking through the ABS national data collections.
2. The role of non-PAYG workers: In addition to existing questions, the 2016 census also asked facilities and outlets to state their reasons for employing non-PAYG workers. Moreover, the 2016 census elicited additional information regarding volunteers about the roles they perform.
3. Quality of services: New questions were added about the quality monitoring undertaken by employers to give a measure of how the quality of the aged care provision is checked by management.
4. Paid travel time: A new question was added on the availability of paid travel time for the home care/home support workforces in order to obtain an overview of this practice.

In some cases of policy interest, the same or similar questions were asked of both employees and employers, on the expectation that they will be answered through a different lens. In several instances the report compares and discusses both perspectives.

2.1.2 Research Design and Implementation

Research design

The initial potential respondent lists were constructed from a set of Australian Government Department of Health lists of residential and home care and home support service providers within Australia. The lists comprised 2,952 residential services (Residential services, National Aboriginal and Torres Strait Islander Flexible Aged Care and Transition Care Program with residential places) and 5,442 home care/home support services (Home Care Packages program, the new Commonwealth Home Support Program (CHSP), HACC in Victoria and Western Australia, Multi-Purpose Services (MPS), National Aboriginal and Torres Strait Islander Flexible Aged care and Transition Care Program with home care/home support places)[3].

[3]Outlets providing DVA Community Nursing, Veteran's Home Care or other DVA administered programs were not part of the original service lists but it was recognised that some 'in-scope' outlets

NILS conducted analysis to determine the number of workforce surveys that were to accompany each census form. This was determined by the size of the service facility/outlet. Each dispatched residential census form was accompanied by either 4, 6 or 8 workforce surveys. For each Home Care and Home Support census form, the number of workforce surveys was 3, 5 or 7. Stratifying the sample of workers improved the likelihood of employees being given an equal chance to participate in the survey. The stratification was implemented so that the number of surveys sent to each organisation differed according to the size of the service as per operational places/funding/services provided in the administrative list. Small residential outlets were sent 4 worker surveys, medium sized were sent 6 and large were sent 8. Overall, an average of 6 surveys was sent to each residential facility. Small home care/ home support outlets were sent 3 worker surveys, medium sized were sent 5 and large were sent 7. Overall, an average of 5 surveys was sent to each home care/home support outlet. Where insufficient service information was available in the administrative data, the average number of surveys was sent (extra population cases that arose during fieldwork were also supplied the average number of worker surveys). The resulting total number of workers selected to receive a survey was 17,717 for the Residential Worker Survey and 27,206 for the Home Care and Home Support Worker Survey.

Fieldwork

The census and survey mail out commenced distribution on 17 June 2016. The original date for survey closure was 23 September. However, the response was slower than anticipated, but steady. In order to ensure an optimal response rate, fieldwork was extended until 11 October for online survey responses and 27 October for hardcopy completions.

At the outset of the census and survey, an interactive webcast presentation (webinar) was hosted by the Department with invitations sent to all organisations on the lists. The webinar was designed and delivered by NILS researchers, and included a set of frequently asked questions. To further support the provider organisations, their facilities and outlet managers and workers to complete the forms, I-view hosted a free 1800 Helpline from 20 June through to 28 September. In all, 2,247 inbound calls were made to the 1800 Helpline. The most common known reason for calling was to confirm distribution requirements from the provider organisation postal address to their facility/outlet service address, often associated with co-location issues where there were multiple services at the same physical facility/outlet address with a combined workforce. Further information and answers to ‘frequently asked questions’ were also made available on a dedicated website. In addition, emails were sent to residential facilities and home care and home support outlets to stimulate participation: an introductory email, two reminder emails and a final thank you/last chance email were sent to facilities/outlets. The Department supplemented these reminders with communications sent to all providers of aged care services and by directly approaching providers who had not completed their forms close to the end of the fieldwork period. The census and surveys were also advertised through professional and peak body organisations and aged care publications.

Further adjustments were required to the original contact lists to accommodate facilities that had opened or closed during the defined period, or which were discovered to be co-located after the packages were sent out. Extra cases arose that were not in the original contact lists, and they were provided with online forms when requested via the 1800 helpline (684 cases, made up of 9 Residential census with 72 related residential worker forms, 67 Home care/home support census with 536 related worker forms).

The census and survey packages, distribution of forms and completion instructions

It was established by the Department of Health that providers would be identified for the dispatch of the mailed forms by the provider organisation administrative postal address. This

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also provided services under these programs and so they were included in the home care and home support lists.

was critical where a service outlet provided more than one type of aged care service with the same provider organisation administrative postal address. Of all services in the sample (8,394), 1,030 were identified as providers with more than one service at the provider administrative postal address. This corresponded to 6,426 Census and survey packages which were sent to these (administrative postal) addresses, with their associated worker surveys numbering 34,862. To these providers, bundles of the relevant number of census and survey packages corresponding to their services were sent together in satchel/s to the provider organisation administrative postal address. Each provider received a cover letter with their relevant number of census and survey packages. The cover letter asked providers to distribute the contents of their survey package to their service facility/outlets for completion of the census by the manager and distribution of the surveys to their workers. The letter introduced the project, explained the contents of the census packages, how many questionnaires they should be expecting to receive overall, the benefits of completion, how to participate in the census and how to distribute the census and survey packages out to the service levels.

Following this distribution, each facility/outlet then received a survey package which contained the census and relevant number of worker surveys. A letter inviting the outlet manager recipients to participate in the census and instructions to workers for completing the surveys was incorporated into each questionnaire. Each census and survey package also contained a separate cover letter addressed to the manager with information about how to distribute the surveys and how to complete the census. The covering letter also nominated the 1800 Helpline that the recipient could call if they had any queries regarding the study. The cover letter requested that facility/outlet managers distribute the surveys by selecting staff who were (a) on the payroll as PAYG employees; (b) providing direct care to older Australians (i.e. to those 65 years and older, or 50 years and older if Indigenous); and (c) who had their birthday nearest to the day the package was received. The latter criterion was added to provide a random element to the selection of workers by their management.

For each census and survey, instructions were also provided for participating online, including unique usernames and passwords. Overall, 53 per cent of responses were received online from residential facilities, 52 per cent of home care and home support outlets, 17 per cent of workers in residential facilities and 20 per cent of workers in home care and home support outlets.

2.2 Responses and Weighting used in this Report

2.2.1 Residential Census and Residential Worker Survey Response Rates

Out of the final population of 2,952 residential facilities, 2,240 provided valid responses. This is a 76 per cent response rate for the residential census. Of the 17,717 surveys circulated to workers in residential aged care who were invited to participate, 8,885 provided valid responses. This represents a response rate of 50 per cent for the residential worker survey. Extra cases arose during fieldwork that were not in the original contact lists, made up of 9 residential census with 72 related residential worker forms with their respective response rates at 90 per cent and 22 per cent. The analysis and discussion of the residential aged care workforce and facilities can be found in Chapters 3 and 4.

2.2.2 Home Care and Home Support Census and Home Care and Home Support Worker Survey Response Rates

As with the 2012 community census and survey, for the 2016 census and survey of home care and home support outlets, it was evident from calls to the 1800 helpline and feedback from motivational calls that a number of home care and home support services on the list were out of scope for a variety of reasons. Using a similar process to calculate the responses to that used for residential aged care, then out of the final population of 5,442 home care and home support outlets a total of 2,307 valid responses were received. This is a 42 per cent response rate for the Home Care and Home Support outlet census. Of the 27,206 surveys circulated to

workers in home care and home support aged care who were invited to participate, 7,024 provided valid responses. This is a 26 per cent response rate for the home care and home support worker survey. Extra cases arose during fieldwork that were not in the original contact lists, made up of 67 home care/home support census with 536 related worker forms. Their respective response rates were 67 per cent and 10 per cent. The analysis and discussion of the home care and home support aged care workforce and outlets can be found in Chapters 5 and 6.

2.2.3 Weighting for Response used in the Report

In order to extrapolate the responses received and make them relevant to the entire workforce that provides direct care services for older Australians, response information from both residential facilities and home care and home support outlets and their worker surveys were weighted to reflect the lists. Appendix 1 contains an explanation of how these weights were formed. Weighted results from the census and surveys are used throughout the report.

2.3 Interviews with Direct Care Workers

Interviews with direct care workers were undertaken to provide a qualitative account of working in aged care and enable better understanding of some of the information obtained from the census and surveys. Upon completion of the workforce survey, direct care workers were given an opportunity to nominate themselves to take part in a qualitative interview about their experiences of working in the aged care sector. Following the 2016 research design, a sample of 100 direct care employees were interviewed, 48 from home care and home support outlets and 52 from residential facilities. The interviews were conducted from August to October 2016 and lasted for approximately 30 minutes each. A copy of the interview schedule is provided in Appendix 2. The focus of the 2016 qualitative research was on newly hired and mature-aged workers in order to understand more about their specific experiences of working within aged care (the 2012 qualitative focus was on the migrant and male workforces). Investigation was undertaken of issues relating to recruitment and retention for these workers; this is of particular importance if the sector is to attract new workers as well as retain its existing ones. The interviews also aimed to identify and explore broader emerging issues for the aged care workforce. The results of the qualitative research are presented in Chapter 7.

3. The Residential Aged Care Workforce

Key Findings

- The total residential PAYG aged care workforce has grown by 17 per cent since 2012 to an estimated 235,764. During the same time period the residential direct care workforce increased by 5 per cent and the FTE workforce by 3 per cent.

- PCAs were the largest occupational group (70 per cent), followed by RNs (15 per cent) and ENs (10 per cent).

- The median age of the residential direct care workforce was 46 years.

- While 32 per cent of the total residential care workforce was born overseas, 40 per cent of recent hires were migrant workers.

- Aboriginal and Torres Strait Islander people accounted for 1 per cent of the residential direct care workforce.

- Over 60 per cent of workers reported being in either very good or excellent health.

- Ninety per cent of workers held post-secondary qualifications. Two-thirds (66 per cent) of facilities reported that more than 75 per cent of their PCAs hold a Certificate III in Aged Care.

- There is a drop in casual employment. Over three-quarters of all residential direct care workers were employed in 2016 on permanent part-time contracts (78 per cent), with approximately 12 per cent on full time permanent and 10 per cent on a casual/contract arrangement. The corresponding percentages for 2012 were 72, 10 and 19, suggesting a considerable shift away from casual/contract arrangement in favour of permanent employment.

- A regular daytime shift was the most common work schedule for all direct care occupations. Rotating shift patterns were the norm for a fifth of nurses and PCAs.

- There are indications of potentially underutilised labour supply as there are more workers who want to work more hours than workers who want to work fewer hours. Although 56 per cent of the residential workforce are happy with their current hours of work, 14 per cent want to reduce their hours, and 30 per cent want to increase them.

- Around a tenth of the residential workforce reported more than one current job.

- Eighty per cent of workers had undertaken training over the previous 12 months, with mandatory training the most common form of training. Dementia and palliative care were seen as priority areas for future training.

- Aged care work was a first occupation for only a small minority of workers. Apart from nursing, there were no clear pathways into aged care for other occupational groups. The aged care sector draws its workers from the broader labour market.

- Attachment to the sector measured by previous paid work in aged care was at its highest for RNs (70 per cent) above half for ENs and AHs (both at 55 per cent) and at its lowest for PCAs (35 per cent). The primary reasons provided for changing aged care employer included personal circumstances and working conditions.

- A tenth of the residential workforce was currently seeking alternative work. Most residential workers (82 per cent) expected to still be with their current employer after 12 months. Only 4 per cent of employees reported intentions to leave the aged care sector altogether.

- Relatively high levels of overall job satisfaction were reported by workers. However, when looking at satisfaction with specific aspects of their job, aged care workers were least satisfied with their total pay and with the time available to them to care for residents.

- The most prevalent unusual job demands made of workers were related to changes in work patterns (due to unanticipated needs of residents, or variations on hours, or location).

- Fourteen per cent of workers reported sustaining a work-related injury or illness over the previous 12 months, most commonly sprains/strains and chronic joint/muscle conditions.

- Most residential facilities (91 per cent) employed at least one PCA from a CALD background, most commonly from India and the Philippines.

- The employment of CALD PCAs was widely seen as offering benefits to a facility – these benefits included enhanced cross-cultural understandings and activities. About a third of facilities reported difficulties in employing CALD PCAs, with communication issues the most commonly stated difficulty.

3.1 Introduction

This chapter provides detailed information about the residential aged care workforce using responses from both workers (N=8,885) and facilities (N=2,240). The census and survey captured information on the main occupational groups within aged care. In selected tables we provide details on each of these occupations (including, as in 2012, Nurse Practitioners and Allied Health Assistants). However, given the relatively low proportion of these latter occupations, most tables in the report combine Nurse Practitioners with Registered Nurses, and Allied Health Assistants with Allied Health Professionals.

We begin the chapter by providing an overview of the residential workforce and the socio-demographic characteristics of the workers themselves. The main characteristics of aged care work are then discussed including employment arrangements, wages, multiple job holding and training. The next sections of the chapter explore career pathways into and out of aged care, the experiences of residential aged care work (job satisfaction and job demands), and the extent of work-related injuries and illness in the sector. The chapter finishes with a focus on workers from culturally and linguistically diverse backgrounds.

3.2 Total Employment and Main Workforce Characteristics

In this section we provide an overview of the residential aged care workforce including the overall size of the PAYG workforce and the different occupational groupings. We then examine the main socio-demographic characteristics of the residential workers themselves – their age, gender, ethnicity, cultural background, health and education.

3.2.1 Total Employment

In order to undertake workforce planning and development effectively it is important to understand the size and composition of the existing workforce. Our estimates of the residential aged care workforce are based on information obtained from the census of residential facilities.

Total PAYG employment in residential aged care in 2016 is estimated to be 235,764 workers, of which 153,854 are in direct care roles. Table 3.1 indicates that the whole residential aged care PAYG workforce is estimated to have grown by 17 per cent since 2012 (from 202,344 to

235,764), and by about 50 per cent since 2003. The growth in residential direct care employment is estimated to have been lower, at 5 per cent between 2012 and 2016, falling from 10 per cent between 2007 and 2012, and 15 per cent between 2003 and 2007. In total, residential direct care employment grew 33 per cent from 2003 to 2016.

The estimated proportion of the residential aged care workforce working in direct care roles continues to fall. In 2016, 65 per cent of residential aged care employees work in direct care roles, compared with 73 per cent in 2012, 76 per cent in 2007 and 74 per cent in 2003.

Table 3.1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

Occupation	2003	2007	2012	2016
All PAYG employees	156,823	174,866	202,344	235,764
Direct care employees	115,660	133,314	147,086	153,854

Source: Census of residential aged care facilities (weighted estimates).

3.2.2 Occupation

The occupational composition of the headcount of residential direct care employees is presented in Table 3.2. Personal Care Attendants (PCAs) are the largest occupational group in residential aged care (70 per cent) and they continue to grow both numerically and as a proportion of the residential aged care workforce. The number of residential aged care PCAs has grown by 7,814 since 2012.

The number of Registered Nurses (RNs) also rose by 539 between 2012 and 2016, reversing some of the decline in numbers observed between 2003 and 2012. Their share of direct care employment was 15 per cent (unchanged from 15 per cent in 2012). The number of Nurse Practitioners rose since 2012, from 294 to 386, however they still only make up a very small proportion of the workforce (0.3 per cent). The estimated number of Nurse Practitioners (NPs) will be imprecise as it is based on a very small number of observations, so strong conclusions about growth in this occupation cannot be drawn.

The number of Enrolled Nurses (ENs) has fallen by 1,218; as a proportion of the workforce, they have decreased from 12 per cent to 10 per cent. The Allied Health (AH) employment categories also experienced a decline, but most of this was for Allied Health Professionals which fell by 438 workers (falling from 2 per cent to 1 per cent share of the direct care workforce).

The overall picture in Table 3.2 suggests that residential facilities continue to rely increasingly on PCAs to provide direct care to residents. There has been some increase in the number of RNs, but there has been a corresponding and larger fall in the number of EN. PCAs are the only residential direct care occupational category to substantively raise its share of employment since 2012, with the PCA share rising by 2 per cent.

Table 3.2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)	386 (0.3)
Registered Nurse (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)	22,455 (14.6)
Enrolled Nurse (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)	15,697 (10.2)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)	108,126 (70.3)
Allied Health Professional (AHP)*	8,895* (7.4)	9,875* (7.4)	2,648 (1.8)	2,210 (1.4)
Allied Health Assistant (AHA)*			5,001 (3.4)	4,979 (3.2)
Total number of employees (headcount) (%)	**115,660 (100)**	**133,314 (100)**	**147,086 (100)**	**153,854 (100)**

Source: Census of residential aged care facilities (weighted estimates).
**In 2003 and 2007 both of these categories were combined under 'Allied Health'.*

Table 3.3 shows the estimated full-time-equivalent (FTE) direct care workforce. There has been a modest increase in the estimated number of FTE employees in direct care roles since 2012. The increase in direct care employment of 3,097 between 2012 and 2016 is comparable to the increase between 2003 and 2007 of 2,843.

Comparing the percentages in Tables 3.2 and 3.3 suggests that the distribution of residential FTE direct care workforce (presented in Table 3.3) is very similar to that of the headcount of the direct care workforce (Table 3.2). The rate of increase in the residential FTE direct care employees was 3.3 per cent, smaller than the corresponding 4.6 per cent headcount increase. This suggests that there has been growth in part-time employment during this period, or more conservatively, an increase in the proportion of workers employed for fewer hours.

Table 3.3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner	n/a	n/a	190 (0.2)	293 (0.3)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)	14,564 (14.9)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)	9,126 (9.3)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)	69,983 (71.5)
Allied Health Professional*	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)	1,092 (1.1)
Allied Health Assistant*			3,414 (3.6)	2,862 (2.9)
Total number of employees (FTE) (%)	**76,006 (100)**	**78,849 (100)**	**94,823 (100)**	**97,920 (100)**

Source: Census of residential aged care facilities.
**In 2003 and 2007 these categories were combined under 'Allied Health'.*

Figure 3.1: Share of the occupations for the residential direct care employees (headcount and FTE, per cent)

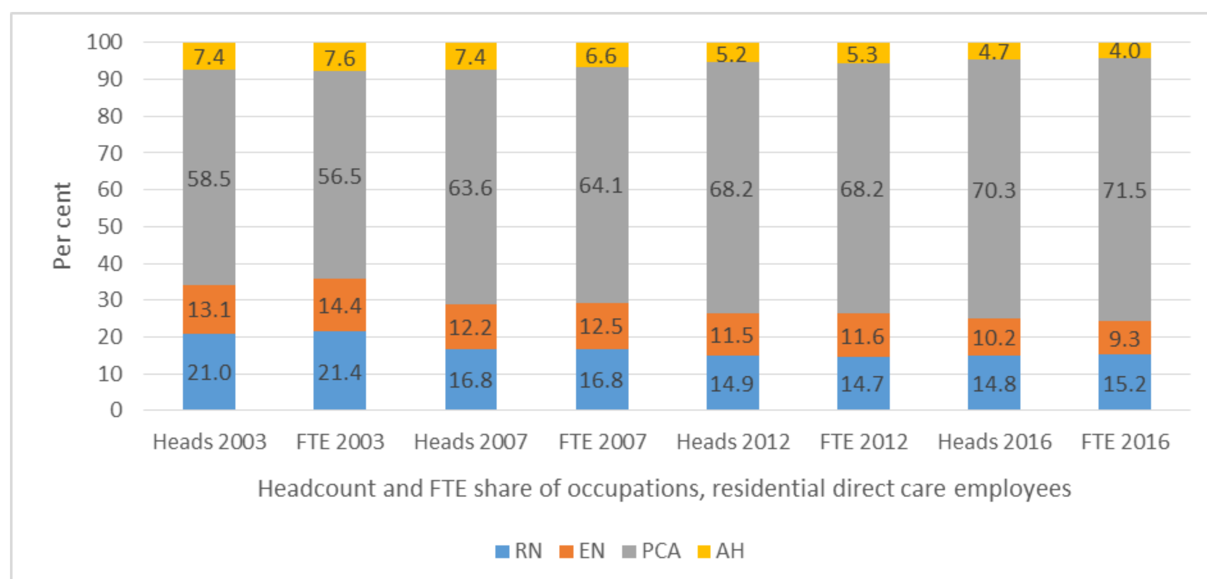
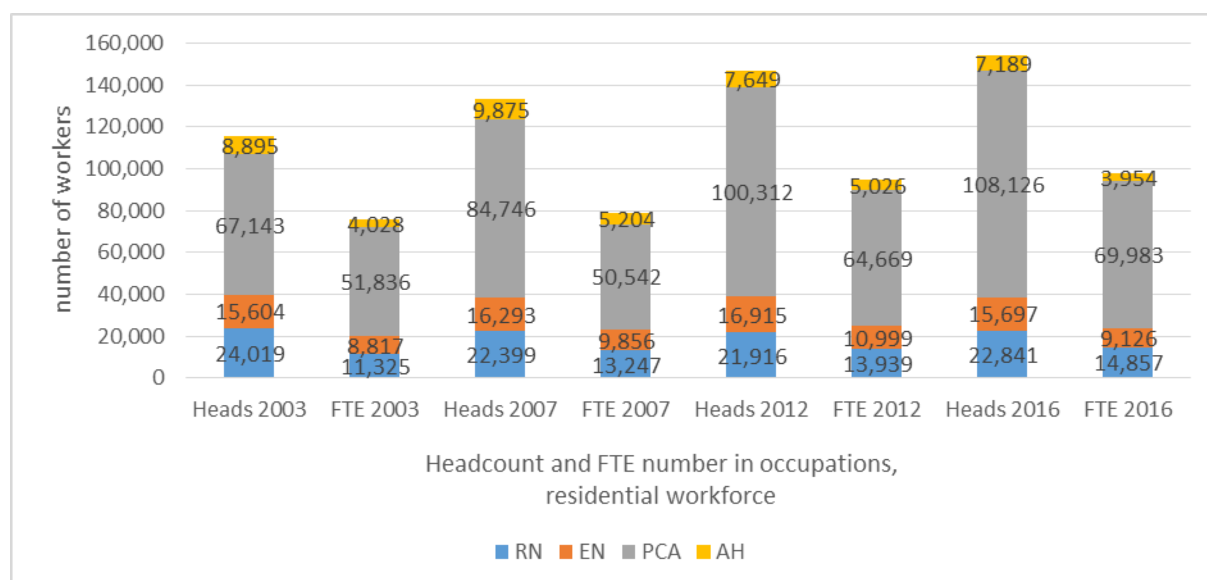


Figure 3.2: Number of the occupations for the residential direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 3.1 and Figure 3.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007, 2012 and 2016 in Figure 3.1 and Figure 3.2.

The shares of non-direct care occupations are shown in Table 3.4 and are mostly unchanged compared with 2012. The majority of employees working in non-direct care occupations are ancillary workers, and they make up 69 per cent of the non-direct care workforce. There has been a very small increase in the share of care manager/coordinators and management (by 0.7 and 0.5 per cent respectively) and a corresponding small decrease in the share of ancillary workers (from 70 per cent to 69 per cent) and spiritual/pastoral care workers (from 2 per cent to 1 per cent).

Table 3.4: Employees not providing direct care in the residential aged care workforce, by occupation: 2012 and 2016 (per cent)

Occupation	2012	2016
Care Manager/Co-ordinator	6.6	7.3
Management	8.8	9.3
Administration	12.6	12.8
Spiritual/pastoral care	1.7	1.2
Ancillary care	70.4	69.3
Total (weighted)	**100**	**100**

Source: Census of residential aged care facilities.

3.2.3 Age and Gender

Previous iterations of the NACWCS conducted in 2003, 2007 and 2012 indicated that the residential aged care workforce was ageing and was, on average, older than the Australian workforce as a whole. In 2016, however, the age of the residential direct care workforce is slightly younger than in previous years.

Table 3.5 and Figure 3.3 show that in 2016 27 per cent of the direct care workforce was aged 55 years or over as in 2012. However, in contrast, the proportion of the workforce under the age of 35 years has risen to 25 per cent in 2016 (up from 19 per cent in 2012) exclusively due to an increase among those aged 25-34 years (from 12 per cent in 2012 to 19 per cent in 2016). The main loss these younger workers are replacing is in the 45–54 year age range which has fallen from 33 per cent (column 3) in 2012 to 28 per cent (column 4) in 2016.

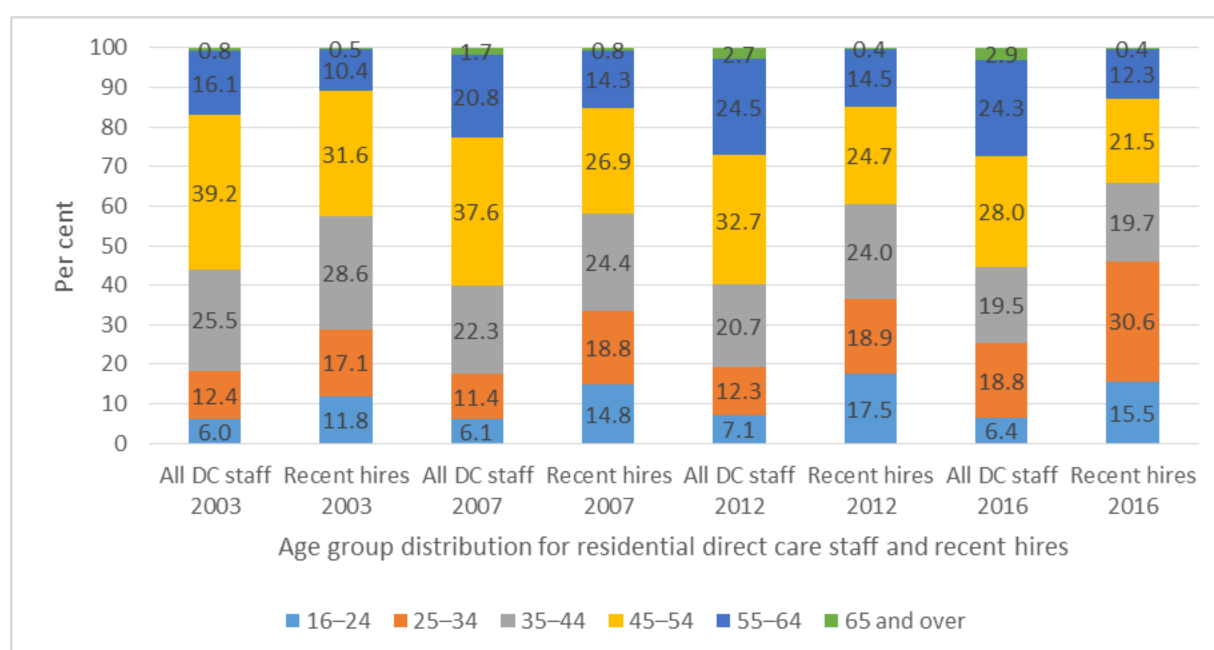
The age distribution of the workforce who have been recently hired (in employment for 12 months or less), presented in columns 5-8 of Table 3.5, emphasises that new hires are a key source of the observed change in the age structure of the workforce. Table 3.5 clearly shows the increased hiring of younger workers within the sector (particularly those aged 25-34 years). Given the strong retention record of the sector, this is an important development, also because younger workers are typically more amenable to up-skilling and to more specialised training. The age group of workers aged 34 years or younger (adding the first two rows) constitutes 46 per cent of all recent hires (column 8), an increase in this share from 36 per cent in 2012 (column 7). This 10 per cent share increase can be decomposed into a rise from 19 to 31 per cent for recent hires aged 25-34 years and a drop from 18 to 16 per cent for recent hires aged 16-24. In contrast the proportion of recent hires aged 55 years and over remained unchanged between 2007 (column 6) and 2012 (column 7) at around 15 per cent and fell slightly to 13 per cent in 2016 (column 8). The share of recent hires in the 45–54 year age group also fell from 25 per cent in 2012 to 22 per cent in 2016. Figure 3.3 also reflects these changes in the share of each age group over time.

Table 3.5: Age distribution of the residential direct care workforce, all direct care employees and recent hires: 2003, 2007, 2012 and 2016 (per cent)

Age (years)	All direct care employees				Recent hires*			
	2003 (Col 1)	2007 (Col 2)	2012 (Col 3)	2016 (Col 4)	2003 (Col 5)	2007 (Col 6)	2012 (Col 7)	2016 (Col 8)
16–24	6.0	6.1	7.1	6.4	11.8	14.8	17.5	15.5
25–34	12.4	11.4	12.3	18.8	17.1	18.8	18.9	30.6
35–44	25.5	22.3	20.7	19.5	28.6	24.4	24.0	19.7
45–54	39.2	37.6	32.7	28.0	31.6	26.9	24.7	21.5
55–64	16.1	20.8	24.5	24.3	10.4	14.3	14.5	12.3
65 and over	0.8	1.7	2.7	2.9	0.5	0.8	0.4	0.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

Figure 3.3: Age distribution of the residential aged care workforce: 2003, 2007, 2012 and 2016 (per cent)



The median age (the mid-point where half of the sample are younger and the other half are older) of the residential workforce for each of the occupations, is shown in Table 3.6. This confirms that the workforce is becoming younger. Compared to 2012, the median age of the residential direct care workforce has decreased from 48 years to 46 years. Looking at column 1, with a median age of 46 years in 2016, PCAs are the youngest of the occupational groups (one year less than the median age of PCAs in 2012); RNs are similar with a median age of 47 in 2016 (lower than their median age of 51 in 2012). Workers in the other occupations have a median age of 50 years in 2016 (unchanged since 2012 for AH but slightly higher for ENs). However, Table 3.6 (columns 2 and 3) clearly demonstrates that workers recently recruited into residential aged care are younger than the direct care workforce overall (36 years compared to 46 years); the extent of this differs by occupation. RNs have the oldest median age across occupations for recent hire workers (42 years). This is in contrast to the relatively youthful median age of recently hired PCAs (35 years) and AH workers (33 years).

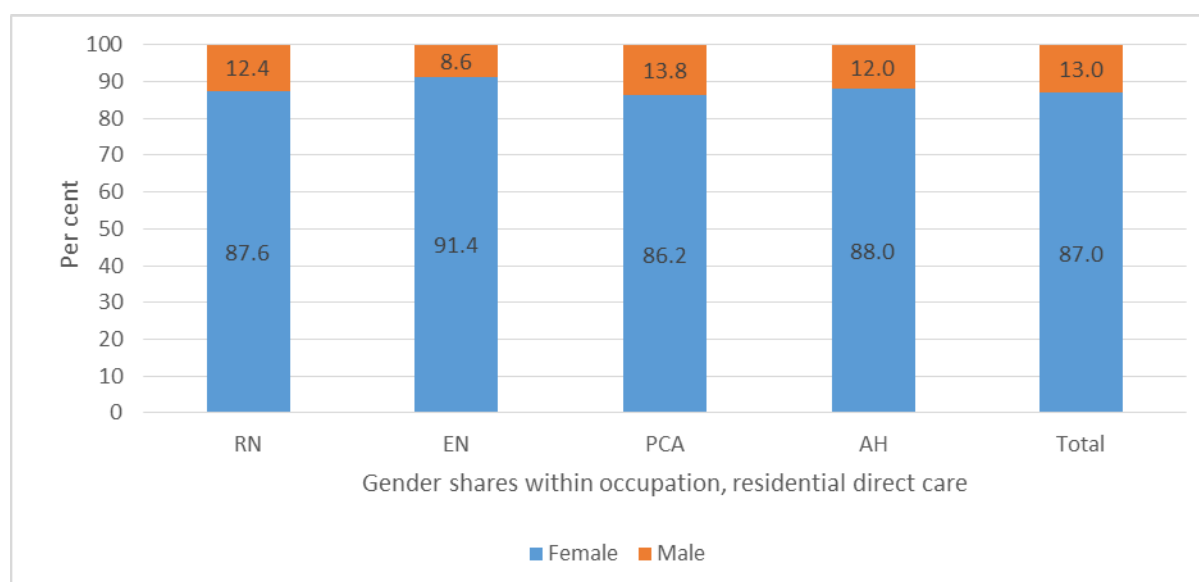
Table 3.6: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

	All direct care employees (Column 1)	Recent hires* (Column 2)	Difference in years in median age recent hires relative to all direct care employees (Column 3)
2016			
Registered Nurse	47	42	-5
Enrolled Nurse	50	37	-13
Personal Care Attendant	46	35	-11
Allied Health	50	33	-17
All occupations	46	36	-10
2012			
Registered Nurse	51	47	-4
Enrolled Nurse	49	44	-5
Personal Care Attendant	47	38	-9
Allied Health	50	41	-9
All occupations	48	40	-8

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

While the share of the male workers within the aged care sector has been increasing slowly over time, Figure 3.4 shows that the residential direct care workforce in 2016 remains predominantly female, (with 87 per cent female direct care workers). Among the different occupational groups, ENs have the smallest proportion of male workers at 9 per cent.

Figure 3.4: Gender distribution of the residential aged care workforce: 2016 (per cent)



3.2.4 Country of Birth

Between 2007 and 2012 there was a slight rise in the proportion of the residential direct care workforce that was overseas born (from 33 to 35 per cent). This rise has not continued; the proportion of the residential workforce born overseas has fallen slightly from 35 per cent in 2012 to 32 per cent in 2016 (see row 'other' in Table 3.7). This suggests perhaps that the retention of Australian born direct care workers has improved compared to that of the overseas born workers. However, a different picture emerges when examining the country of birth of

recently hired workers. The proportion of overseas born new hire workers has shown a continual rise from 34 per cent in 2007, to 37 per cent in 2012 and 40 per cent in 2016.

Table 3.7: Country of birth of the residential direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Country of birth	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
Australia	67.5	65.4	67.7	66.4	63.4	60.0
Other	32.5	34.6	32.3	33.6	36.6	39.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

The distribution of the residential aged care workforce born overseas, by occupation, is explored in Table 3.8. The census form asked facilities to provide the numbers of workers from a culturally and linguistically diverse background (CALD) for each occupation. The worker survey also asked workers to state where they were born and whether they spoke a language other than English. Although not directly comparable, these questions provide different perspectives on the level and distribution of the residential direct care workforce that were born overseas.

Table 3.8 shows that 29 per cent of all workers are migrants (column 1) and that their occupational distribution is broadly similar to that of the overall direct care workforce as reported in Table 3.2, although a slightly higher proportion of the migrant workers are RNs (20 per cent against 15 per cent in the general direct care workforce).

There is a difference in the overall proportion of CALD employees in the residential workforce (column 3), with facilities indicating that 26 per cent of their workers were in the CALD category, while worker responses (column 2) indicated that 22 per cent were both migrant and spoke a language other than English. Care needs to be taken in making direct comparisons of these proportions because they measure slightly different things (but the difference, while noted, is relatively small).

Table 3.8: The CALD residential direct care workforce, by occupation, comparing responses from all workers and all facilities: 2016 (per cent)

Occupation	Worker (migrant)[1] (Column 1)	Worker (migrant + LOTE)[2] (Column 2)	Facility (CALD)[3] (Column 3)
% of direct care employees	28.7	22.2	26.2
Distribution:			
Registered Nurse	19.8	19.8	18.1
Enrolled Nurse	6.0	4.8	5.2
Personal Care Attendant	70.3	72.1	74.0
Allied Health	3.9	3.3	2.7
Total	**100**	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities.
1. Workers who report having migrated to Australia.
2. Workers who report being both migrant and speaking a language other than English.
3. Facilities that report employees from culturally and linguistically diverse backgrounds.

In 2016 (as in 2012) the worker survey asked migrant workers who spoke a language other than English how long they had been living in Australia. Although not precise, this allows exploration of the extent to which workers are likely to be familiar with English as a language

and with Australian customs and norms. Table 3.9 shows that in 2016 39 per cent (a lower share compared to the 52 per cent in 2012) of all migrant workers speaking a language other than English have been in Australia for over 10 years. In contrast, in 2016 a total of 31 per cent (lower than the 35 per cent in 2012) have been here for 5 years or less. Of the occupational groups, more PCAs have been in Australia for 5 years or less (34 per cent in 2016, slightly fewer than the 39 per cent in 2012), while similarly in 2016 to 2012, a higher share of nurses and AH workers have been in Australia for more than 10 years.

Table 3.9: Time spent in Australia for migrant residential direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent)

	0–2 years	3–5 years	6–10 years	>10 years	Total
2016					
Registered Nurse	3.1	21.5	41.9	33.5	**100**
Enrolled Nurse	0.8	10.0	23.3	65.8	**100**
Personal Care Attendant	13.7	20.5	27.9	37.9	**100**
Allied Health	2.0	18.7	27.8	51.5	**100**
All occupations	10.6	20.1	30.4	38.8	**100**
2012					
Registered Nurse	10.7	16.9	20.0	52.4	**100**
Enrolled Nurse	4.0	9.0	12.0	75.0	**100**
Personal Care Attendant	15.1	23.7	11.7	49.5	**100**
Allied Health	11.1	18.1	13.9	56.9	**100**
All occupations	13.5	21.4	13.2	51.9	**100**

Source: Survey of residential care workers.

3.2.5 Aboriginal and Torres Strait Islander Workforce

Table 3.10 compares responses from the workers survey (column 1) and the facilities census (column 2) regarding the distribution of Aboriginal and Torres Strait Islander people in the residential direct care workforce. The proportion of Aboriginal and Torres Strait Islander people in the residential direct care workforce is low, representing 1 per cent of the workforce and 2 per cent of surveyed workers. This is similar to the corresponding figure in 2012. We note that the small sample size makes these estimates rather imprecise. With this caveat in full view we discuss the relevant parts of Table 3.10. Residential facilities report in 2016 that 1 per cent of the residential direct care workforce (approximately 1,848 workers) are of Aboriginal and Torres Strait Islander descent (Table 3.10 Facility, column 2). Amongst the Aboriginal and Torres Strait Islander workforce, around 10 per cent are RNs, 7 per cent ENs, 81 per cent PCAs, and 2 per cent AH workers.

Compared to the overall residential direct care workforce (Table 3.2), Aboriginal and Torres Strait Islander workers are more likely to be employed as PCAs and are consequently less likely to be in a nursing or allied health role. It is not clear whether this is a result of a shortage of Aboriginal and Torres Strait Islander people with the appropriate qualifications or that those who have the qualifications choose not to work in aged care. However, this imbalance in occupational distribution has improved since 2012. Now a higher proportion of Aboriginal and Torres Strait Islander workers are nurses (17 per cent from 12 per cent) and a lower proportion are PCAs (81 per cent from 85 per cent).

Table 3.10: The Aboriginal and Torres Strait Islander residential direct care workforce, by occupation, comparing facility and worker responses: 2012 and 2016 (per cent)

	Worker survey (Column 1) Workforce	Facility census (Column 2) Workforce
2016		
% of direct care employees	2.0	1.2
Of these, distribution in direct care roles		
Registered Nurse	3.6	9.6
Enrolled Nurse	5.5	7.4
Personal Care Attendant	89.0	80.9
Allied Health	1.9	2.1
Total	**100**	**100**
2012		
% of direct care employees	1.9	1.0
Of these, distribution in direct care roles		
Registered Nurse	4.3	5.2
Enrolled Nurse	6.4	6.4
Personal Care Attendant	87.1	85.4
Allied Health	2.1	3.0
Total	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities.
**Because the numbers of Nurse Practitioners are small, Nurse Practitioners are included with RNs.*

3.2.6 Health

Health status impacts upon an employee's capacity to undertake work tasks and, ultimately, their job retention. As in previous years, a standard measure of self-assessed health drawn from the ABS is used (rating health as excellent, very good, good, fair or poor). The proportion of employees indicating in 2016 that they are in either 'very good' or 'excellent' health is always greater than 60 per cent, but for recently hired PCAs it is much higher at 73 per cent (Table 3.11). As recently hired PCAs had a median age of 35 years (Table 3.6), the better reported health of PCAs likely reflects their younger age. Very few direct care workers have fair or poor health (fewer than 10 per cent, except for recently hired AH workers at 11 per cent) which may also be indicative of the health requirements for working in aged care.

Table 3.11: Self-assessed health of the residential direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	PCA	AH	Nurse	PCA	AH
Excellent	17.4	19.8	16.9	20.7	26.9	18.2
Very good	44.0	41.3	47.7	42.9	46.5	50.7
Good	32.7	31.1	26.4	31.4	21.8	19.6
Fair	5.6	7.2	8.1	4.8	4.4	11.4
Poor	0.3	0.5	1.0	0.1	0.4	0.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

3.2.7 Education

This section focuses on the formal education of the workforce in 2016. The expanded number of questions asked about education and training which started in 2012 has been continued in 2016; this includes the collection of information about the qualifications of care managers and care leaders. Additional categories of qualifications related to disability care were added to the education questions in 2016 for the first time.

As shown in Table 3.12, the worker survey asked respondents about the qualifications they had completed post-school (with multiple responses permitted, hence there can be overlap between the shares of each type of qualification held). Looking firstly at the qualifications held by care managers and leaders, different educational pathways were found for these leadership roles. In 2016, the majority of care managers (64 per cent, against 54 per cent in 2012) have at least a degree in nursing, with 18 per cent (similar to the 19 per cent in 2012) holding a Certificate III or IV in management. In comparison, the most common qualification for care leaders in 2016 is a Certificate III (41 per cent, similar to the 42 per cent in 2012) or Certificate IV in aged care (25 per cent, slightly more than the 22 per cent in 2012), yet a substantial minority hold nursing qualifications, and a relatively low proportion hold a qualification in management. This suggests that while residential facility care managers are drawn primarily from nursing (and especially RNs), in contrast residential care leaders are drawn from a wider cross-section of the workforce.

Focusing now on the educational qualifications held by the direct care workforce as a whole, Table 3.12 shows that 90 per cent of these workers hold post-secondary qualifications, indicating widespread engagement in further education. This is a slight increase from 2012 when 86 per cent of workers had post-secondary qualifications (following an earlier increase from 2007 when 79 per cent had these). As might be expected, there is variation between occupations. For example, in 2016 the share of PCAs who had not undertaken further education (13 per cent compared to 16 per cent in 2012) is much higher than that of RNs (3 per cent, the same as in 2012).

The types of qualifications undertaken by direct care workers show there is a quite close correspondence between qualifications and occupations, which is a strong sign for a well-matched and efficient workforce. A high proportion of nurses have qualifications in health-related areas, with RNs having mostly degree-level qualifications, while ENs are more likely to hold a Certificate IV or diploma. A high proportion of PCAs and AH workers hold Certificate level qualifications in Aged Care.

Examining the educational attainments of PCAs further, we see that around two-thirds have a Certificate III in Aged Care (67 per cent in 2016), which is considered to be the standard qualification for working in this occupation. This proportion has stayed constant since 2012, and going back since 2003. In contrast, the proportion of PCAs with a Certificate IV in Aged Care has steadily increased from 8 per cent in 2003 to 20 per cent in 2012 and 23 per cent in 2016.

Residential aged care direct care workers with a disability related qualification (this question was asked for the first time in 2016) are mainly PCAs and AH workers. For PCAs, this qualification is most typically a Certificate III in Disability. AH workers show no concentration in any specific type of disability related qualification. Note that workers can hold more than one qualification type and there can be overlap where Certificate IV holders also have a Certificate III.

Table 3.12: Post-school qualifications completed by the residential direct care workforce, by occupation: 2016 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	PCA	AH	All DCW*
No Post-school							
Year 10 or below	0.4	2.9	0.6	1.1	6.1	2.8	4.7
Year 11/12	2.0	3.3	2.2	2.1	6.5	2.6	5.3
Health							
Certificate IV/Diploma in Enrolled Nursing	8.6	27.3	7.2	82.0	4.5	4.1	12.6
Other basic nursing qualification	16.1	8.2	13.2	8.4	4.3	2.9	5.9
Post-basic nursing qualification	10.3	3.9	10.1	2.7	0.9	0.2	2.3
Bachelor Degree in Nursing	64.2	23.9	75.4	3.4	3.3	1.7	13.6
Bachelor Degree in Allied Health Profession	0.5	1.3	0.8	0.1	0.3	19.6	1.2
Postgraduate allied health qualification	2.3	0.8	2.2	0.2	0.3	6.2	0.8
Other health related	11.0	5.4	8.3	5.1	4.5	12.3	5.5
Aged Care							
Certificate III in Aged Care	11.1	41.2	13.0	32.5	67.4	35.8	54.6
Certificate III in Home and Community Care	2.1	5.9	1.3	4.2	12.0	8.2	9.5
Certificate IV in Aged Care	6.6	24.5	3.7	10.4	22.9	17.6	18.6
Certificate IV in Service Coordination	0.4	1.7	0.3	1.1	1.5	3.5	1.4
Other Certificate in Care Work	2.6	6.0	1.5	3.9	5.8	11.8	5.2
Post basic nursing qualification in aged care	7.0	1.5	5.5	1.5	0.6	0.0	1.4
Other aged care related	8.5	5.2	5.9	3.3	4.1	17.2	4.9
Disability							
Certificate III in Disability	0.5	2.4	0.6	1.4	5.2	2.9	4.0
Certificate IV in Disability	0.2	1.1	0.3	1.1	2.2	2.4	1.8
Diploma in Disability	0.3	0.2	0.2	0.2	0.2	0.5	0.2
Diploma Community Service	0.4	0.3	0.4	0.5	0.4	2.4	0.5
Other (Disability related)	0.5	0.6	0.7	0.7	0.7	1.8	0.7
Management							
Certificate III or IV (Management)	17.6	8.0	11.5	6.4	3.6	5.8	5.1
Diploma (Management)	16.9	3.0	9.3	3.6	2.2	4.6	3.5
Bachelor or Postgraduate Degree (Management)	8.6	2.1	7.4	0.5	1.7	1.5	2.4
Other							
Certificate III or IV (Other)	12.9	12.7	10.1	11.4	12.4	24.8	12.5
Diploma (Other)	5.4	4.9	5.3	7.2	4.6	11.4	5.3
Bachelor or Postgraduate Degree (Other)	10.7	3.5	8.9	2.2	5.5	5.3	5.7

Source: Survey of residential care workers.
**All DCW (direct care workers), does not include care managers or care leaders.*
Note: Because staff can have more than one qualification, the columns do not sum to 100.

The residential facility census also asked facility managers to provide information about the extent to which PCAs working in their facility had completed a Certificate III or IV in Aged Care (Table 3.13). Their responses reinforce the picture of a highly qualified PCA workforce. The proportion of facilities with no PCAs with Certificate III qualifications was 2 per cent, the same as in 2012, but less than half what it was in 2007 (5 per cent). The proportion of facilities with more than three-quarters of PCAs holding a Certificate III rose from 47 per cent in 2007 to 62 per cent in 2012 and rose slightly more to 66 per cent in 2016. While in the past there was a marked decrease in the number of facilities with no PCAs holding a Certificate IV in Aged Care, dropping from 42 per cent in 2007 to 22 per cent in 2012, there was a slight rise to 24

per cent in 2016. The majority of facilities (56 per cent in 2016, slightly fewer than the 58 per cent in 2012) had 1-24 per cent of their PCAs with a Certificate IV.

Table 3.13: Distribution of residential facilities by proportion of Personal Care Attendants (PCAs) with Certificate-level qualifications: 2007, 2012 and 2016 (per cent)

Proportion of PCAs with each type of qualification	Certificate III in Aged Care			Certificate IV in Aged Care		
	2007	2012	2016	2007	2012	2016
Zero	5.2	1.8	2.2	42.2	21.8	23.5
1–24	5.5	4.1	4.5	44.8	57.6	55.6
25–49	14.9	9.3	8.7	8.9	13.4	12.8
50–74	27.0	23.1	18.4	2.5	3.8	4.4
75–99	47.4*	43.9	42.6	1.5*	1.7	2.2
100		17.6	23.6		1.8	1.4
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.
**In 2007, the categories were for 75-100%.*

The survey of residential care workers specifically collected information regarding the undertaking of specialised qualifications in ageing or aged care. Table 3.14 shows that in residential aged care 71 per cent of RNs, 79 per cent of Care Leaders and 63 per cent of Care Managers do not have specialised qualifications in ageing or aged care. As these are the occupations that provide leadership in the provision of care within a residential aged care facility, the extent to which they understand the specific physical and mental health issues facing older Australians is important and relevant. These proportions are very similar or mostly unchanged since 2012. Of those with the specialised aging or aged care qualifications in 2016, palliative care and gerontology are the most prevalent.

Table 3.14: Specialised qualifications in ageing or aged care of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Care Manager	Care Leader	RN	EN	PCA	AH
2016						
None	63.4	78.9	71.0	82.5	85.2	77.7
Specialisation in:						
Gerontology	13.8	2.7	10.2	1.9	0.3	3.3
Palliative care	13.3	11.2	10.8	9.0	7.4	4.0
Psychogeriatrics	1.3	0.2	1.0	0.6	0.2	0.3
Other	12.1	6.6	8.3	7.0	7.1	14.1
2012						
None	63.0	75.8	69.0	80.2	84.0	74.1
Specialisation in:						
Gerontology	14.0	2.5	10.4	1.3	0.1	1.4
Palliative care	12.0	11.5	11.0	8.4	6.8	6.3
Psychogeriatrics	2.4	0.8	2.1	1.0	0.2	0.3
Other	8.6	9.4	7.5	9.1	8.9	17.9

Source: Survey of residential care workers.

The level of study currently being undertaken by the direct care workforce is shown in Table 3.15. Across all occupations fewer residential aged care workers were found to be studying in 2016 compared to 2012 (16 per cent and 22 per cent respectively). In 2016 17 per cent of

PCAs, 12 per cent of RNs, 15 per cent of ENs and 11 per cent of AH workers were engaged in study (in contrast, in 2012, 25 per cent of PCAs, 13 per cent of RNs, 19 per cent of ENs and 21 per cent of AH workers were engaged in study).

Table 3.15: Current study of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	RN	EN	PCA	AH	All occupations
2016					
Not currently studying	88.4	85.3	82.9	89.1	84.2
Currently studying	11.6	14.7	17.1	10.9	15.8
Total	**100**	**100**	**100**	**100**	**100**
2012					
Not currently studying	87.0	81.1	75.1	78.6	77.9
Currently studying	13.0	18.9	24.9	21.4	22.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

3.3 The Main Characteristics of the Work

The experience of aged care work is strongly impacted upon by the context within which the work takes place. In this section the focus is on aspects of work that are primarily shaped by the employer, comprising the forms of employment offered, the shifts and hours worked, and the extent of training provided. The proportion of workers who hold multiple jobs is also included because this is an indicator of whether their current job is meeting their needs.

3.3.1 Employment Arrangements and Hours Worked

The employment arrangements and working hours available in aged care are important factors affecting the attractiveness of work in the sector. In 2016, as was the pattern since 2003, the majority of workers in all residential aged care direct care occupations are employed on permanent part-time contracts (Table 3.16), with these now forming 78 per cent of the workforce employment arrangements, compared with 72 per cent in 2012, and 69 per cent in 2007. We also note a further shift away from casual/contract arrangements. In 2016 these arrangements represented 10 per cent of all workforce employment arrangements (substantially less than the 19 per cent in 2012 and the 22 per cent in 2007). Staffing within residential aged care is therefore derived from an overwhelmingly part-time direct care workforce.

There also continue to be occupational differences relating to the form of employment in 2016 as in 2012, with a higher proportion of RNs than other occupations employed on a permanent full-time basis (22 per cent in 2016, up from 19 per cent in 2012). The proportion of casual or contract employment was halved between 2012 and 2016 for all occupations, with the exception of AHs where it was reduced to a third (from 15 per cent to 5 per cent). These jobs appear to have shifted to permanent part-time employment.

Table 3.16: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	22.4	67.7	9.8	**100**
Enrolled Nurse	13.4	78.9	7.8	**100**
Personal Care Attendant	8.9	80.3	10.8	**100**
Allied Health	19.9	75.3	4.8	**100**
All occupations	11.9	78.1	10.1	**100**
2012				
Registered Nurse	19.3	61.3	19.4	**100**
Enrolled Nurse	10.5	74.7	14.8	**100**
Personal Care Attendant	6.9	73.6	19.5	**100**
Allied Health	12.0	72.9	15.1	**100**
All occupations	9.5	71.8	18.7	**100**

Source: Census of residential aged care facilities.
Row percentages shown.

Table 3.17 presents work schedules by occupation. Between 2007 and 2012 there was a marked change in the types of shifts worked, with a move towards employing more nurses on regular shifts rather than rotating ones (a change that was also observed in previous years between 2003 and 2007). This long-standing trend appears to have been reversed in 2016, with the proportion of nurses working a regular daytime shift having fallen to 61 per cent, accompanied by a corresponding rise in the proportion working a rotating shift (19 per cent in 2016 up from 15 per cent in 2012). The work schedules of PCAs and AH workers do not seem to be changing over time with most of the shifts that are not regular daytime shifts being worked by PCAs and with close to all AH workers working regular daytime shifts.

Table 3.17: Work schedule of the residential direct care workforce, by occupation: 2007, 2012 and 2016 (per cent)

Work schedule	Nurse			PCA			Allied Health		
	2007	2012	2016	2007	2012	2016	2007	2012	2016
A regular daytime shift	57.1	64.9	61.2	50.6	50.8	50.6	95.6	92.0	93.8
A regular evening shift	12.5	8.3	8.8	14.0	14.3	15.0	0.4	2.2	0.7
A regular night shift	5.8	3.9	3.8	5.3	5.1	5.0	0.2	0.0	0.0
A rotating shift	16.2	14.5	19.0	19.7	19.5	19.5	1.7	2.2	1.4
Spilt shift	0.5	0.5	0.3	0.6	1.1	0.8	0.2	0.5	0.1
On call	0.6	1.0	0.6	1.3	1.5	1.5	0.4	0.7	0.3
Irregular schedule	5.1	5.2	5.3	6.7	6.4	6.5	1.1	1.2	2.1
Other	2.1	1.6	0.9	1.8	1.3	1.1	0.4	1.0	1.5
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
Table 3.19 below show the hours worked by employees in residential facilities.

The left side panel of Table 3.18, shows the actual hours worked per week. Over all direct care occupations, 44 per cent of the residential aged care workforce is working for 35 hours or more per week, which falls within the ABS definition of full-time work (this is slightly less than the 46 per cent in 2012). The difference between the proportions reporting to be working

less than 35 hours (35 per cent for RNs, 51 per cent for ENs, 62 per cent for PCAs and 45 per cent for AH workers) in Table 3.18 and those reporting a permanent part-time employment arrangement (68 per cent for RNs, 79 per cent for ENs, 80 per cent for PCAs and 75 per cent for AH workers in Table 3.16). The difference indicates that many people are putting in full-time working hours (i.e. more than 35 hours) while employed on a permanent but part-time contract.

There is some variation in the hours worked across occupational groups. RNs form the occupation with the highest proportion of workers working long hours (>40 hours per week, 23 per cent), while PCAs are most likely to be working for 16–34 hours per week (57 per cent). This suggests a possible skills shortage in RNs and excess capacity among PCAs. This overall picture is similar to 2012.

The columns in the right side panel of Table 3.18, show the hours that employees would prefer to work by the same groups and occupations. As similar to 2012, the hours preferred by the largest proportion of workers are 35–40 hours per week (47 per cent of workers). Table 3.18 highlights some discrepancies between the hours actually worked by aged care workers and the number of hours they would rather work. While only 5 per cent of the RNs express a preference for working more than 40 hours a week, 23 per cent of them report working in excess of 40 hours. A large discrepancy is also seen for AH workers (with 5 per cent preferring to work more than 40 hours per week compared to 5 per cent who actually do). These figures potentially indicate that there is a situation of over-utilisation of some types of aged care workers such as RNs and AHs which may reflect tensions on the labour market, such as skill shortages or other demand-related factors such as rigidities of employment contracts. This is not a new picture and it suggests either the presence of managerial constraints to address these issues or that the training and attraction strategies of the aged care sector have not worked as well as desired.

Table 3.18: Actual working hours and preferred working hours of direct care workers in the residential aged care workforce, by occupation: 2016 (per cent)

Occupation	Actual hours per week				Preferred hours per week			
	1–15	16–34	35–40	>40	1–15	16–34	35–40	>40
Registered Nurse	3.0	32.2	41.8	23.0	2.3	36.6	55.8	5.3
Enrolled Nurse	3.4	47.6	38.2	10.8	3.3	47.0	42.7	7.1
Personal Care Attendant	4.6	57.2	31.8	6.4	2.3	44.7	45.1	7.9
Allied Health	4.7	40.3	43.5	11.6	3.5	36.8	54.3	5.4
All occupations	4.3	51.8	34.4	9.5	2.4	43.4	46.8	7.3

Source: Survey of residential care workers.
Row percentages shown).

In examining the hours worked mismatch shown by the difference between actual and preferred hours worked, Table 3.19 shows the extent of the mismatch in terms of the preferred change in the number of hours (both positive and negative) and how these compare to previous years. Over all, the picture has been stable over time, with between 45-50 per cent wanting different hours. Of these just under two thirds want to increase their hours and just below one third want to decrease them.

The information in Table 3.19 indicates that, similar to 2012, 56 per cent of the workforce are happy with their current hours. Among the 44 per cent of the direct care workforce who reported in 2016 that they would like to change their hours, 14 per cent want to work fewer hours against 30 per cent who would prefer to work longer hours. The proportion of workers wanting to increase their hours has increased slightly since 2012 (from 30 per cent to 27 per cent). Residential direct care workers preferring an increase in hours are most likely to want a relatively small increase per week of 1–5 hours. The reasons for hours worked not being perfectly matched may stem from the inflexibility of employment contracts and the needs of

the employer (the labour demand side), but they may also stem from the specific personal and family circumstances of the workers (the labour supply side). Table 3.19 presents the net mismatch, reflecting all demand and supply pressures. Further investigation would be needed in order to understand what the best policy would be to alleviate the mismatch.

Table 3.19: Preferred change in working hours of the residential direct care workforce: 2003, 2007, 2012 and 2016 (per cent)

Desired change in hours	2003	2007	2012	2016
10+ hours less	5.5	4.0	6.2	4.9
1–9 hours less	8.5	7.5	11.0	9.1
No change in hours	57.6	60.4	55.6	55.8
1–5 hours more	13.2	12.2	12.3	13.0
6–10 hours more	10.5	10.7	9.3	10.5
11+ hours more	4.6	5.1	5.6	6.7
Total	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

3.3.2 Wages

At the time of the 2012 NACWCS, the Australian Productivity Commission Report (2011) highlighted the need for improved wage rates within aged care in order to improve the attractiveness of the sector to current and future workers. The wages paid to direct care workers in aged care continues to be a pertinent issue and the 2016 survey again collected information on earnings within the sector. Table 3.20 presents the reported gross median weekly earnings[4] for each occupation participating in the residential aged care workers survey by four groupings of number of hours worked per week (1-15, 16-34, 35-40, and more than 40).

In 2016, the gross median weekly wage reported by RNs is $1,352 per week. As discussed above, a high proportion of RNs work more than 35 hours per week and we expect this to be reflected in their median weekly wage. However, even when working part-time, RNs report a higher median weekly wage than other occupations. This was also the case in 2012.

More than half (57 per cent) of residential PCAs work 16–34 hours per week (Table 3.18), and they receive a median weekly wage of $689 (Table 3.20). In contrast, 49 per cent of all ENs work 35 hours or more (Table 3.18), with a median weekly wage of between $1,000 and $1,050 (Table 3.20). While AH Professionals ($820) have a higher median wage than AH Assistants ($750), the difference is relatively small. This is somewhat surprising given the higher qualifications required of AH Professionals. Except for those AH Professionals working more than 40 hours, their median wage is similar to that of PCAs than of ENs or RNs. This is unchanged from 2012. The median wage for AH Assistants is lower than that of any other occupation across all hours worked except for those working more than 40 hours per week, and this is also unchanged from 2012. Part of the reason for AH workers having lower median wages than other occupations may be due to the fact that most work a regular daytime shift (94 per cent, Table 3.17) and would not receive any financial benefits of working evenings, nights or being on call.

[4] As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).

Table 3.20: Median weekly earnings (gross) of the residential direct care workforce, by occupation and working hours: 2016 ($ per week)**

Occupation	Hours per week 1–15	16–34	35–40	>40	All hours
Nurse Practitioner	*	*	*	*	1,000
Registered Nurse	525	1,050	1,493	1,600	1,352
Enrolled Nurse	355	800	1,050	1,000	946
Personal Care Attendant	389	689	860	850	750
Allied Health Professional	340	692	969	942	820
Allied Health Assistant	310	627	855	868	750
All occupations	400	709	940	1,000	800

Source: Survey of residential aged care workers.
**Because the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories.*
***As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).*

3.3.3 Multiple Job Holding

The extent to which employees hold multiple jobs is also an indicator of spare capacity within the existing workforce. In 2016, approximately 9 per cent of residential direct care employees have more than one job (Table 3.21). The figure is roughly the same as in 2012. For those concerned, most of the 'other' jobs held by RNs, PCAs, ENs and AH workers are also in residential aged care (4 out of the 9 per cent), a few were in home care and home support (1 per cent), while a further 4 per cent had another job outside of the aged and disability care sectors. Multiple job holdings within aged care reinforce the picture of a loyal sector workforce.

In the 2016 survey, an additional category was added to the question eliciting the number and nature of the jobs currently held by aged care workers. The workers could report whether they had another job in disability care. This information is particularly relevant given the roll out of the National Disability Insurance Scheme (NDIS) which has the potential to generate labour mobility from the aged care sector. The figures show no evidence that aged care workers who hold multiple jobs are now taking up jobs in the disability care sector (the categories that are in common between 2012 and 2016 do not show significant distributional shifts). Since the NDIS has not yet been fully rolled out, it is too early to make any statements about the effect of the NDIS on the mobility of the aged care workforce.

Table 3.21: Prevalence of multiple job-holding among residential direct care workers, by occupation: 2012 and 2016 (per cent)

Jobs held	RN	EN	PCA	AH	All occupations
2016					
Only have one job	88.8	91.3	91.3	89.6	90.9
Other job in residential aged care	4.7	4.6	3.4	3.0	3.7
Other job in home care and home support aged care	0.3	0.4	1.2	0.5	0.9
Other job in disability care*	0.2	0.5	0.4	0.2	0.4
Other job not in aged care or disability care*	6.0	3.2	3.7	6.7	4.1
2012					
Only have one job	88.1	89.0	89.9	88.1	89.4
Other job in residential aged care	5.5	3.5	4.4	2.5	4.4
Other job in community aged care	0.5	0.6	1.0	1.2	0.9
Other job not in aged care	6.0	7.0	4.7	8.4	5.4

Source: Survey of residential aged care workers.
Note: Multiple response allowed.
** 'Other job in disability care' and 'Other job not in aged care or disability care' only asked in 2016.*

Training

Training is an important activity which contributes to the skilling of the aged care workforce. Previously in Section 3.2.7 the extent of the post-school qualifications held by the residential direct care workforce was examined. Now in Table 3.22 we show the training undertaken 'on the job' or to maintain these qualifications, for example, continuing and professional development (CPD). The residential worker survey asked workers about their participation in different forms of training and what the purpose of this training was. It also asked them about the areas of training they thought they needed in the next 12 months, and this question was also asked of facilities with respect to the additional training they thought was required for their PCA workforce. These questions were repeated in 2016 after they were asked for the first time in 2012.

The majority of workers had engaged in CPD (58 per cent) and training (80 per cent) in the past 12 months. Mandatory training was the most common form of training undertaken, with 76 per cent of the workforce having participated in this type of training in 2016. Some differences can be observed between occupations, with participation in non-mandatory training undertaken by a higher proportion of RNs (38 per) than workers in other occupations. The level of engagement in CPD was lower for PCAs than for other occupational groups (47 per cent). Overall, the 2016 figures differ very little from the situation observed in 2012.

Table 3.22: **Participation in training and/or continuing professional development (CPD) by residential aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent)**

	RN	EN	PCA	AH	All occupations
2016					
CPD	91.6	85.4	46.7	63.6	57.8
Training:					
No training	12.8	15.6	21.5	21.2	19.6
Mandatory training	81.3	78.8	74.7	74.7	76.1
Non-mandatory training	37.7	31.7	18.4	24.8	22.8
2012					
CPD	88.0	79.1	49.6	63.4	60.0
Training:					
No training	15.9	19.1	19.2	18.1	18.6
Mandatory training	75.6	75.7	75.7	73.8	75.6
Non-mandatory training	40.8	32.6	21.5	32.9	26.5

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100.

As Table 3.23 shows, those residential aged care workers who did participate in training stated that developing or improving their skills either for their current job or in general was the main motivation for undertaking training. Another widely nominated aim was to maintain professional/occupational standards; this was particularly important for RNs and ENs. Slightly more than half of the workers who undertook training in each occupational category indicated the need to meet accreditation requirements as their purpose for engaging in training.

A less frequently nominated reason for undertaking training was to address health and safety concerns, although this was more commonly indicated by PCAs (25 per cent) and AH workers (20 per cent) than RNs (14 per cent) and ENs (15 per cent). Smaller proportions of the workforce who undertook training viewed engaging in training as a means to help directly with career development in terms of securing a future job or promotion in residential aged care or to help get started in their aged care job. This pattern is very similar to that of 2012.

Table 3.23: **Stated aims of training undertaken by the residential direct care workforce that undertook training during the last 12 months, by occupation: 2016 (per cent)**

Aim of training	RN	EN	PCA	AH
Improve skills in current job	65.6	65.5	71.3	64.3
Develop skills generally	51.8	49.2	49.0	44.6
Maintain professional/occupational standards	74.9	69.5	53.2	56.8
Meet accreditation requirement	50.1	53.4	54.9	56.7
Safety/health concerns	14.0	15.4	25.2	20.3
Prepare for future job/promotion	12.2	8.2	8.8	9.0
Help get started in job	6.5	3.6	7.4	7.2
Other	7.1	4.5	4.1	3.6

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns does not sum to 100.

The types of training viewed as most needed by residential direct care workers are shown in Table 3.24. There was variation between the occupational groups. Residential workers viewed

dementia training and palliative care and, to a lesser extent, wound management, as priority areas. Half of RNs also sought training in management and leadership. The relatively high proportion of workers responding to a number of areas in which training is needed, suggests a willingness to engage in such training where it is offered. The separately gathered responses from residential workers and residential facilities about the training most needed for PCAs show that they are closely matched in terms of priorities, although the extent to which they were nominated differed. The three areas of training viewed as most needed were dementia training, palliative care and wound management. This pattern is similar to that of 2012.

Table 3.24: Areas of training identified as most needed in the next 12 months for the residential direct care workforce, by occupation, comparing facility and worker responses: 2016 (per cent)

Area of training	RN	EN	PCA		AH
	Workers	Workers	Workers	Facilities*	Workers
Dementia training	51.3	54.9	63.3	92.7	68.1
Palliative care	45.9	58.2	52.0	72.4	32.1
Management and leadership training	50.2	27.8	17.5	13.7	27.4
Wound management	38.9	57.0	29.3	44.4	4.7
Mental health	21.0	31.2	32.9	28.8	28.2
Allied health	4.3	4.9	9.0	9.1	24.8
Other	6.1	4.3	5.0	15.0	7.0

Source: Survey of residential aged care workers and Census of residential aged care facilities.
Note: Multiple responses were allowed, columns will not sum to 100.
**Facilities were only asked about their training requirements for PCAs.*

3.4 Career Paths

This section looks at the pathways into and out of aged care jobs, both within the sector and within the current roles of direct care workers. This information explores the occupational backgrounds of the workforce, when they first considered entering the direct care workforce, how long they have been in the workforce and what their intentions are in the near future. Some of the common pathways for different occupations are identified and areas that have changed or may be of interest for future planning are highlighted. Career paths can also be good indicators of the attractiveness of a sector and of the loyalty of the workforce to aged care.

3.4.1 Into Aged Care

For about 8 to 9 per cent of residential direct care workers, aged care work is their first occupation, that is, they have not had another occupation before. The proportion is greater for PCAs (14 per cent) than other workers (Table 3.25). Slightly more than one-third of PCAs (36 per cent) had a background in sales, hospitality, cleaning or clerical work, all of which are female dominated occupations that require minimal qualifications. Apart from nursing, there is no clear pathway into aged care for the other occupations. This is shown in Table 3.25 by the large share with ‘other’ occupational backgrounds (25 per cent ENs, 31 per cent for PCAs, 30 per cent for AH workers). For RNs, in total 48 per cent came from previous nursing work in acute or community care settings, showing that they come to aged care after having worked for a portion of their career in the same nursing occupation within a different setting. While about a quarter of ENs (18 per cent) share this occupational background, 59 per cent had worked in non-care occupations before entering aged care. AH workers came to aged care from a range of occupations, 12 per cent with a professional background (other than nurse) and another 20 per cent had worked in health and social care occupations.

Table 3.25: Activity prior to first job in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Last occupation before first aged care job	RN	EN	PCA	AH
No previous paid employment	8.1	9.4	14.2	7.9
Nurse, acute care	41.0	15.3	2.0	3.2
Nurse, community	7.1	2.8	0.8	1.0
Other health care	9.1	6.2	3.3	7.3
Carer in other setting	3.9	4.7	4.9	5.1
Disability care	2.1	2.9	2.6	3.7
Salesperson	2.3	10.1	7.7	6.6
Clerical worker	2.8	5.4	6.8	8.3
Hospitality worker	4.1	9.9	13.6	10.6
Cleaner	1.1	2.6	7.9	2.8
Professional (other than nurse)	2.4	3.2	2.4	11.7
Manager	4.6	1.9	2.7	2.0
Other paid employment	11.4	25.4	31.1	29.8
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.26 presents the age at which workers entered the aged care sector. As noted for Table 3.25, the majority of direct care workers have worked in other areas prior to entering aged care occupations and this may help explain the relatively high median age of the residential aged care workforce (46 years, Table 3.6). The age at which workers enter aged care also helps to explain the overall age structure of the workforce and its sustainability over time. If workers are consistently recruited from older age groups, then the overall higher median age of the workforce may not be a major issue. Table 3.26 shows that in 2016, 35 per cent of the direct care workforce had entered aged care at age 40 years or above, although there is variation between the occupational groups. For PCAs (39 per cent) and AH workers (38 per cent), slightly fewer than 40 per cent of workers had entered aged care at age 40 years or above, while for RNs (24 per cent) and ENs (24 per cent) this share was around a quarter as these occupations had more often started working in aged care when they were younger. For both nursing occupations, around 48 per cent entered aged care before they were 30 years of age. This likely reflects the educational pathway into aged care for RNs whereby they would complete their education and training within other health sectors before entering aged care on graduation (48 per cent, Table 3.25).

Table 3.26: Age at which began working in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Age (years)	RN	EN	PCA	AH	All
21 or under	15.4	26.2	14.3	16.1	15.7
22–29	33.4	22.1	20.0	24.1	22.3
30–39	27.6	27.3	26.6	21.9	26.6
40–49	16.3	20.6	27.6	26.4	25.3
50+	7.3	3.7	11.5	11.4	10.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

The age at which workers enter aged care (shown in Table 3.26) is partly reflected in the number of years they are able to remain in the residential aged care workforce (shown in Table 3.27). For example, a relatively high proportion of PCAs had started working in aged care at 40 years or above (39 per cent Table 3.26), and they form the lowest proportion of workers

(11 per cent in 2016 Table 3.27), who had been part of the residential aged workforce for more than 19 years. This latter proportion is far lower than the 17 per cent in 2012 (Table 3.27). In contrast, for both RNs (37 per cent) and ENs (46 per cent), a far greater share have worked in aged care for 14 years or more. The information in Table 3.27 suggests that a relatively high proportion of workers have committed many years to working in aged care, with 42 per cent of the residential aged care workforce (see all occupations in Table 3.27) having worked in the sector for more than 9 years in 2016 (but this was the case for far fewer PCAs, where the share was 35 per cent).

Compared to 2012, time spent in aged care in 2016 is shorter (Table 3.27). In 2016 42 per cent of the direct care residential aged care workforce had more than 9 years' experience in the sector compared to 58 per cent in 2012. This is partly due to the slightly younger age profile of the residential workforce in 2016. In particular PCAs are now being hired at a younger age (the median age of recent PCAs is 35 years, Table 3.6).

Table 3.27: Total time spent working in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Total time in aged care (years)	RN	EN	PCA	AH	All occupations
1 year or less	6.1	3.0	13.9	9.3	11.5
More than 1 year–4 years	15.6	9.8	23.5	18.5	20.7
More than 4 years–9 years	23.4	21.2	27.1	24.4	25.8
More than 9 years–14 years	17.7	19.7	15.9	16.2	16.5
More than 14 years–19 years	9.6	13.3	8.4	11.5	9.2
More than 19 years	27.6	33.1	11.2	20.1	16.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.2 Into their Current Job

This section focuses on mobility within the aged care sector. It explores evidence for 'churn' in the residential direct care workforce, whereby when workers leave their job they move between employers within aged care rather than leaving the aged care sector altogether.

Table 3.28 shows that in 2016 43 per cent of the residential direct care workforce had paid work in aged care prior to getting their current job (in 2012 this had been higher at 49 per cent). Nurses in particular had moved from one aged care job to another (paid or unpaid), with 71 per cent of RNs and 60 per cent of ENs having done this. A much lower proportion of PCAs (35 per cent in 2016, much lower than the 41 per cent in 2012) had paid work in aged care before, indicating that a higher proportion had been recruited from other occupations and sectors.

One route into direct care work is to acquire experience through voluntary work, which may be particularly important if a prospective employee had not held a job previously. This was not often the case in 2016 (similar to 2012), but of the occupational groups, higher proportions of PCAs and AH workers (both 5 per cent) than nurses had done unpaid work in aged care prior to getting their current job.

Table 3.28: Whether had worked in aged care prior to current job of the residential direct care workforce, by occupation: 2016 (per cent)

Whether had previous work in aged care	RN	EN	PCA	AH	All occupations
Yes, paid	69.7	55.2	34.6	54.7	42.7
Yes, unpaid	1.2	4.3	4.9	5.2	4.3
No	29.0	40.5	60.5	40.1	53.0
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

We now focus specifically on workers who started working in their current job in the last five years to provide information about recruitment patterns for the most recent cohort. Table 3.29 shows many direct care workers previously worked within their current facility prior to getting their current job. While between 13 and 20 per cent of workers had a previous relationship with their current facility, the pattern differs according to occupation. The likelihood of having previously had paid work in their current facility is strongest for RNs (16 per cent) and ENs (17 per cent). In contrast, 14 per cent of PCAs held unpaid work prior, compared to 5 per cent who had had paid work. The findings reinforce the discussion above surrounding Table 3.28, in which unpaid work was most often part of the workforce background for PCAs and AH workers. This unpaid work could be due to participation in a volunteer position or from having a placement as part of a training course or qualification.

Table 3.29: Whether had worked in current facility prior to obtaining current job of residential direct care workers employed in the last five years, by occupation: 2016 (per cent)

Whether had previous work in current facility	RN	EN	PCA	AH
Yes, paid	15.8	16.6	4.5	7.8
Yes, unpaid or volunteer	2.7	2.9	13.9	5.6
No	81.5	80.5	81.6	86.5
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=4,147 (weighted).

The residential aged care worker survey asked those workers who had worked in aged care previously why they left that job. Understanding the reasons why workers leave one job and move into another within the same sector can provide insights into what may need to change in order to improve the retention of staff within a facility. Table 3.30 indicates that while some residential direct care staff turnover may be addressed at management level, there can also be other reasons, possibly related to the personal circumstances of workers.

Table 3.30 shows that in 2016, the reasons related to the personal circumstances of employees (e.g. the need to move house, find work closer to home or fulfil caring responsibilities) accounted for around 45 per cent of the main reasons given for leaving a job by PCAs, 35 per cent by ENs, 26 per cent by RNs, and 36 per cent by AH workers. These proportions have changed very little compared to the 2007 and 2012 surveys. This reflects the ways in which paid work is embedded in the broader context of family responsibilities and in the household decisions about where the family live and work (for these mostly female workers in their middle age).

Other key reasons for leaving their last aged care job were related to conditions in the workplace and hence may be addressed by residential aged care staff management. Two reasons stand out as being consistently cited across occupational groups. First is the desire to find more challenging work, which was a particular issue for nurses and AH workers (RNs 15 per cent, ENs 12 per cent, and 16 per cent for AH workers). This could be an indication of there being willingness within the current workforce to upskill themselves and to have more

variety and greater complexity in their work. The second reason for mobility is 'to get the shifts or hours desired' (strongest for PCAs with 18 per cent). As discussed previously in Table 3.19, while 56 per cent of residential aged care workers do not wish to change their working hours, the remaining 44 per cent would prefer a change. Table 3.30 indicates that the share that had changed employers in order to achieve their desired work patterns was 18 per cent for PCAs, and 15 per cent for ENs. Of the remaining reasons, some were more important for particular occupations. For example, a higher proportion of residential aged care RNs cited their reasons as not getting along with management (10 per cent), wanting to achieve higher pay (11 per cent) or because the job was too stressful (7 per cent).

Table 3.30: Main reason for leaving prior aged care job of residential direct care workers with previous experience in sector, by occupation: 2016 (per cent)

Most important reason	RN	EN	PCA	AH
Moved house/location	16.3	21.1	26.6	15.0
To find more challenging work	15.4	12.3	6.2	15.8
To get shifts or hours of work I wanted	7.7	14.8	17.5	10.0
To avoid managers/management I did not get along with or like	9.8	8.3	3.7	4.3
To achieve higher pay	11.2	6.4	4.8	9.5
To be closer to home	7.9	8.4	13.4	12.8
The job was too stressful	6.8	2.6	3.4	2.7
To fulfil care responsibilities (including having a baby)	2.2	5.3	5.5	8.0
Made redundant/retrenched	3.0	5.1	2.5	4.6
Not able to spend sufficient time with residents	0.8	1.2	3.4	2.4
To avoid workmates/colleagues I did not get along with or like	1.6	2.4	1.2	1.6
To find easier work	0.6	0.2	0.3	0.4
Other	16.8	11.9	11.4	12.9
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=3,606 (weighted).

For all residential direct care workers, Table 3.31 shows the length of time that workers had been in their current jobs. Fourteen per cent of residential direct care workers had been in their jobs for 12 months or less and 26 per cent of workers had been in their jobs for more than 9 years. Slightly less than half of the workforce had worked in their current job for up to 4 years (46 per cent), but there is variation between the occupational groups as for ENs this share was lowest at 30 per cent. A higher proportion of ENs (44 per cent) and AH workers (31 per cent) had been in their current job for more than 9 years but only 24 per cent of PCAs. Compared with other occupations, a higher proportion of RNs (19 per cent) have been in their job for 1 year or less.

Table 3.31: Tenure in current job of the residential direct care workforce, by occupation: 2016 (per cent)

Tenure in current job (years)	RN	EN	PCA	AH	All occupations
12 months or less	19.4	9.0	14.1	15.6	14.4
More than 1 year–4 years	31.2	20.6	33.5	31.2	31.8
More than 4 years–9 years	25.2	25.9	28.3	22.4	27.4
More than 9 years	24.2	44.4	24.0	30.8	26.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.3 Into the Future

This section examines the intentions of residential aged care workers as they move into the future, including their intentions to leave their current place of employment. Understanding the intentions of the workforce has an important role in thinking about future behaviour and planning.

Table 3.32 shows the share of those actively seeking work for each direct care occupation group, with information about their current job tenure. The final row shows the overall share actively seeking work within each occupation, and the final column shows the overall share of the residential direct care workforce actively seeking work at each length of job tenure. We see that 10 per cent of the residential workforce is actively seeking work (similar to the 9 per cent in 2012). This share of workers seeking work is similar across all occupations, and the lowest proportion seeking work is found for residential aged care workers with tenure of more than 9 years (6 per cent). In contrast, a relatively higher proportion of RNs (17 per cent) and ENs (20 per cent) who have been with their current employer for 12 months or less are actively seeking work.

Table 3.32: Proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job: 2016 (per cent)

Tenure in current job (years)	RN	EN	PCA	AH	All occupations
12 months or less	17.1	20.3	15.7	12.9	16.1
More than 1 year–4 years	14.0	11.4	11.9	9.9	12.1
More than 4 years–9 years	9.9	9.6	9.8	5.4	9.6
More than 9 years	5.6	5.4	5.2	8.7	5.5
All years	11.5	9.1	10.2	9.0	10.2

Source: Survey of residential aged care workers.

Workers also indicated where they saw themselves working in 12 months from now. As reported in Table 3.33, the vast majority (82 per cent) of residential direct care workers indicated that they expect to still be with their current employer after 12 months. Of the remaining, the next highest share (10 per cent) did not have pre-existing intentions as to what they would be doing, while 4 per cent intended to leave aged care. Of all the occupational groups, a higher proportion of RNs (5 per cent) expected to leave their current aged care facility. Only 4 per cent of all employees indicated they intended to leave aged care, either to work in another sector or to retire from the paid workforce. This constitutes a relatively small proportion of the existing residential workforce that would be lost to aged care (although a further 10 per cent did not know what they would be doing). This reinforces a perspective of stability in the existing workforce, but with a degree of 'churn' between individual facilities.

Table 3.33: Expected activity in 12 months' time of the residential direct care workforce, by occupation: 2016 (per cent)

Expected activity in 12 months	RN	EN	PCA	AH	All occupations
Working in aged care, this facility	80.5	82.8	82.5	82.7	82.2
Working in aged care, different facility	4.8	1.8	2.2	1.8	2.5
Working in community aged care	0.3	0.5	0.7	0.5	0.6
Working in disability care	0.0	0.0	0.3	0.5	0.3
Working, but not in aged care	3.5	5.2	3.9	3.7	4.0
Not working for pay	1.5	0.8	0.3	0.5	0.6
Don't know	9.5	9.0	10.0	10.2	9.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.5 Experiences of Working in Residential Aged Care

Findings from the previous aged care census and surveys conducted by NILS in 2012, 2007 and 2003 indicated that aged care workers have relatively high levels of satisfaction in their work. However, this research also indicated particular areas for improvement which could have positive effects on employee retention. In this section we report on what direct care workers think about their work in 2016.

3.5.1 Job Satisfaction

In this section job satisfaction data is presented in Tables 3.34 and 3.35. These tables present responses to questions that were ordered in a scale form, whereby respondents answered on a scale from 1–7 or from 1–10. The discussion needs to be interpreted according to the ordinal nature of these questions which introduce possible limitations:

- First, many of the differences in average satisfaction levels at any point in time between different occupation groups in Tables 3.34 and 3.35 are too small to be of statistical significance and they should not be over-interpreted. Differences in averages will typically also conceal the more informative differences across the whole distribution of the reported values from 1 to 10.

- Second, comparing changes in averages over time for any occupation group (i.e. between the 2007 and 2012 data sets) will depend on the characteristics of the workforces concerned being constant over time, which we know not to be the case in all aspects of the data. This is always a problem when comparing single cross-section data sets and can only be satisfactorily handled through the use of multivariate regression.

- Finally, it should be noted that satisfaction measures are ordinal measures, that is, they can tell us if someone likes something more or less than a clear alternative, but they often lack the capacity to provide convincing information about how much more or less something is liked. This caveat naturally limits the interpretation we can give to these ordinal responses. Further, and more specifically, it means that when we observe two survey respondents, the first being satisfied enough to be ticking the box with value 4, and the second the box with value 6, this does not mean that the second person is 1.5 times more satisfied than the first person because 6 is 1.5 times higher than 4. It may mean that the second person is more satisfied than the first person, but even that may not be a universally accepted conclusion. This limitation is somewhat lessened in the case of comparing the satisfaction scores of a single person provided over time or for different aspects of their lives. The over-time comparison for individuals is not feasible through this data collection as individuals are not observed over time.

The worker survey form asked direct care workers to indicate their level of satisfaction with different aspects of their work on a scale of 1–10. These are subjective assessments about different aspects of work and, as such, they are relative to the context within which they are made. For example, such relative judgements may take into account what people may expect to achieve given their personal circumstances, or what they think they should achieve in their workplace given what they perceive their alternative work options to be. Overall, the findings indicate that workers are satisfied with what they do.

In Table 3.34, the average scores for employees' responses to each aspect of their work is shown. Overall satisfaction measured at 7.9 for all occupations shows that residential direct care workers' average overall satisfaction with direct care work has remained steady since 2012. There are slight differences between the various occupations, with AH workers somewhat more satisfied overall with their work (8.1) than PCAs (7.9) or nurses (7.8). In 2016 total pay stands out as being the area with which residential aged care workers are least satisfied (5.6), with PCAs (5.4) reporting more dissatisfaction with their pay compared to the other occupations. This was also the case in 2012. Apart from pay, residential direct care workers appear to be reasonably satisfied with all other aspects of their work.

Table 3.34: Average scores for responses from the residential direct care workforce, to statements about job satisfaction, by occupation: 2016 (range 1–10)

Satisfaction with	Nurse	PCA	AH	All occupations
Total pay	6.2	5.4	5.6	5.6
Job security	7.5	7.4	7.6	7.4
The work itself	7.8	7.7	8.2	7.8
Hours worked	7.6	7.7	7.8	7.7
Opportunities to develop abilities	7.4	7.5	7.3	7.4
Level of support from your team/service provider	7.6	7.4	7.8	7.5
Level of support from your supervisor	7.9	7.6	8.0	7.7
Flexibility to balance work and non-work commitments	7.4	7.5	7.8	7.5
Overall satisfaction	7.8	7.9	8.1	7.9

Source: Survey of residential aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied).

3.5.2 Doing the Work

Residential aged care workers were also asked to respond to a series of statements about their work on a scale of 1 (totally disagree) to 7 (totally agree). These statements refer to different aspects of their work.

Table 3.35 reports the average scores from direct care workers regarding their work and workplace. These subjective evaluations are important indicators of how confident they are in doing their work and what they view as areas that they would like changed. Overall, the highest average scores are in areas relating to skills and training (statements 2, 3 and 4 for all occupations), which receive scores of between 5.7 and 6.3. There is consistency across the occupations in the average scores for these statements. There is less consistency across occupations for the level of agreement with the statement on 'freedom to decide how to do the work' (4.4 for PCAs, 4.9 for nurses, 5.4 for AH). The relatively low average score of 3.9 for 'time to care' (statement 1) amongst residential direct care workers suggests that many workers do not think they have enough time to provide resident care (this is similar to 2012) and this persistence should be the subject of further investigations and policy discussions.

Table 3.35: Average scores for responses from the residential direct care workforce to statements about their work, by occupation: 2016 (range 1–7)

Statement	Nurse	PCA	AH	All occupations
I am able to spend enough time with each care recipient	3.9	4.0	4.1	3.9
I have the skills and abilities I need to do my job	6.2	6.3	6.3	6.3
I use many of my skills and abilities in my current job	6.0	6.2	6.1	6.1
Adequate training is available through my workplace	5.5	5.8	5.4	5.7
I have a lot of freedom to decide how to do my work	4.9	4.4	5.4	4.6
I feel under pressure to work harder in my job	4.4	4.2	4.0	4.2
My job is more stressful than I had ever imagined	4.1	3.9	3.6	4.0
Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	5.0	4.9	5.1	4.9
Management and employees have good relations in my workplace	5.1	5.0	5.2	5.0

Source: Survey of residential aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree).

In order to further examine how much time residential workers spend in direct caring, Table 3.36 reports on the time spent caring by each occupation with the final column average reflecting all residential direct care occupations. While in 2016, 65 per cent of all workers spent more than two-thirds of their shifts doing direct care tasks, this varied across occupations. Not surprisingly, PCAs spent the most time providing direct care, with slightly more than three-quarters spending the majority of their shift doing this kind of work (77 per cent). This is similar to 2012. For nurses, lower proportions (33 per cent) were providing care for more than two-thirds of their shift, but there was another 33 per cent providing care for less than one-third of their shift. This reflects the increasing managerial role that nurses are performing while PCAs are taking more responsibility for the direct care tasks. Separating RNs from ENs shows the managerial roles more clearly as 44 per cent of RNs spent less than one-third of their work time caring, but 46 per cent of ENs spent more than two-thirds of their time on direct care tasks.

Table 3.36: Responses of the residential direct care workforce to the question 'In a typical shift, how much time do you spend in direct caring?' by occupation: 2016 (per cent)

Time spent caring	RN	EN	Nurse	PCA	AH	All occupations
Less than one-third	43.5	17.4	32.8	6.4	14.0	13.3
Between one-third and two-thirds	33.0	36.2	34.3	17.1	31.4	22.0
More than two-thirds	23.5	46.4	32.9	76.5	54.6	64.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
**Nurse combines RN and EN.*

The quality of relationships between the worker and management, and the worker and colleagues are shown in Tables 3.37 and 3.38. Table 3.37 suggests that most workers consider their relationship with management as good (between 80 and 88 per cent) and some consider it as neither good nor bad (between 7 and 13 per cent). Only a small minority between 4 and 7 per cent report having a bad relationship with their management (6 per cent for nurses, 7 per cent for PCAs and 4 per cent for AH workers). All in all relationships with management are reported to be satisfactory, a good message for a changing sector.

Table 3.37: Residential direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	5.9	6.6	4.2	6.3
Neither good nor bad	8.4	12.9	7.5	11.6
Good	85.7	80.5	88.2	82.2
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2016.
Scale used is 1(very bad) to 7 (very good).

Table 3.38 presents reported workplace relationships between colleagues. It suggests that workers are generally very positive with 89 per cent indicating that the relationship between themselves and their colleagues is good. This overall picture of mostly good relationships with management and a slightly higher share with good relationships with colleagues remains unchanged from 2012.

Table 3.38: Residential direct care workforce assessment of the quality of workplace relationships 'between workmates/ colleagues and yourself', by occupation: 2016 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	2.2	3.7	2.8	3.3
Neither good nor bad	5.8	8.3	7.2	7.6
Good	92.0	88.0	90.0	89.1
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2016.

3.5.3 Job Demands

In 2007 and 2012 the census form asked facilities about several unusual job demands for their workforce that are viewed as stressful (King et al. 2012) in order to establish their prevalence in Australian residential aged care facilities. These demands are:

- Working longer than scheduled
- Variations in hours and location of work
- Working in unsanitary conditions
- Working with aggressive service users
- Working alone late at night.

Facilities were asked if any of these demands are made as (i) part of the normal job requirements; (ii) only in exceptional circumstances; or (iii) never. Their answers are presented in Table 3.39.

Changing work patterns: The most prevalent job demands are associated with changes in work patterns, either in response to unanticipated needs of residents (85 per cent, which is lower than the 91 per cent of facilities in 2012) or because of management needs to vary hours or location at short notice (84 per cent, roughly similar to the 86 per cent in 2012).

Unsanitary conditions: Of the five unusual job demands listed, residential facilities are least likely to ask workers to work in very unsanitary conditions, which is not surprising given that this would breach aged care accreditation standards.

Aggressive service users: Of the more prevalent unusual job demands, working with aggressive service users was a normal expectation in 28 per cent of facilities, with another 56

per cent indicating that workers were required to do this in exceptional circumstances (these are slightly different to 2012 when they were respectively more with normal expectations at 33 per cent and fewer reporting this for exceptional circumstances at 47 per cent). As in 2012, this is likely to be a consequence of the growing number of older Australians with dementia and other mental health problems who are living in residential facilities.

Alone late at night: Twelve per cent of residential facilities ask their workers to work alone at night after 10 pm, but of those that do this is often a normal requirement of the job (9 per cent).

Table 3.39: Prevalence of unusual job demands in residential facilities: 2016 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled due to unanticipated needs of residents	5.0	79.6	15.5	**100**
Variations in hours or location at short notice	9.9	74.3	15.8	**100**
Working in very unsanitary conditions	0.7	3.3	96.0	**100**
Working with aggressive service users	28.0	55.9	16.1	**100**
Working alone late at night (after 10 pm)	9.2	3.1	87.7	**100**

Source: Census of residential aged care facilities 2016.
Row percentages shown. Per cent of outlets.

3.6 Work-related Injury and Illness

Previous research has suggested that workers in caring roles may be at increased risk of work-related injury and illness compared to the general workforce (Howard and Adams 2010; Kim et al 2010). In order to add to understanding of work-related injury and illness in aged care work the 2016 aged care census and survey asked questions regarding the extent, type and causes of these injuries.

Table 3.40 shows combined information from both the facilities census and the workers survey about work related injuries. There can be discrepancies between facilities and workers regarding the extent of reported work-related injuries, for a variety of reasons. Examples would include that workers and facilities may be reporting over different periods; serious work-related injuries may result in the withdrawal from the workforce of the worker, but their injury record remains; and difficulties in accurately recalling incidents over the designated period, especially minor injuries that will be recorded and reported by the facility but often forgotten by the worker. We would expect the reporting differences to be more prominent for the least prevalent injuries and illnesses. Although for these and other reasons the direct comparison between these figures is difficult, we present them together for ease of presentation and reference.

Facilities: The first two columns of Table 3.40 show that in 2016, 77 per cent of residential facilities reported at least one work-related injury/illness in the 3 months prior to the census (roughly similar to the 76 per cent in 2012). The most commonly reported injuries were sprains/strains (45 per cent of all facilities and 69 per cent of those that reported) and superficial injuries (31 per cent of all facilities and 47 per cent of those that reported). These are similar to the 2012 proportions for these same conditions.

Workers: The final two columns of Table 3.40 show work-related injuries and illnesses reported by workers in the previous 12 months. Fourteen per cent of direct care workers experienced a work-related injury or illness during this period. As with reporting by facilities, the most commonly reported injuries are sprains/strains (6 per cent of all workers and 43 per cent of those who reported), followed by chronic joint or muscle condition (4 per cent of all workers and 29 per cent of those who reported). The next most prevalent work-related injury or illness is stress or other mental condition which is reported by 3 per cent of all workers and 19 per cent of those who reported. The 2016 residential worker reports about work-related

injuries and illnesses are very similar to 2012, indicating that no overall sector improvement in health and safety has been achieved between 2012 and 2016.

Table 3.40: Types of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent)

Type of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
At least one injury/illness reported	76.7	n/a	14.3	n/a
None reported	23.3	n/a	85.7	n/a
Fracture	2.6	4.0	0.3	2.6
Chronic joint or muscle condition	12.3	19.0	3.7	28.5
Sprain/strain	44.9	68.9	5.6	43.1
Cut/open wound	17.4	26.6	1.3	10.0
Crushing injury/internal organ damage	0.7	1.1	0.2	1.7
Superficial injury (minor)	30.5	46.9	2.2	16.8
Stress or other mental condition	7.1	10.9	2.5	19.3
Amputation	0.2	0.3	0.0	0.1
Burns	13.1	20.2	0.3	2.2
Other	7.9	12.1	2.5	18.9

Source: Census of residential aged care facilities and Survey of residential aged care workers, 2016.
Note: Multiple response allowed, totals will not sum to 100.

Table 3.41 shows the causes attributed to reported work-related injuries and illnesses, again jointly presented for the facilities' workforce and workers.

For the 77 per cent of facilities that reported in Table 3.40 one or more incidents during the previous 3 months, there were four chief causes: 'lifting, pushing, pulling or bending'; 'hitting, being hit or cut by person, object or vehicle'; 'a fall' or 'repetitive movement'. These are roughly the same as for 2012. The pattern reported by workers in Table 3.41 is quite similar to that of the facilities. The most commonly identified cause was 'lifting, pushing, pulling, bending', followed by hitting or being hit, and falls.

Table 3.41: Causes of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent)

Cause of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
At least one injury/illness reported	76.7	n/a	14.3	n/a
None reported	23.3	n/a	85.7	n/a
Lifting, pushing, pulling, bending	43.5	66.8	5.6	43.2
Repetitive movement	10.0	15.3	0.6	4.4
Prolonged standing, working in cramped or unchanging positions	0.6	1.0	0.1	0.6
Vehicle accident	1.4	2.1	0.0	0.4
Hitting, being hit or cut by person, object or vehicle	26.6	40.9	1.6	12.0
Fall	16.4	25.2	0.7	5.6
Exposure to mental stress	5.2	8.0	0.4	2.9
Long-term exposure to sound	0.0	0.0	0.0	0.0
Contact with chemical or substance	5.5	8.5	0.1	0.7
Fatigue	1.6	2.5	0.3	2.6
Other	14.7	22.6	1.8	13.4

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

The extent to which the employees are on Workcover in 2016 is shown for residential facilities in Table 3.42. Table 3.42 indicates that 44 per cent of facilities had one or more employees on Workcover during the designated fortnight in 2016 (fewer than the 54 per cent in 2012). For each of these facilities, there was an average of 1.9 employees (slightly fewer than the 2.2 in 2012) on Workcover. Although 38 per cent of facilities had PCAs on Workcover in 2016, the proportion of facilities with workers in any of the other occupational groups was much smaller, between 2 and 6 per cent.

Table 3.42: Proportion of facilities with employees on Workcover (per cent) and, of these, the mean number of employees per facility on Workcover during the designated fortnight: 2016

Occupation	Facilities Utilising Workcover (%)	Employees (average per facility)
Registered Nurse	4.7	1.1
Enrolled Nurse	5.7	1.2
Personal Care Attendant	37.8	1.8
Allied Health	2.3	1.3
All occupations	43.6	1.9

Source: Census of residential aged care facilities.

3.7 Cultural and Linguistic Diversity

In Section 3.2.4 it was shown that around a third of respondents in the survey of residential aged care workers were born overseas. This final section of the chapter presents further findings relating to the cultural and linguistic diversity of the residential workforce. In particular, we explore levels of fluency and use of a language other than English and self-assessed English literacy. Finally, this section examines the extent of the employment of PCAs from CALD backgrounds within residential facilities and the stated benefits and difficulties of hiring these workers.

Table 3.43 presents the relatively small proportion of the residential direct care workforce who completed the worker survey and reported that they speak their primary language more fluently than they do English. Of the occupational groups, a higher proportion of ENs (55 per cent) and AH workers (45 per cent) who speak a language other than English are most fluent in English. On the other hand, a higher proportion of RNs (50 per cent) and PCAs (50 per cent) speak both languages equally well. A further 18 per cent of RNs and 19 per cent of PCAs are most fluent in their primary (LOTE) language.

Table 3.43: Fluency in a language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent)

Speak LOTE, most fluent in:	RN	EN	PCA	AH
English	32.1	54.9	31.8	44.7
LOTE	17.9	8.4	18.5	16.3
Both equally well	50.0	36.8	49.7	39.0
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers (weighted).

A large share (39 per cent) of residential direct care workers reported they speak a language other than English in their work (Table 3.44) which is higher than the 31 per cent found in 2012. Table 3.44 shows that of the occupational groups, ENs and AH workers more often speak a language other than English in their work (58 per cent and 50 per cent respectively), however 38 per cent of PCAs and 33 per cent of RNs also use this ability in their jobs.

Table 3.44: Use of language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent)

Speak LOTE and	RN	EN	PCA	AH	All occupations
Use LOTE in job	32.9	57.9	38.1	49.8	38.9
Do not use LOTE in job	67.1	42.1	61.9	50.2	61.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Workers who spoke a language other than English were asked how well they thought they could speak, read and write in English (self-assessment). As shown in Table 3.45, amongst workers who identified as being most fluent in a language other than English, nearly all (93 per cent) indicated that they could read in English 'well – very well' (this is similar to the 95 per cent reporting this in 2012). Of all three English literacy areas, writing was the area in which workers rated themselves lowest, with 14 per cent of workers indicating they could not write in English very well.

Table 3.45: Subjective assessment of English literacy for residential direct care workers most fluent in a language other than English (LOTE): 2016 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0.6	5.5	61.8	31.7	0.4	**100**
Reading	0.2	6.5	45.8	47.4	0.2	**100**
Writing	0.2	13.9	53.5	32.3	0.2	**100**

Source: Survey of residential aged care workers.

In the following tables we turn our attention to PCAs from culturally and linguistically diverse (CALD) backgrounds. Table 3.46 illustrates the extent to which facilities report how PCAs from diverse backgrounds are distributed among facilities in 2016. Very few (12 per cent, slightly fewer than the 13 per cent in 2012) residential facilities employed no PCAs from a culturally and linguistically diverse background.

Table 3.46: Distribution by proportion of personal care attendants (PCAs) from culturally and linguistically diverse backgrounds (CALD) in residential facilities: 2016 (per cent)

% of CALD PCAs per facility	Facilities
Zero	11.5
1–33	40.5
34–66	20.9
67–100	27.1
Total	**100**

Source: Census of residential aged care facilities.

The 2016 census asked facilities to identify the benefits of hiring PCAs from CALD backgrounds. As shown in Table 3.47, almost all facilities reported one or more benefits. Of the nominated benefits beyond culture and language, the opportunity to enhance cross-cultural understandings and activities was most frequently cited (84 per cent). However, 37 per cent of facilities also indicated that employing these PCAs was important for developing networks into particular communities.

Table 3.47: Stated benefits of employing personal care attendants (PCAs) from culturally and linguistically diverse backgrounds in residential facilities: 2016 (per cent)

Benefits	Facilities
No benefits	0.4
Stated benefits:	
Enhance cross-cultural understandings	83.6
Offer different cultural activities	54.7
Language (other than English) skills	56.0
Link clients to ethnic communities	36.8
Link facility to ethnic communities	33.9
Other	4.5

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

Facilities that employ PCAs who spoke a language other than English (LOTE) were asked to nominate the most common ethnic or cultural background of those workers. Table 3.48 (column 1) shows that a higher proportion (91 per cent in 2016 against 79 per cent in 2012) of residential facilities employed PCAs from linguistically diverse backgrounds in 2016. India and the Philippines remain the most common source countries for these PCAs.

When we focus on the facilities in which PCAs who speak a language other than English are present (Table 3.48 column 2), the results confirm widespread engagement of Indian and Filipino workers. In facilities where at least one-third of PCAs are identified as LOTE speakers (Table 3.48 column 3), approximately 35 per cent of facilities identified Indian as the major background of these workers, and another 22 per cent of facilities identified their background as Filipino.

Table 3.48: Proportion of residential facilities that employ personal care attendants (PCAs) from linguistically diverse backgrounds: 2016 (per cent)

Ethnic group	All facilities	Facilities with any PCAs speaking LOTE	Facilities with at least 33% PCAs speaking LOTE
At least one PCA from linguistically diverse background	91.1	n/a	n/a
None	8.9	n/a	n/a
Indian[1]	28.3	31.2	34.5
Filipino	26.7	29.0	21.7
African	7.1	7.8	9.9
Pacific Islander	2.5	2.8	2.1
Chinese	3.0	3.4	4.5
Italian	2.3	2.5	1.3
Greek	0.5	0.6	0.7
South East Asian	7.3	8.1	6.4
Other	13.4	14.7	18.9
Total	**100**	**100**	**100**

Source: Census of residential aged care facilities.
[1] Includes Hindi and other languages spoken in India and Sri Lanka.

While we saw in Table 3.47 that facilities reported considerable benefits of hiring PCAs from CALD backgrounds, the management of a multicultural workforce can also present challenges. Facility managers were therefore asked in the census form to nominate, from a list, areas in which employing PCAs who speak a language other than English creates difficulties in providing and managing care services at the facility. About one third (32 per cent) of residential aged care facilities selected at least one area of difficulty from the list in 2016 (Table 3.49), fewer than in 2012 (40 per cent).

Table 3.49 shows that from the list of stated difficulties, communication was the chief area of concern presenting difficulties for facility managers in 2016 (88 per cent communication with residents, 72 per cent communication with the families of residents, and 67 per cent communication with management/staff).

Table 3.49: Stated difficulties of employing personal care attendants (PCAs) who speak a language other than English in residential facilities: 2016 (per cent)

Difficulties	Facilities
No difficulties	67.6
At least one difficulty	32.4
Stated difficulties (% of outlets stating difficulties)	
Occupational health and safety	26.0
Communication with management and/or other staff	66.5
Communication with residents	87.9
Communication with residents' families	72.4
Other – written communication	9.5

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

4. The Census of Residential Facilities

Key Findings

- Almost two thirds of residential direct care workers were located in major cities, with a further third in regional areas.
- Fifty eight per cent of residential direct care workers were employed in not-for-profit facilities, 34 per cent in for-profit facilities and 7 per cent in government-owned facilities.
- Slightly more than half (52 per cent) of residential facilities were large (i.e. had more than 60 places).
- The total number of operational places available in residential aged care in 2016 was 197,046. The average ratio of residential direct care workers to places (0.78) almost unchanged from 2012. However, since 2012, the ratio of the average number of direct care to PAYG workers has fallen across residential facilities of all size indicating a reduced usage of direct care staff.
- Eighty per cent of facilities belonged to a larger provider group. About 10 per cent of residential facilities also offered community care services from the same location.
- A quarter of residential facilities catered for a specific ethnic or cultural group, most frequently of Italian, Aboriginal and Greek backgrounds.
- Almost two thirds of facilities with direct care staff (63 per cent) reported skill shortages; a shortage of RNs was most common (41 per cent) and skill shortages were more prevalent in locations outside major cities.
- Main reasons for skill shortages were lack of suitable applicants (80 per cent), slow recruitment processes (21 per cent) and specialist knowledge required (19 per cent).
- Facilities responded to skill shortages primarily by having existing staff work longer hours (62 per cent) or by making greater use of agency staff (48 per cent).
- Vacancies were most commonly reported for PCA and RN positions (by 24 per cent of facilities). These facilities had an average of 3.3 PCA and 1.8 RN vacancies.
- The average time taken to fill vacancies was 2.5 weeks for PCA positions and 4.3 weeks for RNs. Residential facilities in remote and very remote locations reported more difficulties in filling staff vacancies.
- The proportions of vacancies that were either very quick to fill (less than 1 week) or very hard to fill (more than 26 weeks) was reduced in 2016 when compared with 2012.
- The most common reasons facilities gave for staff vacancies were resignation (84 per cent), the creation of a new position (31 per cent) and retirement (27 per cent).
- Internet job advertisements (34 per cent) and a combination of internet and newspaper advertisements (23 per cent) were the most frequent recruitment strategies for PCA positions.
- For workers seeking employment in aged care, internet job advertisements and word-of-mouth were the most common strategies used. The use of recruitment agencies was also reported by around 16 per cent of nurses and AH workers.

- Over three quarters (79 per cent) of facilities used Enterprise Agreements to set employment conditions for their staff; almost a fifth (19 per cent) of facilities used award-based arrangements.

- Half of all facilities reported employing at least one non-PAYG worker (particularly RNs and PCAs) in the designated census fortnight. Agency workers (41 per cent) were most commonly used in comparison to brokered (8 per cent) and self-employed (7 per cent) workers.

- Agency staff were used to provide short-term cover for staff absences (88 per cent) and to fill vacancies (51 per cent), while brokered and self-employed staff were mainly employed to obtain specialist skills.

- Approximately 23,537 volunteers worked in residential aged care in 2016. Eighty three per cent of facilities reported one or more volunteer workers who mainly assisted with social and planned group activities and companionship/befriending.

- Methods of quality monitoring in residential facilities included monitoring by managers or supervisors (86 per cent), keeping records of service user feedback (57 per cent) and accreditation processes (56 per cent).

4.1 Introduction

This chapter provides an overview of the key characteristics of residential aged care facilities in Australia with information predominantly based on the census of residential aged care facilities (N=2,240). It should be acknowledged that there has been significant reform to the way residential aged care is delivered to consumers since the last workforce census of residential facilities in 2012. A key change has been the removal of the distinction between high-level and low-level residential aged care funding for all new and existing residents from 1 July 2014.

We begin the chapter with a profile of residential facilities showing the distribution of their employees across all states and territories, and information regarding the operational places offered. The relationship that residential facilities have with broader aged care services and whether these facilities cater for specific ethnic or cultural groups are then discussed. The next sections of the chapter provide evidence regarding skills shortages and staff vacancies within the sector, as these are reported by the employers. The industrial methods used by facilities to set employment conditions and the use of non-PAYG staff are then explored. The chapter finishes with a focus on quality monitoring in residential aged care.

4.2 A Profile of Facilities

Table 4.1 shows the distribution of the residential aged care workforce across States/Territories in 2003, 2007, 2012 and 2016. Direct comparison of the distribution of the workforce by geographical location between 2007 and 2012 is not possible because of a change in the measure used to collect this data.[5]

Although South Australia and Western Australia increased their share and Queensland and Tasmania decreased theirs, the changes are relatively small. The picture is similar whether viewing all PAYG employees or only direct care employees. In 2016, almost two-thirds (65 per

[5] In 2007, the Rural, Remote, Metropolitan Area (RRMA) classification was used, whereas in 2012 the information was categorised according to the ABS 2006 Remoteness Areas based on the 2006 Population Census. In 2016, the ABS 2011 Remoteness Areas are used, based on the more recent and updated 2011 Population Census definitions. There was no substantial change in the methodology used to define the ABS Remoteness Areas for 2012 and 2016 and in most cases comparison of the Remoteness Area is valid - ABS Statistical Geography factsheet.

cent) of direct care workers were located in major cities, one-quarter (23 per cent) in inner regional areas, 10 per cent in outer regional, with just over 1 per cent of workers located in both remote and very remote areas. There is no evidence of a significant change in the distribution of the workforce by geographical location between 2012 and 2016.

Examining the distribution of ownership type in the bottom panel of Table 4.1 shows some change. Between 2003 and 2012 there was a decline in the importance of the not-for-profit sector as an employer. This trend seems to level off as we observe a modest rise in the direct care employment proportion from 56 per cent in 2012 to 58 per cent in 2016. There was a corresponding modest decline in employment in for-profit and government facilities between 2012 and 2016.

Table 4.1: Distribution of residential direct care workforce (per cent) by State/Territory, location, ownership type and facility type: 2003, 2007, 2012 and 2016

	All PAYG employees				Direct care employees			
	2003	2007	2012	2016	2003	2007	2012	2016
State/Territory								
NSW	31.2	31.6	30.6	30.2	32.1	31.8	31.0	30.1
Victoria	30.4	27.9	27.6	27.2	29.4	28.6	27.8	27.5
Queensland	16.1	18.0	18.5	17.1	15.8	17.4	17.7	16.7
WA	7.6	7.9	8.2	8.9	7.8	8.0	8.6	8.9
SA	9.3	9.9	10.4	12.1	9.7	9.9	10.4	12.3
Tasmania	3.6	3.4	3.5	2.9	3.1	3.0	3.2	2.9
ACT	1.5	0.9	1.0	1.2	1.5	0.9	1.0	1.2
NT	0.3	0.4	0.3	0.5	0.4	0.4	0.3	0.4
Location*								
Major cities of Australia			64.0	63.4			65.6	64.6
Inner Regional Australia			24.9	23.7			23.9	23.4
Outer Regional Australia			9.9	11.0			9.3	10.3
Remote Australia			0.8	1.3			0.8	1.2
Very Remote Australia			0.4	0.6			0.4	0.5
Ownership Type								
Not-for-profit	64.5	60.0	56.8	57.8	61.6	58.4	55.7	58.3
For-profit	26.1	31.4	34.1	34.0	28.9	33.0	35.3	34.3
Government	9.4	8.6	9.0	8.2	9.5	8.6	8.9	7.4

Source: Census of residential aged care facilities.
**Direct comparison of location with previous years is not possible due to change in categories.*

When looking at the size of residential facilities (according to their total number of places), Table 4.2 shows that in 2016 over half of facilities (52 per cent) are large (61+ places). The expansion in the proportion of facilities that are large, as evident between 2007 and 2012, appears to have stopped, with the proportion in 2016 the same as that in 2012 (approximately 52 per cent). This supports the suggestion from the 2012 report (King et al. 2012) that the observed expansion between 2007 and 2012 might be explained by both changes in how the data was collected and changes in government policy. There has been a small increase in the proportion of small facilities (with 1-20 places) between 2012 and 2016 (from 6 per cent to 8 per cent), and a corresponding decline in the proportion of facilities with 41-60 places (from 25 per cent to 23 per cent).

The average size of employment in facilities with more than 60 operational places in 2016 is 113 PAYG employees, and on average 75 of these employees are direct care workers (Table A4.2, Appendix 3). These figures are fairly comparable with those obtained from the 2012 census where the largest facilities employed an average of 107 PAYG employees, with 78 of

these on average being direct care workers. Since 2012, however, the ratio of the average number of direct care to PAYG workers has decreased across residential facilities of all size indicating a decreased usage of direct care staff. This indicates a shift in workforce composition with a lower ration of direct care staff.

Table 4.2: Number of places* (per cent): 2007, 2012 and 2016

Number of places*	2007	2012	2016
1–20	7.4	5.7	7.7
21–40	26.7	17.2	17.5
41–60	30.9	24.9	23.0
61+	35.0	52.3	51.8

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

We now look at the distribution of residential aged care operational places across Australia. Table 4.3 shows that the distribution of residential care operational places across State/Territories, location and ownership type, closely mirrors the distribution of the residential care workforce in Table 4.1.

Facilities in NSW and Victoria have the largest share of total residential places, followed by Queensland, SA and WA. Two thirds of places are in facilities in major cities. Remote and very remote facilities make up only a very small share of places. Approximately 57 per cent of residential places are in not-for-profit facilities.

Table 4.3: Distribution of residential aged care operational places* (per cent): 2016

		Total
All facilities	Number of places*	197,046
State/Territory	NSW	33.2
	Victoria	26.5
	Queensland	17.0
	WA	8.5
	SA	10.6
	Tasmania	2.5
	ACT	1.4
	NT	0.4
Location	Major cities of Australia	67.2
	Inner Regional Australia	22.3
	Outer Regional Australia	8.9
	Remote Australia	1.1
	Very Remote Australia	0.5
Ownership Type	Not-for-profit	57.3
	For-profit	35.9
	Government	6.8

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

Estimated staffing ratios (obtained by dividing the total number of direct care workers by the total number of operational places) are presented in Table 4.4. In 2016 the average number of residential direct care workers to places across all facilities is 0.78; mostly unchanged from 2012 when it was 0.77.

There is minimal variation in average staffing ratios between States and Territories. There is also minimal variation in staffing ratios by location. Staffing ratios in for-profit facilities are lower than in not-for-profit facilities. Government facilities have the highest ratio, 0.85 direct care workers per residential place in 2016.

Table 4.4: Average ratio of residential direct care workers to operational places: 2012 and 2016

		2012	2016
All facilities		0.77	0.78
State/Territory	NSW	0.70	0.69
	Victoria	0.82	0.70
	Queensland	0.76	0.81
	WA	0.79	0.76
	SA	0.84	0.91
	Tasmania	0.96	0.82
	ACT	0.74	0.91
	NT	0.79	0.66
Location	Major cities of Australia	0.74	0.75
	Inner Regional Australia	0.81	0.82
	Outer Regional Australia	0.88	0.90
	Remote Australia	0.88	0.88
	Very Remote Australia	1.11	0.85
Ownership Type	Not-for-profit	0.74	0.79
	For-profit	0.77	0.74
	Government	1.03	0.85

Source: Census of residential aged care facilities.

4.3 Facilities' Relationships with Broader Aged Care Services

Many residential facilities have connections to the broader aged care sector. This is strongly highlighted in Table 4.5 which reports that approximately 80 per cent of facilities belong to a larger provider group, with the proportion highest in for-profit facilities (86 per cent). Overall, the proportion of facilities belonging to a larger group has increased with time, from 73 per cent in 2007 and 76 per cent in 2012.

In addition approximately 10 per cent of all residential facilities offer community care from the same location in 2016. The proportion also offering community care has slowly declined over time, from 13 per cent in 2007 and 12 per cent in 2012.

The proportion of residential facilities offering community care differs widely by ownership type, with approximately 21 per cent of government facilities offering community care but only 3 per cent of for-profit facilities offering these services.

Table 4.5: Proportion of residential facilities that are part of larger provider group* or provide community aged care (per cent), by ownership type: 2016

	Not-for-profit	For-profit	Government	All facilities
Part of larger provider group*	78.6	85.6	76.9	80.4
Providing community aged care	10.6	2.7	20.8	9.7

Source: Census of residential aged care facilities.
**A facility is classed as being part of a larger group if the facility is part of a larger organisation e.g. owned by a company or not-for-profit agency that owns other aged care facilities or services.*

As may be anticipated given that some residential facilities also provide community aged care services, Table 4.6 indicates that just under 17 per cent (all facilities all occupations) of all direct care workers in residential facilities also worked in community care. Allied health workers were more likely to be providing community care (21 per cent), compared to nurses (15 per cent) or PCAs (17 per cent).

Government facilities had a much higher proportion of their workforce working in both residential and community care (39 per cent). Not-for-profit facilities had the lowest proportion providing these services (11 per cent).

Table 4.6: Proportion of residential aged care employees that work in both residential and community aged care (per cent), in facilities that provide some community aged care, by ownership type: 2016

Occupation	Not-for-profit	For-profit	Government	All facilities
Nurse	7.2	25.0	31.5	15.3
Personal Care Attendant	12.8	30.4	44.1	16.8
Allied Health	7.6	26.2	64.9	21.0
All occupations	11.2	28.9	39.0	16.6

Source: Census of residential aged care facilities N=272 facilities [N=305 in 2012] providing community aged care (2016 weighted).

4.4 Ethnic Specialisation

The number of older people in Australia from CALD backgrounds is increasing. It is expected that by 2021, almost a third of those aged 65 years and older will have been born overseas (Department of Social Services, 2015). Older Australians from CALD background are not a homogenous group and this diversity needs to be acknowledged and addressed in the aged care sector. The 2016 census of residential facilities collected information regarding ethnic specialisation within aged care. Table 4.7 shows that 25 per cent of residential facilities catered for a specific ethnic or cultural group in 2016. This figure is comparable to that in 2012 (26 per cent).

Looking at facilities that did cater for a specific ethnic or cultural group, residents from an Italian background were most frequently catered for (54 per cent of these facilities), followed by Aboriginal Australians (52 per cent) and Greeks (44 per cent). Almost 44 per cent of facilities who specialise catered for gay, lesbian, bisexual, transgender and intersex residents, illustrating the increasing demand for aged care services to be inclusive of all backgrounds.

Table 4.7: Residential facilities that cater for specific ethnic or cultural groups (per cent): 2016

Ethnic group	% All facilities	% Among facilities that specialise
Catering for specific ethnic or cultural group	25.1	n/a
No catering for specific ethnic or cultural group	74.9	n/a
Polish	9.4	38.1
Italian	13.4	53.9
Aboriginal	13.0	52.4
Chinese	10.0	40.2
Greek	10.9	43.8
Dutch	9.3	37.4
German	10.1	40.7
Indian	9.0	36.2
Gay, lesbian, bisexual, transgender, intersex	10.8	43.5
Other	3.6	14.7

Source: Census of residential aged care facilities. Multiple responses allowed in 2016, percentages do not sum to 100. N=696 facilities providing specific ethnic or cultural aged care (2016, weighted).

4.5 Skill Shortages

Within the aged care system in Australia, demand for services has reached unprecedented levels and, with a rapidly ageing population, demand is expected to continue rising in the future. In such a case the sector will need to respond, either by expanding its workforce or by increasing its productivity, or, as is usually the case by a mix of the two. As demand increases, and depending on the timeliness and the type of reaction by the sector, the possibility exists that skill shortages for direct care workers may arise. It is important, for effective workforce planning and policy development, that current information is available regarding the presence of skills shortages in the aged care sector, their perceived reasons and consequences, and, finally, how they are being responded to by provider organisations and their workforces. To this purpose, the 2016 census collected information on the incidence and composition of skill shortages, the factors that caused these shortages, the consequences of these skill shortages, and how facilities are actually responding to them. This is valuable information at the individual employer level, for example, for benchmarking and similar purposes, at the level of geographical location, and at the overall national level, for example for training and related policy. Moderate and temporary skill shortages have been considered in the literature to be markers of a successfully growing and developing sector. In contrast, deep and persistent skill shortages have been associated with less well performing firms and with sectors with lower productivity, growth, profitability, and competitiveness (Healy, Mavromaras & Sloane 2015).

Table 4.8 (final column) shows that 47 per cent of residential facilities did not report having any skill shortages in 2016. Almost two-thirds of residential facilities (63 per cent) reported a shortage of workers in at least one direct care occupation. When examining skill shortages for participant occupations, a shortage of RNs was most common (reported by 41 per cent of facilities), followed by PCAs (25 per cent). Only a small proportion of facilities reported a shortage of AH workers (6 per cent). Skill shortages are more prevalent in remote and very remote areas, but we note again that the small number of respondents from remote and very remote locations may have skewed related findings.

Table: 4.8: Proportion of residential facilities reporting skill shortages in 2016 (per cent), by location and occupation affected

Whether had skill shortage	Major cities of Australia	Inner regional Australia	Outer regional Australia	Remote Australia	Very remote Australia	All facilities
Yes (of all facilities)	46.5	61.9	62.8	59.7	81.1	53.4
Yes (of all facilities with direct care staff)*	55.9	72.8	70.8	72.7	87.8	63.2
Skill shortage for occupation:						
Registered Nurse	33.9	50.3	51.5	55.2	58.5	41.2
Enrolled Nurse	15.8	27.4	31.1	29.9	22.6	21.2
Personal Care Attendant	23.6	24.6	30.6	37.3	37.7	25.4
Allied Health	6.1	6.3	4.7	11.9	3.8	6.1

*Source: Census of residential aged care facilities *This not available prior to 2016.*
Note: Multiple responses allowed for skill shortage by occupation, columns do not sum to 100.

Facilities that reported having skill shortages were asked to identify the causes of the shortages. Facilities could select more than one of the response options on the questionnaire and could also nominate other factors which were not listed. Table 4.9 (column 1) indicates that amongst facilities with skill shortages for any occupation, the highest proportion reported no suitable applicants as the cause of skill shortages in their facility (80 per cent), followed by geographical location (38 per cent), slow recruitment processes (21 per cent) and specialist knowledge required (19 per cent).

RN and PCA shortages were similar to the reasons given across all occupations. Facilities with a PCA shortage were more likely to identify 'lack of availability of adequate training' as a reason (16 per cent) than facilities with an RN shortage (12 per cent). Facilities with a PCA shortage were also more likely to report that recruitment was too slow (28 per cent) compared with facilities with an RN shortage (21 per cent).

Table 4.9: Proportion of residential facilities with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected

Cause of skill shortage	Facilities that reported skill shortages		
	For any occupation	For RNs	For PCAs
Specialist knowledge required	18.9	20.8	21.3
Geographical location of facility	37.9	40.3	37.9
Wages or salary costs too high	9.9	11.2	9.3
Lack of availability of adequate training	12.0	12.3	16.2
Unsure of long term demands for service	4.6	4.8	4.9
Recruitment too slow	20.6	21.2	27.5
No suitable applicants (skills/qualifications/experience/values)	79.6	79.9	83.6
Other	6.2	6.1	6.0
Facilities (weighted)	1498	1156	712

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100.

The census also asked residential facilities to nominate the responses taken to address their skill shortages. Table 4.10 shows that the most common response to a skill shortage for any occupation is to have the existing workforce work longer hours, with 62 per cent of facilities that reported skill shortages saying they undertook this action. The next most common response was 'greater use of agency staff' (48 per cent of facilities that reported a skill shortage) followed by 'on-the-job training of staff' (36 per cent).

There are few differences when analysing responses taken by facilities with RN and PCA skill shortages compared with the overall picture. Facilities with PCA skill shortages are more likely to use student placements (19 per cent) compared with facilities with RN shortages (13 per cent). Residential facilities with PCA shortages are also a little more likely to react with on-the-job training of staff (42 per cent versus 36 per cent for RN shortages). The use of student placements and volunteers as a response to skill shortages were new categories added in 2016.

Table 4.10: Proportion of residential facilities with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected

Response to skill shortage	Facilities that reported skill shortages		
	For any occupation	For RNs	For PCAs
External training of staff	17.8	18.3	21.8
On-the-job training of staff	35.8	36.4	41.6
Existing workforce worked longer hours	61.9	64.2	68.4
Greater use of agency staff	48.1	49.2	51.0
Sub-contracted or outsourced services	5.7	5.4	4.9
Employed staff on short term contracts	16.8	18.1	14.5
Wages, salaries and/or conditions increased	7.3	8.7	8.6
Reduced outputs or production	2.1	1.9	2.2
Used student placements	13.2	13.0	18.8
Used volunteers	5.9	6.0	8.3
Other	9.8	9.6	8.7
Facilities (weighted)	1,498	1,156	712

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100.

4.6 Vacancies

Given the anticipated future increased demand for aged care services in Australia, the aged care workforce will need to grow considerably creating challenges for the sector and policy makers alike (CEPAR 2014). The number and types of staff vacancies are important indicators of the adequacy of the labour supply to aged care residential facilities. In the 2016 census, facilities were asked to provide information on the vacancies they had for employees across different occupational classifications. As shown in Table 4.11, the highest number of vacancies in 2016 are reported for RNs and PCAs (both 24 per cent). Vacancies are much lower for AH workers, being reported for only 4 per cent of facilities.

The proportion of residential facilities with vacancies appears lower in 2016 for all direct care occupations compared with the earlier years of 2007 and 2012, particularly for RNs and PCAs. Where facilities do have vacancies, they report a higher number of vacancies for PCAs (3.3) than for other direct care occupations. The mean number of vacancies for each occupation in 2016 was similar to that in 2012.

Table 4.11: Vacancy rate (per cent of all residential facilities) and mean number of vacancies (in facilities with vacancies), by occupation: 2003, 2007, 2012 and 2016

	Full-Time Equivalent			
	2003	**2007**	**2012**	**2016**
Panel 1: % of facilities with any vacancies				
Registered Nurse	25.7	31.3	32.7	23.9
Enrolled Nurse	10.8	17.7	18.7	14.9
Personal Care Attendant	23.3	31.4	36.4	23.6
Allied Health	6.3	6.7	8.8	3.6
Panel 2: Mean number of vacancies in facilities with any vacancies				
Registered Nurse	n/a	n/a	1.7	1.8
Enrolled Nurse	n/a	n/a	2.2	1.9
Personal Care Attendant	n/a	n/a	3.6	3.3
Allied Health	n/a	n/a	1.0	1.4

Source: Census of residential aged care facilities.

In order to further assess shortages for residential aged care workers, the time that facilities took to fill these vacancies is shown in Tables 4.12 and 4.13. The last column of Table 4.12 shows that across all occupations just over a quarter (26 per cent) of the most recent vacancies took less than a week to fill. The first four columns show that there is considerable variation by occupation in how quickly vacancies are filled. The first row shows that 63 per cent of facilities were able to fill their most recent AH vacancy in less than a week. The corresponding proportion was 22 per cent for RN vacancies, and 21 per cent for PCA vacancies. On the whole AH and EN vacancies appear quicker to fill than vacancies for RNs and PCAs.

The proportions of vacancies that were either very quick to fill (less than 1 week) or very hard to fill (more than 26 weeks) was reduced in 2016 when compared with 2012. Compared with 2012, RN vacancies are still sometimes more difficult for facilities to fill than PCA vacancies (for RNs, 28 per cent of vacancies take more than for 4 weeks to fill, while for PCAs this share is only 12 per cent, against 30 per cent and 14 per cent respectively in 2012). Fewer vacancies are taking longer than 8 weeks to fill in 2016 (6 per cent across all occupations in 2016, but 14 per cent in 2012).

Table 4.12: Weeks required for residential facilities to fill most recent vacancy, by occupation: 2016 (per cent)

% of facilities that took	RN	EN	PCA	AH	All occupations
Less than 1 week	22.0	39.1	20.9	62.9	26.2
1 week	7.5	6.8	17.5	4.9	10.5
2 weeks	13.9	10.3	21.4	6.9	11.3
3 to 4 weeks	28.9	24.3	28.1	15.4	30.8
5 to 8 weeks	16.9	13.1	10.0	7.9	15.1
9 to 12 weeks	5.9	3.1	1.7	0.7	3.2
13 to 26 weeks	4.0	2.3	0.3	0.7	2.7
More than 26 weeks	0.9	0.8	0.0	0.6	0.2
Facilities (weighted)	2,149	1,666	2,244	1,340	-

Source: Census of residential aged care facilities.
Facilities reporting weeks for the most recent vacancy, for that occupation.

The time taken to fill staff positions is further examined in Table 4.13 which looks at the average and the median speed at which vacancies are filled. Although there is less information in these two measures, it allows us to look at differences between State/Territories and also across location. The overall figures show that vacancies for PCAs took on average less time to fill (2.5 weeks) compared with vacancies for RNs (4.3 weeks).

There is some variation across States and Territories, with Queensland and NSW taking longer than the average (5.4 weeks and 4.9 weeks respectively) to recruit RNs, and SA and the ACT taking longer than the average to recruit PCAs (in each case 2.9 weeks).

The most pronounced observation emerging from Table 4.13 is that facilities in remote and very remote areas take considerably longer on average to fill vacancies than facilities in major cities. Vacancies for RNs in remote and very remote facilities face an even longer delay before being filled compared with vacancies for PCAs.

Table 4.13 also shows the median duration[6]. This can help give more information about the shape of the distribution of the durations. The median vacancy duration is lower than the average, particularly in cases where the average vacancy duration was high. For example, the average vacancy rates in remote areas were 7 weeks for RNs, and 11.3 weeks in very remote areas and in contrast the median is lower with the median duration for RN vacancies of 5.5 weeks in remote areas, and a median of 8 weeks in very remote areas. The median vacancy duration for all facilities is also lower than the average, at 3 weeks for RNs (the average was 4.3 weeks) and 2 weeks for PCAs (the average was 2.5 weeks). For PCAs the median and average are quite close (2 and 2.5 weeks).

[6] The median is the "middle" of a sorted list of numbers, in this case half of vacancies take longer than the median to fill and half take shorter. Hence, the median can reveal the centre of the durations the outlets reported without distortion. When the median is contrasted with the average, if the median is much lower than the average it shows that the average has been affected by cases with longer durations (and also the other way round if the median is much higher than the average then the average has been influenced by the share with shorter durations).

Link to the ABS website for further information about measures of central tendency.

Table 4.13: Average and median vacancy duration (weeks) for residential RNs and PCAs, by State/Territory and location: 2016

		RN	PCA
All Facilities	Average	4.3	2.5
State/Territory	NSW	4.9	2.6
	Victoria	3.7	2.2
	Queensland	5.4	2.5
	WA	3.3	2.4
	SA	3.8	2.9
	Tasmania	3.8	2.0
	ACT	2.5	2.9
	NT	3.9	2.0
Location	Major cities of Australia	3.2	2.2
	Inner Regional Australia	5.4	2.6
	Outer Regional Australia	5.8	2.8
	Remote Australia	7.0	3.7
	Very Remote Australia	11.3	4.8
All Facilities	Median	3.0	2.0
State/Territory	NSW	3.0	2.0
	Victoria	3.0	2.0
	Queensland	4.0	2.0
	WA	2.0	2.0
	SA	2.5	2.0
	Tasmania	4.0	2.0
	ACT	2.0	3.0
	NT	2.0	2.0
Location	Major cities of Australia	2.5	2.0
	Inner Regional Australia	4.0	2.0
	Outer Regional Australia	4.0	2.0
	Remote Australia	5.5	2.5
	Very Remote Australia	8.0	3.0

Source: Census of residential aged care facilities.

The census asked facilities about the causes of staff vacancies, with multiple responses permitted. The most common reason facilities gave for their most recent vacancy for all occupations was resignation (Table 4.14). Around 84 per cent of facilities gave this reason, and it was the most common reason when asked about RNs (52 per cent) and PCAs (73 per cent).

Other important reasons that facilities gave were the creation of a new position (31 per cent) and the retirement of staff (27 per cent). Almost 8 per cent gave injuries/illness as a reason for a vacancy arising, possibly indicating some of the physical risks and demands of residential aged care.

Table 4.14: Proportion of residential facilities giving each reason for their most recent vacancy (per cent), by occupation: 2016

% of facilities stating	RN	PCA	All occupations
New position	20.0	17.1	30.8
Retirement	20.0	20.3	26.9
Injury/illness	0.0	3.8	7.9
Resignation	52.0	72.8	84.2
End of contract	8.0	2.5	7.3
Involuntary separation	0.0	7.0	11.8
Other	14.7	13.3	33.3
Facilities (weighted)	75	158	2,439

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

As shown in Table 4.15, the most common recruitment strategy used to hire new PCAs in 2016 was internet job advertisement (34 per cent of facilities) followed by a combination of internet and newspaper advertisements (23 per cent of facilities). These were also the predominant choices in 2012. This finding supports the view that agency services are very rarely the first option for facilities looking to hire additional PCAs (1 per cent); this was also the case in 2012.

For workers, the most common source of information for all direct care occupations was internet job advertisements followed by word of mouth. Word of mouth is particularly important for PCAs in 2016 (36 per cent), as was the case in 2012. The use of Internet job advertisements has risen for workers since 2012, becoming the most common source of information in job searching for all direct care occupations. The use of agencies is a far more common method amongst nurses and AH workers (16 per cent) compared with PCAs (7 per cent).

Table 4.15: Sources of information about recruitment opportunities used by recently hired* residential direct care workers and facilities: 2016 (per cent)

Source of job information	Nurse	PCA		AH
	Worker	Worker	Facility	Worker
Walk-in	n/a	n/a	9.0	n/a
Word of mouth	28.6	35.8	7.2	21.7
Newspaper job advertisement	4.7	5.7	7.1	4.6
Internet job advertisement	40.9	37.5	33.8	51.9
Both internet and newspaper advert	n/a	n/a	23.3	n/a
Job placement program/career service	0.1	8.3	11.1	0.0
Agency	15.8	7.2	0.9	15.6
Other	9.1	5.5	7.2	5.8
Don't know	n/a	n/a	0.6	n/a
Total (weighted)	3,512	5,939	2,038	720

Source: Census of residential aged care facilities and Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100.
**Recently hired workers have been employed for 12 months or less.*

4.7 Setting of Employment Conditions

The 2016 census collected information regarding the industrial methods used by residential facilities to set employment conditions for their staff. Table 4.16 reports the proportions of employees, across all residential facilities, whose employment terms and conditions are prescribed by each of several main methods. We suggest that these figures be treated with some caution, because some of the methods can operate in tandem (for example awards and agreements) and in some instances employers may not recognise clearly the distinctions between them.

Enterprise Agreements are by far the most common method of setting employment conditions. The census form defined these to include union and non-union agreements, whether certified with an industrial authority or not. Facilities reported that 79 per cent of all their employees had their employment conditions determined by Enterprise Agreements in 2016. This is higher than in 2012 when facilities reported 74 per cent of all employee conditions were set in this way. The proportion within each occupation was similar for nurses and PCAs (each 79 per cent), but lower for AH workers (72 per cent). These proportions within occupation are all higher than in 2012, but in particular facilities have reported that AH workers have raised coverage by Enterprise Agreements, rising from 66 per cent in 2012 to 72 per cent in 2016.

Award-based arrangements were the other main method of setting employee conditions in the residential aged care sector with 19 per cent of all facilities reporting this method.

Beyond Enterprise Agreements and Awards, other methods for setting employee conditions were rarely used.

Table 4.16: Industrial methods used by residential facilities to set employment conditions (per cent), by employee occupation: 2016

% of employees with conditions set by method	Nurses	PCA	AH	All occupations
Award	19.3	19.2	21.0	19.3
Enterprise Agreement	78.9	79.1	72.3	78.8
Common Law Contract	0.7	0.4	3.3	0.6
Individual Flexibility Agreement	0.7	0.7	1.9	0.8
Don't Know	0.3	0.5	1.5	0.5
Total	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.

4.8 Agency, Brokered and Self-employed Staff

Although the 2016 census of aged care facilities predominantly collected information regarding the employment of PAYG direct care workers, providers may also hire non-PAYG staff in order to meet their employment needs. For example, non-PAYG workers may be required to allow service flexibility, cover staff absences or vacancies, or to meet the needs of specific clients on a short-term basis. Facilities were therefore asked about their use of three different types of non-PAYG workers – agency, brokered and self-employed staff. Table 4.17 presents the proportion of facilities that employed at least one non-PAYG worker (in any occupation) in the designated fortnight (last pay period in November 2015). It shows quite widespread use of non-PAYG workers by residential facilities in 2016, with half of all facilities (50 per cent) reporting some use.

Of the three types of non-PAYG workers, agency workers are the most widely used, with 41 per cent of residential facilities reporting using agency workers in 2016. The use of agency workers by facilities is lower in 2016 than that reported in 2012 (46 per cent).

Facilities most often used agency workers for RN or PCA positions. About 28 per cent reported using agency PCAs, 27 per cent agency RNs, 13 per cent agency ENs and 5 per cent agency AHs.

Table 4.17 shows that many facilities engage several agency workers in different occupations at the same time. The fact that 41 per cent of facilities in total use agency workers implies that the 27 per cent of facilities using agency RNs cannot be entirely separate from the 28 per cent using agency PCAs. Rather, these figures tell us that there is overlapping use of agency workers across different occupations within individual facilities.

Table 4.17 suggests that residential facilities use the other two types of non-PAYG workers (brokered and self-employed) mostly in order to acquire AH worker services. We note that the proportion of facilities reporting AH workers in brokered positions increased from 5 per cent in 2012 to 7 per cent in 2016, while reporting AH workers in self-employed positions decreased from 12 per cent in 2012 to 6 per cent in 2016.

Table 4.17: Proportion of residential facilities (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	27.0	0.9	0.7	28.3
Enrolled Nurse	13.0	0.3	0.3	13.4
Personal Care Attendant	28.0	0.9	0.2	29.1
Allied Health	5.4	7.3	6.2	17.6
All occupations	40.6	8.3	6.5	49.8

Source: Census of residential aged care facilities.

Estimates for each State/Territory of the proportions of residential facilities using non-PAYG RNs and/or PCAs across 2003 to 2016 are shown in Table 4.18.

There are quite noticeable differences in these proportions by State/Territory in 2016. Facilities located in the ACT, SA, Tasmania and the NT had much higher than the average use of non-PAYG RNs in 2016 (28 per cent).

There is evidence of change since 2012, with a strong increase in the use of non-PAYG RNs by ACT facilities (rising from 29 per cent to 38 per cent), and a small increase by NT facilities (up from 40 to 42 per cent). In contrast, with the exception of WA which remained fairly steady in their reported use of agency RNs (28 per cent), the other states recorded declines in the use of non-PAYG RNs (large declines for Queensland, SA, Tasmania).

The pattern of agency worker use to obtain PCA services was different to that of agency worker use to obtain RN services, also with noticeable differences between State/Territory in 2016. Facilities located in the ACT, SA and WA had much higher than average use of non-PAYG PCAs in 2016. Only 6 per cent of Tasmanian facilities reported using agency PCAs, which is much lower than the 29 per cent national average use.

Finally, Table 4.18 presents evidence of a strong increase in the use of non-PAYG PCAs by ACT and WA facilities since 2012. In contrast, the other states recorded reductions in the use of non-PAYG PCAs, since 2012 (with a large reduction in Victoria and a very large reduction in Queensland, SA and NT).

Table 4.18: Proportion of residential facilities (per cent) using any non-PAYG RNs or PCAs in the designated fortnight, by State/Territory: 2003, 2007, 2012 and 2016

State/Territory	RN				PCA			
	2003	2007	2012	2016	2003	2007	2012	2016
NSW	19.1	23.6	26.7	24.1	21.7	25.4	22.2	20.7
Victoria	25.9	31.9	31.2	25.3	31.6	45.7	35.9	29.9
Queensland	27.3	44.1	37.6	29.4	24.1	42.2	35.2	23.4
SA	44.6	44.8	47.3	41.0	51.2	64.1	60.8	46.6
WA	30.3	38.9	28.4	28.3	48.3	62.3	28.4	48.1
Tasmania	15.6	21.4	47.1	40.0	2.2	5.7	10.0	6.2
ACT	44.4	23.5	29.2	37.9	50.0	35.3	29.2	51.7
NT	40.0	81.8	40.0	42.1	50.0	63.6	40.0	26.3
All facilities	26.1	33.3	32.6	28.3	30.1	41.1	34.3	29.1

Source: Census of residential aged care facilities.

Table 4.19 provides a different picture of the extent to which non-PAYG workers contribute to the residential direct care workforce, indicating how many non-PAYG workers had been engaged in the designated fortnight across all residential facilities. Amongst the total number of direct care workers, the most widely used by facilities were non-PAYG PCAs, with 9,085 in residential facilities in the designated fortnight and of these, they were mainly agency PCAs (8,588). The next most widely used were non-PAYG RNs of which there were 3,323 and again the bulk of these were agency RNs (3,185). Reinforcing the findings from previous tables, almost all non-PAYG workers contributing to the residential aged care workforce are RN and PCA agency workers, but also including a sizeable number of ENs (1,708).

Table 4.19: Number of non-PAYG workers in residential facilities in the designated fortnight, by occupation: 2016

Occupation	Number of workers			
	Agency	Brokered	Self-employed	Total
Registered Nurse	3,185	69	69	**3,323**
Enrolled Nurse	1,708	62	51	**1,821**
Personal Care Attendant	8,588	176	321	**9,085**
Allied Health	890	487	369	**1,747**
All occupations	14,371	794	810	**15,976**

Source: Census of residential aged care facilities.
N=2,795 facilities (weighted).

Further questions on the reasons for non-PAYG worker use were added in the 2016 census and are shown in Table 4.20. The two most frequently cited reasons for agency workers were ‘short-term cover for staff absences’ (87 per cent), followed by being ‘unable to fill vacancies’ (51 per cent). These were followed by ‘matching staff to peaks in service user demand’ (14 per cent), ‘covering for maternity leave or annual leave’ (19 per cent) and ‘obtain specialist skills’ (4 per cent). The reasons ‘freeze on permanent staff numbers’ or ‘other reasons’ were rarely cited.

In contrast, the main reason for the much less frequent use of brokered positions and self-employed workers was to 'obtain specialist skills' (65 and 75 per cent respectively).

Table 4.20: Reasons for using non-PAYG workers in residential facilities in the designated fortnight, by type: 2016

Reason	Agency	Brokered	Self-employed
Matching staff to peaks in service user demand	14.2	9.2	6.2
Short-term cover for staff absences	87.2	10.5	9.6
Covering for maternity leave or annual leave	18.6	3.1	5.6
Unable to fill vacancies	51.1	9.2	5.6
Obtain specialist skills	4.3	64.9	75.3
Freeze on permanent staff numbers	1.9	0.9	1.7
Other reason	1.3	8.3	6.2
Facilities (weighted)	1,129	228	178

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

4.9 Volunteers in Residential Aged Care

As in 2012, the census collected information about the extent of volunteering in residential aged care. In addition, the 2016 census also asked about the roles undertaken by volunteer staff. A high number of volunteers (23,537) provided 114,897 hours of service to residential facilities as a whole in 2016 (Table 4.21). Both the overall number of volunteers and the total hours offered by them are higher than in 2012. Responses from facilities using volunteers indicate they have an average of 10 volunteers per facility (the same as in 2012), with each volunteer contributing an average of 4.9 hours per fortnight (roughly the same as in 2012).

Table 4.21: Total number of volunteers and volunteer hours worked in residential facilities in the designated fortnight: 2012 and 2016

Year	Volunteer numbers, per fortnight	Volunteer hours, per fortnight	Average number of volunteers per facility, per fortnight	Average hours per volunteer, per fortnight
2016	23,537	114,897	10	4.9
2012	22,261	101,555	10	4.8

Source: Census of residential aged care facilities.

As shown in Table 4.22, 83 per cent of facilities have one or more volunteers. Residential facilities in inner regional locations are most likely to have volunteers, while those in remote and very remote areas have fewer volunteers than the average. The use of volunteers by residential facilities also differs by ownership type, with not-for-profit facilities more likely to use volunteers (91 per cent), than for-profit (72 per cent) or government facilities (69 per cent). Residential facility volunteering patterns in 2016 are very similar to those in 2012.

Table 4.22: Proportion of residential facilities employing volunteer workers (per cent) in the designated fortnight, by location and ownership type: 2016

		% of all facilities
All facilities		82.6
Location	Major cities of Australia	81.6
	Inner Regional Australia	88.9
	Outer Regional Australia	85.2
	Remote Australia	71.6
	Very Remote Australia	30.2
Ownership type	Not-for-profit	91.3
	For-profit	72.1
	Government	68.9

Source: Census of residential aged care facilities.

Table 4.23 presents the answers to a new question which was added in 2016 about what roles were undertaken by volunteers in aged care. Residential facilities very often used volunteers for 'social activity support assistance' (82 per cent). A high proportion of facilities also had volunteers undertaking roles such as assisting in the 'planning of group activities' (68 per cent) and to support 'companionship/befriending' (64 per cent). A smaller share of facilities had volunteers undertaking roles of 'transport assistants' (23 per cent), 'shopping/appointment assistants' (16 per cent), and 'gardening assistants' (15 per cent). Proportions of less than 10 per cent of facilities had volunteers undertake 'domestic activity assistance' (9 per cent), 'meal/preparation assistance' (6 per cent) and 'other activities' than those listed (8 per cent) with 'respite care assistance' (2 per cent) and 'home maintenance assistance' (2 per cent) rarely undertaken by volunteers.

Table 4.23: Roles undertaken by residential facility volunteer workers (per cent): 2016

	% of facilities (weighted)
Domestic activity assistance	8.9
Respite care assistance	1.8
Social activity support assistance	81.7
Planned group activity assistance	67.7
Home maintenance assistance	2.3
Gardening assistance	14.6
Transport assistance	22.9
Shopping/appointment assistance	15.7
Meal/preparation assistance	6.4
Companionship/befriending	63.8
Other	7.6
Total (facilities with volunteers, weighted)	2,319

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

4.10 Quality Measures in Residential Aged Care

For the first time, the 2016 residential facilities census contained questions regarding the monitoring of quality in aged care. Information regarding quality in residential aged care is particularly pertinent given the establishment of the Australian Aged Care Quality Agency in 2014.

The most common form of quality monitoring undertaken by facilities/outlets was that 'managers or supervisors monitor quality' (86 per cent of facilities reported this). Keeping records of feedback or complaints from service users' was the second most common method (57 per cent), followed by 'accreditation' (56 per cent). Just over a third of residential facilities also reported that they use 'surveys of service users' (36 per cent) and/or 'inspectors from another organisation monitor quality' (32 per cent). Other less frequently used measures included 'individual employees monitor quality' (20 per cent) and 'external auditing' (16 per cent). The fact that the 'other methods' category was rarely cited (3 per cent) suggests that the list presented covered most measures used.

Table 4.24: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016

	% of all facilities
Managers or supervisors monitor quality	86.1
Inspectors from another organisation monitor quality	32.4
Individual employees monitor quality	20.3
Keep records of feedback or complaints from service users	56.9
Surveys of service users	35.6
External auditing	16.2
Accreditation	55.9
Other	2.9

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

5. The Home Care and Home Support Aged Care Workforce

Key Findings

- The total home care and home support workforce has decreased by 13 per cent since 2012 to an estimated 130,263. During the same time period the overall direct care workforce fell by 7 per cent and the FTE workforce by 19 per cent.
- CCWs were the largest home care and home support direct care occupational group (84 per cent) followed by RNs (8 per cent) and AH professionals (5 per cent).
- The median age of the home care and home support direct care workforce was 52 years, and they were predominantly female workers (89 per cent).
- The proportion of overseas born workers in the home care and home support sector has reduced from 28 per cent in 2012 to 23 per cent in 2016.
- Aboriginal and Torres Strait Islander people accounted for 2 per cent of the home care and home support direct care workforce.
- Around 64 per cent of workers reported being in either very good or excellent health.
- Eighty eight per cent of home care and home support workers held post-secondary qualifications. Forty five per cent of outlets reported that more than three-quarters of their CCWs held a Certificate III in an aged-care related field.
- Three-quarters of all home care and home support direct care workers were employed on permanent part-time contracts. The proportion of workers on casual/contract arrangement fell from 27 per cent in 2012 to 14 per cent in 2016.
- A regular daytime shift was the most common work schedule for all direct care occupations. However, 14 per cent of CCWs reported an irregular work schedule.
- Mostly CCWs preferred to work more hours. Less than half (46 per cent) of the home care and home support workforce were happy with their hours of work, 14 per cent wanted to reduce their hours, 40 per cent wanted to increase them.
- Sixteen per cent of the home care and home support workforce reported more than one current job.
- Three quarters of workers had undertaken training over the previous 12 months, with mandatory training the most common form of training. Priority areas identified for future training included dementia, palliative care, and mental health.
- Aged care work was a first occupation for about 5-6 per cent of the home care and home support direct care workforce. No dominant career pathways into home care and home support aged care were identified for CCWs and AH workers.
- Forty two per cent of the home care and home support workforce had paid work in the sector prior to their current job. Improved working conditions, along with changing personal circumstances, were the primary reasons for moving to a different aged care employer.
- Most (81 per cent) home care and home support workers expected to still be with their current employer after 12 months and 6 per cent of the workforce was seeking alternative work.

- Slightly higher levels of job satisfaction were reported by home care and home support than residential care workers.
- The most prevalent unusual job demands made of workers were associated with changes in work patterns (working longer than scheduled, variation to hours/location).
- Twelve per cent of home care and home support direct care workers reported a work-related injury or illness over the previous 12 months, most commonly sprains/strains and chronic joint/muscle conditions.
- Seventy two per cent of outlets employed CCWs from a CALD background, most commonly from Italy and South East Asia.
- All home care and home support outlets reported benefits of employing CALD CCWs – these included enhanced cross-cultural understandings and language skills. Only a fifth of home care and home support outlets reported difficulties in employing CALD CCWs, with communication issues being most common.

5.1 Introduction

This chapter provides detailed information about the home care and home support aged care workforce using responses from both workers (N=7,024) and outlets (N=2,307). The census and survey collected information on the main occupational groups working within the sector. In selected tables we provide details on each of these occupations (including, as in 2012, Nurse Practitioners and Allied Health Assistants). Where these occupational groups are not listed separately, Nurse Practitioners are combined with Registered Nurses, and Allied Health Assistants with Allied Health Professionals under the umbrella of Allied Health worker.

The information provided in this chapter to a large extent parallels that provided for the residential workforce in Chapter 3. In some areas in this chapter direct comparisons are made between the residential and home care and home support workforces. In this chapter we examine the characteristics of the residential workforce and aged care work, career pathways into and out of aged care, the experiences of home care and home support work, the extent of work-related injuries and illness in the sector, and the cultural and linguistic diversity of the workforce.

5.2 Total Employment and Main Workforce Characteristics

The following section provides an overview of the home care and home support aged care workforce including the overall size of the PAYG workforce and how this is distributed across the different occupational classifications within the sector. We then examine key socio-demographic characteristics of the home care and home support workers themselves including age, gender, ethnicity, cultural background, health and education.

5.2.1 Total Employment

The home care and home support sector is likely to play a larger role in the provision of aged care services owing partly to an increasing preference of older Australians to continue to live and receive care in their own homes as they age. Indeed by 2050 it has been estimated that around 80 per cent of all aged care services will be community based (Productivity Commission, 2011). In order to determine how the aged care workforce can most effectively be developed to meet the future care needs of older Australians, an understanding of the size and composition of the existing workforce is necessary. Our estimates of the home care and home support aged care workforce is based on information obtained from the census of home care and home support outlets.

The 2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct care roles. Table 5.1 compares the 2016 estimates with those from 2012 and 2007. It suggests that the whole home care and home support PAYG workforce reduced in size by 13 per cent between 2012 and 2016 (falling by 19,538 from 149,801 to 130,263). This reduction has followed an earlier rise between 2007 and 2012 (from 87,478 to 149,801).

Direct care employment also fell between 2012 and 2016. It fell by 7 per cent (an estimated fall of 6,896 from 93,359 to 86,463). There was an earlier major employment rise between 2007 and 2012 in the background (a rise of 19,292 from 74,067 to 93,359). These substantial differences indicate that the sector is undergoing considerable structural change and this is reflected in the way labour is used both in numbers but also in the differential use of direct and non-direct care employees.

The proportion of the PAYG home care and home support aged care workforce working in direct care roles continues relatively steady at 66 per cent. In 2016, 66 per cent of home care and home support aged care employees work in direct care roles, compared with 62 per cent in 2012 (85 per cent in 2007).

Table 5.1: Size of the home care and home support aged care workforce, all PAYG employees and direct care employees: 2007, 2012 and 2016 (estimated headcount)

Occupation	2007	2012	2016
All PAYG employees	87,478	149,801	130,263
Direct care employees	74,067	93,359	86,463

Source: Census of home care and home support aged care outlets.

5.2.2 Occupation

The occupational composition of the headcount of home care and home support direct care employees is presented in Table 5.2. Community Care Workers (CCWs) are the largest occupational group in the home care and home support direct care workforce (84 per cent). While their estimated headcount fell by 3,551 (5 per cent) since 2012, as a proportion of the home care and home support direct care workforce the CCW share rose from 81 per cent in 2012 to 84 per cent in 2016.

The number of home care and home support RNs also fell by 662 (9 per cent) between 2012 and 2016, but their share in the whole direct care workforce remained constant at 8 per cent. The number of nurse practitioners still only make up a very small proportion of the home care and home support direct care workforce (0.1 per cent). The number of home care and home support ENs has fallen by 1,753 since 2012 (48 per cent) and as a proportion of the direct care workforce they have fallen from 3.9 per cent to 2.2 per cent. The Allied Health employment categories had a stable share of direct care employment with 6 per cent in 2012 and in 2016.

The overall picture suggests that home care and home support outlets continue to rely on CCWs to provide direct care without much change in the occupational distribution for direct care workers. There has been a small fall in share for most occupations, with a small rise in the share of CCWs, from 81 per cent in 2012 to 84 per cent in 2016.

Table 5.2: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201 (0.2)	53 (0.1)
Registered Nurse	7,555 (10.2)	7,631 (8.2)	6,969 (8.1)
Enrolled Nurse	2,000 (2.7)	3,641 (3.9)	1,888 (2.2)
Community Care Worker	60,587 (81.8)	76,046 (81.4)	72,495 (83.8)
Allied Health Professional*	3,925 (5.3)	3,921 (4.2)	4,062 (4.7)
Allied Health Assistant*		1,919 (2.1)	995 (1.2)
Total number of employees (headcount) (%)	**74,067 (100)**	**93,359 (100)**	**86,463 (100)**

Source: Census of home care and home support aged care outlets.
** Note: in 2007, these categories were combined under Allied Health.*

A different picture arises from the headcount measure (Table 5.2) compared to the Full Time Equivalent (FTE) employment measure (Table 5.3). These two measures when put together provide a more complete and complementary picture. Table 5.3 shows that there was a 19 per cent fall in the home care and home support FTE direct care workforce (by 10,450 workers from 54,537 in 2012 to 44,087 in 2016). In percentage terms this is a larger decline than in the headcount corresponding comparison (7 against 19 per cent), which suggests that there has been an increase in the proportion of workers employed for fewer hours.

The distribution of the home care and home support FTE direct care workforce in 2016 presented in Table 5.3 is slightly different to that of the headcount number of persons working in direct care occupations shown in Table 5.2. The share of CCWs is lower in the distribution of the home care and home support FTE direct care workforce than in the headcount distribution in Table 5.2 (79 per cent FTE against 84 per cent headcount).

Table 5.3: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	55 (0.1)	41 (0.1)
Registered Nurse	6,079 (13.2)	6,544 (12.0)	4,651 (10.5)
Enrolled Nurse	1,197 (2.6)	2,345 (4.3)	1,143 (2.6)
Community Care Worker	35,832 (77.8)	41,394 (75.9)	34,712 (78.7)
Allied Health Professional*	2,948 (6.4)	2,618 (4.8)	2,785 (6.3)
Allied Health Assistant*		1,581 (2.9)	755 (1.7)
Total number (FTE) (%)	**46,056 (100)**	**54,537 (100)**	**44,087 (100)**

Source: Census of home care and home support aged care outlets.
** Note: in 2007, these categories were combined under Allied Health.*

Figures 5.1 and 5.2 can help show these changes over time with their patterns. Figure 5.1 portrays the changes over time in distributional proportions for the two measures of headcount

and FTE direct care workforce information shown in Tables 5.2 and 5.3. Figure 5.2 portrays the distribution of the numerical headcount and FTE direct care workforce information shown in Tables 5.2 and 5.3.

Figure 5.1: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)

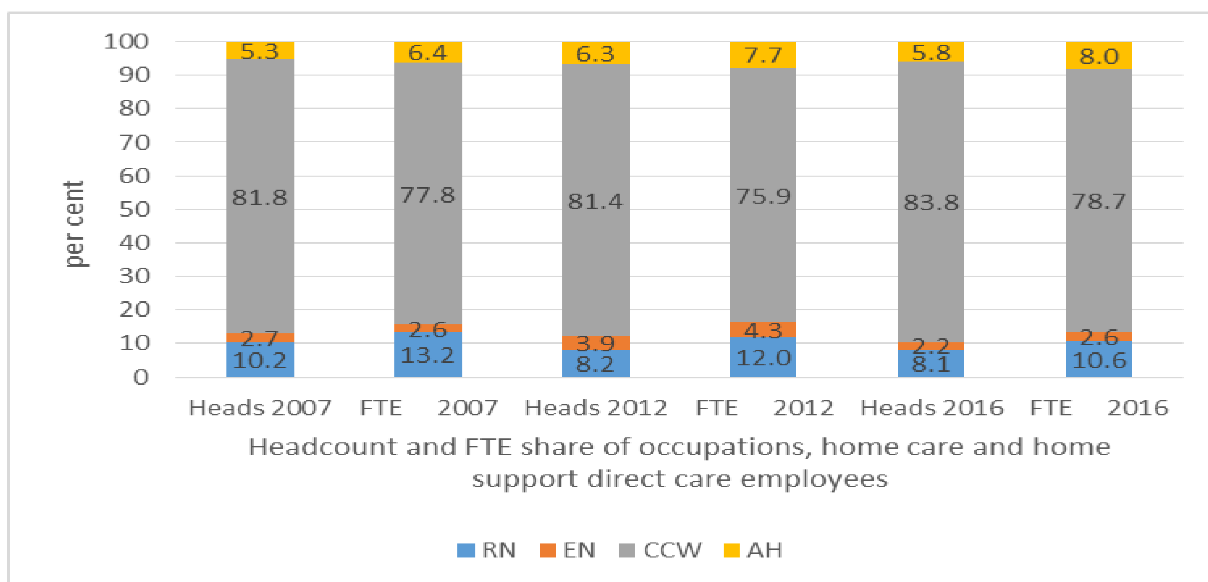
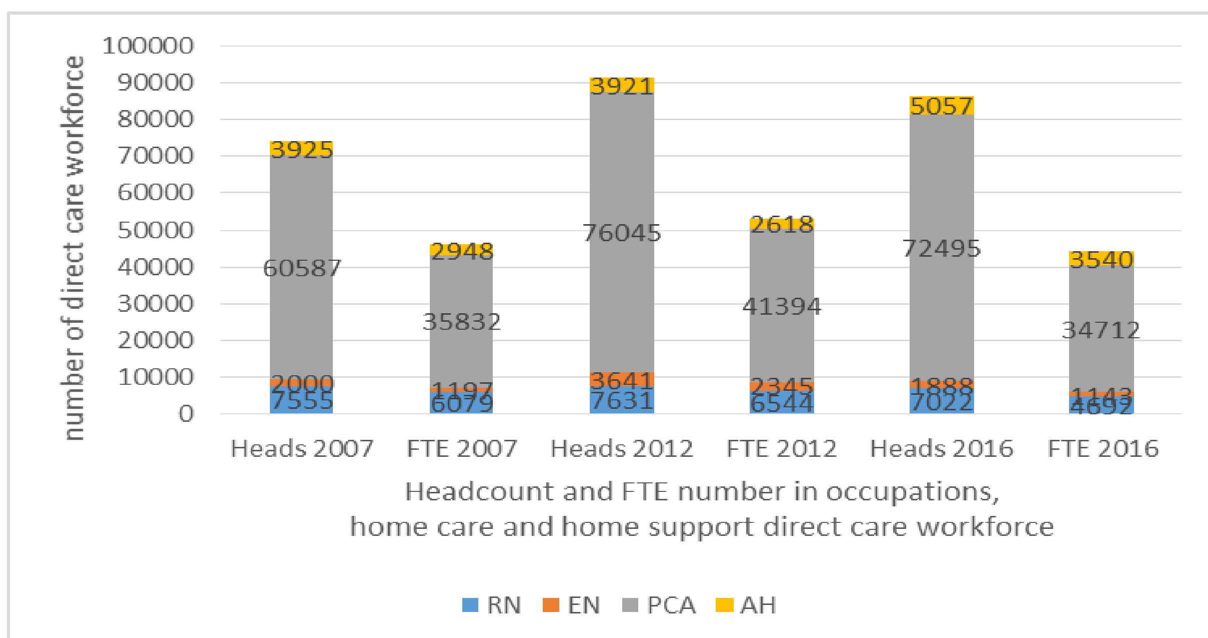


Figure 5.2: Number of the occupations for the home care and home support direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 5.1 and Figure 5.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 5.1 and Figure 5.2.

Table 5.4 shows the roles of staff not providing direct care in home care and home support aged care. There is a slight change in the distribution of non-direct care staff in home care and home support aged care between 2012 and 2016. Management and administration roles have seen a small rise in their share, while other non-direct care roles have seen a drop in their share.

Table 5.4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

Occupation	2012	2016
Care Manager/co-ordinator	33.2	29.8
Management	22.3	25.6
Administration	35.3	37.0
Spiritual/pastoral care	1.6	0.5
Ancillary care (home maintenance, modification, etc.)	7.7	7.1
Total	**100**	**100**

Source: Census of home care and home support aged care outlets.

5.2.3 Age and Gender

Understanding the age structure of employees in an industry aids future workforce planning and development. Particular workforce strategies may be required in sectors with an older worker profile, such as the implementation of measures to accommodate the needs of older workers and the addressing of staff turnover due to retirement. The aged care sector (across both residential and home care and home support) has traditionally had an older workforce compared to the Australian workforce in general. Table 5.5 and Figure 5.3 present the age distribution of home care and home support direct care workers for 2007, 2012 and 2016, and compare the direct care workforce with those recently hired (i.e. those who have been employed for 12 months or less). Looking at the whole sample, it is clear that this is an ageing workforce as the only age groups that are continually increasing in share are those above 54 years (with the exception of the 25-34 year olds who show a small increase). This pattern in the age profile of home care and home support direct care workers (Table 5.5) is in clear contrast to that of the residential direct care workforce which is getting younger (Table 3.5).

For home care and home support workers who have been hired in the last 12 months, Table 5.5 shows that 47 per cent are under the age of 45 years (compared with 28 per cent for all direct care workers). This suggests that younger people are attracted into home care and home support aged care. The age profile of recent hires in home care and home support is a little different to that in 2012, but with only slight variation in the two younger age brackets. There was a small fall in 16-24 year old new hires (from 10 per cent in 2012 to 8 per cent in 2016), a slight rise in those aged 25-34 years (from 14 per cent in 2012 to 16 per cent in 2016) and a larger fall in the share of those aged 35-44 years (from 28 per cent in 2012 to 23 per cent in 2016). These are not new hires to the sector, but to their current employers, therefore they may have been working in the aged care sector before. The new hires appear younger than the total workforce. This appears to be a trend as we see the same phenomenon in 2007 and 2012. Observing this flow of younger workers suggests that the home care and home support workforce should have been getting younger since 2007, but this is not what we actually observe. This could be happening for several reasons. It could be, that these are not new hires to the sector, but instead reflect within-sector mobility by younger workers. Alternately, it could be that these new hires may indeed be younger than the average, but those who leave the sector may also be younger than the average, because retention may be lower for the younger workers.

Another way to look at the age of the workforce is to compare the median age (mid-point) of the workforce for each of the occupations, as presented in Table 5.6. Table 5.6 shows that the median age of 52 years in 2016 is slightly higher than the 50 years in 2012. Table 5.6 also shows that the median age of 52 years in 2016 for all direct care workers is higher than that of recent hires (46 years in 2016, but it was 44 years in 2012 and so the home care and home support recent hires are older in 2016 than in 2012).

One of the key differences between the residential and home care and home support aged care workforces is in the median age of CCWs/PCAs. In 2016 residential PCAs had a younger

median age than other occupations across the workforce (46 years, Table 3.6) and for recent hires (35 years), whereas home care and home support CCWs had the highest median age at 52 years (with ENs at 51 years and RNs at 48), with recent hire CCWs (46 years) only 6 years younger. In home care and home support aged care, the youngest median age in the recent hires is for AH workers (41 years in 2016, but this is older than in 2012 when it was 36 years). Recently hired RNs in home care and home support are older by 3 years than RNs for the full direct care workforce.

Table 5.5: Age distribution of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Age (years)	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
16–24	2.0	2.7	2.4	6.5	9.5	7.7
25–34	7.7	8.0	9.1	15.9	13.7	15.9
35–44	20.4	19.3	16.3	27.4	27.6	23.4
45–54	40.7	37.2	33.4	32.6	32.0	29.4
55–64	26.7	29.7	32.9	16.3	16.0	22.2
65 and over	2.5	3.1	5.9	1.4	1.2	1.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Recent hires have been employed for 12 months or less.*

Figure 5.3: Age distribution of the home care and home support aged care workforce: 2007, 2012 and 2016 (per cent)

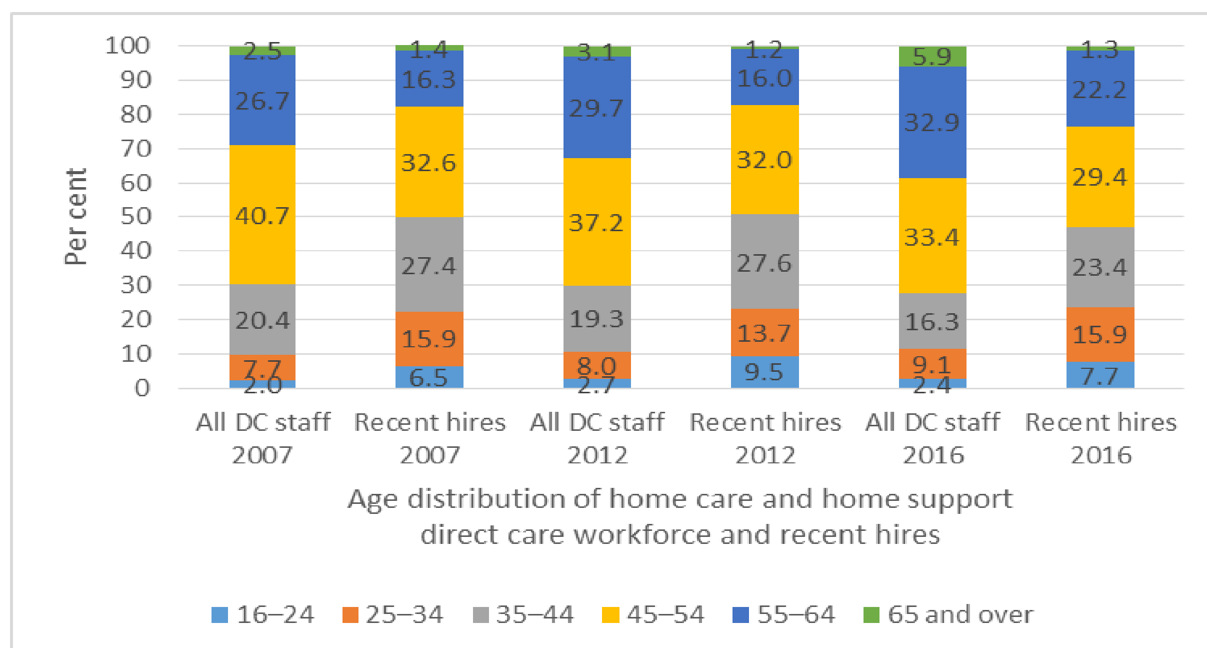


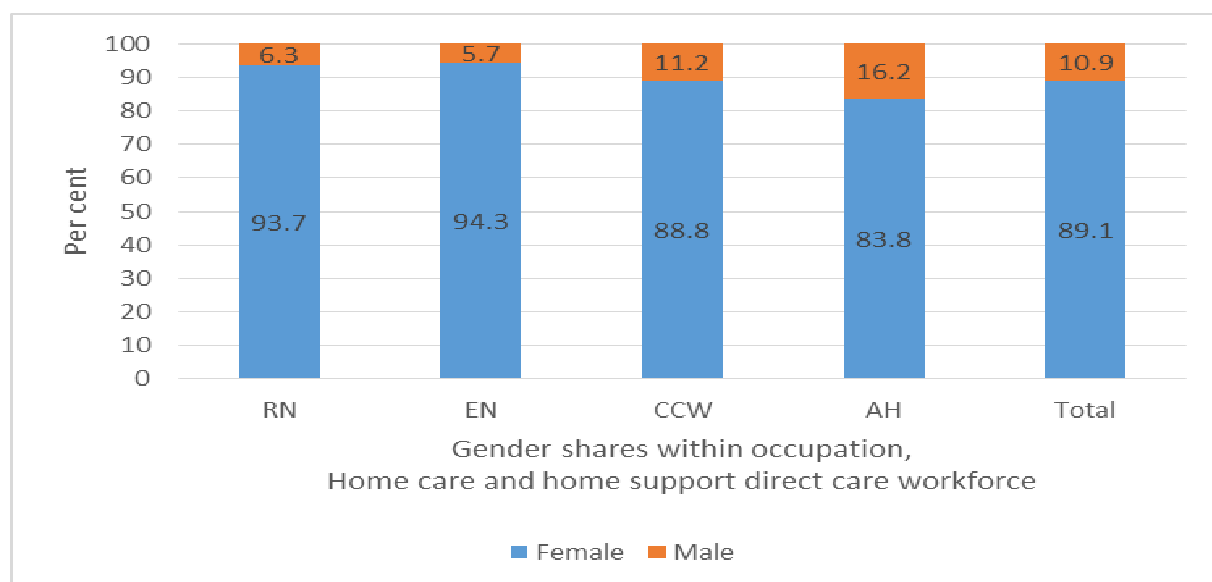
Table 5.6: Median age of the home care and home support direct care workforce, by occupation, all direct care employees and recent hires: 2012 and 2016 (number of years)

	All direct care employees	Recent hires*	Difference in years in median age for all recent hires relative to all direct care employees
2016			
Registered Nurse	48	51	3
Enrolled Nurse	51	43	-8
Community Care Worker	52	46	-6
Allied Health	47	41	-6
All occupations	52	46	-6
2012			
Registered Nurse	50	47	-3
Enrolled Nurse	49	45	-4
Community Care Worker	50	45	-5
Allied Health	48	36	-12
All occupations	50	44	-6

Source: Survey of home care and home support aged care workers.
** Recent hires have been employed for 12 months or less.*

While the proportion of male workers within aged care has slowly been increasing over time, Figure 5.4 shows the home care and home support direct care workforce in 2016 continues to be predominantly female (with 89 per cent female and 11 per cent male direct care workers). While RNs and ENs are occupations where slightly fewer men are employed within the home care and home support direct care workforce (6 per cent), more AH roles are undertaken by men (16 per cent).

Figure 5.4: Gender distribution of the home care and home support aged care workforce: 2016 (per cent)



5.2.4 Country of Birth

Table 5.7 presents the share of the home care and home support workforce born in Australia and elsewhere. The proportion of these workers born outside of Australia has fallen from 28 per cent in 2012 to 23 per cent in 2016. The profile of workers who had been hired in the last 12 months is very similar to that of all direct care workers with the share of those born overseas slightly lower at 21 per cent in 2016. A higher proportion of direct care workers in home care and home support outlets are born in Australia (77 per cent) than amongst residential aged care workers (68 per cent, Table 3.7).

Table 5.7: Country of birth of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Country of birth	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
Australia	73.3	72.2	77.1	69.0	70.1	79.3
Other	26.7	27.8	22.9	31.0	29.9	20.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
** Recent hires have been employed for 12 months or less.*

The distribution of the overseas born workforce by occupation is explored further in Table 5.8. The census asked all facilities to provide the numbers of workers they employ from a culturally or linguistically diverse background for each occupation. The workers survey asked workers themselves to state where they were born and whether they spoke a language other than English. Although not directly comparable, these questions are complementary to each other as they provide different perspectives on the occupational level and distribution of the part of the workforce that were born overseas.

Table 5.8 shows that 23 per cent of all home care and home support direct care workers who responded to the survey are migrants (column 1). It also shows that the migrant worker occupational distribution is broadly similar to that of the overall home care and home support direct care workforce as reported in Table 5.2. Table 5.8 column 2 shows 14 per cent are both a migrant and speaking a language other than English (LOTE). This compares with the information from outlets in column 3 of Table 5.8 which indicates that 18 per cent of employees come from culturally and linguistically diverse (CALD) backgrounds. The proportions of nurses and AH workers derived from the workers' responses in the workers survey are somewhat higher than the proportions derived from the employers' responses in the census. The opposite holds for the CCW proportions.

Table 5.8: The culturally and linguistically diverse (CALD) home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent)

Occupation	Worker (migrant)[1]	Worker (migrant + LOTE)[2]	Outlet (CALD)[3]
% of direct care employees	22.9	13.7	18.0
Distribution			
Registered Nurse	7.5	6.0	2.8
Enrolled Nurse	1.3	1.1	0.6
Community Care Worker	84.3	86.2	92.8
Allied Health	6.9	6.7	3.8
Total	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, Census of home care and home support aged care outlets.
1. Workers who report having migrated to Australia.
2. Workers who report being both migrant and speaking a language other than English.
3. Facilities that report employees from culturally and linguistically diverse backgrounds.

The worker survey asked migrant workers who spoke a language other than English how long they had been living in Australia. This question allows the exploration of the extent to which workers are likely to be familiar with English as a language and with Australian customs and norms. Table 5.9 presents the proportions of time spent in Australia by LOTE migrants, by occupation and for 2012 and 2016. Table 5.9 shows that in 2016 70 per cent of the migrant direct care workforce in home care and home support outlets who speak a language other than English have been in Australia for more than 10 years. There is considerable variation between occupational groups. For example, in 2016, 49 per cent of RNs had been in Australia for 10 years or more, compared to 83 per cent of AH workers.

The proportions of all migrant workers in the sample who speak a language other than English and who have been in Australia for over 10 years in Table 5.9 is 76 per cent for 2012 and 70 per cent for 2016. This is a much different profile to residential aged care workers with a higher proportion of migrants who have recently arrived in Australia, and where only 39 per cent of all residential aged care migrant workers speaking a language other than English have been in Australia for over 10 years, (Table 3.9). The difference relates mainly to workers in CCW/PCA roles, where a higher proportion of home care and home support CCWs (71 per cent, Table 5.9) than residential PCAs (38 per cent, Table 3.9) have been in Australia for longer than 10 years.

Table 5.9: Time spent in Australia of migrant home care and home support direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent)

	0–2 years	3–5 years	6–10 years	>10 years	Total
2016					
Registered Nurse	4.4	11.7	35.4	48.6	**100**
Enrolled Nurse	0.0	27.5	0.0	72.5	**100**
Community Care Worker	1.9	7.5	20.0	70.7	**100**
Allied Health	2.2	5.8	9.2	82.8	**100**
All occupations	2.1	7.9	19.9	70.1	**100**
2012					
Registered Nurse	9.7	6.5	25.8	58.0	**100**
Enrolled Nurse	*	*	*	*	*
Community Care Worker	4.7	8.8	9.6	76.9	**100**
Allied Health	14.0	10.0	14.0	62.0	**100**
All occupations	5.5	8.5	10.3	75.7	**100**

Source: Survey of home care and home support aged care workers.
**The proportion of ENs in these categories was too small to report.*

5.2.5 Aboriginal and Torres Strait Workforce

Home care and home support outlets provide a range of services (both culturally specific and as part of broader service options) to older Aboriginal and Torres Strait Islander people. Table 5.10 presents the distribution of the Aboriginal and Torres Strait Islander workforce in home care and home support outlets. We note that the small sample size makes these estimates rather imprecise. Home care and home support outlets report in 2016 that 2 per cent of the direct care workforce are Aboriginal and Torres Strait Islander descent (Table 5.10 Outlet, column 2). Amongst these direct care workers of Aboriginal and Torres Strait Islander origin, home care and home support outlets report in 2016 that their occupational distribution is 3 per cent RNs, 1 per cent ENs, 94 per cent CCWs, 2 per cent AH workers.

The outlet reports from the census reveal that 10 per cent of the home care and home support direct care workforce works in a nursing role (see earlier Table 5.2), three times as many compared with 3 per cent of the Aboriginal and Torres Strait Islander direct care workforce shown in Table 5.10. The vast majority of Aboriginal and Torres Strait Islander home care and home support direct care workers are employed as CCWs (94 per cent, Table 5.10, more than the 84 per cent of all home care and home support workers, Table 5.2). Correspondingly, this means that they are slightly less likely to be in a nursing or AH role.

There is no improvement in the occupational distribution of home care and home support workers for Aboriginal and Torres Strait Islander people since 2012, when also 3 per cent were nurses). The present data collection is not designed to generate information at the required depth for such a small sub-population. More extensive in depth research would be required in this area.

Table 5.10: The Aboriginal and Torres Strait Islander home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2012 and 2016 (per cent)

	Worker survey (Column 1) Workforce	Outlet census (Column 2) Workforce
2016		
% of direct care employees	2.8	2.1
Of these, distribution in direct care roles		
Registered Nurse	1.2	2.9
Enrolled Nurse	2.6	1.1
Community Care Worker	93.2	93.9
Allied Health	3.0	2.1
Total	**100**	**100**
2012		
% of direct care employees	2.7	2.3
Of these, distribution in direct care roles		
Registered Nurse	3.9	1.8
Enrolled Nurse	1.6	0.7
Community Care Worker	92.2	95.6
Allied Health	2.4	1.9
Total	**100**	**100**

Source: Survey of home care and home support aged care workers, Census of home care and home support aged care outlets.

5.2.6 Health

Given the often physical nature of aged care work, the health status of the workforce provides an indication of their capacity to undertake these work tasks. Using a standardised measure of self-assessed health drawn from the ABS (which uses a rating of health as excellent, very good, good, fair or poor), Table 5.11 presents information on the self-assessed health of the home care and home support workforce. Differences between the occupations exist, with a smaller proportion of CCWs saying they had excellent or very good health. Self-assessed health is high across each of the occupations, with around 65 per cent of nurses, 59 per cent of CCWs and 67 per cent of AH home care and home support direct care workers reporting that they are in ‘excellent’ or in ‘very good’ health. This is similar to 2012 when it was about 60 per cent for direct care workers in excellent or very good health, with variation by occupation.

Table 5.11 contrasts the health of all home care and home support direct care workers with that of the new hires. The most notable difference is that both CCW and nurse new hires report much better health than existing workers. The health of recent hires is noticeable for CCWs, where 67 per cent indicate they have excellent or very good health compared with 59 per cent of CCWs in the direct care workforce more generally; and nurses (73 per cent compared with 65 per cent in recent hires).

Table 5.11: Self-assessed health of the home care and home support direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	CCW	AH	Nurse	CCW	AH
Excellent	14.4	15.8	21.2	19.9	19.4	20.3
Very good	50.2	43.3	46.3	53.5	48.0	48.4
Good	23.4	33.2	25.1	19.9	27.5	25.8
Fair	10.0	7.2	7.0	6.3	4.6	4.7
Poor	2.0	0.6	0.4	0.5	0.5	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Recent hires have been employed for 12 months or less.*

5.2.7 Education

Having an appropriately qualified and skilled workforce is important for career development within the aged care sector and also for the provision of quality care to older Australians. From the point of view of the sector as a whole and the national aged care policy in the context of an increasing consumer directed home care environment, an appropriately qualified and skilled workforce is not only important, but also critical for attracting the necessary investment for the growth of the sector. In all advanced economies the presence of adequate labour supply in the form of a skilled and well qualified workforce can act like a magnet for investment. The aged care sector has such a well-qualified and skilled workforce at its disposal and our reports since 2003 suggest that it is getting better. The need to monitor regularly is met through the NACWCS data collections.

This section presents information about the formal education of the home care and home support workforce. Additional categories of qualifications related to disability care were added to the 2016 questionnaires for the first time to account for a possible linkage between aged care and disability care labour supply and demand. The questions about the qualifications of care managers and care leaders, which were first asked in 2012, have been continued, together with the further training questions.

Examining the educational qualifications held by the direct care workforce as a whole, Table 5.12 shows that in 2016 88 per cent of home care and home support direct care workers have post-school qualifications, a small rise from 86 per cent in 2012, and is now nearly as high as for residential direct care workers (90 per cent, Table 3.12). Of the occupations, a higher proportion of CCWs than others have no post-school qualification (14 per cent), although this is slightly lower than the 16 per cent recorded in 2012.

The types of qualifications held generally reflect workers' occupational roles. RNs mostly have a Bachelor Degree in Nursing (78 per cent), with many having other nursing or health related qualifications; 86 per cent of ENs have a Certificate IV/Diploma in Enrolled Nursing; and CCWs have mostly certificate level qualifications in aged care (51 per cent Certificate III, 12 per cent Certificate IV). The AH category contains both AH Professionals and AH Assistants, and so their post-school qualifications are split between health and aged care.

The proportion of CCWs with aged care or related qualifications has increased only slightly since 2012. Just over half have a Certificate III in Aged Care (51 per cent in 2016, 48 per cent in 2012) and just over a quarter have a Certificate III in Home and Community Care (27 per cent in 2016, 20 per cent in 2012). However, while in 2012, 19 per cent of CCWs held an Aged Care or Service Co-ordination Certificate IV qualification, this has fallen to 15 per cent in 2016.

For the first time in 2012 information was added about the post-secondary qualifications of care managers and care leaders.[7] The educational profile of these two leadership positions is quite similar. As in 2012, a slightly higher proportion of care leaders have Certificate III in Aged Care (42 per cent in 2016, higher than the 37 per cent in 2012), while care managers are more likely to have a Bachelor Degree in Nursing (27 per cent in 2016, also higher than the 18 per cent in 2012), or management qualifications; but the differences between them are not of the same scale as for the equivalent staff in residential facilities. One of the chief differences between care managers and leaders in residential and home care and home support aged care is that, in home care and home support outlets, a higher proportion hold qualifications in non-work related fields, suggesting that they had a different occupation before entering aged care.

Home care and home support aged care direct care workers with a disability related qualification (asked for the first time in 2016), are mostly CCWs with a Certificate III in Disability (9 per cent), with a Certificate IV in Disability held by 6 per cent (these may overlap since some may hold both). These are slightly greater shares than in residential aged care. In both types of aged care services, it is mainly CCW/PCAs holding a Certificate III in Disability.

[7] Care managers were defined as having responsibility for all direct care workers in the outlet; while care leaders were defined as having responsibility for a team of direct care workers, but reporting to a care manager.

Table 5.12: Post-school qualifications completed by the home care and home support direct care workforce, by occupation: 2016 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	CCW	AH	All DCW*
No Post-school							
Yr 10 or below	2.1	1.5	0.6	0.0	6.9	1.0	5.9
Yr 11/12	2.4	4.3	1.1	0.0	7.3	1.7	6.3
Health							
Certificate IV/Diploma in Enrolled Nursing	7.8	9.1	2.8	86.4	3.5	2.6	5.2
Other basic nursing qualification	7.6	2.8	13.3	9.7	2.6	3.4	3.7
Post-basic nursing qualification	5.3	2.7	18.4	3.8	0.6	0.4	2.1
Bachelor Degree in Nursing	26.9	18.0	78.2	0.0	1.4	1.4	7.6
Bachelor Degree in Allied Health Profession	3.9	2.6	0.6	0.0	0.9	41.8	3.2
Postgraduate allied health qualification	3.0	0.7	1.2	0.4	0.4	11.4	1.1
Other health related	7.9	6.7	12.1	3.2	5.6	9.3	6.3
Aged Care							
Certificate III in Aged Care	19.3	41.9	4.4	28.0	50.9	12.5	44.4
Certificate III in Home and Community Care	8.1	14.7	0.4	3.1	26.6	6.9	22.8
Certificate IV in Aged Care	10.4	20.4	1.9	10.3	12.2	4.6	10.9
Certificate IV in Service Coordination	6.4	4.0	0.0	1.0	2.8	4.5	2.6
Other Certificate in Care Work	7.4	9.0	1.0	1.6	8.2	6.3	7.3
Post basic nursing qualification in aged care	2.6	1.8	5.8	2.7	0.5	0.1	1.0
Other aged care related	7.5	6.7	4.3	2.1	5.7	5.7	5.5
Disability							
Certificate III in Disability	3.5	4.2	0.2	4.0	8.6	3.5	7.5
Certificate IV in Disability	5.8	5.5	0.2	0.4	6.3	4.0	5.6
Diploma in Disability	1.9	0.4	0.0	0.0	0.6	0.9	0.5
Diploma Community Service	2.5	2.4	0.0	0.0	1.8	0.5	1.6
Other (Disability related)	1.5	2.3	0.2	2.3	1.6	0.6	1.4
Management							
Certificate III or IV (Management)	12.4	7.2	7.8	6.1	4.6	3.6	4.8
Diploma (Management)	14.3	4.0	4.1	5.0	3.5	7.7	3.8
Bachelor or Postgraduate Degree (Management)	6.5	2.0	9.1	0.0	1.3	3.9	2.0
Other							
Certificate III or IV (Other)	15.7	16.0	9.2	19.0	14.9	16.1	14.6
Diploma (Other)	12.2	9.2	4.9	13.1	9.7	7.7	9.3
Bachelor or Postgraduate Degree (Other)	14.1	10.7	13.4	3.4	8.2	16.6	9.0

Source: Survey of home care and home support aged care workers.
**All DCW (direct care workers), does not include care managers or care leaders.*
Note: Because staff can have more than one qualification, the columns do not sum to 100.

Table 5.13 shows the percentage of workers with aged care Certificate III and IV within home care and home support outlets for 2007, 2012, and 2016. In 2016, the proportion of outlets with more than 75 per cent of CCWs with a relevant Certificate III was 45 per cent (between 2007 and 2012 this share rose from 28 per cent to 40 per cent)). While CCWs with relevant Certificate IV qualifications are found less often, the proportion of outlets with no CCWs

holding these qualifications was steady with 30 per cent in 2016, against 30 per cent in 2012 (in a substantial earlier change this share decreased from 42 per cent in 2007 to 30 per cent in 2012).

The prevalence of CCWs with relevant Certificate III qualifications in outlets is not as high as it is for PCAs in residential facilities (11 per cent of outlets have no CCWs with Certificate III qualifications Table 5.13, whereas only 2 per cent of residential facilities have no PCAs with Certificate III qualifications Table 3.13).

The share of home care and home support outlets with no CCWs with relevant Certificate IV qualifications is now 30 per cent, against the 24 per cent of residential facilities with no PCAs with Certificate IV qualifications.

Table 5.13: Distribution of community outlets by proportion of Community Care Workers (CCWs) with relevant Certificate-level qualifications: 2007, 2012 and 2016 (per cent)

Proportion of CCWs with each type of qualification	Relevant Certificate III			Relevant Certificate IV		
	2007	**2012**	**2016**	**2007**	**2012**	**2016**
Zero	10.9	12.5	11.4	41.6	29.9	29.6
1–24%	14.5	8.5	8.9	35.8	41.1	42.3
25–49%	22.0	14.2	13.1	11.1	14.0	13.7
50–74%	24.7	25.1	22.1	6.7	8.0	6.9
75–99%	16.2	25.7	25.8	1.8	1.7	2.9
100%	11.8	14.0	18.8	3.0	5.3	4.6
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support aged care outlets.

As older Australians increasingly choose to stay and receive care within their own homes, direct care workers in the community often provide support to people with a wider range of care needs than previously. The worker survey therefore asked workers if they had specialised qualifications that would help them deal with certain types of aged care needs. These specialisations were selected as being important for aged care, but this is not an exhaustive list.

Table 5.14 shows that in home care and home support aged care, 80 per cent of care leaders and 79 per cent of care managers do not have specialised qualifications in aging or aged care. These proportions have improved since 2012 when 92 per cent of care leaders and 89 per cent of care managers did not have specialised qualifications in ageing or aged care. Of those with the specialised ageing or aged care qualifications in 2016, palliative care and gerontology are the most prevalent, and this is similar to 2012. Across all occupations, the most common specialty was in palliative care.

Just under a quarter of home care and home support RNs (23 per cent) had one of these specialised qualifications and 20 per cent of ENs. This was higher than other occupational groups, with only 14–16 per cent of other direct care workers. More of care managers and care leaders had qualifications in any of the areas of specialty listed (21 per cent and 20 per cent respectively). This reflects a smaller proportion of the home care and home support workforce with specialised qualifications than in residential facilities (Table 3.14).

Table 5.14: Specialised qualifications in ageing or aged care of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent)

	Care Manager	Care Leader	RN	EN	CCW	AH
2016						
None	79.2	80.2	77.0	80.3	85.2	85.9
Specialisation in:						
Gerontology	2.8	0.4	5.4	0.7	0.4	1.3
Palliative Care	5.9	12.1	9.8	9.3	6.4	2.5
Psychogeriatrics	0.6	0.3	0.6	4.2	0.1	0.5
2012						
None	88.8	91.8	77.9	93.7	96.2	96.0
Specialisation in:						
Gerontology	4.3	1.4	9.1	0.7	0.5	2.2
Palliative Care	5.1	6.0	10.1	4.2	3.0	0.9
Psychogeriatrics	1.8	0.7	2.9	1.4	0.3	0.9

Source: Surveys of home care and home support aged care workers.

The level of study currently being undertaken by the home care and home support direct care workforce is shown in Table 5.15. Far fewer home care and home support aged care workers are studying in 2016 (11 per cent) than there were in 2012 (21 per cent). Split by their occupation, in 2016 11 per cent of CCWs, 11 per cent of RNs, 16 per cent of ENs and 9 per cent of AH workers were engaged in study. The corresponding 2012 percentages were 21 per cent of CCWs, 13 per cent of RNs, 28 per cent of ENs and 17 per cent of AH workers. Furthermore, in comparison to the residential workforce, fewer home care and home support workers report that they were currently studying in 2016 (11 per cent compared to 16 per cent residential Table 3.15).

Table 5.15: Current study of the home care and home support direct care workforce, by occupation: 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
Not currently studying	89.2	84.3	89.4	91.0	89.4
Currently studying	10.8	15.7	10.6	9.0	10.6
Total	**100**	**100**	**100**	**100**	**100**
2012					
Not currently studying	86.6	72.1	78.6	82.8	79.2
Currently studying	13.4	27.9	21.4	17.2	20.8
Total	**100**	**100**	**100**	**100**	**100**

Source: Surveys of home care and home support aged care workers.

5.3 The Main Characteristics of the Work

The next section examines the structural features of working in aged care. These include the types of arrangements under which workers are employed, their shifts and whether they are working their preferred hours, their wages and whether they need to hold multiple jobs, and the opportunities provided by employers for additional training.

5.3.1 Employment Arrangements and Hours Worked

The employment arrangements and working hours in aged care provide an indication of the level of flexibility required by both employers and employees. These factors also reflect the current robustness of the labour market. For example, in a strong labour market employees are more likely to be able to have the form of employment contract, shifts and hours they prefer. Table 5.16 presents the different forms of employment in the home care and home support aged care in 2012 and 2016, distinguishing between permanent full-time, permanent part-time and casual or contract. The proportions have changed since 2012. In particular, the proportion of workers employed under permanent part-time arrangements has increased from 62 per cent in 2012 to 75 per cent in 2016. This increase has been principally through a reduction in casual and contract arrangements, from 27 to 14 per cent. Full time permanent employment remained unchanged at around 11 per cent.

There was an increase of CCWs in permanent part-time employment from 63 per cent in 2012 to 79 per cent in 2016. For nurses, the increase in permanent part-time is modest and the AHs show a decrease. Similarly, what appears to be a constant proportion of overall full-time permanent employment conceals a modest decrease for CCWs (7 to 6 per cent), a modest increase for RNs (33 to 35 per cent), and a sizeable increase for ENs and AHs (17 to 24 per cent and 27 to 39 per cent respectively).

In contrast to the situation in 2012 when a higher proportion of direct care workers were on casual or contract basis (27 per cent) in community aged care, compared with residential aged care (19 per cent, Table 3.16), the situation in 2016 shows a narrowing down of the gap between the two types of care. Indeed in 2016, 14 per cent of home care and home support workers are on casual contracts similar to those in residential aged care (10 per cent, Table 3.16). Also a roughly similar proportion (11–12 per cent) is employed under permanent full-time arrangements across home care and home support and residential care in 2016, but this is largely unchanged from 2012 when it was 10-11 per cent.

Table 5.16: Form of employment of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	34.9	59.4	5.7	**100**
Enrolled Nurse	23.8	71.5	4.7	**100**
Community Care Worker	5.7	79.0	15.3	**100**
Allied Health	39.0	55.7	5.3	**100**
All occupations	11.2	75.3	13.5	**100**
2012				
Registered Nurse	32.6	53.3	14.2	**100**
Enrolled Nurse	17.0	67.2	15.8	**100**
Community Care Worker	6.7	62.9	30.4	**100**
Allied Health	27.4	60.0	12.5	**100**
All occupations	10.6	62.1	27.3	**100**

Source: Census of home care and home support aged care outlets.

Table 5.17 presents the distribution of work schedules in the home care and home support direct care workforce. Unlike the employment arrangements in the previous Table 5.16, where considerable change was observed between 2012 and 2016, here our evidence goes further back to 2007 and finds no major change between 2007, 2012 and 2016 work schedules. The majority of home care and home support direct care workers continue to be employed on regular daytime shifts. We note some slight changes in rotating shifts and irregular shifts, among nurses and CCWs, but the numbers are too small and this finding of change is probably unreliable and should not be over-interpreted.

Table 5.17: Work schedule of the home care and home support direct care workforce, by occupation: 2007, 2012 and 2016 (per cent)

Work schedule	Nurse			CCW			AH		
	2007	2012	2016	2007	2012	2016	2007	2012	2016
A regular daytime shift	84.2	82.4	82.5	75.4	79.5	76.2	95.9	96.0	93.2
A regular evening shift	1.1	1.7	1.7	0.9	0.7	1.0	0.0	0.0	0.1
A regular night shift	1.3	0.8	0.4	0.5	0.4	0.2	0.0	0.0	0.1
A rotating shift	6.6	10.4	7.4	3.2	2.1	3.0	0.0	0.8	0.6
Spilt shift	0.5	0.6	2.2	3.4	2.5	2.9	0.0	0.0	0.0
On call	0.5	0.2	0.3	0.8	1.0	0.8	0.5	0.4	0.7
Irregular schedule	5.5	2.5	4.5	15.3	11.9	13.8	3.1	1.6	1.0
Other	0.2	1.4	1.0	0.5	1.9	2.1	0.5	1.2	4.2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

The number of hours an employee prefers to work is often associated with the ability to achieve a required level of financial security and also to effectively undertake non-work responsibilities. Table 5.18 presents and contrasts the number of actual hours worked with number of the hours individual workers say they would prefer to work. The majority of home care and home support workers work between 16–34 hours per week (56 per cent), as was the case in 2012 (54 per cent).

There are occupational differences in the hours worked. More than half of the RNs (55 per cent) and half AH workers (50 per cent) work 35 hours or more per week, compared to only 22 per cent of CCWs. CCWs are the major occupational category working 1–15 hours (20 per cent), with the majority of CCWs working 16–34 hours per week (58 per cent). However, since 2012 there has been a fall in the proportion of CCWs working 35 hours or more or longer (from 25 per cent in 2012 to 22 per cent in 2016) and this reverses the rise in their longer hours observed from 2007 to 2012.

When we look at the reported hours that workers would prefer to work, the least preferred categories are working for 1–15 hours or for >40 hours categories, followed by the 35–40 hours per week. The most preferred category for all types of direct workers is 16-34 hours per week. The preference to work 35-40 hours per week is particularly noticeable for RNs, ENs and AH workers who had 16 per cent, 14 per cent and 11 per cent working more than 40 hours per week. The preference for longer hours relates mainly to CCWs where there is a clear preference to move away from working 1-15 or 16-34 hours and into working 35-40 hours. Table 5.18 shows that many people would like to be working different hours than they actually do, some fewer, but most, more hours.

Table 5.18: Actual working hours and preferred working hours of direct care workers in the home care and home support direct care workforce, by occupation: 2016 (per cent)

Occupation	Actual hours per week				Preferred hours per week			
	1–15	16–34	35–40	>40	1–15	16–34	35–40	>40
Registered Nurse	3.6	41.2	38.9	16.3	2.5	51.5	43.5	2.6
Enrolled Nurse	8.0	51.1	27.4	13.6	6.0	51.9	35.0	7.2
Community Care Worker	19.9	58.1	17.6	4.5	13.3	53.7	30.7	2.3
Allied Health	6.9	43.1	38.6	11.4	5.0	48.6	42.4	4.1
All occupations	17.5	55.7	20.8	6.0	11.8	53.2	32.5	2.5

Source: Survey of home care and home support aged care workers (Row totals).

To further investigate these preferences in working hours, Table 5.19 shows the direction of preferred change (more or less hours) and the extent of the preferred change in terms of the number of hours workers want to increase or decrease their hours by. The preferences are compared with those of workers in earlier years 2007 and 2012.

There has been a slight change between 2016 and 2012 in the proportion of home care and home support workers happy with the hours they currently work, falling from 49 per cent in 2012 to 46 per cent in 2016. Alongside this 40 per cent of workers are seeking more hours in 2016 compared with 36 per cent in 2012. The two extreme categories (10+ hours less and 11+ hours more) are mostly stable between 2012 and 2016 for home care and home support, in that there are still few people who would wish to work considerably fewer hours (down from 5 per cent in 2012 to 4 per cent in 2016) and more people who would wish to work considerably more hours (up from 6 per cent in 2012 to 7 per cent in 2016).

The major finding in these two tables is that throughout the period of 2007 to 2016 most of those workers who want to change their hours, are looking to increase their hours. One implication of this finding is that the demand for labour is soft. This suggests that this sector has considerable labour reserves in the form of the observed under-utilisation of its present workforce. This would mean the possibility that present or future skill shortages could be accommodated through the use of the present workforce. This is in line with the evidence presented in the skill shortages section of the report.

Table 5.19: Preferred change in working hours of the home care and home support direct care workforce: 2007, 2012 and 2016 (per cent)

Desired change in hours	2007	2012	2016
10+ hours less	3.5	4.7	3.8
1–9 hours less	7.6	10.6	10.0
No change in hours	47.3	48.7	46.4
1–5 hours more	23.1	19.9	20.3
6–10 hours more	12.6	10.4	12.4
11+ hours more	6.0	5.8	7.1
Total	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.3.2 Wages

The worker survey collected information on the wages earned by direct care workers in the home care and home support sector. Table 5.20 presents the reported gross median weekly earnings for each occupation participating in the residential aged care workers survey by the four groupings of number of hours worked per week (1-15, 16-34, 35-40, and more than 40).

In 2016, the gross median weekly wage reported by RNs is $1,200 per week. As discussed above, a high proportion of RNs work more than 35 hours per week (Table 5.18) and we expect this to be reflected in the overall median weekly wage for the profession. When working part-time, RNs report a higher median weekly wage than other occupations for the 16-34 hours category and a lower weekly wage for the 1-15 hours category, almost certainly reflecting the differences in the weekly hours worked between the occupations.

AH professionals, who have a similar level of qualifications to that of RNs, have a slightly lower median wage than RNs ($1,153), but this is reversed in the 1–15 hour category ($386 whereas RNs $325). AH professionals are the only occupational group with a higher median wage in home care and home support than in residential aged care across all categories. A higher proportion of workers are part-time in home care and home support aged care, especially in the 1–15 hours category. Of these workers only AH Professionals with 1-15 hours per week have a higher median wage than similar workers in residential facilities.

Table 5.20: Median weekly earnings of the home care and home support direct care workforce, by occupation and working hours: 2016 ($ per week)**

Occupation	Hours per week				All hours
	1–15	16–34	35–40	>40	
Nurse Practitioner	*	*	*	*	750
Registered Nurse	325	1,000	1,350	1,400	1,200
Enrolled Nurse	350	781	993	1,274	874
Community Care Worker	330	650	920	1,000	650
Allied Health Professional	386	945	1,311	1,318	1,153
Allied Health Assistant	270	600	982	890	660
All occupations	330	656	1,000	1,117	693

Source: Survey of home care and home support aged care workers.
**As the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories.*
***As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).*

5.3.3 Multiple Job Holding

Within the broader Australian workforce, approximately 5.3 per cent of employees hold more than one job (ABS, 2013). As shown in Table 5.21, multiple job holding is more common within aged care than the national average. In 2016, 16 per cent of home care and home support direct care workers reported holding multiple jobs (comparable to 14 per cent in 2012). Within this 16 per cent, 7 per cent have another job in aged care (5 per cent in home care and 2 per cent in residential care), another 7 per cent have another job not in aged care or disability care, and a final 2 per cent have another job in disability care. This fits in with the information already presented showing low working hours (1-15 hours, Table 5.18) and preference for more hours of work (Table 5.19) for home care and home support CCWs, which shows there is scope for them to hold more than one job. The overall picture of multiple job holding and its split by occupation has not changed in a pronounced way since 2012. Overall 2 per cent are also working in disability care alongside their aged care job. It is possible that as the NDIS expands more aged care sector workers may be attracted to this alternative career.

Table 5.21: Prevalence of multiple job-holding among home care and home support direct care workers, by occupation: 2012 and 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
Only have one job	83.7	87.0	84.3	83.0	84.3
Other job in residential aged care	3.0	3.0	1.7	2.2	1.9
Other job in home care and home support aged care	3.5	0.0	5.2	1.3	4.7
Other job in disability care*	0.8	1.0	2.2	0.6	2.0
Other job not in aged care or disability care*	9.0	8.9	6.5	12.9	7.1
2012					
Only have one job	88.4	83.2	85.9	86.2	86.0
Other job in residential aged care	2.0	5.4	2.1	1.5	2.2
Other job in community aged care	1.1	1.8	3.6	6.1	3.5
Other job not in aged care	8.5	9.6	8.5	6.1	8.4

Source: Survey of home care and home support aged care workers.
**'Other job in disability care' and 'Other job not in aged care or disability care' category added in 2016. Multiple response.*

5.3.4 Training

In Section 5.2.7 a high proportion of the home care and home support workforce were shown to hold formal post-school qualifications. This next section presents information on the training and continuing professional development (CPD) undertaken 'on the job' or to maintain these qualifications. Within aged care, training is an important element of the work. New questions about training were asked of workers in 2012 to establish their participation, the aims of the training undertaken, and the areas in which they would like further training. This last aspect of training was also asked of outlets in relation to training required for CCWs, the largest component of their workforce. These questions were repeated in 2016 and we present this comparison in Table 5.22.

Table 5.22, shows that 48 per cent of the home care and home support workforce undertook CPD in 2016, a smaller share than the 53 per cent in 2012. It also shows that 75 per cent undertook training during the previous 12 months (slightly fewer than in 2012 at 78 per cent). As with residential aged care, mandatory training was the most common type of training undertaken in home care and home support aged care, 69 per cent of the workforce participated in this type of training (however this is a lower share than the 76 per cent in residential care). A much smaller proportion of CCWs than workers in all other occupations undertook any form of training or CPD, which implies that the training gap between CCWs and the rest of the workforce is set to intensify. Comparing the 2012 and 2016 percentages supports this view. The same lower CPD/training is observed among PCAs in the residential sector (Table 3.22), but not of the same scale as in Table 5.22 among CCWs.

Similar to residential care, the more specialised occupations (nurses and AHs) in home care and home support engage in greater levels of CPD and training. Some of this training/CPD will be a compulsory requirement by their professional associations. ENs show the strongest increase in training between 2012 and 2016, especially in the increasing proportion of mandatory training from 59 per cent to 73 per cent. RNs show the same pattern, but somewhat weaker than ENs. AHs give a mixed picture of more training but less CPD in 2016, whilst CCWs show less training and less CPD. There was an overall fall in CPD from 2012 to 2016 for CCWs (47 per cent in 2012 to 41 per cent in 2016) and AHs (75 per cent in 2012 to 71 per cent in 2016). There is some change in the composition of mandatory versus non-mandatory training for CCWs (non-mandatory training fell from 19 per cent in 2012 to 14 per cent in 2016) and AHs (mandatory training rose from 68 per cent in 2012 to 70 per cent in 2016).

Table 5.22: Participation in training and/or continuing professional development (CPD) by home care and home support aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
CPD	95.4	87.1	40.6	70.9	47.8
Training:					
No training	15.8	18.5	26.5	18.7	25.0
Mandatory training	77.4	73.2	67.4	70.1	68.5
Non-mandatory training	32.5	21.3	13.6	30.9	16.3
2012					
CPD	89.8	73.8	46.5	75.1	52.5
Training:					
No training	20.6	23.7	22.5	21.7	22.3
Mandatory training	67.9	58.9	69.6	67.7	69.0
Non-mandatory training	36.7	33.7	19.2	31.2	21.8

Source: Survey of home care and home support aged care workers.
Note: Multiple response allowed, totals will not sum to 100.

Workers engage in training with a variety of aims, as illustrated in Table 5.23. The two most commonly selected aims were 'to improve skills' and 'maintain professional/occupational standards. A high proportion of workers, particularly RNs (78 per cent), selected 'to maintain professional/occupational standards' as one of their aims, and this is similar to 2012 when this share was 76 per cent. 'Meeting accreditation requirements' was a relatively popular reason for home care and home support workers undertaking training (over 40 per cent for each occupation) however this was not as high as it was for residential workers (where it was over 50 per cent for each occupation). In line with 2012, just under a quarter of CCWs nominated 'safety/health concerns' as an aim of the training they had undertaken within the last 12 months. A relatively low proportion of workers viewed training as having direct relevance to being able 'to secure a job or promotion' or 'to help get started in their job' and again this was similar in 2012.

Table 5.23: Stated aims of training undertaken by the home care and home support direct care workforce during the last 12 months, by occupation: 2016 (per cent selecting)

Aim of training	RN	EN	CCW	AH
Improve skills in current job	56.8	70.1	66.8	57.5
Develop skills generally	45.1	49.4	43.6	42.6
Maintain professional/occupational standards	77.7	72.6	53.6	56.9
Meet accreditation requirement	45.9	41.5	47.1	48.3
Safety/health concerns	12.2	13.2	24.1	18.2
Prepare for future job/promotion	7.2	3.4	7.1	8.4
Help get started in job	2.5	0.8	6.6	7.3
Other	6.9	7.4	3.6	4.2

Source: Survey of home care and home support aged care workers.
Note: Multiple response allowed, totals will not sum to 100.

In Table 5.24 it can be seen that home care and home support workers identified numerous areas in which they thought additional training was needed for their workplace in the next 12 months. The relatively high proportions of workers that identified multiple areas suggest that they believe their skills could be improved in a range of areas. In particular, for CCWs, dementia training was viewed as needed by the largest share of workers (61 per cent). Outlets also identified dementia training as most needed for CCWs (83 per cent). When compared

with the responses from CCWs, although the proportions are different, the outlet priorities are the same. The top three areas of training are dementia training, mental health and palliative care. In home care and home support mainly it was a higher proportion of RNs (41 per cent) than workers in other occupations (proportions lower than 30 per cent) that sought training in management and leadership.

Table 5.24: Areas of training identified as most needed in the next 12 months for the home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent)

Area of training	RN Workers	EN Workers	CCW Workers	CCW Outlets	AH Workers
Dementia training	41.8	47.4	61.0	82.7	46.7
Palliative care	35.9	48.3	29.5	28.4	17.7
Management and leadership training	40.5	19.6	20.9	12.9	28.0
Wound management	39.2	59.8	18.3	18.2	7.0
Mental health	14.5	23.8	41.4	42.6	33.2
Allied health	2.4	4.2	11.4	5.3	33.4
Other	10.5	11.1	6.1	23.3	5.8

Source: Survey of home care and home support aged care workers and Census of home care and home support aged care outlets.
Note: Multiple responses were allowed, columns do not sum to 100.

5.4 Career Paths

In order to meet the increasing preference for community-based care by older Australians, the sector needs to attract new entrants into home care and community support roles and retain them once employed. This section looks at the pathways into and out of home care and home support aged care jobs, both within the sector and within the current roles of direct care workers. This information explores the occupational backgrounds of the community workforce, when they first considered entering the direct care workforce, how long they have been in the workforce, and what their intentions are in the near future. Some of the common pathways for different occupations are identified and areas that have changed or may be of interest for future planning are highlighted. Similar to residential care, career paths can also be good indicators of the attractiveness of a sector and of the loyalty of the workforce to aged care.

5.4.1 Into Aged Care

Very few workers start their career in aged care. Table 5.25 shows that only 5 to 7 per cent of the home care and home support direct care workforce reported that aged care is their first occupation. Most home care and home support direct care workers have worked in other jobs before aged care. This aspect of the workforce was observed in 2012 as well. Nurses have a clear pathway into aged care, as 69 per cent of RNs (a smaller share than the 77 per cent of RNs in 2012) and 38 per cent of ENs had worked in a different health or social care setting such as acute care, community or other health care (roughly the same as the 43 per cent in 2012). In comparison, a relatively high proportion of CCWs have worked in quite different occupations, as 36 per cent (similar to the 38 per cent of CCWs in 2012) had a background in sales, hospitality, cleaning or clerical work (with AH 24 per cent, 21 per cent of ENs but only 8 per cent of RNs). As noted in 2012, these are areas of work that are dominated by women and often do not require post-school qualifications. AH workers also have diverse backgrounds, 15 per cent with backgrounds of other health or social care jobs and just over a quarter (27 per cent) from professional or management jobs. For CCWs and AH workers there is no dominant pathway into aged care work, as in 2012. Attracting these workers into aged care will continue to require a variety of strategies that emphasise the benefits of this work compared with their current jobs.

In 2016, disability care was added to the list of occupations. Table 5.25 shows that disability care was rarely a prior job for home care and home support nurses and only 5-6 per cent of CCW and AH workers had a disability care background. The implication is that there has not been a shift of workers from disability into aged care due to the National Disability Insurance Scheme (NDIS), which commenced in small volumes in 2013. If there is to be such a change, this will only be discernible after at least one to two years of the NDIS implementation when NDIS volumes will have increased and the various transition agreements with pre-NDIS providers will be coming to an end.

Table 5.25: Activity prior to first job in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Last occupation before first aged care job	RN	EN	CCW	AH
No previous paid employment	5.2	5.6	6.8	5.8
Nurse, acute care	53.1	23.4	1.7	1.8
Nurse, community	11.5	5.7	1.2	0.5
Other health care	4.2	8.9	4.0	12.3
Carer in other setting	0.6	5.3	5.0	2.3
Disability care	1.5	3.2	4.5	5.8
Salesperson	2.9	7.4	9.7	6.9
Clerical worker	2.0	3.8	11.2	5.6
Hospitality worker	2.2	8.1	7.2	8.2
Cleaner	0.6	1.3	7.9	3.0
Professional (other than nurse)	0.7	0.5	4.5	19.6
Manager	2.4	1.3	4.3	6.9
Other paid employment	13.2	25.4	32.0	21.3
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

Table 5.25 shows that more than 90 per cent of all home care and home support direct care workers have worked in other jobs before aged care and they join the sector at the relatively high median age of 46 for recent hires (Table 5.6). Aged care is not, therefore, a career choice of many young people. Further details on the age profile of the home care and home support workforce is provided in Table 5.26 which shows the age distribution of the workforce on entry into the sector by occupation. In 2016 55 per cent of all direct care workers were 40 years or older when they first started working in home care and home support aged care.

When broken down by occupation, the proportion of the 40 years or older is 60 per cent for CCWs, 33 per cent for AHs, 28 per cent for RNs and 29 per cent for ENs. At the other end of the age spectrum, 40 per cent of RNs, 44 per cent of ENs, 46 per cent of AH workers and just 17 per cent of CCWs began working in aged care before the age of 30. Compared with direct care workers in residential facilities, a greater share of home care and home support direct care workers start working in the sector at a later stage in life. There are no noteworthy differences between the 2012 and the 2016 proportions.

Table 5.26: Age at which began working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Age (years)	RN	EN	CCW	AH	All occupations
21 or under	17.4	27.5	7.4	10.5	8.8
22–29	32.1	16.6	9.5	35.9	13.0
30–39	23.0	27.4	22.7	20.5	22.7
40–49	21.2	25.6	35.3	19.4	33.0
50+	6.3	2.9	25.1	13.7	22.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

The age at which workers are first employed in aged care influences the total time they can remain in the workforce. Table 5.27 shows the total time spent working in aged care across the different occupational groups on the home care and home support workforce.

About a third of RNs (34 per cent) and ENs (34 per cent), have been in aged care for more than 19 years, which is in accordance with the younger age at which they started working in aged care, compared to other occupational groups (Table 5.26). The majority of RNs and ENs have been working in home care and home support aged care for more than 9 years, demonstrating that once people come into aged care, they often stay for a considerable length of time (64 per cent and 71 per cent respectively). The lower proportion of CCWs who have been in aged care for more than 9 years (39 per cent) can be in part attributed to their older starting age (25 per cent of CCWs started working in aged care when 50 years or older, as shown in Table 5.26). On the whole, this is a very stable workforce, which may be exposed to the risk of high levels of retirement, but which sees few leakages to other sectors. Whether this picture will persist as parts of the workforce becomes younger (as we see happening in the residential workforce) and as alternative forms of similar employment becomes available through the NDIS, is a question that this data cannot answer.

Table 5.27: Total time spent working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Total time in aged care (years)	RN	EN	CCW	AH	All occupations
1 year or less	3.0	5.3	10.3	13.0	9.8
More than 1 year–4 years	11.3	8.7	24.0	14.5	22.1
More than 4 years–9 years	21.5	15.2	26.9	22.7	25.9
More than 9 years–14 years	18.0	21.8	18.3	17.1	18.3
More than 14 years–19 years	12.7	15.1	9.0	11.3	9.6
More than 19 years	33.5	34.0	11.5	21.4	14.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.4.2 Into their Current Job

Aged care providers in Australia commonly express concerns regarding difficulties recruiting and retaining skilled staff. It is important, therefore, to understand the level of turnover within the home care and home support sector and the reasons why workers choose to move to a different aged care employer. This next section examines pathways into the current job held by direct care workers and finds out the extent of, and reasons for, job mobility.

Table 5.28 shows that about half of the direct care workers had worked in aged care prior to getting their current job (48 per cent). There were occupational differences, with a lower

proportion of CCWs (45 per cent in 2016 and 44 per cent in 2012) than workers in other occupations who had worked in aged care previously. While the proportion of workers who had worked in aged care on an unpaid basis was low, it appears that unpaid work is a more important pathway for CCWs (6 per cent) and AH workers (6 per cent) than for nurses (1-2 per cent).

Table 5.28: Whether had worked in aged care prior to current job of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Whether had previous work in aged care	RN	EN	CCW	AH	All occupations
Yes, paid	70.4	74.9	38.3	50.2	42.4
Yes, unpaid	0.7	1.6	6.4	6.1	5.9
No	28.9	23.5	55.2	43.7	51.7
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

In order to examine recruitment patterns among the newer worker in aged care, Table 5.29 presents the proportion of home care and home support workers who had been in the sector for up to 5 years and whether they had worked in their current outlet previously. Table 5.29 shows that a higher proportion of nurses (RNs 26 per cent, ENs 28 per cent) than CCWs (13 per cent) have worked in the outlet previously. This pattern is similar to that for residential workers but with higher shares than in residential care (RNs 19 per cent, ENs 19 per cent, PCAs 18 per cent, Table 3.29). CCWs (5 per cent) and AH workers (6 per cent) but also ENs (4 per cent) had past unpaid or voluntary work in the outlet of their current job.

Table 5.29: Whether had worked in current outlet prior to obtaining current job of home care and home support direct care workers employed in the last five years, by occupation: 2016 (per cent)

Whether had previous work in current outlet	RN	EN	CCW	AH
Yes, paid work	25.8	23.9	8.0	18.3
Yes, unpaid or volunteer work	0.6	3.9	5.2	6.1
No	73.6	72.1	86.8	75.6
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
N=2,644 (weighted).

The home care and home support aged care worker survey asked those employees who had worked in aged care previously why they left their prior job. Understanding the reasons why workers leave one job and move into another within aged care can provide insights into what may need to change to improve the retention of staff within a facility. Table 5.30 indicates that while some of the home care and home support worker turnover may be addressed at management level, other reasons may also be responsible, often related to the personal circumstances of workers.

A third of home care and home support RN and CCW workers (33 and 34 per cent respectively) cited personal reasons for leaving their last job, such as moving house, fulfilling care responsibilities or wanting a job closer to home. These reasons reflect the gender, age and other demographic characteristics of the workforce. It is female dominated (see figure 5.4) and therefore workers are more likely to bear the majority of domestic (day-to-day) responsibilities; and it is largely part-time or casual (Table 5.16) and therefore workers are less likely to be primary wage earners. These factors provide the context within which workers have to make decisions about their aged care work.

Some of the reasons for leaving a job may have to do with work conditions and work roles and may be amenable to management intervention. After moving house, five reasons were cited by home care and home support workers for leaving their previous aged care job that have to do with work conditions and work roles, namely higher pay, challenging work, get preferred hours, avoid managers, relief from stress. Together these five reasons account for more than 40 per cent of the total of workers who left their previous job (41 per cent RNs, 50 per cent ENs, 40 per cent CCWs, 47 per cent AH).There were some differences between the occupational groups in the proportions of workers citing each of these reasons. More AHs had left for higher pay (11 per cent); more ENs and CCWs left in order to get their preferred shifts or hours (20 per cent and 13 per cent respectively), and 18 per cent of RNs and 19 per cent of AH workers left in order to find more challenging work.

Table 5.30: Main reason for leaving prior aged care job of home care and home support direct care workers with previous experience in sector, by occupation: 2016 (per cent)

Most important reason	RN	EN	CCW	AH
Moved house/location	23.6	14.4	19.8	9.8
To find more challenging work	18.3	15.7	9.7	19.1
To get shifts or hours of work I wanted	8.4	19.9	12.7	5.3
To avoid managers/management I did not get along with or like	4.3	3.9	6.3	5.4
To achieve higher pay	5.6	8.9	5.9	11.2
To be closer to home	7.4	2.1	5.1	11.1
The job was too stressful	5.0	1.5	5.1	5.6
To fulfil care responsibilities (including having a baby)	2.2	8.5	9.1	7.6
Made redundant/retrenched	2.8	3.3	5.7	6.6
Not able to spend sufficient time with residents	2.4	5.8	5.1	2.4
To avoid workmates/colleagues I did not get along with or like	1.1	0.0	0.6	0.5
To find easier work	2.9	0.9	1.0	0.7
Other	16.1	15.1	14.0	15.0
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers (weighted).

Returning now from those workers who had worked in aged care previously to all direct care workers, Table 5.31 shows the proportion of the home care and home support workforce that has worked in their current jobs for various lengths of time. For all occupations, 47 per cent of the home care and home support direct care workforce has been in their job for up to 4 years (15 per cent 12 months or less and 32 per cent for more than one year and up to 4 years), which is a smaller share than reported by residential direct care workers (46 per cent, Table 3.31).

A very slightly lower proportion of workers in home care and home support outlets have been in their jobs for longer than 9 years (24 per cent, which is higher than the 20 per cent in 2012) than direct care workers in residential facilities (26 per cent, which is slightly lower than their 24 per cent in 2012).

Table 5.31: Tenure in current job of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Tenure in current job (years)	RN	EN	CCW	AH	All occupations
12 months or less	9.8	23.1	14.3	20.7	14.5
More than 1 year–4 years	30.7	20.5	33.1	27.9	32.3
More than 4 years–9 years	30.5	24.7	28.9	26.5	28.8
More than 9 years	29.0	31.7	23.7	25.0	24.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support aged care workers.

5.4.3 Into the Future

In this section the focus is on the future intentions of home care and home support workers. Intentions to leave a job have been shown to have a significant impact on actual turnover in aged care (King et al., 2013). The 2016 survey therefore asked direct care workers whether they planned to stay in their current jobs and the future work plans of those seeking a change.

Table 5.32 presents those who are actively seeking alternative work by occupation and tenure. It shows that in 2016 around 9 per cent of home care and home support direct care workers were actively seeking work at the time of the survey, which is largely unchanged from 2012 (8 per cent). This varies across occupational groups, with slightly higher proportions of AH workers (11 per cent) seeking work than other occupations. Across the workforce, intentions to leave are lowest for workers who have been employed in their current job for more than 9 years. Two sub-groups appear to differ in Table 5.32 with relatively high proportions of job seeking (RNs who have been in their jobs for 4 to 9 years, at 16 per cent, and AH workers who have been in their jobs for 1 to 4 years, at 15 per cent).

Table 5.32: Proportion of the home care and home support direct care workforce actively seeking work by occupation and tenure in current job: 2016 (per cent)

Tenure in current job (years)	RN	EN	CCW	AH	All occupations
12 months or less	11.4	5.7	7.2	10.1	7.7
More than 1 year–4 years	8.5	9.1	10.9	15.3	10.9
More than 4 years–9 years	15.7	11.6	9.2	9.9	9.8
More than 9 years	3.5	4.0	5.1	9.8	5.2
All years	9.5	7.3	8.5	11.4	8.7

Source: Survey of home care and home support aged care workers.

What workers thought they would be doing in 12 months is shown in Table 5.33, which indicates that in 2016 the vast majority (81 per cent, slightly more than the 82 per cent in 2012) expect to be working for their current employer. Indeed, around 83 per cent of RNs, 81 per cent of ENs and CCWs, and 74 per cent of AH workers thought they would be staying in their current job. The next large group was those who did not know what they would be doing (between 9 and 16 per cent). A small proportion (2 per cent) of the existing workforce is intending to leave aged care completely (although there was a fairly high share of home care and home support direct care workers who did not know where they would be in 12 months, 12 per cent).

Table 5.33: Expected activity in 12 months of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Expected activity in 12 months	RN	EN	CCW	AH	All occupations
Working in aged care, this outlet	82.4	80.5	80.9	73.5	80.6
Working in aged care, different outlet	3.6	0.7	2.2	3.8	2.4
Working in residential aged care	0.1	2.1	0.7	1.1	0.7
Working in disability care	0.0	0.0	0.7	0.8	0.6
Working, but not in aged care	2.9	4.5	2.2	4.7	2.4
Not working for pay	2.5	1.6	0.9	0.8	1.0
Don't know	8.5	10.6	12.4	15.4	12.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.5 Experiences of Working in Home Care and Home Support Aged Care

Aged care employees work in the sector for a variety of reasons including enjoyment of care work, wanting to make a difference in the lives of older Australians, financial imperatives, and to enable an effective work-life balance. Findings from the previous aged care worker surveys in 2007 and 2012 indicated widespread job satisfaction amongst the home care and home support workforce. The next section of this report investigates worker experiences of home care and home support work in 2016.

As in the corresponding earlier Section 3.5 for residential care workers, this section presents job satisfaction data in two separate Tables 5.34 and 5.35. These tables show responses to questions that were ordered in a scale form, whereby respondents answered on a scale from 1–10 in Table 5.34 and from 1–7 in Table 5.35. The discussion needs to be interpreted according to the framework set out and described earlier in Section 3.5.1, including the limitations due to the use of an ordinal measure of job satisfaction.

5.5.1 Job Satisfaction

In this section we examine the range of factors that contribute to job satisfaction. The home care and home support worker survey form asked workers to rate their satisfaction with aspects of their work on a 10-point scale with the range of 1 (totally dissatisfied) and 10 (totally satisfied). Average scores from these responses are shown in Table 5.34.

The overall job satisfaction score is 8.1 in 2016, roughly equivalent to the score in 2012 of 8.2, indicating widespread job satisfaction with direct care work. CCWs are slightly more satisfied overall (8.2) than nurses or AH workers (7.8 each). Satisfaction with total pay has risen to 6.3 in 2016 from 5.6 in 2012 (this is also higher for home care and home support workers than the 5.6 for residential workers Table 3.34). Home care and home support direct care workers are slightly more satisfied with their work overall (8.1) than those in residential facilities (7.9). It is interesting that the highest scores are found for 'the work itself', the 'hours worked' and the 'flexibility to balance work and non-work commitments', all of which can be used as, at least partial, explanations for the high retention of the home care and home support sector.

Table 5.34: Average scores for responses from the home care and home support direct care workforce to statements about job satisfaction, by occupation: 2016 (range 1-10)

Satisfaction with	Nurse	CCW	AH	All occupations
Total pay	6.7	6.2	6.4	6.3
Job security	7.0	7.1	6.7	7.1
The work itself	8.0	8.2	7.8	8.1
Hours worked	7.7	7.3	8.0	7.4
Opportunities to develop abilities	7.2	7.3	6.8	7.3
Level of support from your team/service provider	7.6	8.0	7.4	7.9
Level of support from your supervisor	7.7	8.1	7.5	8.0
Flexibility to balance work and non-work commitments	7.4	8.0	7.4	7.9
Overall satisfaction	7.8	8.2	7.8	8.1

Source: Survey of home care and home support aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied).

5.5.2 Doing the Work

Home care and home support workers responded to a number of statements about 'doing' care work in the worker survey questionnaire. For each statement, they were asked the extent to which they agreed this to be the case for them, and they could give a score on a scale of 1 (totally disagree) to 7 (totally agree), with 4 being considered the midpoint. Although subjective, these assessments of their work are important indicators of what they would like changed and their confidence in performing the work.

Table 5.35 reports the average scores for each statement by occupation. Home care and home support direct care workers agree most strongly with statements about having skills (statement 2: average score of 6.3), using these skills in their current job (statement 3: 6.1) and the availability of adequate workplace training (statement 4: 5.6). Residential workers also agreed most strongly with these three statements. Average scores on pressure to work harder (statement 6: 3.3) and stress (statement 7: 3.2) were the lowest scores reported, indicating disagreement.

Overall, home care and home support direct care workers had lower average scores than residential workers for statements about pressure/stress indicating they on average disagreed with the statement (statement 6: 4.2 residential workers Table 3.35, 3.3 home care and home support workers; statement 7: 4.0 residential workers Table 3.35, 3.2 home care and home support workers). Having sufficient time to care (statement 1) was more commonly agreed with by home care and home support workers (average score 5.1) than by residential workers who on average disagreed with this statement (average score 3.9 Table 3.35). Having job freedom (statement 5: 5.0) and receiving respect (statement 8: 5.2) are slightly higher than for residential workers (4.6 and 4.9, Table 3.35).

On the whole these satisfaction statements reflect a hard-working workforce, confident in their skills and the way these skills are utilised in their workplace, willing to take on challenges, who like a lot what they are doing, but who are at the same time feeling under pressure regarding some aspects of their jobs.

Table 5.35: Average scores for responses from the home care and home support direct care workforce to statements about their work, by occupation: 2016 (range 1-7)

Statement	Nurse	CCW	AH	All occupations
I am able to spend enough time with each care recipient	4.8	5.2	4.9	5.1
I have the skills and abilities I need to do my job	6.0	6.3	6.2	6.3
I use many of my skills and abilities in my current job	5.8	6.1	5.9	6.1
Adequate training is available through my workplace	5.2	5.7	5.0	5.6
I have a lot of freedom to decide how I do my work	5.2	4.9	5.4	5.0
I feel under pressure to work harder in my job	4.3	3.2	4.1	3.3
My job is more stressful than I had ever imagined	3.8	3.1	3.6	3.2
Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	4.9	5.2	4.8	5.2
Management and employees have good relations in my workplace	5.0	5.4	5.0	5.3

Source: Survey of home care and home support aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree).

It is widely acknowledged by care workers that one of the most rewarding and, at the same time, challenging aspects of the job is the time spent actively caring for clients. Table 5.36 shows that in 2016, 61 per cent of direct care workers in home care and home support outlets spend more than two-thirds of their shift actively caring (slightly more than the 59 per cent in 2012). CCWs (68 per cent) are the dominant occupational group who spend more than two-thirds of their shift actively caring. Far fewer of nurses (35 per cent of ENs and 28 per cent of RNs) and AH workers (25 per cent) spend this much time with their clients.

The amount of time spent actively caring is lower for all occupations in home care than in residential facilities (especially CCWs at 68 per cent Table 5.36, compared to residential PCAs at 77 per cent, Table 3.36).

Table 5.36: Responses of the home care and home support direct care workforce to the question 'In a typical shift, how much time do you spend actively caring for care recipients?', by occupation: 2016 (per cent)

Time spent caring	RN	EN	Nurse*	CCW	AH	All occupations
Less than one-third	35.2	27.8	33.6	18.1	38.1	20.9
Between one-third and two-thirds	36.4	37.1	36.6	14.4	36.5	18.0
More than two-thirds	28.4	35.0	29.8	67.5	25.4	61.1
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Nurse combines RN and EN.*

Workers in the home care and home support aged care sector may also provide care to younger people with disability. As Table 5.37 shows, 33 per cent of nurses, 37 per cent of AH workers and 45 per cent of CCWs work solely with aged clients[8]. A further 41 per cent of workers across all occupational groups report that between 75 and 99 per cent of their clientele are aged care clients. The remaining workers have more variety in the type of clients they care for.

[8] Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.

Table 5.37: Distribution of the proportion of aged clients cared for by home care and home support direct care workers, by occupation: 2016 (per cent)

% of aged clients* cared for	Nurse	CCW	AH	All occupations
Less than 50% aged clients	3.1	7.1	9.6	6.8
50–74	11.8	8.1	14.2	8.8
75–99	52.1	39.4	38.8	40.7
100% aged clients	33.0	45.4	37.4	43.6
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.*

An important aspect of the functioning of a workplace is the degree to which workers get along with their managers and colleagues. Dissatisfaction with this aspect of the workplace leads to lower job satisfaction, poorer staff retention and is generally associated with worse career progression, outcomes and lower quality of production. Information from workers about their relationships with management and colleagues were separately recorded in Tables 5.38 and 5.39. Most workers report that positive relationships with their management (an average of 85 per cent in Table 5.38) and even more believe that their relationship with colleagues is good (91 per cent in Table 5.39). Table 5.38 shows that CCWs are the most satisfied with the quality of management relationship (86 per cent) followed by nurses (82 per cent) and AH workers (81 per cent). Table 5.39 shows that AHs are the most satisfied with their colleagues (96 per cent) followed by nurses (93 per cent) and CCWs (91 per cent). The overall picture of the sector is one of very good workplace relationships, which is also shown by other related measures of the quality of the job and the workplaces.

Table 5.38: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	8.2	5.5	10.1	6.0
Neither good nor bad	10.4	8.8	9.0	9.0
Good	81.5	85.8	80.9	85.0
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, 2016.
Scale used is 1 (very bad) to 7 (very good).

Table 5.39: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between workmates/colleagues and yourself', by occupation: 2016 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	1.5	2.9	0.8	2.6
Neither good nor bad	5.5	6.5	3.4	6.3
Good	92.9	90.6	95.8	91.1
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, 2016.
Scale used is 1 (very bad) to 7 (very good).

5.5.3 Job Demands

The home care and home support outlet census form asked questions about the prevalence of unusual job demands that may be made of their workers, shown in Table 5.40. Two types of demands are considered, those that are made under normal circumstances and those that are made only in exceptional circumstances. Such demands may be perfectly justifiable from the point of view of the aged care clients who themselves may face life uncertainties, as it will be perfectly understandable that the employers and the workers will be willing to provide the necessary support. However, they inevitably create an element of uncertainty in organising the workplace for employers and in organising working hours for employees. Especially for smaller size employers where substitutes may not be easy to find, such demands may make it difficult for employees to plan their workload and to meet their non-work responsibilities at the same time.

Of the five unusual job demands listed, the most widely made demand under normal circumstances is to vary hours or location at short notice (36 per cent of outlets). This is slightly higher than the 32 per cent reported in 2012. Working longer than scheduled due to unanticipated needs of clients occurred under normal circumstances for workers in 14 per cent of outlets.

As with residential facilities, in home care and home support outlets the most prevalent job demands are related to unanticipated changes in work patterns, working longer than scheduled or varying hours or location at short notice. While the majority of outlets who make these demands indicated that it was only done in exceptional circumstances, slightly more than a third of outlets (36 per cent) vary hours or location at short notice under normal circumstances, and 14 per cent normally ask employees to work longer than scheduled hours because of unanticipated needs of residents. These demands create an element of uncertainty in working hours for employees and may make it difficult for them to plan their workload or meet their non-work responsibilities.

There are 62 per cent of outlets which in exceptional circumstances ask their direct care employees to work with aggressive service users, with 11 per cent doing so under normal circumstances (both slightly different shares than in 2012 when they were 53 per cent and 16 per cent). Given that most home care and home support direct care workers work alone, the need to visit aggressive service users could raise concerns about safety issues.

Table 5.40: Prevalence of unusual job demands in home care and home support outlets: 2016 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled because of unanticipated needs of clients	13.7	70.7	15.7	**100**
Variations in hours or location at short notice	35.9	48.0	16.2	**100**
Working in very unsanitary conditions	1.7	29.5	68.8	**100**
Working with aggressive service users	10.8	62.1	27.1	**100**
Working alone late at night (after 10 pm)	7.2	15.3	77.6	**100**

Source: Census of home care and home support aged care outlets.
Row percentages shown. Per cent of outlets.

5.6 Work-related Injury and Illness

Within home care and home support the type of work performed and the environment in which it occurs is different to the services provided in a residential aged care setting. Workers often work alone rather than in teams, they work in the private homes of service users rather than in a managed facility, and they can only influence the health and well-being of clients for short

periods of time rather than being able to have them under constant surveillance. This diversity of working environments and the lack of the explicit structure that a single physical workplace can offer, means that home care and home support workers are often exposed to work-related risks in their work that could impact on their own health and safety. The additional questions that were first introduced in 2012 about workplace injuries and illnesses in both the employer census and the workers survey, were continued in 2016. This section presents the findings from both sources.

Table 5.41 shows the types of work-related injuries and illnesses that were reported by outlets and workers separately and independently. These percentages reported by outlets and by workers are not directly comparable, as the outlet ones refer to the incidents for *all workers* in this outlet and the worker ones refer to only the *one worker* who is responding. Further, the outlets refer to the last three months while the worker refers to the last 12 months.

There were no work related incidents reported in the 3 months leading up to the census for 52 per cent of outlets. Of those outlets with incidents, the most commonly reported injuries were sprains and strains (59 per cent), superficial injuries (30 per cent), chronic joint or muscle conditions (26 per cent) and stress or other mental condition (18 per cent).

Twelve per cent of all workers reported a work-related injury or illness had occurred to them in the last 12 months. The most commonly reported incidents (by those who reported one) were similar to those reported by outlets: sprains and strains (43 per cent), chronic joint or muscle conditions (22 per cent), stress and other mental conditions (18 per cent), and superficial injuries (14 per cent). A further 2 per cent of all workers (and 19 per cent of those workers who reported an incident) indicated that they had experienced ‘other’ (unspecified) injuries or illnesses as a consequence of their work.

Table 5.41: Types of reported work-related injuries and illnesses, comparing outlets and workers: 2016 (per cent)

Type of injury/illness	Outlets (last 3 months)		Workers (last 12 months)	
	All outlets	With any incidents	All workers	Who reported incidents
None reported	51.6	n/a	87.6	n/a
Fracture	2.5	6.7	0.4	3.5
Chronic joint or muscle condition	9.9	26.2	2.5	21.6
Sprain/strain	22.2	58.5	5.0	43.2
Cut/open wound	4.9	12.8	1.0	8.7
Crushing injury/internal organ damage	0.2	0.4	0.1	0.7
Superficial injury (minor)	11.4	30.0	1.6	13.5
Stress or other mental condition	6.9	18.1	2.1	18.1
Amputation	0.0	0.0	0.0	0.0
Burns	2.3	6.0	0.6	5.2
Other	3.8	10.0	2.2	19.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, columns will not sum to 100.

It is important to understand better the causes of reported injuries, as both employers and employees wish to see their prevalence reduced. Table 5.42 shows the causes of reported work-related injuries and illnesses for home care and home support outlets and workers. For the 48 per cent of home care and home support outlets that had any incident in the last 3 months, the four main causes are: lifting, pushing, pulling and bending (54 per cent); a fall (29 per cent); hitting or being hit or cut by a person, object or vehicle (19 per cent); and repetitive movement (19 per cent). These were similar to the causes identified by workers who reported incidents in the last 12 months: lifting, pushing, pulling and bending (39 per cent); a fall (17

per cent), repetitive movement (9 per cent). Both outlets (15 per cent) and workers (13 per cent) indicated that a substantial minority of work-related injuries and illnesses were due to 'other' causes.

Table 5.42: Causes of reported work-related injuries and illnesses, comparing outlet and worker responses: 2016 (per cent)

Cause of injury/illness	Outlets (last 3 months)		Workers (last 12 months)	
	All outlets	With any incidents	All workers	Who reported incidents
None reported	51.6	n/a	87.6	n/a
Lifting, pushing, pulling, bending	20.6	54.2	3.7	39.1
Repetitive movement	7.3	19.2	0.9	9.4
Prolonged standing, working in cramped or unchanging positions	0.8	2.1	0.1	1.0
Vehicle accident	6.3	16.7	0.3	2.9
Hitting, being hit or cut by person, object or vehicle	7.1	18.8	0.7	7.3
Fall	10.8	28.5	1.6	17.0
Exposure to mental stress	4.4	11.6	0.5	5.5
Long term exposure to sound	0.2	0.4	0.0	0.0
Contact with chemical of substance	1.0	2.7	0.1	1.6
Fatigue	1.3	3.5	0.3	3.3
Other	5.8	15.2	1.2	13.0

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, columns will not sum to 100.

The extent to which Workcover is used by outlets and workers provides an indication of the seriousness of reported occupational injuries and illnesses. Table 5.43 shows that 26 per cent of outlets had one or more employee on Workcover in the designated fortnight, slightly more than the 24 per cent in 2012. Reflecting the relative sizes of each occupation, most outlets had Workcover cases for CCWs. The 25 per cent of outlets that had CCWs on Workcover, used it for an average of 2 CCWs; while the 1 per cent of outlets using Workcover for RNs had an average of 2.5 RNs on Workcover during the designated fortnight.

Table 5.43: Proportion of outlets with employees on Workcover (per cent) and, of these, the mean number of employees per outlet on Workcover during the designated fortnight: 2016

Occupation	Outlets using Workcover (%)	Employees (average per outlet)
Registered Nurse	1.4	2.5
Enrolled Nurse	0.9	1.5
Community Care Worker	24.5	2.0
Allied Health	1.1	1.2
All occupations	26.3	2.1

Source: Census of home care and home support aged care outlets.

5.7 Cultural and Linguistic Diversity

Cultural and linguistic diversity is an important aspect of aged care provision in Australia in terms of both the demand and the supply of aged care services. Currently around a fifth of older Australians are of culturally and linguistically diverse origin and within the next five years it is expected that more than 30 percent of this cohort will have been born overseas (Department of Social Services, 2015). On the demand for services side, service users often prefer or even require the supports that can be afforded by culturally and linguistically sensitive and well equipped service providers. On the supply of services side, some of the labour and skill shortages that are often felt in the Australian health, care, and related services sectors can be addressed by hiring recent migrants. The aged care sector is culturally and linguistically diverse in both these demand and supply perspectives. This section explores the experiences of workers from culturally and linguistically diverse backgrounds in home care and home support aged care.

The next three tables (Tables 5.44 – 5.46) relate only to those respondents to the home care and home support survey who identified that they are fluent in a language other than English. An important aspect of service provision within aged care is the ability to speak fluid English. Table 5.44 shows that a relatively high proportion of workers in home care and home support aged care are most fluent in English although this varies by occupation. Most RNs (73 per cent) and ENs (85 per cent) are most fluent in English, although a substantial minority speak both English and their primary language equally well (12 and 15 per cent respectively). About two thirds of the AH workers are most fluent in English (68 per cent), with another 21 per cent speaking both English and their primary language equally well. For CCWs, 39 per cent speak both languages equally well, with 43 per cent most fluent in English. Of all the occupational groups, CCWs have the highest proportion that is most fluent in LOTE (19 per cent).

Table 5.44: Fluency in a language other than English (LOTE) of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Speak LOTE, most fluent in	RN	EN	CCW	AH
English	73.1	84.8	42.5	68.2
LOTE	14.9	0.0	18.9	10.7
Both equally well	12.0	15.2	38.6	21.1
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers (weighted).

The use of a language other than English in the workplace was far more commonly reported by workers in home care and home support than in the residential sector. As shown in Table 5.45, 67 per cent of home care and home support workers who are fluent in a language other than English use it in their work. This compares to only 39 per cent of direct care workers based in residential facilities (Table 3.44). Of the occupational groups, a higher proportion of ENs (74 per cent) and AH (76 per cent) than other occupations use these language skills in their work.

Table 5.45: Use of language other than English (LOTE) by the home care and home support direct care workforce, by occupation: 2016 (per cent)

Speak LOTE and	RN	EN	CCW	AH	All occupations
Use LOTE in job	58.1	74.0	66.7	76.3	66.8
Do not use LOTE in job	41.9	26.0	33.3	23.7	33.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

Workers who were fluent in a language other than English were asked in the survey form to assess their skills in reading, writing and speaking English. Of the three areas of English literacy, workers are most confident in their ability to speak and read in English (Table 5.46). Slightly more than a quarter of home care and home support direct care workers who speak a language other than English assessed their fluency in writing in English as 'not very well' (26 per cent). This could be viewed as a concerning percentage of workers particularly around service provision where they are expected to undertake important medication or recording roles. As in residential aged care (Table 3.45), writing was viewed as the area in which these home care and home support workers are least fluent in English. As provision becomes more complex with time (older clients and more stringent formal education requirements) this share with low capacity in written English may not be able to continue to be part of the workforce.

Table 5.46: Subjective assessment of English literacy for home care and home support direct care workers most fluent in a language other than English (LOTE): 2016 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0.8	11.6	55.1	32.6	0.0	**100**
Reading	0.3	10.7	49.7	39.4	0.0	**100**
Writing	0.5	25.9	49.6	24.0	0.0	**100**

Source: Survey of home care and home support aged care workers.

Information provided by outlets about the CCWs they employ who come from culturally and linguistically diverse (CALD) backgrounds are shown in Tables 5.47 to 5.50. CCWs are of special interest because they are the largest occupational group in home care and home support aged care (in 2016 there are over 72, 000 CCW workers, 84 per cent of the home care and home support direct care workforce, Table 5.2).

Table 5.47 shows that 31 per cent of all outlets had no CCWs from CALD backgrounds (slightly fewer than the 35 per cent in 2012). Another 39 per cent of outlets indicated that CCWs from diverse backgrounds comprised between 1 and 33 per cent of their CCW workforce. This indicates that the employment of CCWs from CALD backgrounds is widespread and goes beyond those outlets that provide specialised services to particular groups. However, the employment of CCWs from CALD backgrounds is not as widespread as in residential facilities (where 12 per cent of residential facilities had zero, Table 3.46, compared to 31 per cent of home care and home support outlets, Table 5.47).

Table 5.47: Distribution by proportion of community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent)

% of CALD CCWs per outlet	Outlets
Zero	30.8
1–33	38.9
34–66	14.4
67–100	15.9
Total	**100**

Source: Census of home care and home support aged care outlets.

Home care and home support outlets were asked in the census about the benefits of employing CCWs from CALD backgrounds. As shown in Table 5.48, all outlets indicated that they received benefits from hiring these workers. Of these benefits, the opportunity to enhance cross-cultural understandings (85 per cent) and the use of language skills (other than English skills (68 per cent) were cited most frequently.

Table 5.48: Stated benefits of employing community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent)

Benefits	Outlets
No benefits	0
Stated benefits:	
Enhance cross-cultural understandings	84.7
Offer different cultural activities	50.0
Language (other than English) skills	67.6
Link clients to ethnic communities	49.5
Link outlet to ethnic communities	47.7
Other	5.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100.

Outlets that employ CCWs from CALD backgrounds were asked to nominate the most common ethnic or cultural background of those workers. Table 5.49 shows that 72 per cent of all home care and home support outlets employed CCWs who spoke a language other than English (this is much higher than in 2012 when it was 52 per cent). Of those outlets that did employ CCWs who spoke a language other than English (column 2), the most common languages spoken were Italian (16 per cent) and South East Asian (11 per cent). For home care and home support outlets with more than a third of CCWs speaking a language other than English (column 3), Chinese, Italian and South East Asian were the three most widely spoken language groups.

Table 5.49: Proportion of home care and home support outlets that employ community care workers (CCWs) from CALD backgrounds: 2016 (per cent)

Ethnic group	All outlets	Outlets with any CCWs speaking LOTE	Outlets with >33% CCWs speaking LOTE
At least one CCW from a linguistically diverse background	72.1	n/a	n/a
None	27.9	n/a	n/a
Indian[1]	5.4	7.7	5.2
Filipino	6.5	8.8	5.2
African	4.0	5.7	3.2
Pacific Islander	2.5	3.6	0.5
Chinese	6.5	8.9	14.0
Italian	11.2	15.6	13.0
Greek	4.1	5.8	5.9
South East Asian	8.0	11.1	11.1
Other	23.8	32.9	42.0
Total	**100**	**100**	**100**

Source: Census of home care and home support aged care outlets.
[1]*Includes Hindi and other languages spoken in India and Sri Lanka.*

While Table 5.50 indicates that managing a multilingual workforce can in some instances present challenges, the majority (80 per cent) of home care and home support outlets indicated no difficulty in employing CCWs who speak a language other than English. Of those home care and home support outlets reporting difficulties, the main concerns focused on communication with management/staff (73 per cent) and communications with clients (63 per

cent). Other stated difficulties such as 'occupational health and safety' (37 per cent) and 'communicating with client families' (43 per cent) were identified by fewer outlets, but still a reasonably high share.This is in contrast to residential aged care, where communication with residents was the main reported area of concern (88 per cent, Table 3.49),

Table 5.50: Stated difficulties of employing community care workers (CCWs) who speak a language other than English in home care and home support outlets: 2016 (per cent)

Difficulties	Per cent of outlets
No difficulties	80.0
At least one difficulty	20.0
Stated difficulties (% of outlets stating difficulties)	
Occupational health and safety	37.4
Communication with management and/or other staff	72.9
Communication with clients	63.0
Communication with client families	42.5
Other – written communication	20.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100 N=1391 outlets.

6. The Census of Home Care and Home Support Outlets

Key Findings

- Sixty per cent of home care and home support direct care workers were located in major cities, with a further 36 per cent in regional areas. Since 2012, the proportion of the total PAYG home care and home support workforce based in Victoria increased from 23 per cent to 33 per cent.

- Seventy per cent of PAYG home care and home support workers were employed in the not-for-profit sector and 20 per cent in government outlets. The proportion of workers employed in for-profit outlets has increased since 2012.

- Fourteen per cent of all PAYG employees and a quarter of direct care workers were employed in very small outlets (with 1 to 5 employees).

- Employment numbers in larger outlets (more than 40 PAYG staff) have grown since 2012, particularly for direct care employment.

- Commonwealth Home Support Program (64 per cent) and Home Care Packages Program (45 per cent) services were most commonly provided by outlets. Smaller outlets with 1-5 direct care staff commonly provided CHSP services (28 per cent), while large (21-40 direct care staff) and very large (more than 40 direct care staff) outlets often provided Home Care Packages (53 per cent).

- Sixty one per cent of home care and home support outlets belonged to a larger provider group. Thirteen per cent of outlets also offered residential aged care.

- Forty three per cent of outlets catered for a specific ethnic or cultural group, most frequently Aboriginal and Torres Strait Islander and Italian older adults.

- Almost half of outlets with direct care staff reported skill shortages; a shortage of CCWs was most common and skill shortages were more prevalent in very remote areas. The main reasons for these skill shortages were a lack of suitable applicants (72 per cent), the geographical location of the outlet (39 per cent) and slow recruitment processes (28 per cent).

- Outlets primarily responded to skill shortages by requiring existing staff to work longer hours (55 per cent), providing on-the-job training (37 per cent) and making greater use of agency staff (29 per cent).

- Vacancies were most frequently reported for CCW positions (by 25 per cent of outlets). These outlets had an average of 3.6 CCW vacancies. The average time taken to fill vacancies was 4.1 weeks for CCW positions and 4.7 weeks for RNs.

- The most common reasons for staff vacancies were resignation (63 per cent), creation of a new position (33 per cent) and retirement (21 per cent).

- Internet job advertisements (36 per cent) and a combination of internet and newspaper advertisements (30 per cent) were the most frequent recruitment strategies for CCW positions by outlets.

- For workers seeking employment in home care and home support outlets, internet job advertisements and word-of-mouth were the most common strategies used. The use of recruitment agencies was also reported by 14 per cent of nurses and 13 per cent of AH workers.

- Fifty nine per cent of home care and home support outlets used Enterprise Agreements to set employment conditions for their staff; 39 per cent of outlets used award-based arrangements.

- Seventy per cent of all outlets provided paid time for travel between care appointments; 48 per cent provided a petrol/depreciation allowance for work-related transport costs.

- Twenty seven per cent of outlets reported employing at least one non-PAYG worker (mainly CCWs, 21 per cent) in the designated census fortnight. Brokered staff (15 per cent and agency workers (12 per cent) were most commonly used.

- There were 44,879 estimated volunteers working in home care and home support outlets in 2016. About half (51 per cent) of all outlets had one or more volunteers who mainly assisted with social/group activities and transport.

- Multiple methods of quality monitoring in home care and home support outlets were reported including monitoring by managers or supervisors (78 per cent), keeping records of service user feedback (66 per cent) and undertaking client surveys (52 per cent).

6.1 Introduction

This chapter provides details of the key characteristics of home care and home support aged care outlets in Australia with information predominantly based on the census of home care and home support aged care outlets (N=2,307).

We begin the chapter with an overview of the reforms which have occurred in the sector since the last NACWCS was undertaken in 2012 and the aged care programs which are now provided by home care and home support outlets. A profile of home and community support outlets showing the distribution of their employees across all states and territories, and information regarding the programs offered is presented. The relationship that home care and home support outlets have with broader aged care services and whether these facilities cater for specific ethnic or cultural groups are then discussed. The next sections of the chapter examine the extent of, reasons for, and responses to skills shortages and staff vacancies within the sector. The industrial methods used by outlets to set employment conditions and the use of non-PAYG staff are then explored. The chapter finishes with a focus on how quality of care is monitored in community-based aged care.

6.1.1 Home Care and Home Support Aged Care Programs

Home care and home support outlets provide a range of aged care services delivered usually at the home of the aged care client. There has been significant reform to the way home care and home support aged care is delivered to consumers including the introduction of the new Home Care Packages Program, Commonwealth Home Support Program and the Consumer Directed Care model of care provision.

In this 2016 report we cover and report by these specific programs of services:

- Commonwealth Home Support Program
- Home Care Packages Program
- Home and Community Care in Victoria
- Home and Community Care in Western Australia
- Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program
- DVA Community Nursing, Veteran's Home Care or other DVA administered program[9]

[9] While DVA programs were not part of the in-scope lists, some in-scope outlets also provide services under the DVA programs.

- Transition Care Program

These programs are described below and where relevant, previous programs that have now been replaced are noted.

Home Support Programs

Home support programs provide entry-level support services for frail, older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who need assistance to keep living independently at home and in their community. In 2015–16 these services were delivered in most states and territories through the Commonwealth Home Support Program (CHSP). Over the same time period, within Victoria and Western Australia the jointly funded and state-operated Home and Community Care (HACC) programs continued operating.

The CHSP was introduced by the Australian Government on 1 July 2015 to provide streamlined access to services through the consolidation of four former Commonwealth-funded aged care programs. These programs include the Commonwealth Home and Community Care (HACC) program[10], the National Respite for Carers Program (NRCP), the Day Therapy Centres (DTC) program and the Assistance with Care and Housing for the Aged (ACHA) program.

The CHSP provides a range of services to older Australians including:

- transport
- social support
- assistance with food preparation in the home and delivery of meals
- nursing care and personal care
- allied health services like podiatry, physiotherapy and speech pathology
- domestic assistance including help with cleaning, washing and shopping
- support for carers including respite services
- home maintenance and modifications.

Home Care Packages Program

The Australian Government recognises that many older people want to remain living independently in their own homes for as long as possible. To support this, the Government subsidises packages to provide home-based care that can improve older Australians' quality of life and help them to remain in their homes and connected to their communities. Under a home care package, a range of personal care, support services, clinical services and other services is tailored to meet the assessed needs of the consumer.

On 1 August 2013 the Home Care Packages Program replaced the former community packaged care programs – Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages. Subsequently, from 1 July 2015, all home care packages were required to be delivered on a consumer directed care (CDC) basis. CDC provides greater transparency to consumers about what funding is available under their package and how those funds are spent through the use of an individualised budget. CDC also aims to give a consumer more choice and flexibility about the types of care and services they access and how the care is delivered to best meet their needs.

Eligibility and the level of Home Care Package an older person can receive is determined through an assessment by an Aged Care Assessment Team (ACAT). The Home Care

[10] Except in Victoria and Western Australian where the joint Commonwealth-State HACC programs continued to operate separately to the CHSP in 2015–16.

Packages Program provides four levels of packages, each with a different associated subsidy amount:

- Home Care Level 1 – to support people with basic care needs
- Home Care Level 2 – to support people with low level care needs
- Home Care Level 3 – to support people with intermediate care needs
- Home Care Level 4 – to support people with high care needs.

Multi-Purpose Service Program

The Multi-Purpose Service Program is a joint initiative between the Australian Government and all states and territories (except the ACT). The program recognises that the delivery of some health and aged care services may not be viable in rural and remote communities if they are provided separately. Through the use of pooled funding arrangements, Multi-Purpose Services deliver a mix of aged care, health and community services in rural and remote communities. In general, these services are operated by state, territory, and local governments.

Innovative Pool Program

The Innovative Pool Program (also known as the Innovative Care Program) provides opportunities to develop and test flexible models of service delivery to provide care where mainstream aged care services may not be appropriate for a specific location or target group. This program aims to allocate aged care places to services who will work with client groups for whom current service provision is limited or to client groups which are newly-emerging.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Services funded under this program provide culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community. The program allows the provision of both residential and home care services mainly in rural and remote areas.

Transition Care Program

The Transition Care Program enables older people to return home after a hospital stay, rather than prematurely entering a residential aged care home. A person can only enter transition care directly after being discharged from hospital. The program provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay.

Department of Veterans' Affairs Programs

Veterans' Home Care (VHC) is a DVA-funded program designed to assist eligible veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance.

The DVA Community Nursing Program provides home community nursing services for entitled persons to meet their assessed clinical and personal care needs.

6.2 A Profile of Service Outlets

Firstly we examine the distribution of the home care and home support workforce by state and territory, location and type of outlet. As shown in Table 6.1, there is evidence of some significant change in the distribution of the workforce across States/Territories between 2012 and 2016. Victoria increased their home care and home support PAYG workforce share substantially, rising from 23 per cent in 2012 to 32 per cent in 2016, with a slightly smaller rise in their direct care workforce (from 21 per cent to 27 per cent). In contrast, NSW had a large

fall in their PAYG workforce (falling from 31 per cent in 2012 to 26 per cent in 2016; and their direct care workforce falling by slightly more than the PAYG total (from 33 per cent to 26 per cent). Further analysis indicates that this change in workforce distribution across Victoria and NSW was due to two factors. Firstly, the share of outlets located in Victoria has increased since 2012. Secondly, while the average number of workers per outlet increased in both Victoria and NSW, this increase was larger in Victoria. Although Tasmania increased their PAYG workforce share very slightly, the share for all other states and territories fell slightly compared to 2012.

The picture is not always similar when viewing PAYG employees or only direct care employees. In WA, for example, while the proportion of PAYG employees fell slightly from 2012 (from 13 per cent to 12 per cent), it rose for direct care employees (from 11 per cent to 14 per cent).

Direct comparison of the distribution of the home care and home support workforce by location category before 2016 is not possible because of a change in the reporting of this data. In 2016 information regarding the location of home care and home support outlets was based on current ABS remoteness area categories; this information was not previously available at the time of the 2012 NACWCS.

Examining ownership type, the distribution shows some change. In 2016, not-for-profit providers employ 70 per cent of the total PAYG workforce in home care and home support aged care services, a slight decline from 74 per cent in 2012 (Table 6.1). The not-for-profit share of direct care employment in home care and home support, now at 68 per cent, has experienced a more marked decline (from 76 per cent in 2012). For-profit outlets employ 9 per cent of the PAYG workforce, and 12 per cent of the direct care workforce, an increase since 2012. The for-profit share of the direct care workforce has grown by 5 per cent since 2007.

Table 6.1: Distribution of home care and home support direct care workforce Total PAYG and Direct Care (per cent) by State/ Territory, location, and ownership type: 2007, 2012 and 2016

	Total PAYG employees			Direct care employees		
	2007	2012	2016	2007	2012	2016
State/Territory						
NSW	20.5	31.2	25.7	22.7	32.9	26.4
Victoria	30.5	22.6	32.3	27.6	20.9	26.5
Queensland	20.3	16.9	15.8	22.3	19.1	17.8
WA	11.3	13.1	12.1	10.7	11.1	13.7
SA	9.0	10.7	7.4	9.4	9.5	8.1
Tasmania	6.2	2.5	4.4	4.9	3.0	5.1
ACT	1.2	2.1	1.8	1.2	2.0	1.8
NT	1.0	1.0	0.6	1.3	1.4	0.6
Location*						
Major cities of Australia			63.5			59.7
Inner Regional Australia			16.9			18.9
Outer Regional Australia			14.6			17.0
Remote Australia			4.0			3.5
Very Remote Australia			0.6			0.6
Ownership Type						
Not-for-profit	70.0	74.4	70.4	72.9	76.1	68.0
For-profit	7.6	5.2	9.3	4.7	6.7	12.1
Government	22.5	20.4	20.3	22.4	17.1	19.9

Source: Census of home care and home support outlets.
**ABS remoteness area categories.*

The home care and home support census uses the number of total PAYG and direct care employees reported by outlets as a method of estimating their size. Table 6.2 shows overall that since 2012, the proportion of smaller outlets (employing up to 10 workers) has decreased while the share of larger outlets (with more than 10 workers) has grown for both all PAYG employees and direct care workers. This suggests that the average size of outlets in the home care and home support sector has increased over time. We also see that in 2016 very small outlets employing 1 to 5 employees now account for a quarter of direct care employees and 14 per cent of all PAYG employees. In contrast large outlets (employing more than 40 people) account for 28 per cent of all PAYG staff and 21 per cent of direct care employees in 2016.

The average size of employment in outlets which employ more than 40 PAYG employees in 2016 is 116 PAYG employees (Table A6.2, Appendix 3); 75 of these are direct care workers. These employment numbers in larger outlets have grown since 2012, particularly for direct care employment (in 2012 larger outlets employed on average 111 PAYG employees of which 65 were direct care workers). This trend was not found for small to medium outlets (with 40 or fewer workers), for these outlets the average number of PAYG and direct care employees has remained stable since 2012.

Table 6.2: **Distribution of home care and home support direct care workforce (per cent) by size of outlet, by number of Total PAYG and direct care employees: 2007, 2012 and 2016 (per cent)**

Number of employees	Total PAYG employees			Direct care employees		
	2007	2012	2016	2007	2012	2016
1–5	22.3	19.8	14.0	24.0	26.1	24.7
6–10	21.0	21.3	16.4	22.3	19.2	17.6
11–20	20.5	16.9	22.1	20.3	16.2	19.4
21–40	16.8	18.7	19.2	16.9	20.9	17.6
More than 40	19.3	23.3	28.3	16.4	17.6	20.6
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.

The following tables focus on the distribution of home care and home support outlets that offer particular type of programs to older people living in the community. It should be noted that outlets can provide services under more than one program. Almost two thirds of outlets (64 per cent) provide services under the Commonwealth Home Support Program (CHSP), as shown in Table 6.3. HACC Victoria services are delivered by 15 per cent of outlets and HACC Western Australia by 8 per cent of outlets. There are 45 per cent of outlets providing services under the Home Care Packages Program, while just over 17 per cent of service outlets deliver services for DVA. A further 9 per cent of outlets provide services under the Transition Care Program for post-hospital aged care needs and 3 per cent of outlets deliver home care places under Flexibles Programs (the Multi-Purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, and Innovative Pool Program).

Table 6.3: **Distribution of home care and home support outlets (per cent) between programs in the last reporting period: 2016**

Program	% of outlets
Commonwealth Home Support Program*	63.9
Home Care Packages Program	45.1
Home and Community Care Victoria	14.8
Home and Community Care Western Australia	7.8
Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program	3.1
DVA Community Nursing, Veteran's Home Care or other DVA administered program	17.1
Transition Care Program	9.0
All outlets (weighted)	3,040

Source: Census of home care and home support outlets.
Note: Multiple responses allowed, percentages do not sum to 100.
Outlets can provide services under more than one program.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*

Table 6.4 shows the distribution of home care and home support outlets providing services under these programs across state, location and ownership type. Note that the final row shows the number of outlets providing services under each program type; as outlets can provide services under more than one program each outlet can be counted under one or more columns in Tables 6.4 and 6.5.

Looking first at the state distribution for each program type, we see that outlets providing services under the Commonwealth Home Support Program (Table 6.4, column 1) are chiefly within NSW (35 per cent) and Queensland (29 per cent), and with the two remaining state HACC reflected in the lower 13 per cent for CHSP in Victoria and 4 per cent in WA (HACC Victoria and HACC Western Australia are in columns 3 and 4). The remaining States and Territories in CHSP show fewer than 10 per cent of outlets are within each of these locations.

Outlets providing services for the Home Care Packages Program, which is shown in column 2, is also chiefly serviced with outlets in NSW and Queensland (27 per cent and 28 per cent respectively) with 16 per cent in Victoria, 11 per cent in WA, 8 per cent in SA, 6 per cent in Tasmania and with other States and Territories each at less than 5 per cent.

The DVA administered programs shown in column 6 have a different State and Territory distribution, with the largest share of outlets servicing this program within Queensland (35 per cent) followed by Victoria (22 per cent) and NSW (21 per cent). The remaining States and Territories have a share of less than 10 per cent.

The largest share of outlets servicing the Transition Care Program are found in Queensland (36 per cent), NSW (26 per cent) and Victoria (18 per cent), with the remaining States and Territories each at less than 10 per cent.

Outlets providing services under Flexible Program (column 5) have the highest share within NSW (31 per cent), followed by WA and NT (18 per cent respectively), with 13 per cent in Queensland and the remaining States and Territories with shares lower than 10 per cent.

Table 6.4 also shows the distribution of outlets categorised by the remoteness area classification of their outlet location. The majority of outlets delivering services under most programs are found within major cities: 41 per cent of outlets providing CHSP, 44 per cent of Home Care Packages, 54 per cent of HACC Victoria, and 60 per cent of HACC Western Australia. Exceptions to this city-based concentration are outlets servicing DVA administrated programs where a much lower 33 per cent are within metropolitan cities and a greater share are in the outer regional areas with 33 per cent; and outlets under Transition Care where 30 per cent are within major cities and a greater share are in inner and outer regional areas (32 and 30 per cent respectively). A further exception were outlets delivering home care places under Flexible Programs as only 11 per cent of these outlets were located in major cities compared to 42 per cent in outer regional areas, 16 per cent in remote areas and 20 per cent in very remote Australia.

There is variation in the concentration of outlets amongst ownership types within the programs (bottom part of Table 6.4). Not-for-profit outlets provided the majority of services under all program types (with the exception of the Flexible Programs). For-profit outlets meanwhile were the least common ownership type across all programs, accounting for less than 5 per cent of outlets providing services under the programs of CHSP, HACC Western Australia, and Flexible Programs and none under HACC Victoria. Slightly higher shares of for-profit outlets delivered home care and home support services under the Transition Care Program (9 per cent), the Home Care Packages Program (10 per cent), and DVA administered programs (13 per cent). Outlets delivering services under Flexible Programs had the highest share of government ownership at 63 per cent, reflecting their specialist role in supporting the supply of aged care services in communities mostly within rural and remote areas.

In Table 6.5 we can see that the size of an outlet impacts upon the type of aged care program services offered. For example, there is a higher share of very small outlets (with up to 5 PAYG employees) providing services under CHSP (15 per cent of all outlets), HACC Victoria (18 per cent) and Flexible Programs (17 per cent) compared to other program types such as the Home Care Packages Program (7 per cent) and DVA programs (1 per cent). In contrast very large outlets (with more than 40 PAYG staff) accounted for a greater share of services provided under DVA administered programs (52 per cent), HACC Western Australia (50 per cent), Transition Care Program (44 per cent) and the Home Care Packages Program (40 per cent).

The same trend persists when considering program service provision according to outlet size for direct care employees. Very small outlets (with up to 5 direct care employees) again accounted for a relatively greater share of services provided under CHSP (28 per cent of all outlets), HACC Victoria (27 per cent) and Flexible Programs (26 per cent) compared to other program types. Meanwhile very large outlets (with more than 40 direct care staff) accounted for a greater share of services provided under DVA administered programs (42 per cent), Transition Care Program (33 per cent), HACC Western Australia (38 per cent), and the Home Care Packages Program (31 per cent).

Table 6.4: Proportion of outlets offering services under each program in the last reporting period, by state, geographical location and ownership type: 2016 (per cent)

	Commonwealth Home Support Program*	Home Care Packages Program	Home and Community Care Victoria	Home and Community Care Western Australia	Home Care places under Flexible Programs**	DVA Community Nursing, Veteran's Home Care or other DVA administered program	Transition Care Program	Total
All outlets	63.9	45.1	14.8	7.8	3.1	17.1	9.0	n/a
State/Territory								
NSW	34.6	27.1	0.4	0.0	30.9	21.1	25.9	29.2
Victoria	13.0	15.5	98.9	0.0	9.6	21.5	17.5	22.4
Queensland	28.5	28.4	0.2	0.0	12.8	34.7	36.1	22.2
WA	4.1	11.2	0.2	100.0	18.1	8.1	3.3	10.3
SA	9.4	7.8	0.0	0.0	2.1	8.3	9.5	7.4
Tasmania	5.7	5.5	0.0	0.0	8.5	5.6	3.6	4.7
ACT	1.6	1.0	0.0	0.0	0.0	0.2	0.4	1.3
NT	3.1	3.4	0.0	0.0	18.1	0.8	4.0	2.6
Location								
Major cities of Australia	41.0	43.7	53.5	60.0	10.6	32.9	29.6	44.3
Inner Regional Australia	22.3	22.6	18.9	12.3	8.5	24.2	32.3	21.3
Outer Regional Australia	23.1	21.0	20.7	15.3	41.5	33.1	29.6	22.6
Remote Australia	9.9	8.6	6.0	9.4	16.0	8.1	8.5	8.7
Very Remote Australia	3.0	3.4	0.4	3.0	20.2	0.8	0.0	2.4
Ownership Type								
Not-for-profit	80.8	80.0	62.2	69.6	33.0	67.8	58.0	75.8
For-profit	4.9	9.9	0.0	3.0	4.3	12.5	9.1	6.0
Government	13.6	9.9	37.6	25.3	62.8	18.8	32.5	18.2
Outlets (weighted)	1,942	1,371	450	237	94	521	274	3,040***

Source: Census of home care and home support outlets; Note: Question A3.1 Programs is a multiple response question, outlets can provide services under more than one program.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*
***Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program.*
****As outlets can provide services under more than one program, the total number of outlets cannot be derived from the number of outlets offering services across the different program types.*

Table 6.5: Proportion of outlets offering services under each program in the last reporting period, (per cent) by size of outlet in number of Total PAYG and direct care employees: 2016 (per cent)

Number of employees	Commonwealth Home Support Program*	Home Care Packages Program	Home and Community Care Victoria	Home and Community Care Western Australia	Home Care places under Flexible Programs**	DVA Community Nursing, Veteran's Home Care or other DVA administered program	Transition Care Program	% of all outlets
Total PAYG								
1–5	15.4	7.1	18.4	4.7	17.4	1.2	3.0	13.9
6–10	16.9	11.3	13.5	9.5	20.7	4.6	8.5	16.5
11–20	22.5	20.2	12.6	18.5	18.5	18.9	18.1	22.0
21–40	17.1	21.8	20.6	17.7	18.5	23.3	25.9	19.3
More than 40	28.1	39.6	35.0	49.6	25.0	52.0	44.4	28.4
Outlets (weighted)	1,882	1,370	446	232	92	519	270	2,971***
All Direct Care								
1–5	27.9	15.0	27.0	11.8	25.6	3.9	9.8	24.6
6–10	17.8	13.2	14.2	8.2	20.0	8.0	10.5	17.7
11–20	17.3	18.6	16.8	20.9	17.8	21.7	20.3	19.4
21–40	16.1	22.0	19.8	20.9	23.3	24.2	26.7	17.7
More than 40	20.9	31.2	22.1	38.2	13.3	42.2	32.7	20.6
Outlets (weighted)	1,778	1,314	429	220	90	512	266	2,816***

Source: Census of home care and home support outlets Note: Question A3.1 Programs is a multiple response question, outlets can offer services in more than one program, rows do not total 100.
The number of outlets differs to that of Table 6.4 due to the combination of different non-response for employee questions and the effects of weighting.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*
***Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program.*
****As outlets can provide services under more than one program, the total number of outlets cannot be derived from the number of outlets offering services across the different program types.*

6.3 Outlets' Relationships with Broader Aged Care Services

Many home care and home support outlets have connections to the broader aged care sector either as part of a larger provider organisation or through the provision of both residential and community-based aged care services. Table 6.6 shows that 61 per cent of all outlets are part of larger organisational groups, the same as in 2012. The proportion of for-profit outlets belonging to a larger group has risen from 67 per cent in 2012 to 76 per cent in 2016, a large increase that continues the consolidation from the 46 per cent of for-profit outlets that were part of a larger organisation in 2007.

There is also evidence of greater specialisation as the proportion of home care and home support outlets also providing residential aged care services has fallen since 2012, from 20 per cent to 13 per cent in 2016. The proportion of outlets providing a combination of home care and home support with residential services has markedly declined since 2012 for all ownership types.

Table 6.6: Proportion of home care and home support outlets that are part of larger provider group or provide residential aged care (per cent), by ownership type: 2012 and 2016

	Not-for-profit	For-profit	Government	All outlets
2016				
Part of larger provider group	62.9	76.1	48.2	61.0
Providing residential aged care	12.3	5.0	20.8	13.4
2012				
Part of larger provider group	65.0	66.9	40.5	60.6
Providing residential aged care	18.2	13.7	26.4	19.5

Source: Census of home care and home support outlets.

Table 6.7 concentrates on those outlets that provide both home care and home support as well as residential care. Focusing on the 13 per cent of outlets (409 outlets) that also provide residential aged care services (Table 6.6), 21 per cent of staff (18 per cent of nurses and 17 per cent of CCWs, Table 6.7) working in these outlets provide both residential and home care and home support care services. In contrast, Allied Health workers commonly provide services for both residential and home care and home support care (53 per cent, Table 6.7). No for-profit outlets reported a joint workforce for residential and home care combined services.

Table 6.7: Proportion of home care and home support aged care employees that work in both residential and home care/home support aged care (per cent), in outlets that also provide some residential aged care, by ownership type: 2016

Occupation	Not-for-profit	Government	All outlets*
Nurse	19.4	17.7	18.2
CCW	18.1	19.5	17.4
Allied Health	55.6	51.9	53.4
All occupations	20.6	23.9	21.0

Source: Census of home care and home support outlets.
**For profit not shown (2 cases weighted).*

6.4 Ethnic Specialisation

As previously discussed in Section 4.4, the number of older people from CALD backgrounds in Australia is increasing and therefore also the need for ethnically and culturally appropriate services for this cohort. The 2016 census explored the extent of ethnic specialisation in the

home care and home support aged care sector, and found that almost 43 per cent of outlets cater to a specific ethnic or cultural group (Table 6.8), compared with 41 per cent of outlets in 2012.

Amongst outlets that did cater for a specific ethnic or cultural group, Aboriginal and Torres Strait Islander clients were most frequently catered for (67 per cent of outlets), followed by clients from an Italian (41 per cent), Greek (36 per cent) and Chinese (35 per cent) backgrounds. Almost 41 per cent of outlets who specialise indicated that they cater for gay, lesbian, bisexual, transgender and intersex clients. This figure is much higher than the 1 per cent of community outlets that reported catering to residents with this background in 2012, illustrating the increasing supply of aged care services which are sensitive to and inclusive of diverse backgrounds.

Table 6.8: Home care and home support outlets catering for specific ethnic or cultural groups: 2016 (per cent)

Ethnic group	% All outlets	% among outlets that specialise
Catering for specific ethnic or cultural group	42.5	n/a
No catering for specific ethnic or cultural group	57.5	n/a
Polish	13.1	30.6
Aboriginal/Torres Strait Islander	28.9	67.4
Italian	17.4	40.6
Chinese	15.2	35.4
Dutch	11.7	27.2
Greek	15.3	35.6
Gay, lesbian, bisexual, transgender, intersex	17.4	40.6
German	13.0	30.3
Indian	12.7	29.7
Other	5.2	12.1

Source: Census of home care and home support outlets.
2016 N=1577 outlets catering for specific ethnic or cultural groups (weighted).
Note: Multiple responses were allowed, columns do not sum to 100.

6.5 Skill Shortages

The provision of quality aged care services depends considerably upon adequate numbers of workers with the required skills being employed in the workforce. In order to advance understanding of skill shortages which may exist within the sector, the 2016 census of home care and home support outlets collected information on the incidence of skill shortages, the factors that cause these shortages, and how facilities respond to them. Table 6.9 shows that skill shortages were reported by 42 per cent of all home care and home support outlets, and 49 per cent of outlets with direct care staff (final column Table 6.9). This table also shows the proportion of outlets with skill shortages for particular direct care occupations. Similar to 2012, a shortage of CCWs was the most commonly reported occupation in which there was a skills shortage (33 per cent in 2016, 37 per cent in 2012), followed by RNs (10 per cent of outlets) and AH (7 per cent) with ENs rarely reported to be in shortage (3 per cent).

Table: 6.9: Proportion of home care and home support outlets reporting skill shortages in 2016 (per cent), by location and occupation affected

Whether had skill shortage	Major cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia*	All outlets
Yes (of all outlets)	40.8	43.4	43.3	43.8	51.4	42.4
Yes (of all outlets with direct care staff)	46.9	49.7	51.1	52.2	60.7	49.2
Yes, for:						
RN	7.3	12.5	12.0	16.5	12.5	10.4
EN	1.7	2.8	3.5	3.4	5.6	2.6
CCW	33.1	33.7	32.3	34.8	43.1	33.3
AH	7.1	7.8	6.2	4.1	2.8	6.6

Source: Census of home care and home support outlets.
Note: Multiple responses allowed, columns do not sum to 100.
**N=24 cases (weighted); Overall outlets with skill shortages N=1,277 outlets (weighted).*

For those 1,277 outlets reporting skill shortages (42 per cent of outlets, Table 6.9), the managers were asked to identify factors to which the shortage was attributable, shown in Table 6.10. The main skills shortage issue was a lack of suitable applicants reflecting the desired skills, qualifications, experience or values sought (72 per cent), with very little variation by occupation skill type (76 per cent of outlet managers cited this for RNs and 73 per cent for CCWs). The second most commonly reported issue was the geographic location in which the outlet services were delivered (39 per cent), however this was more commonly reported for RN shortages (54 per cent) than for CCW shortages (40 per cent). Recruitment being too slow for the outlet service needs was the third most common issue for skill shortages (28 per cent), and this was also more commonly reported for an RN shortage (35 per cent) than a CCW shortage (27 per cent). Specialist knowledge was reported by home care and home support outlets as a key source of skills shortages for RN occupations by 28 per cent of outlets (in contrast to only 19 per cent reporting this for CCWs). While these three reasons were also the most commonly reported sources of skills shortages for residential facilities, slightly more residential facilities reported no suitable applicants (80 per cent, Table 4.9) than did home care and home support outlets (72 per cent, Table 6.10).

Table 6.10: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected

Cause of skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
Specialist knowledge required	20.4	28.2	19.1
Geographical location of outlet	39.3	53.9	39.9
Wages or salary costs too high	11.7	16.1	12.1
Lack of availability of adequate training	15.9	14.6	18.4
Unsure of long term demands for service	17.0	18.6	19.2
Recruitment too slow	28.4	35.0	27.3
No suitable applicants (skills/qualifications/experience/values)	71.7	75.9	72.8
Other	7.9	5.6	7.7

Source: Census of home care and home support outlets.
Note: Multiple responses were allowed, columns do not sum to 100.
N=1,277 outlets (weighted).

For those outlets reporting skill shortages, an additional question asked outlet managers what strategies they used in response to having these shortages (shown in Table 6.11). As also found in 2012, a majority of these outlets (55 per cent) asked their existing staff to work longer hours. This was also the most frequent strategy nominated by residential facilities in 2016 (62 per cent, Table 4.10).

The second most frequent strategy for responding to skills shortages differed by the type of occupation that was in shortage. Outlets responded with greater use of agency staff for a shortage of RNs (38 per cent) but for a shortage of CCWs used on-the-job training of staff (41 per cent). In contrast, and also frequently used, the third most used strategy for an RN skills shortage was on-the-job training of staff (33 per cent) and for a shortage of CCWs was greater use of agency staff (29 per cent).

In 2016, the categories of student placement usage and volunteer usage were added to this question. For a shortage of CCWs, volunteers were reported to be used by 12 per cent of outlets and student placements were used by 7 per cent of outlets. Along with increasing wages, salaries or conditions, these were among the least common responses to skills shortages (reported by up to 10 per cent of outlets for any occupation shortage).

Table 6.11: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected

Response to skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
External training of staff	20.2	18.3	23.4
On-the-job training of staff	36.8	33.4	41.0
Existing workforce worked longer hours	55.1	57.0	56.9
Greater use of agency staff	28.7	37.5	29.0
Sub-contracted or outsourced services	21.0	24.8	21.9
Employed staff on short term contracts	17.9	22.9	13.7
Wages, salaries and/or conditions increased	7.4	9.0	7.6
Reduced outputs or production	14.4	18.3	12.3
Used student placements	5.5	6.2	6.6
Used volunteers	9.5	3.1	11.7
Other	5.1	4.3	4.0

Source: Census of home care and home support outlets.
Note: Multiple responses were allowed, columns do not sum to 100.

6.6 Vacancies

The overall number and types of staff vacancies are further indicators of current conditions within the aged care labour market. Combining this information with the data collected on skills shortages, we are able to present evidence on the extent of difficulties experienced by home care and home support outlets in recruiting adequate numbers of skilled staff.

Outlet managers were asked to report in the census form on the number of vacancies they had at the time of completion, for employees in each direct care occupational classification. This information has been used in Table 6.12 to calculate the proportion of outlets with vacancies in each direct care occupation (Panel 1) and the average number of vacancies for these outlets (Panel 2). Outlets that did not report any vacancies were excluded.

Panel 1 of Table 6.12 shows that a small proportion of outlets reported FTE vacancies across the range of occupations, but similarly to 2012 (and also 2007), more outlets reported vacancies for CCWs (25 per cent in 2016) than other occupations. This is understandable given the distribution of the different occupations in home care and home support aged care,

because CCWs comprise the greatest part of the direct care workforce. Panel 2 of Table 6.12 shows that in 2016 amongst outlets with vacancies, the average number of unfilled FTE positions was 3.6 for CCWs but less than 2 for other occupations (this is very similar to 2012 when there were 3.5 for CCWs).

Table 6.12: Vacancy rate (per cent of all home care and home support outlets) and average number of vacancies (in outlets with vacancies), by occupation: 2007, 2012 and 2016

	Full-Time Equivalent		
	2007	**2012**	**2016**
Panel 1: % of outlets with any vacancies			
Registered Nurse	6.1	5.5	5.7
Enrolled Nurse	2.5	2.1	1.0
Community Care Worker	22.2	21.4	25.3
Allied Health	5.2	3.8	4.3
Panel 2: Average number of vacancies in outlets with any vacancies			
Registered Nurse	n/a	1.4	1.5
Enrolled Nurse	n/a	1.6	1.3
Community Care Worker	n/a	3.5	3.6
Allied Health	n/a	2.3	1.7

Source: Census of home care and home support outlets. Outlets that did not report any vacancies were excluded. N=2,473 outlets (weighted).

A further way of investigating vacancies in aged care is to consider the amount of time that it takes to fill positions for different occupations. Tables 6.13 and 6.14 examine vacancy duration (measured in weeks) with reference to the most recent vacancy that outlets advertised. Table 6.13 shows that in 2016, with the exception of AH, two thirds or more of vacancies lasted up to 3-4 weeks (68 per cent RN, 82 per cent EN, 76 per cent CCWs) but for AH only 61 per cent were filled within 4 weeks. Whereas for EN and CCW only 6 per cent of vacancies were reported by outlets as taking longer than 8 weeks to fill, in contrast this was reported for 13 per cent of RN vacancies and 15 per cent of AH vacancies.

Table 6.13: Weeks required by home care and home support outlets to fill most recent vacancy (in outlets with vacancies), by occupation: 2016

% of outlets that took	RN	EN	CCW	AH	All occupations
Less than 1 week	31.3	48.9	12.5	26.5	13.1
1 week	4.6	3.2	9.4	2.4	8.7
2 weeks	8.8	8.6	18.9	7.4	16.0
3 to 4 weeks	23.1	21.4	35.1	24.3	33.5
5 to 8 weeks	19.5	12.2	18.1	24.8	19.5
9 to 12 weeks	7.0	3.5	3.9	7.9	5.5
13 to 26 weeks	4.1	1.1	1.5	5.7	2.7
More than 26 weeks	1.5	1.1	0.6	1.0	0.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.
Outlets that did not report any vacancies were excluded.
N=2,473 outlets (weighted).

Table 6.14 shows that in 2016 there was mixed experience for outlets with a much higher than average vacancy duration for RNs in WA (7.5 weeks) and very slightly higher than average vacancy durations in NSW (4.9 weeks) and Queensland (4.9 weeks). For CCW vacancies, slightly higher than average vacancy durations were reported in WA (4.4 weeks), ACT (4.6

weeks) and marginally higher than average vacancy durations in Victoria (4.3 weeks) and SA (4.3 weeks).

Variation in the average vacancy duration by the outlet's remoteness area location, depending on the occupational classifications was also found. For RN vacancies, outlets in major cities, inner regional areas and also very remote locations reported durations less than the average 4.7 weeks to fill the vacancy. For CCW vacancies, major cities and inner regional located outlets reported durations less than the average 4.1 weeks.

Table 6.14 also shows the median[11] vacancy duration. Contrasting the average with the median can give more information about the distribution of the durations as the median always shows the centre of the distribution. In the case of WA, where the average vacancy duration for RNs was very high (7.5 weeks) the median is much lower at 4 weeks. This indicates that while for half of the outlets in WA the RN vacancies lasted up to 4 weeks (the median), the higher average shows the average was affected by vacancies longer than this. For CCWs, there was a higher average vacancy duration for outlets in outer regional areas (5.6 weeks), and the corresponding median is 3 weeks. This indicates that while for half of the outlets in outer regional areas the CCW vacancies lasted up to 3 weeks, the higher average reflects that it was affected by vacancies that were filled after 5 weeks and longer.

[11]The median is the "middle" of a sorted list of numbers. Hence it can reveal the centre of the durations the outlets reported without distortion. When the median is contrasted with the average if the median is much lower than the average it shows that the average has been affected by cases with longer durations (and also the other way round if the median is much higher than the average then the average has been influenced by the share with shorter durations). Link to the ABS website for further information about measures of central tendency.

Table 6.14: Average and median vacancy duration (weeks) for RNs and CCWs, by State/Territory and location: 2016

		RN	CCW
All outlets	Average	4.7	4.1
State/Territory	NSW	4.9	3.9
	Victoria	3.6	4.3
	Queensland	4.9	4.1
	WA	7.5	4.4
	SA	4.0	4.3
	Tasmania	3.0	3.3
	ACT	1.0	4.6
	NT	0.7	5.5
Location	Major cities of Australia	3.8	3.7
	Inner Regional Australia	4.1	3.2
	Outer Regional Australia	5.8	5.6
	Remote Australia	6.7	4.4
	Very Remote Australia	3.6	6.2
All outlets	Median	3.0	3.0
State/Territory	NSW	4.0	3.0
	Victoria	4.0	4.0
	Queensland	3.0	3.0
	WA	4.0	3.0
	SA	4.0	3.0
	Tasmania	1.0	2.0
	ACT	0.0	3.0
	NT	1.0	3.0
Location	Major cities of Australia	3.0	3.0
	Inner Regional Australia	4.0	3.0
	Outer Regional Australia	3.0	3.0
	Remote Australia	4.0	3.0
	Very Remote Australia	4.0	4.0

Source: Census of home care and home support outlets.
Outlets that did not report any vacancies were excluded.
N=2,473 outlets (weighted).

As vacancies can exist for a variety of reasons, the census asked outlets about the cause(s) for their most recent vacancy for each of the occupations (Table 6.15). As in 2012, the primary reason for an outlet vacancy across all direct care occupations in 2016 was resignation (63 per cent). In the case of CCW vacancies, a quarter of outlets (25 per cent) cited that it was for a new position.

Table 6.15: Proportion of home care and home support outlets giving each reason for their most recent vacancy (per cent), by occupation: 2016

% of outlets stating	RN	CCW	All occupations
New position	5.6	25.3	32.7
Retirement	11.1	18.3	20.7
Injury/illness	7.4	5.4	6.3
Resignation	59.3	54.1	62.7
End of contract	3.7	1.5	3.4
Involuntary separation	0.0	4.6	5.2
Other	20.4	17.7	21.1
Total outlets (weighted)	54	1,581	2,686

Source: Census of home care and home support outlets.
Note: Multiple response allowed, columns will not sum to 100.

The census form asked outlets what was the primary method they used when they recruited CCWs. Table 6.16 summarises their responses (see column 3). Outlets in 2016 most commonly advertised these vacancies through the internet (36 per cent), or the internet and newspaper jointly (30 per cent). Newspaper only advertising was reported by far fewer outlets (10 per cent) as well as the use of word of mouth (10 per cent). Fewer than 5 per cent of outlets reported other alternatives such as walk-ins, agency or job-placement/career service routes.

For recently hired home care and home support workers, the pattern is similar to that found for recently hired residential workers (Table 4.15). Word of mouth and internet job advertisements are the most commonly reported sources of job information for workers in Table 6.16. For nurses, word of mouth is the most common source (41 per cent), while CCWs (41 per cent) and AH workers (52 per cent) are more likely to find their jobs through internet job advertisements. Internet job advertisements have grown in importance since 2012, particularly for CCWs. The increasing use of internet job advertisements has corresponded with a decline in use of newspaper job advertisements as a source of information, and for CCWs, internet job advertisements (41 per cent) appear to have all but replaced job placements and career services (less than 1 per cent) as a source of information. While only 3 per cent of outlets use agencies to recruit CCWs, agency use is far more common among the workers themselves, with 9 per cent of CCWs, 14 per cent of RNs and 13 per cent of AH workers finding out about jobs through agencies.

Table 6.16: Sources of information about recruitment opportunities used by recently hired* home care and home support direct care workers and outlets: 2016 (per cent)

Source of job information	Nurse	CCW		AH
	Worker	Worker	Outlet	Worker
Walk-in	n/a	n/a	3.0	n/a
Word of mouth	40.8	31.4	10.2	20.6
Newspaper job advertisement	15.5	11.2	9.7	6.7
Internet job advertisement	22.5	41.4	35.8	52.0
Both internet and newspaper job advertisement	n/a	n/a	30.2	n/a
Job placement program/career service	1.9	0.3	2.7	0.4
Agency	13.8	9.3	3.1	13.0
Other	2.7	5.2	4.5	5.0
Don’t know	n/a	n/a	0.9	n/a
Total cases (weighted)	856	7,096	2,220	806

Source: Census of home care and home support outlets, and Survey of home care and home support aged care workers (weighted).
Note: Multiple response allowed for workers, columns will not sum to 100.
**Recently hired workers have been employed for 12 months or less.*

6.7 Setting of Employment Conditions

The industrial method used by a home care and home support outlet when setting employment conditions for their workers provides an indication of the degree of flexibility that an organisation can have over working arrangements. Table 6.17 reports the proportions of employees across all home care and home support outlets that are bound by particularly forms of agreement for employee conditions. It should be noted that some of the methods operate in tandem (e.g. awards and agreements) and employers may not recognise the distinctions between them. However, we report the responses as provided by outlets.

Similar to residential aged care but to a lesser extent, the most common method of setting employment conditions is Enterprise Agreement (Table 6.17), with 59 per cent of home care and home support outlets using this method, compared with 79 per cent of residential facilities (Table 4.16). Alongside this, a higher share of home care and home support outlet employees are under Awards (39 per cent, Table 6.17) than in residential facilities (19 per cent, Table 4.16). This pattern has not changed since 2012.

Table 6.17: Industrial methods used by home care and home support outlets to set employment conditions (per cent), by employee occupation: 2016

% of employees with conditions set by method	Nurses	CCW	AH	All occupations
Award	35.6	39.3	43.6	39.1
Enterprise Agreement	61.5	59.1	52.8	59.0
Common Law Contract	1.1	0.7	0.3	0.8
Individual Flexibility Agreement	0.7	0.3	2.8	0.4
Don't Know	1.1	0.6	0.5	0.7
Total	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.

Table 6.18 shows the proportions of home care and home support outlets that reported they supply allowances to their employees. This was a new question added in 2016. Seventy per cent of outlets supply an allowance to employees to account for travel between home care and support appointments. Less than half of outlets (48 per cent) supply a petrol or depreciation allowance for transport costs related to the work home care and support appointments. To offset this some organisations may supply a work car for rostered staff. Slightly less than a fifth of outlets paid allowances for time for travel between home and care/support appointments (17 per cent) and 16 per cent paid no allowances of any type.

Table 6.18: Allowances supplied by home care and home support outlets to employees (per cent): 2016

% of outlets paying allowance to their employees	All outlets
Paid time for travel between care/support appointments	70.1
Paid time for travel between home and care/support appointments	16.7
Petrol/depreciation allowance for transport costs related to care/support appointments	47.5
None of these allowances paid to employees	15.7
Outlets (weighted)	3,049

Source: Census of home care and home support outlets Question A7.
Note: Multiple response allowed, column will not sum to 100.

Table 6.19 reports the proportions of home care and home support outlets that reported they supply allowances to their employees by the remoteness area of the outlet. Differences were found depending on the location of the outlet. Overall, outlets in remote (21 per cent) and especially very remote (36 per cent) locations were less likely to pay allowances to their staff.

Table 6.19: Allowances supplied by home care and home support outlets to employees (per cent) by remoteness area: 2016

% of outlets paying allowance to their employees	Major cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	All outlets
Paid time for travel between care/support appointments	69.0	74.3	72.4	66.7	45.8	70.1
Paid time for travel between home and care/support appointments	15.4	15.0	16.2	24.7	27.8	16.6
Petrol/depreciation allowance for transport costs related to care/support appointments	53.6	49.3	41.6	37.1	19.4	47.5
None of these allowances paid to employees	15.0	12.6	16.3	20.6	36.1	15.9
Total (weighted)	**1,333**	**641**	**681**	**267**	**72**	**3,015**

Source: Census of home care and home support outlets Excludes don't know N=21.
Note: Multiple response allowed, column will not sum to 100.

6.8 Agency, Brokered and Self-employed Staff

In order to supplement an organisation's regular PAYG workforce, workers may be sourced through nursing or employment agencies, other aged care providers, or through networks of independent care workers. We refer to these 'agency', 'brokered' or 'self-employed' employees as 'non-PAYG'. The traditional use of non-PAYG workers is to fill temporary gaps when permanent or casual staff are on leave, or where there is an unexpected vacancy. Outlets may also use non-PAYG workers on a more permanent basis and view them as part of their core staff. Outlets were asked in the census form to provide information about their use of non-PAYG workers, to gain information about the extent to which these workers augment the workforce in home care and home support aged care.

Table 6.20 shows that a minority of home care and home support aged care outlets (27 per cent) used at least one non-PAYG worker in the designated fortnight. This is the same scale of non-PAYG use as in 2012. Of the three types of non-PAYG workers, outlets were most likely to engage brokered workers (15 per cent), with 12 per cent using agency workers and 5 per cent using self-employed workers. This distribution across the types of non-PAYG staff used by outlets is very similar to that of 2012. The bulk of non-PAYG workers were CCWs (21 per cent). Brokered staff are used more often in home care and home support (15 per cent, Table 6.20) than in residential care (8 per cent, Table 4.17).

Table 6.20: Proportion of home care and home support outlets (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	3.2	3.2	0.2	6.5
Enrolled Nurse	0.5	0.7	0.0	1.2
Community Care Worker	8.6	12.7	1.8	21.2
Allied Health	2.0	4.0	2.7	8.3
All occupations	11.8	15.4	4.5	27.1

Source: Census of home care and home support outlets.

Table 6.21 reflects the State and Territory variation in the use of non-PAYG workers by outlets in the two occupations of RN and CCW for the years 2007 to 2016. The proportion of outlets using non-PAYG RNs in 2016 is always less than 10 per cent (overall 7 per cent), whereas for CCWs the rate is strikingly higher with an overall rate of 21 per cent and only one state (NT at 5 per cent) having a low share for non-PAYG CCWs. The States and Territories with higher shares of outlets using non-PAYG RNs were NT (8 per cent), WA (9 per cent) and NSW (8 per cent). Meanwhile the locations with higher usage of non-PAYG CCWs were ACT (45 per cent), WA (26 per cent) and SA (25 per cent).

Table 6.21: Proportion of home care and home support outlets (per cent) using any non-PAYG RNs or CCWs in the designated fortnight, by State/Territory: 2007, 2012 and 2016

State/Territory	RN			CCW		
	2007	2012	2016	2007	2012	2016
NSW	7.5	6.9	7.9	14.3	21.1	23.1
Victoria	1.7	11.9	6.3	13.0	26.8	20.6
Queensland	3.0	9.9	5.8	8.8	14.4	17.6
WA	1.9	5.3	8.6	12.1	18.2	25.7
SA	3.3	1.6	4.4	13.0	27.6	25.3
Tasmania	0.0	5.0	2.8	3.4	21.3	16.1
ACT	7.7	5.3	2.6	15.4	28.1	44.7
NT	3.0	6.9	7.7	6.1	20.7	5.1
All outlets	2.2	7.9	6.6	11.6	21.0	21.3

Source: Census of home care and home support outlets.

In our examination of the non-PAYG workforce in the home care and home support aged care sector, Table 6.22 reports the number of non-PAYG workers employed by outlets in the designated fortnight. Overall 12,103 non-PAYG workers were employed during this time period. Across occupations, non-PAYG CCWs were the most widely used direct care occupation hired by outlets; there were 10,099 non-PAYG CCWs in outlets in the designated fortnight, also reflecting their role as the majority of the home care and home support workforce generally. The next most widely utilised occupation were non-PAYG AH workers of which there were 1,443. This is similar to the 2012 distribution of non-PAYG usage by outlets but a lower scale of use. As discussed above, the majority of non-PAYG workers in home care and home support were brokered. Extremely few nurses were reported to be self-employed but there was a reasonable share of CCWs and AH workers that outlets reported were self-employed.

Table 6.22: Number of non-PAYG workers in home care and home support outlets in the designated fortnight, by occupation: 2016

Occupation	Number of workers			
	Agency	Brokered	Self-employed	Total
RN	226	254	5	**484**
EN	26	49	1	**77**
CCW	2,774	6,586	739	**10,099**
AH	220	787	437	**1,443**
All occupations	3,246	7,676	1,182	**12,103**

Source: Census of home care and home support outlets.
N=3,066 outlets (weighted).

Further questions on the reasons for non-PAYG worker use were added in the 2016 census and are shown in Table 6.23. The two most frequently cited reasons for home care and home support use of agency workers were ‘short-term cover for staff absences’ (66 per cent), followed by being ‘unable to fill vacancies’ (38 per cent). For the use of brokered staff, the most common reasons were ‘matching staff to peaks in service user demand’ (44 per cent), and ‘short-term cover for staff absences’ (43 per cent). Self-employed staff, meanwhile, were most commonly hired to ‘obtain specialist skills’ (45 per cent) and ‘matching staff to peaks in service user demand’ (33 per cent). The reason ‘freeze on permanent staff numbers’ was rarely cited except for self-employed (7 per cent).

Table 6.23: Reasons for using non-PAYG workers in home care and home support outlets in the designated fortnight, by type: 2016

Reason	Agency	Brokered	Self-employed
Matching staff to peaks in service user demand	36.1	44.2	33.1
Short-term cover for staff absences	65.9	42.5	6.6
Covering for maternity leave or annual leave	12.3	12.9	2.2
Unable to fill vacancies	38.4	34.3	8.8
Obtain specialist skills	18.3	29.5	44.9
Freeze on permanent staff numbers	3.2	1.7	6.6
Other reason	7.2	26.1	12.5
Outlets (weighted)	349	464	136

Source: Census of home care and home support aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

6.9 Volunteers in Home Care and Home Support Aged Care

The outlet census collected information on the extent of volunteers in home care and home support aged care programs. Information about the number of volunteers and the hours they contributed in home care and home support outlets, was collected in the census for the first time in 2012. Table 6.24 shows that outlets responding to this question engaged 44,879 volunteers who provided 206,531 hours of service in the designated fortnight. This equates to an average of 29 volunteers per outlet indicating use of volunteers, with each volunteer averaging 4.6 hours for the fortnight.

Table 6.24: Total number of volunteers and volunteer hours worked in home care and home support outlets in the designated fortnight: 2012 and 2016

Year	Volunteer numbers, per fortnight	Volunteer hours, per fortnight	Average number of volunteers per outlet, per fortnight	Average hours per volunteer, per fortnight
2016	44,879	206,531	29	4.6
2012	56,729	258,373	27	4.6

Source: Census of home care and home support outlets. Outlets N=1,536 (weighted).

As shown in Table 6.25, 51 per cent of outlets reported the use of one or more volunteers (the same as in 2012). The distribution of volunteers is fairly consistent for most locations with the exception of remote and very remote areas, where their contribution is lower with 43 per cent of outlets and 11 per cent respectively reporting volunteering activity. The use of volunteers also differs by the ownership type of outlets, with for-profit outlets much less likely to engage volunteers than not-for-profit or government outlets.

Table 6.25: Proportion of home care and home support outlets employing volunteer workers (per cent) in designated fortnight, by location and ownership type: 2016

	% outlets (weighted)
All outlets	50.9
Location	
Major cities of Australia	52.7
Inner Regional Australia	48.8
Outer Regional Australia	52.1
Remote Australia	42.7
Very Remote Australia*	11.1
Ownership type	
Not-for-profit	54.5
For-profit	5.6
Government	45.9

Source: Census of home care and home support outlets.
**Very remote N=8 (weighted).*

A new question was added in the 2016 census to gain a better understanding of what roles were undertaken by volunteers in aged care (Table 6.26). As found in residential facilities, home care and home support outlets most often used volunteers for 'social activity support assistance' (55 per cent). However the use of these roles was less frequent than in residential facilities (at 82 per cent, Table 4.23). A high proportion of home care and home support outlets also had volunteers undertaking roles such as 'planned group activity assistance' (50 per cent Table 6.26, and this was also lower than for residential settings where 68 per cent of facilities used volunteers for this role, Table 4.23) and 'companionship/befriending' (34 per cent almost half of the 64 per cent in residential facilities). However for 'transport assistance', 44 per cent of outlets reported volunteer roles supporting this service, while a smaller share of residential facilities had volunteers undertaking roles of 'transport assistance' (23 per cent, Table 4.23). 'Shopping/appointment assistance' was also more often a volunteer role for home care and home support outlets (20 per cent against 16 per cent of residential facilities reporting this) as was 'meal/preparation assistance' (30 per cent against 6 per cent of residential facilities). Somewhat surprisingly, volunteer roles for 'gardening assistance' were less commonly reported by home care and home support outlets (8 per cent against 15 per cent by residential facilities). Twelve per cent of volunteers provided 'respite care assistance'. Fewer than 10 per cent of home care and home support outlets had volunteers undertake 'domestic activity assistance' (5 per cent), and 'home maintenance assistance' (3 per cent), with these last activities rarely undertaken by volunteers.

Table 6.26: Roles undertaken by volunteer workers in home care and home support outlets (per cent): 2016

	Outlets where volunteers undertaking roles
Domestic activity assistance	4.8
Respite care assistance	11.5
Social activity support assistance	55.3
Planned group activity assistance	50.1
Home maintenance assistance	2.8
Gardening assistance	7.7
Transport assistance	44.2
Shopping/appointment assistance	20.1
Meal/preparation assistance	29.8
Companionship/befriending	34.0
Other	18.8
Total (facilities with volunteers, weighted)	1,536

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100.

6.10 Quality measures in Home Care and Home Support Aged Care

Quality monitoring questions were added within the census in 2016 to give a measure of how the quality of the aged care provision is checked (Table 6.27). The most common form of quality monitoring undertaken by home care and home support outlets was that 'managers or supervisors monitor quality' 78 per cent (86 per cent in residential facilities, Table 4.24), with 'keeping records of feedback or complaints from service users' a second key method reported by 66 per cent of home care and home support outlets (57 per cent in residential facilities). About half of home care and home support outlets (52 per cent) had 'surveys of service users to monitor quality'. This last finding about using surveys is in contrast to residential facilities where just over a third of facilities had surveys of service users (36 per cent, Table 4.24), instead reporting 'accreditation' as the third most preferred method (56 per cent of residential facilities, Table 4.24).

Some quality methods were much less commonly reported by home care and home support outlets than by residential facilities. 'Inspectors from another organisations monitor quality' was found in only 16 per cent of outlets (Table 6.27), which is only half of the 32 per cent of residential facilities who reported this method, Table 4.24). Slightly less than a quarter (22 per cent) of home care and home support outlets used 'external auditing' for monitoring quality, whereas in residential facilities 16 per cent undertook this form of quality monitoring. Similar to residential facilities, slightly less than a quarter said that 'individual employees monitor quality' (22 per cent, Table 6.27) against 20 per cent in residential facilities (Table 4.24). Similar to residential facilities, additional methods of quality monitoring were rarely cited (3 per cent).

Table 6.27: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016

	% of all facilities
Managers or supervisors monitor quality	78.3
Inspectors from another organisation monitor quality	16.2
Individual employees monitor quality	21.5
Keep records of feedback or complaints from service users	66.2
Surveys of service users	52.1
External auditing	21.6
Accreditation	43.7
Other	3.0

Source: Census of home care and home support aged care outlets N=3,049.
Note: Multiple response allowed, column will not sum to 100.

7. Interviews with Direct Care Workers

Key Findings

- In-depth interviews were conducted with 100 direct care workers – 40 mature workers, 30 new hire workers and 30 general workers.
- Most respondents had entered aged care with substantial employment histories. Some reported additional sources of paid work in order to supplement their hours or income.
- Motivations for choosing to enter aged care included a direct interest in the work, job availability, flexible working hours and the potential for future healthcare employment.
- Positive aspects of aged care work included good relationships with clients, making effective use of skills and training, and having autonomy and task diversity.
- Workers reported difficulties in their aged care work, most commonly high workloads and levels of administration. Unsatisfactory working conditions, client care issues, and challenging relationships with managers and co-workers were also reported.
- The majority of respondents wished to remain working within aged care in their current role. Some employees (primarily residential new hire and mature workers) intended to leave the sector to either move to other healthcare settings or retire.
- Effective aged care workers were described as possessing personal qualities and specific skills and qualifications. A range of workers of different ages, gender and cultural background was seen as being beneficial to the sector.
- Adequate staffing and funding, supportive management, positive organisational values and effective workplace policies were seen as contributing to quality client care.
- Respondents had good awareness and understanding of OHS policies and procedures. A quarter of workers expressed OHS concerns in their work, mainly around manual handling techniques, physical hazards and client medication.
- A majority of PCAs and CCWs felt that their Certificate Level III training had equipped them well for their work. Concerns raised about aged care training included the length of courses and placements, a lack of face-to-face training and gaps in content.
- While work-related training was widely available, access was limited in regional/ remote areas. Training in dementia and palliative care was found to be most useful.
- Most workers had extensive responsibilities outside of their aged care work, most commonly caring for children and elderly parents. Strategies used to promote work-life balance included using flexible work arrangements, maintaining boundaries between work and home, and utilising support from family and friends.
- Three emergent themes were raised in the interviews relating to aged care sector reforms and funding, staffing levels in residential facilities, and negative perceptions of aged care work.
- Concerns were raised about the recent aged care reforms including future funding for organisations, possibly leading to reduced service provision and reduced staffing levels, and about re-assessments of clients for higher packages. Home care and home support workers raised concerns about the future sustainability of their organisations and their own employment.

- Concerns were raised regarding staffing levels in residential aged care. Perceptions of insufficient staff numbers and the replacement of RNs with lesser qualified staff were considered to be negatively impacting on resident care.

- Workers were concerned that aged care work was held in low esteem by the general community and those working in other healthcare sectors. Respondents recommended that negative perceptions and working conditions be addressed to make the sector more attractive to potential workers.

Qualitative interviews with 100 direct care workers were undertaken following the aged care workforce survey. These interviews had four primary aims. Firstly, as limited previous research has focused on newly hired and mature workers within aged care, we sought to understand more about their specific experiences of working in the sector. Secondly, a key focus of the qualitative interviews was to investigate issues relating to recruitment and retention in aged care. Thirdly, we sought to explore direct care workers experiences of job satisfaction, knowledge and skills, work-life balance, occupational health and safety, and quality aged care services. Finally, the interviews identified and explored emerging issues for the aged care workforce.

7.1 The Interview Process

Upon completion of the workforce survey, direct care workers were given an opportunity to nominate themselves to take part in a qualitative interview about their experiences of working in the aged care sector. This section outlines the sampling and recruitment strategies undertaken and provides a description of the sample of direct care workers who participated in an interview.

7.1.1 Sampling and Recruitment

A purposive sampling strategy was used to identify eligible participants for the qualitative interviews. In total we aimed to interview 100 aged care workers with equal numbers based in residential and home care and home support facilities/outlets. The sample was then further stratified to oversample our two target groups: new hire workers (who had been working in aged care for a year or less) and mature workers (aged 55 years and older). A third group of general workers (who did not meet the criteria for the other two groups) was also selected. Overall, we aimed to interview 30 new hires, 40 mature workers, and 30 general workers. Within these three groups, we sought to select approximately equal numbers of workers from the two main occupations within aged care - nursing staff (RNs, ENs and nurse practitioners) and care workers (PCAs and CCWs).

The recruitment process for the qualitative component involved randomly generating a sample of workers using the purposive sampling strategy described above. The NILS research team then called potential participants to schedule telephone interviews at a time that was convenient for the participant. Three attempts were made to contact each person and if this was unsuccessful he or she was replaced in the sample. Those who expressed a desire not to take part in an interview were also replaced. This process occurred until interviews with 100 workers were completed.

The interviews were conducted from August to October 2016 and lasted for approximately 30 minutes. A copy of the interview schedule is provided in Appendix 2.

After obtaining consent from each participant, the interviews were digitally recorded and transcribed verbatim by a professional transcription service. The transcribed data were entered into NVivo 11 in order to assist with the management and analysis of the data. Following familiarisation with the data through the reading of the transcripts, a thematic framework was developed and agreed upon by the qualitative research team. This thematic framework was based around the core topics outlined in the interview schedule and included

the main sub-themes which had emerged during the interviews in relation to these topics. The interview transcripts were then coded according to this thematic framework. Key themes were developed and refined throughout the data analysis to enable further emergent categories to be identified.

In order to maintain anonymity, each interviewee was designated an identification number which reflected key attributes of their work sector, employee group and occupation. An identification number with the prefix R indicates a worker from a residential facility, while H indicates a home care and home support worker. The identification suffix identifies the sample group a worker belonged to (with N for new hire, M for mature worker and G for general worker) and their occupational group (RN for registered nurse, EN for enrolled nurse, NP for nurse practitioner, PCA for personal care attendant and CCW for community care worker). Therefore a quote by worker R14M_PCA relates to interview number 14 of the residential workers; and as the suffix is 'M_PCA', this person was a mature worker employed as a PCA.

7.1.2 The Interview Sample

Using the stratification process described above, a randomised sample of employees was selected. Overall, semi-structured interviews were conducted with 100 workers. Of these, residential workers accounted for 52 of the interviews and home care and home support workers for 48 interviews. Across occupational groups, 43 nurses (29 RNs, 11 ENs and 3 NPs) and 57 care staff (31 CCWs and 26 PCAs) were interviewed. Parity with regard to work setting and occupation was unable to be reached due to a relative lack of new hire nurses in the sample, particularly in home care and home support settings (further detail on this is provided below in Section 7.1.2.1).

As planned the total sample included 30 new hires, 40 mature workers and 30 general workers. A description of the workers interviewed in each of these groups is provided below.

7.1.2.1 New hire workers

In total 30 new hire workers were interviewed. Within this group we had aimed to interview equal numbers of nurses and care workers. At the time of recruitment for the qualitative interviews, however, fewer new hire nurses than anticipated nominated themselves to take part in a qualitative interview (in total two new hire nurses in the community and 11 residential nurses). As several of these workers were subsequently unable to be contacted or declined to participate, interviews were only able to be conducted with eight residential new hire nurses (and no nurses from the home care and home support sector). Thus in order achieve a total of 30 new hire interviews, additional CCWs and PCAs were recruited and interviewed.

Thirteen of the new hire workers interviewed were employed in home care and home support outlets (all working as CCWs) and 17 worked in residential care (9 PCAs, 7 RNs and 1 EN). All the new hire interviewees had worked within the sector for a year or less (the shortest tenure was three weeks). The age of these interviewees ranged from 20 to 62 years; including four mature workers who were aged 55 years and older. A fifth of the new hire sample were male workers.

7.1.2.2 Mature workers

Interviews with mature aged care workers were conducted with 20 home care and home support employees (10 CCWs and 10 RNs) and 20 residential workers (10 PCAs, 6 RNs, 3 ENs and 1 NP). These workers were aged from 55 to 72 years of age; 12 workers were aged 55-59 years, 16 were 60-64 years, and 12 were 65 years and older. Experience in the aged care sector ranged from two to 43 years. While several mature aged workers had spent their entire working lives in aged care, around half of the interviewees were relatively new entrants to the sector and had worked in aged care for less than 10 years. The mature worker sample included four males.

7.1.2.3 General workers

The sample of general workers interviewed included 15 home care and home support workers (8 CCWs, 4 ENs and 3 RNs) and 15 residential workers (7 PCAs, 3 RNs, 3 ENs and 2 NPs). The general worker group had between two and 28 years of experience in the sector and their ages ranged from 21 to 54 years. Six of the general worker sample were male.

7.2 Recruitment and Retention in the Aged Care Workforce

Over coming decades the aged care workforce will need to expand considerably if it is to meet the forthcoming anticipated increase in demand for aged care services. It is therefore of primary importance that new workers are attracted to enter the sector and that the retention of the existing workforce is improved. A key aim of the qualitative interviews then was to identify specific issues relating to recruitment and retention in aged care. The interviews examined pathways into aged care including previous work histories, the interviewee’s current role in aged care and whether they held more than one paid job. Motivators of becoming an aged care worker were explored with respondents including the reasons for choosing a career in aged care and for selecting to work in their current organisation. In order to examine issues relating to staff retention, interviewees were asked about positive and negative aspects of their work and also about their career plans over the next three to five years.

7.2.1 Pathways into Aged Care

Only a small number of workers reported that their employment in the aged care sector was their first paid work experience. Typically the majority of respondents had entered the sector following quite substantial employment histories. For the new hire sub-sample, the working backgrounds of CCWs and PCAs was diverse, ranging from factory and cleaning work to employment in the corporate sector. Several of the new hire PCAs reported that while they had previously worked in the aged care sector, this was in non-care related roles, such as kitchen assistants.

> *My pathway is completely very, very different. I have no medical background or nursing background or anything like that, I come from completely a corporate world, and it's a huge switch to move into community services.* (H23N_CCW)

> *I'd actually worked in another aged care facility, but I was actually in the kitchen. So, I was kitchen staffing before I started my nursing and throughout my first year. And, then at the end of the first year I got my certificate and did my placement.* (R33N_PCA)

A majority of new hire nurses had had established long-term careers in other fields of nursing; only three nurses in the sample reported that their role in aged care was their first position as a qualified nurse.

> *I’ve only been in aged care for about 12 months. I've been in general practice for seven years and prior to that, nurse management - well I've been in nurse management per se for the past 20 years, but I've been in the acute sector.* (R21N_RN)

Most aged care workers held only one current paid job in aged care and were not seeking additional sources of employment.

> *No, no, this is my only job…I couldn’t even work five days, I can’t do anymore than - I mean it’s such a physically demanding job…so my body could not do any more than I’m doing now.* (H35N_CCW)

However, reports of having additional paid work on top of their primary aged care role were not uncommon within the sample (particularly for the new hire home care and home support and general workers). Some respondents reported that they combined their direct care work with a different role for the same organisation – these secondary roles included administrative work, primary health nursing, diversional therapy and, for some home care and home support

staff, doing residential nursing or care work. Other workers reported having additional employment with different employers, predominantly casual nursing and care worker roles within aged care. However, several direct care workers were also working in non-aged care related roles in other healthcare sectors, research, retail, labouring and some were running their own businesses.

> *I take two roles under the same company. On different days and different shifts as well…in the afternoon is helping out at the aged care facility, and after 3:00, 4:00 to 6:00 PM or 7:00 PM I'll be helping out at the client's house.* (H21N_CCW)

The need to supplement their income from their primary aged care job was a primary reason given for the taking on of additional work, thus indicating the presence of underemployment in the sector. For others, diversity of work and flexibility were motivations for a second paid job.

> *I think it works for me, it gives me lifestyle. And mental stimulation I think, it prevents burnout in one particular area.* (R27N_RN)

7.2.2 Choosing to Work in Aged Care

When asked why they had chosen to work in aged care, direct care workers from across all three groups described their primary motivations. These included having a direct interest in aged care, job availability and opportunity, flexible working conditions and seeing aged care work as a stepping stone to employment in other healthcare sectors.

Around half of the workers interviewed attributed their decision to work in the sector to an active interest in aged care work. Respondents predominantly described wanting to care for the elderly or deriving enjoyment in working directly with people. For some workers, and particularly those in the community, previous experiences of caring for elderly relatives had led them to view aged care as a viable option for paid work.

> *I had been an at-home mother for 18 years, and so was looking to go back into workforce… I've always worked/enjoyed dealing with aged people, and I knew it was a growth sector.* (H29N_CCW)
>
> *Sort of the reason I went into aged care, I was taking my nan up from Sydney and taking her home and doing all her personal care and everything like that, so I had a lot of compassion there and stuff like that, so I just went into retraining myself to go into aged care.* (H22N_CCW)

For other workers, undertaking care work in other industries led to them viewing employment in the aged care sector favourably. The completion of a placement in aged care as part of a training course had also cemented a decision to work in aged care for several interviewees.

> *I was working in childcare before I went on maternity leave and instead of going back to childcare I decided to try something new.* (H24N_CCW)
>
> *When I was doing my study to get my registration back, I did a placement in an aged care facility, and I was absolutely gobsmacked by how much I enjoyed it. I wouldn't have predicted that. And, I think the other thing is that my mother at that time was in an aged care facility and I just saw how important it is.* (R04M_RN)

Half of the mature-aged and general worker sample (and a smaller proportion of new hire respondents) attributed their decision to work in the sector primarily to the presence of an available position when they were seeking work. Some nursing staff had experienced difficulties in securing work in other areas of nursing due to their location or a difficult job climate while a number of care workers described the aged care sector as *"something that I fell into"* (R48G_PCA).

> *It's going to sound awful, but I'm a new grad nurse, and in WA the job climate is just absolutely ridiculous, there's not a lot going on. We've got a freeze on all public health positions, yeah, and so…that's how we ended up in aged care. Not to say that I don't like it.* (R24N_RN)

It was probably by accident. I'd had a change of career and in the interim, while I was deciding what to do next, I was working for an agency, and as part of that agency employment I got sent to aged care to do some work, and just being exposed to it through the agency I ended up in this area. So I didn't seek it out, it was just where I ended up and I liked it. (R47G_PCA)

The ability to achieve a good work-life balance was a common motivator for entering aged care particularly for respondents in home care and home support settings. Working conditions in aged care were perceived as being fairly flexible, enabling a more effective combining of work and non-work responsibilities.

Well, I wanted something that was through the week. Because before I'd been doing like hotel work or baking and so having a young child, could no longer do weekends or nights, so I wanted something more nine to five, Monday to Friday, and so the days were perfect. And I enjoy working out in the community and meeting new people. (H24N_CCW)

Amongst new hire employees, and particularly those working in residential care, a further common reason for choosing to work in the sector was that it would act as a *"stepping stone"* (R23N_RN) for a career in other areas of healthcare. For most of these respondents, aged care work was seen as a first step towards achieving their ultimate goal of qualifying and/or working as a nurse in the hospital system.

I've always loved the idea of helping others, and my eventual goal is nursing. There was a study opportunity for me to study under a scholarship, and so I kind of grabbed it. It was to study aged care, and I thought that would be a nice gentle ease into the healthcare industry. (H32N_CCW)

In addition to providing information about why they had chosen to enter the sector, some new hire workers described the reasons they had specifically selected to work in a home care and home support setting. Positive perceptions of community aged care (compared to residential care) which had influenced this decision-making included views that a home care and home support setting allowed workers to have more time with their clients, leading to more meaningful interactions and greater job satisfaction. Community aged care was also seen as providing more variety and, due to the lower care needs of clients in that setting, necessitating less intensive care responsibilities.

When I went for my placement in the nursing home, it sort of gave me a scare, like I didn't expect certain things and I was not ready for it, and I was not prepared, and I thought, oh it's not going to work with this being in high care and low care, it's not going to work out for me with the duty of care. But, the community services I came on again is different. I mean, it is attending to aged care people, but it's in their own home. That was much more easier and more fulfilling at end of the day, because you had a one-to-one interaction with the clients, and you sort of build that bonding and you get to know them better, and you can serve better to them personally…yeah that was the driving point for me. (H23N_CCW)

When asked why they had chosen to work for their current employer, most respondents identified that this choice had been a matter of convenience rather than a definite preference. For many the availability of work at the organisation was the key factor informing their decision to work there. Others (mostly new hire workers) had secured their employment with the organisation as a result of doing a placement there as part of their studies.

It was circumstances, they were recruiting at the time and I wanted to get my foot in the door. (R27N_RN)

I was offered a position. I still had to go through a formal application process, in terms of referees and a resume, but I was approached while I was training, if I would be interested in a position. (H32N_CCW)

The location of the work setting was of particular importance to residential workers across all three groups; geographical convenience contributed to many decisions as to which organisation to work for. The location of the workplace was especially important for those who had made a lifestyle decision to move to the country or were seeking a reduced commute

time: *“I like to work in country hospitals, I don't like working the bigger ones, and I saw this position come up, so yeah. And, I needed to come closer to home for work*” (R10M_RN).

Having had personal contacts within an aged care organisation that had facilitated work opportunities was a further reason noted by several respondents in their choice of employer.

> *Well, we have limited areas available over here, being in the country, for employment…I had friends working out there as well and they said, "They're looking for more people. Put an application in and see how you go." And, yeah that's how I started, I put an application in and I'm still there today.* (R45G_PCA)

Finally a minority of workers reported that an existing positive perception of the organisation had influenced their choice of workplace. Their organisation was seen as having a good reputation and values they admired, provided good quality patient care or was perceived to give their staff job stability and diversity of work experience.

> *Because I actually liked their values, their set of beliefs. It's pride, respect, resilience, teamwork, empathy and trust. I thought, if that's true then that's the place I want to work for.* (R06M_NP)
>
> *I chose to move to [Name of organisation] because…I prefer to work… where you get a range of different clients.* (H20M_CCW)

7.2.3 Job Satisfaction

In order to inform understanding of factors which influence workforce retention in aged care, the interviews explored job satisfaction in the sector. Interviewees were asked about the elements of their work that they liked best. The interviews also examined aspects of aged care work that were perceived to be difficult or stressful, the impact these issues had on the workers themselves and their daily work, and the strategies used to deal with these difficulties.

7.2.3.1 Positive aspects

When asked what they liked best about their work, direct care workers most frequently described the close relationships and interactions they had with their clients.

> *It’s the residents. I think once you start doing a job like (this) and you become involved, you recognise their individual personalities and their sense of humour and just everything.* (R14M_PCA)
>
> *Now I'm in community care, I feel I get more of that one-on-one time to socialise with people…when I became involved with people in residential care, I'd have five minutes with them before it was moving onto the next thing, and so I felt like I was being rushed in that sense...Whereas, now that I'm in home care some of my clients I'm with them for an hour, I'm with some of my clients for three hours, so I feel like I get so much time to get to know them, and spend that time with them I suppose.* (H32N_CCW)

The sense of fulfilment gained from knowing that they were making an important difference to the quality of the lives of older people was a further important aspect of job satisfaction for the workers interviewed. For respondents in the community, the understanding that they were helping their clients to remain living in their own homes was also valued.

> *You make a difference because they’re able to stay at home. If those services weren’t in place they wouldn’t be able to stay at home.* (H47G_CCW)

Specific aspects of aged care work which led positively to job satisfaction were also discussed by many interviewees (and particularly by those working in home care and home support settings and by residential nursing staff). These workers appreciated being able to effectively use their skills and training, make autonomous care decisions, and have diversity in their day-to-day work.

[I like] the fact that it's different every day. The fact that you get to be autonomous in your role here, and when I say that you don't have doctors sort of over you managing the situation. You're able to use your clinical expertise which you wouldn't be able to do in a hospital system. (R40G_NP)

Further positive aspects of working in aged care that were highlighted by interviewees included having good relationships with co-workers and valuing the teamwork which occurred within an organisation to provide quality client care. Supportive relationships with management and flexible working conditions were also noted by a small number of interviewees.

We've got a really lovely team and we don't let anything stress us or anything and we work as a team to, like, the best we can and to meet all the client's needs, you know. (H22N_CCW)

The managers and everyone is really good, like they appreciate what we do, whereas in other places you just don't get appreciated, which is important I think to get appreciated. So especially with the job like carer, which is really hard, like physically and mentally draining. So it's very important to get appreciated for your work I think. (R29N_PCA)

7.2.3.2 Negative aspects

While a small proportion of workers reported that there was nothing difficult or stressful about their work, the majority of interviewees identified negative aspects of working in aged care. Excessive workload and perceived time stress was a significant issue for many workers. High workloads were attributed to inadequate staffing numbers (particularly in residential settings) and excessive amounts of administrative tasks and paperwork. Levels of administration were considered by some workers (and particularly those in home care and home support outlets) to have increased with recent changes to the sector.

It's usually very, very busy and I think you're just constantly in a state of juggling multiple demands on your time that are often in conflict, and that can be stressful. (R04M_RN)

The most difficult and stressful would be the amount of administration that's required now, from the government basically. And, the regulations and the referral pathways and systems that are being put in place without the support, because that's impacting on patient care. (H38G_RN)

The difficulties caused by high workloads led many in the sample to undertake significant amounts of overtime and unpaid work or to be unable to take available leave. High staff workloads were also perceived to impact negatively on the care received by clients.

Well, you have to shortcut and that's the only honest answer I can give you, you have to shortcut. You don't have the time to do everything that you would like to do and that we should be doing for these residents. (R12M_PCA)

Some respondents reported feeling overwhelmed and unable to address underlying work pressures: "*because nurses don't complain, we're our own worst enemies, at least a few of us*" (R08M_RN). Other direct care workers related strategies utilised for dealing with excessive work responsibilities. These included leaving the work for the next shift, getting help from or delegating tasks to other staff, prioritising activities that needed to be done, and delaying spending quality time with residents until urgent tasks had been completed. Others felt impelled to be assertive in advocating for change: *"So I am fairly vocal with things that I don't like, and I think that's a personality experience thing, and so far, it's worked"* (H17M_CCW)

Working conditions and arrangements were a further source of stress for many aged care workers. Respondents across all settings and occupations were unhappy about the rates of pay in the sector, comparing their pay rates unfavourably to those offered in different settings.

One of the issues that I think all of us have as care workers is the pay rates. It's not very good…For what we do I don't think we are paid enough and I'm not being greedy. (H25N_CCW)

Further issues relating to working conditions in aged care were raised by home care and home support staff (and predominantly CCWs). Insecure employment – in the form of casual contracts, insufficient hours, being on-call, irregular rosters and split shifts – was a major source of stress for these workers. A lack of financial compensation for travel time when commuting between clients' houses was a further frustration expressed by some home care and home support workers.

> *You might have 10 hours today and next week it's only 15, and next week could be 20 and then back to zero…That would be much easier for me to know that every day I got a normal 35 hour shift, to be able to live out of that. But I understand that it's not the way it is and at the moment it makes things difficult for me, because I need to think of the future too, and eventually I might have to do some other stuff to have a budget to live on.* (H31N_CCW)

> *The other day…they wanted me to drive 20 kilometres to do a one-hour service and then drive back home sit around for three hours, well, be off work for three hours, and then go back to the same place 20 kilometres away and work for two hours, and then again come home and have an hour off and then go off and do two more hours work of an evening.* (H17M_CCW)

Interviewees also commonly raised specific concerns about their work with clients and their families. The deteriorating health and death of clients was perceived to be emotionally draining. Workers also reported finding the care needs or challenging behaviours of some clients difficult to deal with; this was particularly pertinent for those working in palliative and dementia care. In addition some respondents expressed concern that unreasonable expectations of clients or family members negatively impacted upon job satisfaction. In order to deal with the psychological impact of these stressors, workers reported relying upon their support networks from both inside and outside their work environment.

> *Since I've started there we've had a few pass on, so we as PCAs tend to have a bit of a chat and remember good things, bad things, funny things, strange things, whatever it is about those residents. When we're working we have a chat and when we are at lunch or dinner we'll often have a few chats, and I'm lucky I've got quite a few friends that are all nurses, so I can speak quite discretely with them about feelings I'm having and not having and go through the process. I'm quite lucky that I've got a large support system around me, at work and outside.* (R31N_PCA)

Difficulties relating to relationships with co-workers and management were a further source of stress for some direct care workers. Some co-workers were perceived as having negative attitudes to their fellow colleagues and providing poor quality care to their clients. Dissatisfaction with management was also reported by several workers. This ranged from concerns about decision-making by senior staff, the absence of supervision and frustrations about the quality of management (including not listening to, understanding or respecting the experience of care staff).

> *There are some staff which didn't attain at least a Cert III in aged care or community service. They just joined the organisation but they've been working with the company for 18 years. So they do things their way, but from my perspective, sometimes I see them carrying out the task but I feel that it's very dangerous for the client.* (H21N_CCW)

> *They [management] sit in the office and have a meeting and then make their decisions from that rather than actually (having) the knowledge of what goes on.* (R12M_PCA)

7.2.4 Retention in the Aged Care Workforce

When questioned about their future work plans, around three-quarters of direct care workers (and all but one of the home care and home support new hire staff) expressed a desire to remain working in the sector over the next three to five years. These workers frequently cited enjoyment in their work, positive relationships with clients, and satisfaction with their current employer as contributing to this intention to stay. Some mature-aged workers also reported wanting to stay in aged care in order to complete on-going projects or promote improvements within their organisation.

I can see myself still working for the same organisation. I really enjoy working here and I enjoy the people I work with. It's a good work environment. You've got a lot of support. I can't see me being anywhere else. (H43G_CCW)

I'd love to achieve, what I'm chasing now for our unit, is a better practice award. I've come home from this…conference with a bit of a new module of care in my mind, which I want to implement. (H04M_RN)

Most employees who intended to remain in aged care expected to maintain the same position with their current organisation. Other respondents hoped to pursue other roles within aged care including taking on, or extending, managerial responsibilities. Some staff also planned to undertake further education and training to enhance their skills and job opportunities. This included several CCWs and PCAs, who were either currently undertaking, or expressed a future desire to start, a nursing qualification.

With home care I'm not really getting anywhere further. I would like to go further in my career. I'm looking into becoming a nurse, because that's just the next step up from being an aged care carer. (H46G_CCW)

Maybe doing some stints in a managerial role and especially knowing, in aged care about the budgeting and all the sort of administration that goes behind running a nursing home, the healthcare management. (R27N_RN)

While the vast majority of mature-aged and general workers wanted to remain working with their current employer, some new hire respondents expressed a desire to move to a different aged care organisation. The reasons provided for this proposed move included finding a facility that was closer to home, working in a setting that better matched their personal values, and moving into the community aged care sector.

I really want to really get into palliative care in community work. I have done it as a placement, absolutely loved it. Just not quite sure how I'm getting there, but that's my focus right now. (R25N_RN)

For a small number of new hire respondents (and particularly those working for home care and home support organisations) their future work goals in aged care included improving their working conditions through obtaining more secure employment, increasing their hours or improving rates of pay.

It's because I'm casual, like it's really quite simple, like at least 20 hours, but it's not constant and I sometimes get ten hours, sometimes get 15, so it's just being casual, yeah…I would really prefer to have at least 20 hours per week…Yeah, I'm keen to be a permanent part-time. (H23N_CCW)

If a public facility was to offer the same sort of hours and close to home and salary packaging, and the rate of pay that my nursing federation award gives us – because the private actually pay less – I would move. Because they will give me my full awards rate and they would pay me penalties right through Sunday nights, Monday morning where my facility will only pay Sunday rates till midnight on Sunday…So I suppose, you know, for wages wise and pay I would move. (R27N_RN)

Although several older workers (including some aged 65 years and older) were keen to remain in their roles in aged care, they acknowledged that their future capacity to manage the work was dependent on maintaining their health and fitness as they aged.

Providing my fitness and ability to do the job continues I would continue as long as possible in the industry…I do see that in other workers, that people don't always make it to retirement age in the aged care industry. But having said that, as basically unskilled workers they wouldn't have made it in probably any other industry that requires them to be on their feet all day. It's probably not specific to aged care. (R47G_PCA)

I would like to work until the day I die. I really - as long as I'm fit, because I'm pretty fit, as long as I'm fit and well enough. (R01M_EN)

However, not all respondents planned to remain working within aged care in the longer-term. Intentions to leave aged care were particularly prevalent for residential new hire workers and older workers. A fifth of the new hire workers (mostly residential staff) reported that they planned to leave the sector. Although most were aiming to move into hospital nursing, some were considering a return to aged care once they had expanded their skill set in an acute setting.

> *I'm a new grad that was hoping to get into a hospital…I'm learning a lot and getting to use my clinical skills. So basically just working on doing well at this position and I would still like to get into a hospital. ED is my main goal. But I'm certainly making the most of the job while I'm here. (R24N_RN)*
>
> *I'm not sure if I'll stay in this role for that long. Probably towards the next year or so I'll be staying in here but then I'll be moving over into something else. Just because I'm going into arts and business and that sort of side of things.* (H33N_CCW)

For many in the mature aged cohort retirement was foremost in their minds, with almost half of the sample reporting expectations of retiring in the next three to five years. In some cases poor health or existing workplace injuries were forcing this decision. Some had already begun to make active plans for this transition, for example reducing their hours of work.

> *I just felt really tired…I've got to that 25-year milestone and I thought…"oh no I can't do this anymore. It's been a great job, but I just can't do it anymore*. (H03M_RN)
>
> *My plan is in five years' time, I'm going to be out of here, because I'm already 56 and I've got that many injuries…a couple of whiplash injuries and got multiple fractures in my upper back and six bulging discs in my lower back. And I've got bursitis in my hips and in my shoulders…And my plan for probably next year is to try and find a part-time job, so that I can work part-time for the next five years before I retire.* (R06M_NP)

7.3 Experiences of Working in Aged Care

A further aim of the qualitative interviews was to understand the experiences of direct care workers in relation to quality in aged care, occupational health and safety, job satisfaction, knowledge and skills, and work-life balance.

7.3.1 Quality Aged Care Services

The interviews examined worker perspectives on quality within aged care. Specifically respondents were asked about the characteristics, skills and qualifications that make a good aged care worker. At an organisational level, the factors which enable an aged care outlet to provide quality care to its clients were also discussed.

7.3.1.1 Characteristics of good aged care workers

When respondents were asked about their perception of what makes a good aged care worker, overwhelmingly they spoke about particular "qualities" a person needed to have to be able to work with older people. Possessing personal qualities such as patience, understanding, compassion and empathy were seen as being more important than other characteristics such as aged care skills: "*Well, skills can be taught but a personality can't*" (R23N_RN). Qualities relating to aged care work itself - having a strong work ethic, being a team player, having a willingness to learn and a desire to work with older people – were also valued highly.

To a lesser extent, respondents discussed factors relating to skills and qualifications when describing what makes a good aged care worker. Core skills perceived to be important in aged care work included effective communication, being person rather than task-focused, literacy skills, good time management, conflict resolution skills and being organised. For nursing staff, being comfortable with autonomy and decision-making was also seen as being vital. Many respondents (and particularly those who had been working for longer in the sector) stressed

the importance of minimum requirements for workers to hold a Certificate Level III aged care qualification. However, as discussed below in Section 7.3.3, reservations were expressed regarding the quality of some certificate level courses. Consequently, respondents stressed the importance of care workers also having hands-on experience and ongoing work-related training.

> *I think you just need to be the right sort of person, so qualifications help with knowledge and when you get into situations, but it's as much to do with experience as the qualification.* (H17M_CCW)

Socio-demographic factors such as age, gender and culture were felt to play a minor role as to whether or not someone was a good aged care worker. Having both younger and older workers in the sector was thought to offer benefits to client care. Older workers were seen as contributing valuable life experience and reliability (in presenting for shifts and loyalty to the organisation). Clients were also often reported to be more comfortable working with mature workers. In contrast, younger workers were perceived to bring energy and be a *"breath of fresh air"* (R21N_RN) to the sector.

> *The young ones that work at our facility they're very good. They're very, very caring and most of them want to be nurses so they've got that nurse personality, so very caring.* (R13M_PCA)
>
> *Some of the elderly that we look after prefer to have an older carer because they might be embarrassed about their incontinence or things like that.* (R21N_RN)

Likewise, although the gender of an aged care worker was recognised to be a barrier for some older people (e.g. if they preferred to have their personal care needs undertaken by a male or female worker), on the whole respondents welcomed a mix of both male and female workers in the sector. Some respondents believed that the sector would benefit from more men entering aged care work, particularly with regard to assisting with the care needs of male clients. Male workers were seen as being as competent and skilled as female workers and were particularly valued for their perceived ability to deter threatening behaviour from clients and being able to assist with tasks which required physical strength such as client transfers.

> *Well, a lot of our residents, if they're female, they really struggle with having a male carer. We do have, there's one particular carer that's male that I work with quite a lot. He's absolutely amazing, he's brilliant, and he's very good at helping those ladies that don't really want a male person showering them, and he's very understanding with that, and if it's too much for them, he just steps back.* (H36G_EN)
>
> *In a lot of ways in so many situations we need the men because there are clients that only want to go out with guys. They want to go down the pub or whatever and they want to be with a guy. At our service we're in a coastal area and there are men that all used to be surfers and beach goers and they need to have a carer that's got more strength to help them down the beach and places like that.* (H44G_CCW)

While respondents reported overall that a worker's cultural background made little contribution as to whether they provided good care or not, having staff who shared a mutual language and cultural background with CALD clients was considered a favourable employee characteristic. The importance of English proficiency in an aged care worker, however, was also thought important by some respondents in order to aid communication with clients.

> *My last facility…was more of a multicultural facility, and staff as well, and certainly if we have staff on that are multicultural and actually can speak a native language to a resident who kind of reverts back to their native tongue in dementia, it's a great resource.* (R39G_NP)

7.3.1.2 Factors enabling aged care organisations to provide quality care

The factor most emphasised by respondents as enabling aged care providers to deliver quality care was the presence of adequate levels of skilled staff. In particular, organisations were seen as needing the ability to cover shifts when staff were absent rather than relying on agency

and casual staff or working short-staffed. Negative impacts of inadequate staffing on client care are discussed further in Section 7.4.2.

> *I think that's the biggest thing, if you have adequate staff and staff that are trained properly, they're able to do their job the best they can.* (H32N_CCW)

Many respondents also noted the importance of good management in contributing to the provision of high quality aged care. Many reported the need for managers to value staff skills and experience, to promote lines of communication with their staff, and to listen to and advocate for their workers. This was thought vital in supporting good teamwork and a respectful and well-functioning workplace. Other respondents suggested effective management provided good oversight and supervision to ensure quality of care, and supported flexible and innovative care options. It was also considered important that managers personally have previous direct care work experience in order to be able to make decisions that lead to quality care.

> *Excellent management. You need good managers because without a good manager, the ship just doesn't go.* (R01M_EN)
>
> *Our manager there worked on the floor for a long time before she took on a management role so she's quite sympathetic to us and she understands. She's quite good. But the higher-ups in the company…are there for the bottom line rather than for the care of the residents I think.* (R23N_RN)

Adequate funding for aged care services was seen as impacting upon an organisation's ability to provide quality care. Appropriate levels of aged care funding (as further described in Section 7.4.1) were important in enabling good staffing levels and also in improving care in residential settings through an enhanced physical environment (e.g. large rooms for residents), a broad range of resident activities and the ability to purchase and maintain specialised equipment.

> *They're quite generous with their funding, so if we feel we need a piece of equipment for a resident, we can get it. So, if I felt if someone needed a pressure mattress, we would have it, if I felt someone needed a specialised wound product we would get it. So, yes they are very accommodating from that point of view.* (R38G_RN)

Some respondents (and especially the mature workers) noted the importance of organisational values in supporting quality client care. Evidence of positive values included communicating expectations of high quality care to staff, providing access to ongoing training, and demonstrating clear accountability (e.g. being responsive when problems occurred). Several respondents highlighted the perceived differences in operational imperatives between for-profit and not-for-profit aged care providers; in order to provide quality aged care services it was seen as being important that organisations prioritised the needs of their clients rather than be driven by business practices.

> *It's always the values of the organisation. It's also the staff. It's the culture of the organisation. What they promote as good care, acceptable care, and the standards that they expect of their staff.* (H01M_RN)

Finally, effective workplace policies and procedures were thought to be core components of a good aged care organisation and assisted in the provision of quality care. Respondents recommended that these policies and procedures should follow best practice, be well-structured and clear, and easily accessible to staff members.

> *Ours (policies and guidelines) up until recently were a little bit outdated, and they've all just been reviewed, basically the whole file got turned upside down and shaken out. And they all got reviewed and rewritten and it has made a vast improvement with the procedure for a lot of the care practices, just being improved and updated, and yeah being monitored to make sure that it's the best practice.* (H36G_EN)

7.3.2 Occupational Health and Safety

The qualitative interviews explored issues relating to occupational health and safety (OHS) in aged care. Interviewees were asked about the OHS policies and procedures in their workplace, how these were communicated to staff, and how well these policies and procedures were working. Participants were also questioned about concerns relating to health and safety in their work and, if raised, the responsiveness of their employer to these issues.

7.3.2.1 OHS policies and procedures in the workplace

Awareness and understanding of OHS policies and procedures in the workplace was high amongst interviewees (including the newly hired workers). These included policies and procedures on manual handling and use of equipment, fire safety, first aid, infection control and hygiene, medication management, and chemical spills and waste disposal. For workers based in the community, policies and procedures were also reported regarding home risk assessments and travel.

Respondents advised that a range of methods were used to communicate information about OHS policies and procedures to staff. The interviews suggested that most organisations undertook initial communication of these policies and procedures at the point of employee induction, followed by annual refresher training (conducted either online or face-to-face). Concerns were raised, however, around access to, and the level and quality of, this training. Some respondents felt that face-to-face training days for staff were occurring less frequently, or not at all in some organisations, attributing this to funding constraints. Others thought that some areas of health and safety – specifically manual handling – were inadequately covered in online modules or in passive face-to-face presentations. Some respondents observed that they were either expected to complete the OHS training in their own time or struggled to attend sessions in worktime due to workload pressures.

> *I think it's something that has to be learnt on the job. You can sit in the classroom and learn something, but I think manual handling and support and all that has to be done on the floor. (*H20M_CCW)
>
> *…so we get a half an hour training during our break sometimes, which I find it a bit hard to cope with because we are trying to have a break and they want us to come for training.* (R29N_PCA)

Respondents suggested OHS policies and procedures were easily accessible in their workplaces. In some cases they were in electronic format: *"You can always go to the computer and if you're not sure what the rules and regulations are you can always access it"* (R09M_RN). Others reported that hard copies of manuals and other OHS documents were centrally placed (e.g. in staff rooms or offices), or noted that some policies were posted to office walls. Changes to OHS policies and procedures were typically communicated to staff at their regular staff meetings or through emails, communication books and message boards.

In addition to the direct reporting of OHS issues, most respondents noted their organisation had administrative procedures in place relating to the reporting of health and safety concerns. These took the form of client and personal incident reports and hazard reporting forms. Completion of these forms ensured concerns were logged and forwarded to site managers. The majority of respondents in both residential and home care and home support settings were satisfied with how well OHS policies and procedures were operating in their workplace. The value of these processes in protecting staff and clients well-being was also recognised.

> *I think some of them [the OHS policies] are a little bit overkill, but…rather be you have it than you don't, because it protects you, it protects the client, it protects your business.* (H45G_CCW)

7.3.2.2 OHS concerns in aged care

While most direct care workers felt that their workplace was a safe environment, around a quarter of those interviewed raised OHS concerns. These concerns were predominantly about co-workers not following appropriate procedures such as manual handling techniques. This was attributed to a lack of available equipment or poor room design not allowing the use of equipment, as well as workers choosing to ignore directives. Furthermore the pressure of work demands was seen as leading to workers rushing their job tasks and staff shortages meant that staff were working alone rather alongside co-workers; these were additional factors which contributed to breaches in OHS protocols. Home care and home support workers also raised specific concerns relating to physical hazards in and around client's homes, a lack of oversight of client medications, and an observation of elder abuse.

Some PCAs also acknowledged that they themselves did not follow recommended OHS protocols due to work pressures when working with residents.

> *These days more and more people are getting sick, so meaning to say we are understaffed. So, by the time that I have to call someone to help me lift one resident and then other carers are engaged with the other residents, I have to find another way to help the resident to stand up, and it's difficult, or else I have to wait for them, when they're going to finish.* (R52N_PCA)
>
> *You become tired, your attention span isn't the same, you take risks and then someone else is hurt, which (has) proved true.* (R20M_PCA)

A fifth of the mature-aged respondents (mostly, but not exclusively, CCWs and PCAs) described having health problems or injuries which were thought related to having worked in aged care for an extended time. Several noted that their conditions were in part a consequence of less stringent policies around manual handling and lifting in previous years. The cumulative stress caused by constant overwork was also reported to have taken an emotional toll for some older workers.

> *I remember all those stupid lifts that they used to make us do when we were younger…They killed our bodies by making us lift patients around. We followed all the rules, we did what they told us to do…It wasn't that we did anything wrong, but by using our body as a lifting machine for years and years, now everyone my age that's been in nursing for years, it's taken its toll. I haven't fell over at work or had a bad accident or anything like that, it's just wear and tear and general deterioration. It's just cracked from working too hard.* (R06M_NP)
>
> *I work a lot of unpaid overtime, I'm certainly stressed, everybody's stressed but yes, it takes a toll over years and years and years of doing this. Things are getting worse not better, so it takes an emotional toll.* (R03M_RN)

Respondents discussed how management in their workplace had responded to OHS concerns which had been reported by themselves, other staff or clients. On the whole satisfaction was expressed that these concerns had been responded to quickly and remedied if possible. Actions undertaken to address OHS concerns included removing hazards, providing more carer hours, organising training or making adjustments to existing policies and procedures. Staff also described the role of facility health and safety representatives in ensuring OHS practices were followed.

> *Any risks that arise are dealt with straight away, any hazards, and management's usually onto any hazards pretty quickly. If we find something that we deem as a worker as a hazard or a risk, we document it straight away, and it's pretty much followed up within a day.* (R45G_PCA)
>
> *We have health and safety representatives all around and they're actually, they're very good. We have one there…and she's actually brilliant. She's right onto it with the people especially if they're not doing anything safely or, she's jumps on them, reports them straightway. She doesn't muck around.* (R13M_PCA)

A lack of management and organisational responsiveness to health and safety concerns, however, was expressed by some workers. These interviewees reported feeling that their

concerns were not being adequately heard and a subsequent lack of action or follow-up had occurred.

> *When these people are getting injured I went to the boss at OH&S, at that time. I said, 'Look, these people are working short, you're going to have trouble. More people are going to get hurt' and he said, 'Well, look, I've got this pie here and this pie is all full. I have no more money.'* (R20M_PCA)

7.3.3 Training and Skills

The qualitative interviews examined issues relating to aged care training and skills. Interviewees were asked about any specific qualifications in aged care that they had undertaken and how well they felt this training had equipped them to work in the sector. The extent that employers supported their staff to do work-related training was also explored as well as the kinds of training direct care workers found most useful for their work.

7.3.3.1 Aged care qualifications

The majority of nurses in the sample did not report holding any aged care specific qualifications, in addition to relevant training received as part of their primary nursing qualification. A small number, however, indicated they had done further post-qualifying training including courses in dementia, mental health, gerontology, and aspects of aged care (continence and wound care).

Some nurses felt that their nursing qualification provided an appropriate basis of their work in aged care, considering their university studies gave: *"a foundation, I think, as with any training should do. You've got to go in with that theory before you apply it to the practical"* (R02M_EN). However, most nursing staff reported that university-level nurse training was too narrowly focused to prepare new entrants for the complexities of working with older people; many instead recommended that nurses in both home care and home support and residential settings have prior practical experience of working with older people before moving into the aged care sector.

> *Aged care is totally different from your normal kind of patient I suppose, because you've got different challenges, it's just not them being sick; it's them being elderly, mobility, (and) communication. And, I think that if you're not or you don't have the right training, even as far as your nurses, we find a very high turnover.* (H05M_RN)

All of the PCAs and a majority of the CCWs interviewed held certificate-level qualifications in aged care. Of the remaining CCWs, some had certificates in other fields of care work including home and community care, disability, health services and child care. The majority of care workers who held aged care qualifications (including many of the new hire group) reported that the training had equipped them well for their subsequent work in the sector. In particular, the course placement undertaken as part of a certificate-level qualification was viewed as being very important in highlighting the realities of aged work. Respondents, however, acknowledged that there were some aspects of care work (such as behaviour management and techniques for working with people with dementia) that could only be learned on the job.

> *I think with this kind of job it needs to be more hands-on training. The Certificate III gives you only the theoretical part of it whereas when you go for placement it gives you the practical part of it. You learn every day I think with this work. You can't just train a carer to be a carer in six months, that's impossible.* (R29N_PCA)

A minority of respondents raised serious concerns about the quality of some certificate-level qualifications in aged care. These included a perception of the declining quality of certificate training with reports of shorter courses and reduced placement times, ineffective online training and significant gaps in the content of courses (e.g. communication skills, behaviour management, dementia care).

I went to a school in north Melbourne. They were a kind of Mickey Mouse school. There's plenty of us. What I know about aged care I think I learned about working there, being not at school. (R34N_PCA)

The standard of training for staff to work in aged care is getting poorer. A person can virtually walk off the street, do sometimes an online course in aged care, and in they come. There's no, from what I can see, no basic standard for these people to achieve. (R02M_EN)

7.3.3.2 Work-related training

The majority of direct care workers interviewed reported that their employer supported them to do work-related training. This included induction training for new staff, mandatory training courses and professional development activities. Support provided by employers to enable their workers to undertake additional training included offering training in-house, disseminating information about training courses, paying for staff time or flexible rostering and, to a lesser extent, funding course fees. Barriers to training were reported by some interviewees including having to undertake training in their own time and a lack of access to training in regional and rural areas.

It's hard for training in regional areas…you have to travel a fair bit for proper training…that is expensive with travel and then accommodation…and expenses aren't reflected in our funding, because they don't care that we live 400 kilometres away from our nearest big centre. (H45G_CCW)

The new hire workers in the sample described the induction training they had received upon commencing their employment in aged care. Induction processes took various forms from full day intensive training, shorter periods of training held over several weeks and the use of buddy shifts with more experienced staff. Induction training commonly included the provision of information about the organisation and its workplace policies and procedures, as well as mandatory training on issues such as manual handling and fire safety. Some criticisms were made regarding induction training with several new hire workers commenting that they would have preferred to receive more initial training or buddy shifts. Furthermore some home care and home support workers felt that their induction training was modelled on a residential rather than a community care setting. Overall, however, most new hire workers found their induction training to be satisfactory.

When I started, we do what they call a buddy shift so I go out with the more experienced carers. I think I did that for about a week, all the different carers, and they explain as you go what they're doing, what you have to do. That was very good. (H25N_CCW)

With regard to work-related training beyond induction, workers reported that most of this training was typically of good quality and of direct relevance to their day-to-day work. Respondents had especially valued opportunities for training in dementia and palliative care; courses in wound management, manual handling, mental health and first aid were also thought to be useful. New hire staff identified topics for further training that would be beneficial in their work and enable them to become more effective aged care workers. This included training on aged care practices (dementia and palliative care, chronic disease management, medication and wound management, first aid) and skills (behaviour management, communication with clients and families, and time management).

I'm fairly new to aged care so there is a big gap there in my knowledge. Yeah, so anything to do with aged care and Parkinson's, dementia management, that kind of thing…I'm very lucky, I'm actually exposed to lots of experts. So they provide lots of onsite training and education. I get invited to symposiums and forums and things like that, so I'm really very lucky. (R21_RN)

7.3.4 Work-life Balance

The final area examined in the qualitative interviews related to work-life balance. Interviewees were asked about the responsibilities and activities they had outside of their work in aged care and how they managed to combine these with their work responsibilities. The most common out-of-work responsibility reported by respondents was the care of family members (primarily children and elderly parents). Other non-work responsibilities and activities undertaken by the sample included studying, business interests, community activities and volunteer work, sport and fitness, and social and recreation activities.

Many workers were able to identify strategies they employed to successfully combine their work and non-work responsibilities. Most frequently cited was taking advantage of the flexibility in working hours or rostering offered by their employer. Part-time work, and having a set shift pattern assisted caring responsibilities to be achieved. Many respondents also noted that their employers where possible adapted rosters to fit in with staff needs or allowed workers to have time off if required. Some home care and home support workers described being able to work "school hours", a major factor that had determined their choice to work in community rather than residential aged care.

> *I've negotiated to have the one Friday off a fortnight, because my parents are ageing and sometimes you've got to spend time with them or take them for appointments.* (R06M_NP)
>
> *When [my supervisors] realised that my husband and I had split up and whilst I needed a really steady income I also had limitations on my time and they customised my roster so that it was almost entirely school hours…Working in an aged care facility would be different because you've got very fixed rosters and none of them are family-friendly…home care is definitely the way to go for me with younger children at home.* (H30N_CCW)

Further strategies centred on the creation and upholding of boundaries between work and home-life including not taking work home, leaving work on time and choosing not to work on weekends. Support was also obtained from family and friends to assist with caring responsibilities and household tasks. Keeping fit and healthy for both work and non-work activities through a good diet and regular exercise was a final strategy reported by some respondents.

> *I didn't have a very healthy work life balance originally and I spent most of my days at work and nights, and that soon wore thin…I've got a very good dear friend who's my deputy here and she makes me go home on time too, and she doesn't allow me not to, and so I get to five o'clock and I'm out the door now.* (R40G_NP)
>
> *I've got a very supporting husband…(he) works permanent very early mornings, so luckily he's home in the afternoon so that I predominantly do an afternoon shift, which is a short shift, a 4 o'clock till 9 o'clock at night. He does a lot of the afterschool runnings, pickups, gets dinner ready sometimes as well, so I'm lucky that I've got someone that can do that without asking or paying for extra care…It's finding that balance which works.* (R31N_PCA)

Barriers to a successful work-life balance were also discussed by some workers. A minority of respondents reported that they had been unable to get their preferred shift pattern or that their employer was reluctant to provide paid time off to staff, instead requiring the use of annual leave days. The availability and cost of child-care was a further factor which hindered the ability of some workers to negotiate an effective work-life balance.

> *I've had my children on the waiting list at their primary school now for over a year-and-a-half. Their before school care and after school care has been fully booked, and it's usually a rollover of children from the previous year, so of course trying to get three children in is nearly impossible.* (H32N_CCW)

Respondents also described factors which, while not in place at present, would assist them to more successfully combine their work and non-work responsibilities. These included having changes to their working conditions (more flexible work arrangements, reduced hours, regular shift patterns or working from home) as well as their employer hiring additional staff to cover

excessive workloads. However, for some these changes were seen as being difficult to achieve due to the demands of current work roles or financial imperatives.

> *I think amount of staff needs to be increased to be honest because as I said I look after 13 residents at work - they have got high demands as well. So I have to prepare myself to give everyone what they want and make sure they're cared for. If I get help from someone, like if they put another staff or someone, so that wouldn't stress me out that much, so I can have, not stressing, but less stress at work. So it's working for my outside work life as well I think.* (R29N_PCA)
>
> *It would be nice to have a proper 30 hours' work that you know that you have, and then you don't worry about anything else.* (H32N_CCW)

7.4 Emergent Themes

The interviews were conducted using a semi-structured approach and respondents were encouraged to raise any issues that they felt were important regarding their experiences of working in aged care. In addition to the themes described in the preceding sections, three emergent themes relating to aged care reforms and funding, staffing in residential care facilities, and perceptions of aged care work were commonly discussed by the interview respondents.

7.4.1 Aged Care Reforms and Funding

Many respondents (and particularly mature aged workers and those working in home care and home support settings) raised concerns about the impact that the recent aged care reforms and associated changes to funding models had had on their workplaces. Within community aged care the move to a consumer-directed care model was perceived to be changing the client base of some organisations and impacting upon the caseloads of home care and home support workers. Staff in the community also raised concerns about the future funding of their organisations and the impact this had on their own job security.

> *It does worry me a bit, the stability of it, because so many services like ours are just going from year to year funding-wise. They don't know where they're going…The only alternative is to go and work for a bigger organisation, to work for a big aged care residence, a company that has a few residences, but that seems pointless to me because everyone wants to stay in the community so aged care service residences should only be for end of life. You generally die within an hour once you're there, so why is that the stable job? The stable one should be out in the community because that's where everyone wants to be.* (H44G_CCW)
>
> *(My employer's funding) contract is up soon so we don't know what work, how much work, if any work we're going to have at the end of that contract…Any organisation in the country can package any client anywhere now. It makes it a bit tougher for us…We've definitely lost clients…I lost seven hours in one hit because a client went to a package with a different company*. (H47G_CCW)

Within the community, workers also expressed concerns for their elderly clients under the new funding arrangements. A lack of general awareness of the changes which had occurred in the aged care system and specific understanding of what could be funded under the scheme was noted. The ability of clients to be re-assessed and moved to a larger package if their support needs increased was also questioned by some workers. Moreover, in both home care and home support and residential settings, examples were provided of changes to funding models leading to reduced service provision (including equipment maintenance) and threatening the future sustainability of some programs.

> *If they're on a smaller package and their needs get more over the years, sometimes it's harder to get onto a higher package.* (H22N_CCW)
>
> *We do a lot of other programs, and it's just it's evolved like that. We sort of started an exercise program…that's been going probably 15 years, of gentle exercise, tai chi and a gym, and then we get extra funding from the carer group and link people in with a music therapist…so we do*

some music therapy in the home, and in-home diversional activities for people that don't want to join the other diversional activity group, but eventually we try and transition them across. So, I don't know, I think those programs won't keep going. (H03M_RN)

Within residential aged care facilities, changes to funding models were not seen as reflecting the actual care needs of residents. As described below in Section 7.4.2, these changes were perceived to have negatively impacted on the overall funding available to aged care organisations leading to reduced staffing levels and increased workloads.

For a resident to be classified as high care, which means more funding, it's a lot more difficult. They changed the criteria. That was really disappointing because now, it's based mainly on their cognitive functioning. So if a resident has poor cognitive functioning, e.g. mental health issue or dementia or whatever, they receive more funding. Whereas if we've got a resident who's got PEG feeds or indwelling catheter in or is on two hourly turns, they receive less funding. Which is ridiculous, because they need more or just as much care as the one with the cognitive functioning deficit. So that was pretty disappointing. (R02M_EN)

A minority of respondents believed that the new aged care reforms had led to positive changes, particularly to service provision in the community. Service quality and flexibility was reported to have increased and clients now had greater choice over their supports.

Once upon a time when aged care services were given funding, they were like they said, "You can provide A, B and C. And, that's all you're funded for and you can't do any more." And, that closed our books, and that's what we could do, A, B, and C. But, now under the (new funding model), what things are different is we have a little bit more flexibility, so I think being able to provide flexible services, because every client is different. I think that's really important. (H45G_CCW)

7.4.2 Staffing Issues in Residential Care Facilities

Concerns regarding staffing levels within residential care facilities were raised by respondents from all three groups (new hires, mature workers and general workers). Funding constraints were felt to be contributing to insufficient numbers of staff within facilities including a lack of cover when regular workers were absent or staff not being replaced when they retired. Subsequently increased staff-to-resident ratios had been experienced and led to workload pressures and poorer quality care for residents.

There's not enough staff, either carers and/or nurses on all shifts; that's primarily due to the reduced funding from the government although they spruik on about what they do… but of course the general population doesn't really know that, facilities are being run as a business rather than as a caring organisation…When there's not enough staff it's harder for everybody to give out how they want to and it certainly hard for the recipients or residents who get to come into an aged care facility already stressed but expecting really good end-of-life care and we do our best, everybody does their best but we all know now it's not good enough. (R03M_RN)

In addition to general concerns regarding inadequate staffing numbers within residential care, respondents reported particular issues affecting nursing care within the sector. Increasing RN-to-resident ratios were reported alongside an emerging trend of replacing RNs with less qualified workers (Certificate IV nurses and PCAs). This trend was largely attributed to inadequate government funding and aged care organisations wanting to generate larger profit margins. In order to ensure quality care within residential facilities, several respondents recommended the need for mandatory staffing ratios and the retention of staff with nursing qualifications.

We're losing a lot of nursing staff and I find a lot of organisations are putting in PCAs to do nursing work. I think we just need to be careful that we're not blurring the boundaries a little bit too much…Because it's cheaper to have PCAs to do - so the PCAs can do obs and things like that, but if something goes wrong, they don't necessarily have the depth of assessment skills to really be able to deal with that…I find a lot of the big private companies now are getting rid

of the RNs and things or only having one RN for 120 residents because it's too expensive to have an RN. (R36G_RN)

7.4.3 Perceptions of Aged Care Work

The existence of poor perceptions of aged care work by the general community was considered to be problematic by some workers. Moreover, the interviews were conducted at a time when a case of abuse within the aged care system was prominent within the media and these negative perceptions were thought to have been exacerbated as a consequence.

> *In the media those handful of bad carers give everyone a bad reputation. That's absolutely distressing for us that do a good job to think that somebody has the audacity to treat someone so badly.* (R31N_PCA)

Respondents also reported that within other areas of healthcare, aged care was seen as offering few career pathways and being a low status job which required little clinical or technical expertise. As a consequence of these factors, the aged care industry was considered to be unattractive to new workers, and students and newly qualified nurses and care workers were reported to be reluctant to join the sector.

> *If you work in aged care you have to know cardiac, you have to know renal, you have to know palliative care, you have to know dementia, because the people you're working with have such a broad range of conditions that you need to know a lot of different skills instead of being specialised…we have students here quite a bit, PCA students and EN students and I always ask them where are you thinking about going with your nursing. I will always say please consider aged care. I said, it's a great industry to work in.* (R36G_EN)

This perceived low value placed on aged care work was seen as being reflected in the relatively poor pay rates offered within the sector and a lack of workforce development by the federal government.

> *They say, "You could be doing a job that pays double this and less manual work. Why are you doing this?" and I said, "Well, apart from the fact that I enjoy the smiling faces, happy, all that type of thing, don't you know the theory of the more that you actually help people, the less you get paid? If I don't turn up for my shift, there's a lot of people that could be sitting in their own filth because they can't get to the toilet. If a CEO of a company that gets a million dollars a year doesn't turn up for a month would anyone know? The more help you have for another individual, the lower you get paid."* (R31N_PCA)

Concerns were also expressed that employment agencies were actively encouraging unemployed people to undertake aged care training without consideration as to whether they were well suited or committed to working in the sector. This was seen as contributing to poor quality care and high staff turnover. Similarly, it was understood that many students (e.g. trainee nurses who aimed to work in a hospital setting) saw aged care work as a stepping stone to other employment opportunities rather than a career in itself.

> *A lot of the time these days I don't know (how) the government sees the unemployed… 'You've been long-term unemployed. How about you do a carer's course?' They shove them out there and do a carer's course and then they get employed and consequently that's not where they ever wanted to be. Out of a group of ten you might get two really good carers, but by God, you get some crap.* (H04M_RN)
>
> *We get a lot of uni students that are filling the gaps while they're doing their uni courses, so you have to cover them when they're off at prac or resi school and things like that, and then when they get the qualifications they leave.* (R15M_PCA)

7.5 Summary

In-depth qualitative interviews were conducted with 100 direct care workers following completion of the aged care workforce survey. This sample included 40 mature workers, 30 new hire workers and 30 general workers. The qualitative interviews aimed to (1) explore the specific aged care experiences of new hire and mature-aged workers, (2) investigate issues relating to recruitment and retention in aged care, (3) explore the experience of working in aged care (with relation to quality services, OHS, training and skills, and work-life-balance) and (4) identify and explore emerging issues for the aged care workforce.

7.5.1 Recruitment and Retention in the Aged Care Workforce

Most respondents had entered aged care with substantial employment histories; care workers reported coming from a diverse range of industries while many nurses brought considerable experience from other fields of nursing. A career in aged care, therefore, was a first job for only a small minority within the sample. Although most of those interviewed held only one current paid job in aged care, some reported having additional sources of paid work (primarily to supplement hours or income from their primary job).

Key motivations for choosing to work in aged care included a direct interest in the work, job availability and opportunity, flexible working hours within the sector, and the perception that aged care work could lead to employment in other healthcare sectors. Employment within the home care and home support sector was also seen as being particularly favourable by some workers due to perceptions of greater time with clients, more work variety and less intensive care responsibilities. Most workers in the sample had not made a direct preference when choosing their aged care employer. Rather this decision was informed by the availability of work, having undertaken a placement at the organisation, the location of the workplace, and having existing personal contacts within the facility.

Direct care workers reported that they gained much job satisfaction from their work in aged care. Positive aspects of their daily work included having good relationships and interactions with clients and a feeling of making an important difference to the lives of older people. Being able to use their skills and training, having autonomy and diversity in their work, and good relationships with colleagues and management were further factors contributing to job satisfaction. These workers also, however, reported encountering stresses and difficulties in their working lives. High workloads and levels of administration were the most common concern among respondents. Unsatisfactory working conditions (in the form of pay rates and insecure employment) was a further source of dissatisfaction for some workers and especially those working for home care and home support outlets. Difficulties relating to client care and relationships with co-workers and managers were also frequently reported by respondents.

Despite these reported difficulties, the majority of interviewees wanted to remain working in the aged care sector into the future. Although many workers were satisfied with their current role and organisation, some respondents sought to undertake training which could enhance their skills and job opportunities; others were hoping to transition to roles which offered greater levels of responsibility. Additionally some workers (particularly in home care and home support outlets) aimed to improve their current working conditions while some new hire workers expressed a desire to move to a different aged care organisation. Intentions to leave the sector were noted primarily by residential new hire workers and mature-aged workers. For the former group this was typically to pursue a nursing career within an acute setting, while retirement was a forthcoming pathway from the sector for half of the mature-aged sample. However, many mature workers were keen to continue working in aged care for as long as their health permitted.

7.5.2 Experiences of Working in Aged Care

The qualitative interviews also examined quality in aged care provision, OHS, training and skills, and work-life balance. Respondents discussed worker and organisational characteristics which they believed promote quality client care. Effective aged care workers were thought to possess innate personal qualities, alongside specific skills and qualifications, which made them suitable for their role. Having a range of workers across different ages, genders and cultural backgrounds within the sector was also perceived as contributing to good client care. Adequate staffing was strongly viewed as being a key factor which enabled organisations to provide quality care to their clients and residents. Supportive management, adequate aged care funding, positive organisational values, and effective workplace policies and procedures were also considered to contribute strongly to care provision.

Awareness and understanding of OHS policies and procedures was high among respondents. Most felt that they had received adequate training in OHS issues and that workplace guidelines operated effectively. Although most direct care workers considered their workplace to be a safe environment, specific OHS concerns were raised by a quarter of workers. The pressure of work demands and staff shortages were felt to contribute to breaches in OHS protocols by respondents and their co-workers (particularly around manual handling techniques). Specific concerns relating to physical hazards, client medication and elder abuse were also raised by some home care and home support workers, while reports of work-related injuries were described primarily by mature aged workers. Overall, however, interviewees expressed satisfaction that their employers addressed any OHS concerns effectively.

The qualitative interviews also examined training and skills in the aged care workforce. All the PCAs and most of the CCWs interviewed reported having undertaken, at a minimum, Certificate Level III training in aged care. While most of these workers considered that their training had equipped them well for working in the sector, concerns were raised regarding the quality of some Level III training courses. These included misgivings about the length of courses and placements, a reliance on online rather than face-to-face training methods, and gaps in course content. Work-related training was available to most of the respondents, including induction training, mandatory training courses and professional development activities. However, barriers to training were described by some workers including a lack of access in regional and rural areas. The training received by respondents was perceived to typically be of good quality and of direct relevance to aged care work; training in dementia and palliative care was reported to be particularly useful. New hire workers also identified specific types of training (centred on aged care practices and skills) which they considered would be beneficial for their future work in the sector.

Work-life balance was a final area explored in the qualitative interviews with direct care workers. Most workers reported extensive responsibilities and activities outside of their work in aged care, most commonly caring responsibilities for children and elderly parents. Strategies used by aged care workers to effectively combine work and non-work responsibilities included taking advantage of flexible working hours or rostering, maintaining boundaries between work and home and utilising support from family and friends. Not all respondents, however, felt able to have an effective work-life balance. Difficulties were reported by some workers in obtaining flexible working conditions or paid leave from their employer; the availability and cost of childcare was a further barrier experienced by some respondents.

7.5.3 Emergent Themes

Three emergent themes were raised by respondents during the interviews relating to aged care sector reforms and funding, staffing levels in residential care facilities and negative perceptions of aged care work. Concerns were expressed regarding the impact of the recent aged care reforms on the sector across provider, worker and client levels. Home care and home support workers were particularly worried about the future funding and sustainability of

their organisations and the potential effects this could have on their own employment. A lack of client awareness and understanding of recent changes within the aged care system was also reported. In contrast, a minority of workers felt that the aged care reforms had been beneficial, enhancing service provision and client choice in the community.

Associated with concerns regarding aged care funding arrangements, were reports of staffing issues within some residential care facilities. Perceptions of insufficient staff numbers and the reported replacement of RNs with lesser qualified staff led to unease about the quality of resident care in some organisations (and particularly within the for-profit sector). A final emerging theme which arose from the interviews with direct care workers was a sense that aged care work was held in low esteem by both the general community and those working in other healthcare sectors. At a time when the aged care workforce needs to expand, respondents recommended that negative perceptions and working conditions be addressed in order to make the sector more attractive to potential workers.

8. Conclusion

8.1 Overview of the 2016 National Aged Care Workforce Census and Survey

The National Aged Care Workforce Census and Survey (NACWCS) 2016 provides information about the size and composition of the workforce, the characteristics of aged care workers and the organisations in which they work, experiences of working in the sector, and factors related to staff recruitment and retention.

The NACWCS consists of two separate data collections: one for the residential facilities and one for home care and home support outlets. Each data collection comprises of two linked parts - a census of all employers and a survey of their employees. From these we have two large employer-employee data sets representing the residential and the home care and home support sides of the aged care sector. The structure of aged care programs and services in Australia has changed considerably since the NACWCS was last conducted in 2012. These changes impacted on the responding framework for the census, which was relaxed in the 2016 data collection, necessitating a longer duration of fieldwork in order to achieve comparable response rates.

The NACWCS gains further in-depth knowledge on the sector through the addition of a qualitative research element connected with issues of specific policy importance. In the 2012 NACWCS we focused on migrant and male workers in aged care, motivated by the expectation that they will form an important source of new workers for the sector. In 2016 we focus on recently hired and mature-aged workers, again motivated in a broader way by issues of attraction and retention of the aged care workforce. We conducted 100 in-depth qualitative interviews with recently hired, mature-aged and general employees from the direct care workforce. These interviews provide further detailed information on experiences of working in the aged care sector including factors related to recruitment and retention.

Throughout the report we have compared the residential and home care and home support workforces (with a particular focus on the direct care occupations), differences between various components of the workforce (including occupational groups and recent hires) and, where appropriate, contrasted the characteristics of the aged care workforce with the broader Australian population. This concluding chapter provides a summary of findings and identifies a selection of emerging issues that may benefit from further investigation.

This was the fourth time that the National Institute of Labour Studies (NILS) has undertaken this important research – previously the NACWCS was conducted by NILS in 2003, 2007 and 2012. The accumulated evidence is remarkable in its continuity and completeness. As a consequence this research is the best available source of information for tracing the changes that have occurred in the Australian aged care workforce over this time period and guiding relevant workforce policy. In doing so however, we need to bear in mind several generally well-understood, but often under-reported or even ignored, statistical caveats.

The structure of aged care programs and services in Australia has changed considerably since the NACWCS started to be conducted in 2003. Measuring and comparing in the midst of change will always remain an imprecise undertaking. For example, a question we asked in 2003 may not have been asked of the same (type of) people as in 2016, or may have a different meaning in 2016 due to sector changes that have happened in the meantime. The answers provided in 2003 and 2016 may, therefore, not be directly or fully comparable. Although the NACWCS employs the most powerful tool for the employers' evidence, that is, a census where all employers in scope are invited to respond, and a large-scale survey for employees, with the added granularity that can be gained through the employer-employee linkage, structural change will nevertheless always have an impact but whose size and magnitude is hard to estimate. Consequently, this statistical caveat should always be kept in mind when making direct comparisons of aged care services across different parts of the

sector over time and we should be careful to not over-interpret the estimates derived from this data. With these thoughts in mind, we turn to the conclusion of this research.

8.2 The Size and Composition of the Aged Care Workforce

In 2016, the estimated total aged care workforce comprised 366,027 PAYG employees (an increase of 4 per cent from 2012). Of these, 235,764 were employed in residential facilities and 130,263 in home care and home support outlets. This report focuses primarily on direct care workers within the sector, i.e. those workers who provide care services to older Australians as a key part of their work. Our 2016 estimates suggest that 240,317 aged care workers were employed in direct care roles; this figure being very close to the corresponding estimate in 2012. There were 153,854 direct care workers in residential facilities and 86,463 in home care and home support outlets.

While both the residential and home care and home support sectors experienced a considerable increase in their direct care workforces between 2007 and 2012 (by 10 per cent and 25 per cent respectively), this increase has not been observed between 2012 and 2016. The 2016 estimates suggest that, since 2012, residential direct care employment has grown (but at the lower rate of 5 per cent and not uniformly) and home care and home support employment has shrunk (at a contraction rate of 7 per cent). When converted to full-time equivalent (FTE) employees we see a different picture. From 2012, the FTE residential direct care workforce has increased by 3 per cent and the home care and home support workforce has decreased by 19 per cent (compared to 5 per cent growth and 7 per cent contraction respectively in the headcount figures). These estimates suggest that the sector is undergoing considerable structural change and that there has been an increase in the proportion of workers employed for fewer hours.

The direct care workforce consists of six primary occupational groups: Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN) Personal Care Attendants (PCA)/Community Care Workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA). Within residential aged care, the proportion of PCAs has continued to grow and now constitutes 70 per cent of the residential workforce. The number of RNs in this workforce has also increased since 2012, reversing a previous negative trend seen in the sector since 2003; however, we note that the proportion of RNs in residential care remained unchanged from 2012. In contrast the proportion of ENs and AHPs working in residential aged care has fallen slightly (from 12 per cent to 10 per cent; and from 2 per cent to 1 per cent respectively). The proportion of AHAs in the residential workforce has remained constant at 3 per cent.

Looking at the occupational composition of the home care and home support sector, CCWs are by far the largest group and their share of the workforce has increased from 81 per cent in 2012 to 84 per cent in 2016. While the proportion of ENs working in community-based aged care has fallen since 2012 (from 4 per cent to 2 per cent), minimal change was seen within the other occupational groups.

Almost two thirds of the aged care workforce is located in major cities, with a further third in regional areas. While little change was seen in the distribution of residential workers across the states and territories since 2012, greater changes were observed in the home care and home support workforce. In particular the proportion of the total PAYG workforce in home care and home support increased from 23 per cent to 32 per cent in Victoria, while the proportion of workers located in NSW fell from 31 per cent to 26 per cent. This appears to be due to an increase in the share of outlets located in Victoria and also in the average number of workers per outlet in that state.

The type of organisation a worker is employed in varies considerably between residential and home care. Within residential aged care 58 per cent of direct care workers were employed in not-for-profit facilities, 34 per cent in for-profit facilities and 7 per cent in facilities owned by the

government; this distribution is largely unchanged since 2012. Within home care and home support aged care in contrast, the proportion of workers in not-for-profit outlets has fallen considerably since 2012 to 68 per cent (from 76 per cent), while employment in for-profit organisations has increased to 12 per cent (from 7 per cent).

While the key focus of the 2016 NACWCS was on the direct care workforce, we also examined the use of other types of workers within aged care. Around a third of all PAYG employees across both the residential and home care and home support sectors are non-direct care staff. Since 2012, the proportion of non-direct care staff working in residential settings has increased by 8 per cent; the share found in home care and home support outlets meanwhile remains unchanged. Non-direct care workers are found predominantly in ancillary care roles in residential facilities (70 per cent). In home care and home support outlets, managers (including care managers and co-ordinators) and administrative staff account for 92 per cent of the non-direct care workforce.

During the designated fortnight (the last pay period in November 2015) 28,079 non-PAYG staff (agency, brokered and self-employed workers) were employed across the aged care sector. This constitutes a decrease of 29 per cent in the use of non-PAYG staff since 2012. The use of non-PAYG staff remains more common within residential aged care with 50 per cent of facilities reporting employing at least one non-PAYG worker compared to only 27 per cent of home care and home support outlets. Non-PAYG workers were most commonly employed to fill PCA and RN positions in residential care and CCW roles in the community. For the first time in 2016, the census included a question on the reasons for the employment of non-PAYG workers. Within both residential facilities and home care and home support outlets, agency staff were most commonly hired to provide short-term cover for staff absences and unfilled vacancies.

The use of volunteer staff is widespread within aged care, with 83 per cent of residential facilities and 51 per cent of home care and home support outlets using the services of volunteers. Our estimates suggest that during the designated fortnight, 68,416 volunteers worked in the sector. There were 23,537 volunteers in residential facilities who worked an average of 4.9 hours each per fortnight, and 44,879 volunteers in home care and home support outlets working an average of 4.6 hours each. The 2016 census contained a new question relating to the roles undertaken by volunteer workers in aged care. Volunteer staff were found to provide a variety of roles: in residential facilities they assist most commonly with providing social and planned group activities and also companionship. In home care and home support outlets volunteers most frequently assist with social and group activities and transport.

The overall picture of the size and composition of the aged care workforce is mixed and suggestive of considerable structural change taking place. The institutional changes that have occurred concurrently within the sector make the generation, the reading, and the interpretation of these estimates harder. The overall PAYG workforce is estimated to have increased by 4 per cent as a whole, with its direct workers proportion being 5 per cent higher in residential care and 7 per cent lower in home care (or a 3 per cent increase and 19 per cent decrease in FTE positions respectively). Since 2012, the relative share of both PCAs and CCWs have increased, whilst evidence suggests that non-PAYG numbers have dropped substantially. Meanwhile, the number of volunteers working has increased in residential facilities but fallen in home care and home support outlets.

8.3 Characteristics of the Direct Care Aged Care Workforce

The characteristics of the direct care aged care workforce in 2016 were largely similar to those found previously in 2012, with the exception of some differences traced in the estimated age and sex of the workforce and also in the proportion of migrant workers in the sector.

Previous iterations of the NACWCS (2003 to 2012) had indicated that the aged care workforce was ageing. While this trend has continued within the home care and home support sector (the median age is now 52 years compared to 50 years in 2012), the median age of residential direct care workers has fallen to 46 years (from 48 years in 2012). A similar pattern is seen for recently hired employees: the median age of new hires in the home and community care sector has increased to 46 years but has reduced considerably for recently hired residential workers to just 36 years (from 44 and 40 years respectively in 2012).

Although aged care remains a female dominated sector, the proportion of males in the workforce is continuing to grow, albeit slowly and from a small base. In residential aged care, 13 per cent of workers are now male, and in the home care and home support sector men represent 11 per cent of all workers.

Reversing its previous trend, the overall proportion of the workforce born overseas has decreased since 2012; 32 per cent of the residential and 23 per cent of the home care and home support workforce in 2016 are migrant workers. When looking at the country of birth of recently hired workers, however, the residential sector continues to attract an increasing proportion of overseas-born workers (40 per cent compared to 37 per cent in 2012). In contrast, the share of recently hired migrant employees in home care and home support outlets has fallen to just 21 per cent (from 30 per cent in 2012). Most residential facilities and home care outlets (91 per cent and 72 per cent respectively) reported employing at least one PCA/CCW from a CALD background. Within residential aged care these workers were most commonly from India and the Philippines, and in home care and home support from Italy and South East Asia.

Aboriginal and Torres Strait Islander people account for around 1-2 per cent of the aged care workforce reported by outlets; this share has remained similar since 2012.

The aged care workforce is in relatively good health with 60-65 per cent of workers across all occupational groups rating their health as excellent or very good. Unsurprisingly given their younger age, recently hired employees report higher self-assessed health than the aged care workforce in general.

The aged care workforce has high levels of post-school education and training. Most workers (around 90 per cent) hold a post-secondary school qualification. Around three quarters of RNs reported having a nursing degree (compared to around two-thirds in 2012) while a similar proportion of ENs hold a Certificate IV/Diploma of Enrolled Nursing. The proportion of PCAs with a Certificate III in Aged Care has remained the same since 2012 at around two-thirds of the workforce. Meanwhile, the proportion of CCWs with a relevant certificate-level qualification is growing; in 2016, 51 per cent of CCWs have a Certificate III in Aged Care and 27 per cent a Certificate III in Home and Community Care. Two-thirds of residential facilities and almost half of all home care and home support outlets reported that at least three-quarters of their PCAs/CCWs had relevant Certificate III qualifications.

The qualitative interviews explored the adequacy of Certificate-level courses in preparing workers for a career in aged care. While most PCAs and CCWs felt that their training had equipped them well, concerns were also commonly raised regarding the inadequate length of courses and placements, the use of online training methods, and gaps in course content.

A relatively small proportion of the workforce has a specialised qualification in ageing; the most common areas being palliative care and gerontology. However, the levels of specialised qualifications increased across most occupational groups in home care and home support

from 2012 and are now fairly comparable to those in residential settings. Far fewer direct care workers were currently studying for a qualification in 2016 than in 2012 (11 per cent of home care and home support workers and 16 per cent of residential workers compared to around 20 per cent across both sectors in 2012).

Access to ongoing training is common within aged care; 80 per cent of residential workers and 75 per cent of home care and home support workers had engaged in work-related training (mostly mandatory training) in the previous 12 months. Continuing and professional development was undertaken more frequently by residential than home care and home support workers (58 per cent to 48 per cent). Priority areas identified in both the worker surveys and qualitative interviews for future training included dementia, palliative care and (in home care and home support) mental health. The newly hired workers taking part in the interviews also highlighted the need for further training on aged care practices and skills. Barriers in accessing work-related training were also identified in the interviews with direct care workers; a lack of access to training for workers in regional and rural areas was particularly prevalent.

The NACWCS 2016 finds that the aged care workforce remains predominantly female, older, and in good health. It is a well-qualified and trained workforce, with good access to further work-related training. In 2016 the aged care workforce comprises of a sizeable but reducing migrant share and a very small proportion of Aboriginal and Torres Strait Islander people.

8.4 Characteristics of Aged Care Facilities and Outlets

As in 2012, slightly more than half of all residential facilities were large (i.e. had more than 60 places). Within home care and home support aged care, however, the trend towards larger outlets has continued. Twenty eight per cent of the home care and home support PAYG workforce are now employed within very large outlets (with more than 40 staff).

In 2016, the services most commonly provided by home care and home support outlets were the Commonwealth Home Support Program (by 64 per cent of outlets) and Home Care Packages Program (45 per cent). The size of an organisation strongly determined the type of program services offered. Smaller outlets (with up to 5 direct care staff) were responsible for over a quarter of all CHSP services, while very large outlets (with more than 40 staff) provided almost a third of all Home Care Package supports. Within the residential sector, the 2016 census indicated that the total number of operational places was 197,046. The average ratio of residential direct care workers to places (0.8) was unchanged from 2012.

A strong relationship to the broader age care sector was apparent in both residential and home care and home support. The proportion of residential facilities belonging to a larger provider group increased to 80 per cent in 2016 (from 76 per cent in 2012); the proportion of home care and home support outlets has remained constant (at 61 per cent). The share of providers offering both residential and home care and home support care has fallen since 2012 indicating that provider organisations are becoming increasingly specialised within their respective sectors. The proportion of home care and home support outlets also offering residential care has fallen particularly sharply since 2012, from 20 per cent to just 13 per cent.

Around a quarter of residential facilities and 43 per cent of home care and home support outlets cater for a specific ethnic or cultural group, most frequently Aboriginal and Torres Strait Islander and Italian older adults. A much higher proportion of facilities and outlets reported catering for the needs of gay, lesbian, bisexual, transgender and intersex clients in 2016. This illustrates the increasing supply of aged care services which are inclusive of older adults from diverse backgrounds.

Methods of quality monitoring in aged care were explored for the first time in the 2016 census. Multiple methods were used across both sectors, in particular monitoring by managers or supervisors and keeping records of service user feedback. Issues around quality care provision were more broadly discussed in the qualitative interviews. Factors identified as contributing to quality aged care included having adequate funding and numbers of

appropriately skilled staff, supportive management, positive organisational values, and effective workplace practices and procedures.

The overall picture that emerges of the key characteristics of aged care facilities and outlets in 2016 is somewhat mixed, due to the intense recent organisational change in the sector. A majority of residential aged care facilities are large, and business units within the home care and home support sector appear to be getting larger. The way these business units respond to change also appears to differ by the size of the unit. For example, within home care and home support, the size of an outlet appears to determine the type of program service provision. Moreover, the differentiation between residential and home care appears to be intensifying and service provision which accounts for the diverse needs of older Australians from different ethnic and cultural groups is becoming more mainstream.

8.5 Working Arrangements and Conditions in Aged Care

Working arrangements and conditions offered within aged care are important factors for attracting new workers and retaining current ones. A considerable shift away from casual or contract employment arrangements has been seen since 2012, particularly within the home care and home support sector. In 2016 only 10 per cent of the residential and 14 per cent of the home care and home support workforces were casual or contract employees (compared to 19 per cent and 27 per cent respectively in 2012). In contrast, little change over time was noted in the work schedules of the direct care workforce; the most common shift pattern remains a regular daytime shift across both sectors.

Employment conditions for residential and home care and home support staff were predominantly determined through the use of Enterprise Agreements (79 per cent and 59 per cent respectively). Award-based arrangements were more commonly used by home care and home support outlets (39 per cent compared to 21 per cent of residential facilities). Home care and home support outlets were asked about the allowances supplied to their workers for the first time in 2016. Eighty-four per cent of outlets provided some form of allowance, most commonly paid time for travel between appointments (70 per cent) and for petrol/depreciation (46 per cent).

There are indications of potentially underutilised labour supply within the aged care sector as a considerable proportion of workers (30 per cent of residential and 40 per cent of home care and home support staff) reported that they would prefer to work more hours than they do. The proportion of workers with a preference for more hours has increased slightly across both sectors since 2012, and PCAs and CCWs are the occupation most likely to prefer an increase in their working hours.

The extent of multiple job holding by aged care workers provides further evidence of spare capacity within the existing workforce. Multiple job holding is far more common within aged care than in the whole Australian workforce and rates remain similar to those found in the 2012 NACWCS. In 2016, 9 per cent of residential workers and 16 per cent of home care and home support workers had more than one job (compared to 5 per cent of the whole Australian workforce). Most of the additional jobs of multiple job holders were within the aged and disability care sectors. The need to supplement hours or income from their main aged care job was the primary reason for multiple job holding given in the qualitative interviews.

Working conditions are impacted upon by unusual job demands that an employee may perceive to be stressful. Across both sectors the most prevalent job demands were related to unanticipated changes in work patterns including working longer than scheduled and variations being made to hours or location of work at short notice. While the majority of facilities and outlets that made these demands indicated that it was done only in exceptional circumstances, more than a third of home care and home support outlets vary the hours or location of their workers at short notice routinely. Additionally the overall prevalence of unusual job demands had increased within the home care and home support sector since 2012.

A similar proportion of workers in residential care and home care and home support (14 per cent and 12 per cent respectively) reported sustaining a work-related injury or illness over the previous 12 months; this was unchanged from 2012. These injuries were most commonly sprains/strains and chronic joint/muscle conditions caused by lifting, pushing, pulling or bending. The next most prevalent issue was stress or a mental health condition, reported by around a fifth of aged care workers.

Occupational health and safety was a key topic in the qualitative interviews. While most workers felt that OHS issues were dealt with well by their employer, specific concerns were raised by a quarter of the workers interviewed. These concerns were primarily around breeches in protocols for manual handling techniques due to the pressure of work demands and staff shortages. Reports of work-related injuries were primarily described by mature-aged workers and were attributed to the years of undertaking a physically demanding role and also to following poor manual handling protocols earlier in their careers.

The general picture that emerges regarding working arrangements and conditions is one of improving working conditions without any major imbalances identified by the data. Although there are indications of continuing modest underutilisation of the workforce as a whole, (as preferred hours are longer than actual and some workers hold multiple jobs), this is not to the point of being a driving force for the deterioration of working conditions in the sector.

8.6 Recruitment and Retention

Aged care work has been their first ever occupation for only a small minority of workers. Apart from nursing, we find no clear pathways into aged care for all other occupational groups. The aged care sector typically draws its workers from the broader labour market. These findings were confirmed in the qualitative interviews. While many of the nurses interviewed had previously worked in other fields of nursing, the PCAs and CCWs had come to aged care from a diverse range of previous employment. The interviews also found that workers enter the sector for a variety of reasons including an interest in the work, job availability, and as an employment pathway into other healthcare fields.

The direct care workforce is relatively mobile with almost half of the workforce having had previous work with another employer in the sector. Across the different occupational groups, PCAs and CCWs are more likely to be new entrants to aged care. As in 2012, around a third of job mobility within aged care is due to factors relating to the personal circumstances of workers. However, work conditions and work role are further factors which considerably contribute to churn within the sector. In particular, a desire to find more challenging work, the attainment of preferred shifts or hours of work, and the achievement of higher pay were frequently cited in the worker surveys as reasons for moving to a new aged care employer.

Relatively high levels of job satisfaction were reported by workers in aged care and are similar to those found in 2012. When looking at satisfaction with specific aspects of their job, aged care workers reported most satisfaction in those areas which related to skills and training. Relationships with managers and colleagues were also seen in a positive light by a large majority of the workers. Although aged care workers continued to be least satisfied with their total pay, satisfaction in this domain has increased since 2012. Some salient differences were found across the residential and home care and home support workforces. Home care and home support workers had greater job satisfaction across several domains including time available to care for clients and having freedom in their work. These workers also reported feeling under less pressure and stress in their work than their residential counterparts.

Job satisfaction was further explored in the qualitative interviews. As found in the worker surveys, job satisfaction was high. Positive relationships with service users, colleagues and managers; being able to make effective use of skills and training; and having autonomy and diversity in their work contributed strongly to job satisfaction. However, these workers also

described issues which impacted negatively on their working lives. High workloads (including levels of administration) and unsatisfactory working conditions were commonly discussed.

Aged care has a highly committed and stable workforce that predominantly wishes to stay working in the sector. Similar to 2012, around a tenth of the aged care workforce were actively seeking alternative work. In order to examine future work intentions, we asked workers where they saw themselves working in 12 months' time. About 80 per cent of workers expected to still be with their current organisation and 3 per cent intended to move to a different aged care employer. Around a further tenth of aged care employees were unsure of their future work intentions. Only a small minority of aged care employees (2-4 per cent) reported definite intentions to leave the aged care sector altogether within the next year.

The qualitative interviews explored the longer-term career plans of the direct care workforce. Looking at work intentions over the coming three to five years most interviewees expressed a desire to remain within the sector and also with their current employer. However, some of these workers were seeking to develop their skills and take on more responsibilities in their role, while others (mainly newly hired workers) planned to move to a different aged care organisation. Intentions to leave the sector were primarily expressed by residential new hire workers (seeking nursing careers in acute settings) and mature-aged workers who were considering retirement. It should be noted, however, that many older workers planned to continue working in the sector while their health permitted.

The incidence of skill shortages in the sector has declined considerably since 2012, particularly in the residential sector. Skill shortages were reported by 53 per cent of residential facilities and 42 per cent of home care and home support outlets (compared to 76 per cent and 49 per cent respectively in 2012). Across both sectors skill shortages were more prevalent in locations outside major cities. Within residential care a shortage of RNs was most common, while an inadequate supply of CCWs was noted by home care and home support outlets. A lack of suitable applicants was the primary reason given for these skill shortages; slow recruitment processes leading to skill shortages was also common across both aged care sectors. In addition, residential facilities reported the need for specialist knowledge while the geographical location of the outlet contributed to skill shortages in home care and home support.

Common responses to address skill shortages across both aged care sectors included having existing staff work longer hours and making greater use of agency staff. Home care and home support outlets also frequently provided on-the-job training when addressing skill shortages.

The 2016 census collected information regarding current vacancy rates across the different occupational groups. FTE vacancy rates across all occupational groups have fallen within residential aged care since 2012. Around a quarter of residential facilities reported currently having vacancies for PCA and RN positions. The average number of vacancies reported by aged care organisations across the different occupations meanwhile remains relatively the same as in 2012. The highest average number of vacancies were found for PCA positions (at 3.3 positions per facility reporting a vacancy). The average time taken to fill vacancies was 2.5 weeks for PCA positions and 4.3 weeks for RNs; slightly quicker than in 2012. The pattern as to when vacancies are filled has also changed over time. The proportion of vacancies that are very quick to fill (less than one week) or very hard to fill (more than 26 weeks) has reduced and a greater number of vacancies are now taking around 3 to 4 weeks to fill. As was also found in 2012, residential facilities in remote and very remote locations reported more difficulties in filling staff vacancies.

The proportion of home care and home support outlets reporting vacancies is fairly similar to 2012. Vacancies for CCW positions continue to be most commonly reported by outlets (25 per cent), with an average of 3.6 unfilled CCW positions reported by these outlets. Similar to 2012, the average time taken to fill vacancies was 4.1 weeks for CCW positions and 4.7 weeks for RNs. Similar to the trend found in the residential sector, the proportion of vacancies across all occupational groups which are filled within a week by home care and home support outlets

has reduced and more positions are now taking between 3 to 8 weeks to fill. Also staff vacancies located in remote and very remote Australia take longer to fill, particularly for RNs.

As in the 2012 census, across both sectors the most common reasons given for staff vacancies were resignation, the creation of a new position, and retirement. The use of internet job advertisements has become more widespread since 2012 and is the most common recruitment strategy used by both facilities/outlets and recently hired workers. Word-of-mouth information about recruitment opportunities remains an important source for direct care workers. Although the use of agencies by aged care organisations to recruit PCAs and CCWs has not increased since 2012, considerably more recently hired workers are now using agencies as a method for identifying employment opportunities.

In summary, the 2016 NACWCS showed that the aged care workforce is both stable and committed. Moreover, its workers report relatively high levels of job satisfaction and a large majority wish to stay working in the sector. The overall picture that emerges from the skill shortages and vacancies evidence is that both the retention of current workers and the attraction of new workers to the sector seem to be working well with no major bottlenecks or hurdles that the labour market could not sort out by itself and without intervention.

8.7 Emerging Issues

Several emerging issues have arisen from the information collected in the 2016 NACWCS across the organisational census, worker surveys and qualitative interviews with direct care workers which may require further investigation.

First, findings from the 2016 census and survey indicate that the size of the home care and home support workforce has declined since 2012. Given that demand for home care and home support services by older Australians is expected to increase considerably over coming years, investigation appears to be necessary to examine the reasons for this decline, the impact this may have on the provision of aged care services, and the strategies which need to be implemented for the future planning and development of this workforce.

Second, our findings suggest that as an overall response to change, a majority of residential facilities continue to be large in scale, while outlets in the home care and home support sector are growing in size over time. However, preliminary further investigations suggest that this trend conceals two important differences. The first one is that large outlets within home care and home support are expanding their workforce more than smaller outlets, which raises issues of market power, especially where local monopolies may be likely to emerge for instance in rural settings. The second difference is that facilities within the residential sector are growing by opting for a workforce composition with lower use of direct care staff, which may have future implications regarding quality of provision.

Third, at present there appears to have been very little interaction at the workforce level between the aged care and disability sectors. This is not surprising as at the time of the 2016 NACWCS fieldwork, the NDIS was still in its starting phase with less than 15 per cent of its total participants with operational support plans. As the NDIS rolls out to full implementation and demand for disability supports increase, we can expect that the two sectors will end up sharing some of one another's workforces. Given the large numbers involved in the NDIS full roll out over the next two to three years, this could have substantial impacts on the aged care workforce.

Fourth, the qualitative interviews highlighted worker concerns regarding the impact of the recent aged care reforms. In particular home care and home support workers were fearful of the future sustainability of their organisations and their own working conditions and employment. The consumer-directed model of care which has been introduced into the sector was already perceived to be changing the work undertaken by home care and home support workers. As CDC is further implemented, it is important that resulting impacts on the home care and home support workforce are monitored and addressed.

Concerns regarding staffing within residential care was a further issue raised in the interviews with direct care workers. Strong perceptions were expressed that insufficient staff numbers, higher workloads and the replacement of RNs with less qualified staff were impacting negatively on resident care in some facilities (particularly within the for-profit sector). These perceptions were not strongly supported, however, by the census and survey data. The worker survey confirmed that residential care staff report greater levels of stress and pressure in their work than those in the home care and home support sector; dissatisfaction was also expressed by these workers regarding the time available to care for residents. However, the census indicated that overall staffing ratios and the proportion of RNs in the residential sector had remained constant since 2012. The discrepancies between the perceptions of residential workers and the findings from the census could benefit from further examination.

A final emerging issue which was raised in the qualitative interviews focused on perceptions of aged care work. Interviewees were concerned that aged care was considered an unattractive industry by potential employees due to perceptions that it was a low status job which offered poor pay and few career pathways. Future workforce planning and development of the aged care workforce may need to further explore and address these issues.

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Appendix 1: Weights for the National Aged Care Workforce Census and Survey

While the National Aged Care Workforce Census purports to be a complete collection, in practice there is substantial non-response.

To address this, we calculate 'weights' for each respondent such that a tabulation of respondents provides an estimate for the entire population. The general approach is to create strata and assume that within each stratum the respondents are a simple random sample of the corresponding population. By creating strata we allow for differential non-response, at least to some extent; each respondent is assumed to be representative of the strata rather than the whole population.

The strata make use of information which is available for the whole population as well as the sample. The finer the level of the strata, the smaller is the bias caused by differential non-response. On the other hand, if the stratification is too fine then the estimates will become very sensitive to the responses of a small number of respondents. Typically, 20 respondents in a stratum are considered more than adequate. To ensure robustness, the approach is to have a stratification broad enough to have a reasonable number of respondents in each stratum, and a stratification which does not result in an excessive spread of weights. The level of stratification is thus a matter of judgment.

The stratification for the residential outlet census collection is as follows, noting that the strata are mutually exclusive and comprehensive:

Table A1.1: Stratification design for residential aged care service facilities

	Notes
All very remote	All very remote facilities are in a single stratum because of small numbers
All remote	All remote facilities are in a single stratum because of small numbers
All Transition Care[12]	All facilities offering transition care are in a single stratum because of small numbers
Residential and flexibles with residential, excluding those that are remote or very remote	Residential facilities and those offering flexible care as well are combined because of the small number of the latter group. The facilities are then stratified by geography and size (nine cells)
Major cities	
Small	
Medium	
Large	
Inner regional	
Small	
Medium	
Large	
Outer regional	
Small	
Medium	
Large	

[12] All very remote, all remote, and all transition care are mutually exclusive (there are no transition care facilities in remote and very remote Australia.)

The size of the facility is taken from the number of worker forms sent to the facility (4, 6 or 8). The weights are obtained by dividing the number of the facilities in the cell by the number of responding facilities in the cell. Outlets where the questionnaire was 'returned to sender' are excluded from both the numerator and the denominator. Respondents who were 'out of scope' are included, with the idea that the respondents we know to be out of scope are representative of facilities who did not respond. The weights are also adjusted to account for a couple of coding errors (with a residential outlet mistakenly coded as a home care outlet and *vice versa*). The weights are in the table A1.2.

Table A1.2: Weights for the residential census

	N	n	Weight
Very Remote Australia	57	27	1.9655
Remote Australia	75	40	1.6667
All transition care	75	21	2.4194
Major cities			
Small	375	268	1.2931
Medium	612	474	1.2541
Large	670	532	1.243
Inner regional			
Small	246	175	1.337
Medium	243	190	1.2526
Large	185	156	1.1783
Outer regional			
Small	232	147	1.3728
Medium	109	83	1.2976
Large	69	47	1.4375
Total	**2,948**	**2,160**	

There are a number of 'respondents' for whom fundamental data on number of workers is missing in B2 (How many employees in each classification are female and how many are male?). These are treated as 'non-respondents'. There are also a number of 'respondents' for whom B2 is zero, despite evidence from other questions such as A6 (How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?) that the facility does have direct care employees. In addition, there are facilities with zero employees recorded in B2 but where workers have returned questionnaires in the worker survey, indicating that the facility also had direct care employees. The estimates on the number of direct care employees will be underestimates to the extent that these respondents actually have direct care employees.[13]

Home Care and Home Support Census

A similar methodology for deriving weights is used, although the program is also used to define strata. The variables used as a proxy for the size of the service outlet is the number of worker

[13] There were some 46 respondents with data for A6 and zero recorded for B2. Based on B2, the estimate of the direct care workforce is of the order 150,000. If these respondents were to be treated as missing then the estimate would increase by around 3,000.

forms sent to the outlet (small is 3, medium is 5, large is 7). The size of some of the outlets was unknown in which case five worker survey forms were sent to the outlet. These are included in the ‘medium’ size category.

Table A1.3: Stratification design for home care and home support service outlets

	Notes
All very remote	All very remote outlets are in a single stratum because of small numbers
All remote	All remote outlets are in a single stratum because of small numbers
Outlet program types: all except CHSP, VIC_HACC, WA_HACC	
Major cities	
Small	
Medium	
Large	
Inner regional	
Small	
Medium	
Large	
Outer regional	
Small	
Medium	
Large	
CHSP	No remote classification on file
Small	
Medium	
Large	
VIC_HACC	No remote classification on file and only medium outlets
WA_HACC	No remote classification
Small	
Medium	
Large	

Note that the remoteness classification was not available for HC_CHSP, HC_VIC and HC_WA_HACC, so any remote or very remote outlets will be in the strata associated with those programs.

The weights (Table A1.4) are derived using the same rules as for the residential facility census collection.

Prior to finalisation of the data file, the Department of Health identified a number of outlets as being out of scope. These were removed from the population file with the exception of a handful who had supplied valid responses.

As for the residential care, there are a number of respondents for which the essential information on the number of direct care employees is missing for B2 (How many employees in each classification are female and how many are male?). These are treated as non-respondents if the outlet had indicated that it has some PAYG direct care employees (in question A10.3 (If your service outlet does not employ PAYG paid staff, please indicate here) and as a nil response otherwise.

Table A1.4: Weights for the home care and home support outlet census

	N	n	weight
All very remote (excluding CHSP, VIC_HACC, WA_HACC)	93	42	2.214286
All remote (excluding CHSP, VIC_HACC, WA_HACC)	58	26	2.230769
Major cities (excluding CHSP, VIC_HACC, WA_HACC)			
Small	249	196	1.270408
Medium	363	260	1.396154
Large	426	315	1.352381
Inner regional (excluding CHSP, VIC_HACC, WA_HACC)			
Small	160	117	1.367521
Medium	181	113	1.60177
Large	131	81	1.617284
Outer regional (excluding CHSP, VIC_HACC, WA_HACC)			
Small	100	61	1.639344
Medium	82	40	2.05
Large	63	35	1.8
CHSP			
Small	639	306	2.088235
Medium	723	384	1.882813
Large	626	304	2.059211
VIC_HACC	598	313	1.910543
WA_HACC			
Small	76	37	2.054054
Medium	88	54	1.62963
Large	72	54	1.333333
Total	**4,728**	**2,738**	

Residential Workforce Survey and the Home Care and Home Support Workforce Survey

These worker surveys are two stage collections with service facilities/outlets asked to distribute a specified number of survey forms to a sample of aged care workers. The service managers are asked to ensure that the selected employees work in direct care roles, are

employed as PAYG staff and are randomly selected by choosing the employees with a date of birth closest to the date the letter is received.

While the first stage of the collection is notionally a census, in practice not all service facilities/outlets participated in the workforce census, and of those that did participate in the census not all distributed the survey forms to their workers. Therefore we need to treat the worker survey as a two stage collection where:

- The first stage consists of all those service facilities/outlets who distributed worker survey forms and there is at least one responding worker. For this stage, we adopt the same stratification as for the residential care census (or home care census), and assume that those service facilities/outlets are a random sample of all service facilities/outlets (with at least one direct care employee) in a particular stratum.

- The second stage consists of the responding workers.

The standard way of proceeding is to derive weights for each stage and combine them to an overall weight for the responding worker. However, there is reason to believe that many service facilities/outlets have not followed the instructions about sample selection and therefore the sample of workers is biased. If this is the case then an estimate of say, the number of nurses, obtained from the worker survey will differ from the estimate obtained from the service facility/outlet census collection. We account for this bias by modifying the respondent worker weights so that an estimate of workforce size from the worker survey is the same as the estimate from the service facility/outlet census collection. Moreover, we apply this modification differentially so that the estimates of workforce size are consistent for four groups:

- Registered nurses combined with nurse practitioners
- Enrolled nurses
- Personal care attendants
- Allied health professionals and assistants

The question we use in the service facility/outlet census collection is B2: employee classification by sex. This is the most straight forward question involving employee classification and is considered to be the most robust measure of the total number of direct care employees.[14]

A further complication is that there are cases where worker forms were returned but there was no corresponding return for the service facility/outlet census or the census form recorded zero direct employees, and cases where the number of worker forms exceeds the number of direct care employees recorded in the census form. In the first of these, we impute the number of direct care employees for the service facility/outlet based on the average number of employees in the corresponding stratum. In the latter, we did not change the weights, implying that it is possible that the weights are less than one. This approach was adopted in order to maintain coherence between the worker and service facility/outlet collections. The approach means that the estimates of number of direct care workers for each of the four groups are consistent between the service facility/outlet and worker collections.

[14] That said, we know that there are data quality issues with this question, and the treatment of facilities/outlets without data for B2 (employee classification by sex) has an element of arbitrariness. The main issue is whether the facility/outlet is treated as a non-respondent – that is, has not provided data for B2- or a respondent with no direct care employees.

Appendix 2: Interview Schedule

1. What is your current role in aged care?
    - Do you have more than one job? *If yes - probe:*
        - *What do you do?*
        - *If in aged care, with this provider or another?*
        - *Why do you need to have more than one job?*
        - *How do you manage to combine the jobs?*

2. How long have you worked in aged care?
    - Why did you choose to work in aged care?
    - Why this organisation?

3. What do you like best about your work?

4. Is there anything about your work that you find difficult or stressful? *If yes, - probe:*
        - *What do you find difficult or stressful?*
        - *How does this impact on your work/availability for work?*
        - *What strategies do you use to deal with this issue?*
        - *Is support available at work to help you with this?*

5. What do you think makes a good aged care worker?
   Probe:
        - *Issues re age, gender, culture, language*
        - *Qualifications, skills, qualities*

6. What factors enable an aged care outlet to provide quality care?
   Probe:
        - *Staffing – ratio, skills, working conditions*
        - *Management – support, supervision*
        - *Policies and guidelines*
        - *Organisational values*

7. What health and safety policies and procedures are in place at your work? *Probe:*
        - *Communication of policies and procedures by employer*
        - *Processes for reporting concerns*
    - How well do these policies and procedures work?
    - What training have you received regarding workplace health and safety?

8. Do you have any health and safety concerns in your work?
    - Have you reported these to your employer? *If yes - probe*
        - *How has your employer responded to these?*

9. Do you hold any specific qualifications in aged care?
    - (If yes) How well do you feel this training has equipped you to work in aged care?

10. To what extent does your employer support you to do work-related training?
    - (For new hires only, i.e. less than twelve months in aged care) What induction training did you receive? When did this take place?
    - What kinds of training do you find most useful?
    - Have you done any training that hasn't been useful? If yes, what kinds?
    - Is there any training which you have not done, which you feel would be useful in your work? If yes, what kinds?

11. We are interested in knowing how your work fits into your life. What responsibilities and activities do you have outside of your work in aged care? *Probe:*

- *Caring for children/relatives, other caring responsibilities*
- *Studying*
- *Volunteer work*
- *Community activities*
- *Other main activities, e.g. social, fitness*

12. How do you manage to combine your work and non-work responsibilities and activities?
    - What has worked?
    - What hasn't worked?
    - Is there anything that might make it easier to combine your work and non-work responsibilities and activities? *Probe*
        - *Changes to job (role, hours, schedule)*
        - *Support from employer*
        - *Workplace policies*

13. What would you like to achieve in your work over the next 3-5 years?

14. Is there anything else that you would like to talk about in regards to working in aged care?

Appendix 3: Additional Tables

Table A4.2: Average number of residential direct care workforce by size of outlet (places), by number of Total PAYG and direct care employees: 2012 and 2016

Number of places	Average Total PAYG employees		Average direct care employees		Ratio of Average Direct Care/Total PAYG	
	2012	2016	2012	2016	2012	2016
1–20	31	32	20	19	0.65	0.59
21–40	40	48	29	29	0.73	0.60
41–60	56	63	41	40	0.73	0.63
61+	107	113	78	75	0.73	0.66

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

Table A6.2: Average number of home care and home support direct care workforce by size of outlet, by number of Total PAYG and direct care employees: 2012 and 2016

Number of Total PAYG employees	Average Total PAYG employees		Average direct care employees		Ratio of Average Direct Care/Total PAYG	
	2012	2016	2012	2016	2012	2016
1–5	3	3	3	2	1.00	0.67
6–10	8	8	7	5	0.88	0.63
11–20	15	15	12	11	0.80	0.73
21–40	29	29	21	22	0.72	0.76
More than 40	111	116	65	75	0.59	0.65

Source: Census of home care and home support outlets.

Appendix 4: Questionnaires

Australian Government

Department of Health

barcode
BSP:xxx-Sequence
Provider contact position
Provider name
Provider POSTAL address line 1
Provider POSTAL address line 2
Provider POSTAL Suburb, State, Postcode

MAILING DATE

To Provider contact position, Provider name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at: Survey.ipsos.com.au/NACWCAS.

The National Aged Care Workforce Census and Survey collects important information that allows the Australian Government to make more informed strategic decisions about how to provide quality care to older Australians. The research in 2003, 2007 and 2012 has informed decisions about workforce planning and addressed workforce issues.

Responsibility to complete the census

All approved providers of aged care services must ensure completed census returns, as set out in the *Accountability Principles 2014* Part 5, made under subsection 96-1 of the *Aged Care Act 1997*.

Commonwealth Home Support Programme (CHSP) grant recipients must ensure completed aged care workforce censuses are returned, as set out in Section 5.3.5 within the *CHSP Programme Manual 2015*.

How to participate and distributing the census and survey packages

Provider name has been sent X census and survey package(s) for the number of aged care services your organisation provides.

We request that you send each hardcopy census and survey package to the person best suited for completing the census (and distributing the surveys) in each of your aged care service locations. The person best suited to receive the package and complete the Census is either **the personnel manager or the person who recruits and manages staff at each of your aged care service locations**.

There are two different census and survey packages: the Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys) and the Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys). Please call the free helpline 1800 071 735 if you need any assistance.

Larger organisations with multiple aged care services; co-located services

If your organisation is large and provides multiple aged care services, you should provide information for each type of service (Residential and/or Home Care and Home Support – please see table on the next page), at each aged care service location, in each specific census form.

Services that are provided from one location are called co-located services. If your organisation has co-located services and the workforce for these services is coordinated, only one census and survey pack is required for the co-located services (rather than one for each of the services). Please note that where Residential and Home Care/Home Support services are co-located then both Residential and Home Care/Home Support census and survey packages should be completed.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

Census and Survey Packages

Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys)	**Census of Home Care and Home Support Aged Care Outlets** (with a set of Home Care and Home Support Worker Surveys)
This is for services which provide care under the following programmes: • Residential aged care • Flexible programmes with residential places: National Aboriginal and Torres Strait Islander Flexible Aged Care Programme; Multi-Purpose Services Programme; Innovative Pool Programme • Transition Care (in residential setting)	This is for service outlets which provide care under the following programmes: • Home Care Packages Programme • Flexible programmes with home care places: National Aboriginal and Torres Strait Islander Flexible Aged Care Programme; Multi-Purpose Services Programme; Innovative Pool Programme • Commonwealth Home Support Programme • Home and Community Care (Victoria) • Home and Community Care (Western Australia) • Transition Care (in community setting) • DVA Community Nursing, Veteran's Home Care or other DVA administered programme

If you have any queries about the census or survey, please contact the free helpline on 1800 071 735.

Query	**Action**
More census and survey packs than service locations	Please call the helpline on 1800 071 735.
More service locations than census and survey packs	Please call the helpline on 1800 071 735 and request more census and survey packs.
The services at a single location are of only one type (Residential only or Home Care/Home Support only)	Please call the helpline on 1800 071 735 if you don't have the correct type of census and survey pack. Distribute only the correct census and survey pack (Residential or Home Care/Home Support) to the service location.
The services at a single location are of both types (Residential or Home Care/Home Support)	Please call the helpline on 1800 071 735 if you need another type of census and survey pack. Distribute one of each census and survey pack (Residential and Home Care/Home Support) to the service location.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

barcode
BSP:xxx-Service ID-Sequence
The Manager of the aged care service outlet
Service outlet: Service Name
Provider: Provider Name
Service Postal address1
Service Postal address2
Service Suburb, State, Postcode

MAILING DATE

To The Manager of the Home Care/Home Support aged care service outlet provided by Provider Name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. The National Aged Care Workforce Census and Survey collects critical information about residential, home care and home support aged-care services and the people who work in aged care. More details can be found at Survey.ipsos.com.au/NACWCAS.

There are two different census and survey packages:
The Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys); and
The Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys).

As the manager of the Home Care/Home Support service outlet at this location, we are asking you to complete the *Home Care/Home Support Census* (pink) and distribute the *Home Care/Home Support worker surveys* (pink) to your employees (see over page).

The census collects information about workers at the ***service outlet location*** at which your aged care services are coordinated. When home care/home support services are co-located (i.e. where more than one service outlet operates from the same location), and the workforce is coordinated, only one Home Care and Home Support Census needs to be completed.

If your aged care service belongs to a larger organisation, the information provided in the census needs to be for the home care/home support service outlets at this location only, not for the whole organisation.

Please call the free helpline 1800 071 735 if you need any assistance.

How to participate in the census

You can participate online via a secure website or by filling in the enclosed census and returning it in the reply paid envelope. The census cover has the website, username and password needed for online participation.

Unless you have told us otherwise, complete only one Home Care/Home Support Aged Care Census about the workforce at this service outlet location.

Some questions require you to refer to your personnel/payroll records (e.g. to calculate numbers of full time equivalent staff or calculate hours worked).

The person best suited to complete the census is either **the personnel manager or the person who recruits and manages staff**.

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

Distributing the worker surveys

We are asking you to distribute X surveys to a sample of aged care workers.

The person best suited to distribute these surveys is either the **manager or care coordinator**. If you are not this person, please pass the surveys onto this person, along with this letter.

It is important that a broad cross-section of the aged care workforce participate in the survey. This may mean providing encouragement and support to assist employees with literacy or English language difficulties to complete the survey.

When selecting employees (including yourself) for participation, please ensure that they:

a. work in direct care roles (i.e. nurses, allied health professionals, allied health assistants, community care workers), associated with the aged (i.e. they provide care for persons 65 years and older, or 50 years and older if Indigenous); **and**

b. are employed as PAYG staff (i.e. do not include volunteers or agency/brokered/self-employed staff); **and**

c. are randomly selected by choosing employees with a date of birth closest to today's date.

If you follow these distribution guidelines, our survey will include persons who are representative of all aged care workers in all services across Australia.

Aged care workers can participate online via a secure website or by filling in the enclosed survey and returning it in the reply paid envelope. The cover of each worker survey has specific information about online participation.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

If you have any queries about the census or survey, please call the free helpline on 1800 071 735.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

barcode
BSP:xxx-Service ID-Sequence
The Manager of the aged care service
Service Name
Service Postal address1
Service Postal address2
Service Suburb, State, Postcode

MAILING DATE

To the Manager of Service Name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

There are two different census and survey packages:
The Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys); and
The Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys).

As the manager of the residential service at this location, we are asking you to complete the *Census of Residential Aged Care Facilities* (blue) and distribute the *Residential Worker Surveys* (blue) to your employees (see below).

The census collects information about workers at the ***service location*** at which your aged care services are coordinated. When residential services are co-located (i.e. where more than one residential service operates from the same location), and the workforce is coordinated, only one residential census needs to be completed.

If your aged care service belongs to a larger organisation, the information provided in the census needs to be for the facilities at this location only, not for the whole organisation.

Please call the free helpline 1800 071 735 if you need any assistance.

How to participate in the census

You can participate online via a secure website or by filling in the enclosed census and returning it in the reply paid envelope. The census cover has the website, username and password needed for online participation.

Unless you have told us otherwise, complete only one Census of Residential Aged Care Facilities about the workforce at this location. Some questions require you to refer to your personnel/payroll records (e.g. to calculate numbers of full time equivalent staff or to calculate hours worked).

The person best suited to complete the census is either the **personnel manager or the person who recruits and manages staff**.

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

Distributing the worker surveys

We are asking you to distribute X surveys to a sample of aged care workers.

The person best suited to distribute these surveys is either the **manager or director of nursing**. If you are not this person, please pass the surveys onto this person, along with this letter.

It is important that a broad cross-section of the aged care workforce participate in the survey. This may mean providing encouragement and support to help employees with literacy or English language difficulties to complete the survey.

When selecting employees (including yourself) for participation, please ensure that they:

a. work in direct care roles (i.e. nurses, allied health professionals, allied health assistants, community care workers), associated with the aged (i.e. they provide care for persons 65 years and older, or 50 years and older if Indigenous); **and**

b. are employed as PAYG staff (i.e. do not include volunteers or agency/brokered/self-employed staff); **and**

c. are randomly selected by choosing employees with a date of birth closest to today's date.

If you follow these distribution guidelines, our survey will include persons who are representative of all aged care workers in all services across Australia.

Aged-care workers can participate **online** via a secure website or by filling in the enclosed survey and returning it in the reply paid envelope. The cover of each worker survey has specific information about online participation.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

If you have any queries about the census or survey, please call the free helpline on 1800 071 735.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

MAILING DATE

Service Name: Service name, Service ID

Provider Name: Provider name

Form Type: Home Care and Home Support Census

Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Census

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

How to participate in the census

We are asking you to complete this census for the home care and home support services provided by Provider name at this location only.

You can participate online via a secure website. Go to Survey.ipsos.com.au/HC2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use one of the reply paid envelopes to return it.

Please call the free helpline 1800 071 735 if you need any help.

Ethics and Privacy

All responses to the census are confidential and identifying details will be removed prior to analysis. Your census will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras

Director, National Institute of Labour Studies

Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

Additional information about the 2016 National Aged Care Workforce Census

When completing this form, please ensure that you…

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this ☒
3. Enter numbers into individual boxes like this 1 2 3
4. If the answer to a question is nil, please write '0' and go to the next question.
5. Please write clearly using a BLACK or BLUE pen.
6. Sometimes you will find the box you have marked has an instruction to go to another question.

   By following the instructions carefully you will be able to skip questions that do not apply to you.
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this ■ and mark the correct box like this ☒
8. Call the toll-free helpline on 1800 071 735 if you have any queries, or visit Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible. Please refer to payroll or staffing records where necessary. **The pay period referred to in the census is the last pay period (i.e. fortnight) in November 2015.**

Key Definitions

Throughout this questionnaire, the following definitions are used when referring to employee classifications. Please refer to these as you answer the questions.

Allied health assistants *support allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.*

Allied health professionals *include professional accredited allied health workers such as physiotherapists, diversional therapists, speech therapists, social workers and similar. Exclude employees solely engaged in a coordinator/management role.*

Ancillary care workers *have responsibility for providing services to care recipients such as home repairs, home modification, and home maintenance.*

Care manager *is responsible for all direct care staff; other job titles may be Director of Nursing, Care Co-ordinator and others.*

Community care workers *provide personal, domestic, social and other home care to care recipients as a core part of their jobs. For example: showering, medication, respite, cleaning, meals, transport, shopping. Job titles of community care worker vary widely.*

Direct care staff *provide care directly to care recipients as a core component of their work.*

Enrolled nurses *provide nursing care, working under the direction and (direct or indirect) supervision of the registered nurse.*

Nurse practitioner *is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.*

Pastoral/spiritual care workers *include professional pastoral/spiritual care workers (eg chaplains).*

Registered nurses *provide and supervise nursing care.*

Section A: About the Service Outlet

The following questions ask for basic information about the home care and home support aged care services provided at this location. We refer to these as your 'service outlet'. The information will help us to understand how the aged care workforce is distributed across different types of service outlets.

A1.1 Where is your service outlet located? *(Please describe the actual location from which these services are delivered, ABS Remoteness Areas category)*

- Major Cities of Australia ☐ 1
- Inner Regional Australia ☐ 2
- Outer Regional Australia ☐ 3
- Remote Australia ☐ 4
- Very Remote Australia ☐ 5
- Don't Know ☐ 6

A1.2 What is the postcode for the location of this service outlet?

☐☐☐☐

A1.2a What is the name of the suburb/town/locality for the location of this service outlet?

☐

A2 Is your service outlet:

- Not-for-Profit ☐ 1
- For Profit ☐ 2
- Government ☐ 3

A3.1 In the last reporting period, under which programmes did your service outlet provide services?

- Commonwealth Home Support Programme* ☐ 1
- Home Care Packages Programme ☐ 2
- Home and Community Care Victoria ☐ 3
- Home and Community Care Western Australia ☐ 4
- Home Care places under Multi-Purpose Service Programme ☐ 5
- Home Care places under National Aboriginal and Torres Strait Islander Flexible Aged Care Programme ☐ 6
- Home Care places under Innovative Pool Programme ☐ 7
- DVA Community Nursing, Veteran's Home Care or other DVA administered programme ☐ 8
- Transition Care Programme ☐ 9

A4 Is your service outlet part of a larger organisation, ie owned by a company or not-for-profit agency that owns other aged care facilities or services?

Yes ☐ 1 No ☐ 2

A5.1 Does your service outlet aim to cater for specific cultural or ethnic groups?

Yes ☐ 1 No ☐ 2 → If 'no', go to A6.1

A5.2 For which cultural or ethnic group/s does your service outlet cater? *(Cross all relevant boxes)*

- Aboriginal and/or Torres Strait Islander ☐
- Chinese ☐
- Dutch ☐
- Gay, lesbian, bisexual, transgender, intersex ☐
- Greek ☐
- Italian ☐
- Polish ☐
- German ☐
- Indian ☐
- Other *(please specify)* ☐

☐

A5.3 Does your service outlet employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A5.2?

Yes ☐ 1 No ☐ 2

A6.1 What qualifications does the Care Manager/ Care Coordinator in your service outlet have? *(Cross one box only)*

- Nursing qualifications ☐ 1
- Managerial qualifications ☐ 2
- Nursing and managerial qualifications ☐ 3
- None of the above ☐ 4
- Don't know ☐ 5

A6.2 What specialised qualifications in ageing does the Care Manager/Care Coordinator in your service outlet have? *(cross all relevant boxes)*

Gerontology	☐	Other	☐
Palliative Care	☐	None of the above	☐
Psychogeriatrics	☐	Don't Know	☐

**From 1 July 2015, the Commonwealth Home Support Programme brought together Commonwealth HACC Programme, Planned Respite from National Respite for Carers Programme (NRCP), Day Therapy Centres Programme (DTC), Assistance with Care and Housing for the Aged Programme (ACHA).*

A6.3 What are the three most important methods used to monitor the quality of aged care services/supports provided by this outlet?
(Cross three boxes only)

Managers or supervisors monitor quality	☐ 1
Inspectors from another part of the organisation monitor quality	☐ 2
Individual employees monitor quality	☐ 3
Keep records of feedback or complaints from service users	☐ 4
Surveys of service users	☐ 5
External auditing (beyond accreditation, e.g. third party inspectors)	☐ 6
Accreditation	☐ 7
Other *(please specify)*	☐ 8

A7 Do employees receive?
(Cross all relevant boxes)

Paid time for travel between care/support appointments?	☐
Paid time for travel between home and care/support appointments?	☐
Petrol/depreciation allowance for transport costs related to care/support appointments?	☐
None of these	☐

A8 How many people does your service outlet employ in total, including all full-time, part-time and casual employees, excluding agency staff?
(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave for the last fortnight pay period.)

☐☐☐☐ **PAYG Employees**

A9 How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?
(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave. Be sure to write '0' if no employees in a particular classification. Where an employee works in more than one classification, provide the number of hours for each classification. For example, if an employee works 40 hours per fortnight as a care manager and 20 hours per fortnight as a registered nurse, mark 1 in the care manager 31-69 hours category and 1 in the registered nurse 1-30 hours category).

Employee Classification (Definitions on Page 2)	**Hours worked in a fortnight**				**On leave**
	1 – 30	**31 – 69**	**70 – 80**	**81+**	
Management					
Administration					
Pastoral/spiritual care worker					
Direct care staff					
• Care manager/care co-ordinator					
• Nurse practitioner					
• Registered nurse					
• Enrolled nurse					
• Community care worker – personal, domestic or social care					
• Allied health professional					
• Allied health assistant					
• Ancillary care worker (e.g home repairs, modification, maintenance)					

A10.1 **Does this service outlet provide residential as well as home care/home support aged care services?**

Yes ☐ 1 No ☐ 2 → If 'no', go to A10.3

A10.2 **How many of your direct care PAYG employees in each classification work in your home care/ home support and/or residential services?** *(Please be sure to write '0' if no employees in a particular classification work in both services)*

Employee Classification	Number of direct care employees working in.... Residential ONLY	Home care/ home support ONLY	BOTH residential and home care/ home support
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant/Community care worker			
Allied health professional			
Allied health assistant			

A10.3 **If your service outlet does not employ PAYG paid staff, please indicate here and go to Section D, page 12.**

No PAYG paid staff ☐ 1

Section B: About the Direct Care Workforce

The following questions ask about the direct care workforce currently employed in your service outlet. Please note:

- *Definitions for employee classifications of direct care staff are on the inside cover, page 2.*
- *Only employees for whom PAYG tax is deducted by your organisation should be included. Agency and other non-PAYG contract staff are covered in Section D.*
- *Include staff who were on paid leave during the designated period.*
- *Only employees providing home care/home support aged care, including staff working in BOTH home care /home support and residential aged care, should be included here. Information about employees who ONLY provide residential aged care will be in the Census of Residential Aged Care Facilities.*

Unless otherwise indicated, when completing Section B please provide information based on the last pay period (ie fortnight) in November 2015.

*If you have **no employees in a category** please **write '0'** in the appropriate space.*

*It is important to be as **accurate** as possible. Please refer to your records where necessary.*

B1.1 **How many people employed in each classification work in your outlet as permanent full-time, permanent part-time or casual/fixed term contract?** *(Include staff on paid leave)*

Employee Classification	Permanent full-time*	Permanent part-time*	Casual/ contract full-time*	Casual/ contract part-time*
Nurse practitioner				
Registered nurse				
Enrolled nurse				
Community care worker				
Allied health professional				
Allied health assistant				
Total				

**The ABS definition of full-time work is 35 hours or more per week.*

B1.2 **Please record the number of full-time equivalent (FTE) employees*, in each classification in your outlet for the last pay period in November 2015.** *(Include staff on paid leave)*
**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. If an employee is on leave, count the number of hours they would usually have worked in the FTE calculation.*

Employee Classification	Total hours worked	Divide by 70 to calculate	Full-time equivalent employees (FTEs)*
Nurse practitioner		Divide by 70=	
Registered nurse		Divide by 70=	
Enrolled nurse		Divide by 70=	
Community care worker		Divide by 70=	
Allied health professional		Divide by 70=	
Allied health assistant		Divide by 70=	
Total			

We now ask for more detail about the employees listed in B1.1

Please ensure that:

- *You include all these employees in your answers.*
- *If you have no employees in a particular category, write '0' in your answer.*
- *The information is for the last pay period in November 2015 (unless stated otherwise in question).*

B2 **How many employees in each classification are female and how many are male?**

Employee Classification	Female	Male	Employee Classification	Female	Male
Nurse practitioner			Community care worker		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

B3 **How many of the employees in each classification fall into the following age categories?**

Employee Classification	Under 30 years	30 – 39 years	40 – 49 years	50 – 59 years	60+ years
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Community care worker					
Allied health professional					
Allied health assistant					

B3a For this outlet, what was the direct care staff headcount?

Employee Classification	Care staff headcount for the last pay period in November 2014	Number of care staff who left in the 12 months to the last pay period in November 2015	Number of care staff hired in the 12 months to the last pay period in November 2015
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Community care worker			
Allied health professional			
Allied health assistant			

B4 How many employees in each classification identify as being of Aboriginal and/or Torres Strait Islander origin?

Employee Classification	Number of employees	Don't know	Employee Classification	Number of employees	Don't know
Nurse practitioner		☐	Community care worker		☐
Registered nurse		☐	Allied health professional		☐
Enrolled nurse		☐	Allied health assistant		☐

B5 For each employee classification, how many are from culturally and linguistically diverse backgrounds*? *(not including those reported in B4)*

Employee Classification	Number of employees	Don't know	Employee Classification	Number of employees	Don't know
Nurse practitioner		☐	Community care worker		☐
Registered nurse		☐	Allied health professional		☐
Enrolled nurse		☐	Allied health assistant		☐

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

B6.1 For each employee classification, please indicate how many employees you have working under each form of employment contract.

Employee Classification	Award	Enterprise Agreement*	Common Law Contract	Individual Flexibility Agreement	Don't Know
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Community care worker					
Allied health professional					
Allied health assistant					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements.*

B6.2 For each employment classification, please indicate all awards that apply to employees in your service outlet. *(Note: all agreements will have a base condition award)*

Employee Classification	Aged Care Award 2010	Nurses Award 2010	SACH Award 2010	Other *(please specify relevant State Award)*	
Nurse practitioner	☐	☐	☐	☐	
Registered nurse	☐	☐	☐	☐	
Enrolled nurse	☐	☐	☐	☐	
Community care worker	☐	☐	☐	☐	
Allied health professional	☐	☐	☐	☐	
Allied health assistant	☐	☐	☐	☐	

B7.1 For each employee classification, please indicate whether you had skill shortages during the last 12 months.
(cross all relevant boxes)

Employee Classification	Yes
Nurse practitioner	☐
Registered nurse	☐
Enrolled nurse	☐
Community care worker	☐
Allied health professional	☐
Allied health assistant	☐
No skill shortages	☐

If no skill shortages go to B8.1

B7.2 Were these skill shortages due to any of the following? *(cross all relevant boxes)*

- Specialist knowledge required ☐
- Geographical location of service ☐
- Wages or salary costs too high for business ☐
- Lack of availability of adequate training ☐
- Unsure of long-term demands for service ☐
- Recruitment too slow ☐
- Lack of suitable applicants (skills/ qualifications/experiences/values) ☐
- Other *(please specify)* ☐

If specialist knowledge go to B7.2a, otherwise go to B7.3

B7.2a If specialist knowledge was required, was this ? *(cross all relevant boxes)*

- ICT/IT ☐
- Dementia Care ☐
- Palliative Care ☐
- Clinical skills for high care ☐
- Medications ☐
- Other *(please specify)* ☐

B7.3 How were these skill shortages addressed in the last 12 months?
(cross all relevant boxes)

- More use of external training of staff ☐
- More use of on-the-job training of staff ☐
- Existing workforce worked longer hours ☐
- Made greater use of agency staff ☐
- Sub-contracted or outsourced services to other businesses ☐
- Employed staff on short-term contract basis ☐
- Wages, salaries and/or conditions increased ☐
- Reduced outputs or production ☐
- Used student placements ☐
- Used volunteers ☐
- Other *(please specify)* ☐

B8.1 How many vacancies do you currently have in each classification?

Employee Classification	Total vacancies Full-time Equivalent*	How many POSITIONS are vacant? Full-time	Part-time
Nurse practitioner	☐	☐	☐
Registered nurse	☐	☐	☐
Enrolled nurse	☐	☐	☐
Community care worker	☐	☐	☐
Allied health professional	☐	☐	☐
Allied health assistant	☐	☐	☐

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE.*

B8.2 Approximately how long did it take you to fill the MOST RECENT vacancy for employees in each classification?

Employee Classification	Weeks	Employee Classification	Weeks
Nurse practitioner	☐	Community care worker	☐
Registered nurse	☐	Allied health professional	☐
Enrolled nurse	☐	Allied health assistant	☐

B8.3 What was the reason for the most recent vacancy for employees in each classification?
(cross all relevant boxes)

Reason	New position	Retirement	Injury/ illness	Resignation	End of contract	Involuntary separation	Other
Nurse practitioner	☐	☐	☐	☐	☐	☐	☐
Registered nurse	☐	☐	☐	☐	☐	☐	☐
Enrolled nurse	☐	☐	☐	☐	☐	☐	☐
Community care worker	☐	☐	☐	☐	☐	☐	☐
Allied health professional	☐	☐	☐	☐	☐	☐	☐
Allied health assistant	☐	☐	☐	☐	☐	☐	☐

B9 Are direct care workers required to do any of the following as part of their job?
(cross one box per row)

	Under normal circumstances	In exceptional circumstances	Never
Working longer than scheduled due to unanticipated needs of care recipients	☐	☐	☐
Variations in hours or location at short notice	☐	☐	☐
Working in very unsanitary conditions	☐	☐	☐
Working with aggressive service users (due to dementia etc)	☐	☐	☐
Working alone late at night (after 10 pm)	☐	☐	☐

B10.1 **In the last three months, how many instances of the following work-related injuries or illnesses were reported at your service outlet for direct care workers? Please check your records/incident reports.**
(If no work-related injuries or illnesses were reported, please write '0' and go to B11)

Reported Work-related Injury/Illness	Number	Reported Work-related Injury/Illness	Number
Fracture		Stress or other mental condition	
Chronic joint or muscle condition		Amputation	
Sprain/strain		Burns	
Cut/open wound		Other *(please specify)*	
Crushing injury/internal organ damage			
Superficial injury (minor injury)			

B10.2 **How many of these work-related injuries or illnesses reported at your service outlet were caused by:**

Cause of Reported Work-related Injury/Illness	Number	Cause of Reported Work-related Injury/Illness	Number
Lifting, pushing, pulling, bending		Fall	
Repetitive movement with low muscle loading		Exposure to mental stress	
Prolonged standing, working in cramped or unchanging positions		Long-term exposure to sound	
Vehicle accident		Contact with a chemical or substance	
Hitting, being hit or cut by person, object or vehicle		Fatigue	
		Other *(please specify)*	

B11 **How many of your PAYG direct care employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last three months?**

Employee Classification	Number of employees	Employee Classification	Number of employees
Nurse practitioner		Community care worker	
Registered nurse		Allied health professional	
Enrolled nurse		Allied health assistant	

Section C: Community Care Workers

We would like to know some further information about the community care workers (CCWs) employed in your aged care outlet. If no CCWs please go to Section D.

C1 **How many of your CCW employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

☐ **Completed** Certificate III (only) ☐ **Completed** Certificate IV

C2 **In the next 12 months, what areas of training will your CCWs most need/like to undertake:**
(cross all relevant boxes)

Dementia	☐	Allied health	☐
Mental health	☐	ICT/IT	☐
Management and leadership	☐	Other *(please specify)*	☐
Wound management	☐		
Palliative care	☐		

C3 **If you wished to employ additional CCWs, how would you be most likely to find them?** *(cross one box only)*

Wait for walk-ins	☐ 1	Employ those already working through a job placement program	☐ 6
Word of mouth	☐ 2	Agency	☐ 7
Place a newspaper job advertisement	☐ 3	Other	☐ 8
Place an internet job advertisement	☐ 4	Don't know	☐ 9
Place both newspaper and internet job advertisements	☐ 5		

C4.1 **Does your outlet employ CCWs from culturally and linguistically diverse backgrounds*?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

C4.2 **Please indicate the benefit which employing CCWs from culturally and linguistically diverse backgrounds has for your outlet** *(cross all relevant boxes)*

	Yes		Yes
Enhance cross-cultural understandings	☐	Link clients to ethnic communities	☐
Offer different cultural activities	☐	Link service to ethnic communities	☐
Language (other than English) skills	☐	Other *(please specify)*	☐
Don't know	☐		

C5.1 **What proportion of your current CCWs speak a language other than English as their first language?**

None ☐ 1 → **If 'none', go to D1** OR ☐☐☐ **Per cent (%)**

A number 1 to 100

C5.2 **What is the most common ethnic or cultural background of CCWs who speak a language other than English as their first language?** *(cross one box only)*

African	☐ 1	Italian	☐ 6
Chinese	☐ 2	Pacific Islands	☐ 7
Filipino	☐ 3	South-East Asian (other)	☐ 8
Greek	☐ 4	Other *(please specify)*	☐ 9
Indian	☐ 5		

C5.3 **Does lack of English language skills amongst your CCWs cause any difficulties in your outlet?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

C5.4 **In which areas does lack of English language skills amongst your CCWs cause difficulties?** *(cross all relevant boxes)*

Occupational Health and Safety	☐	Communication with residents' families	☐
Communication with management and/ or other staff	☐	Other *(please specify)*	☐
Communication with residents	☐		

Section D: Volunteers, Agency, Brokered, and Self-Employed Staff

We would now like to ask about the nursing or employment agency staff, brokered staff, self-employed staff and volunteers for whom you do not deduct PAYG tax, who worked in your service outlet during the last pay period in November 2015. If you did not have any of these staff types, please write '0' for each category.

D1 **How many people from nursing or employment agencies, brokered or self-employed staff worked at your aged care service outlet during the last pay period in November 2015?**

Employee Classification	Number of agency staff	Number of brokered staff	Number of self-employed staff
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Community care worker			
Allied health professional			
Allied health assistant			

Definitions:
Agency staff are contracted from a nursing or employment agency (i.e. labour hire agency). Your service outlet has responsibility for training and supervising these staff members.
Brokered staff are contracted from other care providers.
Self-employed staff are individuals who have their own ABN and operate as independent care workers. Your service outlet would broker directly with the individual to engage their services.

D2 **Why does this outlet choose to use agency, brokered, or self-employed staff?** *(cross all that apply)*

	Agency staff	Brokered staff	Self-employed staff
Matching staff to peaks in service user demand	☐	☐	☐
Short-term cover for staff absences	☐	☐	☐
Covering for maternity leave or annual leave	☐	☐	☐
Unable to fill vacancies	☐	☐	☐
Obtain specialist skills	☐	☐	☐
Freeze on permanent staff numbers	☐	☐	☐
Other *(please specify)*			

D3 **How many volunteers worked in your service outlet in the last two weeks?**

☐☐☐ **Volunteers** → If '0', go to survey end

If 'volunteers' at D3

D4 **What was the total amount of hours worked by all volunteers in the last two weeks?**

☐☐☐☐

If 'volunteers' at D3

D5 **If you have volunteers, what is the area or role that they undertake?**

Domestic activity assistance	☐ 1	Transport assistance	☐ 7
Respite care assistance	☐ 2	Shopping/appointment assistance	☐ 8
Social activity support assistance	☐ 3	Meal preparation/delivery assistance	☐ 9
Planned group activity assistance	☐ 4	Companionship/befriending	☐ 10
Home maintenance assistance	☐ 5	Other *(please specify)*	☐ 11
Gardening assistance	☐ 6		

Barcode

THANK YOU FOR YOUR HELP

For future surveys, please tell us approximately how long it took to complete this form. ☐☐☐ **Minutes**

MAILING DATE
Service Name: Service name, Service ID
Provider Name: Provider name
Form Type: Residential Census
Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Census

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

How to participate in the census

We are asking you to complete this census for the residential services provided by Provider name at this location only.

You can participate online via a secure website. Go to Survey.ipsos.com.au/RC2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form and use one of the reply paid envelopes to return it.

Please call the free helpline 1800 071 735 if you need any help.

Ethics and Privacy

All responses to the census are confidential and identifying details will be removed prior to analysis. Your census will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

Additional information about the 2016 National Aged Care Workforce Census

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this [X]
3. Enter numbers into individual boxes like this [1][2][3]
4. If the answer to a question is nil, please write '0' and go to the next question.
5. Please write clearly using a BLACK or BLUE pen.
6. Sometimes you will find the box you have marked has an instruction to go to another question.

   By following the instructions carefully you will be able to skip questions that do not apply to you.
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this ■ and mark the correct box like this [X]
8. Call the toll-free helpline on 1800 071 735 if you have any queries, or visit Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible. Please refer to payroll or staffing records where necessary.
The pay period for the census is the last pay period (i.e. fortnight) in November 2015.

Key Definitions

Throughout this questionnaire, the following definitions are used when referring to employee classifications. Please refer to these as you answer the questions.

Allied health assistants *support allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.*

Allied health professionals *include professional accredited allied health workers such as physiotherapists, diversional therapists, speech therapists, social workers and similar. Exclude employees solely engaged in a coordinator/management role.*

Ancillary staff – other *have responsibility for ensuring that the buildings, property and gardens are maintained.*

Ancillary staff – resident wellbeing *have responsibility for cleaning residents rooms, providing meals and other services that support the personal care provided by direct care staff.*

Care manager *is responsible for all direct care staff; other job titles may be Director of Nursing, Care Co-ordinator and others.*

Direct care staff *provide personal care directly to residents as a core component of their work.*

Enrolled nurses *provide nursing care, working under the direction and (direct or indirect) supervision of the registered nurse.*

Nurse practitioner *is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.*

Pastoral/spiritual care workers *include professional pastoral/spiritual care workers (e.g. chaplains).*

Personal care attendants *provide personal care to residents as a core part of their jobs (usually under direction of nursing staff). Job titles of personal care attendants vary widely. They include assistant or aide, personal care worker, assistant-in-nursing and others.*

Registered nurses *provide and supervise nursing care.*

Section A: About the Facility

The following questions ask for information about your aged care facility. This information will help us to understand how the aged care workforce is distributed across different types of homes.

A1 Is your facility part of a larger organisation eg owned by a company or not-for-profit agency that owns other aged care facilities or services?

Yes ☐ 1 No ☐ 2

A2.1 Does your facility aim to cater for specific cultural or ethnic groups?

Yes ☐ 1 No ☐ 2 → **If 'no', go to A3.1**

A2.2 For which cultural or ethnic group/s does your facility cater? *(cross all relevant boxes)*

- Aboriginal and/or Torres Strait Islander ☐
- Chinese ☐
- Dutch ☐
- Gay, lesbian, bisexual, transgender, intersex ☐
- Greek ☐
- Italian ☐
- Polish ☐
- German ☐
- Indian ☐
- Other *(please specify)* ☐

A2.3 Does your facility employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A2.2?

Yes ☐ 1 No ☐ 2

A3.1 What qualifications does the Care Manager/ Care Coordinator in your facility have? *(cross one box only)*

- Nursing qualifications ☐ 1
- Managerial qualifications ☐ 2
- Nursing and managerial qualifications ☐ 3
- None of the above ☐ 4
- Don't know ☐ 5

A3.2 What specialised qualifications in ageing does the Care Manager/Care Coordinator in your facility have? *(cross all relevant boxes)*

- Gerontology ☐
- Palliative Care ☐
- Psychogeriatrics ☐
- Other ☐
- None of the above ☐
- Don't know ☐

A3.3 What are the three most important methods used to monitor the quality of aged care services/supports provided by this facility? *(cross three boxes only)*

- Managers or supervisors monitor quality ☐ 1
- Inspectors from another part of the organisation monitor quality ☐ 2
- Individual employees monitor quality ☐ 3
- Keep records of feedback or complaints from service users ☐ 4
- Surveys of service users ☐ 5
- External auditing (beyond accreditation, e.g. third party inspectors) ☐ 6
- Accreditation ☐ 7
- Other *(please specify)* ☐ 8

A5 How many people does your facility employ in total, including all full-time, part-time and casual employees, excluding agency staff? *(Count all employees for whom PAYG tax is deducted by your facility, including staff on paid leave; for the last fortnight pay period.)*

☐☐☐☐ **PAYG Employees**

A6 **How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?** *(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave. Be sure to write '0' if no employees in a particular classification. Where an employee works in more than one classification, provide the number of hours for each classification. For example, if an employee works 40 hours per fortnight as a care manager and 20 hours per fortnight as a registered nurse, mark 1 in the care manager 31-69 hours category and 1 in the registered nurse 1-30 hours category).*

Employee Classification (definitions on page 2)	Hours worked in a fortnight: 1 – 30	31 – 69	70 – 80	81+	On leave
Management	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐
Pastoral/spiritual care work	☐	☐	☐	☐	☐
Direct care staff					
• Care manager/care co-ordinator	☐	☐	☐	☐	☐
• Nurse practitioner	☐	☐	☐	☐	☐
• Registered nurse	☐	☐	☐	☐	☐
• Enrolled nurse	☐	☐	☐	☐	☐
• Personal care attendant	☐	☐	☐	☐	☐
• Allied health professionals	☐	☐	☐	☐	☐
• Allied health assistants	☐	☐	☐	☐	☐
Ancillary staff					
• Resident wellbeing (e.g. cleaning, kitchen)	☐	☐	☐	☐	☐
• Other ancillary staff (e.g. gardening, maintenance)	☐	☐	☐	☐	☐

A7.1 **Does this facility provide home care/home support aged care services as well as residential services?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to A7.3**

A7.2 **How many of your direct care PAYG employees in each classification work in your residential and home care/home support services?** *(Please include staff on paid leave. Be sure to write '0' if no employees in a particular classification work in both services)*

Employee Classification	Number of direct care employees working in....: Residential ONLY	Home care/ home support ONLY	BOTH Residential and home care/home support
Nurse practitioner	☐	☐	☐
Registered nurse	☐	☐	☐
Enrolled nurse	☐	☐	☐
Personal care attendant/Community care worker	☐	☐	☐
Allied health professional	☐	☐	☐
Allied health assistant	☐	☐	☐

A7.3 **If your facility does not employ PAYG paid direct care staff, please indicate here and go to Section D (page 11).**

No PAYG paid staff ☐ 1

Section B: About the Direct Care Workforce

The following questions ask about the direct care workforce currently employed in your facility. Please note:

- *Definitions for employee classifications of direct care staff are on the inside cover, page 2.*
- *Only employees for whom PAYG tax is deducted by your organisation should be included. Agency and other non-PAYG contract staff are covered in Section D.*
- *Include staff who were on paid leave during the designated period.*
- *Only employees providing residential aged care, including staff working in BOTH residential and home care/home support aged care, should be included. Information about employees who ONLY provide home care/home support based aged care will be captured in the Census of Home Care and Home Support Aged Care Outlets.*

Unless otherwise indicated, when completing Section B please give information for the last pay period (i.e. fortnight) in November 2015.

If you have ***no employees in a category*** *please* ***write '0'*** *in the appropriate space.*

It is important to be as accurate as possible. Please refer to your records where necessary.

B1.1 How many people employed in each classification work in your facility as permanent full-time, permanent part-time or casual/fixed term contract*?

(Include staff on paid leave)

Employee Classification	Permanent full-time*	Permanent part-time*	Casual/ contract full-time*	Casual/fixed term contract part-time*
Nurse practitioner				
Registered nurse				
Enrolled nurse				
Personal care attendant				
Allied health professional				
Allied health assistant				
Total				

**The ABS definition of full-time work is 35 hours or more per week.*

B1.2 Please record the number of full-time equivalent (FTE) employees*, in each classification in your facility for the last pay period in November 2015. *(Include staff on paid leave)*

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. If an employee is on leave, count the number of hours they would usually have worked in the FTE calculation.*

Employee Classification	Total hours worked	Divide by 70 to calculate	Full-time equivalent employees (FTEs)*
Nurse practitioner		Divide by 70=	
Registered nurse		Divide by 70=	
Enrolled nurse		Divide by 70=	
Personal care attendant		Divide by 70=	
Allied health professional		Divide by 70=	
Allied health assistant		Divide by 70=	
Total			

We now ask for more detail about the employees listed in B1.1

Please ensure that:

- *You include all these employees in your answers.*
- *If you have no employees in a particular category, write '0' in your answer.*
- *The information is for the last pay period in November 2015 (unless stated otherwise in question).*

B2 How many employees in each classification are female and how many are male?

Employee Classification	Female	Male	Employee Classification	Female	Male
Nurse practitioner			Personal care attendant		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

B3 How many of the employees in each classification fall into the following age categories?

Employee Classification	Under 30 years	30 – 39 years	40 – 49 years	50 – 59 years	60+ years
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Personal care attendant					
Allied health professional					
Allied health assistant					

B3a For this facility, what was the direct care staff headcount?

Employee Classification	Care staff headcount for the last pay period in November 2014	Number of care staff who left in the 12 months to the last pay period in November 2015	Number of care staff hired in the 12 months to the last pay period in November 2015
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant			
Allied health professional			
Allied health assistant			

B4 How many employees in each classification identify as being of Aboriginal and/or Torres Strait Islander origin?

Employee Classification	Number of employees	Don't know
Nurse practitioner		☐
Registered nurse		☐
Enrolled nurse		☐
Personal care attendant		☐
Allied health professional		☐
Allied health assistant		☐

B5 For each employee classification, how many are from culturally and linguistically diverse backgrounds* *(not including those reported in B4)*?

Employee Classification	Number of employees	Don't know
Nurse practitioner		☐
Registered nurse		☐
Enrolled nurse		☐
Personal care attendant		☐
Allied health professional		☐
Allied health assistant		☐

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

B6.1 For each employee classification, please indicate how many employees you have working under each form of employment contract.

Employee Classification	Award	Enterprise Agreement*	Common Law Contract	Individual Flexibility Agreement	Don't know
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Personal care attendant					
Allied health professional					
Allied health assistant					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements.*

B6.2 For each employment classification, please indicate all awards that apply to employees in your facility. *(Note: all agreements will have a base condition award)*

Employee Classification	Aged Care Award 2010	Nurses Award 2010	SACH Award 2010	Other *(please specify relevant State Award)*	
Nurse practitioner	☐	☐	☐	☐	
Registered nurse	☐	☐	☐	☐	
Enrolled nurse	☐	☐	☐	☐	
Personal care attendant	☐	☐	☐	☐	
Allied health professional	☐	☐	☐	☐	
Allied health assistant	☐	☐	☐	☐	

B7.1 For each employee classification, please indicate whether you had skill shortages during the last 12 months.

Employee Classification	Yes
Nurse practitioner	☐
Registered nurse	☐
Enrolled nurse	☐
Personal care attendant	☐
Allied health professional	☐
Allied health assistant	☐
No skill shortages	☐

If no skill shortages go to B8.1

B7.2 Were these skill shortages due to any of the following? *(cross all relevant boxes)*

- Specialist knowledge required ☐
- Geographical location of facility ☐
- Wages or salary costs too high for business ☐
- Lack of availability of adequate training ☐
- Unsure of long-term demands for service ☐
- Recruitment too slow ☐
- Lack of suitable applicants (skills/qualifications/experience/values) ☐
- Other *(please specify)* ☐

If specialist knowledge go to B7.2a; otherwise go to B7.3

B7.2 a If specialist knowledge was required, was this? *(cross all relevant boxes)*

- ICT/IT ☐
- Dementia care ☐
- Palliative care ☐
- Clinical skills for high care ☐
- Medications ☐
- Other *(please specify)* ☐

B7.3 How were these skill shortages addressed in the last 12 months? *(cross all relevant boxes)*

- More use of external training of staff ☐
- More use of on-the-job training of staff ☐
- Existing workforce worked longer hours ☐
- Made greater use of agency staff ☐
- Sub-contracted or outsourced services to other businesses ☐
- Employed staff on short-term contract basis ☐
- Wages, salaries and/or conditions increased ☐
- Reduced outputs or production ☐
- Used student placements ☐
- Used volunteers ☐
- Other *(please specify)* ☐

B8.1 How many vacancies do you currently have in each classification?

Employee Classification	Total vacancies Full-time Equivalent/FTE*	How many POSITIONS are vacant? Full-time	Part-time
Nurse practitioner	☐	☐	☐
Registered nurse	☐	☐	☐
Enrolled nurse	☐	☐	☐
Personal care attendant	☐	☐	☐
Allied health professional	☐	☐	☐
Allied health assistant	☐	☐	☐

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE.*

B8.2 Approximately how long did it take you to fill the MOST RECENT vacancy for employees in each classification?

Employee Classification	Weeks	Employee Classification	Weeks
Nurse practitioner	☐	Personal care attendant	☐
Registered nurse	☐	Allied health professional	☐
Enrolled nurse	☐	Allied health assistant	☐

B8.3 What was the reason for the most recent vacancy for employees in each classification?
(cross all relevant boxes)

Reason	New position	Retirement	Injury/ illness	Resignation	End of contract	Involuntary separation	Other
Nurse practitioner	☐	☐	☐	☐	☐	☐	☐
Registered nurse	☐	☐	☐	☐	☐	☐	☐
Enrolled nurse	☐	☐	☐	☐	☐	☐	☐
Personal care attendant	☐	☐	☐	☐	☐	☐	☐
Allied health professional	☐	☐	☐	☐	☐	☐	☐
Allied health assistant	☐	☐	☐	☐	☐	☐	☐

B9 Are direct care workers required to do any of the following as part of their job?
(cross one box per row)

	Under normal circumstances	In exceptional circumstances	Never
Working longer than scheduled due to unanticipated needs of residents	☐	☐	☐
Variations in hours or location at short notice	☐	☐	☐
Working in very unsanitary conditions	☐	☐	☐
Working with aggressive service users (due to dementia etc)	☐	☐	☐
Working alone late at night (after 10 pm)	☐	☐	☐

B10.1 **In the last <u>three months</u>, how many instances of the following work-related injuries or illnesses were reported at your facility? Please check your records/incident reports.** *(If no work-related injuries or illnesses were reported, please write '0' and go to B11)*

Reported Work-related Injury/Illness	Number
Fracture	
Chronic joint or muscle condition	
Sprain/strain	
Cut/open wound	
Crushing injury/internal organ damage	
Superficial injury (minor injury)	
Stress or other mental condition	
Amputation	
Burns	
Other *(please specify)*	

B10.2 **How many of these work-related injuries or illnesses reported at your facility were caused by:**

Cause of Work-related Injury/Illness	Number
Lifting, pushing, pulling, bending	
Repetitive movement with low muscle loading	
Prolonged standing, working in cramped or unchanging positions	
Vehicle accident	
Hitting, being hit or cut by person, object or vehicle	
Fall	
Exposure to mental stress	
Long-term exposure to sound	
Contact with a chemical or substance	
Fatigue	
Other *(please specify)*	

B11 **How many of your PAYG employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last three months?**

Employee Classification	Number of employees
Nurse practitioner	
Registered nurse	
Enrolled nurse	
Personal care attendant	
Allied health professional	
Allied health assistant	

Section C: Personal Care Attendants

We would like to know some further information about the personal care attendants (PCAs) employed in your aged care facility. If there are no PCAs please go to Section D.

C1 **How many of your PCA employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

☐ **Completed** Certificate III (only) ☐ **Completed** Certificate IV

C2 **In the next 12 months, what areas of training will your PCAs most need/like to undertake:** *(cross all relevant boxes)*

Dementia	☐	Allied health	☐
Mental health	☐	ICT/IT	☐
Management and leadership	☐	Other *(please specify)*	☐
Wound management	☐		
Palliative care	☐		

C3 **If you wished to employ additional PCAs, how would you be most likely to find them?** *(cross one box only)*

Wait for walk-ins	☐ 1	Employ those already working through a job placement program	☐ 6
Word of mouth	☐ 2	Agency	☐ 7
Place a newspaper job advertisement	☐ 3	Other	☐ 8
Place an internet job advertisement	☐ 4	Don't know	☐ 9
Place both newspaper and internet job advertisements	☐ 5		

C4.1 **Does your facility employ PCAs from culturally and linguistically diverse backgrounds*?**

Yes ☐ 1 No ☐ 2 **→ If 'no', go to D1**

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

C4.2 **Please indicate the benefits which employing PCAs from culturally and linguistically diverse backgrounds has for your facility:**
(cross all relevant boxes)

	Yes		Yes
Enhance cross-cultural understandings	☐	Link facility to ethnic communities	☐
Offer different cultural activities	☐	Don't know	☐
Language (other than English) skills	☐	Other *(please specify)*	☐
Link clients to ethnic communities	☐		

C5.1 **What proportion of your current PCAs speak a language other than English as their first language?**

None ☐ 1 **→ If 'none', go to D1** OR ☐☐☐ **Percent (%)**
A number 1 to 100

C5.2 What is the most common ethnic or cultural background of PCAs who speak a language other than English as their first language? *(cross one box only)*

African	☐ 1	Italian	☐ 6
Chinese	☐ 2	Pacific Islands	☐ 7
Filipino	☐ 3	South-East Asian (other)	☐ 8
Greek	☐ 4	Other *(please specify)*	☐ 9
Indian	☐ 5		

C5.3 Does lack of English language skills amongst your PCAs cause any difficulties in your facility?

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

C5.4 In which areas does lack of English language skills amongst your PCAs cause difficulties? *(cross all relevant boxes)*

Occupational Health and Safety	☐	Communication with residents' families	☐
Communication with management and/ or other staff	☐	Other *(please specify)*	☐
Communication with residents	☐		

Section D: Volunteers, Agency, Brokered, and Self-Employed Staff

We would now like to ask about the nursing or employment agency staff, brokered staff, self-employed staff and volunteers, for whom you do not deduct PAYG tax who worked in your facility during the last pay period in November 2015 (fortnight). If you did not have any of these staff in your facility, please write '0' for each category.

D1 How many people from nursing or employment agencies, brokered or self-employed staff worked in your aged care facility during the last pay period in November 2015?

Employee Classification	Number of agency staff	Number of brokered staff	Number of self-employed staff
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant			
Allied health professional			
Allied health assistant			

Definitions:

Agency staff are contracted from a nursing or employment agency (i.e. labour hire agency). Your facility has responsibility for training and supervising these staff members.

Brokered staff are contracted from other care providers.

Self-employed staff are individuals who have their own ABN and operate as independent care workers. Your facility would broker directly with the individual to engage their services.

D2 **Why does this facility choose to use agency, brokered, or self-employed staff?**
(cross all that apply)

	Agency staff	Brokered staff	Self-employed staff
Matching staff to peaks in service user demand	☐	☐	☐
Short-term cover for staff absences	☐	☐	☐
Covering for maternity leave or annual leave	☐	☐	☐
Unable to fill vacancies	☐	☐	☐
Obtain specialist skills	☐	☐	☐
Freeze on permanent staff numbers	☐	☐	☐
Other *(please specify)*			

D3 **How many volunteers worked in your facility in the last two weeks?**

☐☐☐ **Volunteers** → **If '0', go to survey end**

If 'volunteers' at D3

D4 **What was the total amount of hours worked by all volunteers in the last two weeks?**

☐☐☐☐ **Volunteer Hours**

If 'volunteers' at D3

D5 **If you have volunteers, what is the area or role that they undertake?**
(cross all relevant boxes)

Domestic activity assistance	☐	Transport assistance	☐
Respite care assistance	☐	Shopping/appointment assistance	☐
Social activity support assistance	☐	Meal preparation/delivery assistance	☐
Planned group activity assistance	☐	Companionship/befriending	☐
Home maintenance assistance	☐	Other *(please specify)*	☐
Gardening assistance	☐		

THANK YOU FOR YOUR HELP

FOR FUTURE SURVEYS, PLEASE TELL US APPROXIMATELY HOW LONG IT TOOK TO COMPLETE THIS FORM. ☐☐☐ **Minutes**

Barcode

MAILING DATE

Form Type: Home Care and Home Support Workforce Survey

Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

Workers in aged-care services across Australia are being approached to take part in this survey.

In order to provide an accurate picture of the aged care workforce it is important to include information from workers such as yourself. We are interested in your experiences of working in aged care; your characteristics (such as age and gender etc.), the conditions under which you work, and how you feel about what you do.

How to participate in the survey

We are asking you to complete this survey as an employee of the home care and home support services provided at this location. To take part online go to the secure website Survey.ipsos.com.au/HW2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use the reply paid envelope to return it.

If you have any queries regarding the survey, please contact the free helpline on 1800 071 735.

Ethics and Privacy

All responses to the survey are confidential and identifying details will be removed prior to analysis. The information from your survey will be combined with all other data and no individual site or person will be identified.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras

Director, National Institute of Labour Studies

Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

Additional information about the 2016 National Aged Care Workforce Survey

When completing this form, please ensure that you…

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this ☒
3. Enter numbers into individual boxes like this 1 2 3
4. If the answer to a question is nil, please write '0' and go to the next question
5. Please write clearly using a BLACK or BLUE pen
6. Sometimes you will find the box you have marked has an instruction to go to another question.

   By following the instructions carefully you will be able to skip questions that do not apply to you.
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box

   like this ■ and mark the correct box like this ☒
8. Call the toll-free helpline on 1800 071 735 if you have any queries
9. More detailed information about the National Aged Care Workforce Census and Survey can be found

   at the following website: Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible.

Section A: About Your Work

Please answer the questions in this section by thinking about the direct care job you do for this aged care service outlet, unless the question refers specifically to another job you may have. Please remember that this questionnaire is completely confidential. Only the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

A1.1 What is your main job?

- Nurse practitioner ☐ 1
- Registered nurse ☐ 2
- Enrolled nurse ☐ 3
- Physiotherapist ☐ 4
- Occupational therapist ☐ 5
- Social worker ☐ 6
- Speech therapist ☐ 7
- Diversional therapist ☐ 8
- *Community care worker ☐ 9
- *Allied health assistant ☐ 10

If 9 'community care worker' or 10 'allied health assistant', go to A1.2. Otherwise go to A2

- Other *(please specify)* ☐ 11

____

Definitions:

Community care worker: provides personal, domestic, social and other home care to care recipients as a core part of their job. Job titles of community care workers vary widely.

Allied health assistant: supports allied health professionals in providing personal, social and emotional care to care recipients. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.

A1.2 If you are a community care worker or allied health assistant, what is your main role?

- Personal care ☐ 1
- Home care/domestic assistance ☐ 2
- Respite care ☐ 3
- Planned activity group assistant ☐ 4
- Home maintenance/modification ☐ 5
- Gardening ☐ 6
- Transport ☐ 7
- Shopping/appointments ☐ 8
- Meal preparation/delivery ☐ 9
- Therapeutic support assistance ☐ 10
- Social activity support assistance ☐ 11
- Other *(please specify)* ☐ 12

____

A2 What proportion (percent) of the care recipients you work with are:

☐☐☐ **% Aged***

☐☐☐ **% Younger people with a disability**

☐☐☐ **% Other**

Definition:

Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.

A3 Does your role involve managing or supervising direct care staff?

- Yes, I am a care manager/co-ordinator* ☐ 1
- Yes, I am a care leader* ☐ 2
- Yes, but neither of the above ☐ 3
- No ☐ 4
- Don't know ☐ 5

Definitions:

A care manager or care co-ordinator has responsibility for all direct care staff; other job titles may be Director of Nursing and others.

A care leader has responsibility for a team of direct care staff but will report to a care manager.

A4.1 Which of the following best describes your current work schedule?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A4.2 Would you prefer to maintain your current work schedule or change it?

- Prefer to maintain current schedule ☐ 1 If 'maintain', go to A5.1
- Change to a different schedule ☐ 2

A4.3 Which describes the work schedule you would *prefer*?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A5.1 How many hours on average do you *usually* work each week in this job *(include all paid and unpaid hours)***?**

☐☐ **Hours per week**

A5.2 How many hours would you *like* to work in this job?

☐☐ **Hours per week**

A6 How many of the hours you usually work each week are paid and unpaid? *(If you do not work any unpaid hours write '0' in the corresponding box)*

☐☐ **Paid hours**

☐☐ **Unpaid hours**

A7 What was the minimum number of hours in a day that you were required to work last week? *(ie the minimum number of hours that you worked before your roster/shift ended)*

☐☐ **Hours**

A8 Thinking about a typical shift, how much of your shift would you spend actively caring for recipients of the aged care service *(as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)***?**

- Less than a third ☐ 1
- Between one third and two thirds ☐ 2
- More than two thirds ☐ 3

A9 Which best describes your form of employment?

- Casual ☐ 1
- Permanent (full or part-time) ☐ 2
- Fixed term contract ☐ 3

A10 Are you entitled to paid sick leave?

- Yes ☐ 1
- No ☐ 2
- Don't know ☐ 3

A11.1 For this job, what was the total amount of your most recent pay before tax or anything else was taken out? *(Amount to the nearest dollar)*

$ ☐ , ☐☐☐ . 0 0

A11.2 For what period does that cover?

- Week ☐ 1
- Fortnight ☐ 2
- Month ☐ 3

A12 How long have you worked for this home care / home support aged care service?

☐☐ **Years** ☐☐ **Months**

A13 How old were you when you first began working in aged care?

☐☐ **Years**

A14 Excluding any breaks from working in aged care, for how many years have you actually worked in aged care?

☐☐ **Years**

A15 Before you first obtained this job, had you done any work for this provider?

- No ☐ 1
- Yes, paid work ☐ 2
- Yes, unpaid work/volunteer ☐ 3

A16.1 When you approached this aged care provider for your job, did you know there was a job available?

- Yes ☐ 1
- No — If 'no', go to A17.1 → ☐ 2
- Don't know ☐ 3

A16.2 How did you find out your job was available? *(cross one box only)*

- Job network employment agency ☐ 1
- Other employment agency ☐ 2
- Career service at a tertiary educational institution ☐ 3
- School programs ☐ 4
- Newspaper advertisements ☐ 5
- Internet sites ☐ 6
- Centrelink job search services/ touchscreens ☐ 7
- Company or professional contacts ☐ 8
- Workplace noticeboards ☐ 9
- Word of mouth ☐ 10
- Other *(please specify)* ☐ 11

A17.1 What was your last paid job before you FIRST worked in aged care?

- No previous paid employment — If 'no', go to A18 → ☐ 1
- Nurse, acute care ☐ 2
- Nurse, community care ☐ 3
- Other healthcare ☐ 4
- Carer in other setting ☐ 5
- Disability care ☐ 6
- Salesperson ☐ 7
- Clerical worker ☐ 8
- Hospitality worker (waitress, etc.) ☐ 9
- Cleaner ☐ 10
- Professional (other than nurse) ☐ 11
- Manager ☐ 12
- Other paid employment ☐ 13

A17.2 Why did you leave that job? *(cross one box only)*

- Family reasons ☐ 1
- Personal reasons (including health) ☐ 2
- Did not like job ☐ 3
- Contract ended ☐ 4
- Redundancy ☐ 5
- Career change ☐ 6
- Other ☐ 7

A18 Had you worked in aged care before you began your CURRENT job?

- Yes, paid ☐ 1
- Yes, unpaid/voluntary ☐ 2
- No — If 'no', go to A20.1 → ☐ 3

A19 What was the most important reason you left the last (paid) aged care job you held before your current one? *(cross one box only)*

- To achieve higher pay ☐ 1
- To avoid workmates/colleagues I did not get along with or like ☐ 2
- To avoid managers/management I did not get along with or like ☐ 3
- The job was too stressful ☐ 4
- Not able to spend sufficient time with clients ☐ 5
- To get shifts or hours of work I wanted ☐ 6
- To be closer to home ☐ 7
- To fulfil care responsibilities (including having a baby) ☐ 8
- To find more challenging work ☐ 9
- To find easier work ☐ 10
- Made redundant/retrenched ☐ 11
- Moved house/location ☐ 12
- Other *(please specify)* ☐ 13

A20.1 Did you have more than one job last week?

- Yes ☐ 1
- No — If 'no', go to A21 → ☐ 2

A20.2 Where did you work in your other job(s) last week? *(cross all relevant boxes)*

- A residential aged care facility ☐
- Another home care / home support aged care service ☐
- Disability care ☐
- Not in aged or disability care, something else ☐

A20.3 How many hours each week do you usually work in your other AGED CARE job(s)?

☐☐ **Hours p.w. in other AGED CARE jobs**

A20.4 How many hours each week do you usually work in your other job(s) OUTSIDE OF aged care?

☐☐ **Hours p.w. in NON aged care jobs**

A21 Are you currently actively seeking work outside of this aged care provider?

Yes	☐ 1
No	☐ 2

A22.1 Do you expect to be working for this aged care provider in 12 months time?

Yes If 'yes', go to A23 →	☐ 1
No	☐ 2
It depends	☐ 3
Don't know	☐ 4

A22.2 Where do you see yourself working 12 months from now?

Working in aged care, different provider	☐ 1
Working in residential aged care	☐ 2
Working in disability care	☐ 3
Working, not in aged or disability care	☐ 4
Not working for pay	☐ 5
Don't know	☐ 6

A22.3 What is the main reason you may finish work for this aged care provider in the next 12 months? *(cross one box only)*

Family reasons	☐ 1
Financial reasons	☐ 2
Employment conditions	☐ 3
Nature of care work	☐ 4
Stress/burnout	☐ 5
Other health related reasons	☐ 6
Returning to study	☐ 7
Travel	☐ 8
Retiring	☐ 9
End of contract	☐ 10
Retrenchment/redundancy	☐ 11
Falling quality of care	☐ 12
Other *(please specify)*	☐ 13

A23 Where do you see yourself working 3 years from now? *(cross one box only)*

Working in aged care, this provider	☐ 1
Working in aged care, different provider	☐ 2
Working in residential aged care	☐ 3
Working in disability care	☐ 4
Working, not in aged care or disability care	☐ 5
Not working for pay	☐ 6
Don't know	☐ 7
Other	☐ 8

A24 **The following statements are about your current job for this home care / home support aged care provider.**
(Please indicate, by putting a cross in one box on each line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.)

	Strongly disagree						Strongly agree
a) I am able to spend enough time with each care recipient	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
b) I have the skills and abilities I need to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
c) I use many of my skills and abilities in my current job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
d) I have a lot of freedom to decide how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
e) I feel under pressure to work harder in my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
f) My job is more stressful than I had ever imagined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
g) Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
h) Management and employees have good relations in my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
i) Adequate training is available through my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A25 **In general, how would you describe relations at your workplace?**
(Using a scale from 1 to 7, where 1 is when workplace relations are very bad and 7 is when workplace relations are very good, please put a cross in one box on each line)

	Very bad						Very good
Between management and yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Between workmates/colleagues and yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A26 **The following questions ask about how satisfied or dissatisfied you are with different aspects of your job.**
(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' and 10 is 'totally satisfied', please put a cross in one box on each line to indicate how satisfied or dissatisfied you are with the following aspects of your aged care job. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number)

	Totally dissatisfied									Totally satisfied
a) Your total pay	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
b) Your job security	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
c) The work itself (what you do)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
d) The hours you work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
e) The opportunity to develop your abilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f) The level of support from your team/ service provider	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f2) The level of support from your supervisor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
g) The flexibility available to balance work and non-work commitments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
h) All things considered, how satisfied are you with your job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

A27.1 **In relation to the balance between your work and the rest of your life, please put a cross in one box on each line on the scale from 1-6** *(where 1 = never, 5 = almost always and 6=don't know)*, **for how often your WORK:**

	Never	Rarely	Some-times	Often	Almost always	Don't know
a) Interferes with your responsibilities or activities outside of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) Keeps you from spending the amount of time you would like with family or friends.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Interferes with your ability to develop or maintain connections and friendships in your community.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A27.2 **Thinking about your life in general, how often do you feel rushed or pressed for time?**

Never	Rarely	Some-times	Often	Almost always	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A27.3 **Thinking about your life right now, how satisfied are you with the balance between your work and the rest of your life?**

Not at all satisfied	Not very satisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A28.1 **In the last 12 months have you sustained a work- related injury or illness at work (in this job)**

- Yes ☐ 1
- No If 'no', go to A28.6 ☐ 2

A28.2 **What kind(s) of work-related injury or illness did you sustain in the last 12 months?**
(cross all relevant boxes)

- Fracture ☐
- Chronic joint or muscle condition ☐
- Sprain/strain ☐
- Cut/open wound ☐
- Crushing injury/internal organ damage ☐
- Superficial injury (minor injury) ☐
- Stress or other mental condition ☐
- Amputation ☐
- Burns ☐
- Other ☐

A28.3 **Did the <u>most recent</u> work-related injury or illness sustained in the last 12 months result in you taking time off work?**

- Yes ☐ 1
- No If 'no', go to A28.5 ☐ 2

A28.4 **How long did you take off work?**

- Part of 1 day ☐ 1
- 1 whole day ☐ 2
- 2-5 days ☐ 3
- 6-15 days ☐ 4
- More than 15 days ☐ 5

A28.5 **What was the cause of your <u>most recent</u> work-related injury or illness you sustained in the last 12 months?**
(cross one box only)

- Lifting, pushing, pulling, bending ☐ 1
- Repetitive movement with low muscle loading ☐ 2
- Prolonged standing, working in cramped or unchanging positions ☐ 3
- Vehicle accident ☐ 4
- Hitting, being hit or cut by person, object or vehicle ☐ 5
- Fall ☐ 6
- Exposure to mental stress ☐ 7
- Long term exposure to sound ☐ 8
- Contact with chemical or substance ☐ 9
- Fatigue ☐ 10
- Other *(please specify)* ☐ 11

____

A28.6 **For your daily work, do you receive?**
(cross all relevant boxes)

- Paid time for travel between care/support appointments? ☐
- Paid time for travel between home and care/support appointments? ☐
- Petrol/depreciation allowance for transport costs related to care/support appointments? ☐
- None of these ☐

Section B: About You

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

B1 Are you male or female?

- Male ☐ 1
- Female ☐ 2

B2 How old were you on your last birthday?

☐☐ **Years**

B3.1 In what country were you born?

- Australia — If 'Australia', go to B4 → ☐ 1
- Other (please specify) ☐ 2

[ ]

B3.2 In what year did you first arrive in Australia to live for six months or more (even if you have spent time abroad since)?

☐☐☐☐

B3.3 Are you an Australian citizen?

- Yes — If 'yes', go to B3.5 → ☐ 1
- No ☐ 2

B3.4 Are you a permanent resident of Australia?

- Yes ☐ 1
- No ☐ 2

B3.5 Which of the following categories best describes your migration category when you or your family first arrived in Australia to stay? *(cross one box only)*

- Skilled migrant ☐ 1
- Business migrant ☐ 2
- Family migrant ☐ 3
- Refugee or special humanitarian migrant ☐ 4
- New Zealand citizen ☐ 5
- None of the above ☐ 6
- Don't know ☐ 7

B4 Are you of Aboriginal or Torres Strait Islander origin? *(cross one box only)*

- No ☐ 1
- Yes, Aboriginal ☐ 2
- Yes, Torres Strait Islander ☐ 3
- Yes, both ☐ 4

B5.1 Are you fluent in a language other than English?

- Yes ☐ 1
- No — If 'no', go to B6.1 → ☐ 2

B5.2 Do you use this language in your job?

- Yes ☐ 1
- No ☐ 2

B5.3 Which language are you most fluent in?

- English — If 'English', go to B6.1 → ☐ 1
- Language other than English ☐ 2
- Both equally well ☐ 3

B5.4 How well would you say you: *(cross one box on each row)*

	Not at all	Not very well	Well	Very well	Can't say
Speak English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Read English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Write English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

B6.1 **Do you have financial dependents?**

- No — If 'no', go to B7 → ☐ 1
- Yes, spouse/partner only — If 'spouse/partner only', go to B7 → ☐ 2
- Yes, children only ☐ 3
- Yes, spouse/partner and children ☐ 4
- Yes, other ☐ 5

B6.2 **How many financially dependent children do you have in each of the following age groups?**

- ☐ **0 – 5 years**
- ☐ **6 – 15 years**
- ☐ **16 – 24 years**

B7 **In a normal week, about how many unpaid hours would you spend caring for family members (eg children or disabled or elderly relatives)?**
(if you have no care responsibilities write '0')

☐☐ **Hours**

B8 **In general, would you say your health is:**

- Excellent ☐ 1
- Very good ☐ 2
- Good ☐ 3
- Fair ☐ 4
- Poor ☐ 5

B9.1 **What is the highest level of primary or secondary school you have completed?**

- Did not go to school ☐ 1
- Year 8 or below ☐ 2
- Year 9 or equivalent ☐ 3
- Year 10 or equivalent ☐ 4
- Year 11 or equivalent ☐ 5
- Year 12 or equivalent ☐ 6

B9.2 **Have you completed any post-school qualifications?**

- Yes ☐ 1
- No — If 'no', go to B11.1 → ☐ 2

B9.3 **What qualifications have you completed?**
(cross all relevant boxes)

Health

- Bachelor Degree in Nursing ☐
- Bachelor Degree in Allied Health Profession ☐
- Certificate IV/Diploma in Enrolled Nursing ☐
- Other basic nursing qualification ☐
- Post-basic nursing qualification (not in aged care) ☐
- Post-graduate allied health qualification ☐
- Other (health related) ☐

Aged Care

- Certificate III in Aged Care ☐
- Certificate III in Home and Community Care ☐
- Certificate IV in Aged Care ☐
- Certificate IV in Service Coordination (Ageing and Disability) ☐
- Other Certificate in Care Work ☐
- Post basic nursing qualification in aged care ☐
- Other (aged care related) ☐

Disability

- Certificate III Disability/Disability work ☐
- Certificate IV Disability/Disability work ☐
- Diploma Disability/Disability work ☐
- Diploma Community Service (Disability work) ☐
- Other (Disability related) ☐

Management

- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Postgraduate Degree ☐

Other

- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Postgraduate Degree ☐

B9.4 **Where did you complete your highest level of qualification?**

- Australia ☐ 1
- Overseas ☐ 2
- Overseas, with recognition obtained in Australia ☐ 3
- Overseas, not recognised ☐ 4

B9.5 **Do you have other relevant specialised qualifications in ageing or aged care?** *(cross all relevant boxes)*

- No ☐
- Yes, in gerontology ☐
- Yes, in palliative care ☐
- Yes, in psychogeriatrics ☐
- Yes, other ☐

B9.6 **How satisfied or dissatisfied are you with the match between your work and your qualifications?** *(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' (ie a bad match) and 10 is 'totally satisfied' (ie a good match), please cross one box)*

Totally dissatisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally satisfied

If at B9.3 your qualification is 3 'Certificate IV/Diploma in Enrolled Nursing' (box 3)

B10 **Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a community care worker (CCW)?**

- Yes ☐ 1
- No ☐ 2
- Never worked as a CCW ☐ 3
- Do not have a Cert IV/diploma in enrolled nursing ☐ 4

B11.1 **Are you currently studying for any qualifications?**

- Yes ☐ 1
- No If 'no', go to B12 → ☐ 2

B11.2 **What qualification are you currently studying for?** *(eg Certificate III in Aged Care)*

☐

B12 **During the last 12 months have you undertaken any continuing professional development / education?**

- Yes ☐ 1
- No ☐ 2

B13.1 **During the last 12 months have you undertaken any training (not including professional development), as part of your employment?** *(cross all relevant boxes)*

- No If 'no', go to B14 → ☐
- Yes, mandatory training ☐
- Yes, non-mandatory training ☐

B13.2 **What were the aims of this training?** *(cross all relevant boxes)*

- To help you get started in your job ☐
- To improve your skills in your current job ☐
- To maintain professional status and/or meet occupational standards ☐
- To prepare you for a future job or facilitate promotion ☐
- To develop your skills generally ☐
- Because of safety/health concerns ☐
- To meet the provider's accreditation requirement ☐
- Other aims ☐

B13.3 **Have you contributed towards the cost of any of this training?**

- No ☐ 1
- Yes, contributed to some of the cost ☐ 2
- Yes, paid for all of it ☐ 3

B13.4 **To what extent do you think you can use the new skills you have acquired from any of this training in your current job?** *(cross one box only)*

- Not at all ☐ 1
- Only to a limited extent ☐ 2
- To a moderate extent ☐ 3
- To a great extent ☐ 4
- To a very great extent ☐ 5
- Did not learn any new skills ☐ 6

B14 **In the next 12 months, what is the area of training you think you will most need / you would most like to undertake:** *(cross all relevant boxes)*

- Dementia ☐
- Mental health ☐
- Management and leadership ☐
- Wound management ☐
- Palliative care ☐
- Allied health ☐
- ICT/IT ☐
- Other (please specify) ☐

☐

B15 What are the best things about your job at the moment?

B16 What are the worst things about your job at the moment?

Thank you for sharing your experiences of working in aged care.

PLEASE TELL US HOW LONG IT TOOK YOU TO COMPLETE THIS SURVEY ☐☐☐ **Minutes**

Do you have more to say about your work?

We invite you to tell us more about your work. We would like to add to our understanding of your experiences of working in aged care by interviewing 100 direct care workers like yourself. These interviews will be by phone and will take approximately 30 minutes of your time.

If you would like to participate please provide your name and phone number:

Name: **Telephone Number:**

Please be assured that these details will be removed from the survey form and will not be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University in August/September 2016.

Barcode

MAILING DATE
Form Type: Residential Workforce Survey
Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

Workers in aged-care services across Australia are being approached to participate in this survey.

In order to provide an accurate picture of the aged care workforce it is important to include information from workers such as yourself. We are interested in your experiences of working in aged care; your characteristics (such as age and gender etc.), the conditions under which you work, and how you feel about what you do.

How to participate in the survey

We are asking you to complete this survey as an employee of the residential aged care services provided at this location.

To take part online go to Survey.ipsos.com.au/RW2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use the reply paid envelope to return it.

If you have any queries regarding the survey, please contact the free helpline on 1800 071 735.

Ethics and Privacy

All responses to the survey are confidential and identifying details will be removed prior to analysis. The information from your survey will be combined with all other data and no individual site or person will be identified.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

Additional information about the 2016 National Aged Care Workforce Survey

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this [X]
3. Enter numbers into individual boxes like this [1][2][3]
4. If the answer to a question is nil, please write '0' and go to the next question
5. Please write clearly using a BLACK or BLUE pen
6. Sometimes you will find the box you have marked has an instruction to go to another question.

   By following the instructions carefully you will be able to skip questions that do not apply to you.
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this ■ and mark the correct box like this [X]
8. Call the toll-free helpline on 1800 071 735 if you have any queries
9. More detailed information about the National Aged Care Workforce Census and Survey can be found at the following website: Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible.

Section A: About Your Work

Please answer the questions in this section by thinking about the direct care job you do in this aged care facility, unless the question refers specifically to another job you may have. Please remember that this questionnaire is completely confidential. Only the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

A1 What is your main job?

- Nurse practitioner ☐ 1
- Registered nurse ☐ 2
- Enrolled nurse ☐ 3
- Physiotherapist ☐ 4
- Occupational therapist ☐ 5
- Social worker ☐ 6
- Speech therapist ☐ 7
- Diversional therapist ☐ 8
- *Personal care attendant ☐ 9
- *Allied health assistant ☐ 10
- Other *(please specify)* ☐ 11

Definitions:
Personal care attendant: provides personal care to residents as a core part of their jobs (usually under direction of nursing staff). Job titles of personal care attendants vary widely. They include, for example: personal care attendant, assistant or aide, personal care worker, assistant-in-nursing and others.
Allied health assistant: supports allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.

A2 Does your role involve managing or supervising direct care staff?

- Yes, I am a care manager ☐ 1
- Yes, I am a care leader ☐ 2
- Yes, but neither of the above ☐ 3
- No ☐ 4
- Don't know ☐ 5

Definitions:
A care manager has responsibility for all direct care staff in the facility; other job titles may be Director of Nursing and others.
A care leader has responsibility for a team of direct care staff but will report to a care manager.

A3.1 Which of the following best describes your current work schedule?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A3.2 Would you prefer to maintain your current work schedule or change it?

- Prefer to maintain current schedule — If 'maintain', go to A4.1 → ☐ 1
- Change to a different schedule ☐ 2

A3.3 Which describes the work schedule you would *prefer*?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A4.1 How many hours on average do you *usually* work each week in this job *(include all paid and unpaid hours)*?

☐☐ **Hours per week**

A4.2 How many hours would you *like* to work in this job?

☐☐ **Hours per week**

A4.3 How many of the hours you usually work each week are paid and unpaid? *(If you do not work any unpaid hours write '0' in the corresponding box)*

☐☐ **Paid hours**

☐☐ **Unpaid hours**

A5 **Thinking about a typical shift, how much of your shift would you spend actively caring for residents of the aged care facility** *(as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)*?

- Less than a third ☐ 1
- Between one third and two thirds ☐ 2
- More than two thirds ☐ 3

A6 **Which best describes your form of employment?**

- Casual ☐ 1
- Permanent (full or part-time) ☐ 2
- Fixed term contract ☐ 3

A7 **Are you entitled to paid sick leave?**

- Yes ☐ 1
- No ☐ 2
- Don't know ☐ 3

A8.1 **For this job, what was the total amount of your most recent pay before tax or anything else was taken out?** *(Amount to the nearest dollar)*

$ ☐,☐☐☐.0 0

A8.2 **For what period does that cover?**

- Week ☐ 1
- Fortnight ☐ 2
- Month ☐ 3

A9 **How long have you worked in this aged care facility?**

Y Y **Years** M M **Months**

A10 **How old were you when you first began working in aged care?**

Y Y **Years**

A11 **Excluding any breaks from working in aged care, for how many years have you actually worked in aged care?**

Y Y **Years**

A12 **Before you first obtained this job, had you done any work for this facility?**

- No ☐ 1
- Yes, paid work ☐ 2
- Yes, unpaid work/volunteer ☐ 3

A13.1 **When you approached this aged care facility for your job, did you know there was a job available?**

- Yes ☐ 1
- No If 'no', go to A14.1 → ☐ 2
- Don't know ☐ 3

A13.2 **How did you find out your job was available?** *(cross one box only)*

- Job network employment agency ☐ 1
- Other employment agency ☐ 2
- Career service at a tertiary educational institution ☐ 3
- School programs ☐ 4
- Newspaper advertisements ☐ 5
- Internet sites ☐ 6
- Centrelink job search services/ touchscreens ☐ 7
- Company or professional contacts ☐ 8
- Workplace noticeboards ☐ 9
- Word of mouth ☐ 10
- Other *(please specify)* ☐ 11

A14.1 **What was your last paid job before you FIRST worked in aged care?**

- No previous paid employment If 'no', go to A15 → ☐ 1
- Nurse, acute care ☐ 2
- Nurse, community care ☐ 3
- Other healthcare ☐ 4
- Carer in other setting ☐ 5
- Disability care ☐ 6
- Salesperson ☐ 7
- Clerical worker ☐ 8
- Hospitality worker (waitress, etc.) ☐ 9
- Cleaner ☐ 10
- Professional (other than nurse) ☐ 11
- Manager ☐ 12
- Other paid employment ☐ 13

A14.2 Why did you leave that job? *(cross one box only)*

- Family reasons ☐ 1
- Personal reasons (including health) ☐ 2
- Did not like job ☐ 3
- Contract ended ☐ 4
- Redundancy ☐ 5
- Career change ☐ 6
- Other *(please specify)* ☐ 7

A15 Had you worked in aged care before you began your CURRENT job?

- Yes, paid ☐ 1
- Yes, unpaid/voluntary ☐ 2
- No If 'no', go to A17. 1 → ☐ 3

A16 What was the most important reason you left the last (paid) aged care job you held before your current one? *(cross one box only)*

- To achieve higher pay ☐ 1
- To avoid workmates/colleagues I did not get along with or like ☐ 2
- To avoid managers/management I did not get along with or like ☐ 3
- The job was too stressful ☐ 4
- Not able to spend sufficient time with residents ☐ 5
- To get shifts or hours of work I wanted ☐ 6
- To be closer to home ☐ 7
- To fulfil care responsibilities (including having a baby) ☐ 8
- To find more challenging work ☐ 9
- To find easier work ☐ 10
- Made redundant/retrenched ☐ 11
- Moved house/location ☐ 12
- Other *(please specify)* ☐ 13

A17.1 Did you have more than one job last week?

- Yes ☐ 1
- No If 'no', go to A18 → ☐ 2

A17.2 Where did you work in your other job(s) last week? *(cross all relevant boxes)*

- Another residential aged care facility ☐
- Home care/home support aged care service ☐
- Disability care ☐
- Not in aged or disability care, something else ☐

A17.3 How many hours each week do you usually work in your other AGED CARE job(s)?

☐☐ **Hours p.w. in other AGED CARE jobs**

A17.4 How many hours each week do you usually work in your other job(s) OUTSIDE OF aged care?

☐☐ **Hours p.w. in NON aged care jobs**

A18 Are you currently actively seeking work outside of this aged care facility?

- Yes ☐ 1
- No ☐ 2

A19.1 Do you expect to be working for this aged care facility in 12 months time?

- Yes If 'yes', go to A20 → ☐ 1
- No ☐ 2
- It depends ☐ 3
- Don't know ☐ 4

A19.2 Where do you see yourself working 12 months from now?

- Working in aged care, different facility ☐ 1
- Working in home care/home support aged care ☐ 2
- Working in disability care ☐ 3
- Working, but not in aged or disability care ☐ 4
- Not working for pay ☐ 5
- Don't know ☐ 6

A19.3 What is the main reason you may finish work for this aged care facility in the next 12 months? *(cross one box only)*

Family reasons	☐ 1
Financial reasons	☐ 2
Employment conditions	☐ 3
Nature of care work	☐ 4
Stress/burnout	☐ 5
Other health related reasons	☐ 6
Returning to study	☐ 7
Travel	☐ 8
Retiring	☐ 9
End of contract	☐ 10
Retrenchment/redundancy	☐ 11
Falling quality of care	☐ 12
Other *(please specify)*	☐ 13

A20 Where do you see yourself working 3 years from now? *(cross one box only)*

Working in aged care, this facility	☐ 1
Working in aged care, different facility	☐ 2
Working in home care/home support aged care	☐ 3
Working in disability care	☐ 4
Working, not in aged care or disability care	☐ 5
Not working for pay	☐ 6
Don't know	☐ 7
Other	☐ 8

A21 The following statements are about your current job in this aged care facility. *Please indicate, by putting a cross in one box on each line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.*

	Strongly disagree						Strongly agree
a) I am able to spend enough time with each care recipient	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
b) I have the skills and abilities I need to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
c) I use many of my skills and abilities in my current job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
d) I have a lot of freedom to decide how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
e) I feel under pressure to work harder in my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
f) My job is more stressful than I had ever imagined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
g) Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
h) Management and employees have good relations in my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
i) Adequate training is available through my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A22 In general, how would you describe relations at your workplace? *(Using a scale from 1 to 7, where 1 is when workplace relations are very bad and 7 is when workplace relations are very good, please put a cross in one box on each line.)*

	Very bad						Very good
Between management and yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Between workmates/colleagues and yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A23 The following questions are about how satisfied or dissatisfied you are with different aspects of your job.
(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' and 10 is 'totally satisfied', please put a cross in one box on each line to indicate how satisfied or dissatisfied you are with the following aspects of your aged care job. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number)

	Totally dissatisfied									Totally satisfied
a) Your total pay	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
b) Your job security	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
c) The work itself (what you do)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
d) The hours you work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
e) The opportunity to develop your abilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f) The level of support from your team /service provider	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f2) The level of support from your supervisor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
g) The flexibility available to balance work and non-work commitments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
h) All things considered, how satisfied are you with your job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

A24.1 In relation to the balance between your work and the rest of your life, please put a cross in one box on each line on the scale from 1 – 6 *(where 1 = never, 5= almost always and 6=Don't know)*, **for how often your WORK:**

	Never	Rarely	Some-times	Often	Almost always	Don't know
a) Interferes with your responsibilities or activities outside of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) Keeps you from spending the amount of time you would like with family or friends.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Interferes with your ability to develop or maintain connections and friendships in your community.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

	Never	Rarely	Some-times	Often	Almost always	Don't know
A24.2 Thinking about your life in general, how often do you feel rushed or pressed for time?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

	Not at all satisfied	Not very satisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Don't know
A24.3 Thinking about your life right now, how satisfied are you with the balance between your work and the rest of your life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A25.1 In the last 12 months have you sustained a work- related injury or illness at work (in this job)

Yes	☐ 1
No If 'no', go to Section B	☐ 2

A25.2 What kind(s) of work-related injury or illness did you sustain in the last 12 months? *(cross all relevant boxes)*

Fracture	☐
Chronic joint or muscle condition	☐
Sprain/strain	☐
Cut/open wound	☐
Crushing injury/internal organ damage	☐
Superficial injury (minor injury)	☐
Stress or other mental condition	☐
Amputation	☐
Burns	☐
Other	☐

A25.3 Did the most recent work-related injury or illness sustained in the last 12 months result in you taking time off work?

Yes	☐ 1
No If 'no', go to A25.5	☐ 2

A25.4 How long did you take off work?

Part of 1 day	☐ 1
1 whole day	☐ 2
2-5 days	☐ 3
6-15 days	☐ 4
More than 15 days	☐ 5

A25.5 What was the cause of the most recent work-related injury or illness you sustained in the last 12 months? *(cross one box only)*

Lifting, pushing, pulling, bending	☐ 1
Repetitive movement with low muscle loading	☐ 2
Prolonged standing, working in cramped or unchanging positions	☐ 3
Vehicle accident	☐ 4
Hitting, being hit or cut by person, object or vehicle	☐ 5
Fall	☐ 6
Exposure to mental stress	☐ 7
Long term exposure to sound	☐ 8
Contact with a chemical or substance	☐ 9
Fatigue	☐ 10
Other *(please specify)*	☐ 11

Section B: About You

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

B1 Are you male or female?

- Male ☐ 1
- Female ☐ 2

B2 How old were you on your last birthday?

☐☐ **Years**

B3.1 In what country were you born?

- Australia — If 'Australia', go to B4 → ☐ 1
- Other *(please specify)* ☐ 2

____

B3.2 In what year did you first arrive in Australia to live for six months or more (even if you have spent time abroad since)?

☐☐☐☐

B3.3 Are you an Australian citizen?

- Yes — If 'yes', go to B3.5 → ☐ 1
- No ☐ 2

B3.4 Are you a permanent resident of Australia?

- Yes ☐ 1
- No ☐ 2

B3.5 Which of the following categories best describes your migration category when you or your family first arrived in Australia to stay? *(cross one box only)*

- Skilled migrant ☐ 1
- Business migrant ☐ 2
- Family migrant ☐ 3
- Refugee or special humanitarian migrant ☐ 4
- New Zealand citizen ☐ 5
- None of the above ☐ 6
- Don't know ☐ 7

B4 Are you of Aboriginal or Torres Strait Islander origin? *(cross one box only)*

- No ☐ 1
- Yes, Aboriginal ☐ 2
- Yes, Torres Strait Islander ☐ 3
- Yes, both ☐ 4

B5.1 Are you fluent in a language other than English?

- Yes ☐ 1
- No — If 'no', go to B6.1 → ☐ 2

B5.2 Do you use this language in your job?

- Yes ☐ 1
- No ☐ 2

B5.3 Which language are you most fluent in?

- English — If 'English', go to B6.1 → ☐ 1
- Language other than English ☐ 2
- Both equally well ☐ 3

B5.4 How well would you say you: *(cross one box on each row)*

	Not at all	Not very well	Well	Very well	Can't say
Speak English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Read English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Write English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

B6.1 **Do you have financial dependents?**

No	If 'no', go to B7 →	☐ 1
Yes, spouse/partner only	If 'yes', go to B7 →	☐ 2
Yes, children only		☐ 3
Yes, spouse/partner and children		☐ 4
Yes, other		☐ 5

B6.2 **How many financially dependent children do you have in each of the following age groups?**

☐ **0 – 5 years**

☐ **6 – 15 years**

☐ **16 – 24 years**

B7 **In a normal week, about how many unpaid hours would you spend caring for family members (eg children or disabled or elderly relatives)?**
(if you have no care responsibilities write '0')

☐☐ **Hours**

B8 **In general, would you say your health is:**

Excellent	☐ 1
Very good	☐ 2
Good	☐ 3
Fair	☐ 4
Poor	☐ 5

B9.1 **What is the highest level of primary or secondary school you have completed?**

Did not go to school	☐ 1
Year 8 or below	☐ 2
Year 9 or equivalent	☐ 3
Year 10 or equivalent	☐ 4
Year 11 or equivalent	☐ 5
Year 12 or equivalent	☐ 6

B9.2 **Have you completed any post-school qualifications?**

Yes		☐ 1
No	If 'no', go to B11.1 →	☐ 2

B9.3 **What qualifications have you completed?**
(cross all relevant boxes)

Health

Bachelor Degree in Nursing	☐
Bachelor Degree in Allied Health Profession	☐
Certificate IV/Diploma in Enrolled Nursing	☐
Other basic nursing qualification	☐
Post-basic nursing qualification (not in aged care)	☐
Post-graduate allied health qualification	☐
Other (health related)	☐

Aged Care

Certificate III in Aged Care	☐
Certificate III in Home and Community Care	☐
Certificate IV in Aged Care	☐
Certificate IV in Service Coordination (Ageing and Disability)	☐
Other Certificate in Care Work	☐
Post basic nursing qualification in aged care	☐
Other (aged care related)	☐

Disability

Certificate III Disability/Disability work	☐
Certificate IV Disability/Disability work	☐
Diploma Disability/Disability work	☐
Diploma Community Service (Disability work)	☐
Other (Disability related)	☐

Management

Certificate III or IV	☐
Diploma	☐
Bachelor or Post-graduate Degree	☐

Other

Certificate III or IV	☐
Diploma	☐
Bachelor or Post-graduate Degree	☐

B9.4 **Where did you complete your highest level of qualification?**

Australia	☐ 1
Overseas	☐ 2
Overseas, Australian recognised	☐ 3
Overseas, not recognised	☐ 4

B9.5 **Do you have other relevant specialised qualifications in ageing or aged care?** *(cross all relevant boxes)*

- No ☐
- Yes, in gerontology ☐
- Yes, in palliative care ☐
- Yes, in psychogeriatrics ☐
- Yes, other ☐

B9.6 **How satisfied or dissatisfied are you with the match between your work and your qualifications?** *(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' (ie a bad match) and 10 is 'totally satisfied' (ie a good match), please cross one box)*

Totally dissatisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally satisfied

If at B9.3 your qualification is 'Certificate IV/Diploma in Enrolled Nursing' (box 3)

B10 **Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a Personal care attendant (PCA)?**

- Yes ☐ 1
- No ☐ 2
- Never worked as a PCA ☐ 3
- Do not have a Cert IV/diploma in enrolled nursing ☐ 4

B11.1 **Are you currently studying for any qualifications?**

- Yes ☐ 1
- No **If 'no', go to B12** → ☐ 2

B11.2 **What qualification are you currently studying for?** *(eg Certificate III in Aged Care)*

[ ]

B12 **During the last 12 months have you undertaken any continuing professional development/education?**

- Yes ☐ 1
- No ☐ 2

B13.1 **During the last 12 months have you undertaken any training (not including professional development), as part of your employment?** *(cross all relevant boxes)*

- No **If 'no; go to B14** → ☐
- Yes, mandatory training ☐
- Yes, non-mandatory training ☐

B13.2 **What were the aims of this training?** *(cross all relevant boxes)*

- To help you get started in your job ☐
- To improve your skills in your current job ☐
- To maintain professional status and/or meet occupational standards ☐
- To prepare you for a future job or facilitate promotion ☐
- To develop your skills generally ☐
- Because of safety/health concerns ☐
- To meet the facility's accreditation requirement ☐
- Other aims ☐

B13.3 **Have you contributed towards the cost of any of this training?**

- No ☐ 1
- Yes, contributed to some of the cost ☐ 2
- Yes, paid for all of it ☐ 3

B13.4 **To what extent do you think you can use the new skills you have acquired from any of this training in your current job?** *(cross one box only)*

- Not at all ☐ 1
- Only to a limited extent ☐ 2
- To a moderate extent ☐ 3
- To a great extent ☐ 4
- To a very great extent ☐ 5
- Did not learn any new skills ☐ 6

B14 **In the next 12 months, what is the area of training you think you will most need / you would most like to undertake:** *(cross all relevant boxes)*

- Dementia ☐
- Mental health ☐
- Management and leadership ☐
- Wound management ☐
- Palliative care ☐
- Allied health ☐
- ICT/IT ☐
- Other *(please specify)* ☐

[ ]

B15 What are the best things about your job at the moment?

B16 What are the worst things about your job at the moment?

Thank you for sharing your experiences of working in aged care.

PLEASE TELL US HOW LONG IT TOOK YOU TO COMPLETE THIS SURVEY ☐☐☐ **Minutes**

Do you have more to say about your work?

We invite you to tell us more about your work. We would like to add to our understanding of your experiences of working in aged care by interviewing 100 direct care workers like yourself. These interviews will be by phone and will take approximately 30 minutes of your time.

If you would like to participate please provide your name and phone number:

Name:

Telephone Number:

Please be assured that these details will be removed from the survey form and will not be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University in August/September 2016.

Barcode