Productivity, Participation and Employee Wellbeing in the Residential Aged Care Sector

Katherine Ravenswood

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

The following presentations relate to work undertaken for this thesis:

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Katherine Ravenswood Date

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This thesis is dedicated to Ruby and Leo, my two beautiful, loving and fun children.

Once upon a time I thought I would do a PhD in medieval literature but life took a different path. Thinking of my previous journeys, Geoffrey Chaucer's *The Canterbury Tales* provides a nice metaphor for the PhD journey. *The Canterbury Tales* is a collection of tales shared by travellers on their pilgrimage to Canterbury in the 14th century. My journey has been similar; it has been my own personal pilgrimage but the journey has been supported by a wide group of people along the way. They have encouraged me, and shared tales of hilarity, empathy, fun and toil to get me to my destination. In that sense, this thesis belongs not only to me, but also to those who have walked with me.

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Ethical Approval

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Abstract

The way in which employee participation, productivity and employee wellbeing interact is shaped by power relationships in the workplace and its broader political and economic environment. This thesis investigates the relationship between employee participation, productivity and employee wellbeing at an organisational level. It also examines the role that the external environment has on the relationship between employee participation, productivity and employee wellbeing in organisations. It does that in the context of a highly feminised, low paid sector: residential aged care.

The analysis of this specific relationship is guided by a feminist epistemology. This facilitates examination of the role of gender and power. A feminist epistemology focuses the investigation on the experiences of the participants and the formal and informal processes that form the context for that experience.

A multiple case study approach of four residential aged care providers is used to gain the contextual information necessary for this research. Sources of information at each organisation include interviews with employees and managers; organisational documentation; and a survey developed specifically for this thesis. The case organisation information is compared with information at a sector level. This includes information from interviews with owners' associations and union representatives, public reports and academic research.

The findings of this thesis show that the relationship between productivity, employee participation and employee wellbeing is one in which all three aspects are integral to each other. In particular, the productivity approach of managers influences the way in which employee participation is implemented in the workplace. Effective representative participation does have a positive influence on employee wellbeing. However, the best employee outcomes resulted from multiple participatory practices including union and non-union, direct, and representative participation. Managers' choices were pivotal to employee participation but they were guided by organisational structure and external factors.

This thesis extends traditional concepts of power which do not pay sufficient attention to the role that gender plays in the relationship between employee participation, productivity and employee wellbeing. Gender regimes in society were found to result in under-valued work. This in turn limited employee participation at both organisational and sector levels. Limited employee participation and associated lack of employee

power meant that employee outcomes were continually overlooked in favour of organisational outcomes.

Chapter One: Introduction

The consideration of organisational outcomes of employee participation has become a significant topic in employment relations, human resource management (HRM) and related fields. Indeed over several decades the focus of employee participation has shifted from one of sharing power and improving workers' rights to one of improved organisational efficiencies, productivity and other organisational outcomes (Gollan & Wilkinson, 2007; Kim, McDuffie & Pil, 2010; Knudsen, 1995; Markey, 2001). Research has identified some links between participation and organisational outcomes such as improved occupational health and safety (OHS) outcomes (Eaton & Nocerino, 2000; Gunningham, 2008; Markey & Patmore, 2011; Sorensen, Hasle & Navrberg, 2009), and better utilisation of employees' skills and knowledge for organisational outcomes (Dundon & Gollan, 2007).

Positive outcomes for employees have also been identified from employee participation. This is particularly so with the high performance workplace practices (HPWP) paradigm which identifies employee outcomes such as improved job satisfaction, greater skills that can leverage increased pay, and reduced fatigue and stress associated with increased autonomy (Appelbaum, Bailey, Berg & Kalleberg, 2000). The extent of employee outcomes is debated, with some arguing that they are overlooked in favour of organisational outcomes (Baptiste, 2008; Boxall & Macky, 2009; Conway & Monks, 2009; Delaney & Godard, 2001; Guest, 2002; Haynes, Boxall & Macky, 2005). It appears that when employee participation increases the power of employees, it achieves better outcomes for them (Busck, Knudsen & Lind, 2010; Hvid & Hasle, 2003).

There are connections between productivity and participation, and participation and wellbeing. There is little research that explores how all three concepts interact, however. Furthermore, the role of power and gender in this relationship is under-researched. This thesis investigates the relationship between employee participation, productivity and employee wellbeing. It also asks what the impact of representative participation is on employee wellbeing. This study recognises that employee participation in organisations does not occur in isolation from external influences. Consequently, it questions how external factors influence the relationship between employee participation, productivity and wellbeing. The specific research questions of this thesis are:

1. Is there a relationship between productivity, participation and employee wellbeing?
2. What is the impact of effective representative employee participation on employee wellbeing?
3. How does the external environment, for example government regulations and industry standards, impact on questions one and two?

This thesis shows that consideration of power relationships both within an industry and at organisational level are crucial to understanding the way in which participation, productivity and employee wellbeing are connected. Furthermore, through an analysis drawing on feminist epistemology, this thesis suggests that employment relations' traditional concepts of power do not pay sufficient attention to the role that gender, and ethnicity, have in that power relationship.

Why Residential Aged Care?

This thesis investigates employee participation, productivity and wellbeing using the New Zealand residential aged care sector as its setting. Residential aged care has been chosen because of several critical factors. Firstly, at the time that this research commenced, New Zealand was identified internationally as having low productivity in the health sector generally (OECD, 2009). This was despite significant funding increases in the health sector in the years immediately prior. Secondly, residential aged care in particular is significant in New Zealand, and indeed internationally, because of its rapidly ageing population that will fuel increased demand for residential aged care services in the near and more distant future (Badkar, 2009; Carryer, Hansen & Blakey, 2010; Kaine, 2010, 2011; Kiata, Kerse & Dixon, 2005; Lazonby, 2007). An ageing population means an ageing workforce; consequently there are concerns about the availability of labour to provide residential aged care.

Another concern in New Zealand is the cost associated with the provision of residential aged care. The primary source of funding for it is the government. The current New Zealand government does not wish to disproportionally increase the amount funded for residential aged care (Grant Thornton, 2010; Lazonby, 2007).

The employee and owner characteristics of residential aged care also provide an interesting context for the study of employee participation, productivity and employee wellbeing. In New Zealand large, privately owned organisations are becoming more common in the sector. This is a shift away from not-for-profit, single-site, residential aged care providers that used to dominate the market (Grant Thornton, 2010; Kiata et al., 2005; Lazonby, 2007; New Zealand Aged Care Association, 2010). The shift in ownership has led to public debate on the role that profit-driven, privately owned organisations have in residential aged care (New Zealand Labour Party, Green Party of Aotearoa New Zealand & Grey Power New Zealand, 2010).

The workforce in residential aged care is highly feminised and increasingly ethnically diverse. Caregivers are considered to be low skilled workers, and generally have few formal qualifications. Residential aged care is low paid work, with registered nurses often paid less in residential aged care than in other settings. Caregivers in particular are disadvantaged, with average hourly rates paying little more than the national minimum wage (Lazonby, 2007). The work carried out by caregivers has increased in physical difficulty, as well as in emotional and knowledge based complexity. When once the elderly would be mobile and reasonably self-sufficient when they entered residential aged care, residents are now increasingly frail and dependent (Boyd et al., 2008; Carryer et al., 2010; Haultain, 2011; Lazonby, 2007). Increasingly caregivers are expected to complete a national qualification in residential aged care. The increased training is expected despite the qualification often making little or no difference to wage rates, and not being legally required for residential aged care.

Furthermore, work conditions may be poor. Although there is greater demand for residential aged care employees, the labour demand and some labour shortage has not increased employee power as might have been expected (Hyman, 1981). Work conditions are underscored by low wages and a desire on the part of owners to restrain rising staffing costs. This has been achieved through delegation of more complex tasks to unqualified caregivers (Networkers, 2005); increasing workload (Carryer et al., 2010; Haultain, 2011); and low staffing levels (Carryer et al., 2010; Haultain, 2011; Kiata et al., 2005; Networkers, 2005). Residential aged care is therefore a sector in which productivity is of considerable concern and employee wellbeing may be poorer than ideal. Furthermore, there are suggestions that employee participation, or at least job autonomy, in residential aged care may be limited (Kiata et al., 2005; King & Meagher, 2009; Provis & Stack, 2003).

Residential aged care therefore provides a rich context for examining the relationship between employee participation, productivity and employee wellbeing. The workforce is disadvantaged through lower work conditions and there is limited employee participation. This research may highlight the formal and informal processes at organisational and national level that influence this situation. The highly feminised and increasingly ethnically diverse workforce may provide insights into the role that gender and ethnicity have in power, and the relationship between participation, productivity and employee wellbeing.

Research Design

The philosophical underpinnings of this research are based in a critical ontology: that reality is something that is experienced and that experience is influenced by values and ideologies, often those of the dominant groups in society (Kincheloe & McLaren, 2008; Guba & Lincoln, 2008). The power that some groups have over other groups in society impacts on the experience and reality of both (Kincheloe & McLaren, 2008). This thesis draws on a feminist epistemological approach. In particular, it investigates a group, specifically residential aged care employees, that may be disadvantaged in their work conditions (Brooks, 2007; Harding, 2007, 2008; Hekman, 2007; Naples, 2007). It explores the relationship between employee participation, productivity and employee wellbeing in terms of both the formal and informal processes that influence the relationship, and in particular the role of power in that relationship (Ackerly & True, 2010; Brooks, 2007; Calas & Smircich, 2009; Harding, 2007, 2008; Leckenby, 2007; Reinharz & Kulick, 2007). This thesis acknowledges that the experiences and power relationships of the employees in residential aged care are shaped and influenced by the broader context within which it is located (Reinharz & Kulick, 2007). The research is, consequently, based in in-depth contextual research at both organisational and sector levels (Hesse-Biber, 2007).

The method chosen for this research is a multiple case study approach. Case study research enables the researcher to gather information through multiple methods, and also encourages analysis at multiple levels (Baxter & Jack, 2008; Eisenhardt, 1989). Case study methods also facilitate a focus on the viewpoints of the participants (Tellis, 1997, 1997b; Yin, 1994). The case studies were conducted at four residential aged care

providers. The case organisations were chosen to represent a range of organisation structures within residential aged care. Three of the four are not-for-profit organisations. Of these three, one was a religious organisation, one was operated by a charitable trust, and the third was operated by a multinational not-for-profit organisation. The religious and charitable trust organisations were single-site facilities. The multinational not-for-profit and the fourth case organisation operated multiple residential aged care facilities across New Zealand.

In New Zealand employee participation in OHS is required by law for all organisations of 30 or more employees. One of the selection criteria for the case organisations was that they had an OHS committee. This criterion meant that there would be at least one similar form of employee participation across all case studies. This allows comparison across the case studies of how the OHS committees operate and how the organisational context may influence that. It also enables comparison of the effectiveness of the committees in terms of employee outcomes. Furthermore, the criterion allows consideration of the regulatory framework as an external factor on employee participation.

Organisational data was sourced from organisational documentation, including policy and OHS meeting minutes and agendas as available. A small survey was conducted of employees. The survey provided information from a broader range of employees than is possible from interviews alone. Interviews with both managers and employees were also conducted at each case organisation. Among the employees there were some union delegates and some OHS representatives, meaning information from interviewees at different levels of the organisation in terms of the power and participation they have was gained (Holvino, 2010). In total 23 interviews were conducted across the four case organisations.

Information was also sought on the relationship between employee participation, productivity and employee wellbeing at a sector level. This was gained through public reports and secondary academic research. A further three interviews were conducted at the sector level. These were with one representative each from the New Zealand Aged Care Association, the New Zealand Nurses Organisation, and the Service and Food Workers Union.

Chapter Overview

Before examining the relationship between employee participation, productivity and wellbeing it is necessary to establish how this thesis defines these concepts. Chapter Two reviews the literatures in employee participation, productivity and employee wellbeing. It explains the links in the relationship that have been suggested in the extant literature and illustrates the way in which power influences patterns and mechanisms of employee participation. This in turn guides the focus for organisational or employee outcomes as a result of participation. The chapter critiques traditional employment relations concepts of employee participation and the role that gender and power have in this.

Organisational outcomes are often linked with concepts of productivity. Chapter Two summarises how productivity has been treated in the employee participation and related literatures. It critiques these concepts and suggests broader measures for organisational performance and outlines how the effectiveness of participation for employees may be measured with particular reference to Gaffney's (2002) measures and Cox, Zagelmeyer and Marchington's (2006) measure of embeddedness of participation.

Finally, Chapter Two reviews the employee wellbeing literature. Employee wellbeing has often been considered as an individual response to the workplace. This chapter explains how broader measures of employee wellbeing may be included and concludes by defining wellbeing for the purpose of this thesis and suggesting how it might connect with employee participation and productivity.

Chapter Three outlines the research design. It expands on the design briefly explained above and describes in greater detail the rationale for the case study method. It provides details of the four case organisations as well as indicative interview questions used and the survey questions asked at each organisation. The rationale and appropriateness of an analysis drawing on a critical feminist approach is explained.

Chapter Four provides the reference point for external factors that may influence the relationship between employee participation, productivity and employee wellbeing. This chapter uses reports and statistical information on residential aged care in New Zealand in combination with international academic research on employment conditions in residential aged care. It not only describes the roles of the traditional 'actors' in the employment relationship, that is government, unions and owners/managers, it also analyses the effect of informal factors such as gendered perceptions of care work. This

furthers the argument that consideration of employee participation and its relationship with both organisational and employee outcomes must include a gender perspective, and the external environment, in an analysis of how power shapes this relationship. Chapter Four indicates the tension between government and owner approaches to productivity and union concern for working conditions. It illustrates the lack of participation at a sector level.

Chapters Five through Eight present the findings of each case organisation individually. The chapters present the findings on representative participation, mainly OHS committees and union representation; other forms of participation; aspects of employee wellbeing; approaches to productivity; and organisational performance. The discussion of representative participation is guided by Gaffney's (2002) measures of effectiveness for employees. Direct participation and the overall effect of employee participation in each organisation is discussed in relation to Cox et al.'s (2006) concept of embeddedness. Each chapter concludes with an indicative analysis of how employee participation, productivity and employee wellbeing may interact in the individual organisation.

Chapter Nine draws together the findings from the individual case organisations. It identifies themes among the case organisations and identifies how this relates to the literatures identified in Chapters Two and Four, with reference to Poole, Lansbury and Wailes' (2001) favourable conjunctures theory. The chapter highlights clear differences in both the effectiveness of representative participation and the embeddedness of participation overall across the four case organisations. Gender and power are identified as having a considerable influence in the relationship between employee participation, productivity and employee wellbeing. The chapter suggests that there is indeed a relationship between employee participation, productivity and wellbeing. Finally, it suggests that effective representative participation has a positive effect on wellbeing, but that overall a combination of participatory practices had greatest effect on wellbeing.

The final chapter of the thesis considers what the findings of the case organisations in residential aged care might contribute in general to the literature in employee participation, productivity and wellbeing. It compares the concepts of the discussion chapter more closely with the literature reviewed in Chapter Two. The thesis concludes that there *is* a relationship between employee participation, productivity and employee wellbeing. The relationship at organisational level is shaped by external factors such as

the regulatory framework. The most important external factor in this study was the role of gender, and potentially ethnicity, in the power relationships that under-value care work.

Chapter Two: Literature Review

Introduction

Throughout employment relations there is an often implicit reference to the power relationship between employees and employers and the impact this has on employee participation (Abbott, Heery & Williams, 2011; Brigden, 2007; Pocock, Williams & Skinner, 2011). This power relationship is evident in employee participation in the 'level' or extent of employee participation in an organisation, such as participation at a task based or strategic level. What is suggested by Pateman (1970) and Knudsen (1995), and made clear by Cox et al. (2006), is that employees will have more power not only when participation is at multiple levels, but when there are multiple forms of participation within one organisation. Power is also evident in the often divergent intentions for employee participation on behalf of management and employees. Indeed, a lack of attention in the literature to employee outcomes of employee participation has been noted by some (Cox et al., 2006; Haynes et al., 2005; Wood & Wall, 2007).

These power relationships are outlined in the first section of this chapter; they influence patterns of employee participation and also the terms used to describe the structures and mechanisms of employee participation. This chapter defines employee participation for the purpose of this thesis and outlines the direct and representative practices that are part of employee participation.

Power relationships, or the extent of employee participation, affect the outcomes of employee participation. For example, where participation shares little power with employees, the participation tends to focus on organisational rather than employee outcomes. Outcomes of employee participation may be grouped broadly into organisational and employee outcomes. Organisational outcomes have often been referred to as improved productivity. This chapter examines how productivity has been used as a measure of organisational outcomes. It considers the limitations of these approaches and how they may apply to contemporary forms of work. It suggests a broader definition of productivity that will be used in this thesis.

The chapter then considers employee outcomes of participation. Employee outcomes that have been identified include improved OHS outcomes, reduced stress, and improved work-life balance. Recent research into employee outcomes of participation

has begun to use employee wellbeing as its measure. Employee wellbeing has included job satisfaction and mental health. Some studies incorporate work-life balance, but few if any include OHS in wellbeing. This chapter defines employee wellbeing for the purpose of this thesis, which is that employee wellbeing includes OHS, work-life balance, pay, and work conditions.

The chapter concludes by summarising the known links in the relationship between employee participation, employee wellbeing and productivity. It suggests that analysing that relationship through the lens of gender and power will contribute to the research in this area.

Power in Employee Participation

The way in which the different actors in employment relations interact and how this impacts on work underlies the field of employment relations. Dunlop (1993) defines the three actors in this relationship as being employees and their representatives, management organisations, and government agencies. These three actors 'interact with each other, negotiate, and use economic and political power or influence in the process of determining the rules of the work places that constitute the output of the employment relations system' (Dunlop, 1993, p. 13). Power and influence, be it political or economic, are significant to how the relationship between the actors is manifested.

Hyman (1981) explains that because the employment relationship is based on an unrealistic ideal of equal individuals entering a contract, the relationship is inherently skewed in favour of the employer. Employees have less power than employers because although they are 'free' to decide to contract their labour, usually they have little real choice but to enter a contract for work because the alternative for them is poverty. The power of employers is based in beliefs about the rights of management, their resources in terms of ownership and control of production, and also in the formal power granted (and removed) through legislation. Given that the interests of employees and employers are often contradictory, Hyman (1981) contends that the employment relationship is one of continual power struggle, with each party asserting their power and shifting the boundaries in their favour. Hyman defines power as 'the ability of an individual or group to control his (their) physical and social environment; and, as part of this process, the ability to influence the decision which are and are not taken by others' (Hyman,

1981, p. 26). The power and influence of an individual or group is based in their control over the means of production, and also the 'ability to call on certain generally accepted beliefs and values – the rights of management' (Hyman, 1981, p. 26).

According to Poole (1978), 'workers participation is viewed as the principal means of obtaining greater control by workers over several aspects of their working lives and in so doing augmenting their power *vis-a-vis* that of management' (p. 24). Heller (2003) distinguishes 'between participation, meaning taking part in an activity, and power, which implies a degree of influence over the activity' (p. 144). Rasmussen (2009), in terms of employee participation, distinguishes between *influence*, which gives employees a say in matters, and *power* which gives employees potential control. Power and influence may both be partial or total in the organisation, depending on the level at which the employee participation occurs (Rasmussen, 2009). What these definitions concur on is that power is multi-faceted and exists at different levels of the organisation. It underlies the employment relationship and affects the outcomes of employee participation for employees.

There is some agreement in employment relations literature that power comprises the resources (physical, social, legal and so on) or capacity for control, and influence is the resulting action or control over decisions that are made regarding the employment relationship (Abbott et al., 2011). There is less research in employment relations, and indeed in employee participation, that acknowledges the role that gender has in power relationships. Employment relations has tended to view employees as anonymous workers (Danieli, 2006; Kirton & Greene, 2005; Pocock, 1997; Rubery & Fagan, 1995; Wajcman, 2000). Institutions and 'actors' have been the focus of the employment relationship – other dimensions of power such as gender and race are generally overlooked (Forrest, 1993; Pocock et al., 2011).

Power relationships have shaped the trends and patterns in employee participation. Participation had been viewed as a means of power sharing with employees in the 1960s and 1970s. However in the ensuing decades perceptions of employee participation moved towards a focus on employee participation as a tool for increasing organisational efficiency (Gollan & Wilkinson, 2007; Kim et al., 2010; Knudsen, 1995; Markey, 2001). The focus on organisational efficiency coincides with an increase in human resource management programmes that rely upon increased employee commitment and engagement (Benson, 2000; Butler, 2005; Holland, Pyman, Cooper & Teicher, 2009; Markey 2001, 2007). This is summarised succinctly by Busck, Knudsen & Lind (2010):

> where participation used to be based on the mutual recognition of a social compromise between two parties with different interests, it has evolved into a participation based on the mutual recognition of the company's needs and aims. Participation is no longer constructed as a means for promoting individual or collective wage earners' interests, but as a contribution to the success of the company and of the individual on the premises of the company. (p. 2)

The increased focus on efficiency has been fuelled by increased managerial power in the employment relationship. This in turn has been influenced by global competitiveness, technological change, change to flexibility in production (and labour), and growth in service and 'knowledge' sectors (Budd, Gollan & Wilkinson, 2011; Markey, 2001). During a similar timeframe there has been declining trade union membership in most countries (Butler, 2005; Dundon & Gollan, 2007; Haynes et al., 2005; Markey, 2001; Pyman, Cooper, Teicher & Holland, 2006). As union representation has decreased there has been an increase in non-union forms of representative employee participation (Charlwood & Terry, 2007; Dundon & Gollan, 2007; Markey, 2007). Some have argued that managerial intentions for employee participation have been to weaken trade unions, in part explaining the increase in non-union forms of participation (Butler, 2009; Charlwood & Terry, 2007; Gollan, 2006; Taksa, 2009; Taras & Kaufman, 2006). Furthermore, decentralisation of the employment relationship has resulted in decisions on workplace conditions and collective bargaining occurring at enterprise level rather than industry level (Holland et al., 2009; Hyman, 1997). This has further increased managerial power in the employment relationship.

Hyman (1981) states that managerial power may be mitigated by legal requirements that limit what managers may demand of employees. A further influence on the rise of non-union forms of employee participation has been the advent that of legislation requiring employee participation. Much of Western Europe is governed by European Union directives for works councils (Markey, 2007; Rasmussen, 2009) that 'must be consulted by management about important workplace decisions on such topics as redundancies, transfers of the business, investment in the company and threats to employment (Patmore, 2010, p. 77). In comparison, Anglo-Saxon countries' legislation for employee participation has predominantly been in the area of occupational health and safety (OHS), influenced by the United Kingdom's Robens report of 1975. This recommended

joint regulation to decrease the incidence of work-related injury and illness (Lamm, 2010; Markey & Patmore, 2011; Walters, 2004).

There are several key theories that explain the changing patterns of employee participation. Ramsay (1977) proposed a pattern of 'cycles of control' in which participation is used by management to regain control over workers in broad terms. Ramsay suggested, based on analysis of historical patterns, that employers would introduce more participatory practices when trade unions were strong. The purpose of this would be to usurp the union role with management control over the employment relationship in the workplace (Holland et al., 2009).

The cycles of control theory explains the increase in employee participation schemes that coincides with greater union and worker power. It is now argued that while Ramsay's theory explains the patterns of employee participation well until approximately the 1980s, since then such patterns have changed (Marchington, Wilkinson, Ackers & Goodman, 1993). It does not, for example, explain the increasing incidence of non-union representative employee participation and coinciding decrease in union density. Marchington et al. (1993) propose a 'waves' theory for the patterns of employee participation. The patterns are influenced by a number of factors, but the most significant is 'the career aspirations and mobility of managers, and conflicts between different functions and levels in the organizational hierarchy' (Marchington et al., 1993, p. 555). They find that within an organisation, employee participation schemes tend to be introduced when new managers start, on the supposition that the managers are proving themselves for upwards career movement, and making their mark. Schemes then often tend to fade out when the manager who introduced them leaves and is replaced, initiating the same 'wave' process (Marchington et al., 1993). The waves theory arises from a decentralised employment relations framework where bargaining and conditions are often decided at enterprise level.

However, the waves theory does not consider external and macro influences, such as legislation, industry and union presence. Poole, Lansbury and Wailes (2001) propose a 'favourable conjunctures' theory for the incidence of employee participation which incorporates factors both internal and external to the organisation. Managerial choice does have a role in their theory, but the strength of each factor's influence depends on the particular context. The researchers argue that at a particular point in time employee participation will reflect influences from four sets of variables: '(1) macro conditions (external to the organisation); (2) strategic choices of the actors; (3) the power of the

actors; and (4) organisational structures and processes at the level of the firm' (Poole et al., 2001, p. 32). Poole et al. (2001) include the distribution of power as one of the variables, which may include the 'culture and prevailing ideologies within given nations that either promote or constrain industrial democracy' (Poole et al., 2001, p. 25).

The favourable conjunctures theory draws on the influential strategic choice theory (Kochan, McKersie & Cappelli, 1984; Godard, 1994). Strategic choice theory expands on Dunlop's earlier framework to highlight the role that the choices of managers have in the employment relationship. Whereas Dunlop (1993) viewed managers as representatives of owners who had the same goals of maximising profit, strategic choice theory proposes that there are many influences on managers within an organisation and that they make decisions based on their values and beliefs in what is best for the organisation (Kochan et al, 1984). In other words that the 'behaviour and the outcomes produced by the IR system are determined by the interplay between the environment and the strategic choices made by the actors' (Dellemare, 2000, p.385).

A criticism of the waves theory is that focusing on the actors in the employment relationship could mean that informal regimes such as gender are overlooked (Forrest, 1993; Pocock, 1997; Wajcman, 2000). Gender regimes significantly impact on the strategic choices of the actors, their power, organisational structures and processes and the external conditions (Pocock et al., 2011). There is some evidence that employee participation is restricted by employment status with part-time employees less likely to both feel informed on changes to the workplace and perceive they have influence on working conditions. Part-time employees are less likely to have access to meetings and senior managers. Furthermore, workplaces characterised by a high proportion of part-time workers are less likely to instigate any type of employee participation (Markey, Hodgkinson & Kowalczyk, 2002). Given that women are over-represented in part-time work where there appears to be less employee participation (Webster, 2001), it is possible that gender is a considerable influence in the power relationships and employee participation (Denton & Zeytinoglu, 1993). This is an area that is under-researched in employee participation.

Defining Employee Participation

The previous section illustrated the role of power in employee participation. It described the ways in which the emphasis of employee participation has subtly changed over the last few decades. It also discussed some key theories that explain these changes. These changes have influenced the terminology used in the literature to denote overall terms for participatory structures and practices. There are a number of terms, for example industrial democracy, employee voice, and employee involvement, that are often used interchangeably to indicate employee participation. It has indeed been noted that 'one of the biggest problems with the literature on participation is the lack of a clear and unambiguous definition of its subject matter' (Marchington, 2005, p. 26). These terms are themselves associated with subtly different perceptions of power in the employment relationship.

Industrial democracy tends to link participation with improved employee rights and outcomes. The focus of employee participation in the 1970s was closely linked to concepts of democracy both in the workplace and in society as a whole. Employee participation was framed in terms of employees being disadvantaged and needing more power in the employment relationship through employee participation (Pateman, 1970; Poole, 1978). Indeed, Foley and Polanyi (2006) state that 'workplace democracy exists when employees have some real control over organizational goal-setting and strategic planning, and can thus ensure that their own goals and objectives, rather than those of the organization, can be met' (p. 174). Consequently, industrial democracy is a term that is rarely used by organisations and their managers to describe structures and practices that involve employees in decision making (Markey & Patmore, 2009).

Voice, according to Freeman and Medoff (1984), refers to 'direct communication to bring actual and desired conditions closer together. It means talking about problems' (p. 8). Employee voice, therefore, may denote an articulation of individual dissatisfaction, expression of collective organisation, contribution to management decision making, demonstration of mutuality, and co-operative relations (Dundon, Wilkinson, Marchington & Ackers, 2004; Haynes et al., 2005; Holland et al., 2009), and employee exercise of influence over work conditions and decisions within the workplace (Markey & Patmore, 2009; Poole et al., 2001). Employee voice has been associated with employees airing grievances (Wood & de Menezes, 2011), in particular with reference to Hirschman's (1970) exit-voice-loyalty model. This model assumes that employees

will resolve their dissatisfaction through 'voice' or through leaving the job (Wilkinson & Budd, 2010).

Perhaps following on from Freeman and Medoff's discussion of voice, the participation literature often implies a connection between employee voice and the use of employees' skills and knowledge to gain improved organisational outcomes (Busck et al., 2010; Butler, 2009; Dundon & Gollan, 2007; Wood & de Menezes, 2011). Willman, Bryson and Gomez (2007) describe employee voice as 'the presence of two-way forms of communication between employers and employees in which the employer, in exchange for granting employees voice, can elicit potentially productivity-enhancing benefits' (p. 1322). Employee voice, as a blanket term, is often associated with the context of human resource management (HRM) and high performance workplace practices (HPWP) (Baird, 2002; Baptiste, 2008; Benson, 2000; Holland et al., 2009).

Employee involvement is similarly associated with HRM. However, it has been suggested that voice and involvement differ in intention. Employee voice allows employees to voice interests in the workplace, and aims for co-operation, thereby acknowledging different interests but suggesting compromise (Haynes et al., 2005). Employee involvement is based on unitarist ideas in which it is assumed that managerial and employee interests will be the same (Wilkinson, Dundon & Grugulis, 2007). The purpose of employee involvement is often viewed as creating opportunity for high skilled workers to utilise their skills to increase their performance, and that of the organisation (Batt, 2002; Boxall, Haynes & Freeman, 2007). Employee involvement therefore may carry connotations in the literature of being management driven or initiated, and often limited to involvement in work processes, rather than organisational direction or strategy (Boxall & Macky, 2009).

Employee participation is more often associated with employment relations research. It may be used to encompass a broad range of organisational structures and mechanisms (Busck et al., 2010). Employee participation has also been used to refer to information sharing, consultation, negotiation and co-determination (Howes, 2007), sharing of ideas and grievance airing (Wood & Wall, 2007). It is agreed in the literature that employee participation allows employees to *influence* aspects of their work and working conditions (Foley & Polanyi, 2006; Kalleberg, Nesheim & Olsen, 2009; Markey & Patmore, 2009; Pateman, 1970; Poole, 1978; Poole et al., 2001; Rasmussen, 2009).

Two further terms to consider are information sharing and consultation. These are referred to both as part of the process of employee participation (Gollan & Wilkinson,

2007) and participatory practice itself (Richardson et al., 2010). Employees cannot be involved in decision making if they do not have sufficient information (Wilkinson et al., 2010). Consultation is 'the exchange of views between employers and employees or their representatives' (Gollan & Wilkinson, 2007, p. 1134). Employees may have the opportunity to discuss decisions with management before management make them, but they have no influence over the determination of the issue or the decision making process itself (Gollan & Wilkinson, 2007; Richardson et al., 2010).

Some research differentiates consultation from communication, on the basis that consultation is one-way from manager to employee and communication implies two-way information and dialogue (Marchington, 1992). However, other research refers to communication as one-way from manager to employee (Vander Elst, Baillien, De Cuyper & De Witte, 2010; Wilkinson et al., 2007). For example, Wilkinson et al. (2007) specify 'downward communication' to include newsletters, notice boards and e-mails that communicate information from managers to employees. Communication concerns how much, and what kind of, information employees receive about the functioning of the organisation (Vander Elst et al., 2010).

This thesis uses the term employee participation, one which generally encompasses a number of structures and mechanisms for employees to be involved in, and influence, decision making in the workplace. Information sharing is considered both in terms of how employee participation operates, but also how information sharing may be used as a form of direct participation within the case organisation. Such broad definitions are appropriate for exploring how employee participation, productivity and employee wellbeing interact.

Employee participation may be broadly categorised into direct, representative, and financial participation. Financial participation is not the focus of this thesis. This refers to the ways in which employees may be involved the financial outcomes or ownership of the organisation (Kessler, 2010; Wilkinson et al., 2010). Forms of financial participation may include, but are not limited to, profit sharing or employee share ownership (Kaarsemaker, Pendleton & Poutsma, 2010).

Direct participation is when employees participate directly with managers and supervisors, rather than via a representative (Richardson et al., 2010). It may occur informally or through formal arrangements (Howes, 2007; Walters, Nichols, Connor, Tasiran & Cam, 2005); is usually job or task oriented (Knudsen, 1995; Markey, Hodgkinson, Kowalczyk & Pomfret, 2002); and is usually initiated by management

(Walters & Nichols, 2007). Perhaps because direct participation is more often management initiated (Busck et al., 2010), it is also more explicitly linked to concepts of increased productivity and the competitiveness of the organisation (Poutsma, Hendrickx & Huijgen, 2003) than indirect or representative participation. Direct participation has been criticised because it does not allow employees to take part in managerial decisions and does not share power with employees (Busck et al., 2010; Landsbergis, 2003).

Direct participation may be individually or collectively based. Examples of direct collective participation are workplace or divisional staff meetings, usually consultative in nature but sometimes with the remit to make decisions (Knudsen, 1995; Walters & Nichols, 2007); quality circles; and team work (see Table 2.1). Team work may be supervised and 'refers to the extent to which workers cooperate with other co-workers in a relatively stable group' (Kalleberg et al., 2009, p. 102). Self-managing teams, or autonomous groups, are those that manage aspects of their work such as task or shift allocation, making decisions about day-to-day operations, and sometimes performance (Brown, Geddes & Heywood, 2007). Self-managing teams are a team-based form of direct participation. Self-managing teams usually operate with decision making authority, although with objectives set by management (Markey et al., 2002). They are usually management initiated. It has been argued that because of their decision making authority, self-managing teams have greater power than representative forms of participation (Brown et al., 2007).

Quality circles are small groups of employees meeting to discuss and solve production problems, sometimes making decisions at a task based level (Brown et al., 2007; Taras & Kaufman, 2006; Rasmussen, 2009). Quality circles usually only make recommendations to management rather than making actual decisions (Markey et al., 2002). While employees may identify issues for quality circles to consider, management usually controls the decision making process itself. Quality circles tend to be confined to a single, usually quality related, issue.

Table 2.1 Forms of direct participation

Form of participation	Characteristics
Self-managing teams	• Management determine objectives • Employees make the decision • Employees have the resources to make these decisions • Group of employees • Task oriented
Quality circles	• Management set decision making process • Employees may identify the issue & solution • Decision making usually by management, employees make recommendation • Task oriented, particular issue e.g. quality of product • Problem solving • Group of employees
Job autonomy	• Management determine objectives & parameters • Employee makes the decision • Employee has the resources to make these decisions • Task oriented • Individual

Source: Author's summary

Job autonomy refers to decision making about how tasks are carried out and other decisions within the bounds of the job. It may include decisions about work processes or when the work is carried out. In residential aged care, job autonomy includes judgement decisions on residents' health and when to take action or consult a specialist (Nishikawa, 2011; Provis & Stack, 2003). Busck et al. (2010) criticise job autonomy as it currently occurs because it 'may mean the freedom to perform what others have decided must be performed' (p. 16). Direct participation is strongly skewed towards organisational outcomes, although job autonomy and self-managing teams in particular may have some positive employee outcomes in terms of flexibility for employees in managing when and how they perform their tasks.

Indirect, or representative, participation refers to collective arrangements for employee participation (Busck et al., 2010; Howes, 2007; Knudsen, 1995; Levine & Tyson, 1990; Markey et al., 2002). Representative participation is often associated with participation at higher, more strategic, levels of the organisation rather than task based (Kim et al., 2010; Terry, 1999). It is commonly viewed as allowing employees more substantial involvement in the decision making process than direct participation (Busck et al., 2010; Howes, 2007). However the degree of decision making depends on the form that representative participation takes and the regulatory and organisational context within

which it takes place (Markey & Patmore, 2011). While direct participation is usually task oriented, representative participation may be either task oriented or based on broader issues, ranging from health and safety to strategic or corporate decisions (Busck et al., 2010; Howes, 2007; Knudsen, 1995; Terry, 1999). Representative forms of participation may be initiated by management or management-trade union agreement, or required by legislation or a combination of these (Markey & Patmore, 2011).

Examples of forms of representative participation are joint consultative committees, task forces, works councils and trade unions (see Table 2.2). Joint consultative committees are characterised by representatives from both employees and management and deal with issues that are separate to collective bargaining, where it exists (Markey et al., 2002; Rasmussen, 2009). They often have union appointed members also. Joint consultative committees may be established through formal agreements, statutory, or unilateral management action (Walters et al., 2005). In New Zealand, Australia, the United Kingdom and the United States of America, they are usually initiated by management or management and union agreement (Markey, 2007). They do not necessarily have the remit to make decisions and are usually advisory in nature (Marchington, 1992; Markey, 2001; Markey et al., 2002; Markey & Patmore, 2011).

Table 2.2 Forms of representative participation

Form of participation	Characteristics
Joint consultative councils	• May influence decision • May influence issue • May not have role in determining the decision making process
Works councils	• Take part in decisions • May influence issues and decision making process
Task forces	• Little or no influence on issue or decision making process • May influence decision
Trade unions	• Collective bargaining • May participate in policy and work environment • Potential for participation across several employers and/or enterprises

Source: Author's summary

OHS committees are a common type of joint consultative committee in the aforementioned countries and indeed in most places (Markey & Patmore, 2009). Joint consultative committees in OHS have become more common than in other areas because of the aforementioned Robens report, 'which recommended structures for

ensuring joint regulation of OHS by employees and employers' (Markey & Patmore, 2011, p. 5). The Robens report viewed participation as a co-operative dialogue over shared goals (Walters & Nichols, 2007). OHS committees are the only form of legislated representative employee participation in most Anglo-Saxon countries (Markey & Patmore, 2009).

Research has found that OHS committees have some success with reducing workplace injury (Walters & Frick, 2000). Gunningham (2008) agrees that joint initiatives are more effective in achieving positive OHS outcomes than unilateral management initiatives. Studies have shown that 'employee representation improves OHS outcomes and effective solutions are identified and implemented' (Sorensen et al., 2009, p. 644) and that a co-operative, rather than coercive, approach, is more successful. However, one criticism has been that OHS is marginalised and does not become part of line management (Sorensen et al., 2008). The perceived marginalisation of OHS in organisations indicates a lack of 'embeddedness' in the form of participation, as indicated by Cox et al. (2006).

Unionised organisations are more likely to cover issues such as working conditions, whereas smaller, and also non-unionised, organisations were more likely to deal with performance/quality and personnel issues (Marchington, 1992). Indeed, some research has found that participation in OHS needs to be supported by unions in order to be effective (Markey, 2009; Walters & Frick, 2000). Research in the United Kingdom has shown that joint consultative committees with union appointed members only were the most successful, significantly reducing workplace injuries. However, joint consultative committees with no union-appointed representatives were also important in reducing injuries (Reilly et al., 1995).

Task forces also include representatives of employees and management (Brown et al., 2007). However, while joint consultative committees are usually an ongoing form of representative employee participation, task forces are groups that are usually established to consider a particular issue and are likely to be discontinued once the issue is dealt with.

Works councils are similar to joint consultative committees except that they are usually 'statutory bodies with legally defined rights of codetermination and/or consultation over specified issues' (Markey, 2001, p. 5). A further difference between joint consultative committees and works councils is that the latter comprise only employee representatives whereas joint consultative committees may include managers (Markey, 2001). Works

councils are more likely to operate at a strategic level of the organisation, rather than be task based (Rasmussen, 2009). They are prevalent in Europe, where they are required by national and European Union law as noted above (Markey & Patmore, 2009).

Trade unions are a form of representative participation. They differ from other forms of representative participation in that they are always employee initiated and operate separately from the workplace. They have been shown to improve both employee and organisational outcomes in OHS committees (Marchington, 1992; Markey & Patmore, 2011; Walters & Frick, 2000). Despite no longer being the sole means of representation for employees, unions still have an important role to play in non-union representative employee participation. Research has indicated that consultative committees are more likely to be found in unionised workplaces (Benson, 2000) and that the outcomes of these committees are more effective with union support (Charlwood & Terry, 2007; Cooke, 1994; Haynes et al., 2005; Markey & Patmore, 2011; Walters, 2004). Recent research also indicates that direct participation only has a positive impact on productivity when it occurs alongside union representative participation (Kim et al., 2010). The support of unions has also been linked to the level of autonomy of representative participation (Walters, 2004) and unions offer support in terms of resources such as knowledge and sometimes training. It has been suggested that the presence of unions provides greater job security and protection for employees who participate (Haynes et al., 2005). It is therefore important to consider the context of the organisation and in particular the role of unions when investigating non-union forms of representative employee participation.

Organisational Outcomes of Employee Participation

Aspects of employee participation have been shown to positively affect organisational outcomes, particularly in terms of efficiency and financial outcomes. Consequently employee participation is sometimes viewed as a tool to further organisational objectives (see Table 2.3). These objectives may include gaining employee co-operation and acceptance of management decisions (Baptiste, 2008; Heller, 2003; Donaghey, Cullinane, Dundon & Dobbins, 2011); gaining information from employees (Donaghey et al., 2011); improving OHS outcomes (Eaton & Nocerino, 2000; Gunningham, 2008; Markey & Patmore, 2011; Sorensen et al., 2009); building employee identification with

organisational goals (Taras & Kaufman, 2006); and improving efficiency through increased knowledge and skills of their employees (Dundon & Gollan, 2007). Richardson et al. (2010) suggest that profitability requires stronger managerial control, and therefore less or weaker employee participation. While managerial objectives are often criticised for a lack of consideration of employee outcomes, research has indicated positive outcomes for employees, albeit of a less significant nature (Kim et al., 2010). A highly debated example is the use of employee participation in HPWP. This system is used for organisational purposes and the efficient use of human resources (Black & Lynch, 2001; Theriou & Chatzoglou, 2008), but research indicates it has potential benefits for employees such as increased job satisfaction or increased control over how they carry out their work (Karasek, 1979; Macky & Boxall, 2009).

Table 2.3 Employee and managerial objectives for participation

	Rationale (primary interest)	**Related interests**
Employees and trade unions	Influence	Gains from influence, e.g. work satisfaction, better working conditions or remuneration
Employers and their organization	Higher efficiency	Absence of conflict, employee motivation and commitment to company goals
State	Social integration	Absence of social conflict, economic efficiency

Source: Knudsen (1995, p. 15)

Employee participation may increase employees' acceptance of management decisions through working towards mutual goals (Baptiste, 2008; Heller, 2003). A sense of mutual or shared goals can, through employee participation, result in improved communication, less conflict, and greater co-operation on the part of employees (Gollan, 2006; Markey & Patmore, 2009; Taksa, 2009): it may 'create a harmonious workplace in which workers are aligned with drivers of firm success' (Taras & Kaufman, 2006, p. 524). Research suggests that gaining the co-operation of employees and constructing mutual goals will enhance the organisation's ability to gain employee consent to organisational change (Markey, 2007; Taksa, 2009) and give more legitimacy to decision making processes, ensuring greater organisational commitment

(Baptiste, 2008; Butler, 2005; Gollan, 2006; Taksa, 2009; Taras & Kaufman, 2006). Dundon and Gollan (2007) find that 'effective voice is about affording employees the opportunity to develop their knowledge and skills so that they can…satisfy employer demands for support in organizational change initiatives and productivity enhancement' (p. 1186).

A further managerial objective suggested by participation research in Anglo-Saxon countries is that of union avoidance (Taras & Kaufman, 2006). Ways in which employee participation may be used for union avoidance are: encouraging employees to deal with the organisation rather than a union when they need assistance (Butler, 2009; Taksa, 2009; Taras & Kaufman, 2006); and providing better conditions and opportunities for participation than available through union membership (Charlwood & Terry, 2007; Gollan, 2006; Taras & Kaufman, 2006). These approaches ultimately sway the power balance even further towards management. If organisations achieve employee cooperation and institutionalise it, so that employees expect it as part of the employment relationship, then this will also limit the scope for union action (Gollan, 2006). This may be a form of 'symbolic' representation which is strongly underpinned by management direction through management selecting representatives, deciding upon agendas, or limiting the scope and influence of the participation (Gollan, 2006). Organisations, therefore, achieve similar outcomes through non-union representative participation without needing to devolve power or responsibility to unions in the employment relationship.

However, the organisational outcomes that are more commonly identified in participation literature refer to financial and work related outcomes. These discussions rely implicitly on concepts of productivity. Productivity is a term that in economics refers to a ratio measure of output as a factor of input, such as the output of goods as a factor of the resources required to produce the goods. It is concerned with the efficient use of resources and how that relates to outputs. The impact of changes in technology is often measured by productivity (Griliches, 1998; Wilson, 1999).

Labour productivity in turn is usually taken to measure the total output as a factor of the total labour input (De Greef & Van den Broek, 2004; Kopelman, Brief, & Guzzo, 1990; Mathew, 2007). This can be measured by total output as a factor of the number of workers (Abizadeh & Serkan Tosun, 2007; Valadkhani, 2003) or total output as a factor of the number of hours worked (Valadkhani, 2003). Labour productivity is often chosen over other measures of productivity because it is easier to find measures for labour

inputs and outputs that can be quantified, such as sales divided by number of employees (Huselid, 1995; Koch & McGrath, 1996; Kopelman et al., 1990).

Labour productivity may be measured on a national basis, or within a region, industry or organisation (Tang & MacLeod, 2006). Organisational economics is concerned with how an organisation itself functions and 'the relationship between competition and organizations' (Barney & Hesterley, 2006, p. 111). Neo-classical economics assumptions of organisations as entities that exist for the sole purpose of maximising profits underlie these concepts of labour productivity (Barney & Hesterley, 2006; De Greef & Van den Broek, 2004; Dorman, 2000) – it is one measure of an organisation's ability to survive or be competitive.

Labour productivity as a term is often used interchangeably with terms such as performance, effectiveness, efficiency, and profitability in participation literature. These all denote various measures of organisational performance or success (Arthur, 1994; Black & Lynch, 2001; Campbell, 1977; Cappelli & Neumark, 2001; De Greef & Van den Broek; 2004; Forth & McNabb, 2008; Kopelman et al., 1990). The key aspect of these is often improved efficiency in use of human resources (Mahoney, 1988). This has been illustrated by research that criticises HPWP, for example, as focusing on organisational outcomes to the detriment of employee, and indeed societal, outcomes (Black & Lynch, 2001; Delaney & Godard, 2001; Theriou & Chatzoglou, 2008).

Some criticisms of a narrow approach to productivity include a lack of focus in knowledge and service sectors and a lack of contextual information explaining processes behind productivity. Research into participation and productivity has been shown to have focused on manufacturing industries where it is easier to measure labour inputs and outputs (Mathew, 2007). This has resulted in less research establishing factors that may lead to improved productivity in service based sectors (Bartel, 2004; Batt, 2002; Mathew, 2007; The New Zealand Tourism Research Institute, 2007; Theriou & Chatzoglou, 2008). Some research suggests that in service industries in particular it is harder to improve productivity based on traditional measures. This is because the work is by nature labour intensive and it is difficult to accurately measure the outputs created (Dobni et al., 2000). This is especially so in residential aged care which is labour intensive, and where the desired outcomes may include less tangible outcomes such as high quality care (Givan et al., 2010; Palmer & Eveline; 2010; Stack, 2003).

The lack of qualitative research in productivity also means that while productivity phenomena have been noted, the processes contributing to them have not been fully identified (Denzin & Lincoln, 2005). The impact of this could be that phenomena in the service sector are noticed, such as increased labour input with stagnant productivity, but the reasons behind this are left unexplained. Qualitative research is often used to provide in-depth information on organisations and the context of employees, management and government. Indeed these three agents and the power relationships between them form the theoretical basis behind industrial relations systems theory (Dunlop, 1993).

Becker and Gerhardt (1996) noted the need for more qualitative research in order to understand why managers make the decisions they do. Other studies have called for further research into the interactions between organisations and their environment and the effect on their labour productivity (Kopelman et al., 1990; Levine & D'Andrea Tyson, 1990). Lamm, Massey and Perry (2007) note in particular that more research is required that looks at the organisation of work and how that impacts on the connection between OHS and productivity, as do Mylett and Markey (2007). There are similar suggestions that measures of productivity and organisational performance should include the benefits, and costs, to society as well as the organisation (Fairris, 2002; Herzog & Morgan, 1992).

Consequently this thesis, while applying the term productivity to denote organisational outcomes, recognises that the measures used among different organisations will vary. Furthermore, in order to analyse the relationships between participation, productivity and employee wellbeing the definition of productivity for this thesis will be broad. Productivity herein refers to a measure of the organisation's self-selected performance goals. These may include numeric measures such as absenteeism or profit, but also the goals or mission of the organisation. Productivity will be considered in the context of the organisation and the influence external factors may have on it.

Employee Outcomes of Employee Participation

Some participation research argues that direct participation is preferable to representative participation for positive employee outcomes because it involves more decision making by the employees. Representative participation, on the contrary, it is

argued, results in limited decision making by employees and is focused on consultation only (Beirne, 2008; Brown et al., 2007). However, direct participation is almost always associated with task or job related decision making (Knudsen, 1995; Markey et al., 2002), a lower level of participation within the organisation. Representative participation is more often, though not exclusively, associated with participation in workplace conditions, policy, and sometimes strategic decisions in the organisation. Generally, research providing models of effectiveness considers the level or type of decision and whether employees make decisions or recommendations. Some models refer to either direct or representative participation, but more recently, acknowledging the trends towards non-union and direct participation, models have considered multiple mechanisms for participation in an organisation.

Rasmussen (2009) describes three levels of participation in an organisation: the strategic, administrative, and executive. The strategic level is 'where decisions are made about the organisation's goals, objectives and policies; the administrative level is where decisions are made about how policies are to be implemented' (Rasmussen, 2009, p. 495). The executive level is where decisions about day-to-day operations are made. Decision making at an executive level includes decisions over how work is carried out, and when, as well as the distribution of tasks between team members. Administrative decisions involve the implementation of policy. For example, many aged care facilities have a 'no lifting' rule. Employees might be involved in the implementation of the 'no lifting' (manual handling) rule in terms of deciding upon the necessary equipment and training to support the policy, as well as allocating caregivers among the team so that two are available to assist an immobile patient.

Joint consultative committees and work councils may operate at any of these levels, depending on their terms of reference. An OHS committee, for example, may operate more at the executive level if it considers only small hazard identification and prevention in daily tasks. However, if the committee considers issues such as workload and staffing levels then it is operating at an administrative level. Strategic participation may involve long-term objectives over workplace conditions and policy. Examples include having employee representatives on boards of directors (Rasmussen, 2009) or involving unions in the development of organisational policy and/or strategy.

The range of levels at which employee participation occurs contributes to the overall 'embeddedness' of employee participation within the organisation. Cox et al. (2006) suggest that embeddedness reflects the breadth and depth of employee participation

within an organisation. Breadth reflects links between different forms of participation in the organisation and depth is 'the degree to which individual EIP [employee involvement programmes] practices and combinations of EIP involve workers in their operation' (Cox et al., 2006, p. 251). The different forms of participation are included here because research indicates that a single form of participation will have less effect than a combination of forms within one workplace (Cox et al., 2006; Markey & Shulruf, 2008; Pyman et al., 2006). Depth of employee participation may be indicated by the frequency of meetings and how closely the issues covered relate to employees' priorities and concerns (Cox et al., 2006); in other words, the level at which the form of participation operates. Cox et al.'s (2006) model incorporates not only multiple forms of participation, but the interaction between representative, direct, union and non-union participation as well.

Cox et al.'s (2006) model of embeddedness draws from previous measures of the influence and power afforded by different forms of employee participation. Pateman (1970) referred to three types of participation based on the extent of decision making authority that employees have: pseudo participation, partial participation, and full participation. Pseudo participation describes a situation in which participation is used to coerce employees into believing they have participated in a decision which in fact management has already predetermined (Pateman, 1970). As Pateman (1970) describes it, pseudo participation is a management tool used to gain employee co-operation. Pseudo participation would afford employees little or no influence. Partial participation on the other hand, is that in which employees may *influence* decision making, but where decisions are ultimately made by management (Pateman, 1970). Full participation is where employees can make decisions on how work is allocated and carried out. This is more likely to occur when employees participate in decision making at a strategic level (Pateman, 1970). Full or partial participation is connected more with representative participation, which has the objective of power sharing for employees. Pseudo participation would perhaps involve decision making at task based level, such as direct participation. It could also be in the form of consultation, whereby employees may provide feedback on a decision that is then taken by managers, without or without incorporating the feedback.

Similarly to Pateman, Knudsen (1995) refers to the 'intensity' of participation, which is a combination of the degree of influence which employees have on decisions and the 'range and importance of subjects covered by participatory decisions' (Knudsen, 1995,

p. 9). The degree of influence reflects the level at which the decision making takes place and the extent to which employees take part in the decision making, for example whether they are consulted only or actually make the decision. The lowest level of influence is where participation takes the form of consultation and information sharing, and the highest level of influence is when co-decision or co-determination takes place (Knudsen, 1995).

Whereas Cox et al. (2006) look at breadth and depth, Gaffney (2002) suggests measures for the effectiveness of a single form of representative employee participation. Gaffney's (2002) measures are based on how much influence is afforded to employees in the decision making process. His five measures are:

1. The composition of the form of representative participation
2. The independence of the representatives.
3. The representativity of the representatives.
4. The level of expertise available to the representatives.
5. The accountability of the representatives.

The composition of the form of representative participation can be analysed by how autonomously it operates from management. This may be evident in who chairs a committee, and who is on the committee, and whether management is present and in what proportion (Gaffney, 2002). Indications of the independence of representatives include how they are chosen, the resources provided by the organisation, who initiates agenda items, the representatives' access to other employees, and whether the committee has the authority to make decisions (Gaffney, 2002). Independence of representatives is more likely if they have been elected by employees, rather than nominated by management or self-nominated. The obvious way for a representative to gain legitimacy is through their day-to-day interactions with other employees and ensuring employees' interests are considered when agreements, policy and other decisions affecting them are made (Gaffney, 2002).

The comprehensiveness of representation also contributes towards representativity. For example, is every department or unit in an organisation represented on a committee, or only a few? Are day and night shift employees represented? Are full and part-time employees and all genders and diverse groups within the organisation? Access to external training, including paid time off work for this, and advice as well as the qualifications of members are demonstrations of the level of expertise available to representatives. Some measures of the representatives' accountability to employees may

be whether they report to employees and how; do they follow up on issues raised and report back, and when their initial term is up as a representative do they remain on the committee or are they voted back on?

Effectiveness of employee participation offers a way of analysing how much power employees have in the decision making. Effective participation will result in, it is suggested, greater balance of power, and therefore greater determination over the issues that employees can influence. Employee outcomes of participation will, it is indicated, be greater when the participation is effective (Gaffney, 2002).

Research has identified several employee outcomes of participation. These include improved OHS outcomes, reduced stress and increased job satisfaction, and improved work-life balance. Although OHS is concerned with employee health, research has suggested that in practice there has been a narrow focus on accident and injury. This is because accidents and injuries are easier to measure than other forms of disease and mental health (Bohle & Quinlan, 2004). OHS relies upon accepted norms and standards for production, which appear to provide more concrete data on cause and incidence. Consequently research has been predominantly undertaken in manufacturing industries where aspects of OHS such as injury rates, hazard assessment and safety-related processes have been of paramount concern. Furthermore, it is perceived that is easier to prevent a physical injury through accident. Thirdly, power relationships influence how OHS is perceived in the workplace.

OHS has typically focused on workplace injury and illness to the exclusion of mental health. One reason for neglecting mental health is that occupational injury is easier to measure and assign causes to (Bohle & Quinlan 2004). However, this narrow contextual approach has overlooked the role of factors such as assumed norms of work, power relationships, organisational processes workers' compensation systems and concepts of occupational illness in OHS (Bohle & Quinlan, 2004; Dwyer, 1983; Messing, 1998; Williams, 1993).

It has been argued that the causes of industrial accidents extend to contextual factors such as assumed norms power relationships between employees and managers and financial management systems (Bohle & Quinlan, 2004; Dwyer, 1983; Messing, 1998; Williams, 1993). An example of how these underlying issues may affect the incidence of occupational injury and illness can be seen in the design of factory equipment being based on the height of an average man. When a woman uses the equipment and suffers an injury, the woman, rather than the equipment, is seen to be at fault. This is the result

of deep underlying assumptions of how work is done and who does it (Messing, 1998). A further example is the influence of financial management on OHS. Bohle and Quinlan (2004) point out, for example, that workers' compensation systems consistently under-report occupational injury and illness.

Medical perspectives and definitions of occupational illness have predominated in OHS and have focused on individuals rather than broader organisational issues as the cause of occupational illness (Quinlan, 1993; Williams, 1993). Indeed the research has been criticised for concentrating on individual responses to the work environment and therefore failing to consider that the work environment may not be meeting the need of employees (Bohle & Quinlan, 2004). However, OHS literature has begun to broaden the focus of research, perhaps due to a growing recognition of the interdisciplinary nature of OHS (Quinlan, 2004) and changes in the regulatory systems. Scandinavian OHS research, for example, is based on a tradition of viewing OHS in broader terms of the work environment (Busck et al., 2010; Hvid & Hasle, 2003; Sell & Cleall, 2010). Brough (2005) notes that in New Zealand and internationally stress has become an 'occupational hazard that employers must take reasonable steps to prevent' (Brough, 2005, p. 128). Although the literature has not defined it as such, this approach to both physical and mental health, and the contextual factors that may impact on them, contains much of what might be considered to be employee wellbeing.

Many of the positive outcomes for employees of participation are derived from the greater sense of control that employees have when they can make decisions on how they carry out their work, as Karasek (1979) outlined. Job autonomy in particular is associated with increased job satisfaction and decreased fatigue and stress (Macky & Boxall, 2009). Increased job satisfaction in turn often leads to greater commitment on the part of the employee, and therefore decreased turnover (Yeatts & Seward, 2000), which may also benefit employees.

Karasek proposed that low 'decision latitude' combined with heavy job demands leads to mental strain or stress and job dissatisfaction. In contrast, high job demands and high decision latitude combined to create increased job dissatisfaction and lower stress levels (Karasek, 1979). This model has influenced research particularly in management and employment relations. It also signals a relationship between task based employee participation and employee wellbeing. Research based in Karasek's (1979) model looks as much towards organisational culture and processes as it does to the individual employee's characteristics. For example, a recent study illustrates how the demand-

control model has been expanded to include the work environment, including social support, work hours, and employees' control over more task based decisions (Mauno, Kinnunen & Rokolainen, 2006; Vanroelen, Levecque, Moors, Gadeyne & Louckx, 2009). Mauno et al. (2006) expand Karasek's demand-control model to include control over flexibility of work arrangements to minimise work-life spillover. Vanroelen et al. (2009) in turn expand control from the traditional model of control over task variation and job autonomy to include physical demands of work, such as heavy loads or toxic substances, emotional demands and social support, and stressors such as excessive work hours and atypical schedules. These models expand job satisfaction, stress, job demands and control to include social support and work-life balance.

Some work-life balance literature has also indicated improved work-life outcomes as a result of employee participation, both representative and direct participation. Union participation may influence work-life outcomes through collective bargaining, raising awareness among members of organisational policy, and through pushing for work-life balance policies in organisations (Bewley & Fernie, 2003; Budd & Mumford, 2004; Dickens, 1999; Gregory & Milner, 2009; Ravenswood & Markey, 2011; Rigby & O'Brien-Smith, 2010; Seeleib-Kaiser & Fleckenstein, 2009). Research has also found that interesting work and employee participation have a positive effect on an employee's work-life balance (Berg, Kalleberg & Appelbaum, 2003), while work-family conflict has a negative effect on work mental wellbeing (Brough, 2005). Furthermore, flexible hours, a key tenet of work-life balance literature, has been linked in the literature to reduced reports of stress and improved wellbeing (Chiang, Birtch & Kwan, 2010; Halpern, 2005; Hayman, 2010; Russell, O'Connell & McGinnity, 2009). Similarly support for work-life balance has been found to be influential in the emotional wellbeing and intention to quit among women managers and professionals (Burke, 2001).

OHS, reduced stress, and work-life balance are all separate contributors to an overall outcome of employee wellbeing, and draw from a number of related fields such as OHS, HPWP and HRM. Generally, employee wellbeing research refers to mental wellbeing and stress (Danna & Griffin, 1999; Hayman, 2010; Page & Vella-Brodrick, 2009). Some recent research connecting participation and employee wellbeing has identified wellbeing as including job satisfaction, mental health and work-life balance. Baptiste (2008) defines employee wellbeing as employee commitment, job satisfaction and work-life satisfaction. Her definition centres on the individual and the contextual

factors that interact with each other, such as social exchanges at the workplace and HRM practices. Employee commitment contributes to wellbeing because it represents the level of trust and identification with organisational goals that the employee has. In this sense, it suggests good mental wellbeing, or perhaps lower stress levels. Job satisfaction, according to Baptiste (2008), incorporates the employee's perception of the work and the organisational context within which it takes place. Work-life balance is incorporated into wellbeing as part of the work context and acknowledges influences on wellbeing from outside work (Baptiste, 2008). Baptiste's study incorporates organisational context in a case study approach.

Macky and Boxall (2008) use fatigue, job-induced stress, job satisfaction and work-life imbalance as measures of employee wellbeing. Job satisfaction includes Warr, Cooke and Wall's measure (1979, cited in Macky & Boxall, 2008) as well as a factor incorporating involvement in decisions. Their job satisfaction measure therefore includes a number of indicators of satisfaction with the work and conditions. Work-life balance was considered in the sense of negative spill over from work to home life (including personal life and friendships), and the subsequent effect on employee stress and satisfaction (Macky & Boxall, 2008). Macky and Boxall's (2008) study was based on a survey of New Zealand employees across multiple organisations and industries.

Wood (2008) defines wellbeing as incorporating mental health and job satisfaction. Wood's use of wellbeing is not as broad as Baptiste's (2008) or Macky and Boxall's (2008). His definition is based on Karasek's job demand-control model and looks at the role of supportive management and employee voice in addition to Karasek's variables (Wood, 2008). Wood's research, like Macky and Boxall's (2008), is based on a large survey across multiple industries.

Although all three of these studies incorporate some aspects of working conditions, only Baptiste's (2008), by including case study research, is able to make connections between workplace conditions and particular outcomes. None of these studies incorporate the role of the regulatory environment or external factors on employee wellbeing. A further gap in their definitions is OHS as part of employee wellbeing. Some employee participation research into HPWP has indeed highlighted the need for consideration of work and how it interacts with other social institutions (Kochan, 2000).

This thesis will use a definition of employee wellbeing that incorporates OHS and work-life balance. Building on models that use job satisfaction across various factors, this definition will also include pay, and work conditions. As indicated in the research,

OHS will include experience of stress and fatigue as well as physical accident and injury. Work conditions will incorporate workload and the hours worked, as well as factors such as feeling appreciated and training available. The analysis of employee wellbeing will include consideration of the external environment to the organisation, such as regulation and industry trends. Furthermore, consideration of employee wellbeing will include analysis of gender and power relationships and how, if at all, these may influence employee wellbeing.

Conclusion

Power and influence underlie the employment relationship and the negotiation of workplace rules between employees and management through employee participation. Managers and employees may have diverging interests, and the power relationship between the two will affect whose interests have prominence. Managerial interests tend to be focused on productivity and improved efficiency which has been shown to result in a lack of attention to employee outcomes, a gap identified in both the employee participation and productivity literature (Baptiste, 2008; Guest, 2002; Conway & Monks, 2009; Delaney & Godard, 2001; Haynes et al., 2005). Furthermore, both literatures show little research that encompasses the complexities of the relationships between employee participation and productivity (Mylett & Markey, 2007), and also the interplay with the broader employment relationship (Baird, 2002; Delaney & Godard, 2001; Eaton & Nocerino, 2000; Kochan, 2000; Rasmussen, 2009). There is a need for research that identifies complexities and contextual issues within both employee participation and productivity (Becker & Gerhardt, 1996; Boxall & Macky, 2009; Butler, 2005; Conway & Monks, 2009).

Research on employee wellbeing has to some extent considered organisational context in the relationship between participation and employee outcomes. However, it has not explicitly considered the role of power in determining employee outcomes. This thesis uses Gaffney's (2002) measures for effectiveness of employee participation to analyse representative participation in the case organisations. Cox et al.'s (2006) concept of embeddedness will guide the examination of direct and representative participation in the case organisations in general. This chapter has indicated the importance of examining multiple practices and incorporating not only organisational, but external

factors. It has extended Poole et al.'s (2001) theory by including gender in the four variables of patterns of participation. There is some indication from the literature that gender and power may limit outcomes of participation and in OHS for women (Markey et al., 2002; Messing, 1998; Webster, 2001). Poole et al.'s (2001) framework will guide analysis of participation with regard to the influence of external factors such as regulation and industry expectations.

Several connections between employee participation, productivity and employee wellbeing have been established in the literature (see Figure 2.1). Not all of these consider the ways in which all three concepts might interrelate. This thesis will analyse the relationship between employee participation, employee wellbeing and productivity and consider the ways in which external factors may influence this relationship. It will analyse the relationship with an underlying questioning of how gender in power influences it.

Figure 2.1 Examples of connections between participation, productivity and employee wellbeing

Participation & productivity

- Improved efficiency through knowledge and skills of employees (Appelbaum et al., 2000; Dundon & Gollan, 2007; Kim et al., 2010; Markey & Shulruf, 2008; Theriou & Chatzoglou, 2008).
- Employee co-operation and acceptance of management decisions (Baptiste, 2008; Heller, 2003; Donaghey et al., 2011).

Participation & wellbeing

- Improved OHS outcomes (Bohle & Quinlan, 2004; Eaton & Nocerino, 2000; Gunningham, 2008; Marchington, 1992; Markey, 2009; Markey & Patmore, 2009; Reilly et al., 1995; Sorensen et al., 2009; Walters & Frick, 2000; Walters et al., 2005).
- Improved job satisfaction & lowered stress levels (Baptiste, 2008; Karasek, 1979; Macky & Boxall, 2008; Mauno et al., 2006; Vanroelen et al., 2009; Wood, 2008).
- Improved work-life balance (Berg et al., 2003; Brough, 2005; Budd & Mumford, 2004; Chiang et al., 2010; Gregory & Milner, 2009; Halpern, 2005; Hayman, 2010; Ravenswood & Markey, 2011; Rigby & O'Brien-Smith, 2010; Russell et al., 2009; Seeleib-Kaiser & Fleckenstein, 2009).

Wellbeing & productivity

- Decreased turnover (Baptiste, 2008; Yeatts & Seward, 2000).
- Via improved OHS outcomes (Burton et al., 1999; Grawitch et al. 2006).

Source: Author's summary

The following chapter details the research design of this thesis. It presents the research questions and the methodology and methods that will be employed to address those questions. The use of a feminist critical perspective in the analysis of the findings of this thesis is also explained. This thesis intends to explore contexts and relationships in employee participation, productivity and participation. The next chapter argues that a case study approach is the most appropriate for this research, and provides an overview of the case organisations in this thesis.

Chapter Three: Research Design

Introduction

The previous chapter highlighted the role that power has in the relationship between employee participation, productivity and employee wellbeing. Power relationships affect to what extent organisational or employee outcomes take precedence. They have also influenced the patterns of employee participation so that organisational outcomes tend to dominate (Baptiste, 2008; Guest, 2002; Conway & Monks, 2009; Delaney & Godard, 2001; Haynes et al., 2005).

Chapter Two suggested that the role of gender and power in employee participation and wellbeing has been under-considered. It illustrated that the context within which employee participation, productivity and employee wellbeing are measured and implemented is important to understanding not only the relationship between them, but the processes behind it. This relationship occurs, it was suggested, both in the organisational context and the broader one of the regulatory framework or external environment. Chapter Two identified a need for further research into the complexities between productivity and participation (Mylett & Markey, 2007), and the relationship with the broader employment relationship (Baird, 2002; Delaney & Godard, 2001; Eaton & Nocerino, 2000; Kochan, 2000; Rasmussen, 2009). There is a clear need for research that identifies complexities and contextual issues within both employee participation and productivity (Boxall & Macky, 2009; Conway & Monks, 2009) and how these impact on employee wellbeing.

This thesis will address some of these gaps in the literature. There are three research questions for this thesis:

1. Is there a relationship between productivity, participation and employee wellbeing?
2. What is the impact of effective representative employee participation on employee wellbeing?
3. How does the external environment, for example government regulations and industry standards, impact on questions one and two?

These questions are viewed within the framework of employment relations, which is the study of the powers and interests of the key parties in the employment relationship; the strategies adopted by these parties to regulate or control the relationship, including the formal and informal rules and processes used; and the context within which the employment relationship occurs (Dunlop, 1993; Edwards, 2005; Rasmussen, 2009). The context within which the employment relationship occurs may have multiple levels including the workplace, national and international levels (Edwards, 2005). Indeed Poole et al. (2001) suggest that patterns of employee participation are influenced not only by organisational context, but also the impact of external factors and power relationships. Consequently, the research method and methodology of this thesis will need to allow for the study of complex relationships, with an emphasis on employee outcomes, acknowledging that power will impact on the role of employers and employees and how productivity, participation and employee wellbeing may be connected.

The research is set within the context of a gendered sector that has traditionally undervalued the work carried out by employees and its approach will therefore need to consider the role of gender within the sector and workplaces. Fault is found with traditional employment relations research because of a lack of attention to the role that gender plays in how work and workers are researched and understood (Hansen, 2002; Rubery & Fagan, 1995). It is criticized for focusing on men and paid work (Hantrais & Ackers, 2005) and for often focusing on quantitative research in male dominated industries (Danieli, 2006; Pocock, 1997). Kirton and Greene (2005) suggest that 'the dominant masculine construction of industrial relations has contributed to the invisibility of gender and equality' (p. 142). This may be because employment relations research assumes an anonymous, aggregate worker which means that social processes that inform the meanings we bring to work are overlooked (Hansen, 2002; Holgate et al., 2006; Kirton & Greene, 2005; Wajcman, 2000). As mentioned above, employment relations studies the institutions and actors that negotiate workplace conditions (Dunlop, 1993; Edwards, 2005; Rasmussen, 2009). However, this analysis has often overlooked the gender of the actors, and the role that informal practices and processes contribute to the experience of women and men at work (Danieli, 2006; Wajcman, 2000). Forrest (1993) strongly states that:

> the discipline has no interest in the doings of women, or men for that matter; the only 'actors' in the 'system', to use Dunlop's terminology, are workers,

> managers and trade unionists. So fixated are we on the employment relationship as the source of power and conflict at work that all other dimensions of power, most notably gender and race, are disregarded or dismissed as external to the 'system'. (p. 14)

Pocock et al. (2011) point to employment relations' strong current of concern with power and how it impacts on the employment relationship, and highlight that gender, which is less recognised, plays an equally important role in how power is used, and who has power in the employment relationship. Feminist researchers have identified the need for contextual research that incorporates not only the 'institutions and actors, but the broader social context' (Healy, Hansen & Ledwith, 2006). There is an obvious need in employment relations, and in the fields of productivity, participation and employee wellbeing, for contextual, qualitative research. This research should not be confined to the individual or organisational level, but include the impact of external factors and institutions, and societal processes. It should not look at these institutions as 'anonymous' but recognise that gender and power will interplay and influence the way in which work is valued and experienced.

This chapter will present the philosophical underpinning of the research and outline the approach that will be taken for data collection and analysis. It will discuss why the methodology and method employed are appropriate to the research questions and gaps in literature. This chapter also introduces the case study organisations.

Methodology

Methodology refers to the theoretical framework underpinning research and guides the researcher in what method they will choose (Giddings & Grant, 2006). Method on the other hand is the tools chosen to collect and analyse data. Ontology refers to the beliefs that a researcher holds about what reality is (Giddings & Grant, 2006). An example of how ontological beliefs may differ may be seen in a comparison between constructionism and objectivism. According to objectivism, social phenomena are independent of the social actors, whereas a constructivist viewpoint would hold that the social actors continually build and rebuild social phenomena (Bryman & Bell, 2007). Epistemology is what is considered to be acceptable knowledge, and how knowledge is produced (Bryman & Bell, 2007; Lykke, 2010). For example, empiricism is based on

the premise that 'only knowledge gained through experience and the senses is acceptable' (Bryman & Bell, 2007, p. 10), whereas hermeneutics, for example, considers that objective knowledge is gained through the interpretation of text (Arnold, 1994). The particular ontological and epistemological views of the researcher will determine what methodology or framework guides their research, and also what method they will choose to collect and analyse data, in other words the research paradigm.

This thesis draws on a critical approach (see Figure 3.1). While they acknowledge that critical theorists and traditions come from many different schools, Kincheloe and McLaren (2008) define 'a critical researcher or theorist who attempts to use her or his work as a form of social or cultural criticism' (Kincheloe & McLaren, 2008, p. 404). The ontological view of this approach is that reality is something that is experienced and cannot be separated from values and ideologies held by groups within society; it is 'shaped by social, political, cultural, economic, ethnic, and gender values' (Guba & Lincoln, 2008, p. 260). Within society some groups will have more power than others, and this power relationship is socially and historically conducted and leads to some groups being more privileged than others (Harding, 2007; Hyman, 1981; Kincheloe & McLaren, 2008; Lykke, 2010).

Figure 3.1 Common assumptions held by critical theorists and researchers

- All thought is fundamentally mediated by power relations that are socially and historically constituted;
- Facts can never be isolated from the domain of values or removed from some form of ideological inscription;
- The relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption;
- Language is central to the formation of subjectivity (conscious and unconscious awareness);
- Certain groups in any society are privileged over others;
- The oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable;
- Oppression has many faces and that focusing on only one at the expense of others often elides the interconnections among them;
- Mainstream research practices are generally, although most often unwittingly, implicated in the reproduction of systems of class, race, and gender oppression.

Source: Kincheloe & McLaren (2008, p. 405)

While the experience of the researched is important to a critical approach, it cannot account for 'how that experience emerged' (Olesen, 2008, p. 329). Consequently the epistemology of critical research views that findings are mediated by the values of researchers, the researched, and the context within which the research is carried out (Guba & Lincoln, 2008). The context of the research considers not only the values of the 'physical' context, for example the workplace and the sector and country within which it is situated, but also the values that the researcher themselves brings to the research (Guba & Lincoln, 2008). This thesis takes an ontological approach that reality is experienced, and is influenced by values and ideologies. It holds in particular that some groups will have more power than others, and that this impacts on the experience of reality within both groups. In particular, this researcher uses a feminist epistemology, in that the power, values and ideologies which impact on experienced reality are mediated by the role of gender in those power relationships within society. As Kincheloe and McLaren (2008) succinctly state, 'critical researchers enter into an investigation with their assumptions on the table, so no one is confused concerning the epistemological and political baggage they bring with them to the research site' (p. 406).

Feminist research has different connotations to different researchers (Archer, 2004), although Coleman (2009) identifies some common goals of 'gender, equity and social justice' between generations and schools of feminism, academics and activists. Feminist research generally explores the experiences of groups whose experiences are not necessarily represented in dominant thought, research and policy (Harding, 2008). This requires analysis of not only the marginalised group's experience, but the perspectives of those in the dominant group (Harding, 2008). Feminist research is generally based on the experiences, lives and struggles of women, and others who are disadvantaged (Brooks, 2007; Harding, 2007, 2008; Hekman, 2007; Naples, 2007). Central to this is the acknowledgement of the plurality of women's lives and experiences, that is that there is not 'one' woman, and that women's differing identities will influence their experience (Brooks, 2007). Through researching women's lives and experiences feminist research intends, at minimum, to expose the often unspoken structures, and power and gender relationships that oppress women (Ackerly & True, 2010; Brooks, 2007; Calas & Smircich, 2009; Harding, 2007, 2008; Leckenby, 2007; Reinharz & Kulick, 2007). In other words, feminist research analyses the information in its socio-political context (Reinharz & Kulick, 2007). It is therefore interested in in-depth, contextual information that reveals sometimes hidden experiences (Hesse-Biber, 2007).

Feminist research is conscious of power structures even in the research process and the writing up of the research. It considers that the social position and power of the researcher may influence how the experiences of the researched are presented and analysed to meet the researcher's interests. Therefore, while documenting previously unrecognised experiences, the researcher may re-appropriate them, or silence some voices, for their purposes (Opie, 2008). Ludvig (2006) suggests that often who decides on which differences or identities are important in particular contexts is not questioned. This is one reason why reflexivity in the research process is an important aspect of feminist research.

As women's experiences are situated in the socio-political context, Kirton and Healy (2004) suggest that 'identities may shift as individuals engage with the broader social relations and wider structures of society. This interrelationship between social relations and wider society is critical' (p. 305). This supports the call for more consideration of the broad context within which the employment relationship is negotiated. It also underlies one of the key tenets of feminist epistemology, which is intersectionality (Holgate et al., 2006; Holvino, 2010). Intersectionality is acknowledging that any one individual will have multiple 'identities' and that the way those identities are presented and understood will vary according to the social and organisational context (Adib & Guerrier, 2003; Kirton & Healy, 2004; Holgate et al., 2006; Holvino, 2010; Ludvig, 2006). Adib and Guerrier (2003) note that while gender may be studied alone, it is performed in conjunction with other identities, such as class and race, such that any one individual's identity 'is a negotiation of many categories that exist simultaneously and that shift according to context' (p. 431). Holvino develops the concept of intersectionality to incorporate gender, class, race and sexuality as 'simultaneous processes of identity, institutional and social practice' (p. 262). In other words, the processes and actions that produce understandings of an individual by themselves and by other people. These processes happen at the levels of the individual, the organisation, institutions and society. Intersectionality can help explain, for example, the way in which class, gender and race intersect in the production of the identity of care workers so that the work is perceived as low skilled, low paid work by society.

One way in which intersectionality can be used and identified in research is through the narratives of people at different levels of the organisation, and different 'axes of power' (Holvino, 2010, p. 263). While Holvino (2010) presents her development of intersectionality in feminist research for organisation studies, the interaction of

institutions, society and the organisation is very similar to an employment relations framework, while using a lens that acknowledges differing and changing identities. Indeed, intersectionality would address some of the feminist critiques of employment relations research that assert it is too focused on anonymous institutions and actors and disregards the role that gender plays within these (Pocock, 2000).

Critical and feminist research acknowledges that the research process itself is influenced by the assumptions of the researcher and the power relationships between the researcher and researched (Esim, 1997; Guba & Lincoln, 2008; Holgate et al., 2006; Kincheloe & McLaren, 2008; Olesen, 2008). The location of the researcher is paramount. The researcher's ontological and epistemological positions will influence the research process. Location is also the researcher's position in society and the research: their political, academic and social backgrounds, their gender or ethnicity (Lykke, 2010). In other words, reflexivity locates the researcher, the research and the researched in its context, for example how the topic is chosen, as well as influences or pressures on the research, such as publication requirements (Ateljevic, Harris, Wilson & Collins, 2005; Ledwith, 2006).

Reflexivity identifies the power relationship that occurs in the process, and reflexive practice may 'enlighten and enrich analysis of the research relationship' (Ledwith, 2006, p. 380). For example, Esim (1997) explains the role of power in interviewing Turkish women. She found that although she was a Turkish woman herself, her identity as educated, middle-class and living outside of Turkey made her an 'outsider' and exacerbated power relationships. Esim (1997) also found that the method of research influenced the power relationships in the process, with close-ended survey questions creating stronger 'power hierarchies', whereas 'during the qualitative interviews...the women who were the subjects of the research had more voice and brought out issues of importance to them' (p. 138). Reflexivity is an important aspect of feminist research because it acknowledges the power of the researcher in not only researching, but re-presenting the experiences of the researched (Alcoff, 2008; Opie, 2008).

Analysis of both those with more power and those with less underlies not only feminist research but also employment relations (Hyman, 1981; Pocock et al., 2011). Feminist research in employment relations also has some common objectives. It aims to ' (1) redress the gender imbalance of much existing industrial relations work by documenting women's lives; (2) to understand women's experiences from their own perspectives; and (3) to conceptualize their behaviour as an expression of social contexts' (Parker,

2002). Baird, Cooper and Ellem (2009) explain feminist research in employment relations as aiming 'to build knowledge of women's lives and to inform the analysis with the subjects' own understandings of their position and experiences' (p. 396). They describe their research as *for* women and *with* women, in order to not only analyse their experience but to also transform it (Baird et al., 2009).

Holgate et al. (2006) offer a framework for a feminist analysis in employment relations that identifies how women's experiences can be documented, understood and analysed within social contexts. Their three key tenets for a feminist epistemology are intersectionality, material structures and cultural meanings, and reflexivity and positionality (see Table 3.1). These will form the underlying basis for the analysis of information in this thesis, with particular focus on 'the awareness of gender as a dynamic of power relations that are continually reproduced and contested' (Holgate et al., 2006, p. 314). Holgate et al.'s tenets of feminist epistemology meet the needs of research that questions power relationships, that examines contextual information, and intends to look at the context of employee participation, employee wellbeing and productivity at organisational and broader levels.

Table 3.1 Key tenets of feminist epistemology

Intersectionality	A focus on identities/difference/intersecting identities. Recognition of how these vary at different times and places, and how they may be mediated by power relations.
	Awareness of gender as a dynamic of power relations that are continually reproduced and contested.
	Deliberate choice of research sample rather than assuming a norm.
Material structures and cultural meanings	Lived experience: multiple and shifting cultural and material circumstances shaping life experience in public and private space.
	The use of participants' voice to capture authenticity, nuance and meaning. Allowing the researched to speak for themselves.
Reflexivity and positionality	A critical (self-)reflection on the research process.
	Reviewing the role of the researcher in data production.
	Recognising the influence of power in the research process, both between researched and researcher.
	An ethical approach: responsibility and accountability to the researched.

Source: Holgate et al. (2006, p. 314)

Method

This thesis is based on research questions that focus on the workplace, but involve the interactions of employees and employers, and also external influences on these, such as unions, regulatory context and other societal factors. It intends to explore power relationships and role of gender within these. Consequently, rich data that reveals the multiple experiences of participants is required. An appropriate method will therefore be one that will allow for data from several different sources, different types of data that may explain relationships between actors, and data that is in-depth and contextual. The overarching framework chosen for data collection is the multiple case studies approach. Case study research is conducive to contextual research. It facilitates the collection of data by multiple methods (Baxter & Jack, 2008) and allows for analysis of the data at multiple levels, such as the organisational and sector levels, within the case and across cases (Eisenhardt, 1989). The case study method has been chosen because it is appropriate to a critical approach and to the research questions. Case studies facilitate the viewpoint or experience of the participants (Tellis, 1997; Yin, 1994) and furthermore 'give a voice to the powerless and voiceless' (Tellis, 1997b). This is an essential element to feminist critical research (Hardy, 2008).

Case study research allows multiple levels of analysis and multiple types of data. This means that data which uncovers both formal and informal processes and dynamics, such as interview data and organisational documentation, may be utilised (Eisenhardt, 1989 & 2007). In other words, 'it enables the researcher to answer "how" and "why" type questions, while taking into consideration how a phenomenon is influenced by the context within which it is situated' (Baxter & Jack, 2008). A case study allows for comparison between different sets of data, facilitating trustworthiness of the data and an evaluation of the propositions explaining the relationships within the case study (Denzin & Lincoln, 2005; Eisenhardt, 1989; Gillham, 2005; Stake, 1995). Furthermore, it has been argued that different sets of data within case study research enable 'the interpretation of complex interrelated phenomena' (Luck, Jackson & Usher, 2006). Using different levels of analysis and data facilitates the examination of gender and power in the relationship between productivity, employee participation and employee wellbeing. It also allows critical analysis of the connection between the organisational context and the broader external environment (Edwards, 2005; Holvino, 2010; Pocock et al., 2011; Poole et al., 2001). The range of data sources may also ameliorate some of the concerns in feminist research about power relationships in the research where it is

the researcher who chooses which experiences to give voice to and which to silence (Opie, 2008), particularly where there are converging themes across multiple sources of data.

The case study method has been criticised for a lack of rigour and generalisability (Diaz Andrades, 2009; Eisenhardt, 1989, 2007; Luck et al., 2006). However, this criticism has largely arisen from a positivist stance, and has been debated (Diaz Andrades, 2009; Eisenhardt, 1989; Yin, 1994). As already discussed, this thesis is using a multiple case study approach within a critical research paradigm. This paradigm uses in-depth, contextual information to focus on the participants' experience, and the power relationships, values and ideologies that influence this. In this sense, generalisability clearly cannot be claimed. However, this thesis will enable a comparison across several cases and includes information from sector representatives. These sources of information combined with secondary data will mean that findings that occur across several cases may be generalisable to other residential aged care facilities and potentially to other industries with similar contextual environments. The following section provides information on how data was collected.

Data Collection

Ethical approval was sought and gained from the AUT University Ethics Committee in April 2008. The ethics approval process involves an application outlining the proposed research project and methods. Ethics applications must consider any risk to participants in the research. Risk includes the extent of anonymity and how, for example, the employee will be protected from negative outcomes of the research. A requirement of the ethics approval was that the researcher take all reasonable steps to protect the anonymity of both participants and the organisations they belong to (see Figure 3.2). Consequently all organisations have been given pseudonyms, as have those interviewed. In some cases interview material has had to be paraphrased rather than directly quoted because it may reveal detail that could identify the individual should the managers in their organisation read this thesis. All participants were made aware that the information gained from this research would lead to a doctoral thesis, and may be used in academic publications. Participants were given the opportunity to contact the researcher should they wish to withdraw from the research project.

Figure 3.2 Case organisation pseudonyms

National Aged Care: A profit based national residential aged care provider with multiple facilities.

Not-For-Profit: The New Zealand subsidiary of a national residential aged care provider with multiple facilities.

Religious Care: A Catholic based, single-site residential aged care provider. A not-for-profit organisation.

Charitable Trust Care: A non-religious not-for-profit residential aged care provider. A single-site facility

Source: Author

The research was conducted in 2009 and 2010. Four case study organisations were selected from residential aged care providers in New Zealand. Recruitment of case organisations aimed to get some variety in location, such as town size, and also some variety in the structure or ownership of the organisation. Each organisation was required to have some form of health and safety committee as a source of information on representative employee participation in the sector. This also provided a comparison of the role of the regulatory framework because employee participation in OHS is required by law for organisations of 30 employees or more.

Recruitment of aged care facilities occurred in a number of ways. Contact was made with one through an e-mail advertisement for the research through a professional women's organisation. The manager contacted the author in response to the advertisement. The second organisation was recruited through a separate professional network, and the two national organisations were identified through an internet search of aged care provision in New Zealand. They were then contacted by the author, and agreed to participate in the research. Participating organisations were offered a report summarising the findings of the research and a comparison (on an anonymous basis) with other participating organisations. The two managers of the single-site organisations, Religious Care and Charitable Trust Care, participated in order to gain more information on how they perform in terms of participation, wellbeing and productivity. One of the managers was new to her role and eager to take the opportunity to gain more information. The other had previously participated in research and was in the process of studying a tertiary qualification in management, and participated for similar reasons. Not-For-Profit participated because they have a record of helping out research, and it is part of their culture. National Aged Care participated also because the

manager was interested in the results, and had considerable professional experience in related areas before moving into aged care.

The case study organisations are spread across the country with one being from a rural area, one a small city, and two from the Auckland region. Each residential aged care facility is of similar size, the two single-site organisations have about 80 employees in each, and the two nationally operated organisations have nearly 60 employees each. The two facilities in the Auckland region are sites belonging to nationally operated aged care providers. One of these is a multinational not-for-profit organisation, the other is Zealand owned. The facilities in the rural area and small city are single-site providers run by charitable trusts (one a religious organisation). Detailed information on the case study organisations follows below. In addition to the four case study organisations, sector level information was gained through publicly available information and through interviews with representatives of the two unions involved in the sector, and an owner/manager association in the sector.

Drawing on a critical ontological and feminist epistemological perspective, it is essential that this thesis relies upon the voice of participants for information (Baird et al., 2009; Ledwith, 2006), and also highlights the experiences of those participants. Accordingly, in-depth interviews were undertaken within each case study organisation. The interviews were semi-structured in that there were set open-ended questions that were asked of each interviewee. Furthermore, according to feminist research objectives of building 'knowledge of women's lives' (Baird et al, 2009, p.396) the interviews also followed themes or topics that were raised by the interviewee in the process (Baird et al., 2009; Hesse-Biber, 2007). Consequently, information on some themes was gained only from one or two organisations. Where a theme was consistently raised across all four, or was evidenced in information from other secondary sources, it was referred to in the analysis.

Interviews with managers in the organisations lasted from 60 to 120 minutes and interviews with employees took from 20 to 60 minutes. It may be worth noting that union representatives overall felt more confident in discussing their experiences, displayed a greater awareness of the power dynamics, and were also more able to express opinions on the working conditions than other employees. Interviews with the sector level representatives took from 60 minutes to 120 minutes. All interviews were recorded and subsequently transcribed. Feminist research highlights the importance of a range of voices within a given situation or context, and from both marginalised and dominant groups (Harding, 2008). This thesis questions the role of gender and power in

the relationship between employee participation, productivity and employee wellbeing. Consequently, interviews were carried out with both employees and managers in each organisation (see Figure 3.3).

Interviews were carried out on site in all four organisations, and a pool of potential interviewees was identified by each manager, according to the researcher's description. With some interviewees the location and the manager's awareness of who might be interviewed impacted on the interviewees' willingness to respond initially. In these cases, the interviewee was reassured that their anonymity would be maintained in all publications and they would not be identified by name. Furthermore, in reports to the organisation no verbatim quotations would be used from interviewees.

Figure 3.3 Interviews at each organisation

ORGANISATION	INTERVIEWEES
Religious Care	
	• General manager
	• Clinical co-ordinator (second in charge), responsible for 'incident control' & training
	• Health & safety representative
	• Health & safety representative/union delegate
Charitable Trust Care	
	• General manager
	• Facilities manager (health & safety responsibilities)
	• Health & safety representative (also manual handling advisor)
	• Health & safety representative (also team leader)
	• Health & safety representative/union delegate
National Aged Care	
Facility	• Manager
	• Clinical co-ordinator (second in charge)
	• Health & safety representative (maintenance)
	• Health & safety representative/union delegate
	• Employee
National Office	• Regional manager with national responsibilities for health & safety
Not-For-Profit	
Facility	• Manager
	• Clinical co-ordinator (second in charge)
	• Health & safety representative
	• Union delegate
Head office	• General manager – aged care facilities
	• Property facilities manager (national OHS committee)
	• OHS representative
	• National health & safety co-ordinator
New Zealand Nurses' Organisation	
	• Regional organiser in aged care
New Zealand Service & Food Workers' Union	
	• Regional organiser in aged care
National Zealand Aged Care Association	
	• National representative

Source: Author

The researcher's identity as a doctoral student, an 'academic', from the Auckland region influenced interviewees' experiences of power in the research process. For some of the employees interviewed this was perceived as placing the researcher in a more powerful position as 'expert', both because of the involvement in tertiary education but also because of coming from a major city in New Zealand. Those interviewees were mostly

caregivers with little experience of tertiary education. In those cases, when the research was explained, and when it was emphasised that the role of the interviews was to provide information on the *experiences* of the participants (which were central to the research), and that there were no 'right' or 'wrong' answers, all except one participant became more relaxed and felt able to participate. In contrast, managers appeared to feel very comfortable with the research process. All general managers held tertiary qualifications and three of the four had considerable experience in the sector.

Thus, for some interviewees, power relationships with the manager, and also the researcher who may have been perceived to be on the 'manager's side' initially, prevented a full, open response. These are important considerations in terms of reflexivity of the researcher, and the power relationships between the researcher and the researched (Esim, 1997; Guba & Lincoln, 2008; Hesse-Biber, 2007; Holgate et al., 2006; Kincheloe & McLaren, 2008; Olesen, 2008).

Figure 3.3 illustrates that 23 interviews were held with both employees and managers, including OSH representatives and a union delegate where possible. With the two nationally operated multi-site organisations, interviews were conducted at a single site as well as the head office level. The interviews were designed to obtain information on the participants' perspectives of wellbeing, participation and productivity in the following areas:

1. The role of the participants in their respective organisations.
2. Participation in the organisation: how involved in decision making processes they are, what their perceptions and attitudes towards employee participation are and the impact of participation on their workplace, and what forms of employee participation are in use.
3. The role of the health and safety committee, the extent of its decision making power and what issues it covers.
4. The participant's understanding of wellbeing and their perception of the importance of employee wellbeing to the organisation.
5. The participant's understanding of productivity and its importance to the organisation, and how the organisation measures productivity.

A further three interviews were conducted with sector representatives. These interviews followed a similar structure to the organisational interviews. The sector level interviews

aimed to elicit the sector level perspective on, and experience of productivity, participation and employee wellbeing. These interviews, with union and owner representatives, again provided the experience and voice of both those marginalised (unions) and those with power (owners). This relationship at the sector level is explained in more detail in Chapter Four.

In addition to interviews, staff policy; collective agreements; OHS meeting agendas and minutes, and terms of reference; external OHS audits; and staff satisfaction surveys were sought from each organisation (Listed in Appendix 1). Further, contextual information on the organisation in terms of the number of employees, number of employees at each level of the organisation, union density, gender breakdown by position, and percentage of employees by full-time and part-time positions was requested. At the two single-site organisations, Religious Care and Charitable Trust Care, the researcher had full access to organisational policy and health and safety agendas and minutes, and was able to copy or request soft copies of any documentation required. While access to organisational policy was not restricted at the National Aged Care and Not-For-Profit facilities, the researcher was reliant on the respective manager selecting the relevant policy and documentation according to the researcher's descriptions.

An anonymous employee survey was also conducted at each site. The survey provided a greater range of employee responses than possible through interviews alone, intending to strengthen the voice of employees in the research as well as provide more information on the context within which their experience takes place (Baird et al, 2009; Parker, 2002). The purpose of the survey was to gather data on non-managerial employees, those with less power (Hyman, 1981; Pocock et al, 2011), experiences of participation and wellbeing in the organisation, and the effectiveness of the OHS committee (see Appendix 2). The survey data was used to provide more contextual data specific to the individual organisation.

The survey questions addressed aspects of wellbeing (work-life balance, OHS outcomes, stress, workload and conditions), the effectiveness of representative participation (using perceptions of OHS committees) and direct participation. The questions on OHS outcomes also relate to employee perceptions of productivity in the sense that work related injuries are often included in workplace productivity measures. The survey questions were designed to clearly request information on particular topics in anticipation that employees in residential aged care may not speak English as a first

language. Demographic data was requested including age and gender details from respondents in order to aid analysis of the role of gender and other intersecting identities in the experiences of respondents (Adib & Guerrier, 2003; Holgate et al, 2006; Kirton & Healy, 2004).

The surveys were conducted in organisations where the workforce was predominantly female. They were distributed in paper form in the staff rooms of each case organisation. A notice was provided with a brief explanation of the research project. Addressed, postage paid envelopes were provided with each survey so that employees could return the survey anonymously and independently of management, recognising that power differentials between employees and management may discourage employees from responding. The surveys were not conducted online because employees in residential aged care generally do not have access to computers at work. The surveys were distributed via the staffrooms in each organisation. The response rates varied considerably, with the highest at Charitable Trust Care (25 per cent), then National Aged Care (17 per cent), Not-For-Profit (10 per cent) and Religious Care (seven per cent). Response rates were lower than desired.

The total number of respondents across all four case studies was 41. Of these respondents only four were male; the majority (26) were caregivers and the majority were aged 31 years and above. Interestingly equal numbers of respondents were permanent part time and permanent full time. Table 3.2 shows the total demographic details of respondents across all four case organisations.

This small response rates may have been because of the format (paper) and literacy challenges. There had been recent employee attitude surveys conducted at Not-For-Profit facility and Charitable Trust Care which may have meant employees were reluctant to respond to another survey. Another consideration was power relationships with managers: employees may not have felt comfortable completing a survey about the conditions in their workplace in the staffroom, which in relatively small facilities were located near managerial offices. However, in this thesis, the survey responses are not viewed as definitive information in themselves, but contributing to the range of voices and information available in each organisation.

Table 3.2 Demographic details of survey respondents

	Number of respondents
Gender	
Male	*4*
Female	37
Age	
30 and under	6
31 – 50 years	20
Older than 50 years	13
Employment Status	
Casual	2
Permanent Part-Time	19
Permanent Full-Time	19
Not specified	1
Usual weekly hours	
10 or less	3
11 – 25	3
26-39	25
40 or more	10
Position	
Caregiver	26
Nurse	7
Administration	2
Kitchen	1
Non-specified	5

Source: Author's summary

Overall, the range of data provides the contextual information required to analyse the processes and relationships behind productivity, employee participation and employee wellbeing and productivity. The role of gender and power in those relationships are evident through the intersecting identities of employees (indicated through workforce characteristics), and the regulatory conditions that influence the power relationships between employees, managers, owners and government (see Table 3.3 for data sources).

Table 3.3 Data Sources

	Information sought	Source
Employee participation		
	Types of participation	Interviews, documents, survey
	Employee outcomes	Interviews, surveys
	Level of participation	Interviews, documents, survey
	Role of employees	Interviews, documents
	Types of decisions employees can make	Interviews, documents
Productivity	Indicators: absenteeism, turnover	Interviews, documents
	How each organisation measures productivity	Interviews, documents
	Are employee outcomes considered?	Interviews, documents
	How does their measure of productivity impact on participation & wellbeing?	Interviews, documents
Employee wellbeing	What is important in experience of employees?	Interviews
	Is that achieved for/by them?	Interviews, surveys
	What does the organisation consider to be employee wellbeing?	Interviews, documents
	How important is wellbeing to the organisation?	Interviews, documents
	Do employee & employer views of employee wellbeing differ?	Interviews, documents, surveys
	How does wellbeing relate to participation and/or productivity – employers' and employees' opinions?	Interviews, documents, surveys
External/industry context	Views of employee representatives & employer representatives on above issues	Interviews, documents
	Regulatory matters that influence participation, wellbeing & productivity	Interviews, documents
Workforce Characteristics	Industry level characteristics such as gender, employment status, age and positions held	Documents and academic literature from New Zealand
	Workforce characteristics of case organisations	Surveys, documents, interviews

Source: Author

The Case Organisations

The previous sections in this chapter have described the methodological position of this thesis, the method employed to gather data, and how data was obtained. This section provides an overview of the four case study organisations. Table 3.4 provides a comparative overview of the employee statistics of the four case study organisations. This illustrates that they are of similar size, and most employees are female. There are some subtle differences between the organisations: Religious Care has a higher number of enrolled nurses than Charitable Trust Care, yet fewer caregivers. Charitable Trust Care has a higher proportion of managerial positions, and a much lower union density than Religious Care. National Aged Care had similar union density to Charitable Trust Care, and Not-For-Profit did not record union density for the site. National Aged Care had the highest percentage of registered nurses, although when these were combined with enrolled nurses they had a similar percentage to Religious Care. There were fewer managerial and administrative positions in the multi-site nationally run facilities than the single-site organisations. This is probably because the head office of Not-For-Profit and National Aged Care administer payroll and policy and related activities, whereas Religious Care and Charitable Trust Care would have to provide these functions themselves. When the total number of employees is compared to the number of beds, Religious Care and Charitable Trust Care have considerably more staff per bed. However, this is only indicative because it does not distinguish between part and full time, or between function of the employee. Not-For-Profit and National Aged Care have a significantly higher percentage of full-time employees. Data on ethnicity of staff was not obtained from the organisations. However, by observation Religious Care was the least diverse workforce, predominantly of European Descent. Charitable Trust Care was predominantly Maori and European Descent. Both of the facilities in the Auckland region had a greater range of ethnic diversity with employees from the Philippines, African countries and Pacific nations, among others. The following sections give an overview of the type of ownership of each organisation as well as their socio-economic contexts.

Table 3.4 Key statistics of the case study organisations

	Religious Care	Charitable Trust	Not-For-Profit	National
Total beds	59	72	67	60
Total employed	85	86	58	59
Employees per bed	1.44	1.19	0.87	0.98
Full-time employees as % of total	unknown	42 (32–40 hours/week)	64	56
Part-time employees as % of total	majority	55	36	41
Casual employees as % of total	6	4	0	3
Female employees as % of total	97	93	86	90
Union density	67	27	unknown	25
% Managers	2	5	3	3
% Admin	4	2	2	2
% Registered nurses	8	11	6	15
% Enrolled nurses	14	4	2	2
% Caregivers	40	57	57	49
% Therapists	5	4	0	0
% Services, e.g. kitchen	19	20	26	19

Source: Author

Data Analysis

The previous sections have described how the data was collected and presented information about the case study organisations. This section outlines how that data was analysed. Interviews were transcribed and then analysed thematically. The number of interviews allowed manual analysis rather than the use of software. The 'presence' of themes was analysed as was the 'absence' of a particular theme. For example, if one organisation stood apart from the others because there was little mention of something, then this was analysed in terms of the organisational context: why was this theme absent? The analysis of both what is obvious, and what information is missing is key to feminist research. Acknowledging what is absent and then identifying the reasons why may reveal the gender and power processes at work (Reinharz & Kulick, 2007). Organisational documents were analysed in a similar manner, and then comparisons

drawn between the themes in organisational documents and interviews across all four case organisations. The survey data was analysed to provide a percentage of response rate to each question, a higher percentage of responses corresponding to a more strongly representative indicator of employee experience in the case organisation.

As noted above, this thesis draws on a feminist epistemology which includes acknowledging intersectionality, the material structures and reflexivity (Holgate et al., 2006). The analysis of data in this thesis will recognise that gender and power relations are interconnected in social and work processes at organisational and sector levels (Harding, 2007; Kincheloe & Mclaren, 2008; Lykke, 2010; Pocock et al., 2011; Reinharz & Kulick, 2007). Many of the participants had intersecting identities at work, as union representatives, OHS representatives, and employees at the same time. Furthermore, their identities as mothers, wives and women in the community impacted on their experience in the workplace, as did the intersecting identities of age, region, educational achievement and ethnicity. In analysing the data, the following questions were asked: What are the power relationships between employees and OHS representatives? What role does gender play, and does this impact on the effectiveness of representation for the employees? How do power and gender impact on employee wellbeing?

Feminist research in employment relations also aims to document women's working experience (Baird et al., 2009; Parker, 2002) and this research draws significantly on the interview accounts of the participants' experience. In line with allowing 'the researched to speak for themselves' (Holgate et al., 2006, p. 314), quotations from the interviews themselves will be used extensively in the analysis of the data (Baird et al., 2009; Ledwith, 2006).

The findings from each case organisation are presented separately, and then they are discussed in comparison with each other and the sector level information in Chapter Nine. The analysis will question the power relationships that contribute to participants' experiences of wellbeing, participation and productivity in the organisation.

Conclusion

The ontological and epistemological positions of this thesis are based in critical feminist theory (Kincheloe & McLaren, 2008; Holgate et al., 2006). The method used is the case study research method, and the data was obtained from multiple sources and is contextually rich. The thesis intends to explore relationships and processes, and to uncover what, if any, the relationship between employee participation, employee wellbeing and productivity is. It intends to do this through highlighting the experiences of the participants, and through the lens of gender and power relationships. This thesis will be guided by Holgate et al.'s (2006) framework in the analysis of data. It will consider the role that gender may play in the power relations in the case studies, including the context they are situated in, and display a broad awareness of the different identities that interact with gender (Adib & Guerrier, 2003; Kirton & Healy, 2004; Holgate et al., 2006; Holvino, 2010; Ludvig, 2006; Pocock, 2000, 2011). It must be noted that gender does not denote an examination of the role of women only, but the roles of both women and men and how these differ, and why (Danieli, 2006; Forrest, 1993; Holgate et al., 2006; Kirton & Greene, 2005; Rubery & Fagan, 1995; Pocock, 1997). This is an appropriate epistemology for research that intends to focus on employee outcomes of a complex relationship in a highly feminised sector.

Chapter Two discussed the literature in employee participation, productivity and employee wellbeing and identified the gaps in research that will be filled by this thesis. This chapter has stated the research questions, outlined the methodology and method that underpin this research, and why they are appropriate to the research questions. The following chapter presents contextual information gained from the aged care literature, sector based reports, and interviews with sector representatives of the unions and owners' associations. It locates the research in both its sector and geographical position and identifies some key issues for the sector that may impact on the relationship between participation, productivity and employee wellbeing in the case study organisations.

Chapter Four:

Overview of Residential Aged Care in New Zealand

Introduction

The relationship between productivity, participation and employee wellbeing is one that is influenced not only by the organisational context but also by the external context. Residential aged care in New Zealand is a sector with predicted high demand for labour in the future. It is a highly feminised sector characterised by low pay and the undervaluing of the skills required to do the work (Badkar, 2009; Badkar et al, 2009; Kiata & Kerse, 2004; Lazonby, 2007). Residential aged care in New Zealand is primarily government funded and the political environment plays a role in the sector and the workforce. This research took place in the first two years' of a centre-right National Party led government. Previously New Zealand was governed by a centre-left Labour Party led government for a period of nine years.

The change in government impacted on health care in general in New Zealand because of differing approaches to productivity and the regulation of the labour market. The difference in direction for the health care workforce between governments may be seen in two committees on the health workforce. The Health Workforce Advisory Committee provided strategic information to the Ministry of Health on the health workforce from 2000 (Ministry of Health, 2006). A report from this committee on the promotion of healthy work environments concluded that healthy work environments were crucial for New Zealand's health and disability sector. The Committee viewed a healthy working environment as being people centred; valuing team work; involving employees in decision making; and promoting open communication, among other conditions (Health Workforce Advisory Committee, 2006). This committee has since been replaced by Health Workforce New Zealand, established by the Minister of Health, the Honourable Tony Ryall, in 2009. Health Workforce New Zealand also advises the minister on health workforce planning, but rather than focusing on conditions of the workforce as a whole, it aims to 'ensure that we have a fit-for-purpose, high quality and motivated health workforce, keeping pace with clinical innovations and the growing needs and expectations of service users and the public' (Health Workforce New Zealand, 2011) and that 'healthcare employers...make the best use of existing resources and to realise

the full potential of their workforce' (Health Workforce New Zealand, 2011). The governmental focus is on 'organisational' outcomes or productivity as opposed to employee outcomes.

These different approaches are reflected in two key sector reports published in 2010: The *Aged Residential Care Service Review* (Grant Thornton, 2010) and *A Report into Aged Care* tabled in parliament by the Labour Party, the Green Party, and Grey Power (an organisation representing those over 50) (see Figure 4.1). These two reports will be discussed along with New Zealand and international research on residential aged care and employment in this chapter.

Figure 4.1 The *Aged Residential Care Service Review* (2010)

- The review is based on survey data from residential aged care providers – approx. 360 surveys, 61 per cent of all beds in New Zealand.
- It was commissioned by the New Zealand Aged Care Association (and relies upon their member surveys) and the District Health Boards of New Zealand.
- The review had two objectives: "To indicate what are or would be the costs for fair and reasonable service delivery models provided by an efficient and effective provider" and "To assess the current (baseline) and future demand for services against the current and future service delivery models of care available and indicate the resources required to meet such demand including workforce requirements…" (p.16).
- Review participants included a steering group of 13 members, an expert advisory panel of nine, and a project team from Grant Thornton and the New Zealand Institute of Economic Research (a society offering economic consulting and reports for members). Of the 22 members, eight are on the Board of NZACA, six are senior or directors in DHBs, four are senior/directors from providers, one from the Ministry of Health, and three medical specialists. Two of the major providers had a representative on the review: Metlifecare and Ryman Healthcare Limited.
- Unions or other employee representatives were not represented in the review.

Source: Grant Thornton (2010)

Power influences the way in which employee participation, productivity and employee wellbeing interact, as established in Chapter Two. It was suggested there that power influences the outcomes of participation for employees. It highlighted that gender needs to be considered in power relationships. Chapter Three extended the argument that gender and power are integral in examining the relationship between employee participation, productivity and employee wellbeing. A feminist epistemology examines the experiences of the researched in their socio-political context. This chapter provides

an overview of residential aged care in New Zealand. It outlines the broader context within which the four case organisations are situated.

This chapter uses information from public reports, secondary research from academic journals, and information from interviews with a national representative from (1) the New Zealand Nurses' Organisation (hereafter referred to as the 'nurses' union'), (2) the Service and Food Workers Union (hereafter referred to as the caregivers' union), and (3) the New Zealand Aged Care Association (hereafter referred to as the owners' association). Figure 4.2 outlines key characteristics of these organisations.

Figure 4.2 Key national organisations in residential aged care

The New Zealand Nurses' Organisation

- represents both nurses & caregivers
- 45,156 members nationwide
- members are from health care in the public & private sector, & not only nurses, but midwives, hospital aides, other professions & workers in the health care sector

The Service and Food Workers' Union

- covers five sectors: aged care, disability, health & community services; catering, cleaning & contract services; clerical, administration & technical services; food & beverage manufacturing & processing; hospitality, tourism & entertainment.
- 22,447 members nationwide

The New Zealand Aged Care Association

- representative body of aged care facility owners in New Zealand
- approximately 80 per cent of facilities are members
- run by a board of directors who are aged care providers
- aims to represent members at appropriate government forums & official committees as well as to government officials

Source: Department of Labour (2010b); New Zealand Aged Care Association (2010); New Zealand Nurses' Organisation (2010); Service and Food Workers' Union (2010)

This chapter analyses the wider context, each case organisation is examined individually in Chapters Five to Eight. It begins by outlining the characteristics of the workforce and employment patterns as well as how residential aged care is funded in New Zealand. It also gives an overview of the regulatory requirements for residential aged care providers and the measures of quality of care.

The Workforce and Employment Patterns

Demographic trends are an increasing concern in the residential aged care sector as they are also causing a threat to labour supply. There are concerns both in New Zealand and internationally that the demand for residential aged care is increasing steadily (Badkar, 2009; Badkar et al., 2009; Carryer et al., 2010; Dodson & Zincavage, 2007; Kiata et al., 2005), although the extent of the issue in New Zealand has recently been debated (Broad et al, 2011). The increased demand for labour is compounded by the increasing age of the labour force: the majority of aged care workers are aged 45 years or older (NZACA, 2010).

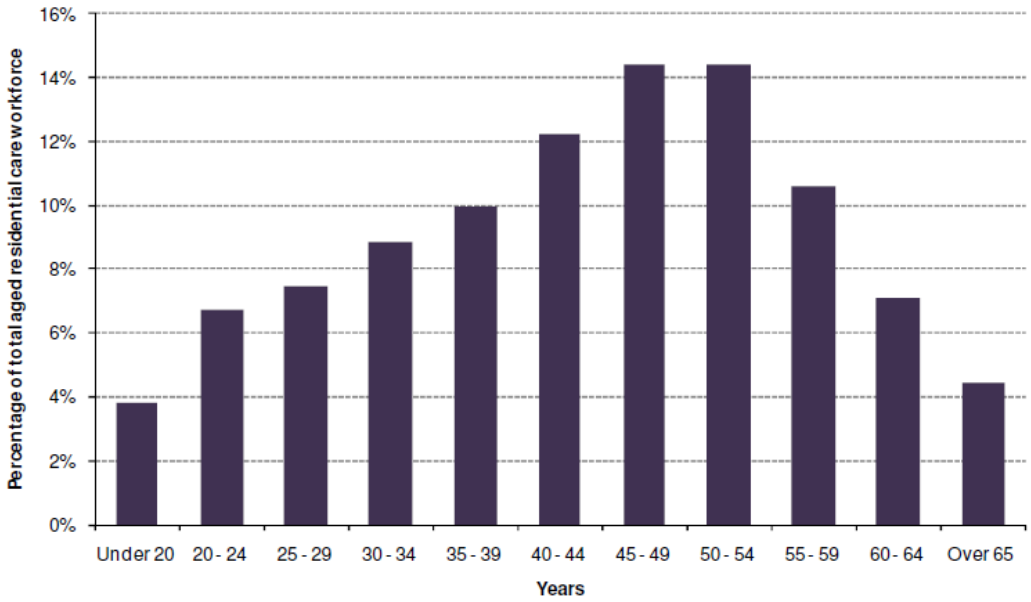
Residential aged care is a significant sector in New Zealand and approximately 33,000 people are employed in the sector (Grant Thornton, 2010). Of these workers, it is estimated that 77 per cent are employed in direct care roles (NZACA, 2010). Unsurprisingly, similar to international trends, the majority of the workforce is female: approximately 92 per cent of all employees in residential aged care (Badkar, 2009). The majority of caregivers work part- time (64 per cent), although New Zealand Aged Care Association member surveys indicate that the percentage of part-time workers has decreased slightly in recent years (NZACA, 2010). There is not readily available information on the proportion of casual workers in the sector, although the New Zealand Aged Care Association surveys indicate that 47 per cent of their member facilities used agency employees in 2009 (NZACA, 2010).

Casual or agency workers are not perceived to be an ideal solution to meeting temporary staff shortages through absences or changes to staffing requirements in individual facilities. The New Zealand Aged Care Association representative indicated that casual employees were not as desirable in the sector because casual labour did not lead to consistent and high quality care. Some strategies suggested by the NZACA were, for example, employing retirees on a permanent part-time basis for 10 hours or less per week. This was viewed as a good alternative for organisations because retirees would be more compassionate towards the residents (being closer in age), had fewer other responsibilities, and were perceived to be more receptive to small weekly hours to supplement their pensions and retain some connection to the workforce.

Consistent with international trends, the aged care workforce in New Zealand is ageing, as indicated in Figure 4.3 (Badkar, 2009; Badkar et al., 2009; Carryer et al., 2010; Kiata et al., 2005). A recent study comparing the elderly care workforce with predicted growth in New Zealand's aged population forecasts a critical need for caregivers in the

future: between 2006 and 2036 the '65+ age group as a proportion of the working-age population is predicted to double' (Badkar et al., 2009, p. 3). Kiata et al. (2005) found that the majority of registered nurses in residential aged care were aged 45 to 60 years, and the majority of caregivers were aged 25 to 45 years, with a significant proportion aged 45 to 60 years. Badkar et al. (2009) predict that based on current workforce composition there will be a shortage of over 20,000 aged-care workers in 2036. This may be compounded by caregiver turnover in the aged care sector, which in New Zealand was estimated at approximately 20 per cent in 2005 (Kiata et al., 2005; Miller, Booth & Vor 2008) and 21 per cent in 2009 (New Zealand Aged Care Association, 2010b).

Figure 4.3 Age of residential aged care workforce in 2009



Source: New Zealand Aged Care Association (2010, p. 73)

One way in which increased demand for residential aged care work may be met is through migrant labour. This is common internationally (Dodson & Zincavage, 2007; Kiata & Kerse, 2004; Ryosho, 2011) and nationally (Kiata & Kerse, 2004). Studies in New Zealand indicate the importance of migrant labour for this labour market (Badkar, 2009; Badkar et al., 2009; Grant Thornton, 2010). Currently, migration is relied upon heavily in some areas for the supply of aged care labour, particularly in the Auckland region. The owners' association representative indicated that the industry views migrant workers as a consistent supply of labour well into the future, with the potential to

compensate for New Zealand's ageing working population. Table 4.4 illustrates that the number of work permits granted by New Zealand for migrants to work as caregivers increased significantly between 2003 and 2008. Reports acknowledge that New Zealand competes on an international basis for these workers and cannot always compete on the basis of wages, but it does have a good reputation for standard of living (Grant Thornton, 2010). Furthermore, due to New Zealand nursing requirements, a foreign registered nurse entering the country may not work as a registered nurse until they have completed additional training. This means that there are many foreign qualified registered nurses bringing the skills and knowledge of a registered nurse to New Zealand, working as a caregiver, and being paid the wages of a caregiver.

Table 4.1 Changes in the number and proportion of caregivers for the elderly issued with a work permit

	2003/4		2004/5		2005/6		2006/7		2007/8		Total	
Nationality	n	%	n	%	n	%	n	%	n	%	n	%
Philippines	13	7	16	6	66	13	304	32	916	52	1315	36
Fiji	11	6	14	5	92	18	148	16	225	13	490	13
China	17	9	26	10	65	13	107	11	115	7	330	9
India	9	5	27	10	17	3	69	7	161	9	283	8
Great Britain	22	12	22	8	38	7	42	4	26	1	150	4
Others	118	62	168	62	234	46	277	29	326	18	1123	30
Total	190	100	273	100	512	100	947	100	1769	100	3691	100

Source: Badkar et al. (2009, p. 11)

While migrant labour may be beneficial in providing needed skills, some negative outcomes for the employees have been noted. Migrant workers are often recruited via agents who take a bond and other service fees from the migrant:

> Once here, migrant nurses have little choice but to work where they are sent by their agents, as their wages are often channelled through agents, who are also the link to employers and their work permit immigration status. Some

> have to work as many as 160 hours a fortnight, in order to repay the agents their initial costs. (New Zealand Labour Party et al., 2010, p. 37)

Owners view migrant labour as a key labour source, and potentially cheaper in terms of wages, but may bring associated costs such as an increased amount of training required for overseas trained staff (Grant Thornton, 2010).

Regulatory Framework

The health system in New Zealand is largely funded by public money from general government revenue (OECD, 2009). The OECD aptly describes the funding system for health in New Zealand:

> Public health spending in New Zealand thus has the character of a public service provision, which is partly outsourced to the private sector. The main hospitals are public, with smaller private hospitals focused on elective surgery. Ancillary services can be provided in public hospitals or privately. (OECD, 2009, p. 99)

Budgets are largely devolved to District Health Boards, apart from maternity care and working-age disability services which are purchased for the entire nation by the Ministry of Health (OECD, 2009). District Health Boards fund the care for the elderly who are entitled to government subsidies for their care (Lazonby, 2007). Subsidies are granted dependent on the elderly person's dependency levels and means testing of income and some assets (Lazonby, 2010; New Zealand Aged Care Association, 2010a). However, the owners' association asserts that the maximum contribution rate would only cover the cost of care in a rest home (rather than hospital or dementia care), so that someone with a higher dependency level would not individually cover the entire cost of care with the maximum contribution rate (New Zealand Aged Care Association, 2010a, 2011). The owners' association, caregivers' union and nurses' union representatives all felt that residential aged care is underfunded.

All aged care residential providers who provide care to subsidised people are funded through contracts of service with their District Health Board. While the contract of service with aged care providers and District Health Boards is negotiated nationally, compliance with the agreements is monitored by the local District Health Board with

which the agreement is made (Office of the Auditor General, 2009). The Age Related Residential Care Services Agreement covers staffing issues such as sufficient staffing, including guidelines for the minimum registered nurse coverage according to the type and size of the facility; training of staff; and staff development (Ministry of Health, 2010). Residential aged care facilities are only required to have 'at least one registered nurse to be responsible for working with staff' (Ministry of Health, 2010, p. 55) and hospitals are required to have at least one registered nurse on duty at all times. The minimum number of caregivers in a hospital setting is two (Ministry of Health, 2010). It must be noted that the agreements cover subsidised residents only.

Quality of care is regulated to some extent through the Health and Disability Services (Safety) Act 2001 (Lazonby, 2007). Aged care facilities are certified for periods of up to five years. The facilities are audited by privately run companies. The Act provides the basis for standards that must be met to gain certification. These include general and core standards, restraint minimisation standard, infection prevention, and control standards (see Table 4.1). Within each standard several specific criteria are included. Table 4.1 shows some of the standards and how they are audited. The standards outline minimum levels of care and service. The standards focus on policy, physical safety and infection control. They do not relate to other indicators of quality care that might include social activities and outings, or time for caregivers to talk to residents.

The standards cover the entire health and disability sector. Auditors must therefore determine how these apply in aged care facilities (Office of the Auditor General, 2009). The auditing process has been criticised because its performance checks are heavily based on documented systems and records, rather than actual performance. Furthermore, facilities employ the auditor themselves so may select a particular auditor, and have lengthy notice of when an audit will take place. There are concerns that this leads to inaccurate representation of practice and staffing levels (New Zealand Nurses Organisation, 2010).

Table 4.1 Examples of how auditors assess facilities' performance against government standards

Standard	Example of what the auditors check
Consumer rights	• Residents are well informed of rights. • Personal privacy is protected. • Check policies, will interview manager, staff & residents.
Organisational management	• Enough staff with the necessary qualification on duty at the rest home. Checked by staff rosters and interviews with manager and staff. • Auditors will check records to ascertain that staff receive adequate orientation and training. • Check that risk management systems are in place and that rest home service is monitored.
Continuum of service delivery	• Residents receive care that is safe and appropriate to their needs. • Residents receive medication in a safe way.
Safe and appropriate environment	• Current building warrant of fitness and evacuation plan. • Will check that it is well kept, clean and safe.
Infection control	• Adequate procedures in place (policy check). • Check staff files to ensure staff received training in infection control. • Check records to see if there has been any outbreaks of infection.
Managing restraint safety	• Standard is aimed at reducing the use of restraints so they are used only when absolutely necessary. • Will check policies and check staff files for evidence of relevant training.

Source: Adapted from Office of the Auditor General (2009, p. 19)

There are two regulatory influences on health and safety in New Zealand. These are the Health and Safety in Employment Act 1992 and the government body that regulates compensation for accidents and injury: the Accident Compensation Corporation. In New Zealand the Health and Safety in Employment Act 1992 covers all employees, and employers are responsible for identifying new hazards and assessing their significance. If a hazard is deemed significant, it is the employer's responsibility to take action to eliminate it, isolate it, or reduce the risk of harm eventuating (Lamm, 2009). The Health and Safety in Employment Amendment Act 2002 included the participation of employees in health and safety management, and also added stress and fatigue as a health and safety hazard (Lamm, 2009). There must be opportunities for employees to

participate in health and safety, and these are usually through representatives on OHS committees. It has been predicted that OHS committees in New Zealand workplaces would over time broaden the issues considered under health and safety from solely physical hazards to incorporate workplace issues related to stress and fatigue (Haynes et al., 2005).

According to the legislation, all OHS employee representatives must receive regular training. Employers are required to allow a certain number of days per year for OHS training: for organisations with six to 50 employees a maximum of six days per year of OHS training must be allowed, and organisations of 51 to 280 employees must allow one day of training per annum for every eight employees. OHS training must be undertaken with approved trainers, which include the Council of Trade Unions, Employers and Manufacturers Association and a polytechnic among others (Department of Labour, 2011a). The Employers and Manufacturers Association provides training specifically aimed at residential aged care (see Figure 4.4), in addition to the standard OHS representative training (Employers and Manufacturers Association, 2011). The training programmes appear to be reasonably heavily focused on processes such as hazard identification and reporting, and it is not clear that broad issues such as mental harm as a hazard are addressed in the training.

Figure 4.4 Examples of OHS Representative Training Courses

OHS Representative Level 1 (CTU)

- Role of the health and safety representative
- HSE Act Overview
- Hazard Management
- Training and supervision
- Emergency Preparedness
- Injury reporting, recording and investigation
- Rehabilitation, return to work compensation
- Workplace Planning

OHS Representative Level 2 (CTU)

- Review, plan and action
- Identifying and preventing harm
- The role of the representative in investigating incidents
- How to investigate incidents
- Hazard Management and control
- Rights, responsibilities and skills of representation
- Presentation and feedback to workers

OHS Representative Level 3 (CTU)

- Role of the health and safety representative
- Cost of injuries and illness
- Workplace productivity
- Use injury data to identify patterns of injury, hazards and contributing factors
- Improvements and recommendations
- Understand ACC cover and treatment
- The role of the health and safety representative in rehabilitation

Residential Care Health & Safety Training (EMA)

- Improve awareness of everyday hazards
- How to minimise risk to client and staff
- Identify contributing factors to injury and accidents and how to prevent them

Practical Hazard Identification and Control (EMA)

- Systematic identification and control of hazards in the workplace

Implementing and running effective safety committees (EMA)

- How to construct an agenda
- How to write minutes and a recommendation
- How to report back to reinforce communication & participation

Source: Employers and Manufacturers Association (2011); Council of Trade Unions (2011)

One influential aspect of the regulatory environment for OHS in residential aged care is the Accident Compensation Corporation. Accident Compensation Corporation is a Crown organisation operating under the directive of the New Zealand government. It

processes claims from injury for treatment and provides partial income replacement if someone is unable to work due to injury. All paid employees and employers pay Accident Compensation Corporation levies through their wages. Injuries that may be covered by Accident Compensation Corporation do include gradual process injuries incurred through work, physical injury, and mental injury resulting from physical injury, but not stress or illness (Accident Compensation Corporation, 2011a).

One of the reasons that Accident Compensation Corporation influences the sector is that it offers two programmes that can reduce employer levies. One is the Workplace Partnership Programme for large organisations which gives them the potential to reduce their employer levies by up to 90 per cent (Accident Compensation Corporation, 2011b). In this programme the organisation takes responsibility for its employees' injury claims including 'the delivery of all statutory entitlements, such as weekly compensation for lost earnings' (Accident Corporation Compensation, 2011b). Entry level requirements include having active health and safety processes in place and evidence of employee participation and representatives in health and safety (Accident Compensation Corporation, 2011b). The other programme is the Workplace Safety Management Practices programme. There are three levels of discount that may be achieved, up to 20 per cent of employer levies. Organisations are audited on an annual basis according to criteria that include employer commitment to safety management practices; planning review and evaluation; and employee participation in health and safety management (Accident Compensation Corporation, 2011c).

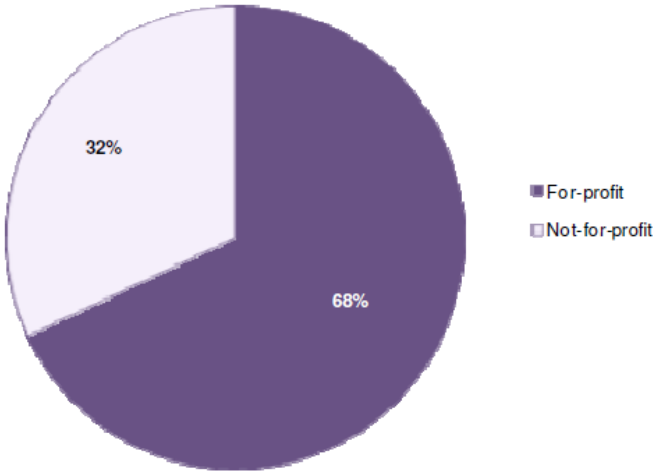
As an audit process, the verification is by evidence from policy documents and written procedures as well as other written documentation such as injury reports and meeting minutes. The first element includes showing commitment to consult with unions and other OHS representatives (Accident Compensation Corporation, 2011c). The employee participation requirement includes training at least every two years for representative; that there is a forum for employees, employers and union to communicate on issues related to health and safety; and that there is a process that is agreed upon by employees for the involvement of union or representative in health and safety management (Accident Corporation Compensation, 2011c). While the Health and Safety in Employment Amendment Act 2002 includes mental harm and fatigue as hazards, Accident Compensation Corporation does not include these as injuries that may be compensated for, and they are therefore not included in the Accident Compensation

Corporation audits. Accident Compensation Corporation is guided by the Injury Prevention, Rehabilitation and Compensation Act 2001 (Lamm, 2009).

Ownership and Productivity

There is some debate in the public domain in New Zealand about whether profit imperatives are driving workplace practices and conditions in privately owned residential aged care facilities. This arises because residential aged care is principally funded through public money, although most providers are privately owned. The majority of new facilities developed in the past ten years have been developed by not-for-profit organisations (Grant Thornton, 2010). However, as illustrated in Figure 4.5, the majority of facilities are operated on a for-profit basis (Grant Thornton, 2010; Kiata et al., 2005; Lazonby, 2007; New Zealand Aged Care Association, 2010a; New Zealand Labour Party et al., 2010). Those operated on a not-for-profit basis are spread among religious organisations, trusts and welfare organisations (New Zealand Aged Care Association, 2010). There is some evidence that for-profits are expanding and not-for-profits are leaving the market, sometimes after being bought by for-profit companies (Lazonby, 2007).

Figure 4.5 Ownership of residential aged care facilities



Source: Grant Thornton (2010, p. 44)

Given that the majority of residential aged care is privately owned, the impact of ownership structure on allocation of resources is an important consideration. There is limited research in the aged care literature on this. Research from the United States (Harrington, Woolhandler, Mullan, Carrillo & Himmelstein, 2002), Australasia (Kiata et al., 2005; Lazonby, 2007; King & Martin, 2009), Canada (McGregor et al., 2005) and on an international level (Comondore et al., 2009) points to lower staffing levels in privately owned residential aged care facilities. Swedish research, on the other hand, suggests that there is little difference in ownership structure (for example between for-profit, not-for-profit and publicly owned facilities) in the allocation of resources and working conditions (Gustafsson & Szebehely, 2009).

In New Zealand, the *Aged Residential Care Service Review* finds that inadequate funding does not provide reasonable profits and sufficient finance to develop new facilities (Grant Thornton, 2010). The New Zealand Labour Party et al. (2010) suggest that privately and internationally owned residential aged care providers are making substantial profits without any requirement to report on how funding is used, as is required of public hospitals. The same report further highlights this concern with regard to international ownership of the facilities as ownership is concentrated among approximately seven providers with significant international interests, as illustrated in Table 4.2. It is suggested that returning a profit to the international interests occurs at the expense of the quality of care and of staffing ratios.

Table 4.3. International interests in residential aged care facilities in New Zealand

Provider	Number of facilities	International interests
Oceania Care Group	58	Macquarie Bank (Australia)
BUPA Care Services	45	BUPA UK
Radius Residential Care	22	Kuwait Financial House
Ryman Healthcare	21	Garlow Management (Canada)
Metlifecare	17	JP Morgan Nominees (Australia) FKP Property Group (Australia) Macquarie Investment Holdings (Australia)

Source: New Zealand Labour Party et al. (2010, p. 18)

There are conflicting views on productivity in the sector. Industry reports in New Zealand point to narrow measures of productivity (Badkar, 2009; Grant Thornton, 2010). For example, the approach to productivity taken in the *Aged Residential Care Service Review* is one with a narrow focus centred on organisational outcomes. In discussion of the workforce, the report states that:

> There is always potential for the sector to make productivity gains, which will lead to lower demand for workforce. Productivity gains may arise from:
>
> *Substitution of cheaper labour for expensive labour;
>
> *Consolidation of facilities and economies of scale
>
> *Improved processes and working practices
>
> *Advancement in technology (Grant Thornton, 2010, p. 111).

The *Aged Residential Care Service Review* assumes that current staffing levels are adequate. It discusses potential productivity gains through cheaper labour, which could involve, for example, caregivers carrying out registered nurse tasks. A report written for the Department of Labour also suggests that 'redefining the skill mix and job tasks so that similar tasks can be delegated to less qualified workers' (Badkar, 2009, p. 8) would be one means of coping with skills and labour shortage. This is contrary to what is discussed in the aged care literature which states that narrow productivity measures are not adequate for aged care work. Palmer and Eveline (2010) point out that service work, such as aged care, is labour intensive and it is therefore difficult to leverage productivity gains. The two union representatives interviewed perceived that quality of care comes from the time taken to be able to talk with residents and look after their needs. This, however, according to the Caregivers' and Nurses' union representatives, tended to be viewed by managers as extra time resulting in additional wage costs. It is argued that rather than narrow productivity measures, broader performance indicators across a range of stakeholders should be used (Givan et al., 2010; Stack, 2003). Health care performance has looked at a narrow range of outcomes, such as financial or clinical ones, seldom in conjunction with each other (Givan et al., 2010). Nishikawa (2011) suggests that as knowledge workers, aged care employees' acquisition and accumulation of knowledge is central to their productivity. Nishikawa finds that the knowledge is acquired and shared in a team context, therefore confirming findings that

staffing levels impact significantly upon the quality of care (Duffield et al., 2010; Given et al., 2010; Haapakorpi, 2009; Meagher, 2006; Schmidt & Diestel, 2010; Stack, 2003).

In the larger centres of New Zealand such as Auckland there is competition among facilities for residents because funding is reliant upon occupancy of beds (Lazonby, 2007). In this instance, quality of care becomes an important measure because a residential aged care facility's reputation is pivotal in attracting potential residents. Quality of care has been debated in the public domain in New Zealand, with allegations of inadequate care and even elder abuse (Barton, 2010; Cameron, 2005; Johnston, 2010, 2011; New Zealand Labour Party et al., 2010).

Employee Participation in Residential Aged Care

Some research has noted that there is a lack of work autonomy and influence in aged care (King & Meagher, 2009). Acknowledging that care work involves more than physical skills, it has also been suggested that there is a need to give employees more opportunity to use their knowledge and experience in decision making over care of the elderly (Bonias, Bartram, Leggat & Stanton, 2010; Harley, 2007; Martin, 2007; Stack, 2003). Bonias et al. (2010) argue that increased autonomy and decision making influences patient outcomes as 'decreasing organisational commitment and job satisfaction among nurses is associated with declining quality of patient care' (p. 320). Consistent with this, Schmidt and Diestel (2010) found that greater opportunity to control work scheduling and the way tasks are carried out helped lessen the adverse effects of high job demands. Interestingly, research indicates that there are more positive outcomes of high performance workplace practices among low-skilled employees, such as caregivers, than high skilled employees, such as nurses (Harley, 2007). However, allowing greater authority or decision making is in contrast with often strict procedures and guidelines for caregivers in aged care (Provis & Stack, 2003). One New Zealand study mentions that a source of dissatisfaction among aged care employees was a lack of involvement in care planning (Kiata et al., 2005). Furthermore, lack of autonomy is not confined to caregivers as some facility managers have also been found to have to work within specific administrative processes, and with little autonomy (King & Meagher, 2009). This is important given recent research that indicates the role

of managers in employee participation in residential aged care and health care in general (Kaine, 2011; O'Donoghue, Stanton & Bartram, 2011).

At the industry level in New Zealand participation of employee representatives in aged care is limited structurally. Despite the Age Related Residential Care Services Agreement contracts covering staffing issues such as training and staffing levels, the two unions representing workers in aged care, the nurses' union and the caregivers' union, are not involved in the national aged care contract negotiations. The negotiations are held between the district health boards as a collective group, and the owners' association (caregivers' union representative, 2010; nurses' union representative, 2010). Perhaps reflecting this, the *Aged Residential Care Service Review* also did not include any employee representation (Grant Thornton, 2010).

Although unions are excluded from negotiating the Age Related Residential Care Services Agreement, legislation in New Zealand does allow for collective bargaining. The Employment Relations Act 2000 was intended to increase collective bargaining in New Zealand, and allows multi-union collective agreements and multi-employer collective agreements. However, collective agreement coverage in New Zealand is low at 45.6 per cent in the private sector in 2009 (Blumenfeld, 2010). In comparison, collective bargaining coverage in the public sector was 49 per cent in 2009 (Blumenfeld, 2010). Most collective bargaining occurs at enterprise level (Rasmussen, 2009).

Nationwide, union density was 17.4 per cent overall in 2010 (Department of Labour, 2010b). The residential aged care sector does pose some difficulties in unionisation in that while large providers operate the majority of beds overall, there are many single-site individually owned residential aged care facilities (New Zealand Aged Care Association, 2010) which are logistically hard to organise (nurses' union representative, 2010). As noted above, there are two main unions involved in residential aged care, the nurses' union and the caregivers' union. They have a joint campaign for improved funding called 'Fair Share for Aged Care' and at some sites have a multi-union collective agreement. On a national basis, unionisation in residential aged care between the two unions is approximately 30 per cent (caregivers' union representative, 2010).

There is little information on non-union representative participation in New Zealand. However, one study found reasonably high incidences of consultative committees (94.8 per cent), and committees that discussed problems with management on a regular basis (Haynes et al., 2005). Furthermore, 85.9 per cent of employees surveyed worked in

places with an open door policy and 58 per cent had managers who held regular staff meetings (Haynes et al., 2005). The survey was conducted in 2003 across a range of industries, so its results may or may not be similar to those of the case organisations.

Gendered, Undervalued Work

The residential aged care workforce in New Zealand is highly feminised. One study has indicated that 92 per cent of aged care caregivers are women (Badkar, 2009). Caregivers in particular receive low hourly rates, usually not more than the New Zealand minimum wage. In 2006, residential aged care caregivers typically received between $10.50 and $11.50 per hour (Lazonby, 2007). That compared with the national minimum wage of $10.25 (Department of Labour, 2006). In 2010 the minimum wage was $12.75, approximately half of the average total hourly earnings for New Zealand at the time (Department of Labour, 2010a).

Aged care caregiver pay rates still average little more than the minimum wage (see Table 4.4). Owner representatives in the industry argue that they cannot pay higher wages because of the level of funding, and state that wages have increased recently (New Zealand Labour Party et al., 2010). Table 4.4 indicates that wages have increased, but they remain little more than the legislated minimum wage. The Minimum Wage Act 1983 sets out the minimum wage for adults aged 18 years and above (Rasmussen, 2009). Among the staff categories, gardening/maintenance positions receive considerably more than caregivers and this is the one role in residential aged care that is usually held by men. The table below shows the median hourly rate, but there is some variance across the industry. For example, in 2009 a survey of owners' association members showed that caregivers received a minimum of $12.50 and a maximum of $26.92 per hour. The maximum is not likely to be representative of the sector as the upper quartile of the range was $14.75 (New Zealand Aged Care Association, 2010).

Table 4.4 Median hourly standard wage rate 2005-2009 in NZACA surveyed members

Staff Category	2005 ($)	2006 ($)	2007 ($)	2008 ($)	2009 ($)
Cleaning staff	10.50	11.00	12.55	13.00	13.35
Caregiver	11.20	11.80	13.00	13.81	14.00
Gardening/maintenance	13.00	14.10	15.00	15.00	16.25
Administration staff	15.00	16.00	16.50	17.59	18.00
Enrolled nurse	15.00	16.00	16.56	18.04	18.59
Registered nurse	20.00	21.00	22.78	24.43	25.23
Clinical manager	24.00	25.00	27.45	30.00	29.00
Facility manager	27.64	29.50	31.00	35.80	34.13
National minimum wage	**9.50**	**10.25**	**11.25**	**12.00**	**12.50**

Source: Adapted from NZACA (2010, p. 78); Department of Labour (2010a)

Care work has traditionally been seen as unpaid work carried out by women in the family. Care work's origins in the private and unpaid domain have led to the work and skills of aged caregivers being undervalued and underpaid (Kaine, 2010; Martin, 2007; Palmer & Eveline, 2010). Rather than viewing caregivers as skilled employees, care work is viewed as something done out of love, compassion, or by vocation (Palmer & Eveline, 2010) – these are immeasurable qualities that do not fit into the concept of quantifiable skills. A union representative stated that there were a

> *...hoard of assumptions made about the women who work in the industry – that they're doing it because they care. When actually they are mothers, they are parents, they are pretty amazing people and they are undervalued. (caregivers' union representative)*

The underlying perception of care work as carried out through a sense of vocation or compassion means that caregivers may provide care across several roles: 'the employees' commitment to providing care was not restricted to caring for residents. It also extended to caring for their families and caring for their co-workers' (King & Meagher, 2009, p. 139). This gendered perspective considers that female employees are more likely to enjoy the work because they see it as an extension of the unpaid care work they have done for family and friends (Stack, 2003).

The association between family and care work remains embedded in paid care work. While notions of family and care are used to encourage compassion and caring work,

some studies have found that managers often express that caregivers 'of colour were naturally suited for this type of caring work because their culture respects older people' (Ryosho, 2011, p. 61). Dodson and Zincavage (2007) argue that a model of 'family care' is used by managers to benefit residential aged care facilities and the residents in order 'to extract more work from the lowest-paid workers' (p. 906). The connection between family and caring is such that employees care for residents almost as if they were part of their own family. This is exemplified in Dodson and Zincavage's (2007) study of migrant women who felt that their care work with residents compensated for the absence of their own family. This was also expressed by a union representative from the caregivers' union:

> *these are the women who will engage joyfully and tearfully with residents, who will often be the people who in their own time go to that resident's funeral. (caregivers' union representative)*

However, the same sense of high quality care and obligation was not extended towards caregivers who were dissatisfied with low pay, and their own families were often viewed as 'work obstacles' (Dodson & Zincavage, 2007, p. 918). Caregivers who had treated residents almost as family, and formed personal bonds with them, were often not allowed time off work to attend funerals when residents died as it might have interrupted the work flow (Dodson & Zincavage, 2007).

The rhetoric surrounding care work is such that many caregivers themselves share this 'gender defined image of nursing work that has undervalued the skills associated with caring work' (Bach et al., 2009, p. 17). The hierarchies in the health professions often exacerbate this, with caregivers being marginalised and assigned the less desirable work by other health workers such as nurses (Bach et al., 2009). This is complicated by nurses' efforts to gain professional recognition and status:

> Although there is some acknowledgement that shifting occupational boundaries have consequences for lower paid health care workers, most attention has been directed at the implications for nursing in relation to medicine…This stems from a preoccupation in nursing to shed its association with a gender defined image of 'caring work' skills that are invariably undervalued in the workplace and the academy. (Bach et al., 2009, p. 2)

Within these hierarchies, both caregivers and nurses in aged care are considered to have less status among health professionals (Jervis, 2002; Stack, 2003).

General undervaluing of the skills required and the work done by caregivers is inevitably intertwined with issues of low pay. As demonstrated, stereotypes of care and women's work tend to normalise low pay and undervaluing of skills in the literature. Indeed, Palmer and Eveline (2010) assert that it is the undervaluing of aged care work that enables managers to maintain it as a low paid job. By emphasising that it is low skilled work, despite caregivers often taking on the work of more qualified nurses, managers can maintain low wages. Managers also manipulate caregivers' orientation towards care to 'offset the need for decent pay and work conditions' (King & Meagher, 2009, p. 140). Taken to extremes, some argue that if the pay is low, then employees who still carry out the care work are more likely to have a strong sense of 'vocation' and will thus work harder than an employee attracted by the pay (Palmer & Eveline, 2010), as suggested by the owners' association representative. This is in part explained through neo-classical economics which presents the theory of compensating wage differentials whereby employers can hire employees for less in jobs with non-monetary reward, such as the fulfilment or satisfaction gained from providing care to the elderly. In this view, care workers are compensated for their work; they just 'choose to take a portion of their pay in warm feelings instead of cash' (Palmer & Eveline, 2010, p. 4).

Low pay is one of the most cited problems or sources of dissatisfaction for caregivers in the sector in New Zealand (Point Research, 2008; Walker, 2009). Furthermore, sector representatives – both union and owner representatives – have pointed to the lack of parity of aged care pay with those working in district health boards. Caregivers in a hospital setting working for a district health boards directly receive higher wages and better conditions for the same type of work as caregivers working in residential aged care facilities (Grant Thornton, 2010; New Zealand Labour Party et al., 2010). The New Zealand Labour Party et al. (2010) report that those working in residential aged care facilities do not have the same support as, for example, health care assistants and nurses in a hospital. Employees in residential aged care do not have medical specialists on hand to refer difficult decisions to (New Zealand Labour Party et al., 2010). It would therefore seem logical to assume that staff working in residential aged care facilities require a wider variety of skills and experience than those working in hospitals for district health boards. This indicates several issues, one of which is how funding is used by private, profit based companies, another is how the work in aged care is generally

undervalued both as gendered care work, but also in terms of professional hierarchies (Jervis, 2002). It also possibly reflects the higher percentage of unionisation in the District Health Boards, where union membership density is as high as 80 per cent (nurses' union representative, 2010).

However, not only gender, but also race, class and power issues are implicit in the sector, evidenced in the way that skills are undervalued, and in the expectations surrounding who carries out the work. For example, Dodson and Zincavage (2007) note that while in the United States the majority of caregivers are women of colour, the managers and residents are predominantly white, a finding confirmed by Jervis (2002). Some aged care literature also indicates that class is an issue as the women who enter aged care are those who are already in low paid jobs, have had limited education and, to some extent, expect to carry out low paid work (Dodson & Zincavage, 2010; Kaine, 2010; Kiata & Kerse, 2004; Ryosho, 2011).

Jervis (2001) points to the history of nursing as contributing to inequalities among employees in residential aged care. Strict hierarchies have been embedded in nursing throughout its history, beginning with its origin in military orders in medieval Europe, to the beginning of the professionalisation of nursing when Florence Nightingale 'began a campaign to improve its reputation by instituting hygienic and educational reforms' (Jervis, 2002, p. 13), and high standards and professionalism have been represented through hierarchy. The professionalisation of nursing has continued to emphasise hierarchies, Jervis argues, with 'bedside care' being associated with less skilled work (2002). In Jervis' study, power relationships restricted the autonomy and opportunities for employee participation, while managers and senior nurses had relatively high levels of autonomy and job satisfaction (2002). It has also been noted that employees choose this type of work because they see it as compatible with their skills and flexible enough to fit around their role as primary caregivers in their own family (Kaine, 2010).

A nurses' union survey of aged care found that caregivers have a 'depth and breadth in the levels of qualification and training' (Walker, 2009, p. 6) that is not recognised. Of the caregivers who responded to that survey, 80 per cent had nursing or caregiving qualifications, and those who did not have formal qualifications had in excess of ten years' experience (Walker, 2009). Training is a topic that receives less attention in aged care literature. One study in New Zealand found that caregiver training and education does have a positive effect on the quality of care (Smith, Kerse & Parsons, 2005), yet training is not always considered by employers for what is viewed as low skill work.

Both the union representatives interviewed mentioned the need for standardised national qualifications that lead to career paths or increased wages according to the level of the qualification completed (caregivers' union representative, 2010; nurses' union representative, 2010). However, it was also seen as important to recognise the experience and skill gained on the job by caregivers who have considerable experience, such as ten years or more, so that they were not disadvantaged by the introduction of new formal training requirements. There is a national qualification in aged care, but it is not a formal requirement of caregivers in the sector (except for those working in a dementia unit) and is not consistently offered by all employers (Haultain, 2006).

The low value of skills in aged care work is a dominant issue in the literature, and arises from the gendered nature of care work. The discussion centres around the lack of recognition for skills required for physical tasks, but also the lack of recognition of emotional skills and knowledge required to provide care for the elderly (Bach, Kessler & Heron, 2009; Mears, 2009; Palmer & Eveline, 2010; Provis & Stack, 2003). Furthermore, longstanding traditions of nursing and hospital models may have influenced management and care so that care is expected to be carried out efficiently, focusing on physical tasks (Stack, 2003).

Studies have shown that caregivers perceive themselves to be skilled in the work they do (Martin, 2007). The skill involved is not just physical, or a desire to care for people, but the ability to make decisions about the needs of elderly, and to make judgements on those needs and how to meet them with the resources available (Provis & Stack, 2003). Nishikawa (2011) suggests that employees in aged care should be viewed as knowledge workers. The type of knowledge referred to is the constructing, understanding and sharing of the contexts in which care takes place. This knowledge has a substantial impact on the quality of care, and requires collective work, reflection and dialogue (Nishikawa, 2011). Reframing the work as knowledge work emphasises the complexity of the knowledge and skills required to provide quality and consistency of care to the elderly.

The skills of caregivers in particular are not seen to be specific to aged care, in contrast to those of nurses and managers; indeed they are viewed by owner representatives as 'more or less generic to the whole economy' (Grant Thornton, 2010, p. 118). This view of the skills required is reflected in that caregiving is not seen as a valued or worthwhile career path (New Zealand Labour Party et al., 2010). While it is seen as unskilled, the work carried out by caregivers is 'an important component of the workforce that

provides the day-to-day care giving activities such as bathing, dressing and feeding the elderly' (Badkar, 2009, p. 9). Even within the sector there is some evidence that other employees, such as nurses, do not value the skills and experience of caregivers: 'A caregiver can be trained in a very short time to strap on a plastic brief, change a bed, thrust a spoon full of mush into a mouth and soap and shower a patient. It takes time and persistence to enlighten them to the emotional well being of a human being' (New Zealand Labour Party et al., 2010, p. 30).

While the previous quotation indicates the attitude of some registered nurses towards caregivers, it also highlights the way in which care work is misunderstood. It has been pointed out that although some of the physical aspects of nurse's work may be taught to caregivers, the knowledge and experience to monitor and observe reactions , for example to a medication, cannot be taught easily and comes as a result of the registered nurses' training and experience (New Zealand Nurses Organisation, 2010). The standards included in the Health and Disability Services (Safety) Act 2001 include some aspects that directly relate to how a caregiver might use knowledge and experience, rather than physical skill, in their care: some of the 'inputs' required of staff include complex skills such as monitoring changes in mood, monitoring hydration and nutritional status, and reporting pain behaviours.

Work Conditions and Job Satisfaction

The majority of discussion around residential aged care workplace conditions centres on low pay and low staffing levels and the consequences for both quality of care and employee satisfaction. Another, less studied, consideration is OHS in residential aged care. Some New Zealand studies have pointed to health and safety hazards such as physical and verbal abuse from residents (Kiata & Kerse, 2004; Point Research, 2008). Violence and verbal abuse from residents was identified as a concern in the sector by the nurses' union, caregivers' union and owners' association representatives (Manderson & Schofield, 2005; owners' association representative, 2010; nurses' union representative, 2010; caregivers' union representative, 2010). One report in the Auckland region found that 61 per cent of caregivers surveyed had experienced a violent or abusive resident (Point Research, 2008). Abuse from aggressive residents is a common enough occurrence that many caregivers view it as part of the job (Kiata &

Kerse, 2004; nurses' union representative, 2010). As well as this, the Department of Labour has identified residential aged care as a high risk industry for workplace injury (nurses' union representative, 2010; Point Research, 2008). The two dominant risks are back injuries and abuse from residents. The nurses' union has implemented a project on health workplaces across all sectors it represents and one of its aims is to address staffing levels as a health and safety concern (nurses' union representative, 2010).

Intersecting identities of race, ethnicity and class have a significant impact on the wellbeing of employees in aged care (Neysmith & Aronson, 1997). It is increasingly acknowledged that ethnic minorities working as caregivers are subjected to abuse from residents who are most often white and middle class (Kiata & Kerse, 2004; Ryosho, 2011; Dodson & Zincavage, 2007). Furthermore, conflict among employees from different ethnic groups sometimes occurs because of communication difficulties and different understandings of care and work (Ryosho, 2011).

At the same time as skills of employees in residential aged care are undervalued, employees are increasingly required to do more work and more complex work. Workload and staffing levels are often pointed to as issues in aged care and some research highlights that caregivers do not have sufficient time to carry out care for the residents (King & Meagher, 2009). The work is both physically and emotionally difficult, and staffing levels are such that caregivers do not have time to carry out the caring duties that they would wish to (Stack, 2003). There is evidence that residential aged care facilities are understaffed in New Zealand (Carryer et al., 2010; Haultain, 2011; Kiata et al., 2005; Networkers, 2005) and that there is more work required than caregivers can reasonably carry out (Carryer et al., 2010; Haultain, 2011). A survey by the nurses' union found that

> many nurses feel the workload and pressure caused by increasing numbers and higher acuity of patients, combined with a perceived lack of experienced staff, high vacancy rates, and the inability to cover vacancies, holidays and sickness is contributing significantly to reduction in job satisfaction, and to increased stress. (Walker, 2009, p. 4)

Corroboration of this is also found in other recent reports on aged care, where several submissions from employees in the industry expressed that the workload on registered nurses was high, and that the number of caregivers was low. This was seen to affect the standard of care that residents received (New Zealand Labour Party et al., 2010). Caregiver workload in the Auckland region has been found to be high, with many

looking ‘after 10 residents, over one-quarter look after between 10 and 20 residents and one-fifth care for more than 20’ (Point Research, 2008, p. 4).

Research suggests that more registered nurse tasks are being delegated to caregivers, which also increases their workload (Duffield et al., 2010; Networkers, 2005; Palmer & Eveline, 2010; Walker, 2009). This creates issues of workload for caregivers, but also is a source of stress for registered nurses, who are responsible for ensuring the tasks are carried out safely, and who bear responsibility should mistakes occur through lack of knowledge or training on part of the caregiver. Some registered nurses feel that they are placed in a difficult position when managers expect them to delegate tasks, and time pressures are such that they have to, yet they are uncomfortable with the skill of the caregivers they are delegating to and they have little influence on the performance management of caregivers (Carryer et al., 2010). Registered nurses are in a similar position in the United States, where ‘although NAs [nursing assistants] provide the vast majority of direct care in nursing homes, nurses are ethically and legally responsible for ensuring the competency of this care’ (Jervis, 2002, p. 12).

The residential aged care literature points to increasing workload and difficulty in tasks placed on caregivers, and consequently a lack of time to carry out caring. Both caregivers and the elderly recipients of care have been shown to consider that ‘the quality of relationship between the carer and the cared recipient affect the quality and efficacy of care work’ (Meagher, 2006, p. 35). Not only does an increased level of staff improve the levels of care, but it also decreases the levels of stress experienced by caregivers (Haapakorpi, 2009).

Another source of dissatisfaction indicated in the aged care literature, and in New Zealand (Carryer et al., 2010), is the inability to provide the quality of care that caregivers wish to. One reason they are unable to do this is through a lack of autonomy and decision making authority to make judgements on how to best meet the needs of their residents (Mears, 2009). This is significant in relation to the rhetoric that the rewards of providing care are sufficient to overcome the low pay in the industry (Dodson & Zincavage, 2007; King & Martin, 2009; Palmer & Eveline, 2010). Martin (2007) found that the areas that create greatest job satisfaction are those in the control of facility managers, such as allocation of hours and shifts, how employees can use their skills, and daily allocation of tasks. Another reason which caregivers cannot always provide the standard of individualised care they may wish to is through the workload

itself, and lack of time to carry out even basic physical care tasks (Dodson & Zincavage, 2007).

Despite clear indications that adequate staffing benefits both quality of care and satisfaction among caregivers, there is little evidence globally of mandatory minimum levels of staffing (Schmidt & Diestel, 2010). In New Zealand, there are recommended minimums for staffing levels, and the district health board agreements provide guidelines, but there are no mandatory staffing levels except for the minimum coverage by registered nurses in hospitals and rest homes. Some of the standards for the Health and Disability Services (Safety) Act 2001 also include indicators for adequate staffing and training. Some of these rely upon the training and competence and staffing levels of caregivers: the standards also include measures of trends that may impact on 'staffing and staffing effectiveness' for 'facilities seeking to improve quality in this area: a)Turnover of staff; b) supervision of care giving staff; c)Absenteeism; d) Staff satisfaction; e) Education and competency…' (Standards New Zealand, 2004, p. 25). However, the standards are criticised for inadequate monitoring and also the lack of minimum staffing requirements for training, staffing levels and pay (New Zealand Nurses' Organisation, 2010). The New Zealand Nurses Organisation notes that in the legislation prior to the Health and Disability Services (Safety) Act 2001, safe staffing levels were regulated in the Old People's Homes Regulations 1987 and the Hospital Regulations 1993 (New Zealand Nurses' Organisation, 2010).

One study finds that financial worries create stress which impacts on job satisfaction, and that this is common because it is low paid work (Ejaz, Noelker, Menne & Bagaka, 2008). However, Ejaz et al. (2008) view financial worries as a stressor brought from home or personal life, rather than a work stress. Martin (2007) suggests that workers may remain in the jobs because they find meaning in such work that they would not find in other unskilled jobs. This idea is confirmed in other studies that indicate that caregivers may gain a sense of reward or satisfaction when they perceive that their work contributes to the quality of life of the residents (King & Meagher, 2009), and that this may compensate for low pay. However, in New Zealand it is apparent that low pay and lack of recognition are two of the biggest concerns of caregivers in aged care (Walker, 2009).

Conclusion

Employees' intersecting identities of gender, ethnicity, professional and educational status influence power dynamics and can result in a negative influence on employee wellbeing in residential aged care in New Zealand. Owners, and government, continue to undervalue the work of caregivers in residential aged care. Wages, therefore, are low and the increasing skills and knowledge required are not fully recognised or rewarded. Owners and government are interested in keeping staffing costs low. This results in higher workloads, and some delegation of tasks to 'cheaper' labour. It also results in limited employee participation at a sector level because employees and their skills and knowledge are perceived to be less important than organisational outcomes.

This chapter has brought to light the power relationships that influence the relationship between employee participation, productivity and employee wellbeing at a sector level. The following four chapters respectively present the findings from each case study organisation. Those findings will then be discussed in Chapter Nine in the context of the sectoral issues raised in this chapter.

Chapter Five: National Aged Care

Introduction

The National Aged Care facility reflected many of the characteristics of residential aged care identified in Chapter Four. The workforce was highly feminised and caregivers' pay rates low. There was a diverse staff at the facility with employees from eight different countries providing care to mainly Pakeha (New Zealand European) residents. The nature of work was similar to that described in Chapter Four: residents have become increasingly frail and dependent and the work has become heavier and more emotionally difficult over the years. Caregivers are now required to undertake formal qualifications in aged care but this is not significantly reflected in increases to pay rates.

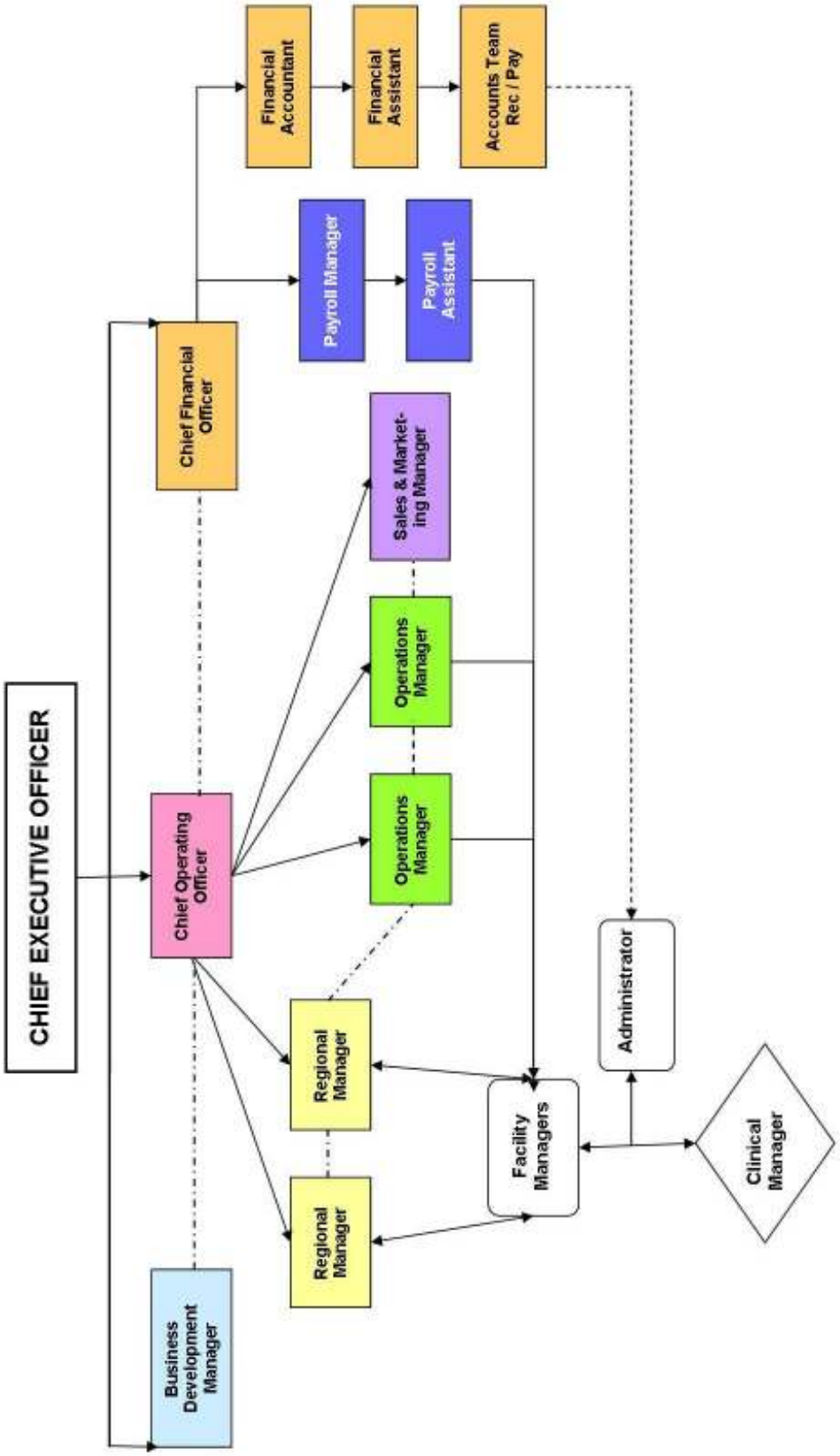
This chapter presents the findings drawn extensively from interviews, organisational documents (listed in Appendix 1), and an anonymous survey carried out in the organisation. The interviews provide in-depth information on employee and managerial experiences of productivity, employee participation and employee wellbeing. The organisational documents are another source of information on the managerial and organisational perspectives, and the completed surveys provide further responses from employees on participation and wellbeing.

The first section of this chapter provides detail on the organisational context. It is followed by discussion of employee participation in health and safety and how effective this is for employees. Other forms of participation, namely union representation and direct participation are then presented. Managers and employees' different views on employee wellbeing are discussed in the section that follows participatory practices. Employee wellbeing is discussed in sections pertaining to workload and stress, work-life balance, violence and bullying, health and safety and training. The next section describes the approach to productivity that National Aged Care takes. The conclusion summarises the findings for National Aged Care and suggests how employee participation, wellbeing and productivity may be connected in this organisation.

The Organisational Context

National Aged Care is a New Zealand owned for-profit national provider of residential aged care with 22 residential aged care facilities nationwide. Facilities operate independently on a day-to-day basis and all are expected to make a profit. Policy is decided upon on a national basis, although generally appointing and managing of employees is carried out by the managers at each facility (see Figure 5.1 for organisational structure).

Figure 5.1 National Aged Care national structure



Source: Organisational documents, National Aged Care

The facility in which this research took place was on the outskirts of Auckland, the largest city in New Zealand with one of the most diverse populations in the country (see Figure 5.2).

Figure 5.2 National Aged Care key characteristics

Regional demographic information

- Auckland's population approximately is 1.4 million: 56% Pakeha (NZ European), 11% Maori, 14% Pacific peoples and 18% Asian
- Median income for Auckland is $26,800 (national $24,400)

National Aged Care facility

- 60 beds (hospital and rest home)
- 59 total employees of which:
  - 3% managers
  - 2% administrative
  - 15% registered nurses
  - 2% enrolled nurses
  - 49% caregivers
  - 90% female
- Union membership approximately 25%
- Ratio of employees to residents is 0.98 employees for each resident

Source: Department of Labour (2011b); Organisational information; Statistics New Zealand (2009)

The National Aged Care facility had 60 beds in total with a mixture of hospital and rest home care beds. There were a total of 59 employees including management, administration and other services such as kitchen and maintenance. Employees came from a diverse range of countries including New Zealand, several Pacific nations, African countries, the Philippines, India and England. Union density was 25 per cent overall, with the majority of the members in the caregivers' union. Consistent with industry level trends, the majority of employees were involved in direct care, with most of those caregivers. However, in contrast to industry trends, only 41 per cent of all employees were employed on a part-time basis with 56 per cent full time and 3 per cent casual employees. The low percentage of casual employees may reflect the manager's practice of not using agency employees to cover unexpected staffing shortages.

Generally, permanent employees would be asked to take extra shifts to cover other employees' absences.

Interviews at National Aged Care were conducted with a regional manager with national oversight for health and safety from the head office and then interviews at a facility. Interviews at the facility were carried out with the facility manager, clinical co-ordinator (second in charge), OHS officer, OHS representative, and an employee representative. The OHS officer at the facility, and the regional manager were both male. All other interviewees were women. The documentation gained from National Aged Care was primarily the national policy for the organisation, reflecting the role that the head office has in steering and producing national guidelines and policies for the facilities. The findings also use survey data carried out at the organisation. There was a 17 per cent response rate (10 respondents) for the survey at the facility. All except one respondent were full-time and eight were caregivers. All respondents were female.

Table 5.1 Interviews at National Aged Care

Regional manager	• Responsible for OHS portfolio nationally • Replaced national HR manager • With organisation 6 months • Prior work experience as auditor for ACC
Facility manager	• Registered nurse • Also regional manager • 7 years at National Aged Care • Approx. 20 years' experience in aged care
Clinical manager	• Registered nurse • Second in charge at facility • With National Aged Care approx. 5 years • Responsible for training & education at facility
Caregiver	• With National Aged Care approx. 5 years • Previously union delegate • Possibly OHS representative
Cleaner	• With National Aged Care approx. 10 years
Maintenance engineer	• OHS officer • With National Aged Care approx. 4 years • Union delegate at previous job

Source: Author

Employee Participation in Occupational Health and Safety

There was no national OHS committee at National Aged Care. Although National Aged Care policy required each facility to have an OHS committee, and the OHS representative and facility manager perceived that there was a separate OHS committee, in practice it was incorporated into the monthly staff forum. This forum included all staff on duty, including managers. The forum was held during the day shift which implies that night duty staff may not have access to the forum and to raising health and safety issues through it. Both the facility manager and the OHS officer commented that the reason for not having a separate OHS meeting was to try and consolidate the number of meetings required in the facility. National Aged Care stands out from the other case organisations in not having a separate OHS committee.

There was a set agenda for the meeting, including OHS. However the agenda would be displayed in the staff room prior to the meeting and employees could add any items they had for the meeting. There was a set list of items to be covered, and OHS was one of these. Management were present at and chaired the meeting.

According to the facility manager, OHS representatives were nominated and elected on an annual basis in the January staff meeting. The OHS officer was elected to his role. This in practice meant that he had volunteered to be the OHS officer and was elected by default in the absence of other nominees. The manager viewed these circumstances as usual for an OHS committee:

> *Theoretically there is meant to be an election process. In practice it's whoever's slowest in getting out of the room, you know. And I think that's pretty standard for most OHS committees that I've come across...Obviously what we look at in terms of that is to try and get appropriate representation. (Facility manager)*

The survey results confirmed the way in which the OHS officer and representatives were chosen: five responded that employees were voted upon by everybody, and three responded that an employee volunteers. Only one responded that the manager decides who the representative is.

There was a formal description for the OHS officer which was part of national policy. The position of OHS officer was in addition to the holder's substantive position at the facility. The position description for the OHS officer included leadership in health and safety, and updating and reviewing OHS policy (Health and Safety Officer Job

Description, National Aged Care). The OHS officer had limited independence from management in how he carried out his role. He followed up any physical hazards that could be repaired without consultation with management. However, the scope of his role was clearly delineated. The OHS officer perceived clear demarcations between his role in OHS and that of management and other specialised staff. For example, he considered manual handling (of the residents) issues to be the sole domain of the physiotherapist. When asked about broader aspects of health and safety such as stress and workload, the OHS officer clearly saw this as a management role:

> *I think they'd be sort of more a management area I think. Oh somebody will come to me if they think there's something too heavy and I'll have a look and see if we need to get another hoist or something or if we've got something that needs fixing. As far as workload goes I don't handle it. (OHS officer)*

Interestingly, the National Aged Care policy on stress required consultation with union representatives and the OHS committee on all proposed means of preventing workplace stress.

Terms of reference for the OHS committees clearly state as an objective 'to provide a forum for staff representatives to raise and discuss staff health and well being issues and concerns, including mental health' (Terms of Reference Health and Safety Committee, National Residential Aged Care). It would be expected therefore that the OHS officer would have some overview of these types of issues.

The limited scope of the OHS officer's role was reflected in the types of issues that the caregiver and cleaner interviewed mentioned as typical OHS issues. The caregiver spoke of health and safety in terms of infection control and hygiene to prevent spread of infectious diseases, with a focus on resident health and safety more than employee health and safety. The cleaner also mentioned the importance of hygiene and infection control.

The OHS officer addressed health and safety in the staff meeting. He was accountable to any staff that raised a health and safety issue in the meeting. The OHS officer appeared to be very systematic in how he approached OHS and he stated that any issue raised in a meeting would be followed up and reported back on in the subsequent one:

That's all noted and then in the next meeting it's noted and if there's a broken step I'll go yeah, I've done that, I've painted that, white lines on there. So they're re-addressed and fixed. Yeah, we're pretty onto it here mate. (OHS officer)

In contrast to the OHS officer's experience, the thesis survey responses indicated that a large proportion of employees who had raised issues for the OHS committee felt that they had not been dealt with satisfactorily: six respondents had raised an issue with the committee, and of those half felt that it had not been dealt with satisfactorily. The survey results also indicated that the majority of issues were dealt with either immediately or within one month (four respondents out of six who raised an issue). Interestingly, one third of respondents reported that their issue was not dealt with at all.

The primary means of communication of OHS from the committee was via the staff meetings held monthly with all day staff. The OHS officer also stated that he would remind people about OHS on a daily basis if he noticed any potential hazards. The hazard register was kept in the front office. Policy updates were communicated to staff through memos available in the staff room and notices on the notice board. All employees were required to sign a sheet to record that they had read newly updated policy. There was no indication that this was available in any language other than English. The regional manager did note that there was no way to ascertain that the employees had actually read the policy, as opposed to merely signing to say they had. He perceived this to be a gap in meeting Accident Compensation Corporation audit standards:

There's meant to be clear consultation with staff over the policy. They have the opportunity to look at it but there's no formal process and I want to get us to tertiary [level] next time so that's something we'll be looking at. (Regional manager)

The OHS officer received training to support him in his role. He had attended training for levels one and two of OHS representative training (explained in Chapter Five). The training was paid for by the organisation and he was given paid time off work to attend the training courses. The OHS officer was proud of his training and showed the researcher his certificates. His role as an OHS officer gave him a sense of responsibility and importance in the organisation. He took his role very seriously and was proud of his record of following up reports of hazards and eliminating them:

I'm the main one. We're all, like we're all responsible. Like I said at the meeting, I know I'm the top of OHS but don't forget we're all responsible for health and safety... This is a big place to look after. (OHS officer)

However, the demarcation in management and OHS officer roles in OHS restricted the influence employees had on workplace issues. The main forms of communication from the 'committee' were via 'all staff' meetings and written communication. This may have created barriers to any employees with English as a second language. As noted above, it is significant that one third of survey respondents felt that their issues were not dealt with by the OHS committee.

Other Participatory Practices

National Aged Care had a multi-union collective agreement with the nurses' and caregivers' unions. This agreement covered all the sites, excluding head office. Perceptions of unionism at the facility were not altogether positive. One of the caregivers interviewed had been a union delegate previously. She had resigned because she did not like the position. She found that members would come to her to complain about conditions. However, complaints were rarely followed by action upon the member's request. This frustrated the caregiver. Employees raised staffing levels, workload, stress and sore backs as complaints.

The clinical manager stated that all employees were able to join the union if they wished, or could choose to be on an individual agreement. She did remark that employees on individual agreements had more flexibility in negotiating pay rises:

If they're in the union then they have to wait for the union negotiators to negotiate the collective contract. But those who are on individual contracts can negotiate their pay at their appraisal. They can actually do it more often than that if they want to, but they usually do it at their appraisal. (Clinical manager)

While the facility manager did not necessarily discourage union membership, she viewed lower union density as a sign that her facility was a good place to work. She felt fortunate that the union members at her facility were co-operative which did not always occur at other facilities. This contributed to her sense that unions were only necessary

when work conditions and management were poor, and that unions were generally adversarial in nature and did not work with the organisation.

Table 5.2 Other ways that employees can be involved in National Aged Care

	Employee reps on boards *	Team work	Problem solving groups	Quality circles	Joint consultative committees	Working parties	Other	Total respondents
No. of response	1	2	4	0	1	1	1	6
*Multiple answers allowed mean that numbers of responses equal more than total respondents to this question								

Source: Thesis survey, National Aged Care

The thesis survey indicated that respondents thought there were a number of ways in which employees could be involved in National Aged Care (see Table 6.2). This was not reflected in interviews however. The main form of employee participation was through communication. Communication of information from management to employees was predominantly through notice boards in the staff room and various staff and departmental meetings.

Communication of information was very important to the facility manager. Communication was more about work processes than strategic matters:

> *We communicate for everything. We communicate for new admissions, discharges, changes to policies, we have an agenda for our meetings so that goes out. When we come up to our budget talks I put a sign out for, a list out for the staff. What equipment we are needing? So they have input into that... (Facility manager)*

The manager and clinical manager operated an 'open door' policy. Either the manager or clinical manager would be on-call 24 hours a day, so in a sense there was an element of 'open door' policy for employees on night shift. The clinical manager also made a point of phoning the facility during the weekends in order to ensure staff did not feel isolated.

The three employees interviewed felt that they were able to approach either the manager or the clinical manager if there were any issues that they wanted to discuss or get help with. The cleaner said that 'they're easy enough to talk to. They listen.' The caregiver made a similar, albeit qualified, statement:

Yeah, you can go and ask. Like I find that you can, but other people might have different experiences with the management. But I find that if you've got a problem they're pretty open with you going and talking to them. (Caregiver)

Employees had limited input into policy development, with the opportunity to provide feedback only once policy had been developed. They were dependent on facility managers requesting employee feedback. They were also dependent on facility managers for policy updates. National Aged Care policy was communicated to employees via the facility managers because it was sent electronically. Despite this, thesis survey responses indicated that half of the respondents felt that they got information on important decisions, changes and future plans. Two respondents felt neutral, and three disagreed that they received information on these aspects (see Table 5.3).

Table 5.3 Information and influence on work practices

I get information on important decisions, changes and future plans in due time.						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total
No. of responses	1	4	2	2	1	10
I have significant influence on how my work is done						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total
No. of responses	1	2	6	0	1	10
Do you have significant influence on how much work you have to do?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	0	3	0	1	6	10

Source: Thesis survey, National Aged Care facility

Job autonomy and decision making appeared to be minimal and varied by occupation: caregivers had the least autonomy. Survey respondents indicated that the overwhelming majority (seven respondents out of ten) either rarely or never had significant influence

on how much work they do. Three felt that they did have significant influence on how they did their work. Six responded neutrally and one strongly disagreed that they had significant influence on how they did their work. This is similar to the information gained from interviewees. The cleaner and maintenance engineer both indicated that they had some degree of autonomy. The maintenance engineer had a relatively large degree of autonomy as he was able to make decisions on purchases for equipment to make repairs. He could decide when and how he completed his tasks. He also had some degree of flexibility around when he chose to work his hours.

The cleaner had specific jobs to complete, but had some autonomy in how and when they were completed:

> *you get into a routine so you know how long it's going to take to do certain things and if something crops up and you've got to do something different you just don't vacuum half the rooms or something and that's okay with management... (Cleaner)*

The caregiver did not express the same degree of autonomy over what tasks she completed and when she did them. However, some degree of judgement was required in observing and noting changes in the residents that may indicate declining health.

Enabling decision making was important to the facility manager. She had over several years attempted to build the confidence and skills of the registered nurses so that they could make decisions without management present. She perceived that some of her registered nurses had considerable experience in aged care. She felt that they had more specialised knowledge than the local general practitioner on some matters. However they did not have the confidence to decide care issues themselves:

> *Five years ago I'd have the RN [registered nurse] on the phone every five minutes saying 'Can I give Panadol [paracetamol brand] here? Can I do this? Can I do that?' I now have the RN challenging the doctor: 'Why are you making that decision'?...So the whole training package throughout those five years has made them have the confidence and the self-esteem and know that their decisions are done from best practice. (Facility manager)*

Overall there were limited opportunities for employees to participate in National Aged Care: there was little or no representative participation. Direct participation was limited to communication of information. Certain staff within the facility had more autonomy,

such as the maintenance man and the cleaners. Registered nurses had also been encouraged to make more decisions within their roles. Policy was decided upon on a national basis for the organisation.

Employee Wellbeing – Workload and Stress

Generally, workload, stress and staffing levels were identified by employees as issues for their wellbeing. Low pay was important, but was perceived to be something that could not be changed. Managers perceived stress more as an issue of employees being unable to balance home and work lives than as an issue of work conditions.

Workload and stress was an important issue for caregivers in employee wellbeing. Neither the cleaner nor maintenance man experienced stress in their work. The cleaner, however, did mention that she knew the caregivers had a high workload and some found this stressful. She would not want to do the same work as them because of the hard physical and emotional work:

> *I know the caregivers seem more stressed than the cleaners really. That's why I never wanted to be a caregiver. And they seem more stressed now than a few years back...now they come in and they're really ill so I think it's harder for the caregivers. (Cleaner)*

The caregiver also stated that the workload was heavy, and that there was not enough time to do all the work that they were required to do. She became frustrated at times because there was no longer time to stop and talk with the residents. She also noted that staffing levels were not always adequate. Often when a caregiver was on annual leave or called in sick they were not replaced. This created a higher workload for those on duty, and impacted on the experience of stress among caregivers.

The cleaner and caregiver both mentioned that issues of staffing levels were raised by employees. However, the facility manager's response had been that there was not a budget to allow for increased staff. Both the cleaner and employee understood that their manager was constrained by the national policy. They perceived that she had only limited control of what she could expend on staffing. The cleaner noted that they had stopped getting 'bureau' staff to replace employees on sick or annual leave because it was too expensive. She felt that this policy was 'at the expense of staff wellbeing'. The

caregiver also felt, while acknowledging the constraints the facility manager worked within, that 'staff should be taken care of, over the budget' (Caregiver).

Although the employees mentioned work related stress, the facility manager perceived that stress was often 'people who've got family issues at home bringing it to work which is really hard as opposed to work related' (Facility manager). Management had provided some stress management training sessions for employees. The facility manager felt that employees were aware of stress in general, but did not recognise it in themselves:

> *It's the individuals recognising their own limits. I think that's the hard part. Particularly for females if you've got a family you tend to just carry on and carry on and carry on and you're always so busy looking after your family it's very easy to forget about yourself. (Facility manager).*

The facility manager had in several cases instructed employees to take leave because of their stress levels. The clinical manager noted that some of the employees who 'get burnt out' had accumulated annual leave, and were then encouraged to use that. She also mentioned that the managers would sometimes shorten the employee's working hours, or change the area in the facility in which the employees were working if they were getting stressed.

The clinical manager thought that long working hours sometimes caused stress for the employees. However, this was usually caused by employees taking additional shifts, not because of their rostered hours. The rosters would usually have no more than 40 hours per week for each employee.

Avoiding stress and fatigue was important because of the perceived effect on quality of care. The facility manager felt that on occasion a tired employee might be more rough and less patient with the residents. It was not intentional, she thought, but a result of the fatigue experienced by the employee.

The facility manager observed that the work had become physically and emotionally more difficult in the approximately 20 years she had been in residential aged care. This was because of the increasing dependency and worsening states of residents when they entered residential aged care. This made it harder for caregivers to complete their day's work and still have energy for their home life. The clinical manager agreed and suggested it could impact on home life:

This is a really stressful industry to work in. It's hard work...you're touching and dealing with human beings all the time which is really draining. Then you go home to husbands and kids and dinners to cook and family issues. You do have to make sure you take time out for yourself. (Clinical manager)

National Aged Care identified workplace stress as an OHS hazard. Its Stress Policy and Procedure document defined stress 'as the adverse reaction people have to excessive pressure or other types of demand placed upon them in the workplace'. The policy stipulates that the organisation would identify workplace stressors and develop means to either minimise or eliminate them. However, there was no indication that management perceived staffing levels to contribute to work load and stress.

The survey results indicated that respondents experienced reasonably high levels of stress and fatigue related to work (see Table 5.4). These responses reflected the perceptions of both the facility manager and the clinical manager that aged care work was increasingly more difficult. Two respondents felt that they always had more work than they could complete in one shift. This combined with three who responded that they often have more work than they could accomplish in one shift indicates that this may occur for the majority of employees at the facility. Most respondents were not required to work overtime. The lack of overtime is possibly because of the practice of not replacing absent employees.

Table 5.4 Survey responses on workload and stress at National Aged Care

	Always	Often	Now and Then	Rarely	Never	
How often have you felt stressed?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	0	5	1	4	0	10
Do you think your work takes so much of your energy that it affects your private life?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	1	3	1	1	1	10
How often have you felt really tired from work?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	3	2	2	3	0	10
Do you have more work to do than you can accomplish in one shift?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	2	3	0	2	2	9
Are you required to work overtime?						
	Always	Often	Now and Then	Rarely	Never	Total
No. of responses	0	1	5	2	2	10

Source: Thesis survey, National Aged Care facility

Workload and stress was perceived by management to be closely related to changes in residential aged care. Heavier work was compounded by a possibly lean workforce in the facility. There was an emphasis on minimising staffing costs resulting in absent employees not being replaced. Managers, however, equally perceived stress to be caused by the personal lives of employees. The managers responded by controlling employees' work hours and leave. Employees, on the other hand, perceived stress as stemming from physically heavier work, higher workloads, and insufficient staffing levels.

Employees and managers identified the type of work as requiring large amounts of energy from employees. Employees perceived staffing levels to be less than desirable.

The consequence of this was stress for some employees. These conditions impacted negatively on some employees' work-life balance. The facility manager in particular was very aware of employees' home lives, and of the intersection of caring at work and at home. She was conscious of many individual employees' home circumstances which she factored into the roster. She did this to aid the employees in work-life balance. However, she also found that unexplained absences would be less frequent if the roster was suited to the employees' personal commitments.

The facility manager tried to accommodate the needs of employees with dependent children:

> *We have flexibility with our working hours. I have a lot of mums here with children obviously, and it's not always easy to get to a doctor after work or at the weekends... They will come and talk to me about what their needs are and we'll work around the roster a bit with that. (Facility manager)*

Flexibility in hours benefited National Aged Care through a sense of mutual obligation. Employees were more likely to take an extra shift when needed, to help out, and reciprocate the flexibility. The roster was a set roster, not a rotating roster. This meant that employees could request certain shifts to accommodate their personal responsibilities. The facility manager tried to meet these requests as much as possible.

Financial pressures influenced work-life balance. This was because, according to the facility and clinical managers, some employees would take additional shifts to increase their income. The financial imperatives were such that those employees would commit to additional hours regardless of whether or not they could cope with them. Some employees would therefore enter a cycle of poor work-life balance because of taking extra shifts for additional wages.

Issues of balancing family and work life were not restricted to the employees, and the managers both experienced some work-life conflict. Both managers were on call 24 hours a day, seven days a week:

> *It's intrusive on your family. I've been nursing for 20 something years in aged care and other roles like this...Yes, sometimes it can be a bit much, but I don't know, you just get by. I take plenty of time for myself when I get home. (Clinical manager)*

Work-life balance also posed organisational difficulties in terms of covering all shifts. The managers did not refuse employees a weekend off when it was requested.

Weekends, however, were difficult to staff, according to the clinical manager, because of employees' cultural expectations and church attendance.

Home and work lives also intersected in some instances with women who suffered domestic violence at home. The clinical manager recalled at least two occasions when employees had come to work having obviously been the victim of domestic violence. On both occasions management assisted the employees with information on where to seek help. Time off or altered rosters would also be offered should it be required. The managers had previously arranged for in-service education from a local women's refuge.

It was clear then that the facility and clinical managers were aware of their employees' personal circumstances. They tried to accommodate these in the rosters, and with support and education. Financial pressures did impact negatively on work-life balance, but this was considered outside of the managers' control.

Employee Wellbeing – Aggression and Bullying

Unexpected aspects of employee wellbeing were raised at National Aged Care. There were two issues arising from the ethnic diversity of employees. One was aggression from residents towards 'ethnic minority' employees; the other involved a culture of bullying that had been prevalent in the facility. National Aged Care's policy on wellbeing focused on 'a healthy and safe work environment that is free from bullying, harassment and discrimination' (Staff Wellbeing at Work, National Aged Care). The policy required managers and employees to consider the needs of Maori employees. It also required consideration of the special cultural and customary needs of a multicultural staff.

Most of the residents at the facility were Pakeha (New Zealand European). The generation in which they grew up did not have the same exposure to, or awareness of, different cultures that is now experienced. This created a situation in which employees faced aggression and violence from residents because of the employee's ethnicity:

> *They [employees] can be abused by the residents just because they're different. Because although we're used to having a multicultural society now, the resident isn't and this might be the first time that the resident has been exposed to a different culture as well. It is a major thing. (Clinical manager)*

An ethnically diverse staff had also caused communication issues. The managers at National Aged Care had arranged cultural training for employees. This included an outline of the Treaty of Waitangi and biculturalism, but also how to communicate between different cultures. Communication issues had been central to resolving a previous bullying culture at the facility. Management had used in-service training to promote acceptable behaviour and communication with colleagues 'so you know how to ask for something without demanding and how to support each other' (Clinical manager).

Employee Wellbeing – Physical and Mental Health

Although bullying was identified in National Aged Care's Staff Wellbeing at Work Policy, neither of the managers raised bullying as an aspect of employee wellbeing. The facility manager viewed employee wellbeing as 'keeping them well both mentally and physically. Looking after them so they can look after our residents' (Facility manager). The regional manager's perception of employee wellbeing was similar, with mention made of the impact on the organisation:

> *I mean personally it's looking after employees' physical and mental health. If we look after our employees, our clients get good care so one follows suit. Where possible try to ensure that our staff are fit and healthy in all aspects. (Regional manager)*

The clinical manager perceived employee wellbeing as important. For her it entailed ensuring employees did not get burnt out or stressed. Employee wellbeing was also about employees taking sick leave when they were sick. There had been instances of team pressure influencing sick employees to come to work. This was because they did not want to leave their colleagues with a higher workload.

Physical health as part of employee wellbeing was emphasised in National Aged Care's annual wellness month. During wellness month management offered staff blood pressure checks, weight checks and glucose testing. In addition there were events such as barbeques for the employees. Some seminars during wellness month had focused on emotional wellbeing and budgeting.

When asked what employee wellbeing comprised, the caregiver associated it with employees being happy and stress-free, especially when the workload was manageable:

I guess when everyone's not overly stressed. When everyone's more relaxed and on top of things. It makes it all better when staff are happy (Caregiver).

This view of employee wellbeing was shared by the cleaner. She also mentioned that when people get stressed they get sick and are unable to come into work. Management perceived employee wellbeing as important to achieve good organisational outcomes such as quality care for the residents. There was a contrast between national policy which focused on harassment exclusively and the managers' perception of wellbeing, which was employees being mentally and physically healthy and fit to work.

Employee wellbeing incorporated physical and mental health in the managers' perspectives. Employees, meanwhile, perceived wellbeing to be not feeling stressed and being happy at work. The caregiver mentioned that friendly managers who showed they valued employees contributed to being happy at work, while the facility manager mentioned several ways they attempted to show appreciation for employees. The managers organised barbeques throughout the year and an employee of the month award. Significant personal events would be recognised with flowers for employees. Small gestures like these, and the baked goods the managers made for employees occasionally, contributed to employees feeling valued, according to the maintenance man. There was some differentiation in the expression of appreciation by occupation. For example, registered nurses would have an annual Christmas dinner with the local doctor.

Employees in return showed appreciation for the management. This included understanding that they could not always provide the staffing and pay levels employees wanted. Office staff and the maintenance man would make small gestures like getting coffee for the managers. The maintenance man felt about the employees and managers at the facility that 'we're sort of like a family here' (Maintenance engineer).

Employee Wellbeing – Training and Pay

The National Aged Care Training Policy states that training is important in order 'to have appropriate trained staff to meet the needs of their residents and to ensure the health, safety and wellbeing of staff within the workplace', and this was echoed by the regional manager, manager and clinical manager. The regional manager noted that residential aged care has one of the highest accident and injury rates in New Zealand

and that training was important to try and rectify that situation. Training, according to the policy, began with the recruitment policy which required all new employees to be committed to a high standard of quality care.

Training was not confined to regulatory requirements. National Aged Care expected all caregivers to complete the national qualification in aged care. The course fees were paid the Training Policy confirmed that paid time may be given to complete the studies:

> [National Aged Care] may allow an employee the opportunity to gain further qualifications during working hours. Each request will be considered on an individual basis and consideration will be given to the Employee's circumstances and company operational requirements (Training Policy).

There was some support for caregivers studying for the national aged care qualification. The clinical manager and a registered nurse were trained as assessors for the qualification. Although time was allowed at work it was expected that caregivers would do self-directed study at home. Time was made in the afternoon for those who had difficulty with the written content to study with the clinical manager or registered nurse. Some employees also worked on the qualification in groups when there was free time in the afternoon.

The facility manager perceived training as important for caregivers because:

> *It's really important that they have the knowledge to provide the cares: why do we need to turn somebody in bed who can't get out; why do we need to make sure that somebody is having enough food and fluids, what is the implications if they're not. And the only way you can provide good care is by having staff that know why we provide that care. (Facility manager)*

She also extended this to staff such as cleaners who needed to understand why they need to clean carefully and what to do in an infection outbreak and to kitchen hands who needed to understand the importance of hygiene. Training was not a large component of the budget for the facility, but the facility manager said that she often went over budget for training because she was 'very keen on making sure my staff keep up with their skills' (Facility manager).

However, the facility manager did take an innovative approach to training: she had made use of the district health board gerontology nurse to provide training particularly for the registered nurses. In addition to this the facility had been pivotal in developing a guide for registered nurses to aid in carrying out their work and decision making. The

registered nurses in the facility had been involved in its development, and the guide was now in use in Australia and England. A further guide for caregivers was being developed with their input.

Low pay was an issue in the organisation. National Aged Care managers perceived this to be a consequence of sector trends and government funding, rather than National Aged Care conditions. The regional manager thought that health care was not as well paid in general as other industries. Lower pay in health care generally was compounded for aged care caregivers who were still not well paid, despite often having formal caregiver qualifications. The regional manager thought that wage rates at National Aged Care were about average for the sector:

> *Pay is a major issue. People that come into this, there'd be very few that come into this because of the money. It's a lousy, mucky job in lots of ways. It has some very nice sides, but it has some basic stuff. I don't believe that anyone would stay for what we pay them. You've got to have other motivations. (Regional manager)*

The regional manager perceived that caregivers work in residential aged care for the reward of providing care itself, rather than for pay. The facility manager agreed that the motivation of working with people helped retain caregivers in residential aged care and commented on the changes in residential aged care work. The work had been more enjoyable 20 years previously when residents were mobile and independent. She felt that then employees would work more hours than rostered without requesting payment because they enjoyed the work. The current situation was exacerbated by inadequate funding and low pay:

> *The staff these days, it's very hard to attract that same commitment and as soon as they hear [a supermarket] pays more they'll often toodle off there. There have been huge changes to the system, the funding hasn't changed much in that time, the commitment of staff, and that is right across the board, is not what it used to be…they choose to stay because they do love what they're doing and it is a family at the end of the day. (Facility manager)*

National Aged Care's pay rates were set nationally. The facility manager did not have much control over these. For example, she had to seek head office approval before increasing an employee's pay. The manager's perceived lack of instrumentality in pay

rates at an organisational and sector level meant that this issue was not addressed for employees. Low pay rates were seen as an issue created by 'the system' and one which could not be resolved by employees or National Aged Care.

Productivity and Performance

All facilities in National Aged Care were required to return a profit to the organisation. National Aged Care relied upon the outcome of quality of care, but only to the extent that it could be achieved without exceeding budgeted staff costs. Managers described productivity in terms of costs:

> *It always comes down to cost doesn't it? The priority is the resident, first and foremost, but the next thing would be keeping the cost down. We're always trying to be cost efficient. (Clinical manager)*

Quality of care related directly to the organisation's ability to attract new residents and keep full bed occupancy. Reputation for quality care was essential because their funding was reliant upon bed occupancy:

> *If your occupancy is low therefore there's not as much revenue and therefore you don't have enough to spend on good staff, equipment, whatever. If you have that good reputation you usually have a higher occupancy which means there is more revenue and whatever surplus you have can go back into maintaining your high standards. However, the margins are not a lot because we're a very underfunded industry. (Facility manager)*

Employees and managers were aware of the focus on National Aged Care's reputation for quality care. This, and full occupancy, were perceived to be indicators of good organisational performance. Indeed, the facility manager expressed their organisational goal was to be the best provider of care in the region.

The approach of trying to provide quality care with minimal staffing costs affected employees because it was the basis of work practices such as non-replacement of absent staff on a shift. Another way in which this approach to productivity affected employees was the way in which it guided the rosters. In order to minimise staffing costs, employees were employed as either part-time or full-time. They were not employed for

a set total of hours per week. This meant that when there was a change in bed occupancy, employees' hours could be changed. For example, a full-time employee could expect to be rostered for any number of hours greater than 35 hours per week, and up to 40 hours. This created flexibility for the organisation in the cost of staffing, but had considerable impact on employees who often struggled with low pay.

The facility manager perceived that funding had decreased proportionally over the year. The level of dependency among residents had increased significantly; regulatory requirements had increased yet there was not a similar increase in funding. The manager indicated that although there had been some increase to funding in the sector it did not amount to much in employees' wages:

> *So even though they might say we've had an increase of 1.7 per cent on the overall picture that equates to when you're talking about a caregivers increase about a 20 cent increase an hour which isn't a lot when you're already on a low wage. It might sound like big dollars but it's not coming through (Facility manager).*

The regional manager spoke of different productivity measures for National Aged Care. These included financial and non-financial measures. Profit was the primary financial measure. Non-financial measures included complaints, feedback and accidents to staff and employees.

Turnover was an issue that influenced productivity. The regional manager estimated that a new registered nurse would require at least six months from joining to be able to work at full capacity The cost of training new registered nurses, and the loss associated with them getting up to speed was approximately NZ$40,000. He suggested that the cost of losing one registered nurse and training up another was around NZ$80,000. It was therefore in the interest of National Aged Care to retain registered nurses.

The work conditions that encouraged retention also valued employees. The regional manager perceived that through looking after employees the organisation would also benefit from reciprocated goodwill. National Aged Care would develop a reputation as a good employer and they could then choose from the best of potential employees:

> *There's a lot of institutional knowledge within our staff. You want to retain that rather than training new staff. We can buy that level of knowledge but what we can't buy is expertise within our company and therefore you want to retain that wherever possible. And all of that falls back onto the bottom*

line. If you get those things right, if your staff are happy and you are the employer of choice it means the residents are getting very good service and we become the provider of choice. (Regional manager)

National Aged Care's key measures of productivity were quality of care and bed occupancy. These were underpinned by minimising staffing costs through, from an employee perspective, lean staffing levels. Training was important to productivity as it contributed to the standard of care that employees were able to give. Training also provided some incentive for the retention and recruitment of good employees. This, according to the regional manager, was essential to the provision of consistently good quality care.

Conclusion

Employees and managers had sometimes contrasting perceptions of National Aged Care. Generally, opportunities for employee participation were limited or non-existent. Employees did not have significant input into decisions that affected their working conditions. On the contrary, it would appear that some of the key concerns for employees, staffing levels and pay, were repeatedly passed over by management.

Management did not intentionally create poor working conditions. Rather, they felt constrained by the national policy of National Aged Care and also by the national context of residential aged care funding. The regional manager implied that National Aged Care was constrained by the funding available for residential aged care. However, none of the managers interviewed reported any action to improve the situation.

Employees' limited participation was evident in the absence of an OHS committee, despite national policy being to have OHS committees in all facilities. The OHS manager and OHS officer both perceived that there was a separate OHS committee. However, in practice OHS was treated as an agenda item on the 'all staff' meeting. This severely reduced independence from management in terms of participation and there was therefore a lack of representativity. The only OHS representative, apart from the OHS officer, was not aware that she held the role. The issues considered by the OHS officer were limited to physical hazard identification and remedy. He viewed stress, fatigue and workload as solely management concerns. Although he perceived that he was accountable to employees and followed up all concerns, employees felt that he did

not deal with the issues they raised. There was evidence that employees raised concerns over pay and workload that were continually passed over.

Union membership was relatively low. The facility manager felt that there would be little need for union representation if she did her job correctly and work conditions were good. The caregiver had previously been a union delegate but had resigned, indicating only limited workplace presence for the unions.

Opportunities for autonomy varied according to occupation. Registered nurses were encouraged to participate in decision making about care. The maintenance man and cleaner had some influence over how they did their work. Caregivers seemed to have little autonomy in their work, while managers were also constrained in some decision making by national policy.

Traditional productivity measures were inadequate for National Aged Care. Their primary productivity measure was bed occupancy – the primary source of funding – compared to the cost of provision of quality care. Full bed occupancy was achieved through a reputation for quality care in the community which in turn attracted residents. However, there was a tension between providing quality of care and maintaining low staffing costs.

Quality of care could not be provided without adequate staffing levels and training of employees. Adequate staffing levels would positively impact on quality of care in several ways: caregivers would have time to provide individualised care for residents over and above the essential physical care tasks; adequate staffing levels would reduce employee stress and fatigue. Employees indicated that minimising staff costs resulted in insufficient staffing levels much of the time. Employees reported considerable workload and stress.

Low pay rates helped maintain costs for National Aged Care, but they had a considerable negative impact on employees. Workload and pay were major issues for employees. Low pay rates were linked with poor work-life balance. Managers perceived that financial concerns in employees' personal lives created stress which employees brought to work. Low pay rates encouraged longer hours and consequent stress for some caregivers; some employees would work additional shifts in order to gain more money.

Managers felt that stress was often the result of an individual employee's choices around work. They saw stress as resulting more from pressures of personal life than

from work life. The managers were very aware that many of their employees were mothers. They tried to incorporate employees' personal circumstances when organising rosters. This was part of their 'hands on' approach to helping their employees with work-life balance and stress. The managers spoke of having to instruct employees to take leave when they became burnt out. They also closely monitored employees' shifts worked.

While low pay was an issue for National Aged Care, managers tried to show their appreciation of employees in other ways. Training sessions included information on dealing with domestic violence and getting support and stress management, for example. Managers would also try to maintain communication and be available for all shifts so that both managers were on call permanently. Management held events such as barbeques or morning teas. It was also perceived that the type of work, caring for people, provided some reward in itself for employees. The workplace was viewed by employees and managers as similar to family. However, lower staffing levels and higher workload created stress for some employees who found the workload prevented them from spending the time with residents that they needed to.

Overall, National Aged Care's productivity measures significantly impacted on employee wellbeing. Organisational outcomes were favoured over employee outcomes. A balancing act was evident so that quality of care could be provided with the minimum number of staff without jeopardising the standard of care. This approach was compounded by, or potentially caused by, a lack of employee participation in decision making in the workplace. Employees appeared to have little say on workplace conditions. The productivity approach taken by National Aged Care influenced both the way in which employee participation was implemented, and also employee wellbeing. This was a reciprocal relationship because employee wellbeing, in terms of lack of stress, was associated with the desired organisational outcome of a high standard of care.

Chapter Six: Not-For-Profit

Introduction

Not-For-Profit exhibited several of the characteristics of the residential aged care sector described in Chapter Four. It had an ethnically diverse, highly feminised workforce and was a large organisation that operated multiple residential aged care facilities around New Zealand.

This chapter presents the findings from the interviews conducted at Not-For-Profit and the analysis of organisational documentation (listed in Appendix 2). Firstly, an overview of the organisational context is given. The following two sections analyse employee participation at the Not-For-Profit facility: firstly, the effectiveness of the OHS committee as a form of representative participation is analysed; secondly the effectiveness of union representation, followed by the direct participation practices at the facility. The discussion of employee participation precedes sections that analyse different aspects of employee wellbeing: workload and stress, work-life balance, wellbeing, recognition of employees, training, and pay. The final section before the conclusion investigates Not-For-Profit's approach to productivity and organisational performance.

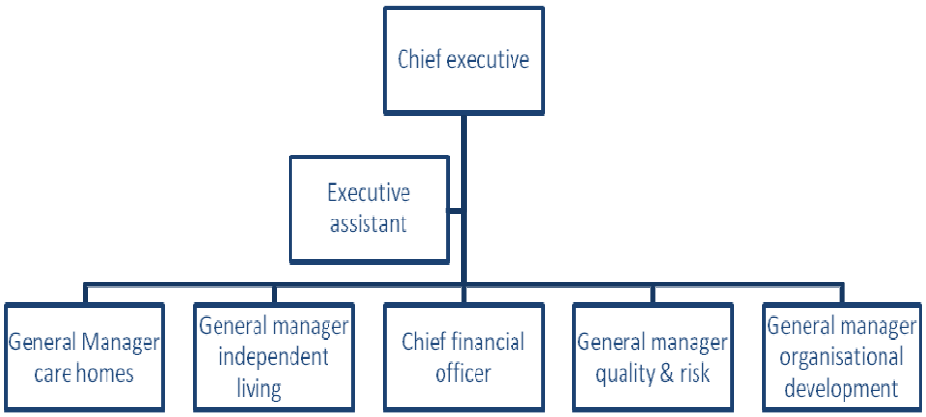
Organisational Context

Not-For-Profit was a New Zealand subsidiary of a multinational company. It operated independently from the parent company, but had to seek approval for major expenditure such as the acquisition of a new property. The New Zealand director of Not-For-Profit reported directly to the parent company managing director, who visited the New Zealand operations occasionally.

There were three arms to Not-For-Profit New Zealand. One of these was residential aged care. It has 45 residential aged care facilities in New Zealand with over 3,000 employees and around 3,000 residents in total. The general manager of residential aged care was based at the head office in Auckland. She was responsible nationally for the

financial performance and allocation of human resources within residential aged care (see Figure 6.1). She had five operational managers who reported to her.

Figure 6.1 Senior management at Not-For-Profit New Zealand



Source: Organisational documentation, Not-For-Profit New Zealand

The facility in which the research took place was based in suburban Auckland, which has a population of around 1.4 million people (see Figure 6.2). The facility had 67 beds in rest home, hospital and dementia care. In total there were 58 employees (see Figure 6.2) of which 86 per cent were female. The majority of employees at the facility were employed on a permanent full time basis. Part-time permanent employees comprised 36 per cent of all employees at the facility. There were no casual employees. As with National Aged Care, absences or temporary staffing shortages were dealt with by increasing the workload of existing employees or through existing employees taking on additional shift. The Not-For-Profit facility had an ethnically diverse staff with the two biggest single groups from the Philippines and from Fiji, very similar to trends indicated for New Zealand (Badkar et al., 2009). Other countries represented were African countries, Pacific nations, England, India and New Zealand. The facility had recruited overseas as well as locally for employees.

Figure 6.2 Key characteristics of the Not-For-Profit facility

Regional demographic information

- Located in suburban Auckland
- Auckland's population approximately 1.4 million: 56% Pakeha (NZ European), 11% Maori, 14% Pacific peoples and 18% Asian
- Median income for Auckland is $26,800 (national $24,400)

Not-For-Profit facility

- 67 beds (hospital, rest home and dementia)
- 58 total employees of which:
  - 3% managers
  - 2% administrative
  - 6% registered nurses
  - 2% enrolled nurses
  - 57% caregivers
  - 90% female
- Ratio of employees to residents is 0.87 employees for each resident

Source: Department of Labour (2011b); Organisational information, Not-For-Profit New Zealand; Statistics New Zealand (2009)

Interviews were carried out at both the New Zealand head office and an Auckland facility (see Table 6.1). The head office interviews were with the general manager of residential care services, the national facilities manager, the national OHS co-ordinator, and the head office OHS representative. The interviews conducted at the Not-For-Profit facility were with the facility manager, clinical manager, a registered nurse who was also the OHS representative, and a caregiver who was also a union delegate. In addition to interviews the anonymous survey was conducted at the facility. There were six respondents in total (response rate of just over ten per cent). All respondents were caregivers with the possible exception of one who did not specify their position. They were all female and four were in the age range of 31 – 50, with one aged younger than 30 and one aged older than 50. All the survey respondents were permanent full time employees at the facility.

Table 6.1 Interviews at Not-For-Profit

HEAD OFFICE INTERVIEWS	
General manager, residential care	• Postgraduate qualifications in health care management • Significant experience in health care management • Oversaw residential aged care operations in NZ
National facilities manager	• National OHS committee member • Responsible for properties in Not-For-Profit
National OHS co-ordinator	• Registered nurse • Responsible for injury prevention and management at Not-For-Profit New Zealand • With organisation three years • Chair, national OHS committee
Head office OHS representative	• Head office manager • OHS representative for almost 4 years • On national OHS committee
FACILITY INTERVIEWS	
Manager	• Not registered nurse • Some previous residential management experience • With organisation 3 years
Clinical co-ordinator	• Registered Nurse • Completing PG nursing papers
Health and safety representative	• Registered Nurse • Completing nursing papers to upgrade overseas qualification. • With organisation 2 years • OHS representative for 18 months
Union delegate	• Caregiver • With organisation approx. 4 years • Caregivers' union delegate • Previously OHS representative

Source: Author

Employee Participation in Occupational Health and Safety

There was a national OHS committee at Not-For-Profit as well as a committee at each facility. The national OHS committee met approximately four times a year via teleconference because of the geographical spread of members. It comprised management and employee representatives. There was not an employee representative from each facility. Not-For-Profit's OHS – Employee Participation Policy stipulated

that national union representatives would be on the committee but no mention of this was made in the interviews. Potential members of the committee were identified by the national OHS co-ordinator according to where she thought representation was needed. This somewhat limited the representativity of the committee.

The national OHS committee was not independent from management. The national OHS co-ordinator chaired the meetings. She held the position of chair because it fell under her substantive role in the organisation as OHS co-ordinator. She had designed the health and safety system around the Accident Compensation Corporation audit topics. This influenced the issues for the national OHS committee. The national OHS co-ordinator produced the agendas, which did have an 'other business' item which any member could add to. The OHS co-ordinator did have considerable influence over the issues discussed at the meetings. The national OHS committee dealt with strategic decisions such as responses to change in the regulatory and legislative environment. The national OHS committee could initiate and change policy for Not-For-Profit.

The national OHS committee representatives were not very accountable to employees. Communication from the national committee to employees was a regular point of discussion on the national OHS committee. Generally communication was via a newsletter which was sent by e-mail to the facilities. Caregivers did not usually have computer access in the facilities. Communication was therefore reliant upon managers printing the newsletter and communicating key points to employees. There was no training available for members of the national OHS committee.

The OHS – Employee Participation Policy stipulated selection of committee members and OHS representatives for facility OHS committees. The difference between members and representatives was that the OHS representatives were in accordance with regulatory requirements. OHS representatives could attend government funded representative training. However, there was a cap on numbers of OHS representatives according to organisational size.

The policy required a minimum of four members. These were to include an OHS officer, OHS representative and the facility manager. Representatives would serve for a two-year period and members and representatives were elected by secret ballot (OHS - employee participation policy, Not-For-Profit). However, the employees interviewed did not all agree that this was the case in practice. The registered nurse reported that she had been nominated and elected by employees. The caregiver however perceived that OHS representatives were chosen by the manager. The difference in experience over the

selection of the OHS representative was reflected in the thesis survey. The majority of respondents indicated that representatives were elected (see Table 6.2). At the Not-For-Profit facility, members were elected from each unit and included a night shift representative, indicating reasonable representativity.

Table 6.2 OHS committee and representatives

Is there a health and safety committee at work?						
	Yes		No			Total
No. of respondents	6		0			6
*Who is on the committee?** **Responses are greater than total respondents because multiple responses were allowed*						
	Employees	Line managers	HR staff	Senior management	Other	Total
No. of responses	3	1	1	3	1	6
If employees are on it, how are they selected?						
	Employees volunteer	Everyone votes	Management decides	Other		Total
No. of responses	0	3	1	1		5

Source: Thesis survey, Not-For-Profit facility

The meetings would usually take place during day shifts and weekdays. Any members who attended outside of their shifts would be paid for attendance. The OHS representative interviewed had been to a two-day training course for health and safety representatives.

Terms of reference for the committee included standard agenda items. There was a strong focus on hazard and injury prevention, informed by Not-For-Profit's annual objectives and goals for OHS. Members could raise any issues in addition to the standard agenda. OHS committees were expected to have active input into the facility's annual objectives for OHS. The facility manager was responsible for ensuring that the objectives were worked towards. This may have influenced the independence of the committee from management.

The OHS committee focused on hazard and injury management. However, as a result of OHS representative training, the registered nurse investigated accidents and injuries with a view to the role of broader working conditions, as well as the individual's

actions. She was aware that conditions such as insufficient staff or heavy workload may increase the likelihood of accident or injury. One example she gave was with the lifting of residents. Some back injuries occurred because caregivers did not follow policy to use two caregivers for heavy residents. However, their decision to lift a resident alone was guided by the number of residents they had to attend to and the availability of other caregivers to assist. Obviously, when workload was heavier and there were fewer employees rostered on, it would be easier to choose to lift a resident alone.

The registered nurse felt that the committee did not communicate effectively to the rest of the staff. The main form of communication was via the manager who would provide OHS committee updates in all staff meetings and in unit meetings. The facility manager however thought that the OHS representatives would address OHS matters with employees if they needed:

> *And the health and safety reps have I suppose been given the opportunity and the power to be able to sort of pull people up if they see that best practice is not being delivered. (Facility manager)*

The standard agenda included follow-up of actions as an agenda item. There was only one respondent who reported that they raised an issue for the OHS committee and they had an immediate response and were satisfied with that. However, while only that respondent reported an issue to the OHS committee, of all the respondents half reported suffering a work related injury in the previous three years. This suggests that the effectiveness for employees of OHS participation may be limited.

Other Participatory Practices

The relationship between Not-For-Profit and the two unions, the caregivers' and nurses' unions, occurred mostly at a national level. The general manager identified herself as the main point of contact in Not-For-Profit for the unions. She had expressed the view that a good working relationship existed with the unions. This had been challenged recently when the union organiser changed. She did not actively encourage union participation, yet perceived the benefits for the organisation when unions and Not-For-Profit worked towards similar outcomes.

Both the nurses' and the caregivers' unions were involved at Not-For-Profit and had negotiated a multi-union collective agreement. The general manager represented Not-For-Profit in negotiations for the collective agreement. The unions were not involved in policy at Not-For-Profit; they were merely advised of changes.

There had been one significant project on which Not-For-Profit and the unions worked on together through the Department of Labour Partnership Resource Centre and this was the development of a Career Path policy. This clearly articulated the skills, training, education and experience caregivers needed to move to the next level, including becoming a registered nurse if they chose to. Each level was attached to an increased pay rate. The existence of this policy therefore indicates significant input from the unions into the strategic planning of the organisation and of employees' workplace conditions, with particular reference to pay and training.

The facility manager did not seem to be as confident dealing with the union. Issues that involved the unions were escalated to head office. This may have been because the general manager was the point of contact for the unions. One example was given by the registered nurse. She had agreed to return early from parental leave because the Not-For-Profit facility was short staffed. However, she agreed to this with the request for flexibility in shift assignments so that she could manage childcare. She was not rostered the shifts she had asked for, however. The registered nurse wrote a letter requesting flexibility, following union advice in accordance with the Employment Relations (Flexible Working Arrangements) Amendment Act 2007). When the facility manager became aware that the union was involved she escalated the matter to head office.

> *So the union people advised me to write a letter to the manager and put it in writing. And the next thing I found she said we've got a meeting with the head office to discuss the issue. And I said, 'If an employee raises an issue, is this the way you reply? Because all I needed to know is a yes or no.' (Registered nurse)*

The caregiver felt that the facility manager was not averse to union membership. She felt that union involvement had improved working conditions at the facility. The clinical manager viewed the union as somewhere employees could go if they felt they were having trouble coping with their work, for a cup of tea and a break.

Other than union representation, thesis survey respondents indicated that there were several ways for employees to be involved in the organisation (see Table

6.3). The majority of respondents indicated team work as a means of being involved in the organisation. Team work, however, was not something mentioned by the employees interviewed, or by managerial staff. The only vague mention of it was related to the impact of absences on colleagues, and the need for caregivers to work in pairs to lift residents. There was no mention of employee representatives on boards or working parties, with the exception of the Lean Thinking Pilot, which is discussed later in this chapter.

Table 6.3 Participation at the Not-For-Profit facility

What other ways can employees be involved in this organisation?								
	Employee reps on boards	Team work	Problem solving groups	Quality circles	JCCs	Working parties	Other	Total respondents
No. of responses	1	4	0	0	0		0	5
I get information on important decisions, changes and future plans in due time								
	Strongly Agree	Agree	Neither	Disagree	Strongly Agree	Total respondents		
No. of responses	1	3	1	1	0	6		

Source: Thesis survey, Not-For-Profit facility

The general manager perceived a weakness in Not-For-Profit's lack of formal means for employees to be involved in the organisation. She spoke of the *in*formal means of communication from management to employees, and also in the other direction, upwards. Despite this perception the thesis survey indicated that most of the respondents felt that they received information on important decisions, changes and future plans in due time.

Communication of information centred on upward information from employees to head office with the purpose of improving work practices. There were both formal and informal means of doing this. The most significant formal means of upward communication was via Not-For-Profit's staff attitude survey. The survey had been carried out on an annual basis for the previous three years. It was an anonymous survey of all staff in the organisation. It was incentivised through a donation made to a charitable cause for each response received. The survey involved approximately 60 questions centred around ten key topics: leadership, service mission, adaptive culture,

management practices, job satisfaction, career development, team climate, group working, role balance and role clarity. Several questions related to various aspects of employees' perceptions of opportunities to participate in the organisation (see Figure 6.3). The national staff attitude survey had similar responses to the thesis survey carried out in the facility: nearly 70 per cent of respondents felt that they were sufficiently involved in change, and more than 70 per cent felt that they got all the information they needed to know from management and top 'leadership'.

Figure 6.3 Staff attitude survey – employee participation

• Employees are sufficiently involved when Not-For-Profit undertakes change	69.6%
• Top leadership communicates everything I need to know from them	73.2%
• My manager explains what is happening across the wider organisation	76.2%
• I feel free to communicate upward	73.9%
• My opinions are taken seriously at work	80.0%
• I have enough say over how I do my work	78.5%

Source: Staff Attitude Survey 2009, Not-For-Profit

Apart from the staff attitude survey, Not-For-Profit relied upon informal means of communication. The properties manager, OHS co-ordinator and the general manager all spoke about ideas that would 'percolate' or 'filter' upwards from employees at the different facilities. This in practice meant that if ideas or issues were circulating repeatedly among employees at a site they would be communicated to head office or senior management either via a site visit by senior management or facility managers communicating them. Employees would have the opportunity to provide feedback on draft policy, especially if it related to employees.

The general manager included communication directly with senior management as a means of communication for employees. She gave an example of a woman who felt comfortable ringing the chief executive directly:

> *There was a senior caregiver in West Auckland who has no problem in picking up the phone and ringing the chief exec and he'll take the call and he'll handle them very nicely. So whilst there's not a formal thing there's a good track record of people being able to call. (General manager).*

However, this employee was noted as 'senior' and was perhaps someone with extensive experience and more confidence in the organisation. Direct communication with management did pose problems for the registered nurse interviewed. She was a migrant worker with English as her second language. She came from a culture where it was not appropriate to directly communicate with senior management:

> *Another time when the CEO came I wanted to ask him for leave, but I said, 'Oh God, I can't be trouble'… for me I can't communicate with the head office…Maybe if that scenario happens it might be considered more like a complaint because you know you want to formalise it with the communication channel… You know the way I was trained I often go to the clinical manager and then if they don't resolve them… (Registered nurse)*

In contrast to this experience, the Not-For-Profit staff attitude survey indicated that 73.9 per cent felt free to communicate upwards, bypassing their immediate manager. Similarly, 80 per cent in the staff attitude survey felt that their opinions were taken seriously. There were clear differences between what happened at the facility where the research took place and the organisation overall.

The clinical manager mentioned that some employees preferred to raise issues face to face, rather than to fill out a form. One reason for this, she felt, was because 'they don't want to write anything because people will blame them for something' (Clinical manager). Some employees also felt uncomfortable writing in English. It was important to the clinical manager that she had a good relationship with employees and therefore she kept an 'open door policy' for any employees who wanted to approach her. The clinical manager was also 'on the floor' for large periods of time and talked with employees frequently.

Employees' experiences of participation varied according to their professional status or role within Not-For-Profit. For example, the manager and department heads seemed to have more input into national policy than employees. When asked about opportunities for employees to participate in Not-For-Profit the manager described a number of ways in which she was involved in the organisation, rather than her employees. She was a member of a number of nationally based committees. There were also the regular meetings she had with the department heads where they would discuss any policy updates that they had received. These updates would then be communicated to the employees. Perhaps because of her own experience of participation the manager of the facility felt that involving employees was integral to the organisation:

I guess one of the philosophies here is total inclusion and participation of everyone. And I would say more of the changes have come about through people on the floor giving feedback. (Facility manager)

The Not-For-Profit staff attitude survey indicated that the majority of employees nationally were satisfied with the amount of influence they had on how they did their work. They were also satisfied with communications upwards and from managers to employees (see Figure 6.3). This was similar to the responses to the thesis survey at the Not-For-Profit facility. The thesis survey showed that two thirds of respondents had significant influence on how much work they do. Furthermore, all respondents felt they had significant influence on how they do their work (see Table 6.4). However, two thirds of respondents agreed that they should have more influence at their place of work. This could imply that employees did not have influence over some of the workplace conditions.

Table 6.4 Influence at the Not-For-Profit facility

I have significant influence on how my work is done						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total
No. of responses	2	4	0	0	0	6
Do you have significant influence on how much work you have to do?						
	Always	Often	Now & then	Rarely	Never	Total respondents
No. of responses	2	2	1	1	0	6
I should have more influence at my place of work						
	Strongly Agree %	Agree %	Neither %	Disagree %	Strongly Disagree %	Total respondents
No. of responses	1	5	0	0	0	6

Source: Thesis survey, Not-For-Profit facility

The caregiver indicated that lack of influence on working conditions was an issue. Under the collective agreement, employees were not guaranteed a set number of hours' work per week, in the same manner as National Aged Care (Chapter Five). They were employed as either full-time or part-time. Full-time hours were considered to be anything above 32 hours per week. Employees could be rostered for any number of

hours within this range. The caregiver, who was also the union delegate, reported that nobody got 40 hours per week, however. When bed occupancy lowered, the manager would respond by cutting the number of hours employees were rostered to work. The consequence of this was that employees did not have a stable, guaranteed income. Their pay could change every six weeks with the roster. She explained that while not all of the employees were happy with this 'the girls didn't get anywhere with arguing about it' (Caregiver). The caregiver and the registered nurse both reported occasions when employees had no influence over their working hours, which could be consistent with a workplace in which the employees had little influence on other workplace conditions as well.

Employee Wellbeing – Workload and Stress

Financial concerns, caused by low pay and variable hours, emerged as a strong theme for employee wellbeing. Low pay was a source of stress for employees, as was workload and staffing levels. Low pay and associated stress created difficulties for employees' work-life balance. Employees at Not-For-Profit had limited influence on their workplace conditions, particularly the hours that they worked. This limited influence created potentially stressful situations for employees. However, the clinical manager and the national OHS co-ordinator perceived that stress was often brought from home. The caregiver felt that stress was a significant health and safety concern because the work involved care of frail people, and therefore any mistake made by a stressed employee could have significant consequences.

The facility manager and caregiver agreed that the work could be emotionally difficult. Working in the dementia unit had more potential for stress. Furthermore, the union delegate felt that the physically and emotionally hard work combined with low pay could be a source of stress.

The facility manager did not view workload as a source of stress for employees. She believed that the facility had sufficient employees. They had established an adequate ratio for calculating the number of employees required per resident. She perceived that this was working well and would not change overall. The clinical manager did remark that temporary staff shortages could create stress. She would help out when this occurred:

> *Occasionally we get short of staff but that's where I pitch in you know. I do caregiving as well so when we're short staffed I'll come and help them feed and help them get residents up. So the stress thing sometimes we bring it from home to work, sometimes vice versa but probably not much at work because we've got enough staffing on most days. (Clinical manager)*

The registered nurse did not agree that staffing levels were adequate. She thought that low staffing would be one reason behind accidents and injury during manual handling. The general manager perceived that the funding for residential aged care influenced staffing levels and workload. She believed the industry was underfunded. Furthermore, she perceived that the quality of care Not-For-Profit delivered was excellent value compared with the funding they received.

One example of the way in which workload was viewed by Not-For-Profit was the 'Lean Thinking Pilot' they had implemented in two of their facilities, including the one at which this research took place. The aim of this had been to identify inefficient work processes and create more staff time. The pilot identified an additional two hours' time per day for each resident that had been freed up through the systematisation of tasks. The general manager felt that the pilot confirmed her beliefs that staffing levels were sufficient, but that work processes could be improved.

Low pay impacted on employees' stress levels because in order to earn sufficient money employees would take any additional shift that was available. This would lead to fatigue and stress. Financial pressures were indicated as a source of stress by the national OHS co-ordinator and also the facility manager:

> *I don't know if this is peculiar to the industry or peculiar to here, but there are sort of financial pressures as well. We had the budgeting service come in and give an in-service about budgeting and some of the pitfalls of seeking financing for example. Because I've noticed that that represents quite a pressure on the staff. (Facility manager)*

There was a difference between the number of hours that registered nurses and caregivers worked. Caregivers had variable hours, often not 40 hours per week. The registered nurse interviewed had enough hours and worked five days a week. However, she too pinpointed a lack of hours of work as a source of stress for the caregivers. She was aware of this because she arranged cover for a shift when employees called in sick. Caregivers let her know that they wanted more hours and would work at short notice. A

reasonable proportion of respondents to the thesis survey worked overtime (see Table 6.5).

Table 6.5 Workload and stress at the Not-For-Profit facility

How often have you felt stress?						
	Always	Often	Now & Then %	Rarely	Never	Total respondents
No. of responses	1	2	0	3	0	6
Do you think your work takes so much of your energy that it affects your private life?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	2	2	0	2	0	6
How often have you felt really tired from work?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	2	2	2	0	0	6
Are you required to work overtime?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	3	1	2	0	6
Do you have more work to do than you can accomplish in one shift?						
	Always	Often	Now & Then	Rarely %	Never	Total respondents
No. of responses	3	1	1	0	1	6

Source: Thesis survey, Not-For-Profit facility

Despite management viewing workload and staffing levels as reasonable, the survey indicated significant occurrence of stress among employees. Work also affected the energy levels that employees had for their personal lives. The majority of respondents also had more work than they could complete in one shift (See Table 6.6). The experience of respondents contrasts with the Not-For-Profit Leave Policy which states that 'all employees need time for recuperation, rest and relaxation'. There were, overall, different perceptions of workload and stress.

Employee Wellbeing – Work-Life Balance

There was a contrast between employees' experience and managerial perceptions of workload and stress. Stress was also seen by managers to be usually caused by home or family issues rather than work issues. The perception that stress was brought to the workplace from home resonated with the interviewees' ideas and experiences around work-life balance. There was a strong sense that it was an individual's responsibility to manage work and personal commitments, expressed by the caregiver and managers. The caregiver felt that although employees took extra shifts out of financial need, they also had to consider their family commitments. Management were passive rather than active in their approach to aiding work-life balance. They identified operational constraints, noting that shift work enabled some flexibility for employees.

Financial issues were mentioned throughout the interviews, and this clearly impacted on employees' work-life balance. Caregivers' financial constraints were also raised in discussion of work-life balance by the clinical manager who mentioned that they have several social events for their employees each year:

> *Some people perhaps because of financial restraints they haven't got any social life so what we've done this year is to go out in teams and we pay for their dinner. (Clinical manager)*

The facility manager suggested that work-life balance was integral to OHS. It was important for keeping employees fit for both home life and work. Consequently some of the work-life balance initiatives she had used in the facility included Zumba and yoga classes at work. This view of work-life balance was shared by the national OHS co-ordinator who noted that Not-For-Profit had held a pedometer wearing competition.

Not-For-Profit was responsive only to critical incidents rather than supporting work-life balance on an ongoing basis. The facility manager mentioned that they had given time off at short notice for family situations. The general manager also referred to unplanned family events, and financial difficulties:

> *We're very good, to be honest, about people who've had significant events. A number of our staff were impacted by tsunamis in the islands and a) we made a significant donation, but also I do a lot of financial cash advances for staff. So you know, my mother's died in the islands and I need to get back for the funeral. (General manager)*

However, flexibility on an ongoing basis was created by employees picking up extra shifts when they wanted, rather than organisational policy. The general manager confirmed that there was no formal policy on work-life balance and that operationally there was not always much they could do. They could not have a clear policy on it because the residents' needs took priority. Operational reasons often prevented flexible working.

Just as managerial perceptions and employee experience of workload and stress differed, so too did managerial and employee experience of work-life balance at the facility. The properties manager was satisfied with how he achieved work-life balance. He acknowledged that the responsibility of his role meant that at times he worked very long hours. However, the benefits of his role were that he chose when he worked and how he did his work. He was not aware of any formal policy on work-life balance, but knew of a colleague who had been able to relocate to another New Zealand city and remain in the same position in order to meet his family needs. From these experiences the properties manager felt strongly that Not-For-Profit was concerned with and willing to take action on employees' work-life balance and family needs.

Employee Wellbeing- Mental Health

Employee wellbeing entailed happy and contented employees, according to the general manager. It was influenced by the home life of employees, such as an argument with a spouse. Happy and contented employees were crucial because that would affect the quality of care delivered:

> *I mean I think one of the things for me is that they are able to interact in a positive way with the residents. (General manager)*

One way in which Not-For-Profit kept their employees happy was the aforementioned Career Path policy. They had also guaranteed that there would be no redundancies for a year during the recent recession.

The general manager felt that it was important for Not-For-Profit to give a lot of recognition to employees because the pay rates were low. She mentioned service awards for employees who had been with the organisation for two, five, 15, 25 and 30 years. Head office employees had morning tea supplied and a weekly fruit bowl in the staff room. The facility manager described several informal means of recognising employees at the facility. One was specifically for OHS performance, with a quarterly award for

the employee who had displayed excellence in health and safety practices' (facility manager). The facility manager perceived that meals out and occasional barbeques showed management's appreciation. Some impromptu recognition occurred in response to specific events such as when the facility received a satisfactory survey report and the facility manager organised a wrapped single rose for each employee. Employees received shopping vouchers when they had done really well or 'gone the extra mile', as the facility manager put it, based on a compliments register or the manager's or clinical manager's observations.

The clinical manager at the facility hoped that employees felt valued. She personally felt valued as an employee in part because Not-For-Profit paid for her postgraduate nursing studies. The caregiver and registered nurse however felt that the small rewards given did not show real appreciation of employees. They generally perceived that little was done overall to show that employees and the hard work they did were appreciated.

Overall, managerial perceptions of wellbeing and recognition at Not-For-Profit were to promote happier employees who would then provide higher quality of care. Not-For-Profit also tried to compensate for low pay rates through recognition and rewards. The employees interviewed did not feel that the recognition of their work was genuine, but the thesis survey did indicate that a majority of employees at the facility felt their work was appreciated by management (see Table 6.6).

Table 6.6 Appreciation of employees at the Not-For-Profit facility

My work is strongly appreciated by management						
	Strongly Agree	Agree	Neither	Disagree	Strongly disagree %	Total respondents
No. of Responses	1	4	0	0	1	6

Source: Thesis survey, Not-For-Profit facility

Employee Wellbeing - Training

Training was viewed as integral to Not-For-Profit's performance and was perceived to influence the quality of care given:

> *One of the indicators around staff that we have is that we have to have a certain percentage of staff enrolled in training programmes because we're*

working on the assumption that better trained staff means better care for the resident which is higher quality. (General manager)

Key components of training at Not-For-profit were the Core Education programme designed to meet regulatory and organisational requirements; the national aged care qualification; orientation; ad hoc training in response to needs; and the newly introduced Personal Best programme specific to the organisation. Training was linked with career progression and salary steps in the Career Path policy, and had a strong customer service focus overall.

The Core Education programme was delivered through in-service training sessions at facilities and all employees were expected to take part in these. The topics covered by the training were mostly skills based, and all topics centred on skills and knowledge required for the job (see Figure 6.4).

Figure 6.4 Core Education programme at Not-For-Profit

Areas covered:

- Abuse and neglect
- Communication
- Challenging behaviour
- Code of rights
- Privacy and dignity
- Informed consent
- Cultural awareness
- Falls – assessment, prevention and management
- Health and safety
    - Chemical safety
    - Accident and incident reporting
    - Emergency procedures
    - Fire safety
    - Infection control
- Privacy and dignity
- Restraints
- Manual handling
- Ageing process
- Death of a loved one
- Medication management and administration

Source: Caregiver Training Programme, Not-For-Profit

Many of the topics in the Core Education programme also contributed to the national qualification in aged care. Not-For-Profit encouraged employees to study towards the

national certificate, aiming to have more than half of all employees complete it. Course fees were paid for all caregivers who had been with Not-For-Profit for six months or more. Most of the work on the aged care qualification was to be done either on the job or through self-directed study in the caregiver's own time. Self-directed study may have discouraged employees on two counts: firstly the emphasis on written English may have disadvantaged some caregivers because of literacy or language issues; secondly, the course work was added into already busy jobs. Some of this was addressed in the Not-For-Profit Caregiver Training programme, which stated that support was available to employees who had difficulty with the reading and writing component. Caregivers were able to access organisational support to continue education after the caregiving qualification to progress to a Bachelor of Nursing. This did happen in practice, according to several interviewees.

In addition to the schedule of topics and training sessions in the Core Education programme, ad hoc training sessions would be implemented according to perceived needs or issues that had arisen in the facilities. These training sessions were known as quality improvement days and would focus on an issue that had arisen from the facilities. The clinical manager referred to them as 'corrective action plans'. The issues may have been identified through a cluster of complaints or an audit process. One example was training that focused on the nutritional requirements of dementia patients. This was in response to Not-For-Profit becoming aware that some registered nurses did not know how to calculate the nutritional requirements, and were uncertain when to seek outside assistance from a dietician or other specialist.

Training at Not-For-Profit had a clear customer service focus, as noted above. This was most obvious in the Personal Best programme. The general manager explained that this was more about improved customer service than encouraging or recognising employees:

> *Aged care does become quite task focused and it can be very, very routine… And so personal best looks at well, how do I make the most of what I'm doing? So somebody showers you, has a little chat, talks about something relevant. It makes a lot of difference from somebody scaring the living daylights out of you because they haven't said anything to you, for example. But then I might be a resident who doesn't like people to talk to me when I'm showering. So it's about knowing them and taking the time to find out those things (General manager).*

Personal Best was referred to as a training programme and was part of the Core Education programme. However, that the progamme is described as being 'about recognising and rewarding all employees who put the resident/customer at the centre of everything they do' (Personal Best, Not-For-Profit). Its focus was on behaviour that contributed to continuous improvement in customer service and referred to 'a continuous improvement journey'. It states that:

- Employees who feel appreciated are more positive about themselves and their ability to contribute.
- Timely recognition will enhance positive feelings.
- Motivated employees are encouraged by their success and contribution. (Personal Best, Not-For-Profit)

Personal Best required employees to identify a 'project' that would improve customer service. This was in addition to their existing tasks. There were four levels of achievement in the Personal Best programme: bronze, silver, gold and legend. Employees would receive financial recognition when they achieved gold status. The final 'legend' level would only be awarded to those who were nominated and had 'consistently given of their Personal Best within their Care Home/Business Unit over time' (Personal Best).

Chapter Four discussed the way in which aged care is still viewed as unskilled work even though the knowledge and skills required have increased with the dependency of residents. The national OHS co-ordinator recognised this tension, particularly with respect to the amount of education and training expected of caregivers at Not-For-Profit. Furthermore, she indicated a tension between the actual skills and knowledge required of caregivers, and the persisting perception of the job as a low skilled job:

> *It's an unskilled thing but you're looking after people. And people, it's not like a block of wood. It's the unknown stuff, the cognitive stuff, the physical ability stuff, it's all that stuff. If you don't put all that stuff together in a sequence and go, 'This is what I've got and this is how I need to manage the situation' then you set them up for failure. (OHS co-ordinator)*

Training was linked to salary increases in the Career Path policy. There was also some reference overall to benefits to employees from training. These benefits did not compensate for the low pay rates and thus financial concerns were significant for employees. These issues were raised by both employees and managers in terms of stress, work load and work-life balance. The general manager acknowledged that pay

was not high, but that Not-For-Profit was reasonably well placed, possibly above average, within the industry for caregivers' pay rates.

Not-For-Profit had worked on career progression linked to skills, training and education. As caregivers moved through the levels they would receive incrementally higher wage rates. The general manager also expressed that while caregivers were not paid a lot, Not-For-Profit could offer stability in times of recession. She hoped this would help with employees' satisfaction. Although employees might feel certain that they had a position at Not-For-Profit at the facility level, they did not have guaranteed weekly hours.

The national OHS co-ordinator and facility manager were both aware that employees had little money. The national OHS co-ordinator gave the example of a caregiver who could not afford to retire:

> *She wanted to come into the workplace and she was, I'd say about 65, couldn't afford to leave work, look after herself. It's very sobering to see what people really, really have to struggle with when they come to work for us and I just, I take my hat off to them. (National OHS co-ordinator)*

However, neither the national OHS co-ordinator nor the facility manager made the connection with the socio-economic status and the low pay that Not-For-Profit and the sector paid to their caregivers. Generally there was little said about pay levels at Not-For-Profit, with the exception of the caregiver. She had the most to say on the matter and mentioned that the union was trying to improve pay scales across the sector. She explained that employees doing similar work at the district health board were paid at a higher rate. The union was trying to gain higher rates and parity with the district health board. The caregiver viewed the caregivers' union as instrumental in obtaining the pay rates that they had at Not-For-Profit. She perceived that the difference in pay rates between the district health board and residential aged care was because of profit imperatives:

> *The DHB [district health board] think they are giving out enough [funding]. It's the private sector. They want to make a profit at the workers' expense. (Caregiver)*

Productivity and Performance

The previous sections have shown that organisational outcomes take precedence over employee outcomes in participation at Not-For-Profit. The outcomes of quality and quality improvement were central to Not-For-Profit's organisation, as evidenced in the 'Quality Programme' organisational policy:

> The organization recognizes the value and importance of Continuous Quality Improvement (CQI) and is committed to ensuring initiatives and opportunities are identified in order to enhance Quality in all departments and services. (Quality Programme, Not-For-Profit)

Not-For-Profit based their quality measurements on the Baldridge framework which comprises seven areas including leadership, strategic planning, customer and market, process management, business results, measurement and analysis, and human resources. The purpose of the human resources area of the framework was 'how the business unit/organisation enables its workforce to develop its full potential and how the workforce is aligned with the organisation's objectives' (Quality Programme). Table 6.7 outlines the human resources measures which included Core Education completion, vacancies, recruitment, orientation, and staff incidences.

Table 6.7 Employee related KPIs

KPI	Definition
Education – Core Education	Ratio of employees completed compared to target number
Personal Best	Actual employees completed compared to target number of completions
Annual performance appraisals	Timeliness of completion, number completed compared to number due
Manual handling	Reduce incidents related to manual handling
Staff costs	Ratio of staff costs against revenue
Agency usage	Actual agency cost versus total staff cost as %
National qualification	Total number of staff enrolled in ratio to total staff

Source: Combined Balance Scorecard, Not-For-Profit

All employees were responsible in their roles for CQI and this explains the focus of the Personal Best programme which operationalised employees' involvement in and

commitment to CQI. Personal Best was one of the key performance indicators for Not-For-Profit's Combined Balance Scorecard. The registered nurse remarked that Not-For-Profit encouraged everyone to be involved in quality improvement, and mentioned Personal Best as part of that.

Each facility measured their performance against the Combined Balance Scorecard targets. Their performance was reported to the head office regularly and benchmarked against the other facilities nationwide. Although there was some emphasis on the development of employees, the focus was on efficient use of human resources. The general manager mentioned that she believed the industry was underfunded, and that the quality of care they delivered for the funding they got was very good. However, there was also room for more efficient working processes:

> *And I think this is where we've gone for a quality model believing that that will lead to better quality and lower cost. I also think there's more to, it's interesting how inefficient some people can be and I mean it's quite interesting. We did a lean thinking pilot. I mean it was just fascinating to see when people analysed it they actually reconfigured how they did the breakfast service and it saved two hours a day. (General manager)*

As noted above, the Lean Thinking Pilot took place in two of Not-For-Profit's facilities, including the one where this research took place. The facilities were chosen for their high level of functioning, not because it was anticipated that they would need major improvements. Not-For-Profit employed a consultant to run the pilot, which involved identifying 'what tasks the carer and RN [registered nurse] roles carried out during a twelve hour day' (Lean Thinking Pilot). Some of the early results were that standardisation of tasks and processes reduced the time taken by employees on those particular tasks. Communication processes were clarified which led to an improvement in communication which was 'an unexpected consequence of the pilot' (Lean Thinking Pilot).

The pilot had been mentioned as a form of participation for employees by the general manager. However, as a form of participation it was very limited as employees had little or no say in the direction of the pilot because that was pre-determined. The pilot was run by an external consultant with little mention of employees providing input into how it progressed. The pilot was perceived to be successful in that it identified inefficient work processes and it 'found' two hours of time per resident per day in which quality care could be delivered. One outcome were 'blue sky' workshops that brainstormed a

list of characteristics of a good facility from the employee perspective, in essence the employees' organisational vision, and outcomes they wished to achieve (see Figure 6.5).

Figure 6.5 Employees' perspectives of a good facility

Why are we here?

- Providing quality of care
- To get paid
- Life of residents
- To learn

What does that mean?

- Spending time with residents
- Smile & listening
- Giving them something to look forward to
- Communication – their lives, their stories

What should a good facility look like?

- Well paid
- Clean, tidy &homely
- Individual care
- Full occupancy
- All working the same way
- Friendly
- Safe & secure
- Good staff/resident relationship
- Happy residents/happy staff
- Dedicated, manners, respectful
- Policy & procedures understood & used
- Staff well trained
- Good staffing levels
- Respectful of cultural differences

Source: Adapted from Lean Thinking Pilot, Not-For-Profit

The caregivers' primary motivation was to provide care, followed by earning money. Many of the ways in which they understood quality of care were those activities which above all else require time and, logically, higher staffing levels. The caregivers wanted to spend time with residents, smile and listen, and communicate with them. Not-For-Profit wanted to achieve the same outcomes, but through more efficient use of their staffing, rather than through increasing staffing levels to allow more time for caregivers to spend with residents.

Quality of care was important, but what drove the business was bed occupancy. The properties manager indicated that this was one measure of meeting Not-For-Profit's goals. He thought that they aimed for about 94 per cent of their beds occupied at all times. The reputation and appearance of the facility was important in this because:

> *People will take their mum or dad or grandparents to different facilities and look at what condition they are and we're very big on the first impression people get when they walk through the door because that's where they make their mind up. (Properties manager)*

The need to maintain a high as possible level in bed occupancy was also mentioned by the head office OHS representative. Although she did not work in a residential aged care facility, she was very aware that 'so long as there aren't any empty beds then we're being successful for the business side'. (Head Office OHS representative). The facility manager also thought that reputation for quality of care was very important to Not-For-Profit:

> *You know our core business is residents who come in and mostly it's by reputation. So there's an obligation on us to make sure we don't spiral out on our costs. But there's also an obligation to make sure that we're at the very least abiding by the rules of our contract and beyond that we need to deliver good care in order to have a good reputation in our community and there's a huge emphasis on that. (Facility manager)*

However, while bed occupancy was very important for funding, it was not a required measure for the quality assessments. Overall, Not-For-Profit's approach to productivity was to use a balanced scorecard and measure a variety of organisational outcomes. As a not-for-profit organisation it did not need to make a surplus to return to shareholders; surpluses would be reinvested in the business. The general manager did not mention occupancy in relation to organisational outcomes or productivity.

Conclusion

The key performance measure for Not-For-Profit was quality of care. This impacted on employee participation because the participatory practices were centred on initiatives aimed at improving quality of care. Consequently there were limited opportunities for

employee participation at Not-For-Profit. The two representative participation practices were OHS committees and union representation. Direct participation was limited to information sharing and some job autonomy. Organisational intentions for employee participation were to strengthen organisational performance, again measured through improved quality of care.

Information sharing was mainly on an informal basis: senior managers visited sites from time to time; there was evidence of an open door policy in the facility; and employees were able to directly contact senior managers if they wanted to raise an issue. These forms of communication were not utilised by all employees; some felt unable, because of their own culture or understanding, to contact senior managers directly without first speaking with their immediate manager. Job autonomy was limited to influence over how much work was done, and how the work was done. Employees had little control over the number of hours they worked or the particular shifts that they were rostered on to. An annual attitude survey also operated to convey organisational expectations and culture as well as to gain employees' opinions and attitudes towards Not-For-Profit.

Representative participation took the form of a national OHS committee, facility OHS committees, and union representation. These had limited effectiveness for employees, especially the national OHS committee: there were employee representatives on the committee but they were chosen by management. There was no training available for representatives, and little other support and expertise. The national OHS co-ordinator decided the issues to be considered in the meetings which centred on organisational outcomes. She also chaired the meetings and dominated the discussion. Communication to employees was only via managers who disseminated information. There was little accountability of representatives to employees. The national committee did have the potential to change and create OHS policy.

The facility OHS committee was more effective for employees than the national committee: there was good representativity of employees on it. Representatives were elected to the committee, with one from each department, including a night shift representative. However, independence of the committee was limited because the agendas were initiated by the manager who was also the committee chair. Representatives received regular training which did influence their approach to workplace issues on the OHS committee. The OHS committee communicated to other employees through the manager at all-staff and departmental meetings. Minutes of the

meetings were available in the staff room. The representatives did communicate with employees at daily communication meetings and were accountable to employees.

Union representation occurred primarily at a national level. The general manager was the main contact for the unions for Not-For-Profit. Union representation was limited to collective agreement negotiations with little or no input into Not-For-Profit policy. There was one exception to this: the development of the Career Path policy which linked training and education to salary progressions for caregivers. Union involvement in its creation indicated significant strategic involvement. This was however limited to that one occasion. The manager at the facility did not actively discourage union membership but appeared to be uncomfortable dealing with union representatives. This resulted in the manager escalating any issue with union involvement to head office level.

Not-For-Profit's measures of organisational performance, ultimately quality of care, impacted on the way in which employee participation was implemented. Participatory practices were within bounds set by management. Management was represented on the OHS committees. Even the union representation was controlled by the general manager who was the primary contact for unions in Not-For-Profit. No other managers dealt directly with the unions on a regular basis. Other organisational performance measures, such as meeting Accident Compensation Corporation obligations, were a strong influence on representative participation and provided clear direction to the way the OHS committees operated.

Overall, employee participation at Not-For-Profit did not have a significant effect on employee wellbeing. Employee wellbeing was not a top priority for management in itself. Wellbeing was only important as far as happy or healthy employees provided improved quality of care. The general manager believed that the training and rewards that they had for employees compensated for the low pay. Management was cognisant of positive employee outcomes of initiatives such as the Career Path policy, the training programme and the Personal Best programme. However, the objectives of these initiatives were to improve organisational outcomes such as improved efficiency and improved quality of care. Organisational outcomes were prioritised over employee outcomes and management had only a shallow awareness or acknowledgement of the effect of low pay and the uncertain hours on their employees. Consequently, some of the factors that employees considered crucial to their wellbeing, such as higher pay rates

for caregivers, regular and consistent weekly hours, and flexibility in rostering, were not given due consideration by management.

Chapter Seven: Religious Care

Introduction

Religious Care was a not-for-profit organisation, and it conformed with the New Zealand research that shows that not-for-profits have better staffing levels than private, profit based organisations. Religious Care had a higher employee to resident ratio than the National Aged Care facility, and a greater number of registered and enrolled nurses than the other case organisations.

This chapter begins with an overview of the organisational context. The remainder of the chapter is divided into discussions of representative participation, other forms of participation in the organisation, wellbeing and productivity. Employee wellbeing is discussed in relation to workload and stress, physical health, work-life balance, training and work conditions.

Organisational Context

Religious Care is a not-for-profit Catholic residential aged care facility. It had originally been operated by nuns, but a decline in the number of nuns meant that secular managers and employees replaced them in the 1990s. Religious Care remained a Catholic organisation and mission and objectives of the organisation (see Figure 7.1) were strongly rooted in the faith of the founding nuns who intended to be ‘a supporting and life-giving presence in the world’ and to bring a ‘healing presence of Christ to all they meet, in compassion and solidarity’ (Organisation History, Religious Care).

Figure 7.1 Religious Care's Mission

The Mission is to make visible the healing presence of Christ in the midst of human suffering in union with Mary on Calvary by her example and prayer, compassion and solidarity and by:

a) Upholding the fullness and sacredness of life;
b) Reverencing the value, culture and integrity of each person, especially the dying;
c) Being a nurturing and life-giving presence in today's world and by upholding the moral position of the Catholic Church in the operation of [Religious Care];
d) Providing a centre of excellence in health care;
e) Providing for the care of the aged, the sick and the dying for the benefit of the people of [the district] without regard to religious affiliation.

Source: Religious Care Mission Statement, Religious Care

Religious Care had 67 residents in hospital and rest home care, and an additional eight independent flats. It was run by a charitable trust overseen by a board of directors. The board of directors comprised seven men and two women who predominantly represented business owners in the area. All policy required the ratification of the 'chairman' of the board of directors. The manager reported that two members from the board of directors had also been involved in collective agreement negotiations. This involvement in policy suggests strong influence from the board of directors over workplace practices and conditions. Prior to the current manager beginning at Religious Care, a consultant had been used to advise on human resource and OHS policy and procedures. The use of the OHS consultant had been discontinued with the appointment of the current manager.

The current manager had been in the role for approximately 18 months at the time of the research. When she took up the role absenteeism and turnover had been high. There had also been difficulty in staffing weekend shifts. The manager had instigated a number of changes to employment practices, including negotiations and rosters. She spoke about herself as acting in opposition to the board of directors' wishes, particularly in reference to collective bargaining and staffing levels. Interestingly, the current manager had been on the board of directors until she took on the role of manager. This was not divulged during interviews at Religious Care, but found by the researcher in information on Religious Care as a legal entity (Companies Office New Zealand, 2011). One interpretation of how the manager positioned herself in opposition to the board of directors is that the manager was, as a former member of the board, already aware of the

work conditions and wanted to change them and therefore changed her role. This could explain her confidence in 'defying' their wishes.

Religious Care was situated in a small city of approximately 54,000 (see Figure 7.2). The city was not as ethnically diverse as some other areas in New Zealand and had a lower median income than the national median (Statistics New Zealand, 2009). Unemployment there was lower than the national unemployment rate also (Department of Labour, 2011b). In terms of competition and the need for elderly care beds, this city had a 'serious' shortage of hospital level beds, with all being occupied the year prior to this research taking place. This is in contrast to the National Aged Care and Not-For-Profit facilities which were located in Auckland, where there is more competition for residents.

Figure 7.2. Key characteristics of Religious Care

Regional demographic information

- Located in a small city of approximate population 54,000
- Population: 78 % Pakeha, 13.7 % Maori
- Median income for the city was $22,000 (national $24,400)
- Unemployment rate for city was 4.5%

Religious Care

- 67 beds (hospital and rest home)
- 85 total employees of which:
  - 2% managers
  - 4% administrative
  - 8% registered nurses
  - 14% enrolled nurses
  - 40% caregivers
- Union membership 67%, mostly nurses' union
- Ratio of employees to residents is 1.4 employees for each resident

Source: Department of Labour (2011b); Organisational information, Religious Care; Statistics New Zealand (2009)

Religious Care had a total of 85 employees (see Figure 7.2 above). A large proportion of these were caregivers and 97 per cent were female. Most of the employees were part-time. Religious Care had the highest proportion of casual employees of the four organisations. The general manager had developed a pool of casual employees that she could draw on to cover staff shortages. This meant that she had casual employees who were experienced at working at Religious Care. Some of these casual employees wanted

casual work and some took casual shifts in order to better their chances of getting a permanent position should vacancies arise.

Interviews were conducted with the manager of Religious Care' the clinical co-ordinator; an enrolled nurse; and the pastoral carer. Both the manager and the clinical co-ordinator were new in the organisation, which had for the previous five years been under a manager whom the employees had not always got along with and who had reportedly left after a nervous breakdown. It is possible that those experiences influenced the employees' perception of management, which overall was very good.

Table 7.1 Interviews at Religious Care

Manager	• With organisation 18 months • Registered nurse • First management position • Previously union delegate
Clinical co-ordinator	• With organisation for 8 months • Registered nurse
Enrolled nurse	• OHS co-ordinator • OHS representative for about 8 years • With organisation for 15 years • Union delegate
Pastoral carer	• With organisation for 13 years • OHS representative • Provided support to residents and their families

Source: Author

The interviews took place over two days at Religious Care. The researcher was granted full access to organisational policy and meeting minutes stored in the manager's office, and permitted to copy them. During the two days one of the organisation's weekly hikes took place, and also an OHS committee meeting, both of which the researcher was invited to join. The interviewees, apart from the manager, were not particularly confident and two did make comments similar to 'Is that what you wanted to hear?' during the interview. Even the OHS co-ordinator who was proud of her experience and knowledge had little to discuss on workplace issues, as did the pastoral carer. This

situation may have arisen from a lack of confidence at the workplace under previous management, or it could reflect a perceived power imbalance in the research process.

The survey at Religious Care had a small number of respondents, totalling six. These respondents had the greatest proportion of registered and enrolled nurses out of the surveys at all four organisations (two respondents of six) and administration positions. Only one caregiver responded with one respondent not specifying their position. The respondents all held permanent part-time positions and were all female. Two respondents were aged over 50, and the remainder were between 31 and fifty years of age. Five of the respondents worked weekly hours between 26 and 39 hours, and one worked 40 or more hours per week (a registered nurse).

Employee Participation in Occupational Health and Safety

The OHS committee met monthly, although the manager intended to reduce the frequency of meetings. Membership of the OHS committee included two formal positions, OHS officer and the OHS co-ordinator. As well as these the manager and clinical co-ordinators were members. The terms of reference also allowed for representatives from each department. Most respondents of the thesis survey indicated that they thought that employees and senior management were on the OHS committee (see Table 7.2), concurring with the membership noted in meeting minutes.

Table 7.2. OHS Committee and representatives

Is there a health and safety committee at work?						
	Yes		No		Total respondents	
No. of responses	6		0			
*Who is on the committee?**						
	Employees	Line Managers	HR Staff	Senior management	Other	Total respondents
No. of responses	6	2	1	6	0	6
*Number of responses adds to more than six because multiple answers were allowed						
How are employees selected?						
	Employees volunteer	Everyone votes	Management decides	Other	Total respondents	
No. of responses	5	0	1	0	6	

Source: Thesis survey, Religious Care

Although each department was represented, caregivers were not well represented in committee membership. Caregivers comprised 40 per cent of all employees but did not have similar representation on the OHS committee. Management and office holders comprised four of 14 positions, registered and enrolled nurses two positions, administration and other service areas had five representatives, and there was a maximum of four caregivers on the committee (Health and Safety Questionnaire; Health and Safety Meeting Minutes, Religious Care). Caregivers have a significantly lower representation on the OHS committee than is suggested by the proportion of caregivers among total employees. This is significant because, as noted in Chapter Five, caregivers in the sector are generally undervalued, have low pay (less than maintenance and administrative employees) and have limited influence at a sector level.

The terms of reference noted that a quorum of five members present was required before the meeting could go ahead which would mean that reasonable representation would be required for decisions to take place. The meetings took place during work time on weekdays and there was no mention of the inclusion of night shift or weekend employees on the committee and it appeared that all members worked on week days.

Elections for representatives took place if more than one person from each department wanted to be on the committee and each representative held the position for 12 months (see Figure 7.3 for membership). However, most of the representatives on the committee had in practice been in the role for a long time.

Figure 7.3 Membership of the Health and Safety Team

- If there is more than one person in an area who wishes to be on the Health and Safety Committee an election will take place
- Selected committee members hold office for 12 months with the right of renomination
- Should a vacancy arise this is to be filled by a staff member from the same department
- Other staff may be co-opted/invited, according to interest and area of experience
- The following are members of the committee:
- *Nominated Health and Safety representatives from*
    - Hospital
    - Residential
    - Laundry/flats
    - Kitchen
    - Administration
    - Pastoral Carer

  Management Representatives
    - Manager
    - Health & Safety Officer/Maintenance Officer
    - Health and Safety co-ordinator

Source: Terms of Reference for the Health and Safety Team, Religious Care

In practice nomination happened by 'shoulder tapping' and representatives continued to hold office until they resigned, without having an annual formal nomination or voting process. The OHS representative suggested that there was not a lot of interest from employees in being on the OHS committee and so whoever expressed interested usually became a representative:

> *Normally they put a notice out and say, if there's a position available but nobody seems to put their name up, so they're kind of gently tapped on the shoulder and persuaded! [Researcher: Would that be the manager who persuades them or one of the committee?] Probably one of the committee that you think you could work with you know? And that has got quite a good standing with the other staff so that they can get them on side. (Enrolled nurse)*

The thesis survey showed similar responses to the OHS representative's statement. They indicated that the majority thought that employees volunteered to be on the OHS committee (see Table 7.2). Interestingly, none of the respondents thought that representatives were elected, suggesting a perceived lack of influence on who the representatives were.

Despite the perceived lack of input into who their representatives were, there was some accountability of the representatives. Each was readily identified by name badges and the names and photos of all the OHS representatives were displayed in the staff room. The enrolled nurse felt they were accountable to employees and that employees would follow up issues quite quickly with the representatives:

> *Staff are pretty quick to point out anything that's wrong. They know the people to go to, and if it's not fixed they're pretty quick actually to tackle you. (Enrolled nurse)*

This was confirmed in the organisation's hazard and incident reports. There was only one survey respondent who had raised an issue for the OHS committee, which does not give a broad indication of the workplace. The main forms of communication between the committee and other staff were via notice boards and minutes in the staffroom, some reporting back to departmental meetings, and a biennial health and safety week with activities and competitions designed to raise awareness of health and safety in the workplace.

The manager chaired the meetings, but was not heavily involved in the committee as she was occupied with establishing herself in her role. This appeared to have the effect of enabling the committee to be reasonably autonomous:

> *People can add to it [the agenda] and bring other things to it. I have to admit because I've been so busy when it comes to the meetings they tell me the meeting's on and I really need more time to do it, you know, preparation. (Manager)*

The clinical co-ordinator was also new to health and safety and so the representatives perhaps had more influence than they otherwise might. While this lack of involvement of management in OHS may have caused difficulties if they did not support initiatives, it appeared that both the manager and the clinical co-ordinator were supportive of the committee and employee initiatives. The OHS co-ordinator felt that she had a lot of say in the committee because she had considerable experience and knowledge in health and safety. She had been involved in all five Accident Compensation Corporation audits that Religious Care had undergone. During the meeting there did not appear to be any reluctance of employees to voice their concerns or raise an issue even if it did not directly concur with the manager's opinion. Furthermore, the representatives provided

comment and feedback to the manager on health and safety aspects at other meetings and in non-meeting contexts.

All OHS committee members had access to training. Terms of reference stipulated that the committee itself agreed on the training scheme for its members. The enrolled nurse had completed three levels of representative training. In addition to formal OHS representative training, the OHS committee had a member who was also a part-time employee at the local public hospital. She was involved in infection control at the public hospital and shared the information she gained from that with the OHS committee at Religious Care. The administrative person provided resources to the committee with respect to the preparation of agendas and recording of minutes.

All interviewees reported that the OHS committee could change policy if they wanted to. This could be because the manager was on the committee, but organisational policy indicated that the committee did have some influence. For example, the organisation's Occupational Health and Safety Policy was issued by the Health and Safety Team.

One of the key health and safety objectives identified in Religious Care's Quality and Risk Management Plan was to 'ensure that the Annual ACC/WSMP [workplace safety management practices] Self assessment tool has sufficient information that identifies how the standard criteria is met'. Religious Care had just attained tertiary level in the workplace self management programme. Additionally, the committee was to aid the organisation in meeting their regulatory OHS obligations, including the contract with the district health board. The terms of reference for the committee itself included setting health and safety objectives, knowing the relevant legislative requirements and standards, and reviewing OHS 'data'. These goals impacted on the issues covered by the OHS committee and how participation in OHS was manifested at Religious Care.

The meetings were heavily focused on injury and accident reporting. This was taken seriously and seen as a very important role of the representatives and the committee:

> *[Items include] your accident investigation, you have to have everything documented. There's continual education, questionnaires. We have monthly meetings, we have hazard controls, we have any new equipment like we have reports on new equipment. (OHS co-ordinator)*

The constant reviewing of incident reports and looking out for potential hazards seemed to give a sense of importance and busy-ness to the representatives. The OHS co-ordinator stated:

We've never had a major accident. We've had a few back injuries but I mean I think that's just the nature of our occupation actually. (Enrolled nurse)

It is interesting to note that the OHS co-ordinator, while viewing OHS as very important to the organisation, also accepted a certain level of injury as part of the job. This finding, combined with the clinical co-ordinator who was responsible for accidents and injury reporting and investigation not having a background in health and safety, suggests that there was only a limited integral OHS culture at Religious Care. Despite this none of the survey respondents reported feeling threatened at work or having experienced violence at work in the previous three years, and only one respondent reported a work related injury in the previous three years.

While accident prevention and injuries were a strong focus of the committee, physical health was also important. The OHS co-ordinator felt that one of the biggest things the committee had achieved was that employees' physical health had improved. They had recently started a hiking group and a netball team that were sponsored by Religious Care, and had held a 'Biggest Loser' competition where employees were weighed and had blood pressure checked regularly. As part of the focus on health, Religious Care had also introduced healthier food and were having fruit for morning teas rather than muffins. The importance of physical health to Religious Care was apparent in a Health and Safety Information for New Employees document:

> Health is an important part of your 'Health and Safety' at work. Try to ensure you get regular exercise, enjoy a balanced diet and get enough sleep (a minimum of 8 hours is recommended). (Health and Safety Information for New Employees, Religious Care)

However, there was little mention in meeting minutes of stress and workload issues as part of health and safety, which was contradictory to organisational documentation. Religious Care's Occupational Health and Safety Policy referred to the Health and Safety in Employment Amendment Act 2002 and defined harm as physical or mental harm, and hazards including mental fatigue. Stress and fatigue were more clearly defined and identified as hazards in the 'process relating to hazard identification' (see Figure 7.4) and 'the management of fatigue and stress will be identified as a hazard in all areas and recorded in hazard registers with controls to minimize' (Occupational Health and Safety Policy). The one mention of stress in the OHS committee minutes was the mention of an employee who was nominated for the health and safety recognition award one month because she had offered to take on extra shifts when

people were off sick. The minutes noted that her extra work relieved the stress of her colleagues (OHS committee minutes, Religious Care).

Figure 7.4 Definition of stress and fatigue as hazards

Fatigue is defined as:

The temporary inability, or decrease in ability, or strong disinclination to respond to a situation, because of previous over-activity either mental, emotional or physical.

Stress is defined as:

Interaction between a person and their (work) environment and is –

a) The awareness of not being able to cope with demands of one's environment.

b) This realisation is of concern to that person, in that both are associated with a negative response.

Source: Occupational Health and Safety Policy, Religious Care

Chapter Four of this thesis indicated the role that Accident Compensation Corporation and the Health and Safety in Employment Amendment Act 2002 may have on employee participation. Both Accident Compensation Corporation and the legislation require participation of employees in health and safety and these influences were noted in the organisational documentation. Religious Care's Occupational Health and Safety Policy stated that one of the manager's responsibilities was 'to ensure there is a robust employee participation system in place'. In addition, the policy noted that 'health and safety representatives at [Religious Care] agreed at the health and safety meeting to forward [Religious Care's] Health and Safety Policy to their unions for approval'. There was also provision for the union representatives' signatures on the policy. Another document that appeared to encourage participation and involvement of OHS representatives was the Stress Hazard and Controls document, which stipulated that:

> A person who wishes to raise an issue around stress in the workplace should contact any member of the Health and Safety Committee who will discuss their concerns and accompany the person to a meeting with management where the parties will endeavour to work through the problem. (Stress Hazard and Controls, Religious Care)

It also outlined the training requirements for OHS representatives, which appeared to allow some influence for OHS representatives on the committee to ensure they have appropriate training and education for their roles.

Other Participatory Practices

Union density at Religious Care was high at approximately 67 per cent compared to around 30 per cent for the sector nationally (caregivers' union and nurses' union representatives, 2010), and this was because the manager had encouraged employees to join the union. Most of the employees (49) were members of the nurses' union and only eight members of the caregivers' union. The manager herself had been a union delegate in her previous positions at the public hospital, as had the clinical co-ordinator. It was not clear why more employees were members of the nurses' union, but the greater proportion of enrolled and registered nurses and the manager's background possibly influenced the union the employees chose to join. The manager encouraged union membership by requiring those on individual employee agreements to each negotiate with her should they want a pay rise, rather than Religious Care automatically passing on the conditions of the collective agreement. The manager had done this in response to the unions' request, but also because she felt that dealing with the union was more efficient than negotiating with employees individually.

> *When you're doing negotiations it was actually easier I think instead of having people on all sorts of individual agreements to have nurses and caregivers on collective agreements. It makes it a bit more cohesive and I think it works better… (Manager)*

The manager, because of her experience with unions, did not perceive them as a threat to her managerial position, but as useful and potentially more efficient in managing her workforce.

Under previous management, collective bargaining had been more adversarial. Religious Care's negotiating team had included the manager, a lawyer and board representatives. When the current manager began she responded to the union's request to negotiate without the lawyer present. This went against the board's wishes, who had difficulty trusting that she could successfully negotiate with the unions. The manager had also approached the union beforehand to agree a set of issues in order to facilitate

quicker negotiations. This suited her organisational outcomes. The unions agreed on the basis that the following negotiations would address some unresolved issues in the agreement. While the manager encouraged unionism and spoke about her negotiating with the union as being flexible and open to issues, rather than 'claims' based negotiating, she took an approach that very much put her in control of unionism in Religious Care. When she spoke of talking to the unions prior to the negotiations, it was as someone who was setting the ground rules rather than someone who was open to suggestions.

Despite the manager's apparent encouragement of unionisation at Religious Care there was not significant indication that the unions were involved in the workplace other than during collective agreement negotiations. The Accident Compensation Corporation audit report in 2009 remarks on several occasions that there were good relations with the unions. One example is that the election of employee representatives on the OHS committee had been agreed to by both unions, and that the OHS representative training courses were those provided by the Council of Trade Unions (Accident Compensation Corporation Workplace Safety Management Practices Programme report for Religious Care, 2009). Another indication of union relations in the report was that an employee focus group 'was positive about the working relationship with the Unions involved on site' (Accident Compensation Corporation Workplace Safety Management Practices Programme report for Religious Care, 2009). However, none of this was mentioned in organisational policy, including the terms of reference for the OHS committee.

The OHS co-ordinator/union delegate at Religious Care felt that relations with the union were fine. New policies were shared with the union before they were implemented, according to the union delegate. She did not report any ongoing issues from members, and felt that the manager was amenable to the union and approachable, so that when an issue arose in the workplace she would address it directly with the manager, only taking it to the union if it remained unresolved:

> *if I think something wasn't right I'd come back to management first actually because I always think it's nice to go through management and if it wasn't dealt with here, then yeah. (Enrolled nurse)*

She felt comfortable in approaching the manager with any issue that arose at the workplace. This was also expressed by the OHS representative and the clinical co-ordinator. The manager herself operated an 'open door' policy and this was in evidence during the interview with her which was interrupted on several occasions by employees

coming with queries, and also with suggestions and comments. One example was the maintenance officer who approached the manager with a health and safety concern over new equipment that they were considering purchasing. Although the 'open door' policy was being used, the manager's work hours were usually Monday to Friday during the day, so night shift and weekend employees would not necessarily be able to take advantage of it.

Some information sharing practices were indicated in the Organisation Wide Quality Risk Management Plan, which stated that all employees had the responsibility and right 'to be informed about contractual, legislative requirements and personal responsibilities through a culture of information and appropriate training'. It also listed the regular information sharing meetings that occur in the facility (see Figure 7.5), including departmental meetings, occupational groupings, and OHS meetings. There was a regular senior management team meeting which any employees could attend and raise issues at.

Figure 7.5 Information and other meetings at Religious Care

Regular meetings

- Unit Information sharing meetings
- Registered nurses/enrolled nurses meetings
- Caregiver meetings
- Senior staff operational meetings
- General staff meeting (6 monthly)

Monthly meetings

- Leadership and management team
- Safe environment and health and safety teams
- Clinical audit review quality team

Source: Organisation Wide Quality Risk Management Plan, Religious Care

Communication was clearly important, and in addition to the open door policy and meetings, other forms of communication used at Religious Care were a communication book for updating information on residents and task related information, and a notice board. Communication did appear to be effective for employees and the OHS co-ordinator/union delegate felt that employees were included in planning and policy at the facility. She gave the example of a project to build a new hospital building. She felt that

employees had had input into the plans for the building which had been displayed in the staff room. Employees had also had the opportunity to give feedback on those plans. The survey responses confirmed this, with 100 per cent of respondents agreeing that they get information on important changes in due time. Organisational policy did not strictly agree with this perception in terms of policy development and there were clear statements that 'organisation wide management policies and procedures are the responsibility of the manager' and 'policies and procedures that relate to contractual and legislative requirements are developed and reviewed by the manager' (Organisation Wide Quality Risk Management Plan). The broad coverage of 'management' policies included policy that may affect employees, such as leave, staffing ratios and workload.

Although it appeared that employees were involved in major plans, they were not always consulted about changes to work practices and processes. The manager and clinical co-ordinator had recently introduced a change in the allocation of residents in the hospital wing. This meant that the caregivers would have to work with the same residents for a period of three or four days per week, rather than changing who they worked with more regularly. The purpose of this, from the managerial perspective, was to improve the quality of care. This was a managerial initiative and although the manager and clinical co-ordinator discussed their proposal with employees, it was only with the registered nurses, not caregivers:

> *[The manager] and I talked about it and then I did a wee notice…I have a board [showing the residents] and I rearranged the board and showed them how to set it out. I set it out the way I thought; discussed it with a couple of RNs [registered nurses] over a few days; got the feedback that it's never going to work and so it was sort of jostled around a wee bit and it pretty much just works. (Clinical co-ordinator)*

This process had not been entirely successful and some of the caregivers had failed to implement the change, unilaterally deciding to continue allocating residents the way they previously had, particularly on nights and weekends.

The survey responses accordingly indicated some restrictions on participation: respondents identified only team work as a way of being involved in Religious Care; and four responded that they neither agreed nor disagreed that they should have more influence (see Table 7.3). Interestingly, all respondents felt that they had significant influence on how they did their work, which is evident in the above example.

Table 7.3 Participation, information and autonomy

What other ways can employees be involved in this organisation?								
	Employee reps on boards	Team work	Problem solving groups	Quality circles	JCCs	Working parties	Other	Total respondents
No. of responses	0	5	0	0	0	0	0	5
I get information on important decisions, changes and future plans in due time								
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents		
No. of responses	0	5	0	0	0	5		
I have significant influence on how my work is done								
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents		
No. of responses	1	5	0	0	0	6		
Do you have significant influence on how much work you do?								
	Always	Often	Now & then	Rarely	Never	Total respondents		
No. of responses	0	1	3	2	0	6		
I should have more influence at my place of work								
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents		
No. of responses	0	1	4	1	0	6		

Source: Thesis survey, Religious Care

The survey and some interview comments indicate that employees did have some autonomy in their work in that they could decide how they did their work, and to some extent how much work they had to do (see Table 8.4). The manager had actively been developing her employees' confidence so that they could make a decision without the need to call her to check:

> *The staff weren't good at making decisions but I've encouraged them that if I'm not here and they make a decision we'll go through with it. And if it happened to be the wrong one we'll work out how to right it... (Manager)*

The interviewees all felt confident that the manager would support them in their work, and was approachable for raising any issues in the workplace. There was some evidence of information sharing and consultation, evidenced in the planning of the new hospital

wing described above. There were also indications that unionisation was encouraged and evidence of Religious Care involving the unions in OHS. It would therefore seem that representative participation was stronger than direct participation at Religious Care. One important aspect of this case organisation is that both the surveys and interviews were predominantly with enrolled and registered nurses and administration, the researcher could not therefore discover whether caregivers have the same levels of satisfaction with the participatory practices available to them. This pattern occurred in the OHS committee, where it appeared that caregivers were not represented in proportion to their overall numbers. Furthermore, the union that most members joined was the nurses' union (representing nurses, and often caregivers) rather than the caregivers' union (representing caregivers but not nurses). There is the possibility therefore that employee participation at Religious Care was greater among, and more open to, administration and nurses than caregivers.

Employee Wellbeing – Workload and Stress

Some of the themes that arose in interviews most often were those of good staffing levels and moderate workload in relation to employee wellbeing. This section discusses those themes as well as work-life balance and employees feeling valued at Religious Care. As noted in the previous section, the manager had taken action to increase unionisation and also the decision making of employees. This was in part because she believed that if employees were well looked after, then they would provide good quality care. One aspect of looking after her employees was easing the workload of employees. The manager had increased staff numbers since beginning in her role and aimed to have sufficient employees on duty so that they would have some periods of 'downtime'. She felt that this would mean that even if they were experiencing a busy period, they would know that it would not be long until the workload would ease a little. The manager reported that since staffing levels had increased Religious Care had gained a reputation as a facility that had good and safe staffing. The consequence of that was that the facility had a waiting list of potential employees for when vacancies arose:

> *The word has gone around very quickly that we have a good staffing and it's a safe staffing so that when people come they're not working at a high level all the time. You know in rest homes people work at a certain level and*

it doesn't change... So they're happy now because if they're busy today in a day or two it quietens down and it's made a massive difference. (Manager)

The manager also used a strategy whereby she had a pool of casual employees who were available to work shifts when needed to cover permanent employees' absences. The manager found this approach worked because it meant that the workload did not increase as much when employees were absent, and Religious Care would then also get replacement employees who were familiar with the organisation. Although she did not specifically mention it, the use of regular casual employees rather than sourcing from a nursing bureau would be more cost effective.

Table 7.4 Workload and stress

	Are you required to work overtime?					
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	1	1	3	1	6
	How often have you felt stressed?					
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	0	4	2	0	6
	How often have you felt really tired from work?					
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	2	2	2	0	6
	Do you have more work to do than you can accomplish in one shift?					
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	0	4	2	0	6

Source: Thesis survey, Religious Care

Table 7.4 shows responses to survey questions about workload and stress. These responses indicate that overall workload was acceptable, with four out of six respondents having more work than they could accomplish 'now and then', and a similar response rate for feeling stressed. These responses corroborate the manager's view that staffing levels were good through indicating that while workload may occasionally be high, it was not so consistently

There were conflicting perceptions of stress. The clinical co-ordinator perceived that staffing levels impacted on stress. She also felt that the increased physical activities contributed to the improved mental health of employees. However, overall she felt that stress was something that was brought from home. Residential aged care work in general had become more stressful over the years, she felt, with residents' illness-level and dependency increasing when they entered residential aged care

The enrolled nurse felt that stress was taken seriously at Religious Care. Employees could approach the priest or pastoral carer or raise concerns with their OHS representative. Senior employees had been instructed to advise the clinical co-ordinator if they thought that any employee was stressed. There was informal support from colleagues who would help out with workload if an employee was stressed. She also felt that there was support from the manager to relieve stress.

> *Just recently we've had quite a lot of hospital admissions, you know like there's no beds in hospital so residential has to have them. And residential runs on a fairly skeleton staff and we're not used to dealing with people that can't walk or you know... We quickly knocked on [the manager's] door and said 'we can't cope we need more staff'. So she's increased the hours so we can manage. (Enrolled nurse)*

Employee Wellbeing – Physical Health

Stress and workload were issues that the interviewees did not discuss in-depth. They were more interested in, and felt able to discuss, the relation of physical activity to health and safety in the workplace. The manager had encouraged employees to take up physical activity through several initiatives supported by Religious Care. A hiking group and netball team had been established. Some of these activities were initiated by employees. Religious Care provided some administrative and resource support such as the use of the facility's van to transport employees to the sports or hiking venue. Both

the manager and employees interviewed spoke about these activities enthusiastically and felt that the physical activity improved morale, stress levels and health of employees. Taking part in the activity also helped to build social relationships between employees, and several employees had shown increased self-confidence:

> *When I first came one of the, the man in the kitchen was very removed I found. Could barely speak to me and was quite anti. Well he's taken us out on a tramp [hike] and come on the Kepler [three day hike] and he's great and he'll do anything. And he'll have a great time and he chats with people...going out like that gives everybody, especially women on their own they can do it without feeling uncomfortable, that's part of it. (Manager)*

The OHS co-ordinator spoke of how the majority of employees were now taking part in physical exercise and that it helped employees get to know each other, and broke down barriers between them. There was also a positive impact on the workplace in that employees were more willing to work, and had increased energy levels.

Increased social ties in the workplace were a benefit of the group physical activities that were organised at Religious Care. These social connections may have contributed to awareness among employees of the personal circumstances of their colleagues. This was not restricted to women with small children, but included women who were older and were single through divorce or widowhood, and women who had elderly parents to care for. The enrolled nurse noted that Religious Care was a small organisation and the city it was in was small also, and felt that this meant that employees knew a lot about each other's personal lives. In the workplace the awareness of each other's personal circumstances meant that there was support for employees who had to collect children or meet sick parents at short notice. The employees also ran raffles to fundraise so that when a colleague had a special family occasion or bereavement they could buy them flowers or a gift. The OHS representative, who was also the pastoral carer, saw it as part of her role to be familiar with the employees:

> *It's to take an interest in them and befriend them kind of thing because if they have a problem I like to think they can come to me and talk about it. (Pastoral carer)*

However, it is interesting that even in the role of pastoral carer, the OHS representative had little to say about social connections, work-life balance or stress among employees in the organisation.

Employee Wellbeing – Work-Life Balance

The manager made efforts to accommodate the domestic lives of her employees, particularly those with young children, because she could remember how difficult she had found it trying to juggle shift work as a registered nurse with raising her own children. She commented on several issues that arose for her employees, and one of those was the lack of support from their partners. One employee had had to change her shifts because her husband did not want her to work and would not help out with childcare, so the manager worked with her to change the shifts so that she could fit them in around her childcare responsibilities. The enrolled nurse had experience of asking to change her shifts, and this had been done successfully. When asked if her shift changes might affect other employees, she felt that they would not because the manager was willing to work with all employees to roster shifts that suit:

> *I didn't want to do afternoons and I was able to cut out my afternoons. I didn't want to do weekends because… I thought I'd done my share of weekends. So I just wrote a letter saying I didn't want to do weekends and waited for the bomb to drop but that was fine. And I actually think if one shift really doesn't suit you they will really try to accommodate. (Enrolled nurse)*

As well as providing individual flexibility when employees raised issues over the shifts they worked, the manager also changed the way that the rosters were implemented. This was against the board of directors' wishes. She implemented a fixed roster rather than a rolling roster (four days on, two days off) because she thought that the rolling shift, the board of directors' preference, was extremely difficult to manage for those employees with childcare responsibilities. The manager of Religious Care found that if employees with childcare responsibilities had the shifts they needed then absenteeism would be lower and it would also create a sense of mutual helping out:

> *the girls that have childcare I give them the hours they want, the hours they can work. And they are fair. They have come back to me and they will do extras on the weekends when their husbands are home. And I believe, by giving them what they really needed, not so much what they wanted, they wouldn't take so much sick leave.. So I went against the board that way and did my rostering that way. (Manager)*

There was an element of managerial instrumentality in organising the employees' work. In several instances the manager had 'talked employees into' reducing their hours or taking leave. The manager commented that she was giving the employees what they needed, not what they wanted. Overall, the manager was concerned with maintaining good staffing levels and reasonable workload.

Employee Wellbeing - Training

As well as investing in increased staffing levels, Religious Care had increased the budget available for staff training. The clinical co-ordinator oversaw the training of employees. The Staff Education and In-Service Training Policy stipulated the regular training that would be provided (see Table 7.5). This training was largely provided in-house, and the in-service training was designed to meet the regulatory requirements of eight hours' training per year for nurses and seven hours' per year for caregivers.

Table 7.5 In-service training topics

Training topic	**Training provided by:**
Mission integration	Incorporated into the course of their work
CPR, first aid and emergency procedures updates	Registered nurses only on a two yearly basis – external provider
Food and Hygiene Certificate updates	Kitchen employees, by dietician
Infection control	Infection control officer
Chemical safety	Provided by chemicals supplier
Manual handling	Physiotherapist

Source: Staff Education and In-Service Training, Religious Care

Caregivers were able to study for the national aged care qualification and one of the registered nurses co-ordinated that. Study was largely conducted through self-directed learning which would be done in the employees' own time. Some of the time for caregivers to study towards their qualification would be paid for by Religious Care, and all fees would be paid. There was no mention of any other learning support for caregivers, aside from 'Competency Reviews' for each module carried out by the

'Education Officer' who would also complete the final checklist for the qualification to ensure that all areas were covered. While this education had been available to caregivers prior to the current manager, the enrolled nurse remarked that the current manager had made more training available to caregivers than the previous manager:

> *Actually since our last manager's come here she's actually incorporated the caregivers to do quite a lot of training which was always sort of broken to the trained staff and I think that's made a big difference. You know because really training's training isn't it and it should be open to all staff. (Enrolled nurse)*

Employee Wellbeing – Work Conditions

Increased training for caregivers had impacted positively on the employees themselves, as well as the work they were doing. Employees' confidence had improved and they had a better understanding of their work, and the enrolled nurse felt that it helped 'make them feel better about their jobs'. The manager shared the view that while training was a cost to Religious Care it was beneficial to them, so long as it was relevant to the work that the employees were doing. She had increased the amount of money spent on training since she had started in the position. She had managed this through savings from discontinuing the use of a consultant. The manager did have some discretion in how she managed the budget.

Survey responses indicated that generally employees felt valued at Religious Care. Two four out of six of the respondents agreed that they were appreciated by management and two 'neither agreed nor disagreed' that they were appreciated (see Table 7.6). Furthermore, all respondents felt that Religious Care was a 'good workplace' and all indicated that they did not 'often think of leaving my job'. The manager was perceived to be supportive. The enrolled nurse felt valued and would not have stayed if she did not. Feeling valued, according to her, was associated with feeling pride in the work and in the reputation of Religious Care. The reputation of Religious Care was such that despite a shortage of registered nurses, the manager stated that she had had no difficulty in recruiting new registered nurses. The clinical co-ordinator said: 'The word on the street is that we're the best. That's the feedback we keep getting.'

Table 7.6 Satisfaction with the workplace and conditions

My work is strongly appreciated by management						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total Respondents
No. of responses	2	2	2	0	0	6
Do you agree that your work 'is a good place to work'?						
	Yes	No	Not Sure %			
No. of responses	6	0	0	6		
Do you agree with the statement that 'I often think of leaving my job'?						
	Yes	No	Not Sure			
No. of responses	0	6	0	6		

Source: Thesis survey, Religious Care

The sense of pride and belonging was encouraged by the manager, and in an application to owners' association for the Excellence in Care Awards, the goals for the healthier employees were explained as: 'our objective was to motivate staff, build morale, self esteem and develop leadership and teamwork while providing a health lifestyle'. As noted above, the projects that comprised this were the 'Biggest Loser' competition and weekly hikes. The application indicated that employees across all sections of Religious Care were involved in the initiatives, as well as 'community providers' who donated goods for prizes and events.

In contrast to what is found in the sector overall, there was little mention of financial issues or pay. This could be because the employees interviewed did not represent caregivers, often the lowest paid. However, the OHS co-ordinator/union delegate did mention that in the previous round of collective agreement negotiations they had agreed to a $40 shift allowance for the weekend. This had, in her opinion, significantly improved attendance on the weekends, and employees were more willing to take an extra weekend shift to cover shortages or absences. It is significant that Religious Care had a reputation as a good workplace, attracting employees even from the public hospital, particularly as district health board pay rates generally are higher than those in the residential aged care sector. It could be inferred from the good reputation of Religious Care among prospective employees that its pay levels must at minimum meet the average paid in residential care facilities. The manager did mention that, particularly with the increase in staffing levels, the amount spent on wages had increased dramatically to about 60 per cent of total expenditure. This is comparable with general

industry figures indicated by the nurses' union representative in Chapter Five. Further, the median wage in the city was lower than the national median, and therefore what might be considered a low wage in Auckland, for example, may not be perceived as such by employees in the city in which Religious Care is located.

Productivity and Performance

The manager of Religious Care indicated that she was willing to increase expenditure on training and increased staffing levels and this would, she felt, have a positive impact on the care provided at Religious Care. The facility had the objective of providing good care and compassion as expounded by the founding nuns and is a not-for-profit organisation. The chairman of the board of directors had been quoted in a local newspaper as saying:

> *We don't work for profit. We don't service shareholders. We service the people who come into our beds and any surplus that we do make at the end of the financial year is really spent back on the services that we provide and the maintenance of the buildings. (Chairman of the Board of Directors, Newspaper article)*

However, Religious Care did need to generate income to provide its services to the community and one way in which it was doing that was through expanding the hospital care wing. According to the manager, the decision was made to increase the number of hospital beds because there was research that indicated that in order to make money on residential aged care you needed to have approximately two thirds of a facility in hospital beds and one third rest home level care. Religious Care was also able to access grants from the local licensing trust and a charitable trust that contributed significantly to the building of the new hospital wing. The manager noted that in that respect they were fortunate because their not-for-profit status enabled them to apply for such avenues of funding.

Generating income through provision of care was still important to Religious Care. The manager reported that the primary measure of productivity for her was the number of beds occupied because this determined how much money they would gain through funding, and that if all beds were full every day, the facility would break even. This became a juggling act for her when a resident died, as she would need to show respect

for the family of the resident and allow time for them to make arrangements for the funeral. However, the manager felt that in order to maintain the safe staffing levels she preferred, in other words expenditure, she needed to minimise the days that beds were not generating funding:

> *some days you'll feel as if you're being a bit harsh but if a patient dies and you leave that bed empty for 3 or 4 or 5 days to a week you're losing quite a bit of money on that… It's like a juggling thing so you try to have some fairness and that to the patients… (Manager)*

The manager was not entirely comfortable with that situation, but it was necessary in order to ensure the facility continued to operate.

While it was necessary to make money in order to provide a standard of care that the manager felt was good for the residents with safe staffing levels, the mission and aims of the organisation allowed some leeway for how money was allocated. One example was that they had recently refurbished a room to turn it into a respite care room. This was a short stay room with the purpose of giving family members a short break from caring for their elderly relative. The cost of renovating the room was around $20,000, and the manager did not foresee that they would make enough money on the room to cover those costs. However, it did not affect her overall idea of productivity or organisational performance because it met community needs and aligned with the mission and objectives of the organisation.

Employees measured the performance of Religious Care through how it met its broader goals. These measures were important to the employees, as indicated by the enrolled nurse:

> *The organisation works well. I think the success is very high. We get a lot of feedback from people coming out. I know this is one of the top homes that people want to come to. There's quite a long waiting list of people wanting to come in and there's no beds. And even the assessors who come in and assess people tell us that this is the home that everyone wants to come into. But it has got a good name. I mean I've been here 15 years and I wouldn't have stayed that long otherwise. (Enrolled nurse)*

Religious Care did need to generate money and any profit was directed towards developing the facility. However, the mission and objectives of Religious Care allowed the manager to focus on broader goals than just efficiency or productivity,

and she was able to direct more of the budget towards, for example, higher staffing levels.

Conclusion

Representative participation was encouraged at Religious Care, both through the OHS committee and through increased union membership. The OHS committee met regularly and was able to make decisions on policy, although this was probably because the manager was on the committee. There was evidence that OHS policy was formed by the committee, and its terms of reference included that it was responsible for overseeing adequate training of its members. The OHS committee agenda was open for all members to contribute to and the manager felt that she did not have significant input into it because she had been too busy establishing herself in her role as manger. The OHS committee therefore had considerable potential to drive policy and practices within Religious Care.

All recent initiatives had been instigated by the manager, but the OHS committee members felt that these were important. It was interesting to note that there was policy on stress at Religious Care and the facility encouraged participation in the OHS committee although this did not appear to happen in practice. There was a union representative on the OHS committee but regular union involvement in the committee was not obvious. Despite this, there was some evidence of good union relations in the Accident Compensation Corporation audit report and evidence of broader consultation with the union in OHS policy.

Representation of all employees may not have been consistent on the OHS committee. Long-term members remained on the committee without further nominations or elections, and caregivers were not represented according to their percentage of total employees. There may not have been night shift or weekend representation on the committee. Management, administration and registered nurses were well represented.

The regulatory framework clearly impacted on OHS participation at Religious Care. A positive impact was that OHS policy clearly reflected the requirements for participation in OHS stipulated in the Health and Safety in Employment Amendment Act 2002 and through Accident Compensation Corporation. One negative impact, as remarked upon in Chapter Five, was that the OHS committee focused on reporting and auditing in its

meetings so that there was more time and effort allocated to accident and injury prevention and management than to broader issues of health and safety, such as workplace conditions.

The other main forms of participation at Religious Care were unionism, consultation, and information sharing. The manager actively encouraged employees to join the union. Of the two unions in the sector, most employees who joined a union joined the nurses' union, which does represent caregivers as well as nurses, although across the sector caregivers tend to join the caregivers' union. This possibly reflects the manager's own affiliation and could potentially restrict the caregivers' opportunities to participate in Religious Care.

There were regular department meetings for information sharing, usually based on sharing task based information. The senior management team also met regularly and this meeting was open to employees to attend and raise issues. The manager consulted employees on significant projects such as the building of the new hospital wing, but there was evidence to suggest that employees, particularly caregivers, were not consulted on changes to workplace practices, such as the allocation of patients to employees. There was limited opportunity for autonomy although the manager reported that she was trying to build the confidence of employees so that they could make decisions on care.

The manager of Religious Care had a goal of good and safe staffing levels and in her 18 months in the job had increased the number of employees, particularly registered and enrolled nurses. She wanted to make sure that the workload was reasonable and that there were periods of 'downtime' when employees would not be so rushed. Accordingly there was little indication that employees at Religious Care had workloads that were too great. The manager did refer to 'safe and good staffing levels', which was the same phrase used by the nurses' union representative – it features in the union's campaigns – and therefore union involvement had an impact on working conditions through the influence it had on the manager.

The employees interviewed were very excited by the recent health initiatives supporting physical activity and these were the basis of much of their discussion. These initiatives (the hiking group and netball team) had had a positive impact on employees' physical health and but had also built their confidence and established stronger social ties among employees at Religious Care. The social ties were viewed as very important and

rewarding, especially for some of the older women who were single through divorce or widowhood.

The manager wanted to ‘look after’ her employees and was aware of the difficulty of raising children and working shifts as a nurse or caregiver. Consequently she had changed the roster system, against the board of directors’ wishes, so that it was a set roster, rather than a rolling roster. She also prioritised the needs of her employees who had young children when allocating shifts on the roster. This was mutually beneficial because she knew that they would not be unexpectedly absent, and the employees felt more willing to help the manager out and work weekends and other shifts from time to time.

Religious Care was a not-for-profit organisation and included providing care and meeting community needs in its mission and goals. This meant that while the facility needed to generate money for its operations, there was no need to generate a surplus to satisfy shareholders, for example. Religious Care’s status as a not-for-profit also enabled the manager to apply for money from community charitable trusts and this was a significant contributor to the new building project. The manager stated that productivity was beds filled, and this in turn was achieved through a reputation for good quality of care. The manager’s approach to achieving this was to prioritise employee needs, as evidenced in the increased staffing levels. She felt that if the employees were looked after the desired outcome of quality of care would ‘take care of itself’.

Chapter Eight: Charitable Trust Care

Introduction

Charitable Trust Care also was a residential aged care facility in a small town. It stood out from the other case studies because of its geographical location: a small town in a rural area. Employees at Charitable Trust Care were not as diverse as those in the Auckland case studies, with most being either Maori or Pakeha. This chapter analyses the findings from interviews, organisational data and policy, and an anonymous survey at Charitable Trust Care. The organisational context is discussed first, including the socio-economic details of the area. The external factors that have impacted on the relationship between productivity, employee participation and wellbeing will be discussed and compared across all four case studies in Chapter nine. This chapter then examines representative participation in the form of OHS committees. The section on other participatory practices begins with union representation and then analyses the other participatory practices at Charitable Trust Care. Having presented the findings on both representative and direct participation, the chapter then discusses employee wellbeing. Employee wellbeing is discussed in relation to workload and stress, work-life balance, support and appreciation, and training and work conditions. The final sections look at pay and productivity. The chapter concludes by suggesting how productivity, participation and employee wellbeing may interact at Charitable Trust Care. It also suggests how the effectiveness of representative employee participation may impact on employee wellbeing.

Organisational Context

Charitable Trust Care is a not-for-profit residential aged care facility. It is not a religious organisation, but was set up through a bequest for the purpose in the 1950s. Since that time Charitable Trust Care has grown considerably from the original 14-bed facility. It is overseen by a board of trustees consisting of two male general practitioners (one retired) and a male solicitor. The membership of the board of trustees is stipulated by the Trust Deed, which 'is very specific about the number and experience of the trustees' (Orientation Booklet, Charitable Trust Care). The members usually serve for long periods of time; only 14 different members have served since its inception in 1955.

The vision, mission and objectives for Charitable Trust Care include providing leadership in the provision of care for the elderly within their geographic area. The organisational values outline how the facility expects work to be organised to meet its vision. In particular, efficiency and effectiveness are mentioned with regard to the quality of outcomes. Although the values emphasise team work and empowering teams, individuals are responsible for updating their skills and knowledge. Continual improvement and excellence should underlie all their activities (see Figure 8.1).

Figure 8.1 Charitable Trust Care's vision, mission and values

VISION
Our vision is to provide leadership in the care of older people, and a range of services for their changing and diverse needs. These services will continuously evolve to exceed expectations.

MISSION
The relief, care, welfare and benefit of aged needy persons within the geographic area of [Charitable Trust Care].

Our Values

- Be ***client*** and ***quality*** focused and ethical in all dealings
- Work ***efficiently*** and ***effectively*** to produce high ***quality*** outcomes in everything that we do
- Take ***ownership*** of and act in accordance with the ***Mission*** Statement and Strategic ***Vision*** of the Trust
- Apply the principles of ***teamwork*** across all departments to develop and share solutions and **empower** teams to resolve issues
- Be ***personally responsible*** to be up to date with training, education and professional skills
- Be ***alert*** to issues pertaining to our business so that we can ***respond*** immediately and effectively
- ***Enquire, challenge*** and be ***innovative*** in order to constantly seek ***improvement and excellence*** in everything we do
- ***Value staff performance and recognise success***

Source: Organisational documentation, Charitable Trust Care

Charitable Trust Care is situated in a rural area in a small town of approximately 5,000 people. The population in the small town is approximately 57 per cent Maori and 51 per cent Pakeha (Statistics New Zealand, 2009). The median income is around $17,000 per annum and unemployment is around 13 per cent (Department of Labour, 2011b). The median income of this area is considerably lower than the area in which the National Aged Care (Chapter 6) and Not-For-Profit (Chapter 7) facilities were located (the Auckland region). It is also lower than the small city facility Religious Care (Chapter 8). The unemployment rate in the region is considerably higher than those in the other three case studies also. The main occupations listed for the town were 'labourers' and 'managers', and the region is known as a low socio-economic region, with higher than average unemployment, lower levels of education, and reputed higher than average incidences of domestic violence.

Figure 8.2 Charitable Trust Care key characteristics

Regional demographic information

- Located in small town in rural region
- Town's population approximately 5,000 people
- Population: 57 % Maori, 51 % Pakeha*
- Median income for the region is $17,000 well below both the national median of $24,400 and Auckland's median of $26,800
- Unemployment rate for the region was 13%

* These figures add to more than 100%, this may be due to people selecting more than one ethnicity they identify with. The original report also claims that '*Individual figures may not add up to totals*'

Charitable Trust Care

- 72 beds (hospital and rest home)
- 86 total employees of which:
  - 5% managers
  - 2% administrative
  - 11% registered nurses
  - 4% enrolled nurses
  - 57% caregivers

Source: Department of Labour, 2011b; Organisational information, Charitable Trust Care; Statistics New Zealand, 2009

Charitable Trust Care has 72 rest home and hospital beds. It also offers day care in the form of a social club and some respite care. Most employees were part-time, with the

majority being caregivers (see Figure 8.2). There was a small percentage (four per cent) of casual employees, but as with the other case organisations temporary staffing shortages were filled through current employees' workload increasing or taking additional shifts. Charitable Trust Care's location meant that agency employees were not readily available.

There was a greater proportion of managerial staff than the other case organisations, with a general manager, human resources (HR) manager, facilities manager and nurse manager (equivalent to clinical co-ordinator in other cases). These positions comprise the management team. Nearly all of the employees were women (93 per cent). The men in the organisation were the facilities manager, the gardener, the maintenance man, and two caregivers. Charitable Trust Care had a strong focus on manual handling and OHS and had received awards and recognition from a number of organisations, including the Department of Labour.

The research took place towards the end of winter in 2009 over two days. Interviews were carried out with the general manager, facilities manager, a registered nurse, a caregiver OHS representative and union delegate, and a cleaner who was a team leader and OHS representative (see Table 8.1). The general manager of Charitable Trust Care had been in the position for approximately 12 years. She was previously a registered nurse. She did not mention any union affiliations herself. She took great pride in her role and was in the process of gaining a tertiary management qualification through distance education. Her higher education did play an important part in her work as a manager as she would apply things that she learnt and found useful. This had influenced her style of management, and meant that she was also amenable to taking part in research. She had a strong focus on quality assurance and benchmarking, perhaps even more so than required by the sector regulatory environment. The facilities manager was male and was in charge of property, overseeing the laundry, kitchen, maintenance and garden employees. He purchased any equipment needed such as hospital beds and cutlery. He also had general oversight of health and safety and was the chair of the OHS committee. He had been in his position for five years.

Table 8.1 Interviews at Charitable Trust Care

General manager	• Registered nurse • With organisation for 12 years
Facilities manager	• With organisation for 5 years • Chair of OHS committee, and in charge of OHS for the organisation
Registered nurse	• With organisation 9 years • In charge of manual handling • On OHS committee
Caregiver	• With organisation 9 years • Team communicator • OHS representative, union delegate
Cleaner	• With organisation 2 years as employee, total 6 years cleaning • Cleaning supervisor • OHS representative

Source: Author

The registered nurse was a member of the OHS committee and also had responsibility for manual handling in the facility. She provided the in-service training on manual handling for all employees. She had been with the organisation for approximately nine years, seven of those in her current position. The caregiver had been with the organisation for nine years, and as well as her caregiver role she occasionally did relief shifts in the laundry. She was the union delegate, an OHS representative and also a team communicator in the organisation. The cleaner was the supervisor of the cleaning team. She had been a cleaner at Charitable Trust Care for six years in total, but for the first four years cleaning had been outsourced and she had worked for the companies that provided the cleaning service. Two years prior to the research taking place Charitable Trust Care had brought cleaning services back under the organisation, and the cleaner's employer then changed to Charitable Trust Care.

The survey gained 19 respondents. Four of the respondents were male, and only one of those males (a caregiver) specified their position. Twelve caregivers in total responded, four registered nurses and three respondents did not specify their position in Charitable Trust Care. Twelve respondents were employed on a permanent part-time basis, one casual, five permanent full-time and one did not specify. The majority of respondents worked 26 to 39 hours per week, with the casual worker working less than 10 hours and only three working 11 to 25 hours per week.

Employee Participation in Occupational Health and Safety

Employees at Charitable Trust Care were aware that there was an OHS committee, which met a minimum of ten times a year. Overall, the meetings were monthly, with a break over December or January when employees often took leave. There was good representativity on the OHS committee which comprised representatives from each department, including enrolled nurses and caregivers, and even included one night-shift representative. The meeting times were arranged to suit the night staff person. As well as departmental representatives, the facilities manager, a union delegate, and the registered nurse in charge of manual handling were on the committee, which was chaired by the facilities manager. The general manager did not sit on the OHS committee. Respondents to the anonymous survey identified the members of the OHS committee as employees and senior management (see Table 8.2), which corresponds with the membership in practice.

Table 8.2 OHS committee and representatives

Is there a health and safety committee at work?						
	Yes		No			Total Respondents
No. of responses	18		1			19
Who is on the committee? **Note that multiple answers were allowed for this question, consequently the total comes to more than*						
	Employees	Line managers	HR staff	Senior management	Other	Total Respondents
No. of responses	12	3	4	12	2	16
If employees are on it, how are they selected?						
	Employees volunteer	Everyone votes	Management decides %	Other		Total Respondents
No. of responses	3	6	1	0		10

Source: Thesis survey, Charitable Trust Care

The OHS committee indicated reasonable independence of representatives. Although they were not always elected, there was often informal discussion among teams about who would be their representative. There was no agreement between interviewees on

how employees became OHS representatives. The cleaner thought that generally teams would nominate their representative for the OHS committee:

> *It's really discussed who is available and can come to the meetings from the particular wings. But you know, it's generally someone from each wing, and the different departments that we've got, but it's generally something that they sort out themselves, who's going to be on the committee. (Cleaner)*

The caregiver had been an OHS representative for her department until her union decided that they wanted representation on the committee. She had then become the union representative there. She reported that OHS representatives were nominated and voted onto the committee at all staff meetings. The chair of the committee, the facility manager, and registered nurse said that employees overall were reluctant to be on the committee and so often had to be shoulder tapped to join. This was evident in the survey responses with six out of ten responses indicating that employee representatives were voted for, and three out of ten volunteering (perhaps encouraged) and only one respondent replying that management decided.

There were a few respondents who were not aware that there was an OHS committee. This could indicate a lack of effectiveness in representativity and communication. It could also negatively impact on accountability of the representatives. Notably, there was no mention of the OHS committee in the OHS information in the orientation booklet given to all new employees. Indeed OHS responsibilities are listed under 'managers', supervisors/team leaders and employees. Employees' responsibilities include that they should 'Immediately report any unsafe work condition or equipment to their supervisor or team leader' (Orientation Booklet, Charitable Trust Care) rather than report to an OHS representative. There was, however, mention of the OHS representatives in the 'Workplace Bullying Booklet for All', which mentioned that 'if you observe or are the recipient of one or more of these [bullying] behaviours contact the human resource manager or an OSH representative for advice'. The lack of information in HR policy may have been caused by the division between HR management and OHS at Charitable Trust Care. OHS policy was the responsibility of the facilities manager, whereas other employee policy fell under the remit of the HR manager, herself under the general manager's guidance.

As noted above, the committee was chaired by the facilities manager who set the agenda and provided overall direction for the committee:

they get to do their own stuff, I only steer them if they're not going, or they wander off track that's all. And set up their agenda for them. (Facilities manager).

The minutes noted him as the facilitator, rather than the chair of the committee. The use of 'facilitator' may indicate intention to further involve the members of the committee. Alternatively, it could have reflected the facilities manager's belief that the general manager had the final say on all OHS committee recommendations. The issues covered by the committee included both resident and employee health and safety. The committee, as evidenced in the minutes, monitored the use of restraints and noted when they were not being reported adequately. Any points of concern would be assigned an action which would be recorded in the minutes and followed up. The minutes showed that usually the facilities manager would be the committee member who would follow up actions.

The committee was responsible for the implementation and monitoring of OHS policy. Employees would be notified by committee members if they had not adhered to policy. The minutes noted that employees at several levels of the organisation had been reminded of appropriate OHS policy and behaviour. One example was of a registered nurse who had to be reminded to be a good role model and not to cross the kitchen floor when it was wet.

The OHS committee also had some input into the development of policy. One example was a trial policy on the type of footwear that employees could wear. Some employees had complained that their footwear was too hot and that they wanted to wear 'Crocs' (a plastic open backed sandal). It was agreed that this would be trialled and the committee identified the parameters for the policy. Committee members monitored the usage and noted when these rules were not adhered to; the committee also spoke to employees who did not follow the policy, and would ultimately decide whether the trial policy had worked and would continue or not.

The influence of the committee was not confined to employee matters: the minutes also recorded 'challenging behaviour' among residents and recommended actions for the care plans of the residents. The committee noted patterns of resident falls and made recommendations to the nurse manager. This is more significant when the fact that the chair, or facilitator, of the committee was not a registered nurse is taken into consideration. The power held by the committee was also mentioned by both the facilities and general managers who used terminology like 'policing' and 'powerful' to

describe the action and influence that the OHS committee had. This terminology reflected a top-down approach from the committee, an approach that suggests power and control over the other employees, which is in line with the management structure of Charitable Trust Care. Interestingly, even the cleaner felt empowered by being on the committee:

> *it's good to know that we have the biggest pull in the place. If we need to get something done the health and safety committee is, how can I say it? God! (Cleaner)*

Although the committee had significant power over other employees, and some input into policy, their influence was within bounds set by the general manager. The committee reported to her and the management team, which she of course led, set the direction of policy for Charitable Trust Care. The general manager had the final say on all policy.

There was reasonable expertise available to representatives on the OHS committee. Representatives did receive training OHS representative training and the minutes noted that all members of the committee had completed level one of the training. However, there had been difficulties in organising the next level of training because, it was noted, one or two courses had been cancelled. The general manager had also noted that it had been difficult to send employees to training that year because of the high rate of absence because of influenza, and the consequent staff shortages. The registered nurse reported that she had not been to training the previous year and perhaps would not be able to go in the current year either. This was because a shortage of registered nurses in the organisation meant that she could not take the time out. However, training and education was not limited to OHS representative training. The facilities manager regularly went to OHS conferences and would pass on new ideas and information to the OHS committee and the management team. There was also an element of education within the committee meetings. One example was when the Challenging Behaviour Policy was introduced. The policy was discussed, along with implementation and how it would be monitored.

Any policy changes that were implemented on the committee's recommendation had to be reported on and reviewed before they became permanent. The committee was also accountable to employees. The facilities manager mentioned that employees would complain if they thought that an issue they had raised was not followed up. According to the facilities manager, the OSH representatives were becoming more aware of the

need to report back to other employees on how they had followed up on issues. Thesis survey responses indicated that overall employees were satisfied with the committee's response to their issue raised. However, two responded that their issue had not been dealt with very promptly, only within two-to-four months (see Table 8.3).

The committee communicated with other employees by making minutes available in the staff room and reporting back to departmental or team meetings. If a representative from a particular department was absent from a meeting a different representative would be nominated to report to that department. Memos would also be attached to payslips from time to time with information from the OHS committee. The committee was trying to raise awareness of OHS hazards and accidents among employees. As shown in Table 8.3, ten survey respondents had never raised an issue for the OHS committee. Charitable Trust Care also used forms to report near misses, called 'OSH-it' forms. The title of the form was intended to encourage employees to look out for and report OHS hazards. The importance of this activity was communicated through the incentive of a chocolate fish for every form completed. The OHS committee would record all reports and corresponding actions, and recorded the number of OSH-it forms received against the target number. They had been increasing which was viewed as a positive response.

Table 8.3 OHS committee's response to issues raised

Have you ever raised an issue for the committee?						
	Yes		No		Total respondents	
No. of responses	7		10		17	
Was it dealt with satisfactorily?						
	Yes		No		Total respondents	
No. of responses	7		1		8	
How quickly was it dealt with?						
	Immediately	1 month or less	2 – 4 months	More than 4 months	Not dealt with	Total respondents
No. of responses	3	2	2	0	0	7

Source: Thesis survey, Charitable Trust Care

Other Participatory Practices

Employee participation was stated as important to Charitable Trust Care. Indeed, the Orientation Booklet included a message that 'employees are encouraged to participate in guiding our future direction…both informally and through structured surveys and staff meeting forums' (Orientation booklet, Charitable Trust Care). Overall the intention behind employee participation at Charitable Trust Care was to promote more efficient work processes. Representative participation was limited to the OHS committee, as discussed, and union representation. There were also a number of direct participation practices, including quality circles (discussed below), an employee suggestion scheme, team work, autonomy and practices centred on information sharing. Survey responses indicated that team work was the most easily identified means of being involved in Charitable Trust Care. The next was employee representatives on boards followed by problem solving groups. There was an employee representative on the board of trustees. The researcher found no evidence of working parties, but it could be that they were being confused with quality circles.

Table 8.4 Other ways employees can be involved in Charitable Trust Care

What other ways can employees be involved in this organisation?	
	Numberof responses
Employee reps on boards	8
Team work	12
Problem solving groups	5
Quality circles	2
Joint consultative committees	2
Working parties/task forces	1
Other	2
Total respondents	17
*Respondents could choose multiple answers for this question. Correspondingly the number of responses may add to more than 17	

Source: Thesis survey, Charitable Trust Care

Union participation was neither actively encouraged nor discouraged. Apart from union representation on the OHS committee and collective bargaining, there was little other union involvement in Charitable Trust Care. The union delegate did not enjoy her role; she found that it placed her in conflict with the general manager who she liked as a colleague. She also found it difficult to meet perceived organisational expectations of her role as team communicator as well as the union's expectations of her as delegate:

Being a union delegate and a team communicator I find goes against the grain. Because with the union it's, 'If the workload's heavy don't pick up your pace, just stay at your own slow speed.' Whereas as a team communicator or if you're down one, loss of staff or something, you pick up the pace. So I think that conflicts with me being a union rep and a team communicator because on one hand I'm saying, 'Ok well don't do that', whereas I'll be going to my team and saying, 'Speed it up, pick it up'. (Caregiver)

There were many more direct participation practices than representative participation ones. The majority of these were initiated by management, with only informal team work being employee initiated. Charitable Trust Care also had quality circles, which was congruent with a focus on participation to improve business processes and outcomes. The quality circle policy was initiated and established by management. Quality circles were issue based and could be either employee or management initiated. Some of the issues for quality circles would be identified by employees. If the issue involved more than one work team and was complicated then management would initiate a quality circle to address it. The general manager did not participate in quality circles herself. There were clear guidelines for recording and reporting on quality circles which included an action plan and record of completed actions. There were also guidelines for how the quality circle should approach issues (see Figure 8.3). The checklist however did not attempt to guide employees towards particular actions or issues; it was meant as a guide to problem solving. Although policy distinctly labelled this practice 'quality circles', none of the respondents to the anonymous survey indicated quality circles as a means for employees to participate in their workplace.

Figure 8.3 Quality Circle checklist

1. Problem identification
2. Collection of data
3. Identify key issues
4. Develop action plan
5. Implement action plan
6. What are the expected outcomes of action plan
7. Re-evaluate – have all the desired results have been achieved
8. Feedback to staff through the entire process

Source: Quality Circle – Follow Up, Charitable Trust Care

One means of identifying issues was through an employee suggestion scheme. This allowed employees to have some influence in the workplace and was based around a form called 'Improvements to Our Work Areas'. The employee suggestion scheme was a management initiative. The form restricted the suggestions to managerial intentions for improved efficiencies in work practices. Its focus was on whether the idea would:

- Prove to be short or long term improvement
- Improve use of time, or people or materials
- Save money
- Improve the service. (Improvements to Our Work Areas Form, Charitable Trust Care)

Employees could complete the form with their name or anonymously. All suggestions would be followed up by the general manager, with the actions taken reported to all staff. There was a record kept of the follow-up actions which included thanking the employee who made the suggestion. The caregiver interviewed felt that the suggestion scheme was effective. Usually suggested changes would be implemented on a trial basis, with the possibility of becoming permanent. The manager was the person who would decide whether the trial change had been successful.

The employee suggestion scheme was not well communicated to employees, however; they were advised of it at orientation but this was not effective because it was

> *too much to take in at first because you come in, you're fired at with all these forms and manuals and things you've got to sign and read. I think people just generally forget and not realise about it. (Caregiver)*

Employees not only did not know about the suggestion scheme, but also did not understand how to use it. The caregiver, in her role as union delegate, was continually reminding employees of the suggestion scheme and how to use it to have conditions changed to better suit the employees.

The board of trustees' objectives specifically included team work. Team work was explained as 'the power of the team is greater than that of the individual' (Orientation Booklet, Charitable Trust Care). A recent management initiative had changed the way that caregivers and nurses worked in the facility. Previously the care staff had worked across the whole facility. This meant that on each shift they might work with different residents in different wings of the facility. A new form of team work had been introduced so that care staff were allocated one particular wing or department to work in. They would be in that wing for every shift they worked. This was introduced in

order to encourage a better knowledge of individual residents among a team, and to create efficiencies in work processes. The initiative had been introduced with little or no employee involvement. The general manager described the process as one in which employees were reluctant to accept the changes at first:

> *We had to drag them kicking and screaming there, they didn't want to go there. They wanted to carry on roving around the building working one place or another. Now we can't get them out of their team. (General manager)*

While there was a formal direction to encourage team work, it also operated informally among employees. The cleaner spoke about how, as a team, the cleaners were all aware of each other's personal commitments and this meant that they worked with each other to ensure that shifts were still covered if one of them had to pick up children or had similar personal activities. The cleaning team also had the freedom to work out their annual leave and shifts with each other, and to then advise their departmental manager. This was the most significant indication that some employees had autonomy over some of their working conditions. This may have been because of the type of work – cleaning rather than caregiving – which was not operated on a shift basis, 24 hours a day. However there may also have been more flexibility because the team was smaller and they reported directly to the facilities manager. Survey respondents did indicate a good level of autonomy, with four responding that they strongly agree and seven agreeing that they have significant influence on how their work is done (see Table 8.5). The response that employees do have influence on how they do their work is consistent with Charitable Trust Care's focus on participation to make work processes more efficient. Fewer respondents felt that they had significant influence on how much work they have to do (2 responded 'always, five responded 'often'), and seven respondents did not. This response is not surprising given that employee participation is almost entirely confined to management initiatives and parameters.

Table 8.5 Job autonomy at Charitable Trust Care

I have significant influence on how my work is done						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents
No. of responses	4	7	7	1	0	19
Do you have significant influence on how much work you have to do?						
	Always	Often	Now & then	Rarely	Never	Total respondents
No. of responses	2	5	4	4	3	18

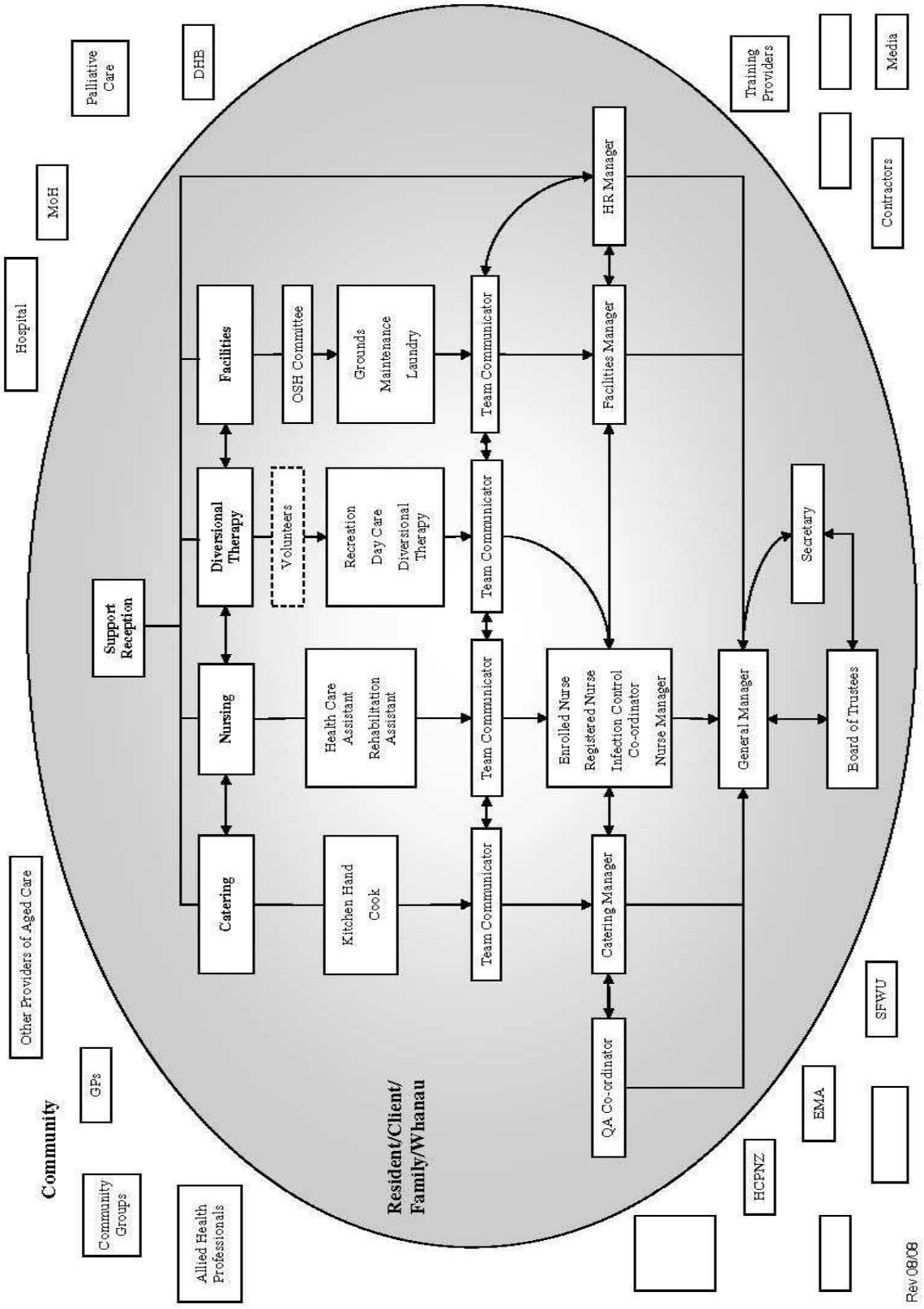
Source: Thesis survey, Charitable Trust Care

The manager did state that she was trying to improve employees' ability to participate in decision making. She had been building employees' confidence over several years:

> *I think it's about putting the decision making process back into their hands and saying 'look, I'm not responsible for all that happens here'. Actually this is your workplace, what would you like to do?… It's taken me, took me probably eight years to embed it. Now we can't make a decision without consultation. (General manager)*

One example of how the manager involved employees was in the development of the facility's 'Organisational Chart' (Figure 8.4). This was designed to show lines of communication, in order of which positions met with clients as they came to Charitable Trust Care. It had been instigated by the senior management team. Employee feedback was sought before it was finalised. This process reflects what appeared to be the general process for decision making at Charitable Trust Care: in practice, in effect employees did not make decisions on issues such as policy or practice affecting their work, but made recommendations for the manager to decide upon.

Figure 8.4 Charitable Trust Care Organisational Chart



Source: Charitable Trust Care

Employees did feel overall that they got information on important decisions and change. However, the responses to whether they should have more influence at their workplace indicate that the situation is more complex: two disagreed that they should have more influence, eight neither agreed nor disagreed and seven to varying extents that they should have more influence (see Table 8.6).

Table 8.6 How much influence employees have at Charitable Trust Care

I get information on important decisions, changes and future plans in due time						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents
No. of responses	5	10	4	0	0	19
I should have more influence at my place of work						
	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Total respondents
No. of responses	1	6	8	2	0	17

Source: Thesis survey, Charitable Trust Care

Favourable responses to the thesis survey on whether employees get information on important decisions indicates the importance of communication and information sharing at Charitable Trust Care.

There were three major formal ways of communication and information sharing at Charitable Trust Care. These were a formal position of 'Team Communicator', a staff forum and an attitude survey. The manager did not explicitly state that she had an 'open door' policy, and contact with her may have been limited.

The team communicator role had been recently introduced at Charitable Trust Care. This position was not remunerated, but was a formally appointed role, the duties of which were in addition to the duties and responsibilities that the employee had in their substantive position. Team communicators were a management initiative. The role had been designed specifically to improve the information flow between management and employers, in accordance with the board of trustees' objectives. Team communicators were also appointed by the department manager and HR manager, according to policy. This may have varied in practice, with the general manager and two interviewees stating that team communicators volunteered or were nominated by employees. The team

communicators would meet regularly with the HR manager who would convey information to them from the management team. The team communicators would then pass this information on to other employees and vice versa (Team Communicator Constitution, Charitable Trust Care). The role had originally been called 'Team Leader' but the general manager explained that the team leaders had taken that to mean they had supervisory roles and had begun to give directions to other employees. She stated that they were a conduit of information only.

Communication lines were important, and another forum that was intended to improve communication was the staff forum. This was a meeting for all employees, but was separate from the general staff meeting. While a management initiative, the staff forum was a meeting that managers could only attend by invitation from an employee. The team communicators had an important role in this forum. They would 'elect' a facilitator and recorder and their role in this context was to facilitate participation of other employees, as well as being a conduit of information. The agenda was to be formed by employees writing down agenda items and handing them anonymously to the team communicator. These written issues were the only issues that could be addressed at the meeting (Procedural Points for Whole Staff Forums, Charitable Trust Care). Records were kept in the staffroom, and a copy also given to the general manager. The management team was then supposed to follow up any issue raised within one month of the staff forum. The staff forum was designed to allow employees to raise issues in an environment without management present and intended to be a safe environment for employees, with their anonymity protected should they want it to be.

Another 'safe' formal means of communication and information sharing was the annual staff attitude survey. This acted not only to gauge employees' levels of satisfaction and commitment to Charitable Trust Care, but also to communicate the purpose and objectives of the facility to employees. There was 'Working the Charitable Trust Care Way' section which asked about co-operation, sharing knowledge and the application of the organisational values to employees' work. Respondents' perceptions of how open communication was had decreased compared to the previous year's survey, as had the response to being 'kept up to date with what is happening where I work'. The annual staff attitude survey was used by the general manager to monitor employees'

perceptions of the workplace. She would take action to remedy any particular issues that were identified through a negative change in responses.

Formal information sharing and communication channels were stronger than informal ones at Charitable Trust Care. The general manager placed great importance on communication, which was confirmed by the registered nurse:

> *they're really big on communication and how to communicate and trying to communicate to people in different ways. (Registered nurse)*

However, the general manager and the registered nurse made little mention of direct informal communication with employees, such as an 'open door' policy. Further, the caregiver mentioned that while she herself had no difficulties in approaching the HR or general manager to discuss an issue, she had heard among employees that they were reluctant to approach the general manager:

> *A lot of them find that she's unapproachable. She can be at times but then, I don't know. I get on well with her, well I like to say I do. I suppose being the general manager you are going to have some issues that are on your mind. You can't make everybody happy. But they just find that she can't be approached a lot of the time and gets her back up against the wall. (Caregiver)*

There was also reportedly some concern among employees that because of the close relationship between the HR manager and the general manager that they could not approach the HR manager with confidential issues. They were concerned that their issue would be relayed to the general manager.

The cleaner had a different perception of communication with management. She reported to the facilities manager in the first instance. The cleaner was comfortable approaching him with any issue that arose. If the issue was not resolved she would then take it to the general manager. The facilities manager also felt that all managers operated 'open door' policies, and were approachable:

> *I mean, my door's always open. The nurse manager's door's always open. So is the general manager's; so is the HR manager's. There's always opportunities for one on one. (Facilities manager)*

There was some difference between perceptions of the availability of management for employees to talk to and this may have been influenced by the power relationships between management and employees. The people interviewed were either managers or

OHS representatives who perhaps were more familiar with managers, and dealt with them more regularly in that capacity.

Employee Wellbeing – Workload and Stress

Absenteeism and turnover had an important role in employee wellbeing. Charitable Trust Care's rural location had contributed to a labour shortage, particularly of registered nurses. Although the general manager thought she had a sufficient number of employees, there had been two critical incidents that impacted on that. The first was a shortage of registered nurses. This had almost led to the temporary closure of the hospital wing. It had also impacted on continuity of training because there had not been sufficient employees to cover while colleagues were at training courses, as noted above. The second critical incident had been an influenza outbreak in the year of the research which had contributed to higher than usual absenteeism.

Absenteeism was connected to workload and stress. Indeed, the caregiver identified absenteeism, and turnover, as the sole source of stress at work. This was because they increased the workload of employees. Workload was a significant issue at Charitable Trust Care. It contributed to low morale, according to the caregiver. She found that the greatest impact on her workload was the high turnover among employees. The general manager placed turnover in the year of the research at 17 per cent, which she thought was relatively low for the sector. The level of turnover placed a strain on the caregivers and others because of the time involved in giving on-the-job training to new employees.

There was little mention of stress being experienced at Charitable Trust Care. Respondents to the thesis survey reported experiencing little or no stress. Few were required to work overtime (one responded 'often' and six responded that they were 'now and then' were required to work overtime) which may have been because management would not let them exceed 80 hours per fortnight due to the cost involved in overtime payments. More employees responded that they had more work than they could accomplish in one shift: 50 per cent 'now and then' and one each responded 'always' and 'often' had more work than they could complete in one shift (see Table 8.7). The factors given above – labour supply and unusual sickness that year – may well have contributed to the perception that there was more work than could be finished in

one shift 'now and then'. What did not occur much at all in interviews was talk about the frustration of not being able to provide quality of care.

The facilities manager however felt that there was workplace stress at Charitable Trust Care. He concurred with the caregiver in pinpointing absenteeism as the main cause of stress. Stress had been the topic or theme for the OHS committee that year. One part of that was, according to the facilities manager, to increase employees' awareness of how their behaviour affected not only themselves, but their fellow employees. For example, if they did not turn up to work then other employees would have to take on extra work. All the employees interviewed were members of the OHS committee, so it is surprising that they did not have more to say on the topic of stress.

Several of the interviewees felt that stress was caused by an employee's personal circumstances, rather than by work. The caregiver noted that the area had a high rate of domestic violence and that caused a great deal of stress for the women in those circumstances. The registered nurse also pointed to personal circumstances causing stress for employees. She felt that overall there was little or no stress caused by work issues.

Table 8.7 Workload and stress

Do you have more work to do than you can accomplish in one shift?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	1	1	10	4	3	19
Are you required to work overtime?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	1	5	6	7	19
How often have you felt stressed?						
	Always	Often	Now & Then	Rarely	Never	Total respondents
No. of responses	0	1	6	8	3	18

Source: Thesis survey, Charitable Trust Care

Employee Wellbeing – Work-life Balance

Despite stress being perceived as something that was caused by employees' personal lives, there was little recognition of the need for work-life balance. This may have been because employees did not perceive the need for it. Survey responses showed some impact of work on personal lives: six respondents felt work took so much of their energy it affected their private life 'now and then'. In contrast, 14 employees felt really tired from work now and then (see Table 8.8). The results indicate that for the majority of the respondents work did not have a negative impact on their personal life in terms of their energy levels.

Table 8.8 Thesis survey responses related to work-life balance

Do you think your work takes so much of your energy that it affects your private life?						
	Always	Often	Now & then	Rarely	Never	Total respondents
No. of responses	1	0	6	2	8	18
How often have you felt really tired from work?						
	Always	Often	Now & then	Rarely	Never	Total respondents
No. of responses	2	1	14	1	1	19

Source: Thesis survey, Charitable Trust Care

Opportunities for employees to have flexible hours were limited by the employee's position and department in Charitable Trust Care. Work-life balance was an important concept to the facilities manager who had small children himself. He managed to get some amount of flexibility in when he worked although this was also at the cost of being on call almost permanently for emergencies. The facilities manager allowed his employees some flexibility in hours, however he acknowledged that it was easier to accommodate in his department because they were not working directly with clients, and did not operate on a 24-hour basis. He allowed flexibility for his employees for a number of personal commitments, not just the care of children, and also planned to encourage discussion of work-life balance through making it the next 'theme' for the OHS committee.

Work-life balance was integral to wellbeing for the caregiver. Wellbeing for her meant a balance between home life and work life. Conditions both at work and at home needed to be good, she felt, and one should not conflict with the other:

> *That's wellbeing because if it's not going good at home then how can you perform good at work? Because if you're going to have all these problems, taking them to work's not going to help. So to me wellbeing is not just work, it's home as well and it's all incorporated into one. That's how I'd like to see it. (Caregiver)*

The caregiver and facilities manager did not represent the dominant perception of work-life balance at Charitable Trust Care. As with stress, the general perception was that work-life balance was important in the way that it impacted on work. The general manager gave two examples of how home life impacted on work. Both of these related to the low socio-economic status of the area in which Charitable Trust Care was located. The first was a high rate of domestic violence, and the second was low levels of education and high unemployment. Similarly to the managers at the National Aged Care facility (Chapter Five) and Religious Care (Chapter Seven), the general manager at Charitable Trust Care took action to help employees with their personal problems. The facility had introduced information on where to go for help in response to the issue of domestic violence. They were intending to also hold information sessions on domestic violence provided by external support agencies. Part of the general manager's view of employee wellbeing was that the work environment was enjoyable and safe. She felt that for some of her employees work was one of the few safe places they could go to.

Employee Wellbeing- Support and Appreciation

The second aspect of personal lives that impacted on the workplace was the low qualifications and limited experience in the workforce of many potential employees. The general manager's view of wellbeing therefore extended to providing role models and expectations of what doing good work was. For some employees, policy would need to be clearly explained, and expectations of turning up to work, working hard, and being part of a team sometimes needed to be explained and learned. Wellbeing also included the employees feeling cared about and supported. In some instances the general manager had followed up repeated absenteeism with employees. One case she explained was an employee who it turned out had asthma. Her asthma had got worse,

preventing her from working every day. The employee had not been able to afford to go to the doctor and so had to resort to calling in sick. Once the general manager had found this out, Charitable Trust Care paid for the employee to see a doctor, she received new treatment and no longer needed to call in sick.

Overall, the general manager took a broad view of employee wellbeing. It included feeling safe and comfortable, encouragement to set high standards for oneself, and also employees having a say in the workplace:

> *It's a whole big thing isn't it? It's about being comfortable about coming to work. About enjoying the environment that you're working in, about feeling that you have a say so about your direction and people that you're caring for. It's about encouraging people to raise their standard all of the time… And it's about hopefully being a bit of a role model, not smoking and you know drinking heavily and those sorts of things and being here at work all the time... That they feel that they're cared about, that if they have a problem that we're going to try to support them with it. (General manager)*

This was reiterated to some extent by both the registered nurse and the cleaner who felt that wellbeing was enjoying the work environment, and being in a happy environment. They also felt that wellbeing included feeling that you could approach your manager if you had an issue to discuss.

The general manager indicated that part of what she considered to be employee wellbeing was that employees felt they were supported and appreciated within the organisation. There were a number of ways in which Charitable Trust Care tried to achieve this. One recent initiative was a monthly employee reward. The reward was dinner out for the employee and their partner. Initially the employee was nominated by other employees. However feedback from employees was that they did not like nominating each other because everyone worked hard. The selection process was then changed so that the management team did the nominating. The management team aimed to reward employees from different departments:

> *We try to spread it across so it's not just registered nurses getting it so it might be a health care assistant one month, laundry, catering and so it goes across the board. And very quietly they come back and say, 'Oh it's great', so it's working. (General manager)*

Although the general manager originally intended to announce the employee each month, she was told by employees that they did not like that. Consequently she would approach the nominee and notify them that they were the recipient. This process highlights the manager's control over the work processes at Charitable Trust Care. Twice in the process the employees had indicated discomfort with the reward, yet the management team continued with it. The way it was retold, that the employees said they thought that they all worked hard, suggests that they may not have felt that the award was appropriate recognition of their work.

The general manager had a set amount she budgeted each year to provide for awards, bonuses and social events for employees. The previous Christmas she had given all employees a ham each, which they had enjoyed. Charitable Trust Care also held a Christmas dinner and would from time to time have a barbeque or champagne breakfast to show appreciation of employees. Overall, as indicated by the thesis survey results in Table 8.9, employees at Charitable Trust Care felt appreciated by management.

Table 8.9 Appreciation by management

My work is appreciated by management						
	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total respondents
No. of responses	5	11	2	1	0	19

Source: Thesis survey, Charitable Trust Care

Employee Wellbeing – Training and Work Conditions

One form of support for employees is training in order to increase their skills, knowledge and confidence. One of the objectives of Charitable Trust Care was to have 'a skilled, motivated and committed work force' (Orientation Booklet, Charitable Trust Care).

Training was provided through in-service training sessions, particularly on the core training required, and through external training and education. The caregiver reported that the national aged care qualification was compulsory for caregivers because Charitable Trust Care aimed to have everybody as a 'certified health care assistant'. The enrolment fees for the qualification were paid for by Charitable Care Trust, but the caregivers had to complete the modules in their own time. This had been an issue raised by the union, according to the caregiver, and one of their claims in the negotiations is to

get one hour per week paid time for each caregiver studying the Aged Care Education modules:

> *That's actually on our own time. That's part of our negotiation, is to get one hour a week paid and that's just to give the girls the incentive to carry on and do it because a lot of them think well why should they do it on their own time? You know it's to benefit work so work should pay for it (Caregiver).*

Employees could identify training and education that they wanted, but the budget was limited. Training was provided to all staff, not only care staff. The rural location was a barrier to some extent to training and some employees travelled up to two hours on their own time to attend a training course. Overall, training was provided in order to meet organisational outcomes including regulatory requirements. The general manager did not speak about the benefits of the training for employees. Training was not consistently available, although in practice the national aged care qualification was compulsory for caregivers.

In addition to training of employees, one of Charitable Trust Care's staffing objectives was:

> To attract and retain above-average employees, the Trust endeavours to pay salaries that are comparable to those paid by other employers in our industry. In line with this objective, we monitor our salary rates to ensure that they are in line with local as well as national economic conditions (Orientation Booklet, Charitable Trust Care).

However, in practice the caregiver advised that Charitable Trust Care was one of the lowest paying facilities in the country. The facility was in a rural town with high unemployment and a median annual wage that was considerably lower than the national median wage. It could be concluded, therefore, that they were keeping in line with the policy. The continuing low wage was affecting employee morale, particularly as the union consistently tried to negotiate higher wages. The general manager also acknowledged that Charitable Trust Care paid low wage rates:

> *We have a low pay, they're low paid jobs on the whole. We'd like to do better but that's how it is right now. We're working at it. So we recognise that some of the people working here are low socio economic, don't have very much and looking at hierarchy of needs if you like, they're on the lower end of the scale. (General manager)*

There was some acknowledgement of the conditions of employees in terms of wages and there was a section included in the orientation on 'advances', which were overall discouraged except for emergencies. The registered nurse was aware that a number of employees at Charitable Trust Care came from low socio-economic backgrounds and would be living 'from one wage packet to another wage packet', which would, she surmised cause some stress.

There was little discussion from managers or employees that framed care work as a calling which in some way compensated for low wages. However, several of the employees interviewed did mention that they were working in the 'residents' home'. The employees wanted to make Charitable Trust Care as comfortable as possible for the residents. They enjoyed the work, and did feel some sense of 'contribution':

> *I'd say this would be one of the most enjoyable places that I've worked and I think it's just I like the fact that I can give a little back to the elderly you know. Because I've got my mum with me and you know, yeah. They've done their dash so it's our turn to look after them is how I see it. And each one of us can do their bit just to make the, you know the later years of their lives a little bit more comfortable. It'll come back. They say what goes around comes around. (Cleaner)*

Productivity and Performance

Charitable Trust Care, as a not-for-profit organisation, needed to generate enough income to cover outgoings and to fund development of the facility. Its values included 'work efficiently and effectively to produce high quality outcomes in everything that we do' (Orientation Booklet, Charitable Trust Care). The general manager took this very seriously, and greater efficiency was the rationale behind a lot of the initiatives she introduced. She mentioned that she was very interested in quality management.

The general manager had been trying to improve work processes to make the way they worked more efficient and used the expression 'working smarter'. She felt however that traditional measures of productivity were not useful in a human service environment, and was a little sceptical of them:

> *It's very difficult to measure productivity in this environment. I was really surprised when I went to my accountant's last week and he's saying things like, 'Oh we see how much work they're doing in an hour and then we come up with a figure, oh you know 75% productive'. (General manager)*

Greater work efficiency, as far as possible when working with people, was also associated with productivity by the caregiver. She felt that time management, and not spending too long with each person contributed to productivity. The caregiver also pointed out how she thought the increased staff turnover negatively impacted on productivity because new employees were being trained by relatively new employees who had not yet had the opportunity to organise good routines for their work. They would therefore take longer to complete their tasks.

However, productivity for the general manager also involved containing costs, and that was largely the purpose of the focus on efficiency. She used several indicators of performance and regularly benchmarked those against other residential aged care facilities in the region. Her measures included absenteeism, turnover, accidents and injuries to staff and residents, and infections among residents. She considered the cost of care was increasing, along with the dependency of residents. Rather than increase the number of staff, she intended to make work processes more efficient and free up more time of existing employees to get work done.

Although cost and efficiency were the primary measures of productivity, the general manager also included broader measures such as staff happiness, resident satisfaction and a lack of complaints. The facilities manager spoke about what he viewed as good outcomes in his job. He noted that apart from wages, facilities was the biggest amount in the budget. This meant that if he managed to make savings he would be commended. However, in his view and for his role, what was most important was that his employees were well looked after, that they enjoyed their job and were not going home tired and irritable at the end of the day.

Conclusion

Charitable Trust Care had a number of participatory practices. These were predominantly of the direct participation kind and were focused on work processes. The implementation of employee participation was very much influenced by the general

manager and her approach to productivity. She did not find traditional measures of productivity useful for measuring organisational performance at Charitable Trust Care. This was because she did not view the work as readily mechanised and measurable. It was not simple to break the work down into small tasks and create efficiencies that way. Despite this, her focus for organisational performance and productivity was on containing cost. She tried to achieve this through making work processes more efficient. She had increased, and formalised, channels of communication at the facility. In addition, the employee participation practices aimed to elicit improvements to how work was done. The employee suggestion scheme and quality circles were based on identifying a work process that did not work well and could be improved.

The result of this aim of improved efficiency through employee participation meant that employee wellbeing was sometimes overlooked, or viewed instrumentally. Key concerns for some groups of employees, such as pay rates, were continuously ignored in favour of cost containment. Other issues such as work-life balance and work stress appeared to be overlooked. This was because the general manager perceived that home life impacted on work, rather than vice versa. Significantly, several processes had been introduced unilaterally by management without consultation. One example was the process of employee recognition which appeared to over-ride what employees wanted from the workplace, even after employee feedback. Employees had not want individuals singled out because they felt they all worked hard. Another example was the introduction of team work which employees had not wanted to take part in initially.

Representative participation was somewhat limited at Charitable Trust Care. The OHS committee was not as effective as it could be for employees. Management was represented on the committee, chaired it, and set the agenda. Representatives were elected but in practice because of a lack of volunteers, representatives were often shoulder tapped. Furthermore, any decisions made by the committee on policy or workplace issues had to be agreed to by the general manager. However, employees did have some influence on the OHS committee. The committee commented on patterns of falls or injuries among residents which would be followed up with the nurse manager. This indicated some sense of responsibility and expertise among committee members. OHS representatives also monitored the trial of new policy and made recommendations on it. They felt increased confidence in their role in Charitable Trust Care and also felt comfortable dealing with management.

Union participation was mostly limited to collective bargaining. The caregivers' union had not been successful in achieving higher wages and had had difficulty gaining paid time off for caregivers studying towards the aged care qualification. However, one positive outcome of union participation had been the increased knowledge of sector conditions and legal entitlements gained by the union delegate. The caregiver had increased interaction with the general manager and therefore felt more confident in approaching her if an issue arose. The increased awareness of organisational policy and procedures meant that the caregiver played an active, informal role, raising awareness among employees about items such as the employee suggestion scheme. Representative participation in the form of union representation had limited effectiveness for employee outcomes, but it did appear that informal activities of the union delegate would promote employee outcomes.

Chapter Nine: Discussion

Introduction

Representative participation had variable outcomes across the four case organisations. OHS committees were all limited to some extent in the issues that they covered, and the decision making authority that they had. This limited employee participation influenced employee outcomes. Generally there were few opportunities for employee participation. Power relationships were particularly influenced by ethnicity and professional status and affected who had access to participation in the organisation.

Employee wellbeing was perceived differently by managers and employees, with managers somewhat oblivious to the role that workplace conditions have in employees' stress and wellbeing. Power relationships influenced the way in which employee wellbeing was considered by managers and employees. Managers had more distinct perceptions of wellbeing than employees. Managerial responses tended to view negative employee outcomes as a result of employees' lack of skill and capability. Managerial actions therefore included instruction and intervention in how employees managed work and home lives. Quality of care was an important outcome for all case organisations because it influenced funding via bed occupancy. There were, despite this, some differences in approaches to productivity across the organisations.

This chapter explores these findings in more detail in the context of the external factors identified in Chapter Five. It evaluates employee participation, the managers' approach to productivity, and employee wellbeing. It explores the relationship between them, and the role that external factors have on those. OHS committees are used as a point of comparison for non-union representative participation. The first section examines the effectiveness of representative participation for employees using Gaffney's (2002) measures. This section specifically analyses the effectiveness of the OHS committees and union participation as representative participation. The second section then analyses the direct participation practices across the four case organisations, referring to Cox et al.'s (2006) model of embeddedness to determine the effectiveness of direct participation and combined participatory practices for employees. The third section suggests reasons for the way in which employee participation has been introduced in the

case organisations. In particular, this section suggests that managerial choices are paramount in how employee participation occurs in the case organisations.

The fourth section finds that although productivity is not often well articulated in the organisations, there are three different approaches visible. It discusses approaches to productivity with reference to issues in the sector identified in Chapter Five. This is followed by an analysis of employee wellbeing.

The final part of this chapter discusses how productivity, employee participation and employee wellbeing may be connected, as well as the role that external factors may have on that. It finds that there are connections between approaches to productivity and participation and employee wellbeing. Employee wellbeing also has some influence on organisational outcomes or productivity. Employee participation, in turn, guides how much employee outcomes are considered at the organisational and sector levels.

The Effectiveness of Representative Participation

Gaffney's (2002) model assigns measures for assessing the effectiveness of representative participation for employees. This model implicitly assesses how much the balance of power in the employment relationship leans towards employees. As described in Chapter Two, Gaffney (2002) suggests five measures for the effectiveness of representative participation for employees: the composition of the form of participation; the independence of the representatives; the representativity of the representatives; the level of expertise available to the representatives; and the accountability of the representatives. Gaffney's measure is used here to discuss the effectiveness of representative participation across the case organisations.

There were two forms of representative participation in all four case organisations. Those were OHS committees and union representation. Although each organisation had some form of OHS committee, they varied in effectiveness for employees. There were many similarities among the OHS committees. In terms of composition, all included management as members. The chair of all committees was a management member who generally set the agenda for the meeting. This limited the effectiveness of all committees and may have weakened employees' influence on the issues considered.

One measure of effectiveness is the accountability of the representatives. OHS representatives in all four organisations were accountable to employees in terms of reporting to them on the meetings. Issues would be followed up in meetings and actions recorded in meeting minutes. Generally there was a reasonable level of accountability. One exception was Religious Care, where employee representatives remained on the OHS committee until they resigned. This had resulted in several representatives serving for more than seven years without re-election. Representatives in general would report back to employees in team and general staff meetings. The National Aged Care facility was noticeable for its lower accountability through the OHS officer's narrow perception of OHS issues. Overall, Charitable Trust Care exhibited the greatest accountability of representatives on the OHS committee.

Training for OHS representatives on the committees was standard across the case organisations. All representatives attended training. The training fees and the time off work was paid for in all cases. Religious Care and Charitable Trust Care stood out for using different sources of expertise, such as increased information via the union delegate at Charitable Trust Care; attendance at OHS conferences by the facilities manager at Charitable Trust Care; and committee members who were involved in OHS at other organisations at Religious Care. Generally there was reasonable expertise available to the OHS committees, with the highest degree of expertise available at Charitable Trust Care.

There was variable representativity across the four organisations. Only Charitable Trust Care and the Not-For-Profit facility had included night shift representatives in the OHS committee. Generally there would be representatives from each department, and registered nurse representatives. This did not happen at the National Aged Care facility, which did not have a separate OHS committee. It also did not occur at Religious Care, which had a representative from each department, but exhibited a distinct lack of caregiver representation in comparison. Charitable Trust Care and the Not-For-Profit facility had the greatest degrees of representativity. Religious Care and the National Aged Care facility had lesser representativity, but for different reasons.

The nomination and election of representatives was variable across the organisations. Religious Care and National Aged Care had particularly weak processes. There was an overall trend among the case organisations that in practice employees would be shoulder tapped to be an OHS representative. This was because there was a general difficulty in getting volunteers for the role. Shoulder tapping mostly occurred from management.

However, it did occur by colleagues or teams in some instances. Charitable Trust Care's and the Not-For-Profit facility's OHS committees appeared to have the greater degree of independence as indicated by the election processes.

Charitable Trust Care's OHS committee contrasts clearly with National Aged Care, which divided OHS topics and decision making between management and the OHS officer. Management made decisions on work place conditions and policy at National Aged Care. Religious Care, in comparison made decision on policy, but mainly because the manager was there to agree or not on their decisions. The Not-For-Profit facility's OHS committee was restricted by the national organisation's structure. The national OHS committee could make decisions but was not very effective for employees in terms of Gaffney's measures (2002).

Haynes et al. (2005) suggest that consideration of effectiveness should include not only the increased decision making of employees, but the impact on their physical and psychosocial health. While some of the policy overseen by the Charitable Trust Care's OHS committee appeared to be at a lower level, such as the change in footwear allowed, these were issues that were important to the employees and initiated by them. This was similar to Religious Care and its introduction of social sports teams.

Generally however, the issues considered by the OHS committees were lower level. They did not often extend to psychosocial health. For example, there was limited understanding of workplace stress or of the broader workplace conditions that might impact on OHS (Bohle & Quinlan, 2004; Brough, 2005; Dwyer, 1983; Quinlan, 1993; Williams, 1993). The Not-For-Profit facility was the exception, with its representative considering staffing levels and workload in accident and injury investigation. Charitable Trust Care's OHS committee was beginning to consider broader workplace conditions.

The degree of effectiveness of the OHS committees did appear to be connected with the level of decision making that the committees were involved in (Cox et al, 2006; Knudsen, 1995; Rasmussen, 2009). For example, Charitable Trust Care's committee had begun to introduce topics such as workplace bullying and work-life balance. Furthermore, the OHS committee monitored the implementation of policy and was able to make recommendations on a new policy's continuation. The committee also, significantly, monitored resident falls and made recommendations to the nurse manager to follow up trends in falls. Given that many of the members were not registered nurses, this indicated that the committee had considerable power.

Markey and Patmore (2011) found that the limited scope of OHS committees in the Australian steel industry was related to a lack of independence from management, as well as a lack of representativity. In that study, management did not deal with issues to the satisfaction of employees. This is confirmed in this thesis in residential aged care. Charitable Trust Care was the most effective for employees of the OHS committees. It showed reasonable degrees of all Gaffney's (2002) criteria except for the composition of the committee. The Not-For-Profit facility's OHS committee had reasonable effectiveness, although less than Charitable Trust Care. However, the former was not very independent from management and had little input into policy, which was instigated at a national level. The national OHS committee, according to Gaffney's (2002) criteria, was not effective for employees. Religious Care had some effectiveness for employees but was restricted by its lower representativity and accountability. Management at National Aged Care kept tight control over health and safety through the lack of independence and representativity of the representatives.

Haynes et al. (2005) expected that in New Zealand the OHS committees would over time broaden the issues they considered to include stress and fatigue as potential harm and hazards. They suggested this because of changes to the Health and Safety in Employment Amendment Act 2004 (Lamm, 2009 and see Chapter Five). However, this is not apparent in the majority of this thesis' case organisations. Indeed, it would appear that effectiveness was determined by a range of issues.

Union representation has been shown to be instrumental in the effectiveness of OHS committees (Charlwood & Terry, 2007; Cooke, 1994; Haynes et al., 2005; Markey & Patmore, 2011; Reilly et al., 1995; Walters, 2004). The findings from the four case organisations showed similar links between union participation and OHS committees. Charitable Trust Care had the most effective OHS committee and the most effective union participation. Its union representative had more knowledge of organisational policy.

Although union representation was not strong at Charitable Trust Care it had the greatest impact on employee outcomes of the case organisations. It was largely confined to collective bargaining, but the union had some influence via the union delegate, who had increased knowledge of organisational policy. She also had greater confidence and expectations of the employment relationship than the employees interviewed at the other case organisations. This meant that she was able to use the existing policy and procedures to the advantage of employees.

Religious Care, on the other hand, had a very high percentage of union members. The manager actively encouraged unionisation. She had previously been a union delegate and the union officials were able to informally negotiate some changes to the employment relationship. However, while unionisation was high, the terms on which the union was involved were under the manager's control. The union delegate did not appear instrumental in increasing employee involvement in Religious Care or in improving employee outcomes. In this case it is possible that the manager's power was greater through her encouraging and controlling union participation than it might have been with lower union membership.

The Not-For-Profit facility's union representation had a significant effect in terms of a national policy that linked training and skills with salary steps. However, that occurrence was not indicative of usual relationships between unions and Not-For-Profit. Generally, at the facility level union influence was limited because the facility manager escalated any issue with union involvement to head office level. It is feasible that this discouraged employees from actively seeking union representation.

Of all the case organisations, the National Aged Care facility had the weakest union representation. The manager perceived that higher union involvement and unionisation was an indication of poor management. Given the lack of effectiveness of the OHS committee at the facility, it appears that there is a lack of employee influence and considerable power imbalance with management.

Regulation of employee participation in OHS may positively influence the likelihood of representative participation in OHS occurring in organisations. However, it appeared to have little impact on the effectiveness of OHS committees for employees in the case organisations. It was apparent in the case organisations that the most effective OHS committee also had the strongest union representation. The organisation with the least effective OHS committee had the weakest union representation of the case organisations, which is consistent with participation literature (Charlwood & Terry, 2007; Cooke, 1994; Haynes et al., 2005; Markey & Patmore, 2011; Reilly et al., 1995; Walters, 2004).

Direct Participation Practices

The previous section indicated that OHS committees and union representation appear to be more effective in combination than when they occur singly. The connection between different forms of employee participation is not limited to representative participation. Some research suggests that direct participation is more effective in conjunction with union representation (Kim et al., 2010). Cox et al. (2006) also suggest that employee participation overall is more effective for employees when there are more forms that are interconnected. They look at the breadth and depth of the participatory practices to assess their effectiveness (Cox et al., 2006). Cox et al.'s (2006) model of breadth and depth of participation allows a comparison between union and non-union forms, as does Gaffney (2002), as well as representative and direct participation. This is important because, as noted in Chapter Two, rather than relying upon union representation alone, dual or non-union-only channels of representation are more common in contemporary organisations (Charlwood & Terry, 2007; Dundon & Gollan, 2007; Markey, 2001, 2007; Pyman et al., 2006; Terry, 1999). Using Cox et al.'s (2006) model, the effectiveness of all channels of employee participation in one organisation can be assessed.

Charitable Trust Care had the greatest number of direct participation practices among the case organisations. Its number of practices indicates considerable breadth of participation. The practices themselves were linked. Issues considered by quality circles or the OHS committee were sometimes identified through the employee suggestion scheme, staff forum or 'open door' policy. All of these direct participation practices were ongoing, although the quality circles and employee suggestion scheme were ad hoc in response to issues as they arose.

Job autonomy however was restricted by the area in which employees worked, and their position: non-care employees had more autonomy, as did the facilities manager. The cleaners, for example, had some flexibility in how and when they performed tasks. They also worked as a team to ensure coverage of their shifts, and co-ordinate when they took leave. This did not occur for caregivers because it was more operationally difficult to roster flexibility over a 24-hour schedule. The work carried out by caregivers was more important to the immediate care of residents than the cleaners. Therefore if one cleaner was absent, some tasks could be postponed to a following day.

Although there were numerous participatory practices at Charitable Trust Care, there was a clear power relationship that favoured the manager. Employees could recommend

decisions but the manager had final say. The manager therefore had considerable influence over the issues that could be considered by employees and the organisation. However, there were indications that the power imbalance was slowly being changed through the direct and representative participation at the facility. This change in the power relationship was linked with the embeddedness and effectiveness of participation for employees. Employees were using the participatory practices to improve their work conditions.

In contrast to Charitable Trust Care, at the National Aged Care facility there were few means for direct participation. The key aspects of direct participation were the 'open door' policy of the managers and a general staff meeting. There was limited autonomy for some employees, such as the cleaners and maintenance man, but not the care staff. The only autonomy for caregivers was the 'judgement' required to observe residents' physical and mental health and take action accordingly. The caregiver interviewed mentioned this as part of the complexity of the job that was not always recognised. The manager at National Aged Care facility had tried to increase the confidence of employees to make decisions on care without the manager present, however this was focused on registered nurses. This is contrary to some research that indicates that increased job autonomy, in the form of high performance workplace practices (HPWP), will have greater positive impacts in low skilled employees such as caregivers, than in higher skilled employees like registered nurses (Harley, 2007). However, it does reflect the traditional boundaries and hierarchies, as well as the strict guidelines for caregivers, within nursing and care work (Bach et al., 2009; Jervis, 2002; Provis & Stack, 2003; Stack, 2003).

The intention to increase decision making capacity was also mentioned by the manager at Religious Care. Despite this, the facility had limited direct participation. Direct participation mostly involved an 'open door' policy and some consultation. Although employees were consulted on the layout of the new hospital wing, they were not consulted on changes to the way residents were allocated among caregivers on a shift. Consultation on change to work practices only applied to registered nurses, not caregivers. This may have been because of an underlying assumption of the differences in status between nurses and caregivers (Bach et al., 2009; Jervis, 2002; Stack, 2003).

The Not-For-Profit facility had some forms of direct participation. These centred on information sharing, largely in an upwards direction. This was consistent with an approach that favoured organisational outcomes, such as where employees are a source

of ideas that may contribute to improved productivity (Donaghey et al, 2011). The general manager reported a lack of formal participation processes. Employees were free to directly phone senior management. This, however, was in practice not available to all employees because of perceived power imbalances.

Limited access to employee participation because of ethnicity and language may also have occurred at the National Aged Care facility. The manager was aware that some employees had difficulty with reading and writing English. This prevented them from using the notice board in the staff room which was an important means of communication, and may have discouraged those employees from active participation in staff meetings.

Of all the case organisations, Charitable Trust Care showed the greatest effectiveness of both representative participation and embeddedness of participation. The number of different forms of participation at the facility led to participation being more effective for employees (Cox et al., 2006; Markey & Shulruf, 2008; Pyman et al., 2006). Despite high union density, Religious Care had only limited effectiveness of representative participation, and very little direct participation.

Limited employee access to participation was explained as a lack of interest on the part of employees in three of the four case organisations (the exception was Charitable Trust Care). However, this was solely in terms of the OHS committees. Power played an important role in who had access to participation in each of the case studies. It was highly likely that power associated with professional status influenced who was able to participate at Religious Care and make use of the 'open door' policy. Some employees at Charitable Trust Care did not feel confident in approaching management. At both the Not-For-Profit and National Aged Care facilities language and ethnicity were perceived as barriers to some forms of participation.

Explaining the Patterns of Participation

There were clear differences in both the effectiveness of representative participation and the embeddedness across all types of participation in the four case organisations. Poole et al.'s (2002) model suggests that organisational structures and processes influence patterns of participation. While three of the four organisations (Religious Care, Charitable Trust Care and the Not-For-Profit facility) were not-for-profit organisations,

each had a different organisational structure. Both Religious Care and Charitable trust Care were single-site residential aged care providers. Not-For-Profit was the New Zealand subsidiary of a multinational company. The main point of difference was therefore between the two single-site organisations and the two multiple-site organisations. Although it appeared that managerial choices were the strongest influence on employee participation (O'Donoghue et al., 2011), these were confined by the organisational structure within which they operated (Kaine, 2011; King & Meagher, 2009).

The managers at the two single-site facilities were able to implement policy at their facility as they saw fit. The manager at Religious Care intended to strengthen the decision making capacity of her employees and encouraged unionisation. She had not instigated any other formal means of employee participation other than the OHS committee and union representation. Under previous management, employees had felt intimidated by an OHS consultant. They were accustomed to following managerial direction rather than having influence themselves. This contextual information on Religious Care may explain the lack of initiative shown by employees, despite the manager's intention to increase decision making.

On the other hand, Charitable Trust Care had clear policy for employee participation, instigated by the manager. There were multiple practices, both representative and direct, union and non-union. There was some evidence that the increased knowledge and skills of the union delegate was beginning to have an effect on employee outcomes. She knew the organisational policy and how to use it. Several other interviewees also mentioned that the OHS committee had reasonable power to get things done.

Charitable Trust Care had greater effectiveness of participation for employees than Religious Care. One unanticipated explanation for this could be the stage of development or implementation of participation by the manager. The manager at Charitable Trust Care had been in her position for 11 years. What was evident at the facility at the time of the research was the culmination of years of implementing and encouraging employee participation. The manager at Religious Care had only been in the position for 18 months. In that time she had significantly increased union density, and initiated social sports teams which were a new phenomenon at Religious Care. The manager had also removed some decision making concerning employees from the board of directors. It is possible that Religious Care's limited participation will become more like that of Charitable Trust Care as employees' confidence and skills develop.

The facility managers at the National Aged Care and Not-For-Profit facilities may have been limited by national policy for their organisations (King & Meagher, 2009). Not-For-Profit union participation was regulated by the national general manager in terms of policy and negotiations. This may have contributed to the facility manager escalating issues which involved the union to head office. Policy in general was quite prescriptive at Not-For-Profit. There was frequent quality benchmarking and facilities reported regularly against the KPIs of the balanced score card framework. The manager at the Not-For-Profit facility was younger, and less experienced in managing residential aged care than the other organisations' managers.

There was less policy at National Aged Care that governed how managers managed employees at the facilities. National Aged Care did have a national OHS policy for employee participation. This indicated more effective participation in terms of representativity, accountability and independence of the OHS committee. The OHS policy also included stress and fatigue as issues to be considered by OHS representatives. Had the national policy at the National Aged Care facility been adhered to more closely, the representative participation may have been more effective. The manager at the National Aged Care facility had considerably more experience than the manager at the Not-For-Profit one. Furthermore, as a regional manager and member of the national senior management team, she had more influence. This may have led to her having more discretion to manage the facility in the way she saw fit. The difference between national policy and practice at the facility indicates that the choice of the manager is critical to the way in which participation occurs.

Organisational processes and structures can represent the role of power in relation to participation (Poole et al., 2001). Power is determined not only by the position, for example manager or employee, but also factors such as gender, ethnicity, education and professional status (Pocock et al., 2011). One stark indicator of how power may have influenced participation is that all four managers of the facilities were Pakeha (New Zealand European), tertiary educated women, which reflected the findings of American research (Jervis, 2002). They were in managerial positions over employees of whom the majority had no tertiary education; some also had limited secondary education. Further contributing to this was that the managers at the National Aged Care facility, Charitable Trust Care and Religious Care were all registered nurses with considerable experience (20 years or more). The manager at the Not-For-Profit facility was tertiary educated, but was not a registered nurse.

The power relationships influenced union participation at the case organisations. For example, union participation at Religious Care and the Not-For-Profit facility was controlled by the manager and national general manager respectively. The managers determined to some extent the level at which unions participated in the organisations. There was low unionisation at the National Aged Care facility, where the manager perceived union involvement to be necessary only in cases of bad management.

Power relationships also influenced how employees could access employee participation practices. Ethnicity played an important role in this at the National Aged Care and Not-For-Profit facilities. Employees may have been disadvantaged in participation because they did not feel confident in English skills. Differing cultural expectations of the employment relationship also meant that some employees did not feel comfortable directly contacting senior management, even though senior management considered that practice to be acceptable.

Professional status also influenced who had access to employee participation. This was most apparent at Religious Care where caregivers were underrepresented on the OHS committee. Registered nurses had greater job autonomy and were consulted more on decisions. Managers aimed to increase the decision making capacity of registered nurses, more than they did of caregivers.

Power relationships influenced the issues considered through employee participation. For example, at the National Aged Care facility workload and stress were perceived to be issues for managers to consider rather than OHS representatives. Employees therefore had little opportunity for influence on how those issues would be addressed. Employees at Religious Care tended to follow managerial initiatives, and these were centred on physical health more than workplace conditions.

The influence of professional status in the power relationships was less obvious at Charitable Trust Care. For example, its OHS committee, which had fewer registered nurse members, made recommendations on care practices. It recommended, implemented and monitored policy, and indeed there were fewer examples of power differences at Charitable Trust Care which, as noted above, had the most effective and embedded participation.

Employee Wellbeing

Employee wellbeing comprises work-life balance (Baptiste, 2008; Burke, 2001; Chiang et al, 2010; Halpern, 2005; Hayman, 2010; Macky & Boxall, 2008' Russell et al, 2009), pay, work conditions (Baptiste, 2008; Macky & Boxall, 2008; Mauno et al, 2006; Vanroelen et al, 2009; Wood, 2008), and OHS. The issues related to wellbeing that were identified by employees in the case organisations were work conditions (pay), workload, and some identified meaningful work. Managers identified different issues from employees, which were: financial difficulties and stress. However, managers tended to attribute negative employee outcomes to individual employees' characteristics or personal circumstances. Managers and employees, therefore, had differing perceptions of what was important for employee wellbeing.

One of the most important issues identified by employees was pay, an international problem in the sector (Bach et al., 2009; Kaine, 2010; Kiata & Kerse, 2004; King & Meagher, 2009; Lazonby, 2007; Martin, 2007; Mears, 2009; Palmer & Eveline, 2010). Low pay was not identified by managers as an issue that might impact on employee wellbeing. They did however mention the financial difficulties and stress that employees suffered. Financial stress was attributed by managers to a lack of skill in budgeting, for example, or the caregivers' low socio-economic background, rather than low pay. Low pay was not perceived by managers to result from their management, but from circumstances beyond their control: the funding of the industry in general.

Pay was an issue at every case organisation except Religious Care. This may have been because the manager had been trying to reasonably increase wages. Some research in residential aged care does point to better conditions in not-for-profit organisations than in profit based ones (Comondore et al., 2009; Kiata et al., 2005; Lazonby, 2007; Martin, 2005; McGregor et al., 2005), although this is debated (Gustafsson & Szebehely, 2009; King & Martin, 2009), and conditions varied even among the three not-for-profit case organisations in this thesis.

Financial difficulties were exacerbated by variable hours rosters at the National Aged Care and Not-For-Profit facilities. Variable hours allowed the managers to reduce staffing levels when bed occupancy lowered. However, the impact on employees was that they did not have a guaranteed income from one roster to another, even though they were permanent employees.

Managers tried to compensate for low wages through other means. These included budgeting and financial advice in training for employees. A further way in which the managers tried to compensate for low wages was in providing 'rewards' or special occasions for employees. The purpose of these was to show appreciation for the employees through means other than higher wages.

Training was also perceived by managers to be a benefit to employees that may compensate for low wages. However, training and education were increasingly required by the regulatory environment, rather than employee demand. Training was in many respects important to employees, but it was perceived as yet another duty added to an already difficult workload. Furthermore, a large amount of the national aged care qualification was carried out through self-directed study. This meant that the caregivers often had to undertake the qualification in their own time. Unpaid time studying contributed to employees' opinion that the training and education benefited the organisation more than themselves.

Employees at the National Aged Care and Not-For-Profit facilities identified workload as an issue that impacted on their wellbeing. The managers at both these organisations viewed their staffing levels as adequate. The way in which workload caused stress for employees at the National Aged Care facility was twofold: the intensity of work and the fact that many of the caregivers took pride in providing quality care. This sense of pride in their work, and in doing important caring work, to some extent compensated for the low pay (Bach et al., 2009; Martin, 2007; Palmer & Eveline, 2010). However, the amount of work they had to complete in a shift meant that they could not provide the level of care they wanted to. This caused them stress and also lowered their morale (Carryer et al., 2010). At the Not-For-Profit facility, the workload impacted on health and safety. The OHS representative indicated that inadequate staffing meant that caregivers would often undertake a two-person lift by themselves because they could not afford the time to wait for a second person to help. This practice led to back injuries, and sometimes injuries to residents also.

Stress was an issue at the case organisations. Managerial responses to employee stress were based on their perception that personal circumstances were the cause of most stress. There were some exceptions to this view. The facilities manager at Charitable Trust Care strongly advocated work-life balance as part of making his employees' work lives more comfortable. The manager at Religious Care, rather than holding the individual employee responsible, talked about the difficulties of balancing work and

childcare. She saw this as a current problem due to the inflexibility of childcare arrangements in New Zealand.

Managers at all four organisations took somewhat paternalistic approaches to employee stress. Workplace conditions, such as workload, employee-centred flexibility and pay, generally were not addressed. Managers instead took the approach of instructing stressed employees to take leave to allow them time to recover, or to organise their personal lives. On occasion stressed employees would also be persuaded to permanently reduce their hours in order to lessen their experience of stress. Research in residential aged care has suggested that the traditional hierarchies between nurses and caregivers influences the nurse managers' attitudes towards employees (Dodson & Zincavage, 2007; Jervis, 2002; Nishikawa, 2011; Palmer & Eveline, 2010; Ryosho, 2011). The professional hierarchies would also be exacerbated by the difference in educational status between nurses and caregivers. As low skilled employees, caregivers are considerably less educated than nurses, and therefore also likely to experience a greater power imbalance than nurses in a residential aged care facility.

Employees' response to managing work and personal responsibilities was to provide team support for each other. Employees at Charitable Trust Care and Religious Care in particular were very aware of each other's personal lives. Employees' awareness of their colleagues' personal lives was not mentioned at the Not-For-Profit and National Aged Care facilities. This may have been in part because of organisational structure. It is possible that the single-site facilities foster a greater sense of community because administration, managers and employees are based at a single site, as opposed to dispersed across multiple sites in the national organisations. Another explanation is that both Charitable Trust Care and Religious Care were located in smaller centres where there was a greater sense of community in general, than in metropolitan Auckland where the Not-For-Profit and National Aged Care facilities were located.

Overall, employees felt that their primary concern for wellbeing, pay, was overlooked. Low pay was an issue that employees perceived management had little control over. It was perceived by both employees and managers to be related to government funding of the sector, and managers themselves expressed a lack of influence over pay rates and government funding.

Gender and Power in Wellbeing and Participation

Across all four case organisations, the balance of power remained strongly with managers. Caregivers were more disadvantaged than nurses in the power relationship because registered nurses were sometimes scarcer in labour supply and were also more highly valued. The overwhelming reason for caregivers' lack of power was the gendered notions of care work. Consequently, care work has been low paid and viewed as low skilled work because it is seen to be work that is vocational and carried out by women, originally without pay in the domestic sphere (King & Meagher, 2009; Palmer & Eveline, 2010; Stack, 2003). Power relationships are further influenced by intersecting identities of ethnicity and gender in care work as indicated in these case studies by differences between managers who were all pakeha, and caregivers who represented a number of different ethnicities (Dodson & Zincavage, 2007; Ryosho, 2011). Professional hierarchies and power impacted on the effectiveness of participation for employees because managerial influence determined the issues considered and how decisions arising from employee participation would be treated. In some cases representation in OHS committees was greater for nurses than for caregivers, despite caregivers comprising the majority of employees in the organisation. This too relates to gendered notions of care which render caregiving as lower status and value than nurses (Bach et al, 2009; Jervis, 2002; Stack, 2003).

Employee wellbeing was strongly impacted on by gendered notions of care work. This was reproduced at an organisational level by managers who although consciously spoke of the skill and dedication required of caregivers, but unconsciously reverted to concepts of caregivers being low skilled, low educated and in need of managerial direction. This was a particularly interesting finding because the managers were all female themselves, indicating the pervasive nature of gendered notions of care work, but also the role of power and hierarchies in the health professions (Bach et al, 2009; Jervis, 2002; Stack, 2003). This resulted in negative effects on caregivers' wellbeing. The impact of low wages on their wellbeing was not recognised by managers who attributed financial difficulties to the caregiver's individual inability to manage their own personal lives (implicitly because they are low-skilled, low educated employees). Low wages also negatively impacted on caregivers' work-life balance because they often sought additional shifts in order to earn sufficient money to cover living costs.

There is a large proportion of caregivers employed in part-time positions in the residential aged care sector. These proportions were not always reflected in the four case studies with overall about half of all employees full time and half part-time. Part-time work is often associated with women's choices to balance work and family life. However, patterns of employment in the case organisations clearly indicated managerial power, rather than employee choice. Several caregivers interviewed expressed the desire for more work, or often took temporary additional shifts to supplement their usual roster. Furthermore, the two national organisations did not provide guaranteed hours to their employees. Employees were employed as either part-time or full-time, with the range of hours varying from one roster to another.

Managerial power in employment patterns also influenced the workload of employees in the case organisations. There was reluctance on the part of managers to engage casual employees from agencies because of the expense involved and also because of perceived disadvantages to consistency and quality of care. This was also expressed at an industry level by a New Zealand Aged Care Association representative. The impact on caregivers and other employees was that workload would be increased to cover temporary staffing shortages, or current employees would be asked to take extra shifts.

Managerial power at an organisational level mirrored owner and managerial power at the industry level which excluded employee representation on the nationally agreed *Age Related Residential Care Services Agreement.* This lack of representation was directly influenced by gendered notions of care work that undervalued the work that caregivers carry out (King & Meagher, 2009; Palmer & Eveline, 2010; Stack, 2003). This was acknowledged by industry representatives who at the same time expressed the idea that they would not want wages to be too high (aside from productivity concerns) because then facilities would not retain the same quality of caregiver who currently is perceived to feel a sense of vocation for their care work which is what rewards them more than money. The manipulation of the sense of vocation as recompense for low wages is important in its role in reproducing gendered, undervalued notions of care (King & Meagher, 2009; Palmer & Eveline, 2010).

It could be proposed that these very gender and power relations impact on the nurse managers in the facilities. All managers expressed the opinion that caregivers were not paid enough, yet they also to some extent perceived themselves to be powerless to try to gain increases for their employees. They expressed the idea that pay increases for

caregivers were not possible because residential aged care funding is determined by government and therefore increased revenue to cover pay increases would be dependent on government funding policy. This is particularly pertinent given that the owners' association expresses the idea that current funding is sufficient for wages (but not sufficient to cover expansion of facilities) (Grant Thornton, 2010).

Approaches to Productivity and Organisational Performance

Managerial choice, power relationships and organisational structures and processes shaped employee participation in the case organisations (Poole et al, 2001). One element of these decisions and structures was the manager's approach to productivity. The nature of residential aged care in New Zealand means that the primary consideration for productivity is that all beds are occupied. This secures government funding. The next most important consideration is the need to compete with other providers to attract residents, and therefore funding. The primary source of differentiation is in the standard, or quality, of care provided and the organisation's reputation. All four case organisations considered bed occupancy and quality care as important measures of organisational performance.

However, because the funding is regulated by the government and there are limited alternative sources of revenue, the cost of providing quality care was pivotal. The provision of quality of care had to be balanced with not only its cost, but also with the need to make enough profit to invest in developing the facility (Grant Thornton, 2010). Furthermore, depending on the ownership type of the organisation, some revenue needed to be allocated to return to the company and/or shareholders (Grant Thornton, 2010). Religious Care and Charitable Trust Care had no imperative to return profit, other than what might be required to further develop their facilities. The Not-For-Profit facility was expected to at least break even, but also had some leeway through the parent company. The National Aged Care facility was required to meet budget and return some profit and was not subsidised by the national operation. National Aged Care and Not-For-Profit had facility budgets, including staffing costs, that were set by head office.

Generally, the managers of the facilities had to ensure provision of high quality care through effective use of their human resources. There appeared to be three approaches

to this across the case organisations: (1) a focus on increasing the efficiency or work processes; (2) increasing staffing levels; and (3) a minimalist approach to staffing.

Charitable Trust Care and the Not-For-Profit facility attempted to increase employee participation in order to improve organisational performance. Both organisations focused on participation that would identify weak or inefficient work processes and improve them. Although this is often linked in the research with HPWP, the approach at Charitable Trust Care did not match HPWP expectations. The manager introduced low or no cost initiatives such as quality circles and staff forums. However, staff skills and knowledge, as well as performance incentives, were not emphasised as much as might have been expected in an HPWP environment (Appelbaum et al., 2000). The Not-For-Profit facility on the other hand clearly incentivised the additional training and development through salary steps related to levels of training and experience.

In contrast, the manager at Religious Care's approach to improving productivity and organisational performance was less developed. Her underlying assumption about quality of care was that it could only be achieved when staffing levels were safe, and pay was sufficient. Her approach therefore was to invest in increased staffing levels, pay and training, rather than focus on more efficient work processes. She perceived that her approach had already improved organisational performance. The improved quality of care and reputation as a good employer had improved Religious Care's reputation as a provider of residential aged care.

The National Aged Care facility had the least clear approach to productivity and organisational performance. Quality of care was very important, and this was communicated to employees. Training was encouraged for caregivers and especially registered nurses. However, overall, the approach in general appeared to be to minimise the cost of employing staff with particular reference to minimising staffing levels.

How are Productivity, Participation and Wellbeing Connected?

The four case organisations illustrate a connection between the effectiveness of representative employee participation and employee wellbeing (Gaffney, 2002). . Representative participation appeared to be the most effective at Charitable Trust Care. Followed by Religious Care, which had high union density. The employee outcomes at these two organisations were superior to those found at the National Aged Care and

Not-For-Profit facilities – the latter had particularly low levels of representative participation which was not very effective.

Furthermore embeddedness of participation, direct and representative forms (Cox et al, 2006), had a positive effect on wellbeing. The National Aged Care facility had very limited employee participation overall. Employees there reported higher levels of stress and dissatisfaction with workload and staffing levels. They did not feel able to change these situations. The Not-For-Profit facility had limited employee participation. Employees there also reported stress caused by unpredictable weekly hours, and a negative effect of staffing levels on health and safety.

Religious Care had limited direct participation, but the manager encouraged representative participation. Employees reported increased levels of confidence and wellbeing through social support at work, which may improve job satisfaction and the ability to cope with stress (King & Meagher, 2009; Schmidt & Diestel, 2010). There was also some indication that the improved confidence and wellbeing may begin to influence participation at Religious Care. Some of the activities available, such as sports teams, were beginning to be instigated by employees rather than the manager. Although the participation was limited in the issues it covered, it is possible that it was the beginning of the development of increased participation across broader issues.

There were clear indications that the productivity approach of managers influenced how employee participation would be implemented. For example, at Charitable Trust Care the manager had a strong focus on improved efficiencies in work processes. This resulted in a number of direct participatory practices that encouraged improvements to work processes, for example quality circles and employee suggestion schemes. The manager at Religious Care had an approach that prioritised employees. She felt that if she looked after her employees then quality of care would result from that. Her approach resulted in strengthened union membership and a focus on employee physical health and social inclusion through participation. The Not-For-Profit facility had a quality improvement focus on human resources. Their principal measure was to have a workforce that was skilled and able to meet organisational needs. Meanwhile, the manager at the National Aged Care facility was cost focused. She intended to provide quality of care at minimum costs. There was almost no employee participation at the National Aged Care facility.

Employee wellbeing did influence organisational outcomes. While the manager at Charitable Trust Care felt her staffing levels were sufficient, this was challenged in a

year in which there was high incidence of influenza. The higher numbers of employees taking sick leave meant the facility had had to reduce training because there were insufficient employees to cover the work. It could be argued, therefore, that good staffing levels, as an indicator of wellbeing, influence organisational productivity and performance.

Absenteeism had also negatively impacted on organisational outcomes at Religious Care. Prior to the manager increasing staffing levels, caregivers would fail to present at work. This had caused significant difficulties in planning workload and care. The manager reported that since staffing levels and pay had increased there were no longer the same issues with absenteeism.

Traditional measures of productivity have been shown to be inadequate for service work (Given et al., 2010; Palmer & Eveline, 2010; Stack, 2003). This is particularly so in residential aged care where quality of care is an important organisational outcome. Managers at both Religious Care and the Not-For-Profit facility expressed the opinion that happy or well looked after employees would result in higher quality care. This was a significant link between employee wellbeing and productivity, which was also indicated by employees at the National Aged Care facility who, in accord with other research into residential aged care employees (Carryer et al., 2010), expressed frustration that the staffing levels were not sufficient for them to provide the standard of care they felt was desirable.

The Role of the External Environment

Power and gender in the residential aged care sector are fundamental to the relationship between productivity, employee participation and employee wellbeing. Chapter Five illustrated this relationship at the sector level, which was very much influenced by gendered views of care work that perpetuate the low value attached to the skills and knowledge required in residential aged care work (King & Meagher, 2009; Palmer & Eveline, 2010; Stack, 2003). The workforce is highly feminised, and research into aged care points to the gendered views of care work as the cause of this. The low value ascribed to the skills of aged care workers because of their gender decreased their power in the sector so that organisational outcomes take precedence over employee outcomes.

Government and owner representative views have considerable influence in the sector. The government is the key funder for residential aged care. Government and owner views of productivity include the minimisation of staffing costs through re-allocation of skills to lower paid jobs and the improvement of work practices (Grant Thornton, 2010). The government view of the role of the health workforce is to have a 'fit-for-purpose' workforce (Health Workforce New Zealand, 2011). From that perspective employee outcomes would only be considered to the extent that they clearly fit the needs of the organisation.

It is not surprising, therefore, that employees and their representatives have little opportunity for participation on the sector level. Union representatives were excluded from the negotiations for service agreements in the sector. Consequently, employee outcomes are not considered in those agreements. Unions' response to the conditions in the sector have been to join forces in a campaign to strengthen their position overall. The caregivers' and nurses' unions have also negotiated together for multi-union enterprise bargaining. One change in the sector that may work in the unions' favour is the increasing role that multiple-site national organisations have. The number of single-site organisations has impeded union organisation.

The way in which residential aged care is perceived has had an enormous impact on the sector. Although several of the managers interviewed noted the increasing skills and knowledge required of caregivers, they still adhered in practice to the view that it was a low or unskilled job. Consequently, while additional training was required of caregivers, it was often on caregivers' own time and sometimes had no positive effect on how much they were paid.

The dominant gendered view that aged care work is low or unskilled impacted on the influence the employees had in the labour market. Registered nurses, required to have at least degree-level education and regular training and registration, were in greater demand. Although demand for caregivers in aged care is increasing, because it is seen as low skilled work anyone can take a job in the sector. There are no special skills, knowledge or qualifications formally required. Therefore, while registered nurses have been able to leverage a skill shortage and gain increased pay rates, caregivers have not been able to do so to the same extent.

The dominance of government and owner views also restricted the managers' own sense of instrumentality in the sector. This was especially the case with reference to the low pay levels for caregivers. Managers accepted the low pay rates as inevitable. They did

not necessarily agree that the wages were fair, but took no action to change the rates. Government funding was seen as the over-riding cause of low pay rates, not the way in which budgets were allocated. The general manager of the Not-For-Profit facility specifically mentioned that although she would like to pay caregivers more, she was restricted by government funding.

Employee participation was limited in the four case organisations. However, there was some form of participation for health and safety across the board. This was in response to the regulatory environment. The Health and Safety in Employment Amendment Act 2004 requires organisations of greater than 35 employees to provide opportunity for employees to participate (Lamm, 2009). A further significant regulatory influence in all four organisations was the Accident Compensation Corporation system. Religious Care, Charitable Trust Care and the National Aged Care facility all were part of the Accident Compensation Corporation Workplace Safety Management Practices Programme. The Not-For-Profit facility had joined the Accident Compensation Corporation Partnership Programme. The audit parameters for these schemes included employee participation in health and safety, and also union participation (ACC, 2002). However, although the Health and Safety in Employment Act 2002 defines stress and fatigue as a workplace hazard (Brough, 2005; Lamm, 2009), these issues and causes were given little consideration in the case organisations. One potential reason for the lack of consideration of stress and fatigue could be the influence of the Accident Compensation Corporation compensation categories. Accident Compensation Corporation does not include stress as a workplace injury and it is therefore not compensated.

There was limited opportunity for direct participation in any of the case organisations. This is comparable with other research into residential aged care. The lack of autonomy in caregivers' jobs is in part due to the traditions of nursing that are highly hierarchical, and routinised (Jervis, 2002; Stack, 2003). The perception of aged care work as low skilled also means that skills beyond physical care are not recognised (Nishikawa, 2010). Therefore, the aspects of their work that would lend themselves to further autonomy, such as observation of residents' health, are unrecognised. Some research suggests greater autonomy would maximise the use of skills and knowledge of aged care workers for organisational outcomes (Bonias et al., 2010; Harley, 2007).

Although demand for aged care workers is projected to increase, the gendered perceptions of care work remain. Furthermore, these power imbalances in the sector may be reinforced with increasing migrant labour (Ryosho, 2011). Migrant labour is

perceived by government and owner representatives as a solution to the increasing need for aged care workers because the workers are predominantly recruited from developing countries and therefore wages will not need to increase significantly with increased labour demand.

External factors to the case organisations have significantly influenced the relationship between employee participation, employee wellbeing and productivity. This is through formal regulation, such as legislation requiring OHS participation, and funding for the sector. Perhaps greater influence, however, has come from the role that gender and ethnicity play in the power relationships in the sector. These power relationships maintain the weak position of caregivers in the sector.

Conclusion

Power relations, underlined by gendered perceptions of aged care work, shaped employee participation and wellbeing at both the sector and organisational levels. The lack of value ascribed to aged care work resulted in limited union participation at sector level. In particular, unions were excluded from national negotiations for the Age Related Residential Care Services Agreement. Consequently, employment conditions are overlooked in the agreement. This has led to little change in wages for residential aged caregivers, who identified low pay as a key concern for their wellbeing.

Limited employee participation at the sector level is mirrored at the organisational level. Generally employee participation is limited, and is strongly influenced by managerial choice and organisational structures (Kaine, 2011; Marchington et al., 1993; O'Donoghue et al., 2011; Poole et al., 2001). The managerial influence is, of course, supported by power imbalances between employees and managers. Gender, ethnicity and professional status all contribute to the power relationship (Pocock et al., 2011), leaving caregivers at a disadvantage in comparison to their managers.

Despite limited employee participation, the findings illustrate a connection between effective representative participation (Gaffney, 2002) and employee wellbeing. Representative participation and union participation is also associated with increased opportunities for participation overall (Charlwood & Terry, 2007; Cooke, 1994; Haynes et al., 2005; Markey & Patmore, 2011; Reilly et al., 1995; Walters, 2004). Furthermore,

the findings suggest that union participation is linked with improved effectiveness for employees of direct forms of participation at an organisational level (Kim et al., 2010).

As noted above, employees identified pay as the most important issue for their wellbeing. This was closely followed by workload and work intensity. Interestingly, social support had a considerable role in employee wellbeing. Social support was provided informally by colleagues, and at Religious Care through organised sports teams and activities. Managerial perceptions of wellbeing were different from employees': managers attributed poor indicators of wellbeing, such as stress, to individual employees' lack of skill or personal circumstances rather than workplace conditions. Managers took an almost interfering approach to individual employees' wellbeing in the form of instructing stressed employees to take leave and to permanently reduce their hours. Again, this reflects power differences in the relationship between the employees and their managers.

The external environment had a pivotal role in the wellbeing of employees. Low wages were perceived by managers to be because of low funding at sector level. Managers did not perceive that low wages and associated employee stress were related to the way in which managers prioritised budgets. Some employees shared this view, although union delegates in particular expressed the view that managers and the organisations could increase wages if they made less profit, or re-organised budgets.

Finally, managers' approach to productivity shaped the way in which employee participation was implemented at an organisational level. There were three approaches to productivity apparent in the case organisations: (1) a focus on increasing the efficiency of work processes; (2) increasing staffing levels; and (3) a minimalist approach to staffing. The extent to which the manager viewed employee wellbeing as pivotal to desired outcomes such as quality of care guided the way in which participation was implemented. Notably, Religious Care increased staffing levels, and had union membership, because the manager viewed this as the source of improved quality of care. In contrast, the National Aged Care facility had minimal employee participation coinciding with the manager's approach to minimise staffing costs.

This chapter has analysed the four individual case organisation findings together. It has compared the differences and similarities between organisations and with the external environment at a sector level. The following, final chapter considers the initial research questions of this thesis and suggests areas of future research that arise from the thesis.

Chapter Ten: Conclusion

Employee participation, productivity and employee wellbeing in residential aged care is strongly underpinned by gender and ethnicity and their role in power relationships. These relationships occur at a sector level and influence the way in which employee participation, productivity and employee wellbeing interact at an organisational level. Gendered concepts of care influence wages, and the owners' narrow approach to productivity influences both participation and employee wellbeing.

This chapter considers the relationship between employee participation, productivity and employee wellbeing introduced in Chapter Two. The research questions for the thesis are reviewed in relation to how they have been addressed. The chapter concludes by discussing the contribution of this thesis and implications for future research that arise from it.

Chapter Three outlined the research questions for this thesis. They sought to investigate the relationship between productivity, employee participation and employee wellbeing. The thesis has done this both in an organisational context and within the broader context of the external environment. The specific research questions were:

1. Is there a relationship between productivity, participation and employee wellbeing?
2. What is the impact of effective representative employee participation on employee wellbeing?
3. How does the external environment, for example government regulations and industry standards, impact on the first two relationships?

These questions have been explored drawing on a critical feminist epistemology. This enabled examination of both formal and informal processes, such as gendered concepts of care, that influence the power that employees and managers have in these relationships. It influenced the use of case study research including semi-structured, in-depth interviews, which provided contextual information in each organisation through the experiences of the people interviewed.

Chapter Two reviewed the literature and defined employee participation, productivity and employee wellbeing for the purpose of this thesis. Employee participation was defined as including mechanisms that enable employees to influence and take part in

decision making. These include direct and representative forms, as well as union and non-union. This thesis similarly adopted a broad interpretation of productivity to include an organisation's self-selected measures of organisational performance. The definition of employee wellbeing was more prescribed, but still reasonably open. It included OHS, work-life balance, pay and work conditions.

These definitions were purposely broad because this research intends to explore relationships and processes. Broader definitions enable the researcher to gather more in-depth and contextual information, and also to allow the experiences of those researched to be highlighted (Brooks, 2007; Harding, 2007, 2008; Hekman, 2007; Naples, 2007). Broader definitions of participation and productivity may also have defrayed power imbalances between the researcher and those interviewed, especially employees with lower education levels, lower confidence or, for example, English as a second language. It enabled the research to go beyond the researcher's expected or defined concepts (Esim, 1997; Guba & Lincoln, 2008; Holgate et al., 2006; Kincheloe & McLaren, 2008; Olesen, 2008).

Chapter Nine illustrated that there is a relationship between productivity, participation and employee wellbeing. It is a relationship in which all three aspects are integral. For example, productivity and wellbeing have a reciprocal connection. Participation is also connected with employee wellbeing, specifically where multiple forms of employee participation occur in an organisation. The remainder of this chapter discusses the research questions in depth. It then outlines the key contributions of this thesis and the implications of this thesis for future research.

There were three different approaches to productivity apparent in this thesis: (1) a focus on increasing the efficiency of work processes; (2) increasing staffing levels; and (3) a minimalist approach to staffing. The first and third approaches, which intended to reduce labour costs, were influenced by narrow concepts of productivity based on outputs of labour as a factor of inputs. These types of measures do not allow for increased labour costs in industries such as service industries (Bartel, 2004; Batt, 2004; Dobni et al., 2000; Mathew, 2007; Theriou & Chatzoglou, 2008). They are also more difficult to apply to less tangible outcomes such as quality of care. Furthermore, they do not consider the broader context of the organisation and the impact of regulatory framework (De Greef & Van den Broek, 2004; Kopelmann et al., 1990; Lamm et al., 2007; Levine & D'Andrea Tyson, 1990).

Even though several managers considered ways of improving efficiency of work processes and reducing labour costs, there was still some recognition that narrow concepts of productivity were limited in use for residential aged care. This was because quality of care was one of the key measures of organisational success. It was defined to some extent by numbers of injuries, falls and infections among residents. It was also somewhat nebulously viewed as the *atmosphere* of the residential aged care facility: a family atmosphere, a lack of unpleasant odour, a nice place to be. These measures are subjective and difficult to accommodate into narrow definitions of productivity (Givan et al., 2010; Palmer & Eveline, 2010; Stack, 2003). Quality of care was connected to the reputation of the facility in the community, and therefore the demand for beds, a more objective measure.

One difficulty of quality of care as an organisational performance measure is that it is provided by human service work. While the numbers of hours worked may be measured, it is more difficult to quantify the effort or cost of an employee in relation to good care. Quality of care may be associated with increased staffing levels and, therefore, increased costs. Residential aged care research has pointed to the role that increased staffing has in quality of care (Duffield et al., 2010; Givan et al., 2010; Haapakorpi, 2009; Meagher, 2006; Schmidt & Diestel, 2010; Stack, 2003). This may be why more efficient work processes were perceived as desirable in order to reduce costs and allow more time for care.

However, at the sector level both government and owner representatives clearly assumed narrow approaches to productivity (Badkar, 2009; Badkar et al., 2009; Grant Thornton, 2010). The approach of government and owners implicitly requires greater managerial control of the workplace and work conditions (Richardson et al., 2010). Weaker employee power was indicated in the exclusion of unions, by government and owners, from negotiations for the service agreements in the sector. Employee outcomes were not so much overlooked, as viewed largely irrelevant to the desired productivity increases.

At an organisational level, there was more concern with employee outcomes because it was perceived to be important for quality of care. Employee wellbeing has an important effect on organisational outcomes which is well documented in terms of job satisfaction, stress, turnover and OHS outcomes (Baptiste, 2008). Furthermore, in care work, satisfaction and staffing levels affect quality of care (Bonias et al., 2010; Carryer et al., 2010; Schmidt & Diestel, 2010). One further factor worthy of consideration is workload

and work intensity. This was an issue for many employees in this research, and indeed is an international trend in residential aged care (Boyd et al., 2008; Carryer et al., 2010; Duffield et al., 2010; Haultain, 2011; Lazonby, 2007; King & Meagher, 2009; Palmer & Eveline, 2010). Workload and work intensity are also associated with increased stress levels and decreased satisfaction (Karasek, 1979).

Chapter Two defined wellbeing as incorporating work-life balance, pay, OHS and work conditions. This was confirmed by employees in this study. However, what was not predicted was the priorities of employees. For nearly all, pay was a high priority that impacted on their work and personal lives. Social support at work was also important. For some, social support was provided formally, as at Religious Care. At other workplaces it occurred informally, through teams acknowledging each other's domestic responsibilities and arranging their work around them. Interestingly, OHS appeared to be more a concern for organisational outcomes than for employee wellbeing.

Managers' concepts of employee wellbeing were different from those of their employees. This is, to some extent, congruent with existing wellbeing literature which has investigated wellbeing as an individual concern (Danna & Griffin, 1999; Lamm, 2010; Page & Vella-Broderick, 2009). Consequently, negative outcomes are often perceived to be the employee's responsibility. This perception of individual responsibility for negative outcomes was apparent in three of the four case organisations (National Aged Care, Not-For-Profit, Charitable Trust Care). Despite residential Aged are's reputation for low pay and increasingly harder work, even matters such as financial stress were viewed as resulting from employees' inability to manage their finances.

Work-life balance is a critical aspect of employee wellbeing (Baptiste, 2008; Brough, 2005; Danna & Griffin, 1999; Guest, 2002; Kochan, 2000; Macky & Boxall, 2008; Mauno et al., 2006; Wilkinson et al., 2007). Work-life balance was often achieved by employees through informal team support. As with outcomes such as stress, managers perceived that any conflict between work and home life was caused by an individual employee's inability to manage their responsibilities.

Although negative employee outcomes were often attributed to employee responsibility, positive outcomes were identified as the result of managerial action (Karasek, 1979; Delaney & Godard, 2001; Macky & Boxall, 2009). Managers in this research were eager to pinpoint positive employee outcomes of training, incentives and information sharing. Some outcomes they identified were: improved communications and

relationships at work; increased confidence and skills; and positive influence on family life. However, managers did not recognise systemic issues, such as low pay, or power relationships and the role they had in employee wellbeing.

Productivity influences employee wellbeing. This study showed how the connection occurred at a national level, specifically through the funding for residential aged care and government direction that focused on cost and efficiencies rather than working conditions for employees. Narrow approaches to productivity, such as this, appear to result in poorer working conditions for employees. This is also influenced by power relationships, and in particular the roles of gender and ethnicity. Gendered perceptions of care work justified low wages and narrow productivity approaches. Assumptions of 'poor' migrant workers strengthened owners' power and further influenced the negative influence of their productivity approach on employee wellbeing.

Employee wellbeing influences organisational outcomes or productivity. This is most apparent in turnover and absenteeism, but also in the quality of service for customers. There are, for example, connections between employee stress, including financial stress (Ejaz et al., 2008) and quality of care (Bonias et al., 2010; Schmidt & Diestel, 2010).

Productivity also influenced how employee participation was implemented, for example where the manager's focus was on improving efficiencies employee participation centred on direct participation with issues related to work processes and quality improvement. Where a manager used broader measures of organisational performance that included staffing levels and workload, employee participation appeared to be more focused on union representation and representative participation.

Power relationships influence to what extent employee participation favours organisational or employee outcomes. Employee participation has been linked with decreased stress and fatigue (Grawitch et al., 2007; Karasek, 1979; Macky & Boxall, 2008) and improved job satisfaction and commitment (Baptiste, 2008; Berg et al., 2003; Grawitch et al., 2007). There are links between improved OHS outcomes and participation also (Bohle & Quinlan, 2004; Charlwood & Terry, 2007; Cooke, 1994; Grawitch et al., 2007; Haynes et al., 2005; Markey & Patmore, 2011; Sorensen et al., 2009; Walters, 2004; Walters & Frick, 2000).

The second research question of this thesis was to examine what effect representative participation has on employee wellbeing. Although employee participation was limited across the case organisations, it is clear that *effective* representative employee

participation does have a positive influence on employee outcomes. However, employee participation has the greatest effect on employee outcomes when it occurs in multiple forms in one organisation, including direct and representative, union and non-union, forms of participation, confirming previous research (Cox et al., 2006; Kim et al., 2010; Markey & Patmore, 2011). This has been described as 'embeddedness' and it indicates how integral employee participation is to the organisation (Cox et al, 2006). It suggests that employees have more influence over a greater range of issues when employee participation exists in multiple and connecting forms. Union representation has also been found to support the effectiveness of the OHS committees (Charlwood & Terry, 2007; Cooke, 1994; Haynes et al., 2005; Markey & Patmore, 2011; Reilly et al., 1995; Walters, 2004). Union representation has been shown to support other forms of participation through training, increased job security, and information sharing (Haynes et al., 2005). Some research has also indicated that employee participation is more likely to consider broader issues such as work conditions in organisations with union presence (Marchington, 1992). This thesis confirms the findings of the participation literature and contributes to the understanding of multiple forms of participation.

The third research question of this thesis was to investigate the influence of the external environment on the relationship between productivity, participation and wellbeing; and also its influence on effective representative participation and employee wellbeing. Poole et al. (2001) propose that rather than managers and organisations alone, the external environment in the form of the 'actors' in the employment relationship, as well as organisational structures and processes and managerial choice, influence patterns of employee participation.

The gendered notions of care work and consequent outcomes for employees at both organisational and sector levels determine power relations to a large extent (Pocock et al., 2011). Care work has little or no monetary value because it is perceived to be low skilled work that is replacing work that would 'usually' be carried out unpaid in the domestic sphere by women (Herzog & Morgan, 1992; Kaine, 2010; Martin, 2007; Palmer & Eveline, 2010). The result of this is that the balance of power remains solidly with manager and government interests in the employment relationship.

The imbalance of power at the sector level meant that the approach of the government and owners to productivity directly affected employee wellbeing. The starkest indicator of this in New Zealand is the funding for residential aged care. The narrow approach to productivity on the part of the government and owners intends to minimise the cost of

labour. This in itself perpetuates the low value and therefore low pay for caregivers in the sector. The impact on employee wellbeing, as identified by employees, was significant.

Furthermore, the focus on cost may necessitate tighter control over labour (Richardson et al., 2010). Consequently, unions are excluded from the negotiation of the national agreements between district health boards and residential aged care providers, employment conditions are overlooked. This lack of opportunity for employee participation continues the power imbalance that favours organisational outcomes. Therefore, low wages and conditions are maintained.

The regulatory environment influenced employee participation in OHS. This was through legislation requiring employee participation, but also through the state funded Accident Compensation Corporation. To some extent, the requirements of the Accident Compensation Corporation audits influenced the issues that employees could discuss and have influence over in their workplaces. Specifically, although OHS legislation includes mental harm and fatigue as workplace hazards, these are not considered workplace *injuries* that will be compensated for by the Accident Compensation Corporation. While this study is limited because it is case study research in a specific sector, the OHS legislation and Accident Compensation Corporation cover all industries in New Zealand. It is possible that the findings of this thesis may be comparable to other industries.

One external factor that may influence the power relationship at a sector level is the labour market. Residential aged care is a growing sector with an aging workforce. It might be considered that this would place caregivers and other employees in the sector in a stronger position in the employment relationship (Hyman, 1981). However, owners and managers are increasingly seeking migrant labour from developing countries. Research into ethnicity and residential aged care employees has identified that when gendered assumptions coincide with racial stereotypes and assumptions employee power is weakened further (Dodson & Zincavage, 2007; Kiata & Kerse, 2004; Neysmith & Aronson, 1997; Ryosho, 2011). Owners and government perceive employees from developing countries to be more amenable to the existing low wages than New Zealand employees (Badkar, 2009; Badkar et al., 2009; Grant Thornton, 2010). This is because they are perceived to come from countries with lower wages and worse conditions than New Zealand's.

External factors, including formal and informal regulation, influence the relationship between employee participation, productivity and employee wellbeing. They influence how employee participation manifests at both the sector and organisational levels. The sectoral power relationships influence whether organisational or employee outcomes will be the focus of employee participation.

Contributions and Implications of this Thesis

This thesis makes several contributions to the literature in employee participation, employee wellbeing and productivity. Firstly, the productivity approaches of the case organisations influenced both employee participation and employee wellbeing. Productivity measures have also been criticised for a lack of attention to costs and benefits outside of the organisation (De Greef, 2004; Dorman, 2000). There is some indication in public debate in New Zealand that current productivity measures of residential aged care have a negative consequence for societal outcomes (New Zealand Aged Care Association, 2011; New Zealand Labour Party et al., 2010). The cost of providing care with minimum staff and work conditions for employees is not fully accounted for: the cost to employees and their families is unconsidered, and the cost to residents, families and communities is under-considered. Recent research in health care in particular has suggested that broader performance measures, including multiple stakeholders, should be utilised (Given et al., 2010). This suggests that productivity, particularly in publicly funded human service sectors, should include not only organisational measures (of which quality of care is one), but also the costs and benefits to society and employees.

The findings of this thesis lend support to the broadening of organisational performance measures to include employee outcomes. The inclusion of the 'cost' of low wages to the community and society may also contribute to a re-assessment of the value of care work. Furthermore, employee outcomes as measures of organisational performance may encourage greater participation of employees and their representatives at both organisational and sector levels.

Some research has suggested that employee outcomes of participation have been overlooked (Baptiste, 2008; Boxall & Macky, 2009; Guest, 2002; Conway & Monks, 2009; Delaney & Godard, 2001; Haynes et al., 2005). Studies also associate increased

direct participation with worsening employee outcomes (Busck et al., 2010; Fairris, 2002; Wood & Wall, 2007). Some researchers contend that effective representative participation will have more positive effects on employee participation, although this has not always been possible because of a focus on organisational outcomes (Busck et al., 2010; Hvid & Hasle, 2003). Although there is some debate on the role of employee participation in employee outcomes, this thesis confirms that effective representative participation has a positive effect on employee outcomes.

The findings of this thesis confirm the pertinence of analysing the effect of multiple and interacting forms of participation in an organisation (Cox et al., 2006). Effective and embedded employee participation also positively influences employee wellbeing. Consequently, the findings of this thesis suggest that if employee outcomes could be considered at the centre of this relationship, rather than as a by-product of the relationship between employee participation and productivity (Baptiste, 2008; Kalleberg et al., 2009; Pyman et al., 2006), this might strengthen employee power and participation. Employee outcomes would thereby be improved, and productivity or organisational performance, resulting from participation and improved employee wellbeing, might improve as well. Furthermore, it would facilitate the analysis of power relationships and the impact of external factors in the residential aged care sector.

This thesis extends our understanding of the role that gender and power have in the relationship between employee participation, productivity and employee wellbeing. Poole et al. (2001) suggest that patterns of employee participation are influenced by external factors, including power relationships. However, particularly in employment relations, these suggestions have been based in traditional concepts of the power relationship between employees, managers and government (Dunlop, 1993; Edwards, 2005; Rasmussen, 2009). These assumptions overlook the role of gender in the employment relationship and generally focus on institutions and aggregate, anonymous workers (Danieli, 2006; Forrest, 1993; Holgate et al., 2006; Kirton & Greene, 2005; Rubery & Fagan, 1995; Wajcman, 2000). Such a framework is no longer adequate to understand the way in which power relationships are played out in workplaces (Forrest, 1993; Healy et al., 2006; Holgate et al., 2006; Kirton & Greene, 2005; Pocock et al., 2011; Rubery & Fagan, 1995; Wajcman, 2000).

The findings of this thesis make it abundantly clear that the external factors and strategic choices of the actors in the residential aged care sector are underscored by deeply held assumptions of gender and care work, at both organisational and sector

levels. These assumptions influence the power relationships between employees and managers, and therefore also influence patterns of employee participation. Furthermore, ethnicity influences the role of power in the relationship between employee participation, productivity and employee wellbeing. This thesis extends the employee participation and wellbeing literature by highlighting the way in which factors beyond formal institutions and regulation influence both organisational and employee outcomes. It clarifies some of the ways in which power influences these outcomes, with particular reference to gender and ethnicity. This is a finding that has not explicitly been addressed in the existing employee participation literature.

These findings suggest that future research could examine employee participation and its outcomes with an analysis of power that includes the way in which gender and ethnicity are played out in power relationships. This might be best undertaken with a consideration of the external environment that includes not only the regulatory framework of, for example, Dunlop's (1993) employment relationship, but also interactions with community and family (Kochan, 2000; Healy et al., 2006; Pocock, 2000; Pocock et al., 2011). Studies have indicated the role that ethnicity takes in the power relationship (Dodson & Zincavage, 2007; Kiata & Kerse, 2004; Neysmith & Aronson, 1997; Ryosho, 2011), which is situated in a context of increasing migrant labour in the workforce (Badkar, 2009; Badkar et al., 2009; Grant Thornton, 2010).

The findings of this thesis highlight the need for further research that investigates the role an international labour market will have on both employee wellbeing and employee participation. Future investigations could consider, for example, the effect of recruitment from developing nations on the employment conditions of all employees in the sector in New Zealand and how this influences power relationships and, in turn, employee wellbeing and participation.

In summary, this thesis has examined the relationship between employee participation, productivity and employee wellbeing. It has done this in the context of a highly feminised sector: residential aged care. A feminist epistemology contributed critical analysis of power and gender in this relationship which was used as a lens through which to interpret the experiences of the employees and managers involved in the research. This analysis illustrated that there are linkages between employee participation, productivity and employee wellbeing, but rather than being in a linear relationship, they are instead integral to each other. It also revealed that the most significant factor that influenced the relationship between employee participation,

productivity and wellbeing is the way in which work connects with the personal circumstances of employees and with greater society. In particular, it has shown the way in which gender regimes shape our expectations of care work, both in terms of the type of care expected and the work conditions for those who do the care work.

Appendix 1: List of Organisational Documentation

National Aged Care

Accident/Incident Action Plan

Accident/Incident Form

Accident/Incident/Near Miss Reporting & Examining Cause & Taking Corrective Action

Alternative Duties Form

A Safe & Healthy Work Environment

Blood Body Fluid/Needle Stick Injury Occupational Exposure

Early Report Form

Early Reporting of Pain or Discomfort – Policy & Procedure

Electrical Safety Policy

Emergency Planning & Fire Policy & Procedure

Environmental Policy & Procedure

External contractor service providers Health and Safety Agreement

Hazard Identification Form

Hazard Identification & Management

Hazard Identification Register

Health & Safety Management Policy & Procedure

Health & Safety Officer Job Description

Health & Safety Programme Introduction

Health & Safety Training Evaluation Form

Individual Rehabilitation Programme Consent Form

Injury Rehabilitation Checklist

Manual Handling Policy

Material Safety Data Sheets

New Capital Equipment Health & Safety Assessment

Noise Policy & Procedure

Orientation of Staff

Physical Hazard Inspection

Rehabilitation Action Plan

Rehabilitation Policy

Security Policy & Procedure

Staff Wellbeing at Work Policy

Stress Policy & Procedure

Terms of Reference Health & Safety Committee

Training Policy

Not-For-Profit

Career Path

Caregiver Training Programme

Combined Balance Scorecard

Lean Thinking Pilot

Health and Safety Committee Meeting Minutes Template

Health and Safety Induction Checklist

Health and Safety Plan for 2010

HR – Leave

Orientation Record Caregiver

OSH – Employee Participation

OSH – Management & Evaluation

OSH – Training and Supervision

Personal Best Programme

Quality Indicators (Clinical)

Quality Programme

Senior Management Structure

Staff Attitude Survey

Staff Survey Responses 2009

Work and Life Awards

Religious Care

NZACA Excellence in Care Awards application

Health & Safety Induction Training Checklist

Health & Safety Health & Safety Information for New Employees

Health & Safety Manual

Health & Safety Officer Responsibilities

Health & Safety Questionnaire (to accompany Induction)

Incidents & Accidents (for period of 1 year – graph)

Injury Sites (historical over 3-year period – graph)

Minutes of the Health & Safety Meeting (for period of 1 year)

Minutes of the Safe Environment Meeting (for period of 1 year)

Newspaper Article (on activities at workplace)

Occupational Health & Safety Policy

Organisational History

Organisation Wide Quality Risk Management Plan

Security

Smoking

Staff Education & In-Service Training

Stress Hazard & Controls

Terms of Reference for the Health & Safety Team

Workplace Bullying

Charitable Trust Care

Audit Schedule

Collective Employment Agreement

Discrimination & Harassment Policy

Equal Employment Opportunity Policy

Harassment Policy & Procedures

Staff Attitude Survey

Health and Safety Committee Meetings

Improvements to Our Work Areas Form

In-Service Training Schedule

Orientation Booklet

Orientation Programme Checklist

Quality Circle

Quality Circle Follow Up

Quality Management System

Procedural Points for Holding Staff Forums

Staff Rewards

Team Communicator Constitution

Welcome to the Charitable Trust Care (orientation booklet)

Workplace Bullying Booklet for All

Appendix 2: Survey Questions

Employee wellbeing – work-life balance

Do you think your work takes so much of your energy that it affects your private life?

Employee wellbeing – OHS outcomes

Have you suffered a work related injury in the last 3 years?

Have you experienced violence at work in the last 3 years?

Have you ever felt threatened at work?

Are you satisfied with the safety and comfort of your working conditions?

Does your work put you in emotionally distressing situations?

How often do you experience conflict at work?

How often have you felt stressed?

How often have you felt really tired from work?

Employee wellbeing – work conditions

Do you have more work to do than you can accomplish in one shift?

Do you agree that your work 'is a good place to work'?

Do you agree with the statement that 'I often think of leaving my job'?

Are you required to work overtime?

My work is strongly appreciated by management

Effectiveness of Representative Participation

Is there a health and safety committee at work?

If yes, who is on it?

If employees are on it, how are they selected?

Have you ever raised an issue for the committee?

If yes, was it dealt with satisfactorily?

How quickly was it dealt with?

What other ways can employees be involved in this organisation?

Direct Participation

Do you have significant influence on how much work you have to do?

I get information on important decisions, changes and future plans in due time.

I have significant influence on how my work is done.

I should have more influence at my place of work.

List of Statutes

Health and Disability Services (Safety) Act 2001

Health and Safety in Employment Act 1992

Health and Safety in Employment Amendment Act 2002

Hospital Regulations 1993

Injury Prevention, Rehabilitation and Compensation Act 2001

Minimum Wage Act 1983

Old People's Homes Regulations 1987

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* Denotes a reference that has been altered, or where specific details cannot be provided, in order to preserve the anonymity of a case organisation.