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Shield or Sword? Moral Distress in Australian Aged Care Employees Related to Regulation and Compliance

Abstract

This paper reports on one finding of a qualitative study using interpretive phenomenological analysis (IPA) in a mixed-methods study examining the relationship between leadership style and job satisfaction in aged care employees. The qualitative data suggest that aged care employees are experiencing moral distress relating to the regulatory environment that governs the aged care sector and the compliance processes adopted by regulators and accreditors.

One of the reasons for the design and operationalisation of the regulatory environment is to protect vulnerable consumers, the public and the workforce. However, the findings of this research are that it is this environment that also causes damage to the aged care workforce. The question is whether compliance requirements and the regulatory scheme itself a shield or a sword is. The causes of the moral distress were different for leaders and raters. This paper reports on this finding. Moral distress is one of three undesirable outcomes identified in the study and labelled as Workplace Maladies.

Moral distress due to regulatory systems and processes experienced by leaders appears to be caused by different factors than the moral distress experienced by raters. Leaders experienced moral distress because of the system and methods of regulatory and standards compliance. In contrast, their followership experienced other regulatory processes such as the scope of practice for health professionals and the requirement to supervise and accept responsibility for unregulated workers who do not have a scope of practice. Unregulated workers reported that the absence of scope of practice is a cause of moral distress.

Recommendations are made for changes to the system and processes of compliance assessment and action and for developing a scope of practice for unregulated workers to reduce the moral distress experienced by aged care employees and thus reduce workforce turnover in an already scarce workforce.

Introduction and Background

With the demand for aged care growing rapidly in Australia and globally, there is a consistent demand for an aged care workforce. The Australian Royal Commission into Aged Care Quality and Safety handed down its final report in February 2021. They found significant issues in aged care, and many of the recommendations in the final report represent a failure of leadership. The implementation of many of the recommendations of the Royal Commission requires well-trained and insightful leaders. These leaders will need to deal with the funding system's economic constraints, workforce shortages, safety and quality issues with the care delivered, and the system's ability to meet consumers' expectations. For these reasons, it is critical to understand what makes an effective aged care leader through their followers' eyes at all levels.

The mixed-methods study from which this paper is an output sought to answer questions relating to the effects of leadership style on organisational identification (OID) and job satisfaction (JS) in aged care employees. The study sought to determine what associations existed with leadership style and the strategies deployed to increase OID and JS. This research had ethics approval from the Griffith University Human Research Ethics Committee number MED/2017/030).

One qualitative finding was that leader and rater participants experienced significant moral distress due to their work in aged care as the basis of this paper. There were two other undesirable outcomes identified in the study. These undesirable outcomes were role stress that affected leaders' and raters' groups, and disengagement that was related only to members of the raters' group. The three undesirable outcomes were labelled as "Workplace Maladies" that are the subject of other papers that report on those findings in the future. Figure 1 details the streams of consciousness identified and the workplace maladies that resulted.

The design of the regulatory environment is to protect consumers and employees, yet the findings of the study suggest that the regulatory environment and compliance actions that result from the regulation cause damage in the form of moral distress for aged care workers. The researcher questioned whether compliance requirements and the regulatory scheme itself acted as a shield to protect the aged care consumers and its workforce or whether they are a sword damaging what they were designed to protect. The causes of the moral distress were different for leaders and raters. This paper discusses one of those workplace maladies, Moral Distress, related to the regulatory environment of aged care.

Literature Review

Moral distress occurs when the health or aged care worker makes a moral judgment about the care they are involved in delivering, and others in authority make it difficult or impossible for the care worker to act on that moral judgement [1-3]. The literature extensively reports moral distress in health and social care [2, 4-6].

The potential consequences of moral distress are that staff may become morally numb to situations that cause them an ethical challenge and render them unable to recognise or engage in situations requiring moral sensitivity [7]. The most damaging consequence of ongoing moral distress is job burnout [8]. Burnout is a psychological syndrome involving chronic emotional and interpersonal stressors that individuals' experience at work and their subsequent responses to their tasks, organisations, co-workers, clients, and themselves [9] and there are reports that care staff have considered leaving their position or profession due to moral distress [10, 11]. The findings of two studies record workforce attrition and turnover in aged care and that experienced aged care workers and professionals are at a premium. Moral distress is associated with job burnout and reduced JS [12-15], which is related to the provision of lower standards of care [14]. The current shortage of staff in the aged care system [16-18] means that the sector cannot afford to lose valuable and morally invested aged care workers at any system level.

A qualitative study reported in 2016 found that the primary source of moral distress arose from conflicts between their leaders and the expectations of the follower group of their role and their perception of insufficient resources in terms of time, staffing, technology, and poor support from leaders [19]. In a 2016 reported study that examined moral distress in intensive care nurses, Mealer and Moss

categorised strategies to prevent and deal with moral distress that described three groups of interventions. These interventions are, educational interventions, interventions focusing on enhancing the work environment, and interventions focussed on helping individuals cope with their work environment [20] and discussed interventions to promote resilience, such as mindfulness-based stress reduction, self-reflection, cognitive flexibility, self-awareness programs, journaling, and professional networking. Leadership development programs must be central in training leaders in these strategies must equip leaders with the skills to prevent and manage moral distress and job stress for their followers [21].

Method

The research used a mixed-methods approach that consisted of two separate but inextricably related studies. Study 1 was quantitative in approach and examined differences in responses between the Leaders who self-rated and those who rated them in the quantitative study labelled as Raters in this study. The online questionnaire contained three prior validated tools of the Multi-Factor Leadership Questionnaire [22], the Identification with a Psychological Group Scale [23] that measured OID and the Measure of Job Satisfaction [24].

Analysis of the response data for the differences identified in the two groups of leaders and raters was the basis of the agenda for semi-structured interviews deployed in the qualitative study (study 2). Study 2 implemented Interpretive Phenomenological Analysis (IPA) to understand better the Leaders' and Raters' lived experiences from transcripts of semi-structured interviews of semi-structured interviews designed around the areas of difference found in study . The IPA provided a more granular understanding of the identified differences and why they occur. The researcher used the Consolidated Criteria for Reporting Qualitative Research (COREQ) [25] for reporting guidance for the qualitative synthesis derived from the IPA.

Findings and Discussion

The participants of the quantitative study demonstrated similar demographics to those reported in the 2016 Aged Care Workforce study [26], and the participants of the qualitative study were drawn from the participants of the qualitative study. The IPA revealed four themes by clustering the streams of consciousness interpreted from the transcripts. Figure 1 shows the lower level threads (streams of consciousness) and clusters them to form a theme.
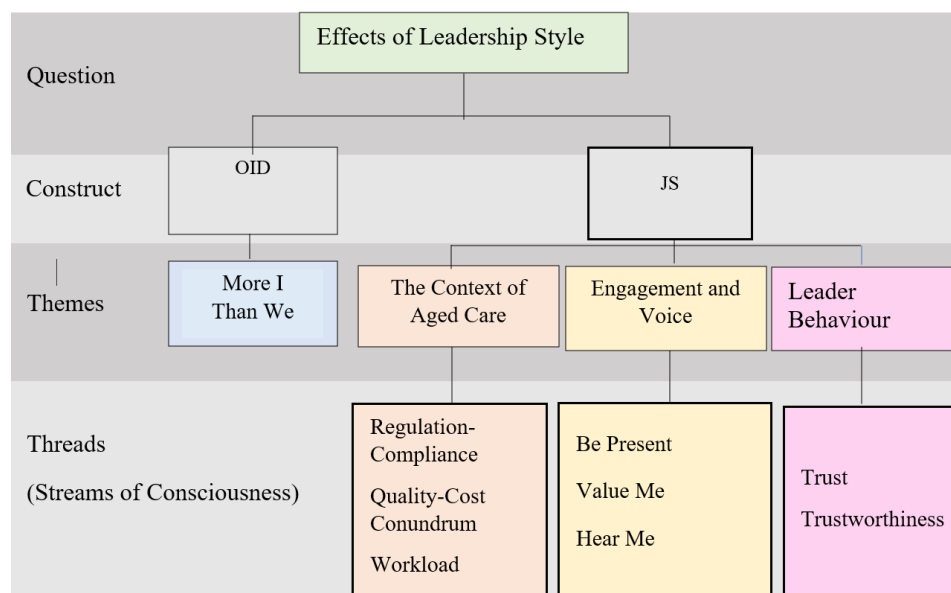

Figure 1- Cluster Map of Emerged Streams of Consciousness

Leaders and raters reported different causes of their moral distress they experienced. Participants of both groups raised legitimate concerns about the intersection of their employing organisation's policies and procedures and the regulatory environment of aged care. Concerns about

regulation and compliance were evident in the accounts of both groups for different reasons. These concerns revealed a level of distress among the participants, which sometimes involved the participant being tearful when describing their lived experiences.

Leaders were directly asked about their experience of the regulatory environment in aged care to determine whether their meaning-making had a task or outcome focus, as identified as a difference between leaders and raters' quantitative study responses. Leaders tended to describe outcomes because that is the term used in the Aged Care Quality Standards [27], whereas raters were more focused on task completion. The responses by some of the Leaders group demonstrated a high level of concern, some to the point of becoming distressed about regulatory compliance, their experiences, and the processes for assessing compliance by regulator representatives and the resultant outcome of a negative assessment.

The leaders described concerns and recounted lived experiences with regulation and compliance in the aged care sector. They outlined the difficulties of conforming with what they regarded as the copious amount of legislation and the anachronistic nature of the *Aged Care Act 1997 (Cth)*. Leaders further flagged the behaviour of assessors employed by the Aged Care Quality and Safety Commission and the restrictive nature and interpretation of the Aged Care Quality and Safety Standards as a significant concern. There was a pervading sense of an adversarial flavour of these compliance-driven interactions.

> *They came in for an unannounced [visit]. The unannounced [visit] caused them to come back a week later because they had some tweaking concerns, which led to a review, which led to monitoring. So, they were there for another four days auditing. For me, getting a phone call saying, "Just letting you know, we are really concerned about this place, so an auditor will be there nine o'clock Saturday morning", which was the next day (as I'm finding out at four o'clock on a Friday afternoon) to monitor the facility.* (L3)

L5 described the consequence of this interaction style as creating a task focus rather than focusing on outcomes for care recipients. This change in direction was evident to her despite the aim of consumer-directed care environment in community aged care and developing in residential aged care:

> *The organisation has now switched to becoming more task-focused and quite transactional – waiting for stuff to come in rather than being proactive.* (L5)

The outcome of this is that government-funded aged care recipients may miss out on the benefits of innovative thought and translating that into better, appropriate, more efficient and effective care for older people receiving government-funded aged care.

> *We can innovate around the edges of the regulatory form and regulatory funding, so we take pride in innovation that mostly operates outside of government funding. But that's well and truly away from the regulatory constraints of residential age care.* (L1).

Some leaders observed that regulators, bureaucrats, and politicians had adopted legal and regulatory responses to address contentious issues arising from poor practice, which increased the regulatory and compliance requirements in the aged care sector, as exemplified in the following quote from L1.

> *The compliance in aged care is dreadful, and I think every time something goes wrong, the department's natural reaction in Canberra or the politician is to introduce more regulatory oversight.* (L1).

L5 revealed that many staff, including managers, were now more reticent to do anything new or different.

> *Being innovative, or in any way different, creates a situation in which the care service will be very visible to regulators because of the difference in the way services are provided. This leads to further review and possible compliance action, so we mostly*

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wait for another aged care provider to innovate or change care practices before implementing the changes. (L5).

The reluctance to attempt something new or innovative described by L5 was consistent with other leaders' lived experiences expressing a sense of frustration with the regulatory system and processes and described the degree of regulation as:

Crippling and stifling of innovation in care practice. I think the incredible levels of regulation and compliance are extraordinary compared to any other age care sector in the world and it cripples or at least stifles innovation. (L1).

Aged care organisations must adhere to the Government's consumer-directed care (CDC) requirements, which emphasise choice, control, and information and knowledge to provide the means for care recipients to make informed decisions about their care. Meeting CDC requirements are mandated to receive government subsidies to support home aged care, and there is a phased introduction of CDC principles in residential aged care. Some leaders expressed anxiety about deploying innovative care strategies, perceiving this as a high risk to their accreditation status.

Aligning with the reported lived experience of participants in this research, Bradley in 2018 reported on a study that enquired into the issues and challenges experienced by care recipients, informal carers, and staff with the introduction of the CDC [28]. These researchers found that existing industry regulation, culture, and practice supports an established service model in Australia that stifles translation of the CDC objectives into practice [28]. Another study by Biggs and Carr in 2019 also concluded that aged care regulation is not keeping up with contemporary aged care practice models [29], and a previous study reported in 2017 by Nusem and colleagues had similar findings concerning new business models for aged care service delivery [30].

Leaders' responses often conveyed a sense of anxiety and foreboding during visits from aged care assessors employed by the Aged Care Quality and Safety Commission. One leader participant perceived a noticeable change in the attitudes of aged care quality assessors undertaking accreditation audits and reviews:

Unannounced visits have changed ... the agency's attitude has certainly changed since the Royal Commission was announced. We have certainly seen a change. They want to find fault so that some compliance action was [sic] required, justifying the role of the aged care assessors and the Aged Care Quality and Safety Commission and giving the impression that the Government is doing something to protect those in our care. (L2).

A strong sentiment emerged in the Leaders group that the present regulatory control methods (including accreditation standards compliance) created risk-aversion, rather than risk-awareness, impacting compliance risk management. Leaders described feeling powerless and at the mercy of regulators, expressed their opinions on regulatory controls, and described anachronistic requirements and processes.

Raters related various work practices and regulatory requirements and were particularly concerned with medication management and unregulated workers. No raters mentioned accreditation standards compliance during interviews, and it was as if the compliance with accreditation requirements is the responsibility of others who are not involved in direct care. No Raters provided any comment on the Royal Commission's findings into Aged Care Quality and Safety. From their collective responses to direct questions about the Royal Commission, the raters regarded this as a management issue rather than something that directly affected their present or future work.

The regulatory compliance concerns raters mentioned were related to the state or territory jurisdictions laws such as the *Drugs and Poisons Acts* in each of the State and Territory jurisdictions and their regulations and workplace health and safety provisions. Many raters provided accounts of being placed in vulnerable and anxiety-evoking medication administration and management situations, such as being required to administer medications outside what they perceived as their scope of practice, which created moral distress for many nurses and personal care workers. The raters recounted lived

experiences of organisations changing medication management policies and procedures that might contravene drugs and poisons provisions operating in the various state and territory jurisdictions.

One Rater participant described an experience where she felt compromised over instructions provided by policy and practice changes that ignored the poisons regulations' obligations. The non-verbal behaviour observed during this part of her interview echoed frustration and anger at what the researcher interpreted as moral distress and conveyed this was an ongoing issue with incomplete resolution and causing ongoing and considerable moral distress.

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

Another rater was concerned about liability in undertaking a care procedure without, in her view, the authority or training to do so. Her anxiety about the situation led her to avoid providing care to the client rather than giving the medication that she believed was unlawful, causing what the researcher interpreted as considerable moral distress.

> *A letter came out stating that personal care workers had been trained to give medication and administer S8 medications. So, when we had to administer the S8 medication, I just asked if I could be put off the client so that I didn't have to give it. Then it ended up being that I had to. I had no choice. It was in my scope of practice. Apparently, I had to give it. I felt very compromised and angry that I was put in this position.* (R2).

R2 became upset when recounting this experience, and it became apparent that it was quite a personally painful situation that she would have preferred to have avoided. While R2 did not want to withdraw from providing care for the client, she found herself in a conflicted situation where compliance with the employer's instruction would be acting, in her view, in breach of the law. As a result, she attempted to avoid being in such a position by asking to provide care for another resident and reassigning the resident to someone else to provide care. As background, the gravity of the experience, R2 disclosed during the interview. R2 had previously responded to a subpoena to give evidence in a coronial enquiry related to the administration of schedule 8 medication and the unexpected death of a resident in care, which added to her distress.

Another rater participant expressed a similar concern, reporting experiences where many unregulated care workers operated outside the poisons regulations' provisions but did not feel supported by her employing organisation when she questioned the practice. She recounted that her manager provided her with written advice that it was acceptable and legal. This rater participant felt this placed her in a situation where she either complied with her employer's instructions, and she firmly believed that this would cause her to act outside the law. The concerns expressed appeared to be rational and reasonable, but she stated her manager did not address these.

> *I was not sure of the laws about the scope of practice for an AIN [assistant-in-nursing] to administer an S8 drug in the community. I was questioning if an AIN can administer oral morphine, liquid morphine to a palliating client. Here, there is no restriction because the organisation insists we are trained in measuring medication doses. Whether it's S8 or Panadol or anything, how would they calculate the strength? Is it within their scope of practice to measure medication?* (R4).

The researcher's experience is that many aged care providers view unregulated care workers as equivalent to an informal carer who administers medication to a home care person. The limits on the role of unregulated carers are unsettled without a clear scope of practice from regulating this important

workforce group. This absence of a scope of practice statement causes confusion and anxiety in aged care employees for licensed health professionals and unregulated aged care workers.

Similarly, but not explicitly relating to medication administration safety, another Rater related other experiences that caused her concern about compliance with the scope of practice and professional practice requirements set down by the Nursing and Midwifery Board of the Australian Health Practitioners Regulation Agency related to licensed nurses:

> *We have to trust our personal care workers. They're left here alone. When we're on-call, we have to trust that they give us the correct information over a phone to say whether a client has had a fall, got chest pain, or had a head strike. We rely on what information we're given. It's hard some days; it's really hard.* (R3).

The experience recounted by R3 appeared to cause her ongoing anxiety relating to care recipients' welfare and care workers and protection of her practising license as a registered nurse. She described making decisions based on the information provided with the best intentions from unqualified and often poorly trained personal care workers acknowledging that her decision-making in the face of a clinical information deficit caused frustration, anxiety and distress, with referral to acute care services often being her only option.

> *If in doubt, I just ring an ambulance because I've got a registration to be looking after, it's my livelihood, and I've got a PCW telling me what's happening kilometres away and [I'm] not seeing the client. They're not able to do a set of observations on a client, which could be majorly helpful at times sometimes. So, things like that, I think, get a bit frustrating.* (R3).

Most raters described anxiety and distress relating to their scope of practice and legal liability, which they ascribed to their organisation either maximising revenue or containing costs at the expense of safety and quality. For example, one Rater described her experience of being the only enrolled nurse on duty in a large, aged care facility. There was no registered nurse or medical practitioner on-site, resulting in concern about working beyond her scope of practice out of necessity in support of aged care consumers.

> *After office hours, I am here on my own. I feel very overwhelmed. There's a lot – I'm always taking a pad with me because if someone calls me and tells me someone's very unwell, I'm basically doing what an RN would do. After all, someone's lacking the confidence to call an RN. I'm supposed to be on the floor doing things, and the on-call RN is supposed to take that call, give advice, and the person who is there is meant to follow through.* (R4).

R4 described her experience as a common event, and she was clearly on the verge of tears, which appeared to be related to the ongoing distress caused by this problem. While not stated explicitly, the ongoing situation appeared to further contribute to her feelings of being overwhelmed at work, carrying the full weight of responsibilities that she believed were unfairly placed on her when she was not qualified nor paid to take them.

Figure 2 conceptualises the findings of the IPA and identifies the workplace malady of moral distress addressed in this paper.
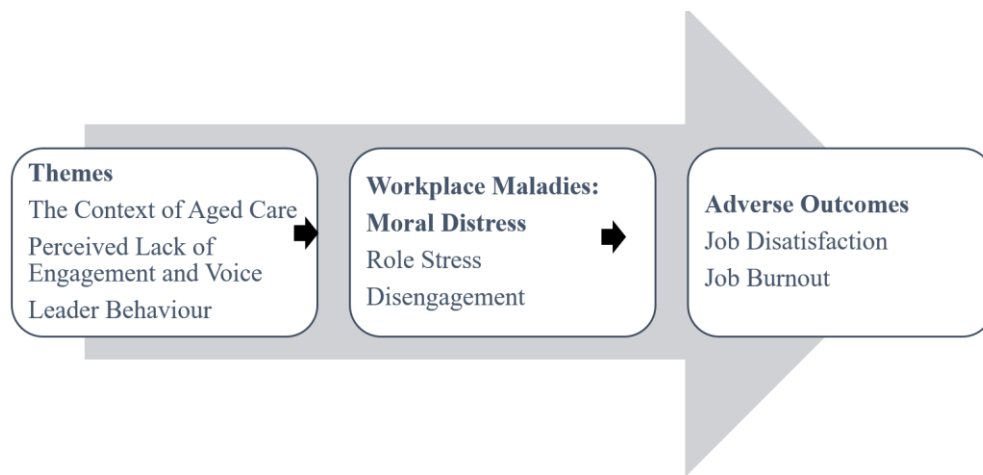
Figure 2- Adverse Outcomes Experienced from Persistent Exposure to the Workplace Maladies

Conclusion

Leaders described the problematic interface between regulatory controls and quality assessment at the corporate level impacting their approvals or licenses to provide aged care and the provision of care itself. Raters described moral distress relating to the scope of practice concerns. They felt the organisation expected them to perform at a level where they believed they had not received adequate training or lacked statutory authority to undertake the expected functions. The distress experienced by the Rater participants appears to be related to medication management or direct supervision of unregulated workers by licensed health professionals or by unregulated care staff who believe they are working beyond their training and skill level.

Raters provided numerous accounts of being placed in vulnerable and anxiety-evoking situations relating to medication administration, and these were a common cause of concern among raters. The administration of medicines was an issue of significance and a source of moral distress for them. Their leaders' actions or inactions caused Rater distress related to changing medication administration policies and procedures without observing the various drugs and poisons provisions operating in state and territory jurisdictions. Concerns about the scope of practice under the national law regulating health professionals were prevalent among the Raters group members. The dilemma for employers, licensed nurses, and unregulated care workers concerning staff retention and quality failures in aged care are well described in the literature [31, 32].

The lived experiences described system issues related to the copious amounts of legislation, regulation and policies that increase work complexity and implementing compliance auditing for the leaders. There was a perception that the amount and types of regulation and compliance auditing confounded innovation and engendered a risk avoidance approach, causing only a task focus rather than an outcome focus. There were also numerous examples of poor relationships and mistrust in the officers charged with industry regulation responsibility. The system of increased unannounced visits during the Royal Commission's proceedings into Aged Care Quality and Safety caused great anxiety and distrust between the leaders and regulators. There was a belief that the system was under strain, causing considerable moral distress and role confusion. Raters stories related to moral distress appeared to be caused by a lack of understanding about the dimensions of unregulated care workers' role by members of that workgroup and some of their leaders. Licensed health professionals were also concerned about their supervision responsibilities, accountabilities, and impact on their practicing licenses. It is contended that urgent changes to the regulatory environment and the process of accreditation and compliance action is needed, along with statutory reform of the *Aged Care Act, 1997 (Cth)* that has not had substantial review since enactment. These statutory and process reforms would then focus on protecting and shielding consumers and the aged care workforce rather than being perceived as a sword that has the potential to cause further harm.

The findings and conclusions of this research demonstrate the need for a leadership development program that addresses concepts related to authentic and ethical leadership at all levels of the aged care system, including aged care providers, regulators, funders and line managers to manage the contested terrains evident in the aged care system. Additionally, there is an urgent need to deal with staff numbers and the skill mix available to provide care and a clear scope of practice for unregulated care workers.

Implications

Resolution of these regulation and compliance stressors will assist in maintaining the aged care workforce at the leader and worker level. Failure to address this will result in ongoing and increasing workforce shortages.

Limitations of the Study

The nature of qualitative research does not aim for generalisability or validity in the scientific sense of these terms and may be considered a limitation. However, recording the lived experience opened a valuable window enabling explanation and authenticity as a starting point for further exploration.

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