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

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Received 30 July 2022
Revised 23 August 2022
Accepted 29 August 2022

Abstract

Purpose – The themes that emerged from the qualitative data of a mixed methods study that explored the effects of leadership style on the job satisfaction of aged care workers.

Design/methodology/approach – The study is a mixed methods study with the qualitative approach informing the interpretative phenomenological analysis from the transcripts of semi-structured interviews.

Findings – Three themes related to the effects of leadership style on job satisfaction of aged care employees emerged from the IPA. These themes were, The Context of Aged Care, Employee Engagement and Voice and Leader Behaviour. Job burnout and organisational disengagement were prevalent in participants of the qualitative study.

Research limitations/implications – The research deployed quantitative measurements to determine the differences between aged care leaders and their followers and used these to explore participants' lived experiences and how they made sense of their personal and social worlds at work. In the quantitative study, there may be an overstatement of the strength of the relationship between variables among those motivated to participate in the study. The qualitative study requires the researcher to be thorough in describing the research context, and it may be that those who wish to transfer the results of this study to a different one are responsible for making the judgement on the suitability of the transferability of findings.

Practical implications – Decreasing job disengagement and burnout will positively impact reducing attrition and turnover and, thus, the availability of the aged care workforce. It will inform leadership development programs and training in aged care and other health and social care sectors.

Social implications – The workforce is a primary consideration for aged care in Australia and globally. Reducing burnout and disengagement will reduce workforce attrition, thus, improving the care for some of the most vulnerable in the population.

Originality/value – This report is from original research with ethical clearance from a university human research ethics committee contributing to the knowledge of leadership practice in aged care in Australia.

Keywords Eldercare, Leadership, Trust, Job satisfaction

Paper type Research paper

Introduction

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

The author gratefully acknowledges the academic guidance of my PhD supervisors, Professor Simon Broadley, Professor Eleanor Milligan, Associate Professor Patricia Lee and Professor Gary Rogers.

Leadership in Health Services

1751-1879
DOI 10.1108/LHS-07-2022-0080

of producing generalizations from quantitative results, it aims to offer insights into how a given person, in a given context, makes sense of a given situation.

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

Background and literature review

Employee engagement and job burnout are common areas of concern for organisations, and more attention and skills training for leaders is required to increase productivity and decrease turnover intentions. In Australia, it is estimated that actively disengaged employees cost the Australian economy more than $2bn a year (Gallup, 2021); however, there is no credible evidence of the cost of a disengaged workforce specifically related to aged care in Australia. Organisations with high employee engagement experience several benefits, such as lower workforce turnover (Santhanam and Srinivas, 2019), less absenteeism (King *et al.*, 2020) and fewer workplace safety accidents (Haga *et al.*, 2021). An early definition of employee engagement recognised full physical, cognitive and emotional connection with work roles (Kahn, 1990). A more recent definition by Schaufeli (2002, p. 74) cited in Albrecht's Handbook of Employee Engagement (Albrech, 2011) defined engagement: as "a positive and fulfilling work-related state of mind characterised by vigour, dedication, and absorption".

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

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

change and other stressors so that burnout may be recognised early or avoided altogether.

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

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

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

Ethical approval

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

Method

An online questionnaire provided the data input for Study 1 – quantitative. The differences in responses to three evidence-based and prior-validated tools, all using a five-point Likert scale, were recorded in a database. The results and findings reported here relate to the differences observed in the responses to questions in the MLQ5X[Short] (Bass and Avolio, 1998) measured at the factor level. The differences between leaders who self-rated and those who rated themselves in a 360° feedback process provided the agenda for semi-structured interviews in study two, which was qualitative.

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

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

Results and findings

Study 1 – quantitative

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

Relevant quantitative findings. The following table shows the ascribed leadership styles associated with each factor of the MLQ5X[Short] (Avolio *et al.*, 1999) (Table 1).

MLQ5X[short] Mann–Whitney U test results. A Mann–Whitney U test was used to compare outcomes between the two independent groups of Leaders and Raters. There were six MLQ5X[Short] factors that demonstrated significant leader-rater differences: IIA – builds trust (U = 3,192, p = 0.047); IIB – acts with integrity (U = 3,024, p = 0.033); IM – encourages innovating thinking (U = 3,004, p = 0.038); CR – rewards achievement (U = 2,953, p = 0.048); MBEA – management by exception – active (monitors deviations and mistakes) (U = 3,392, p = 0.043); MBEP – management by exception – passive (fights fires) (U = 3,403, p =0.022). These differences between the leaders' and raters' groups found in the quantitative data informed the agenda developed for the semi-structured interviews conducted in the qualitative study by constructing questions related to leaders for the leaders' interviewers and raters for the raters' interviews.

Study 2 – qualitative analysis using interpretive phenomenological analysis

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

Relevant qualitative findings

Regulatory system and compliance processes

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

Table 1. Ascribed leadership style for each factor contained in the MLQ5X[Short]

Factor name	Code	Ascribed leadership style
Builds trust	IIA	Transformational
Acts with integrity	IIB	Transformational
Encourages others	IM	Transformational
Encourages innovative thinking	IS	Transformational
Coaches and develops people	IC	Transactional
Rewards achievement	CR	Transactional
Monitors deviations and mistakes	MBEA	Transactional
Fights fires	MBEP	Transactional
Avoids involvement	LF	Laissez-faire

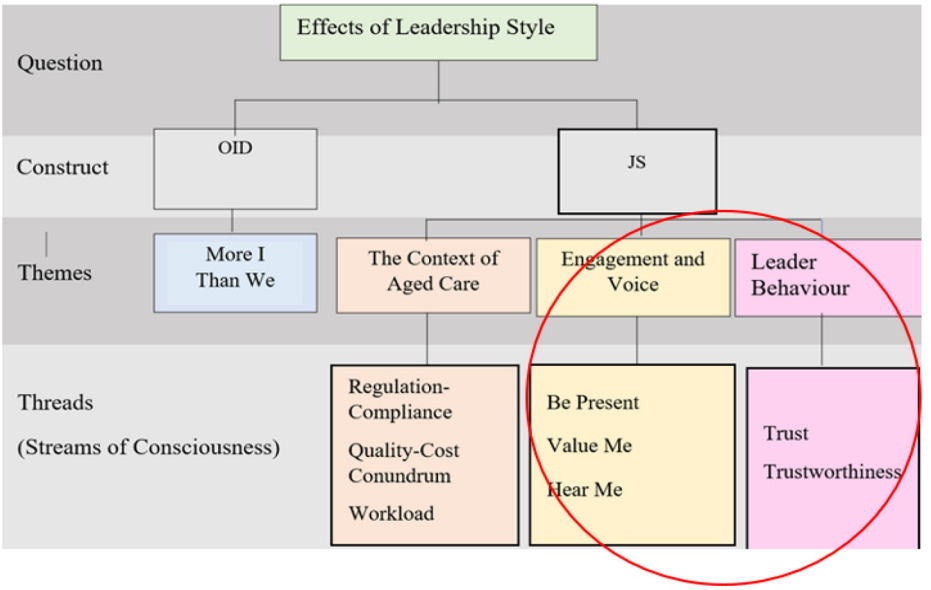

Figure 1.
Thematic analysis cluster map

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

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

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

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

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

The quality-cost conundrum

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

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

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

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

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

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

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

Workloads and scope of practice

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

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

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

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

Training and development

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

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

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

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

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

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

Engagement and voice

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

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

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

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

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

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

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

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

Leader behaviour

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

> *[My previous leader] had no clinical background; [it's] very difficult to trust someone giving you information from a clinical point of view that is not a clinician. But I'm hoping that this person will be fine. She's clinical; she's an RN (R3).*

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

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

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

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

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

Discussion

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

Raters expressed a common concern about being placed in vulnerable and anxiety-evoking situations relating to medication administration. Raters who were licensed health professionals, predominantly nurses and unregulated care workers, raised concerns about the scope of practice under the national law regulating health professionals. They described the dilemma for licensed nurses and unregulated care workers concerning nurses' retention and quality failures in aged care. The literature appears supportive of their concerns (Baldwin *et al.*, 2015; Chenoweth *et al.*, 2010).

The participants raised serious concerns about the rigours of regulation and compliance within Australia's aged care sector. The lived experiences described system issues related to the copious amounts of legislation increasing work complexity and implementing compliance auditing for the leaders. There was a perception that the amount and types of regulation and compliance auditing confounded innovation and engendered a risk

avoidance approach, causing only a task focus rather than an outcome focus. There were also numerous examples of poor relationships and mistrust in those charged with industry regulatory responsibility. Additionally, there were calls from licensed health professionals and unregulated care workers for a scope of practice for unregulated care workers.

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

The leader behaviour theme contained two threads, trust in leaders and trustworthiness of leaders. Trust is a party's willingness to be vulnerable to another party's actions (Schoorman *et al.*, 2007). This illuminated the gap between leaders' intentions to act with integrity and raters' experience concerning their leader's integrity. The researcher has labelled this phenomenon as Intention-Experience Disparity. This disparity impacts how organisations lay the foundations for trust or distrust. Many raters' accounts described distress and the vulnerability they experienced due to their leaders' decisions and directions. Monitoring the relationship between the leader and the team member is important prevention of employee disengagement. Fostering a culture that actively listens provides feedback to employees and demonstrates that their input is welcome and is given serious consideration.

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

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

Conclusion

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

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

Consequently, for leaders in aged care, building trust with staff through acting in a trustworthy manner is paramount. Eminent author and academic Baroness Onora O'Neill describes the trustworthiness of leaders as reliable, competent and honest (O'Neill, 2002), which is a critical competency that will directly impact organisational culture and quality of care. Being trustworthy can foster trust in followers by demonstrating authenticity, and integrity, displaying ethical leadership practice and promoting equity in the work area.

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

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

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

References

Al Sabei, S.D., Labrague, L.J., Miner Ross, A., Karkada, S., Albashayreh, A., Al Masroori, F. and Al Hashmi, N. (2020), "Nursing work environment, turnover intention, job burnout, and quality of care: the moderating role of job satisfaction", *Journal of Nursing Scholarship*, Vol. 52 No. 1, pp. 95-104, doi: 10.1111/jnu.12528.

Alarcon, G., Eschleman, K.J. and Bowling, N.A. (2009), "Relationships between personality variables and burnout: a meta-analysis", *Work and Stress*, Vol. 23 No. 3, pp. 244-263.

Albrech, S.L. (2011), "Handbook of employee engagement: perspectives, issues, research and practice", *Human Resource Management International Digest*, Vol. 19 No. 7.

Alessandri, G., Perinelli, E., De Longis, E., Schaufeli, W.B., Theodorou, A., Borgogni, L. and Cinque, L. (2018), "Job burnout: the contribution of emotional stability and emotional self-efficacy beliefs",

Journal of Occupational and Organizational Psychology, Vol. 91 No. 4, pp. 823-851, doi: 10.1111/joop.12225.

Alzyoud, A.A.Y. (2018), "The influence of human resource management practices on employee work engagement", *Foundations of Management*, Vol. 10 No. 1, pp. 251-256, doi: 10.2478/fman-2018-0019.

Avolio, B.J., Bass, B.M. and Jung, D.I. (1999), "Re-examining the components of transformational and transactional leadership using the multifactor leadership", *Journal of Occupational and Organizational Psychology*, Vol. 72 No. 4, pp. 441-462, doi: 10.1348/096317999166789.

Bakker, A.B. and De Vries, J.D. (2020), "Job Demands-Resources theory and self-regulation: new explanations and remedies for job burnout", *Anxiety Stress Coping, Ahead-of-Print(Ahead-of-Print)*, Vol. 34 No. 1, pp. 1-21, doi: 10.1080/10615806.2020.1797695.

Bakker, A.B. and Demerouti, E. (2017), "Job demands-resources theory: taking stock and looking forward", *Journal of Occupational Health Psychology*, Vol. 22 No. 3, pp. 273-285, doi: 10.1037/ocp0000056.

Bakker, A.B. and Heuven, E. (2006), "Emotional dissonance, burnout, and in-role performance among nurses and police officers", *International Journal of Stress Management*, Vol. 13 No. 4, p. 423.

Baldwin, R., Chenoweth, L., Dela Rama, M. and Liu, Z. (2015), "Quality failures in residential aged care in Australia: the relationship between structural factors and regulation imposed sanctions", *Australasian Journal on Ageing*, Vol. 34 No. 4, pp. E7-12, doi: 10.1111/ajag.12165.

Basinska, B.A. and Gruszczynska, E. (2019), "Job-related emotions and job burnout among civil servants: examining the shape of the relationship in cross-sectional and longitudinal models", *MED PR*, (Emocje a wypalenie zawodowe urzednikow administracji publicznej: testowanie ksztaltu relacji w modelach poprzecznych i podluznych), Vol. 70 No. 2, pp. 201-211, doi: 10.13075/mp.5893.00750.

Bass, B. and Avolio, B. (1998), *Manual for the Multifactor Leadership Questionnaire*, Mindgarden, Menlo Park, CA.

Brown, L.W. and Quick, J.C. (2013), "Environmental influences on individual burnout and a preventive approach for organizations", *Journal of Applied Biobehavioral Research*, Vol. 18 No. 2, pp. 104-121, doi: 10.1111/jabr.12002.

Charlick, S., Pincombe, J., McKellar, L. and Fielder, A. (2016), "Making sense of participant experiences: interpretative phenomenological analysis in midwifery research", *International Journal of Doctoral Studies*, Vol. 11, pp. 205-216, doi: 10.28945/3486.

Chenoweth, L., Jeon, Y.H., Merlyn, T. and Brodaty, H. (2010), "A systematic review of what factors attract and retain nurses in aged and dementia care", *Journal of Clinical Nursing*, Vol. 19 No. 1-2, pp. 156-167, doi: 10.1111/j.1365-2702.2009.02955.x.

Cole, M.S., Walter, F., Bedeian, A.G. and O'Boyle, E.H. (2011), "Job burnout and employee engagement", *Journal of Management*, Vol. 38 No. 5, pp. 1550-1581, doi: 10.1177/0149206311415252.

Creswell, J.W. and Plano Clark, V.L. (2007), *Designing and Conducting Mixed Methods Research*, Sage Publications, Thousand Oaks, CA.

Demerouti, E., Bakker, A.B., Nachreiner, F. and Schaufeli, W.B. (2001), "The job demands-resources model of burnout", *Journal of Applied Psychology*, Vol. 86 No. 3, pp. 499-512, doi: 10.1037/0021-9010.86.3.499.

Dixon-Woods, M., Campbell, A., Martin, G., Willars, J., Tarrant, C., Aveling, E.L. and Pronovost, P. (2019), "Improving employee voice about transgressive or disruptive behavior: a case study", *Academic Medicine*, Vol. 94 No. 4, pp. 579-585, doi: 10.1097/ACM.0000000000002447.

Dyne, L.V., Ang, S. and Botero, I.C. (2003), "Conceptualizing employee silence and employee voice as multidimensional constructs*", *Journal of Management Studies*, Vol. 40 No. 6, pp. 1359-1392, doi: 10.1111/1467-6486.00384.

Frisch, C. and Huppenbauer, M. (2013), "New insights into ethical leadership: a qualitative investigation of the experiences of executive ethical leaders", *Journal of Business Ethics*, Vol. 123 No. 1, pp. 23-43, doi: 10.1007/s10551-013-1797-9.

Fusch, P. and Ness, L. (2015), "Are we there yet? Data saturation in qualitative research", *The Qualitative Report*, Vol. 20 No. 9, pp. 1408-1416.

Gallup. (2021), "State of the Global Workplace 2021 Report", Gallup, available at: www.gallup.com/workplace/349484/state-of-the-global-workplace.aspx

Genly, B. (2016), "Safety and job burnout: understanding complex contributing factors", *Professional Safety*, Vol. 61 No. 10, pp. 45-49.

Glew, D.J., O'Leary-Kelly, A.M., Griffin, R.W. and Van Fleet, D.D. (1995), "Participation in organizations: a preview of the issues and proposed framework for future analysis", *Journal of Management*, Vol. 21 No. 3, pp. 395-421.

Haga, J., Huhtamäki, F. and Sundvik, D. (2021), "Ruthless exploiters or ethical guardians of the workforce? Powerful CEOs and their impact on workplace safety and health", *Journal of Business Ethics*, Vol. 177 No. 3, pp. 641-663, doi: 10.1007/s10551-021-04740-4.

Hakanen, J.J. and Schaufeli, W.B. (2012), "Do burnout and work engagement predict depressive symptoms and life satisfaction? A three-wave seven-year prospective study", *Journal of Affective Disorders*, Vol. 141 No. 2-3, pp. 415-424.

Harris, A. (2016), "Burnout and work disengagement implication of supervisor support in project success", *Journal of Business Strategies (Karachi)*, Vol. 10 No. 2, p. 37.

He, P., Peng, Z., Zhao, H. and Estay, C. (2017), "How and when compulsory citizenship behavior leads to employee silence: a moderated mediation model based on moral disengagement and supervisor–subordinate Guanxi views", *Journal of Business Ethics*, Vol. 155 No. 1, pp. 259-274, doi: 10.1007/s10551-017-3550-2.

Herachwati, N., Sulistiawan, J., Alfirdaus, Z., Anggara, B. and Atsiruddin Ruslananda, M. (2018), "Safety supports on employee safety voice", *Problems and Perspectives in Management*, Vol. 16 No. 2, pp. 49-55, doi: 10.21511/ppm.16(2).2018.05.

Hillhouse, J., Adler, C. and Walters, D. (2000), "A simple model of stress, burnout and symptomatology in medical residents: a longitudinal study", *Psychology, Health and Medicine*, Vol. 5 No. 1, pp. 63-73.

Kahn, W.A. (1990), "Psychological conditions of personal engagement and disengagement at work", *Academy of Management Journal*, Vol. 33 No. 4, pp. 692-724, doi: 10.2307/256287.

King, A.T., Gontarz, J. and Wei, H. (2020), "Employee engagement and absenteeism: a step towards improving patient care", *Nursing Forum*, Vol. 55 No. 3, pp. 356-361, doi: 10.1111/nuf.12435.

McCall, J.J. (2015), "Employee voice in corporate governance: a defense of strong participation rights", *Business Ethics Quarterly*, Vol. 11 No. 1, pp. 195-213, doi: 10.2307/3857877.

Maslach, C., Schaufeli, W.B. and Leiter, M.P. (2001), "Job burnout", *Annual Review of Psychology*, Vol. 52 No. 1, pp. 397-422, doi: 10.1146/annurev.psych.52.1.397.

Mavromaras, K., Knight, G., Isherwood, L., Crettenden, A., Flavel, J., Karmel, T., Moskos, M., Smith, L., Walton, H. and Wei, Z. (2017), "The aged care workforce 2016", available at: www.gen-agedcaredata.gov.au/Resources/Dashboards/Australia-s-aged-care-workforce

Maximo, N., Stander, M.W. and Coxen, L. (2019), "Authentic leadership and work engagement: the indirect effects of psychological safety and trust in supervisors", *SA Journal of Industrial Psychology*, Vol. 45 No. 1, pp. 1-11, doi: 10.4102/sajip.v45i0.1612.

Meyers, M.C., Adams, B.G., Sekaja, L., Buzea, C., Cazan, A.-M., Gotea, M. and Van Woerkom, M. (2018), "Perceived organizational support for the use of employees' strengths and employee well-being: a cross-country comparison", *Journal of Happiness Studies*, Vol. 20 No. 6, pp. 1825-1841, doi: 10.1007/s10902-018-0026-8.

Mowbray, P.K., Wilkinson, A. and Tse, H.H. (2015), "An integrative review of employee voice: identifying a common conceptualization and research agenda", *International Journal of Management Reviews*, Vol. 17 No. 3, pp. 382-400.

O'Neill, O. (2002), *A Question of Trust*, Vol. 2002, Cambridge University Press, Cambridge.

Osborne, S. and Hammoud, M.S. (2017), "Effective employee engagement in the workplace", *International Journal of Applied Management and Technology*, Vol. 16 No. 1, doi: 10.5590/ijamt.2017.16.1.04.

Paley, J. (2014), "Heidegger, lived experience and method", *Journal of Advanced Nursing*, Vol. 70 No. 7, pp. 1520-1531, doi: 10.1111/jan.12324.

Reid, K., Flowers, P. and Larkin, M. (2005), "Interpretative phenomenological analysis: an overview and methodological review", *The Psychologist*, Vol. 18, pp. 20-23.

Santhanam, N. and Srinivas, S. (2019), "Modeling the impact of employee engagement and happiness on burnout and turnover intention among blue-collar workers at a manufacturing company", *Benchmarking: An International Journal*, Vol. 27 No. 2, pp. 499-516, doi: 10.1108/bij-01-2019-0007.

Schaufeli, W.B., Bakker, A.B. and Van Rhenen, W. (2009), "How changes in job demands and resources predict burnout, work engagement, and sickness absenteeism", *Journal of Organizational Behavior*, Vol. 30 No. 7, pp. 893-917.

Schoorman, F.D., Mayer, R.C. and Davis, J.H. (2007), "An integrative model of organizational trust: past, present, and future", *Academy of Management Review*, Vol. 32 No. 2, pp. 344-354, doi: 10.5465/amr.2007.24348410.

Seibert, S.E. and Kraimer, M.L. (2001), "The five-factor model of personality and career success", *Journal of Vocational Behavior*, Vol. 58 No. 1, pp. 1-21.

Seppala, E. and Moeller, J. (2018), "1 In 5 employees is highly engaged and at risk of burnout", Harvard Business Review.

Sharron, A. (1985), "The mainstream of consciousness: an interactions analysis of a phenomenological concept", *Symbolic Interaction*, Vol. 8 No. 1, pp. 47-62, doi: 10.1525/si.1985.8.1.47.

Shuck, B., Nimon, K. and Zigarmi, D. (2016), "Untangling the predictive nomological validity of employee engagement", *Group and Organization Management*, Vol. 42 No. 1, pp. 79-112, doi: 10.1177/1059601116642364.

Slosberg, M., Nejati, A., Evans, J. and Nanda, U. (2018), "Transitioning to a new facility: the crucial role of employee engagement", *Journal of Healthcare Management*, Vol. 63 No. 1, pp. 63-77, doi: 10.1097/JHM-D-16-00019.

Smith, J.A. and Osborn, M. (2015), "Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain", *British Journal of Pain*, Vol. 9 No. 1, pp. 41-42, doi: 10.1177/2049463714541642.

Smith, J. and Osborn, M. (2008), "Interpretative phenomological analysis", *Qualitative Psychology: A Practical Guide to Research Methods*, Vol. London, Sage, Thousand Oaks, CA, pp. 53-80.

Smith, J., Flowers, P. and Larkin, M. (2009), *Interpretative Phenomenological Analysis: theory, Method and Research*, Sage Publications, Thousand Oaks, CA.

Smith, J.A., Jarman, M. and Osborn, M. (1999), "Doing interpretative phenomenological analysis", *Qualitative Health Psychology: Theories and Methods*, pp. 218-240.

Van Steenbergen, E.F., van der Ven, C., Peeters, M.C.W. and Taris, T.W. (2018), "Transitioning towards new ways of working: do job demands, job resources, burnout, and engagement change?", *Psychological Reports*, Vol. 121 No. 4, pp. 736-766, doi: 10.1177/0033294117740134.

Walumbwa, F.O. and Schaubroeck, J. (2009), "Leader personality traits and employee voice behavior: mediating roles of ethical leadership and work group psychological safety", *Journal of Applied Psychology*, Vol. 94 No. 5, pp. 1275-1286, doi: 10.1037/a0015848.

Wilkinson, A. (2009), *The SAGE Handbook of Human Resource Management*, Sage Publications, Thousand Oaks, CA.

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