Leadership Skills And Quality Health Care For Older Australians

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Research Article

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Abstract

Background

With increasing recognition of the quality and safety issues in residential aged care (RAC), there is an urgent need to better understand the role of leadership teams who are often responsible for addressing these concerns. This qualitative study sought to explore the leadership skills that positively influence quality of care within Australian residential aged care facilities (RACFs); and better understand the professional development needs of senior managers to positively influence care within these complex environments.

Methods

We conducted 19 semi-structured interviews with senior managers in 14 RACFs in northern Queensland, Australia. *GEN Aged Care Data* was reviewed to assist the recruitment of "high performing", non-government RACFs across different geographical areas of remoteness. Thematic analysis was used, including inductive identification of the leadership skills and strategies employed to promote quality of care.

Results

The leadership skills reported by senior managers were structured under five domains including: i) communication and relationship management, ii) stewardship, iii) professional development, iv) health care knowledge and v) information technology and finance. A majority of participants highlighted communication and relationship management skills as being influential to RAC quality performance. We found that while most participants recognised the link between leadership skills and quality of care, only managers with a formal health qualification, highlighted the role of health care knowledge as a critical component of their leadership competency.

Conclusions

The skills and strategies employed by leadership and management teams are critical to quality outcomes for organisations and, ultimately, care recipients. With ongoing pressures facing RACFs, more work is needed to identify sector specific professional development (PD) strategies that better prepare RAC senior managers to lead quality health care services within an increasingly complex environment.

Background

Compared with many nations of the world, older Australians are living longer than expected.¹ By 2057, it is projected there will be 8.8 million older people in Australia (22% of the population); by 2097, approximately 25% of the population will be aged 65 and over.² While most older Australians are in relatively good health, extended longevity is often accompanied by increasing health issues, requiring frequent and complex attention by services including in residential aged care (RAC).¹

For many Australian RAC organisations, increasing service demand now runs concurrent to concerns about financial viability, workforce shortages and associated issues with quality of care.^{3,4} Quality of care (QoC) is

defined here as the degree to which health care and social services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.⁵ Just as in mainstream health care organisations (HCOs), quality of health care in RAC has been a long-standing concern internationally⁶ and recently in Australia, the shortcomings of many aged care service providers were made public as part of a *Royal Commission into Aged Care Quality and Safety*.⁷

Factors noted in the Royal Commission report to contribute to substandard health care practices included the “flawed” and “inadequate” national aged care funding instrument which has not kept pace with population growth and affects multiples aspects of aged care delivery.⁷ For instance, in 2020/21, over half of Australian residential aged care facilities (RACFs) recorded an operating loss.⁸ Financial constraints have made recruitment and retention of sufficient numbers, and sufficiently skilled staff difficult,⁹ exacerbated in rural and regional areas by competition with typically better paid ‘mainstream’ health care (e.g. hospital and family medicine practices) services. Slow uptake of technology has reduced accuracy of quality reporting and access to accredited virtual training opportunities.¹⁰ Yet critically, leadership skills and strategies employed by RAC managers to promote service quality were also noted in the Royal Commission report to be lacking in comparison to other Australian mainstream HCO’s as well as international aged care services.⁹

Since the early 1900’s, many classification systems have been developed to define the dimensions of leadership.¹¹ Despite multiple conceptualisations, commonly mentioned characteristics include that: i) leadership involves influence, ii) leadership is a process, iii) leadership involves common goals, and iv) leadership occurs in groups.^{11,12} Combining these common characteristics produces a working definition of leadership as: a process whereby an individual influences a group of individuals to achieve a common goal.¹¹

Leadership is regarded from different perspectives depending on the specific context in which it is enacted.¹¹ In the context of health care, a *skills perspective* (approach) to leadership is often adopted.¹³ This approach can be described as a leader-centred outlook which emphasises the leadership skills and abilities that can be learned and developed to strengthen the quality outcomes of an organisation.¹⁴ While health care leadership is a broad term, with a diverse range of applications,¹³ the *skills perspective* can be used to identify and describe the capabilities (knowledge and skills) that are required by managers to influence high quality care across multiple health care settings.¹

Substantial research has been conducted around leadership skills in mainstream HCOs;¹¹ yet comparatively little is known about the skills or combinations of skills required in the distinctive settings of RACFs. This gap in knowledge is notable because although mainstream HCOs and RACFs share some common features, they also differ in a number of critical ways.¹⁵ Clients’ purpose for attending and length of stay; the nature of clinical services delivered; the attendant organisational structures and staff skills mix required; and the broader financial and regulatory context are all quite different in RAC as compared to mainstream hospital settings, for example, with different health care needs and imperatives in relation to quality of care arising.² Attending to these requirements, the role, and responsibilities of RAC managers are also unique with RAC senior managers responsible for clinical care responsibilities, but also institutional governance and risk

operations, finance and asset performance, ethical conduct issues, people development, inter-professional collaboration and a range of commercial and political.¹⁶ Together, these factors suggest that the type and combinations of leadership skills required by RAC senior managers to achieve high-quality service outcomes are likely to be distinctive.¹⁷

Against the backdrop of an aging Australian population and considering the distinct service variations and a general evidence gap in relation to the optimal mix of leadership skills, there is need for a more refined examination of leadership skills among senior management in Australian RACFs. With a view to addressing the gap in current knowledge regarding leadership skills and the quality of RAC, the current study aimed to qualitatively explore senior management leadership skills that are linked to quality of care in Australian RAC facilities and to better understand the professional development needs of RAC senior management personnel.

Methods

Study design

This exploratory qualitative study aimed to understand the leadership skills that influence high quality performance, as reported by RAC senior management personnel from a sample of regional, rural and remote RACFs in northern Queensland. This study was exploratory, as with a few notable exceptions^{1,17} there is little empirical evidence that recognises how leadership does or should influence the quality of Australian RAC services. Qualitative methods were deemed appropriate to capture expressed beliefs, values, feelings, and motivations regarding important RAC leadership skills.¹⁸ We conducted in-depth interviews (IDIs) to gain a deeper understanding of participants' views and experiences regarding the leadership competencies that influence quality of care in RACFs.

Study Setting

The current study was conducted across the region covered by the Northern Queensland Primary Health Network (NQPHN)¹⁹ (Fig. 1). Spanning an area of 510,000km², approximately twice the land size of the United Kingdom (UK), this tropical environment is home to approximately 700,000 people.¹⁹ A majority of the population is located within the regional centers of Cairns, Townsville, and Mackay, while approximately 8.0% of inhabitants live in remote and very remote areas. The Australian Statistical Geography Standard (ASGS) distinguishes five classes of relative remoteness across Australia (Australian Bureau of Statistics, 2019).²⁰ The NQPHN region contains various degrees of geographical remoteness including inner and outer regional, remote and remote very localities (ASGS 2–5). Facilities eligible for recruitment in the current study were located in ASGS categories 2–5 and included for-profit and not-for-profit organisations.

Site Selection and participant recruitment

Site selection was designed to promote a representation of facilities with important characteristics including a quality and safety rating of 'high performing' and differing degrees of geographic remoteness. First, *GEN Aged Care Data*²¹ was reviewed to obtain a list of "high performing", non-government RACFs with the

NQPHN region. “High performing” RACFs were those that obtained the maximum score (44//44) against the Accreditation standards and as assessed by the Aged Care Quality and Safety Commission in 2019.

Recruitment was conducted using a combination of email with phone follow-up. Targeting of ‘high performing’ facilities was taken to ensure a ‘strengths based’ approach to understanding how and in what ways leadership by senior management was positively influencing quality of care. Overall, 19 in-depth interviews (Table 1.) were conducted between December 2019 and January 2020. All participants agreed to the interview being audio recorded, transcribed, and were provided with a copy of the transcription as an opportunity to correct or remove data prior to the analysis.

Table 1
Description of participants based on professional role, qualifications and ASRG category

Participant	Professional Role	Qualification/s	ASRG Category
1	CEO	Registered Nurse Diploma of Business & Human Resources	2
2	Facility Manager	Registered Nurse (UK) Management short course (over 10 years ago)	2
3	CEO	Certificate in Business and Hospitality Financial cadetship	4
4	Clinical Care Coordinator	Registered Nurse	3
5	Senior Administration Officer	Certificate IV Administration	2
6	Director of Nursing	Registered Nurse	4
7	Residential Facility Manager	Registered Nurse Industry accreditation short courses	2
8	Facility Manager	Business short courses – no formal qualification reported	3
9	General Manager	No formal qualification	3
10	Director of Care	Emergency Nurse (NZ) Bachelor of Geography and Social Policy	4
11	Clinical Care Manager	Registered Nurse	4
12	Clinical Care Manager	Registered Nurse	4
13	Clinical Care Manager	Registered Nurse (UK) Dip. Leadership and Management	2
14	Facility Manager	Dip. Management Bachelor of Business	2
15	Clinical Operations Manager	Registered Nurse	2
16	Facility Manager	Registered Nurse	4
17	Director of Nursing	Registered Nurse	2
18	Facility Manager	Bachelor of Hospitality	2

Participant	Professional Role	Qualification/s	ASRG Category
19	Facility Manager	Registered Nurse	5

Data management and analysis

A range of approaches were conducted to ensure rigor and credibility of the study findings (Table. 2). The data from each interview was transcribed verbatim. We conducted open coding in which codes were created based on identified issues and assigned to specific sections of transcripts. Coding involved assigning text from across the dataset to a label (or code). Code summaries were then completed and aided in the aggregation and synthesis of inductively identified themes. NVivo software was utilized throughout to assist with this inductive process.

Table 2
Principles guiding data analysis

(Adapted from Gilson (2010) Health Policy and Systems Research (HPSR) reader)

Principles guiding data analysis	Methods used in this study
Reflexivity	Hand written memos were collated immediately after each interview to ensure that a reflexive stance was maintained in relation to the research situation, participants and documents under study; Familiarisation through careful and repeat reading of transcripts and research memos, noting emergent themes
Triangulation	The development of organisational descriptions which included an account of each interview and discussed the findings relevant to the RACF organisational structure, profit status, policy and regulatory directives, facility geographical location and the role and each senior manager and other participants
Peer debriefing and support	Transcribed interview verbatim was reviewed by the advisory panel.
Respondent validation	Each individual participant was emailed a copy of the transcribed verbatim to ensure that the investigators records corresponded with those of the participants from whom those data were derived
Data representation	Data was displayed and analysed using matrices including summary tables

Limitations

Due to resource constraints, this study was not able to include residential aged care facilities owned and managed by government. This is a potential limitation as the unique regulatory and funding structures influencing the senior management role in government organisations are not represented in the study findings.

Results

Overview

In this section, we present our inductive findings of reported leadership skills under five inductively identified domains i) communication and relationship management, ii) stewardship; iii) professional development; iv) knowledge of the healthcare environment; and v) information technology and finance. Domains and leadership skills are referred to simply as 'domains' and 'skills' respectively to improve clarity. Participants were purposefully grouped into two categories to explore potential differences between the leadership skills described by study participants: i) with a health qualification (n = 13) and ii) without a health qualification (n = 6).

Communication and relationship management

'Communication and relationship management' skills included a leader's ability to communicate clearly and concisely with internal and external stakeholders, share clinical and industry related knowledge and employ effective complaint management processes within the organisation. As part of the current study, relationship management and communication skills were strongly emphasized by most study participants, however skills including the ability to negotiate with external stakeholders were less of a focus.

Participants who possessed a formal health qualification reported that a managers' ability to build and nurture collaborative relationships with residents, staff and external providers was important to promoting the quality performance of an organisation.

"So when you are dealing with the various stakeholders, trying to be a bit more collaborative as opposed to directive. This can be an effective way to developing rapport and longstanding relationships" Clinical Care Coordinator, Regional Facility, ID4.

Among these health-qualified participants, a key theme was senior manager's capacity to share knowledge and build working relationships with other RACFs. Participants describe how this helped designing and implementing processes that influenced the quality of RACF health care services. Of note, however, the importance of networking and collaboration with other organisations was not described by any of the senior managers who did not possess a formal health qualification.

"As organizations, big or small, we [senior managers] need to collaborate and share our knowledge. We do not do that very well. We do have a regional facility management group meeting, and we talk. We talk to things that could help with raising quality within our facilities" Clinical Operations Manager, Regional Facility, ID15.

As an important mechanism to developing positive RACF stakeholder relationships, almost all of the participants with a formal health qualification recommended that senior managers develop the skills to foster trust and rapport with residents and their families. The need for managers to effectively address resident complaints was strongly emphasised as a mechanism to ensure quality of care, as described by one participant:

"Your ability to manage complaints is important. It drives positive clinical care outcomes and it helps to you to effectively negotiate with service providers to come in to look after your community in a way that the community expects" Facility Manager, Regional Facility, ID7.

As a method to developing sustained relationships with staff, it was recommended that senior managers develop and employ effective interpersonal skills such as active listening techniques to enhance teamwork across all levels of the organisation. However, this leadership strategy was only emphasised by participants who were qualified health practitioners such as this CEO who possessed both formal nursing and business qualifications:

"The first thing that comes to mind is being able to listen. I think that is a key thing in terms of managing and caring for people. So I am opening to listening to people. I've certainly learned to be more patient and take in what is happening around me before making a decision that could impact the way that care is carried out" CEO, Regional Facility, ID1.

A manager's ability to build and nurture collaborative relationships with residents, staff and external providers was emphasized by both health-qualified and non-health qualified participants as important to promoting the quality performance of an organisation. As one qualified health practitioner reported: .

"You have to understand people, relationships and what drives them. This helps you to pick up how you can get the best out of them. For the residents, you have to understand their story and what they need from you as the provider" Clinical Care Coordinator, Rural Facility, ID3.

Stewardship

'Stewardship' skills included the ability of senior managers to inspire organisational change and create a positive organisational culture that celebrates the diversity of staff and residents. Less emphasis was placed on skills including a managers' ability to promote lifelong learning or provide the leadership of ethical health care services.

Senior managers from both participant categories recognised the importance of interpreting regulations that influence health service delivery within an organisation, particularly during a time of regulatory and legislative change. Of the qualified health practitioners that were interviewed, one CEO and one Facility Manager reported that the ability of all RAC senior managers to comprehend and monitor legal and regulatory standards is an essential leadership skill influencing quality of care.

"Above all, you need to be aware of and fully understand the frameworks and policies that dictate the way your organisation operates. Without this, you don't know where to start when planning for quality compliance" Facility Manager, Regional Facility, ID22.

"Managers need to be familiar with the legislation or the accreditation, all of the regulatory compliance issues that go with this unique type of industry [residential aged care]" CEO, Regional Facility, ID2.

One Director of Nursing, strongly emphasised the importance of managers being able to interpret regulatory environments, and then educate staff and residents regarding quality compliance to ensure quality performance across the organisation.

"Another really important skill is being able to educate patient care team members and the resident on the legislative and regulatory processes and methods for influencing both during daily operations" Director of Nursing, Rural Facility, ID6.

Drawing attention to recent regulatory changes in Australia, including the introduction of the new Aged Care Quality Standard and Charter of Aged Care Rights in 2019, several participants reflected on the way senior managers needed to be able to serve as a "change agent" to assist staff and residents to understand reasons for change. Interestingly, however, descriptions regarding the influence of change management on quality of care were only reported by those who did *not* possess a formal health qualification.

"Sometimes there are people who have worked in this industry for 30 or 40 years and say this is the way they've always done it and they're not going to change, and so then your conversation has to be probably a bit more directive around, well, actually, it needs to change. You need to be a vessel to filter messages around change and make sure that actions follow" Facility Manager, Rural Facility, ID19.

To develop a comprehensive change management plan that positively influences RACF care quality, two participants reported that senior managers require the capacity to acknowledge obstacles to organisational change, including employee resistance. It was also reported by one Facility Manager that RAC senior managers should possess the ability to patiently observe the challenges to change management before employing the change process.

"So my advice to a new manager is just be very comfortable to listen, observe, sit back and understand, and get to know what you're actually dealing with. Without this insight, you will struggle to manage resistance to change" Facility Manager, Regional Facility, ID8.

As a strategy to minimise employee resistance, one Facility Manager with a tertiary Business qualification emphasised that a collaborative approach to decision-making processes was a successful method to empowering staff at all levels of the organisation to help embrace and champion change.

"I always aim to be motivating; a motivational leader that staff can follow and be inspired by, particularly when the message of change is on the table" Facility Manager, Regional Facility, ID18.

The ability of senior managers to develop and lead a positive organisational culture was reported across both participant categories as a contributing factor to quality of care. Linking positive organisational culture to high quality outcomes across the organization for example, one participant noted:

"Culture is critical, and something I always bang on about here is that you can walk into a workplace and within five minutes you can actually have a pretty good idea of what the quality of care would be like" Facility Manager, Regional Facility, ID7.

The same Facility Manager also reported that the RACF leadership team should possess the skills to define diversity within its organisation.

"So part of my role is I do some social profiling of our consumers and of our staff, trying to get to know who they are as a community. So I definitely do try and orientate them to the different cultures and what's important. It helps everyone to feel connected to each other" Facility Manager, Regional Facility, ID7.

Professional development

'Professional development' skills included the ability of a senior manager to create working environments that promoted the accountability of internal and external services to the delivery of quality health care. Skills that were strongly emphasized by both participant categories within this domain included the capacity of a manager to mentor junior staff and to participate in opportunities for continuing professional development and lifelong learning. Skills relating to promoting staff accountability for RAC quality of performance were only reported by participants who possessed a formal health qualification.

In order to promote and sustain quality performance, senior managers who were also qualified health practitioners, emphasised the importance for leadership teams to establish a professional work environment where staff and external health care providers were responsible and accountable to ensuring quality. A Clinical Care Coordinator operating in an inner regional RACF, suggested that reward and positive feedback mechanisms proved an effective leadership strategy to enhance employee accountability for quality assurance. Still of note, promoting staff accountability towards quality assurance was not emphasised by participants who did not possess a health qualification.

"Managers need to devise strategies so that each department is accountable for the health care they provide. This way you are making everyone, regardless of their professional role, accountable for his or her actions. Regularly rewarding and showcasing high quality performance is really important" Clinical Care Coordinator, Regional Facility, ID4.

The capacity of senior managers to mentor junior staff and seek mentorship from respected colleagues, was viewed by both participant categories as an important RAC leadership skill. Of the qualified health practitioners who were interviewed, three Facility Managers reported that management teams required the capacity to mentor and coach junior managers to deliver sustained care quality within an organisation. Also, the willingness and opportunity of senior managers to actively seek mentorship from respected colleagues was suggested as an important strategy to enhancing leadership capacity within a RACF.

"And I guess accessing mentoring was is also important. Accessing other managers, who are really high performers and working ways to integrate this into your routine, can only help professional development" Facility Manager, Rural Facility, ID7.

Managers who did not possess a formal health qualification also reported the importance of actively seeking mentorship from respected colleagues to improve RACF quality systems, as suggested by one General Manager operating in an outer regional area.

"Accessing mentoring was also important. Accessing other managers, and looking at, developing through them". General Manager, Regional Facility, ID9.

Knowledge of the healthcare environment

Skills and strategies associated with a managers' understanding of the health care system and environment in which they operate are linked to 'Knowledge of the health care environment'. Only participants who possessed a formal health qualification emphasised skills within this domain. Four participants, spanning different managerial roles and geographic areas of remoteness, suggested that senior managers require the health knowledge to recognise the scope of practice for each health care profession working within an RACF.

"Every manager should have basic clinical skills that you can continue to build on in whichever direction you need to through education and other avenues. Overall, you need to know that your staff are meant to be doing to ensure a safe, quality service" Facility Manager, ASGS RA 5 – Participant 19.

One Director of Nursing also reported that senior managers required a developed clinical perspective to ensure that organisational decisions regarding quality of care were made with the appropriate insights and knowledge of the health care environment.

"So your clinical assessment and observation skills need to be really on the ball if quality is to prevail" Director of Nursing, Regional Facility, ID17.

Few participants made the link between skills to monitor trends in the local and national health care settings, demonstrate familiarity with the regulations affecting health care delivery, or understand the impact of public policy decisions on cost, quality and access to care. Only one Facility Manager noted the importance of senior managers having the knowledge to assess quality and safety performance, noting it was important for managers to reward positive behaviours for staff who promote safe and quality health care practices. Of note, throughout most participant interviews, service quality was predominantly framed in relation to general business operations, rather than quality of health care per se.

"I always go back and I complement them and I do that often in front of the team at handover, saying this was really good in regards to your safety documentation. You were clear. So, my compliments are also very specific" Clinical Care Coordinator, Regional Facility, ID4.

Information technology and finance

Several participants emphasised the importance of utilising contemporary information technologies (IT) to assist staff education, quality compliance and reporting. Managers without a health qualification described the importance of financial management skills to ensure cost-efficient service delivery. Skills associated with strategic planning to enhance quality improvement and compliance were less of a focus for all study participants.

Senior managers across both participant categories recommended that senior managers develop the knowledge and skills to effectively utilise IT platforms. One Facility Manager with a formal health qualification recommended that RAC management teams employ innovative IT to deliver staff education about strategies to improve patient quality outcomes and to support the successful integration of new regulations including the new Aged Care Standards. Two managers located in inner regional RACFs reported that education contributed to increased knowledge across the organisation and a greater opportunity for high quality care to be achieved.

The importance of utilising IT platforms to increase RACF efficiency and accuracy with documentation and quality reporting requirements was also emphasised by one General Manager who did not possess a health qualification. Another participant who possessed a tertiary qualification in Business and management experience within the hospitality industry strongly emphasised the importance to recognising the role of finance in quality improvement programs. This participant reflected that senior managers should possess the skills to effectively oversee the RACF financial position and ensure that appropriate resources are available to support high quality of care.

"Yeah so it's about having information systems. So it's important to have a structure where we have a forum where they concentrate on different topics to enhance the skills and knowledge of our staff across multiple areas" Facility Manager, Regional Facility, ID16.

"Senior managers must be aware of IT that can support quality reporting and compliance in line with its unique organisational profile. Senior managers must have knowledge regarding the operation of RACF IT platforms" Facility Manager, General Manager, Regional Facility, ID9.

"If you want to see quality outcomes, you need to know how to budget for quality staff, technology and other resources. Quality health care costs money" Facility Manager, General Manager, Regional Facility, ID18.

Discussion

Drawing on interviews with 19 individuals across 14 facilities in northern Queensland, this study brings new knowledge regarding the skills that Australian RAC senior managers believe to be critical to quality of care. Senior managers described quality-related skills in five major domains of i) communication and relationship management, ii) stewardship, iii) professional development, iv) knowledge of the health care environment and v) information technology and finance. Of note, service quality tended to be framed in relation to general business operations, rather than quality of health care and despite many having clinical qualifications, we found participants placed greater emphasis on the skills in the communication and relationship management domain, as compared with knowledge of health and healthcare environment.

A key finding from the current study was the largely overlooked connection between knowledge of health and health environment in promoting quality of care, among study participants. Quality performance is linked to the knowledge of leaders regarding the health care environments in which they operate.²³ While exploring the leadership skills that influence quality of care in mainstream organisations, Boyatzis (1982)²⁴

found that effective managers who positively influence care quality possess a range of technical skills including knowledge about health care services, treatments and technologies; and knowledge about the organisation's health care environment. In the current study, senior managers with a formal health qualification reported knowledge of health professional scope of practice as important for assessing and monitoring quality performance of individual practitioners. Yet links between health knowledge and health environment and quality of care went otherwise unmentioned with no reference, for instance, to traits such as the capacity of managers to maintain the knowledge of various delivery models and innovations; or to design safe clinical systems, processes, policies and procedures that promote person-centred care and quality improvement activities.

Previous studies have shown how insufficient knowledge and awareness of health care operations specifically, can reduce RACF manager's capacity to form and enact quality-enhancing systems.²⁵ Australian senior managers who participated in the current study did not mention this link. A possible explanation for this finding is that some study participants did not possess a formal health education; and the health knowledge required to develop and monitor quality services within their respective organisations. Without a basic awareness of the health, environment, leaders and managers may have a limited capacity to formulate policies that develop a team system and accomplish organisational quality goals.²⁶ In addition, many participants reported increasing regulatory requirements across the Australian aged care sector, possibly leading RAC management teams to prioritise administrative responsibilities such as quality *reporting*, over the design of innovative health care environments that are conducive to the actual delivery of high quality care.

Findings from the current study demonstrate the perceived importance among senior managers of a leaders' ability to develop and nurture stakeholder collaborations, yet the emphasis in participants' accounts lay on collaboration with external stakeholders including clients' families; regulatory bodies and external service providers. Senior managers' accounts placed far less emphasis on the importance of building effective clinical leadership or middle management within RACFs as a way to influence health care quality. Previous research has demonstrated the importance of middle management for enhancing quality outcomes in mainstream HCOs.^{1,18} Yet in Australian RACFs, fundamental constraints on resourcing, and chronic challenges with recruitment of skilled professionals into the aged-care may limit senior managers' ability to even contemplate such structures.⁸ Research on RAC staffing levels conducted as part of the Royal Commission into Aged Care Quality and Safety, for example, found more than half of Australian aged care residents were living in facilities with unacceptable levels of health care and managerial personnel.⁷ These issues are particularly acute in regional and rural locations in Australia, where competition for the same limited pool of skilled health workers from better funded and often more flexible mainstream health services is intense.²⁷ With poor staffing availability across many frontline RAC health occupations, the prospect of senior managers forming a middle management tier with suitably qualified personnel may be perceived as unrealistic, and a possible explanation as to why this leadership skill was not emphasised by participants in the current study.

Some RAC senior managers in this study linked senior managers' ability to lead change and quality of care. At the facility level, Andreessen *et al.* (2016) suggest that senior managers play an important role to supporting organisational change and should possess the knowledge to inspire new approaches to high quality care.²⁸ Although empirical evidence supports change management as a key HCO leadership attribute, in this study only a few RAC senior managers, all with formal business qualifications, emphasised the importance of these skills. A potential explanation for this finding could be the absence of structured job pathways, training and development programs, and leadership-training experience for Australian aged care management personnel; meaning that as an occupation, RAC senior managers' possess a range of different qualification types, professional skills and leadership experience.

Conclusion

As a strategy to better understand the optimal skill – mix of managers who lead Australian aged care services, the Royal Commission into Aged Care Quality and Safety - Final Report recommends that aged care leadership accountabilities and professional development strategies be better defined. This recommendation includes that RAC senior managers possess professional qualifications or high-level experience in management roles, while receiving the continuous learning required to positively influence the quality RAC within in an increasingly complex health care environment. Yet the link between leadership and quality of care is poorly defined in the context of Australian RAC. This study aimed to reduce this evidence gap and explore leadership skills and strategies employed by senior management teams to influence high quality of care in RACFs. Findings demonstrate that senior managers view communication and relationship management skills as critical to ensuring service quality; however, few participants emphasised the linked role of health knowledge and health environment to quality outcomes. With ongoing concerns and challenges to RACF quality of care, more work is needed to identify sector specific professional development (PD) strategies that prepare RAC senior management personnel with the appropriate skills to positively lead quality care within an increasingly complex environment.

Declarations

Ethics approval

Ethical clearance was obtained from the James Cook University Human Research Ethics Committee (H6652) in August 2019.

Consent for publication.

All participants provided verbal and/ or written consent for data to be published.

Availability of data and materials

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests Statement

No potential conflict of interest was reported by the authors

Authors' contributions

ND was responsible for collecting and interpreting the participant data. ND and ST were both responsible for data analysis. ND conducted the primary manuscript draft. ND and ST both completed subsequent manuscript revisions. Both authors read and approved the final manuscript.

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Figures

Figure 1

Northern Queensland Primary Health Network Region - Study locations Note: Source: (Adapted from: Northern Queensland Primary Health Network website, 2015)