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Title: Quality and safety in aged care: What Australian research published in the AJA tells us

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MeSH Keywords: Homes for the aged, Home care services, Health services for the aged, Nursing care, Patient-Centered Care, Quality of health care, Patient Safety

Conflict of Interest: None

Acknowledgements: None

Word Count: 3189

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/AJAG.12638](https://doi.org/10.1111/AJAG.12638)

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Article type : Review Article

TITLE: **Quality and safety in aged care: What Australian research published in the AJA tells us**

Objectives: To review studies published in the Australasian Journal on Ageing (AJA) about the aged care work force, to identify influences on quality of care and potential policy directions.

Methods: Articles in the AJA on the aged care workforce published from 2009 to 2018 were identified, grouped into themes, and rated for quality.

Results: Twenty-eight articles were identified. Articles fell into three broad types: 1) Staff knowledge, skills, and attitudes; 2) Environmental factors that influence staff capacity; and 3) Interventions to improve staff capacity. Studies reinforced the importance of staff-consumer, staff-relatives, and staff-staff relationships and a supportive workplace culture for staff capacity to provide high quality care and support work ability.

Conclusions: It is possible to improve practice in community and residential aged care, given better training in person-centred practice; and having enough staff and a supportive staff culture to encourage staff to put their training into practice.

Keywords: **Homes for the aged, Home care services, Health services for the aged, Nursing care, Patient-Centered Care, Quality of health care, Patient Safety**

The Royal Commission into Aged Care Quality and Safety established in October 2018 has provided an impetus to review what we know about the determinants of the quality and safety of community and residential aged care in Australia and the future challenges and

opportunities for delivering high quality services. Peer-reviewed publications in the Australasian Journal on Ageing (AJA) can provide a unique insight to inform the Royal Commission.

The focus on Australia's aged care system is important. Cross-national studies have shown that the policy and cultural contexts in which aged care operates vary significantly between nations, even those with comparable systems of health care [1, 2]. One of the terms of reference for the Royal Commission is: how best to deliver aged care services in a sustainable way, including through . . . investment in the aged care workforce . . . [3]. Workforce issues were previously identified as a key issue for community care research in Australia [4]. The current review includes AJA research about the aged care workforce relevant to quality of care, with a view to informing development of policy and practice in aged care.

The most recent National Institute of Labour Studies survey on the aged care workforce [5] included over 4,500 service outlets and more than 15,000 staff from residential and home- and community-based care. The aged care workforce is growing; between 2012 and 2016 there was a 5% increase in the number of employees in direct care roles. Most are women (close to 90%) with median ages of 46 years in residential care and 52 years in the community sector. The workforce comprises large numbers of personal care attendants (PCAs; 70% of the workforce), smaller numbers of registered and enrolled nurses (RNs; 15%; ENs; 10%), and relatively few allied health staff (5%).

The aged care workforce is increasingly multicultural. Although most care workers are Australian-born, the number of carers from 14 countries doubled between 2006 and 2011. Increases were highest among those from South Asia and sub-Saharan Africa [6].

We know from Australian and overseas studies that the quality of the aged care workforce has an impact on the quality of care delivered to consumers. The knowledge, attitudes and skills framework has been used to assess staff capacity [7], and job satisfaction is also an important factor in the quality of care provided [8]. More broadly, the quality of residential aged care is affected by skilled staffing levels [9, 10] and the quality of nursing leadership [11]. Consumers consistently recognise staff continuity, appropriateness and training as essential to good outcomes for service users [12].

Hence, questions for the review included: "What are the skills, knowledge and attitudes of staff working in Australian aged care settings?"; "What factors influence staff

skills, knowledge and attitudes?"; and "How can staff skills, knowledge and attitudes be improved?"

Studies were included in the review if they appeared in the *AJA* in the past 10 years (from 2009 to 2018). This period was chosen because: articles need to be relatively current; 2009 was a seminal year in the field; and the *AJA* was Medline listed late in 2008, marking a "watershed" in the journal's history. A preliminary search of the EBSCO database of peer-reviewed articles in the *AJA* with any mention of staff in the abstract (search terms staff OR workforce OR nurs*) from 2009 to 2018 yielded 57 articles, compared with less than half that number—only 24—in the previous decade from 1999 to 2017.

Method

The review identified 28 relevant studies, which were grouped into themes. Editorials were omitted, as were articles focusing solely on residents (e.g., tools to measure resident functioning, or studies of the impact of the physical environment on residents). Risk of bias assessments of quality were carried out using Joanna Briggs Institute (JBI) criteria [13].

Results

The review identified:

- Fifteen studies on question 1: Staff characteristics (skills, knowledge and attitudes) likely to affect quality and safety of care;
- Eight studies on question 2: Contextual determinants of staff capacity to provide high quality care;
- Five studies on question 3: Interventions to improve staff capacity.

Of these 28 studies, 14 were qualitative in design, eight were quantitative only, and six involved mixed methods (e.g., survey and interviews or focus groups).

Theme 1: Staff knowledge, skills and attitudes

One included study explored PCAs' skills and knowledge. Staff knowledge was assessed directly in four further studies: two were intervention studies (Theme 3 below). The six remaining studies were about staff attitudes, and of these, three examined job satisfaction and intentions to remain in the job.

Knowledge and skills

The study on PCA training [14] employed an expert committee to develop criteria to assess Certificate III courses for PCAs, and then used these to survey 10 registered training organisations (RTOs) that offered this qualification and 10 aged care facilities. Training organisations provide widely different experiences, with varying fee structures, content, clinical experience and levels of student supervision. In general, aged care facilities are not satisfied by levels of skills and knowledge of graduates.

The study on knowledge of caring for older people with dementia [15] included 35 care staff working in secure dementia units: PCAs comprised most (86%) of the sample. A dementia knowledge survey and structured individual interviews identified only mediocre levels of knowledge. Knowledge deficits were attributed to participants' ethnic origins and short residency in Australia. Participants acknowledged the importance of dementia education and training but criticised the low relevance of the training they had received.

Together, these two studies highlight issues in PCAs' training and capacity. However, coming from a culturally and linguistically diverse background is not always a drawback. One study highlighted staff with a non-English language as a resource in residential care [16].

The fourth study highlighted issues among enrolled nurses in crushing medications, which often resulted in inappropriate administration, including drug mixing, spillage, and incomplete dosing [17]. Staff lacked knowledge on how to locate and use existing resources to reduce the rate of inappropriate medication crushing.

The remaining studies explored the knowledge of mixed groups of staff about various topics. Staff knowledge of delirium was explored through asking staff (two RNs, 2 ENs, and two PCAs) about their experiences [18]. Five of the six participants had not previously heard of delirium, and all confused delirium, depression and dementia. Staff care decisions were not based on formal clinical assessment.

Aged care staff knowledge and attitudes toward later life sexuality and intimacy in people with dementia were explored with staff working in facilities with secure dementia care units [19]. Results indicated that staff members' knowledge of later life sexuality is inadequate, but their attitudes are relatively permissive.

Finally, a study explored aged care service managers' perceptions of their staff's capacity to provide care for older people who had survived genocide or mass trauma [20].

Most respondents reported that their agency provided services for older survivors. Most perceived staff to be moderately well-informed about trauma-related issues, but only half rated staff trauma skills positively.

Attitudes and beliefs

Ageist attitudes and behaviours are common in undergraduate nurses. Frost [21] surveyed 185 first year nursing students. Almost all participants reported engaging in some ageist behaviours in common social situations. Most of the cohort (88%) reported behaviours such as talking slowly and loudly to an older person. Despite this, a majority (63%) said they would work in aged care in the future.

Care staff attitudes to dementia are generally positive and job satisfaction is also high [22]. Participants of this study were most satisfied with their contact with residents and least satisfied with their work environment. Work experiences predicted staff attitudes to people with dementia. For example, staff satisfaction with feedback at work predicted person-centredness and hopefulness in approaches to dementia care.

A qualitative study [23] of perceptions of resilience in the aged care workforce found staff identified having clinical expertise, a sense of purpose in a holistic care environment, a positive attitude, and work-life balance as important resources. Participants highlighted the importance of maintaining long-term, meaningful relationships with residents for their capacity to cope. Collegial support and the use of humour to defuse stress also promoted resilience, and some staff relied on their religious faith.

Two studies [24, 25] explored challenges in managing acutely unwell older people in residential care. Stokoe's study [25] highlighted nurses' commitment to providing care in the facility whenever possible, but staff said they often felt out of their depth with acutely unwell residents. Staff were more confident about their decisions when advance care plans were in place and they were supported by the GP or palliative care clinicians. Arendts' study [24] reported burden caused by having to make decisions whether to transfer residents from residential care to hospital emergency departments. Staff took pride in their professionalism but had to balance providing optimal treatment for one ill resident with their obligations to other residents.

These studies identified largely positive attitudes in trainee and qualified nurses towards older people and those with dementia. They highlight the importance of relationships

with both residents and other staff and the support of management and external expertise in being able to provide high quality care and maintain positive attitudes.

Staff wellbeing and workforce stability

Three studies examined staff retention. Austen et al. [26] used survival analyses of administrative data to explore staff retention in a large aged care provider. Median employment duration was only 1.4 years, and 63% of carer employment spells ended within two years. The authors concluded that strategies for workforce training and development should be focused on women in mid-life to maximise workforce stability.

Radford et al. [27] examined relationships between job satisfaction and intention to stay. Community care workers were more satisfied with their work, their supervision, their clients and colleagues, and the job in general than those in residential care. In regression analyses, high job satisfaction was the only unique predictor of intention to stay.

A large survey by Austen et al. [28] examined work ability, age and intention to leave. Work ability was high in comparison with international figures. As expected, intention to leave was higher among those with low work ability. Unexpectedly, age did not predict work ability and registered nurses had lower work ability than other groups.

Together these studies reinforce the importance of relationships with managers and attention to fit between work demands and workers' capacities. They also highlight the value of employing mature age women in aged care for workforce stability.

Theme 2: Environmental influences

Seven qualitative studies explored environmental influences on employee attitudes and capacity. One examined the physical environment, while the others were about the psychosocial work environment, workplace culture, and external influences.

The study on the physical environment [29] identified workplace design features that influence whether residential aged care staff feel valued, productive, safe, belonging and connected. Key design features were: a home-like environment; access to outdoor spaces; a high-quality indoor environment; and access to safe, open, comfortable workplaces.

Six studies show the direct impact of quality of relationships, management issues, workplace culture, and external demands on the quality of care. The first of these [30] focused on barriers to developing positive relationships in aged care settings. Themes

included rigid professional boundaries, high task-related burdens and care demands, and discordant staff expectations.

The second study [31] researched nurses' experiences of providing palliative and end-of-life care in residential aged care settings. A major theme was managing conflicting expectations. Tensions were caused by having to address complex decision making and organisational administrative expectations at the same time. These issues impeded discussions about the goals of care and provision of palliative care.

In the third study [32], PCAs were asked about pain management. A common overarching theme in their accounts was having extended responsibilities, including making clinical decisions, initiating clinical care and advocating for residents. This study reinforced the need to ensure PCAs are adequately prepared and supported in their role, as their actions have a direct impact on the quality and safety of care provided.

Sheridan et al.'s [33] study conducted with direct care staff in residential care highlighted a moral conflict between staff protecting their own safety and providing care. One-half felt that employee safety came before resident safety. However, others believed inadequate staffing showed management prioritised resident safety over staff safety. Poor communication about and follow up of incidents involving staff risk reduced staff motivation to report them.

The remaining two studies reference external pressures. Ostaszkievicz et al.'s qualitative study [34] explored staff attitudes towards continence care. Staff experiences of the quality framework and funding model in aged care fostered a climate of fear and risk averseness, which incentivised dependence on continence management and equated effective continence care with use of continence pads.

The influence of aged care reform on nurses' perceptions was explored in a study of RNs and ENs in rural Australia [35]. Nurses highlighted issues with funding and resource shortfalls, staffing levels, skills mix and knowledge deficits. Deficits were identified in provision of complex care, such as pain management, medication review and wound care. External reasons for shortfalls in care provision included the introduction of means-tested accommodation payments and the funding model. Consequently, increases in resident acuity were not matched by staff qualifications and experience.

A final study involving health professionals (nurses, social workers, and welfare workers) [36] highlighted challenges where elder abuse was encountered. Issues included

intimidating contexts (e.g., feeling threatened by family members), practice dilemmas (e.g., whether to report abuse), and lack of guidance from management. Despite these issues resulting in frustration and stress for many staff, they remained committed to working with older people experiencing abuse.

Theme 3: Increasing staff capacity.

Five studies were identified with a focus on interventions to improve staff capacity. Jamieson et al. [37] evaluated the Cooperative for Healthy Ageing Research and Teaching (CHART) intervention, which involved partnerships between aged care providers, tertiary institutions and the hospital and non-government sectors. Governance processes emerged as key to enabling both formal partnerships and informal networks. Often these processes were invisible and relied on individual efforts. The program was difficult to sustain once funding ceased—many partnerships reverted to student placements only. Despite this, many achievements were seen positively. Multi-facility partnerships can work but require clear project governance and strong engagement from all parties.

Multilevel engagement and formal partnership agreements also featured in an intervention to improve the oral health of older people in home care [38]. At baseline, the work was perceived as a series of tasks to be completed as quickly as possible, and staff paid no attention to oral health, although they understood it was important. The intervention, comprising individually tailored oral care strategies, improved home care workers' knowledge about oral care for older people and confidence in managing this care.

The remaining three interventions were more modest in scale. Brooke et al. [39] examined the impacts of actions designed to increase workability, including: work organisation (e.g., higher numbers of PCAs in high care, not using agency staff, and more staff hours on rosters); activities to foster trust (e.g., subsidised meals, social clubs, staff events, and recognition and awards); workplace actions (counselling, empowering PCAs, and management support when residents and families were aggressive); training (e.g., in resident-focused care and empowerment); and ergonomic actions (equipment, workplace design and task rotation). Work ability scores increased from pre- to post-test. However, the only action perceived as contributing to post-test work ability was higher numbers of PCAs in high care.

Lau et al. [40] used mixed methods to evaluate a seven-module educational intervention to improve nurses' self-efficacy in providing aged care. The program resulted in

an increase in nurses' ratings of their self-efficacy, knowledge, confidence, and quality of care. Nurses' ability to critically evaluate their workplaces and practices also increased.

A third intervention study evaluated impacts of diversity training using telephone interviews [41]. Diversity concepts were positively received but applying diversity principles in practice was fraught with challenges, including time or organisational pressures, role constraints, and wider systemic issues.

Together, these studies show that it is possible to improve the quality of care provided in community and residential aged care settings. Interventions involving partners need strong support from all stakeholders to succeed. Interventions to improve work ability must be supported by adequate staff-resident ratios. An unintended consequence of increasing staff self-efficacy is that staff become better able to critique and change care practices at their workplaces.

The quality of included studies

Overall, most studies were reported comprehensively, with clear justifications, methodology and analyses. However, no quantitative studies identified any potential confounding variables, leaving questions as to cause and effect. Several studies failed to report measures' internal reliability, which may affect replicability and confidence in the findings. Finally, although all studies were situated in Australia, only one author located themselves culturally and acknowledged cultural influence on the research.

Summary and conclusion

This review highlighted the importance of improving staff-consumer ratios and staff training and skills, especially for PCAs, for quality and safety in residential and aged community care. Both actions are essential to underpin a positive staff culture and supportive relationships between all stakeholders. PCAs have replaced trained staff to reduce nursing home costs, and it is essential that they possess the skills required to provide safe care. Reliance on under-skilled PCAs in a context of staff shortages is a risk for resident abuse, as outlined in the Royal Commission Terms of Reference. In this context, work ability is a useful concept encompassing staff training and competence, adequacy of resources, and supporting workforce health and wellbeing.

The review has limitations, and these are reflected in the results. For example, while studies recognised the importance of staff training in person-centred residential care, requiring attention to individuals' characteristics and care needs, few acknowledged the co-

participation of older individuals in care decisions. A further gap is evidence on staff attitudes to death and dying.

Studies tended to be undertaken with organisations that were positively predisposed to research and research-based interventions; and ‘worst case’ scenarios in residential care were not captured. Regarding the Royal Commission Terms of Reference, none of the studies were whole-of-industry surveys, and so did not ‘investigate the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response’.

One-half of the studies in the review were competent qualitative studies. Quantitative and mixed methods studies were fewer in number, especially for themes 2 and 3, and their quality was more difficult to assess. High quality, large scale quantitative studies are required to improve our understanding of the factors that influence staff capacity to provide care and interventions that improve staff capacity to ensure care recipients’ safety. Conducting reliable quantitative research on these topics requires samples of sufficient size in stable research environments. This poses a particular challenge in longitudinal studies, given attrition rates (see [25]).

Finally, the Royal Commission Terms of reference are also concerned with ‘people's desire to remain living at home as they age’. Given this policy direction, a critical question for the future of aged care quality is how older people living the community can be cared for by a workforce fully responsive to individual dependencies in a policy context of funding constraints.

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Title:

Quality and Safety in Aged Care Virtual Issue: What Australian research published in the Australasian Journal on Ageing tells us

Date:

2019-03-01

Citation:

Wells, Y., Brooke, E. & Solly, K. N. (2019). Quality and Safety in Aged Care Virtual Issue: What Australian research published in the Australasian Journal on Ageing tells us. AUSTRALASIAN JOURNAL ON AGEING, 38 (1), pp.E1-E6. <https://doi.org/10.1111/ajag.12638>.

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