COVER SHEET

Edwards H, **Chapman H**, Foster E, Gaskill D, Morrison P, Sanders F. (2003). Challenges associated with implementing an education program in a residential aged care setting. *Australian Health Review*, *26*(3), 107-115

Abstract

The link between independence and well-being of older people in residential care is well established. This paper reports some challenges encountered during implementation of an education program designed to assist nursing staff to adopt an independence-supporting model of residential care. The education program was part of a larger project aimed at developing an example of best practice in supported care which promotes independence, well-being and community linkages. Implementation of the program created many interesting challenges which were overcome by strategies and facilitating forces such as support from management and some staff, and the collaborative nature of the project. Positive outcomes of the education program included increased awareness of, and change in, practice; increased staff-resident interaction; and increased encouragement for residents to be independent and to engage with the wider community. Moreover, a facilitator manual - Promoting Independence: A Learning Resource for Aged Care Workers was subsequently developed so that the program can be implemented in aged care facilities elsewhere.

Need for continuing education in aged care

The increasing number of elderly people needing care in our society means that nurses can expect to face more and more complex biological, psychological and social challenges in caring for people in both institutional and community settings. Continuing education in this sector is a vital prerequisite for quality care. The need for “cost-effective care, competent care providers and professionals who will meet the unique needs of elders” (Wykle 2001) is obvious. However, for a variety of reasons there is a shortage of nurses who are qualified with appropriate clinical aged care skills (Pearson, Nay, Koch, Ward, Andrews & Tucker, 2001).

Many employers have responded to the shortage of appropriately qualified nurses by allocating more duties to unskilled workers who may not have undertaken any formal nurse education program (Commonwealth Department of Health and Aged Care 2000). Such a response not only devalues older people and their care but also directly affects the quality of the care provided. It also intensifies the need for continuing education in aged care settings for all grades of staff working in this sector.

This paper analyses some of the challenges encountered during the implementation of an education program in an aged care setting. Details about the study and resources that were developed can be found in Edwards, Gaskill, Sanders, Forster, Morrison, Fleming, McClure, and Chapman (2003). The challenges are considered through three key themes: attendance, trust and empowerment. The paper also raises some important factors that may facilitate the successful uptake of educational interventions.

Lifelong learning is an imperative for any professional workforce. Health care professionals "who do not continue to improve their skills and knowledge will quickly become obsolete" and gradually become unreceptive to new ideas (Dolan 2002). In the aged care sector, continuing education assumes critical importance in light of the limited, if any, educational preparation in aged care knowledge and skills held by many who provide care (Edwards & Forster 1998). While many groups have embraced the rhetoric of lifelong learning the concept of professional development in the aged care sector may be seen as superfluous given the varied nature of the workforce and the increasing demand for basic care.

In Australia, registered nurses (RNs) undertake a three-year undergraduate nursing degree at a university. However, current approaches to the basic education of RNs largely focus on primary health care and the provision of acute care in hospitals – the majority of practitioners graduate with little if any course work in ageing (Burggraf & Barry 1998, Pearson et al 2001). A small minority undertake postgraduate study in gerontic nursing.

Enrolled nurses (ENs) undertake a one to two year diploma course through the Vocational Education and Training (VET) sector. Personal care assistants, also known as assistant nurses (ANs) are not required to have formal qualifications or to have achieved a minimum standard of training. The number of unregulated workers or ANs employed in

aged care is growing (Francis & Humphreys, 1999) and while an increasing number are undertaking aged care training at the Certificate 3 level offered by the VET sector, they still generally rely upon on-the-job training (Pearson et al 2001).

The diversity of educational experience together with the overall lack of formal knowledge of aged care strongly suggests a need for a coordinated program of continuing education in aged care settings. Continuing education can not only increase the knowledge base of all who provide nursing care but also support the RNs who work with and supervise unregulated workers to acquire up to date knowledge and skills. Professional staff also require additional skills in promoting effective teamwork and a well-coordinated approach to daily care.

Background and setting

In 1997 a team of researchers from the School of Nursing at the Queensland University of Technology (QUT) formed a collaborative partnership with the management and clinical staff of an aged care facility. The ensuing collaborative research project, entitled Maximising independence and autonomy for vulnerable older people in a residential setting: Facilitating best practice was funded by a grant from the Commonwealth Department of Health and Aged Care – Healthy Seniors Initiative. The setting for the collaborative study was a 78 bed residential aged care facility in Brisbane, Australia. The 68 staff members comprised 14 RNs, two ENs, 35 ANs, one physiotherapist, two diversional therapists and 14 domestic staff.

The specific objectives for the project were to:

1. Develop an example of best practice for vulnerable older people in residential care by providing a model of supported care, which promotes independence, well-being and community linkages.

2. Develop an education program to assist registered and non-registered nursing staff to adopt an independence-supporting model of residential care.

3. Explore the benefits for residents of establishing reciprocal links between residential care units and relevant community organisations.

The implementation of the education program drew on the work of Margaret Baltes (Baltes 1996) and colleagues, which explored the problems of dependency-supporting care and its antecedents and also established the effectiveness of education as an intervention to improve the well-being of older people in residential care.

The education program was conducted in small group settings at the aged care facility. It consisted of seven 90 minute sessions, covering the following topic areas: older people in society, older people in nursing homes, understanding the older person and promoting abilities, and making changes.

Implementation of the program created many interesting challenges for the researchers/educators. Most can be subsumed under the themes of attendance, trust, and empowerment.

Challenges associated with attendance

Staff attendance was a major challenge that persisted despite very strong support for the project from management and clinical staff. Attendance was low and varied: of the 51 nursing staff, 12 (two RNs, one EN, and nine ANs = 23.5%) attended the education program. However, only eight nursing staff attended four or more sessions.

Strategies and incentives to maximise attendance included consultation with nursing staff regarding the most suitable location, day and time for the sessions. This resulted in each session being offered twice in the same week in the early afternoons to coincide with the overlap of morning and afternoon shifts and to maximise the ability of staff to attend. Light refreshments were provided.

The agency proprietors supported staff attendance and participants were paid for half of the time they attended the program. Furthermore, attendance was included in records of inservice education and the names of all staff attending more than four sessions were entered in a draw to win a cash prize of $500. Eye catching posters and flyers advertised commencement of the program and individual staff members were asked to spread the word.

The only available setting was a sitting room, which not only housed the staff desk but also was occasionally used by the residents. Because of these circumstances, the location proved to be a challenge in terms of interruptions and distractions that may have affected attendance. This was addressed by establishing a relaxed and inclusive atmosphere where everyone in, or entering, the room was encouraged to join the discussion.

During the first session all participants contributed to setting ground rules for the operation of the group. Optional between-session activities facilitated further reflection on discussion issues and motivated staff to apply their understanding of concepts to contemporary real-life situations. Each session began with a review of these between-session activities, which proved a useful strategy in promoting discussion and providing a link between sessions.

Despite the numerous strategies and incentives the inconsistent and disappointing levels of staff attendance persisted. It is uncertain why this was so – it may simply have reflected the discrepancy between high care needs and inadequate staffing levels. It is also possible that because the strategies used to promote attendance were directed primarily at overcoming institutional barriers (such as cost, inconvenient location or time), they did little to address the situational barriers (such as home responsibilities) or the dispositional barriers (such as attitudes and perceptions to learning) (Cross 1981).

Motives for working in aged care

Evidence suggests that health care professionals generally hold negative attitudes towards aged care. Aged care nursing is largely considered to be of lower status and appeal than more acute areas of nursing; it continues to be an undesirable career choice; and interest in aged care nursing as a career choice decreases during nurse education (Courtney et al 2000, Nay & Closs 1999, Pearson et al 2001, Percival 1999, Stevens & Herbert 1997). Apart from the negative image and perceived lower status of working in aged care, there are also wage disparities. In the private aged care sector in Australia for example “some aged care nurses now earn more than $100.00 per week, or $5000.00 per year, less than their equivalent colleagues in a public hospital or state government nursing home” (Australian Nursing Federation 2001).

Clearly, issues such as negative image, lower status and appeal as a career choice, and wage disparity underpin the difficulties experienced in recruiting and retaining qualified nurses to work in aged care. Indeed, in many countries the situation has reached a crucial point where "the rarest commodity is not gold or diamonds, but people" (Larsen 2000). For example, in Australia from 1986 to 1996 registered and enrolled nurse employment in nursing homes fell by 4.7% (Australian Institute of Health and Welfare 1999). It is equally clear that many of the nurses who do work in aged care do so not because of career choice but for other reasons such as preference for a low-technology, non-acute environment, because it better suits family commitments, or because other suitable employment cannot be attained (Percival 1999). Such reasons are arguably not closely attuned with motivation for professional development.

Motivation for professional development

In the past there has been a view that advanced nursing knowledge and skills were largely unnecessary in aged care settings (McCoppin & Gardner 1994). This view was consistent with the belief that aged care is merely custodial care – that nothing can be done as old people only die anyway. While this may no longer be the predominant view, it is still difficult to attract highly skilled and professionally motivated nurses into gerontological nursing (Percival 1999). It is probable that aged care nursing is still largely seen as just a job and attendance at continuing education programs is seen as an unnecessary inconvenience rather than an opportunity for professional development.

For example, an increasing number of unregulated workers or ANs employed in aged care are undertaking aged care training at the Certificate 3 level offered by the Vocational Education and Training (VET) sector, and the ANs in the study facility may have seen no reason for attending another program deeming that they had done what was necessary to secure their position and salary. A similar value-perspective may have existed for the RNs and ENs in the study.

The average age of nursing staff members was 39 years, with the majority having worked for many years in the aged care sector. The qualified staff may have believed that their original knowledge base, together with their experiential knowledge, was more than

adequate for the care of older persons. This thinking demonstrates little, if any, valuing of older people much less life-long learning approaches or professional development.

The reasons just explained for working in aged care together with possible beliefs and value-perspectives are consistent with situational and dispositional barriers to participation and have been elaborated elsewhere (Cross 1981). The dispositional deterrents also relate to three assumptions from Malcolm Knowles' theory of adult learning. According to these assumptions (Knowles 1990), adults need to know why they need to learn something before doing so; they are motivated to learn something if they perceive the need; and the most potent motivators for learning are internal pressures such as a desire for increased job satisfaction, self esteem, quality of life, and the like.

Dispositional barriers, particularly in the form of poor motivation, are clearly important factors in determining attendance at continuing education programs. However, the challenges associated with maximising attendance were exacerbated by the challenges related to achieving the trust of the staff in the residential care facility.

Challenges associated with trust

Creating an atmosphere of trust between the staff at the aged care facility and the university researchers/educators proved to be another ongoing challenge. Despite the collaborative nature of the project, there was a pervading atmosphere of reservation concerning the ability and legitimacy of the university researchers/educators to provide an education program applicable to aged care clinicians.

The overall scepticism was such that the university researchers/educators mostly felt that they were perceived as complete outsiders who neither understood nor knew the world of residential aged care even though they were all registered nurses with expertise in gerontic nursing. Some staff members seemed opposed to the whole project, perceiving it as an invasion of resident privacy, and despite determined efforts made to gain and then maintain their trust, they remained suspicious. The pervading atmosphere of reservation concerning their ability and legitimacy was a major challenge for the university researchers/educators.

Strategies to gain and maintain the trust of staff were proactive and continuous. Several information sessions were held to explain both the project and the education program. The need for the education program was explained in connection with research data which indicated that residents experience some limitations in exercising their independence. The powerful role played by nursing staff in supporting or hindering resident autonomy was explained and emphasised in the information sessions.

Collaborative measures such as negotiation, consultation, and mutual setting of ground rules for the operation of the group were employed. Potential participants in the educational program were consulted to determine their prior educational experience and to ensure that the program was responsive to their needs. This was further ensured by the incorporation of process evaluation feedback from each session into subsequent sessions.

The education sessions were conducted in as non-didactic and informal a manner as possible. They were essentially small group interactive learning sessions based on adult learning principles. By using video excerpts or short journal articles as catalysts for discussion, the experiences of the participants were drawn upon in each session. Teaching and learning materials were current and appropriate to the aged care setting and whenever possible, Australian examples and materials were used. Criticism of overseas audiovisual material was circumvented by inviting discussion about the similarities and differences in the views expressed in the video and those of Australian society.

However, many staff members remained suspicious of the purposes and legitimacy of both the research and the education program. As with the challenges associated with attendance it is uncertain why this situation persisted, but it is likely that attitudes and perceptions again played a key role. Experiential knowledge and formal knowledge are not mutually exclusive truths, and there can be no question that clinical nursing competency requires knowledge and skills acquired through both personal experience and formal learning on a regular and continuing basis. Without continued learning, there is risk not only of knowledge becoming obsolete but also of it becoming fixed as immutable truth impervious to new ideas (Dolan 2002).

In the circumstances of this study, it is perhaps not surprising that an education program, essentially promoting a different model for providing care (with the inevitable

implication that current practice was not considered good practice) and being initiated and implemented by perceived outsiders, would be challenged. The staff may have seen the project as an affront to their current knowledge and skills.

The third cluster of challenges centre on the theme of psychological or personal empowerment. These challenges are closely linked to trust but rather than trust in others they involve trust in oneself to make a difference.

Challenges associated with personal empowerment

Psychological empowerment refers to feelings of individual self-worth and self-reliance (LeCompte & DeMarrais 1992, Rappaport 1985, Smith 1993). It is personal, and based on a heightened self-awareness and the unblocking of repressed feelings: on "growing recognition that personally constraining perceptions are socially constructed rather than personal pathologies" [Smith 1993]. Although challenges associated with personal empowerment could be expected to be most evident at the AN level, where supervision and direction from RNs or ENs is obligatory, lack of trust in oneself to make a difference arguably poses challenges for most if not all nurses who work in aged care.

Given the issues associated with working in aged care (eg. poor image, undesirable career choice, wage disparity, increasing numbers of unskilled workers, inadequate formal knowledge) it is not surprising if the nursing staff did not experience feelings of individual self-worth and self-reliance in terms of their ability to contribute to changes in aged care.

Undoubtedly, some of the nursing staff recognised the need for change in the attitudes of society and change in the approach to the provision of aged care. However, it seemed that few recognised or exercised their individual capacity or power to effect change, and may have retreated into cynicism, discontent and indifference.

Such retreat is unfortunate. While any change is complex and difficult, individual capacity or power to effect change - and thus eventually change the system - lies within all of us. Change in the thinking, believing, perceiving or acting of just one person can impact on a system: systems don’t change by themselves; people change systems (Fullan 1993).

While the education program participants were enthusiastic about making changes to their practice, they were frustrated and hindered by the actions and attitudes of staff members who did not attend the program. Several participants described how co-workers resisted attempts to promote resident independence and continued to do things for residents in face of their obvious ability to do the activity for themselves. Similarly, participants described how they would implement a strategy to enhance a resident's independence that was not continued or reinforced by other staff members. Such experiences would likely affect peer cohesion. They would also be likely to adversely affect burgeoning feelings of self-worth and self-reliance or any inclination for change of practice.

The challenges associated with personal empowerment and resistance to change were so well disguised behind the cynical attitudes of many of the staff that they were almost overlooked. However, until they are addressed the many challenges related to the provision of aged care - including the challenges associated with attendance at continuing education programs and trust in others - will remain.

It is important to note that, while there were many barriers to overcome, there were also many facilitating forces. Four of these will now be briefly discussed.

Four facilitating forces

• *Enthusiasm and support from some staff members*. These staff members had a professional approach to the care they provided and were keen to develop professionally and to improve care practices.

• *Collaboration.* Strategies such as consultation and negotiation between staff members and the researchers/educators proved to be major facilitating forces. Indeed, the collaborative nature of the project not only encouraged staff members to voice their needs, problems and issues and to generate possible solutions but also was instrumental in breaching barriers to change.

• *Support and incentives from management.* The entire project received wholehearted cooperation from management, and strong support and incentives were offered to staff members.

• *The research approach of the project.* This project used an action research methodology, which guided the strategies employed in both the research and the education program. Action research not only emphasises collaboration, but also allows for the subjective realities of those involved; a necessary precondition for engaging in any successful change effort, according to Fullan (1993). The purpose of the project was to change practice.

While there were other facilitating forces, the collaborative research partnership between the academics and the management and clinical staff of the aged care facility was paramount. The contributions from enthusiastic and supportive management and staff members and the collaborative process did much to produce the positive outcomes of the education program.

Positive outcomes

The program was successful in that it stimulated the participants to discuss, examine and change their practices. Most importantly, staff-resident interaction increased and residents were encouraged to be independent and to engage with the wider community. A summary of the comments and outcomes is presented below.

Participants described the sessions as “eye opening” and enjoyed exploring different perspective’s on ageing and older people. Feedback indicated recognition of the diversity of older people and appreciation of the opportunity to hear colleagues’ views and experiences in small group discussions. The participants claimed they had gained greater awareness of the patronising nature of much communication in aged care settings and of the importance of individualising communication to meet the preferences of older people. Participants also claimed a deeper insight into the losses and gains residents’ experience through living in an aged care facility.

Participants were very enthusiastic and somewhat surprised at the results of the strategies they implemented to promote independent behaviours in residents. Some of their experiences are described below.

> *I just kept poking my head around the corner and seeing what she was doing and saying, every time she did something, “Gee that’s good M, you’ve done that all by*

yourself today. You didn't need me did you?" I gave her the face washer and the towel, and she sat there and did it all herself, and she actually said to me on the way out the door, "Oh thank you nurse". She was happy that she'd done it herself.

I [now] realise that just because the residents are in a nursing home, we should not take [independence] away from them, if they can do it themselves. It may take them longer, but who cares as long as they achieve the outcome.

She [tries to dress herself] now, which is really good. Sometimes she would before but not very often. Now that I'm [prompting her] more and more, she's getting really good at it and she actually put on a pair of long pants herself the other day.

By doing [the education program] I think a lot more about what I do first before I do it and try to promote their independence.

I would just encourage her to get her confidence up to walk along with me. She was doing marvellously. She does pretty well, but she lacks confidence because she's had a few falls and just lacks the confidence in walking. She also seeks praise, she says, "I'm doing pretty well, aren't I?" and I said "Yes G, I think you're doing wonderfully".

These comments suggest that the participants in the education program had learnt new ways of working with residents; were more aware of residents' abilities or potential abilities; and had changed their own practice accordingly to better promote independence.

Based on the feedback obtained from the participants, consultation with management at the aged care facility and the research data, the education program was revised. Subsequently, the facilitator manual – Promoting Independence: A Learning Resource for Aged Care Workers - has been developed so that the program can be implemented in other aged care facilities. A copy of the facilitator manual may be obtained by contacting the corresponding author of this paper.

Conclusion

The challenges encountered during the implementation phase of the program were analysed under three key themes: attendance, trust and empowerment. The challenges were many and varied. However, there were also powerful facilitating forces, such as enthusiasm and keen support from management and some staff members and the collaborative nature of the whole project. These forces did much to generate positive outcomes of the program: increased awareness and changes in practice, and subsequent development of the facilitator manual - Promoting Independence: A Learning Resource for Aged Care Workers. It is also likely that the academics, management and clinical staff who worked together in this collaborative partnership came to see each group as complementary to the other when developing quality care, education and nursing practice.

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