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What are we waiting for?

What are we waiting for? [guest editorial]
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The clinical education of Australia's aged care nurses can no longer be treated as the Cinderella of nursing's specialities. It is urgent that ways be agreed and measures taken to bring this branch of the profession, and residential aged care nursing in particular, into mainstream health care services.

There should be no need to describe again the evolving shape of Australia's demographic profile between now and the middle of this century; and no need to prove here that the ageing bulge is already placing a severe strain on staffmg in the sector. A substantial percentage of the aged care nursing workforce is nearing retirement and the ratio of departures to recruits seems set to worsen at the same time as demand for high quality nursing care escalates. Important indicators - the number of the most highly dependent residents has doubled in the past seven years; compounding co-morbidities are increasingly common and an estimated 60-80% of residents in residential aged care facilities (RACFs) have a dementing illness - reveal the rapidly rising levels of frailty and dependency in the RACF population.

While Australia's aged care standards, including those in RACFs, have their weaknesses, they are internationally respectable. Whether they can remain so, let alone improve, is doubtful unless concerted action is taken now to overcome supply and quality problems with our future aged care workforce.

Where do the roots of our problems lie? Some of the 'external' or macro difficulties are obvious. Wage disparities are important. The workforce structure, closely connected to the industry structure, virtually ensures professional isolation for registered nurses, with manifold negative consequences. Much of the sector struggles with a lack of capacity among staff to effectively engage with contemporary technologies, which undermines access to key training options. Most branches of the media project at best a dull image of residential aged care and, at worst, portray a heartless industry dominated by abusive staff. The damage to recruitment, retention and morale-raising efforts is great, to say nothing of the

damage to public confidence.
Our focus in this editorial however is on systems of education, training and recruitment. University nursing faculties generally lack sufficient numbers of experienced, qualified specialists teaching in the aged care area. The distinctive features of aged care nursing practice remain under-elaborated, making a collective inferiority complex widespread in the discipline. Curriculum thinking remains at a rudimentary level, despite recent moves toward a more coherent posture (Queensland University of Technology 2004). An underdeveloped knowledge base, combined with a limited capacity to facilitate change, does not provide the wherewithal for an evidence-based practice to become the expected standard. This is obvious and well known, but a concerted plan of scheduled actions 'owned' by stakeholders seems to be lacking.
We have abundant evidence to show that, around the world, students beginning their education rate aged care nursing as among their least likely career destinations. Worse, a clinical placement in the sector is more likely to strengthen than weaken those prejudices. Many students appear susceptible to 'body shock' do not feel confident in their dealings with older people; and unprepared and insecure when the older person has dementia or displays other behaviours of concern.
Students' reports suggest that some university teachers appear dismissive of the sector, reinforcing media stereotypes. RACF nursing staff are usually inadequately prepared and, some will argue, despite significant federal funding injections, not resourced to function effectively as preceptors/clinical teachers for students of nursing. Further, these students say, unregulated staff actually carry out a significant amount of their on-site supervision and teaching during clinical placements even though, as role models, they often administer care in ways contrary to the practice norms taught to students during their university preparation.
Support for students during aged care placemetits is often found wanting. For example about 50% of students report not heing told what to do in the event of an emergency with a resident, and reported that the staff they were joining for the placement seemed not to know they were coming on the day of arrival (Robinson et al 2006).
To conclude that our problems outnumber our solutions would be to underestimate the available resources for change. In what may be the world's biggest published systematic review of articles, theses and reports relating to clinical placements in aged care (Abbey et al 2006) several relevant things emerged:
1. The Australian Government has sponsored some of the best published work in existence on the subject during the past decade in the fonn of expert inquiries and reviews (Pearson et al 2001, Clare and van Loon 2003).
2. A document outlining the core principles of curriculum has been produced by a team at QUT; and other useful work on the subject has been produced by one or two of the state nursing regulatory agencies.
3. Little of what is said or done around the world to

improve clinical education in aged care is supported by high quality evidence. The systematic review mentioned above however, reveals a remarkable level of agreement among experts as to what needs to be done (Abbey et al 2006).

4. Australia already has underway what is probably the world's longest running and most fully reported experimental attempt at devising an evidence-based model for aged care clinical placements, and that research demonstrates that sustainable improvements are possible with modest additional expenditure (Robinson et al 2002; Robinson et al 2005, Robinson et al 2006)

5. From that research emerges a draft model, based on the best available local and international evidence and ready for further trialling, of how to conduct more effective clinical placements in aged care to secure measurable gains in key indicators of success in training, sector image and career intentions (Robinson et al 2006).

So: what is to be done? Action on four fronts is necessary. The resources for change (1-5 above) must be collaboratively integrated.

A deliberate, rigorous program of refining and testing the evidence base for the model or models for clinical practice for undergraduates in RACFs must continue with all possible speed, with research underpinned by continuing dialogue among the stakeholders. That said we should not delay urgent reforms until every last proposition has been pushed by strict quantitative testing over the threshold of certainty. We must use the best available knowledge to take action where we can. simultaneously conceding its limited evidentiary status and relentlessly striving to raise it.

We must recognise the path to improvement will be through capacity building. A critical review of the aged care system's current capacity to match the training standards expected of mainstream health care services is a logical first step. This involves raising and then progressively refining two questions:

- How many Australian nursing schools have the capacity to produce nurses competent in aged care and enthusiastic about it?
- How many aged care sites, residential sites in particular, have the capacity to provide quality clinical education to the next generation of nurses on whom the system will depend?

These questions about capacity are overdue; but they are not rhetorical, accusatory or an invitation to play the 'blame game'. Insensitivity would waste the sector's good will and commitment and inflame its frustration. Answers to the questions are imperative.

The fourth and final stage is the most important of all: we must decide on how change is to be packaged, delivered, applied and evaluated. At present our knowledge of what to do, while incomplete and sometimes tentative, is stronger and clearer than our knowledge about how to do it. We ean anticipate a diversity of views from the different stakeholders' perspectives. The target must be a binding agreement to a

clear, comprehensive plan and timeline, acceptable to universities, industry, government, professional and industrial bodies, student and consumer groups. Anything less will not generate the necessary energy. Patient negotiation will be required and can be successful. We know a lot in Australia about how to responsively mix encouragement, support and prompts to successfully achieve organisational and sectoral change.
Clinical training in aged care for student nurses is a key pillar for maintaining and improving care standards in the fastest growing sector of our health services. Many, many millions of dollars of public money is spent on it each year. It is presently organised with vigour, dedication and good will, but within the limits of a cottage industry model. This cannot deliver sufficient transparency, proper public accountability or even comparability of its outcomes or the standards achieved. It is unlikely to be able to deliver the benefits that could be achieved by a closer integration of the elinical training of future generations of health professionals, such as might be offered by formally designated and aecredited teaching nursing homes. We are almost certainly wasting some money with present arrangements. There is no doubt we are wasting a lot of evidence, and with it the chance to improve systematically. To continue as we are is simply unacceptable.

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