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Abstract

This study explored how culture shapes relationships in aged care and the extent to which the residential aged care sector supports a cohesive multicultural workforce. An exploratory methodology utilising semi-structured questionnaires collected data from 58 participants comprising: staff who provide direct care to residents; managers; and family members from six residential care facilities in Perth, Western Australia. Communication issues emerged as an over-arching theme, and included interpersonal communication, the effect of cultural norms on communication and the impact of informal and formal workplace policies relating to spoken and written language. Sixty percent of participants from a culturally and linguistically diverse (CaLD) background had experienced negative reactions from residents with dementia, linked to visible cultural difference. They used a range of coping strategies including ignoring, resilience and avoidance in such situations. CaLD participants also reported prejudicial treatment from non-CaLD staff. The findings highlight the need for organisations to incorporate explicit processes which address the multiple layers of influence on cross cultural communication: internalised beliefs and values; moderating effects of education, experience and social circumstance; and factors external to the individuals, including workplace culture and the broader political economy, to develop a cohesive multicultural workplace.

Key words

CALD workforce, aged care, culture, dementia care

A growing aged care workforce in Australia is linked to the ageing of the population and the increased participation of women in the workforce (Davis and Smith 2009; Howe 2009). As in other countries, (Cangiano, Shutes et al. 2009; Walsh and O'Shea 2009) the aged care workforce in Australia is increasingly dependent on migrants. This pattern is reflected in residential aged care facilities (RACFs) where over half the residents have dementia or cognitive impairment (Australian Institute of Health and Welfare 2011). In 2012, more than one third of the workforce (35%) was born overseas; and two-thirds of these migrants came from a culturally and linguistically diverse (CaLD) background[1] (King, D., K. Mavromaris, et al. 2013). A recent report on cultural and linguistic diversity in aged care found that 29% of residents in RACFs were born overseas, however the majority are from English speaking backgrounds (Australian Institute of Health and Welfare 2014). Southern and Eastern European migrants represent the largest cohort of CaLD residents, at 7%. In contrast, the majority of the CaLD migrant aged care staff were born in Asian countries including: Vietnam, Hong Kong, China, Philippines, India or Fiji (King, Mavromaris et al. 2013). A survey of over 600 participants attending certificate-based training in dementia care in Perth, Western Australia, in 2009, revealed that the countries of origin of the CaLD participants reflected those in the AIHW report, albeit with a higher representation of participants from African countries, including Zambia and Ethiopia.

Despite the multicultural nature of the residential aged care workforce, there has been limited research undertaken in Australia to understand the experiences of staff from culturally different backgrounds, and the impact of multiculturalism on the workplace and workplace relationships, including relationships with residents with dementia. This project aimed to

[1] The term CaLD is a broad descriptor for groups and individuals who differ according to religion, race, language and ethnicity, but excluding those whose ancestry is Anglo-Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander. (Community Relations Commission for Multicultural NSW n.d.).

address this limitation by exploring the way a multi-cultural workforce effects workforce interactions and relationships, and how the residential aged care sector supports and manages its multicultural workforce.

Literature

The international literature highlights the impact of market forces and the changing workforce demographic on the aged care sector. It identifies broad policy and management processes for addressing the challenges arising from an increasingly multicultural workforce. It also provides some evidence of the experiences and motivations of migrant care workers in this sector.

The aged care workforce

Much of the literature on the aged care workforce from high income countries, particularly the United Kingdom, the European Union, the United States of America and Australia, highlights the increasing reliance on a migrant workforce in what is known as the global care chain (Hochschild 2000; Fine and Mitchell 2007; Sherman 2007; Williamson 2007; Cangiano, Shutes et al. 2009; Doyle and Timonen 2009; Howe 2009; Simonazzi 2009; Walsh and O'Shea 2009; Hussein, Stevens et al. 2011; Shutes 2012; Walsh and Shutes 2013; Mears n.d.). The migrant workforce comprises people from a range of countries, particularly those described as low-income and countries in political and economic turmoil.

Cangiano et al. (2010) argue that underfunding of social care and interrelated workforce shortages are largely responsible for the extensive reliance on migrant workers among social care providers, and raise concerns for workforce inequalities and for the quality of care. The demand for care workers is such that illegal workers are being employed in an informal market in many countries (Doyle and Timonen 2009). Furthermore staff with nursing qualifications in their country of birth are working in positions of lower pay and responsibility because their qualifications are not recognised (Shutes 2012).

In Australia, there is growing concern about staff shortages in aged care in the future. It is estimated that the number of people requiring care will more than double in the next few decades which will increase the demand for services and human resources (Fine and Mitchell 2007; Howe 2009; Hugo 2009; Australian Government Productivity Commission 2011). While overseas recruitment is suggested as a solution, difficulties such as transferability and recognition of qualifications for professionals and proficiency in English, have been identified (Australian Government Productivity Commission 2011).

CaLD workforce experiences

King et al (2013) found that 25% of the CaLD migrant carers they interviewed identified poor English language skills and a lack of cultural knowledge of Australia as a disadvantage in working in the aged care sector. Not only did it present difficulties for carers when communicating with residents, it also impacted their ability to understand the training offered to them. King et al (2003) also found the CaLD migrant workers in Australia experienced discrimination. However, most did not identify this as a problem specific to working in aged care because they also experienced discrimination in the wider community. They identified skin colour as the major basis of discrimination from residents, rather than language.

Policy and management strategies

Beheri (2009) recommends that mentoring and interpersonal and intercultural communication skills should be introduced at the workforce level and that management should foster a workplace environment to encourage interaction. On a similar theme, Howe et al. (2012) identified a number of variables associated with intention of migrant carers to stay in the aged care workforce in the foreseeable future. They include training and enabling the use of languages other than English in their work practice and, in so doing, increase the sense of value that those who with a second or more languages bring to their position. Davis and Smith (2013) recommended expanding the provision of training in language, print literacy and

health literacy and understanding cultural attitudes towards dementia and ageing. They are supported by a growing body of literature on training in cultural competence (Sherman 2007; Williamson 2007; Pearson et al 2007; and Renzaho et al. 2013).

Method

The aim of this study was to use the empirical findings from interviews with participants from the residential aged care sector to generate a model for supporting the needs of a multicultural workforce working with residents with dementia. An exploratory design was selected using semi-structured questionnaires to facilitate the collection of data from staff providing direct care to residents, managers and family members of a resident with dementia from six residential care facilities in metropolitan Perth, Western Australia.

The questionnaire for managers focused primarily on the quality of care provided by staff; workforce relationships; and how the learning and psychosocial needs of the workforce are addressed. The questionnaire for family representatives explored their perception of the quality of care provided by staff and interactions between CaLD staff, their family member with dementia and themselves.

Participants

Six aged care facilities were recruited to the project according to criteria that included having a dementia specific wing or unit and a staff cohort with representation from a number of CaLD backgrounds. Interviews were undertaken with the facility manager at each facility and one cross-facilities dementia care manager prior to interviewing staff who provide direct care to residents and family members. As initial methods of recruitment, via information flyers and postcards resulted in just a handful of respondents; the researchers sought permission from facility managers to be present at the facility for set periods during the working day and for staff to be informed of their availability. Participating staff took advantage of this method of recruitment and presented themselves for an

interview during an allocated break. Interviews were conducted in a designated room to provide privacy during the interview session. An average of eight participants from each facility took part in the research project. Just five family members from three participating organisations were recruited to the project during this phase of the project and, as such, the data from this source added little to the emerging themes. A total of 58 participants were recruited for interviews between July and October, 2012, and they included 35 CaLD and 11 non-CaLD care staff (see Table 1).

Table 1. Research participants by role

Participant type	Number
Management	7
CaLD staff	35
Non-CaLD staff	11
Family member	5
Total	58

Data collection and analysis

All interviews were audio taped and transcribed. Demographic data were transferred to the statistical program, SPSS. The first three interviews, which included a facility representative and two care staff, one from a CaLD background and one Australian born, were analysed by three researchers to review the interview process and quality of data as well as inter-rater reliability of analysis. Twelve coding nodes were created in, NVivo, based on the main interview questions. Subsequent nodes were created during the coding process to accommodate emerging themes.

Three researchers independently analysed the qualitative data from the first 35 (66%) interviews. Agreement on four key themes was achieved. Statements pertaining to the key themes were developed to test for relevance with a wider audience from the residential aged care sector and were

presented to twenty four representatives from residential aged care organisations at a purpose designed workshop. The statements are:

- Culturally and linguistically diverse (CaLD) staff experience the effects of cultural stereotyping by co-workers, management, residents and families;
- There is a lack of knowledge about and understanding of the cultural beliefs and practices of workers and residents within the aged care workforce;
- Policy and guidance is needed to address the complexity of issues around a multicultural workforce;
- Within the multicultural workforce in aged care, effective communication is paramount.

The workshop participants were asked to comment on the relevance of the statements and to explore ideas to overcome these barriers to workplace harmony. The participants supported the themes, providing further examples of their relevance for explaining the issues.

The remaining interviews were analysed and coded and no new themes or sub-themes emerged. A key word search for terms relating to these themes was applied to all data in NVivo. It produced fewer references than those identified via the manual process of coding.

Results

Part A provides a profile of the CaLD participants. Part B describes the key themes relevant to understanding their experiences in the workforce and the additional factors affecting the multicultural work environment.

Part A: Profile of CALD workers

The 35 CaLD participants were born in 18 different countries. Fourteen participants were born in south-east Asian countries or China. Twelve participants were born in one of eight African countries. Seven participants were born in the western Pacific region, primarily in the Philippines,

and two were born in European countries. The average age of the CaLD participants was younger than the non-CaLD participants. Twelve CaLD participants were under 30 years of age, whereas all non-CaLD participants were over 30 years of age. CaLD participants were also more highly represented in non-professional caring roles: 77% of CaLD participants compared with 27% of non-CaLD participants were employed as personal carers as opposed to nurses or allied health staff. Despite a greater representation in the non-professional caring roles, CaLD participants were more likely to have post-secondary educational qualifications than the non-CaLD participants. Twenty three CaLD participants had earned a diploma or degree in their country of birth, the majority of which (13) were health related qualifications. Just nine of these participants stated that their prior qualifications were recognised or partially recognised in Australia. Five of the nine had completed a bridging course prior to recognition of their qualification.

CaLD participants were asked to explain their reason for migrating to Australia. The majority (80%) gave reasons linked to lifestyle opportunities; that is, pull factors. They include the offer of employment for them or for their spouse, opportunities for their children, marriage or family reunion, and access to study, particularly nursing or health related studies.

> "For me, only for my daughter, only one reason. Because in China I've got a good job and my husband got a good job. But for my daughter, when she was very young, like seven years old, she always sick. But in China always push children to study hard, hard, hard, that's why"

For six participants, migration to Australia was politically motivated. They were responding to push factors. Four participants came from war-torn countries. A fifth participant left their country post-war, in search of better opportunities.

> "Because our country we have a war 21 years … because we haven't got good skills and good education and no hospitals for children and that is when I came here to Australia"

The CaLD participants were asked to describe their understanding of dementia in their country of birth or prior to their arrival in Australia. The most frequent responses were that dementia, or the symptoms, are accepted as part of the ageing process or that there was no knowledge or experience of dementia.

> "… we didn't realise it was dementia, we just knew that we had to look after them because that is what we do in our culture"

> "My mum say aged people… aged people as a baby, they don't know anything because their brain going down and they go back to childhood"

Those who had trained as a health professional in their country of birth indicated that they had very limited knowledge and usually no experience of caring for people with dementia..

> "The thing is, the dementia, I was learned in only the student life, just the one word on the definition aspect"

When asked how people with changes consistent with dementia would be cared for in their country of birth, the majority said they would be cared for at home or by family members and it was a family responsibility.

> "Back home, this dementia and then elderly is all taken care by the family"

However, some participants felt that their relatives missed out on additional care needs.

> "I was very sad for [mother-in-law] because she was not placed in a home like here. She stayed at home with us, we didn't have any equipment or anything, it was hard, but even then my husband and I and my father-in-law, we coped with it, until she passed away"

Both CaLD and non-CaLD participants were asked why they had chosen to work in aged care. The most frequent response by the CaLD participants was linked to ease of access. Language proficiency

and non-recognition of prior qualifications created barriers to gaining other forms of employment for 14 CaLD participants. They learnt from community networks how to access alternative employment in aged care.

> " When I came here the first week I got an interview [as a legal secretary] with a solicitor ... I did not succeed into the interview... therefore a Mauritian friend ... said 'I have friends, carers, have taken Certificate III and so on', then I started with the Cert III"

Others linked their motivation to pursuing or holding a nursing qualification or other health profession and the aged care sector provided an entry point. By comparison, non-CaLD staff with nursing qualifications were more likely to have made a career move from general nursing into aged care.

Part B: Key Themes

Interactions between CaLD staff and people with dementia

CaLD participants were asked to provide examples of positive and negative experiences in their interactions with residents with dementia and their families. More than 50% of participants provided examples of positive interactions. They include benefits for residents and the opportunity to share interests and beliefs.

> "We have a resident … she's Asian lady and, because I speak her language, so I'm allowed to attend to her. When … some Australian carer attend to her she won't listen to them"

Despite many examples of positive interactions, they were outweighed by examples of negative interactions, which highlighted an initial lack of acceptance of CaLD workers by residents with dementia. Twenty one CaLD participants (60%) described personal experiences or gave an account of having witnessed situations where a resident had reacted negatively because of visible cultural difference, particularly colour.

> “Some of them will tell you to go back home. Or you black this - you black that.”

It is likely that memories of past experience, such as war, underpin the reactions from residents who may no longer be able to differentiate time or differences between cultural groups. One CaLD participant recalled a resident’s reaction to her:

> " ‘I don't want to have that Japanese carer looking after me’. I am not Japanese, you know, when they see Asian they thought we are all the same”

These situations do not go unnoticed by management. Four of the seven managers also gave examples of negative reactions from residents towards CaLD staff, which they explained as based on colour prejudice, past experience or long held beliefs about different cultural groups. Family members were also aware of the potential for their parent or spouse to react negatively to staff who are CaLD.

CaLD participants who indicated they had experienced racially motivated reactions from residents were asked how it had made them feel. Some participants reported they had been badly affected by the experience, Others explained that when they were first exposed to the comments or actions it affected them, but the majority indicated that they understood the negative responses from residents with dementia were due to the disease process. CaLD participants learnt to deal with the racial prejudice they encountered from the residents using a range of strategies including ignoring, resilience and avoidance of such situations.

> “… some abusive language, especially in my first year. But then, before, I feel so much humiliated, but now I ignore it”

Interactions between staff

When asked to describe the working relationship with their colleagues, over half of the CaLD participants (57%) provided examples of positive or supportive relationships. Despite reports of collegiality, however, there were also numerous examples of disharmony that appear to be motivated by prejudgement and a lack of tolerance. Some CaLD participants felt their non-CaLD co-workers lacked trust in their abilities.

> "I would say sometimes it's like other people they don't have confidence in you thinking you know, even whether you experienced ... I sometimes feel it's about the colour"

Similarly, a non-CaLD participant noted friction between which they perceived to be based on approaches to care provision.

> " … the way they work, some staff don't feel like they keep their side of doing the caring as good as what they could do ... I think it causes a bit of friction"

A facility manager observed that the older non-CaLD staff appeared to be less accepting of the CaLD staff than younger staff members.

> "I think the younger workforce are ... more accepting of cultural need but ... some of my staff are older and coming towards retiring age and some of them are quite set in their ways"

A young registered nurse from a CaLD background experienced this directly, linking it to a strong cultural belief of respect for elders on her part, which created issues for her when supervising the older non-CaLD carers on her team.

> "… because in our culture if somebody is, like, older than you, if they tell you to do something you just do it, you don't question ... But sometimes they take advantage of that"

Others identified conflict between cultural groups which may be linked to pre-existing cultural bias or from a concern that newer migrants threaten their job security,

> "The others, [from countries where migration patterns are longer established] ... they feel you are from Africa, you have come to take the jobs here in Australia, and especially these jobs"

Cultural competence in the workplace

Despite the apparent tensions associated with a multicultural workforce, some staff appreciated the benefits.

> "Because over here, all the staff here are all multicultural … and it's really interesting, because that's what I like"

However, CaLD participants talked about the culture shock they personally faced when they first entered the workforce. One described feeling like a '"fish out of water". Another described "the work culture ... it's already a culture. ... Very difficult. We learn to accept it".

They identified a need to understand local customs and how this influences workplace customs, including customs relating to food and eating.

> "I'm not used to Australian food. So when I got here, first got here, the resident told me, 'I want marmalade, I want vegemite'. I was like, 'What's that?' "

They also identified a need for the sharing of cultural information to facilitate better understanding of other cultures in the workplace, be they residents or staff.

> "Because, I been talking ... with some of the girls from Africa, and ... I thought myself, Africa is a big country and they have … nursing home on every part, you know. But some of the girls they said, "No, they have to take care of their elders at home"

One manager explained how a CaLD worker had found it difficult to explain to her work colleagues that she was observing Ramadan.

> "We had a lady who was fasting and often felt quite faint and dizzy because, obviously she hadn't eaten all day, and the staff ganged up on her because she was lazy"

Her reluctance to explain may have been rooted in a fear of divulging cultural beliefs that differ from the mainstream culture shaping workforce attitudes.

Policy, guidelines and practices to support cultural diversity

Managers and staff were asked if the facility had specific policies, procedures or practices to encourage cultural diversity and to discourage discrimination towards staff because of race, colour, descent, national origin or ethnic origin.

All seven managers stated that their organisation had policies on equity and non-discrimination. Two managers stated a preference for employing CaLD staff, for the caring qualities they brought to their relationship with residents.

> "it's my preference now to take on people from different cultures, they work extremely well together, they are very patient, they are good mentors as well"

However one qualified this by generalising care-giving approaches to physical attributes.

> "But you do have people from other parts of Africa that are not as gentle, they are more bombastic I suppose if you like, they are a heftier build, they are a darker colour, and I am not being discriminatory here, this is just as it is"

Managers gave examples of the practices they employed to prepare CaLD staff for their new role. All facilities provided a short period of mentoring for new staff and one acknowledged the psychosocial impact of discrimination that the CaLD staff may face.

> "... that's another thing that we talk a lot about in interview with the staff, how we deal with it"

Most CaLD staff were also aware of the practical support available to them.

> "So I think maybe when people are new because we do two buddy shifts like one in the morning to see how the morning shift is like and then you do afternoon shift but that's not enough"

Some also acknowledged that they could talk to their managers if they experienced discrimination. However, as one staff member reported, when he approached his manager about a specific work task that conflicted with his religious belief, he was told it was part of his job and he would have to learn to deal with it.

> "I'm an Adventist so we don't eat pork, and … on Sundays the residents eat … bacon and egg. At one time I was supposed to be doing the breakfast and I just couldn't touch the pork and that was a problem"

A major source of tension amongst staff, regardless of category, was speaking languages other than English in the workplace. In most of the participating facilities rules had been put in place to manage the tension.

> "One problem I had is that people from different cultures started talking in their own language … and those people that didn't come from those cultures started to complain that 'it's not fair, we don't know what they are talking about' "

One manager acknowledged the difficulty this must pose for people whose proficiency in the English language was limited.

> "… we don't encourage them to speak in their own language in front of residents for obvious reasons, but when they're out of the resident's rooms or whatever, it must be much more comfortable for them to speak"

In the main, CaLD participants agreed with the English only ruling, yet as one non-CaLD participant noted "... there doesn't seem to have been any discussion or policy".

Effective communication is paramount

Staff who provide direct care to residents use a range of language and literacy skills as part of their daily work, including collecting information from residents and interacting with other members of the care team and families. As one manager noted:

> "… the Aged Care Funding Instrument is what determines the funding for a resident and filling in this instrument and ongoing documentation to support it requires a reasonable level of English literacy … it is important … and efforts must be made to recruit and retain staff who are able to contribute meaningfully to this process."

Despite this, communication difficulties emerged as an over-arching theme: proficiency with spoken language, colloquial language and slang, cultural norms of communication and interpersonal communication.

Non-CaLD staff reported concerns relating to language comprehension.

> "I know that I sometimes personally have issues with language barriers, it's very difficult if you need something done and you're having a problem getting that through"

One manager believed that cultural forms of communication were implicated in some of the barriers with residents.

> "They don't talk to the resident, so they just come, the individuals just come in and do the work and walk out so there's no communication whatsoever."

From a CaLD participant's perspective, communication is a two-way process and requires support from colleagues.

> "We don't speak English in our country – that is a problem to understand people speaking English, so I think if our colleagues can understand our ... language problem, they can speak slowly, they can speak clearly"

Other CaLD staff identified a need for access to English language lessons.

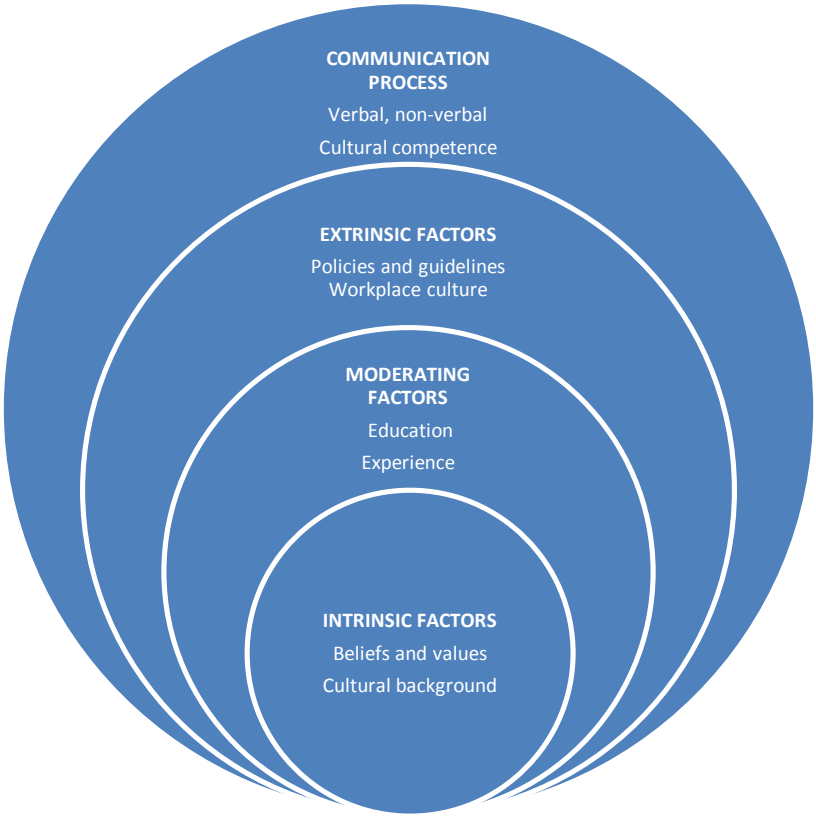
> "People coming from the different countries they have many other languages so they might be having difficulty in talking communication, so there should be some training or something for that. Like you know, even they speak English but the way of talking is different"

Despite the availability of English language programs in some workplaces, not all CaLD staff were aware of these or able to access them.

Discussion

Informed by the findings we propose a model comprising the multi-dimensional components that are important for developing an understanding of and response to the needs of the multicultural workforce in residential care facilities (see Figure 1).

Figure 1. Components of a cohesive multicultural workforce in residential aged care



Intrinsic factors – beliefs and values

Values, beliefs and attitudes are developed throughout the course of our lives. Family, friends, community and experiences contribute to our sense of who we are and our place in the world. For example, in many of the countries from which the CaLD participants originated, elders are afforded a status of respect and their family assumes the role of care. The majority of CaLD participants confirmed that the care of their elders would be a family responsibility, a private matter. They came with little or no experience in institutionalised care provision.

In the workplace the majority of CaLD staff experienced discrimination and intolerance from residents with dementia and, reportedly, from some residents without dementia. Such prejudice is understandable in those with dementia. Their responses are likely to be linked to past or long held beliefs and the progression of the disease, which diminishes insight and judgement. However, discriminatory behaviour from people without dementia, including

work colleagues and management, demonstrates a lack of sensitivity to and acceptance of cultural diversity.

Despite this, and possibly because of their respect for elders, many of the participants developed strong relationships with the residents in their care and demonstrated resilience and an ability to adapt their new environment.

Moderating factors – education and experience

The contrasting demographic profile of CaLD and non-CaLD staff in our study may contribute to tension within the multicultural workforce. In our study, the CaLD workforce in RACFs is, on average, younger than the non-CaLD workforce; more likely to have post-secondary qualifications prior to working in aged care; and, likely to face non-recognition of prior qualifications. For some, this was linked to difficulties achieving the English language and literacy requirements for their particular degree.

A lack of prior experience in working in the formal aged care environment together with the limited time afforded to mentoring the new CaLD staff suggests a lack of awareness that the aged care workplace is a culturally constructed place, resulting in assumptions about the normalisation of this form of care provision and the requisite skills. CaLD participants identified a need for greater support with learning the everyday skills required for their role.

Extrinsic factors – policy, guidelines and workplace culture

Unlike other countries where an informal workforce has emerged, Australia's policies on migration and migrant workforce participation ensure that migrant workers do not experience exploitation in employment conditions compared with their Australian born colleagues (Howe 2009; Hugo 2009). However, non-recognition of overseas earned qualifications and English language proficiency requirements does affect the level of entry into the workforce.

Despite workplace policies promoting diversity and non-discrimination, the primary application of these policies appeared to be limited to employment practices. Managers noted the racial and cultural diversity of the workforce, yet failed to link their over-representation in aged care, compared with other sectors of the workforce, to the barriers that non-recognition of qualifications and language proficiency levels present when seeking alternative options and more senior roles.

In practice, the requirement of speaking English only in the workplace, including in some facilities, in staff tearooms, suggests that the workplace is yet to fully recognise diversity, which affects not just staff, but CaLD residents as well. Furthermore, the application of general traits to one cultural group over another, as described by those managers who identified caring abilities in relation to different groups of CaLD workers, indicates implicit racism is evident and likely to influence factors such as staffing mix and, potentially, promotional opportunities.

The workplace culture in residential aged care comprises a range of assumed norms, some of which are made explicit in policies and guidelines and others which are implicit and derived from historical practice. Broadly, the workplace culture is made up of a set of

> assumptions shared by the workforce about what behaviours can be 'expected' in the workplace and 'accepted' by the rest of the team … the way people communicate with each other, both verbally and non-verbally (the languages); and what they see about '*how it's done around here'* (Department of Training and Workforce Development n.d.)

For many of the CaLD participants, particularly those who had no prior experience in the aged care sector, the workplace culture and practices associated with the workplace were new and bewildering. A lack of recognition of this impact is likely to have contributed to

misunderstandings between non-CaLD staff whose knowledge of different cultural values and practices appears to be limited.

These factors point to a need to ensure that policies on discrimination and equity are embedded within workplace practices, including communication practices, and not limited to employment processes.

Communication process

Language and literacy skills enable care staff to participate in day-to-day activities on an equal basis with those whose first language is English. In recognition of the language and literacy deficits amongst staff working in various sectors of the workforce, programs have been developed for CaLD staff and others with poor literacy. Some of the participating facilities were assisting carers to access English language classes through the Workplace English Literacy and Learning (WELL) program, which is available to organisations through competitive grants. Several CaLD participants had identified a need for this type of support.

However, proficiency in English language and literacy is just one essential component for effective communication in the residential aged care sector which has become increasingly multicultural. As we have shown in this paper, there are multiple layers to effective two-way communication. These include an understanding that individuals bring a range of beliefs, values and assumptions to the workplace about dementia, ageing and care of the elderly. These intrinsic factors are culturally imbued and influence the way in which individuals view and respond to their surroundings.

This intrinsic or culturally imbued way of understanding is moderated by exposure to new experiences and information, however, when these new situations involve interaction with others whose own assumptions and values contribute to a negative experience, communication difficulties are inevitable.

Strong leadership is necessary for ensuring policies and protocols, that is, the extrinsic factors that are crucial for regulating the workplace, are embedded in workplace practices and workplace culture. Hunt (2007) recommends that employers should ensure the workplace has strong governance procedures which include performance indicators for managers targeting their commitment to equality, diversity and non-discrimination.

Collectively, these four components contribute to the experience of the CaLD migrant workforce in aged care. They could also provide a model for supporting and managing a cohesive multicultural workforce as summarised in four key messages.

Key messages

A synthesis of the findings in this study reveals four key components which, if addressed systematically, could shift the emphasis to recognising the benefits of an increasingly multicultural workforce and expand the model of care to be inclusive of all stakeholders.

1. Intrinsic factors – acknowledge the range of beliefs and values that the multicultural workforce brings to the workplace. Provide opportunities for staff to share their cultural heritage to encourage greater understanding and tolerance towards each other through exposure to formal cultural training processes as well as informal engagement opportunities.
2. Moderating factors – recognise the benefits of training and mentoring programs to improve skills in the workplace, including understanding the impacts of dementia on residents' behaviours and reactions and skills to respond effectively. Provide culturally sensitive opportunities for staff to further their skills in these areas.

3. Extrinsic factors – recognise the benefits to the residents and the workforce of a stronger, more culturally diverse workforce. Identify gaps in the implementation of policies on non-discrimination and diversity in workplace practices and the barriers to expressions of diversity in the workplace culture.
4. Communication processes - understand the extent to which communication is a two-way process imbued with cultural meaning. Provide access to culturally sensitive language and literacy learning opportunities and ensure that communication processes, which include verbal and written forms of reporting, are sensitive to the literacy skills of the whole workforce.

Implications for practice

A multicultural workforce will continue to form the basis of the aged care workforce in Australia. The residential aged care sector needs to support and manage its multicultural workforce to engender a cohesive workplace. This research suggests that aged care providers who wish to develop a culturally competent and supported workforce within their facilities would benefit from addressing all of the components necessary for a cohesive multicultural workforce. A focus on just one or two aspects or perceived problems, such as language and literacy skills or workplace skills is unlikely to achieve the desired outcome of cohesiveness.

Conclusion

This study explored the way culture shapes workforce interactions and relationships, and how the residential aged care sector supports and manages its multicultural workforce. The study found evidence of positive relationships, including support for residents who are from a CaLD background. However, CaLD staff experience prejudice, discrimination and stereotyping from residents with dementia, based on cultural differences. The study also revealed prejudicial

treatment from non-CaLD staff which manifest in prejudgement about workplace skills, assumptions about the universality of workplace norms and a reticence to tolerate diversity in language and cultural practices. The study revealed gaps in the implementation of policies on non-discrimination and diversity into workplace practices. Over-all, it indicated that tensions within the multicultural aged care workforce are linked to the ways in which culture interacts with and impacts effective two-way communication. The findings of the study suggest that a multi-component approach to addressing the needs of a multicultural workforce in residential aged care would contribute to benefits to be gained from diversity and engender a truly multicultural workplace.

Limitations

The data were drawn from just six facilities and the cultural workforce within them. Other cultural groups and other workplaces may have enriched the diversity of findings. Recruitment of participants was voluntary and may have favoured those who were more accepting of their workplace experience. Alternatively, it may have favoured those who were more dissatisfied. Furthermore, we had no way of accessing and exploring the experiences of CaLD staff who may have left employment because of issues relating to lack of cultural inclusion and support.

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