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Multicultural workforce development model and resources in aged care

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Disclaimer:
This book introduces the multicultural workforce development model, relevant resources and examples to implement the model in residential aged care homes. The views expressed in the book are those of the authors and not necessarily those of the Commonwealth of Australia. Readers should be aware that the information presented in the book is not necessarily endorsed, and its contents may not have been approved or reviewed by the Australian Government Department of Health who funded the project.

Multicultural workforce development model and resources in aged care

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Consortium

Flinders University, Resthaven Inc., AnglicareSA Inc. formed a consortium to implement the project led by Flinders University.

Participating sites

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Tables and Figures

Abbreviations

AAAQ: Availability, accessibility, acceptability and quality of care services

CALD: Culturally and linguistically diverse

CCCS: Cross-cultural care services

MCWD: Multicultural workforce development

RACH: Residential aged care home

VET: Vocational education and training

WHO: World Health Organization

Introduction

Cultural and linguistic diversity between residents and staff is significant in residential aged care homes in Australia. Residents are from over 170 countries with 31% born overseas and 20% born in a non–English speaking country (AIHW 2016). Staff who care for residents are also from culturally and linguistically (CALD) diverse backgrounds. It is estimated that 32% of staff were born overseas and 26% were born in a non–English speaking country (Mavromaras et al. 2017). The majority of overseas-born residents come from Europe while the majority of overseas-born staff come from south Asian and African regions (AIHW 2016, Mavromaras et al. 2017). It is estimated that 88% of residential aged care homes employ staff from CALD backgrounds (Mavromaras et al. 2017). This is evidence that cross-cultural interactions widely exist in residential aged care homes. The diversity generates many opportunities for aged care organisations to address equitable and culturally appropriate care for residents. In the 2016 aged care workforce census, 39% of residential direct care workers reported they spoke a language other than English in their work (Mavromaras et al. 2017). This is an indicator that the cultural and linguistic assets of the workforce actually contribute to the residential aged care services in Australia. However, the diversity can also be a challenge to achieving high-quality care for residents and to staff cohesion.

This book introduces the multicultural workforce development (MCWD) model, relevant resources and examples to implement the model in residential aged care homes. The model and the resources were developed from a 2-year action research project entitled 'Developing the multicultural workforce to improve the quality of care for residents'. This project was supported by funding from the Australian Government Department of Health under the 'Service Improvement and Healthy Ageing Grants' in 2015. During the project life, the project team worked with residents and staff in four participating residential aged care homes to develop, implement and evaluate the MCWD model and resources. The details of the research project are presented in the project final report and a number of peer reviewed journal articles (Xiao et al. 2017e, Xiao et al. 2017f, Xiao et al. 2017d).

Aims

The aims of developing the MCWD model were to:

1. conceptualise and explain the relationships in the four domains of aged care workforce described as:
    - providing residents with effective cross-cultural care services
    - developing a culturally competent workforce to enable effective cross-cultural care services
    - building an enabling environment in residential aged care homes
    - building an enabling environment in the aged care system
2. provide stakeholders with resources and examples to implement the MCWD model
3. inform stakeholders of the need to invest in the aged care workforce to meet residents' cross-cultural care needs

Target audience

The book targets stakeholders in residential aged care including policy makers, consumer representatives, researchers, educators, people in leadership positions in the aged care industry and staff who have management and supervisory responsibilities in residential aged care homes.

Main sections

The book includes five sections. Section 1 introduces the MCWD model. Section 2 discusses cross-cultural care audit tools to support the implementation of the MCWD model. Section 3 presents cross-cultural care self-reflection tools and Section 4 outlines a cross-cultural care education program for aged care staff. In section five, case scenarios are provided to facilitate the uptake of the MCWD model and the resources.

Section 1: Multicultural workforce development model

This section outlines the process of developing the MCWD model, the findings from a study that informed the MCWD model and the elements and relationships in the MCWD model.

The process

Objectives in the process

Under the aim of developing the MCWD model as described above, the project team worked with stakeholders to achieve these objectives in the process:

- Identify key factors enabling or impeding cross-cultural care for residents
- Identify key issues experienced by multicultural care teams that impact on teamwork and quality of care
- Determine a multicultural workforce development (MCWD) model to address the key factors and issues identified
- Develop an education program to support the MCWD model
- Embed the MCWD model and education program in workforce management and day-to-day activities of staff
- Evaluate the impact of the MCWD model on residents and staff
- Use the evaluation findings to inform and update the MCWD model and education program

The process of developing the MCWD model and resources are showed in Figure 1. The MCWD model was developed in phase one (a 12-month period from steps 1 to 5) and evaluated in phase two (a 12-month period in step 6). As the purpose of this book is to introduce the MCWD model and resources to support the implementation of the model, the phase two of the project is not included in this book. Readers may refer to the project final report for more details of the whole project (Xiao et al. 2017d).

Outline of a study on residents' and staff's experiences in cross-cultural care

Prior to the study, the project team conducted a comprehensive literature review to analyse and critique the current research evidence regarding factors enabling or impeding cross-cultural care for residents in residential aged care. The literature review also examined issues arising from the multicultural workforce in aged care. The literature search was undertaken in a systematic way that covered major databases including PubMed, CINAHL, Scopus, Web of Science and Science Direct. The search was limited to 10 years (2007 – 2017) and to articles published in English. Google search, Government' website sites, project and health professional websites were searched to identify relevant 'grey literature' to be included in the review. In total, 17 articles were included in the review. The summary of the included articles is presented in the project final report (Xiao et al. 2017d). Five categories were identified from the literature review: (1) Care disparities between non-CALD residents and CALD residents; (2) Cross-cultural communication challenges; (3) Relationships shaped by culture and language use; (4) Cultural and linguistic assets of staff; (5) The need to build a responsive system.

Findings from the literature review informed the design of a study to explore factors affecting cross-cultural care and workforce cohesion. The study applied a double hermeneutic methodology described by Giddens (Giddens 1984). A double hermeneutic is 'the intersection of two frames of meaning as a logically necessary part of social science; the meaningful social world as constituted by lay actors [interpretive hermeneutic] and the meta-languages invented by social scientists [critical hermeneutic]' (Giddens 1984, p. 374). This methodology enabled the project team not only to interpret the perceptions of residents and staff of factors affecting cross-cultural care (interpretive hermeneutic), but also to critically reflect on the interplay between structures (rules and resources in a system) and people's actions in the system (critical hermeneutic) using Structuration Theory. The critical reflection on factors enabling or impeding cross-cultural care played a crucial role in enabling the project team to work with stakeholders to develop the MCWD model and resources to improve the current system.

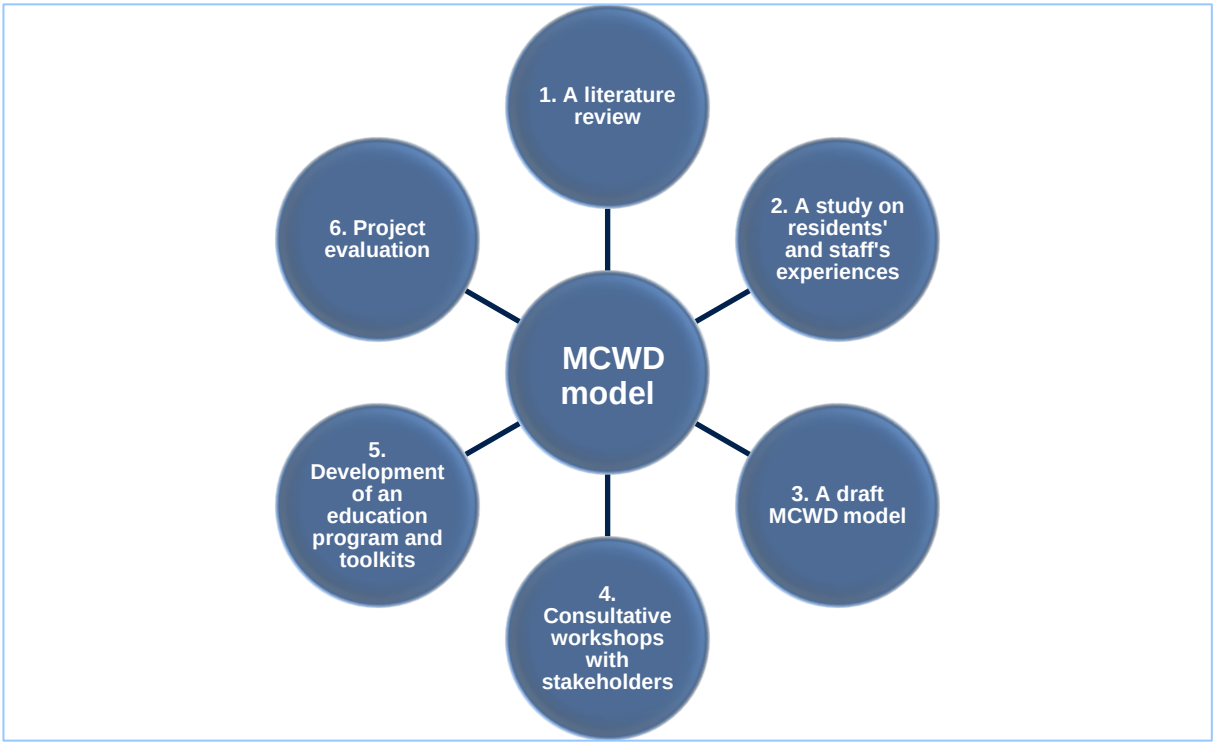


Figure 1 The process of developing the MCWD model

Methods used in the study were interviews and focus groups. In total, the project team interviewed 23 residents and seven resident proxies. Of these, nine were from a CALD backgrounds, making the CALD proportion 30% of the sample. Resident/proxy participants who were born overseas were from nine countries and eight of these countries were non-English speaking countries. The majority of residents from a CALD background were from the European region. The project team conducted focus groups/interviews with 56 staff. Of these, 16 were from a CALD background, making the CALD proportion 29% of the sample. Staff participants who were born overseas were from 13 countries and 12 of these countries were non-English speaking. The vast majority of staff from a CALD background were from Asian and African regions.

Findings from the study are presented as themes and are outlined in Table 1. The detailed findings with excerpts are reported in the project final report and the publications from the project (Xiao et al. 2017e, Xiao et al. 2017f, Xiao et al. 2017d). Findings not only add new understandings of factors affecting cross-cultural care to the literature, but also informed the development of the MCWD model, resources to support the model and an action research project to implement the model in four participating aged care homes.

Table 1 Outline of findings

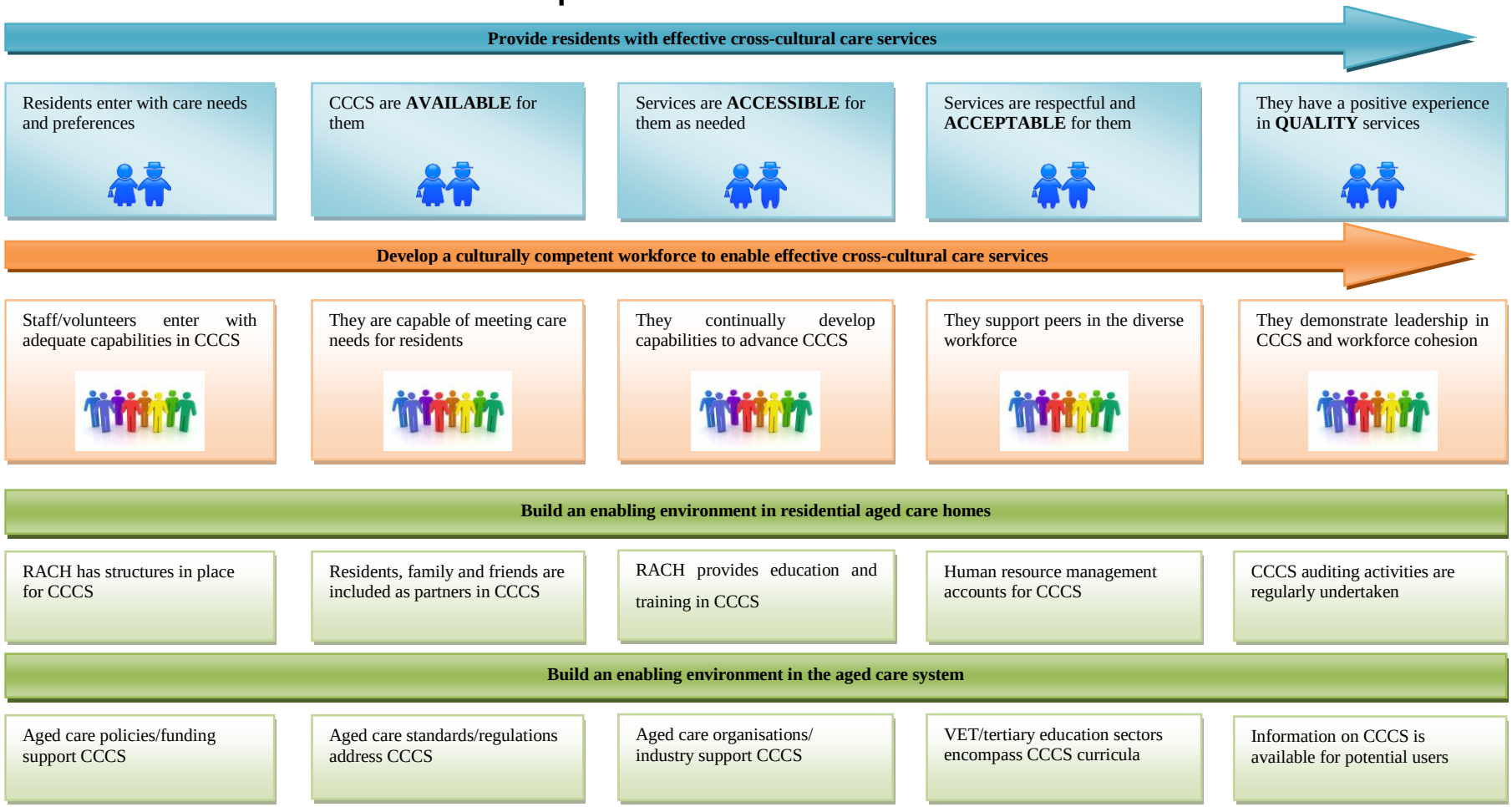
	Enablers	Barriers / areas to be improved
Residents'/families' perspectives	• Universal caring behaviours across cultures • Satisfaction with care and services provided by the multicultural team • Enjoying diversity in the care facility • Accommodating preferences and choices when engaging with consumers • Communicating effectively • Support networks for consumers	• The need to improve the dining experience • Communication difficulties with staff: non-CALD residents' perspectives • Communication difficulties with staff: CALD residents' perspectives • Variations of care practice which negatively impacted on the experience of residents • The need to apply person-centred approaches to promote psychosocial well-being • Consideration for CALD residents who have language barriers
Staff' perspectives	• Leadership in responding to challenges and opportunities arising from workplace diversity • Cultural awareness • Accommodating CALD residents' care and service needs • Strategies used to facilitate cross-cultural communication with CALD residents • Utilising assets and strengths in a multicultural team • Peer and mentoring support for CALD staff to adapt practice in residential care	• CALD staff's perceptions of the impact of language barriers on their work • Australian-born staff's perceptions of CALD staff's language barriers • Communication difficulties in staff-resident cross-cultural interactions • The need to recognise and respond to residents' culturally influenced behaviours • Negative attitudes in cross-cultural interactions • Staff's perceptions of difficulties in meeting CALD residents' dietary preferences • Workplace issues compounded by cultural diversity • The need for CALD staff to receive adequate education/training prior to employment.

The MCWD model

Findings from the study and evidence from the literature supported the project team to further analyse factors affecting cross-cultural care for residents and workforce cohesion. These factors can be grouped as (1) resident factors: examples are residents' preferences and expectations of care services that are associated with their cultures and language use, and their attitudes towards people from other cultures; (2) staff factors: examples are staff leadership, knowledge, skills and attitudes in cross-cultural interactions; and (3) system factors: examples are policies, funding, standards, guidelines, resources and capacities to deliver equitable

and culturally and linguistically appropriate care services to residents and to ensure the workforce is skilled, inclusive and culturally competent. These factors have been considered in the conceptual model of the multicultural workforce development as presented in Figure 2.

Figure 2 The multicultural workforce development model



Colour code: The blue boxes illustrate residents' journey in the effective CCCS. This journey relies upon the staff and volunteers' capabilities in providing CCCS illustrated in orange boxes and the enabling environments to support and sustain this workforce illustrated in green boxes.
AAAQ=Availability, accessibility, acceptability and quality of care services; **VET**= vocational education and training; **CCCS**=Cross-cultural care services; **RACH**=Residential aged care home

Provide residents with effective cross-cultural care services

Effective cross-cultural care services in the model are based on four core domains in a Universal Health Coverage (UHC) care service system. Government subsided aged care services and programs are viewed as a form of Universal Health Coverage (UHC) to ensure accessible and equitable care for all older people in a country (World Health Organization 2015). UHC has two indicators: (1) health services coverage and (2) financial protection coverage (World Health Organisation 2014). There is extensive evidence that effective health service coverage includes the whole health spectrum (promotion, prevention, treatment, rehabilitation and palliation) and is made up of four core domains (availability, accessibility, acceptability and quality of care services or AAAQ domains) (Campbell et al. 2013, Tanahashi 1978, World Health Organization 2015).

The AAAQ domains have been implemented in various healthcare service settings around the world and are strongly recommended by the World Health Organization (WHO) in its recent report, the 'World Report on Ageing and Health', as an effective care and services model for achieving equity-based aged care or long-term care (World Health Organization 2015). The AAAQ domains have also been discussed as a suitable framework to support 'A human rights approach for ageing and health' in Australia (Australian Human Rights Commission 2012). As the AAAQ domains in the universal health coverage put emphases on (1) effective care services, (2) care recipients/ control and engagement and (3) human resource development, they have been selected as a framework for informing the MCWD model in this project.

The project team acknowledges that there are a variety of care models in residential aged care reported in the literature, for example, relationship-centreness models, individualised care and person-centred care (Berdes and Eckert 2007, Nolan et al. 2004, Walsh and Shutes 2013, Willemse et al. 2015). These models contribute to the quality of care for residents and have implications for systems as a whole and human resource management. However, these models were not developed to address all three group-factors in cross-cultural interactions as described above. The effective CCCS described in the present project complements these existing models with an emphasis on care services for residents from diverse cultural and linguistic backgrounds that are provided by care staff from various cultural and linguistic backgrounds.

The definitions of the AAAQ domains are explained in the 'World Report on Ageing and Health' (World Health Organization 2015, pp. 14-15). The project team adapted these definitions in the context of CCCS for residents in Australia. The AAAQ components in the MCWD model are explained as follows:

Availability of CCCS for residents

Availability means the RACHs are responsive to the needs of residents who are from diverse cultural and linguistic backgrounds. The cultural and linguistic profiles of the residents shape what is provided. **ALL STAFF** are involved in CCCS in RACHs, for example, management group, nursing and allied health professionals, personal care assistants, lifestyle coordinators/enhancers, hospitality and housekeeping staff, maintenance staff, clerical support staff, and staff that provide pastoral care and social care. They are required to work collaboratively in providing CCCS to meet residents' care and service needs. A team approach is highly recommended in order to ensure CCCS are available across all aspects of residents' health, personal care

and lifestyle needs. These approaches should focus on maintaining the resident's personhood and promoting their physical, psychological, spiritual and social well-being.

Mainstream RACHs are required to establish CCCS including cross-cultural communication services to meet the care needs of residents from diverse backgrounds if they have not had these services before. They are also required to have sufficient quantities of CCCS to meet the specific care needs of residents (Australian Human Rights Commission 2012, Australian Government 2012, Australian Government ComLaw 1997). For example, if the care home admits 10 residents from CALD backgrounds, the quantity of CCCS to meet these residents' needs may be significantly different from what was provided where there were fewer CALD residents. The specific care and services needs are identified, either requested by residents/their family and friends or assessed by staff, at admission and throughout residents' journey in the RACH.

Accessibility of CCCS for residents

The concept of accessibility has four sub-dimensions: non-discrimination, physical accessibility, economic accessibility (or affordability) and the accessibility of information. Non-discrimination can be enhanced through education on cross-cultural communication and leadership practices for staff that in turn increases accessibility for the residents. Accessibility of information may require the RACH to provide interpreter services, linguistically appropriate assessment tools/instruments/information, culturally appropriate diet and menus, information on health, well-being and care/social services in the resident's language. It also means that aged care organisations need to provide pre-admission information in a way that is accessible for CALD people who are potential service users. This domain also has a link to organisational policies that should promote access to services based on needs, rather than CALD or non-CALD status.

In the Australian context, economic accessibility or entry into residential care is shaped by the person's ability to pay a possible bond and then weekly payments (Australian Government 2012, Australian Government ComLaw 2014). In the 2012 aged care reform, the Australian Government emphasised that meeting specific care needs for CALD residents is part of standard care for service providers without additional financial cost for them (Australian Government 2015b, Australian Government 2012). The Government does however provide funding for Translating and Interpreting Services (TIS National), Community Visitors Scheme (CVS) and other specific activities which support CALD residents (Australian Government 2015b). The need to build capacity including education and training in order to meet specific care needs for CALD residents in mainstream RACHs has also been recognised in the 'Strategic goals and actions' (Australian Government 2015b). Therefore, funding is required to support this capacity building.

Acceptability of CCCS for residents

The CCCS is respectful and acceptable to residents/their family and friends. Staff who demonstrate culturally appropriate approaches to providing care services for residents will ensure that these are acceptable to them. Acceptability would also be demonstrated through policies that identify the specific needs of CALD residents that are important to living and to maintaining their personhood, for example, religious/spiritual needs, the use

and placement of religious and cultural artefacts, the RACHs' approach to providing culturally appropriate food and other hospitality services and the way in which person-centred care is developed.

Quality of CCCS for residents

CCCS provided by staff should demonstrate high-quality, continuous improvement against criteria/standards and be regularly monitored. Quality improvement in CCCS needs to be based on robust measurement and evidence through continuing education and auditing. It also needs to take into account how the care home engages residents/their families in evaluating the quality of care and what they and their families actually say about this. A cross-cultural care service audit tool was developed to enable residential aged care homes to assess their performance against the AAAQ components in the MCWD model as described above. This audit tool is introduced in Section 2.

Develop a culturally competent workforce to enable effective CCCS

In the 2016 aged care workforce census, 39% of residential direct care workers reported they speak a language other than English in their work (Mavromaras et al. 2017). This is an indicator that cultural and linguistic assets in the multicultural workforce contribute to the CCCS in residential aged care homes. These assets should be formally recognised and incorporated in the workforce planning due to the socio-economic benefits. The cultural and linguistic assets that staff bring to the CCCS have been considered in the core cross-cultural care attributes for staff as discussed in the following:

Core cross-cultural care attributes for staff

The workforce that is capable of providing effective cross-cultural care services should be prepared with core cross-cultural care attributes. In the literature competent cross-cultural interactions have five components described as (1) motivation and passion for effective cross-cultural communication; (2) English proficiency when communicating with English speakers; (3) ability to use language other than English to communicate with people who are unable to speak English or unable to speak English well; (4) ability to use resources/means/strategies (i.e. cue cards, interpreters, Apps) to achieve cross-cultural communication; and (5) the knowledge and skills to interpret meaning from non-verbal communication (Lund and O'Regan 2010, Ting-Toomey 2010). Cultural humility, as part of cultural competence, is described as developing a reciprocal and equal partnership when engaging in cross-cultural interactions (Foronda et al. 2016, Hook et al. 2013).

The project team developed a draft version of 'Core cross-cultural care attributes for staff' based on the literature review and the feedback from the consultative workshops. The draft version was reviewed by staff (end users) in participating sites. Minor changes were made to address feedback from staff. The final version of 'Core cross-cultural care attributes for staff' is presented in Table 2. These attributes are grouped in three domains: (1) respect for differences in values; (2) effective communication with residents and staff in cross-cultural interactions; and (3) positive attitudes and actions in cross-cultural interactions with residents, families and staff. The domains along with attributes reflect enablers in cross-cultural interactions discussed by participants in our study. These domains and attributes can be further expanded by aged care organisations to meet their vision and mission in cross-cultural care and workforce development. A cross-cultural care staff

self-reflection tool was developed to assist staff to assess their own strength and areas for further improvement in providing cross-cultural care for residents and interactions with co-workers. This tool is introduced in Section 3.

Table 2 Core cross-cultural care attributes for staff

Domains	Attributes
Respect for differences in values	• Capacity for reflection on cultural values and beliefs • Demonstrates self-awareness around cultural values and beliefs • Ability to understand different values and beliefs • Explores, tolerates, reconciles and respects the values and beliefs of others
Effective communication with residents and staff in cross-cultural interactions	• Ability to use a range of means to communicate with residents and staff from culturally and linguistically diverse backgrounds • Able to engage with residents, their families and staff in English • Actively seeks knowledge and skills in cross-cultural communication
Positive attitudes and actions in cross-cultural interactions with residents, families and staff	• Fosters high-quality cross-cultural care and services by working in partnership with residents and families • Contributes to an inclusive, cohesive workforce by supporting peers

Core leadership attributes in cross-cultural care services

Leadership is highly regarded in leading and sustaining quality improvement and workforce development in cross-cultural interactions. 'Leadership refers to the behaviour of those with responsibility for directing or influencing the actions of others' (Australian Government and Departnment of Industry 2014, p. 5). The Australian health leadership framework was adapted to build core leadership attributes in cross-cultural care services (Health Workforce Australia 2013). In the MCWD model every staff member is considered to have leadership potential or have capabilities to direct or influence team members, residents or their family members to achieve and/or improve quality of care. The core leadership attributes are organised under the five domains: (1) Leads self, (2) Engages others, (3) Achieves outcomes, (4) Drives innovation, and (5) Shapes systems (see Table 3).

A cross-cultural care self-reflection tool for leaders was developed to assist staff to assess their own strengths and areas that need to be further improved in leading the improvement of cross-cultural care for residents and team cohesion. This tool is introduced in Section 3. The domains and attributes can be further expanded to suit aged care organisations' needs.

Table 3 Core cross-cultural care leadership attributes

Domains	Attributes
Leads self	• Aware of own cultural values and beliefs and how these may impact on own practice in leading self and others • Understand and manage the impact of own cultural background, assumptions, values and attitudes on self and others • Actively promote understanding, respect and trust between different cultural individuals and groups
Engages others	• Engage with others and act in accordance with values, beliefs and skills that facilitate cross-cultural communication • Be approachable and listen to differing cultural needs of both staff and residents • Listen, inspire and enable staff and others to share ideas in improving cross-cultural care and services
Achieves outcomes	• Work in collaboration with residents, their families and staff to set goals for cross-cultural care and services • Motivate self and others to provide culturally appropriate care that contributes to continuous quality improvement • Monitor, evaluate progress and account for culturally sensitive care
Drives innovation	• Champion the need for innovation and improvement in cross-cultural care and services • Build support for change, encourage diverse voices and consumer involvement in providing culturally appropriate care • Communicate system and negotiate within and across care teams in providing culturally appropriate care services
Shapes systems	• Explore, implement and disseminate new care practices in regards to cross-cultural care and services • Systematically maximise the potential benefit of change while minimising unintended consequences in providing culturally appropriate care

The model describes a culturally competent workforce as having five characteristics: (1) Staff/volunteers enter with adequate capabilities in CCCS; (2) They are capable of meeting care needs for residents; (3) They continually develop capabilities to advance CCCS; (4) They support peers in the diverse workforce; and (5) They demonstrate leadership in CCCS and workforce cohesion. It is estimated that 23,537 volunteers worked in residential aged care (Mavromaras et al. 2017). This group have a role to play in CCCS. Therefore, the MCWD model includes this group as part of an informal workforce. The characteristics of a workforce with capabilities to provide residents with high-quality CCCS are explained as in the following:

Staff/volunteers enter with adequate capabilities in CCCS

Ideally staff/volunteers should have had education and training in cross-cultural care for residents and in working with team members from multicultural backgrounds prior to entering RACHs. Education and training institutes should have an explicit cross-cultural care program in the curricula that considers the core cross-cultural care attributes for staff. The program should not be elective, but compulsory to reflect the cross-cultural interactions in this care setting as 88% of residential aged care homes employ staff from CALD backgrounds (Mavromaras et al. 2017). Experiential learning approach needs to be applied to support

students/learners to learn in cross-cultural care environments and to enable them to apply knowledge to own practice. Educators who deliver the program should be passionate, knowledgeable and skilful in facilitating students/learners to develop adequate attitudes, beliefs, knowledge and skills in cross-cultural care services.

Education and training programs for staff with leadership, management and supervisory responsibilities should incorporate the core cross-cultural care leadership attributes into the program. Employers should incorporate the core cross-cultural care attributes for staff and the core cross-cultural care leadership attributes to job descriptions, selection criteria and skill tests where appropriate. This selection process will ensure the quality of the workforce at the entry level. However, many times people are not coming to recruitment with pre-existing levels of knowledge. Therefore, the employer will support education and training.

Staff/volunteers are capable of meeting care needs for residents

Staff/volunteers should be capable of providing care services for residents in cross-cultural interactions to meet their care needs independently or through a team approach. Residents' care needs should be analysed in a holistic way that include physical, psychological, spiritual, cultural and social aspects. Staff need to be aware of the resident's cultural background, language use, their preferences of how the care services should be delivered and whether the resident/family is satisfied with the services. Staff need to be self-regulating and demonstrate their performance against the core cross-cultural care attributes for staff or the core cross-cultural care leadership attributes where appropriate.

Staff/volunteers continually develop capabilities to advance CCCS

Staff/volunteers need to be self-aware of own strengths and the areas that need to be further improved through self-reflection. They should also be capable of seeking feedback from residents and peers to improve their performance and advance cross-cultural care services. They should be aware of their own learning needs and willing to engage in cross-cultural care education and training activities to improve their own practice and performance.

Staff/volunteers support peers in the diverse workforce

Staff/volunteers should be willing to support or mentor new staff and assist them to assimilate into the RACHs. Staff should know the cultural background of team members, be willing to share and learn from each other's culture, learn the way to communicate and work effectively with team members from diverse cultural backgrounds. They should encourage team members to contribute their cultural and linguistic assets to cross-cultural care services. Staff should also be self-aware of cultural inclusion in the workplace and positively contribute to team building, team collaboration, rather than group separation based on culture and language use. When cultural differences and cultural clashes arise, staff need to be aware of approaches that can be used to resolve the differences in a culturally appropriate and friendly manner.

Staff/volunteers demonstrate leadership in CCCS and workforce cohesion

Staff/volunteers should be aware the difficulties and barriers to meeting residents' care needs in cross-cultural interactions and be willing to take a leadership role in leading others to overcome these difficulties and

barriers. They also need to take proactive action to improve the way cross-cultural care services are delivered, managed, and monitor the care services in order to continuously improve the system. They should be aware of their leadership potential in improving team communication and collaboration. They need to take proactive action to prevent group alienation and separation, but contribute to positive inter-group interactions. They should understand the impact of racially negative attitudes and comments on the care of residents and on team work and step up to contain and resolve such issues. They need to take proactive action to embrace cultural diversity and promote tolerance and harmony.

Build an enabling environment in residential aged care homes

Residential aged care homes are the primary environment for creating and sustaining effective CCCS for residents and for developing the multicultural workforce. Cultural and linguistic diversity adds complexity to meeting residents' care service needs (Nichols et al. 2015, Runci et al. 2012, Runci et al. 2014, Runci et al. 2005). Various government initiated strategies, including free interpreter services, supporting ethno-specific aged care services and recruiting staff with bilingual and bicultural backgrounds have been used to address this complexity (Australian Government 2015b, Runci et al. 2014). It is estimated that 25% of residential aged care homes provided ethno-specific aged care services for residents in 2016 (Mavromaras et al. 2017). However, given the increased cultural diversity within Australia, it is anticipated that more capacity building or enabling environments are required to ensue mainstream residential aged care homes support effective CCCS. The characteristics of an enabling environment that create and sustain effective CCCS are described as: structures for CCCS, education/training, targeted human resource management strategies, CCCS auditing activities and support from residents/their family and friends. These characteristics are discussed as follows:

RACH has structure in place for CCCS

The enabling structures for creating and sustaining effective CCCS include investment in targeted personnel and resources to develop new or expand existing care services to meet residents' care needs. Investing in personnel in order to create and sustain CCCS was explored in this project. In our project, two multicultural workforce development facilitators (see Appendix 1 Job description for multicultural workforce development facilitators) and four multicultural workforce development site champions (see Appendix 2 Job description for multicultural workforce development site champions) were employed. The job descriptions and time contributed to the project by these staff increased the capacity building of CCCS in the RACHs. These two positions may be considered as career progression opportunities for aged care workers.

New or expanding care services developed to meet residents' specific care needs include cross-cultural communication needs, information needs, dietary preferences/requests, meaningful relationships and interactions with others, activities focused on maintaining personhood, promoting functional ability and lifestyle aspirations linked to physical, psychological, spiritual and social well-being. These care services cannot be provided without skilled staff, infrastructure, equipment and technology. As a consequence they have implications for investing in the aged care system. Together, the structures (human and material

resources) have implications for aged care policies and funding. Providing affordable and cost-effective CCCS needs to be explored by the aged care industry and the funding body.

Residents, relatives and friends are included as partners in CCCS

Residents, family and friends play an active role in advocating for change in care services to meet the specific care needs of residents, assure quality improvement and assist in cross-cultural communication. They are crucial partners in developing and advancing CCCS. Including them as partners is a fundamental principle in enabling and supporting consumer-directed care in this environment. Examples that enhance partnerships with residents, their family and friends in CCCS include co-developing culturally appropriate care plans, cultural exchanges between residents/families and staff, cross-cultural communication resources that are linguistically accessible and additional materials for those residents who have sensory impairments or other conditions affecting their ability to read and make their opinions and requirements known.

It is also important to instigate regular education and other activities that address racial issues that arise when residents refuse to be cared for by some CALD staff. Suggestions by residents, their family and friends that enhanced cross-cultural communication and relationship building needs to be encouraged and acknowledged.

RACH provides education and training in CCCS

Up-skilling and educating staff is one significant way to enable effective CCCS. Developing education and training activities that target staff learning needs and advance CCCS for residents is essential in maintaining an enabling environment. A detailed discussion on developing, implementing and evaluating the education and training activities to support the MCWD model is presented in Section 4.

Human resource management accounts for CCCS

Staff diversity adds complexity to the capacity of the organisation's human resource team. The organisation's recruitment processes need to ensure they attract staff with adequate CCCS capabilities, for example providing processes that include on-boarding support and interview questions that test CCCS capabilities. The core cross-cultural care service attributes developed in this project are one of the resources that support the recruitment process. Rostering staff needs to take account of cultural and religious events that have a significant impact on the provision of adequate care for residents. Cultural discordance and conflicts within the team need to be identified, investigated and resolved in a timely manner in order to maintain team cohesion and productivity. Racially negative attitudes/behaviours that occur in the workplace need to be reported, investigated and managed to ensure quality of care is built on positive resident-staff relationships. Mainstream RACHs need to have human resource management strategies to recognise staff's bicultural and bilingual assets and optomise the use of these in the workforce. A multicultural workforce management audit tool was developed to assist aged care organisations to improve workforce cohesion and productivity. This tool is discussed in Section 2.

CCCS auditing activities are regularly undertaken

Auditing activities are necessary for creating expectations of continuous quality improvement. The CCCS audit tools developed in the project assist RACHs to periodically perform self-assessment of CCCS and to know their strengths and areas that need to be improved. Outcomes from the auditing activities can be used as evidence to inform in-service education and training to address issues identified in the audit. The audit tools are introduced in Section 2.

Build an enabling environment in the aged care system

Providing residents with high-quality CCCS requires both a sustainable workforce of adequate quantity and quality in the aged care system. It is estimated that the aged care workforce will nearly triple from 366,027 in 2016 to 980,000 in 2050 (Australian Government Productivity Commission 2011, Mavromaras et al. 2017). Approximately 53% of residential aged care homes report skill shortages, most commonly for Registered Nurses (RN) who usually have leadership, management and supervisory responsibilities (Mavromaras et al. 2017). In order to comply with the Aged Care Act 1997 the aged care system including RACHs are required to ensure staff have adequate skills to meet the individual care needs of residents. In the context of the increased diversity of residents and the staff in mainstream RACHs, developing an inclusive and culturally competent workforce has become an important aim in the Australian Government's policies and funding decisions (Australian Government et al. 2015). The present project contributes to this aim by exploring the enabling environments for effective CCCS and the required capabilities of the residential aged care workforce in cross-cultural interactions. Aged care policies, funding, standards, regulations, the industry, vocational education and training (VET), the tertiary education sector and potential users of residential aged care services have an important role to play in creating an enabling environment for CCCS in the aged care system. These elements are discussed as follows:

Aged care policies and funding support

Providing CCCS for residents from CALD backgrounds in mainstream residential aged care homes requires investment and innovation. Policies and funding are required to support organisations who demonstrate a willingness to develop CCCS to meet the care needs of residents. When the present project was undertaken, the Australia Government announced a Senate inquiry into the 'Future of Australia's aged care sector workforce' (Parliament of Australia 2015). One of the terms of reference in the inquiry was 'challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, CALD groups and lesbian, gay, bisexual, transgender and intersex people' (Parliament of Australia 2015). The present project supports this Government priority.

As discussed in the first and second domains of the MCWD model, *providing effective CCCS for residents, and enabling the workforce to deliver the effective CCCS* are associated with investment in new business development or business expansion and in workforce development. For example, meeting residents' requests for a special diet to maintain their life-long dietary patterns is essential for the maintenance of good nutrition and quality of life, but may require increased investment in this area. Furthermore, the accessibility of information on health, diet menus and other services for residents translated into languages other than

English is also an investment issue. Funding support to enable the investment is one way to address access and equity in care services for all residents regardless of their cultural backgrounds and language use.

Aged care standards and regulations address CCCS

The current aged care accreditation standards are limited in the requirements for providing residents with cultural needs to '3.8 Cultural and spiritual life: Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered' (Australian Government ComLaw 2014, p. 17). The findings from our study indicate that CCCS draws on other accreditation standards, including Part 1—Management systems, staffing and organizational development; Part 2—Health and personal care; Part 3—Care recipient lifestyle; and Part 4—Physical environment and safe systems.

Aged care organisations and industry support CCCS

Residential aged care providers in Australia are experiencing workforce shortage in meeting the demand for business growth and providing high-quality care for residents. With increases in the population aged 85 and over, including clients with dementia who have complex care needs and potentially require places in residential care, workforce pressures will continue to expand. The Residential Aged Care sector will continue to compete with other sectors in attracting quality staff while at the same time there will be a decline in the domestic supply of workers and an increased supply of CALD migrant workers (Australian Bureau of Statistics 2013). Aged care organisations that provide opportunities for staff to develop skills and positive workplace relationships with management and colleagues are more likely to attract skilled staff (Chenoweth et al. 2010, King et al. 2013). By implementing the MCWD model supported by education and training activities, aged care organisations and industry will demonstrate their commitment to enhancing workforce integration, up-skilling and promoting a long-term solution to these workforce pressures.

VET and tertiary education encompass CCCS curricula

The vocational education and training sector plays a crucial role in supplying staff with adequate skillsets at entry level. The findings from our study indicate that the majority of personal care assistants (PCA) who participated in the focus groups/interviews did not engage in studies in CCCS, cross-cultural communication and cross-cultural leadership as part of their VET education. In the revised Certificate III in aged care, there are two elective units that address cross cultural care issues. These are: (1) Work effectively with culturally diverse clients and co-workers; and (2) Work effectively with Aboriginal and/or Torres Strait Islander people (Australian Government 2015a). Although these units are useful for all potential students to learn about the impact of socio-cultural factors on the care of residents, they may not be sufficient for CALD staff who clearly described their knowledge deficiencies about Australian-born residents and their culture as well as other cultures. Many staff who participated in the focus group and interviews did not do these electives when undertaking their VET course. Additionally, there are many other staff, such as lifestyle coordinators, domestic and catering staff and volunteers who deliver CCCS and require education and training in cross-cultural communication, who may not have undertaken any education or training.

The tertiary education sector plays a crucial role in supplying entry level RNs, ENs and allied health professionals. These staff play a supervisory and leadership role in residential aged care. The curricula for these roles needs to emphasise leadership in CCCS including cross-cultural communication, leadership and education of other staff. Furthermore, most participants in management position who engaged in focus groups and interviews were RNs. Postgraduate curricula for RNs who are likely to take up management roles in aged care should have content that covers issues in the multicultural workplace, leadership in developing and advancing CCCS for residents and evidence-based practice in CCCS. These skills should also be provided through ongoing continuing education to up-skill staff in CCCS. Additionally, in the 2016 Aged care workforce census, around 17.9% of RNs were from countries where people speak a language other than English (Mavromaras et al. 2017). They may gain RN qualifications through undergraduate nursing programs in Australian universities. Therefore, much more can be done in the tertiary sector to address CCCS, particularly by utilising the skills and experiences of international students.

Information on CCCS is available for potential users

The findings from this study reveal that cross-cultural communication is a major challenge for residents and staff to engage in meaningful conversations and in the development of positive relationships. Residents may refuse to be cared for by CALD staff based on their stereotypical views, the skin colour of the staff, accents or poor English proficiency of staff. Proactive actions are required to prevent these negative cross-cultural interactions between residents and staff and to prepare residents for a smooth transition from home to residential care. Information on CCCS, the characteristics of the multicultural workforce who provide care for residents and the policies in aged care organisations for managing diversity in residential aged care homes need to be shared with the potential residents, their families and friends so that they are better informed of their choice of the care environment.

Consultation with stakeholders

Three workshops with stakeholders were conducted between February and April 2016 to gain their feedback on the draft MCWD model and resources. The documents used in the consultative workshops for discussion and for gaining written feedback after the workshop included:

- The draft MCWD model and explanations
- Skill sets required to provide effective cross-cultural care services
- Skill sets to support peers in the diverse workforce
- Effective cross-cultural care services audit tool
- Human resource management audit tool
- The aged care organisation support for cross-cultural care services audit tool
- Cross-cultural communication: A sample learning module in the cross-cultural care program for aged care staff

In total 58 participants attended the workshops. Participants represented staff from Resthaven (workshop 1), AnglicareSA (workshop 2) and the various organisations (workshop 3) including Multicultural Communities Council of SA, Alzheimer Australia SA, Australian College of Nursing, Multicultural Aged Care Inc. South

Australia (workshop 3). Discussions on these materials were recorded for analysis. Participants were encouraged to provide written feedback after the workshop and return to the project manager. Ten out of 58 provided written feedback. In analysis, five categories were identified from the discussions and written feedback: (1) A useful conceptual model, (2) Revising the audit toolkit, (3) Rethinking the skillset, (4) Preferred education modules and learning styles, and (5) Building the system. A summary of the feedback is presented in Table 4.

Table 4 Summary of feedback from the consultative workshops

Categories	Summary of feedback
A useful conceptual model	• The model informs system design and governance. These are key to CCCS. • We need to be aware of all the elements in the model when developing business, especially when delivering care services. • The model has potential for creating an enabling environment: Good and simple signage is important. • The model is quite useful, especially to initiate discussions. • The model creates good discussion. • The model is useful for management. • The model has potential for a big impact on staff retention and resident satisfaction.
Revising the audit toolkit	• The toolkit is easy to use. • It is useful for quality improvement. • We need to dispense with formality when completing audit – just have an open conversation face to face resident/family. • The audit tool is very useful and can be used to measure and validate CCCS. • The audit tool will help make sure CCCS is not overlooked in the busy workplace. • The toolkit can help as evidence for a CI [clinical improvement] project. • We need to check wording – suggested sub series of questions/prompts for some points, for example: - Diet/drinking needs - Dining activities/utensils needs - Needs associated with dressing/make-up - Needs associated with hospitality, housekeeping, maintenance, clerical support and IT services • It may take too long to complete. Staff are under pressure. • Cultural information is often 'hidden', therefore, audit needs to be mixed methods for example, documentation and interviews, including with residents. • Scoring is not always relevant in an audit. Qualitative information is preferable over quantitative.

Categories	Summary of feedback
	• We need to split interpreter services to professional, family or staff member. • Effective IT systems leads to more accurate input of data.
Rethinking the skillset	• Skills should not be assessed – outside scope of this project. • Language could be more about expectations. • We need to focus on attitudinal shift of staff rather than skills. • It would be very complex when measuring cultural competence. • Skills sets have already been covered in prior education. • How are we going to measure skills at entry level? • It is more about education of staff - Staff like to have feedback from management about how they're going. • How do we determine if they have met competencies – who is doing this? • Workforce may struggle with English. • It is unrealistic expectations for staff. • It is unrealistic for carers/support workers, particularly given demographic and labour market. • Staff need passion and caring –may not always have this. • Reflection is a good idea.
Preferred learning modules and learning styles	• Site champions could work with different staff in organised groups to discuss issues raised in the auditing activities. • Staff learn better through group activities. • Learning activities could be done at a meeting or handover. • Unfolding case studies is a great idea. • Web based resources and tools should be available for educators. • The program needs to cover modules over several sessions, discuss themes and then have staff reflection. Staff are more likely to do their own reflective processes. Site champions are needed to facilitate staff to learn. • It should allow staff to sit down and do the module in own time. • We need a facilitator version of modules. • Task based exercises are needed: i.e. identify workers from different cultural background, talk to them and describe what you discover. • It would be great for group discussion – small group. • Use of videos in program is a good idea. • Tips are good and would be useful. • If we do not provide study time, will staff use this? • Snippets can be used in varied contexts. • Tool kit and resources are useful for educators/facilitators. • In community staff paid for face to face time but in residential care it's different.

Categories	Summary of feedback
	• The word 'racism' needs to be replaced with 'cultural differences'. • The project should not just Resthaven & AnglicareSA. How will this communicate to smaller organizations? • The program should be practical and solutions focused. • Ageing in place leads to more dementia and end of life care. The program needs to focus on these areas. • Residents with dementia have more difficulties accepting CALD staff and have a fear of skin colour. • Dementia creates complications with CCCS. • We need to consider low level of literacy of some staff. • The program should be used with face to face debrief although this is resource intensive. • We need management support. • Staff may not do the program unless they are paid. • We need to encourage self-learning. • We need to debrief, need face to face learning, need very skilled staff for debriefing or can be dangerous. • A joint activity encourages staff to bring a significantly cultural item and share their culture.
Building the system	• Cross-cultural care services need to be part of the philosophy and mission of the organisation. • How do you stay true to your philosophy and mission? • Management need to have knowledge of the cultural background of staff. • Availability of a tool i.e. iPad for the stroke patient/resident should be considered. Currently this is a financial issue for the facility to provide this. • Italian and Greek translation apps for aged care are excellent. These include audio and improve availability in cross-cultural communication. • Items may be available but resident can't access it i.e. their TV – confused by the buttons. Same applies for other technology but the resident can't access it. • Organisation change is needed to support the CCCS. • We need to encourage the use of professional interpreter services. Families may tend to filter information. • In relation to CCCS in large organisations, unless someone takes on the responsibilities it will be piecemeal. What is the role of that individual and how will they be skilled up? • Where to access resources to support the cross-cultural care services? • Language and communication are significant barriers with CALD workers. How can we overcome this? • Culturally aware organisation: How can this be communicated externally to staff that might be looking to work in the facility? • Who will educate residents to use technology i.e. iPad. Can volunteers do this?

Categories	Summary of feedback
	• Documents [MCWD model and toolkits] need to be submitted to management level in a very serious manner and need to get management involved. • Management of staffing needs to cover weekends. Cultural needs of staff and residents often not met in weekends. • We need attitudes based recruitment and a qualification with increased pay.

The project team considered most of the feedback when revising the MCWD model and resources. Representatives of industry partners argued that staff might have a fear of utilising the skillset as they might attribute failure to meet the skillset with being dismissed or other negative consequences. They strongly suggested that developing self-reflection tools might provide staff with a safe approach to assessing their own strength and areas that needed to be improved. This approach would more positively engage them in cross-cultural care education and training activities. Changes were made in these areas to address the feedback:

- MCWD model: A minor revisions was made by replacing the skillset with words of 'Capabilities in across-cultural care services'
- Cross-cultural audit toolkit: A major revisions was made by replacing items that were viewed to be unclear or not realistic with clearer statement as suggested by participants.
- Skillset: The skillset was replaced by staff cross-cultural reflection tools and a cross-cultural leader self-reflection tool.
- Education program: A cross-cultural care program for aged care staff that includes five learning models was confirmed (see Section 4) to address learning needs discussed in the consultative workshop and findings from our study. The methods used to engage staff in the program were also described in the program.
- Building the system: Feedback in this area reinforced that developing the conceptual model of MCWD and resources to support the model are imperative.

Section 2: Cross-cultural care toolkit

The cross-cultural care toolkit assists aged care providers to collect data to improve the CCCS, to effectively manage human resources and to support the system to respond to issues arising from CCCS in a timely manner. The toolkit includes three audit tools: (1) Cross-cultural Care Service Audit Tool, (2) Multicultural Workforce Management Audit Tool, and (3) Organisational Support for Cross-cultural Care Services and the Multicultural Workforce Audit Tool. The toolkit covers most aspects of CCCS. The toolkit was pilot tested by the MCWD facilitators prior to the implementation in phase two of the project. During the implementation of the MCWD model in the present project, the multicultural workforce development facilitators undertook internal audits every 6 months in collaboration with facility management and the site champions. The auditing activities in this project enabled the multicultural workforce development facilitators and site champions to support staff to advance cross-cultural care services for residents and to develop in-service sessions for staff to address their learning needs in CCCS. The content of these three tools are presented in Appendices 3-5. Examples of how to use these tools in practice are given in Section 5.

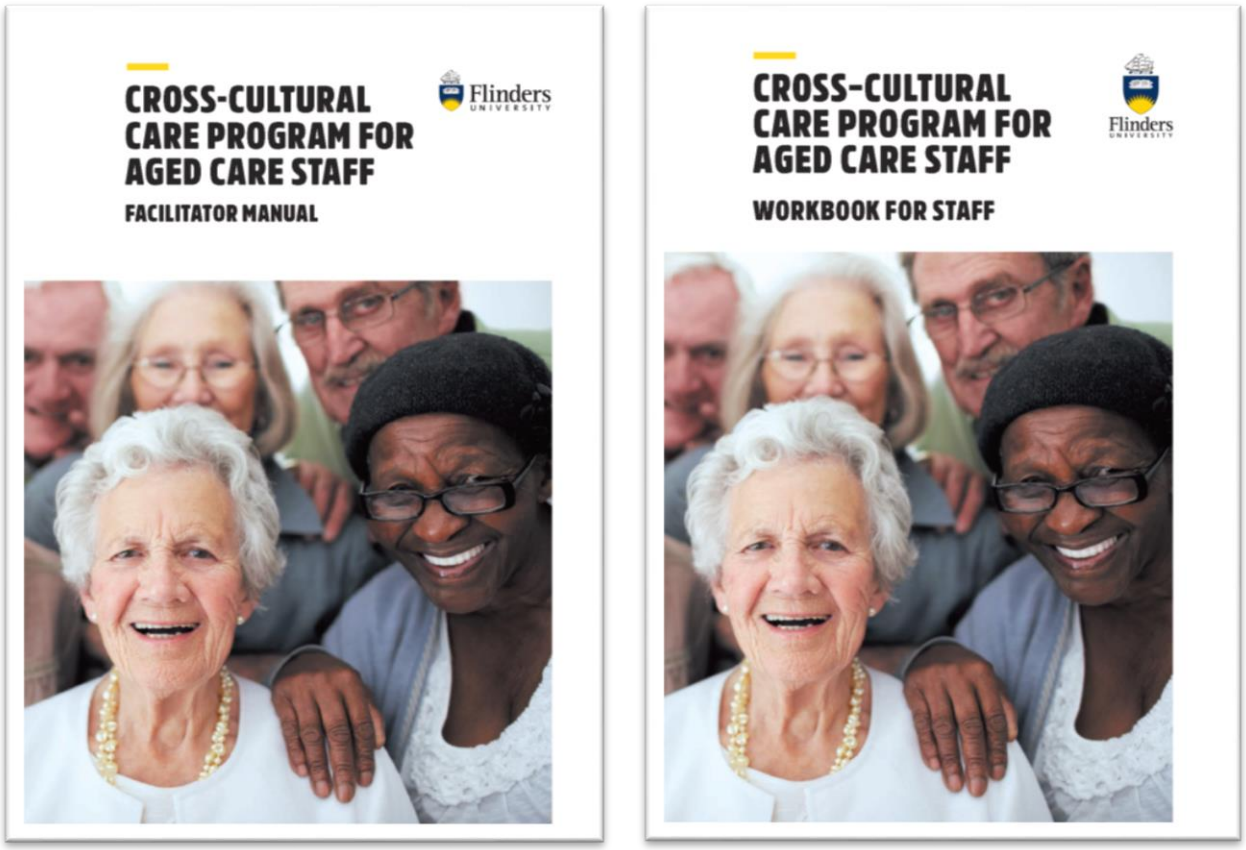
Section 3: Cross-cultural care self-reflection toolkit

The Cross-cultural care self-reflection toolkit assists staff to perform self-assessment in cross-cultural interactions with residents and staff, recognise their own strengths and use these to contribute to improved care services for residents, team cohesion and bring positive changes in the system via local leadership. The toolkit also supports staff to recognise their own weaknesses in cross-cultural interactions with residents and co-workers so that they seek learning opportunities and mentoring support to improve. The toolkit includes two tools: (1) A staff cross-cultural care self-reflection tool and (2) a Cross-cultural Care Self-Reflection Tool for Leaders. These tools are presented in Appendices 6-7. Examples of how to use these tools in practice are given in Section 5.

Section 4: Cross-cultural care program for aged care staff

The program includes two separate books: (1) Cross-cultural care program for aged care staff: facilitator manual and (2) Cross-cultural care program for aged care staff: workbook for staff (Xiao et al. 2017a, Xiao et al. 2017c). During the project life, the project team worked with residents and staff in the four participating residential aged care homes to implement and evaluate the program. Access to the PDF version of the program is listed as follows:

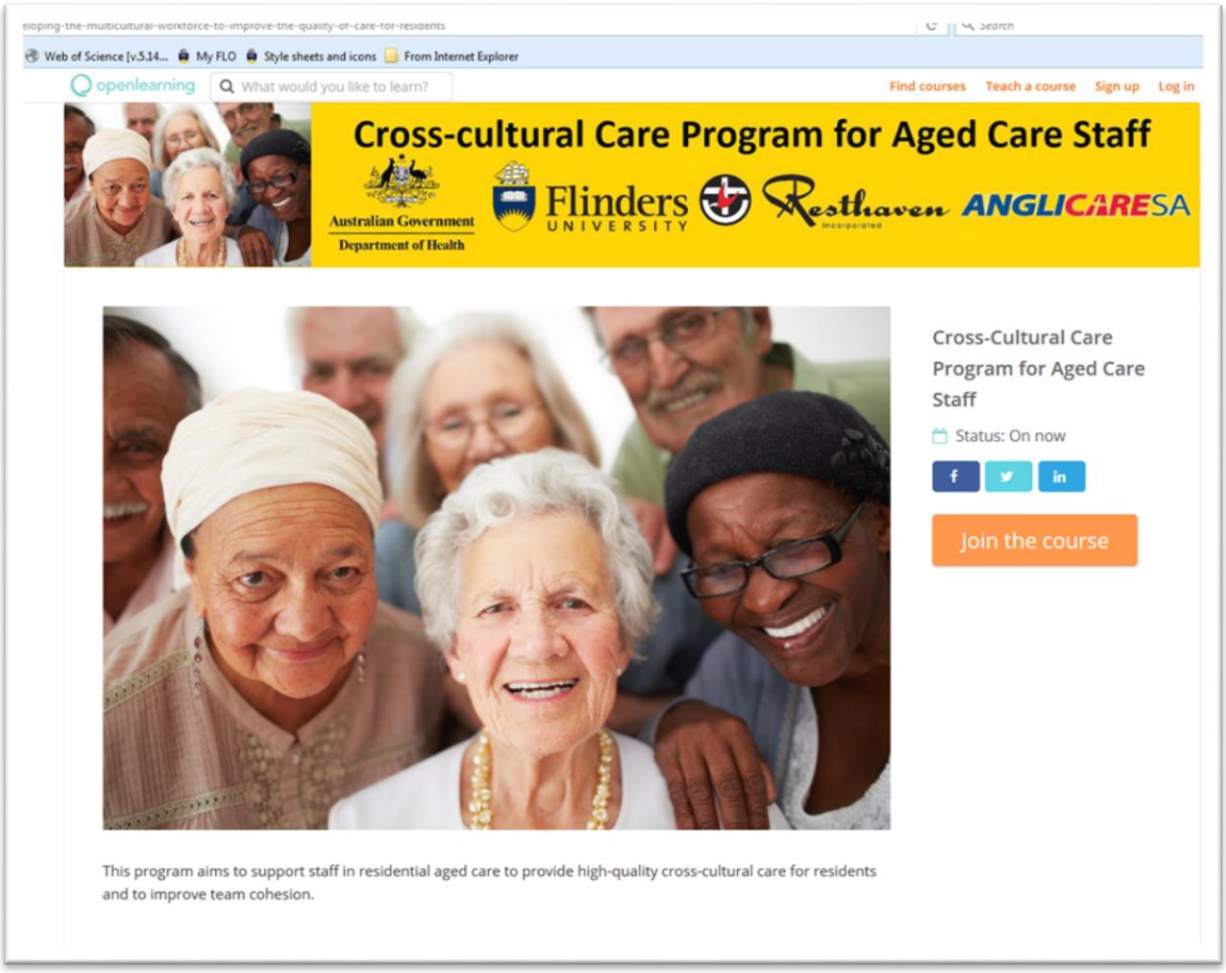
- Xiao, D., Willis, E., Harrington, A.C., Gillham, D.M., De Bellis, A.M., Morey, W., et al. (2017). *Cross-cultural care program for aged care staff: Facilitator manual.* Adelaide, Australia: Flinders University. Open Access: http://dspace.flinders.edu.au/xmlui/handle/2328/37323
- Xiao, D., Willis, E.M., Harrington, A.C., Gillham, D.M., De Bellis, A.M., Morey, W., et al. (2017). *Cross-cultural care program for aged care staff: Workbook for staff.* Adelaide, Australia: Flinders University. Open Access: http://dspace.flinders.edu.au/xmlui/handle/2328/37324



Printed copies of the Facilitator Manual and Workbook for staff (see the photos above) can be ordered via:
Flinders University Press
Phone: 08-82013150
Email: robert.breen@flinders.edu.au

The program has been adapted into an online self-learning program using the Massive Open Online Course (MOOC) with free access (Xiao et al. 2017b). The online program aims to improve access to the education program and to give staff options to learn in a self-directed and flexible manner. Instructions for accessing the

online program are presented in Appendix 8. A self-directed learning portfolio is available to assist staff to document the evidence of their learning and apply knowledge to their own practice. Staff may use the evidence as part of their professional development. The self-directed learning portfolio is attached as Appendix 9. The following picture shows the program website (www.flinders.edu.au/cross-cultural-care).



Aim

The aim of this program is to support staff in residential aged care homes to provide high-quality cross-cultural care for residents and to improve team cohesion.

Learning modules

This program includes five learning modules that cover most care activities in residential aged care homes:

- Module 1: An introduction to cross-cultural care for new staff including 'Work related English Language Resources for Staff'
- Module 2: Cross-Cultural Communication
- Module 3: Cross-cultural leadership
- Module 4: Cross-cultural dementia care
- Module 5: Cross-cultural end of life care

Module 1 is designed for new staff to develop basic knowledge and skills in cross-cultural interactions. The module includes:

- Part 1: Introduction to cross-cultural care for residents
- Part 2: Introduction to fostering team cohesion and collaboration
- Part 3: Work related English language resources for staff

Modules 2- 5 are designed for all staff who provide direct or indirect care and services for residents and work with team members from different cultural backgrounds.

Each module includes two parts:

- Part 1: Learning to improve practice and performance. Staff will learn principles, knowledge and skills in cross-cultural interactions with residents and team members. Case studies are developed to support staff to apply new knowledge and skills to their practice context.
- Part 2: Unfolding case study. Staff will watch a short video, engage in self-reflection and respond to challenging questions.

The program has embedded current research evidence or evidence-based guidelines in cross-cultural communication, leadership, dementia care and end of life care into the learning modules. The cross-cultural care toolkit developed in the project is also incorporated in learning modules to facilitate changes in practice. The toolkit includes:

- Cross-cultural Care - Staff Self-reflection Tool
- Cross-cultural Care - Leaders Self-reflection Tool
- Cross-cultural Care Service Audit Tool
- Multicultural Workforce Management Audit Tool
- Organisational Support for Cross-cultural Care Services Audit Tool

Teamwork to improve cross-cultural care services

This program is designed for staff to work with a facilitator appointed by the care home to learn and improve cross-cultural care services and team cohesion. The **Facilitator Manual** provides the facilitator with planned learning activities, education tools and audit tools to work with staff to improve cross-cultural care and team work. Facilitators are encouraged to use the manual at a time when on the job training is required by individuals or a group of staff members. Some strategies tested in the development phase are listed below and may be useful for facilitators to apply to their own practice context:

- Undertaking internal cross-cultural care service audits to create expectations for improving quality of care and team cohesion
- Identifying good practice and performance demonstrated by staff in cross-cultural interactions with residents or with team members and promoting them
- Selecting learning activities to mitigate issues you identified in cross-cultural interactions
- Embedding the program into workforce management and day-to-day staff activities
- Applying one-on-one mentoring, coaching, group learning and self-learning to engage staff in improving cross-cultural care for residents and team cohesion

The **Workbook for Staff** is designed for staff to interact with the facilitator and their peers in sharing experiences and engaging in the case studies. Following each case study, multiple choice questions are developed to assist staff to consider the application of the learning to their practice. Please note, the multiple choice questions are not test questions. Staff do not need to submit their answers, or their workbook to the facilitator. They keep the workbooks as a resource for themselves as part of their own personal and professional development. Staff are encouraged to refer to this resource during the face to face sessions, but also at any time they want to improve their performance in cross-cultural care services.

Ground rules for staff involved in the program

Prior to each session, staff will need to be mindful of the following key points when working in a multicultural team:

- Confidentiality is paramount: What's said in the room stays in the room.
- Allow others to speak and also listen to others: you may learn something about another person's culture, their values and beliefs. Respect one another.
- Support one another: in cross cultural care this is referred to as cultural humility and may give you the confidence to speak about your own experiences.
- Have healthy discussions: be assertive however, also be mindful that in some cultures assertiveness could be defined as 'rude'. We encourage your discussion. Discussion, even if a little uncomfortable and in contrast to another's opinion, can lead to great innovation and resolution if done respectfully.
- Please be conscious of body language and nonverbal responses as these can be disrespectful. Body language can be effective for positive communication, as well as being harmful if negative. Please discuss with the facilitator if you have questions about disrespectful body language.

Section 5 Case scenarios

Five scenarios have been prepared to facilitate the uptake of the MCWD model and resources. The organisations' names used in the scenarios are fictitious. These scenarios simulate situations that staff may encounter in aged care organisations in their attempts to achieve their vision and mission, to expand their business and to demonstrate excellence in the care of residents and support for staff. These scenarios include:

Scenario 1: Use the MCWD model for business planning

Scenario 2: Support new staff from CALD backgrounds

Scenario 3: Identify and meet CALD residents' dietary needs

Scenario 4: Facilitate positive cross-cultural interactions

Scenario 5: Embed the 'Cross-cultural Care Program for Aged Care Staff' into existing training programs

Scenarios 1: Use the MCWD model for business planning

Sunny Residential Aged Care had six nursing home sites that provided comprehensive care services for residents. The vast majority of residents and staff were from an Anglo-Saxon background. In the past decade, the organisation observed socio-cultural demographic changes of residents and staff. By 2016 the proportion of CALD residents and staff from CALD backgrounds reached 15% and 55% respectively. The records indicated that residents were from 78 different countries and staff were from 72 different countries. The majority of CALD residents came from Europe while the majority of CALD staff came from south Asian and African regions. A marketing investigation revealed that the demand for residential care for older people from CALD backgrounds in the areas where Sunny homes were located would increase in the future.

The organisation was in the process of discussing a business development plan in order to accommodate the increased numbers of CALD residents. While there were a number of approaches to planning business development, the Multicultural Workforce Development Model was chosen to serve as a road map for the planning. Three workgroups were formed to take charge of the domains in the model as described below.

Workgroup 1: Accommodate residents' cross-cultural care service needs

'Provide residents with effective cross-cultural care services' in the MCWD model was considered by this workgroup when analysing the availability, accessibility, acceptance and quality of services for residents. Cross-cultural communication was viewed as the most challenging area. Although free downloaded Cue Cards were used to facilitate the cross-cultural communication in the nursing home, the workgroup identified the need to have voice-based communication between residents and staff using an iPad with a multilingual translation App, for example, Ciao App (Italian-English), Let's go Greek! App (Greek-English) and Go Vietnamese APP (Vietnamese-English). This approach to cross-cultural communication would improve the availability of different ways to communicate with CALD residents. The other challenging area the workgroup identified was to meet CALD residents' dietary preferences. In the planning report, the workgroup suggested that investment in IT would enable cross-cultural communication. They also recommended that a training program for hospitality staff and other staff was imperative in order to provide a culturally appropriate diet for residents.

Workgroup 2: Prepare the workforce to enable the CCCS

The concept 'Develop a culturally competent workforce to enable effective cross-cultural care services' assisted the workgroup to brainstorm support, resources and investment in workforce development. The Cross-cultural care self-reflection toolkit was identified as a useful resource and the workgroup made some modifications to these resources to suit the organisation's needs. For example, the self-reflection toolkit was modified to be an annual appraisal tool for staff with different roles and responsibilities. Some of the questions in the self-reflection tool were adapted as interview questions for use in recruitment.

The workgroup also identified that the 'Cross-cultural care program for aged care staff' was a useful education resource to support staff to develop their capabilities in CCCS. Therefore, in the planning report the workgroup suggested that investment in staff education and training was necessary. The Board approved a budget for the educator to lead the education and training program using both face-to-face and online self-learning approaches.

Workgroup 3: Build the organisation's capacity in CCCS

The third and fourth domains in the MCWD model, 'Build an enabling environment in residential aged care homes' and 'Build an enabling environment in the aged care system' were used as a guide for capacity building. The workgroup identified required personnel to support and sustain the CCCS. In the planning report the workgroup suggested that appointing a CCCS officer at the organisational level and a site champion in each nursing home was needed. Job descriptions for these positions were developed. It was proposed that the CCCS officer would work under the leadership of the Executive Manager of Workforce Development to address the need to recruit, develop and support staff and to build partnerships with stakeholders to enable the CCCS.

The workgroup also suggested that investment in leadership development in CCCS was necessary. A quarterly workshop for site managers, care coordinators and site champions was recommended. The workgroup considered that the cross-cultural care service audit tool was relevant for the site champion to use in order to identify care needs of CALD residents and to trigger investigation of barriers to meeting their care needs. The tool was modified to suit the organisation's needs.

Scenario 2: Support new staff from CALD backgrounds

Seaview Residential Nursing Home was a large size nursing home that provided care services for 170 residents and employed 200 staff. Recently, the nursing home opened a new unit for 30 residents. This meant 50 new staff were employed in a very short period. Approximately 30% of the new staff were from new migrant and CALD backgrounds. The countries of birth of these new staff were mainly south Asian and African regions with some s from refugee backgrounds. These new staff brought their cultural richness to the nursing home and contributed to the cross-cultural care services. For example, their culture attracted residents to engage in conversations; and they offered different cultural activities to residents through various events organised by the lifestyle enhancement coordinator. However, in the regular survey with residents and staff, suggestions indicated that these new staff needed to improve their cross-cultural communication, and be familiar with the English names of items commonly used in daily care activities.

Identify learning needs

The care coordinator Judith organised a meeting with new staff and invited the educator, Jenn to participate in the meeting to find out the educational needs of these staff and how to meet their needs. A week prior to the meeting, Jenn distributed the 'Staff Cross-cultural Care Self-reflection Tool' to each new staff member and requested that they undertook the self-assessment. Jenn also encouraged them to list what they would like to learn to improve their cross-cultural interactions with residents and co-workers.

In the meeting staff confirmed that they encountered difficulties when communicating with residents and co-workers. They indicated that they would like to learn how to improve their cross-cultural communication. They also recognised that they would like to improve their knowledge about the care needs of residents from CALD backgrounds. They also said that they were not familiar with the names and pronunciations of items and equipment used in the nursing homes. This barrier affected the team work and productivity. They would like to have mentoring support so that they could learn and debrief with their mentors when needed.

Introduce learning resources

In the meeting, Jenn introduced 'Module 1: An Introduction to Cross-Cultural Care for New Staff', an online free access learning module to them. She also introduced the 'Work related English Language Resources for Staff' to these new staff. The resources provided photos and pronunciations of the commonly used items and the equipment needed for activities of daily living in the nursing home. She organised regular group sessions for them to discuss difficulties they encountered at work and the ways to overcome these difficulties.

Build mentoring support

Based on staff's requests for mentoring support, Judith reported to the management group and gained organisational support to develop a mentoring program for new staff. A two-way selection of mentor and mentees was undertaken to allow staff to choose their mentor or mentee. Jenn organised a training session for both mentors and mentees to introduce guidelines and activities into the mentoring program. The mentorship program was planned for 3 months, but could be extended based on individual needs. At the end of the mentoring program, the organisation formally issued a certificate to mentors and mentees. Mentors

were encouraged to use their experience in the support of new staff as evidence for promotion applications. Mentees were encouraged to be future mentors for new staff. The mentorship was evaluated to inform future mentoring programs within the organisation.

Sustain support for new staff

On the completion of the first round of the program for new staff, Jenn made a recommendation to the organisation to embed ‘Module 1: An Introduction to Cross-Cultural Care for New Staff’ and the mentoring program into the existing induction and orientation program in the organisation. The changes ensured all new staff recruited to the organisation were offered a comprehensive induction, orientation and mentoring support.

Scenario 3: Identify and meet CALD residents' dietary needs

Good Life Nursing Home was a mainstream nursing home and the vast majority of residents in the home were born in Australia. In recent years, the nursing home accommodated residents from CALD backgrounds and had 15 residents from various CALD backgrounds including India, the Philippines, China, and Vietnam. While these residents enjoyed their lives in their adopted new home, they also expressed concerns in a resident survey that their dietary preferences were not always met.

Audit activities

Care coordinator Mary appointed Registered Nurse (RN) Julie to undertake a cross-cultural care service audit using the 'Cross-cultural care service audit tool' to identify CALD residents' diet preferences and how these might be met. The findings from the audit activities enabled Mary to work with management group to develop a quality improvement plan to address the issues of concern.

Education interventions

Based on the evidence gathered from the cross-cultural care service audit, care coordinator Mary worked in partnership with CALD residents and their families to identify the best way to address dietary preferences. Realistic care plans were developed and agreed by CALD residents/families. An education session for all staff was offered to facilitate their understanding of culturally influenced dietary preferences and the most appropriate way to meet these preferences. Hospitality staff were offered an additional session to learn how to communicate with residents about their dietary preferences and the most practical way to meet these.

Evaluate the outcomes

Mary led the team in carefully monitoring the process and outcomes of meeting CALD residents' dietary preferences. The evaluation also included the cost of the cultural diet. Evidence showed that residents were satisfied with the outcome and the cost of the cultural diet was within budget.

Scenario 4: Facilitate positive cross-cultural interactions

Nursing home manager John was analysing incident reports and noticed some cross-cultural interaction issues as described in the following:

Incident 1: Residents refuse to be cared for by CALD staff

In the incident report, CALD staff reported that some resident said 'I don't want that negro coming to my room'. Some residents called staff 'a chocolate drop' and staff associated such language with racially negative attitudes towards them because of their skin colour.

Incident 2: Group alienation among staff

Recently an incident took place in the staff room over lunch. Dave and Tilly, both personal care workers, were having lunch and felt intimidated by a group of CALD staff members who were all originally from Greece and were talking in their native language. Dave and Tilly reported to the Registered Nurse in Charge, Elizabeth, that they were sick and tired of this group talking in a 'foreign' language whilst in the staff room and felt they were being talked about as at times, this group would look at them, say something, and then laugh.

Identify solutions

In responding to these incidents, John organised a meeting with residents/families to give them an opportunity to discuss their concerns about care services provided by staff. Most residents/families said they found CALD staff were very supportive, warm, and caring. However, they mentioned that they saw many new faces and knew little about their backgrounds. They said they were keen to learn more about staff from overseas in order to have them as part of their 'family members' in the nursing home.

John also organised a meeting with staff to facilitate discussions about how to build positive relationships with residents/families and positive inter-group interactions among staff members. Staff suggested that activities that promoted cultural exchanges in the nursing home were needed.

Appoint a Multicultural Workforce Development Champion

John discussed his plan for developing a cultural exchange program to address cross-cultural issues in the regular management meeting and gained support from the organisation to appoint a 'Multicultural Workforce Development Champion' to lead the program. RN Asha from an Indian background was appointed as the champion. She conducted consultations with residents and staff and developed the following activities in the nursing home:

- *Work with residents and families to create 'My Important Treasure'*: This activity enabled residents to identify an important personal artefact. The residents involved in the activity wrote a short paragraph about the artefact for inclusion on a poster. The posters featured a photo of the artefact and were displayed in the resident's room to inform staff and visitors of something of importance to them.
- *Work with staff to create a 'Rainbow folder'*: This folder encouraged staff to write short introductions to themselves, their culture, birth place, and photos and recipes they would like to share with others. The folder was displayed in the staff room and residents' activity rooms.

- *Organise cultural activities:* Asha led the team in organising cultural days, cultural food events, and identifying on a world map the birthplace of residents and staff so that they could get to know each other, and have positive conversations about their culture and experiences.
- *Introduce staff to 'Module 3: Cross-cultural leadership',* an online free access learning module, and encourage staff to select relevant case studies from this module to study.
- *Organise group discussions*: Asha also used activities introduced in the learning module to allow staff to discuss their concerns and identify positive solutions in cross-cultural interactions with residents and co-workers.

Leadership development of the Champion

RN Asha fully committed to her champion's role and facilitated positive cross-cultural interactions and relationship building between residents and staff and between different groups of staff. She carefully monitored the activities, and provided the management group with the process and outcomes of the cultural exchange program. The outcomes of the program provided the organisation with evidence to embed these activities into the system. After a year in leading the program, RN Asha demonstrated her leadership capabilities. The evidence of her leadership in leading the program was used in her application for promotion to a care coordinator in the nursing home. Her application was successful. She passed the champion's role to a new champion and provided mentoring support for the new champion.

Scenario 5: Embed the 'Cross-cultural Care Program for Aged Care Staff' into existing training programs

Coastal Residential Care was a large aged care organisation with multiple sites of residential aged care homes. The organisation had a high reputation and played a leading role in staff development in the industry. The organisation had a well-developed dementia care program and a palliative care program. In response to the increased diversity of residents and staff, the organisation undertook a staff survey and audited activities in dementia care and palliative care. The results from these two sources of evidence revealed that staff encountered difficulties and issues in dementia and end of life care when caring for residents from a culture other than their own. Staff said they would benefit from opportunity to learn more in these areas.

Plan learning activities

At the organisational level, the educator worked with managers and staff representatives to plan learning activities. They identified that 'Module 4: Cross-cultural dementia care' and 'Module 5: Cross-cultural end of life care' from the online free access program entitled 'Cross-cultural care program for aged care staff' were relevant to staff. They planned to support staff to engage in self-directed learning using the online program and organise regular group learning activities to discuss issues of concern in cross-cultural dementia care and cross-cultural end of life care. The educator applied the train-the-trainer model to strengthen support for staff in each nursing home. A site champion from each nursing home was selected and prepared to facilitate group learning.

Facilitate knowledge translation

The site champions were supportive of staff and ensured they engaged in the online program and used the self-directed learning portfolio to record their evidence of learning and knowledge translation. In group learning activities, site champions invited experts in dementia and palliative care to facilitate discussions and to encourage staff to share their experience in the areas of care services. The learning activities in these two modules were well-received by staff. Program evaluation revealed this program had a very positive impact on staff and the care outcomes for residents.

Summary

The opportunities to use the MCWD model and resources in the workplace are not limited to these five scenarios. At an organisational level, management is encouraged to apply the MCWD model during internal assessment of organisation's capacity to develop cross-cultural care services. This approach helps an organisation to not only develop and improve CCCS, but also to bring about organisational change to attract a skilled, inclusive and culturally competent workforce. This kind of workforce is the backbone of successful aged care organisations. The complexity in providing and improving CCCS is widely recognised. Aged care organisations are encouraged to build partnerships with universities and network with organisations who have demonstrated excellence in cross-cultural care services in order to apply best practice in the organisation's context.

Appendix 1 Job description for multicultural workforce development facilitators

During the project life, two Multicultural Workforce Development (MCWD) Facilitators (RN) were appointed to work with the project team to develop and implement a multicultural workforce development model and a staff education/training package to provide culturally-appropriate high-quality care to residents and to improve teamwork and inter-cultural communication in the workplace. The details of job description for the MCWD facilitator are listed below:

Summary of the role

A consortium of two aged care organisations, Resthaven Inc. and AnglicareSA Inc. has joined with Flinders University to undertake a project titled 'Developing the Multicultural Workforce to Improve the Quality of Care for Residents'. Two Multicultural Workforce Development Facilitators will be appointed to work with the project team to develop and implement a multicultural workforce development model and a staff education/training package to provide culturally-appropriate high-quality care to residents and to improve teamwork and inter-cultural communication in the workplace.

Key Responsibilities and Duties

1. Work collaboratively with the Site Manager, Project Team of the MCWD project and site staff to develop and implement a MCWD model which demonstrates how this can impact on positive outcomes for staff and residents across the residential aged care setting.
2. Accept accountability and responsibility for facilitation activities by:
    - 2.1. practicing within own abilities and qualifications
    - 2.2. ensuring the consistent application of policy framework by self and others
    - 2.3. Maintaining contemporary continued professional knowledge and skills in facilitation and mentoring through participation in professional development programs
    - 2.4. Providing facilitation, leadership and mentoring to staff
    - 2.5. Conducting internal audit and analysis of incident and other reports, policy, procedure and quality improvement activities to identify key factors enabling or impeding CCCS
    - 2.6. Conducting workshops and other consultations with managers and staff in order to determine a MCWD model and work with Flinders University collaborators to develop an educational package to support the model
    - 2.7. Developing, implementing and evaluating action plans to ensure the MCWD model is embedded in workforce development
    - 2.8. Assisting staff to identify individual learning needs and facilitating education and development opportunities to improve staff knowledge in cultural competency. This will include use of the developed education package and may include:
        - Skills demonstration assessment
        - Observation of task/skills and giving feedback
        - Discussion in small groups or one to one mentoring
        - Education presentations
        - Development or sourcing of learning materials
    - 2.9. Provide mentoring support to site champions

2.10. Ensure cultural competency practice is improved across site by:

- active involvement in the identification and implementation of relevant continuous improvement initiatives
- reviewing and assessing current methodologies, identifying and implementing strategies for Better Practice service provision for residents from CALD backgrounds
- active participation in and contribution to organisational meetings/consultations
- providing staff access to relevant cultural competence information

2.11. Ensure professional and articulate communication by:

- positively interacting with staff, members of the health team, residents and their representatives
- informing the management team of any relevant issues
- Identify a specific site-based champion(s) and provide mentoring/training and support for their site-based mentoring role

Essential criteria

1. Current registration as a Health practitioner with the AHPRA
2. Minimum of a 3-year experience in aged care

Desirable

1. Experience in working with Indigenous Australians and people from culturally and linguistically diverse groups
2. Knowledge of mentoring principles
3. Qualification or working towards a cert. 4 in Training and assessment or equivalent.

Appendix 2 Job description for multicultural workforce development site champions

During the project life, four Site Champions (RN) (one in each participating facility) were appointed to work with the project team to implement a multicultural workforce development model to provide culturally-appropriate high-quality care to residents and to improve teamwork and inter-cultural communication in the workplace. The details of job description for the MCWD facilitator are listed below:

Summary of the role

In accordance with the purpose and values of Resthaven, the Site Champion Multicultural Workforce Development Project will work collaboratively with the Multicultural Workforce Development Facilitator and site management in defined project activities associated with the mentoring of clinical and non-clinical staff at participating sites. This work will be undertaken in nominated workforce development priority areas and includes delivering education/training packages to support the improvement of teamwork and inter-cultural communication in the workplace.

Key responsibilities and duties

The site champion works collaborative to implement activities which support multicultural workforce development to demonstrate positive impact on outcomes for residents, their representatives, staff and volunteers within residential aged care services.

1. Accept accountability and responsibility by:
    - 1.1. Practicing within their professional scope of practice
    - 1.2. Ensuing the consistent application of Resthaven's policy framework by self and others
    - 1.3. Maintaining contemporary professional knowledge and skills in workforce development through participation in professional development program
    - 1.4. Providing on site leadership, direction and mentoring to staff and volunteers
    - 1.5. Supporting the implementation of action plans in relation to the identified workforce development priority
    - 1.6. Assisting staff to identify individual learning needs and facilitating opportunities for staff development within the identified workforce development priority area
    - 1.7. Providing education and development opportunities for staff to improve knowledge, job skills and effectiveness in the nominated workforce development priority area.
2. Ensure workforce effectiveness is improved by:
    - 2.1. Being actively involved in the identification and implementation of continuous improvement initiatives in the nominated workforce development priority area
    - 2.2. Identifying and reviewing best practice related to the workforce development priority area and facilitating staff access to the information
    - 2.3. Actively participating in organisational meetings/consultations to disseminate best practice knowledge
    - 2.4. Implementing the action plan in relation to the workforce development areas at the site which may include:
        - Staff education

- Observation of tasks/skills and giving feedback
- Discussion in small groups or one-to-one

3. Ensure professional communication by:
    3.1. Positively interacting with staff, members of the care service team, residents, resident representatives and volunteers
    3.2. Informing the management team and Multicultural Workforce Development Facilitator of any relevant issues.

Appendix 3 Cross-cultural care service audit tool

The cross-cultural care service audit tool is designed to assist staff to collect data to inform quality improvement activities. This audit tool is informed by the Availability, Accessibility, Acceptability and Quality (AAAQ) framework developed to address access and equity for consumers in government subsidised health and social care systems. The AAAQ framework is defined as follows in the cross-cultural care service context:

- **Availability:** The residential aged care home has a sufficient quantity of effective cross-cultural care services to meet the specific care and service needs of residents from culturally and linguistically diverse (CALD) backgrounds.
- **Accessibility:** The accessibility of cross-cultural care services for residents has four sub-dimensions: non-discrimination, physical accessibility, economic accessibility (or affordability) and accessibility of information.
- **Acceptability:** Cross-cultural care services are respectful and acceptable to residents, family and friends.
- **Quality:** Cross-cultural care services provided by staff demonstrate high-quality, continuous improvement against criteria/standards and is monitored in the aged care system.

The auditor needs to randomly select 5-10 residents from CALD backgrounds. The auditor needs to check care plans, progress notes, incident reports and interview residents/proxies to gather evidence. Besides these data collection methods, it is strongly recommended that the auditor observes the home for two hours on at least two consecutive days, to clarify evidence from other sources. Periodic audits are needed to provide evidence of the improvement of CCCS.

Name of residential aged care home: _____ Audit period: _____ Auditor: _____

Required Cross-cultural Care Service for residents	CCCS needs assessed & recorded at admission & via regular care plan review	Services are AVAILABLE for residents to meet their needs*	Services are ACCESSIBLE as needed*	Services are respectful/ ACCEPTABLE*	Services have met High- QUALITY standards*	Further actions are required
Score	*1=Not identified* *2=Partially identified* *3=Identified* *NA=Not applicable*	*1=Not available* *2=Partially available* *3=Available* *NA=Not applicable*	*1=Not accessible* *2=Partially accessible* *3=Available* *NA=Not applicable*	*1=Not respectful or acceptable* *2=Partially acceptable* *3=Respectful/acceptable* *NA=Not applicable*	*1=Met standards* *2=Continuous improvement* *3=Using robust evidence* *NA=Not applicable*	*Yes/No* *If yes, action plan needs to be developed*
Diet, drinking and dining activities that require special considerations in cross-cultural care services						
Needs associated with culturally appropriate dressing/make-up						
Ability to speak, read and write English and special considerations in cross-cultural communication						
Interpreter services needs and/or the need for working with family members as communication resources						
Sensory impairments that require special						

Required Cross-cultural Care Service for residents	CCCS needs assessed & recorded at admission & via regular care plan review	Services are AVAILABLE for residents to meet their needs*	Services are ACCESSIBLE as needed*	Services are respectful/ ACCEPTABLE*	Services have met High- QUALITY standards*	Further actions are required
Score	*1=Not identified* *2=Partially identified* *3=Identified* *NA=Not applicable*	*1=Not available* *2=Partially available* *3=Available* *NA=Not applicable*	*1=Not accessible* *2=Partially accessible* *3=Available* *NA=Not applicable*	*1=Not respectful or acceptable* *2=Partially acceptable* *3=Respectful/acceptable* *NA=Not applicable*	*1=Met standards* *2=Continuous improvement* *3=Using robust evidence* *NA=Not applicable*	*Yes/No* *If yes, action plan needs to be developed*
considerations in cross-cultural communication						
Cognitive impairment that requires special considerations in cross-cultural communication						
Religion/spirituality needs that require special considerations in cross-cultural care services						
Needs associated with cultural occasions/special dates of significance						
The need for regular activities/visits organised by CALD communities or interest groups						

Required Cross-cultural Care Service for residents	CCCS needs assessed & recorded at admission & via regular care plan review	Services are AVAILABLE for residents to meet their needs*	Services are ACCESSIBLE as needed*	Services are respectful/ ACCEPTABLE*	Services have met High- QUALITY standards*	Further actions are required
Score	*1=Not identified* *2=Partially identified* *3=Identified* *NA=Not applicable*	*1=Not available* *2=Partially available* *3=Available* *NA=Not applicable*	*1=Not accessible* *2=Partially accessible* *3=Available* *NA=Not applicable*	*1=Not respectful or acceptable* *2=Partially acceptable* *3=Respectful/acceptable* *NA=Not applicable*	*1=Met standards* *2=Continuous improvement* *3=Using robust evidence* *NA=Not applicable*	*Yes/No* *If yes, action plan needs to be developed*
Needs associated with Complementary and Alternative Medicine						
Needs associated with culturally/linguistically appropriate lifestyle						
Need to avoid cultural taboos, culturally unacceptable behaviours and language						
Need to avoid triggers that lead to difficult behaviours in cross-cultural interactions						
Needs arising from behavioural patterns related to cultural factors (i.e. sitting on the floor, not a chair)						

Required Cross-cultural Care Service for residents	CCCS needs assessed & recorded at admission & via regular care plan review	Services are AVAILABLE for residents to meet their needs*	Services are ACCESSIBLE as needed*	Services are respectful/ ACCEPTABLE*	Services have met High- QUALITY standards*	Further actions are required
Score	*1=Not identified* *2=Partially identified* *3=Identified* *NA=Not applicable*	*1=Not available* *2=Partially available* *3=Available* *NA=Not applicable*	*1=Not accessible* *2=Partially accessible* *3=Available* *NA=Not applicable*	*1=Not respectful or acceptable* *2=Partially acceptable* *3=Respectful/acceptable* *NA=Not applicable*	*1=Met standards* *2=Continuous improvement* *3=Using robust evidence* *NA=Not applicable*	*Yes/No* *If yes, action plan needs to be developed*
The need to use culturally and linguistically appropriate social worker and counselling services						
Others (add more rows if needed):						
Score:	**Mean=** **Total=**	**Mean=** **Total=**	**Mean=** **Total=**	**Mean=** **Total=**	**Mean=** **Total=**	

Key points from observations

Items as described in table above	Key points

Items as described in table above	Key points

Appendix 4 The Multicultural Workforce Management Audit Tool

The Multicultural Workforce Management Audit Tool has been designed to assist staff in management, education and training roles to collect evidence to inform staff development activities. The auditor needs to check relevant documents, staff meeting agendas, minutes, incident reports and interview staff to gather evidence. Besides these data collection methods, it is strongly recommended that the auditor observes in the home for two hours on at least two consecutive days, to gather evidence from other sources. Periodic audits are needed to provide evidence of the improvement of the multicultural workforce management.

Name of residential aged care home: _____ **Audit period:** _____ **Auditor:** _____

Support/resources for the multicultural workforce	**Score:** *1=Not met 2=Partially met 3=Met NA=Not applicable*	**Further explanations & actions**
Updated summary information on cultural diversity of the workforce are available for the public to access.		
Culturally acceptable behaviours/languages have been identified and presented in writing for staff to access.		
Buddy support for new staff from culturally and linguistically diverse (CALD) groups are available and tailored to their needs.		
Mentoring support for new staff on effective cross-cultural care services are available and tailored to their needs.		
Resources on enhanced cross-cultural care services are available for staff to access.		
Resources on enhanced cross-cultural communication with residents/their family and friends are available for staff to access.		
Resources on enhanced cross-cultural communication in the multicultural care team are available for staff to access.		

Support/resources for the multicultural workforce	Score: *1=Not met* *2=Partially met* *3=Met* *NA=Not applicable*	Further explanations & actions
In-service education sessions on cross-cultural care services are available for staff.		
Cultural exchange activities between staff and residents to enhance cross-cultural understanding are available.		
Cultural exchange activities for the care team to enhance cross-cultural understanding of team members are available.		
Cultural occasions/special dates for staff and the impact on rostering have been identified and managed.		
Policies which address dress/make-up/body markings for staff from diverse backgrounds are in place.		
Policies are in place to meet the specific needs of staff associated with their culture and religious beliefs.		
Culturally and linguistically appropriate counselling services for staff are available and accessible when needed.		
Incidents of cross-cultural communication, conflict in a team and racially negative attitudes/behaviours have been identified, investigated and resolved in a timely manner.		
Residents/family complaints on cross-cultural communication issues have been investigated and resolved in a timely manner.		
Other incidents and resolutions (please specify):		
Others (please add more rows if needed):		
Scores:	**Mean=** **Total=**	

Appendix 5 Organisational Support for Cross-cultural Care Services and the Multicultural Workforce Audit Tool

This audit tool is designed to assist aged care organisations to collect evidence to improve the system in order to enable cross-cultural care services for residents and to effectively manage human resources. The auditor needs to check relevant documents and interview key people in the organisation to gain evidence. Besides these data collection methods, it is strongly recommended that the auditor observes in the home for two hours on at least two consecutive days, to gather evidence from other sources. Periodic audits are needed to provide evidence of improvements in the organisational attributes that support cross-cultural care services and the development of the multicultural workforce.

Name of residential aged care home: _____ Audit period: _____ Auditor: _____

Demographic information of residents and staff

	Non-CALD	CALD	Total (%)	Country of birth if born overseas	Language spoken at home if speaking a language other than English
Residents					
Staff					

Organisational attributes	Score: *1=Not met* *2=Partially met* *3= Met* *NA=Not applicable*	Further explanations and actions
1. The organisation has updated data on the diversity of residents and staff.		
2. The organisation uses the updated data on the diversity of residents to inform CCCS development.		
3. The organisation's recruitment policies/guidelines/staff development/skill testing consider the requirement for culturally and linguistically appropriate care for residents.		
4. The organisation's recruitment policies/guidelines/staff development/skill testing considers the requirements for an inclusive and culturally competent workforce.		
5. The organisation has policies/guidelines/resources and supporting mechanisms to enable culturally and linguistically diverse (CALD) staff to adapt their practice in the organisation environment if needed.		
6. The organisation has resources and supporting mechanisms to enable culturally and linguistically diverse (CALD) staff to improve their English communication in the workplace.		
7. The organisation has education/training resources for staff to engage in continuing staff development to advance cultural diversity for residents.		
8. The organisation has personnel to manage issues arising from the diversity of the workplace.		
9. The organisation has systems and processes in place to ensure all staff know it is their responsibility to facilitate and advance CCCS for residents.		
10. The organisation has policies/ guidelines/procedures/resources for identifying and resolving racially negative attitudes/behaviours in the workplace.		
11. The organisation has culturally and linguistically appropriate counselling support for residents and staff when needed.		

Organisational attributes	Score: *1=Not met* *2=Partially met* *3= Met* *NA=Not applicable*	Further explanations and actions
12. Job descriptions for different levels and categories of staff /volunteers consider the performance of effective resident-staff and staff-staff cross-cultural interactions.		
13. Competency assessment for different levels and categories of staff /volunteers considers the performance of effective resident-staff and staff-staff cross-cultural interactions.		
14. Appraisals for different levels and categories of staff considers the performance of effective resident-staff and staff-staff cross-cultural interactions.		
15. Promotion policies/guidelines consider the performance of effective resident-staff and staff-staff cross-cultural interactions.		
16. Induction and orientation has an introduction to effective resident-staff and staff-staff cross-cultural interactions.		
17. Updated summary information on the multicultural workforce is available for residents, family/friends and potential service users to access.		
18. Others (please add more rows if needed):		
Scores:	**Mean=** **Total=**	

Appendix 6 Staff cross-cultural Care Self-reflection Tool

The Staff Cross-cultural Care Self-reflection Tool was designed for use by all staff including those in direct care, non-direct care and those in management, education and supervision roles. It has been developed using principles from 'Cultural Humility' which is described as developing a reciprocal and equal partnership when engaging in cross-cultural interactions. When you undertake self-reflection using this tool, please take notes to help you recognise your strengths and areas that need further development.

Cultural humility & it's attributes	Self-reflection cues	Notes
Respect for differences in values • **Capacity for reflection on cultural values and beliefs** • **Demonstrates self-awareness around cultural values and beliefs.** • **Ability to understand different values and beliefs** • **Explores, tolerates reconciles and respects others values and beliefs**	1. How would I describe my values to another person?	
	2. How might someone else's values differ to my own?	
	3. How do I engage with someone else who has different values to my own?	
	4. What do I do to ensure I don't impose my values on others?	
	5. How do I tolerate my co-workers' cultural values?	
	6. How do I encourage others to maintain their cultural and ethnic needs?	
	7. How do I celebrate with others their values and beliefs that are associated with culture and ethnicity?	
	8. How do I accommodate residents' values and beliefs and foster their health and well-being?	
	9. How do I actively seek out information about cross-cultural care?	
	10. How do I participate in cross-cultural activities and events?	

Cultural humility & it's attributes	Self-reflection cues	Notes
	11. How do I embrace working in a multicultural team as something to broaden my learning?	
Effective communication with residents and staff in cross-cultural interactions • **Ability to use a range of means to communicate with residents and staff from culturally and linguistically diverse (CALD) backgrounds** • **Able to engage with residents, their families and staff in English** • **Actively seeks knowledge and skills in cross-cultural communication**	1. Am I aware that I need to speak English in a clear way to minimise communication errors in cross-cultural interactions?	
	2. Should I use slang? Which slang? Why should I not use slang?	
	3. Do I use appropriate eye contact, body language, sign language and cue cards to assist with communication?	
	4. Is there a time when it is appropriate to use a language other than English in the workplace?	
	5. Am I aware that my accent might make it difficult for others?	
	6. Do I encourage the understanding of my own and other cultural norms, beliefs and common terms?	
	7. Do I seek confirmation that others have understood the conversation and how do I do show this aspect?	
	8. Do I practice or encourage others to practice English to improve communication?	
	9. Do I have patience to listen to residents and staff from culturally and linguistically diverse (CALD) backgrounds without interruption?	

Cultural humility & it's attributes	Self-reflection cues	Notes
	10. Am I willing to learn a few words from residents from culturally and linguistically diverse (CALD) background and communicate with them?	
Positive attitudes and actions in cross-cultural interactions with residents, families and staff • **Fosters high-quality cross-cultural care and services by working in partnership with residents and families** • **Contributes to an inclusive, cohesive workforce by supporting peers**	1. Do I actively seek and provide support for residents to preserve their cultures and beliefs that have positive outcomes for their well-being?	
	2. Could my interactions ever be interpreted as arrogant, or humiliating?	
	3. Do I actively seek to understand diverse cultures and beliefs of the residents and staff?	
	4. How can I include family members in care decisions to ensure I meet residents' cultural needs?	
	5. Where appropriate, how do I engage with visitors of residents from culturally and linguistically diverse (CALD) backgrounds to support their and the residents' needs?	
	6. How do I ensure resident's decision making is respected without imposing my values?	
	7. Do I contribute to resolve cross-cultural issues or cultural clashes in the workplace that have positive outcomes for residents' care and for workforce cohesion?	
	8. Do I know the process required to report and investigate a 'cultural' issue in the workplace?	

Cultural humility & it's attributes	Self-reflection cues	Notes
	9. Am I aware of workplace policies, legislation and standards that support cultural inclusion, equal opportunity, anti-discrimination and zero tolerance of racism?	
	10. Are there any continuous improvement opportunities related to high-quality cross-cultural care services	
	11. Are there any continuous improvement opportunities related to workforce cohesion in the multi-cultural workplace?	

Appendix 7 Cross-cultural Care Self-Reflection Tool for Leaders

This tool is designed for use by staff who are in management, supervision and team leader roles. It has been developed using the 'Australian Health Leadership Framework' (Health Workforce Australia 2013). When you use self-reflection tools, please take notes to help you recognise your strengths and areas that need further development.

Domains	Self-reflection Cues	Notes
Leads self	1. Am I aware of my own cultural values and beliefs and how these may impact on my practice in leading the team?	
	2. Do I understand and manage the impact of my cultural background, assumptions, values & attitudes on myself and others?	
	3. Do I promote understanding, respect and trust between different cultural individuals and groups?	
Engages others	1. Do I engage with others and act in accordance with values, beliefs and skills that facilitate cross-cultural communication?	
	2. Am I approachable and do I listen to differing cultural needs of both staff and residents?	
	3. Do I listen, inspire and enable staff and others to share ideas in improving cross-cultural care and services?	
Achieves outcomes	1. Do I work in collaboration with residents, their families and staff to set goals for cross-cultural care and services?	
	2. Do I motivate self and others to provide culturally appropriate care that contributes to continuous quality improvement?	
	3. Do I monitor and evaluate progress and am I accountable for culturally sensitive care?	
Drives innovation & improvement	1. Do I champion the need for innovation and improvement in cross-cultural care and services?	
	2. Do I build support for change, encourage diverse voices and consumer involvement in providing culturally appropriate care?	
	3. Do I communicate system and negotiate within and across care teams in providing culturally appropriate care?	
Shapes systems	1. Do I explore, implement and disseminate new care practices in regard to cross-cultural care and services?	
	2. Do I systematically maximise the potential benefit of change while minimising unintended consequences in providing culturally appropriate care?	

Appendix 8: Instructions for accessing the online Cross-cultural Care Program for Aged Care Staff

Step	How to do this
1. Accessing the program	Go to: www.flinders.edu.au/cross-cultural-care If you are not already registered with Open Learning, you will need to create a username and password before you start. Please follow these steps:
2. Create a username	A username is a personal ID for you to use online. It is also a way for you to remain anonymous when you are online. Some people use their initials and a favourite number, for example 'LBD2000'. You may have to try a few combination if someone else is already using the username you are trying.
3. Creating a password	Usually, a password must be 8 characters in length and have a mixture of letters and numbers, for example 'Banana25'. You may also like to add a capital letter.
4. Find the course	Search for 'Cross-cultural Care Program for Aged Care Staff' or use the link above
5. Get help with module navigation	On the Welcome page, there is information about how to move around within the modules and within the program.
6. Start the program	You will be able to view the whole program but only have to review modules that are relevant to your work.
7. Our survey	Your feedback is very important to us. Please complete our Survey for the modules you undertake. The survey will take under five minutes to complete. A link to the survey can be found in the Summary section.

Appendix 9 Cross-cultural Care Program for Aged Care Staff Self-directed Learning Portfolio

This self-directed learning portfolio provides you with a professional record that you have completed Each Module of the 'Cross-cultural Care Program for Aged Care Staff' and as evidence of professional development. The portfolio includes five parts:

1. A self-assessment of your prior learning
2. Your learning process
3. Discussions with your managers and supervisors
4. Your learning outcomes
5. Your manager or supervisor sign off.

You are encouraged to take notes as you complete the module. You may also attach relevant documentation such as procedures, articles and data sheets for future reference. You will need to interact with your managers and supervisors in the workplace to discuss and share your learning journey, working with them to improve quality of care for residents. You can also work with mentors and peers to complete this record.

Your name:
Your organisation:
Your position:
Your education/qualification:

Module 1: An Introduction to Cross-Cultural Care for New Staff

Self-assessment of prior learning

Select one option in each column

How much do I know about the following topics	Not at all	A little	Some what	Quite a bit	Very
Cross cultural care in the Australian aged care system					
Cross-cultural care services provided by the residential aged care home					
Self-assessment of my strengths and areas that need to be developed, when working with residents in cross-cultural care					
Self-assessment of my strengths and areas that need to be developed, when working with team members from multicultural backgrounds					
The resources and support available for staff to help them provide high-quality cross-cultural support for residents					
The resources and support available for team members to help them work with staff from multicultural backgrounds in a cohesive and collaborative way					

My learning process

List how you learned when completing the module	
The dates/times I used the module:	
The case studies I completed:	
What I learned from the module:	
What I felt I already knew:	
Other:	

Discussion with managers and supervisors

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

My learning outcomes

List what you learned when completing the module	
I have improved my knowledge and skills in the following areas:	
I have worked with managers or supervisors to improve the following areas in cross-cultural care for residents:	
I have improved my ability to work with co-workers from the following cultural backgrounds:	

Management or supervisor sign off

MODULE 1: An Introduction to Cross-Cultural Care for New Staff	
Name	
Title/role	
Signature	
Date	
Phone number	
Email address	

Module 2: Cross-Cultural Communication

Self-assessment of prior learning

Select one option in each column

How much do I know about the following topics	Not at all	A little	Some what	Quite a bit	Very
Cultural and linguistic characteristics of residents and staff in the residential aged care home					
The value of my culture and the cultural diversity of others					
Cultural competence and cultural humility in cross-cultural communication					
The challenges and opportunities in achieving cultural competency and cultural humility in: - **Cross-cultural communication between you and residents, and their family and friends** - **Cross-cultural communication between you and other team members**					
Resources and strategies to achieve cross-cultural communication in the workplace					
Applying effective cross-cultural communication					

Your learning process

List how you learned when completing the module	
The dates/times I used the module:	
The case studies I completed:	
What I learned from the module:	
What I felt I already knew:	
Other:	

Discussion with managers and supervisors

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

My learning outcomes

List what you learned when completing the module	
I have improved my knowledge and skills in the following areas:	
I have worked with managers or supervisors to improve the following areas in cross-cultural communication:	

List what you learned when completing the module	
I have improved my ability to communicate with co-workers from the following cultural backgrounds:	

Management or supervisor sign off

Module 2: Cross-Cultural Communication	
Name	
Title/role	
Signature	
Date	
Phone number	
Email address	

Module 3: Cross-Cultural Leadership

Self-assessment of prior learning

Select one option in each column

How much do I know about the following topics	Not at all	A little	Some what	Quite a bit	Very
The definition of a leader and leadership within the Australian Health Leadership Framework					
Applying leadership attributes to my practice in cross-cultural care services					
Leading and engaging with others to identify and meet residents' care needs in cross-cultural encounters					
Leading and engaging with others to identify and resolve potentially negative cross-cultural interactions in a timely and culturally appropriate manner					
Mentoring new staff, promoting self-care in the workplace and identifying culturally and linguistically appropriate counselling services for others					
Working in partnership with residents, their families and other stakeholders to enable an inclusive and culturally competent workforce					

Your learning process

List how you learned when completing the module	
The dates/times I used the module:	
The case studies I completed:	
What I learned from the module:	
What I felt I already knew:	
Other:	

Discussion with managers and supervisors

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

My learning outcomes

List what you learned when completing the module	
I have improved my knowledge and skills in the following areas:	
I have worked with managers or supervisors to improve the following areas in cross-cultural leadership:	
I have improved my ability to lead co-workers from the following cultural backgrounds:	

Management or supervisor sign off

Module 3: Cross-Cultural Leadership	
Name	
Title/role	
Signature	
Date	
Phone number	
Email address	

Module 4: Cross-Cultural Dementia Care

Self-assessment of prior learning

Select one option in each column

How much do I know about the following topics	Not at all	A little	Some what	Quite a bit	Very
The influence of culture in dementia care in cross-cultural interactions with residents and family members, and reflecting on my experiences					
Responding to residents from CALD backgrounds, including the use of appropriate assessment tools					
Communicating effectively in cross-cultural interactions with residents with dementia					
Applying person-centred dementia care principles to foster the quality of cross-cultural dementia care					
Identifying unmet needs in cross-cultural dementia care, working with the team to identify possible causes of changed behaviours and applying a person-centred approach to address changed behaviours					
Identifying and reporting other conditions residents with dementia may have developed					

Your learning process

List how you learned when completing the module	
The dates/times I used the module:	
The case studies I completed:	
What I learned from the module:	
What I felt I already knew:	
Other:	

Discussion with managers and supervisors

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

My learning outcomes

List what you learned when completing the module	
I have improved my knowledge and skills in the following areas:	
I have worked with managers or supervisors to improve the following areas of cross-cultural dementia care:	
I have improved my ability to work with residents with dementia from the following cultural backgrounds:	

Management or supervisor sign off

Module 4: Cross-Cultural Dementia Care	
Name	
Title/role	
Signature	
Date	
Phone number	
Email address	

Module 5: Cross-Cultural End of Life Care

Self-assessment of prior learning

Select one option in each column

How much do I know about the following topics	Not at all	A little	Some what	Quite a bit	Very
The influence of different cultures, spiritualties, religions, traditions on end of life care for the resident and their families					
The principles, guidelines and tool kit to support optimal end of life care and death for residents and their families from various cultural backgrounds					
Communicating effectively with residents and their families to enable high-quality cross-cultural end of life care					
How grief and loss is expressed by the resident's family and friends from various cultural backgrounds					
Applying culturally and linguistically appropriate support for the resident's family and friends who experience loss, grief and bereavement					
Applying peer support and self-care strategies to cope with loss, grief and bereavement that staff experience					

Your learning process

List how you learned when completing the module	
The dates/times I used the module:	
The case studies I completed:	
What I learned from the module:	
What I felt I already knew:	
Other:	

Discussion with managers and supervisors

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

Summary of discussion: topics and main points	Name of manager and supervisor (or mentor or peer)	Date

My learning outcomes

List what you learned when completing the module	
I have improved my knowledge and skills in the following areas:	
I have worked with managers or supervisors to improve the following areas of cross-cultural end of life care:	
I have improved my ability to work with residents the following cultural backgrounds who need end of life care:	

Management or supervisor sign off

Module 5: Cross-Cultural End of Life Care	
Name	
Title/role	
Signature	
Date	
Phone number	
Email address	

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