
Developing the multicultural workforce to improve the quality of care for residents: Final report



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Disclaimer:

This document is an education resource for staff and educators in residential aged care homes. The program is designed to assist staff to improve cross-cultural care for residents and to work with co-workers from diverse cultural backgrounds. The views expressed in the program are those of the authors and not necessarily those of the Commonwealth of Australia. Readers should be aware that the information presented in the program is not necessarily endorsed, and its contents may not have been approved or reviewed by the Australian Government Department of Health who funded the program.

Developing the multicultural workforce to improve the quality of care for residents: Final report

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Abbreviations

AAAQ	Availability, accessibility, acceptability and quality of care services
ACFI	Aged care funding instrument
ADLs	Activities of daily living
CALD	Culturally and linguistically diverse
CCC	Cross-cultural communication
CCCS	Cross-cultural care services
DBMAS	Dementia Behavioural Management Advisory Service
MCWD	Multicultural workforce development
MOOC	Massive Open Online Course
RACH	Residential aged care home
VET	Vocational education and training

Executive Summary

Cultural and linguistic diversity between residents and staff is significant in residential aged care homes in Australia. The diversity generates many opportunities for aged care organisations to address equitable and culturally appropriate care for residents. However, diversity can also be a challenge to achieving high-quality care for residents and to staff cohesion. This final report describes the project: 'Developing the multicultural workforce to improve the quality of care for residents'. This project was funded by the Australian Government Department of Health under the 'Service Improvement and Healthy Ageing Grants' in 2015. Flinders University, AnglicareSA Inc. and Resthaven Inc. formed the consortium to undertake the project led by Flinders University. Participating sites from these organisations included four residential aged care homes (RACHs). The aim of the project was to work with stakeholders to develop, implement and evaluate a multicultural workforce development model (MCWD), an education program and resources to support the implementation of the model. The specific objectives were to:

- identify key factors enabling or impeding cross-cultural care;
- 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/training package in workforce management and day-to-day staff activities; and
- evaluate the impact of the MCWD model on care outcomes and care staff.

A Critical Action Research approach was applied to achieve the aims and objectives described above. The project was completed in two phases over a 2-year period. In phase one (12 months), the project team undertook a comprehensive literature review to examine the current research evidence in cross-cultural care services in a global context. The project team also undertook a study of residents and staff experiences in cross-cultural care services in the four participating sites. Findings from the literature review and the study informed the development of the MCWD model and resources to support the implementation of the model. These resources are (1) Cross-cultural care toolkit, (2) Cross-cultural care self-reflection toolkit and (3) Cross-cultural care program for aged care staff. The project team engaged stakeholders and peers with expertise in the study field to discuss, comment and review the MCWD model and the resources in three consultative workshops and several rounds of peer reviews of written materials. Feedback from these activities enabled the project team to revise and improve the MCWD model and the resources.

In phase two (12 months), a site champion in each participating site was appointed by their organisation to implement the MCWD model, cross-cultural care toolkit, cross-cultural care self-reflection toolkit and cross-cultural care program for aged care staff. The site champions carefully planned their actions, undertook cross-cultural care auditing activities to identify the areas that needed to be improved, applied a variety of activities to engage residents and staff in process change and evaluated the outcomes of the activities they led. Site champions adapted the five learning modules from the 'Cross-cultural care program for aged care staff' to their learning environment and engaged staff in learning and knowledge translation processes. They

applied various activities to implement the program including one-on-one mentoring activities, group learning, self-learning and self-reflection. Site champions also participated in quarterly workshops facilitated by the project team to share their experiences in the project and discussed strategies and resources that were necessary for facilitating positive changes in cross-cultural care services. Findings from the analysis of their action plan, cross-cultural audit records, reports on the outcomes of their actions and staff focus groups supported the view that the site champions played a crucial role as change agents in improving cross-cultural care services. The site champion model was an effective model to enable quality improvements in cross-cultural care services.

The project team engaged residents and staff in project evaluation in phase two using multiple sources of data collected at 3 time points: (1) prior to the intervention in phase two (time 1); 6 months (time 2) and 12 months (time 3) after the commencement of the intervention. Data sources included: (1) a resident satisfaction survey; (2) a staff survey with regards to their perceived cultural competence and their perceptions of the capacity of their care home to create and sustain changes; (3) staff focus groups, (4) cross-cultural care audit records and (5) reports from site champions on their activities. The main findings are summarised below:

Improved resident satisfaction with cross-cultural care services

- There was no statistically significant difference between the Australian-born group and the Overseas-born group with regard to their satisfaction across the three time points.
- The proportion of residents who indicated their interactions with other residents showed a statistically significant increase from time 1 to time 2.
- Residents' satisfaction with interactions with other residents showed a statistically significant improvement from time 2 to time 3.
- Residents' satisfaction with the facilities' efforts to meet their language needs showed a statistically significant increase across the 3 time points.
- Residents perceived that a particular staff member/volunteer in the facility with whom they could speak in their language about their care showed a statistically significant increase across the 3 time points.

Improved staff perception of cultural competence

- Staff self-perceived knowledge, skills, comfort level, self-awareness, education and training showed a statistically significant increase. The increase of the scores in these areas between time 1 and time 3, is an indicator that a sufficient time period is needed for the intervention.
- Across the 3-time points, both Australian-born and overseas-born groups showed statistically significant increases in 'knowledge' scores.
- Prior to the intervention, overseas-born groups showed a statistically significant higher score of cross-cultural skills compared to the Australian-born group. Across the 3-time points, the Australian-born group showed a statistically significant increase of skill score while the overseas-born group showed no statistically significant change.
- Prior to the intervention, the overseas-born group showed a statistically significant higher score of 'comfort level' in cross-cultural interactions compared to the Australian-born group. Across the 3-time points, the Australian-born group showed a statistically significant increase of 'comfort level' score while the overseas-born group showed no statistically significant change.
- Prior to the intervention, the overseas-born group showed a statistically significant higher score of 'importance of awareness' compared to the Australian-born group. Across the 3-time points, the

Australian-born group showed a statistically significant increase of their 'importance of awareness' score while the overseas-born group showed no statistically significant change.

- Across the 3 time points, both the Australian-born and the overseas-born groups showed statistically significant increase in 'self-awareness' scores.
- Prior to the intervention, the overseas-born group showed a statistically significant higher score in 'Education and training' compared to the Australian-born group. Across the 3 time points, both the Australian-born and overseas-born groups showed statistically significant increases in 'Education and training.'

Staff satisfaction with cross-cultural education and training

- Staff showed significant improvement in satisfaction with education and training, the desire to learn and the impact of education or training on staff practice indicating changes in all three items.
- At time 2, the overseas-born staff showed a higher level of satisfaction with the quality of the cross-cultural care and service training compared to the Australian-born group. There was no statistically significant differences between the two groups at time 3.
- With regard to the survey question 'My desire to learn more about the cross-cultural care and service training', there was no statistically significant differences between Australian-born and overseas-born groups at time 2 and time 3.
- At time 2 there were no statistically significant differences between Australian-born and overseas-born groups with regards to the impact of the education program on their practice. At time 3 the overseas-born staff showed a higher agreement that the cross-cultural care and service training had a positive impact on their ability to cope with the demands in their work activities, compared to the Australian-born group.

Satisfaction survey with participants of the online program

By the 20th August, 2017, 215 people had participated in the program. Among them, 67 completed the online satisfaction survey. The survey included 6 questions using a 7 point-Likert scale with 1-7 representing strongly disagree to strongly agree respectively (4=neutral). The median satisfaction score was 6 and the IQR was 6-7. The results indicated a high satisfaction with the online program. Selected comments from the online survey were: (1) *This module would be extremely helpful to someone who has no experience working in a multicultural environment.* (2) *I have worked and lived all over the world and did have most of this knowledge but it is still helpful to refresh this knowledge.* (3) *I learnt a lot. Thank you.* (4) *Can we have another module regarding the behavioural management of cross cultural residents? Thank you!*

Findings from staff focus groups

In total, 37 staff from four participating facilities attended one of the six focus groups at time 2 and 37 staff from four participating facilities attended one of the four focus groups at time 3. Six themes were identified from focus group discussions. These themes were: (1) Leadership in cross-cultural interactions; (2) Engaging residents and staff in the project; (3) Perceived positive impact of the project on residents and staff; (4) Varied approaches to learning activities; (5) Challenges encountered; (6) Suggestions to embed the program into the organization's policies and practices. Detailed discussions on these themes are presented in Chapter 7.

Recommendations for improving cross-cultural care services for residents

- Recommendation 1: Residential aged care homes (RACHs) undertake regular cross-cultural care auditing activities using the cross-cultural audit tool to identify unmet care needs.
- Recommendation 2: RACHs negotiate with CALD residents and their families to provide culturally appropriate diets.
- Recommendation 3: RACHs have resources to assist CALD residents to communicate their care needs. Resources include but are not limited to interpreter services, culturally and linguistically appropriate assessment tools (for example using the Rowland Universal Dementia Assessment Scale or RUDAS), cue cards, iPads with translation Apps.
- Recommendation 4: RACHs provide opportunity for CALD residents who cannot speak English or have returned to their first language, to talk with community visitors (or staff) in their first language, as they desire, either by phone, social media or face-to-face
- Recommendation 5: RACHs support residents to access culturally and linguistically appropriate social worker and counselling services as needed.
- Recommendation 6: RACHs provide residents/family members with general information about the cultural and linguistic profiles of staff, activities to facilitate cultural exchange between residents and staff and general guidelines on cross-cultural interactions.

Recommendations for developing culturally competent workforce

- Recommendation 1: RACHs have selection criteria to guide staff appointments with regard to cultural competencies, cross-cultural care knowledge, skills and attitudes.
- Recommendation 2: RACHs embed the 'Staff cross-cultural Care Self-reflection Tool' and the 'Cross-cultural Care Self-Reflection Tool for Leaders' into staff performance review and staff development activities when appropriate.
- Recommendation 3: RACHs provide staff with education and training activities to meet their learning needs in cross-cultural care and team cohesion.
- Recommendation 4: RACHs provide 'buddy' support and mentoring support for new staff to learn cross-cultural care for residents and work effectively with co-workers from other cultures.
- Recommendation 5: RACHs provide new CALD staff who are also new migrants to Australia, with a tailored induction and orientation to enable them to understand the aged care system in Australia, and basic knowledge, skills and attitudes in cross-cultural communication.
- Recommendation 6: RACHs support CALD staff to overcome cross-cultural communication difficulties.
- Recommendation 7: RACHs support staff to engage in cultural exchange activities with residents and co-workers to enhance cross-cultural understanding.
- Recommendation 8: RACHs provide culturally and linguistically appropriate and accessible counselling services for staff when needed.

Recommendations for organisational support for cross-cultural care services and workforce development

- Recommendation 1: Aged care organisations have policies, structures, strategic plans and resources to support and sustain cross-cultural care services for residents.
- Recommendation 2: Aged care organisations have personnel at the organisational level capable to lead, coordinate and manage cross-cultural care for residents and workforce development. The multi-cultural workforce development facilitator position trialed in this project provides an example for aged care organisations to consider.

-
- Recommendation 3: Aged care organisations have personnel at their facility to champion and lead cross-cultural care services and team building. The site champion positions trialed in this project provides an example for aged care organisations to consider.
 - Recommendation 4: Aged care organisations have education and training programs to enable induction, orientation and staff development with regard to cross-cultural care services and workforce cohesion.
 - Recommendation 5: Aged care organisations have resources to support management to lead and resolve issues arising from cross-cultural interactions between residents and staff and between staff from different cultural backgrounds.
 - Recommendation 6: Aged care organisations recognise and reward staff members who contribute their bilingual and bicultural knowledge and skills to cross-cultural care for residents.
 - Recommendation 7: Aged care organisations train, recognise and reward staff members who contribute to 'buddy' support and mentoring support for new staff.
 - Recommendation 8: Aged care organisations engage stakeholders in consultations with regard to development and improvements in cross-cultural care services and the workforce.
 - Recommendation 9: Aged care organisations provide potential users and the public with general information about the cultural and linguistic profiles of staff, the availability, accessibility and quality of cross-cultural care services for users, and consumer expectations when using the services.

Conclusion

The implementation of the Multicultural Workforce Development (MCWD) Model and resources using the site champion model was associated with improved resident satisfaction with cross-cultural care services, staff perceptions of cultural competence, and experiences in cross-cultural interactions with residents and co-workers. There is a need to embed and sustain the MCWD model in residential aged care homes using the site champion model.

Chapter 1: 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 (Australian Institute of Health and Welfare 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 diversity generates many opportunities for aged care organisations to address equitable and culturally appropriate care for residents. The diversity can also be a challenge to achieving high-quality care for residents and for staff cohesion. The widely recognised issues of concern in the literature are: (1) cross-cultural communication barriers between CALD residents and staff that affect the ability of residents to adapt to the care home; (2) unmet care needs and preferences for CALD residents and (3) the lack of English proficiency of staff from migrant and non-English speaking countries that affects the communication and relationship building with residents and co-workers (Li et al. 2014, Runci et al. 2012). There is an increasing number of studies across the globe on the impact of cultural diversity of care workers on services (Nichols et al. 2015, Walsh and Shutes 2013), and factors affecting quality of care for residents from a CALD background in aged care homes (Kim et al. 2015, Runci et al. 2012). However, research on how to address these issues through a systematic approach that includes a workforce development model, resources and actions in an aged care system is scarce. This study addresses this gap in research by working with stakeholders in an Action Research project.

The global context of diversity in residential aged care

International migration has reached an unprecedented high and has had a significant impact on residential aged care globally. Many host countries have an increasing number of elderly migrants who are either part of the post-World War II migration or arrived as part of family reunion programs and they require access to residential aged care services (United Nations 2015, Westbrook and Legge 1991a). In 2015 the older migrant population reached 12% of the global migrant stock and the vast majority reside in developed countries (United Nations 2015). Additionally, the shortage of care workers in aged care in developed nations is viewed as a 'pull factor' attracting international migrants to work in the sector. In 2009 data from 14 Organisation for Economic Co-operation and Development (OECD) nations showed that migrant care workers increased by 50% between 1995 and 2006 and made up to 25% of the aged care workforce (Fujisawa and Colomboand 2009). Further, the flow of migrant care workers is from developing to developed nations and the cultures and languages of migrant care workers do not always match those they care for (Fujisawa and Colomboand 2009, World Health Organization 2015). In this global context, residential aged care homes are facing the double-challenge of providing high-quality care to frail older people and an increased cultural diversity that adds more complexities to care.

The cultural and linguistic diversity of both resident and staff populations means that cross-cultural communication (CCC) is extremely important in order to identify and meet residents' care needs. CCC is defined as 'the symbolic exchange process where individuals from two (or more) different cultural communities negotiate shared meanings in an interactive situation' (Ting-Toomey 1999, p. 16). Language

and communication are not only culturally-bound, but also socially constructed. Effective CCC entails intercultural understanding between the two parties involved (Ting-Toomey 1999). Studies identify that both residents and staff needed to learn from each other regarding the different meanings, manners, styles, accents and non-verbal body language (Walsh and Shutes 2013). It is important that CCC be embedded into the care provided for residents in aged care homes.

Studies have also identified that personal factors affect residents' adjustment to the care setting. Residents from a CALD background experience more challenges and difficulties in adapting to mainstream nursing homes compared with their peers from a non-CALD background. Food preferences are frequently reported as one of these personal factors that hinders residents from diverse ethnic backgrounds adjusting to mainstream aged care services (Hutchinson et al. 2011, Runci et al. 2014). Language preferences are an additional issue. A lack of meaningful conversations with peers and staff impeded residents from developing reciprocal relationships and a sense of belonging to the home (Walsh and Shutes 2013, Kim et al. 2014, Small et al. 2015).

Migrant care workers who provide care services for residents from the mainstream culture usually encounter cross-cultural communication difficulties (Bourgeault et al. 2010, Walsh and Shutes 2013, Nichols et al. 2015). In these studies, residents report that interactions with migrant care workers who have a low level of English proficiency can result in misunderstanding and errors. Residents might exhibit frustration, conflict, avoidance, negative attitudes and behaviours towards migrant care workers. Further, residents or their family members perceive that care activities provided by migrant care workers are more technical and task-orientated and lack components of affective care that are built on good communication (Walsh and Shutes 2013, Bourgeault et al. 2010).

The study context

In Australia the majority of overseas-born residents come from Europe (Mavromaras et al. 2017, Australian Institute of Health and Welfare 2016). 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, mainstream residential aged care homes (RACHs) also provide care services for residents from various CALD backgrounds (Runci et al. 2012, Xiao et al. 2017e). It is anticipated that the proportion of CALD residents in mainstream RACHs will increase given the increased diversity of the older population in Australia. More mainstream capacity building is required to ensure all residential aged care homes can support effective cross-cultural care services.

In the 2016 workforce census, 88% of residential aged care homes employed staff from CALD backgrounds and the majority of them came from South Asian and African regions (Mavromaras et al. 2017). It is estimated that the number of aged care workers will nearly triple from 366,027 in 2016 to 980,000 by 2050 (Productivity Commission 2011). Approximately 53% of residential aged care homes report skill shortages,

most commonly for Registered Nurses (RN) who usually take leadership, management and supervisory responsibilities (Mavromaras et al. 2017). The job vacancies attract CALD staff to work in the sector, especially those from new migrant backgrounds. The proportion of overseas-born staff in the recent hires (less than 12 months) category reached 40% in 2016. This group of staff expect to encounter more challenges in adapting their practice in RACHs compared with their non-CALD counterparts. It is important that RACHs have structured education and training programs to support them to assimilate to the system. 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 may contribute to the residential aged care services in Australia.

In this 2-year Action Research project, the project team worked with residents and staff from four mainstream RACHs. Cultural diversity in the four homes was evident. Up to 16% of residents were from CALD backgrounds. The workforce exhibited even greater diversity, with up to 50% of staff interviewed identifying as CALD (See Table 1.1).

Table 1.1 The dual nature of diversity in the four care homes

Code	No. of Residents	% of residents from CALD	No. of Staff	% of Staff from CALD
A	108	15%	126	26%
B	78	16%	98	49%
C	75	9%	112	50%
D	120	15%	145	50%
Summary	381	9-16%	481	26-50%

Note: CALD= culturally and linguistically diverse background

Aim

The aim of the project was to work with stakeholders to develop, implement and evaluate a multicultural workforce development model (MCWD), an education program and resources to support the implementation of the model. The specific objectives were to:

- identify key factors enabling or impeding cross-cultural care;
- 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/training package in workforce management and staff day-to-day activities; and
- evaluate the impact of the MCWD model on care outcomes and care staff.

Methodology and methods

A Critical Action Research approach was applied to achieve the aims and objectives described above. The MCWD model was developed in phase one (12 months) and implemented and evaluated in phase two (12 months). In phase one, a comprehensive literature review, interviews with residents/families and focus

groups with staff were used to identify factors affecting cross-cultural care for residents and team work. Findings informed a draft MCWD model, a cross-cultural care program and cross-cultural care toolkits. Consultative workshops with stakeholders were conducted to gain feedback and to revise the model and resources.

In phase two, four site champions were appointed by participating RACHs to embed the MCWD model, toolkits and the education program. Surveys on residents' satisfaction with cross-cultural care services, staff's perceived cultural competence, and the organisation's capacity to sustain positive changes in cross-cultural care were conducted three times (baseline, 6-month and 12-month) to evaluate the project. Focus groups with staff at 6 and 12 months after the commencement of the MCWD model were also conducted to ascertain staff experiences in the project.

The main outcomes of the project

In line with the aim and objectives of the project, the team worked with stakeholders to achieve these main outcomes: (1) The Multicultural workforce development (MCWD) model, (2) Cross-cultural care toolkit, (3) Cross-cultural care self-reflection toolkit and (4) Cross-cultural care program for aged care staff. These are introduced in the section below.

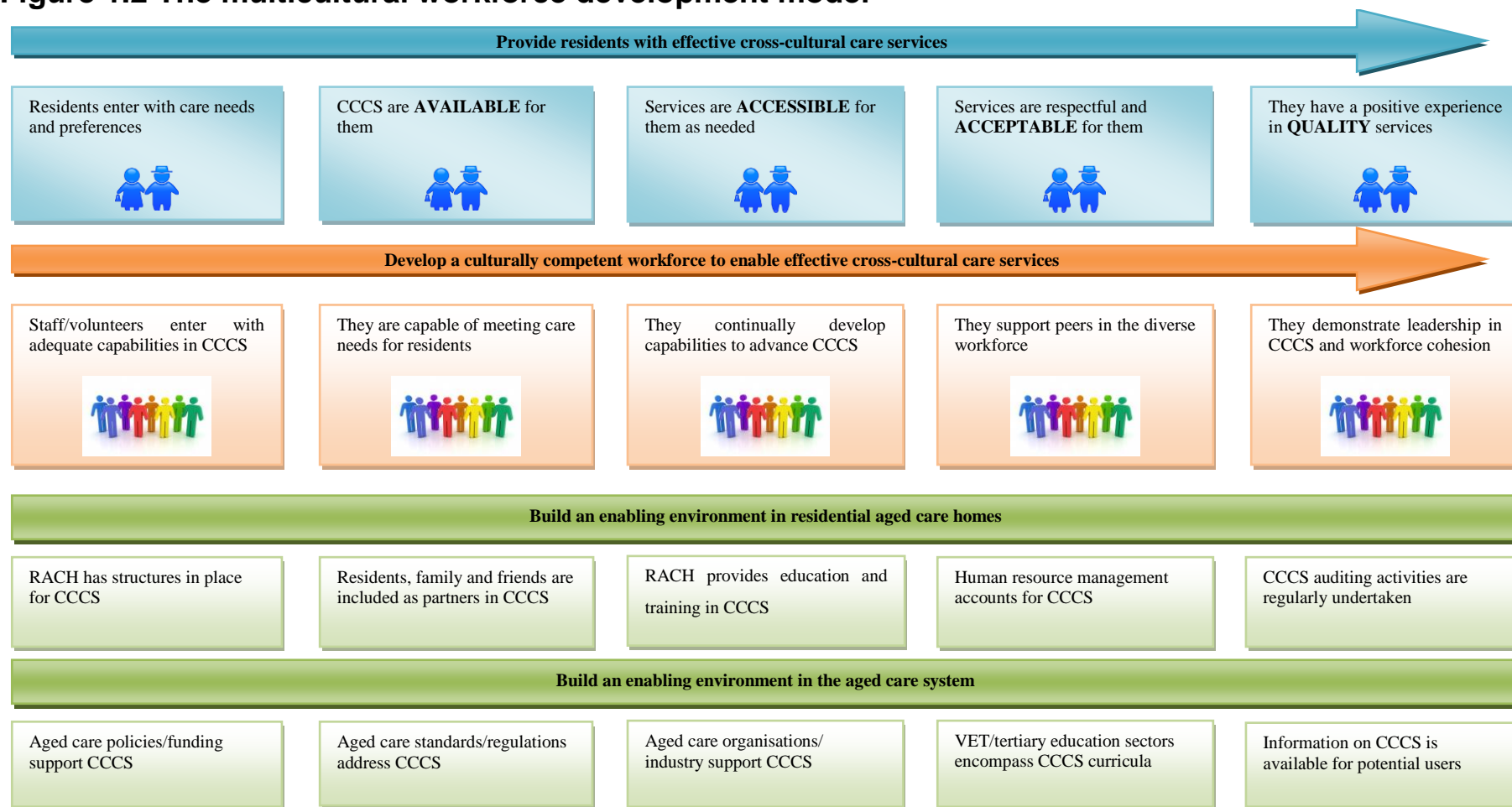
The MCWD model

The MCWD model conceptualised and explained 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

The conceptual model of the multicultural workforce development is presented in Figure 1.2. The explanations of the model are presented in a separate book entitled 'Multicultural workforce development model and resources in aged care' (Xiao et al. 2017b). The MCWD model provided the project team and stakeholders a road map to guide collaboration to improve cross-cultural care services for residents and to develop cultural competence in the workforce.

Figure 1.2 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

Cross-cultural care toolkit

The cross-cultural care toolkit assists aged care providers to collect data to improve cross-cultural care services (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) a Cross-cultural Care Service Audit Tool, (2) a Multicultural Workforce Management Audit Tool, (3) an 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 1-3.

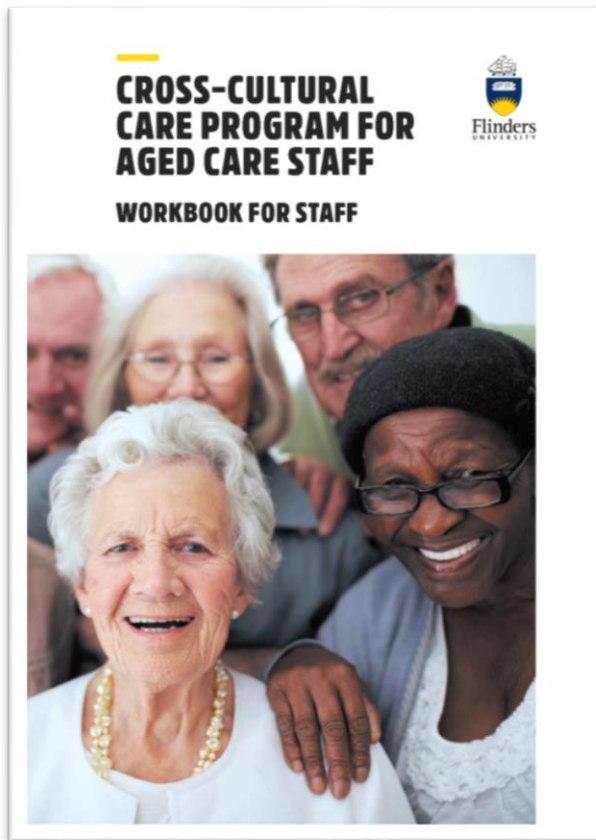
Cross-cultural care self-reflection toolkit

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 to 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 can seek learning opportunities and mentoring support to improve their performance. 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 4-5.

Cross-cultural care program for aged care staff

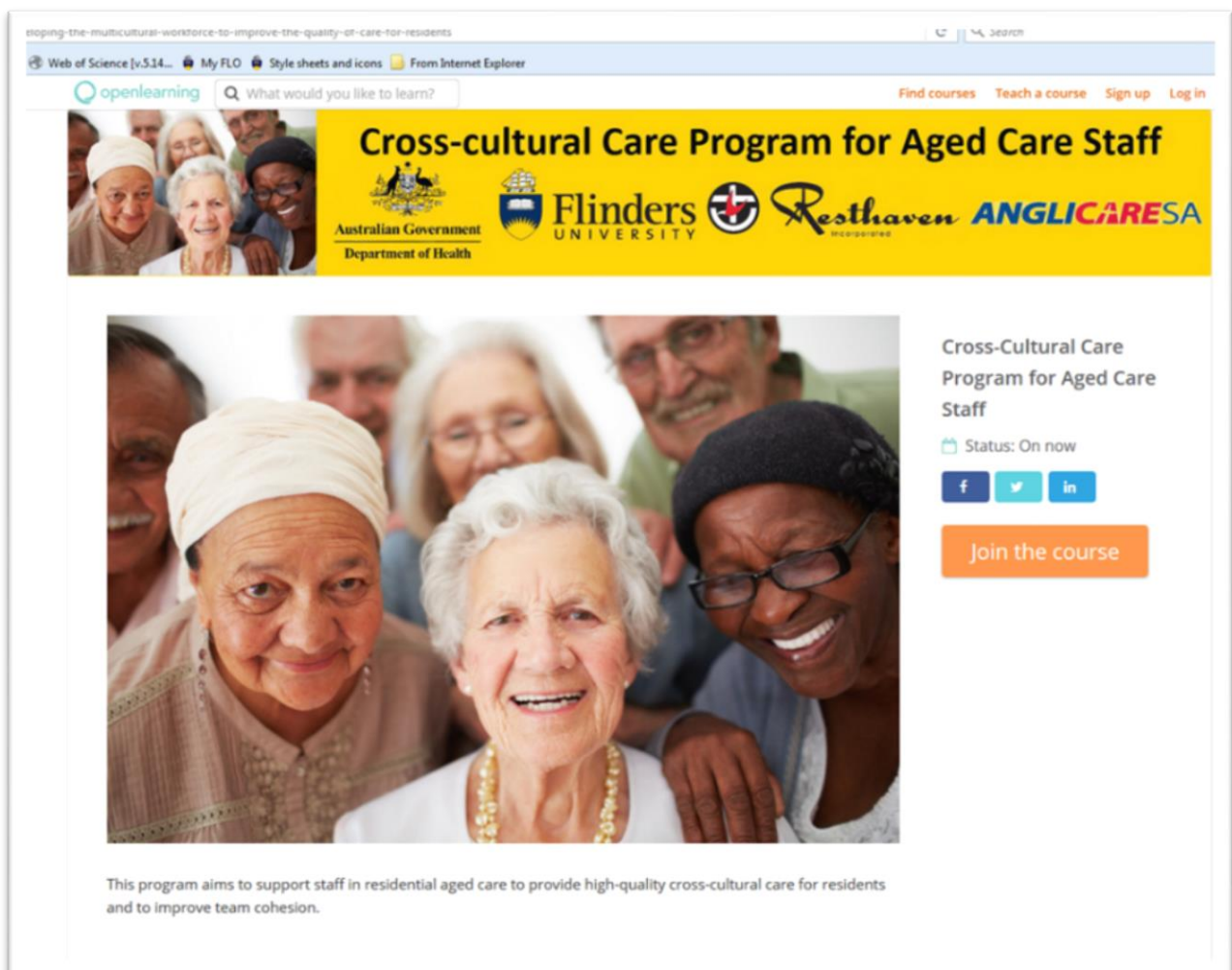
The program includes two separate books: (1) Cross-cultural care program for aged care staff: facilitator manual and (2) Cross-cultural care program for aged care staff: workbook for staff (Xiao et al. 2017c, Xiao et al. 2017d). During the life of the project, the team worked with residents and staff 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>



Cross-cultural care program for aged care staff on Massive Open Online Course (MOOC)

The program has been adapted into an online self-learning program using the Massive Open Online Course (MOOC) with free access (Xiao et al. 2017a). The online program aims to improve access to the education program and to give staff the opportunity to learn in a self-directed and flexible manner. Instructions for accessing the online program are presented in Appendix 6. 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 following picture shows the program website (www.flinders.edu.au/cross-cultural-care).



escaping-the-multicultural-workforce-to-improve-the-quality-of-care-for-residents

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openlearning What would you like to learn? Find courses Teach a course Sign up Log in

Cross-cultural Care Program for Aged Care Staff

Australian Government Department of Health Flinders UNIVERSITY Resthaven ANGLICARE SA

Cross-Cultural Care Program for Aged Care Staff

Status: On now

Join the course

This program aims to support staff in residential aged care to provide high-quality cross-cultural care for residents and to improve team cohesion.

Significance of the study

It is anticipated that many aged care organisations will implement a business development model that responds to the increased number of residents from diverse backgrounds and their care preferences associated with culture, language use, religious and spiritual needs. Currently, CALD staff make up one third of the workforce in RACHs (Mavromaras et al. 2017). It is evidence that the skill shortage in aged care is a pull factor that attracts people from migrant and CALD backgrounds to job vacancies (Bourgeault et al. 2010, Howe 2009, Walsh and Shutes 2013). Therefore, the proportion of this group in the aged care workforce will maintain the same or increase as aged care organisations continue to experience a workforce shortage. An explicit and evidence-based conceptual model of MCWD is much needed to address these factors and to provide policy makers, aged care organisations and other stakeholders with a road map for considering factors affecting cross-cultural care and policies, resources and business planning.

The demand for capacity building of education and research in the aged care sector is high in the context of increased consumer expectation of care services for residents and the need for a competent workforce to deliver high-quality care services (Barnett et al. 2015, Xiao et al. 2012). In this project developing an

evidence-based cross-cultural care program and toolkits through collaborative Action Research with stakeholders supported the capacity building of this care sector. Experiences from the implementation of the MCWD model, the education program and toolkits in real care settings provide invaluable evidence for others to consider further action in cross-cultural care and workforce development.

The structure of the report

The final report includes nine chapters. In Chapter 1, the aim, objectives, process and outcomes are introduced. A comprehensive literature review is presented and current research evidence in the study field is analysed and discussed in Chapter 2. In Chapter 3 the research design, methodology and methods used in phase one and phase two are presented and discussed. In Chapter 4 findings from resident perceptions of cross-cultural care services are reported. Chapter 5 presents staff perceptions of cross-cultural care services and the multicultural workforce. In Chapter 6 activities led by industry partners are analysed and reported. In Chapter 7 the findings from the project evaluation are discussed. Chapter 8 discusses the main findings from phase one and phase two of the project. The Report finishes with Chapter 9 Recommendations and Conclusion.

Chapter 2: Literature review

A comprehensive literature review was conducted in phase one and updated throughout the project. The literature review was planned to inform (1) the design of an original study on residents and staff experiences and perceptions in cross-cultural interactions; (2) the development of the Multicultural Workforce Development Model; (3) and the Cross-cultural Care Program for Aged Care Staff. This chapter reports the process and outcomes of the literature review.

Aim and objectives

The aim of the literature review was to search and critique the current research evidence on issues affecting cross-cultural care in residential care settings. The objectives of the literature review were to:

- identify factors enabling or impeding cross-cultural care; and
- identify factors enabling or impeding teamwork and team cohesion in multicultural care teams.

Methods

A literature review based on a systematic search of research articles in the study field was undertaken. Selected studies were critically reviewed with regard to quality of study and significant findings. The main findings were synthesised to address the aim and the objectives of the literature review.

Literature search strategies

Five databases that index research articles in health sciences, nursing and social sciences were searched. These databases are PubMed, CINAHL, Scopus, Web of Science and Science Direct. The search was limited to the past 10 years (2007 – 2017) and included only articles published in English. The reference lists of included articles were manually screened to identify further research articles. Google, Government websites and health professional websites were also searched to identify relevant 'grey literature' to be included in the discussion of main findings.

Key words and free words were used to search relevant studies. Boolean search strategies were applied by combining keywords. Key words used in database search were: ("aged care" OR "residential care facilities" OR "nursing home") AND ("cultural competence" OR "cultural humility" or "cultural safety").

Inclusion and exclusion criteria

Inclusion criteria for this review were:

- studies undertaken in aged care settings with multicultural populations of residents and staff
- studies on quality, care outcomes of residents from culturally and linguistically diverse backgrounds
- studies on policies, standards, governance, management, education and training, resources or monitoring in relation to the multicultural workforce
- studies reporting at least one of these results:
 - resident or their family experiences and perceptions in cross-cultural interactions
 - staff experiences and perceptions of cross-cultural interactions

- socio-cultural demographic profiles of residents and aged care workers in countries with multicultural populations

Articles that were did not meet these criteria were excluded.

Quality assessment of research articles

The critical appraisal tools used to evaluate rigour of the qualitative studies, quantitative studies, cross-sectional questionnaire survey, observational studies and randomised controlled trial were adapted from the 'Critical Appraisal Skills Programme' (CASP) (Critical Appraisal Skills Programme 2017).

Findings

In total, 827 articles were identified from the databases and 17 articles were included in the review (see Figure 2.1). The summary of the included articles is presented in Appendix 7.

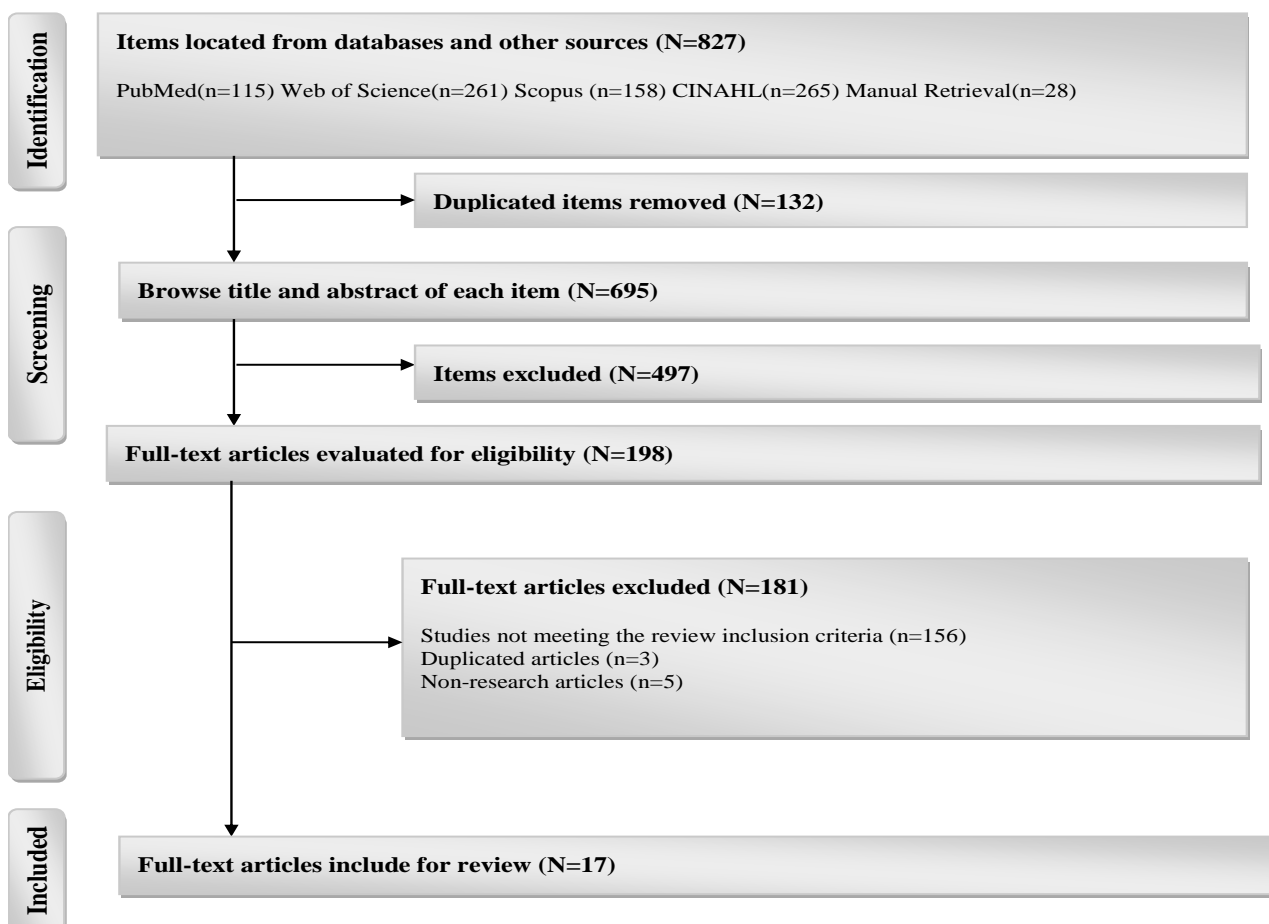


Figure 2.1 Flow diagram for the selection of studies included in the integrative review.

Five categories were identified from the analysis that addressed the objectives of the literature review. These were: (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; and (5) The need to build a responsive system. These categories are discussed in the section below.

Care disparities for residents from non-CALD and CALD groups

A body of evidence showed care disparities for residents from non-CALD and CALD groups. In an observational study on cross-cultural dementia care in Australia, resident-to-resident interaction rates were higher in ethno-specific nursing homes than in mainstream nursing homes (Runci et al. 2012). The study also showed that CALD residents with dementia living in ethno-specific nursing homes were associated with significantly lower rates of prescribed antipsychotic use (Runci et al. 2012). However, further analyses of factors contributing to this kind of disparity were lacking.

In a cross-sectional study in Australia, families of CALD residents living in mainstream nursing homes reported lower satisfactory levels for care services compared with those whose family members lived in ethno-specific nursing homes (Runci et al. 2014). In this study unmet care needs among CALD residents in mainstream nursing homes were resident-to-resident interactions, having opportunities to communicate with staff from the same language background and dietary preferences. This study echoed a number of larger survey studies from the USA where the families of residents from ethnic group showed lower level of satisfaction with care services and social engagements for residents (Li and Cai 2014, Li et al. 2014).

Poor staff-resident interactions in a nursing home that predominantly accommodated residents from ethnic backgrounds were attributed to staff having poor communication skills (Ryvicker 2011, Kim et al. 2015, Small et al. 2015). Conversely, staff with bilingual and bicultural backgrounds were associated with a higher rate of CALD consumer satisfaction with care services (Runci et al. 2014, Kim et al. 2015). In these studies low staffing levels were associated with low satisfaction with care services among families of CALD residents.

Cross-cultural communication challenges

Cross-cultural communication challenges were widely reported in the following group interactions: CALD residents to non-CALD residents, staff to CALD residents, non-CALD residents to CALD staff and staff communication in a multicultural team. CALD residents who spoke little to no English usually encountered greater challenges in interacting with non-CALD residents, had less social networks and engagements and were more likely to experience isolation (Runci et al. 2012, Ryvicker 2011, Casey et al. 2016). However, these studies mainly used questionnaire surveys or observations. In-depth understanding of possible solutions to these issues of concern and testing these solutions were not explored.

Research evidence revealed that effective staff to CALD residents communication had the following components: culturally appropriate verbal and non-verbal communication, learning greeting words from the

language of CALD residents and using these words to greet them, making allowances for CALD residents by simplifying words and sentences and using communication aids (Kim et al. 2015, Runci et al. 2012, Small et al. 2015). Ineffective staff to CALD resident communication had the following characteristics: a lack of awareness of culturally acceptable behaviours in communication, little knowledge about how to address residents in a culturally acceptable manner and an inability to use communication aids or resources (Kim et al. 2015, Runci et al. 2012).

CALD staff to non-CALD resident communication challenges were widely reported in the literature. The most frequently reported findings were: the lack of English proficiency of CALD staff, strong accents that affected residents' understanding, lack of vocabulary related to western food, dress, items and equipment that were commonly used in the care settings and unfamiliarity of colloquialisms/slang used by residents (Nichols et al. 2015, Ow Yong and Manthorpe 2016, Walsh and Shutes 2013). As communication is a two-way interaction, effective communication was also associated with non-CALD residents' effort to facilitate communication. Positive attitudes towards and tolerance of CALD staff were identified as enablers for achieving effective communication. Residents' racially negative attitudes and verbal aggression towards CALD staff were reported and were associated with staff avoidance behaviours towards residents by which relationships and quality of care were also negatively affected (Nichols et al. 2015, Ow Yong and Manthorpe 2016, Walsh and Shutes 2013).

Communication challenges in a multicultural team were widely reported. Factors enabling team communication included peer support for CALD staff to adapt communication and practice in the workplace and to be inclusive, respectful and tolerant of each other's cultures, values and beliefs (Nichols et al. 2015, Ow Yong and Manthorpe 2016). A study on Indian migrant care workers in the UK identified that it would take a considerable time (at least two years) for this group of care workers to adapt their communication and practice in the care homes (Ow Yong and Manthorpe 2016). A study on migrant care workers in Australia supported these findings, suggesting that mentoring support for migrant care workers helped them to smooth the adaptation and learn in a safe environment (Nichols et al. 2015). Migrant care workers acknowledged that they were not familiar with items and equipment used in nursing homes leading to an impact on team work (Nichols et al. 2015). Providing CALD care workers with English language support and recruiting staff with sufficient English proficiency for the job were also suggested as enablers to team communication. Barriers to communication in the multicultural team were described as lack of tolerance of each other's culture, cultural bias and prejudicial attitudes toward staff based on their skin colour and culture (Nichols et al. 2015, Ow Yong and Manthorpe 2016).

Relationships shaped by culture and language use

A study in Australia reported resident to resident relationships in a mainstream nursing home where 36% of the residents participating in the study were from CALD backgrounds (Casey et al. 2016). Findings revealed that residents did engage in friendship and positive social networks. Those with dementia perceived less social support. However, little is known about whether non-CALD and CALD groups showed differences regarding their engagement in friendship and social networks due to lack of comparisons in the study.

Two studies reported three types of CALD staff relationship with residents: 'professional relationship', 'friendly relationship' and 'discriminatory relationship' (Bourgeault et al. 2010, Walsh and Shutes 2013). Professional relationships were described as client-service provider relationships with little additional interpersonal attachment while 'friendly relationship' was described as reciprocal relationship with interpersonal attachment. Residents' perceptions of caring behaviours of CALD staff contributed to these two types of relationships. Residents strongly believed that CALD staff needed to learn their culture in order to know the most appropriate way to identify and meet their care needs (Bourgeault et al. 2010). 'Discriminatory relationships' were mainly associated with racially negative attitudes and behaviours towards CALD staff. This relationship was associated with the psychological stress that CALD staff experienced and resulted in them avoiding the residents (Berdes and Eckert 2007, Nichols et al. 2015). These relationships may have had a negative impact on staff job satisfaction and their commitment to high-quality care.

Positive inter-group relationships between staff were reported and were associated with cultural exchange, respect and understanding each other's culture, beliefs and values, and support for each other (Nichols et al. 2015, Ow Yong and Manthorpe 2016). Mentoring support for new staff contributed to CALD staff assimilating with the team and relationship building (Nichols et al. 2015). However, group alienation was also reported in these studies, for example, speaking a language other than English with staff from the same cultural group by which other staff had a sense of being excluded. Tensions between staff from different cultures existed and were associated with cultural bias, prejudicial attitudes toward other cultures, different approaches to caring for residents and lack of English proficiency of CALD staff that slowed down teamwork (Nichols et al. 2015, Ow Yong and Manthorpe 2016).

Cultural and linguistic assets of staff

The frequently mentioned advantages of employing CALD staff in nursing homes included: their bilingual and bicultural background that contributed to culturally appropriate care and social interactions with CALD residents. CALD staff were purposively recruited to care for residents from the same cultural backgrounds in ethno-specific nursing homes and residents/families showed higher levels of satisfaction with this kind of cultural and linguistic concordance in care (Kim et al. 2015, Runci et al. 2012). CALD staff with cultural and linguistic assets were also highly valued by CALD residents living in mainstream nursing homes (Nichols et al. 2015, Small et al. 2015). They played a key role in helping CALD residents in cross-cultural communication with others and as cultural brokers in mediating cross-cultural understanding of the care needs of residents and the way to meet their needs. The Australian 2007 and 2012 aged care workforce census reports show consistently that around 38.0% of RNs from North-East Asia used a language other than English in their employment in nursing homes (Isherwood and King 2017). However, studies on organisational policies, recognition and awards for staff cultural and linguistic assets are scarce.

Evidence also showed that CALD staff are able to apply their culturally-educated values of caring and respect for older people to their practice to enhance their relationships with residents (Berdes and Eckert

2007, Walsh and Shutes 2013). When confronted with racial discrimination these cultural values enabled them to resolve conflict with residents in a positive manner and they gained strength to help maintain their professional relationship with residents (Berdes and Eckert 2007, Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013).

Demand for building a responsive system

While issues arising from the increased cultural and linguistic diversity in nursing homes in developed nations are described above, studies identified that the aged care system is slow to respond (Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013). Commonly mentioned recommendations from stakeholders for building a responsive system to better govern diversity in nursing homes were: policies and service development to ensure CALD residents' care needs were met; support for CALD staff to assimilate to the aged care system by providing education, training, mentoring support and English language support; cultural exchange between residents and staff, and between staff from different cultures to enable positive group interactions.

The commonly mentioned unmet care needs for CALD residents included dietary preferences, communication needs, social engagement with people from CALD communities and leisure activities that reflect their life style (Kim et al. 2015, Runci et al. 2012, Runci et al. 2014, Small et al. 2015). The lack of cross-cultural communication and cross-cultural dementia care for residents were recognised as the main challenges in nursing homes (Kim et al. 2015, Runci et al. 2014, Runci et al. 2012). Education and training for staff were strongly suggested as a positive solution to these issues. However, studies on cross-cultural care programs for all staff were scarce. Although poor English proficiency among CALD staff was widely reported as a barrier to interaction between residents and care workers (Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013), English language programs to support new migrant care workers were rarely reported in the literature.

In Australia, CALD staff make up one third of the workforce in residential aged care homes (Isherwood and King 2017). CALD staff are mainly from Asian and African countries where residential aged care is underdeveloped and most of these CALD staff had not been exposed to the aged care setting. CALD staff also had less working experience in the care setting in Australia compared with Australian-born group. These were seen as indicators of lack of experience and unfamiliarity with this care environment (Isherwood and King 2017, Nichols et al. 2015). CALD staff, especially CALD RNs make up a large proportion of the aged care workforce, and are under-represented in leadership positions (Isherwood and King 2017). A systematic approach to support this group to develop their leadership potential was valued as a way to improve equal opportunities for all, and to enhance career development, retention and workforce cohesion. Evidence of organisational awards for staff who had contributed to culturally and linguistically appropriate care for residents was lacking, but this was suggested as a way to improve productivity and cost-effective care in a multicultural society (Isherwood and King 2017, Nichols et al. 2015).

Although studies reported different forms of discrimination and racially negative attitudes towards CALD staff and that CALD staff might experience additional job strain due to discrimination in the workplace, evidence on how to manage this kind of issue and the education required to prevent similar issues was lacking (Berdes and Eckert 2007, Nichols et al. 2015, Walsh and Shutes 2013). The research from Australia and the USA reports that CALD staff receive lower working hours, fewer shifts per fortnight and lower payment compared with non-CALD staff (Hurtado et al. 2012, Isherwood and King 2017). Studies also reported that CALD staff who encountered racially negative attitudes and behaviours experienced psychological distress or even cultural shock, but they rarely received culturally and linguistically appropriate health counselling services (Nichols et al. 2015, Walsh and Shutes 2013). Organisational responses to these issues, including resources and support are much needed.

Discussion and implications

The findings from the literature review reveal that factors affecting cross-cultural care services in residential aged care homes can be grouped as (1) resident factors: examples are resident 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 knowledge, skills and attitudes in cross-cultural interactions; and (3) system factors: examples are policies, 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. The intersection of these three groups of factors requires a systematic approach in order to overcome the barriers to cross-cultural care services

The World Health Organization (WHO) report, 'World Report on Ageing and Health', suggested that effective care and services for achieving equity-based aged care should have four core domains: availability, accessibility, acceptability and quality of care services or AAAQ domains (World Health Organization 2015). The AAAQ domains have also been highlighted as a suitable framework to support "A human rights approach for ageing and health" in Australia (Australian Human Rights Commission 2012b). The AAAQ domains emphasise (1) effective care services, (2) care recipients control and engagement and (3) human resource development. The care disparities for CALD residents living in mainstream nursing homes identified in the literature strongly suggest that capacity building to improve the availability, accessibility, acceptability and quality to meet residents care preferences is much needed. Such capacity building should involve stakeholders and include residents/families as partners in the process. A model of multicultural workforce development that provides a road map for the aged care industry to enable their efforts and commitment to address the care disparities is required. Resources including education and training programs and toolkits to assist staff to implement the model need to be developed.

Challenges reported in cross-cultural communication and care services strongly suggest that a systematic approach to developing a cross-cultural care program for staff and making the program accessible for all is imperative. Aged care is viewed as lacking resources and the capacity to support education and research compared with the acute hospital sector (Barnett et al. 2015, Xiao et al. 2012). Although much cross-sector effort has been made to invest in education and research in aged care, cross-cultural care education has

not been the main focus. As communication is a two-way interaction concerning all parties involved in the communication, all staff should be engaged in the education. The focus needs to be on improved staff capability to apply cross-cultural care knowledge, skills and attitudes to their own practice. An experiential learning approach supported by case studies, group activities and reflections is widely recognised as an effective way to achieve knowledge translation in the workplace (Straus et al. 2009). The Train the Trainee model is recognised as a feasible learning approach for such programs that involve large numbers of staff (de Beurs et al. 2015, Franzmann et al. 2010).

Positive relationship between residents, between residents and staff and between staff are paramount for fostering high-quality cross-cultural care services and improving resident and staff cross-cultural experiences. Findings from the literature review indicate that cultural exchange and activities that enable residents and staff to understanding each other's cultures may improve relationships (Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013). However, most studies on cross-cultural relationships among different groups in nursing homes were based on qualitative or quantitative surveys. Interventional studies that provide evidence on improved relationships are scarce.

The idea of building ethno-specific nursing homes to enable cultural and linguistic concordance between residents and between residents and staff support the finding that staff with bilingual and bicultural backgrounds have much to offer to improve culturally and linguistically appropriate care for CALD residents in a multicultural society (Department of Health and Australian Government 2012). There are potential social and financial benefits for the government, the aged care industry and other stakeholders to work in collaboration to officially recognise and accredit staff with bicultural and bilingual knowledge and skills to sustain high-quality cross-cultural care and improve leadership development of this group of staff. Considering that CALD staff have less experience in residential aged care and make up a large proportion in the newly hired staff category (Isherwood and King 2017, Mavromaras et al. 2017), tailored induction and orientation programs for this group of staff are needed in order to smooth their assimilation to the system.

Summary

The systematic approach to the literature has enabled the project team to carefully analyse the current research evidence on factors affecting cross-cultural care for residents and workforce cohesion. Findings from the literature review support a systematic approach to address care disparities for residents and to enhance workforce development. This approach needs to take account of the organisational structure, a multicultural workforce development model, cross-cultural education programs and relevant resources to support the implementation of the workforce model. Interventional studies to achieve these outcomes are required to produce research evidence to improve the system. This project explores interventions and resource development based on findings from the literature and an Action Research approach as presented in the following chapters.

Chapter 3: Methodology and methods

Findings from the literature review enabled the project team to plan the study to identify issues of concern in cross-cultural care services in residential aged care homes, the most appropriate interventions to these issues and to evaluate the outcomes. This chapter presents the methodology and methods of the study.

Aim

The aim of the project was to work with stakeholders to develop, implement and evaluate a multicultural workforce development model and an education program and resources to support the implementation of the model. The specific objectives were to:

1. identify key factors enabling or impeding cross-cultural care;
2. identify key issues experienced by multicultural care teams that impact on teamwork and quality of care;
3. determine a multicultural workforce development (MCWD) model to address the key factors and issues identified;
4. develop an education program to support the MCWD model;
5. embed the MCWD model and education/training package in workforce management and staff day-to-day activities; and
6. evaluate the impact of the MCWD model on care outcomes and care staff.

The project team achieved the objectives 1-4 in phase one of the project over a 12-month period and achieved objectives 5-6 in phase two. The processes in each phase of the project are presented below.

Methodology

The project applied a Critical Action Research framework to achieve the study objectives. Principles that underpin the Action Research are: (1) considering structures, processes and resources that enable stakeholders to take action to improve cross-cultural care services for residents; (2) modifying the course of action or activities based on consultations with stakeholders; and (3) valuing stakeholders' engagement, experiences and satisfaction with the project.

Action Research enables stakeholders in a project to be both co-researchers and co-subjects in the process of action-reflection (Heron and Reason 2001). There are four elements that Action Researchers undertake: identifying problems in practice, planning actions, implementing-monitoring-modifying actions, and evaluating outcomes of actions (see Figure 3.1) (Xiao et al. 2012, p. 324). Among different types of Action Research, critical Action Research was the most suitable for this project in that it aimed to engage and empower all stakeholders in the process of change and sustained changes by creating a suitable social structure with adequate resources and supporting mechanisms (Kemmis 2001). The study adopted Giddens' Structuration Theory (Giddens 1984). This theory provides one avenue for analysing social structures that shape people's actions, and illustrate changes in ways that are realistic and practical. Social structure, as used by Giddens, refers to the 'rules and resources' associated with the exercise of power over people's actions (Giddens 1984, p.25). The rules in a society are either formal (legislation and policies) or informal (tactical and cultural norms). Resources are divided into allocative and authoritative resources,

with the former concerned with the material resources (infrastructure), and the latter dealing with the capability of harnessing human activities. Social structures and people's actions (or agency) are not separated as 'a dualism', but are 'a duality', inseparable and shaped by each other (Giddens 1984, p.25).

Structuration Theory enabled the project team not only to interpret the perceptions of residents and staff of factors affecting cross-cultural care services and workforce cohesion, but also to critically reflect on the interplays between structural power and human agency. Collective critical reflection with stakeholders is at the heart of the process of critical Action Research. This kind of reflection requires all stakeholders to engage in egalitarian dialogue on challenges and barriers affecting cross-cultural care services for residents and the workforce cohesion. Changes in workforce development are based on a new understanding of how social structures (rules and resources) enable and inhibit cross-cultural care services and team work.

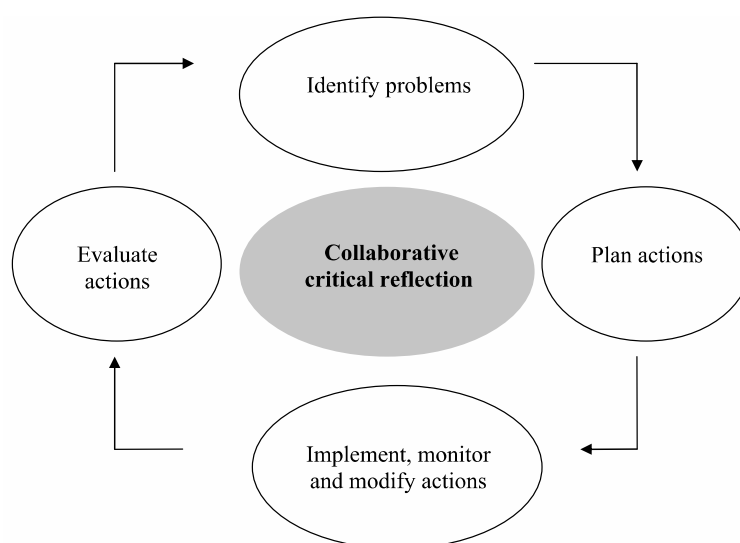


Figure 3.1. The process of action-reflection cycle

Project management structure

The project management structure that governed this project is presented in Figure 3.2. The structure is designed to ensure the project objectives were achieved. A Steering Committee was established to oversee the project. Committee members included the project team on the grant, Project Manager and MCWD Facilitators from Consortium members of AnglicareSA Inc. and Resthaven Inc.. The Committee members met monthly to discuss the progress, findings and issues identified in the project and to advise solutions. The Steering Committee also published quarterly project Newsletters to inform residents, their families and staff as well as consortium members of the processes and outcomes of the project. Residents/families and staff were encouraged to contribute short articles, photos or other materials that enhanced cultural exchange and cross-cultural communication. The project team on the grant played a key role in disseminating the project results.

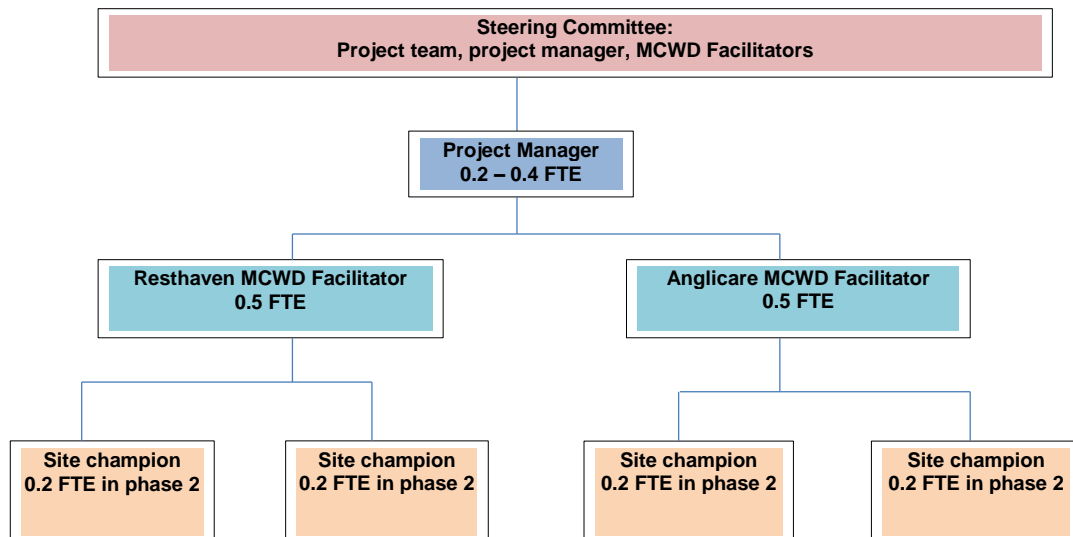


Figure 3.2 The project management structure

A project manager (0.2-0.4 FTE) was appointed to maintain open and regular communication with all partners, undertake data collection, analyses and project reporting. A MCWD facilitator (0.5 FTE) was employed by each industry partner to assist in data collection within their organisation, and develop and implement the MCWD model across multiple sites in collaboration with the project team. In each participating site one champion (0.2 FTE) was appointed in phase two. The job description of MCWD facilitator and site champion are presented in Appendix 8 and Appendix 9. The MCWD facilitators and site champions worked under the leadership of the representatives of the two industry partners to embed the ‘Multicultural workforce development (MCWD) model’, the ‘Cross-cultural care program for aged care staff’ and other cross-cultural care resources in workforce management and staff day-to-day activities.

Outline of processes of the project

The project team conducted the project in two phases to achieve the six objectives as described above. The main processes in each phase are summarised in Table 3.1 and the main points are discussed as follows:

In phase one the team developed a project plan that included activities to address the objectives. Throughout the project, the team evolved and modified the planned activities in response to feedback from stakeholders in consultative workshops, regular meetings with industry partners, MCWD facilitators and site champions. The co-developing and modifying actions ensured that the activities and outcomes were acceptable to stakeholders and feasible in the implementation phase. For example, stakeholders argued that staff might have a fear of utilising the skillset the project team planned to develop as they might attribute failure to meet the skillset with being dismissed or other negative consequences. They suggested that developing a self-reflection tool 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 by replacing the skillset with a

'Cross-cultural care self-reflection toolkit'. Other examples of the changed action plan were to replace the measure of quality indicator and adverse events from the evaluation plan with self-assessment of cross-cultural care services by site champions using the cross-cultural care services audit toolkit.

In phase two, MCWD facilitators and site champions developed action plans and recorded activities they led to implement the MCWD model, the education program and resources. The action plan template is presented in Appendix 10. The project team at Flinders University met MCWD facilitators and site champions at quarterly workshops to discuss the action plan, the processes and outcomes of the plan, the findings from their cross-cultural care service auditing activities and actions they undertook to address issues they identified from the auditing activities. The project team also coached them on how to implement the learning modules in the 'Cross-cultural care program for aged care staff' and shared experiences and strategies with them to engage staff in learning activities and in changes of practice. All staff in participating sites received a hardcopy of each learning module of the 'Cross-cultural care program for aged care staff' and information on how to access the online self-learning program. This supporting mechanism enabled 100% coverage of the learning resources for staff.

Table 3.1 The main processes and outcomes

	Objectives	Planned activities	Actual activities/Outcomes
Phase one	<ul style="list-style-type: none"> Identify key factors enabling or impeding cross-cultural care and services Identify key issues experienced by multicultural care teams that impact on teamwork and quality of care 	<ul style="list-style-type: none"> Focus groups with staff Interviews with residents/proxies 	<ul style="list-style-type: none"> A comprehensive literature review Focus groups with 56 staff Interviews with 30 residents/proxies Three consultative workshops with stakeholders
	Determine a MCWD model to address the key factors and issues identified	A heuristic model including: <ul style="list-style-type: none"> guidelines skillsets toolkits case scenarios 	<ul style="list-style-type: none"> 'Multicultural workforce development model and resources in aged care' that conceptualise and explain the relationships in the four domains of aged care workforce described as: <ul style="list-style-type: none"> 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; and building an enabling environment in the aged care system. Cross-cultural care audit toolkit Cross-cultural care self-reflection toolkit Case scenarios
	Develop an education package to support the MCWD model	An education/training package for in-service education and staff development that include four modules: <ul style="list-style-type: none"> Module 1 Intercultural communication, Module 2 Cultural competency in multicultural teams, Module 3 Care safety and care quality in cross-cultural encounters, Module 4 Cultural competency in cross-cultural care with case studies in dementia care, palliative care and continence management in 	'A cross-cultural care program for aged care staff' that included five learning modules: <ul style="list-style-type: none"> 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

	Objectives	Planned activities	Actual activities/Outcomes
		cross-cultural interactions.	
Phase two	Embed the MCWD model and education/training package in workforce management and staff's day-to-day activities	For the respective corporate offices, site managers and care coordinators to incorporate the MCWD model and education package into the agencies to capitalise on the diversity in the residential aged care.	MCWD facilitators and site champions undertake cross-cultural care auditing activities three times using these audit tools: <ul style="list-style-type: none"> • Cross-cultural Care Service Audit Tool • Multicultural Workforce Management Audit Tool • Organisational Support for Cross-cultural Care Services and the Multicultural Workforce Audit Tool MCWD facilitators and site champions also: <ul style="list-style-type: none"> • engage staff in learning activities using the 5 modules • translate knowledge into practice • engage residents and staff in cultural exchange to enhance learning outcomes and relationship building
	Evaluate the impact of the project on care services for residents and on staff's cultural competencies	Conduct surveys with key stakeholders Conduct focus groups with staff Measure quality indicators Measure adverse events	<ul style="list-style-type: none"> • Resident satisfaction survey at three time points • Staff cultural competency survey at three time points • Staff's perceptions of the facilities' capacity to create and sustain improvement • Focus groups to understand staff's experiences in the project

Ethical considerations

Ethical approval for this project was gained from the Social & Behavioural Research Ethics Committee of Flinders University (Project number: 6841). Informed consent was obtained before data collection. Guarantees of privacy and confidentiality, freedom of refusal to either participate or to withdraw from the study, or to refuse to discuss particular questions were provided to all participants. The data were de-identified and stored in a secure area in the University. The interviews were coded, and the participants and the residential home they lived in were given pseudonyms in all documents to ensure anonymity and confidentiality.

Methods in phase one study

Phase one aimed to achieve the objective 1-4 as described above. Interviews with residents and focus groups with staff were used to explore factors affecting cross-cultural care services and the workforce cohesion.

Setting and participants

The study was conducted in four RACHs. Residents or a family member and staff were invited to participate in the study. Residents who lived in the home for at least one year were included in the study. The resident recruitment process included distribution of the Participant Information Sheet and Participant Response Sheet. If residents had a cognitive impairment or if they chose a family member to be their proxy due to language barriers, the information pack was sent to a family member. Residents or family members were asked to return the Participant Response Sheet via a pre-paid, pre-addressed envelope to the first author. The research assistant then contacted the residents or their family member to arrange a time and venue for interview. Interpreter services were offered to help residents or family members should they wish to use their first language in the interview.

Staff recruitment included those employed in the facilities for a minimum of one year. They were invited via the information pack. Staff who met the selection criteria and were willing to participate were asked to provide their contact details on a response slip and return it to the first author via a pre-paid and pre-addressed envelope. The researchers contacted participants by email or phone to inform them of the time and venue for the focus group according to categories of CALD, non-CALD and managers. One-to-one interviews were also used for those who were unable to attend the focus groups.

Data collection

Data were collected over five months in 2015 using a semi-structured interview guide (see Appendix 11). One-to-one interviews were conducted with residents or their family members. Interpreters were not used as all residents who could not speak English preferred family members to be their proxy. Each resident interview was undertaken in their room in the aged care home. Interviews with family members were held in a meeting room in the aged care home or by phone depending on their preference. Interviews lasted between 45-60 minutes. Focus groups and interviews were conducted with staff and went for 60 to 120

minutes. All interviews and focus groups were audiotaped and transcribed for analysis by the research team.

Data analysis

Data analysis and interpretation were informed by Giddens' critical concepts and the two levels of understanding of the interplays between structural power and human agency (Giddens 1984, p. 374). Critical hermeneutic was performed by critically reflecting on the interplay between structural power and human agency. The detailed data analysis methods were reported in a publication from this project (Xiao et al.). The first level of understanding was to identify participant perceptions of factors enabling or inhibiting cross-cultural care services (interpretive hermeneutic) while the second level was to analyse the interplay between structural power and human agency (critical hermeneutic). Data were transcribed verbatim for analysis. A generic procedure of thematic analysis through coding, grouping codes, summarising codes into categories and identifying themes was applied (Liamputtong 2013). Initially each transcript was analysed by two researchers in the project team. Each transcript was read to gain insight into the participant's views. Initial codes identified in each transcript were highlighted, compared with codes from all transcripts, and grouped based on similarities of meaning. The grouped codes were reviewed and summarised as categories. These categories represent findings from the interpretive hermeneutic.

Study rigour

Critical theorists believe that structural changes should be decided upon by the stakeholders who are most affected by power differences (Kincheloe and McLaren 2000, Fay 1987). Rigour is achieved in critical theory research through the process of catalytic validity in which the researchers work in partnership with stakeholders to evaluate changes that might have occurred as a result of the research (Kincheloe and McLaren 2000, Fay 1987). In this study this was fulfilled by highlighting actions residents/ their families and staff had undertaken to improve CCC in their daily interactions, including pointing out the unintended consequences of specific actions. These changes have the potential to bring about further changes in the aged care system to improve the quality of care for residents from all cultural backgrounds. The potential for improved CCC was considered through comprehensive discussion of the significant findings and implications for practice that were then implemented in phase two of the same project using Critical Action Research.

As the study mainly used qualitative data collection methods, it also followed qualitative study criteria described as credibility, dependability, confirmability and transferability (Lincoln and Guba 1985). The credibility included audio-taping the interviews and focus groups and transcribing them verbatim. A summary was provided at the end of each interview and focus group members and participants were encouraged to correct misinformation. Each transcript was analysed by two researchers and meetings were held to discuss codes, categories and themes. Two research assistants cross-checked excerpts used to support categories and themes. Dependability that emphasised the consistency of data was enhanced by detailed discussions on data collection, the analysis and interpretation process, and adhering to the application of interpretive critical hermeneutic. Confirmability was enhanced by taking field notes during data

collection, and numerous rounds of team discussions on coding, data interpretation and categories. Strategies that enhanced transferability or the application of the findings to similar social contexts were enhanced by a rich description of the field of study, using excerpts from the participants to support the findings.

Methods in phase two

The objectives of phase two were to evaluate the impact of implementing the MCWD model and the cross-cultural care program on (1) resident satisfaction with care services; (2) staff perceived cultural competency; and (3) staff perceived aged care homes' capacity to create and sustain cross-cultural care services.

Design

A mixed-methods research design was applied to address these objectives. This design included (1) a Questionnaire survey with residents/families at baseline, at 6 months and 12 months; (2) a Questionnaire survey with staff at the baseline, 6 months and 12 months; (3) focus groups with staff at the 6 months and 12 months following the implementation of the MCWD model and the cross-cultural care program, and (4) analysis of activity reports from MCWD site champions and facilitators.

Participants

All residents or their family representatives in the four participating sites of the project were invited to participate in the surveys. Survey packs were distributed to the person who was the liaison for each participating site. Research assistants employed by Flinders University were available for residents who needed assistance to fill in the survey form due to disability or language barriers. Residents also had the opportunity to choose to work with family members to complete the survey. A survey pack was distributed to the resident's representative if they had a cognitive impairment which prevented independent participation. Pre-paid and pre-addressed envelopes were provided to residents or family members to return the completed survey to the chief investigator at Flinders University directly.

All staff in the four participating sites of the project were invited to participate in the survey. Survey packs were distributed to the person who was the liaison for each participating site. Survey drop-boxes were provided in staff rooms for the research assistant from Flinders University to collect. Staff were also provided with pre-paid and pre-addressed envelopes to return their completed survey to the chief investigator at Flinders University if they preferred this approach.

Data collection

Demographic information of participants was included in the survey with residents and staff. Three survey instruments were selected to address the objectives of the evaluation study.

Resident satisfaction survey

This project adopted the 'Life in a mainstream nursing home questionnaire' originally developed by Westbrook and Legge to measure residents'/families' satisfaction with cross-cultural care services

(Westbrook and Legge 1991a). This questionnaire was developed through the authors' intensive studies on CALD residents living in mainstream nursing homes in Australia, and the comparison of CALD residents' and non-CALD residents' satisfaction with the care services in 1990s (Westbrook and Legge 1991a, Westbrook and Legge 1991b, Westbrook and Legge 1992). The questionnaire was also used in a recent similar study in Australia by Runci and colleagues (Runci et al. 2014), providing evidence of the relevance of content of the questionnaire to an Australian socio-cultural context. There were 10 questions included in the survey. The project team gained permission from the authors to use the questionnaire. The 'Resident satisfaction survey questionnaire is presented in Appendix 12.

Staff perceived cultural competency

The 54-item Clinical Cultural Competency Questionnaire (CCCQ) developed by Like (2004) was adapted for the survey. The CCCQ includes six sub-scales (see Table 5): (1) Knowledge, (2) Skills, (3) Comfort level (Encounters/Situations), (4) Awareness, (5) Self-awareness and (6) Education and training. Items in each sub-scale are presented in Table 5. The CCCQ is rated on a 5-point Likert scale with higher scores indicating better Cultural Competence. The internal consistency of the total CCCQ scale (Cronbach's alpha coefficient) is 0.8 which is an acceptable value for survey questionnaires (Mareno and Hart 2014). The project team gained permission of the authors to use the questionnaire. The 'Staff cross-cultural care service survey' is presented in Appendix 13.

The capacity to create and sustain cross-cultural care services as perceived by staff.

The 26-item 'Aged care facilities' capacity to create and sustain improvement' (ACFC-scale) questionnaire was developed by Scott and colleagues (2005). This questionnaire was adapted for the staff survey to measure their perceptions of the facility's capacity to create and sustain improvements in multicultural workforce development and cross-cultural care services for residents. The questionnaire includes two subscales: Relationship & Communication (15 items, See Table 7) and Team work & Leadership (11 items, See Table 8). These scales are rated on a 5-point Likert scale with higher scores indicating the better capacity to create and sustain improvement in the care home. The internal consistency of the total CCCQ scale (Cronbach's alpha coefficient) is 0.89. The project team gained permission of the authors to use the questionnaire. The 'Staff perceived aged care homes' capacity to create and sustain cross-cultural care services questionnaire' is presented in Appendix 13.

Focus groups with staff at time 2 and time 3

Semi-structured questions were developed to discuss with staff their perceptions of cross-cultural care services for residents and team cohesion in their care homes. These questions also encourage them to share their experiences in the project. The focus groups semi-structured questions are presented in Appendix 14.

Data analysis

Resident satisfaction survey

Data were entered into SPSS Statistics Version 22 for descriptive and inferential statistical analysis. A Chi-square test for independence was used to test the differences in satisfaction with cross-cultural care services between Australian-born group and Overseas-born groups and the differences across the three-time points of project, evaluation.

Staff perceived cultural competency and care homes' capacity to create and sustain cross-cultural care services

Data were entered into SPSS Statistics Version 22 for descriptive and inferential statistical analysis. A Mann–Whitney Test for two independent samples was used to test the differences between Australian-born groups and Overseas-born groups. One-way ANOVA was used to test the differences of (1) 'Cultural competencies' and (2) 'Aged care facilities' capacity to create and sustain improvement' across the three-time points of project evaluation.

Focus groups with staff at time 2 and time 3

Data were transcribed verbatim for analysis. A generic procedure of thematic analysis through coding, grouping codes, summarising codes into categories and identifying themes was applied (Liamputtong 2013). Initially each transcript was analysed by two researchers in the project team. Each transcript was read to gain insight into the participant's views. Initial codes identified in each transcript were highlighted, compared with codes from all transcripts, and grouped based on similarities of meaning. The grouped codes were reviewed and summarised as categories. These categories were further analysed by how they were related to the objectives of the project evaluation and the significance of findings. The final findings were presented as themes from the focus groups.

Summary

This chapter discussed the aim and the objectives of the project, the organisational structure, the process to enable the governance and implementation of the project. The application of a Critical Action Research design enabled the project team to work with stakeholders to critically analyse factors affecting cross-cultural care services and workforce cohesion in phase one of the project and to plan, implement and monitor, modify and evaluate actions in phase two of the project. Critical Action Research using the Structuration Theory also enabled the project team to examine the rules (or the workforce model in this project) and resources (the cross-cultural audit toolkits and education program) in cross-cultural care services that would improve cross-cultural care for residents and workforce development.

Chapter 4: Residents' perceptions of cross-cultural care services

This chapter reports findings from interviews with residents or their family members. Interviews were conducted between May and August 2015. Participants included 23 residents and 7 family members. The number of residents from a CALD background was 10. The demographic information of residents and staff is presented in Table 4.1.

Table 4.1 The demographic information of residents (n=30)

Participants' characters	Non-CALD Residents (n=20)	CALD Residents (n=10)	The total (n=30)
Age: median (IQR)	88 (6.7)	92.5 (11.1)	88 (7.2)
Male (%)	7 (35)	0	7 (23)
Female (%)	13 (65)	10 (100)	23 (78)
Months in the home: median (IQR)	29.5 (25.8)	27.5 (38.5)	29.5 (27)
Years in Australia: median (IQR)	NA	58 (25.5)	NA
Code used for quotes:			
Interview with residents	R1-R18	RC1-RC5	
Interview with family members	RF1, RF2	RCF1-RCF5	

NA=not applicable; Code used for quotes: R=resident; F= family member; C=CALD.

Participants' perceptions of factors affecting cross-cultural care services are presented as themes. These themes are outlined in Table 4.2 and discussed as follows:

Table 4.2 Outline of findings

Enablers	Barriers or areas to be improved
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Part One: Residents' perceptions of enablers

Six themes were identified from the positive experiences and perceptions of interviews with residents/family members. The findings demonstrated residents'/family members' contribution to relationship building with staff and illustrated how they made allowances for staff in cross-cultural interactions. These positive aspects of consumer cross-cultural care and service need to be acknowledged, valued, sustained and used to

overcome challenges identified in care and service settings with diverse resident and staff populations. Each theme is explained and discussed in detail.

Universal caring behaviours across cultures

Generally, residents from both non-CALD and CALD backgrounds commented that staff were caring regardless of their cultural backgrounds. They described their experiences and perceptions of being cared for in a positive way:

They've all been very supportive, and warm, and yeah, caring – caring. RP8

I find them [the multicultural care team] very caring yes I quite like them. I've never come up against anyone here that's been a problem. R16

All the staff are patient and all the ones that I see are patient and helpful as well. RCP27

It was evident that the caring behaviour of staff contributed to their rapport with residents as described by residents/family members:

I like them [staff] a lot. There's a lot of nice ones here. They like me. Some of them are very, very nice. RC29

Oh yeah well you can talk to the staff any one of them you know man or woman they're all very kind and gentle and thoughtful. R19

The finding suggests that the rapport between residents and staff is possible in cross-cultural care settings and is built on receptivity and respect for each other. Although different cultures have their own culturally specific forms of caring behaviours, they also share many similarities or 'universal' caring behaviours that transcend cultures in the way they relate to and provide care to older people.

Satisfaction with care and services provided by the multicultural team

The diversity of staff in the care facility was noticed by residents and their families. They were satisfied with the care and services provided by the multicultural team:

I'm not sure of the countries – I don't like to ask them which country they come from but India and Africa definitely and Bangladesh and places in between I should think. Their English is pretty good I think. R1

I [a family member of a resident] haven't really heard a complaint about any of the staff. She's had quite a variety of staff and different nationalities. She seemed to accept their nationalities without any hesitation. RP4

As I say this there's quite a variety of employees with Asian backgrounds, with African backgrounds and I've not really seen a problem in that area. RP4

Oh yes with the staff alright, it's very good, very, very good. They'll do anything for you and if you want anything they'll try and get it for you. R18

I recommend it [the facility] to anyone. We're well cared for. R11

This finding suggests that residents/families accept the diverse background of staff based on their judgement of performance in providing good care and quality services. The residents/families who were satisfied with the care and services also showed their appreciation for staff, an indicator of a reciprocal relationship. This finding has implications for identifying strategies for supporting new staff from a CALD background to be accepted by residents/families. The finding also has implications for engaging residents/families in cross-cultural education to facilitate positive relationship building between residents and staff considering that refusal to be cared for by CALD staff was also identified among residents in the project.

Enjoying the diversity of the care facility

Overall residents/families in the interviews made positive comments on the diversity they had experienced in the facilities. Many of them saw diversity as an attraction, rather than a problem:

Oh what I find good and fascinating is actually the range of different races and cultures here. R2

Well you know we're not all the same religion but that doesn't matter you know religion has never bothered me I've always had friends Roman Catholics, Church of England, Methodists. R16

Well I'm very happy here. I realise that they're very short staffed all the time but it's very interesting when you see the new ones come in and get to know where they're coming from. R17

Australian residents developed meaningful relationships with CALD staff, especially when they shared hobbies:

Oh have you met XX yet? ...Because she's Sri Lankan as well and we got on very well, particularly when the cricket was on because she's a great cricket fan and she was impressed that I knew how to pronounce the names of the Sri Lankan players. R2

The finding indicates that diversity in aged care homes can be an advantage in facilitating positive resident-staff or resident-resident cross-cultural interactions based on common interest and genuine openness to difference. These interactions may help achieve meaningful relationships between residents and caring

relationships between residents and staff. Additionally, matched interests and hobbies may also help residents and staff develop a friendly relationship.

Accommodating preferences and choices when engaging with consumers

Residents from diverse backgrounds appreciated the autonomy and choices they had in the care facility when they engaged in activities that promoted active and healthy ageing:

Yes, you get your list of all that's on for the day so that you know just when you start and where you're going to be and what you're going to be doing if you want to. R13

Oh yes you're always given a choice. It is quite a large choice actually and they are helpful people that handle those things too I believe. R1

No, I go find out for myself what I need here. ...It [engaging activity] keeps your brain working yeah. ...I've got my own music. RC14

Yes I go to that – I like the singing. R7

Residents preferred activities that were strongly influenced by their cultural values, health related beliefs and past experiences. Providing a range of options for residents and ensuring the activities address their choices are important. Accommodating the diverse needs and keeping residents informed of these activity options encourages them to be active and to exercise choice. The lack of options for activities may contribute to inequality in participating in activities that are developed to improve residents' mental well-being.

Communicating effectively

Cross-cultural communication difficulties were widely recognised and compounded by residents' sensory impairments. Some residents demonstrated proactive actions that facilitated cross-cultural communication with staff:

Very often you know they ask if I want – “do you want a shower?” I say yes. I can say yes and then if I want my hair washed I make this sort of thing [gesture]. But of course some of them know now that with the new ones you've really got to sort of try and say. I always say look I'm very deaf so just watch what I do [gestures] and we get on very well. R17

CALD resident families used written notes to ensure the message was passed to all staff regarding their plan to visit their relative:

If I want to take him out somewhere I always let them [care staff] know. If they're busy I just put a note: “I'll come the next morning”. RCP23.

The finding reveals that residents and their families play a crucial role in facilitating cross-cultural communication. Documenting and updating resident/family communication styles and the meanings of non-verbal actions and gestures in the care plan and having a summary of these on a card in the resident's room will remind staff of communication strategies with the resident.

Supporting networks for consumers

Family support was highly valued by residents from all cultures. Residents loved the time they spent with their family members:

I've got three children and they're always coming and going and one lot will take me out somewhere and another lot will take me somewhere else. ...I'm very fortunate. When I say to them thank you very much I appreciate it they said we're only giving back what you gave to us mum. R16

Some residents from CALD expected their family members to visit them every day:

I always have my sons to come to see me every day. They also take me out sometimes. ...These are recent photos from my family. RC29

Australian residents also demonstrated their independence and did not want to be a burden to their family:

It comes at a time when you lose your husband and you don't want to go and live with your family. R11

Oh sometimes if it's just my birthday that they come in yeah. I mean I have got plenty of family that are very, very good to me but like everything else they've got work to do. R17

Family support is observed across cultures. However, family members from different cultures may exhibit different forms of support, love and caring. Acknowledging these differences and documenting the patterns of family support in the care plan may assist staff to understand the cultural value-based performance of family members and reduce cross-cultural stereotyping. Additionally, being familiar with the patterns of family support may also help staff in conversations with residents and their families and facilitate positive interactions between the resident and the family.

Part Two: Residents' perceptions of barriers or areas to be improved

Residents/family members identified care and services that needed to be improved and their expectations of how to improve them. The areas for improvement are presented in six themes outlined below. The findings point to possible actions for phase two of the project in order to improve cross-cultural care and the multicultural workforce from the consumers' perspective. Each theme is explained and discussed in detail.

The need to improve the dining experience

Culture has a strong impact on residents' preferences and food choices. It also will influence mealtime activities, for example the desirable atmosphere and decoration in the dining room, the use of utensils or hands to eat and interaction with others.

Unmet diet preferences for CALD residents

CALD residents expressed concern about food and their expectations of having different food to meet their dietary needs, as three family members described:

The main thing that was an irritation for mum and still is an irritation is the food. Now this is my point about nursing homes – they forget that the most important thing in that is food. Food is a great healer... RCP26

I don't think so really, I suppose food wise, perhaps it would be nice if there was a little more variety and XX [the resident's name] is not the best at English style food anyway, he prefers something with a bit of flavour, but not too spicy. RCP23

The only thing mum feels disappointed in is the food. She is under the special soft diet because of her swallowing problem. She usually takes a longtime to finish her meals and ends up with cold meals. ...It would be good to make the diet more tasting and smelling for her. RCP30

Residents from Asian countries requested rice. Although their requests were considered, their expectations of the way to cook rice were not met, as a CALD resident noted:

I don't like the meals or they're not real cooks. ...I would like a bit better food. I like rice and it needs to be cooked in the way we usually do. RC14

In this case, the resident's request for rice and rice cooked in the way they did at home could be met with a minimal additional workload, for example by consulting residents/families about how to cook the rice and the equipment they used at home. Many residential facilities that have experience in meeting CALD residents' dietary needs may have these procedures in place. For those who do not, there may be the need to establish guidelines and procedures in order to meet CALD residents' dietary requests.

CALD residents were aware that it was not possible to request the same diet as they had had at home. Family played a role in bringing "family style" food to meet their needs, as they stated:

I can't request that, if I want rice every day you can't do that. Occasionally they do but I prefer cooked rice probably. Yeah, sometimes I ask my sister if they're coming bring me this or this, I miss chicken and rice. RC22

In this this case, the family's contributions to meeting the resident's diet needs were evident. Meeting CALD residents' individualised diet preferences is associated with cost and resources for service providers. The finding has implications for policies, financing, resources and staff development when planning to address "family style mealtimes" for CALD residents.

Creating pleasant mealtime for residents

Mealtime is also an opportunity for residents to socialise with others. In general, making the mealtime pleasant, stress free and respecting residents' cultural values and norms helps them eat and maintain health. Staff need to be mindful of how to make the mealtime pleasant so that residents eat adequate food.

Australian-born residents reported that some male staff from CALD backgrounds talked loudly in their language during mealtime which they found irritating and disturbing while they were trying to have a meal and socialise with other residents:

Only about one thing – sometimes and it hasn't happened very often, but some of those helping serve the evening meal talk to each other loud and clear in their own language which is discourteous I think. But I haven't noticed it with the women – only the men seem to do it. R1

Although these incidents were not mentioned often, it would be valuable to develop strategies to eliminate unpleasant mealtime tensions. This could be part of staff education, mentoring and modelling of better practice. For example, it may be necessary to identify relevant behaviours that impact on resident's enjoyment of meals, through guidelines, induction and orientation information for staff.

Communication difficulties with staff: non-CALD residents' perspectives

Competent cross-cultural communication is a crucial part of cultural competency in health care. Four sub-themes revealed that a range of difficulties in cross-cultural communication were present.

Ineffective communication contributes to adverse events

Ineffective cross-cultural communication between residents and staff threatens safe practice and contributes to preventable adverse events. An Australian-born resident attributed an adverse event to ineffective communication between herself and a CALD staff member who assisted her with a shower:

Oh she was showering me and I said to her "I'm slipping". And instead of holding the chair and holding myself until someone come to help her, she walked back to the basin and down I went. So I was lucky I didn't hurt myself, or broken.... R6

It was not possible to verify the factors contributing to this incident. While the care worker may have acted according to occupational health and safety protocols, the resident saw it as a consequence of poor communication. However, the resident may not blame the staff if they were informed of the result of an incident investigation through effective communication.

Ineffective cross-cultural communication is a potential risk factor if residents do not understand what staff say to them in situations when medications are administered or other clinical care activities are performed:

I have a bit of trouble understanding them sometimes. You just guess what they say. R20

This situation can be addressed by asking the resident to report back to staff what they have heard or by using written communication to get the information across.

Accent was a factor affecting residents in understanding staff in cross-cultural communication:

I have to ask them to repeat sometimes because of their accent. R9

Using written communication may overcome communication barriers that arise from the difficulties of understanding some accents. This strategy was used by CALD staff and is reported in Chapter 5 of the findings.

Inadequate English proficiency

Residents said that some CALD staff were not proficient in English. This caused frustration and stress. Attitudes and actions to respond to these situations varied:

Yeah other people do, some people that are from foreign countries. You get a lot of misunderstanding. Well I can't get them to understand me. ...it's just hard to know what they're talking about. Well there's XX [a cultural group] in here and they're very hard to understand. ...You just don't know what they're talking about. Yeah YY [a cultural group] people are very hard to understand to me. ...I try to understand them but I can't always get it because they don't speak very well. R18

Well one lady – one nurse came in one morning and I said you're not wearing your name tag? Her answer was I haven't got a name. R7

When CALD staff lack English proficiency this may affect their capacity to build a relationship of trust with residents.

Some residents recognised that staff understood what they want them to do:

I just tell them what to do and they understand that. But to talk it's very hard. R6

In this case, the barrier of cross-cultural communication in resident-CALD staff was evident. The finding has implications for identifying or modifying (if the organisation has in place already) skill sets for CALD staff and their use to inform recruitment and staff development.

One resident recognised that CALD staff had difficulty understanding the conversation she had with them. As a consequence she tried to help CALD staff improve their English:

Some of them haven't got the real true feeling of Australian language or English language I think. But I think they try as hard as they can. They come in and they haven't quite got the grasp of the English language and therefore they probably miss a bit of the understanding of those things. But I always say you want a little schoolroom when staff is with bed making and all that sort of thing. R3

This example demonstrates the proactive action this resident took to support the multicultural workforce in understanding English. The resident assisted the CALD staff to improve their English in a friendly manner. It demonstrates the ongoing support and a positive work environment for CALD staff.

Difficulties with phone communication

Phone communication with CALD staff was perceived as more difficult by residents/family members. A resident described her daughter's frustrations in phone conversations with a CALD staff:

...it's like my daughter when she rings here and she'll get a - probably XX [a CALD staff] on the phone or such and anyway she'll say, "I can't understand you. Give me an Aussie on the phone." She [the daughter of the resident] said, "I don't know what you're talking about". Oh it improves, it improves. R11

This resident identified that phone conversations between families and CALD staff did improve over time and that these staff made an effort to improve their phone skills. As communication is two-way, residents/families can contribute to enhanced communication. Guidelines, training and ongoing support on phone communication for new staff who speak English as a second language are necessary. Peer support for phone communication in situations where the recipient (residents' relatives, GPs or other health professionals) has difficulties in understanding CALD staff is needed based on the best interests of residents.

Using enhanced communication technology, such as SKYPE, SMS, and email prior to, and following conversations, to facilitate distance cross-cultural communication could be considered for residents' families. For those residents whose families do not live locally this would enhance support. These difficulties in cross-cultural phone communication could also be addressed by making visual communication available and accessible within the organisation, although clearly this is expensive infrastructure and affects budgets for aged care organisations.

Lack of initiatives in cross-cultural communication

Culture has a strong influence on communication styles and verbal and nonverbal behaviours. People from the same cultural background share some patterns of thinking and behaviours in communication. CALD staff may not be aware of particular communication patterns among Australia-born residents as a resident's family member identified:

But there are some members of staff I think that are, whether they're new, or not, haven't initiated it enough personally that don't communicate or feel free. I suppose to communicate more readily. They are shy. Yeah, I think they feel, can I say subservient, or can I say uncomfortable. I don't think its lack of wanting. I think it's perhaps because they feel that they may intrude. I find that the older staff members have more confidence and communicate more freely than the younger staff members. RP8

This finding indicates that the use of English is limited by lack of knowledge of residents' culture and customs, suggesting English proficiency cannot be achieved by study alone, but requires interacting with native speakers in a cultural context. The finding also strongly suggests that education and ongoing support for CALD staff is required to assist them in adapting to Australian culture. Mentoring for CALD staff by Australian-born staff is necessary in order to improve resident satisfaction with staff in cross-cultural interactions. The cultural influence on communication styles is introduced in the literature review and discussed in detail in the Discussion section.

Communication difficulties with staff: CALD residents' perspectives

Residents from CALD backgrounds faced more difficulties in cross-cultural communication with staff due to their low levels of English proficiency and cultural influences in communication. Three sub-themes identified from interviews presented below have implications for practice.

Residents need sufficient time in cross-cultural communication due to multiple challenges

Communication difficulties for CALD residents were compounded by sensory impairments besides the lack of English proficiency:

Yeah it's just they should be aware that we are old people and they have to repeat themselves sometime because you can't hear them. I don't know what they're talking about and my hearing is not so good. It's not only their fault but it's mine too. ...You can't say yes or no but you don't know the question. Yeah that they have to be patient. RC14

I can see you but I can't hear you. RC23

One resident's family said her mother's hearing impairment had implications for intervention strategies in communication:

She won't eat. She won't watch television because she is hard of hearing. So anyone trying to have conversations with her would find it extremely difficult. She would probably smile and all that kind of thing but even hear what's being said unless people are talking right up into her ear. RCP26

Residents from CALD backgrounds may be less likely to discuss with staff their needs and requests due to language barriers. Staff should take proactive action to discuss these with them. Staff should be mindful when communicating with all residents by checking hearing aids and helping residents wear spectacles prior to explaining or discussing activities with them. Regular review and follow-up for hearing aid checks need to be done to adjust the hearing aids to the residents' conditions. Gaining feedback from residents/families on a regular basis regarding their communication needs in the care facilities should be considered in cross-cultural care audits considering that many interactions are between either Australian staff and CALD residents, CALD residents and CALD staff, or CALD staff and Australian residents.

CALD residents perceived more difficulties in communicating with CALD staff:

No, she is a problem. She's from XX [a country] and she can't understand me probably. RC22

Factors affecting CALD staff-CALD residents' cross-cultural communication may include, but not be limited to the lack of English proficiency, strong accents and unfamiliarity of words used by each party involved. In this situation, staff need to give CALD residents sufficient time to comprehend and respond to communication. Using strategies to enhance cross-cultural communication, clarifying whether residents have understood what has been said, as mentioned before, are crucial in meeting residents' care and service needs.

The need to follow family's communication notes

The CALD resident families play a key role in facilitating cross-cultural communication with staff to ensure that CALD residents remain socially active by taking them out regularly. In this study they indicated they had a high expectation that staff followed their suggestions as the CALD residents may not have been able to explain the planned activities to staff due to a language barrier:

*The notes [the family member wrote to staff about her plan for taking her mother out] have never been put in the book [message book for staff]. **Little things like that.** But I can cope with that. It's not so bad. RCP23*

CALD families involved in managing residents' washing and laundry also expected staff to read and follow the notices and messages used to enhance cross-cultural communication where there were language barriers:

And weekends, and they have some agency staff. The only issue I might have is we've just put that noticed up about washing because things were getting lost in the laundry, and so I thought I'll do the washing up myself, so I put a basket there and put a notice up and things still disappeared into the laundry. So yesterday one of the RN's put that notice up, so we're hoping that might help. So that's a common issue I think with, especially with agency nurses rushing in and out they don't tend to read notices. RCP23

The need to address residents in a culturally appropriate manner

Culture has a strong impact on how people should be addressed. Words and behaviours used in communication with older people in one culture may be inappropriate or offensive in another culture as a CALD family member pointed out:

Yes you can use the word darling and sweetie and all those kind of things which irritates my mother anyhow because sometimes it sounds terribly patronising. ... They are not children and that's one of the things that I sometimes think that the carers forget. These are mature adults. ...My mother's mental faculties are pretty acute. And so you've still got to provide that dignity of relationship. ...I simply said that they had no understanding of cultural differences and cultural concerns of people... RCP26

Variations of care practice which negatively impacted on the experience of residents

Variations of care practices that contributed to suboptimal care and services were identified by residents. One resident perceived care activities provided by CALD staff were not as good as they expected, as a CALD resident said:

Yeah and sometimes when the staff from XX [an Asian country] help me make bed, sorry about this, I shouldn't say that about Asian people, they're not as good as Australian care staff. RC14

Residents also raised concerns about CALD staff's skills in providing ADLs, but did not want to say anything negative about them:

And then I said would she wash my hair? And she wet it and that was it. I need to tell them how to do things appropriately. ...but I don't like doing that. They mightn't like me. R7

These examples have implications for VET and tertiary education curriculum development, the complaints process, care plan evaluation, time and checking on quality of care, care observation, skills checking on the job, mentoring and access to educational materials on the job and induction.

A family member noticed the variation in practice provided by staff from various cultural groups although the conclusion they made needs to be further investigated through a cross-cultural care audit:

Well I'm assuming what nationality they are, but I would say the XX culture is more hands-on caring and embracing. YY background culture [is] not so much. Yeah, so, I mean I keep on different cultures, but I'm not quite sure whether I'm correct. ZZ culture people they're, I would say they're middle of the road. RP8

This situation may mean that that CALD staff were at different levels of readiness to adapt to care practices applied in Australian residential care facilities. This could also be reflective of the level of experience of staff. The finding has implications for the identification of learning needs for staff with different skill levels and stages of experience when engaging in staff education and training programs.

The need to apply person centred approaches to promote psychosocial well-being

The way to make the aged care facility a truly caring home for residents is to provide holistic, individualised person-centred care and services that enable them to achieve their personal goals. Residents expect staff to see them as persons with psychosocial care needs:

Well it's – and there's a man next door and we are a fair way from everybody else. Why don't the nurses come in early morning and say good morning? Well I would like them to if they would. ...Well, at the end of the line, we are fair way from everybody else. R7

Residents/families expected staff to have as much meaningful interaction with them as they could, rather than simply performing tasks for them:

Yeah well they haven't got time to stop and talk very much. You've got to – only what you can do while they're attending you. That's about they're very short on time and I miss that a bit. I'd like to have more conversation with them but it's not available because of their time limit. They seem to be, I was going to use the word pushed, but I don't think that's the right word. R3

To be passionate about what they're doing and not look at it as just a job, which I don't think the staff do there. RP8

As residents become frailer, it was the staff who were the social group interacting with them most of the time and who gave them psychosocial and emotional support.

A daughter who was interviewed had concerns about her mother's daily activities and wellbeing. She even suggested the use of a notebook to facilitate staff actions in promoting meaningful activities for her mother:

I think more insight into them, as human beings, maybe via a notebook in mum's room, some comments by staff. What I find about mum, or what mum did that day, ...you know, the little comments, so that there is another line of communication... They [staff] haven't really got time to sit around and have a chat. RP8

Residents' families held strong views of the approach required to achieve psychosocial support for CALD residents based on their own past experiences as caregivers. They had high expectations that staff would be knowledgeable regarding health promotion for residents:

One thing that upsets me a lot about the care or the level of, or the environment he's in, he spends a lot of the time every day sitting down in front of the TV, and I don't think that's particularly appropriate or good for his health or wellbeing but I've raised it numerous times and I don't know there's really much that can be done about it. ...Well, I'll go into see him and take him out. We'll go for a walk and we'll come back and the staff will say oh he doesn't need to do that. You don't need to be doing that sort of stuff anymore. ...In that instance I think the staff was ill-informed. But it's just an illustration that she's got to respect my wishes and my wishes were seen to take him out to go for walk, and she wasn't considering my point of view. RCP25

In this instance, staff attitudes towards individual activities that promoted healthy ageing were pessimistic and there was a lack of recognition of the family member's contribution to care. Regular education and training for staff, particularly for those who are new to residential aged care and have little understanding of the concepts of healthy ageing and care activities and services that enable healthy ageing, are imperative. The findings have implications for how to use multiple sources of information, for example surveys with residents/families to identify staff learning needs in relation to in-service education. The lack of activities for the resident in this case may also arise because funding tools do not provide adequately for activities in line with resident's family expectations. A systematic approach is required in order to strengthen psychosocial support for CALD residents.

Family members also advocated on behalf of residents in terms of person-centred leisure activities:

You reach that stage where you feel you no longer are of any use to the world. And that's a mental issue so I know they tried to have things like sing along and concerts and all that kind of thing. ...they [staff] tried their best but the last thing my mother wants is any of that. She finds it offensive. ...Yes she says they insist on wheeling her. Sometimes they don't ask her. They are going to take her to the hall and my mother does not wish to go there. And then one time she had to almost fight because my mother can be feisty. RCP26

This observation suggested that inviting residents to participate in activities they dislike may trigger protest. Staff need to assess resident needs for participating in these activities and respect their autonomy in engaging in activities. This instance pointed to the need for careful assessment of person-centred approaches to activities through admission and evaluation of the care plan. Care plans needed to reflect

and regularly update resident preferences for engaging in leisure activities through review considering that the residents' health will change overtime and these changes may affect their usual pattern for engaging in activities. This instance may be an indicator that the activities provided for residents no longer, if they ever did, reflect cultural tastes. Promoting evidence-based practice in developing and implementing leisure activities is one way to enable relevance and more options for activities for residents with cultural and linguistic diversity.

Consideration for CALD residents who have language barriers

CALD residents may experience more difficulties in expressing their care needs due to language barriers. The families of CALD residents have a high expectation of staff being more thoughtful:

Mum had falls several times in the past. ...Sometimes of course when the call button has been pressed it has taken some time for a response and I've been there when called the call button and it's taken a long time for them to come. Now it depends on staffing and where they are in all that kind of thing. ...I remember when finally a carer did arrive; I said my mother could have been in a very serious situation. RCP29

CALD residents may be less likely to ask for help from staff due to linguistic and cultural factors. Families of CALD residents had more concerns about minimising risk and higher expectations of staff that they be more thoughtful in meeting residents' care needs:

And so it's little touches – sometimes you may find that a particular – her glass is out of her reach range and you sort of go just think of those things. It's not just ticking the boxes or like "I've been in this room, done that". ...There is a person here and there's a person who needs to be treated with dignity and you need to make sure that she's comfortable and whether everything is within her reach. It's little things like that. Little things but they can become mountains if things go wrong. RCP26

Again, the "little things" mentioned by the resident's family, reflect their deep involvement in the residents' care and the control and power relationship with staff that are widely reported in the residential care literature.

A CALD resident who was in respite care was capable of managing her own medication, but was concerned about missed or delayed medicines due to lack of communication from staff. The resident took proactive actions to manage medications:

...you have to run after them and you can't find them, so I'm left without eye drops in. ... so I requested my doctor ... to please (allow me to) administer my own ... and she approved that and then my medicine which occasionally you take your medicine very late, like nine o'clock and that's

impossible. I like to have it together with my meal or before meal to come all that. They yeah, approved that and then sometimes they don't follow it. RC22

This example revealed the lack of a self-care approach and encouragement of the resident to be independent when the resident was capable of taking control of some of their own care activities. Staff need to create situations to allow residents to exercise their participation in and control of care including medications if it is safe to do so and is in line with care standards.

Summary

This study revealed that residents and family members were generally satisfied with the cultural and linguistic diversity in care homes. The caring attitudes and behaviors they observed in staff enhanced their positive experiences. Participants in this study reported positive relationships with staff from diverse backgrounds. This may be due to the relatively long length of stay in the home of this group of residents (median=29.5 months). Despite these positive findings, cross-cultural communication was perceived as a challenge and compounded by residents' sensory impairments. CALD residents and non-CALD residents had different experiences in cross-cultural interactions with staff who were from diverse backgrounds. Findings provided more details of how to accommodate residents' cross-cultural communication needs in the multicultural workplace. Findings revealed that residents demonstrated an ability to facilitate communication and ensure their care needs were met. This finding indicated that residents also contribute to cross-cultural communication. This study adds new understandings to residents' self-determination by identifying resident-initiated communication strategies in cross-cultural care settings. CALD residents and their family members ranked food choices as a high priority and elaborated this care concern in the context of cultural diversity in aged care homes. Residents had expectations of RACHs to accommodate individualised food preferences. CALD residents'/families' expectations of meeting psychosocial care needs were identified. The findings provided insight into how to address these issues of concern.

Chapter 5: Staff perceptions of cross-cultural care services and multicultural workforce

This chapter reports findings from focus groups and interviews with staff. Focus groups and interviews were undertaken between May and August 2015. Participants included 56 staff. The number of staff from a CALD background was 16. The demographic information of residents and staff is presented in Table 5.1.

Table 5.1 The demographic information of care workers (n=56)

Participants' characters	Non-CALD (n=40)	CALD (n=16)	The total
Age: median (IQR)	45.5 (15.0)	40 (16.5)	45 (15)
Gender: n (%)			
Male	10 (25)	1 (6.2)	11 (19.6)
Female	30 (75)	15 (93.8)	45 (80.4)
Speaking a language other than English: n (%)	1 (2.5)	16 (100)	17 (30.4)
Position: n (%)			
Personal care assistant	8 (20)	6 (37.5)	14 (25)
Enrolled Nurse	4 (10)	1 (6.3)	5 (8.9)
Registered Nurse	4 (10)	3 (18.8)	7 (12.5)
Management †	16 (40)	0 (0)	16 (28.6)
Other	8 (20)	6 (37.5)	14 (25)
Years in Australia: median (IQR)	NA	10.5 (13.5)	NA
Code used for quotes:			
Focus group with staff	S1, S2, S3 (3 groups)	SC1, SC2, SC3 (3 groups)	
Focus group with management	M1, M2, M3 (3 groups)		
Interviews with staff	3 interviews	2 interviews	

Participants' perceptions of factors affecting cross-cultural care services are presented as themes. These themes are outlined in Table 5.2 and discussed as follows:

Table 5.2 Outline of findings

Enablers	Barriers or areas to be improved
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • CALD staff perceptions of the impact of language barriers on their work • Australian-born staff perceptions of CALD staff 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.

Part One: Staff perceptions of enablers

The positive experiences and perceptions in providing cross-cultural care and services for residents identified in focus groups/interviews with staff included six themes as detailed below. There was a high demand for leadership to respond to challenges and opportunities at different levels. The findings demonstrated the contributions staff made to achieve cultural competence in staff-resident and staff-staff cross-cultural interactions.

Leadership at an organisational level

The changing demographic in residential aged care homes was noticed by senior staff, and managers in the aged care organisations through their observations of data monitoring and from knowing their residents in the facilities:

We see the changing demographic in our resident and client populations. ...There were more residents that were from a CALD background but English speaking, than our own staff. M2

[CALD residents'] Families are constantly there. ...They have a great impact on our services now. M2

Various activities and support mechanisms have been developed to assist staff to develop cultural competence. This was often done as part of staff orientation to the organisation:

Our corporate induction includes presentation on cultural diversity. ...We have discussion during induction about understanding, especially around spirituality. The culture of dying in some religions and some cultures is far different. M2

Our Multicultural Project Officer is doing a small segment so it's actually quite powerful. M2

We do have cultural days. ...If we had a cultural week it was all about what happens in that country and tasting the food that comes from the country; listening to the music that they play and playing the games that they might play and making it relevant for the aged care facility. M3

In these instances, senior leaders and managers within the organisation prepared the workforce to engage positively with residents who had different cultural understandings, and also to cope with challenges that might arise from cultural differences.

The senior management group recognised that the most responsive way to identify problems at an organisation level was not sufficient. They acknowledged that there were continuous improvement opportunities to develop the workforce and improve cross-cultural care at individual residential care sites:

We need to provide ongoing support for those people (CALD staff) through that buddy element. We need to have some champions in the workplace. M2

I think one of the opportunities might be if the carer or residents come from another culture and they tell you about where they're from, how they care for the older generation or how they care for their parents or their grandparents, and it kind of makes you think, well I could adapt certain things to my level of care or how I talk to someone or approach someone. S4

Leadership at a facility and team level

Facility managers, care and service coordinators and staff are in leadership positions in the frontline of service delivery. Their responses to opportunities and challenges arising from workplace diversity have an immediate impact on improving quality and efficiency of care/services. In this study it was evident that leadership was demonstrated at different levels within the organisation via 'leading by example'.

Staff said that **being open to engage others** was one of the leadership attributes demonstrated by facility managers and care/service coordinators in responding to opportunities and challenges from diversity in the workplace:

Their doors are always open, always available to knock and come in and discuss something. S4

The leadership attribute demonstrated by the site manager ensured issues could be raised, investigated and plans made to address them in a timely manner to minimise any detrimental outcomes. It also meant that positive opportunities or ideas could be floated and considered as part of the quest for continuous improvement. This finding supports the roles Registered Nurses, allied health professionals, coordinators of the hospitality services and Enrolled Nurses played in problem solving for the staff they supervised. They were usually the first line of contact for team members when issues arose in the care setting.

Being approachable and supportive for team members was also viewed by participants as key leadership attributes:

If I have any problem with my workmate I ask them first and if not then I'll go to the [registered] nurse and then the nurse will fix it up. SC3

The carers, they do have a big task here. ...they should be able to come to myself (RN in the facility) or XX (an allied health professional) or the enrolled nurse, whoever's on the floor and say "Look I have difficulties with this lady, can you help me"? So we need to be on the receiving end to help them with their care activities. S4

Effective communication amongst team members and across different teams was identified as a leadership attribute that ensured coordinated care and services for residents:

I think we've got a very good culture of communication with each other here. We all seem to work really well amongst different departments. ... And quite often by fielding ideas from each different area, we can sort of get a little bit of a better handle of what's going on. So if I see something in lifestyle, you know that might affect the way they (resident) move and their mobility and things, I'll be talking to the physiotherapist about it. ...or if there's a nursing issue, I will be talking to our Care Coordinator. S4

Another leadership attribute in the multicultural team that ensured high-quality care, was the ability to monitor the quality of services from both the residents' and the staff perspective, assess staff needs for information, and then meet these needs:

I write a memo every time if something happens to residents. ...I put it in the memo folder. ...And so the carers, it's appears that they've signed it, so they've read it. But they're not implementing what I've asked. And so, and I think "Oh they're just not paying attention". But I think sometimes it actually is that it doesn't make sense even though I'm trying to keep my language very simple, that they are not actually understanding that. So I probably need to be a bit more mindful of that, and I know at times I have tried to implement photographs of things, rather than it being a big long worded description. ...I have a photograph of the wrong way and a photograph of the right way, and I think that's helpful for lots of people because even Australians have very different levels of literacy. So, but I think we do assume that people can read and write easily because they can speak easily in English. S4

This example demonstrated the way information was communicated to improve the quality of care and services in the care homes where the vast majority of staff were personal care assistants and a large proportion of them were migrants speaking English as a second language. Information needed to be

presented to these staff in a way that made sense to them so that they came on board and then led on a continuous improvement journey.

Leadership in responding to prejudicial and racially negative attitudes or comments

CALD staff sometimes encountered negative attitudes and examples presented in the report were sourced from a variety of workplaces including previous workplaces. The examples they provided did not involve residents who were cognitively impaired:

And I just tried slowly – gentle touch and she said “don’t touch me you are going to transfer that [skin] colour to me” (note: The staff is from an Asian background). SC3

I’ve been called a chocolate drop several times by some residents. Other times they say “I don’t want that negro coming to my room”.... So if the resident is very supportive, the work is not hard. SC5

These incidents are akin to verbal abuse, bullying and harassment, common workplace issues regardless of workplace diversity or setting. This finding demonstrated that diversity adds more complexity to the workplace that can place extra demands on the leadership.

The management group was aware of the detrimental impact that these racially negative attitudes/comments, bullying and harassment had on CALD staff wellbeing. Alterations were made to the rosters in an attempt to mitigate the issue:

Or you wouldn’t send the African male into a room where you know he’s going to get abused by somebody. So we have a responsibility to protect our staff to a certain degree as I wouldn’t leave someone that was not up to scratch to be in charge maybe. We have to protect them as a duty of care really to them and to the organisation. And it’s the right thing to do. M1

Verbally aggressive residents are certainly verbally aggressive to all staff, doesn't matter whether they're CALD or non-CALD but the verbal aggression focussed on CALD is generally focussed on that particular issue as opposed to non-CALD staff, ...if they happen to be from Africa, well they'll be called a black bitch. M2

At a team level, Australian-born personal care assistants sometimes took proactive action to protect co-workers from racially negative comments and verbal abuse:

If it’s a new person who has just come in, you would protect them to a degree. ...You wouldn’t put them with, if you knew, a staff member had issues with another colour or race. S2

Australian-born personal care assistants also demonstrated several strategies to address the negative impact that these racially negative attitudes and verbal abuse had on the care for residents and on CALD staff wellbeing:

Sometimes I'll go into a room with somebody who's very dark skinned and the resident will look at me and say, "Get them out of here," quite bluntly and I'll say, "I need them to help me, you need them to help you." ...then I'll say that's okay I'll do, I'll get them to do the non-personal bits and they'll just help us and then you can distract the resident or you can get them to know that carer. You can introduce them as actually a person and they'll get to know them. ...I don't think that you can fairly to that employee ask them to just not be around that resident because that is quite, I think that's racist in itself. S1

The management group participants recommended that education on diversity and tolerance should be extended to residents:

I think as an organisation we definitely need to assist the residents and provide education for them to help break down some of those barriers. M2

I remember we had an agency staff member who wore a head scarf and several of the residents said, "I don't ever want her looking after me again, look at what you see on the TV, it's not safe." ...And I wonder whether as an organisation we have some responsibility to help them through that. M2

The finding reveals that issuing the Charter of Residents' Rights and Responsibilities alone may not be sufficient to ensure residents/family members respect carers from CALD backgrounds.

Staff reported that CALD staff who were affected by racially negative attitudes/comments and behaviours were less likely to report these incidents, which meant they may have remained unresolved:

So, and I think a lot of the, if people do face racism they don't report it because they don't want to lose their job. They don't want to make an issue of it and they think it's a personal failing I think. S1

I do know that a lot of them (CALD staff) get racism from the residents that they don't talk about. They don't report it. S1

CALD staff also mentioned that they were unlikely to report racially negative attitudes/comments and bullying:

For me I didn't report them because I feel that people are sort of not aggressive or they sort of are opposed. I don't know. They look like they will not accept somebody they don't know. SC5

Underreporting of negative attitudes, bullying and harassment hampers preventative efforts in two ways. It results in an underestimation of the prevalence and severity of these issues in the workplace which make it less likely to trigger investigation and timely prevention before reaching a crisis point. This also contributes to an inability to accumulate knowledge and an accurate database of these issues nationally that may inform policies, funding and resources to address these issues. Leadership in leading cross-cultural care and multicultural workforce development in residential care is highly demanding considering the changing demographic characteristics of both staff and residents.

Cultural awareness

Staff observed that engaging in cultural exchange activities contributed to positive inter-group interactions and helped raise cultural awareness:

There was a big table of food that people brought, so you got to talk across the table about your culture, and you say "Oh where's this from", "How'd you know that", and so you'd say "Oh my grandma made this back in the day". S4

These activities also helped them to recognise cultural differences in a relaxing atmosphere:

And it was nice that we're all sharing and sort of like a bit of that culture on a plate. A lot of the carers too, you'd say "Oh I haven't got a culture, I'm Australian". A lot of the residents said the same thing. But they did love to see all the different. S4

We learn each other's cultural background and knowing that I think the quality of care it's good. SC3

Adding components that allow Australian-born staff to showcase their culture would complement the educational value of the cultural exchange activities in raising awareness that Australians also have a culture.

Participants reflected on cross-cultural training programs they engaged in and recognised the impact of these programs on their understanding of the concept of culture and cultural awareness:

One of the things that I really liked about some of the training we did a few years ago was the notion that everyone has culture. Acknowledge that so that it doesn't segregate certain people. Culture that impacts on what we do, the way we live. M2

The program made me aware that some cultures for example, eye contact is different. ...male to female care is different and how, for example, at the moment I'm doing study with Muslim care, so it's generally the difference is the male's head of the family and head of the carer. S4

The findings suggest that staff demonstrated raised cultural awareness when they recognised their ignorance about the cultures of others and were willing to learn more in order to improve their performance in cross-cultural encounters. Ideally, cultural exchange activities need to target the interest of all groups and should be grounded on egalitarianism principles allowing different cultural groups to share and learn from each other in positive ways. Australian-born staff can play a key role in introducing Australian culture to CALD staff as a way of supporting them to adapt their practices in the residential care homes to an Australian cultural and social context.

Accommodating CALD residents' care and service needs

Raising cultural awareness is only the first step towards cultural competence. Efforts to achieve the other components of cultural competence were also identified.

Psychosocial support for CALD residents

Management teams knew that the past experiences of some migrants and refugees in engaging in community organisations or social networks have a strong impact on CALD residents' psychosocial response to institutional living. Therefore, they were able to ensure staff accommodated these needs as a way of improving residents' psychosocial wellbeing:

I'm noticing a recent phenomenon is a community of Italian people coming into the facility. One resident was admitted to the facility. Her friends are now following her into there to create their own community. M2

Some people from CALD background are probably more fearful of institutional style living because of their past. Our CALD residents have a much closer connection with their community networks and family groups. M2

There has been times where it's been available that someone could come and talk to a resident in their mother tongue so they could have that flow of conversation that we can't provide. M3

Some of them like say listening to some music. ... We used to put the radio (provided by the CALD community in the resident's first language) on for him. He had a CD music player so the family asked us to play the music whenever he's in the room. M1

This kind of support addresses resident isolation as an issue of concern for CALD residents living in mainstream aged care facilities in Australia. The psychosocial support provided by managers and carers was seen as an important component of the service and demonstrated leadership in facilitating this support.

Meeting special dietary requests

Consideration of cultural food preferences was part of the care provided by the two services. Both agencies reported taking considerable effort to provide residents with their preferred food choices:

We did have a resident...He was from the UK and he really enjoyed kippers. ...Once a week, the cook would make sure that that was something that he got to enjoy. M3

She's Indian. We ended up making her special curries and everything because that's all she would eat. In the end that was worked through with her family as well. SC3

This example demonstrated an adaptable and inclusive service. Staff also accepted and accommodated food supplied by families for CALD residents.

Special considerations around food were also given to CALD residents experiencing medical problems, weight loss, or who were in the end of stage of their life:

I encouraged the family to bring in meals...every couple of days...of the food she liked....They noticed that she started to put on weight again. SI12

Some families they bring in some food cooked at home that they put in the freezer. M1

Knowledge and skills used to assessing and meeting care needs for CALD residents

Staff know that the past experience of some residents prior to migration could have an impact on their behavioural patterns. They accepted these unusual behaviours as gracefully as possible. Staff indicated that they were able to investigate, accept and accommodate the behaviours:

Knowing residents' culture helps the determination of normal or abnormal behaviours. This lady [from a CALD background] she wanted to be on the floor that was what she was used to. She was comfortable just to be seated on the floor. S4

Staff were aware that assessing residents' cultural needs, values and beliefs was a prerequisite to providing person-centred care and services:

We've got all the religious and cultural differences that we have to look at end of stage life too. ...We have to know about the culture before we can deliver and what we think is right. M2

You just have to be respectful of the individual as well, and get to know them before you can treat them a certain way. ...You have to tread carefully with any resident. I suppose more so with people who come from other cultures. S2

We get that through the leisure-lifestyle team. They find out what the likes, their religious beliefs. What special holidays they are interested in. S112

Staff also demonstrated skill in assessing pain in cross-cultural encounters:

We look at the non-verbal facial expressions and their body language when they're walking or sitting or holding onto one of the limbs. S1

These findings suggest that staff were capable of learning and applying culturally sensitive care, knowledge and skills when caring for CALD residents. Such capability was built into their awareness of the need to provide culturally competent care for residents. For example, in the instance above, had the staff been intolerant of residents' behaviour and corrected them without investigating their past experiences, such action may have had a negative impact on the resident's satisfaction of care and services or could even have triggered resistance directed towards staff.

Strategies used to facilitate cross-cultural communication with CALD residents

Staff perceived that communication with CALD residents who could not speak English or could not speak English well, was the most challenging aspect in identifying and meeting their care needs. Staff reported that they used a range of strategies and resources to enhance cross-cultural communication with residents.

Supporting CALD residents to communicate in English

Staff reported that encouraging residents to speak English was an effective strategy for those who could speak English, but knew these residents were worried that they were making mistakes. In order to achieve this goal, staff tried to be supportive, learned some words and sentences in the residents' first language, spoke these and reassured the residents that their English was better than the second language the staff had learned.

Using written English to enhance CALD staff to CALD resident communication worked well for staff wanting to identify care needs:

He is German. ... He can understand English and he can read it but sometimes he would pray in German. So he's got a small whiteboard where we can write. So once we write on the small board he will answer in English. ... so it's really good. That's how we get to fulfil their needs. SC3

This communication strategy helped staff and residents overcome communication barriers caused by both parties having strong accents. The findings have implications for cross-cultural communication in residential care homes.

Staff described a number of strategies they used to encourage CALD residents to communicate in English:

I try to learn a few words, at least say, “How are you?” And “Are you comfortable or are you hungry? SC16

There was a man, he was from Germany, and we had, actually a good bond. ...I used to ask him to teach me German, with numbers and names, just nothing very hard, but it was just one way to communicate, our personal way, and it was good. SC10

But you know, once they brought their language and you give them a little hug, or you know, sometimes just nice with them, like, “oh hello, how are you”. ... And they change and laugh, and they talk English to you. SC10

She always understood a lot of English but wasn't confident to speak it. But now she's a lot more confident, and yeah we're more confident to speak French with her too, yeah cool. ...We still talk to her in XX (the resident's first language) and different XX phrases and stuff. She has come a long way. This is her home now and she's very happy. S4

Using communication aids in cross-cultural interactions

Communication aids were widely used in the residential care homes to help staff meet residents care needs:

We also use little cue cards, one for the carer and one for the medical person and one for the RN. S4

Some sort of sign language easily put it here in their room: the toilet needs; do you need to brush your teeth; would you like to clean your eyes, some sort of thing. SC5

Staff even installed Apps on their smart phones to assist cross-cultural communication:

Some of the RNs have got apps on their phones. S1

There was one, I used to be able to do it on the computer and it actually spoke. S1

I used to use my Smartphone to communicate with residents who were unable to speak English. Just like speaking English to my phone and then my phone was translating into other language. SC5.

Other communication aids using advanced technology could be considered in order to promote more meaningful interactions with residents not only to meet their physical care needs, but also to ensure person-centred psychosocial care. The findings have implications for the MCWD model in terms of how to use available information technology appropriately to enhance cross-cultural communication.

Non-verbal communication

Staff identified that non-verbal communication skills enhanced cross-cultural understanding, communication and rapport with residents:

If you have good eye contact with them and allow them as much time as possible to reply to you, that tends to diffuse the situation in terms of language. Having a bit of a sense of humour can diffuse the situation. S4

If you know, you know a hand on their shoulder or just holding their hand to get them to talk about how they're feeling and they're comfortable, before you can start anything in the room you've got to have that relationship between yourself and the resident. S4

Some of the best people I've ever worked with, their English has been very poor but they've had the best rapport with residents because they've had the non-verbal communication. S114

The findings suggested that CALD staff who lacked the ability to communicate adequately in English, but had a high level of non-verbal skills, provided quality care for residents. This finding reinforced the view that knowledge and skills in non-verbal communication need to be a core component of any module in cross-cultural communication for CALD staff. The findings suggested that Australian-born staff also needed to learn and gain skills in decoding non-verbal cues from CALD residents and CALD staff, and how to use non-verbal communication appropriately as some non-verbal communication styles were acceptable in one culture, but may not be in another culture. Examples included the use of touch, where the body can be touched, and direct eye contact in certain situations. Examples of poor and good non-verbal communication needed to be provided so that staff could reflect on their own behaviour. These findings suggested the need to provide staff and residents with sufficient time to communicate, to comprehend the information and to respond to each other (see Part One of the findings).

Using family members and bilingual staff as resources in cross-cultural communication

Family members played a key role in supporting cross-cultural communication:

We soon learn from the children. They usually let us know exactly what it is that's needed as well as language prompts for us in their rooms that help us deal with anything that we're unsure of. M3

Some families will tell you "Just ring me if you're stuck" so we sort of get them on the phone and they communicate what we want to tell them. SC5

Bilingual staff were used as a resource to aid cross-cultural communication:

We use family members or even other staff to help out in language situations. SC5

If we have to ask them [residents from a CALD background] a menu and they don't understand what we're saying, we find someone [bilingual staff] that can help. SC3.

Communication booklets created by families were helpful for staff in identifying CALD residents' basic care needs:

.....often when we have someone from a different background the families will put together a booklet of basic things, like "Would you like a cup of tea," or "Are you in pain?". Along with a picture book – yeah, it's a book of a translation that we can then refer to them. S1

CALD residents/family members were reluctant to use professional interpreters, and indicated they preferred family members who were bilingual when being assessed. Although staff usually accommodated these requests, they were aware of underlying issues and they used multiple sources of information in assessment:

During a time of assessment, we try as far as we can to make that whole transition as painless as possible and so we would rely on family. We also try and gather a lot of information prior and from multiple avenues: from GPs and so it's not just the person telling their story – it's a whole portfolio of information. M3

These findings suggested there was a need to initiate a variety of innovative methods to facilitate communication taking into account the sensitive nature of some cultural norms. Staff awareness and a team approach to appropriate forms of communication with the different cultural groups were fundamental to quality care. Agency and permanent staff needed easily accessible documentation outlining the preferred methods of communication for each resident.

Utilising assets and strengths in a multicultural team

Staff acknowledged that the multicultural team possessed many assets and strengths. Making use of most of these assets and strengths would be beneficial for caring for residents and for workforce development in a multicultural care setting.

Cultural and linguistic assets in the team

Staff identified that they made use of the cultural and linguistic assets of team members to improve residents' care:

We do have people from different cultures. Sometimes we can actually get them to help us with the cultural activities. S4

We had an Indian cultural day, and so a lot of the Indian carers wore Sari's and brought in different foods and things for the staff. M3

Making the most use of the cultural and linguistic assets of CALD staff in cross-cultural interactions with residents not only contributed to cultural understanding between residents and staff, but also offered a sense of recognition of their background and as a consequence, assisted CALD staff to feel accepted as a team member who is able to make a valued contribution. These examples demonstrated that the opportunities arising from a diverse workforce were viewed as strengths.

Strengths that CALD staff brought to the care home

The culturally diverse aged care workforce was viewed as a strength in providing appropriate care and services for residents, as illustrated in these two contrasting instances:

We've got a Spanish lady XX (resident's name), and we took her to happy hour one afternoon, and she rung her bell after about 5 minutes and come back. And I said, "You didn't like it Josephine?" She goes, "It was not in Spanish." So she expected to go to happy hour and it be in Spanish. S2

We can actually find a match-up between staff and residents. And that can be the best gift, knowing that your isolated Chinese person, who's forgotten his English, that on some days of the week there will actually be a Chinese staff member, who speaks the same language, means that he can relax... S14

Most CALD staff were from cultures with strong ties to family that espouse values associated with the family taking direct responsibility for the care of the elderly. They were more likely to have positive attitudes towards older people and chose to work in aged care:

I'm from XX (an Asian country). We don't have residential aged care for people. I never hear of that until I came to Australia. And with our elderly we look after them, so we put, normally like if girl, you marry, you move out from house. So the boys, they bring their wife, so we expect that their wife to look after our elderly. ...two of my sister-in-law are looking after my mum, and my mum has dementia. ...I want to look after them (residents) like I look after my mum so I always show my kindness to the resident. SC10

I think we bring the respect to the elderly to the facility. This is particularly important for residents from Asian countries. Back home we've got like very strong culture of respect to the elderly. We need to very carefully care for them and very polite when talk with them. SC16

I think the very best thing is I brought, because in my culture, we have, I'm not saying nobody's respecting elders, but in our culture we have respect for our elderly people. It doesn't matter if they are angry, it doesn't matter what they say, even though they say wrong things or right things, no,

we don't say anything to them. So we, due to the respect, we don't tell them no, no, no, you're saying this. So I think that's the best, I think it's not respecting is like patience, you have more patience. SCI17

The strengths CALD staff brought to the care of older people and their strong work ethic were identified by management:

They do have to have the skillset. I have noticed though, Filipino, Chinese, they're very hard working, limited sick leave, that is a bonus because they do work, work, work. So I suppose I can rely on them. M1

These examples revealed that whilst CALD staff and residents may not share the same culture they may still share similar cultural norms that enriched the care. The work ethic of CALD staff contributed to the capacity building of the mainstream aged care organisations. Additionally, through well-designed cultural exchange or mentorship, their approaches to CALD residents were highly regarded, and can have a positive impact on their Australian peers.

Peer and mentoring support for CALD staff to adapt practices in residential care

It was widely recognised that immigrant health care workers adaptation to practice in a host country was a key variable affecting workforce integration. The first year of employment was the most difficult period for care workers who have English as a second language as they experienced multiple challenges in dealing with cultural shock, conflict resolution and intercultural communication while adapting their knowledge and practice to the host culture. A number of factors that enabled CALD staff to adapt their practice were identified in focus groups/interviews. These factors included;

CALD staff's self-determination to assimilate into the care home's system

The most important factor that enabled CALD staff to successfully adapt to the work environment in the care home was their determination to assimilate. The key attributes for this included understanding the fundamental values and principles underpinning the care of older people, acknowledging their own strengths and weaknesses in providing high-quality care for residents, demonstrating critical and reflective practice, and taking proactive action to learn.

CALD staff experienced cultural shock when they found the cultural norms for the care of older people in Australia differed significantly from their home country. They explained how they confronted value differences, compared the two systems of care, and the benefits for the older people and their families in both countries. Eventually, they recognised the fundamental values that sustained the care for older people in Australia:

God these people are very unlucky. Why are those children not looking after them and throwing you in here. But when I come to know now I understand. They have different kind of needs they can't do anything and that kind of care like 24 hour care they can't have it home. SC3

Like nursing homes do not exist in my home country or only for the rich people who can afford to pay. Just like my family, my father and mother, they have nine of us – brothers and sisters so we're the ones that supporting them. ...It's really hard for them though because if you don't have money you can't get any help from someone else. ...So I realised oh people in Australia are really lucky. They get care when they need. SC8

CALD staff described their thoughts and the action they took to assimilate into the care home's system:

Well you go to Rome do as the Romans do. ...And it is – it is good experience and if you work in multi-cultural organisation it is a good experience that we can share, we can learn many things now. SC5

But with time, familiarity sort of creates acceptance by residents. SC17

I want to believe that I have been a positive influence to the people I have nursed here in terms of making them feel at home because this is their home...SC5

I find if you want to survive in every place you have to be adaptable. ...I think we come from different backgrounds and you don't want to do something with good intention but it's misinterpreted by the person who's receiving it so the best thing is if you just adapt. Just adapt there. That's how I see it. SC5

The fundamental values in the care of older Australians needed to be introduced to CALD staff who were new their role to support their adaptation to the site. This could be done through induction and orientation programs and ongoing discussions with mentors. This would enable CALD staff to reflect on their attitudes, and adapt them to the care setting when required. Attitude change was usually a prerequisite for changing behaviours and practice. Values included, but are not limited to, accessible and equitable care for residents, holistic care, integrated care, autonomy, person-centred care, consumer-directed care, quality of life, healthy ageing, therapeutic relationships with residents/family members, and psychosocial support for residents.

CALD staff who demonstrated successful adaptation were able to diagnose their need to learn and ability to allocate resources to learn. CALD staff and their supervisors constantly mentioned that using lifestyle care plans helped them to know residents' care needs and preferences. The lifestyle information folders played a role in meeting residents' cultural care needs:

Lifestyle care plans are a very big help. I sit down and get to know about their (residents') background. ...that folder has basically everything. What this resident needs. SC8

We do have the lifestyle care plan. ... So for a care plan that seems quite minimal it over time will potentially develop to more information as we get to know more about the resident and as they feel comfortable to tell them more about themselves. M3

Successful adaptation was associated with a willingness to put one's own cultural norms and values aside in the workplace:

Yeah that's gender issue. Our culture is a bit strict. Even I am not allowed to talk with men in our culture. ...I can't choose male and female – I have to do it. ... I think the main thing here is guilt. I think that you are betrayed your culture – at the same time you also want to fulfil the needs of this person. So it's fighting between I want to do it but again I don't know how my people will – they perspective part of it. It's fighting the guilt battle a bit. It was really hard in the beginning. ...I used to go home crying what I'm doing. ... I used to talk with mum – this is what I'm going to do. SC8

Australian-born staff observed the sacrifices a student made in order to adapt to the practice in the care home:

We had an Indian student here and he was a Hindu and he'd never eaten meat ever in his life and he had to feed a resident meat and so it was his first interaction ever with meat..... and he did it and he was really proud of himself.....so he just had a series of challenges.S114

These examples strongly suggested that mentoring support was needed for new CALD staff who were from a culture that would prevent them from undertaking certain care activities for residents. Inevitably, staff will be confronted by challenges to their values when they meet with cultural norms other than their own. They may show reluctance to undertake certain care activities that will affect team work and the outcome of care for residents. Mentoring support and counselling services were needed to smooth the transition and adaptation.

Adapting communication in the care home

CALD staff reported that communication difficulties in cross-cultural interactions was the number one challenge for them in adapting their practice and achieving optimal care. CALD staff stated they needed to be psychologically strong to cope with communication difficulties and any mistakes they made:

Well I think the main obstacle is it was about language and then if that one is fixed I think every other thing will come in place. SC8

I did suffer racial prejudice first I came here, maybe because I don't speak much English then, back then, so it's really difficult, I tend to feel embarrassed if I say something wrong. But now I just go ahead... People tend to just laugh it off. SC10

Australian-born staff demonstrated sensitivity in supporting CALD staff in English communication that reflected the concept of cultural humility:

A lot of times you do hear people from other cultures say he when they mean she or she when they mean he. I just accept that. So I don't correct them on that because I don't think it's necessary because I understand what they mean. The only time it would need to be corrected is if they're talking to a resident that they can't communicate well so therefore it might be a matter of stepping in. If you hear that conversation stepping in and just helping them in a friendly way. S1

CALD staff also stated that they used written notes to overcome communication barriers due to difficulties in understanding a colleague's accent:

Sometimes like they (Australia-born residents) can be very rude to us because our accent is really different from their accent. It's hard for us to understand them – every word. They are struggling to understand us. But if we can write it down, it is just making so much different. ... and they say oh you mean this. ...It is hard but I'm learning every single word. SC8

CALD staff learned to adopt words and slang terms used in the workplace that they were not familiar with or where they found the interpretations of these words differed from those in their home countries.

We didn't know what bickie was you know. We used to say biscuit. For dinner we never call it tea. In the evening we have either dinner or late we'll have supper. ... it was hard for us as staff members when they (residents) ask "What time is tea time?" we say "It's 2 o'clock, 3 o'clock". SC5

We learn the new words that are used – like I never knew that big was a bad word over here – big means you're fat. Whereas in other country like if my boys do something good, I used to say "Oh you are very good, you are a big boy now". ... The word tells that he's very – if he was fat it could have been worse. He (resident) can even go and complain and say you know "She called me a big boy". SC5

CALD staff suggested that seeking help from native English speakers to clarify meanings was necessary to avoid mistakes and misinterpretations in cross-cultural communication:

Normally with me if I see anything different first of all I will check it. ...I live in Australia and I don't know all the cultures in Australia. Then what I do I normally find a real Aussie person or someone

who's been in Australia for a long, long time and I will go and ask and then I will find the balance.
SC5

Imitating communication styles and the pronunciation of native speakers and practising these helped CALD staff improve their communication skills:

I find another thing that works it's imitating that person; the way they talk, how they pronounce words because we all have different accents and sometimes they might not understand like when you say "Turkey" or "Tuckey" they might not know what you're talking about so it's just listen to how they say it and repeat that and probably that will click "Oh you're talking about the bird or the food". ... so imitating helps and being of – you have to be witty. You just get with the wittiness of Aussies. ...I think that has helped me in the long run, yeah. SC5

In addition to CALD staff using their own adaptation strategies, they needed Australian born staff to assist them to improve their cross-cultural communication skills. The complexity underlying intercultural understanding suggested that both CALD staff and Australian-born staff required knowledge and skills in cross-cultural communication and should be prepared to adapt to each other's communication style and to also adapt to residents' communication styles.

Peer support, tolerance in the care team and training

Australian-born staff who worked side-by-side with CALD staff provided immediate support to them during their adaption period. Their support included, but was not limited to, being approachable for questions, emotional support, cross-cultural communication and assisting in documentation. Australia-born staff also demonstrated a high level of tolerance towards CALD staff and made allowances for them.

Staff stated that being approachable was one of the most important aspects of their interaction with CALD staff and assisted in resolving problems that they might encounter:

Yeah we do have different registered nurses that come on board from different countries, and obviously English is their second language. Again it's making them, receive them well when they come in and then, and you know we've got to be patient and give them time to explain what it is they want to do, and then say "Okay if you've got difficulties come and get me", so just having that support person to go to is very vital. S4

If it's new staff, encouraging them to always ask questions and being encouraging. P13. S4

Staff described that timely support for new staff who may experience emotional reactions to negative comments made by residents with dementia was necessary:

Yeah I think verbally. I can remember these two old ladies in the lounge room and just saying "Oh my god, we've got a lot of black people here, look at them all, look", and like they were saying terrible things about. We had a lot of African carers at the time and they were so rude and so rude to their face that it was embarrassing. It was embarrassing for the rest of us. But thankfully these residents had dementia and so we were able to say to the carers "Look we're so sorry, they have dementia and they don't really know what they're saying". S4

Peer support was focused on improving teamwork:

Making sure it's a team approach and there's like support from all areas. Make sure they [staff from CALD] feel comfortable to be able to speak up. S2

Experienced CALD staff also contributed to supporting new staff:

It doesn't matter which culture of background or nationality you come from you just have to help. The same you would help your brother or sister. SC8

A low level of English literacy in writing incident reports among some CALD staff was identified by Australian-born staff as problematic. They made allowances for CALD staff by working with them to fill in the incident report:

I always do the documentation anyway it's just easier. Doesn't matter where they're from it's just easier to do it and I can do it in 2 seconds so I just always do it. SI14

Dependant on the behaviour of the certain carer, not necessarily a carer but a certain staff member, dependant on their back ground of where they've come from, they, there might be allowances made. SI14

The management group were also aware of difficulties CALD staff experienced in writing progress reports. Training was instigated to support them:

Trainings always important... I do that in the appraisals for the personal care workers and that's come out because I'm seeing them now write more progress notes, they're feeling confident. M1

CALD staff felt the good relationships they had with team members were crucial to gaining continuing peer support:

I think having a good relationship with the staff you work with helps. SC5

CALD staff valued peer support most and appreciated the support:

We have [received] very good help, huge help from other carers....They (the carers) are all understanding, all ready to help people, very flexible....someone new like me, for example, just come along and you know, just learn. You learn from your colleagues. SC10.

I like the work culture. We support each other even with the kitchen staff, with the cleaning staff and the maintenance. This is like a big family here. SC10

CALD staff brought with them their own values and social norms as well as an unfamiliarity with the requirements for care in an aged care facility. Working in an accommodating and unthreatening team environment potentially enhanced learning and adaptation to the cultural requirements of the facility. Peer support for CALD staff to adapt to the organisation's practices needed to be reinforced through job descriptions, annual appraisals, promotion and the organisation's rewards systems. These components of peer support needed to be considered in the MCWD model.

Mentoring (buddying) support

Although mentoring support for CALD staff to assist them to adapt to the organisation's work practices were not directly mentioned by participants in focus groups/interviews, it was evident through the buddying support used in facilities. Staff suggested that colleagues who had broader life experiences, particularly those involving different cultures, were willing to make an effort to understand the background of CALD staff and their needs:

From what I've picked up is a few people who have been exposed to multicultural and a bit mature they know they understand. ...Just having that support person to go to is very vital. S4

First with understanding their (CALD staff) background and their beliefs and really listening to what they're saying because we're not always right. M1

One strategy identified by participants for developing good relationships between residents or CALD staff was to support them to build good relationships with residents:

You try to introduce them to the resident, and try and get them to accept them by just virtues, and actually how good a carer they are. S2

Supporting CALD staff to adapt to Australian culture was a key step in adjusting their practices to those of the organisation:

Ensuring that all staff who are of a cultural variance to Australian have the opportunity to understand Australians and how they act and react. S112

A personal care assistant shared in detail her experiences of supporting a new CALD staff member:

*Some people I think you just have to work with, be consistent working with them showing that you will help them gain experience and slowly direct them, and it takes a long time. There's some people here that when I starting working them, an African girl that I really didn't like her to start with because she was very speedy, very fast, very difficult to understand. She didn't communicate much about her personal life and I knew that she probably had a very difficult upbringing because she was a refugee and she wasn't forthcoming with any of that information about herself and **I didn't push her for any of that**. Now I work fantastically well with her but that **has taken a long time** of just slowly **gaining her trust, never showing any prejudice towards her**. ...So I think **being consistent and fair**. S1*

These crucial components contributed to successful mentorship or buddying support and included: supporting mentees to build good relationships with residents; assisting them to learn the Australian culture; never showing any prejudice towards the mentee; being patient, respecting the mentee's privacy; gaining trust from the mentee; and being consistent and fair. These findings have implications for the MCWD model and the selection and training for mentors.

Part Two: Staff perceptions of barriers or areas to be improved

Staff identified a number of services and workforce factors that need to be addressed and their expectations of how this could be achieved. These factors are presented in the eight themes outlined below. These findings point to possible actions identified by staff that would improve cross-cultural care and staff-staff interactions within the multicultural workforce during phase two of the project. Each theme is explained and discussed in detail.

CALD staff perceptions of the impact of language barriers on their work

CALD staff who have English as a second language believed that language barriers were the number one factor affecting their performance, efficiency and teamwork in the facility. Language barriers often had a negative impact on their interactions and relationships with residents/family members and colleagues.

Affecting performance and relationships with others

A number of CALD staff stated that when they first started working at the facility they experienced distress because of their poor English skills:

Well I think the main obstacle is it was about language and then if that one is fixed I think every other thing will come in place. SC8

It was a big shock for me when I started, even the medical terms and everything it's still sometimes a big shock for me. SC5

Because sometimes like they [the residents] can very rude to us. ...because our accent is really different from their accent. [They said] "Which country are you talking English" SC8

The impact of self-efficacy and teamwork due to unfamiliar words, colloquialism and slangs
Many CALD staff said that in the beginning of their employment they were not familiar with words used by staff and residents to describe clothing, items and equipment used in daily care activities and services. Sometimes they were unable to match the words with materials used in the facility:

We learned English in classes and [from] dictionaries. We did not use English in our country. ...I did not know pants meant trousers when I was asked to get the pants for a resident's. SC5

Australian-born carers sometimes used colloquialisms such as calling men's underpants "jocks", which was very confusing for CALD staff and affected teamwork:

... when I start – they said can you bring jocks. What's jocks – we don't say jocks and I didn't know and I just stand there – what's that? We say underpants in my country – I didn't know – that's underpants. Just the little things that you think everyone knows when they come to work but these little things. SC8

CALD staff also stated the use of slang significantly affected their understanding and contributed to communication breakdown for both parties:

...in the office the girl was calling me "Can you work in the arvo?" I'm like "When?" and they say "Arvo" and I said "Sorry I don't understand you" ... then she was getting frustrated "Oh come on XX (the staff's name)" and I said "I really don't understand what you're talking about, tell me what time you want me to come?" and then she said "Can you please start at 5 o'clock?" I said "Okay you want me to work in the afternoon?" ...then I know when she said "Arvo" means afternoon. SC5

In these instances, teamwork can be improved and frustration in intercultural communication can be minimised if Australian-born staff were aware that CALD staff may have difficulties in understanding slang and colloquialisms, and avoiding using these terms in staff-staff cross-cultural communication in the workplace. The finding confirmed those from previous studies that identified that unfamiliarity of colloquialisms and the culture of the host country further escalated difficulties in cross-cultural communications for migrant care workers. This finding has implications for VET education and tertiary education, as well as resources in the workplace to support CALD staff when unsure of a term.

CALD staff found asking residents what they would like to order from the menu was a challenge as they were not familiar with western food and words in English that were used to explain the detail of the menu:

And I had to bring the menu in and show them the details on the menu and what's for dessert and there's like all different names. I tried to explain the names, [but] they couldn't understand it sometimes. That was difficult. SC16

These barriers can be resolved by creating a menu book or iPad with photos and explanations similar to photo menus used in some restaurants as mentioned above. Menu books in different languages may also be created for CALD residents to understand diet and reduce staff time spent on explanations. The findings indicated that the traditional service model that was built on the assumption that residents and staff want the same thing was no longer suitable if true person-centred care models were to be offered.

Australian-born staff perceptions of CALD staff language barriers

In the multicultural work environment, most communication was cross-cultural. Communication was two-way in nature and affected all parties involved. Staff stated that Australian-born employees also experienced communication difficulties when they interacted with CALD staff.

Impact of communication difficulties on teamwork

The lack of English proficiency among some CALD staff and its impact on teamwork were observed:

We've had a number of staff from overseas who come here and study. ... they pass their practical, but they have to wait 1 or 2 years because their English is so bad ... And that makes it hard for everyone. S111

The management group also reported that sometimes both language barriers and the different communication styles of CALD staff affected the services:

Member 1: I do have a staff member here that's very hard to understand. ...

Member 2: So I'll get a nod and yes I understand but then what I've asked for them to do has not been done. So there's a definite disconnect of understanding. M1

Staff suggested that there was a need to have strategies to address communication issues through the recruitment process and job descriptions:

If someone was being employed here you would hope that by the time they had been employed there would at least be an idea as to whether they could speak English or not speak English, understand English or not understand English ...S2

These findings have implications for the selection criteria, recruitment and on-boarding processes used for new staff. Ongoing support for CALD staff on communication needs to be established as suggested by participants.

Communication difficulties affecting the quality of documentation

The management group reported that some staff from CALD backgrounds had difficulty writing in English which impacts on the quality of the documentation:

Documentation on our computer system is often very poor as well and it's simply English school the way you run words together; the spelling of words – completely change the meaning of what they are actually trying to say. I know what they are trying to say because I know what happened, but anyone – an auditor to come in and read that. M3

So I had an instance where a support worker refused to fill out an incident form ... and I said but why can't you do it? Oh I don't want to do it. Is it because you don't want to or you can't? So I had to try and unpack what was the underlying cause. To be perfectly honest it was both. They didn't want to and they had done it before but they had allowed their own skill base to diminish. M3

Such findings have implications for developing strategies on how to improve documentation and report writing in the workplace. For example, organisations could provide scripted examples that relate to certain care incidents and outcomes for CALD staff to refer to. The findings also have implications for recruitment of candidates, such as English testing of staff education with early support in the workplace and providing peer support to review draft documents that have been used in some facilities need to be considered.

Difficulties in understanding subtleties of jokes

Having a sense of humour was viewed as an enabler in communication and relationship building with residents and staff. However, Australian-born staff perceived that CALD staff may not be aware of the subtleties of joking relationships with residents and could be seen as being rude and sometimes rejected by residents:

...that's very hard to communicate with new staff is the difference between being cheeky and banter with a resident ... some of the male carers that we get here are cheeky and the residents see it as being rude whereas we can have banter. There's banter that's not sarcastic or cheeky or residents see it if you've got a young male carer from another culture who comes in and is cheeky they feel affronted and that it's rude. ...Because they do not understand the difference between cheeky and banter or having the rapport with someone before you can be cheeky. You have to be, you have to gain that respect of an elder person. ... For example, I could say something like, if someone was naked, the things you say when you don't have a gun. I could say that and the resident will laugh. If a young Asian male came in and said that they'd probably want to hit him because they would be very affronted by that. So just, but if that person [CALD staff] sees me say that, they think they can say that and get the same response. SC1

This example reveals that banter between Australian-born staff and residents was possible because of a long-term relationship and the cultural nuances. If a new CALD staff engaged in this banter it may be seen as offensive by the resident depending on the relationship and the situation.

CALD staff also had difficulty in understanding all the nuances in conversations and this could have prevented them from engaging in meaningful interactions with Australian-born staff and eventually affected team building grounded on shared values and interest:

There was a funny situation when I was talking to one of the staff members and I was going on holidays, and I said “Oh look I’m just going to go and recharge my batteries”, and ... I said “Oh yeah it’s just what the doctor ordered”, and she sort of looked at me and went “The doctor wanted you to take a holiday?” S4

Some CALD staff did not have the required English proficiency for work readiness, which has implications for staff recruitment and retention. Appointing mentors for new CALD staff over an extended time period would not only enable them to fit into the workplace culture, but also improve residents’ satisfaction and relationships with CALD staff.

Communication difficulties in staff-resident cross-cultural interactions

Both Australian-born and CALD staff perceived communication difficulties in cross-cultural interactions with residents. Factors that affected cross-cultural staff-resident communication included language barriers, and cognitive and sensory impairments that residents had. In addition, staff also identified inadequate cognitive assessment for CALD residents who had language barriers when communicating in English.

CALD residents’ language barriers

Staff provided examples where a language barrier was the reason for a CALD resident to move to an ethnic-specific residential aged care facility:

... eventually he ended up going to an Italian nursing home because there they could understand him. They knew the culture. SC5

This example indicated that mainstream residential aged care services may need to draw on successful strategies used in ethnic-specific facilities to provide culturally and linguistically appropriate care for CALD.

When both staff and residents spoke English as a second language and were from different cultural backgrounds, communication difficulties were heightened for everyone:

We have a resident. ... we had to focus – he had to pay attention what he’s talking about and we had to try to use the sign language to communicate in. ... So managed to understand what he

wanted at the end to shower him but really we struggled as well. He is struggling to understand us.
SC8

These findings have implications for developing guidelines, strategies or use of technologies that may overcome or improve cross-cultural communication difficulties with residents.

Communication difficulties due to cognitive and sensory impairments

Staff also identified that communication issues with residents were due to their deteriorating health status or behavioural issues as the result of dementia more than cross cultural language difficulties. This behaviour meant staff were required to know the person, provide person-centred care and reflect on their practice in order to improve communication with residents.

Staff discussed difficulties in communicating with CALD residents with dementia:

Quite often our language issue is more based on issues of dementia rather than language ... some do regress to original languages, we tend to try and keep them communicating in the English language as much as possible. S4

Staff also observed that when the health of the CALD resident deteriorated this added more challenges for communicating:

Member 1: But if they don't speak English, and they – and quite often you'll find as they deteriorate in health they go back to their language more so than English. ...

Member 2: But it also is impacted by their health status, in regards to their hearing and all those things. S2

Staff also reported that Australian-born residents with hearing impairments experienced more difficulties in understanding staff with accents:

With some of the residents with worse hearing deficits, they just don't understand with a bit of an accent. S11

A staff member's experience in communicating with residents supported the statement above:

I speak very, very good English, but there's different words that I might say to a resident where they go, they'll give me 50 words other than what I've actually asked them. For example "Have you got pain?" So I've had some examples where residents have said to me "No I don't want a pan" or they misinterpret their pain, even though I talk very good English some of my wording was actually hard for the residents to understand. S4

CALD residents' behaviour may also have affected their communication with staff. Understanding their behaviours may facilitate communication in English:

I just say I can't understand anything but when you mentioned something that he likes he will speak English – he will speak back to you so sometimes his behaviour – it's getting to understand the person more. SC8

These instances demonstrated that staff needed to be aware of different factors that might contribute to communication difficulties in staff-resident interactions and the need to refer this in the care plan to support continuity. The more knowledgeable and skilful staff were in communicating with residents, the better strategies they used. These instances also supported the finding that staff-resident communication in residential aged care was situation-based, often requiring staff to improvise. These findings have implications for the MCWD model and for staff development.

The need to provide culturally and linguistically appropriate cognitive assessment

Staff identified that some residents with English as a second language were not accurately assessed for cognitive impairment. Current cognitive assessment tools may not be validated for CALD residents, especially those who no longer speak English or do not speak English well:

Member 1: One thing I think we don't do very well is assessing cognitive ability because we only use the PAS test. ... It's a very Anglo test; it's very specific you know. So anybody who either doesn't read or write or speaks different language, we don't, will just tick no, no, no, ... We mark them down as being much more cognitively impaired than they actually are. And I think we should really look at having some other cognitive tests available.

Interviewer: Have you used the RUDAS ...

Member 1: No never used it here because we're only allowed to use the PAS, which is because of ACFI. S4

This instance demonstrated that a systematic approach to culturally and linguistically appropriate care and services was needed in order to ensure consistent standards of care using the Aged Care Funding Instrument (ACFI).

The findings on communication difficulties with residents suggest that the MCWD model needs to have guidelines on staff-resident communication. Case studies used to support the guideline need to simulate the difficulties, successes and solutions experienced by both staff and residents. Evidence-based strategies for staff communicating with residents who speak little English have been developed as part of the resources for staff.

The need to recognise and respond to residents' culturally influenced behaviours

CALD residents exhibited culturally influenced behaviours that may have caused harm to other residents and added to the care needs. Some behaviours exhibited may be acceptable in one culture, but not acceptable in other cultures.

Staff may not be aware, nor have the knowledge and skills to manage some CALD residents' "caring behaviours" that may cause harm for other residents in the first instance:

... a lady who was from XX (an Asian Country). And she was in a share room at the time, and because the lady next to her was older than her, they were both well in their 80's, but because the other lady was older, this gorgeous XX lady thought it was her job to look after the other lady. She would massage her, this other lady ended up with all these bruises and we couldn't work out why.
S4

This example demonstrated that assessment and care planning needs to capture these behaviours, and strategies need to be developed to guide staff to manage the behaviour in an effective way for the wellbeing of all residents.

Inappropriate behaviour from a CALD resident, which was excused by his daughter on cultural grounds, could be very distressing when it contravenes a CALD staff's cultural norms and beliefs:

We used to have a resident... he was from Italy.... he used to touch women's back and chest and we reported all this to RN's and supervisors and management and they talked to the daughter and the daughter tell us that we should accept it as a compliment because that's what he used to do in Italy.... it's offended me a bit.... I'm coming from an Islamic country and there is no men allowed to touch me. SC5

In this instance, the staff member from a Muslim background experienced psychological and emotional distress. Staff have a right to a safe workplace just as residents have a right to a safe living environment. Strategies need to be developed and deployed in the workplace to manage these behaviours and support staff to minimise the negative impact. These instances reveal that residents' behaviour influenced by their culture needs to be assessed and documented in the care plan. Staff need to be supported in managing these situations.

Negative attitudes in cross-cultural interactions

Staff from CALD backgrounds reported that they experienced negative attitudes including, but not limited to, stereotypical, prejudicial, ethnocentric and racially negative attitudes. Examples of negative attitudes included exclusion, rude remarks and resident/family members refusal to have CALD staff care for or attend them. Residents stereotyped staff from CALD backgrounds on the basis of their skin colour and their accent and English proficiency. A number of examples were presented in this section in order to inform actions for

phase two of the project. Staff also observed that CALD residents sometimes also experienced stereotyping.

Negative attitudes towards CALD staff

Negative attitudes towards CALD staff complicated the staffing arrangements and the roster, especially when in some instances, there was nobody else available if a resident refused to be attended by CALD staff member:

I've got a registered nurse who's very black, South African or something. He does get quite a lot of residents not liking him come through the door and that's understandable. M1

Anybody that wasn't English, used to always be like, "Get them out of here. I can't understand a bloody word they say." S2

If they're a certain orientation – and we've had men who haven't tolerated someone from Vietnam or somewhere, and they've had past history in war. S2

Sometimes, the Australian-born staff had to intervene to mitigate the problem:

They (residents) can make the shift terrible. ... so sometimes they (Australian-born staff) really have to go and tell them this is the staff we have. They are qualified. They are allocated to you and we are not changing the staffing because you don't like them. SC5

Some relatives stayed away from CALD staff or asked to speak to somebody else when making a request:

I used to do afternoons and no relative would talk to me because they are expecting a certain sort of person. SC5

They just come and see you are a registered nurse and then they will ask you if there is anyone else they can talk to and if you tell them that you are in charge they just want a higher authority ... just because they think that you don't know what you are saying or what you are doing. ... It's quite frustrating. SC8

Negative attitudes from residents towards staff may also have affected staff interactions with residents as Australian-born staff said:

I think sometimes they (CALD staff) close down to those residents [who demonstrated prejudicial attitudes], so they go in there and treat them as a project rather than as a person. S1

High-quality care and services were built on the therapeutic relationships, trust and respect between residents and staff. Negative attitudes that have a detrimental impact on the resident-staff relationship were identified barriers to high-quality care and services.

Negative attitudes towards CALD residents in resident-resident cross-cultural interactions

Staff also observed that sometimes CALD residents engaged in negative attitudes towards their fellow residents, which possibly had an historical basis:

Member 1: Even ... residents – residents have taken offence to other residents ...

Member 2: Of a different culture ...

Member 3: Which we assumed was relating back to the war era, yeah. S2

This finding demonstrated that staff need to be aware of the impact of socio-historical factors on residents' attitudes and behaviours in order to observe, report and manage the incidents from resident-resident cross-cultural interactions. Staff in management positions need to be knowledgeable and skilful in analysing incidents and putting strategies in place to ensure residents' mental wellbeing. This finding has implications for the MCWD model and the education package.

Stereotyping CALD residents in staff-resident cross-cultural interactions

There was also evidence that CALD residents who had a high level of acculturation did not want to be identified by their country of origin or discuss the country of their birth. Staff who were not aware of the impact of acculturation on residents may be viewed as stereotyping residents/family members:

We had a Serbian chap in here, and on our assessment form it came to their cultural background. ... His wife was helping him to communicate. And they were actually a little bit miffed that we were even asking them about their Serbian heritage. ... they said "Look we've been here for 65 years, we're Australian". S4

This instance reveals that staff need to be knowledgeable about the levels of acculturation and skilful in assessing residents' culture and cultural-related care needs. This finding has implications for components of the guidelines in admission assessment interviews.

Stereotyping CALD staff

Sometimes staff and residents made assumptions about the religion of CALD staff. Stress levels may be raised in the team in such a situation if CALD staff felt they were being stereotyped:

I'm coming from a country which has Muslim background and they (staff) expect me to wear hijab ... and I'm like "Oh sorry because I'm XX (a nationality) you think I'm Muslim but no we have another religions in XX (a country) as well". This sort of thing happens all the time. SC5

It means they (Australian-born staff) don't try to understand, even though I explain to them we have too many different cultures [in the country] and every culture has their own things to do. So even though they see XX (a country) as one thing,...It's too many things to explain to them, and sometimes we can't convince them what we say. So I think more cultural awareness program or presentation will be good. SC17

CALD staff were rejected by residents based on their assumptions about the religious beliefs of CALD staff:

"I don't want that girl to come to me" and "Why?" "Because she's not Christian" (The staff member was a Christian from a Muslim country). SC5

Ethnocentric and racially negative attitudes in inter-group interactions

Some staff from different CALD backgrounds did not get on well together. Ethnocentric and racially negative attitudes may contribute to a situation as the management group stated:

Sometimes with when we've been dealing with performance issues at sites, is that at times there is a hierarchy where staff from XX (a country) background are seen by other, some other CALD areas, they equate them to servants and they're at a much lower level. And so all of the, the lousy jobs so to speak, they'll give them to them because they're, they're a lower grouping. M2

Also we see some issues between XX (nationality) and YY (nationality), XX and ZZ (nationality) where XX are seen as the immigrant workers and are at a lower level and that, that has created issues. M2

This finding revealed that ethnocentric attitudes were barriers to team cohesion, productivity and harmony in the workforce. The finding has implications for the guidelines and the code of conduct for staff when working in the multicultural team. Such findings also had implications for education and training activities that need to focus on eliminating these negative attitudes among staff.

Staff perceptions of difficulties in meeting CALD residents' dietary preferences

The impact of culture on dietary preferences has been presented in previous sections of this report while this section adds more examples to the report to inform actions. It was evident that CALD residents requested diet considerations as discussed by the management group:

Member 1: Well we did have a Chinese gentleman ... And he liked his, actually I think of food it's not only just him just a lot of them actually. They come in they want the different foods to what we're supplying them here too. So I think that's just, there's a lot of examples ...

Member 2: They like the Asian sort of foods with a lot of the sauces and spices and stuff like that that they can put on their own meal.

Member 3: They sometimes don't like the bland flavours. M1

Meeting special dietary requests may be determined to be logistically difficult:

Some cultures don't eat pork, so we've got to be aware of that. And obviously if we touch one type of food and then touch another that's offensive to them. S1

Although some considerations had been met, the way food was cooked did not meet some residents' expectations:

One of our Chinese residents she really loves her rice to be cooked in a special way. SC5

If he's totally vegetarian, it's going to be hard here. Well why it's going to be hard? And they are adding some like sauce ... they are thinking seafood is vegetarian. SC17

The findings confirmed that resident dietary preferences were often unmet which has implications for future improvements of diet services as mentioned previously in Part Two.

Staff also observed that sometimes CALD residents refused to eat or had a poor appetite and they were able to take actions to improve the dietary intake of the residents:

There was one lady who couldn't speak English properly, and she keep refusing food and then nobody knew why she refusing. Actually she was from Italian background and she wanted to have a pasta. So eventually staff found out and made for her, and now she's eating more. SC17

This instance revealed that education and resources on culturally related dietary preferences needed to be in place for staff to inform their actions when considering new admissions of residents from different cultural backgrounds as staff may not be familiar with different cultures.

Staff also said that the western style of modifying diet may not be accepted by CALD residents/family members:

Because for our CALD population I think food's very important. And as our residents care needs change in terms of needing to have modified foods, sometimes that can be difficult for the family to understand or the resident to understand the need for that. M2

These findings revealed that staff may need to learn how to modify a CALD resident's diet to meet their cultural expectations, and meeting these requests required additional resources and staff development.

The workplace issues compounded by cultural diversity

Some cultures have practices and beliefs around seniority and gender inequality that operate in the workplace. These status and gender value orientations contradicted those practiced in the Australian workplace and added complexity to the workplace that required additional knowledge and skills for the management groups to manage.

Hierarchies within a cultural group

Gender inequality and status hierarchies in a particular cultural group posed challenges for care in some facilities where the job description was inconsistent with the person's status:

And I know she [an RN from the same country the male carer staff was from] had problems with a male XX (a country) carer who, he would not listen to her because she's female, even though she's the registered nurse and she was in charge. ... She had great problems with getting him to do what she needed him to do because of that cultural issue. S1

I know the YY (a country) have a hierarchy structure between ages I believe, I might be wrong. So I know they were all talking at lunch time deciding who was older and where they sort of sat in the hierarchy. S1

These gender inequalities and hierarchies can be problematic in an Australian workplace. If management is not aware of these cultural issues they may be less likely to pay attention to and have strategies in place to manage them when they emerge. This finding has implications for management groups to explore, and document. The findings have implications for the recruitment phase: ensuring that potential staff knew the expectations of the organisation and were willing to surrender parts of their culture for their work was important.

Conflict in the multicultural team

Staff from a CALD background found that Australian staff often had unrealistic expectations, especially for new staff, and could be insensitive to their needs:

This is the way we do here. We need to explain everything – like that's common sense. Some people say here is ... that's the common sense – use your sense. How are they going to use sense when they haven't done this? SC8

That's my first time. All right you go on with that. Who is that? Which number is that? I don't know where to go and it's like which number is it? Oh my god it's ... you can see their expression – oh my god and talking with a friend like ... I am not dumb. SC3

There was also evidence that some Australian staff were unfair in allocating a workload to new CALD staff and had preconceived opinions of whether someone would be a good worker or not based on race:

I think I experienced it initially when I started working – you know when you are new. There was one care staff ... to give me one of the hardest residents. They know how she is – that's her behaviour. She promised to give me that resident and because she takes a lot of time. SC3

There's two carers left they have to get all the residents in there while everybody else is having lunch ... They take longer for lunch when they shouldn't be taking that long, so these two that are left on the floor need to pick up their work. SC3

When I am working we always do equal but if the staff is from here (Australia) they just make you work. Do this, do this, do this – not a pause but you're taught really bad. SC8

Conflict between CALD staff from different countries was also reported by management groups:

Member 1: Oh we've had two Registered Nurses actually butt heads from different cultures and it did come down to a cultural thing. It was the XX (nationality) lady didn't like the YY (nationality) lady and vice versa ...

Member 2: And not, there was no professional respect for each other either. So sometimes we have to get a mediator from somewhere else and we've had to use interpreters before as well to sort of resolve some of those things. M1

The need for CALD staff to have adequate education/training prior to employment

Australian staff thought that the Certificate III courses were too short and not comprehensive enough for CALD staff to come into aged care and be able to do the job properly:

A lot of these people are paying for the privilege of learning. And they don't necessarily get – they get 6 weeks and then they're put out here ... they're getting a job and they're expected to be able to do all. S2

Aged care is a situation where you can pay a certain amount of money and have a very quick training, and be out in the workforce earning money in a very rapid amount of time. And yeah, I think they need to actually address how well they're training before they're allowed to work. S2

The finding was consistent with findings in the 2013 review of the Certificate III in aged care, but was more specific to CALD staff. The finding has implications for strengthening the Certificate III to meet CALD staff education and training needs.

Staff from CALD backgrounds reflected on their experiences in Certificate III in aged care and described their unmet learning and training needs and expectations of the way that it might meet their specific needs:

Member 1: So for me it's about everything because we're expected to do personal care and we're expected to do documentation. We're expected to sometimes help with the lifestyle and all that.

Member 2: General basics would be Australian knowledge really of the Anzac for example, that is very important here; Christmas, Easter especially if it's not celebrated in your own country ... so what kind of lifestyle they had back in the when you were, they're eighty now so when they were twenty or twelve or whatever, that would be a good idea. SC8

The finding revealed that elective units may be needed that were tailored for students who were from CALD backgrounds and who had not been exposed to aged care in Australia. This may support their understanding about the socio-cultural context of aged care, and the lifestyle of Australian-born residents and their care needs associated with their cultures. Many staff who participated in the focus group and interviews did not undertake these electives. Some examples were listed:

Member 1: No we haven't attended anything, no.

Member 2: Not anything. SC5

I don't remember doing any course for specifically for people from different culture. SC16

For those who said that they had attended training, the session was very brief and generalised:

Member 1: And yeah just little lectures, you know half to an hour, but just in different areas that I worked.

Member 2: Yeah so, well basically just understanding the resident no matter what culture they're from. So it was more or less geared towards understanding the resident irrespective of what culture, you know what I mean, it was generalised. S4

The finding demonstrated that the two elective units on cultural diversity in the Certificate III in aged care were not sufficient for necessary knowledge and skills in cross-cultural care and working with co-workers from CALD backgrounds. Making these two elective units compulsory needs to be considered in order to address the rapid increase in workplace diversity in residential aged care due to the changing resident and staff populations. The findings have implications for the further review and revision of Certificate III in aged care. Engaging stakeholders like multicultural aged care, residents/families, staff and aged care organisations in the review and revision was necessary in considering future review and revision.

CALD staff from developing countries constantly mentioned that they were not familiar with western style clothing for residents when providing activities of daily living (ADLs) in the residential care facilities:

When I was in XX (an Asian country), I wasn't aware about aged care facility at all. The family looks after the elders. ...Yeah while doing their ADL's and picking up the clothes from the cupboard. We get very busy sometimes and I don't get time to ask the reason what they want to wear sometimes.

I just pick up, pick one from the cupboard and mainly with the female residents, they don't like it. And I don't know what sort of clothes they wear, is it a dress or just a skirt and top or some pants? Same with male elderly residents as well. Some, they like to wear singlets, some don't. SC16

Australian-born staff identified variations in providing ADLs among CALD staff from developing countries:

Showering, it was like you lathered them up without actually keeping them warm. Like you'd get them wet, you'd lather them up with soap, and then put the hot water on. ...Yeah, we had a conversation about it. ...that was – apparently that's the way it was done. ...They do like shower that way. ...saving water also. S2

Oh yes I've worked somewhere, about 70% of our staff were CALD staff and our complaints went from zero to 100% in a very short time frame because staff weren't, I guess meeting the care needs that, or the expectations of the residents. So I did have somebody from an XX (an Asian country) background come in and lather someone up in soap and water I guess, leave them in the shower freezing winter day, go and make the bed, just leave them there, go and make the bed, get everything ready and then come and hose them down. M1

A lot of the [CALD] carers are very task oriented,... they don't come across as being as caring or as gentle. S1

Trying to get some rapport with the resident, or whatever. Where you can go into a room and just make small talk while you're doing something – just idle chatter. Where it's just bang, bang, out, isn't it? S2

Interviews with residents and their families indicated that in general they were satisfied with the care and services they received in residential care. They also contributed positively to cross-cultural communication and relationship building with staff and other residents. These strengths in residential care could be used to enhance care and services in phase two. However, residents and their families also pointed out areas that need to be improved, for example, more options for care and services to meet their preferences and choices associated with their culture, language use and spirituality/religions. Residents also had a high level of expectation for staff to demonstrate effective cross-cultural communication, culturally competent care and social care that was grounded on resident-staff rapport, respect and reciprocal relationships.

Focus groups and interviews with staff revealed that staff demonstrated leadership at different levels when required to respond to challenges and opportunities in cross-cultural care settings. Staff engaged in some activities to raise cultural awareness in the multicultural workplace. They also took proactive actions to accommodate residents' care and service needs that were associated with their cultures, language use and spirituality/religions. The multicultural care team showed strength in terms of utilising cultural and linguistic assets to enhance care and services for residents.

The findings also suggest further workforce development to address cross-cultural communication in the workplace, culturally competent care, social care for residents and relationship building with residents/families. Staff need to be well supported and cared for when they experience racially negative attitudes/behaviours. Cross-cultural communication, peer support and mentorship need to be strengthened in the multicultural team to foster a cohesive workforce.

Summary

Findings demonstrated that in mainstream RACHs the cultural and linguistic assets of the workforce actually contributed to the residential aged care services. 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 MCWD model and the core cross-cultural care attributes for staff as discussed in the book entitled 'Multicultural workforce development model and resources in aged care'. Cross-cultural leadership was in high demand to identify and address issues of concerns arising from resident-staff and staff-staff cross-cultural interactions. This study confirmed that poor English proficiency of some CALD staff affected residents' positive experiences in aged care homes. This unintended consequence was also attributed to organisational factors. Aged care homes that employed immigrant health workers may benefit in the selection of suitable staff for the positions by developing a required skill set to guide the selection processes. Aged care homes also have a responsibility to create a positive work environment that smooths the path for migrant care workers to adapt their practice in the best interests of residents.

Chapter 6: Activities led by industry partners

This project was built on partnerships with two mainstream industry partners. Their leadership in the project enabled the outputs of the 'Multicultural workforce development model', the 'Cross-cultural care audit toolkit' and the 'Cross-cultural care program for aged care staff' developed in phase one of the project. Their organisational structure, resources and support for the project also enabled the project team to test the MCWD model and the resources to support the model in phase two of the project. This chapter presents activities led by industry partners so that other organisations may consider how to implement the MCWD model and resources in their context. The activities reported in this chapter include (1) Organisational structure and support, (2) Using multiple sources of information to inform actions and (3) Actions undertaken to improve cross-cultural care and to improve team cohesion.

Organisational structure and resources

Two industry partners appointed MCWD facilitators and site champions to implement the project. Examples from one of these organisations (namely: Organisation One) was used to explain how the organisation's structure and resources enabled the governance and quality of the project, to achieve objectives and to sustain and disseminate the positive outcomes (see Figure 6.1). In Organisation One an Executive Manager, Workforce Development and Governance was appointed as the organisation's representative in the project team and provided leadership to ensure continuing support from the organisation for the project. The Executive Manager also oversaw the activities at all levels, and made decisions on the organisation's support and resources for the project. The Executive Manager approval played a crucial role in facilitating activities that were relevant to the MCWD model, targeted the organisation's vision, mission and strategic plan in service development and workforce development. The Executive Manager directed and supervised the MCWD Facilitator in implementing the project.

The MCWD Facilitator worked with the Executive Manager and coordinated activities in the two participating sites. The MCWD Facilitator informed the organisation of the process and outcomes of the project through presentations at managers' meetings and via the organisation's website and newsletters. Prior to the project, Organisation One had appointed a Multicultural Project Officer to facilitate care services for CALD residents in RACHs and clients in community settings. During the project, the MCWD Facilitator worked in collaboration with the Multicultural Project Officer to ensure resources that were relevant to the portfolio of the Multicultural Project Officer would be applied within the organisation. Organisation One has well-developed induction programs for new staff, and dementia care and palliative care programs for staff. Throughout the project, the MCWD Facilitator worked in collaboration with educators and Nurse Practitioners to embed relevant learning modules from the 'Cross-cultural care program for aged care staff' into the existing programs. The MCWD Facilitator also undertook cross-cultural care auditing activities quarterly using the cross-cultural care audit tool. The MCWD Facilitator used issues identified from the auditing activities and reports from the residents' satisfaction survey as information to work with site managers and site champions to investigate and resolve issues identified from the audit. The MCWD

Facilitator also supported the site champions to develop action plans, implement and evaluate activities and report the outcomes to the Steering Committee.

A champion was appointed in each participating site to work in collaboration with the site managers and the MCWD Facilitator to implement the MCWD model and use the cross-cultural care toolkit and the cross-cultural care education program to support the MCWD model. The site champion developed an action plan on a quarterly basis and submitted this to the MCWD Facilitator to gain the organisation's approval and support. A sample action plan is provided in Appendix 10. Activities led by site champions included, engaging residents and staff in the project to ensure positive changes in cross-cultural care and team cohesion. The site champion played a crucial role as a change agent in the care home.

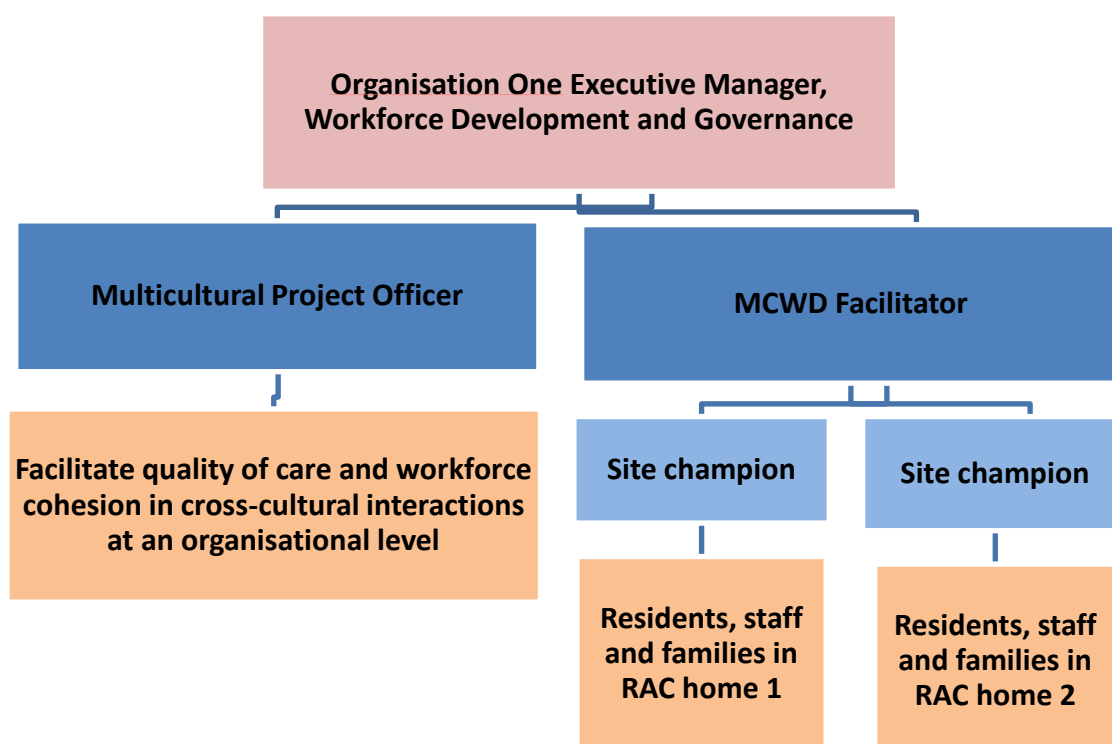


Figure 6.1 Organisational structures to support the project

Using multiple sources of information to inform actions

The MCWD facilitator was required to undertake quarterly cross-cultural care auditing activities and use the outcomes to trigger investigations of issues of concern in cross-cultural care. The cross-cultural care audit tool was developed in the project to enable the auditing activities. The draft audit tool was developed based on a literature review and findings from residents and staff experiences in cross-cultural care services. The content validity of the audit tool was achieved through rigorous peer review and discussed in three consultative workshops. Changes were made to reflect the feedback from the peer review and comments in the workshops. A pilot test of the tool was undertaken by two MCWD Facilitators and a research assistant.

An interrater reliability test was undertaken and the values were between 0.90 and 0.92, indicating an acceptable interrater reliability.

The auditing activities required the auditor to interview 5 CALD residents or their families and discuss with them their expectations of cross-cultural care and the most appropriate way to meet their care needs. The auditor was required to not only rank each item with regards to care needs, but also collect qualitative comments from residents for reflection. An example of how site champions used the findings from auditing activities to facilitate changes was the provision of culturally specific food for residents in care homes. More examples were reported from the focus group discussions in Chapter 7. In total, the MCWD facilitators undertook auditing activities for 15 CALD residents at each time point. The summary of audit results on the mean percentage of totally met care needs across 3-time points are presented in Table 6.1. Items with relatively lower percentages of totally met needs are listed as follows:

- Item 1: Diet/drinking needs
- Item 3: Religious and spiritual needs
- Item 4: Communication needs associated with ability to speak, read and write English.
- Item 13: Needs associated with lifestyle and preferences
- Item 14: The need to avoid cultural taboos, culturally unacceptable behaviours and language
- Item 17: The need to use culturally and linguistically appropriate social workers and counselling services

Table 6.1 Summary of cross-cultural care audit results

Categories	Time 1 total met (%)	Time 2 total met (%)	Time 3 total met (%)
CCCS needs assessed & recorded at admission & via regular care plan review	56	62	100
Services are AVAILABLE for residents to meet their needs*	63	91	87
Services are ACCESSIBLE as needed*	60	65	87
Services are respectful/ ACCEPTABLE	60	65	100
Services have met High- QUALITY standards*	60	100	100
Mean %	60	77	95

Note: The audit tool includes 18 items and ranked on 1 (The need is unmet), 2 (The need is partially met) and 3 (The need is met). The summary presents the mean percentage of totally met needs.

Auditors were encouraged to take notes to facilitate reflection on audit results and the understanding of the audit results. The notes are summarised in Table 6.2.

Table 6.2 Selected notes from Auditors

	Notes
Time 1	<ul style="list-style-type: none"> • Item 1& 2: Enjoys culturally specific foods. Wishes she had more; • Item 1: Daughter brings in culturally specific foods. Family dine with her often. Space for them to do this • Item 3: Family take responsibility for aspects of religious needs. Resident goes offsite to church with family where they attend in the community. Priest/elder visits weekly. • Item 4: Communication needs – resident on admission able to communicate in English – with cognitive decline has reverted to 1st language. Due to being long standing resident, staff are able to ascertain and anticipate needs. Family speak with resident in 1st language. • Item 4: Resident reliant on family for communication needs. Body language/sighing allows staff to be aware of needs – behavioural issue wanting family to be in attendance at all times – also culturally significant that children will exclusively look after ageing parents. Resident has reverted to 1st language in ageing. • Item 5: Longstanding Australian citizen. Family take responsibility for interpretation if needed; Interpreter services declined by family • Item 6: Family take resident offsite for annual appointments • Item 7: No formal service available – reliant on staff attributes to communicate effectively during decline in cognition. • Item 9: Family anticipate and take resident to community events • Item 11: Cultural friends visit regularly for conversation; No outside cultural groups visit at present. Does not interact with people of own culture • Item 12: Resident’s needs are met. For example XXX [an aged care organisations] employs RNs to perform massage on residents as a pain management strategy. Residents are also permitted to continue their personal alternative medication regime which is checked by the Dr during the admission process with alternative medications recorded on the medication charts for staff to monitor/administer (eg. Vitamin C, fish oil). If residents wish to have complementary or alternative medicine services then this can be negotiated through the Manager Residential Services. Lifestyle programs also address this need in part by offering for example ‘Tai Chi’ sessions. • Item 13: Reliant on family input re lifestyle/preference issues • Item 16: Residents’ patterns of behaviour related to culture are not recorded specifically for ‘culture’ however are assessed within other admission and ongoing clinical review assessments. • Item 17: Family members often translate. We often use a Spanish EN • Item 17: XXX (an aged care organisation) employs social workers for Residential Services. RN’s are able to refer residents to the social worker who will do an initial visit and assess the needs of the resident. If the resident is from a CALD background then the social worker can access an interpreter through the Government assisted free service. In the event that the social worker assesses the resident as benefiting more from an external service such as the Older Persons Mental Health Service or an alternative counselling service then this will be recommended to the Clinical Nurse Co-ordinator for action.
Time 2	<ul style="list-style-type: none"> • Item 14: Behavioural triggers are identified. • Item 17: A social worker is accessible. We do not provide cultural specific counselling services however will facilitate contact with a resident’s community/cultural group. The social workers are trained to be culturally sensitive.
Time 3	<ul style="list-style-type: none"> • Item 1: Weekly cultural food prepared by hospitality • Item 1: Daily menu consultation between hospitality re food requirements for the day • Item 1: Specific diet, monitored by hospitality and family • Item 9, 11, 13: Lifestyle assessment, including family input on admission. 6 monthly lifestyle reviews • Item 14: Behavioural triggers are identified. • Item 15: Identified through ACFI process following admission • Item 16: Spiritual and cultural preferences are recorded and met. • Item 17: A social worker is accessible. We do not provide cultural specific counselling

	Notes
	<p>services however will facilitate contact with a resident's community/cultural group. The social workers are trained to be culturally sensitive.</p> <ul style="list-style-type: none"> Item 17: RNs and management able to refer residents to appropriate social worker after consultation with family. Referrals to DBMAS as required

Note: the items in the 'Cross-cultural care audit tool' is presented as Appendix 1

The areas that required improvement were identified at time 1 auditing activities. The increase of the totally met needs across the time points reflected the efforts the MCWD facilitators and site champions made to address the care needs in cross-cultural care services. The positive results also suggested that regular cross-cultural care auditing activities are imperative and allow service providers to focus on residents' perspectives of the areas that need to be improved.

The project team conducted resident satisfaction surveys at 3-time points and provided the management group, the MCWD facilitators and site champions with results and resident comments. They were required to respond to the results and feedback. The information from this part of project evaluation and the process to engage service providers in critical reflection enabled the issues to be addressed and staff development activities were undertaken to ensure staff engaged in the quality improvements. Results of resident satisfaction survey and their comments on cross-cultural care are presented in Chapter 7.

Actions undertaken to improve cross-cultural care and to improve team cohesion

MCWD facilitators and site champions developed a quarterly action plans in phase two of the project. A template of the action plan developed from a previous project in residential aged care was adapted for the project (Morey et al. 2015). A sample action plan submitted to the project steering committee is provided in Appendix 10. The sections in the action plan reflected the objectives of the multicultural workforce development project and targeted the organisation need to improve quality of care for residents and to attract skilled and quality workers. These sections are:

- Summary of the action plan and implementation
- Performance of the activity
- What are the current policies and procedures that relate to this activity?
- Are there any follow up actions required to sustain change as a result of this activity? If so, please detail below.
- Have you identified any further clinical issues or activities as a result of conducting this activity?

Each action plan, and the performance and outcomes were reported to the project steering committee. Discussions were conducted to analyse enablers and barriers to the implementation of the project. Feedback on the activities were provided through meeting minutes and an action sheet to enable site champions to improve their performance in the project. Quarterly workshops were provided with site champions and MCWD Facilitators to discuss their action plan, challenges they encountered and suggestions to how to overcome these challenges and sustain the positive outcomes.

The main actions undertaken by MCWD facilitators and site champions to improve cross-cultural care issues and team cohesion are grouped in three categories described as engaging residents in the project, cultural exchanges between residents and staff, and engaging staff in the project. Examples of these activities are presented in Table 6.3.

Table 6.3 Examples of actions to improve cross-cultural care and team cohesion

	Examples of activities
Engaging residents in the project	<ul style="list-style-type: none"> • Large world map in Main Hall. Identifies “where in the world” our residents come from. • Residents’ armchair travel to Italy in main hall. • Talk with the resident and identify their important treasure (artefact). • Take a photo of the important treasure and write up the residents’ story about it. • Read the story written to the resident to gain their input and ensure accuracy of information. • Produce an A4 poster including the story and the picture of the important treasure. • Display the poster in the residents room for staff, residents and important others to access. • All residents have had a varied and interesting life. By conducting this activity, we are able to demonstrate an important aspect of their life to all who enter their room – demonstrating cultural humility. Staff are able to read and then reflect upon the resident, at times assisting them to engage further. Maintenance of their own self-worth and a sense of belonging will potentially arise for the resident. • This activity impacts greatly upon Standard 3. Lifestyle staff are also able to use this information to help with management of the resident and planning their future activities.
Cultural exchanges between residents and staff	<ul style="list-style-type: none"> • Placement of maps and info to all residents and staff how to mark • Where in the world map placed in the staff room. Coloured pins to identify staff’s country of origin. • Visit by resident Greek family for questions and answers, Greek lunch • Lifestyle set up hall. Hospitality to prepare afternoon tea menu in liaison with Chinese staff • Liaise with staff on afternoon shift re sharing of meal • Lunch 11am -1pm to celebrate. Staff to bring a traditional plate; T shirts printed to promote the occasion • Asked staff to wear cultural dress or something orange. • Asked staff to bring in a plate of food to share • Video recording of staff activity utilising signs expressing personal cultural information. • Poster has been displayed to inform the residents for the upcoming event. • Staff members brought some Mexican items to add to the decoration interior. • Multicultural board reflected Mexican Day with varieties of pictures and decorations including Mexican traditional clothes and hats. • Mexican food ordered and provided to the resident on 19/05/16. Dietary requirements considered. • Residents listened to Mexican Music. • Photos taken.
Engaging staff in the project	<ul style="list-style-type: none"> • Time spent on floor with small groups introducing booklet 3 and going through 1 activity in the book discussion then small group to encourage conversation and reflection • Poster display with regarding cross-cultural communication on notice board and nurses stations • PowerPoint presentation and Questions and answers with regards to learning modules

	Examples of activities
	<ul style="list-style-type: none"> • To discuss case studies and encourage discussion and reflection • Staff approached after 1 week to discuss case studies –done individually or in small groups • Module 4 delivered personally to all staff except management team – pigeon holes. Staff approached after 1 week and invited to group sessions to discuss • Aussie Slang dictionary • Nurse/care and patient language helper • Group activity- 30 mins during mandatory training day • Staff and residents given the opportunity to approach site champions to discuss any multicultural needs. • MCSC approached by Management and staff re identified persons requiring one on one mentoring. • August 2016, Education and Training Package “Workbook Two for Staff”, delivered by XX (MCWD facilitator) to both residential sites. Staff were allowed the time frame > 1 week to read through and potentially study the workbook. After this time, staff were approached by Site champions individually and in informal group settings, to discuss the case studies within the workbooks. Open discussions allowed and staff comments and concerns listened to. Where able, related case studies to situations staff are aware of in their own workplace. • Site champions utilised the Facilitator Manual for tips to guide discussions and for accurate responses to issues raised within case studies. • Site champions had contact with as many staff as possible, across all work domains. • Site champion discussed with MCWDF and MRCS re implementing a self-reflection tool that would offer staff the opportunity to reflect on one’s self. • Site champion identified unmet diet needs for Mrs XXX (resident’s name), from audit. Mrs XXX is originally from Philippines and would like to have rice. Site champion discussed with the housekeeping coordinator about the case and also used a case scenario in the workbook (module three) as an example to discuss how to make changes to meet Mrs XXX’ diet needs. Site champion also worked in collaboration with the RN to individualise Dietary Requirements for Mrs XXX. In discussions with Mrs XXX, the facility now provide Mrs XXX with her cultural meal every Wednesday.

Summary

In phase two the MCWD facilitators and site champions submitted 8 action plans and reported the activities and outcomes in monthly Steering committee meetings and workshops for site champions and MCWD facilitators. Most of activities were also reported in regular project newsletters that were developed to engage stakeholders in the project. Outcomes from project evaluation as reported in Chapter 7 supported that the carefully planned activities were in line with the project objectives. The process and outcomes of the activities in the four participating sites were monitored. The evidence collected reinforced that MCWD facilitators and site champions demonstrated their leadership in facilitating cross-cultural care services and workforce development.

Chapter 7: Findings from project evaluation

Introduction

This chapter reports findings from the implementation of the MCWD model and the education program based on satisfaction surveys with residents, surveys with staff prior to the intervention (baseline surveys or time 1), at 6 months (time 2) and 12 months (time 3) after the intervention. Findings from focus groups with staff at 6 months and 12 months after the intervention are also presented. Findings from each survey and focus groups were reported in 'Project Evaluation Report 1', 'Project Evaluation Report 2' and 'Project Evaluation Report 3' respectively throughout the project life. These reports were discussed in the Steering Committee meetings. The reports were also sent to MCWD facilitators, Residential Care Managers and site champions to review and comment. Summaries of evaluation reports were presented in the regular project Newsletters and disseminated to residents, their families and staff in participating sites and the management and leadership group of the two industry partners. The dissemination strategies enhanced the engagement of stakeholders in the project and facilitated critical reflection so that care service and team cohesion could be improved throughout the project.

Findings from resident survey

Resident demographic information

The baseline surveys with residents were undertaken between March and April 2016 prior to the implementation of the MCWD model and the education program. The surveys were repeated at 6 and 12 months after the commencement of the intervention. The number of residents or their families who completed survey questionnaires and returned them to the project team at Flinders University in time 1, time 2 and time 3 are summarised in Table 7.1. The vast majority (around 90%) of returned surveys were completed by residents themselves with support from the research assistants from Flinders University and around 10% of returned surveys were completed by family members. Resident characteristics are summarised in Table 1. Overseas-born residents are from 15 countries. These were: Bangladesh, Canada, France, Germany, Hungary, India, Italia, Latvia, Malaysia, Netherlands, New Zealand, Philippines, Russia, The United Kingdom and Yugoslavia.

Table 7.1 Resident demographic Information

Resident characteristics	Time 1			Time 2			Time 3		
	Aus. (N=89 72%)	Ove. (N=34 28%)	The total (N=123)	Aus. (N=134 72.8%)	Ove. (N=50 27.2%)	The total (N=184)	Aus. (N=134 72.8%)	Ove. (N=37 23%)	The total (N=160)
Age: median (IQR)	87 (7)	86 (9)	87 (7)	87 (7)	86 (9)	89 (9)	88 (10)	88 (9)	88 (9)
Male (%)	24 (27)	13 (38)	37 (30)	23 (17.2)	22 (44)	45 (24.5)	30 (24.4)	14 (37.8)	44 (27.5)
Female (%)	65 (73)	21 (62)	86 (70)	111 (82.8)	28 (56)	139 (75.5)	93 (75.6)	23 (62.2)	116 (72.5)
Months in the home: median (IQR)	12 (26)	10 (16)	12 (21)	13 (31)	12 (17)	13 (26)	16 (22)	12 (13)	15 (15)
Years in Australia: median (IQR)	NA	50 (11)	NA	NA	58 (14)	NA	NA	50 (16)	NA

Note: Aus.=Australian-born Ove.=Overseas-born

Comparison of resident survey results across the three time points

Residents and families' perceptions of cross-cultural care services at the three time points are summarised in Table 7.2. The findings from Time 1 (prior to intervention) are used to describe the main findings in the order the questions were asked. Resident survey results from three time points were compared in order to understand the changes in resident satisfaction with care and services in the 12 month period (March 2016 – March 2017). There was no statistically significant difference between the Australian-born group and the Overseas-born group for all questions.

- Question 1: Seventy-one percent of residents (71%) settled into their respective residential care homes easily while 29% had difficulties in settling in. There were no statistically significant changes across the 3-time points.
- Question 2: Approximately half of residents (51%) experienced reduced stress when moving into the residential care home while 20% experienced increased stress. An increased proportion of residents perceived that the effect of moving into the facility had increased their stress level across 3 time points. This result needs to be investigated in future projects.
- Question 3: The vast majority of residents (99.2%) perceived that they got along with staff well (combined 'Very well' and 'Moderately well'). There was no statistically significant change across the 3-time points.
- Question 4: Eighty-two percent of residents (82%) were able to interact with others residents while 18% were unable to interact with other residents. The proportion of residents who indicated their interactions with other residents showed a statistically significant increase from time 1 to time 2.
- Question 5: Eighty-four percent of residents (84%) interacted well with other residents (combined 'Very well' and 'Moderately well'), while 16% of them did not interact well with other residents. Residents' satisfaction with interactions with other residents showed a statistically significant improvement from time 2 to time 3.
- Question 6: Seventy-one percent of residents (71%) were satisfied with the care home's efforts to meet their language needs (combined 'Very satisfied' and 'Satisfied') while 5% were dissatisfied. Residents' satisfaction with the facilities' efforts to meet their language needs showed a statistically significant increase across the 3 time points.
- Question 7: Sixty-two percent of residents (62%) were satisfied with the social and leisure activities available to them (combined 'Very satisfied' and 'Satisfied') while 5% were dissatisfied. There was no statistically significant change across the 3-time points.
- Question 8: Sixty-nine percent of residents (69%) were satisfied with the cultural appropriateness of the food provided (combined 'Very satisfied' and 'Satisfied') while 15.4% were dissatisfied (combined 'Dissatisfied' and 'Very dissatisfied'). There was no statistically significant change across the 3-time points.

- Question 9: Among residents from CALD backgrounds: 16 CALD residents (47% of CALD residents) said that there was a particular staff member in the residential care home that they could discuss their care needs with in their primary language while four CALD residents (12% of CALD residents) said that there was no particular staff member in the residential care home that they could discuss their care needs with in their primary language. Fourteen CALD residents (41% of CALD residents) said this question was not applicable for them. Residents perceived that a particular staff member/volunteer in the facility with whom they could speak in their first language about their care showed a statistically significant increase across 3 time points.
- Question 10: Among residents from CALD backgrounds, 6 residents (18%) would have preferred to be in a culturally and linguistically diverse aged care home. There was no statistically significant change across the 3-time points.

Table 7.2 Satisfaction with cross-cultural care services

Items	Time 1 N=123 N (%)	Time 2 N=184 N (%)	Time 3 N=160 N (%)	X ² & P value
1. How well did you settle into the aged care facility?				
Easily	87 (71)	133 (72.3)	115 (71.9)	X ² = 3.077
With difficulty	35 (29)	47 (22.5)	39 (24.4)	P=0.545
Never	1 (1)	4 (5.2)	6 (3.8)	
2. How would you describe the effect of moving into the facility on your stress level?				
Reduced	63 (51) †	65 (35.3) †	35 (21.9) †	X ² = 26.904
No change	35 (29)	62 (33.7)	68 (42.5)	*P=0.0005
Increased	25 (20)	57 (31)	57 (35.6)	
3. How well do you currently get on with the staff in the facility?				
Very well	98 (79.7)	143 (77.7)	125 (78.1)	X ² = 9.216
Moderately well	24 (19.5)	40 (21.7)	35 (21.9)	P=0.162
Not well	1 (0.8)	1 (0.8)	0	
4. Are you currently able to interact with other residents?				
Yes	101 (82) †	170 (92.4) †	143 (89.4)	X ² = 7.866
No	22 (18)	14 (7.6)	17 (10.6)	*P=0.02
5. If yes, how well do you interact with the other residents?				
Very well	56 (46)	86 (46.7)	75 (46.9)	X ² = 11.894
Moderately well	47 (38)	77 (41.8) †	78 (48.8) †	*P=0.018
Not well	20 (16)	21 (11.4)	7 (4.4)	
6. Overall, how satisfied are you with the facilities efforts to meet your language needs?				
Very satisfied	39 (32)	93 (50.5)	32 (20.0)	X ² = 69.133
Satisfied	48 (39) †	62 (33.7)	112 (70.0) †	*P=0.0005
Neutral	30 (24)	20 (10.9)	11 (6.9)	
Dissatisfied	6 (5)	8 (4.3)	5 (3.1)	
Very Dissatisfied	0	1 (0.5)		
7. How satisfied are you with the social and leisure activities provided for you?				
Very satisfied	21 (17)	52 (28.3)	38 (23.8)	X ² = 14.717
Satisfied	55 (45)	78 (42.4)	78 (48.8)	P=0.065
Neutral	41 (33)	45 (24.5)	44 (27.5)	
Dissatisfied	5 (4)	8 (4.3)		
Very Dissatisfied	1 (1)	1 (0.5)		
8. How satisfied are you with the cultural appropriateness of the food provided?				
Very satisfied	26 (21)	48 (26.1)	24 (15.0)	X ² = 12.883
Satisfied	59 (48)	87 (47.3)	91 (56.9)	P=0.116

Neutral	19 (15)	35 (19.0)	28 (17.5)	
Dissatisfied	16 (13)	13 (7.1)	13 (8.1)	
Very Dissatisfied	3 (2.4)	1 (0.5)	4 (2.5)	
9. Is there a particular staff/volunteer in the facility with whom you can speak in your language about your care?				
Yes	46 (37) †	68 (37)	88 (55.0) †	$X^2 = 29.695$
No	10 (8.1)	30 (16.3)	31 (19.4)	* $P=0.0005$
Not applicable	67 (55)	86 (46.7)	25.6)	
10. Would you prefer to be in a mainstream or a culturally and linguistically diverse aged care facility?				
Mainstream	116 (95)	169 (91.8)	154 (96.3)	$X^2 = 3.295$
Culturally & linguistically diverse	6 (5)	15 (8.2)	6 (3.8)	$P=0.193$

Note: (1) Chi-square test was applied to identify changes across the 3-time points. (2) *The significant level is $P < 0.05$. (3) † indicates statistically significant difference between or among different time points of survey.

Residents' comments and suggestions on cross-cultural interactions

In the survey, residents made comments on cross-cultural care and services. The number of positive comments about staff and care services increased across the three time points. Detailed comments were provided for the management group to facilitate reflection on the improvements of care and services. The main findings from residents' comments on cross-cultural interactions with staff are summarised in Table 7.3:

- Residents generally had a positive experience of cross-cultural interaction with staff when staff demonstrated caring and good communication skills.
- Cross-cultural communication between residents and staff was perceived as a challenge to meet residents' care needs.
- Residents had an expectation of culturally appropriate food.
- Residents were curious about CALD background of staff and their culture.
- Residents suggested that education and training on cross-cultural communication and care services for staff was needed.

Table 7.3 Summary of residents' comments on cross-cultural interactions

	Positive comments	Suggestions for improvements
Time 1	<p>No language problem with overseas staff. Needs well met.</p> <p>Do very well with a variety of people living here. If you complain, they do their best to fix it.</p> <p>My wife is cared for in the mental 'ward' because of her short term memory loss. It is a relief that she is so well assisted.</p> <p>I am perfectly happy with what I have seen.</p>	<p>Understanding peoples cultural and how to act. I am OK. Body language is more important than speaking better English</p> <p>More training.</p> <p>I sit here alone, not enough people to take to unless I go out.</p> <p>I have a sore arm today because I was handled the wrong [way]</p> <p>I don't have a lot of interaction with them, just to speak slowly and clearly</p> <p>Training for carer workers from CALD background.</p> <p>Some staffs English is very poor, one staff member couldn't understand what I needed when I was showered. More education of staff would be helpful.</p> <p>More careful in selection of staff with better language skills.</p> <p>Observation: [XX] requested more fresh water in Italian. Staff said "don't speak Italian".</p> <p>May have to ask overseas staff to repeat themselves a few times. But can get there.</p> <p>My mother is an English speaker, but she is quite deaf and very polite. It's really important that the staff who speak to her make sure she has actually heard them that they listen to what she says and check she meant it.</p> <p>I would like a nice plate of pasta but they don't know how to do it here.</p> <p>Shouldn't have to spend money on food when paying 85% of pension. Told her they catered for allergies, but they don't. Staff don't write down what she says when organising the menu. Keep giving her wholemeal bread when she needs white bread and low fibre diet. Would like to be able to cook her own meals.</p>

	Positive comments	Suggestions for improvements
Time 2	<p>I enjoy hearing all different stories. They're all lovely, they like me because they're finding my sense of humour is good. We all treat each other with respect. Couldn't get a better lot- agency staff different. We get new staff all the time. The staff are all lovely, I have no issues at all. They take good care of me I have no trouble understanding people from different countries. My children have married people from other countries so I'm used to different languages and accents. I find the xx girls (staff from a CALD background) very caring. It's easy for me to talk to everybody. The staff are very attentive to my 91 year old mother's needs and they often make time to chat or joke with her. I don't have any trouble with the dark girls and boys. They treat me well and take their time with me. I have learnt about the different cultures here when I talk to them. I had Asian staff help me and they are very good – I have no troubles at all.</p>	<p>I'm deaf and can't remember their (foreign staff) names because they are different from the names that I'm familiar with. It's alright here but I would like someone to come and speak XX (a language other than English) with me. Some of them just don't say anything- why can't they just talk? They talk good English with me and I speak good English with them. Some of them use cards to communicate – that's something that's hard, especially because of my bad eyes. I can't understand some of the staff sometimes. They speak too fast in a little voice. Sometimes they talk in their own language as though I am not there. I just ask them to stop and then they talk in English again. Some of them from overseas are hard to understand. I'll ask them to repeat it until I think I know what they are saying.</p>
Time 3	<p>They learn from us and we learn from them. They are very good workers On the whole they seem to be learning. I think they are having education I enjoy hearing different stories. No trouble at all. They're lovely to me – quite friendly They go out of their way to introduce residents to the different cultures All the staff seem to speak good English and are very caring Sometimes I can't understand but they repeat what they said Staff's understanding of English is good. I'm not affected by their accents On the whole they're lovely I'm glad to have come here Wonderfully clean There are different levels of staff and I get on quite well with all the staff X is a very well run facility and since being here for some time it has become my home The staff are always kind and caring and we feel a great deal of comfort knowing that Mum is well cared for.</p>	<p>I would like more interest in cultural matters. I am interested in science, technology and theatre. There can be more of that. People could come in to give us talks on this. We need to let staff know that we can't hear them when they speak to us. Some speak very quickly Need to listen very intently sometimes to understand foreign staff. This can get a bit worrying as there are so many different accents to cope with..... Sometimes accents are hard and difficult to understand, but that doesn't happen very often Get an interpreter when family is not there I've got an iPad but I can't use it here because they don't have wifi. Several of us have got iPads and we need help to be able to learn how to use them – that would be good. I'd like to have wifi – I have a computer and a smart phone. They could have more activities and it's not everyone's cup of tea Could be more variety and care in the preparation and presentation [of food]</p>

Findings from staff survey

Staff demographic information

The baseline surveys with staff were undertaken between March and April 2016 prior to the implementation of the MCWD model and the education program. The surveys were repeated in 6 and 12 months. The number of staff who completed survey questionnaires and their characteristics are summarised in Table 7.4. Overseas-born staff were from 18 countries. These countries are China, Bosnia and Herzegovina, India, Japan, Kenya, Iran, Italy, Malaysia, Nepal, Philippines, Poland, Russia, South Korea, Sri Lanka, Tanzania, The United Kingdom, Vietnamese, Zimbabwe.

Table 7.4 Socio-cultural-demographic characteristics of Australian-born and Overseas-born staff

Categories	Time 1			Time 2			Time 3		
	Aus. N=62 (55%)	Ove. N=51 (45%)	Total N=113	Aus. N=57 (54.8%)	Ove. N=47 (45.2%)	Total N=104	Aus. N=54 (55.7%)	Ove. N=43 (44.3%)	Total N=97
Male: N (%)	7 (11)	8 (16)	15 (13)	5 (8.8)	11 (23.4)	16 (15.4)	6 (11.1)	12 (27.9)	18 (18.6)
Female: N (%)	55 (89)	43 (84)	98 (87)	52 (91.2)	36 (76.6)	88 (84.6)	48 (88.9)	31 (72.1)	79 (81.4)
Age (Median & IQR)	50 (16)	38 (17)	45 (17)	46 (16)	44 (14)	45 (14)	48 (16)	42 (12)	45 (14)
Years in the organisation (Median & IQR)	4.5 (7)	3 (4)	3.5 (4.5)	5 (5)	5 (6)	5 (5)	5 (5)	3 (5)	4 (5)
Speak a language other than English fluently: N (%)	6 (10)	37 (73)	43 (38)	1(1.8)	34 (72.3)	35 (33.7)	1(1.9)	35 (81.4)	36 (37.1)
Length of stay in Australia if born overseas (Median & IQR)	N/A	16.5 (5-30)	N/A	N/A	8 (9)	N/A	N/A	8 (9)	N/A
RN or EN: N (%)	32(28.3)			33 (31.7)			27 (27.8)		
PCA: N (%)	58 (51.3)			55 (52.9)			58 (59.8)		
Others	23 (20.4)			16 (15.4)			12 (12.4)		

Note: (1) Aus.=Australian-born (2) Ove.=Overseas-born (3) Other categories of staff, including lifestyle enhancer, maintenance, hospitality, reception, therapy support and clerical support.

Staff perceptions of cultural competency across the three time points

Staff perceptions of Cultural Competency at time 1, time 2 and time 3 are summarised in Tables 7.5. Results from time 1, time 2 and time 3 were compared in order to understand the changes in capability of staff in cross-cultural interactions in the 12-month period (March 2016 – March 2017). The results are summarised in the follows:

- Staff self-perceived knowledge, skills, comfort level, self-awareness and education and training showed a statistically significant increase (see Table 7.5). The increase of the scores in these areas mainly between time 1 and time 3, provide an indication that a sufficient time period is needed for the intervention to be effective.
- The factor of 'Importance of awareness' showed no statistically significant changes over time. The mean score for this factor was relatively higher across the 3 time points. This might be an indicator that staff were cognisant that cultural awareness is an important aspect of their care activities prior to the intervention.

Table 7.5 Comparison of Cultural Competency Questionnaire scores across three time points

Factors	Time 1 N=113	Time 2 N=104	Time 3 N=97	F value & p Value
Knowledge 10 items (Mean & SD)	3.0 (0.9) †	3.3 (1.0) †	3.5 (0.8) †	F=10.314 P=0.0005
Skills 15 items (Mean & SD)	2.4 (1.3) †	2.5 (1.3)	3.3 (1.0) †	F=19.264 P=0.0005
Comfort level 16 items (Mean & SD)	3.0 (1.1) †	3.1 (0.9)	3.6 (0.7) †	F=13.973 P=0.0005
Importance of Awareness 5 items (Mean & SD)	4.0 (1.2)	4.2 (1.0)	4.3 (0.8)	F=4.363 P=0.14
Self-awareness 3 items (Mean & SD)	3.7 (1.3) †	3.8 (1.5)	4.3 (0.8) †	F=8.154 P=0.0005
Education and training 5 items (Mean & SD)	3.1 (1.1) †	3.1 (1.1)	3.4 (1.0) †	F=11.206 P=0.0005

Note: (1). The 54-item Cultural Competency Questionnaire was rated on a 5-point Likert scale with higher scores indicating better Cultural Competence. (2). † indicates significant improvement between time1 and time 2 and between time 1 and time 3 using post-hot tests in One-way ANOVA. (3) *The significant level is P<0.05.

Comparisons of cultural competency between Australian-born and Overseas-born staff

Group comparisons between Australian-born and Overseas-born staff were made in order to identify changes over time in each group. The results of the group comparisons are summarised in Table 7.6 and explained in the following points:

- Knowledge: Prior to the intervention, there was no statistically significant difference between the two groups. Across the 3-time points, both Australian-born and overseas-born groups showed a statistically significant increase in 'knowledge' scores.
- Skills: Prior to the intervention, overseas-born groups showed a statistically significant higher score in 'skills' compared to Australian-born group. Across the 3-time points, Australian-born groups showed a

statistically significant increase in skill scores while overseas-born groups showed no statistically significant change.

- **Comfort level:** Prior to the intervention, overseas-born groups showed a statistically significant higher score on 'Comfort level' compared to Australian-born groups. Across the 3-time points, Australian-born groups showed a statistically significant increase on 'Comfort level' scores while overseas-born groups showed no statistically significant change.
- **Importance of Awareness:** Prior to the intervention, overseas-born groups showed a statistically significant higher score on 'Importance of Awareness' compared to Australian-born groups. Across the 3-time points, Australian-born groups showed a statistically significant increase on 'Importance of Awareness' score while overseas-born group showed no statistically significant change.
- **Self-awareness:** Prior to the intervention, there was no statistically significant difference between the two groups. Across the 3-time points, both Australian-born and overseas-born groups showed statistically significant increase of 'Self-awareness' scores.
- **Education and training:** Prior to the intervention, overseas-born groups showed a statistically significant higher score on 'Education and training' compared to Australian-born group. Across the 3-time points, both Australian-born and overseas-born groups showed statistically significant increase on 'Education and training'

Table 7.6 Comparisons of Cultural Competency Questionnaire score between Australian-born and overseas-born staff

Factors	Time 1				Time 2				Time 3				T1-T3	
	Total N=113	Aus. N=62	Ove. N=51	p Value	Total N=104	Aus. N=57	Ove. N=47	p Value	Total N=97	Aus. N=54	Ove. N=43	p Value	Aus.	Ove.
Knowledge 10 items (Mean & SD)	3.0 (0.9)	2.9 (0.9) †	3.1 (0.9) ‡	0.35	3.3 (1.0)	3.2 (1.0)	3.4 (1.0)	0.273	3.5 (0.8)	3.5 (0.9) †	3.6 (0.7) ‡	0.497	F=6.056 P=0.003	F=4.308 P=0.015
Skills 15 items (Mean & SD)	2.4 (1.3)	2.1 (1.1) †	2.7 (1.4)	0.006*	2.5 (1.3)	2.3 (1.2)	2.8 (1.2)	0.038*	3.3 (1.0)	3.4 (1.0) †	3.3 (0.9)	0.681	F=20.721 P=0.0005	F=2.950 P=0.056
Comfort level 16 items (Mean & SD)	3.0 (1.1)	2.7 (1.1) †	3.3 (1.1)	0.003*	3.1 (0.9)	2.6 (1.1)	3.3 (0.7)	0.095	3.6 (0.7)	3.7 (0.8) †	3.6 (0.6)	0.708	F=14.356 P=0.0005	F=2.104 P=0.126
Awareness 5 items (Mean & SD)	4.0 (1.2)	3.7 (1.3) †	4.2 (1.1)	0.037*	4.2 (1.0)	4.2 (1.1) †	4.4 (0.9)	0.462	4.3 (0.8)	4.4 (0.8) †	4.3 (0.7)	0.471	F=5.109 P=0.007	F=0.487 P=0.615
Self- awareness 3 items (Mean & SD)	3.7 (31.3)	3.6 (1.5)	3.8 (1.0) ‡	0.97	3.8 (1.5)	3.2 (1.7)	4.4 (0.8) ‡	0.0005*	4.3 (0.8)	4.2 (0.9)	4.4 (0.6) ‡	0.366	F=7.144 P=0.001	F=9.122 P=0.0005
Education and training 5 items (Mean & SD)	3.1 (1.1)	2.5 (1.1) †	2.9 (1.0) ‡	0.031*	3.1 (1.1)	2.6 (0.9) †	3.7 (1.0) ‡	0.0005*	3.4 (1.0)	3.2 (1.0) †	3.6 (1.0)	0.090	F=8.838 P=0.0005	F=7.977 P=0.001

Note: (1). Australian=Australian-born, Overseas=Overseas-born. (2). The 54-item Cultural Competency Questionnaire was rated on a 5-point Likert scale with higher scores indicating better Cultural Competence. (3). The Mann–Whitney Test was applied to compare the two groups at each time point. (4) T1-T3: comparisons of Australian-born (Aus.) across the 3 time points and overseas-born (Ove.) across 3 time points were made using One-way ANOVA. (5) Australian-born group: †Post-hot tests indicate significant improvement between time 1 and time 2 and between time 1 and time 3. (6) Overseas-born group: ‡Post-hoc tests indicate significant improved between time 1 and time 2 and between time 1 and time 3. (7) The significant level is $P < 0.05$.

Staff perceptions of the care home’s capacity to create and sustain improvement across the three time points

Staff perceptions of the facilities’ capacity to create and sustain improvements across the three time points are summarised in Table 7.7. The scores are based on the two subscales: ‘Relationship & communication’ and ‘Team work & leadership’. Results from time 1, time 2 and time 3 were compared in order to understand the changes over the 12-month period (March 2016 – March 2017). The main interpretations of findings indicated that:

- Relationship & communication: Prior to the intervention, the score for ‘Relationship and communication’ was between ‘agree’ and ‘neutral’. This result revealed that the majority of the participants viewed their ‘Relationship and communication’ in the workplace as good. Across 3-time points, there was no statistically significant change of the score.
- Team work & leadership: Prior to intervention, the score for ‘Team work & leadership’ was also close to the rating category of ‘agree’ (or score of 4 in the 5-Likert scale). The results indicated that the majority of the staff agreed that the ‘Team work & leadership’ in the workplace was good. Across 3-time points, there was no statistically significant change of the score.
- Prior to intervention, the Overseas-born staff showed slightly more positive views on these two subscales. However, there was no statistically significant difference between the two groups across 3-time points.

Table 7.7 Staff perceptions of facilities’ capacity to create and sustain improvement across three time points

Factors	Total N=113	Time 2 N=104	Time 3 N=97	F value & P value
Relationship and communication 15 items (Mean & SD)	3.9 (0.7)	3.8 (0.7)	3.8 (0.6)	F= 0.103 P=0.902
Team work & leadership 11 items (Mean & SD)	3.7 (0.8)	3.6 (0.9)	3.6 (0.8)	F=0.468 P=0.626

Note: (1). The 26-item questionnaire was rated on a 5-point Likert scale from ‘strongly disagree’ to ‘strongly agree’ with higher scores indicating the better capacity to create and sustain improvement. (2). P value is from the One-way ANOVA Test.

Staff satisfaction with Cross-cultural Education and Training at time 2 and time 3

Staff were asked to rank three items regarding Cross-cultural Education and Training they received in time 2 and time 3. The scores for these items are presented in Table 7.8. The results from time 2 and time 3 were compared in order to understand the changes in staff satisfaction with Education and Training over the 6-month period. The results showed significant increase in satisfaction with education and training, the desire to learn and the impact of education or training on staff practice indicating changes in all three items.

Table 7.8 Comparison of Time 2 and Time 3 results on Cross-cultural Education and Training Questionnaire

Factors	Time 2 n=104	Time 3 n=97	p Value
How satisfied were you with the quality of the cross-cultural care and service training (Mean & SD)	2.3 (1.9)	3.3 (1.4)	P=0.001*
My desire to learn more about the cross-cultural care and service training (Mean & SD)	3.0 (1.6)	3.8 (0.9)	P=0.002*
Impact (Mean & SD)	2.3 (1.9)	3.4 (1.4)	P=0.000*

Note: 1. The 3-independent item questionnaire was rated on a 5-point Likert scale, with higher scores indicating the better capacity to create and sustain improvement.

2. P value is from the Mann–Whitney Test.

Comparisons of staff perceptions of Cross-Cultural Education and Training between Australian-born and Overseas-born staff

Group comparisons between Australian-born and Overseas-born staff were made in order to know changes over time in each group. The results of the group comparisons are summarised in Table 7.9 and explained as follows:

- How satisfied were you with the quality of the cross-cultural care and service training?: At time 2 Overseas-born staff showed a higher level of satisfaction with the quality of the cross-cultural care and service training compared to the Australian-born group. There were no statistically significant differences between the two groups at time 3.
- My desire to learn more about the cross-cultural care and service training: There were no statistically significant differences between the two groups at time 2 and time 3.
- Impact: At time 2 there were no statistically significant differences between the two groups. At time 3 Overseas-born staff showed a higher agreement that the cross-cultural care and service training had a positive impact on their ability to cope with the demands in their work activities, compared to Australian-born group.

Table 7.9 Education and Training questionnaire

Factors	Time 2				Time 3			
	Aus. N=57	Ove. N=47	Total N=104	p Value	Total n=97	Aus. n=54	Ove. n=43	p Value
How satisfied were you with the quality of the cross-cultural care and service training (Mean & SD)	2.5 (1.8)	3.2 (1.6)	2.8 (1.8)	P=0.001	3.3 (1.4)	3.2 (1.5)	3.4 (1.2)	P=0.723
My desire to learn more about the cross-cultural care and service training (Mean & SD)	3.3 (1.2)	3.5 (1.4)	3.4 (1.3)	P=0.058	3.8 (0.9)	3.6 (0.9)	4.0 (0.8)	P=0.072
Impact (Mean & SD)	2.6 (1.7)	3.2 (1.8)	2.9 (1.8)	P=0.147	3.4 (1.4)	3.1 (1.5)	3.8 (1.3)	P=0.012

Note: (1). The 3-item questionnaire was rated on a 5-point Likert scale, with higher scores indicating the better capacity to create and sustain improvement. (2) P value is from the Mann–Whitney Test.

Satisfaction survey with participants in the online program

Staff from Resthaven and AnglicareSA were invited to review the online ‘Cross-cultural care program for aged care staff’. In addition, through the ‘Ageing in a Foreign Land’ conference and the Aged & Community Services Australia (ACSA) Symposium, the project team invited aged care organisations to use the online program. By 20th August, 2017, 215 people had participated in the program. Among them, 67 completed the online satisfaction survey. The survey includes 6 questions using a 7 point-Likert scale with 1-7 representing strongly disagree to strongly agree (4=neutral). The median satisfaction score =6 and the IQR= 6-7. The results indicate a high satisfaction with the online program. Selected comments from the online survey are: (1) This module would be extremely helpful to someone who has no experience working in a multicultural environment. (2) I have worked and lived all over the world and did have most of this knowledge but it is still helpful to refresh this knowledge. (3) I learnt a lot. Thank you. (4) Can we have another module regarding the behavioural management of cross cultural residents? Thank you!

Findings from the staff focus groups

In total, 37 staff from four participating facilities attended one of the six focus groups in time 2 and 37 staff from four participating facilities attended one of the four focus groups in time 3. The participants’ role in their facility are summarised in Table 7.10.

Table 7.10 Summary of participants in the focus groups

Facility code	Managers/Care coordinators		RNs		ENs		PCAs		Others *		Total	
	T2	T3	T2	T3	T2	T3	T2	T3	T2	T3	T2	T3
101	1	0	1	0	0	1	5	3	1	2	8	6
102	0	0	1	0	3	0	5	5	6	4	15	9
103	3	0	1	0	0	0	2	4	1	5	7	9
104	1	3	2	0	0	1	3	3	1	1	7	8
Champion/Facilitators				5								5
Total	5	3	5	5	3	2	15	15	9	12	37	37

Note: (1) T2=time 2 and T3=time 3. (2) PCAs=Personal care assistants. (3) Others include: Lifestyle enhancer, maintenance, hospitality, reception, therapy support and clerical support

Six themes were identified from focus group discussion data. These themes are: (1) Leadership in cross-cultural interactions; (2) Engaging residents and staff in the project; (3) Perceived positive impact of the project on residents and staff; (4) Various approaches to learning activities; (5) Challenges encountered; (6) Suggestions to embed the program into the organisation’s policies and practices. Detailed discussions on these themes are presented below.

Leadership in cross-cultural interactions

Site champions played a crucial role in leading the implementation of the project. Management support was also important to ensure the objectives of the project were achieved. The leadership in cross-cultural care services was observed by staff:

Without having a site champion? Yeah that's, that's hard because I think it is the site champion that really has increased the awareness and has really got us all, yep- FG3-T2

If someone had just come in and handed the books to you I can guarantee you that the project would not have been as successful as it has been. It's the fact that XX [a site champion] out there talking about it, making us think about it, asking questions, doing projects, all of that sort of interactive personable thing is what has got it off the ground- FG3-T2

Not only that if there's a problem the staff know who to go to help them talk it out. It's another good thing. So you'd need someone that's, sort of a leadership role to be able to actually if they're having an issue with something they can actually discuss it with someone. FG3-T2

Management leadership was crucial for building an enabling environment for staff to develop and grow in cross-cultural interactions:

I think just being, particularly in terms of being in a more senior role, I suppose just lead by example for other people and help people to feel comfortable and supported, particularly new staff. I think that's really important and just set that supportive environment from here so it filters down and, yeah. FG4-T2

Staff also described a range of strategies site champions used to facilitate staff interaction in cross-cultural interactions:

XX [a site champion] writes them in consultation with the resident and the family and then the level of input from the resident just depends on their cognitive ability and that sort of thing. But yeah they've been great, I've really enjoyed reading those and learning a little bit about the residents and things I didn't know. FG3-T2

XX [a site champion] came around and saw, I don't know how many people, but she asked questions from the module to see if, and yeah because she came and asked me a questions and, but I didn't read the second one because that came out while I was on holidays and I've just got back. FG3-T2

Appointing site champions was recognised by staff as an effective human resource strategy to improve cross-cultural care services. The characteristics of leadership that site champions demonstrated included:

ability to identify cross-cultural issues, consulting with residents and staff about the solutions, posing questions to engage staff in learning, facilitating changes in practice and leading by example. These characteristics have implications for residential aged care homes when developing job descriptions for cross-cultural care service champions and when planning to invest in workforce and service development.

Engaging residents and staff in the project

Site champions developed a range of activities that engaged both residents and staff to share their culture and have meaningful interactions. For example, the world map, cultural events and harmony days were widely used as a means to enable residents and staff from all cultural backgrounds to interact with each other.

World map: where residents and staff come from

Staff described how they engaged in meaningful cross-cultural interactions using the world map and the positive outcomes they observed:

Well I think XX [a site champion] implemented it, but it's just been a map, world map of where people were born, dream holiday destinations, where they've visited, that sort of thing. We've got residents and staff have put little labels of where they've been or lived or all of them. FG1-T2

There was very positive feedback from the staff around the map that we had in the staff room and staff put where they were from because quite often you don't really know where people are from, so, that was really interesting and I know just general talk in the staff room – it created a lot of discussion. FG4-T2

Harmony days and cultural days

Site champions also enabled staff and residents to raise cultural awareness in aged care homes through well organised harmony days and cultural days:

Well most of the time it's lifestyle, doing the resident activities, but within those activities, staff have been involved as well. Like Chinese New Year and Indian Day, we had staff come as dress-ups and they actually did some handy work, some of their artwork on the skin and different things. And we've had something, generally once a month, that we've been all involved in. FG1-T2

Yep so our Harmony Day celebrations. We had a staff lunch and a staff..., everybody had brought food and dressed up for that. FG3-T2

Staff from CALD backgrounds were invited to share their culture and their prior migration experience in these organised cultural awareness activities:

Yeah, for staff – and staff all brought in food, we have that whole multicultural thing, didn't we, and then down in Griffith we had a musical entertainment that sung some songs from around the world and XX [a staff] gave a talk on her experience coming to Australia and working and everything and so did ZZ [a staff], didn't you? FG4-T2

Residents and staff had enjoyable experiences when cross-cultural interactions were carefully planned and embedded in everyday activities. These activities in cross-cultural interactions required little financial cost and time, and had a positive impact on residents and staff in terms of acceptance of diversity and developing positive attitudes towards people from other cultures.

Perceived positive impact of the project on residents and staff

Site champions and facilitators worked with residents and staff to identify areas that need to be improved and took action to ensure that residents' care needs associated with their culture were met, as stated in one focus group:

I was working mostly with the housekeeping coordinator and she actually approved the cultural meal for one of her residents and she was working with the family to find out how the resident would like her cultural meal to be prepared. She also taught her staff how to do it. The resident receives a cultural meal once a week now. They're considering this for other residents from different nationalities later to individualise the dietary requirements. FG5-T3

We have a lady from the Philippines and – so, she's used to having her cultural food, so, I've worked with the RN to try and accommodate with her what she would like. ...She chose what food she would like, and we try to accommodate that within the food safe rules and everything else, so that's something that I've worked with one of the RNs, so that's been a good learning thing for both of us. FG4-T2

So we recently took in a resident who is Indian, he's of Muslim faith so we now have a halal diet for him, you know, certain bathing requirements with him. So that's sort of I guess engaging the staff in what his values are as well, and incorporating that into the care plan. FG1-T2

Site champions also enabled staff from CALD backgrounds to contribute their linguistic assets to resource development that would improve cross-cultural communication with CALD residents living with dementia, as stated in the following:

We fortunately have got a number of staff who can speak the languages of some CALD residents. ...we don't have cue cards but we have a basic list of phrases in that language so that we can talk to these people living with dementia. ... we've noticed an improvement in their [residents'] behaviour because we are able to just say those few little words in their language and it calms them down. FG5-T3

Site champions played a key role in facilitating staff to understand residents' culture by creating "My important treasures", story booklets from residents:

My important treasures were quite useful. ...they [staff] could come in and just read a bit about that resident. So from that perspective culturally that impacted the resident. FG5-T3

Cultural exchange activities had been embedded into lifestyle activities, as a staff said:

I've witnessed the diversional therapist perhaps talk about other countries more to the residents, you know, give them ideas of how other people live and what they eat. Yeah.... educate them a little bit. FG4-T3

Staff perceived that the project had improved their cultural awareness when caring for residents from other cultures, as they discussed:

I think it's useful because I read it [Workbook for Staff] in there one time about when people whose got dementia revert back to their old language aside from the regular things, I realise that if I can get a little bit of knowledge of where they're coming from might help me be able to do my work better you and serve them better. FG4-T3

I have seen some of the activities where they [staff] say to us like what we will do if this was the case or if this group of people were from different cultures and the way it answers. So I think it really helped a lot. I think the project as well as that magical journal even whatever we have been doing here it really helps I think. We am positive that people are knowing more about these things.FG1-T3

Staff perceived that the workbooks with case studies and questions reinforced positive staff with staff cross-cultural interactions:

I think a project like this has to start somewhere and it'll start at the basics and they need to be reinforced in many ways and it's easy for us here to do that because we are a mix of so many different things. But we do practice good communication and courtesy's to our staff and each other because we know we're all here doing our job, delivering a care delivery at a level that has to be consistent and to get cooperation, the number one thing we all agree on is to be polite to someone. FG1-T3

Participants also witnessed positive changes among staff from different cultures since they engaged in the learning activities:

Since we have this multicultural things happening the staff are more comfortable with each other as well through the terms of understanding each another and this sort of thing. They [staff] are much closer to what they do and how they deal with the activities and residents and this surrounding. FG 4-T3

Overseas-born staff described how the learning modules they engaged in built confidence for them in cross-cultural interactions:

I think what the modules have done for the staff is that it's given them a confidence, because this is actually written down, seeing it front of them it gives them a little bit more confidence in their interactions with people like me, with Australians. FG1-T2

For instance, the language, because I don't speak the language. Second is with behaviour, because Australians are really up-front, whereas Filipinos are very shy people sometimes. So we don't talk a lot, I mean we don't speak up to ourselves and things like that. FG1-T2

Mentorship and peer support were highly valued by overseas-born staff during their adaptation to residential aged care in Australia:

Yeah, I think it's important because I found that when I started working here, having the staff when they're here for some time helping me, it took off the pressure from me a lot and my confidence started to build up. FG4-T2

Yeah, when I first started here, I have a mentor for two days which is good. The mentor was just there to guide you but during the time you would have your own strategy how to work with the residents and the co-workers. FG4-T2

Staff described how group discussions about cross-cultural interactions improved their sense of being part of team:

Well, as a personal carer, it's really important also for us to be this group [discussion], so that we can share ideas, ...we can open up and then give a little bit of our opinion. ...so, it's good that every now and then there's a group activity. FG4-T2

As a team we tend to interact much more in person rather than sitting down and studying kind of thing. We do much better having a group discussion about what's working and what's not working and how we can improve and all of that sort of thing. FG3-T2

The impact on residents included providing them with cultural meals. Site champions' cross-cultural care auditing activities enabled them to interview CALD residents, listen to them about their dietary needs and the way to meet these needs. These positive changes indicated that the cross-cultural care audit tools were necessary in order to support site champions to engage residents in continuous quality improvement activities. The positive impact on staff revealed that positive inter-group interactions could be facilitated by site champions. Staff valued activities that enabled them to share their cultural knowledge and improve team work in a safe environment. Investing time in group activities in RACHs is much needed in order to see more grass-roots based positive changes in team work and improved cross-cultural care services. CALD Staff cultural and linguistic assets were in use and contributed to cross-cultural care services.

Various approaches to learning activities

Participants discussed different motives and actions towards cross-cultural care activities ranging from a lack of motivation to being highly motivated to learn. A site champion described a new staff member who was highly motivated to learning in the following excerpt:

I've spoken with a new staff member who's from X [an Asian country] and I was so impressed because I was working with him and he actually told me he went through the book 3 and 4 himself. ...So first of all he's from different background and he's willing to work and to develop his knowledge to provide better quality and better care for the residents. FG5-T3

Participants perceived they learned better when they engaged in group activities and interactive learning as stated in two focus groups as below:

I think it's something that we don't touch on, obviously we all do it and we all know how to do it, but I think actually diving into it and doing it from different perspectives was really, really helped and also doing it with your colleagues as well, that, you learn a lot of things from how your colleagues feel when dealing with palliative care that you may not actually find out while you are doing it. FG2-T3

Instead of the book activities if you had something like, even this kind of meeting or maybe some kind of function, some kind of thing. FG 1-T3

The online learning was seen as an opportunity to improve access to learning resources and enable staff to undertake learning at home:

Member 1: Given that this has probably given us the opportunity to get the education online, so XXX [an aged care organization] is really looking at online learning and how we can facilitate that. Hopefully that will be the way we progress it through online training.

Member 2: See I would find it easier to do it at home and I think.

Member 3: I would too, yeah.

Member 4: Because I'm only here limited hours and I do a lot of stuff I do online I do.

Member 5: And when I'm home I'm relaxed and you can think easier rather than I have to get off of this computer there's somebody else needs it.

Member 6: Whereas if you're home you know right, I've got to do this module tonight, so you get in that mode. FG-T3

Because then I could go home and do it and I'd be more than happy to do that in my spare time especially if I got something out of it to put on my resume. FG2-T3

Site champions and facilitators also took action to embed the cross-cultural care program into their existing organisational education and training activities. They perceived synergy when these were merged together:

We did our palliative care education sessions with the PAL care ... and I added on the Flinders Uni booklets [Workbook for Staff] to that. So that was really great to actually bring some case studies to that session. FG5-T3

So where we invited in someone that specialised firstly in dementia care and then some on module 4 with palliation. That was very effective. Short spurts of education, 10/15 minutes, got a group together, that was a very effective activity and very positive responses from the staff in relation to that. FG5-T3

Site champions applied a whole range of strategies to stimulate staff motivation and to engage in learning activities as stated below:

Map of the World was very effective. It brought people together, lots of communication around cultures about where they were from, the residents were involved in that as well as just to visitors passing by would all stop and look at that map and just have a look and see where every was from. It just really brought about a lot of conversation which was very positive. FG5-T3

Site champions took every opportunity to engage staff in the cross-cultural care program while overcoming time constraints in busy work environments:

I attended every staff meeting and every mandatory training day. So even if I was only in there for 5 or 10 minutes, I made a point of distributing workbooks during those sessions and if time permitted one or two case studies for that group, so that was really good and also during staff appraisals I actually put on their appraisal that I'd given them the 4 workbooks or 1 or 2, however many had been release at their appraisal date for them to go and have a look at and come back to me with any questions. FG5-T3

The preference of learning styles and staff enthusiasm for cross-cultural care encouraged the project team to adapt the program to an online self-directed learning program using MOOC (massive open online

course). Considering that group learning was mentioned as the best way to apply knowledge to practice, RACHs may consider the combination of self-directed learning and group learning. The feasibility of embedding the cross-cultural care program into the organisations existing education programs has challenges for the RACHs to embed the program into their organisations' contexts.

Challenges encountered

Time constraints were constantly mentioned as a barrier to participate in the cross-cultural care program in the workplace.

Member 1: Yeah and you're so busy while you're here, I mean the days are packed, they don't have time.

Member 2: And your focus your in and different mindset aren't you.

Staff stated paid study was an incentive to engage more group learning in the workplace:

I thought one of the limitations was the lack of investment to pay for longer shifts or how to manage the shift work or the smaller shifts with Personal Care Workers and how to cater for extra activities and pay for that. That's why the mentoring worked well because it was on the floor while the Personal Care Worker keeps going about their day but that was a real barrier to the project. It's very difficult to actually get things in and then if there was an Accreditation visit that would hold it up. I think we had some delays earlier from other activities or other projects happening at site as well and business needs change as it goes along. So yes you have to work hard at keeping that momentum. FG5-T3

Most staff have some sort of electronic device now or internet access of some description, but obviously staff time, do you pay them for that, do you not pay them for that, is that something they do in their own time which those sorts of things the things that as managers we are tossing up now, what is the expectation, do people do stuff. If they do stuff at home should they be paid for it all those sorts of things. And it's about being able to access those online modules at home because I mean I know my previous work that's certainly where I did all my online learning was at home on the lounge with my tablet. FG3-T3

A low motivation to read the workbook was also discussed by participants. The preference was for group learning as demonstrated in the statements below:

Member 1: It [Workbook for Staff] was just in the pigeon hole and some said "what is this...I don't want to read this".

Member 2: Because until there was a face to face someone discuss this project here, then I was able to open up (picking up the workbook on the table).

Member 3: So I think what you said about having a group probably just with a cup of tea or just have a chat.

Member 4: Yeah, I think that's a good idea. Because to be honest I didn't read a book. Honestly I said I don't have time. FG3-T3

Site champions echoed some of the same challenges:

Member 1: Keeping their interest. I think, and that's been the hard part is the second half of the year I think is maintaining staff interest in this project.

Member 2: So it's trying to keep up with what staff want, what they're interested in. FG5-T3

Participants said it was a challenge to understand residents' culture-associated care needs:

I think probably something that we could maybe improve on a little bit is really getting information from the resident and their family about their culture because although I think we can discuss/talk/communicate with them very well, but without really understanding what their culture is and what it means to them and what's important to them from that point of view which I yeah, don't have a really good understanding of for example, for that lady because we haven't really got it if that makes sense. FG3-T3

Negative attitudes towards staff from CALD backgrounds were mentioned. This kind of challenge prevented residents and staff from building good relationships:

Member 1: The residents they get quite offended with some of the X [CALD staff] that come in.

Member 2: And I find they [CALD staff] can be quite offensive sometimes with some of the residents do not like them coming in. So there's just something in the background there they [residents] don't particularly like. We have to work out how to, to deal with it.... there are some residents that will say to you, "I don't like that black staff." FG2-T3

Residents' attitudes towards CALD staff also contributed to a necessity to change rosters and additional time needed to negotiate the roster:

Member 1: I've got ladies who don't like them [CALD staff] and, but we've got to work it all out and, and you just had to be pretty calm about it. So we've changed the whole routine around, it's better now. A couple of XX [CALD staff] get quite offended. So they don't really feel comfortable going in. So then we change it again.

Researcher: Do you think the organisation is consciously doing this?

Member 1: I would say so, yes.

Member 2: Or just say, "This isn't going to work, let's see if we can swap with someone from a different area."

Member 3: And carers are usually pretty good if they're asked to go somewhere else or swap with somebody they usually do, don't they?

Member 4: Doing a good job here. So I, I'm walking around I can see hard working people but I, they [resident]’ve got their little favourites and, and they’re very particular, very particular who they, they have. FG2-T3

These challenges mentioned in the implementation phase of the project support the need for long-term investment in cross-cultural care for residents and in workforce cohesion. As discussed in Chapter two, negative attitudes towards CALD staff contribute to them avoiding these residents and have a negative impact on relationship building and quality of care. Investment in changing these negative attitudes is needed. RACHs and the aged care industry need to work with stakeholders to build an enabling environment to support multicultural workforce development. Potential RACH users and stakeholders need to be engaged in discussions about resources and solutions that address the negative attitudes.

Suggestions to embed the program into the organisation’s policies and practices

Participants suggested that more effort was needed to embed the cross-cultural care program into their organisation’s policies, education and training programs and day-to-day practice. One of the suggestions was to have a permanent site champion to facilitate the cross-cultural care:

I think definitely yes that we need a site champion because I think if we didn’t have XX [a site champion] trying to have the time and the resources to get that information out would’ve been rather difficult. I think she certainly helped get it all out there on the floor and with the staff and the little sessions she did with the staff with the scenarios and things like that, she has put a lot of stuff around on the notice boards and things like that. FG1-T3

Participants also suggested that more detailed care plans about residents’ culture-related care needs were required:

It [culture-related care needs] is not in the care plan, it’s nowhere. There might be clue cards so to say, on the walls in the room or something. And we might just all know that this is a clue card. There might be a frame that shows a map or something that is peculiar to that country or to that group that is just there on the wall then. ...When you work in the dementia wing here you find it extremely sometimes, so difficult to work with them. Very challenging physically, mentally, socially, everything, very difficult. FG4-T3

Staff identified investing in resources to enable cross-cultural communication with residents to enable productivity and efficiency in the workplace:

So I think it could be done better, better access to these things, if there are flash cards can they be put in their rooms so that if we do need them we don’t have to run down the corridor to the lifestyle or to the nurses station to get them, and then they’ve already run off to do something else. If we

had better access to these things then we could probably use them to the residents' advantage. FG 2-T3

Participants also recommended that they needed to make further efforts to accommodate residents' dietary preferences:

Member 1: So we're trying to accommodate for these people but then by doing that we're not accommodating for the others. So it's so hard to accommodate for the small group of people that we're trying so hard to do that, but then other people don't like it. So are we supposed to cook 130 different meals to accommodate for everyone?

Member 2: Oh well what you can do is if you're going to cook for, cook on the average, so you just cook for the average. FG2-T3

Site champions and facilitators had confidence that their organisation would make efforts to disseminate the program using existing organisational structures in cross-cultural care and services:

I think from a corporate point of view, being involved in the projects been excellent. We were invited to be part of the new ACSA [Aged & Community Services Australia] Australian multicultural workforce group. ... because our projects finishing we've now got our multicultural project coordinator going to be sitting on that team so the work from this project will still grow. FG5-T3

I think now that we've provided culturally sensitive or culturally appropriate diet at one site that will not flow onto other sites because we do have a group of housekeepers that come together regularly and so Wendy will now share those ideas, that's the housekeeper and that will grow from that. So it's a seed yep. That's been, I think that's one of the main things that's grown and also some of the mentoring that's happened at the other site with relation to communication and respecting the residents cultural background and their native language and when appropriate to try and speak in that native language with them or get a carer that can actually speak their language. FG5-T3

Yes they have a plan to disseminate the project to other sites. I'm not aware of the plan but I've asked if I want to be involved in it and I've said yep I'll take it across to other sites. FG5-T3

Planning for incorporating the cross-cultural care program into mandatory training was discussed by participants:

We're going into an online system and there may be opportunity to actually pop some of those modules on there as a self of learning sort of resource. ...As time goes on and as we become more computerised and accessible for our Personal Care Worker staff. ... mandatory training will be online.FG5-T3

That initial, trying to get corporate on board early and some investment to actually do some development days or have a set day every 3 months where you can actually really do something great with the modules and pay for the workforce to come in and it might be at a middle management level that comes in and so do a train the trainer module so that your leadership within sites has actually got the knowledge to then keep developing their staff with that knowledge. FG5-T3

Participants strongly suggested that Certificate 3 & 4 for aged care workers from CALD backgrounds needed to include curricula in English language studies prior to entering into aged care industry:

Member 1: I think there's still such a gap in language as part of the actual curriculum before staff get to aged care employment, Aged Care Service employment. That seems to still be the key complaint or issue that we have on sites. Aged care organisations per se won't or can't put the resources into language classes and it would just seem to me that it would be so important to have that as part of a cold Cert III or IV specifically designed for cold staff or cold community.FG5-T3

Member 2: The residents do get very angry if someone can't talk English to them or their English is not understood although isn't it?

The suggestions for embedding and sustaining cross-cultural care and multicultural workforce development strategies as tested in the project included the site champion's position in RACHs. Investment in this position also enables career development for RNs in RACHs, and RACHs may see the investment as a strategy to attract and retain high-quality staff in their organisations. Suggestions on overcoming cross-cultural care challenges included cross-sector collaboration by embedding cross-cultural care into curricula in Aged Care Certificates III or IV, and education programs for ENs and RNs. These findings have implications for policy and resource development.

Summary

Engaging residents and staff in project evaluation using both survey and focus groups enabled the project team to analyse the outcomes and the areas that need to be further developed in the future. Findings from the project evaluation supported the implementation of the MCWD model and the resources had a positive impact on residents' satisfaction with cross-cultural care services and a positive impact on staff perceived cultural competencies in cross-cultural interactions with residents and co-workers. The evaluation also revealed challenges to project implementation in a busy working environment and raised questions about how to embed and sustain the positive outcomes. The main findings from the project evaluation and findings from phase one are discussed in Chapter 8 in order to make recommendations based on these findings.

Chapter 8: Discussion

Findings from our study on factors affecting cross-cultural care services and workforce cohesion were grouped as:

- Resident factors: examples are residents' preferences and expectations of care services that are associated with their culture and language use, and their attitudes towards people from other cultures;
- Staff factors: examples are staff leadership, knowledge, skills and attitudes in cross-cultural interactions;
- 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.

Findings from our study and research evidence reported in the literature were considered when conceptualising the MCWD model. Examples provided by residents and staff about enablers and barriers in cross-cultural interactions were used by the project team to inform the development of case studies and learning activities and to incorporate them into the 'Cross-cultural care program for aged care staff' and in the case scenarios in the book entitled 'Multicultural workforce development model and resources in aged care' (Xiao et al. 2017b). Findings were also used as means to facilitate discussion about toolkit development to support the implementation of the MCWD model. Items in the 'Cross-cultural care toolkit' and 'Cross-cultural care self-reflection toolkit' address most issues in cross-cultural care and workforce development identified in this study and reported in the literature (Xiao et al. 2017b). The MCWD model and the education program were implemented in four residential aged care homes. Findings from the project evaluation support that the MCWD model and the education program had a positive impact on residents' satisfaction with care services and a positive impact on staff perceived cultural competence. Cross-cultural care auditing activities undertaken by site champions enabled them to identify areas that need to be improved and to be change agents to improve cross-cultural care services.

This chapter presents discussions of the main findings from the project in four sections:

(1) Cross-cultural care for residents; (2) Culturally competent workforce; (3) Organisational support for cross-cultural care services and workforce development; and (4) Significant findings from project evaluation.

Cross-cultural care for residents

Findings from the present study confirmed previous research that identified that care disparities existed between CALD residents and non-CALD residents. In previous studies, residents and their family members ranked food choices as a high priority (Abbey et al. 2015, Runci et al. 2014). Our findings elaborated on this care service concern in the context of cultural diversity in mainstream RACHs. Studies identified that accommodating individualised food preferences was challenging for RACHs because of the implications for resources, budget and staffing (Abbey et al. 2015, Chisholm et al. 2011). Our study added new understanding that education and training for staff together with partnerships with residents' families and other stakeholders or service providers were strategies that could be used to meet residents' food preferences.

Research evidence shows that unmet diet preference is associated with poor appetites, low food intake and poor scores of perceived quality of life in residential care settings (Carrier et al. 2009, Chisholm et al. 2011,

Nijs et al. 2006). Being able to maintain a diet similar to that prior to admission or so-called “family style mealtimes” is one way residents maintain health and quality of life (Nijs et al. 2006). Residents need to be given a range of diet options to promote quality of life. Staff also need to be mindful that utensils used for eating and drinking are also associated with residents’ culture. Staff should assess resident needs for special utensils and offer them their preferred utensils such as chopsticks, special spoons and using hands to eat (for residents from Indian heritage or other countries) in order to promote “family style mealtimes” (Nijs et al. 2006). In a care facility with residents from diverse backgrounds, evidence-based guidelines for diet, special diet considerations, how to cook the requested food (e.g. rice) and mealtime activities need to be developed and evaluated. Care services to meet CALD residents’ dietary preferences should be available, accessible, acceptable to residents and demonstrate high-quality (so-called ‘AAAQ framework’) in order to address equitable care and consumer-directed care (Australian Government and Department of Health and Ageing 2012, World Health Organization 2015). The AAAQ framework was emphasised in the MCWD model for not only meeting CALD residents’ dietary preferences, but also care disparities in all service areas for residents (Xiao et al. 2017b).

In our study staff endeavoured to improve residents’ diet choices and meet their preferences based on the resources that were available for them at the time. However, participants also described instances when residents’ diet preferences were not met, particularly CALD residents. This challenge will need to be addressed through forward thinking for the “baby boomers” and CALD residents who will demand more choices, consumer-directed services and have the ability to pay for additional services. This outcome could be achieved by integrating the family more in accommodating food preferences when the aged care service may not be able to deliver or the resident is unable to afford this option. These changes in consumer needs will require policy and resource interventions at a higher level and possibly changes to the business model, for example, the provision of restaurants in care homes or the delivery of restaurant prepared meals. The upsurge of pre-prepared meals is certainly a good strategy to assist residents’ dietary preferences again with a cost associated with it. A good example of this approach is the Italian Meals and Services for the aged (Italian Meals and Services for the aged 2015). Services such as this may be an opportunity for business growth, in line with consumer centred services in residential aged care.

CALD residents were more likely to experience isolation within a residential aged care facility as reported in previous studies in Australia (Runci et al. 2012, Westbrook and Legge 1990, Westbrook and Legge 1991a). Lack of English proficiency has been widely reported as a major factor affecting older people from CALD groups to interact with other residents and staff on a daily basis and to use services that are available for them (Xiao et al. 2013, Runci et al. 2014, Runci et al. 2005). Various government initiated strategies including free interpreter services, Community Visitors Scheme and supporting the ethno-specific aged care services have been used to address this issue (Department of Health and Australian Government 2012, Runci et al. 2014). However, interventions on improving CALD residents’ social interactions with others in mainstream residential care homes are still limited (Runci et al. 2014, Runci et al. 2005). In our study the psychosocial support provided by managers and carers was seen as an important component of the service and they demonstrated leadership in facilitating this support. There is a need to ensure that all staff take a

consistent approach in providing psychosocial support for residents. This approach was considered when the project team developed the MCWD model. Using observations to examine the process and outcomes of staff-resident interactions helps in determining the psychosocial support required for residents (Ryvicker 2011, McCloskey et al. 2015). In order to capture the psychosocial support for CALD residents, the 'Cross-cultural Care Service Audit Tool' developed in the project requires the auditor to include observations (Xiao et al. 2017b).

Culturally competent workforce

Findings in the present project supported previous studies that competent cross-cultural communication was a crucial part of cultural competency in health care and social care services (Douglas et al. 2011, Ziaian and Xiao 2014). Cross-cultural communication was defined as 'the symbolic exchange process whereby individuals from two (or more) different cultural communities negotiate shared meanings in an interactive situation' (Ting-Toomey 1999, p. 16). Language barriers, lack of familiarity with each other's communication styles both verbal and nonverbal, including not knowing the connotative and denotative meanings of words used in care homes contribute to a failure to reach intercultural understanding. Communication difficulties between staff and residents were multi-faceted and include staff factors, resident factors, sociocultural factors and system factors in the care homes (Nichols et al. 2015, Walsh and Shutes 2013). It is necessary to differentiate these factors in order to identify appropriate interventions. Cross-cultural communication difficulties in resident-CALD staff cross-cultural interactions were reported in residential care in Australia, Canada and the UK where both residents and staff populations were increasingly multicultural (Bourgeault et al. 2010, Walsh and Shutes 2013, Nichols et al. 2015). Strategies CALD staff used to improve their knowledge and skills in cross-cultural communication with residents included, but were not limited to, learning English in a socio-cultural context, being prepared for feelings of shame due to mistakes made in cross-cultural communication, self-awareness, openness, clarification and seeking help.

The findings supported those in the literature that migrant care workers experience discrimination based on their accents and English proficiency (King et al. 2013) and that English should be tested at the time of recruitment and strategies to increase language skills put in place. Mentoring support for CALD staff for an extended period is necessary in order to allow them to improve their English communication in a safe and supportive environment. RNs from countries without a residential aged care system particularly need sufficient time to work with a mentor to improve their communication skills considering their leadership role in the RACHs, limited transition programs for them, and unfamiliarity with the aged care system in Australia. Mentors appointed to assist CALD staff need to be able to provide language and cultural advice. This finding has implications for the job description of mentors, recognition, and education and training for them in order to support new CALD staff to assimilate into the RACHs.

Culture has a strong impact on how people should be addressed, the non-verbal behaviour used and the manner adopted when communicating with them (Teal and Street 2009, Ting-Toomey 2010, Ziaian and Xiao 2014). Studies identified that people from the same cultural background share similar patterns of

thinking and behaviours in communication including how to address each other by name and the conditions required to address them in different ways (Ting-Toomey 2010). In order to simplify these patterns, cultures are grouped into individualist and collectivist culture (Ting-Toomey 2010). However, no one culture is purely individualistic or collectivist, but most cultures will have a tendency towards one or the other. Individualist cultures encourage individualist values that emphasise personal achievements and independence (Ting-Toomey 2010). People raised in western countries, such as Australia, western European and North America, usually hold individualist values. Collectivist cultures endorse collectivist values that rate group achievements higher than individual achievements (Ting-Toomey 2010) and people raised in eastern countries, such as Asian, eastern European, some Mediterranean (Greece and Italy), South American and African countries usually hold collectivist values.

Evidence from the cross-cultural communication literature suggests that people from collectivist cultures like to be addressed with their title and surname while people from individualistic cultures liked to be addressed with their first name (Ting-Toomey 2010, Ziaian and Xiao 2014). However, conventions for addressing people in cross-cultural interactions might change due to the existence of acculturation (Ting-Toomey 2010, Ziaian and Xiao 2014). The resident's preference for how they would like to be addressed needs to be documented in the care plan and the resident's room identification label. New staff need to be informed about how to address each resident. Cross-cultural audits and care guidelines need to reflect these communication issues. How to address residents is only one of numerous examples in culturally competent cross-cultural communication in the workplace. Demonstrating this kind of competence is required for all staff, given the multicultural Australian population of both residents and staff (King et al. 2013). A systematic approach that incorporates education and training and organisational support for staff is strongly recommended to address the issue in previous studies (Nichols et al. 2015, Walsh and Shutes 2013). The 'Cross-cultural care program for aged care staff' developed in this project has a learning module on 'Cross-Cultural Communication' that includes principles for cross cultural communication, case studies that simulate cross-cultural communication in real care settings and tips in cross-cultural communication.

The findings were in line with previous studies that the lack of social skills among staff was one of the factors contributing to resident/family dissatisfaction with care services (King et al. 2013, Ryan and McKenna 2015, Walsh and Shutes 2013). A set of social skills (or 'informal skills') for staff that emphasise interpersonal relationships, interactions, communication and caring for residents were identified in the 2012 Aged Care Workforce Report (p. 149). These skills were also confirmed in other studies as core factors to strengthen social and emotional care in residential care (Nichols et al. 2015, Ryan and McKenna 2015, Walsh and Shutes 2013). The 'Cross-cultural care self-reflection toolkit' developed in our project considered these skills.

The social and conversational aspects were viewed as conditions for residents to develop and sustain relationships with staff and were crucial for relationship-centred care (Berdes and Eckert 2007, Walsh and Shutes 2013, Nolan et al. 2004). Social and emotional care that focuses on positive relationships, communication and interactions with residents which provides them with a sense of significance in the care

community are highly valued by residents and their families (Nolan et al. 2004, Ryan and McKenna 2015, Ryvicker 2011, Walsh and Shutes 2013). The lack of cross-cultural communication competence with residents and their families significantly affects CALD staff and their ability to meet residents and family expectations for care. The findings indicate that supporting CALD staff to improve their social skills and English throughout the course of their employment needs to be considered as part of workforce development. Again, a systematic approach that includes contributions from government, aged care industry and aged care organisations is required. The Workplace English Literacy and Learning (WELL) program that was developed to support industries to improve the workforce to respond to the knowledge-economy and productivity is an example of a systematic approach to workforce development (Australian Government and Department of Education and Training 2014). The aged care industry and aged care organisations can contribute to the WELL program by applying for competitive grants and by making the program relevant to the aged care workforce.

The findings confirmed a study conducted in the UK that 'little things' are important for residents' families in their involvement in care (Ryan and McKenna 2015). The findings also support previous studies on staff-resident family relationships that effective communication between these two stakeholders was crucial for enabling family participation in resident care and in quality improvements in residential care (Kemp et al. 2009, Nichols et al. 2015, Ryan and McKenna 2015, Wilson and Davies 2009). Our study reported these issues from the perspective of CALD residents and their families that enriched the understanding of staff-residents- family communication and relationships in residential care. The 'little things' mentioned by the resident's family, reflect the family members' deep involvement in residents' care and the control and power relationship with staff that are widely reported in the literature (Bauer 2006, Haesler et al. 2007, Ryan and McKenna 2015). Developing caring partnerships with family members involved in residents' care was highly recommended to recognise the family's contributions to residents' care and the collaborative approach in meeting residents' care needs and fostering quality of care (Bauer 2006, Haesler et al. 2007, Ryan and McKenna 2015).

The study identified that structured activities that improve Australian-born staff understanding of, and their performance in, interactions with CALD staff were imperative. Organisational support and resources are needed in order to select the right staff with the right capabilities to lead these activities. Studies on migrant health workers suggest that it takes 5 to 10 years for many immigrant health workers to achieve an ideal level of adaption in a host country (Adams and Kennedy 2006, Xu 2007, Yi and Jezewski 2000). Positive work environments can smooth this adaption process. Strong leadership is highly demanded to empower CALD staff to actively contribute to care and workforce development (Australian Government and Department of Industry 2014, Toles and Anderson 2011, Jeon et al. 2015, Lynch et al. 2011). Leadership in cross-cultural care and multicultural workforce development in RACHs is highly demanding considering the changing demographic characteristics of staff and residents. Many more studies in this field are needed in order to promote evidence-based practice for leadership approaches.

The need to raise cultural awareness was identified as the first step towards cultural competence in cross-cultural care settings (Campinha-Bacote 2002). Staff with a low level of cultural awareness are more likely to be ignorant of their colleagues' cultures and unaware that they are not culturally competent. Conversely, staff with cultural awareness are more likely to engage in ongoing learning and practice to improve their cultural competence. These components included learning and applying cultural knowledge and skill by engaging in cultural encounters and demonstrating cultural desire (Campinha-Bacote 2002). Cultural desire refers to attitudes, values and drives that enable positive cross-cultural interactions, and is viewed as the spiritual dimension of cultural competence (Campinha-Bacote 2002, Lund and O'Regan 2010, Krajic et al. 2005). Cross-cultural encounters are usually associated with ambiguity, anxiety and anticipated negative consequences (Ting-Toomey 2010). Therefore, people may try to avoid communicating with those from other cultures, alienate them, or prevent them from being included. In the literature cultural humility was also widely recognised as a crucial characteristic for health professionals to be aware of, particularly the power imbalances with clients. As a consequence staff are encouraged to act to empower clients to perform activities in order to achieve optimal care (Foronda et al. 2015, Isaacson 2014). Our project considered these widely recognised cross-cultural care competencies and incorporated them into the 'Cross-cultural care self-reflection toolkit' and reinforced these characteristics and competencies in the 'Cross-cultural care program for aged care staff'. In addition, the 'Staff perceived cultural competency' instrument used in the project evaluation reflected the cross-cultural care competencies.

CALD staff cultural and linguistic skills actually contribute to cross-cultural care services in the workplace and organisational rewards for their contributions were identified as an enabler for attracting and retaining a skilled workforce (Howe 2009, Howe et al. 2012, King et al. 2013). CALD staff should be encouraged to use their linguistic skills in the interactions with CALD residents in the workplace in the best interest of residents. Cross-cultural care guidelines should have a component of promoting positive interactions in CALD staff-CALD resident cultural interactions. Most CALD staff were from cultures with strong ties to family that espouse values associated with the family taking direct responsibility for the care of the elderly. Our findings echoed this. The literature notes that migrant care workers usually referred to family care as the gold standard of effective care (Berdes and Eckert 2007, Bourgeault et al. 2010, Walsh and Shutes 2013, King et al. 2013). The culturally influenced care dispositions of CALD staff need to be further studied to enhance their cross-cultural care competencies and influence their peers.

A system approach to improving cross-cultural care services and workforce development

The findings confirmed previous studies that cross-cultural communication was viewed as the most challenging area to provide CALD residents with effective cross-cultural care services. Although free downloaded Cue Cards were used to facilitate the cross-cultural communication in RACHs, staff identified the need to have voice-based communication between residents and staff using an iPad/iPhone with a multilingual translation App. The latest developments in communication technology make these suggestions achievable. There are increased CALD communities in Australia that have developed cross-cultural communication APPs for older people who cannot speak or cannot speak English well enough to interact

with care service providers, Examples are, 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. Organisational investment in using new cross-cultural communication technology was much needed in order to meet residents' care needs in a timely manner.

It is well documented in the literature that migrant health workers experience difficulties in socialising with host colleagues (Ho and Chiang 2015, Xiao et al. 2014, Zhou et al. 2011). They also encounter challenges in adapting their practice to the host country. Our findings support those studies, but also elaborate that the use of English by CALD staff is limited by lack of knowledge of residents' culture and customs, suggesting English proficiency cannot be achieved without building a supportive environment in RACFs and in the aged care system. Our findings on barriers to CALD staff-Australian-born residents and CALD staff-Australian-born staff cross-cultural interactions also strongly suggest that investment in education and ongoing support for CALD staff is required to assist them to adopt Australian culture and assimilate into the RACHs. Mentoring support for CALD staff by Australian-born staff is necessary in order to improve residents' satisfaction with CALD staff in cross-cultural interactions. In our study, CALD staff described that they encountered difficulties when communicating with residents and co-workers. They were not familiar with slang used by residents and Australian-born staff, and 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 team work and productivity. Our project addressed some of these issues by developing 'Module 1: An Introduction to Cross-Cultural Care for New Staff' that includes the 'Work related English Language Resources for 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. We also introduced resources on Australian slang and Australian culture in the module.

Negative attitudes including, but not limited to, prejudicial and racially negative comments, exist in any multicultural society (Australian Human Rights Commission 2012a, Allen 2010, Stevens et al. 2012, Berdes and Eckert 2001, Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013). As part of the wider Australian society, the aged care sector is not immune to these issues and the need to address them in order to improve cross-cultural care is well-documented in the literature (Johnstone and Kanitsaki 2010, Stone and Ajayi 2013, Berdes and Eckert 2001, Bourgeault et al. 2010, King et al. 2013, Nichols et al. 2015, Walsh and Shutes 2013). Some incidents in residents-staff cross-cultural interactions identified in our study were similar to verbal abuse, bullying and harassment, common workplace issues reported in the literature regardless of workplace diversity or setting (Farrell and Shafiei 2012, Okechukwu et al. 2014, Jussab and Murphy 2015). Residents have a right to refuse care provided by certain staff; however, they also have responsibilities to 'to respect the rights of staff to work in an environment free from harassment' (Australian Government and Department of Social Services 2014). Staff also have the right to work in a safe environment and 'Right of worker to cease unsafe work'(Government of South Australia and Attorney-General's Department 2015, p. 17).

In the residential care literature, although most residents/families demonstrated positive attitudes towards migrant care workers, discrimination, racism and different forms of abusive behaviours towards migrant care workers in aged care had also been reported (Berdes and Eckert 2001, Bourgeault et al. 2010, King et al. 2013, Nichols et al. 2015, Walsh and Shutes 2013). A large scale study in a European country and the report from the World Health Organisation revealed that migrant health workers from non-Western backgrounds were at more risk of bullying from clients/residents than their native counterparts (Hogh et al. 2011, World Health Organization 2012). These issues had detrimental effects on staff well-being, relationships with residents, job satisfaction and retention (King et al. 2013, Nichols et al. 2015). Racial hierarchy, skin colour, accent, and poor English proficiency are associated with the incidence of abusive behaviours (Berdes and Eckert 2001, Bourgeault et al. 2010, Nichols et al. 2015, Walsh and Shutes 2013). Staff usually used 'ignoring, resilience and avoidance' as self-care strategies or coping styles (Nichols et al. 2015). The avoidance coping style might have a negative effect on care outcomes considering that high-performance care is built on relationship-centredness (Nolan et al. 2004, Berdes and Eckert 2007, Walsh and Shutes 2013).

The findings support previous studies that note the under-reporting of workplace issues in health care settings (Arnetz et al. 2015, Kvas and Seljak 2014). In the literature, factors underlying the under-reporting of these issues by individual health workers are associated with a lack of knowledge about the issues, a belief that reporting would not change anything, fear of losing one's job, regarding the issues as minor as they did not result in injury or losing work time, or as a consequence of age, social background, lack of education or dementia (Arnetz et al. 2015, Kvas and Seljak 2014, Nichols et al. 2015, Berdes and Eckert 2001, Bourgeault et al. 2010, Walsh and Shutes 2013, O'Keeffe 2016). A large scale study in one of the American hospital systems reported that up to 88% of workplace violence is not documented; however, more than 45% of health professionals who experienced workplace violence had reported it informally to their supervisors (Arnetz et al. 2015). At the organisational level, under-reporting of workplace issues are associated with 'taboo' topics that are contrary to the legislation or the socially desirable performance by the public (Australian Human Rights Commission 2012a, ANTaR 2012).

The findings suggest that the ability to monitor, investigate and take action to resolve negative workplace issues that risk staff health and well-being, needed to be added to job descriptions for staff who have a management and supervision role in RACHs. Induction and orientation programs for new staff should reinforce the need to address racial discrimination issues, and provide staff with the skills and ability to advocate for anti-racism, along with clear reporting mechanisms and actions. Although these skills have been introduced in the elective units in Certificate III in Aged Care and in the Code of Professional Conduct for Nurses in Australia (Australian Government 2015a, Nursing and Midwifery Board of Australia 2008), more is required. Mandatory in-service sessions for staff to discuss these issues may be necessary if learning needs are determined for the care facility. Staff job satisfaction surveys and staff exit surveys need to have items that seek information on racial issues.

There also needs to be education for residents and families on cultural diversity and equity in the care facility through different strategies and activities. In a study by Berdes and Eckert in residential care in USA, three quarters of staff experienced racism on the job (Berdes and Eckert 2001). A number of studies on racially negative attitudes and comments from residents reveal that staff forgive residents who are cognitive impaired, but they hold those including residents' families and fellow staff to a higher standard (Berdes and Eckert 2001, Bourgeault et al. 2010, Walsh and Shutes 2013).

The unfair treatment of team members, bullying new staff and conflict between team members are common issues in the workplace as reported in the literature (Johnstone 2012, Howe et al. 2012, Whitehead et al. 2013). However, cultural diversity adds more complexity to the existing workplace issues and requires a high level of knowledge and skills to manage these issues (Ang et al. 2007, Dreachslin et al. 2004). The knowledge and skills to manage these issues should be addressed in induction/professional development training alongside cultural competency. This finding has implications for designing position descriptions and staff development for management groups in managing issues arising from diversity. Findings also have implications for induction, orientation and mandatory education/training sessions for staff that address values including, but not limited to, gender equity, equity regardless of age, respect and collegiality in the workplace.

The lack of skills in providing ADLs among CALD staff from developing countries on the completion of Certificate III in aged care support the findings from the 2013 review that up to 80% registered training organisations did not comply with the required placement time and assessment (Australian Government 2013). The need to improve the provision of Certificate III in aged care was reported in a national strategic review of registered training organisations offering aged care and community care sector training (Australian Government 2013). The revision of Certificate III was developed to address issues of non-compliance with assessment requirements, insufficient length of the course and insufficient time in a workplace to develop skills (Australian Government 2013, Australian Government 2015a). In the revised Certificate III in aged care, there are two elective units described as: (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 the impact of socio-cultural factors on the care of residents, they may be not sufficient for CALD staff who clearly described their knowledge deficiencies about Australian-born residents and their cultures. Our findings regarding the lack of capabilities of providing ADLs and lack of knowledge about residents' culture among some CALD staff have implications for education and training providers to strengthen curricula and quality of education.

Significant findings from project evaluation

In our project, the site champion model used to implement the MCWD model and the cross-cultural care program was informed by previous studies on site champion-led evidence-based practice in health care settings (Aitken et al. 2011, Gerrish et al. 2012, Moyle et al. 2013). Findings from our project added new understandings that site champions acted as change agents to enable positive changes in cross-cultural care services and in workforce cohesion. Nominating champions, who were recognised as team leaders by

their peers and familiar with the work environment, was more likely to promote and sustain positive changes in the workplace. It was widely recognised that staff both learned and translated knowledge into practice better through interaction with their trusted social networks and peer supports (Rogers 2010, Straus et al. 2009). Our findings on the need for strong leadership in responding to the workplace diversity supported previous studies that identified positive association between leadership in workplace and staff cultural competence, job satisfaction and retention rates (Chenoweth et al. 2010, Dauvrin and Lorant 2015, de Leon Siantz 2008). These findings have implications for leadership development for staff in RACHs. The main characteristics demonstrated by sited champions in our project include: (1) capabilities to investigate areas in cross-cultural care services that need to be improved; (2) working with residents and staff to negotiate solutions to address issues of concern; (3) mentoring skills to enable staff to adopt new practice; and (4) supporting new staff to assimilate into the system.

The findings that residents showed increased satisfaction with the facilities' efforts to enable them to interact with other residents and to meet their language needs were encouraging. Strategies site champions to lead staff to achieve these outcomes were (1) cultural exchange activities, for example, "My important treasures" booklets, Map of the World to mark the countries of birth and cultural events embedded in leisure activities. Site champions and facilitators played a key role in organising and facilitating these activities. Additionally, at the time 3 of project evaluation, an increased proportion of residents indicated that there was a particular staff member in the facility with whom they could speak in their language about their care, compared to the findings in time 2 project evaluation. These positive changes are in line with activities and strategies, for example, learning words from CALD residents and encouraging bilingual and bicultural staff to lead cross-cultural interactions with residents in cultural exchange events and leisure activities, as discussed in staff focus groups. Sustaining these positive changes after this project requires management groups to embed good practice into day-to-day practice. Analysis of residents' survey comments across 3-time points showed that generally they had positive experiences in cross-cultural interactions with staff. They also highly regarded the caring and respect that staff demonstrated in cross-cultural interactions with them. It is hoped that RACHs undertake regular survey with residents or their family members, use findings to create higher expectations for quality improvements and for staff development activities.

The resident survey consistently showed that moving into care homes was associated with increased stress in time 2 and time 3 survey. This finding needs attention. More strategies are needed to support new residents to smoothly transition from home to the residential home. Studies have revealed that meaningful relationships between residents and caring relationships between residents and staff contribute to residents' transition and their sense of home in the residential care homes (Brownie et al. 2014, Nolan et al. 2004). Much more positive interactions including cross-cultural interactions between residents and between residents and staff may smooth the transition and reduce the stress during the transition from home to the residential home. As discussed in the focus group, staff from all levels and groups can contribute to positive relationship building. Additionally, matched culture, language, interests and hobbies between residents or between residents and staff may help residents develop a friendly relationship in the new homes. The Government funded Community Visitors Scheme is also a strategy to facilitate smooth transition and

overcome isolation for residents, especially those from CALD backgrounds (Australian Government and Department of Health 2017). Studies have also suggested that spiritual care and Chaplains also have a role to play in the transition of older people into residential care (Cowlshaw et al. 2013, Mowat 2014).

The increased scores in self-perceived knowledge, skills, comfort level, self-awareness and education and training support previous studies that education interventions generally had a positive impact on cultural knowledge, skills and attitudes in cross-cultural interactions in health care (Beach et al. 2005, Gallagher and Polanin 2015). Findings in the staff survey were consistent with discussions in staff focus groups about improved cross-cultural understanding of residents and co-workers and changes in practice. Findings also echoed residents' comments in time 2 and time 3 about improved cross-cultural care services. The Cultural Competency Questionnaire was used in two studies. In one of these studies undertaken by Krajic et al (2005), 122 hospital staff (mainly health professionals) in seven European countries completed the survey. The mean scores were: Knowledge=2.5, Skills=2.4, Comfort level=2.8, Awareness=3.9 and Self-awareness=3.5 (Krajic et al. 2005). Our survey scores in these subscales were higher than these reported scores. In the study undertaken by Mareno and Hart (2014) in the USA with 365 RNs across various care settings, scores in these subscales were also lower than those in our study (Mareno and Hart 2014). Among different factors in the Cultural Competency Questionnaire, staff in our survey rated their cultural skills relatively low. This may be due to about 50% of survey respondents being personal care assistants. The Cultural Competency Questionnaire was originally designed for health professionals, rather than for personal care assistants in aged care homes. Items in this subscale or other subscales may be not suitable for them. Developing a new scale to measure cultural competencies for staff in residential care homes is recommended for future studies.

The aged care facilities' capacity to create and sustain improvement questionnaire was used in a large study in Australia across two states involving 21 aged care facilities and 344 staff (Etheron-Beer et al. 2013). In that study, staff ratings for 'Relationship and communication' and 'Team work & leadership' were 3.8 and 3.7 respectively (median). Our results are similar to those scores in the study. The lack of improvement in the scores of staff perceptions of the facilities' capacity to create and sustain improvements between time 2 and time 3 suggest that different strategies, interventions, resources and support mechanisms may be needed in order to improve the Relationship and communication, and Team work and Leadership factors in the workplace. Examples of strategies suggested by staff in the focus group include: (1) substantial support for new staff and staff from CALD backgrounds to assimilate into the residential aged care homes; (2) establishing mentoring support for staff to develop their capabilities and leadership in cross-cultural care and services and (3) providing tailored in-service education and training programs for staff to improve cross-cultural care and team cohesion.

Limitations

The study has some limitations. First, the four RACHs that participated in the project were highly supportive of the project and consequently the findings may not be generalised, but transferred to similar RACHs. A nation-wide study on CALD residents and the actions of CALD staff in coping with cross-cultural care

services is needed in order to understand and facilitate structural changes to accommodate their communication needs in the aged care system. Second, the data collection methods used may not capture the impact of cross-cultural communication on residents and staff. In addition, this study mainly focused on how linguistic diversity affected cross-cultural care services. More studies are needed to explore the intersection of both cultural and linguistic diversity on cross-cultural care services. Third, the study used surveys, interviews and focus groups that might not capture the interplay of actions and structures in real situations. Ethnographic studies underpinned by critical theory would provide more nuanced insights into this field. In addition, critical theory is criticised as overly idealistic, although it has the capacity to re-orient, and re-focus the group and be a catalyst for structural changes (Fay 1987, Kincheloe and McLaren 2000). The practical way to facilitate further action to bring structural change to this field is through building partnerships between researchers and stakeholders in aged care homes and to respect stakeholders' views of the process and outcomes of changes they would like to see.

Due to a low staff survey return rate (23.5%, 22% and 20.2% in time 1, time 2 and time 3 respectively), sampling bias may exist in the survey. The survey results may not represent the staff population under the study. In order to gain a comprehensive understanding of the staff perceived 'Cultural competence' and 'Facilities' capacity to create and sustain improvement', stratified random sampling methods to reflect CALD and non-CALD staff populations are needed in future studies on multicultural workforce development.

The nature of pre- and post- design in this project was unable to control confounding variables such as staff and resident characteristics that might have affected the evaluation outcomes. Interventions developed in this project via Action Research need to be further tested in a large randomised controlled trial to examine the dependent variables reported in this project.

Chapter 9: Recommendations and Conclusion

Activities led by industry partners in facilitating positive changes in cross-cultural care services and multicultural workforce development provided invaluable evidence on how to implement similar activities in other RACHs. Based on research evidence from the literature, and the present project, recommendations were made in order to embed, sustain and further develop cross-cultural care services for residents, achieve a culturally competent workforce and an enabling environment to support cross-cultural care services and the multicultural workforce. These recommendations are grouped and presented as follows:

Recommendations for improving cross-cultural care services for residents

- Recommendation 1: Residential aged care homes (RACHs) undertake regular cross-cultural care auditing activities using the cross-cultural audit tool to identify unmet care needs
- Recommendation 2: RACHs negotiate with CALD residents and their families to provide culturally appropriate diets.
- Recommendation 3: RACHs have resources to assist CALD residents to communicate their care needs. Resources include but are not limited to interpreter services, culturally and linguistically appropriate assessment tools (for example using the Rowland Universal Dementia Assessment Scale or RUDAS), cue cards, iPads with translation Apps.
- Recommendation 4: RACHs provide opportunity for CALD residents who cannot speak English or have returned to their first language, to talk with community visitors (or staff) in their first language, as they desire, either by phone, social media or face-to-face
- Recommendation 5: RACHs support residents to access culturally and linguistically appropriate social worker and counselling services as needed.
- Recommendation 6: RACHs provide residents/family members with general information about the cultural and linguistic profiles of staff, activities to facilitate cultural exchange between residents and staff and general guidelines on cross-cultural interactions.

Recommendations for developing a culturally competent workforce

- Recommendation 1: RACHs have selection criteria to guide staff appointments with regard to cultural competencies, cross-cultural care knowledge, skills and attitudes.
- Recommendation 2: RACHs embed the 'Staff cross-cultural Care Self-reflection Tool' and the 'Cross-cultural Care Self-Reflection Tool for Leaders' into staff performance review and staff development activities when appropriate.
- Recommendation 3: RACHs provide staff with education and training activities to meet their learning needs in cross-cultural care and team cohesion.
- Recommendation 4: RACHs provide 'buddy' support and mentoring support for new staff to learn cross-cultural care for residents and work effectively with co-workers from other cultures.
- Recommendation 5: RACHs provide new CALD staff who are also new migrants to Australia, with a tailored induction and orientation to enable them to understand the aged care system in Australia, and basic knowledge, skills and attitudes in cross-cultural communication.
- Recommendation 6: RACHs support CALD staff to overcome cross-cultural communication difficulties.
- Recommendation 7: RACHs support staff to engage in cultural exchange activities with residents and co-workers to enhance cross-cultural understanding.
- Recommendation 8: RACHs provide culturally and linguistically appropriate and accessible counselling services for staff when needed.

Recommendations for organisational support for cross-cultural care services and workforce development

- Recommendation 1: Aged care organisations have policies, structures, strategic plans and resources to support and sustain cross-cultural care services for residents.
- Recommendation 2: Aged care organisations have personnel at the organizational level capable to lead, coordinate and manage cross-cultural care for residents and workforce development. The multi-cultural workforce development facilitator position trialed in this project provides an example for aged care organisations to consider.
- Recommendation 3: Aged care organisations have personnel at their facility to champion and lead cross-cultural care services and team building. The site champions' position trialed in this project provides an example for aged care organisations to consider.
- Recommendation 4: Aged care organisations have education and training programs to enable induction, orientation and staff development with regard to cross-cultural care services and workforce cohesion.
- Recommendation 5: Aged care organisations have resources to support management to lead and resolve issues arising from cross-cultural interactions between residents and staff and between staff from different cultural backgrounds.
- Recommendation 6: Aged care organisations recognise and reward staff members who contribute their bilingual and bicultural knowledge and skills to cross-cultural care for residents.
- Recommendation 7: Aged care organisations train, recognise and reward staff members who contribute to 'buddy' support and mentoring support for new staff.
- Recommendation 8: Aged care organisations engage stakeholders in consultations with regard to development and improvements in cross-cultural care services and the workforce.
- Recommendation 9: Aged care organisations provide potential users and the public with general information about the cultural and linguistic profiles of staff, the availability, accessibility and quality of cross-cultural care services for users, and consumer expectations when using the services.

Conclusion

In phase one of the project, findings from residents and staff experiences in cross-cultural interactions in residential aged care supported the view that cultural and linguistic diversity added more complexity to achieve high-quality care for residents and for team cohesion. A Multicultural Workforce Development (MCWD) Model was developed in the project to enable aged care organisations to improve and sustain cross-cultural care services for residents while attracting and retaining a quality workforce. The MCWD Model and resources were implemented and evaluated in phase two using a site champion model. Outcomes from the project evaluation supported the implementation of the Multicultural Workforce Development (MCWD) Model and resources using the site champion model. This was associated with improved resident satisfaction with cross-cultural care services, staff perceived cultural competence, and their experiences in cross-cultural interactions with residents and coworkers. There is a need to embed and sustain the MCWD model in residential aged care homes using the site champion model. The project evaluation also revealed that the organisations' structures, personnel, resources and support were crucial to enabling and sustaining positive changes.

Appendix 1 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 considerations in cross-						

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
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						
Needs associated with						

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
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 2 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: <i>1=Not met 2=Partially met</i> <i>3=Met NA=Not applicable</i>	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.		

Support/resources for the multicultural workforce	Score: 1=Not met 2=Partially met 3=Met NA=Not applicable	Further explanations & actions
Resources on enhanced cross-cultural communication in the multicultural care team are available for staff to access.		
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=	

Support/resources for the multicultural workforce	Score: <i>1=Not met 2=Partially met</i> <i>3=Met NA=Not applicable</i>	Further explanations & actions
	Total=	

Appendix 3 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: <i>1=Not met</i> <i>2=Partially met</i> <i>3= Met</i> <i>NA=Not applicable</i>	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: <i>1=Not met</i> <i>2=Partially met</i> <i>3= Met</i> <i>NA=Not applicable</i>	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 4 A 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 & its attributes	Self-reflection cues	Notes
Respect for differences in values <ul style="list-style-type: none"> • 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?	

Cultural humility & its attributes	Self-reflection cues	Notes
	10. How do I participate in cross-cultural activities and events?	
	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 <ul style="list-style-type: none"> • 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	

Cultural humility & its attributes	Self-reflection cues	Notes
	linguistically diverse (CALD) backgrounds without interruption?	
	10. Am I willing to learn a few words from residents from culturally and linguistically diverse (CALD) background and communicate with them?	
<p>Positive attitudes and actions in cross-cultural interactions with residents, families and staff</p> <ul style="list-style-type: none"> • 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?	

Cultural humility & its attributes	Self-reflection cues	Notes
	8. Do I know the process required to report and investigate a 'cultural' issue in the workplace?	
	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 5 A 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 6 Instructions for accessing the online program

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 7 Summary of literature reviewed

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
S1: Allensworth-Davies, D., Leigh, J., Pukstas, K., Geron, S.M., Hardt, E., Brandeis, G., Engle, R.L. & Parker, V.A. (2007)/USA	135 nursing assistants at four New England nursing homes	A cross-sectional survey study	<ul style="list-style-type: none"> Perception of organisational cultural competence and autonomy were associated with job satisfaction; Racio-ethnicity was associated with perceived organisational cultural competence; A comfortable work environment for employees of different races/cultures emerged as the strongest organisational cultural competency factor. 	The study did not explore workforce cohesion and residents factors affecting staff's job satisfaction.	Organisation factors need to be explored in cross-cultural care services and workforce cohesion.
S2: Berdes, C. & Eckert, J.M. (2007)/USA	30 African American and immigrant aides working in three nursing homes	Qualitative face-to-face interviews	<ul style="list-style-type: none"> The Nomenclature of Relationship: Metaphorical Family, Real Attachment: relationships with some residents as emotionally warm and even reciprocated; Valuing Affective Care: Caring Aides, Uncaring Families: Aides distinguished their family-like caring affect and caring behaviour toward residents by contrasting it with uncaring behaviour of residents' real families 	Information on residents culture and language use is lacking.	Migrant or CALD care workers experienced of racism on the job. Metaphorical Family helped this group to cope with stress due to racism on the job.
S3: Bourgeault, I.L., Atanackovic, J., Rashid, A. & Parpia, R. (2010)/Canada	77 migrant workers, 24 employers, and 29 current and future care recipients in multicultural settings	Qualitative face-to-face interviews	<ul style="list-style-type: none"> The Characteristics of a Good Carer: a good carer as one who is patient, compassionate, and capable of understanding and responding to the needs of his or her patients; Types of Relationships between Immigrant Care Workers and Older Persons: "professional relationship", "friendly relationship" and "discriminatory relationship"; Factors Influencing the Types of Relationship 	Information on older people's culture and language use is limited; information on system factors affecting care services is lacking.	This study supports that data collection from different stakeholders is needed to gain holistic understanding of issues around cross-cultural care services.

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
			and Quality of Care.		
S4: Abrahamson, K., Pillemer, K., Sechrist, J. & Sutor, J. (2011)/ USA	655 staff from mainstream and CALD backgrounds in 60 nursing homes	A cross-sectional survey study	<ul style="list-style-type: none"> • Race was not a predictor of staff perception of conflict with family members or of poor treatment from residents' families; (2) Black nursing assistants were more likely to perceive that their own expectations of nursing care are dissimilar from those of residents' family members; • Dissimilarity predicted reports of poor treatment from family members, and poor treatment was a positive predictor of perception of conflict. 	The study did not use interview to clarify issues arising from the survey.	Conflict between staff and residents' family members exist and affect the cross-cultural care services.
S5: Ryvicker, M. (2011)/ USA	Two nursing homes each with 250 beds, non-profit, non-chain, Medicare/Medicaid certified, and nursing staff levels close to the state average	Ethnographic observation in one facility serving residents from a white, middle class and another serving residents from low-income Black and Hispanic clients	<ul style="list-style-type: none"> • In the more affluent facility, staff interacted with residents well evidenced by adapting to residents' responses and well equipped with resident-specific information. • In the safety-net facility, staff interacted with residents not well evidenced by one-directional, "didactic" fashion, providing instruction without a mechanism for adapting to residents' responses, and not as well equipped with resident-specific information. 	No information on cultural and linguistic diversity on staff.	This staff supports that equitable care must be evaluated using: four core domains in terms of availability, accessibility, acceptability and quality of care services.

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
S6: Hurtado, D.A., Sabbath, E.L., Ertel, K.A., Buxton, O.M. & Berkman, L.F. (2012)/USA	237 care workers including Black 110 White immigrant and American direct-care workers at 4 nursing homes	A cross-sectional survey study	<ul style="list-style-type: none"> Black employees were more likely to report job strain, compared with Whites; Analyses stratified by occupation showed that Black CNAs were more likely to report job strain, compared with White CNAs; Black workers earned \$2.58 less per hour and worked 7.1 more hours per week on average, 	The study did not explore organisations' factors on care workers besides the disparities of payment between groups.	Group differences and the impacts on team work need to be examined.
S7: Runci, S. J., Eppingstall, B. J. & O'Connor, D. W. (2012)/Australia	82 older Australians of Greek or Italian background who had been diagnosed with dementia and were residing in mainstream or ethno-specific care.	Mixed methods: An interview with a family member of each resident, observation of each resident, and an interview with a direct care staff member; QoL measures	<ul style="list-style-type: none"> Resident-to-resident interaction rate was higher in the ethno-specific facilities. Staff-to-resident interaction rate did not differ between the facility types. Residents in ethno-specific care were prescribed antipsychotics at a significantly lower rate. 	Residents from two ethnic groups only; did not include residents from the mainstream culture; did not consider the impact of staff's cultures on communication with residents.	It explored cross-cultural residents-staff interactions in mainstream RACHs.
S8: Walsh, K. & Shutes, I. (2013)/UK & Ireland	(1)residents: 41 across Ireland and the UK including those from CALD backgrounds; (2)Staff: 34 migrant care workers in Ireland and 56 migrant care workers in the UK	A mixed-method approach: Interviews, focus groups and survey	<ul style="list-style-type: none"> Perceptions of quality of care and a good care worker; Care relationship themes: Need orientated; Friendship and familial-like; Reciprocal; Discrimination; Influences on care delivery and relationship development: Language and communication; Culture – history, customs and care approaches; Organisational and structural characteristics 	Did not explore the system factors affecting residents and staff perceptions in cross-cultural interactions.	Research on cross-cultural care services should include the main stakeholders in the service system.

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
S9: Kim, H., Woods, D.L., Montes, J.C., Martin, J.L., Moon, A. & Phillips, L.R. (2014)/USA	20 Korean-American and 28 Nursing Assistants from an ethno-specific nursing home	Video-recorded observations	Nursing Assistants' dementia and culturally appropriate communication style influenced the decreased behavioral symptoms of residents.	No interviews with Nursing Assistants to reflect on video-recorded cross-cultural communication with residents.	Cross-cultural dementia care education and training are much needed in order to promote non-pharmacological interventions to dementia management.
S10: Li, Y. & Cai, X.Y. (2014)/ USA	875,593 long-term residents from 90% of nursing facilities in the United States	2008 national Minimum Data Set supplemented with the Online Survey, Certification, and Reporting File and the Area Resource File.	<ul style="list-style-type: none"> Compared with white residents, CALD residents showed lower social engagement. Stratified analyses confirmed that disparities were similar in magnitude across patient and facility subgroups. 	Survey study only; factors contributed to the low social engagement of CALD residents were not further analysed.	The study based on a large sample support the existing care disparities between CALD and non-CALD residents.
S11: Li, Y., Ye, Z. Q., Glance, L. G. & Temkin-Greener, H. (2014)/ USA	227 nursing homes in Maryland in each year; Each year, approximately 17,000 surveys were mailed to responsible parties, and the annual response rate ranged from 55% to 60%.	Consumer ratings publicly reported for Maryland nursing homes during 2007–2010,	<ul style="list-style-type: none"> Overall ratings on care experience remained relatively high; Ratings on individual domains of care improved among all nursing homes in Maryland except for food and meals; Site-of-care disparities existed in each year for overall ratings; Facilities more predominated by black residents having lower scores; such disparities persisted over time. 	Survey study only; factors contributed to the care disparities were not examined in detail.	The study based on a large sample across 4 years support the existing care disparities between CALD and non-CALD residents.

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
S12: Runci, S.J., Eppingstall, B.J., van der Ploeg, E.S. & O'Connor, D.W. (2014) /Australia	Relatives of 83 residents with dementia from Greek or Italian backgrounds; 42 of them from mainstream nursing homes and 41 of them from ethno-specific nursing homes	Cross-sectional study using structured interview	<ul style="list-style-type: none"> Family were more satisfied with the facility's ability to meet the resident's language and cultural needs, social/leisure activities, and the food provided in ethno-specific nursing homes. The presence of a bilingual staff member at admission was associated with reduction in family caregiver stress and higher satisfaction. 	No interviews with residents themselves; no observations to complement the findings.	The satisfaction with cross-cultural care service tool is relevant to be used in evaluation study of the present project.
S13: Casey, A. N., Low, L. F., Jeon, Y. H. & Brodaty H./Australia (2015)	36 residents from 3 units of a nursing home	Cross-sectional interviews, standardised assessment, and observation	<ul style="list-style-type: none"> 22 (61.1%) residents were born overseas; 23 (63.9%) use English as their first language; 5 residents could not speak English and had family members as interpreters in interviews; Residents retained clear concepts of friendship and reported small, sparse networks; Residents with dementia reported less perceived social support; Greater perceived social support was moderately associated with higher number of reciprocated ties. 	No comparisons between CALD residents and non-CALD residents; No analysis of the impact of staff's cultures and language uses on residents perceptions of friendship and networks.	The study supports that positive and meaningful relationships are important for residents including these with dementia.
S14: Nichols, P., Horner, B. & Fyfe, K. (2015)/Australia	58 participants including 35 CALD staff, 11 Non-CALD staff, 7 managers and 5 family members from 6 nursing homes	Qualitative face-to-face interviews	<ul style="list-style-type: none"> Benefits for residents and the opportunity to share interests and beliefs; An initial lack of acceptance of CALD workers by residents with dementia; experiencing racially motivated reactions from residents; Positive or supportive relationships between 	The study did not involve residents or observations of positive/negative cross-cultural interactions/communication.	Findings on system issues need to be further explored.

Study setting &	Participants	Design Methods &	Findings	Limitations	Significance to the concern
			<p>CALD and non-CALD staff;</p> <ul style="list-style-type: none"> • Disharmony between CALD and non-CALD staff; • The need to improve cultural competence in the workplace; • The need to develop policy, guidelines and practises to support cultural diversity; • The need to ensure effective communication. 		
<p>S15: Small, J., Chan, S.M., Drance, E., Globerman, J., Hulko, W., O'Connor, D., Perry, J.A., Stern, L. & Ho, L. (2015)/ Canada</p>	<p>27 residents and 27 staff from diverse cultural and linguistic backgrounds in 2 nursing homes</p>	<p>Video-Recorded Activities</p>	<p>Negative cross-cultural interactions:</p> <ul style="list-style-type: none"> • There were a total of 185 mismatch interactions; • Staff did not accommodate to a language difference; did not appropriately simplify the message; interrupted the resident; persisted in carrying out undesirable action; avoided eye contact <p>Positive cross-cultural interactions:</p> <ul style="list-style-type: none"> • attempted to use language of the resident; • addressed resident by name • planned ahead to involve an interpreter; • made and sustained eye contact; • pointed, touched, gestured, and/or repositioned; • supports resident's independence 	<p>No interviews or focus groups to reflect on findings from video-recorded activities</p>	<p>Findings inform cross-cultural interaction principles</p>

Study setting &	Participants	Design & Methods	Findings	Limitations	Significance to the concern
S16: Ow Yong, B. & Manthorpe, J. (2016)/ England	12 migrant Indian care workers	Qualitative face-to-face interviews	<ul style="list-style-type: none"> Received notion that information about the nature of care home work from friends was not always accurate; Sense of insecurity due to language and socio-cultural uncertainty; Encountered most challenges in the first six months; Identity evaluation in the first six months with initial difficulties in accepting the role of a care worker; Sense of competence when improving knowledge of dementia care. 	One CALD group of staff only	It analysed challenges CALD staff encountered in the care setting.
S17: Isherwood, L. & King, D. (2017)/Australia	CALD staff in nursing homes from 2007 and 2012 Australia workforce census studies	A mixed methods design	<ul style="list-style-type: none"> RNs from Asian groups were far less likely than Australian-born nurses to hold care manager positions The working arrangements and conditions of Asian PCAs in were less favourable; South-East Asian PCAs were the most likely of all the Asian groups to work in a specialist cultural facility, North-East Asian PCAs were the most likely to use a language other than English in their job Asian RN groups had significantly fewer years of aged care experience than Australian-born worker Asian groups were on average, relatively recent employees in the sector. 	The studies did not explore residents/families perceptions of CALD staff	The work condition and leadership potential for CALD staff need to be further examined. The education and training needs for CALD staff need to be examined

Note: CALD= Culturally and linguistically diverse; RN= Registered Nurse; PCA=Personal care assistant;

Appendix 8 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 9 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.

4. 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.

5. 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 10 Action plan template used by MCWD facilitators and site champions

MCWD Site Champion Activity Report

Activity: Self reflection MCWD Site Champion (Please circle): XX (name of the Champion 1)/YY(name of the Champion 2)

Clinical Issue (if applicable): N/A

Residential/Home Care Standards: 1.1, 1.3, 1.5,

Activity Commencement Date: 22/09/2016

Activity End Date: 17/10/2016

Summary of the action plan and implementation

Activity What did you do to achieve the goal? Please add in the person responsible for the task	Mentee's How many people were involved in the activity in total?	Evaluation How did you assess the effect of the action and what were the outcomes?	Outcome How do you propose this action will effect quality of care/life for residents	Outcome Evaluation Plan Can you evaluate this outcome and if so, how will you do this and when?
<ul style="list-style-type: none"> Site champion discussed with MCWDF and MRCS regarding implementing a self-reflection tool that would offer staff the opportunity to reflect on one's self. Flinders Research team sourced a self-directed 'self-reflection' tool that would offer staff the opportunity to build self-awareness and therefore help to be able to lead self. Approval received from MRCS. Heads of departments were personally given the "Leader Cross-Cultural care Self-Reflective Tool for their consideration to reflect upon themselves 60 self-reflection tools were placed in the staff area by SC (site champions) across both sites for staff to be able to utilise in their own time. 	<p>Heads of departments =5 CN=1 Staff= unknown due to the self-section of participation.</p>	<p>Assessing the effect was noted from discussions from staff amongst themselves and towards the SC. Staff were heard conversing and were able to relate to the information and reflected upon themselves. Feedback forms were supplied by the research team for staff and leaders to provide feedback on the self-reflection</p>	<p>Staff will be more inclined to have increased confidence, be increasingly self-aware and therefore be happier within themselves.</p>	<p>The outcome of this activity has the potential to impact staff professionally and also personally.</p>

<ul style="list-style-type: none"> • In Facility One, on the 'Continuous Improvement' information board, a display was placed, highlighting the questionnaire and also giving explanation. This explanation offered staff information re how to inform SC of their involvement in the activity • A form was clipped to the Self-Reflection Tools in Facility Two for staff to document their involvement in the activity. • Discussions were fostered and held informally amongst staff during break times • Staff were also prompted and reminded of the tool availability during other discussions relating to multiculturalism and leadership in the workplace. 		tool.		
--	--	-------	--	--

Activity Overview:

Please describe in detail what you did to perform this activity considering the planning, implementation and evaluation of it?

A self-reflection tool was sourced, edited and supplied by Finders research team. Site champions distributed them to heads of departments on site and also to a staff only area. Staff were given the option to perform the self-reflection tool, if they wished.

Staff were made aware that the outcomes of the tool were personal and not for public display.

The evaluation of this activity was taken from the numbers of questionnaires distributed and the numbers that remained not utilised. Discussions were held with staff and feedback voiced. Feedback taken into consideration to help determine the effect that this activity could have upon staff, now and into the future. Feedback forms were provided by the Flinders research team for those engaged in this activity to complete.

What are the current policies and procedures that relate to this activity?

HR-PRO-34 Workforce Development Procedure

Are there any follow up actions required to sustain change as a result of this activity? If so, please detail below.

Potentially, this could be utilised at Staff Development days and also at induction stage of employment. With this self-reflection tool, staff are offered the opportunity to reflect upon oneself.

The tool also has the ability to be able to be used to guide mentors questions and also to provide examples of questions that could be asked in an interview of a potential new employee.

Have you identified any further clinical issues or activities as a result of conducting this activity?

Not at this time.

Please attach all literature, learning materials, evaluation sheets and other related information to this activity report and submit to the MCWD Facilitator.

Source: Adapted from Morey et al., 2015, Aged Care Clinical mentor Model of Change: Six Steps to Better Practice. A Guide for Implementing Clinical Change through Workforce Development (Morey et al. 2015).

Appendix 11 Semi-structured interview guide in phase one

Questions for residents/families	Questions for staff
<ol style="list-style-type: none"> 1. Can you talk about the cultural background of staff here at (facility name)? 2. How easy is it for you (or your family member) to communicate with the care staff? 3. Are there factors that make it difficult for you to communicate with the care staff? 4. If it is difficult, what help do you (or does your family member) have to communicate with the care staff? 5. Do you have any suggestions for staff to consider improving communications between staff and residents? <p style="text-align: center;">Additional questions for residents from CALD backgrounds</p> <ol style="list-style-type: none"> 6. What is the influence of your language background on the care provided to you? 	<ol style="list-style-type: none"> 1. Can you talk about the cultural background of residents here at (facility name)? 2. Are there factors that make it difficult for you to know what the care needs are of those residents from different cultures? Examples: 3. What about language difficulties? If a resident comes from another culture, does this make it difficult to care for them? Examples: 4. When you are working with a resident from a cultural group different from your own culture, what factors help you identify and meet care needs of the residents? <p style="text-align: center;">Additional questions for staff from CALD backgrounds</p> <ol style="list-style-type: none"> 5. What do you find is the best way to make sure that your residents understand you when you communicate with them in this workplace? <p style="text-align: center;">Additional questions for management groups</p> <ol style="list-style-type: none"> 6. What do you think are the challenges and opportunities for you when you are managing care and services to multicultural residents? 7. What do you think are the challenges and opportunities for multicultural staff from CALD backgrounds?
Giddens' critical concepts framed three concerning areas in the interview questions:	
<ol style="list-style-type: none"> 1. Residents/families' perceptions of factors enabling or inhibiting cross-cultural communication: Questions 1, 2, 3, 6. 2. Active actions (agencies) undertaken by residents/families to enable cross-cultural communication with staff: Questions 4 3. Anticipated changes to improve cross-cultural communication: Question 5. 	<ol style="list-style-type: none"> 1. Staff's perceptions of factors enabling or inhibiting cross-cultural communication: Questions 1, 2, 3, 6, 7. 2. Active actions (agencies) undertaken by staff initiated to enable cross-cultural communication with residents: Questions 4, 5. 3. Anticipated changes to improve cross-cultural communication: Question 6, 7.

Appendix 12 Resident satisfaction survey questionnaire

Section A: Demographic information about resident

1. **Resident's name and title:** _____
2. **Sex:** Male Female
3. **Age:** _____ years
4. **Occupation** (or occupation before retirement): _____
5. **Ethnicity:** Australian born Overseas born: country of birth _____
6. **If born overseas, what is the resident's first language?** _____
7. **If born overseas, how many years has the resident lived in Australia?** _____
8. **What is the date when the resident was admitted to the residential facility:**
_____(month)____(year)
9. **The resident's age when they were admitted to the residential facility:** _____ years

Section B: Demographic information about proxy for residents in the survey

1. Proxy's name and title: _____
2. **Sex:** Male Female
3. **Your relationship with the resident:** spouse son daughter-in-law daughter son-in-law
 sibling other _____
4. **Did you live in the same household with the resident before his/her admission to the residential facility?**
 no yes
5. **Ethnicity:**
 Australia born Overseas born: country of birth _____

Section C: Survey questionnaires

1. How well did you settle into the aged care facility?

Easily

With difficulty

Never

2. How would you describe the effect of moving into the facility on your stress level?

Reduced

Increased

No change

3. How well do you currently get on with the staff in the facility?

Very well

Moderately well

Not well

4. Are you currently able to interact with other residents?

Yes

No

If yes, how well do you interact with the other residents?

Very well

Moderately well

Not well

5. Overall, how satisfied are you with the facilities efforts to meet your language needs?

Very satisfied

Satisfied

-
- Neutral
 - Dissatisfied
 - Very Dissatisfied

6. How satisfied are you with the social and leisure activities provided for you?

- Very satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

7. How satisfied are you with the cultural appropriateness of the food provided?

- Very satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

8. Is there a particular staff member in the facility with whom you can speak in your language about your care?

- Yes
- No
- Not applicable

9. Would you prefer to be in a mainstream or a culturally and linguistically diverse aged care facility?

- Mainstream



Culturally and linguistically diverse

Appendix 13 Staff cross-cultural care service survey

Demographic Information (for time 1 survey only)

Section 1: To be completed by ALL staff

Please answer the questions and circle the response that applies to you.

Gender: Female Male

Age _____ years

Your birthday: ___day___month___year (This information is used to match the survey at three time points only)

What is the highest level of education you achieved?	What is your current rank or position?
<input type="checkbox"/> Hospital trained RN	<input type="checkbox"/> Manager/ Care coordinator/ Director of Care
<input type="checkbox"/> Diploma via Tertiary Education Institution	<input type="checkbox"/> RN/CN
<input type="checkbox"/> Bachelor degree	<input type="checkbox"/> Enrolled Nurse
<input type="checkbox"/> Masters degree	<input type="checkbox"/> Personal Care Worker
<input type="checkbox"/> Nursing student currently enrolled in Bachelor of Nursing	<input type="checkbox"/> Physiotherapist
<input type="checkbox"/> Aged Care Certificate 3	<input type="checkbox"/> Occupational therapist
<input type="checkbox"/> Aged Care certificate 4	<input type="checkbox"/> Lifestyle worker
<input type="checkbox"/> Others (please specify)	<input type="checkbox"/> Clerical
	<input type="checkbox"/> Maintenance
	<input type="checkbox"/> Cleaner
	<input type="checkbox"/> Hospitality
	<input type="checkbox"/> Other (please specify)

How long have you been employed in your current organization? _____ Years

How long have you worked in your current role? _____ Years

Do you work?

1. Full time
2. Permanent Part time - If so how many hours per week? _____
3. Casual - If so how many hours per week? _____

Do you have relatives or close friends from a culture other your own culture?

Yes No

If yes, please list their cultural backgrounds

Are you able to speak a language (languages) other than English fluently?

Yes No

If yes, please list the language (languages) _____

Have you used your language/or languages other than English in the care of residents in the workplace?

Yes No

If yes, please list the language (languages) _____

What is your religion? _____

<i>Section 2: To be completed by <u>Australian-born</u> staff only</i>

Which ethnic and cultural group do you belong to? _____

Have you travelled overseas?

Yes No

If yes, which regions in the world did you travel before?

1. African countries
2. Asian countries
3. European countries
4. North American countries
5. South American countries

Have you worked overseas?

Yes No

If yes, in which country (countries) did you work before? _____

Section 3: To be completed by overseas-born staff only

1. In which country were you born? _____
2. Which ethnic and cultural group did you belong to in your home country? _____
4. Which language do you speak at home? _____

5. How do you rate your English literacy?

English literacy	Very well	Well	Not very well	Not at all	Can't say
Speaking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. What is the highest level of education you achieved before migrating to Australia?

- a) Has not completed primary school education
- b) Completed primary school education
- c) Completed junior high school education
- d) Completed senior high school education
- e) Completed a vocational education other than nursing
- f) Completed a university degree other than nursing
- g) Completed enrolled nurses' training and gained first registration
- h) Completed an education program without bachelor degree for RN and gained first registration
- i) Completed a bachelor degree of nursing and gained first registration
- j) Completed a postgraduate certificate or diploma
- k) Completed Master Degree
- l) Others (please specify) _____

8. What was your main job in your home country prior to migration?

Your job _____ or select: Not applicable

1. How many years did you work in that job? _____ years or select: Not applicable
2. 11. How many years have you lived in Australia? _____ Years

Cultural Competency Questionnaire

A. Knowledge

If you find any question in segments A, B,C,D and E are not relevant for your situation, please choose the field which DOES NOT APPLY.

How **KNOWLEDGEABLE** are you about each of the following subject areas?
(please select one field in each column)

	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
1. The diversity of residents and staff within the care facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The social and cultural characteristics of residents and staff within the care facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Health risks experienced by diverse groups of residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Health disparities experienced by diverse groups of residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Social and cultural issues in treatment/care in your facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ethnopharmacology (i.e., variations in medication responses in diverse ethnic populations of residents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Different Healing Traditions (e.g., Ayurvedic Medicine, Traditional Chinese Medicine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Historical and contemporary impact of racism, bias, prejudice and discrimination in health care experienced by various population groups in Australia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. National/Regional Policies dealing with cultural diversity in health care including aged care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Your Organisation Policy on the subject of cultural diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Skills

How **SKILLED** are you in dealing with social and cultural issues in the following areas of resident care? (select one field in each column)

	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
1. Greeting residents in a culturally sensitive manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Eliciting the resident's perspective about health and illness (e.g., its etiology, name, treatment, course, prognosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Eliciting information about use of folk remedies and/or other alternative healing methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Eliciting information about the use of folk healers and/or other alternative practitioners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Performing a culturally sensitive physical examination/assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Prescribing/negotiating a culturally sensitive care/services plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
7. Providing culturally sensitive resident education and counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Providing culturally sensitive clinical preventive services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Providing culturally sensitive care for dying residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Assessing health literacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Working with interpreters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Dealing with cross-cultural conflicts relating to care/services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Dealing with cross-cultural adherence/compliance problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Dealing with cross-cultural ethical conflicts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Apologizing for cross-cultural misunderstandings or errors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Encounters/Situations						
How COMFORTABLE do you feel in dealing with the following cross-cultural encounters or situations? (select one field in each column)						
	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
1. Caring for residents from culturally diverse backgrounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Caring for residents with limited English proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Caring for a resident who insists on using or seeking folk healers or alternative therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Identifying beliefs that are not expressed by a resident or significant other but might interfere with the care/services regimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being attentive to non-verbal cues or the use of culturally specific gestures that might have different meanings in different cultures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Interpreting different cultural expressions of pain, distress, and suffering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Advising a resident to change behaviours or practices related to cultural beliefs that impair one's health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Speaking in an indirect rather than a direct way to a resident about his/her illness if this is more culturally appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Breaking "bad news" to a resident's family first rather than to the resident if this is more culturally appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Working with staff from culturally diverse backgrounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Working with a colleague who makes inappropriate or offensive remarks about residents from a particular ethnic group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
12. Treating a resident who makes inappropriate or offensive comments about your ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Dealing with residents who make inappropriate or offensive comments about other residents ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Dealing with large groups of family members accompanying and visiting residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Dealing with residents having culturally different eating habits (e.g. Rice, Ramadan, certain standards of food like halal or kosher etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Supporting residents need to practice their religion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Awareness

1. How **IMPORTANT** do you believe sociocultural issues are in your interactions with: (select one field in each column)

	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
a. Residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Residents' significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Colleagues from your own profession/area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How **AWARE** are you of your own? (select one field in each column)

	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
a. Ethnic or cultural identity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Ethnic or cultural stereotypes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Biases and prejudices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. Education and Training

HOW MUCH TRAINING in cultural diversity have you previously had? (select one field in each column)

	Not at all	A Little	Some what	Quite a Bit	Very	Does not apply
a. In school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In basic professional education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. During vocational training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In specific training in the facility/aged care organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. In continuous (professional) education outside the facility/aged care organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Aged care facilities' capacity to create and sustain improvement questionnaire

For the statements in **Sections 1 & 2**, please fill in the circle that best reflects your feelings about what is going on at this facility:

Section 1: Relationship and communication		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I look forward to working with our staff each day to provide cross-cultural care services .	1	2	3	4	5

2	It is easy for me to talk openly with our staff about cross-cultural care services .	1	2	3	4	5
3	There is good communication between staff across shifts.	1	2	3	4	5
4	I feel that the information I get is accurate.	1	2	3	4	5
5	I find it enjoyable to talk to other staff.	1	2	3	4	5
6	Staff members are well informed about what is happening during other shifts.	1	2	3	4	5
7	Information passed between staff is accurate.	1	2	3	4	5
8	It is easy to ask for advice from other staff about cross-cultural care services .	1	2	3	4	5
9	When a resident's needs and preferences for care/services change, I get the right information quickly.	1	2	3	4	5
10	I take pride in being a part of this team.	1	2	3	4	5
11	The staff have a good understanding of each resident's goals.	1	2	3	4	5
12	There are no delays in relaying information about the care of the residents.	1	2	3	4	5
13	I identify with the goals of this facility.	1	2	3	4	5
14	I feel I am a part of this team.	1	2	3	4	5
15	The staff have a good understanding of the resident's care plans regarding cross-cultural care/services.	1	2	3	4	5

Think of ' Leadership team' as applying to all levels of staff in the care facility in cross-cultural care/services.

Section 2: Team work & leadership		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	The leadership team provides strong guidance and advice to the care team.	1	2	3	4	5
2	The leadership team is sensitive to the needs of staff.	1	2	3	4	5
3	The leadership team is clear about what they expect from staff.	1	2	3	4	5
4	The leadership team encourages staff to take initiative.	1	2	3	4	5
5	The leadership team asks us what we think.	1	2	3	4	5
6	Staff are certain where they stand.	1	2	3	4	5
7	The leadership team is in touch with staff views and concerns.	1	2	3	4	5

8	The leadership team makes decisions with input from the staff.	1	2	3	4	5
9	The leadership team gives staff chances to grow.	1	2	3	4	5
10	Other residential care settings seem to have a high opinion of us.	1	2	3	4	5
11	Working as a team with other departments/disciplines makes our work easier.	1	2	3	4	5

Education and Training questionnaire at time 2 & time 3 surveys only

F. Education and Training				
1. Which of the following cultural competency training modules were you able to attend partly or entirely? (mark with a cross)				
			Attended part of module	Attended entire module
Module 1:			<input type="checkbox"/>	<input type="checkbox"/>
Cross-cultural communication				
Module 2:			<input type="checkbox"/>	<input type="checkbox"/>
Cross Cultural Leadership				
Module 3:			<input type="checkbox"/>	<input type="checkbox"/>
Cross-Cultural Dementia Care				
Module 3:			<input type="checkbox"/>	<input type="checkbox"/>
Cross-Cultural End-of-Life Care				
Module 4:			<input type="checkbox"/>	<input type="checkbox"/>
Induction and Orientation for New Staff in Cross-Cultural Care Services				
2. Overall, how satisfied were you with the quality of the cross-cultural care and service training? (Cross one field)				
Not at all	A Little	Somewhat	Quite a Bit	Very
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. My desire to learn more about the subject of the cross-cultural care and service training has:

Decreased a Lot	Decreased Somewhat	Remained the same	Increased Somewhat	Increased a lot
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. IMPACT

1. To what extent do you think the cross-cultural care and service training has had an impact on your ability to cope with the demands in your work activities? (select one field)

None	A Little	Some	Quite a Lot	Very Significant	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Please offer any further comments or suggestions that you may have.

Thank you for completing the questionnaire!

Please put it in the sealable envelope and drop it into the survey drop-box. The researcher from Flinders University will collect the survey.

Appendix 14 Semi-structured questions for focus groups in phase two

Semi-structured questions for focus groups with staff at time 2

The following questions will serve as a guide in the focus groups. Questions may be asked in a different order or some omitted or added, depending on the participants' responses.

1. Would you please briefly describe the purpose of the project and the expected outcomes of the project?
2. What activities have you engaged in this project since its implementation in March 2016?
3. Do you believe that these activities have improved your ability to provide culturally and linguistically appropriate care for residents? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to the site manager, the multicultural workforce development facilitator and the site champion to improve it?
4. Do you believe that these activities have improved your intercultural communication skills and ability to work in a multicultural team? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to the site manager, the multicultural workforce development facilitator and the site champion?
5. During the implementation of the project, what kind of support or leading by example have you observed from:
 - the site manager,
 - multicultural workforce development facilitator,
 - the site champion?
6. Have you seen any positive changes in staff since the implementation of the project? If your answer is yes, please give some examples?
7. Have you seen any positive changes in the way staff communicate or relate to other staff or residents from CALD backgrounds since the implementation of the project? If your answer is yes, please give some examples?
8. What do you see as the limitations of and the challenges to the implementation of the project?
9. What are your suggestions to the site manager, the mentor and the site champion in order to overcome these challenges?
10. Do you have any other feedback about the project overall.

Semi-structured questions for focus groups with staff at time 3

The following questions will serve as a guide in the focus groups. Questions may be asked in a different order or some omitted or added, depending on the participants' responses.

1. Would you please briefly describe the purpose of the project and the expected outcomes of the project?
2. What activities have you engaged in this project since its implementation in the past 6 months?
3. Do you believe that these activities have improved your ability to provide culturally and linguistically appropriate care for residents? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to the site manager, the multicultural workforce development facilitator and the site champion to improve it?
4. Do you believe that these activities have improved your intercultural communication skills and ability to work in a multicultural team? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to the site manager, the multicultural workforce development facilitator and the site champion?
5. During the implementation of the project, what kind of support or leading by example have you observed from:
 - the site manager,
 - multicultural workforce development facilitator,
 - the site champion?

-
6. Have you seen any positive changes in staff since the implementation of the project? If your answer is yes, please give some examples?
 7. Have you seen any positive changes in the way staff communicate or relate to other staff or residents from CALD backgrounds since the implementation of the project? If your answer is yes, please give some examples?
 8. What do you see as the limitations of and the challenges to the implementation of the project?
 9. What are your suggestions to the site manager, the mentor and the site champion in order to overcome these challenges?
 10. Do you have any other feedback about the project overall.

Semi-structured questions for focus groups with site champions at time 3

The following questions will serve as a guide in the focus groups. Questions may be asked in a different order or some omitted or added, depending on the participants' responses.

1. Do you believe that your role in the project has improved your ability to facilitate culturally and linguistically appropriate care for residents in your care home? Please give some examples.
2. What activities have you conducted for staff in this project since your appointment?
3. Do you believe that these activities have improved staff's ability to care for residents in cross-cultural interactions? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to improve staff's ability in cross-cultural care for residents?
4. Do you believe that these activities have improved staff's ability to work with co-workers in the multicultural team? If your answer is yes, please give some examples? If your answer is no, what are your suggestions to improve staff's ability to improve team cohesion?
5. Have you seen any positive changes in cross-cultural care and services for residents in your care home? If your answer is yes, please give some examples?
6. What do you see as the limitations of and the challenges to the implementation of the project?
7. Is your organisation has any plan to disseminate the project to other residential aged care homes? If ye, please describe the plan and your engagement in future activities? If no, what are your suggestions to the organisation regarding the project dissemination?
8. If we disseminate the project to other aged care organisations, what would you like to share with the site champions about the effective way to implement the project?
9. Do you have any other feedback about the project overall.

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