THE UNIVERSITY OF QUEENSLAND

AUSTRALIA

A systematic investigation of communication and mealtime management in residential aged care: Exploring perspectives and management across service providers.

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A thesis submitted for the degree of Doctor of Philosophy at

The University of Queensland in 2014

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ABSTRACT

Residents of Residential Aged Care Facilities (RACFs) represent one of the highest risk populations for communication and mealtime difficulties. Though past studies have examined these difficulties, most have taken a siloed approach exploring specific difficulties or interventions out of context and without consideration of residents' holistic communication and mealtime needs. Further, few studies have investigated communication or mealtime management in RACFs from a multidisciplinary perspective.

As specialists in the management of communication and mealtime difficulties there is potential for speech pathologists (SPs) to have an enhanced role in RACFs. Working in accordance with aged care policy service providers must work within a multidisciplinary and person-centered model of care (PCC) to provide individualised and tailored assessment and intervention, and to facilitate active ageing and subjective wellbeing. However, with vast gaps in literature exploring communication and mealtime management in RACFs there is limited evidence to guide service provision. Furthermore, though past research has identified broad barriers to care in RACFs, whether these barriers extend to communication or mealtime management and the potential consequences for speech pathology service provision is not known. Therefore, the aims of the current thesis were to: (1) obtain a more holistic and representative view of factors that influence optimal care in RACFs, identifying challenges and motivators to working in the setting for a range of service providers; (2) explore communication and mealtime management in RACFs examined in the context of daily care and considerate of documented, resident reported, and staff knowledge of residents' communication and mealtime needs; and (3) explore the perspectives of a range of service providers involved in mealtime management in RACFs to identify shared and disparate issues influencing care.

Four studies were conducted to address these aims. In Study 1, semi-structured in-depth individual and focus group interviews were conducted with 61 service providers including: care managers; nursing staff; assistants in nursing; care, domestic and support staff; and SPs, to explore challenges and motivators to working in RACFs. Content analysis revealed four themes: (1) working in RACFs is both personally rewarding and personally challenging; (2) relationships and philosophies of care directly impact service provision, staff morale, and resident quality of life; (3) a perceived lack of service specific education and professional support impacts service provision; and (4) service provision in RACFs should be seen as a specialist area. Themes 1 and 2 emphasised the importance of effective resident-staff communication to the completion of all care tasks and

highlighted the challenges to care presented by resident cognitive and/or communication difficulties.

Following this finding, Study 2 explored resident-staff communication and current communication management in RACFs. Data was triangulated using resident file reviews (n = 14), resident surveys (n = 14), staff surveys (n = 29), and 123 hours of observation. Results revealed limited documentation of residents' communication needs insufficient to facilitate individualised or tailored intervention. Explicit management by RACF staff of residents' communication needs was not observed. RACF staff surveys indicated staff knowledge of residents' communication needs was also limited. In addition, observed resident-staff communication was largely task focused providing limited opportunity for residents to engage in meaningful conversation.

With similar methodology to Study 2 and involving the same participants, Study 3 explored mealtime management triangulating data from resident file reviews (n = 14), resident surveys (n = 14), staff surveys (n = 29), and resident mealtime observations (n = 41). Results revealed inconsistencies in the communication and implementation of mealtime management recommendations at multiple levels and across all data sources. Observed mealtime management was limited in scope with a primary focus on the compensatory management of dysphagia, and was inadequate in considering residents' psychosocial mealtime needs. In addition, little evidence of effective multidisciplinary care or care consistent with PCC was evident.

Study 4 extended the findings of Study 3, further exploring service provider perspectives about mealtime management in RACFs. Data was obtained using qualitative methodology similar to that of Study 1 and including the same participants as Study 1. Four themes were identified: (1) mealtimes are highly valued; (2) service providers face common barriers to mealtime management; (3) communication among service providers is challenging; and (4) education in mealtime management is limited. These themes are similar to those found in Study 1 indicating broad challenges to service provision in RACFs also impact mealtime management.

This thesis revealed, both communication and mealtime management in RACFs is hindered by numerous barriers to optimal care. Speech pathology involvement and multidisciplinary care in the setting is limited. Furthermore, current communication and mealtime management is inconsistent with PCC, the facilitation of active ageing, and consideration of residents' psychosocial needs and subjective wellbeing. Future research and speech pathology management must aim to reconceptualise communication and mealtime management in RACFs, emphasising residents' holistic needs, the complex nature of care in RACFs, and the need for increased training and support across service disciplines.

DECLARATION BY AUTHOR

This thesis is composed of my original work and contains no material previously published or written by another person, except where due reference has been made in the text. I have clearly stated the contributions by others to jointly authored works that I have included in my thesis.

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PUBLICATIONS DURING CANDIDATURE

Peer-reviewed papers

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2014). Service providers' perceptions of working in residential aged care: A qualitative cross sectional analysis. *Ageing & Society,* Early online doi: 10.1017/S0144686X14000853.

Bennett, M., Ward, E., & Scarinci, N. (submitted). An exploratory investigation of communication management in residential aged care: A comparison of documentation, observed resident-staff communication, resident perspectives, and staff knowledge. *International Journal of Language and Communication Disorders.*

Bennett, M., Ward, E., & Scarinci, N. (in-press). Mealtime management in Australian Residential Aged Care: A comparison of documented, reported, and observed care. *International Journal of Speech-Language Pathology.*

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2014). Perspectives on mealtime management in residential aged care: Insights from a cross disciplinary investigation. *Journal of Nutrition in Gerontology and Geriatrics, 33*(4), 325-339.

Conference Abstracts

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2011, December). A systematic investigation of resident need and current service provision for residents of high care residential aged care facilities with communication and/or mealtime difficulties. *Paper presented at the SHRS Post Graduate Research Conference, The University of Queensland, Brisbane, Australia.*

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2012, June). Speech pathology service provision in residential aged care: An analysis of current practice. *Paper presented at The Speech Pathology Australia National Conference, Gold Coast, Australia.*

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2013, June). An exploration of the perspectives of RACF staff about communication and mealtime management and the role of speech pathologists in aged care. *Paper presented at The Speech Pathology Australia National Conference, Hobart, Australia.*

Bennett, M., Ward, E., & Scarinci. (2013, November). Mealtime management in RACFs: Comparison of perceived and observed care. *Paper presented at the Australian Association of Gerontology National Conference, Sydney, Australia.*

PUBLICATIONS INCLUDED IN THIS THESIS

The following refereed journal publications have resulted from the work included in this thesis:

Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2014). Service providers' perceptions of working in residential aged care: A qualitative cross sectional analysis. Ageing & Society, Early online doi: 10.1017/S0144686X14000853.

This entire manuscript is incorporated as Chapter 2.

Contributor	Statement of Contribution
Michelle K Bennett (Candidate)	Reviewing of Literature (80%) Study Design (60%) Recruitment (100%) Data Collection (100%) Qualitative Analysis (50%) Wrote the paper (70%) Edited the Chapter (20%)
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Bennett, M., Ward, E., & Scarinci, N. (submitted). An exploratory investigation of communication management in residential aged care: A comparison of documentation, observed resident-staff communication, resident perspectives, and staff knowledge. *International Journal of Language and Communication Disorders.*

This entire manuscript is incorporated as Chapter 3.

Contributor	Statement of Contribution
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Bennett, M., Ward, E., & Scarinci, N. (in-press). Mealtime management in Australian Residential Aged Care: A comparison of documented, reported, and observed care. *International Journal of Speech-Language Pathology.*

This entire manuscript is incorporated as Chapter 4.

Contributor	Statement of Contribution
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Bennett, M., Ward, E., Scarinci, N., & Waite, M. (2014). Perspectives on mealtime management in residential aged care: Insights from a cross disciplinary investigation. *Journal of Nutrition in Gerontology and Geriatrics*, *33*(4), 325-339.

This entire manuscript is incorporated as Chapter 5.

Contributor	Statement of Contribution
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Elizabeth C Ward	Reviewing of Literature (10%) Study Design (25%) Qualitative Analysis (5%) Wrote the paper (10%) Edited the Chapter (35%)
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Monique C Waite	Qualitative Analysis (35%) Edited the Chapter (10%)

Tables and figures from these articles have been embedded in the text. References are presented at the conclusion of this thesis. Figure and table numbers, as well as headings, page numbers and general stylistic specifications have been adjusted to align with the guidelines set out by the American Psychological Association to maintain consistency throughout this thesis. An exception to APA referencing style has been made for all references to the chapters of this thesis that have been accepted for publication. In these cases to assist the examiner the reference has been

modified to clarify this e.g., (Bennett, Ward, Scarinci & Waite, 2014 = Chapter 2). For continuity of referencing style throughout this thesis, the first citation will include all authors with each subsequent citation of the same source for articles with three to six authors being referenced using the first author's name followed by et al. Articles with more than six authors which will be referenced with the first author followed by et al. from the first instance as per American Psychological Association style guidelines. All spelling conforms to Australian English.

CONTRIBUTIONS BY OTHERS TO THIS THESIS

The PhD candidate was primarily responsible for the concept and design of this thesis and the studies comprising this thesis including gaining ethical approval, study design, participant recruitment, data collection, data analysis and interpretation, and manuscript preparation. However, the following people have made a significant contribution to this thesis as a whole:

Professor Elizabeth C Ward had substantial input into the design of this thesis and the studies comprising this thesis, the interpretation of data, editing, and critical appraisal of written work comprising this thesis.

Dr Nerina A Scarinci had substantial input into the design of this thesis and the studies comprising this thesis, the interpretation of data, editing, and critical appraisal of written work comprising this thesis.

Dr Monique C Waite had a significant role in qualitative data analysis and interpretation of the analysis in the studies comprising Chapters 2 and 5.

To the best of my knowledge and belief, no person who has offered contributions consistent with the above has been excluded as an author.

STATEMENT OF PARTS OF THIS THESIS SUBMITTED TO QUALIFY FOR THE AWARD OF ANOTHER DEGREE

None

ACKNOWLEDGEMENTS

A PhD is a journey, a journey of exploration, discovery, perseverance, and commitment. It can be a lonely and overwhelming journey. For me lonely by distance as a remote candidate and lonely intellectually when you are lost in your own world of thoughts and ideas. You have notes on the kitchen bench, next to the bed, in the car, on the side of the tissue box! Does anyone really understand where you are coming from or what you are trying to say anyway? It can be overwhelming, drowning in data collection before being left dishevelled by data analysis. You then finish in solitary confinement as you write desperately in the race to the end.

Your intellect is challenged, your patience is tested, and your endurance is pushed. Every time I stumbled, every time I fell, I now see that I wasn't alone. Professor Elizabeth Ward and Dr Nerina Scarinci (my supervisors) were there for all of my highs and lows. They experienced them with me, and they picked me up and carried me when I needed them too. Liz and Nerina you have shared with me a wealth of knowledge, experience, praise, criticism (always kind and constructive), enthusiasm, and passion for the work that you do. You have supported and valued my ideas, my passion, and my direction for change, and have valued them as if they were your own. Thank you so much for your mentorship, guidance, and friendship, both professionally and personally.

The impact of a PhD can be somewhat cataclysmic. The core of a PhD I liken to the sun, with you (the candidate) and those in your life being planets drawn to the sun by its magnetic pull with your life in a constant revolve around the PhD. Each person is connected to you and your planet so when you go of course, when your planet strays out of orbit, there is a chain reaction of chaos that impacts everyone around you. I could not have stayed on course without my parents Bill and Sharon Pittaway or my three little stars Maya, Alec and Samuel who revolve around me each day and each night. Mum and Dad, you raised me with strength and determination, to act with honesty and integrity, and to stand up and work for what I believe in. Thank you, I am so proud to be your daughter. My beautiful children, you bring laughter, cuddles, light, and such wisdom to my life each and every day. You are my world and I love you to the moon and back (a billion times).

I have completed this thesis during a time of huge transition in my life. I would not have made it to the point of submitting this thesis without the support and love of my wonderful friends, Alison, Bec, Katelynd, Maryann, Megan, Paul, and Mel. You have all held my hand, wiped my tears, listened, consoled, encouraged, and supported me, and my children. We are all truly blessed to have you in our lives. This thesis is a celebration of making it through to the other side. Dreams can always be achieved. To everyone and anyone who reads this thesis be proud of who you are and

hold your head up high. Laugh, live, and always let the sun shine on your life no matter what challenges you face.

Finally, this thesis would not have been possible without the many participants who volunteered their time and perspectives. Thank you to BUPA Care Services and UnitingCare Ageing for your ongoing involvement and support, and thank you to all of the individual participants who contributed to the research comprising this thesis.

KEYWORDS

aged care, communication, mealtimes, service provision, speech pathology

AUSTRALIAN AND NEW ZEALAND STANDARD RESEARCH CLASSIFICATIONS (ANZSRC)

ANZSRC code: 920201, Allied Health Therapies (excl. Mental Health Services), 65%

ANZSRC code: 920210, Nursing, 35%

FIELDS OF RESEARCH (FOR) CLASSIFICATION

FoR code: 0321, Rehabilitation and Therapy (excl. Physiotherapy), 65%

FoR code: 1001, Aged Care Nursing, 35%

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LIST OF ABBRIEVIATIONS USED IN THIS THESIS

RACF	residential aged care facility
SP	speech pathologist
QOL	quality of life
UN	United Nations
PCC	person-centered care
NARI	National Ageing Research Institute
WHO	World Health Organization
ICF	International Classification of Functioning, Disability, and Health
HRQOL	health related quality of life
ACFI	Aged Care Funding Instrument
ACAT	Aged Care Assessment Team
PAS	Psychogeriatric Assessment Scale
CSD	Cornel Scale for Depression

AIN	assistant in nursing
CM	care manager
NS	nursing staff
CDSS	care, domestic, and support staff (kitchen staff, recreation and lifestyle staff, domestic support staff, volunteer)
FG	focus group
MECQ-LTC	Montreal Evaluation of Communication Questionnaire for use in Long-Term Care
QOC	Questionnaire of Communication

CHAPTER ONE

LITERATURE REVIEW

1.1. Introduction to this Thesis

People over the age of 65 years represent one of Australia's most rapidly growing age groups (Australian Bureau of Statistics, 2013). One in every three people in this demographic will enter permanent residential care at some stage of their later life (Australian Government Productivity Commission, 2011). Admission to residential care typically occurs when a person's medical frailty increases and/or ability to provide self-care decreases to a point where that person requires daily support to meet their medical and/or personal care needs (Australian Government, Department of Health and Ageing, 2008a).

In Australia, residential aged care facilities (RACFs) provide short (i.e., respite) and long-term care to older people with both low and high care needs. Health services provided in RACFs can involve anything from partial to up to 24 hour a day skilled nursing care. This care is provided under the direction of general practitioners and/or geriatricians and is facilitated with access to external service providers such as allied health services including speech pathology. It is widely recognised that achieving positive and sustained multidisciplinary interaction and optimal care quality in RACFs is a complex endeavour. Past literature has identified several broad barriers impacting service provision in the setting. These barriers will be discussed in depth in this current chapter with more specifically this thesis exploring issues impacting communication and mealtime management in this context. These issues will be introduced in this chapter and expanded upon in the subsequent thesis chapters. Ultimately this information is needed to better inform the role of speech pathologists (SPs) and services provided by SPs in RACFs. With the potential for residents of RACFs to benefit from a wide range of speech pathology services research is needed to determine areas of service need as well as barriers and facilitators to service provision. Sustainable solutions may then be explored to enhance support for staff involved in communication and mealtime management in RACFs, and to advance care in the setting.

Both communication and mealtime difficulties can have a detrimental impact on resident quality of life (QOL). In RACFs providing high-level care services past research has shown that the majority of residents experience some degree of communication and/or mealtime difficulties (Steele, Greenwood, Ens, Robertson, & Seldman-Carlson, 1997; Worrall, Hickson, & Dodd, 1993). Communication mediates social interaction and is integral to self-expression, the development and maintenance of relationships, and one's ability to assert independence and remain an active

participant in life activities (Cruice, Worrall, & Hickson, 2000; Nilsson, Ekman, Ericsson, & Winblad, 1996). Successful adaptation to ageing has been directly linked to effective communication (Lubinski & Welland, 1997). Furthermore, Yorkston, Bourgeois, and Baylor (2010) emphasised the negative influence of communication difficulty on the ability of older people to use health care services, including services provided in RACFs.

Mealtimes present one of the most important times of the day for residents of RACFs. In addition to providing nutritional intake mealtimes represent an opportunity for social interaction, personal expression, and independence (Chan & Pang, 2007; Crogan, Evans, Severtsen, & Shultz, 2004; Palacios Cena et al., 2013). Mealtimes have a key influence on QOL with people who experience mealtime difficulties describing feelings of anxiety, depression, embarrassment, frustration, isolation, and loss of self-esteem as a result of their difficulties (Ekberg, Hamdy, Woisard, Wuttge-Hannig, & Ortega, 2002; Martino, Beaton, & Diamant, 2010; Miller & Patterson, 2014). In addition, poor mealtime management can result in significant medical complications including malnutrition and aspiration pneumonia (Logemann, 1997).

Although SPs are recognised as specialists in communication and mealtime management (The Speech Pathology Association of Australia Ltd, 2003), the role of SPs in aged care and RACFs specifically has received little ongoing research or industry attention. There are currently no professional guidelines for Australian SPs working in RACFs despite literature indicating working with older people requires additional considerations, a broad scope of practice, and an advanced skill set (Casper, 2013; Lubinski, 2006; Worrall & Hickson, 2003). There has also been debate about whether speech pathology services should be provided in RACFs given the often chronic and degenerative nature of resident difficulties (Hopper, Clearly, Oddson, Donnelly, & Elgar, 2007). To restrict services based on this argument is, however, inconsistent with both national and international aged care policy and legislation and is contrary to the *United Nations Principles for Older Persons* (United Nations (UN), 1991). Together this policy and legislation dictates that service providers must move beyond a traditional medical model of care and must work under a person-centered care approach (PCC) to facilitate "active ageing" and QOL, including subjective wellbeing.

To achieve this goal professionals working within this context must understand and be able to apply these principles. PCC emphasises equal partnership between the person receiving the health care service and the health professional/s providing the service, placing responsibility for the health of an individual on both the individual and the treating health professional/s (National Ageing research Institute (NARI), 2006). PCC therefore aims to uphold the health care users right to autonomy and active decision making regarding their care (UN, 1991). Active ageing is an

overarching term aiming to facilitate physical, social, and mental wellbeing at all ages to ultimately optimise QOL throughout the lifespan (World Health Organization (WHO), 2002). Hence to work in a manner consistent with PCC, active ageing, and the facilitation of QOL, service providers must strive to assist older people to maintain active participation in meaningful life activities and to remain active contributors to their health care regardless of the nature or severity of the impairment/s they experience (Aged Care Act, 1997; Australian Government Productivity Commission, 2011; Bundy, Hemsley, Brentnall, & Marshall, 2008; Commonwealth of Australia, 2012; WHO, 2002). Considering the importance of both communication and mealtimes in the lives of older people, ensuring both communication and mealtime management in RACFs is optimised is therefore well supported by current policy.

Care provided in RACFs is, however, complex and dependent on services provided by multiple disciplines (Heumann, Boldy, & McCall, 2001; Lubinski, 2006; Mitchell & Pachana, 2013; Perry et al., 2011; Worrall & Hickson, 2003). Therefore in order for communication and mealtime management in RACFs to be effective there is a need for communication and collaboration across a wide range of service providers including SPs, nursing staff, care staff, facility managers, and referring general practitioners. In providing services in RACFs SPs must strive to work as a part of the larger multidisciplinary care team. However, to what degree SPs currently work within a multidisciplinary model of care in RACFs and how speech pathology services align with aged care policy and legislation within RACFs is not known. Nor is it known what challenges SPs face in providing communication and mealtime management in RACFs, or conversely, what challenges other service providers face in communication and mealtime management in the setting and in working with SPs.

Historically there has been very little ongoing research investigating communication and mealtime management in RACFs within any service discipline with previous research largely focussing on the investigation of specific difficulties or specific populations. Research investigating holistic communication and mealtime management and research reflecting a wider range of care models has been particularly limited. Similarly, research explicitly considering the complex context of care in RACFs including individual resident need and the influence of the organisational, physical, and relational care environment is sparse. This restricted research scope exists despite longstanding recognition of the complex nature of service provision in RACFs and the impact of the care environment on resident outcome (Heumann et al., 2001; Lubinski, 2006; Mitchell & Pachana, 2013; Perry et al., 2011; Worrall & Hickson, 2003). Furthermore, the majority of previous research has excluded residents with cognitive and/or communication difficulty from cohorts of residents studied. As a result of this exclusion the evidence base that is available is limited and applicable to

only the small minority of the resident population without these difficulties (Hickson, Worrall, Wilson, Tilse, & Setterlund, 2005).

In order to shape future communication and mealtime management and speech pathology service provision in RACFs, further exploration of the role and interaction of SPs in RACFs and within the multidisciplinary care team is required. In addition, examination of current communication and mealtime management is needed to identify existing barriers to optimising future service provision. To gain greater insight into the complex nature of service provision in RACFs research must consider these issues within the larger framework of: governance and management, the range of service providers involved in assisting residents of RACFs with communication and mealtime difficulties, the context of daily care, and individual resident need. Results of this research may identify future directions for service change and research. Ultimately this knowledge will help to contribute to an enhanced evidence base for speech pathology services in RACFs as well as the development of a robust and influential service provision model specific to the setting.

Through a series of exploratory investigations this thesis aims to identify challenges and motivators to working in RACFs and to providing communication and mealtime management from the perspectives of a range of service providers. Further this thesis aims to describe current communication and mealtime management in RACFs provided by both SPs and the broader RACF team. In these studies consideration is given to: care in context; individual resident need, including resident perceptions; and RACF staff knowledge of residents' communication and mealtime needs.

The remainder of this introductory chapter provides a review of relevant literature highlighting both knowledge and gaps in existing literature exploring broad service issues in RACFs, as well as issues specifically relating to communication and mealtime management. This chapter includes a discussion of four broad areas of literature relevant to communication and mealtime management in RACFs which will be further discussed in subsequent chapters: (1) the complexity of working in RACFs, including a discussion of key concepts and terminology commonly used in the RACF setting; the influence of RACF governance and accreditation; and the importance of interprofessional communication and collaboration to service provision; (2) considerations in speech pathology service provision in RACFs; (3) the nature and impact of communication and mealtime difficulties in RACFs; and (4) communication and mealtime management in RACFs. The final sections of this chapter will outline the overall objectives of this thesis, the specific aims of this thesis including a rationale for these aims, as well as a provide a summary of the structure of the remaining thesis chapters.

1.2. The Complexity of Working in RACFs

RACFs are a complex and unique work environment for health care providers and a unique home environment for the residents (Heumann et al., 2001; Perry et al., 2011; Worrall & Hickson, 2003). The nature of care in RACFs is heavily influenced by: (i) aged care policy, reform, and terminology; (ii) RACF governance and accreditation; and (iii) interprofessional communication and collaboration. Each of these influences will be discussed in turn and followed by discussion of considerations in speech pathology service provision in RACFs including the influence of funding, advocacy, and the complex nature of working with older people.

1.2.1. The Influence of Policy, Reform, and Terminology

Approximately 14% of Australians (around 3.2 million) are aged 65 years and over, with this percentage estimated to increase to just under 19% (5.8 million) by 2031 (Australian Bureau of Statistics, 2013). Within this population it is the cohort of Australians 85 years and over that demonstrates the most rapid growth (Australian Bureau of Statistics, 2013). Australia is experiencing this growth at a time of: reduced birth rate and family size, increased family separation, increased incidence of families relying on dual incomes resulting in a reduction in adults taking on full time home duties, and a reduced likelihood that adult children and their parents will live in close proximity (Australian Government Productivity Commission, 2011; Hugo, 2007). Together these factors result in reduced availability of family members to serve as carers for older people placing increased demand on primary health services as well as community and institution based long-term care and support (Hugo, 2007).

By virtue of their advanced age older people are at an increased risk of illness and health related disability including both chronic and degenerative health conditions. These conditions often require long-term health care management (Worrall & Hickson, 2003). The associated financial and service implications of an ageing population on the health system have been the subject of ongoing debate by politicians, policy makers, health service managers, and clinicians. Led by the positivist paradigm of ageing, emphasis on active ageing (WHO, 2002), and the need to combat the projected "burden" of an ageing population, Australia has seen a continuum of health reform in the aged care sector (Australian Government Productivity Commission, 2011; Commonwealth of Australia, 2001; Commonwealth of Australia, 2012; New South Wales, Department of Premiere and Cabinet, 2008; WHO, 2002).

Common across reform recommendations has been a push for multidisciplinary care delivered within a PCC approach, facilitating QOL including subjective wellbeing, and striving to

achieve active ageing. To meet these objectives aged care reform aims to address ageing at an individual and societal level to: optimise opportunities for physical, social and mental wellbeing across the lifespan; reduce the prevalence of preventable disease; delay the onset of disease associated with ageing; effectively manage disease processes as they occur through early intervention; and promote active and participatory lifestyles for all people regardless of age (Australian and New Zealand Society for Geriatric Medicine, 2011; Australian Government Productivity Commission, 2011; Commonwealth of Australia, 2001; Commonwealth of Australia, 2012; New South Wales, Department of Premiere and Cabinet, 2008; WHO, 2002). By achieving these aims means more individuals may remain active throughout their older years, be recognised as resources rather than burdens, and be less likely to require higher level and long-term health care thus reducing demand on the health system.

When working in aged care settings, SPs like any other healthcare professional are governed by health reform and aged care recommendations and accordingly must strive to work within a multidisciplinary model of care, in a manner consistent with the principles of PCC, and in a manner that facilitates subjective wellbeing and active ageing. For SPs to meet these objectives they must therefore have a thorough understanding of key concepts and philosophies in current aged care policy and reform recommendations including active ageing, QOL, and PCC. SPs working in aged care must also have an understanding of the known challenges to service provision in the complex context of RACFs, including challenges with a specific impact on speech pathology services.

1.2.1.1. Ageing as a concept.

Ageing is a term understood across nations and cultures but a term for which there is no universal definition. In lay terms ageing is described as "to grow old". The verb "grow" itself a direct contrast to a biomedical definition of ageing where ageing is viewed as biological decline occurring after sexual maturation (Hayflick, 1998). From a socio-cultural perspective age is a social construct with someone's age deemed a social category to which society attaches distinct expectations and values (Hazan, 1994). From a biopsychosocial perspective as adopted by the WHO (2002), ageing occurs across the lifespan, both before and after sexual maturation, and is influenced by many factors. These factors include genetics, life choices, and psychological health, as well as social determinants of health including income, living conditions, health care accessibility and treatment options, level of education, and health literacy (WHO, 2002).

In international and national discussions of ageing there is commonly reference to and emphasis on "healthy ageing", "successful ageing", and "active ageing". These terms are often used interchangeably with again no universal definition available. All three terms reflect the current

positivist age of gerontology and an emphasis on ageing well (Fernández-Ballesteros, Molina, Schettini, & Santacreu, 2013). Healthy ageing is the narrowest of the three terms in its scope. Commonly cited definitions of healthy ageing date back to the late 1980's and reflect a largely biomedical perspective of ageing with an emphasis on low prevalence of disease, high physical functioning, and independence in advanced age (Fernández-Ballesteros et al., 2013). Successful ageing, which predates healthy ageing, is a much broader concept. The origins of successful ageing are attributed to the *Activity Theory of Ageing* (Havinghurst, 1963) and were expanded shortly thereafter by Williams and Wirth (1965). Successful ageing is about adding life to ones years regardless of age and is consistent with a biopsychosocial model of ageing such as the WHO's *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001). A visual representation of interactions between components of the ICF is provided in Figure 1.1.

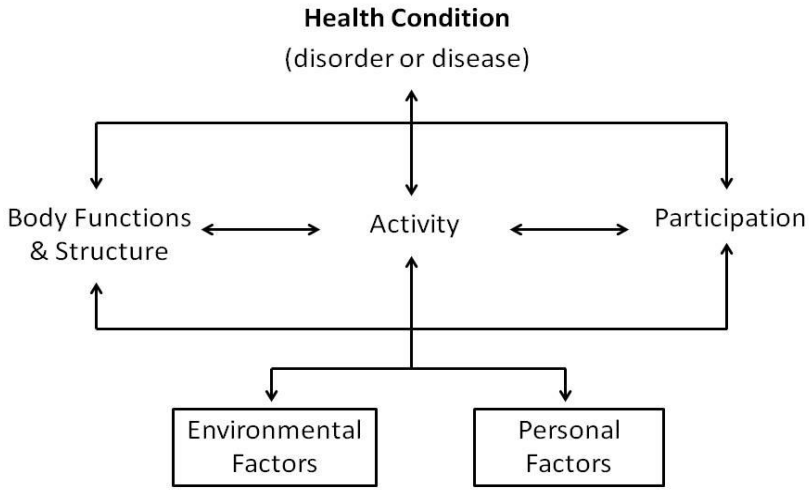


Figure 1.1 Reproduction of a visual representation of the interactions between components of the World Health Organization's International Classification of Functioning, Disability and Health (WHO, 2001, pg.18).

The ICF is hierarchical in nature consisting of two components "Functioning and Disability" and "Contextual Factors" with each of these consisting of two further components classifying health and health related conditions from the perspectives of: (a) "Body Functions and Structures" and "Activities and Participation" and (b) "Personal Factors" and "Environmental Factors". Relationships between components of the model are multidirectional and complex with both positive and negative coding terms used within individual components to enable a description of

health anywhere along the continuum of wellness. Environmental and personal factors are included as distinct components within the model and are acknowledged as having either a positive or negative impact on the individual (WHO, 2001). By explicitly considering the impact of environmental and personal factors on intervention outcomes and subjective wellbeing, biopsychosocial models explicitly promote interventions that facilitate participation and reduce activity limitations as well as aim to ameliorate impairment level disability. This holistic focus renders biopsychosocial models of particular relevance to aged care where impairment level change can be difficult to achieve given the often chronic and degenerative nature of resident illness (Cruice et al., 2000; Worrall & Hickson, 2003).

Active ageing is the most commonly used term today and is the newest term to emerge. Active ageing also reflects a biopsychosocial perspective of ageing and it is the term, at present, most often used by the WHO. For these reasons active ageing is the terminology adopted in this thesis. The WHO defines active ageing as *"the process of optimising opportunities for health, participation, and security in order to enhance QOL as people age"* allowing people to *"realise their potential for physical, social, and mental well-being throughout the life course"* (WHO, 2002, pg.12). Active ageing adds to the concept of successful ageing with increased and more explicit reference to the integration and interrelationship between health, participation, and security (WHO, 2002). This focus on the interrelationship between health, participation, and security has led to active ageing being adopted in the socio-political arena in Australia as a concept on which to base health promotion, health service, and aged care reform. Such an example is the *Living Longer Living Better* initiative, which aims to provide older Australians with more choice and control over their health and available interventions as well as to facilitate a more sustainable and consistent aged care system (Commonwealth of Australia, 2012). An illustrative reproduction of the determinants of active ageing as described by the WHO (2002, pg.19) is provided in Figure 1.2.

In considering both clinical practice and research in ageing it is also pertinent to this thesis to consider the word "old" in some depth. Again, there is no universally agreed definition of the word old or the age at which someone is to be considered to be old. In Australia, it is more common in research literature, policy, and reform documents to use the word old or older as opposed to elderly. Discussion of older Australians commonly refers to Australians aged 65 years and over. This is the age at which people are typically classified as being older within Australian policy and also reflects the age at which the majority of Australians are eligible for retirement benefits and additional aged care benefits and services such as the aged care pension. Assigning the label of "older person" based on a designated age illustrates the influence of the political sector on societies' perception of ageing and the term old.

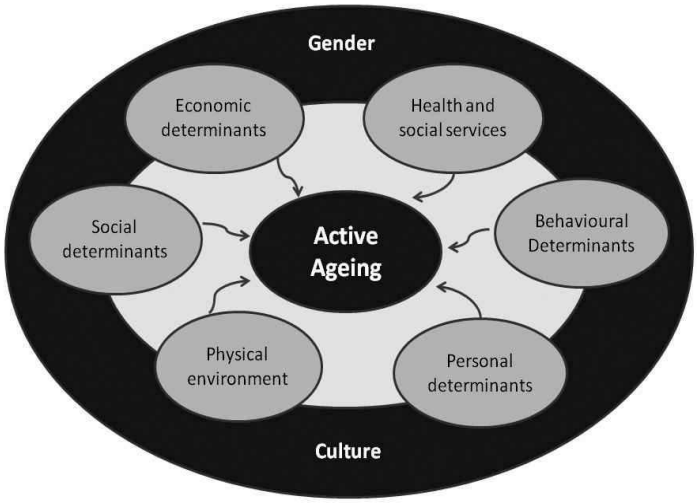


Figure 1.2 Reproduction of the social determinants of active ageing (WHO, 2002, pg.19).

Despite common acceptance that people aged 65 years and over are considered older, cultures and individuals are extremely variable in nature. As such it is acknowledged that not all cultures or individuals would agree with the classification of adults aged 65 years and over as being older. Some may advocate for a higher age range and some a lower age range. Indeed, within the Australian indigenous population it is common to discuss people aged 45-50 years and over as being old or older. This is largely due to differences in life expectancy between indigenous and non-indigenous Australians (Rosenstock, Mukandi, Zwi, & Hill, 2013). It is also common to see the terms "old-old" (persons aged 75-85 years) and "oldest-old" (persons aged 85 years and over), or the terms "young-old" and "old-old" used. These terms have been in use with the age ranges modified slightly to suit individual need since the 1980's (Belsky, 1984). Despite the variation that exists in defining ageing, clinicians, researchers, and policy makers must understand that these categories reflect a social construct and as such are fluid in meaning, reference, and value across situations, use, and among different individuals and cohorts. Therefore when using these terms it is important that the proposed use of the terminology is clearly outlined.

Throughout this thesis the word "older" will be used in preference to the word "elderly" as it is more common to use the word older in the Australian context in which the research forming this thesis has been undertaken. Considering participant age ranges in the studies comprising the subsequent chapters of this thesis, with the exception of reference to specific legislation and policy, older will refer to persons aged 60 years and over. The term "active ageing" will be used throughout this thesis as opposed to healthy ageing or successful ageing. Active ageing aligns with discussion

of biopsychosocial models of service delivery and perspectives on ageing and has been adopted in current Australian and international policy and aged care reform. This renders the term better suited to research aiming to provide evidence for advocacy and to influence service models, policy, and aged care reform, as in this thesis.

1.2.1.2. Quality of life (QOL).

The term QOL is used frequently in health, political, and social science literature and policy, and within the field of speech pathology. In Australia, The Speech Pathology Association of Australia Ltd *Code of Ethics* states *"We undertake to support individuals to maximise their communication and swallowing functions to improve their quality of life"* (The Speech Pathology Association of Australia Ltd, 2010, p.1). In the United States, the American Speech-Language-Hearing Association in the *Scope of Practice in Speech-Language Pathology* states *"the overall objective of speech-language pathology services is to optimise individuals' ability to communicate and swallow, thereby improving quality of life"* (American Speech-Language-Hearing Association, 2007, p.3). Both of these statements endorse QOL as the end goal of speech pathology intervention. As such, clinicians and researchers exploring current and future speech pathology service provision must have an understanding of the construct of QOL, the influence of communication and mealtime difficulties on QOL, and the impact of the service setting and model of care on the facilitation of QOL.

QOL is in itself an overarching philosophy that encompasses multiple domains. These domains differ depending on the definition of QOL that is adopted, the intended use of the definition, and the perception of QOL by the user (Cooney, Murphy, & O'Shea, 2009). To this end, QOL is a fluid concept with elements that differ in presence or absence and degree of importance both within and between different environments, life stages, and individual circumstance. There is, however, general consensus that QOL contains both objective elements including physical wellbeing and function as well as subjective elements or subjective wellbeing (in this thesis termed subjective wellbeing). Subjective wellbeing is determined by one's own cognitive evaluation of global life satisfaction and individual circumstance (George & Bearon 1980).

The WHO defines QOL as *"an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns"* (WHO, Quality of Life Assessment Group, 1993, p.153). This definition is considered to be the gold standard of QOL definitions, however, it does not identify the elements that comprise QOL nor provide guidance to clinicians or researchers aiming to consider these

elements in research or clinical settings. For this reason the WHO definition of QOL is often described as difficult to implement (Cruice et al., 2000).

Seeking a definition of QOL that is more operationally defined, many health professionals both in clinical and research settings have adopted the concept of health related quality of life (HRQOL) (Cruice et al., 2000). HRQOL is commonly described across three levels: at a global level HRQOL relates to a person's overall health; at a middle level HRQOL relates to a person's health within the domains of physical, social, emotional, and mental health; and at the lowest level HRQOL relates to a person's health status within one specific health domain (Cruice et al., 2000). Many health professionals, health services, and third party payers argue that HRQOL outcomes for targeted health care initiatives and specific interventions are the only area of QOL for which the health system may be held accountable. By this view the health system is not responsible for facilitating subjective wellbeing nor is the health system working in a manner consistent with PCC or active ageing. Further, Cruice et al. (2000) claim that it is the satisfaction a person feels with their level of function in any individual health domain and the importance of that function to the person that ultimately determines the impact of physical, social, emotional, cognitive, or mental difficulties on QOL. Therefore, to view QOL only within the context of HRQOL results in a distorted view of both health status and the relative importance of individual health domains.

The distinction between HRQOL and global QOL is even more pertinent when working with older people. For older people QOL encompassing subjective wellbeing has been found to be more about achieving contentment and self-satisfaction with the resources one has than it is about attaining additional resources, including improved health (Nilsson et al., 1996; Zahava & Bowling, 2004). Specifically, older people value continued meaningful participation in society, and independence and control over one's life (Nilsson et al., 1996; Zahava & Bowling, 2004). With older people being more prone to chronic and degenerative health conditions, for many older people subjective wellbeing may indeed be the only component of QOL subject to notable change (Cruice et al., 2000; Worrall & Hickson, 2003). Clinicians and researchers working with older people must therefore take a more holistic approach in considering QOL when planning and implementing services and models of care.

1.2.1.3. Person-centred care (PCC).

PCC is advocated as best practice in working with older people across health care settings (Australian Government Productivity Commission, 2011; Bundy et al., 2008). Retracing the origins of PCC it is generally agreed in the literature that the foundations of PCC lie in Rogerian psychotherapy and the notion of client-centred therapy (Rogers, 1961). Rogers (1961) originally

described client-centred therapy as recognition of and explicit focus on the unique relationship formed between a therapist and client, and the impact of this relationship on the therapeutic process and therapy outcomes. Explicit consideration of the relationship between the therapist and client continues to be reflected in current definitions of PCC with emphasis on a collaborative partnership between the health professional and the service user, including the person receiving the service and the service user's significant others. In this relationship the health professional is not viewed as the primary source of knowledge. Instead the views, knowledge, and beliefs of both the health professional and the service user are given equal weighting and respect by all parties. The principles of PCC also explicitly support the facilitation of subjective wellbeing in addition to HRQOL (NARI, 2006).

In nursing and gerontology literature PCC is a topic of particular interest to academics, researchers, and clinicians. Research investigating the use of PCC in these fields stems from the seminal work of Kitwood (1988). Kitwood (1988) adopted a broad definition of PCC and applied the notion to dementia specific care to distinguish approaches of care that focus on communication and relationships among persons with dementia with therapy grounded in medical and behavioural traditions. In a later publication Kitwood (1997) added in-depth discussion of the concept of personhood and the requirement of understanding this concept in order to implement PCC, as well as an expanded definition of PCC. This definition stated that PCC must aim to: maintain personhood in spite of declining cognitive ability, take the standpoint of the patient, acknowledge the patient's personal experience of life and relationships, and include the social environment as a therapeutic agent. Kitwood (1997) also explicitly discussed the impact of the environment on the provision of PCC including the impact of the organisation, staff structure, and staff wellbeing.

Since the work of Kitwood (1997) several models of PCC relevant to aged care have been proposed. Brooker (2003) emphasised the impact of the interpersonal skills of individual workers and the organisation as a whole in the development of the "VIPS" model, a model of PCC aiming to promote the value of people with dementia and those who care for them. In the VIPS model: "V" reflects anti-discriminatory practice, valuing people with dementia and those who care for them; "I" focuses on individuality and treating people as individuals; "P" is about looking at the world or situation from the perspective of the person with dementia; and "S" emphasises the impact of a positive social environment on people with dementia. In another model, McCormack and McCance (2006) proposed the "person-centred nursing framework". In this framework the impact of the relational environment including the importance of staff relationships, skills, and organisational support were explicitly recognised. Later, McCormack and McCance (2010) further discussed the applicability of the person-centred nursing framework to multidisciplinary service provision and

amended the model to add consideration of the impact of the physical environment on PCC. Then Lynch, McCormack, and McCance (2011) applied the person-centred nursing framework directly to aged care in the development of a leadership model for managers of RACFs to facilitate the delivery of PCC. This leadership model aimed to align the key constructs of PCC with situational leadership as described by Hersey and Blanchard (1982) therefore emphasising the role of management in assessing staff performance, competence, and commitment, as well as in providing flexible support to increase performance and achieve service change.

A multitude of barriers and facilitators to the implementation of PCC have been discussed. Kitwood (1997) discussed a number of negative influences on the implementation of PCC specific to RACFs including: the long existing tradition of institutionalisation of older people; continued low status assigned to aged care by health and community sectors; power imbalance and disagreement between medical professionals, nurses, and allied health that care for older people; and resource constraints. In a summary of PCC, NARI (2006) discussed the negative influence of: lack of time, the feeling of loss of professional power and status by health service providers associated with the use of PCC, lack of knowledge of PCC, the constraining nature of institutions, and working with service users who experience communication difficulties. Factors seen to facilitate the implementation of PCC include: persistence in striving to achieve change, increased resource allocation, and increased training across all staffing levels and professions (Kitwood, 1997). NARI (2006) also identified a number of facilitators of PCC including: a high level of staff knowledge and communication; opportunity for service user involvement in the health system; opportunity for health service providers to reflect on their own views, values, and beliefs regarding health care; strong support from the organisation; a workplace of mutual respect; and a care environment that is both physically and emotionally enriching. Critiques of past research into PCC have indicated a need for further empirical studies to validate the impact of these barriers and facilitators (Edvardsson, Fetherstonhaugh, & Nay, 2010; McCormack, Karlsson, Dewing, & Lerdal, 2010). However, in examining service provision in RACFs, including communication and mealtime management, and in planning future service provision, both clinicians and researchers must be aware of the need to work in a manner consistent with PCC and must be aware of identified barriers and facilitators to PCC.

1.2.2. The Influence of RACF Governance and Accreditation

There are currently over 1750 aged care providers in Australia that manage in excess of 2,500 RACFs nationwide (Australian Government Productivity Commission, 2011; Australian Government, Department of Health and Ageing, 2008a). These services provide care for

approximately one third of Australians over the age of 65 years who will enter permanent residential care at some stage of their later life (Australian Government, Department of Health and Ageing, 2008a). The majority of Australian RACFs are governed by religious or charitable organisations and for-profit companies with only a small number of facilities, whether government or community run, being not-for-profit. Nationally all RACFs are assessed in accordance with the *Australian Accreditation Standards* (Quality of Care Principles, 1997) to ensure legislated standards of care and guidelines for continuous quality improvement are met. This scheme is managed by an independent agency, the Aged Care Standards and Accreditation Agency Ltd, which ultimately will form part of a larger independent regulatory commission, the Australian Aged Care Commission (Australian Government Productivity Commission, 2011).

Governance of Australian RACFs occurs across three levels (Courtney, Minichiello, & Waite, 1997). At a national level, the Commonwealth of Australia ensures all Australians regardless of socioeconomic status or background have access to basic health services including residential care by the provision of the Medicare levy. The Commonwealth sets legislation, policy direction, and reform of the health system such as by: the *Aged Care Act, Act No. 112* (Aged Care Act, 1997); *Living Better Living Longer* (Commonwealth of Australia, 2012); *Caring for Older Australians* (Australian Government Productivity Commission, 2011); and *A Healthier Future for all Australians,* the final report by the Australian Government, National Health and Hospitals Reform Commission (2009). This legislation and reform aims to reflect international perspectives on ageing and aged care including the WHO's *Active Ageing: A Policy Framework* (WHO, 2002). The Commonwealth is also responsible for the standards outlined in the *Australian Accreditation Standards* (Quality of Care Principles, 1997) and indirectly allocates funds to RACFs by providing funds and fund allocation guidelines to the state and territorial governments. At a state or territorial level each individual government allocates funds provided by the Commonwealth as well as distributing self-generated funds to shape health services to meet the individual needs and priorities of each state or territory. At a local level, the local government shapes individual health services based on local government needs, priorities, and budgets (Courtney et al., 1997).

While a tiered system of governance provides individual area health services with valuable flexibility in fund and service allocation it has been critiqued as contributing to disparities of care and service provision across RACFs (Courtney et al., 1997). These disparities are further compounded by differences in the underlying philosophies, care priorities, and policies of RACF providers and the RACFs themselves (Courtney et al., 1997; Harvey, 2001). Resultant differences between services are of such significance that inconsistency in care quality was noted as a key point of concern in recent aged care reform (Australian Government Productivity Commission, 2011).

The *Australian Accreditation Standards* have a key role in ensuring the quality of care provided in RACFs (Quality of Care Principles, 1997). These standards are, however, minimum standards of expectation and not optimal standards for facilities to strive to achieve. Further, as noted by O'Reilly, Courtney, and Edwards (2007) these standards are largely monitored through administrative auditing rather than through direct observation of clinical outcomes. As a consequence, O'Reilly et al. (2007) argued the standards do not encourage RACF staff nor external clinicians to critically examine current practice or adopt service change to strive for optimum care. Furthermore, these standards do not adequately assess care in context or individual resident need (O'Reilly et al., 2007). This point raises a disparity between the acknowledged need for and benefit of consumer choice in health services in delivering market pressure to increase standards of care. It also highlights the reality of the level of care for which health services are professionally and legally held accountable (Australian Government Productivity Commission, 2011).

1.2.3. Interprofessional Communication and Collaboration

RACFs, like all health care providers, are in essence business units existing under the umbrella of larger organisational units, namely the managing aged care service provider, the aged care system, and the health system as a whole. As a business unit facing reform RACFs, therefore, face the same generic barriers to change at the level of the organisation as does any other business in the community. These barriers stem from: workplace culture, working relationships and staff hierarchy, communication among staff, the availability of resources, and individual personality (Kaasalainen et al., 2010; Perry et al., 2011). Further complicating service provision in RACFs are numerous context specific barriers including whether the facility is for-profit or not-for-profit as well as the degree of involvement of religious and charitable organisations, family members, and community groups in the running of the facility (Courtney et al., 1997; Heumann et al., 2001). Other influencing factors include: the ethical and legal requirement to uphold residents' right to autonomy, informed consent and active participation in life and decision making; negative stereotyping of the ageing population by society at large; and a lack of sufficient evidence base from which to develop both general care and discipline specific service provision and care practice models (Balsis & Carpenter, 2006; Dwyer, 2011; Heumann et al., 2001; Mitchell & Pachana, 2013; Pye, Worrall, & Hickson, 2000; Setterlund, Tilse, Worrall, Hickson, & Wilson 2002; Worrall & Hickson, 2003). The impact of these barriers differs both across RACFs and within individual RACFs with different wards, staff, and shifts influenced by varying attitudes, beliefs, and levels of education. These differences inevitably result in inconsistent and at times opposing care practice (Harvey, 2001).

Acknowledging these barriers Lindeman et al. (2003) suggested that in order to facilitate change in RACFs first and foremost the organisational culture, structure, and patterns of staff hierarchy must be reviewed. Further, Lindeman et al. argued that a new culture within RACFs must be built that encourages staff participation and active involvement in change across all levels of staffing. This argument is supported by Jeong and Keatinage (2004) in their exploratory investigation of the implementation of the *Resident Classification Scale*, a former Australian aged care funding and quality assurance instrument. The RACF included in their study adopted an approach to management where all staff opinions were given equal status and value regardless of staff position in the organisational hierarchy. In doing so, all staff perceived themselves and were perceived by others as integral in implementing and maintaining service change (Jeong & Keatinage, 2004).

The role of management in optimising services and achieving service change is pivotal, therefore, the perceptions of management are integral in investigations of service provision. Blackford, Strickland, and Morris (2007) trialling a systems-wide approach to advanced care planning in palliative care found that active participation of senior management at all stages of service and organisational change was instrumental in implementing and maintaining change. Blackford et al. also noted ongoing and consistent support and mentorship by management to be of particular importance to subordinate staff members. By providing a high level of support and active participation, management in the study were rewarded by the positive and active involvement of staff across staffing levels, reducing the burden of initiating and maintaining service change on facility management. Blackford et al. also highlighted a need for support from external associated health services and professionals including the local area health service and general practitioners. This finding is further supported by Perry et al. (2011) and Davies et al. (2011). Perry et al. investigated knowledge translation of best practice nutrition and hydration management in aged care and found that positive and supportive leadership particularly by external facilitators was the key to facilitating service change. Conversely, the complex context of the facility was found to pose a substantial barrier to service change (Perry et al., 2011). Davies et al. (2011) reviewed integrated care between United Kingdom aged care facilities and health care services. Findings of the review emphasised the need for greater interprofessional education and support by external health professionals to all levels of RACF staff. Lack of acknowledgement of care staff expertise and lack of involvement of care staff with external health professionals was found to limit interprofessional practice and integrated care (Davies et al., 2011). Similarity can be seen between this discussion of the need for effective communication and collaboration in achieving service change, with previous discussion of factors found to facilitate PCC (Kitwood, 1997; NARI, 2006). Other factors known to influence multidisciplinary care include: the range of service providers and disciplines within the

team; flexibility in role allocation within the team, and the level of appreciation of differing roles and providers; the degree of collaboration within the team; and how involved providers perceive working as a part of the team impacts their own individual professional identity and development (Bard, Satin, & Lowenstein, 2009). To overcome these barriers a reflective ethic of multidisciplinary care is needed to foster shared understanding and consideration among team members (Trinka & Clark, 2000).

Much of the communication and collaboration that occurs across health services and between health professionals is, however, indirect rather than face-to-face; often through resident notes, online data entry systems, care standard compliance documents, and third parties. As such, means of indirect communication must also be considered in exploring current service provision and in striving to achieve service change. Lack of detail in documentation has been found to be particularly problematic in RACFs where only limited information is passed through medical file notes or online data entry systems with often no further record of resident care and service practice being kept (Pye et al., 2000; Ullrich & McCutcheon, 2008). Blackford et al. (2004) outlined the need for system wide documentation from resident notes through to organisational policy to ensure consistency and continuity in service provision, as well as to provide adequate documentation for ongoing quality improvement and review. Swann (2004) emphasised the importance of accurate and ongoing documentation in the planning and implementation of interventions as well as in ensuring appropriate referrals are made to meet residents' needs. Robinson et al. (2009) extend this discussion investigating the information issues faced by health care providers across allied health, nursing, and medical professions in providing services to older people in the community living with dementia. In their study respondents from all professions commented that, at present, service provision is fragmented with limited communication existing between differing service providers. As a consequence all respondents perceived there to be a negative impact on care quality (Robinson et al., 2009). Furthermore, all respondents except general practitioners and RACF staff stated that fragmented service provision and poor interprofessional communication had a negative impact on patient and family satisfaction with the service. These groups felt that patients and their families often became confused and frustrated by the fragmented services received. All respondents, except general practitioners, also indicated that referrals from general practitioners were problematic and often missing vital case history and diagnostic information. On the other hand, general practitioners reported that current aged care assessment reports are problematic as they often state the services that a client is eligible for without stating on what basis the eligibility has been assessed (Robinson et al. 2009). Halcomb, Shepherd, and Griffiths (2009) also identified a lack of shared understanding across disciplines about provider roles and procedures and limited interprofessional communication and collaboration in their investigation of multidisciplinary case conferencing in RACFs. To

overcome barriers to interprofessional communication, collaboration, and integrated care, structural and procedural changes must be made to explicitly foster and support interprofessional communication, collaboration, and translation of knowledge to care practice (Armstrong & Kendall, 2010; Colon-Emeric et al., 2006; Reed, Cook, Childs, & McCormack, 2005). Reed et al. (2005) however stated that overcoming these barriers is at present unlikely, as too few studies have explored integrated care across care tasks and involving the full range of providers who work with older people.

Prior research does suggest that similar barriers to effective communication and collaboration may also impact speech pathology service provision in RACFs. A study by Kind, Anderson, Hind, Robbins, and Smith (2010) found that 45% of hospital discharge summaries from a large academic medical centre for high-risk patients referred to rehabilitation or long-term care settings omitted all speech pathology recommendations associated with dysphagia related referrals. Though limited to exploring recommendations relating to dysphagia and limited to a single hospital, the findings by Kind et al. support a need for further investigation of speech pathology involvement in and perceptions about interprofessional communication and collaboration in RACFs. Consistent across the studies discussed is the repeat emphasis on the need for interprofessional communication, collaboration, and the development and maintenance of respectful relationships across staffing levels. These issues must therefore be considered when exploring communication and mealtime management in RACFs and when examining challenges to speech pathology management in this setting.

1.3. Speech Pathology Service Considerations in RACFs

RACFs are listed in The Speech Pathology Association of Australia Ltd *Scope of Practice* (The Speech Pathology Association of Australia Ltd, 2003) as an appropriate service setting for speech pathology services. Given the high prevalence of communication and mealtime difficulties among residents of RACFs (discussed in detail in section 1.4) and acknowledged specialist training of SPs in communication and mealtime management, the potential role of SPs in RACFs is significant. In this setting SPs may ultimately work to: facilitate improvement in and assist residents to retain current communication and mealtime skills; facilitate residents' active participation in social, care oriented, and facility based decisions by increasing opportunities for successful communication and independence in residents' functional communication and feeding skills; provide training to staff about communication and mealtime difficulties and evidence-based management of these difficulties; and prevent inequality, ageism, activity limitation, and participation restriction associated with resident's cognitive, communication, and/or mealtime

difficulties (The Speech Pathology Association of Australia Ltd, 2003). In doing so, a RACF environment that values and facilitates communication and mealtimes, and fosters respect for and acceptance of older people with communication and mealtime difficulties may be promoted. Optimising service provision to meet these objectives is, however, difficult and influenced by: (i) funding of speech pathology services; (ii) advocacy of speech pathology services; and (iii) the complex nature of working with older people, including working to uphold residents' right to autonomy and active decision making. The influence of these specific service issues will be discussed in the sections below.

1.3.1. Funding of Speech Pathology Services in RACFs

Linked to governance, accreditation, and policy, it may be argued that the most frequent barrier to achieving optimal health services, including speech pathology services, relates to funding. Barriers due to funding occur not only as a result of limited availability of funds but also as a result of restrictions in the manner in which funds may be used. Both Powell Davies et al. (2006) and Goodwin-Johansson (1996) expressed a need for greater flexibility in health service funding in general. In particular, they argued for the need to expand funding beyond reimbursement for direct impairment based intervention to also fund intervention to reduce activity limitations and participation restrictions. This issue is of particular relevance in aged care where due to the high prevalence of chronic and degenerative disease, interventions that focus on increasing participation and subjective wellbeing are critical (Cruice et al., 2000). With regard to speech pathology services specifically, Lubinski (2006) highlighted the need for SPs to actively advocate for the funding of speech pathology services acknowledging that it is unlikely that aged care administrators will value speech pathology services if the speech pathology profession itself does not make a strong case for their inclusion.

Currently, funding of speech pathology services in Australian RACFs is provided in three ways. The first is through direct payment by the resident or family members. The second is through Medicare with direct funding for speech pathology services provided through subsidises under the *Chronic Disease Management Medicare Items* (Australian Government, Department of Health and Ageing, 2010). The third and perhaps the most commonly used funding arrangement is funding paid directly to the RACF itself for the provision of adequate and appropriate resident care in accordance with the *Australian Accreditation Standards* (Quality of Care Principles, 1997). This funding is not specifically allocated to any particular therapy field but can be used for speech pathology services and is determined by resident assessment on the *Aged Care Funding Instrument* (ACFI) (Australian Government, Department of Health and Ageing, 2008b). There are, however,

limitations in funding provided through these government sources. For example, the amount of funding and guidelines for the distribution of funds provided by these sources is inadequate in meeting the ongoing needs of many residents of RACFs as well as allied health industry rates (Australian Government Productivity Commission, 2011).

In seeking admission to an Australian RACF, prospective residents are assessed by an Aged Care Assessment Team (ACAT), *"a multidisciplinary team of health professionals responsible for determining the care needs and services an individual may require"* (Australian Government Productivity Commission, 2011, p.16). Following assessment by an ACAT the prospective resident is scored on the ACFI (Australian Government, Department of Health and Ageing, 2008b). The ACFI is a resource allocation instrument that aims to identify an individual's needs in comparison to others. The ACFI rates resident need across three domains: (1) Activities of Daily Living, (2) Behaviour, and (3) Complex Health Care, with each of these domains containing several subcategories. Resident level of funding is then allocated based on this rating. The core domains and categories assessed in the ACFI are presented in Table 1.1.

As the ACFI is the primary tool used in allocating funds to services for residents of RACFs, the limited assessment of resident function in regards to communication and mealtime skills within the tool makes allocation of funds to speech pathology services difficult to prioritise. Even when viewed alongside the *Australian Accreditation Standards* (Quality of Care Principles, 1997) and the *Aged Care Act, No. 112* (Aged Care Act, 1997) these three key aged care documents provide very limited guidance to RACFs about the need for and access options in seeking specific allied health services including speech pathology. As a result there is little backing within these documents to advocate for fund allocation to speech pathology services in RACFs.

1.3.2. Advocacy of Speech Pathology Services in RACFs

Compounding barriers relating to funding is a lack of specific policy within the speech pathology profession itself to support advocacy of speech pathology services in RACFs. In Australia SPs are represented by a core national body The Speech Pathology Association of Australia Ltd. The Speech Pathology Association of Australia Ltd emphasises evidence-based practice throughout its practice documents, however, at present there are no formal evidence-based practice guidelines in Australia for clinicians working in aged care in general or RACFs specifically. Aged care settings are listed in scope of practice and training documents as an example of a setting within the scope of speech pathology practice (The Speech Pathology Association of Australia Ltd, 2003; The Speech Pathology Association of Australia Ltd, 2011), yet in the current training of SPs in Australia,

Table 1.1 A simplified summary table of the domains measured by the ACFI (Australian Government, Department of Health and Ageing, 2008b).

Domain / funding	Questions	Specified assessments	Checklist items	What does the rating measure?
Diagnoses	Mental, Behavioural and Medical	n/a	List of disorders & medical conditions	Conditions that impact care needs
Activities of Daily Living	Nutrition	n/a	Readiness to eat Eating	Independent Supervision required Physical assistance required
	Mobility		Transfers Locomotion	
	Personal Hygiene		Dressing and undressing Washing and drying Grooming	
	Toileting		Use of toilet Toilet completion	
	Continence	Continence Record	Continence of urine Continence of faeces Scheduled toileting	Self-managed Frequency of incontinence Managed by scheduling
Behaviour Supplement	Cognitive skills	Psychogeriatric Assessment Scale (PAS)	PAS Score OR Minimal, mild, moderate, severe impairment rating	Level of Impairment
	Wandering	Behaviour records	Type and frequency of behaviour	Frequency of problem behaviour
	Verbal Behaviour			
	Physical Behaviour			
	Depression	Cornel Scale for Depression (CSD)	CSD score OR Level of interference caused by symptoms	Degree of interference with regular activities Diagnosis
Complex Health Care Supplement	Medication	n/a	Time / Specified procedures	Time / Procedures
	Complex Health Care		Specified procedures	Scores for procedures

service provision to older people and within RACFs receives little specific attention. This is contrary to recognition of the unique nature of service provision in RACFs in past literature (Heumann et al., 2001; Kaasalainen et al., 2010; Perry et al., 2011; Pye et al., 2000; Worrall & Hickson, 2003).

Advocates of speech pathology and other allied health services in RACFs are, however, not without their critics including from within the speech pathology profession itself. In a survey of Canadian SPs over 40% of respondents indicated that they were neutral or believed individuals with dementia could not benefit from speech pathology services (Hopper et al., 2007). Indeed rehabilitation professionals, long-term care administrators, and third party payers have gone as far as to say that the provision of cognitive intervention to residents with dementia is unethical (Hopper, 2003). Adding support to the provision of communication services for people with dementia and for residents of RACFs there is growing literature to suggest that people with dementia do have a capacity for learning if tailored interventions are implemented (Davis, 2005; Hopper, 2003; Powell, 2000). Furthermore, to work in accordance with the *United Nations Principles for Older Persons* (UN, 1991), aged care reform recommendations, and PCC, as well as to facilitate QOL and active ageing, service providers cannot justify limiting services to residents of RACFs based solely on the prevalence of chronic and degenerative health conditions. As a result, SPs must step beyond both a medical or rehabilitation model of service delivery to incorporate social models of service delivery in RACFs. Doing so supports the facilitation of subjective wellbeing in addition to intervention to maintain and improve function and to compensate for impairment level difficulties (Worrall & Hickson, 2003).

1.3.3. Working with Older People

Working with older people is complex and requires SPs to embrace a broad scope of practice. Several population specific factors must be considered by clinicians including factors relating to the disease process or health condition associated with the communication or mealtime impairment, as well as the social domain and lifestyle choices of older people (Worrall & Hickson, 2003). In addition, SPs must be aware of the financial cost associated with the service they are providing and the need for justification of this service to third party payers including RACFs (Worrall & Hickson, 2003).

Worrall and Hickson (2003) provide an in-depth discussion of considerations in working with older people. With regard to the disease process itself, clinicians must be aware of the changes associated with both normal ageing and pathological ageing. In addition, clinicians must be aware that as well as being at increased risk for disease and chronic health conditions age itself can impact

the severity and type of the disease process in older people. Co-morbidity of health conditions is also a factor complicating assessment and intervention planning (Worrall & Hickson, 2003). Co-morbidity impacts recovery and contributes to reduced energy levels in older age therefore providing older people with less physical and mental stamina to participate in intervention programs (Lubinski, 2006). There are also specific social issues to consider when working with older people including consideration of the older persons support network (Worrall & Hickson, 2003). In some cases clinicians may need to conduct sessions that encompass the extended family with older people often having adult children and adult grandchildren who all have an interest in the treatment plan. In other cases clinicians must consider that older people may have very little social support or opportunity to implement treatment goals outside of therapy sessions (Worrall & Hickson, 2003).

Specific to speech pathology service provision in RACFs, Lubinski (2006) suggested that clinicians must also have a thorough understanding of the demographics of the residents within a specific facility to adequately address the cultural and social needs of each resident. Furthermore, SPs must have adequate knowledge of third-party payer reimbursement requirements, and have the clinical and administrative competence to meet those requirements. In addition, SPs must have a willingness and the skills to make a positive contribution to the care team at large including with RACF staff and other external health care providers, they must also be comfortable in the role of family counsellor and advocate for the residents, and must be familiar with ethical practice and risk management in RACFs (Lubinski, 2006). In implementing interventions, SPs must be aware of the need for and be competent in the process of environmental engineering to modify the social and physical environment of the RACF to maximise opportunities for resident participation, as well as be creative in developing new assessment methods and methods to effectively measure intervention outcomes (Lubinski, 2006). Casper (2013) in a recent discussion of speech-pathology service provision in RACFs supports these recommendations. These recommendations imply that SPs must step beyond the traditional role of clinician to, in addition, be advocates, liaison officers, counsellors, administrative staff, and accountants. Though in practice these roles may be considered by many SPs to be outside of their general workplace responsibilities, the role of advocate, counsellor, business planner, and financial manager are all listed in profession scope of practice documents as services or roles that may be undertaken by SPs (The Speech Pathology Association of Australia Ltd, 2003).

1.3.3.1. Facilitating resident autonomy and active decision making.

Influencing QOL and PCC in 1991 the UN adopted the *United Nations Principles for Older Persons* (UN, 1991) outlining the rights of older people to be independent and active participants in

society, receive appropriate high quality care, and be self-fulfilled and live with dignity. In the context of providing speech pathology services for residents of RACFs, upholding these principles means acknowledging each resident's right to autonomy and active decision making, providing intervention to maintain independent communication and mealtime skills, and actively facilitating resident participation in activities that are meaningful and self-fulfilling to the resident (Brownie & Horstmanshof, 2012). While these principles are reflected in the principles of active ageing, QOL, and PCC, in practice upholding these rights for residents of RACFs is challenging. These challenges are linked to barriers relating to: the health related conditions of the residents themselves, biased perception of the needs of the residents by RACF staff and external medical professionals, the need for time and resource sensitive service provision, lack of continuing education of RACF staff and external service providers, an erroneous perception of the role of health care workers within RACFs as providers of medical care and not facilitators of both HRQOL and subjective wellbeing, and ageism (Balsis & Carpenter, 2006; Cruice et al., 2000; Dwyer, 2011; Heumann et al., 2001; Hopper et al., 2007; Lubinski, 2006; Mitchell & Pachana, 2013; Pye et al., 2000; Worrall & Hickson, 2003).

Of particular relevance to SPs working in this environment is the impact of cognitive difficulty, communication difficulty, and a high level of frailty on residents' ability to exert their right to autonomy and involvement in active decision making. For many residents of RACFs these difficulties limit the ability of both the resident and/or staff to facilitate resident participation in active decision making. As a consequence decision making is often transferred from the resident to a legally appointed guardian, with the resident being deemed legally incapable of making decisions regarding their care and wellbeing. In other cases the allocation of decision making to a third party may be not be a question of legal competency but one of "decisional capacity". Decisional capacity is a clinical not legal term and refers to a person's ability to comprehend diagnosis and treatment options, consider these options and their consequences in relation to the person's own goals and values, and to subsequently make and communicate a reasoned decision (Appelbaum & Grisso, 1988). Decisional capacity may be influenced by the situation, daily fluctuations in resident status, and the context of care such that a person deemed unable to make an informed and reasoned decision on one day may be able to make an informed and reasoned decision the next day. Decisional capacity must therefore be assessed on a situational basis (Appelbaum & Grisso, 1988). Interestingly, even for residents of RACFs who are cognitively intact Patone (1996) found that these residents did not view themselves as meeting the socially defined norms of independence. Instead the residents viewed themselves as having delegated autonomy where they authorised others to make decisions and act on their behalf. When residents did feel they could express a

choice they reported that fulfilment of that choice was limited as they could not make a choice that would inconvenience other residents or staff (Patone, 1996).

Within the speech pathology profession Worrall and Hickson (2003) advocate that in all cases, best practice and ethical obligation require that treatment decisions are collaborative between the clinician, the client, and family members. The resident's right to self-determination must therefore be upheld regardless of resident impairment. If service providers do not strive to uphold residents' rights on all occasions Harvey (2001) suggests we may find ourselves in a position where we *"surrender to the false truism that silence is consent"* (Harvey, 2001, p.160). SPs as specialists in facilitating communication have the skills to take a key role in advocating for informed consent from people with cognition and communication difficulties, and in facilitating alternative means of gaining consent from people with these difficulties, including residents of RACFs. This process involves assessing people's capacity to make informed decisions and developing communication friendly resources for the transference of information and the recording of consent (Brady Wagner, 2003).

The importance of upholding resident autonomy and assisting residents to make active decisions regarding their care is also evident when seeking informed consent for services or research. Difficulty gaining consent for services for residents of RACFs presents an enormous challenge for clinicians, health professionals, RACF staff, researchers, and family members. Nonetheless despite this challenge, informed consent, active decision making, and autonomy is important for all people including those with cognition and/or communication difficulties. Difficulty gaining consent for research participation combined with difficulty obtaining valid and reliable research data from residents of RACFs has ultimately resulted in a research base that has largely excluded residents with significant cognitive or communication difficulty. For SPs working in RACFs this means that the evidence base derived from RACFs is applicable to only a small portion of the RACF population, and as a consequence there is little evidence from which to develop and implement assessment and intervention practices specific to the needs of the majority of the residents. The pressing need to develop speech pathology assessment and intervention instruments and practices specific to the needs of residents of RACFs is supported in past literature with the uniqueness of the RACF setting and the difficulties experienced by residents of RACFs consistently highlighted (Hopper, 2007; Pye et al., 2000; Worrall & Hickson, 2003). As such, it must be recognised that transferring models of care and workplace practices developed in external settings or using research involving only a small cohort of the RACF population does not constitute evidence-based practice. At present, the nature of communication and mealtime management in RACFs, including management provided by SPs, is largely unknown. As a consequence current

data is insufficient to guide the delivery of effective and sustainable service provision. To begin to fill this gap further exploration including observation of communication and mealtime management in RACFs must be conducted.

1.4. The Nature and Impact of Communication and Mealtime Difficulties in RACFs

By virtue of their advanced age older people are at increased risk of illness and health related disability. Many older people experience common health conditions with increased prevalence as a result of the normal process of ageing. These health conditions include arthritis, diabetes, cancer, heart disease, osteoporosis, respiratory disease, and hearing and vision impairment. Hearing impairment alone is experienced by 60-70% of people over the age of 65 years (Worrall & Hickson, 2003) with this prevalence rising to as high as 95% for residents of RACFs (Stumer, Hickson, & Worrall, 1996).

In pathological ageing people may experience all of the changes experienced in normal ageing as well as additional difficulties relating to disease or chronic health conditions. Several diseases and conditions experienced in pathological ageing that are associated with communication and mealtime difficulties include acute conditions such as stroke, degenerative conditions such as dementia, Parkinson's disease, and Motor Neuron Disease, as well as other acquired conditions such as cancer of the head and neck (Miller & Patterson, 2014; Worrall & Hickson, 2003; Ward & van As-Brooks, 2014). These conditions can result in aphasia, cognitive-communication impairment, dysarthria, apraxia, dys/aphonia, and dysphagia (Worrall & Hickson, 2003), and can contribute to significant impairments in ongoing communication interaction and mealtime participation. Management of both communication and mealtime difficulties in RACFs must therefore encompass multiple and varied methods of assessment and intervention that are sensitive to the broad nature and presentation of communication and mealtime difficulties within the RACF population. Furthermore, management must be considerate of the influence of the care environment and known barriers to service provision in RACFs. In the following section the (i) nature of communication and mealtime difficulties in RACFs, and (ii) impact of communication and mealtime difficulties on QOL will be examined in further detail. This will be followed by a discussion of past literature relating to communication and mealtime management in the setting.

1.4.1. Communication Difficulties in RACFs

Even in a facilitative physical environment, in the absence of sensory or communication difficulties due to pathological ageing older people experience communication breakdown more frequently than younger adults (Hickman et al., 2009). In normal ageing older people experience a

decline in memory and comprehension, changes in interpersonal interaction and attitudes, and change in familiarity and comfort in interacting with others that may all lead to an increase in communication breakdown (Hickman et al., 2009). In addition to these normal ageing effects, other acquired and chronic conditions that occur in older age may cause further disruption to communication ability. As a consequence, it is not unexpected to find communication impairment is highly prevalent in RACFs.

When screened for hearing impairment, cognitive deficit, aphasia, speech intelligibility, voice difficulties, and pragmatic deficits, Worrall et al. (1993) found that 70% of residents failed on more than one screening test. The most frequently identified conditions impacting resident communication skill in the study were hearing impairment and dementia. Overall, 98% of the residents were reported to experience some degree of communication impairment (Worrall et al., 1993). Given the additional high prevalence of hearing and vision impairment experienced by older people, the physical environment including the proximity of the communication partner, background noise, lighting, and the presence of environmental distracters will also have a key influence on the success of the communication interaction (Hickson et al., 2005; Lubinski & Welland, 1997).

1.4.1.1. Communication and QOL.

There is a growing body of research to suggest that communication impairment can have a significant negative impact on QOL (Cruice et al., 2000; Cruice, Worrall, Hickson, & Murison, 2003; Hackett & Pickles, 2014; Hilari & Byng, 2009; Morgan, Hickson, & Worrall, 2002; Nilsson et al., 1996; Park et al., 2013). Effective communication is required to engage socially and is integral to self-expression, initiating and maintaining relationships with others, acquiring and applying knowledge, and participating in community life (Nilsson et al., 1996). In discussing the broader influence of effective communication on ageing Lubinski and Welland (1997) stated that effective communication is critical to a person's successful adaptation to the ageing process, assisting older people to continue to: express their identity; obtain cognitive, social, and emotional benefit from ongoing socialisation; be independent in obtaining basic physical and lifestyle resources; and have meaningful participation in discussions regarding their life and care. Yorkston et al. (2010) reiterated this view discussing the cumulative burden of communication impairment with age, including the detrimental impact of communication impairment on the maintenance of social roles and the ability of older people to access and effectively utilise health care services.

Given these associations significant consideration must be given to the potential negative impact of communication breakdown on the subjective wellbeing of residents of RACFs. Though

the relationship between the experience of aphasia and reduced QOL (Cruice et al., 2003; Hilari & Byng, 2009), hearing impairment and QOL (Morgan et al., 2002), and post stroke cognitive impairment and QOL (Hackett & Pickles, 2014; Park et al., 2013) has been illustrated, systematic investigation of the impact of communication impairment specifically on the QOL of residents of RACFs is lacking. Research has shown that residents of RACFs prioritise the expression of one's sense of self, connectivity to others, the opportunity and ability to make choices, and participation in meaningful activities and events (Ball et al., 2000). Each of these factors is directly mediated by one's ability to communicate. In addition, in investigating the perceptions of residents of RACFs about the quality of the care they receive, Grau, Chandler, and Saunders (1995) found that a disproportionate number of both worst and best experiences reported by residents directly related to the quality of interpersonal interactions and relationship development between themselves and care providers. Both relationship development and interpersonal interaction is again mediated by communication. Similarly, Nakrem, Vinsnes, and Seim (2011), in their investigation of resident experience of interpersonal factors in RACFs highlighted the need for prioritisation of interpersonal resident-staff relationship development. Specifically, the study identified a need for an increase in interpersonal communication as opposed to task focussed communication between residents and staff as well as increased dedication of staff to attain and communicate a deeper level of understanding of each resident's individuality and individual needs (Nakrem et al., 2011).

1.4.2. Mealtime Difficulties in RACFs

Most prevalence studies relating to mealtime difficulties in RACFs have focussed on dysphagia (difficulty swallowing) rather than holistic mealtime difficulties. The reported prevalence of dysphagia in RACFs is generally between 40-60% (Steele et al., 1997). Separate to dysphagia Steele et al. also found that 46% of residents of RACFs had poor oral intake, 35% had poor positioning, and 40% exhibited challenging behaviours during mealtimes. Residents of RACFs also experience increased prevalence of oral disease (Davis & Spicer, 2007; Pearson & Chalmers, 2004), malnutrition (Davis & Spicer, 2007; Pauly, Stehle, & Volkert, 2007), aspiration pneumonia (Carrion, Verin, Clave, & Laviano, 2012; Marik & Kaplan, 2003), cognitive deficit, degenerative disease, and chronic and co-morbid health conditions (Aselage & Amella, 2010; Miller & Patterson, 2014; Worrall & Hickson, 2003). These factors combined can result in significant medical and nutritional consequences particularly if mealtime difficulties are poorly managed.

1.4.2.1. Mealtimes and QOL.

Mealtimes and mealtime difficulties have also been found to have a key influence on QOL (Chan & Pang, 2007; Crogan et al., 2004; Ekberg et al., 2002; Evans, Crogan, Shultz, & Armstrong,

2003; Martino et al., 2010; Miller & Patterson, 2014; Nijs, de Graaff, Kok, & van Staveren, 2006; Palacios-Cena et al., 2013). Common negative feelings associated with mealtime difficulties include anxiety, depression, embarrassment, increased sense of isolation, frustration, and loss of self-esteem (Ekberg et al., 2002; Martino et al., 2010; Miller & Patterson, 2014). For residents of RACFs mealtimes are a particularly important activity of the day (Crogan et al., 2004; Nijs et al., 2006; Palacios-Cena et al., 2013). Crogan et al. (2004) explored the meaning of food from the perspective of residents of RACFs and concluded that mealtimes are about more than meeting nutritional needs they are about sharing food with loved ones as a sign of caring, celebrating the company of others, and expressing one's self-preference and culture. In a similar type of study Palacios-Cena et al. (2013) discussed how the experience of mealtimes is perceived by residents' to be a privilege, a sign of autonomy and normality, an indicator of personal identity, and a time of reference for other activities during the day.

Impacting the quality of the mealtime experience and QOL, Evans et al. (2003) discussed five key elements in their investigation of resident perspectives of quality dining in the nursing home. These elements were: (1) the provision of choice, (2) interaction, (3) assistance and problem correction, (4) eating location, and (5) the availability of adequate foods. Evans et al. discussed the pivotal role of staff in ensuring these elements are consistently addressed, and of family members in enhancing the mealtime experience in RACFs. Food related concerns apply to all residents of RACFs including those approaching the end of life with residents of RACFs in discussing end-of-life care preferences raising feelings of frustration at being unable to have meal preferences met leading to unconcern, reduced QOL, and increased frailty (Chan & Pang, 2007). It is clear therefore that mealtimes have a key influence on the QOL of all residents of RACFs and accordingly must be optimised.

1.5. Communication and Mealtime Management in RACFs

As discussed in section 1.4, communication and mealtime difficulties are highly prevalent in RACFs with both having a key influence on QOL. The facilitation of QOL is an ultimate goal of speech pathology intervention (The Speech Pathology Association of Australia, 2010). Hence, it is pertinent that SPs working in RACFs have an understanding of known challenges specific to the facilitation of QOL, and also PCC, in RACFs before implementing services relating to either communication or mealtimes. These challenges are discussed below before discussion of: (i) RACF staff training in communication and mealtime management, (ii) modifying the care environment, and (iii) speech pathology involvement in communication and mealtime management in RACFs.

Following this section, this chapter concludes with an outline of the thesis objectives, aims, and structure of the remaining thesis chapters.

1.5.1. Facilitating QOL in RACFs

The impact of both resident communication and mealtime needs on resident QOL supports the need for prioritisation of communication and mealtime management in RACFs, and with SPs being specialists in communication and mealtime management, an enhanced role for SPs in the setting. In striving to facilitate resident QOL through communication and mealtime management SPs must be aware of broad considerations in working in RACFs and the nature of and impact of communication and mealtime management on QOL. In addition, they must also consider the meaning of QOL in RACFs and challenges to facilitating QOL inherent in the setting.

When considering QOL within a RACF the unique culture and social domain of RACFs must be acknowledged. Entry to a RACF can involve loss of autonomy and control, increased inactivity and boredom, loss of meaningful activity and privacy, change of one's social environment, and loss of personalisation of one's physical environment (Cooney et al., 2009). As such, even when a person enters a RACF with a positive outlook, the enormity of moving from the community to an institution and the change that move brings in social status and social networks alone can have a significant negative impact on self-esteem and morale (Grau et al., 1995).

On entry to a RACF a new resident must accept that the RACF is now their "home", a word that to the population at large suggests a place of individual belonging, comfort, and attachment (Goodwin-Johansson, 1996). In contrast, within a RACF the word home relates to an institution where individual choice and preference often give way to what is best for residents as a collective whole (Goodwin-Johansson, 1996). It is a home where the physical environment including the structural layout, designation of physical space, the furnishing, and the fittings used have been found to have a significant impact on level of privacy, access to social engagement, the availability of social activities, and resident choice (Voelkl, Winkelhake, Jeffries, & Yoshioka, 2003). It is a home over which residents perceive little ownership feeling they must seek permission to use facility space and resources (Voelkl et al., 2003).

In order to facilitate QOL in RACFs Harvey (2001) argued there must be a focus on social engagement and emphasised that RACFs must not exacerbate barriers to social engagement due to resident health related difficulties and optimally must try to compensate for these barriers. In doing so, RACFs must strive to create an environment that explicitly supports resident social engagement and participation, prioritising resident choice over the routines and interests of the organisation

(Harvey, 2001). To facilitate social engagement however requires effective communication and therefore management of resident communication difficulties. Furthermore, with mealtimes known to provide key opportunity for social engagement in RACFs and to have a key influence on resident QOL (Chan & Pang, 2007; Crogan et al., 2004; Palacios-Cena at al., 2013), mealtime management in RACFs must also be prioritised.

1.5.2. Person-Centered Communication and Mealtime Management in RACFs

An important concept in the provision of communication and mealtime management in RACFs is the application of PCC. Similar to QOL, there are very few studies that have investigated communication or mealtime management in RACFs considerate of PCC in any health discipline. In relation to communication, two recent studies explored the person-centered qualities of resident-staff communication in RACFs (Levy-Storms, Claver, Gutierrez, & Curry, 2011; Savundranayagam, 2014). Both of these studies revealed inconsistency between resident-staff communication in RACFs and the principles of PCC.

Savundranayagam (2014) transcribed and analysed a total of 46 conversations between 13 resident-nursing staff dyads. The results of the study were analysed to identify the presence or absence of utterances reflective of four indicators of PCC: (1) recognition, (2) negotiation, (3) validation, and (4) facilitation. Results indicated while approximately one third of the transcribed conversations contained person-centered utterances there were also 618 missed opportunities for person-centered utterances noted across the 46 conversations. Of the person-centered utterances that were evident in the transcripts, those relating to recognition of the residents life history were noted to be used the least. The highest proportion of person-centered utterances, were utterances used to assist the resident to initiate or sustain a thought or action during the completion of a care task. As a result, Savundranayagam (2014) made several recommendations to facilitate resident-staff communication consistent with PCC. These recommendations included: staff to commence all interactions with a greeting to facilitate rapport; staff to provide choice during routine care tasks such as the colour of clothing for the resident to wear; during tasks where the resident takes a passive role, staff to use the opportunity to ask about the residents past or have a personal conversation with the resident; staff to pay closer attention to residents feelings and validate these through conversation; and staff to strive to facilitate active participation of the resident in care tasks through encouragement, ongoing conversation, listening to the resident, and actively acting on resident requests for increased participation. Savundranayagam (2014) also indicated a need for further investigation of resident-staff communication with other staff members as well as further

exploration of the differential response of the resident to communication consistent or inconsistent with PCC.

In another recent study Levy-Storms et al. (2011) discussed the pivotal role of resident-staff communication in shaping resident-staff interpersonal relationships, individualised care, and PCC. In their study relational dialectic theory (Montgomery & Baxter, 1998) was used to guide qualitative analysis of data from focus group interviews with residents (n = 15) and assistants in nursing (n = 17) from two RACFs. Analysis revealed that the nature of resident-staff communication was influenced by four polarised themes: (1) getting to know the resident versus maintaining a protective distance, (2) mutual respect versus disrespect, (3) avoiding versus addressing conflict, and (4) equity versus perceived favouritism. Levy Storms et al. (2011) found that as staff attempted to balance the extreme ends of these themes the means of communication used by staff when interacting with residents shifted as did the topic of the conversation and the emotional investment of both the resident and staff in the communication interaction. Levy-Storms et al. proposed that the greater the agreement between the resident and staff about where the interaction should fit on the continuum of these themes, the better the resident and staff would relate to one another resulting in a greater likelihood that the communication exchange would be equal, successful, and consistent with PCC.

In regards to mealtimes, Reimer and Keller (2009) provided a valuable summary of characteristics of mealtime management consistent with PCC concluding that mealtime management must: provide choices and honour resident preferences, support resident independence, show respect for the perspective of the resident, and actively promote social interaction during mealtimes. Similarly, Hung and Chaudhury (2011) explored personhood and PCC during mealtimes for 20 residents and identified eight themes reflecting a continuum of congruence with personhood and PCC. Hung and Chaudhury proposed that mealtime management was congruent with personhood and PCC when it provided: a relaxed dining pace, empathetic and empowering care, adequate and appropriate stimulation to facilitate resident independence, respect for the residents dining preferences, and explicit inclusion of the resident in mealtime procedures and social interaction during mealtimes.

The degree to which current speech pathology management of communication and mealtime difficulties in RACFs reflects the principles of PCC is yet to be explored. In order to better align communication and mealtime management in RACFs with current aged care philosophy, policy, and legislation, research is also needed to further investigate the association between communication, mealtimes, and PCC. Although limited, factors identified in the literature as

contributing to person-centered communication and mealtime management should be noted and explicitly considered in current and future service provision.

1.5.3. RACF Staff Training in Communication and Mealtime Management

The need for increased training for RACF staff is raised frequently in literature investigating service provision in RACFs and in aged care policy and reform recommendations. Research investigating communication and mealtime management in RACFs is no exception. With regard to communication, several studies have aimed to increase staff awareness about their own communication skills and methods to enhance these skills as well as to increase staff knowledge of resident communication difficulties (Bourgeois, Dijkstra, Burgio, & Allen, 2004; Bowles, Mackintosh, & Torn, 2001; Bryan, Axelrod, Maxim, Bell, & Jordan, 2002; McGilton, Irwin-Robinson, Boscart, & Spanjevic, 2006; Williams, Ilten, & Bower, 2005). These education and training packages have ranged from very brief (e.g., three-hour training sessions (Williams et al., 2005), to one-day workshops (Bryan et al., 2002), and training continuing over numerous weeks (McGilton et al., 2006). Together these studies have shown that training can result in improved interpersonal and affective communication as well as an increase in staff knowledge and confidence in communicating with residents with communication difficulties.

With mealtime management, although there have been few systematic trials of training in holistic mealtime management for RACF staff, the need for increased training for RACF staff particularly for assistants in nursing who provide the majority of mealtime assistance, has been frequently discussed (Aselage & Amella, 2010; Crogan, Shultz, Adams, & Massey, 2001; Pelletier, 2004; Reimer & Keller, 2009). The expertise of SPs in mealtime management and the value of SPs in providing training to RACF staff about mealtime management have also been emphasised (Kayser-Jones & Pengilly, 1999; Pelletier, 2004), as has the importance of interprofessional training (Davis & Spicer, 2007; Gaskill et al., 2008; Kayser-Jones & Pengilly, 1999; Steele et al. 1997).

In considering staff training it is, however, important to understand that increased knowledge will not necessarily translate to implementation of this knowledge to daily care (Pelletier, 2004). Simmons, Durkin, Shotwell, Erwin, and Schnelle (2013) shared this view acknowledging the limited success of mealtime training to date and criticising past training as failing to adequately consider the translation of knowledge to care practice. Similarly, Levy-Storms, (2008) and Vasse, Vernooij-Dassen, Spijkera, Rikkert, and Koopmans (2010) in critiquing past training in communication management suggested a need to investigate the outcomes of different training packages across varying RACFs, and with residents with varying difficulties. As a result, while it is clear that increased training for RACF staff in both communication and mealtime

management is of benefit, to increase the success of this training factors known to both facilitate and hinder service change in RACFs must be further explored, and explored specifically in relation to communication and mealtime management. By doing so future training may be shaped to better meet the needs of both service providers involved in communication and mealtime management and the residents, and to better facilitate the translation of knowledge to daily care.

1.5.4. Modifying the Care Environment

The care environment (organisational, physical, and relational) plays a key role in shaping resident-staff communication and relationship development in RACFs (Hickson et al., 2005; Lubinski & Welland, 1997; Worrall & Hickson, 2003; Yorkston et al., 2010). Likewise, the care environment also influences the success and experience of mealtimes for both residents and RACF staff (Amella, 2004; Amella, Grant, & Mulloy, 2008; Barnes, Wasielewska, Raiswell, & Drummond, 2013; Coyne & Hoskins, 1997; Hotaling, 1990; Kayser-Jones & Schell, 1997; Reimer & Keller, 2009; Sidenvall, Fjellstrom & Ek, 1994; Sydner & Fjellström, 2005; Ullrich & McCutcheon, 2008; Ullrich, McCutcheon, & Parker, 2014; Van Ort & Phillips, 1995). There are numerous recommendations in the literature to modify the environment in RACFs to facilitate effective communication and optimise mealtimes. These will be discussed further in the sections below.

1.5.4.1. Communication and the care environment.

It is known that effective communication between residents and RACF staff is of critical importance to: the completion of daily care tasks, including mealtime management; resident-staff relationship development; resident QOL; and staff satisfaction in the workplace (Bryan et al., 2002; Kato, Hickson, & Worrall, 1996; McGilton et al., 2006; McGilton et al. 2010; Parsons, Simmons, Penn, & Furlough, 2003). As communication is a dyadic process, when considering resident-staff communication and relationship development it is essential to consider the contribution and influence of both communication partners. In the context of older people this requirement prompts reflection of communication impairment experienced by older people as well as the social construction of ageing including the influence of ageism and “elderspeak”.

Ageism is the discrimination of people based on age (Balsis & Carpenter, 2006). Ageism involves unequal power distribution with older people typically placed in a subordinate position of diminished power. This power imbalance can be exacerbated in health care settings where under a traditional medical model health professionals are commonly viewed as holding a position of higher power over patients, regardless of age. Setterlund et al. (2002) described ageism as the

marginalisation of older people, the erosion of intergenerational ties, and the devaluing of older people within a capitalist based economy and a society driven by materialistic values.

Elderspeak is a term that describes a style of speech commonly used by people when communicating with older adults that is noticeably different to how one communicates with a younger adult. Elderspeak is characterised by speaking with increased volume, slower speech rate, and higher pitch, with older people often spoken to as passive receivers of information rather than as active and equal participants in the conversation (Balsis & Carpenter, 2006; Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005). Elderspeak has been shown to be particularly prevalent in aged care settings and creates an inhibitory communication environment (Williams, Kemper, & Hummert, 2003). Though often defended as being used to accommodate the frailty and needs of older people, elderspeak is by and large perceived as patronising and demeaning (Balsis & Carpenter, 2006). As a consequence, the autonomy of the older person is reduced, as is the effectiveness of the conversation, and the older person's satisfaction with the conversation. Ultimately this leads to an increase in communication breakdown (Balsis & Carpenter, 2006). RACF staff are not ignorant to the presence and negative impact of elderspeak, rather they acknowledge that at times residents are spoken to in a subordinate manner and are perceived as being criticised by staff (Hickson et al., 2005; Williams et al., 2003).

Several researchers have investigated elderspeak and more generally the nature of resident-staff communication in RACFs (Balsis & Carpenter, 2006; Nussbaum et al., 2005). These studies indicate a predominance of task oriented or instrumental resident-staff communication (both verbal and non-verbal) as opposed to affective or interpersonal communication (Caris-Verhallen, Kerkstra, & Bensing, 1999; Carpiac-Claver & Levy-Storms, 2007; Savundranayagam, 2014). When affective communication does occur it has been found to often precede task oriented communication such as greeting the resident or addressing the resident to orient them to the task at hand. Affective communication has also been found to be embedded within task-focussed communication such as to check whether the resident has understood, to encourage the resident to complete a task, or to praise the resident for their participation (Caris-Verhallen et al., 1999; Carpiac-Claver & Levy-Storms, 2007; Savundranayagam, 2014). Caris-Verhallen et al. (1999) also noted an association between the type of communication (i.e., task-focussed or affective) and the type of non-verbal communication used by care staff such that task-focussed verbal communication was associated with an increase in task-focussed touch, and affective verbal communication was associated with an increase in the use of interpersonal touch. More specifically, task-focussed communication was found to be positively associated with instrumental touch (i.e., deliberate physical contact to facilitate the completion of a task) and negatively associated with affective non-verbal communication, such as eye contact,

smiling, and nodding. Conversely, communication about lifestyles and emotions (i.e., affective communication) was positively associated with affective non-verbal communication, and negatively associated with instrumental touch. Further, Savundranayagam (2014) found that while affective or person-centered utterances occurred in approximately one third of transcribed conversations there was missed opportunity for further interpersonal communication during conversation initiation and termination as well as during routine care tasks.

Considering the impact of resident-staff communication on staff wellbeing, Parsons et al. (2003) in their investigation of workplace satisfaction and staff retention in RACFs found that 44.7% of nurses felt their relationship with residents was their highest workplace priority and the primary driver to continue their employment in the sector. Studies discussing the negative impact of resident-staff communication on the nature and success of services provided in RACFs (Bryan et al., 2002; Kato et al., 1996; McGilton et al., 2006; McGilton et al., 2010) have described a consistent negative impact of resident communication difficulty and resulting communication breakdown on the completion of care tasks and the provision of quality care. Most of these studies have, however, focussed on internal RACF staff. Relatively few studies have discussed the association in reference to external service providers. Goodwin-Johansson (1996) directly associated the complexity of physiotherapy management in RACFs to the negative impact of resident communication difficulty and associated communication breakdown. Physiotherapists are often employed in RACFs as external service providers and in Goodwin-Johansson, physiotherapist participants described working in RACFs as similar to working in a *"third-world"* country due to the interplay between multiple and complex influences on service provision. The clinicians stated that while in theory the intervention required for residents of RACFs was often basic, relating to activities of daily living and basic physical function, conducting therapy in RACFs was a complex practice (Goodwin-Johansson, 1996). This complexity was attributed in part to environmental constraints including language barriers with staff, lack of education of RACF staff about physiotherapy management, lack of understanding or acknowledgement by RACF staff of the clinician's therapeutic goals, and the presence of resident co-morbidities; but was largely due to psychosocial factors and the impact of resident cognitive and/or communication impairment (Goodwin-Johansson, 1996).

Further research investigating barriers to service provision faced by a range of service providers involved in providing care to residents who experience communication difficulty is needed. Furthermore, greater consideration must be given to the care environment in which resident-staff communication takes place, to reduce environmental barriers to effective communication and to facilitate opportunity for interpersonal communication. In addition, potential

barriers and facilitators to effective resident-staff communication as well as the impact of and interplay between policy, work task requirements, and documented recommendations relating to communication management, must be further explored.

1.5.4.2. Mealtime and the care environment.

The influence of the care environment on resident mealtime experience, success, and residents' functional mealtime skills is also complex. Hotaling (1990) in an early but holistic commentary about setting the stage for eating in RACFs discussed several modifications to facilitate the mealtime environment. Hotaling (1990) highlighted the importance of: preparing residents for mealtimes by ensuring they are positioned to optimise comfort, safety, and participation in eating; paying attention to the aesthetics of the dining environment to create a calm pleasant atmosphere free from environmental barriers and distractions; placing meal items to optimise mealtime independence; and staff maintenance of a positive and encouraging attitude towards mealtimes. Similarly, Amella (2004) and Coyne and Hoskins (1997) discussed the broad influence of the mealtime environment on the eating behaviours of older people with dementia as well as the importance of positive praise and cueing on the facilitation of feeding. More recently, Barnes et al. (2013) conducted a small observational study of mealtime experience in RACFs and noted increased communication participation of residents with family style dining (food served at the table by staff and residents from communal dishes) over pre-plated dining (resident single serves pre-plated and delivered to the table).

Specifically investigating the influence of environmental modifications on functional feeding skills, Van Ort and Phillips (1995) implemented environmental modifications relating to resident positioning, meal placement, and the reduction of distractions during mealtimes. Results of the study showed improved functional feeding skills for seven residents with dementia following implementation of the modifications. In addition, Van Ort and Phillips (1995) discussed the importance of providing consistency in mealtime assistance and the use of behavioural interventions such as verbal and tactile prompting, role modelling, and positive reinforcement to facilitate feeding. Supporting this discussion, Lange-Alberts and Shott (1994) investigated the use of touch and verbal cueing with 20 residents without severe cognitive impairment and found that both touch and verbal cueing were associated with increased nutritional intake. A more recent study reiterated the benefits of behavioural interventions including resident and staff positioning, verbal prompting and praise, physical assistance, and interpersonal interactions in promoting resident oral fluid intake (Ullrich & McCutcheon, 2008). The study, however, highlighted inconsistency in the use of these interventions and recommended increased education for care workers in behavioural

interventions to promote fluid intake as well as increased communication and collaboration between care and nursing staff about resident mealtime assistance, including increased documentation of care practices by care staff.

Although recommendations regarding the concepts of family style dining and homelike dining have featured in the literature for several decades, recommendations made to facilitate these dining styles have predominantly been based on the perceptions of researchers and staff rather than the residents themselves. As a result, resident perceptions of homelike dining or other preferred mealtime environments in the RACF setting are not clear. In a recent survey of 104 residents (without severe cognitive impairment) from three RACFs, discrepancy was revealed between what residents considered constitutes a homelike mealtime experience in the family home pre-admission, to what constitutes a homelike mealtime experience in the RACF (Adams, Anderson, Archuleta, & Smith Kudin, 2013). Residents in the study indicated a preference for emphasis on cooking meals they once ate in the home environment rather than an emphasis on creating a family dining atmosphere. Residents also indicated they preferred to eat in a quiet atmosphere in the RACF regardless of where they typically ate at home prior to admission (Adams et al., 2013). Philpin, Merrell, Warring, Hobby, and Gregory (2014) in exploring the social construction of mealtimes in RACFs begin to highlight the complexity of the mealtime construct discussing the influence of the geographical location, physical layout, and ambience of the facility as well as the cultural background, family experiences and memories of both staff and residents in shaping the meaning of mealtimes.

One further key influence on mealtimes in RACFs often discussed in the literature and directly mediating the mealtime environment is insufficient staffing. Kayser-Jones and Schell (1997) specifically investigated the impact of staffing on the quality of care provided during mealtimes in a four-year anthropological study investigating the impact of social, cultural, environmental, and clinical factors on eating behaviour in RACFs. Findings from the study demonstrated a clear negative impact of low staffing ratios on the quality of mealtime assistance provided as well as on the mealtime experience of both residents and staff. Crogan et al. (2001) found a similar trend in their exploration of the perspectives of 99 assistants in nursing and 44 nurses about barriers to nutrition care. Participants in this study reported low staffing levels to be a key area of concern commenting that they simply did not have the time to complete all of the duties required of them during mealtimes. As a result, residents often received insufficient mealtime assistance (Crogan et al., 2001). It has been found that regardless of whether residents require visual supervision, verbal cueing, or physical assistance during mealtimes, an average of 35 - 40 minutes of staff time is required per resident per meal (Simmons & Schnelle, 2006). Reimer and Keller

(2009) also noted a negative impact of inadequate staffing on the ability of RACF staff to implement mealtime management consistent with PCC.

As a consequence, while research has demonstrated that optimising the mealtime environment can be an important element in enhancing mealtime skills and experience for some residents, existing evidence indicates that resident preferences about mealtimes are not clearly understood and may vary from what has generally been considered the "ideal" mealtime environment in a number of studies. To fully understand mealtime management it is pertinent that the mealtime environment be considered in all evaluations. It is also critical that resident perspectives about mealtimes and mealtime management be further explored and explicitly addressed alongside the influence of broad barriers and facilitators to care in RACFs as well as barriers and facilitators with a specific influence on mealtime management.

1.5.5. Speech Pathology Involvement in Communication and Mealtime Management in RACFs

As opposed to research into training initiatives there has been little research into rehabilitative interventions or interventions that aim to have a direct impact on resident level impairment or activity limitations pertaining to either communication or mealtime difficulty within the RACF resident population. In the speech pathology field specifically, studies exploring communication and mealtime management in RACFs have been particularly limited. SPs are arguably the profession best suited to provide individualised and tailored intervention for communication and mealtime difficulties in RACFs given their specialist knowledge in communication and mealtime difficulties and management. What is known about speech pathology services in RACFs is that the majority of services provided relate to mealtime management, and more specifically, intervention for swallowing difficulties (Casper, 2013, Hopper et al., 2007). In order to advance speech pathology management in RACFs, an understanding of interventions that have been used in RACFs is necessary, as is exploration of current communication and mealtime management. Literature relevant to speech pathology involvement in communication and management in RACFs is discussed in the sections below.

1.5.5.1. Speech pathology management of communication difficulties in RACFs.

Much of the research conducted regarding tailored interventions for communication difficulties in RACFs has focused on facilitating communication with older people with dementia (Davis, 2005; Hopper et al. 2013; Powell, 2000). These studies demonstrate the benefit of: facilitating explicit memory; incorporating effortless learning, self-generated and communication

partner cueing; and using spaced retrieval training, validation therapy, reminiscence therapy, and daily reality orientation, to maximise learning potential and maintain communication skills and cognition (Davis, 2005; Hopper et al. 2013; Powell, 2000). The recommendations from these studies cannot, however, be applied ad hoc to all residents of RACFs who experience communication difficulty due to the heterogeneous nature of communication impairment within the population as well as the impact of the care environment on resident outcome (Heumann et al., 2001; Worrall & Hickson, 2003).

Studies investigating the use of individualised communication plans of care with residents of RACFs regardless of the nature or severity of resident communication difficulty do show promising results (Genereux et al., 2004; McGilton et al., 2010). These studies demonstrate the benefit of elaborating on the information contained in resident communication plans of care to include additional information about: the residents communication related diagnosis, means of communication by which communication partners may most effectively communicate with the resident and by which the resident may communicate, resident specific factors to consider in getting to know or getting along with the resident, and resident preferences regarding communication interaction (Genereux et al., 2004; McGilton et al., 2010). In these studies, resident communication related diagnosis was heterogeneous including residents with aphasia, cognitive-communication impairment, and dysarthria, with residents' communication plans of care elaborated following thorough assessment of each resident's communication needs by a SP. Findings from both studies indicated RACF staff perceived the elaborated communication plans of care to be a positive intervention. Genereux et al. (2004) reported an increase in staff comfort in communicating with residents, increased staff knowledge of residents' communication difficulties and needs, and increased use of strategies by staff to facilitate communication with residents following implementation of the plans. Similarly, McGilton et al. (2010) found an improvement in staff attitude and staff knowledge about communication difficulties and strategies to facilitate communication with residents, as well as decreased time taken to complete care tasks as staff were better able to understand the residents and meet their needs in a more efficient manner.

The findings of Genereux et al. (2004) and McGilton et al. (2010) are important in demonstrating the benefit of tailored intervention for communication difficulty in RACFs, and the potential role of SPs in providing this care. Whether such tailored interventions for communication management are commonplace in RACFs is not known with further research needed to investigate current communication management in the context of daily care. It is clear, however, from past research that the impact of communication difficulty and resident-staff communication in RACFs is extensive, influencing resident QOL, staff satisfaction in the workplace, and staff ability to provide

optimal care (Parsons et al., 2003; Bryan et al., 2002; Kato et al., 1996; McGilton et al., 2006; McGilton et al., 2010). It is also evident that communication breakdown in RACFs is frequent and results from the interplay between multiple factors including resident level impairment, staff communication skills, and environmental and socio-cultural influences.

1.5.5.2. Speech pathology management of mealtime difficulties in RACFs.

Recent literature indicates that speech pathology service provision in RACFs is, dominated by the management of swallowing (Casper, 2013, Hopper et al., 2007). However, this literature also suggests that management that is currently provided is not optimal. Commentary provided by Casper (2013) indicates that in assessing residents of RACFs for mealtime difficulties SPs primarily rely on bedside assessment with instrumental evaluations noted to be less accessible in RACFs than in acute settings. However, interventions that aim to maintain resident skills or compensate for resident difficulties were found to be favoured over active rehabilitative intervention due to the degenerative and chronic nature of many resident difficulties (Casper, 2013). Compensatory interventions reported to be most commonly used in RACFs include: the provision of texture modified foods and fluids, positioning residents to facilitate a safe swallow, the use of swallowing manoeuvres such as chin tuck, and the use of modified crockery and cutlery to facilitate resident independence (Davis & Spicer, 2007; Kayser-Jones & Pengilly, 1999; Miller & Patterson, 2014).

SPs are specialists in mealtime management and the potential role of SPs in mealtime management in the RACF setting is extensive. Though underexplored, the role of SPs in mealtime management in RACFs is well supported by current scope of practice and clinical guidelines within the profession, both nationally and internationally (American Speech-Language-Hearing Association, 2007; The Speech Pathology Association of Australia Ltd, 2003; The Speech Pathology Association of Australia Ltd, 2012). While the commentary provided by Casper (2013) provides valuable insight into speech pathology considerations in providing mealtime management in RACFs, systematic investigation of mealtime management in RACFs provided by SPs is needed. Mealtime management must also be examined in context and be considerate of the broad nature and impact of mealtime difficulties and factors known to influence care in RACFs. In addition, exploration of holistic mealtime care is needed. This means considering residents medical, nutritional, and psychosocial mealtime needs, and acknowledging the need for individualised intervention tailored to individual resident difficulty and stage of recovery or degeneration (Amella et al., 2008; Chang & Roberts, 2008; Easterling & Robbins, 2008; Kayser-Jones, 1996; Logemann, 2000; McCullough, Rosenbek, Wertz, Suiter, & McCoy, 2007). By doing so, recommendations for research, intervention, and staff training that are considerate of current barriers to mealtime

management faced across providers as well as recommendations tailored to individual resident need may be identified. This will provide a basis on which to develop more effective multidisciplinary service provision models that are specific to RACFs.

1.6. Objectives, Aims, and Structure of this Thesis

1.6.1. Objectives of this Thesis

RACFs represent a unique home environment for many older people and a unique clinical setting for healthcare professionals. The difficulties experienced by residents of RACFs are complex, are often hard to distinguish due to co-morbidity, and often chronic or degenerative in nature. Service provision in RACFs is hindered by a multitude of barriers, some specific to RACFs, some specific to particular health care domains and care tasks, and others common to health systems and health service policy. In order to improve the management of communication and mealtime difficulties in RACFs and provide a platform for service change, a thorough understanding of current communication and mealtime management in RACFs is required. Therefore the overall objective of this thesis is to obtain increased understanding of current communication and mealtime management in RACFs provided by both RACF staff and SPs to inform future service provision. In doing so, known barriers to care in the setting will be considered and further explored for a range of service providers involved in communication and mealtime management in the setting. Common and disparate challenges to the provision of optimal care in RACFs will be identified, and the nature of current communication and mealtime management in the setting including areas of strength and weakness will be investigated.

It is anticipated that the findings of this thesis may assist to: (1) raise the profile of communication and mealtime management in RACFs; (2) clarify the need for service change, including in speech pathology services in RACFs; (3) inform change in primary health care funding as well as facility specific, aged care, and government policy pertaining to communication and mealtime management; (4) promote further evaluation and development of holistic speech pathology assessment and intervention models specific to the setting; and (5) enhance resident care from the identification of resident need through to the provision of consistent and evidence-based intervention.

1.6.2. Aims of this Thesis

Due to the high prevalence of communication and swallowing difficulties in normal ageing, pathological ageing, and in RACFs specifically, it is clear that the vast majority of residents of RACFs may benefit from speech pathology services. The need for inclusion and greater

prioritisation of speech pathology services in RACFs is further exemplified by the significant impact of communication and mealtime difficulties on the QOL of the residents, on residents' families, on RACF, staff and external health care providers, as well as on broad service provision. In order for SPs to adequately address active ageing and subjective wellbeing, and to work under a model of care consistent with PCC, it is clear that SPs will need to develop innovative approaches to service provision in the setting. These approaches must acknowledge and value the importance of a range of service provision models including medical, rehabilitation, and social models thereby adopting a biopsychosocial approach to care, and must be applicable for use with all residents regardless of level of cognition or communication skill.

To achieve this goal an in-depth understanding of current communication and mealtime management in RACFs needs to be obtained including management provided by both RACF staff and SPs. In obtaining this understanding, the perceptions of a range of RACF staff and SPs involved in communication and mealtime management will be considered. In addition, current practice will be examined in context with data analysed across multiple data sources including documented care, resident perspectives, service provider perspectives and knowledge, and direct observation. In meeting the overall objectives of this thesis, three broad research aims will be addressed through four investigations each with specific aims detailed in each subsequent chapter (see Figure 1.3 below). The three broad aims of this thesis are to:

1) obtain a holistic and representative view of factors that influence optimal care in RACFs, identifying challenges and motivators to working in the setting for a range of service providers
2) explore communication and mealtime management in RACFs examined in the context of daily care and considerate of, documented, resident reported, and staff knowledge of residents' communication and mealtime needs
3) explore the perspectives of a range of service providers involved in mealtime management in RACFs to identify shared and disparate issues influencing care

1.6.3. Structure of this Thesis

This thesis was completed in the "thesis by partial publication" format of The University of Queensland. This means this thesis contains four distinct research studies designed and developed for separate publication. To this end, Chapters 2-5 of this thesis, comprise the four investigations that collectively address the three research objectives. Each investigation has its own separate aims and objectives relating to the broad thesis aims. To link each study Chapters 2-5 commence with a brief commentary to connect the investigation to the overall thesis objectives and design of the

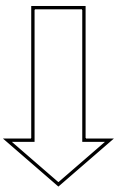
thesis, and to identify for the reader information regarding the status of publication of the study and any information presented in the thesis only. A flow chart outlining these chapters, their aims, and objectives is provided in Figure 1.3.

Chapter 6 concludes this thesis by summarising the key findings in relation to the research aims and overall objectives. In this chapter links between the separate studies will be highlighted and the impact of the findings for service provision discussed. Chapter 6 also provides a detailed discussion of the limitations of the studies comprising this thesis. Final discussion conveys the clinical implications of the findings and direction for future research.

Prior to the commencement of the investigations comprising this thesis, ethical clearance was granted by the Behavioural and Social Science Ethical Review Committee, The University of Queensland (see Appendix A and B), BUPA Care Services Pty Ltd (see Appendix C) and UnitingCare Ageing (see Appendix D). In all studies written consent for participation was obtained from all participants or in the case of residents unable to provide consent, their legally appointed representative. All care was taken to facilitate understanding of the research aims and participation requirements by all prospective participants. Large print font and picture symbols were used to facilitate comprehension for residents with cognitive or communication impairment. Both written and verbal explanation of the research aims and participation requirements was provided to all participants. All participants were informed that they may withdraw participation at any time during the study and all care was taken to ensure data was collected at the convenience of the participants and to minimise impact on resident participants' normal daily activities. All participant data was de-identified and stored in a locked filing cabinet. All electronic data was password protected.

Figure 1.3 Overview of the thesis chapters 2-5 including the thesis aims, study aims, and study objectives

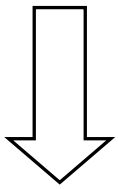
Chapter 2: Service providers perceptions' of working in residential aged care: A qualitative cross sectional analysis.	
Thesis Aim: (1) To obtain a more holistic and representative view of factors that influence optimal care in RACFs, identifying challenges and motivators to working in the setting for a range of service providers. Study Aim: To explore and compare the perceptions of a cross-section of service providers regarding challenges and motivators to working in RACFs.	Study Objective: To obtain a more holistic and representative view of factors with a common impact on service provision in RACFs. Participants: 10 Speech Pathologists; 10 Care Managers; 10 Nurses; 14 Assistants in Nursing; 16 Care, Domestic and Support Staff.



Chapter 3: An exploratory investigation of communication management in aged care: A comparison of documentation, observed resident-staff communication, resident perspectives, and staff knowledge.	
Thesis Aim: (2) To explore communication management in RACFs examined in the context of daily care and considerate of, documented, resident reported, and staff knowledge of residents' communication needs. Study Aim: To explore factors impacting resident-staff communication and communication management in RACFs.	Study Objective: To highlight areas that may be addressed by RACF staff and SPs to enhance communication management and better meet residents' communication needs. Participants: 14 Residents; 19 Assistants in Nursing; 7 Nurses; 1 Enrolled-endorsed Nurse; 2 Recreation Activity Officers.

Figure 1.3 continued

Chapter 4: Mealtime management in Australian residential aged care: An investigation of documented, reported, and observed care.	
Thesis Aim: (2) To explore mealtime management in RACFs examined in the context of daily care, and considerate of, documented, resident reported, and staff knowledge of residents' mealtime needs. Study Aim: To explore factors influencing mealtime management in RACFs by comparing information from documented, reported, and observed care.	Study Objective: To increase understanding of factors influencing mealtime management in RACFs to inform practice change and improve mealtime care. Participants: Same as Chapter 3.



Chapter 5: Perspectives on mealtime management in residential aged care: Insights from a cross disciplinary investigation.	
Thesis Aim: (3) To explore the perspectives of a range of service providers involved in mealtime management in RACFs to identify shared and disparate issues influencing care. Study Aim: To explore the perspectives of a range of service providers involved in mealtime management in RACFs.	Study Objective: To identify common factors that could be targeted in the future to enhance mealtime management in RACFs. Participants: Same as Chapter 2.

CHAPTER TWO

SERVICE PROVIDERS PERCEPTIONS OF WORKING IN RESIDENTIAL AGED CARE: A QUALITATIVE CROSS SECTIONAL ANALYSIS

Chapter 1 presented a comprehensive review of the literature relevant to discussion of communication and mealtime management in Residential Aged Care Facilities (RACFs), the context of care, and known challenges to service provision in RACFs. The potential role of SPs working in RACFs was also discussed. The complexity of working with older people in general and in RACFs specifically was highlighted throughout the review, including discussion of key barriers to service provision in the setting. These barriers have previously been explored largely through the perspectives of single service disciplines, namely nursing staff. With multidisciplinary service provision advocated as best practice in RACFs, exploration of known barriers to optimal service provision in the setting must be explored for a range of service providers including externally based providers such as SPs. Identifying both commonality and differences in the perceptions of a wider range of service providers working in RACFs will assist in informing the development of multidisciplinary models of care that are specific to the setting and considerate of the needs of the wider multidisciplinary team.

Chapter 2 uses qualitative methodology to explore the perceptions of a range of service providers, internal and external, that provide direct care to residents of RACFs. By exploring these perceptions this chapter aims to identify challenges and motivators to working in RACFs for a cross section of service providers, including SPs. The results obtained will assist in guiding the development of multidisciplinary models of care and interprofessional education for service providers that are specific to working in RACFs, and that better meet the needs of the residents and service providers working in the setting. In addition, the results will assist in developing increased understanding both within and across professions about service provider roles in RACFs and challenges faced in striving to provide optimal care.

The content of chapter 2 consists of the manuscript entitled "*Service providers' perceptions of working in residential aged care: A qualitative cross sectional analysis*" which was published by Ageing & Society in July 2014. The manuscript has been inserted as published with the exception of formatting and referencing changes that have been made to align with the style guidelines of the American Psychological Association and to maintain consistency throughout this thesis. The references specific to this manuscript have been included in the overall reference list of this thesis.

2.1. Abstract

A number of professional disciplines employed internally and externally provide services in RACFs. Literature has long highlighted numerous workplace issues in RACFs yet little progress has been made in addressing these. As such there has been a call for greater understanding of shared issues among service providers. The aim of the current study is to explore and compare the perceptions of a cross-section of service providers regarding the challenges and motivators to working in RACFs. In-depth semi-structured interviews were conducted with 61 participants including: care managers; nurses; assistants in nursing; care, domestic and support staff; and SPs. Analysis revealed few issues unique to any one service discipline with four key themes identified: (1) working in RACFs is both personally rewarding and personally challenging; (2) relationships and philosophies of care directly impact service provision, staff morale, and resident QOL; (3) a perceived lack of service-specific education and professional support impacts service provision; and (4) service provision in RACFs should be seen as a specialist area. These data confirm there are key personal and professional issues common across providers. Providers must work collaboratively to address these issues and advocate for greater recognition of RACFs as a specialist service area. Acknowledging, accepting, and communicating shared perceptions will reduce ongoing issues and enhance multidisciplinary care.

Keywords: ageing, communication, long-term care, multidisciplinary care, relationship development

2.2. Introduction

In Australia, skilled nursing facilities or nursing homes are referred to as RACFs. Comparable to skilled nursing facilities Australian RACFs provide a range of domestic, medical, personal care and support services to older people; and employ staff including registered nurses, assistants in nursing (akin to certified nursing assistants), vocationally trained care and support staff, and externally employed allied health and physicians. RACFs serve a diverse population and present a unique setting, a mix of a medical institution and home environment (Heumann et al., 2001; Perry et al., 2011). The environment within RACFs is mediated by many factors including the physical setting, resource availability, staff communication, mentorship and management, staff education, professional development, and attitudes toward ageing and resident care (Heumann et al., 2001; Kaasalainen et al., 2010; Perry et al., 2011). Furthermore, the population within RACFs is complex, with high co-morbidity, and a high prevalence of cognitive impairment, behaviour difficulties, mental health difficulties, and communication impairment (Australian Government Productivity Commission, 2011; Worrall et al., 1993).

With increased international focus on consumer-directed health services, PCC, and QOL issues, staff within RACFs are expected to provide an increased range of services necessitating communication across a broad range of service providers (Australian Government Productivity Commission, 2011; Australian and New Zealand Society for Geriatric Medicine, 2011; WHO, 2002). To facilitate cross-discipline communication recommendation has been made for the implementation of multidisciplinary clinical practice guidelines that explicitly foster interdisciplinary collaboration and relationship development (Australian and New Zealand Society for Geriatric Medicine, 2011). However, research investigating multidisciplinary service provision in United Kingdom nursing homes states that to achieve such guidelines more research is needed to develop generalised models of care specific to the aged care setting and that address service provision across disciplines, and public and private health sectors (Davies et al., 2011). Furthermore, these must be relevant to the running of the facility as a whole rather than reflecting discipline-specific aims (Davies et al., 2011).

To date, the majority of studies investigating service provision considerate of the range of care domains in RACFs and skilled nursing facilities have focused on the perceptions of single disciplines (Davies et al., 2011) with the studies largely focussing on the perceptions and experiences of internally employed nursing and personal care staff (Goodwin-Johansson, 1996; McGilton et al., 2006; Parsons et al., 2003; Perry et al., 2011). Though nursing and personal care staff are a primary workforce in RACFs, holistic service provision is achieved through input from a wider range of additional medical, allied health, management, domestic and support staff, as well as community volunteers and family members. The perceptions of these professional groups and how they are similar or different to other RACF staff needs to be further explored.

Many service providers who work in RACFs are contracted from external agencies and work under management and service structures that are distinctly different to those operating internally within the RACF. These service providers are employed across both public and private health sectors, with RACFs themselves also falling into several categories of administration within the public and private health sectors, e.g. profit or not-for-profit entities. As a result, there is often great division between the philosophies underpinning different work organisations and associated policy and work practice guidelines. Consequently, communication and professional relationship development is by nature quite complex. In the few studies that have examined multidisciplinary care in RACFs and skilled nursing facilities and included external service providers, findings indicate that cross-discipline communication is limited in both frequency and success (Halcomb et al., 2009; Kaasalainen et al., 2010). In these studies neither internally employed RACF staff or externally contracted service providers perceived themselves to be working as a part of a team.

A distinct lack of shared understanding among service providers about the role of different disciplines and multidisciplinary care in RACFs has also been identified (Halcomb et al., 2009) with ineffective communication among service providers found to be a key barrier to the implementation of research innovations in RACFs (Kaasalainen et al., 2010). To overcome barriers to communication and integrated care between professions and across organisations Reed et al. (2005) commented we must first implement structural and procedural changes that foster compatibility of cross-professional and organisational agendas. However, Reed et al. (2005) note that at present, this goal is challenged by a scarcity of research investigating integrated care across care tasks and a paucity of studies exploring the full range of services and service providers involved in delivering care for older people.

Research investigating multidisciplinary service provision and service change in the broader aged care and health sectors provides much general discussion of factors that can influence multidisciplinary service provision and service change. Bard et al. (2009) stated that the success of multidisciplinary teams is dependent on multiple factors including: the range of service providers and disciplines within the team, provider level of appreciation for the role of other disciplines, the frequency and depth to which disciplines learn and work together, the flexibility of role allocation across the team, service provider perception of the impact of working in a team on their own professional identity and development, and the influence of external factors including structural and procedural constraints. Similarly, and of particular relevance to communication among providers Trinka and Clark (2000) called for a reflective ethic of multidisciplinary care including reflection of one's own professional and training background and the differences between backgrounds across the team to increase active consideration and understanding between disciplines, and thereby facilitate collaboration.

While it is accepted that achieving positive multidisciplinary interaction is a complex endeavour, to date, the specific factors influencing multidisciplinary interaction and collaboration within the unique RACF environment have not been fully examined. Specifically, it is clear that as yet full understanding of what constitutes widespread or disparate issues across service providers working in RACFs has not been achieved. Therefore, the aim of the current study is to explore and compare the perceptions of a cross-section of service providers regarding challenges and motivators to working in RACFs. By doing so, both common and unique issues across service disciplines may be identified. Consideration of these issues will help to guide the development of more generalised models of service provision that explicitly foster cross-discipline communication and relationship development and optimise multidisciplinary care.

2.3. Methods

2.3.1. Research Strategy

A qualitative descriptive methodology was adopted in this study to explore multidisciplinary service provision in high-care Australian RACFs. Qualitative descriptive methodology allows for a comprehensive summary of an event or phenomena in everyday lay language while also providing valid and accurate accounts of the meaning attributed to these events and phenomena by the participants (Maxwell, 1992; Sandelowski, 2000).

2.3.2. Participants

Purposive criterion sampling was used to collect information-rich data across cohorts increasing the potential to identify issues of central importance to the aims of the study (Patton, 2002). A total of 61 participants were recruited across five service provider groups: (1) care managers; (2) nursing staff; (3) assistants in nursing; (4) care, domestic, and support staff; and (5) SPs (in the participant quotes these are indicated by CM, NS, AIN, CDSS, and SP, respectively). All participants included in the study were required to have functional English skills adequate for an interview, be working with residents of high-care RACFs at the time of recruitment, and have at least six months prior experience in RACFs and 12 months qualifying experience in their occupation. Care managers were included to provide a management perspective. Nursing staff and assistants in nursing were included to provide two different nursing perspectives, and the care, domestic, and support staff participant group was included to represent a range of other staff in regular contact with the residents. SPs were included as a sample of external service providers contracted by RACFs. Participant recruitment continued until saturation of key themes was reached (Sandelowski, 1995). Participant details are provided in Table 2.1. Only one participant in the study was male, equating to approximately 2% of the RACF staff cohort. A distinct gender imbalance is evident among RACF staff with national data indicating approximately 93% of RACF staff are female (Australian Government Productivity Commission, 2011).

Care managers, nursing staff, assistants in nursing, and care, domestic and support staff were recruited through 10 high-care RACFs in rural and metropolitan areas. All participating RACFs were governed by two independent aged care providers, one for-profit and one not-for-profit. SPs were recruited through the public directory of SPs provided on The Speech Pathology Association of Australia Ltd website (The Speech Pathology Association of Australia Ltd, n.d.). Permission for this study was granted by the, Behavioural and Social Sciences Ethical Research Committee of The University of Queensland, Australia, and the participating aged care providers.

Table 2.1 Participant demographics

Participant Group	Participants	Age (Yrs)	Yrs of Experience
		M(SD)	M(SD)
Speech Pathologists (SPs)	F = 10 M = 0	44.6 (11.12	18.3 (11.88)
Care Managers (CMs)	F = 10 M = 0	48 (11.06)	23.5 (11.87)
Nursing Staff (NS) Registered Nurses, Endorsed-enrolled Nurses	F = 10 M = 0	48.6 (12.45)	23.3 (13.06)
Assistants in Nursing (AINs)	F = 14 M = 0	45 (13.01)	9.3 (8.00)
Care, Domestic and Support Staff (CDSS) Kitchen Staff, Recreation and Lifestyle Staff, Domestic, Support Staff, Volunteer	F = 16 M = 1	47.4 (11.58)	9.2 (6.49)

2.3.3. Procedure

Individual in-depth semi-structured interviews were conducted with the care managers, nursing staff, and SP participants, while focus group interviews were conducted with the assistants in nursing, and care, domestic, and support staff. In-depth interviews provide a comprehensive exploration of the topics of interest by obtaining a detailed account of participant thoughts and behaviours (Patton, 2002). In-depth interviews are particularly useful in obtaining data embedded within the context of a complex setting such as RACFs, and are also an appropriate first step in investigating topics about which little research has been conducted to date (Patton, 2002). In contrast, focus group interviews were used for the assistants in nursing, and care, domestic, and support staff participants, because they have been found to be particularly useful in interviewing participants in more vulnerable or subordinate positions (Madriz, 2000) such as those held by assistants in nursing, and care, domestic, and support staff within the RACF staff hierarchy (in the participant quotes focus groups are indicated by (FG). Focus groups validate participant responses through shared experience in a homogenous and non-threatening group environment (Kruegar & Casey, 2000). Each focus group consisted of between three and six participants with group size

dependent on staff availability at the scheduled interview time. Separate focus groups were conducted for the assistant in nursing, and care, domestic, and support staff participant groups.

During the interviews participants across all five participant groups were asked to comment on: why they work in aged care, the challenges and rewards of working in aged care, what ongoing training and support they receive in their roles, and their perceptions about multidisciplinary care and relationships among service providers. Participants were interviewed either face-to-face or via telephone as determined by their location. The interviews were audio-recorded and transcribed verbatim with the accuracy of transcriptions checked by a second analyst. The key benefit of telephone interviewing in this study was to reduce the financial cost of travel time and associated expenses required to include participants from diverse geographical locations. All individual and focus group interviews were conducted by the first author (MB), a SP with experience in working in RACFs. Interviews ranged from 15 to 67 minutes duration.

2.3.4. Data Analysis

Qualitative content analysis was conducted by two of the authors (MB) and (MW), guided by the systematic stages of the framework approach to analysis (Ritchie & Spencer, 1994). The framework approach to qualitative content analysis uses explicit stages of data analysis, increasing the accessibility of the analysis and interpretation of the data beyond the analysts themselves (Pope, Ziebland, & Mays, 2000; Rabiee, 2004). This transparency renders the approach particularly useful for research aiming to influence service provision and policy direction (Pope et al., 2000; Rabiee, 2004). In accordance with the framework analysis the authors utilised both inductive and deductive methods of enquiry, drawing on “a priori” issues originating from the research aims while remaining sensitive to concepts and ideas emerging from the data itself (Pope et al., 2000; Ritchie & Spencer, 1994). An outline of the stages of analysis is provided in Table 2.2.

Following analysis, a summary of themes and sub-themes for each participant group as well as a small number of additional open-ended questions arising from concepts evident in the data was distributed to all participants for member checking. Feedback provided through member checking was used to further refine the themes and sub-themes, thereby, increasing the validity of the analysis and accuracy in the interpretation of participant views (Hoffart, 1991). Completed member checking documents were received from approximately 50% of participants with all participants indicating overall agreement with the summary provided.

Table 2.2 Steps of data analysis

Step	Description
1	Initial reading and re-reading of the transcripts to familiarise the analysts with the data and gain an overall sense of key meanings and ideas within each interview.
2	Comparison was made across transcripts from the same participant group with the data charted to represent key themes and ideas relevant to that group. Themes and categories charted within each participant group were inclusive to represent the data in its entirety.
3	Comparison was made between the two analysts and subthemes were modified until consistency between the analysts was reached. Disagreement, overlap, or ambiguity in themes or sub-themes not resolved by the first and fourth authors were discussed with the second and third authors until consensus was reached.
4	Comparison was made across participant groups and themes and sub-themes rearranged to identify similarities and differences across groups.
5	Data from all participant groups was synthesised into a single analysis containing themes common across participant groups.

2.4. Results

Four common themes described the perceptions and experiences of participants working in RACFs. These were: (1) working in RACFs is both personally rewarding and personally challenging; (2) relationships and philosophies of care directly impact service provision, staff morale, and resident QOL; (3) a perceived lack of service specific education and professional support impacts service provision; and (4) service provision in RACFs should be seen as a specialist area. The four key themes and corresponding sub-themes are outlined in Tables 2.3-2.6, including participant quotes.

2.4.1. Theme 1: Working in RACFs is both Personally Rewarding and Personally Challenging

Working in a high-care RACF as either an internal or external service provider was identified as highly emotive, providing participants with both personal reward and challenge (see Table 2.3). A broad range of positive and negative emotions were identified by all participant groups with the most common emotions described being *"love"* and *"frustration"* (Sub-theme 1, Table 2.3). Further, all participant groups described how they often found themselves reflecting on their own health and independence and how they would feel if they were a resident. Many factors contributed to the emotive nature of the setting including: the physical environment, the nature of resident difficulties, the degree of personal care provided, resource constraints, and communication among staff.

Another key sub-theme across participant groups was the personal reward gained in being able to provide for the residents and develop relationships with them (Sub-theme 2, Table 2.3). All participants emphasised a strong sense of valuing older people and pride in caring for and providing services to better the lives of older people. This was the primary reason participants chose to continue to work in RACFs. Relationships with residents were described as being *"family like"* (CDSSFG01). Assistants in nursing and SPs described the richness of each resident's experience and stories and the positive connections they made in sharing each resident's history. Care managers discussed the inspirational nature of the residents, the knowledge to be gained from older people, and the reward gained by spending personal non-clinical time with residents. Care managers, nursing staff and assistants in nursing also noted the personal reward gained from the appreciation of family members and friends of the residents, as well as the residents themselves. These participant groups described the best moments of their day as, *"when they say that they are happy with our care and the family come and say thanks to us"* (NS04).

Intertwined with the rewarding aspects of caring for residents in RACFs, all participant groups emphasised that working in a RACF is challenging (Sub-theme 3, Table 2.3). For most internal staff, the challenges arose from their daily interactions with residents. Residents were described as a source of frustration, sadness, anxiety, and at times even being *"a little frightening"* (CDSSFG06). In particular, RACF staff emphasised the frustration they felt in working with residents with communication difficulties and challenging behaviours. They described this frustration as being bi-directional, experienced by both the staff and the residents. For nursing staff and SPs, the inability to facilitate resident improvement was challenging and *"frustrating, when I just can't do anything to make it better for them, no matter how hard I try"* (NS09). SPs discussed the need to balance goal setting with the knowledge that rehabilitation was unlikely. Assistants in

nursing discussed how the fluctuating health status of the residents was challenging and necessitated the need for constant review of resident needs. SPs also described the challenges faced due to variable practices and procedures within and between RACFs. They noted significant variability in documentation and handover requirements between facilities commenting that the success of handover was dependent on the type of documentation completed and to whom handover was given. Assistants in nursing felt that their input was not always valued during handover with some facilities providing direct handover to assistants in nursing, and care, domestic, and support staff only when registered nurses felt information transfer was necessary. A further challenge, expressed primarily by the SP participants was the physical environment of the setting. SPs described the environment as confronting due to the impact of the physical layout and smell as well as the social and communicative isolation of the residents.

Table 2.3 Theme 1: Working in RACFs is both personally rewarding and personally challenging

Sub-themes	**Participant Quotes**
(i) Working in RACFs is emotive	Emotions described included: *"love"*, *"enjoyment"*, *"positive challenge"*, *"rewarding"*, *"joyousness"*, *"frustrated"*, *"sad"*, *"traumatised"*, and *"upset"* *"I would hate it . . . I don't know how they cope, to lose that independence, being told what to do from someone my age . . . I don't know how they handle it".* (CDSS05)
(ii) Working in RACFs is rewarding	*"I work in aged care because it is something that inspires me, the stories of that older members of the community really I find amazing . . . they truly are a privilege to care for".* (CM06) *"I get satisfaction out of helping people do things that they can't do for themselves, and um yeah just helping keep their independence as much as I can ".* (NS07)
(iii) Working in RACFs is challenging	*"It can be very frustrating, it can be quite exhausting and demanding, and certainly challenging at times".* (CM06) *"My first job, I went out to a nursing home . . . there's just people sitting around idly, no one talking, no one interacting, nothing, just people. It was heart breaking".* (SP04)

2.4.2. Theme 2: Relationships and Philosophies of Care Directly Impact Service Provision, Staff Morale, and Resident QOL

The second key theme described how relationships and philosophies of care impact service provision (see Table 2.4). Within this theme three distinct sub-themes were evident, the first illustrating the importance of developing collaborative relationships with co-workers and family members and friends (Sub-theme 1, Table 2.4). Service provision was described as being team dependent by all participant groups, with the team extending beyond RACF staff to external service providers, in particular general practitioners. Care managers, nursing staff, and care, domestic, and support staff emphasised the importance of building multidisciplinary relationships based on mutual respect. Without these relationships it was felt that service provision *"falls apart"* (SP03) and resident care is diminished. The importance of getting along with immediate co-workers was of particular importance especially in close working quarters such as the kitchen. Nursing staff also valued the input of assistants in nursing, and care, domestic, and support staff, acknowledging that as they are not able to be in all places at once they rely heavily on feedback from assistants in nursing and personal care staff to meet residents' needs. In developing quality relationships all participant groups emphasised the need for effective communication as well as consistency in staffing. High staff turnover was identified as the primary barrier to achieving effective communication and relationship development by all participant groups. Further, SPs noted that high staff turnover and poor communication affected the implementation of recommendations. One SP stated, *"It's lack of consistent staffing and poor communication. You go and assess a client, write your recommendations and then someone will ring and ask you why you haven't been to see the client. They just haven't looked in the appropriate part of the file"* (SP06). Another SP stated, *"It's consistency of staff, you give your recommendations and then there's handover and you're not always sure to what degree your recommendations are handed over and because staff change every shift, there's not always the same staff working with the same person"* (SP08). RACF staff reported that high staff turnover led to inconsistencies in resident care, particularly for residents with communication or cognitive difficulties.

Ongoing collaboration and positive relationships among staff and external service providers was also viewed as critical to achieving change in service provision and in implementing new services. Both care managers and SPs stressed the importance of positive relationship development across the staff hierarchy to ensure that support for change is provided from the top down. In contrast, assistants in nursing, and care, domestic, and support staff emphasised the success of communication "up" rather than "down" the chain. Many assistants in nursing, and care, domestic, and support staff questioned whether their opinions were valued by facility management, noting

that their input often did not travel up the staff hierarchy or was not responded to sufficiently. Ineffective communication with management was also viewed by assistants in nursing, and care, domestic, and support staff as having a detrimental impact on staff morale and confidence, particularly for new staff members. Both assistants in nursing, and care, domestic, and support staff described how they often found themselves unsure of what to do in their duties because of incomplete or conflicting communication from superiors and facility management, as well as insufficient information provided during handover. As a result, care, domestic, and support staff participants stated that staff often called in sick and the entire service was affected. A flow-on effect of staff morale to resident morale was also noted, *"You've gotta be able to get along with one another, the residents pick up on it"* (CDSSFG02). This point was also illustrated by care managers who stated that resident QOL was in part dependent on staff mood projected during interactions with the residents and the general atmosphere of the facility.

Participants discussed communication and relationship development with family members and friends as both a positive and negative experience. Care managers and SPs noted that relationship development with family members and friends aided in obtaining knowledge about a resident's past. In addition, when they had a good relationship with families and friends there was the perception that families and friends provided an additional set of hands during care and therapy tasks. On the contrary however, there was much discussion about disagreement between staff and family members in particular in regards to resident care. Participants felt these disagreements often arose from a lack of communication and shared understanding between parties, and was a key source of frustration for staff members. In discussing communication with family members and friends, staff commented on the need to manage unrealistic care and service expectations of family members and friends as well as the unwillingness of family members and friends to accept resident difficulties and challenging behaviours.

The second sub-theme pertaining to relationship development among service providers centred on the inherent complexity of differing motivations and priorities of care across service providers (Sub-theme 2, Table 2.4). Both SPs and care, domestic, and support staff discussed the impact of motivation on service provision. Care, domestic, and support staff described how some staff members worked solely to be paid, performing only those duties outlined in their contract and being unwilling to step outside of their designated duties to help others. SPs described these staff members as *"bank staff"* (SP06) and reported a lack of compliance with recommendations by these staff members.

Table 2.4 Theme 2: Relationships and philosophies of care directly impact service provision, staff morale, and resident QOL

Sub-themes	Participant Quotes
i) The quality of relationships and communication impacts service provision	*"A facility that the staff can communicate with their supervisor or manager opposed to a facility where they can't affects the whole running of the facility. If the staff doesn't have an open door policy with management nothing gets through, nothing gets put into place, no one feels comfortable, staff choose not to come to work, ring in sick".* (CDSSFG06) *"They're (resident) just not managing and the family member completely refutes everything you say, that's the most frustrating part. Family putting them at risk".* (SP03).
ii) Relationships among service providers are complex involving differing motivations and priorities	*"They've got to start learning that you know just because this is the job they come here for that you don't just sit there and go that's not my space not my job".* (CDSSFG02) *"Unfortunately I also get asked to do mass assessments and all of a sudden the facility is up for accreditation and they've realised they haven't completed procedures".* (SP10)
(iii) Philosophies of care influence resident QOL	*"The things that make their day aren't the personal care and all the boxes we have to tick off, it's just a smile or maybe a hug".* (AINFG04) *"Treating them as a person . . . treating the person first and their illness second".* (CM08)

Differences between the motivations and priorities of care of RACFs, the acute hospital setting and general practitioners were also highlighted across participant groups with ageism being discussed extensively. Nursing staff and assistants in nursing perceived that many external service providers did not value the care they provided to the residents, *"It's a nursing home so you know, why bother"* (AIN03). One SP stated, *"Ageism seems alive and well"* (SP01). Care, domestic, and support staff felt more so than any other participant group that other staff, including management, neither understood nor valued their role or duties. Recreation and lifestyle staff discussed how

advocating for their position among the general staff body was like *"dragging teeth"* (CDSSFG02). One participant said, *"Some people think we're baby sitters, that really annoys me, I'm not a babysitter"* (CDSS05). SPs were frustrated with the lack of shared understanding of speech pathology services amongst RACF staff, policy makers, and family members and friends. SPs stated that RACFs did not always value the service they provided and often referred residents for services because of the requirements of upcoming accreditation rather than in response to resident needs.

The third sub-theme reflects the influence of philosophies of care and governing legislation on service provision in RACFs (Sub-theme 3, Table 2.4). The basic principles of PCC were discussed by all participant groups. In particular, participants emphasised the importance of recognising residents as individuals, and providing adequate opportunities for social interactions and recreational activities to ensure residents' lives remained purposeful, and thereby enhance resident QOL. The need to address residents' emotional and spiritual needs was also raised as an important factor in facilitating resident QOL. RACF staff identified the need to create a happy home-like environment where the residents felt safe and trust between the residents and staff was firmly established. RACF staff discussed the importance of getting to know each resident's idiosyncrasies stressing the importance of actively listening to and communicating with the residents. Finally, all participants advocated that one-on-one non-clinical time with residents had the most positive impact on resident and staff global wellbeing.

2.4.3. Theme 3: A Percieved Lack of Service Specific Education and Professional Support Impacts Service Provision

Theme 3 identified issues around ongoing education and professional support and its impact on service provision (Table 2.5). The first sub-theme highlights the positive value RACF staff and external service providers place on ongoing education and training opportunities (Sub-theme 1, Table 2.5). Multidisciplinary training was held in high regard in facilitating understanding and appreciation of the roles of different service providers, as was "hands on" training, which was seen to increase the applicability of training to daily care practice. On-site training was also seen as facilitating access to education for RACF staff.

Mixed views were evident in discussions regarding the perceived support to attend training (Sub-theme 2, Table 2.5). Though some nursing staff noted management was, *"very supportive"* (NS04) of training, others felt that the support received was superficial. For example, assistants in nursing reported that many care staff were not paid to attend training, and at times, were pressured

Table 2.5 Theme 3: A perceived lack of service specific education and professional support impacts service provision

Sub-themes	**Participant Quotes**
(i) Ongoing education is welcomed by service providers	*"I have this terrible fear that there are speech pathologists out there who do not have the skills to provide appropriate care for people in aged care".* (SP09)
	"Learn one thing out of a course it's always useful isn't it". (CDSS03)
(ii) RACF staff support to attend ongoing training is varied	*"Certain training we actually pay them to do so that encourages them a bit more, coming in their own time".* (CM05)
	"Not particularly (supported) because you don't get paid for it. You might get the day off but you'll have to take an annual leave day or something". (NS03)
(iii) There are limitations in current initial and ongoing training for external service providers working in RACFs	*"There are clinicians heading out there who are basically going from uni into aged care facilities and they simply don't have the skills to manage these complex and changing difficulties".* (SP09)
	"I think they need to go out to some facilities, just basically spending time with them, I think a lot of young new grads have very limited contact with the elderly especially the sick elderly". (SP01)
(iv) Multidisciplinary care in RACFs is limited	*"I request that a referral to another health professional be made in the resident's notes and in a letter to a general practitioners who can then follow up".* (SP03)
	Carer involvement with external service providers is limited with 1/10 AINs and 2/17 CDSS reporting they had had direct contact with a SP about resident care.

to attend training solely to meet the training deadlines of the facility. Care, domestic, and support staff had similar perceptions with some participants stating, *"There's lots of education available it's just a matter of whether staff want to attend"* (CDSSFG06) whereas others noted that they often have to attend training on their days off and without financial remuneration due to staffing and time constraints. For SPs, shortfalls in training specific to RACFs were emphasised (Sub-theme 3, Table 2.5). SPs raised concerns that their initial training at university was not sufficient to prepare them for the unique services provided in RACFs and that ongoing training opportunities specific to working in RACFs were very limited. In terms of informal training and support, most SPs had never had a mentor while working in a RACF and felt that peer support in the setting was limited. SPs also commented about a lack of discipline-specific special interest and support groups for service providers working in RACFs.

Sub-theme 4 explores participant perceptions of current multidisciplinary care in RACFs (Sub-theme 4, Table 2.5). All participants indicated they had limited involvement with the wider multidisciplinary team. Assistants in nursing, and care, domestic, and support staff commented that they very rarely had any communication or contact with external service providers, whereas reported registered nurse and care manager contact with external service providers was mixed, as was their desire for contact. For some care mangers and nursing staff, active participation in external service provider consultations was desired others, however, indicated a preference for communication via written recommendations only. SP participants commented that they had little direct or ongoing collaboration with other external service providers describing how referrals to other providers were most commonly made through the registered nurse or general practitioner. Further, following these referrals SPs rarely initiated active follow-up of the referrals or received direct feedback from either RACF staff or the referred service. For RACF staff, care managers felt there was little support from facility staff in completing their duties but acknowledged that this lack of support was often because of the time constraints of staff rather than an unwillingness to provide support. Nursing staff, assistants in nursing, and care, domestic, and support staff all sought most support from their peers and highly valued the support their peers provided. Assistants in nursing did acknowledge that registered nurses will step in to provide support if explicitly asked but that the level of assistance provided was not always consistent.

2.4.4. Theme 4: Service Provision in RACFs should be seen as a Specialist Area

The final theme expresses service provider desire for greater recognition of the duties they perform in RACFs and for RACFs to be recognised as a specialist area (Table 2.6). Lack of recognition of the unique and complex nature of the services provided in RACFs was a key source

of frustration across participant groups (Sub-theme 1, Table 2.6). Care managers, in particular, emphasised the ongoing difficulties they faced in advocating for both residents and staff in health, community, and government sectors. Care managers felt strongly that to increase recognition of RACFs recognition must extend beyond individual persons and service providers to government bodies and policy makers. Further, care managers believed that working in aged care should be seen as a specialist area across health disciplines, with service providers who work in RACFs being required to undertake additional training prior to working in the setting. Care managers felt that recruitment of external service providers was often hindered by difficulty finding providers with not only a genuine interest in working in aged care but also appropriate experience and knowledge specific to working with older people and working in RACFs.

Table 2.6 Theme 4: Service provision in RACFs should be seen as a specialist area

Sub-themes	**Participant Quotes**
(i) There is a perceived lack of recognition of the unique and complex nature of service provision in RACFs	*"I don't think people generally and other health care professionals especially in the acute setting think that aged care nurses of any description have any real training or qualification".* (CM09) *"It is challenging to work in environments which reflect that in our western society we devalue and isolate the elderly".* (SP01)
(ii) Resident impairment impacts service provision	*"I mean you're working with a nursing home population and generally they've got either multiple medical needs or have cognitive impairment so you whilst they certainly improve you don't necessarily see the great sort of rehabilitation improvement that you might see with somebody out in the community".* (SP08) *"Their condition can change so quickly and doing what was right two weeks ago, now it could be completely wrong".* (AINFG01)

The unique impact of resident impairment, in particular medical frailty and cognitive impairment, on service provision in RACFs was also discussed across participant groups (Sub-theme 2, Table 2.6). Cognitive impairment was seen as limiting the nature of the services provided to the residents as well as the ability of RACF staff and external service providers to uphold philosophies of care and meet legislative requirements. In providing daily care, care, domestic, and support staff described the need for flexibility in care practices when working with residents with cognitive difficulties. SPs described how high prevalence of cognitive impairment and degenerative disease in RACFs limited the application of many evidence-based therapy approaches and further led to questions regarding the appropriateness of allocating limited resources to the RACF population. SPs also commented that a lack of resources developed specifically for the RACF population limited both assessment and therapy.

2.5. Discussion

This study identifies vast similarity in the perceptions of service providers, internal and external, working in RACFs. The findings provide valuable common ground on which to base the development of more generalised service provision models to facilitate cross discipline communication, professional relationship development, and multidisciplinary care in aged care settings. Where differences in perceptions did arise, it was clear that these differences arose primarily due to poor communication and a lack of shared understanding among service providers. Consistent with past research (Davies et al., 2011; Halcomb et al. 2009; Kaasalainen et al. 2010) this study re-affirmed that in practice multidisciplinary service provision in RACFs is limited.

This study identified a common “love” of aged care and a great depth of personal reward gained across service providers from working with older people. While shared knowledge of the principles of PCC was demonstrated, the same limitations in providing PCC including the impact of resident impairment and resource constraints were discussed across participant groups. These limitations have been identified in prior studies (Dwyer, 2011; Goodwin-Johansson, 1996; Heumann et al., 2001; Perry et al., 2011) suggesting that despite continual policy redevelopment, barriers to daily practice are still poorly addressed and inadequately recognised. Perhaps this continuing issue relates to the perception shared by prior researchers (Dwyer, 2011) that health sectors, community, and government bodies still fail to truly recognise the unique and complex nature of hands-on practice in aged care. As a result, these sectors continue to give inadequate consideration to the unique challenges faced by service providers when developing policy and practice guidelines. This perception can be classified under the broad notion of ageism, with ageism viewed by all participant groups as continuing to have a direct negative impact on both resident care

and morale. This issue was raised with particular reference to services provided by primary care sectors, general practitioners, and medical specialists. Participants in this study both internal and external to the RACF demonstrated collegiality in advocating for greater recognition of the needs of the residents and the unique challenges faced in working in RACFs.

While the current study is consistent with past studies in Australia and overseas in emphasising the importance of open and equal communication and relationship development among internal staff members (Blackford et al., 2007; Jeong & Keatinage, 2004; Kaasalainen et al., 2010; Perry et al., 2011), it extends our understanding of the importance of ensuring successful communication with external service providers. The current data demonstrates the different degrees of impact of poor communication across RACF service and staffing levels. External providers also noted this difference and discussed a direct impact of poor communication across RACF staffing levels on the following of provider recommendations. Participants holding less authoritative positions within the RACF staff hierarchy discussed a direct relationship between the successful communication with, and support from, superiors with their own personal morale and physical health. Both management and nursing and care staff expressed that staff morale has a direct impact on resident morale suggesting a link between resident wellbeing and staff satisfaction in the workplace. This link has been suggested previously (Ball et al., 2000; Goodwin-Johansson, 1996) and warrants greater consideration in the development of future service provision models.

All participant groups expressed concern about limited opportunity for education specific to working in RACFs and limited professional support provided within the workplace. This finding is consistent with recurrent international discussion of insufficiencies in training within the aged care workforce for several decades thus indicating little progress has been made in this area. The current data found limited education had a direct negative impact on both service provision, and communication and understanding among all service providers. As a result, all participant groups expressed a desire for multidisciplinary training opportunities to facilitate shared understanding of the contribution of different disciplines. Hogan (2004) argued that as a major investor in aged care it is the role of government to actively influence nursing, allied health, and physician curricula to ensure it contains sufficient material specifically tailored to working in aged care.

Though this study was conducted within the specific context of RACFs, results of the study are directly relevant to and support similar research in skilled nursing facilities and nursing homes. Further, the results are applicable to consideration of health-care services for older people and in particular international emphasis on both PCC and active ageing. Despite continued emphasis on PCC as the philosophy of preference in aged care services, a standard definition of PCC is yet to be agreed upon (Australian Government Productivity Commission. 2011; WHO, 2002). Research into

PCC is often discipline-specific, and further, factors claimed to facilitate and hinder PCC are yet to be backed by sufficient empirical studies (Edvardsson et al., 2010; McCormack et al., 2010). As a result, clarity in the practice of PCC and therefore successful implementation of PCC is unlikely to be achieved without further research and development of setting-specific and multidisciplinary service provision guides. Further, the basic premise of active ageing, described as *"optimizing opportunities for health, participation and security in order to enhance quality of life as people age"* and allowing people to *"realize their potential for physical, social and mental wellbeing throughout the life course"* (WHO, 2002, pg.12) is also unlikely to be achieved considering current barriers to multidisciplinary service provision, difficulty implementing PCC, and the continued devaluing of aged care.

Limitations of the current study are acknowledged, including the inclusion of a single external service discipline. The inclusion of general practitioners in future studies would be of particular value with general practitioners providing a central point of contact for both RACF staff and external service providers working in RACFs. In addition, with general practitioners viewed by participants in this study as often having negative perceptions of service provision in RACFs, the opinions and perceptions of general practitioners are necessary to provide a balanced view of service provision in the setting. The perceptions of family members and administrators, two key stakeholders in resident care, were not explored in this study but are pertinent to the development of models of care in the setting. Despite these limitations it is argued that this study adds considerable knowledge in understanding potential barriers and facilitators to communication and relationship development among service providers. It has identified considerable common ground in the perceptions of both internal and external providers, as well as understanding the underlying basis of differences in perceptions across service disciplines.

2.6. Conclusion

Despite ongoing policy redevelopment and research focus on service provision in RACFs and skilled nursing facilities, multidisciplinary care in RACFs continues to be poorly implemented. Communication and relationship development among different disciplines remains infrequent and often limited in success. The results of this study unite the views of management, nursing and personal care staff, domestic, and support staff, as well as SPs, to identify vast commonality in perceptions across providers about key challenges and motivators to working in aged care. It is clear from the findings that regardless of provider role or discipline, those working in aged care are working towards the same common goals and are impacted by the same challenges. This commonality, however, is not being communicated among providers.

There needs to be greater recognition of shared experiences and issues faced by a range of service providers who work in aged care, including greater recognition of the specialist nature of the services provided and the personal challenges inherent in working in the setting. This needs to be achieved through better training and preparation for all service providers working in aged care with a focus on training that facilitates cross-discipline communication and relationship development. By acknowledging, accepting, and communicating shared experiences and perceptions across service providers the divide across disciplines may be reduced. Ultimately, it is hoped this will help to facilitate a workplace that is more personally rewarding, where resident wellbeing is enhanced, and multidisciplinary care optimised.

CHAPTER THREE

AN EXPLORATORY INVESTIGATION OF COMMUNICATION MANAGEMENT IN RESIDENTIAL AGED CARE: A COMPARISON OF DOCUMENTATION, OBSERVED RESIDENT-STAFF COMMUNICATION, RESIDENT PERSPECTIVES, AND STAFF KNOWLEDGE

The results of Chapter 2 identified that service providers across a range of disciplines face many of the same barriers to providing optimal care in RACFs. Regardless of service discipline, providers emphasised the importance of professional communication and collaboration to service provision. In addition, RACF staff, in particular, emphasised the importance of relationship development between staff and the residents. Residents with cognitive and/or communication difficulties were perceived by RACF staff to be among those residents that are the most difficult to work with, with resident cognitive or communication difficulty seen to have a direct negative impact on staff ability to provide consistent and quality care. These perceptions support the inclusion of communication management as a valid and explicit care task in RACFs. The nature of current communication management in RACFs is, however, unknown. Further exploration of communication management in the context of daily care is needed to understand the nature of current communication management in RACFs, including the role of both RACF staff and SPs in providing this care and the impact of known barriers on the provision of communication management.

Chapter 3 uses triangulation of data sources to explore current communication management in RACFs obtaining data from a review of resident files, resident surveys, RACF staff surveys, and observation of resident-staff communication interactions in the context of daily care. This chapter aims to explore the nature of and factors impacting resident-staff communication and communication management in RACFs. The insights gained will highlight areas of need for further investigation and clinical management by both RACF staff and SPs to advance communication management in the setting.

The content of chapter 3 consists of the manuscript entitled *"An exploratory investigation of communication management in residential aged care: A comparison of documentation, observed resident-staff communication, resident perspectives, and staff knowledge"* which was submitted for publication by the International Journal of Language and Communication Disorders in July 2014. It is inserted as submitted for publication including the additional sections unique to this journal "What is already known" and "What this study adds", with the exception of formatting and referencing changes that have been made to align with the style guidelines of the American

Psychological Association and to maintain consistency throughout this thesis. The references specific to this manuscript have been included in the overall reference list of this thesis.

What is already known on this subject?

Communication has a key influence on a person's QOL and their ability to participate in meaningful life activities. In RACFs much of the communication residents engage in is with facility staff, yet little is known about factors that influence resident-staff communication or the way communication difficulties are managed in the setting. There is a need to further explore resident-staff communication and communication management in RACFs, considerate of the complex context of the setting and the role of the resident and staff in the communication dyad.

What this study adds?

This study used triangulation of data sources to explore resident staff communication and communication management in RACFs, comparing data obtained from: a review of resident files, observed resident-staff communication, resident surveys, and staff surveys. Findings of the study indicate that residents regardless of their level of communication impairment had little opportunity to engage in meaningful communication with staff. Documentation of residents' communication difficulties and needs was insufficient to guide RACF staff in facilitating the individual communication needs of the residents. Further, RACF staff were inconsistent in their reported and observed use of strategies to facilitate communication with individual residents.

3.1. Abstract

Background: There is a high prevalence of communication difficulty among residents of RACFs. Such functional deficits can have a negative impact on resident QOL, staff workplace satisfaction, and the provision of quality care. Systematic research investigating the nature of communication management in RACFs and factors impacting optimal communication management is, however, lacking.

Aim: The aim of the current study was to explore the nature of and factors impacting resident-staff communication and communication management in RACFs by examining documentation of residents' communication difficulties and needs, observations of resident-staff communication, resident perspectives, and staff knowledge about residents' communication difficulties and needs.

Methods & Procedure: Participants included a sample of 14 residents and 29 staff directly involved in communication interactions with the residents. Data was obtained from: (1) resident file

reviews (n = 14), (2) direct observations of resident-staff communication (n=14), (3) resident surveys (n=14), and (4) staff surveys (n = 29). Data from each source was examined separately then triangulated.

Outcomes & Results: All residents had limited opportunity for meaningful communication with staff. Documentation of residents' communication needs and strategies to facilitate communication was insufficient to provide individualised recommendations. Though staff were observed to use various strategies to facilitate communication, staff agreement about the applicability of these strategies to individual resident care was inconsistent.

Conclusions & Implications*:* Resident-staff communication and communication management in this study was found to be limited in scope and fell short of meeting residents' communication needs. Improvements in documentation and staff knowledge of residents' communication difficulties and needs as well as tailored and evidence-based strategies to facilitate communication are necessary. All residents of RACFs, regardless of their level of communication skill, require opportunity to engage in meaningful communication. Greater involvement of specialist providers such as SPs in assessing resident communication, providing ongoing support to RACF staff, and providing direct communication management is needed. This involvement must aim to facilitate more optimal resident-staff communication and relationship development, thereby, also assisting RACFs to comply with the principles of PCC and to facilitate resident psychosocial wellbeing.

Keywords: language, long-term care, quality of life, speech and language pathologists

3.2. Introduction

Effective communication is critical to a person's adaptation to ageing and is central to the majority of life activities and domains that have a key influence on QOL. Being able to communicate effectively enables older people to maintain their identity, continue to develop and maintain meaningful relationships with others, and assert and maintain their independence in society (Cruice et al., 2000; Lubinski & Welland, 1997; Nussbaum et al., 2005). In RACFs as many as 98% of residents experience some form of communication difficulty (Worrall et al., 1993). The nature of this difficulty is highly heterogeneous with residents commonly experiencing aphasia, apraxia, cognitive-communication impairment, dysarthria, dysphonia, and hearing impairment (Worrall & Hickson, 2003).

For residents of RACFs most communication takes place with facility staff (resident-staff communication). Past studies have shown that resident-staff communication and the quality of

relationship development between residents and staff has a key influence on both resident QOL (Bennett, Ward, Scarinci, & Waite, 2014 = Chapter 2; Nakrem et al., 2011) and staff satisfaction in the workplace (Bennett et al., 2014 = Chapter 2; Parsons et al., 2003). Further, when effective resident-staff communication is compromised by resident communication difficulty, staff have described an associated negative impact on their ability to complete care tasks and to provide quality care (Bennett et al., 2014 = Chapter 2; Bryan et al., 2002; McGilton et al., 2006; McGilton et al., 2010). Despite the recognised importance of ensuring quality resident-staff communication and the recognised high prevalence of communication difficulty in RACFs, systematic research investigating the nature of communication management in RACFs or factors impacting optimal communication management is limited. Therefore, to advance communication management in RACFs a thorough understanding of potential factors impacting this care must be obtained.

Several past studies have explored the nature of resident-staff communication in RACFs (Caris-Verhallen et al., 1999; Carpiac-Claver & Levy-Storms, 2007; Levy-Storms et al., 2011; Savundranayagam, 2014). What these studies demonstrate is a dominance of task-focussed resident-staff communication, a lack of interpersonal or affective communication, and continued use of elderspeak. Elderspeak is a style of speech characterised by increased volume, slower speech rate, high pitch, and reinforcement of passive involvement of the older person in the communication exchange (Balsis & Carpenter, 2006; Nussbaum et al., 2005). Elderspeak reduces the autonomy of the older person, inhibits a positive communication experience, and results in increased communication breakdown (Balsis & Carpenter, 2006). Where affective utterances have been identified they have generally preceded or been embedded in task-focussed communication and have been used to facilitate rapport or compliance to complete a care task rather than being used for the primary purpose of interpersonal communication with the resident (Caris-Verhallen et al., 1999; Carpiac-Claver & Levy-Storms, 2007; Savundranayagam, 2014). Savundranayagam (2014) related their findings to PCC and identified 618 missed opportunities for person-centred utterances across 46 resident-staff conversations. Approximately one third of the 46 conversations were found to include person-centred utterances, however, the majority of these were used to assist the resident to maintain a thought or action to complete a care task. The least proportion related to discussion of the resident's life history or background. To facilitate person-centered communication Savundranayagam emphasised the importance of: an explicit greeting to initiate interactions and facilitate rapport, the provision of meaningful choice to residents during care tasks, emphasis on personal conversation during care tasks, and increased validation of residents' feelings and requests for participation.

Many further factors impact the nature of resident-staff communication. Levy-Storms et al. (2011) in their analysis of person-centered communication in RACFs categorised influences on resident-staff communication into four polarised themes: (1) getting to know the resident versus maintaining a protective distance, (2) mutual respect versus disrespect, (3) avoiding versus addressing conflict, and (4) equity versus perceived favouritism. Levy-Storms et al. proposed that the higher the level of agreement between the resident and staff about where the communication interaction should be placed with relevance to these themes, then the greater the chance the communication exchange would be equal and person-centered. Other factors that may impact resident-staff communication and the management of communication difficulties in RACFs include: documentation of residents' communication difficulties and needs, and strategies to facilitate communication with individual residents; staff knowledge of and perceptions about residents' individual communication difficulties and needs; staff confidence in caring for and communicating with residents with communication difficulty; the nature and presentation of resident communication difficulty; and resident perceptions about their own communication needs, including their desire for increased or reduced communication interaction.

Lack of depth of information provided in care documentation in RACFs has been previously identified as problematic (Pye et al., 2000; Ullrich & McCutcheon, 2008). Specific to communication management, little is known about the nature of documentation relating to residents' communication difficulties and needs. Past studies have shown positive outcomes following the implementation of more comprehensive communication plans of care (Genereux et al., 2004; McGilton et al., 2010). In these studies residents' existing communication plans of care were elaborated following comprehensive assessment by a SP to include information about communication related diagnoses and associated recommendations to facilitate communication with the resident. Following implementation of these plans RACF staff reported an increase in knowledge about residents' communication needs and strategies to facilitate communication with the residents, as well as increased comfort in and a more positive attitude towards communicating with residents' who experience communication difficulties (Genereux et al., 2004; McGilton et al., 2010). Similar positive outcomes have been reported following studies investigating increased training for RACF staff about communication difficulties and communication management (Bourgeois et al., 2004; Bryan et al., 2002; McGilton et al., 2006).

While these past studies demonstrate that documentation, staff knowledge, and staff perceptions do have an impact on resident-staff communication and communication management, currently there is insufficient detailed research into the complex interplay of factors contributing to these issues (Bryan et al., 2002; McGilton et al., 2006). Exploring issues of documentation, staff

knowledge, and staff perceptions in isolation may fail to adequately identify the challenges faced by staff in engaging in communication with residents. To obtain a more comprehensive understanding of the impact of factors on resident-staff communication and communication management, direct observation in the context of daily care must be conducted. Furthermore, most past studies exploring resident-staff communication have not explicitly considered the contribution of the resident to the communication dyad, or resident perceptions. As such, further consideration must be given to the nature and presentation of residents' communication difficulties, and resident perceptions about their communication needs.

To further advance communication management in RACFs and achieve long-term service change, factors impacting resident-staff communication and communication management must be further explored using a research design that extends beyond measures of staff knowledge and perceptions. The contribution of and interplay between the communicating parties, the nature and severity of resident communication difficulty, and the influence of the care environment must also be considered. The aim of the current study was to explore factors impacting resident-staff communication and communication management in RACFs, triangulating data from facility documentation, direct observation of resident-staff communication, resident perceptions, and staff knowledge and perceptions about residents' communication difficulties and needs. The clinical objective was to highlight areas that may be addressed by RACF staff and SPs to enhance communication management and better meet residents' communication needs.

3.3. Method

Permission for the study was granted by, the Behavioural and Social Sciences Ethics Committee of The University of Queensland, Australia, and the participating RACF providers. This study used triangulation of data sources to increase the accuracy and credibility of the findings (Patton, 2002; Thurmond, 2001). Triangulation generated a description of current resident-staff communication and communication management in the context of daily care as close to truth as possible (Campbell & Russo, 1999).

The study was conducted in two regional high care RACFs. One facility was a for-profit organisation with a capacity of 56 beds and one of 27 facilities run state wide by the provider. The other was a not-for-profit organisation with a capacity of 61 beds and one of 35 facilities run state wide by the provider. Bed capacity of both facilities was within the nations' average range (Australian Institute of Health and Welfare, 2012). Within each facility a two-stage process was used to recruit: (a) residents; and (b) facility staff. Resident participants were recruited prior to data collection. Staff participants were recruited during data collection. Data collection was triangulated

involving an initial review of resident files followed by direct observation of resident-staff communication, then administration of a resident survey and staff survey.

3.3.1. Participants

3.3.1.1. Resident participants.

Due to the high prevalence of communication and cognitive difficulties within the RACF population and the need to gain consent from third-party guardians, obtaining representative resident samples in RACFs has long been acknowledged as challenging (Worrall & Hickson, 2003; Zermansky, Aldred, Petty & Raynor, 2007). To minimize this difficulty, maximum variation sampling was used to select residents consistent with criteria of central relevance to the aims of the study (Patton, 2002). The following characteristics were sought to achieve variation in the sample: gender (male/female); severity of communication difficulty (nil/mild, moderate/severe); and level of function across four key categories of the ACFI including: (1) verbal behaviour, (2) physical behaviour, (3) cognitive skills, and (4) complex health care (Australian Government Department of Health and Ageing, 2008b). Across each of the ACFI categories residents are rated on a 4 level scale from A (least need) to D (highest need). The ACFI is a resource allocation instrument used to determine the care services residents receive based on their needs in comparison to others. The ACFI is not a diagnostic tool.

Selection began by explaining the purpose and procedure of the study, verbally and in writing, to all residents and/or their legally appointed guardian using large font and picture symbols to aid comprehension. Residents with an active palliative care plan were excluded. Interested residents and/or their legally appointed guardian then provided written consent for participation. From this group (n = 19), the final set of resident participants was systematically selected to ensure that final sampling included sufficient variability. Residents were first classified with nil/mild or moderate/severe communication difficulties determined by file review and clarification with the care manager. Following this, the resident's ACFI assessment was accessed in resident files. Attempts were made to include residents with varying levels of function across the sampled ACFI categories before selecting the final sample to ensure distribution across those with nil/mild (n =5) or moderate/severe communication difficulty (n = 9). The final resident sample included 14 residents, five men and nine women, aged between 60 and 99 years (M = 84 years; SD = 10.9 years). Length of residency in the RACF ranged from 6 to 27 years (M = 5.1 years; SD = 8.3 years). Resident demographics and variability within the sample is detailed in Table 3.1.

Table 3.1 Resident demographics based on maximum variation sampling

Resident	Communication relevant diagnosis	Communication Difficulty	*Cognitive Skills	*Verbal Behaviour	*Physical Behaviour	*Complex Health Care
1	Nil	nil/mild	B	B	B	A
2	Dementia, Progressive Bulbar Palsy, Moderate Hearing Impairment	moderate/severe	D	B	D	C
3	Nil	nil/mild	B	D	D	C
4	Nil	nil/mild	A	D	B	B
5	Severe Developmental Delay, Cerebral Palsy, Cerebrovascular Accident	moderate/severe	D	D	D	B
6	Dementia of the Alzheimer's Type, Impaired Vision, Mild Hearing Loss	moderate/severe	D	D	D	B
7	Profound Hearing Loss, Impaired Vision	moderate/severe	A	A	A	D
8	Parkinson's Disease, Dementia, Mild Hearing Impairment, Impaired Vision	moderate/severe	D	D	D	C
9	Nil	nil/mild	A	A	A	D
10	Verbally aggressive	nil/mild	B	C	C	D
11	Cerebrovascular Accident	moderate/severe	D	D	C	D
12	Dementia of the Alzheimer's Type	moderate/severe	D	D	D	D
13	Profoundly Deaf	moderate/severe	D	D	D	C
14	Moderate Hearing Impairment, Vision Impairment, cognitive decline, Cerebrovascular Accident	moderate/severe	D	D	B	B

* (A = lowest care need, D = highest care need)

3.3.1.2. Staff participants.

Recruitment of staff participants was a two-step sequential process. All RACF staff with direct contact with any of the 14 resident participants were provided with written information about the study and were informed they may be observed interacting with these residents. Staff were asked to inform the Care Manager if they did not wish to be observed. No staff member declined observation.

Following this, the staff member who was observed interacting with the resident participant for the longest period during each observation session (three observation sessions were conducted per resident participant) was invited to participate in the study. All staff participants were required to have sufficient English skills to respond to a survey and were required to have worked with the matched resident participant for a minimum of three months prior to data collection. In total, 39 staff were observed interacting with the resident participants during the observation sessions. A total of 29 staff met the inclusion criteria and provided written consent for participation. The 29 staff consisted of 27 women and 2 men, aged between 19 and 62 years (M = 36.2 years; SD = 12.6 years). The staff participants were from the following occupational groups: assistant in nursing (n = 19), registered nurse (n = 7), recreation activity officer (n = 2), and endorsed-enrolled nurse (n = 1). Staff participants had worked with each matched resident for between 6 and 14 years (M = 4 years; SD = 4.4 years) and for between 3 and 5 days per week.

3.3.2. Procedure

The study was conducted in four stages commencing with a review of resident files followed by observations of resident-staff communication then administration of the resident survey and staff survey. A single researcher, a SP with nine years experience working in aged care services conducted all assessments. To minimize observer bias the researcher was unfamiliar to both staff and the residents, and was independent to the setting.

3.3.2.1. File reviews.

A file review was conducted for each resident participant to identify: (1) the nature of any information relevant to communication management, and (2) the location of this information in each resident’s file.

3.3.2.2. Observations.

Resident-staff communication was observed as each resident participant carried out, their daily activities. Each observation session was three hours in duration. For each resident, one session was conducted in the morning, one in the middle of the day, and one in the evening. Observations were scheduled to ensure an equal number of observations on each day of the week, increasing the likelihood the data would capture variability in resident-staff communication occurring at different times of the day, on different days of the week, and with different staff. A total of 41 out of a possible 42 observation sessions were completed totalling 123 hours of observation. One morning observation was discontinued due to resident illness. During the observations the researcher took a passive role, maintaining a seated position adjacent to the resident and between 2 and 4 meters away from the resident. This distance ensured accurate observation but minimised any disruption to the interaction. As resident observations frequently occurred in the presence of other residents the sessions could not be video or audio recorded out of respect for the non-participating residents.

During each observation the researcher collected information about: (1) the location of the interaction; (2) the communication partner; (3) who initiated the conversation, and the means used to initiate the conversation; (4) the purpose of each utterance; (5) whether communication breakdown occurred; (6) whether an attempt was made to repair unsuccessful utterances; (7) the number of utterances per conversation; and (8) who terminated the conversation, and the means used to terminate the conversation (Appendix E). For the purpose of this study a conversation was defined as one or more utterances about a single topic. An utterance was defined as a single communicative unit (verbal or non-verbal), directed at or by, the resident participant irrespective of whether a response was received. In addition the researcher completed the *Montreal Evaluation of Communication Questionnaire for use in Long-Term Care* (MECQ-LTC) (Le Dorze et al., 2000), from an observers perspective. The MECQ-LTC was designed to be administered as a staff questionnaire, however, in the current study the items of the MECQ-LTC were also scored during the observation sessions by the researcher. This enabled data to be collected during the observations that would be directly comparable with staff responses to the same items.

The psychometric properties of the MECQ-LTC have been evaluated previously in a criterion validity study with 31 residents and 62 nurses yielding satisfactory inter-judge and intra-judge (Le Dorze et al., 2000). The MECQ-LTC is divided into two parts. Part 1 describes the means of communication (e.g., facial expressions, speech, gesture, etc.) used by the: (a) resident when they are transmitting a message; (b) communication partner, in order to understand the resident; and (c) communication partner when transmitting a message to the resident. Each type of communication method is rated as either being used frequently, sometimes, or never in these three situations. Part 2

of the tool describes the resident's ability to understand and express information across six broad topics of communication relevant to long-term care: (1) personal care, (2) nutrition, (3) health care, (4) moving about and orientation, (5) recreational activities, and (6) generic communication (described as communication that is not related to a specific care task including broad expression of feelings, requests, social preferences, and general information). The resident's ability to communicate across these six categories is rated as either "yes" or "no" and also scored relative to the effort required to achieve a successful communication exchange (0 = without effort, 1 = some effort, 2 = a lot of effort).

3.3.2.3. Resident surveys.

After the resident observation sessions, all capable residents completed the *Questionnaire of Communication* (QOC) (Looi et al., 2004). The QOC was developed to explore resident perceptions about their communication skills, needs, and communication opportunity in RACFs. The QOC is divided into seven main sections asking the resident to: (1) provide an open-ended description of their communication; (2) rate the quality and quantity of their communication as "good", "ok" or "poor"; (3) indicate using "yes/no" whether their communication could be better; (4) name their most frequent communication partners and describe what they talk about; (5) indicate using "yes/no" whether they have enough communication opportunity in the RACF; (6) indicate if they talk "more", "about the same", or "less" than they did prior to admission; and (7) provide any other feedback or comments about their communication in the RACF. The QOC was administered as a face-to-face survey with resident responses written verbatim and analysed using qualitative content analysis. The resident survey was completed after the observation sessions to ensure the researcher remained blind to resident perceptions during the observations. Of the 14 resident participants, 5 were unable to participate in the survey due to severe developmental delay (n = 1), poor medical state with decreased level of alertness (n = 1), and late stage dementia (n = 3).

3.3.2.4. Staff surveys

After each observation, the staff member observed having the most interaction with the resident participant was asked to provide further written consent to participate in a face-to-face survey to explore their knowledge and perceptions about the resident participant's communication skills and needs. The survey consisted of three open-ended questions: (1) Can you describe the resident's communication? (2) Do you think the resident enjoys communicating? and (3) Does the resident actively engage in opportunities for communication in the facility? Staff then completed the MECQ- LTC administered consistent with the original guidelines of administration (Le Dorze et al., 2000). This resulted in up to three data sets from staff for each resident participant (one from

each observation). Of the 29 staff participants recruited to the study, nine staff were observed on multiple occasions interacting with different residents. As a result, three staff completed data sets for three resident participants and six completed data sets for two resident participants. The remaining 20 completed data sets for a single resident participant.

3.3.3. Data Analysis

Data obtained from the file review, resident survey, and the three open-ended questions in the staff survey were analysed using qualitative content analysis (Patton, 2002). Data from the MECQ-LTC (both in observer condition and staff report) were analysed using descriptive statistics, calculating frequency counts and percentiles across the 41 data sets. Sub-analysis of results by communication severity group (nil/mild versus moderate/severe) was also conducted. To complete data triangulation key categories of information generated from content analysis of the file review, resident survey, and staff open-ended responses were compared. Descriptive statistics from the observational ratings and staff completion of the MECQ-LTC were directly compared to identify similarities and differences. Furthermore, level of agreement across staff ratings on the MECQ-LTC for individual residents was reported.

3.4. Results

Results obtained from each data collection method (file review, observation, resident survey, and staff survey) are presented below. Following this, data from the four sources has been triangulated to explore relationships between documentation of residents' communication difficulties and needs, observed resident-staff communication, resident perspectives, and staff knowledge and perceptions.

3.4.1. Resident File Review

Information relating to residents' communication needs was found in resident's "communication plan of care" and "behaviour plan of care" within each resident's care plan. There was, however, no evidence in any residents' file that a formal assessment of the resident's communication skills had been undertaken, nor was a formal diagnosis of the nature or severity of the resident's communication difficulty included. Identification of diagnoses that may impact the resident's communication skills had to be sourced by thorough review of resident's files in their entirety. Where strategies were documented to facilitate communication with the resident these were found in no single location in the file and with no included rationale for the use of the strategy or relationship to the resident's specific communication needs. Content analysis of the information contained in the files revealed residents' needs were described using six broad categories of

information: (1) record of hearing and vision difficulties (in 14/14 files); (2) lay description of speech and receptive language (in 14/14 files); (3) reference to cognitive deficit (in 5/14 files); (4) description of problematic communication relating to challenging behaviours, including swearing, calling out and repetitive speech (in 3/14 files); (5) reference to English as a second language (in 1/14 files); and (6) brief description of strategies to facilitate communication with the resident (in 14/14 files). Content analysis of documented strategies to facilitate communication with the resident revealed 20 specific strategies categorised into five themes, outlined in Table 3.2. The detail provided across all files was, however, minimal and non-specific, written in lay language (e.g., *"resident talks in garble"*), and contained no indication of the source of the information.

3.4.2. Resident-staff Observations

During the 41 observations, 173 conversations and 354 utterances were counted. Observational data revealed most conversations occurred in residents' bedrooms (53%) or a common lounge/dining area (41%). The average number of conversations per resident was similar for residents with mil/mild (M = 13.6, SD = 4.0) and moderate/severe communication difficulty (M = 11.7, SD = 3.4). The average length of the conversation (number of utterances) was brief for both residents with nil/mild (M = 2.2, SD = 1.8) and moderate/severe (M = 2.2, SD = 2.2) communication difficulty. Most conversations occurred between the resident and an assistant in nursing (63%), while resident-registered nurse conversation accounted for 16%, resident-RAO conversation accounted for 15%, and resident-endorsed-enrolled nurse conversation accounted for 6% of the conversations.

The majority (65%, 113/173 conversations) of all resident-staff conversations were, initiated by staff. Residents with nil/mild communication difficulty were found to initiate more conversations (51%, n = 35/68) than residents with moderate/severe communication difficulty (18%, n = 19/105). Staff also intentionally terminated the majority of conversations (83%, n = 130/138) where a progression of the conversation to a different topic did not occur. Staff typically initiated conversations with residents using a verbal greeting but frequently terminated conversations by physically exiting from the room without an explicit farewell. Staff on occasion pacified or dismissed resident attempts to communicate by comments such as *"That's enough for now"* or *"No, that's a good girl, settle down"*. Residents with nil/mild communication difficulty relied primarily on speech to initiate and terminate conversations; however, residents with moderate/severe communication difficulty primarily used facial expression to initiate conversation and only terminated two conversations. Frequency of the use of different means of communication used by the residents and staff to initiate and terminate conversations is provided in Table 3.3.

Table 3.2 Themes of strategies to facilitate resident-staff communication, and the frequency of recommendation of specific strategies in resident files

Themes of strategies to facilitate resident-staff communication	**Specific strategies**
Theme 1: Increase clarity of staff communication with the resident	Speak clearly (7/14 files) Speak slowly (6/14 files) Repeat if resident does not respond or indicates they have not understood (4/14 files) Speak Loudly (2/14 files)
Theme 2: Simplify communication used with the resident	Ask yes/no questions (2/14 files) Use short simple instructions (2/14 files)
Theme 3: Accommodate the residents communication needs	Provide additional time for resident to respond (8/14 files) Encourage to wear glasses or hearing aid (3/14 files) Observe facial and body language (3/14 files) Spend 1:1 time with the resident (2/14 files) Be patient with residents communication needs (1/14 files) Encourage resident to sing/hum (1/14 files) Give the resident choices (1/14 files)
Theme 4: Create a calm and supportive communication environment	Approach gently/calmly (3/14 files) Provide reassurance (2/14 files) Limit background noise (1/14 files) Listen attentively to the resident (1/14 files)
Theme 5: Gain and maintain resident attention	Maintain eye contact (3/14 files) Gain residents attention before speaking (1/14 files) Orient the resident to time and place (1/14 files)

Table 3.3 Observed means of communication used by residents and staff to initiate and terminate a conversation

Resident communication difficulty	**Means used to initiate the conversation**		**Means used to terminate the conversation**	
	Resident	**Staff**	**Resident**	**Staff**
Nil/Mild	Verbal greeting (75%) Facial expression (19%) Change of posture (6%)	Verbal greeting (56%) Physical entry (17%) Facial expression (15%) Change of posture (10%) Touch (2%)	Verbal farewell (67%) Change of posture (22%) Facial expression (11%)	Verbal farewell (50%) Physical exit (42%) Facial expression (4%) Change of posture (4%)
Moderate/Severe	Facial expression (75%) Verbal greeting (12.5%) Gesture (12.5%)	Verbal greeting (48%) Facial expression (19%) Touch (17%) Physical entry (13%) Change of posture (1.5%) Gesture (1.5%)	Gesture (50%) Change of posture (50%)	Physical exit (56%) Verbal farewell (21%) Facial expression (20%) Gesture (3%)

Table 3.4 Total number of unsuccessful communication attempts, repair attempts, and success of repair attempts, by residents and staff

Resident communication difficulty	**Unsuccessful communication attempts**		**Resident**		**Staff**	
	Residents	**Staff**	**Repair attempts**	**Success of repair attempts**	**Repair attempts**	**Success of repair attempts**
Nil/mild	31 (45.6%)	4 (8.7%)	8 out of 35 (23%)	25%	8 out of 35 (23%)	100%
Moderate/severe	37 (54.4%)	42 (91.3%)	13 out of 79 (47%)	46.2%	49 out of 79 (62%)	26.5%
Total	68	46				

Table 3.5 Observed means of communication used by residents' and staff to communicate a message and repair communication breakdown across the MECQ-LTC Part 1, as rated by the researcher

Resident communication difficulty	**Means used to communicate**		**Means used to repair communication breakdown**	
	Resident	**Staff**	**Resident**	**Staff**
Nil/Mild	Speech (including yes/no) (94%)	Speech (92%)	Speech (38%)	Speech (33%)
	Pointing (1.5%)	Speaking slowly (3%)	Gesture (25%)	Gesture (33%)
	Gesture (1.5%)	Speaking loudly (3%)	Yes/no question (12.3%)	Demonstrate (17.5%)
	Body movement (1.5%)	Simplify sentence (1.5%)	Facial expression (12.3%)	Repeat (16.5%)
	Yes/no head movement (1.5%)	Repeating (0.5%)	Ask open question (12.3%)	
Moderate/Severe	Speech (including yes/no) (35%)	Speech (51%)	Speech (23%)	Repeat (36%)
	Facial expression (24%)	Speaking slowly (22%)	Facial expression (23%)	Speech (16%)
	Body movement (14%)	Speaking loudly (16%)	Body movement (15%)	Reword (12%)
	Vocalisations/behaviours (12%)	Touch (3%)	Gesture (15%)	Speak slowly (12%)
	Gesture (10%)	Simplify sentence (2.6%)	Vocalisations/behaviours (8%)	Touch (8%)
	Yes/no head nod (4%)	Repeat (1.8%)	Yes/no head movement (8%)	Demonstrate (4%)
	Touch (1%)	Facial expression (1.2%)	Ask question (8%)	Gesture (4%)
		Ask for help (0.8%)		Speak loudly (4%)
		Demonstrate (0.8%)		Simplify sentence (4%)
		Ask question (0.8%)		

Overall, 114 (32%) of the 354 utterances were unsuccessful, i.e., they did not receive a response from the communication partner or they received a response incongruent with the intent of the utterance. Of these unsuccessful communication attempts 68 were resident attempts to communicate and 46 were staff attempts to communicate. Together staff and residents attempted to repair 68% (n = 78) of these unsuccessful utterances. As can be seen in Table 3.4, residents with moderate/severe communication difficulty achieved a higher success rate in their repair attempts than did residents with nil/mild communication difficulty. Staff were, however, more successful in their attempts to repair communication breakdown with residents with nil/mild communication difficulty.

Data obtained from the researcher ratings from Part 1 of the MECQ-LTC indicated speech was the most common means of communication used by both residents and staff to communicate a message and to repair communication breakdown (Table 3.5). Facial expression was used more often by residents than staff and particularly by residents with moderate/severe communication difficulty. Both residents and staff also used a greater range of communication means and multiple means concurrently during conversations with residents with moderate/severe communication difficulty.

Researcher ratings across Part 2 of the MECQ-LTC indicated for residents with nil/mild communication difficulties that conversations categorised as generic communication were the most common (44%), followed by conversations about nutrition (30%), and health care (9%). For residents with moderate/severe communication difficulties conversations about nutrition were the most common (34%), followed by health care (25%), and personal care (15%). The vast majority of utterances for all participants' included making a statement (34%), asking a question 30%, or giving an instruction 20%.

3.4.3. Resident Surveys

Resident responses to the open-ended questions contained in the resident survey were very limited in content and length with no resident providing further comments about communication in the facility and many responding with *"I don't know"* when asked to describe their communication. In rating their communication, four residents (resident 2, 7, 8, & 11) described their communication as poor, and five rated their communication as good (1, 3, 4, 9, & 10). Most residents also answered with *"I don't know"* when asked if their communication could be better, and in comparing their communication now to prior to admission. Residents indicated that staff and other residents are their most common communication partners and that they will talk about *"anything"*. Most of the

nine residents who completed the survey (n = 7) indicated they enjoy talking to others, however, five of these residents said they did not have enough opportunity for communication in the facility.

3.4.4. Staff Surveys

Staff description of resident communication difficulty also yielded limited data. Descriptions provided were short and often accompanied with comments such as *"I don't know"* or *"I've never really thought about it".* Content analysis categorised descriptions that were given into three categories of information: (1) information about residents hearing or vision impairment, (2) description of the clarity of the resident's speech, and (3) reference to the resident's cognition. Four words frequently used by multiple staff to describe the resident participant's communication were *"demented"*, *"stutter"*, *"garble"*, and *"mumble".*

Staff responses from Part 1 of the MECQ-LTC indicated residents most often used a yes/no verbal response to communicate, followed by speech (other than yes/no), and facial expression. These means of communication were reported to be used by all resident participants regardless of communication difficulty. A yes/no head nod was also reported to be used by all residents but with less frequency, while gesture and body movement were reported to be used by most residents (n = 9/14), but infrequently. No resident was reported to use writing, drawing, or a communication book/board to communicate.

In communicating a message to the resident, staff reported they most commonly used speech, simple sentences, and explicitly checked if the resident had understood. Most staff also reported they frequently or sometimes used gesture and repetition to communicate a message to the resident. No staff reported they used writing or drawing to communicate with the resident. Staff report of means of communication used to understand the resident indicated all staff felt that knowing the resident's routine was the most frequently used strategy to understand the resident. Staff reported they also often used yes/no questions and provided the resident with explicit choices. The least common strategies reported as being used to understand the resident were to ask someone for help or to guess.

Staff responses from Part 2 of the MECQ-LTC indicated that they generally felt residents experienced more difficulty with expression than comprehension. Staff report of resident communication across the topics of: personal care, nutrition, health care, moving about and orientation, recreational activities, and generic communication, indicated residents with moderate/severe communication difficulties were most competent in expressing their needs about recreational activities (62% of responses indicating competency). Staff rated these residents as most

competent in understanding information about personal care (82%), and least competent in both expressing their needs (47% of responses indicating competency) and understanding information (46% of responses indicating competency, respectively) about health care. For residents with nil/mild communication difficulties, at least 70% of staff responses across all six topics indicated residents were competent in expression and comprehension.

3.4.5. Data Triangulation

Communication needs data obtained from review of each resident's file was compared with staff descriptions of the resident's communication needs. They revealed a similar focus on resident hearing and vision impairment, speech impairment, and resident cognition across the two data sources. Staff perception of whether the resident participants' enjoyed talking was consistent with responses from the residents with nil/mild communication difficulty. However less consistency was evident for residents with moderate/severe communication difficulty with staff perceiving three residents (residents 2, 7, & 8) did not enjoy communicating when the resident themselves indicated they did enjoy communicating. Comparison of residents' need for increased communication opportunities with staff perceptions of whether residents' engaged in communication opportunities also indicated differences. For three of the four residents who felt there was enough opportunity to communicate, staff felt they did not actively engage in communication opportunities. For three of the five residents who indicated they would like increased opportunities for communication, staff indicated these were residents who already actively engaged in communication opportunities.

Data generated from both the staff and researcher ratings of the MECQ-LTC were consistent in reporting residents communicate mainly using speech, with a high frequency of yes/no verbal responses, and in response to a high frequency of yes/no questions. Similarity was also found between staff and researcher reports of residents' use of facial expression, body movement, and gesture. In contrast, the most commonly documented strategy in resident files to facilitate communication was to provide the resident with additional time to respond. This was not observed in resident-staff interactions.

Staff responses from Part 2 of the MECQ-LTC indicated residents with moderate/severe communication difficulties were most competent in expressing their needs about recreation activities and in understanding information about personal care, yet researcher ratings indicated conversations about nutrition and health care were most often observed. For residents with nil/mild communication difficulty there was better agreement with staff rating these residents as competent in expression and comprehension across all areas on the MECQ-LTC. The researcher also noted that these residents participated in a wider range of conversational topics.

The percentage agreement in staff ratings of the MECQ-LTC for individual residents was calculated by tallying the number of identical responses given by staff for that resident across each of the MECQ-LTC, Part 1 and Part 2, items. Staff agreement in these responses for residents with nil/mild and moderate/severe communication difficulty is provided in Table 3.6. The data revealed increased agreement about resident competency in communicating across the six broad topics of communication for residents with nil/mild communication difficulties (MECQ-LTC Part 1). No clear pattern of agreement regarding communication means used by the residents or staff to communicate across the two resident groups was evident (MECQ-LTC Part 2).

Table 3.6 Agreement in staff responses for the same resident across Part 1 and Part 2 of the MECQ-LTC

Resident communication difficulty	**Percentage Staff agreement**			
	MECQ-LTC Part 1			MECQ-LTC Part 2
	Means of communication used by the resident to communicate a message	Means of communication used by staff to communicate a message	Means of communication used by staff to understand the resident	Resident communication competency across conversational topics
Nil/mild	69%	48%	32%	97%
Moderate/severe	44%	62%	36%	48%

3.5. Discussion

The aim of this study was to explore the nature of and factors impacting resident-staff communication and communication management in RACFs, triangulating data from multiple sources. Findings of the study revealed numerous limitations in current communication management in RACFs. These included: poor documentation of residents' communication difficulties and needs, and few tailored strategies to facilitate communication; limited staff knowledge of residents' communication difficulties and needs; and mixed staff agreement about residents' communication needs and appropriate strategies to facilitate communication with individual residents. Observations from this study also revealed a continued dominance of task-focused communication consistent with previous studies (Caris-Verhallen et al., 1999; Carpiac-Claver & Levy-Storms, 2007; Savundranayagam, 2014), a dominance of staff directing the

communication exchange (Williams et al., 2003), limited opportunity for residents to engage in meaningful interpersonal communication with staff, and a desire from residents for more opportunities for communication. Communication per se or the need for communication management is not explicitly discussed in current Australian or international aged care legislation or accreditation requirements. However, the requirement to facilitate active and meaningful participation of older people to meet residents' psychosocial needs and to provide services consistent with PCC is consistently discussed (Quality of Care Principles, 1997; World Health Organization, 2002). The current findings indicate that issues with communication management remain in RACFs. Widespread change at multiple levels is needed to prioritise communication management as an explicit care task. Such change is integral to the success of communication management in RACFs, and the facilitation of resident QOL.

In this study all residents regardless of level of communication difficulty engaged in conversations with staff that were too short to allow a meaningful or satisfying conversation to take place. Further, for residents with moderate/severe communication difficulty, very few utterances were generic or interpersonal in nature and when they were they generally preceded task-focused utterances. Though residents with nil/mild communication difficulties were observed to engage in generic conversation more frequently, again most interpersonal or affective utterances preceded or were embedded in task focused communication. These findings indicate little change in the nature of resident-staff communication from that identified in previous studies (Caris-Verhallen et al., 1999; Carpiac-Claver & Levy-Storms, 2007; Savundranayagam, 2014). This style of communication is inconsistent with recommendations to facilitate PCC and meet residents' psychosocial needs (Savundranayagam, 2014). Discrepancy between staff report of residents' conversational competency about specific conversational topics and the most common topics of conversation initiated by staff with these residents also indicate a failure to capitalise on residents' known communication strengths.

In this study staff were observed to dominate both conversation initiation and termination, and on occasion dismissed resident attempts to communicate and verbally pacified residents. This communication behaviour is characteristic of elderspeak (Balsis & Carpenter, 2006; Nussbaum et al., 2005; Williams et al., 2003) and demonstrates a lack of reciprocity of respect in the communication dyad, reducing the resident to a more passive participant in the interaction. Past research indicates that RACF staff are not ignorant to the use of elderspeak in RACFs (Hickson et al., 2005); however, the continued use of elderspeak and the resulting power imbalance between residents and staff must be addressed. RACF staff must be provided with alternate strategies to facilitate communication and to manage communication related difficulties and behaviours.

In considering the means of communication used by residents and staff, speech was the most common means of communication reported and observed to be used by both residents and staff. Staff also reported and demonstrated awareness of residents' use of facial expression, gesture, and body movement to communicate and reported using a range of means of communication to get a message across to and to understand the residents. Staff, though, demonstrated poor level of agreement about which means of communication were best used with individual residents. The role of non-verbal communication in rapport development between residents and staff in RACFs and in assisting staff to ascertain resident needs has long been acknowledged (Caris-Verhallen et al., 1999). Data from this study suggest that while staff were aware of the need to be attentive to non-verbal communication attempts by residents and to use varying means of communication with residents, they lacked the knowledge and confidence to differentially apply these means of communication to meet residents' individual communication needs. This finding is further supported by staff difficulty in providing an open-ended description of residents' individual communication skills and difficulties, and by the low success rate of staff attempts to repair communication breakdown with the residents.

Further limiting staff ability to facilitate communication was the finding that all resident files in this study lacked any evidence of formal assessment of the resident's communication difficulties and needs. Indeed most provided little information at all relating to each resident's communication difficulties and needs. The strategies to facilitate communication that were included in resident files were brief, non-specific, and without rationale of how these strategies addressed the individual communication needs of the resident. With past literature identifying ongoing issues with lack of detail in care documentation in RACFs (Pye et al., 2000; Ullrich & McCutcheon, 2008) as well as inconsistency in care documentation across RACFs (Bennett et al., 2014 = Chapter 2; Blackford et al., 2004) this issue must be addressed. Change needs to be targeted at systemic, management, and daily care levels to ensure there is more information available about residents' communication needs, that this information is documented, and that it is available to staff to ensure consistent implementation of strategies and provision of support.

Adequate assessment of resident skills is essential to develop appropriate and individualised goals for individual residents, to assist staff in differentially applying strategies to assist residents, and to inform resident referral to additional service providers (Swann, 2004). In this study, the documentation available would suggest that no participant in this research had participated in an assessment of the resident's communication needs. Speech pathology services in RACFs face a number of challenges (Bennett et al., 2014 = Chapter 2; Pye et al., 2000; Worrall & Hickson, 2003). However, as specialists in the management of communication difficulties there is potential for

greater involvement of SPs in the assessment and management of communication difficulties in RACFs. Increased presence and involvement of SPs in RACFs may also facilitate increased understanding between RACF staff and SPs relating to communication difficulties and communication management, and may assist in developing multidisciplinary models of communication management specific to the setting.

Of particular importance, this study considered resident perspectives about their own communication skills and communication needs. These findings indicate that resident desire for communication opportunity is variable and is not always consistent with staff perceptions. The fact that residents acknowledged that staff are their primary communication partners highlights the need for a high level of staff understanding about residents' communication needs including resident desire for communication participation. Resident perspectives about communication opportunity, participation, and communication management in RACFs must be further explored. These perspectives provide key input into the development of staff training in communication management and in the development of facility principles of care and guidelines for resident-staff relationship development.

This study adds valuable data exploring resident-staff communication in RACFs in context and with explicit analysis of the contribution of both the resident and staff to the communication dyad. There are however several limitations of the study that must be noted. In extending the use of the MECQ-LTC this questionnaire was found to be of particular value in providing an easy and effective way of comparing staff report of resident-staff communication with observed resident-staff communication. Two minor difficulties in using the form, however, should be noted. Consistent with reported reliability of specific descriptors in the MECQ-LTC, the descriptors "gestures" and "gesticulations" were unclear for many participants in this study and as a result were collapsed in data analysis. Staff rating of the effort required to communicate across the six topics outlined in the MECQ-LTC was also problematic with staff providing little discrimination in this rating for individual residents both within and across the six conversation topics. Issues were also noted with using the QOC. Although this tool was specifically designed for the RACF environment it is possible that additional data may have been obtained by using semi-structured interviews with the residents and exploring resident perspectives through narrative description and analysis. Classification of resident communication difficulty in this study was largely subjective. Future research investigating differences in resident-staff communication for residents with varying communication difficulties should consider formal assessment of each resident's communication difficulties and needs. It is, however, acknowledged that with limited assessment tools developed specifically for this population combined with the frailty of many residents and the complex nature

of their difficulties, that formal assessment is problematic (Hickson et al., 2005). Finally, issues of possible researcher bias must be acknowledged. Despite the researcher being unfamiliar to the facilities and the participants, and the use of a rigid procedure and data collection protocol to reduce bias, in future research a second observer should be used to validate the data collection processes and subjective rating of resident communication difficulty.

3.6. Conclusion

This study explored factors impacting resident-staff communication and communication management in RACFs by examining multiple data sources. Similarities and differences in resident-staff communication and communication management for residents with nil/mild versus moderate/severe communication difficulty were also explored. Findings from the study indicated that regardless of the severity of resident communication difficulty, residents had little opportunity to engage in meaningful conversation with RACF staff and played a largely passive role in the communication dyad. Many residents also expressed a desire for increased opportunity for communication interaction. For communication management in RACFs to advance, there is a need for more comprehensive documentation of residents' communication needs in resident care plans. There is also a need for increased training for RACF staff about the broader concepts of communication difficulty and communication management in RACFs. Increased interprofessional collaboration with speech pathology services is needed to enhance understanding of residents' communication needs and strategies to facilitate communication. Greater speech pathology involvement in staff training will also be of benefit in achieving service change. With a focus on resident participation, psychosocial needs, and PCC, in policy and legislative documents, increased prioritisation of communication management in RACFs is essential. Without effective resident-staff communication, resident participation cannot be facilitated, residents' psychosocial needs cannot be met, and care consistent with the principles of PCC cannot be provided.

CHAPTER FOUR

MEALTIME MANAGEMENT IN AUSTRALIAN RESIDENTIAL AGED CARE: AN INVESTIGATION OF DOCUMENTED, REPORTED, AND OBSERVED CARE

Discussion in Chapter 1 revealed that mealtimes are an important time of the day for residents of RACFs, providing an opportunity for socialisation and the expression of independence and self-identity while also being a referent of time throughout the day. The key influence of resident-staff interaction on the mealtime experience for both residents and staff was also discussed. This discussion is further supported by the findings of Chapter 2, which highlighted the importance of resident-staff relationship development and interaction to resident QOL, staff workplace satisfaction, and the ability of staff to provide consistent and quality care. As with communication management few studies have systematically investigated the nature of mealtime management in RACFs, including the role of RACF staff and SPs in providing this care. To advance mealtime management in the setting, thorough exploration of mealtime management in RACFs in the context of daily care is needed to identify areas of strength and weakness in meeting residents' medical, nutritional, and psychosocial mealtime needs as well as to further explore the impact of known barriers to service provision in RACFs on mealtime management specifically.

In Chapter 4 data from a review of resident files, observation of mealtimes, resident surveys, and staff surveys is triangulated to explore current mealtime management in RACFs. The insights gained will highlight areas requiring further investigation and clinical management by both RACF staff and SPs to advance mealtime management in the setting.

The content of chapter 4 consists of the manuscript entitled "*Mealtime management in Australian Residential Aged Care: An investigation of documented, reported, and observed care*" which accepted for publication in the International Journal of Speech and Language Pathology in November 2014. It is inserted as submitted for publication with the exception of formatting and referencing changes that have been made to align with the style guidelines of the American Psychological Association and to maintain consistency throughout this thesis. The references specific to this manuscript have been included in the overall reference list of this thesis.

4.1. Abstract

Mealtime management in RACFs should be holistic and comply with the principles of PCC to ensure residents' medical, nutritional, and psychosocial mealtime needs are met. However this is not always achieved and multiple issues with mealtime management in RACFs exist. The aim of the current study was to compare documented, reported, and observed mealtime management to explore factors influencing optimal mealtime care. Data was triangulated from: (1) resident files, (2) observations of mealtimes (n = 41), (3) resident surveys (n = 14), and (4) staff surveys (n = 29). Results revealed multiple discrepancies between data sources leading to the delivery of sub-optimal mealtime care. Poor documentation impacted staff knowledge of required mealtime practices resulting in occasions of inconsistent and inappropriate care. Observational and interview data highlighted discrepancies between residents' mealtime preferences and actual practice. Observed care was neither holistic nor consistent with PCC. Given the significant medical, nutritional, and psychosocial risks associated with poor mealtime management, changes in policy, staff training, and multidisciplinary care are needed.

Keywords: aged care, dysphagia, mealtime care, speech pathology

4.2. Introduction

Many residents of RACFs experience difficulties during mealtimes (Steele et al., 1997). Poor management of these difficulties can have significant negative implications including increased risk of aspiration pneumonia, choking, and malnutrition (Davis & Spicer, 2007; Miller & Patterson, 2014; Steele et al., 1997). Appropriate management of these difficulties involves thorough and careful assessment of resident mealtime needs, and individualized evidence-based intervention (Amella et al., 2008; Aselage & Amella, 2010; Miller & Paterson, 2014; Reimer & Keller, 2009).

A variety of service providers are involved in mealtime management in RACFs including assistants in nursing, dieticians, general practitioners, nurses, occupational therapists, and SPs. Working in RACFs, these disciplines must provide mealtime management consistent with PCC (Australian Government Productivity Commission, 2011; Bundy et al., 2008). To do this, requires equal consideration of residents' psychosocial mealtime needs in addition to their medical and nutritional needs. This involves providing mealtime choices and preferences, supporting independence, showing respect for the perspective of the resident, and promoting social interaction during mealtimes (Amella et al, 2008; Aselage & Amella, 2010; Kayser-Jones, 1996; Reimer & Keller, 2009; Sydner & Fjellstrom, 2005).

Many recommendations have been made to optimize mealtimes and mealtime management in RACFs. These recommendations include: facilitating the mealtime environment and enhancing resident-staff interaction (Kayser-Jones, 1996; Kayser-Jones & Schell, 1997; Reimer & Keller, 2009; Sydner & Fjellstrom, 2005); increasing multidisciplinary care (Davis & Spicer, 2007; Steele et al., 1997); and implementing evidence based individual intervention (McCullough et al., 2007; Miller & Patterson, 2014). Translation of these recommendations to daily care has, however, long been hindered by numerous barriers to service provision relating to: staffing (Bennett et al., 2014 = Chapter 2; Crogan et al., 2001; Kayser-Jones & Schell, 1997; Simmons & Schnelle, 2006); limited recognition and inclusion of mealtime management in aged care sector and facility specific policy (Sydner & Fjellstrom, 2005); resident ill-health and cognitive deficit (Davis & Spicer, 2007); and poor collaboration and communication among service providers (Bennett et al., 2014 = Chapter 2; Crogan et al., 2001). Compounding these barriers, RACF staff must consider situational variables including: staff dynamics and the days' activities, and daily resident status; while also managing inconsistency between facility policy, procedure, resident specific recommendations, and the direction of superiors and specialist staff (Colon-Emeric et al., 2006; Daskein, Moyle, & Creedy, 2009; Mitchell & Pachana, 2013; Ullrich et al., 2014). As a result, while service providers acknowledge the importance of holistic mealtime management, their ability to provide this care on a consistent basis is challenged (Crogan et al., 2001; Ullrich et al., 2014).

Acknowledging this complexity, and to understand why inconsistencies and inadequacies in mealtime management persist, mealtime management must be examined in context and using data from a variety of sources. Only one study to date has attempted to use such methodology to explore issues associated with mealtime care in RACFs. Specifically focused on examining assistant in nursing knowledge and knowledge translation about dysphagia, Pelletier (2004) compared data from: staff critique of a simulated mealtime scenario, staff individual semi-structured interview, and observation of mealtimes. Results revealed discrepancy between assistant in nursing knowledge and knowledge translation to daily care, and a consistent pattern across data sources strengthening the findings of the study and illustrating the benefit of data triangulation (Pelletier, 2004).

With the complexity of service provision in RACFs it is important that issues pertaining to mealtime management are examined using methodologies sensitive to the many factors influencing service provision, and specifically mealtime management. The aim of the current study was to explore factors influencing mealtime management in RACFs by comparing information from documented, reported, and observed care. The objective was to increase understanding of these factors, to inform practice change and improve mealtime care.

4.3. Methods

Permission for the study was granted by, the Behavioural and Social Sciences Ethics Committee, of The University of Queensland, Australia, and the participating RACF providers. This study was based on post-positivist, reality-oriented inquiry (Campbell & Ruso, 1999) using triangulation of data to describe as close to truth as possible current mealtime management in RACFs. Triangulation was used to increase the accuracy and credibility of the findings exploring current mealtime management considerate of context, resident need, and the interplay between documented, reported, and observed care (Patton, 2002; Thurmond, 2001).

Two regional RACFs providing high care services were recruited for this study. One was a 56 bed for-profit organization; the other, a 61 bed not-for-profit organization. The two facilities were chosen to represent typical aged care services within the local area in which the research was conducted. Each had bed capacity within the average range for Australian facilities (Australian Institute of Health and Welfare, 2012), and each facility was governed by long standing aged care organizations that managed multiple (27 and 35 respectively) RACFs state wide. Within each RACF two different participant groups were recruited: a) residents, and b) staff. Recruitment was a two-stage process with resident participants recruited first and staff participants recruited during data collection.

4.3.1. Participants

4.3.1.1. Resident participants.

Due to known challenges in recruiting representative resident samples in RACFs (Worrall & Hickson, 2003; Zermansky et al., 2007) maximum variation sampling was used to select a diverse cohort (Patton, 2002) ensuring: (1) at least 50% of resident participants had moderate to high mealtime needs determined by a rating of “C” or “D” on the Nutrition sub-scale of the ACFI (Australian Government, Department of Health and Ageing, 2008b); and (2) at least 50% of resident participants experienced moderate to severe communication difficulties confirmed by RACF staff and/or documented in the resident’s summary page of their file. To receive a rating of “C” or “D” on the Nutrition sub-scale of the ACFI residents must require either: (a) one-to-one physical assistance from another person to eat the majority of their meal (e.g., placing or guiding food to the residents mouth); or (b) supervision to eat (e.g., standing by to provide physical or verbal assistance) and one-one physical assistance to prepare to eat (e.g., cutting up or vitamising food). Potential resident participants were then further categorized based on classification across five ACFI sub-categories: (1) mobility, (2) verbal behaviour, (3) physical behaviour, (4) cognitive

skills, and (5) complex health care. Each of these sub-categories is rated on a 4-point scale (A = least need, D = highest need). Final sampling included variability across these categories (see Table 4.1). A total of 14 residents were recruited from the 19 who provided initial consent for their file and ACFI data to be reviewed for potential inclusion. The final sample included five men and nine women, aged between 60 and 99 years (M = 84 years; SD = 10.9 years). Length of residency in the RACF ranged from six months to 27 years (M = 5.1 years; SD = 8.3 years).

The purpose and procedure of the study was explained to interested residents verbally and in writing, using large font and picture symbols to aid comprehension. Written consent was obtained from all residents or their legal guardian prior to resident files being accessed. All resident participants were required to be English speaking; however, residents were not excluded based on their current communication or cognition abilities. Residents with an active palliative care plan were excluded.

Table 4.1 Resident maximum variation sampling characteristics

	Resident ID													
Sampling Categories	1	2	3	4	5	6	7	8	9	10	11	12	13	14
*Mobility	D	D	C	C	D	D	D	C	D	D	D	D	D	D
*Cognitive Skills	B	D	B	A	D	D	A	D	A	B	D	D	D	D
*Verbal Behaviour	B	B	D	D	D	D	A	D	A	C	D	D	D	D
*Physical Behaviour	B	D	D	B	D	D	A	D	A	C	C	D	D	B
*Complex Health Care	A	C	C	B	B	B	D	C	D	D	D	D	C	B
*Nutrition	C	D	C	C	D	C	C	C	C	C	C	D	C	D
# Communication	1	4	1	1	4	4	4	4	1	2	3	3	4	4

* (A = lowest care need, D = highest care need)

(1 = nil difficulty, 2 = mild difficulty, 3 = moderate difficulty, 4 = severe difficulty)

4.3.1.2. Staff participants.

Recruitment of staff participants was conducted as a two-step sequential process. Initially all RACF staff with direct resident contact were provided with written information about the study and informed they may be observed during their daily interaction with residents. Staff who did not wish

to be observed were asked to inform the Care Manager. No staff member declined observation. Following this, the staff member observed as the primary carer for the resident during each mealtime observation was approached to participate further. Inclusion criteria specified that all staff participants had worked with the resident they were observed with for a minimum of three months and had sufficient English skills to respond to a face-to-face survey. A total of 39 staff provided care to the residents during the observations, 29 met recruitment criteria and consented to participate further. Staff participants included 27 women and two men, aged 19-62 years (M = 36.2 years; SD = 12.6 years), from the following professional groups: assistant in nursing (n = 19), registered nurse (n = 7), recreation activity officer (n = 2), and enrolled-endorsed nurse (n = 1). Staff participants had worked with each matched resident participant for between 6 months and 14 years (M = 4 years; SD = 4.4 years) and for between 3-5 days per week.

4.3.2. Procedure

Data collection began with a review of resident files followed by mealtime observations, then the resident surveys and staff surveys. Data collection for the chart review and the mealtime observational assessments was completed by, a SP with 9 years experience working in aged care. To minimize observer bias, the researcher was independent to the setting and unfamiliar to both staff and the residents.

4.3.2.1. Resident's file reviews.

Once resident participants were selected, a comprehensive file review was conducted to identify: (1) the nature of any information relevant to mealtime management, and (2) the location of this information in each resident's file. Resident files included the residents care plan, ACFI summary, and progress notes (online and paper based).

4.3.2.2. Mealtime observations.

Each resident was observed during three mealtime sessions including one breakfast, one lunch, and one dinner mealtime, and on different days of the week to allow for variation between meal types and staffing. A total of 41 observations were completed with each mealtime observed in its entirety from meal set-up to completion. One observation session for one resident could not be completed due to resident illness. All observations were conducted by the primary researcher who took a passive role in the observations, maintaining a seated position adjacent to the resident and at a distance of between 2-4 meters from the resident. This distance ensured accurate observation of the mealtime but minimized disruption to the resident and staff. Sessions could not be video or audio recorded out of respect for the non-participating residents.

During the observations the researcher completed a purpose built form to record the mealtime in detail (Appendix F). Content of the form was based on a broad based literature review of factors influencing mealtime function and success including key articles such as Amella, (2004); Evans et al., (2003); Miller & Patterson, (2014); and Steele et al., (1997). The form categorized the mealtime into eight main sections: (1) mealtime environment, (2) location and seating, (3) meal presentation, (4) feeding assistance, (5) resident-staff interaction, (6) diet, (7) use of specific mealtime management strategies, (8) and researcher recommendations. The form was designed to be used by any health professional involved in mealtime care to provide a single rater perspective, identifying potential issues in mealtime management for further multidisciplinary evaluation.

4.3.2.3. Resident surveys.

Following the observations, residents were asked four questions: 1) Where do you like to eat? 2) How do you like your meals to be set-up? 3) What foods and drinks do you like? and 4) What foods and drinks don't you like? The intent of these questions was to gain an indication of individual residents' mealtime preferences enabling comparison with staff knowledge of these preferences. Of the 14 resident participants, 5 were unable to answer these questions, due to severe developmental delay (n = 1), poor medical state with decreased level of alertness (n = 1), and late stage dementia (n = 3). The resident survey was completed after the observations to maintain the researchers' independence and avoid bias during the observations.

4.3.2.4. Staff surveys.

Each staff participant completed a face-to-face questionnaire to explore their knowledge of the resident participants' mealtime needs and mealtime preferences. Staff were initially asked five questions: (1) Does the resident have any preferences about meal set-up or procedure? (2) Are there any foods or fluids that the resident prefers or particularly likes? (3) Are there any foods or fluids that the resident refuses or particularly dislikes? (4) Does the resident have a specific mealtime management plan or mealtime management recommendations, and (5) Does the resident eat their meals in their bedroom? Staff were then asked whether the resident required any of four specific types of mealtime assistance to complete their meal: (1) visual supervision, (2) verbal prompting, (3) physical assistance, or (4) special positioning. Responses were recorded as "yes" or "no". Staff responses of "sometimes" were recorded as "yes" (Appendix G).

4.3.3. Data analysis.

Data obtained from the file review, resident surveys, and staff surveys were initially analysed using qualitative content analysis (Patton, 2002). Yes/no responses from the staff survey,

documentation of specific mealtime management recommendations, and items from the mealtime observation form, were then further analysed using descriptive statistics calculating frequency counts and percentiles across the 14 files and 41 completed surveys and observations. Data obtained from the four data sources were then cross-compared to complete the process of triangulation. Categories identified through content analysis of the file reviews, resident surveys, and staff surveys were compared to identify similarities and differences between resident and staff responses and residents' documented mealtime preferences. Frequency counts of specific mealtime management recommendations in resident files were compared to staff yes/no responses and the observations to provide a direct comparison of documented, reported, and observed use of visual supervision, verbal prompting, physical assistance, and special positioning.

4.4. Results

Results obtained from each of the four data sources are discussed below followed by cross comparison to triangulate the analysis.

4.4.1. Resident File Reviews

All residents had information relating to mealtimes in several locations within their files including in their care plan, progress notes, and ACFI summary. Content analysis revealed five key categories of information but no consistency in the depth of information provided across different residents. The five categories of information were: formal assessment of mealtime difficulties by SPs and dieticians and resulting recommendations (present in 5/14 files); resident likes/dislikes and preferences for meal set-up and procedure (in 9/14 files); recommended meal texture and fluid consistency (in 14/14 files); strategies to facilitate the resident's mealtime experience (in 2/14 files); and informal report of mealtime difficulties and strategies to assist the resident by facility staff, medical officers, family members, and/or the resident (found in 9/14 files). Further analysis of these nine files identified that five of these nine residents required visual supervision, five required verbal prompting, three required full physical assistance, and four required special positioning during mealtimes.

4.4.2. Mealtime Observations

Both physical and verbal interaction between residents and staff during mealtimes was observed to be minimal. During a third (13/41) of the mealtime observations the resident ate alone. For most of these mealtimes, the resident ate alone in their bedroom with no staff interaction other than to deliver and collect the meal.

Across all the mealtime observations there was minimal to no natural ongoing resident-staff communication with 63.4% of resident-staff interaction coded as “no ongoing interaction” (26/41), 31.7% coded as “minimal appropriate interaction” (13/41), and 4.9% coded as “minimal inappropriate interaction” (2/41). All observations coded as either “minimal appropriate interaction” or “minimal inappropriate interaction” involved residents with moderate or severe communication difficulties. Therefore for residents with nil/mild communication difficulties, no ongoing resident-staff interaction was noted during any observation.

Both participating facilities had the capacity to seat all residents in dedicated lounge/dining areas for meals. Observation however revealed 70% of residents ate in their bedroom during more than one observation (29/41). Most residents were seated in recliner chairs for their meals. Almost all (40/41) meals were presented to residents with all courses on a single tray. Few environmental barriers to the mealtime due to odours, lighting, noise, or physical obstructions were noted during the observations. Despite the majority of residents eating in their bedrooms, level of privacy was rated as minimal or fair during 88% (36/41) of the observations. These ratings were assigned as a result of: 1) the presence of other residents and their family members in shared bedrooms, 2) staff in the room carrying out care tasks unrelated to the meal, and 3) observed lack of action to increase privacy for residents positioned in full view of the passing public such as by drawing a curtain or closing the resident’s door.

Each resident participants’ regular carer provided mealtime assistance during the majority of observations (39/41) with assistants in nursing delivering and collecting resident meals and providing mealtime assistance during 36/41 observations, family members during three observations, and during the remaining observations, a registered nurse and a kitchen staff member delivered one meal each. All residents received thin fluids during all observations. A normal diet was given during 34 observations, a soft diet during one observation and a puree diet during six observations. Modified cutlery was provided during three observations and modified crockery during 21 observations.

Visual supervision was observed during 13 observations (31.8%) and recommended as needed by the researcher during 20 observations (48.8%). Verbal prompting was observed during 6 observations (14.6%) and recommended by the researcher during 10 observations (24.4%). Physical assistance was provided throughout the entire meal during 14 observations (34.2%) and recommended by the researcher during 15 observations (36.6%). Residents were specifically positioned for their meal during six observations (14.6%) with special positioning recommended by the researcher during 18 observations (43.4%). Four residents in this study were legally required to be fed by a registered nurse based on their ACFI classification. Mealtime assistance for these

residents was, observed to be, provided by assistants in nursing and family members. During two observations no assistance to these residents other than meal-set up was observed. The assistance given to these residents was noted as insufficient in meeting the resident's mealtime needs during 7/11 observations with the resident observed to struggle to complete their meal (63.6%).

Overall, mealtime management was observed to be consistent throughout the duration of the meal during 80% of observations, and sufficient to minimise the resident's risk of mealtime related medical and nutritional complications during 61% of observations. Limited explicit management of residents' psychosocial mealtime needs was observed during all observations.

4.4.3. Resident Surveys

Content analysis of data from the resident survey indicated most residents had a preference for both general food groups (e.g., sweet vs. savoury), and specific food and fluid items (e.g., apple juice vs. orange juice). Five residents also expressed preferences regarding meal set-up and procedure such as requesting meal items to be placed in a set position on the table and given in a set order. All nine residents expressed specific opinions about where they would like to eat and their preferred level of privacy during meals, five of the nine residents preferred a high level of privacy during mealtimes.

4.4.4. Staff Surveys

Over half (56%) of staff indicated that to their knowledge the resident participant did not have any mealtime likes/dislikes or preferences. Staff reported that 68% of resident participants preferred a high level of privacy during mealtimes with 60% of residents eating in their bedroom at least "sometimes". Just over half (63%) of staff participants were not aware that the resident had documented mealtime management strategies. Of the four residents who had previous SP involvement, 33% of matched staff were not aware of these recommendations. Staff reported that 57.5% of residents required visual supervision, 57.5% required verbal prompting, 50.0% required physical assistance, and 52.5% required special positioning during their meal.

4.4.5. Triangulation of Data across Data Sources

Similar to the residents, staff reported residents preferred a high level of privacy during mealtimes; however, resident preference for privacy was not documented in any resident file. While all residents who completed the resident survey expressed specific mealtime preferences, over half of the staff participants were not aware of these. Resident mealtime preferences were documented

in only 9/14 resident files with the information provided being minimal and limited to resident preference for meal location and one or two specific food likes/dislikes.

During 51% of observations residents received a diet inconsistent with their documentation. In nearly all cases a normal diet was given instead of a soft or pureed diet representing an upgrade to the resident's documented diet. Modified cutlery was supplied to the one resident documented as requiring it during only one of the three observation sessions with this resident. This resident was observed to experience difficulty managing normal cutlery. Modified crockery was supplied to residents as documented during most observations (83%) with the resident observed to use this crockery without difficulty 76% of the time.

Comparison of recommended and observed use of: (1) visual supervision, (2) verbal prompting, (3) physical assistance, and (4) special positioning revealed marked inconsistency across data sources. Staff reported need for the use of all four types of assistance was higher than that documented, researcher recommended, or observed. Visual supervision, verbal prompting, and special positioning were also observed less frequently than documented as needed or researcher recommended.

Staff were observed to follow the residents documented mealtime recommendations during 51% of observations, 18% for residents with additional SP recommendations. Overall consistency in mealtime management across data sources for individual resident participants is illustrated in Table 4.2. Inconsistency in mealtime management can be seen for all residents, however, greatest inconsistency is seen for the four residents classified with the highest mealtime needs (rating of D) and for the one other resident with documented SP recommendations (i.e., residents 2, 5, 8, 12, and 14). Of these five residents, four were also classified as having severe communication difficulty, and one with moderate communication difficulty. For those residents where greater consistency in mealtime management was noted there were no distinguishing demographics other than a pattern of higher cognitive skills.

Table 4.2 Triangulation of data sources (file review, mealtime observations, resident survey, and staff survey) for individual resident participants

	Resident ID													
Mealtime Management Categories	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Diet	✓	x	✓	✓	x	x	x	x	✓	✓	x	✓	x	x
Crockery/Cutlery	✓	x	✓	✓	x	x	x	x	✓	x	x	✓	✓	✓
Meal Set-up	x	x	✓	✓	x	✓	✓	x	x	✓	✓	x	✓	x
Visual Supervision	✓	x	✓	✓	x	x	✓	x	x	x	x	x	✓	x
Verbal Prompting	✓	x	✓	✓	x	✓	✓	x	✓	✓	x	x	✓	x
Physical Assistance	x	x	✓	✓	x	✓	✓	x	x	✓	✓	x	✓	x
Special Positioning	✓	x	✓	✓	x	✓	✓	x	x	✓	✓	x	x	x
Other Strategies	✓	x	✓	✓	x	✓	✓	x	✓	✓	✓	x	✓	✓
Resident Preference	✓	x	x	✓	x	x	✓	✓	✓	✓	✓	x	x	x
Environmental Modifications	✓	✓	x	x	x	x	✓	x	x	x	✓	x	x	x
Resident-Staff Interaction	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total no. Categories Consistent (n/11)	8	1	8	9	0	5	8	1	5	7	6	2	6	2
% Categories Consistent	73	9	73	82	0	45	73	9	45	64	55	18	55	18

x = inconsistency between any two or more of the four data sources

✓ = consistency across all four data sources

4.5. Discussion

This study aimed to compare documented, reported, and observed mealtime management in RACFs to explore ongoing issues and interactions in holistic mealtime management for residents with varying mealtime needs. Triangulation of data sources provided multifaceted analysis of current mealtime management identifying inconsistency in mealtime management across staff and residents. Discrepancies were found between what was documented in residents' files, what was observed, and what staff reported residents needed. Past literature indicates mealtimes are highly valued by RACF staff (Crogan et al., 2001; Ullrich et al., 2014) and residents (Chan & Pang, 2007; Crogan et al., 2004; Palacios-Cena et al., 2013), however, data from this study revealed mealtime management continues to be limited in meeting residents' holistic mealtime needs.

Many care staff in this study were not aware that residents had documented mealtime management recommendations and most were unable to describe in any detail the mealtime preferences of residents in their care. These preferences were also poorly documented in residents' files. Lack of detail of information in resident files and progress noted in RACFs has been noted previously to be particularly problematic (Blackford et al., Pye et al., 2000; Ullrich & McCutcheon, 2008). Ensuring staff are aware of what is documented for residents is also a challenge, with studies noting that recommendations are often documented without verbal handover to care staff (Bennett et al., 2014 = Chapter 2; Pye et al., 2000; Ullrich & McCutcheon, 2008). Overall, in the current study, observed care did not reflect either documented care or the residents' reported preferences resulting in mealtime management strategies that were often poorly matched to the residents needs. These findings highlight a need for change at both management and service levels. There is a need for clear and specific documentation to be recorded regarding individual residents mealtime needs and better processes to ensure these needs are communicated with appropriate care staff.

Only four of the 14 (29%) residents in this study had previous SP involvement and any formal diagnosis of mealtime difficulties. Care provided to these residents was found to be less consistent than care provided to residents with lower level mealtime needs, raising concern for the wellbeing of these residents at most risk of mealtime complications. However it is also important to note that from a SP observer's perspective mealtime management was limited in meeting the holistic mealtime needs of all resident participants. Hence, although some residents were identified through documentation to have specific mealtime needs, as very few residents had undergone any formal mealtime assessment, the true extent of support needs for most residents in this study may be under identified. To confirm this, comprehensive multidisciplinary assessment of each resident's mealtime needs and observation of current mealtime care would be needed. Such assessment would

facilitate evidence-based identification of residents' mealtime difficulties and needs and inform the development of appropriate care plans to support individual residents during mealtimes.

However, more comprehensive resident assessment will only be beneficial if the resulting recommendations are adequately communicated to and followed by all involved staff. Adherence to SP recommendations in the current study was found to be poor, with staff observed to follow documented SP recommendations during only 2 out of 11 observations. This finding likely reflects the identified limitations in staff knowledge of residents documented mealtime management recommendations and suggests the need for increased communication between specialist health professionals and care staff. The need for greater staff awareness and understanding of mealtime issues has been highlighted numerous times in past literature with a consistent call for increased training for RACF staff in mealtime care (Aselage & Amella, 2010; Crogan et al., 2001; Pelletier, 2004; Reimer & Keller, 2009).

By Australian law, residents of RACFs rated as D on the ACFI sub-scale of Nutrition are required to be fed their entire meal by a registered nurse (Australian Government, Department of Health and Ageing, 2008b). However, this was not observed to occur for the four residents with this rating. This finding most likely reflects resource limitations long discussed in the literature, particularly limitations relating to time pressure and staffing (Bennett et al., 2014 = Chapter 2; Crogan et al., 2001; Kayser-Jones & Schell, 1997; Simmons & Schnelle, 2006). Of further concern was poor adherence to documented food texture. Texture modification is used as a therapeutic treatment for dysphagia with the prescription of specific foods or fluids dependent on the nature and severity of the difficulty. Non-adherence can place individuals at increased aspiration risk (The Dieticians Association of Australia and The Speech Pathology Association of Australia Ltd, 2007). These findings suggest residents are being placed at risk of medical and nutritional complications. This finding also has significant implications for facility funding and accreditation.

There has been long standing discussion about the importance of mealtimes as an opportunity for social interaction (Amella, 2004; Kayser-Jones & Schell, 1997; Philpin et al., 2011). Further, the quality of resident-staff interaction during mealtimes has been found to impact resident food and fluid intake, and resident satisfaction during mealtimes (Amella, 2004; Coyne & Hoskins, 1997; Evans et al., 2003; Hung & Chaudhury, 2011; Ullrich & McCutcheon, 2008; Van Ort & Phillips, 1995). Despite this, in the current study minimal resident-staff interaction was observed with most interaction during mealtimes being task-focussed consistent with past studies of resident-staff communication in RACFs (Carpiac-Claver, & Levy-Storms, 2007; Savundranayagam, 2014).

Also impacting social interaction during mealtimes, most residents ate in their bedroom limiting opportunity for social dining. This finding is, however, consistent with resident preference for increased level of privacy during mealtimes but inconsistent with the concepts of group and social dining. This finding suggests further research is needed to explore how residents define the concept of social dining in RACFs. This suggestion is supported by the findings of Adams et al., (2013), in comparing resident mealtime preference in the family home prior to admission and the RACF post-admission. The authors identified inconsistency between what residents viewed as facilitating a positive dining experience in RACFs compared to the family home and also recommended further exploration of resident mealtime and dining style preferences and further involvement of residents in mealtime preparation and planning (Adams et al., 2013). Philpin et al. (2014) again support this need, discussing the complexity of the construct of mealtime experience in RACFs, including the interplay between physical and sociocultural elements of the mealtime, and the importance of shared understanding about mealtimes between residents and staff.

Achieving shared understanding requires effective communication. In this study, minimal resident-staff interaction either verbal or physical was observed with the least resident-staff communication noted between staff and residents with minimal communication difficulties. While it is acknowledged that these residents often required less mealtime assistance and as such may not have been a priority for staff during mealtimes, they were the residents most capable of carrying an ongoing conversation. Hence, while limited resident-staff interaction during mealtimes may not have a significant impact on meal intake for these residents, it may have a significant impact on their psychosocial mealtime needs. Barnes et al. (2013) found similar results noting that residents' who were independent in meal intake were generally left to themselves. Pelletier (2004) however found contrary results with staff noted to initiate more ongoing and varied communication with residents' with better communication skills. Neither of these studies examined the nature of resident-staff communication as a major factor in their research. Exploration of resident-staff communication in this study, though adding valuable data, was also limited suggesting further research in this area is needed. Future research must also involve investigation of resident experience of resident-staff interaction and the mealtime care they receive, as well as exploration of resident-resident interaction during mealtimes.

The results of this study are strengthened by triangulation across data sources (Patton, 2002; Thurmond, 2001); however, several limitations must be acknowledged. Classification of resident mealtime difficulties in this study was based on the ACFI sub-category of Nutrition. Although this measure is used in RACFs to determine residents' mealtime needs and therefore directly mediates assistance given to the resident during mealtimes, the ACFI is not a diagnostic tool (Australian

Government, Department of Health and Ageing, 2008b). Assessment on the ACFI is limited in scope and cannot determine the nature or severity of the resident's specific mealtime difficulties nor does it provide recommendations for individualized mealtime management. Further analysis of mealtime management for residents' with differing mealtime needs would require thorough multidisciplinary assessment. Classification of resident communication difficulty in this study was largely subjective and therefore also problematic. Again, comprehensive multidisciplinary assessment of residents communication needs is needed, however, without assessment tools developed specifically for this population, thorough assessment of residents communication is also problematic (Hickson et al., 2005). Although measures were taken to reduce observer bias, including independence of the researcher to the setting and participants and the use of a rigid procedure and data collection protocol, future research would be strengthened by the inclusion of multiple raters from different disciplines.

4.6. Conclusion

By comparing data across multiple sources this study revealed inconsistency in mealtime management in RACFs, limitations in addressing residents' holistic mealtime needs, and lack of compliance with the principles of PCC. The study design and findings reiterate the complexity of achieving optimal care in RACFs. Barriers and challenges identified were not singular simple problems rather they were complex and arising from breakdowns and interactions at multiple levels from documentation to implementation. Facility management, specialists, researchers, and policy makers must acknowledge this complexity and work together to find sustainable solutions to further support residents and staff during mealtimes. Priority must also be given to comprehensive investigation of residents' psychosocial mealtime needs incorporating the perspective of the resident and exploration of resident-resident mealtime interaction.

CHAPTER 5

PERSPECTIVES ON MEALTIME MANAGEMENT IN RESIDENTIAL AGED CARE: INSIGHTS FROM A CROSS DISCIPLINARY INVESTIGATION

Investigation of current mealtime management in Chapter 4 revealed that while care provided during mealtimes is considered an explicit care task in RACFs, there are numerous limitations in current mealtime management. These limitations relate to: a narrow focus of management, including little consideration of residents psychosocial mealtime needs; inconsistent management; poor documentation of residents' mealtime needs and recommendations to assist residents during mealtimes; poor adherence to documented recommendations including those made by SPs; and limited staff knowledge about residents mealtime needs. Given that mealtime management, unlike communication management as revealed in Chapter 2, is considered an explicit care task in RACFs, increased understanding of the perceptions of service providers about the care they are currently providing may assist in understanding why current gaps in mealtime management as revealed in Chapter 4 and discussed in Chapter 1, are evident.

In Chapter 5 qualitative methodology is used to explore the perceptions of a range of RACF staff and SPs about mealtime management in RACFs. In doing so this chapter aims to explore the prioritisation of and global perspectives of a range of service providers involved in mealtime management. Insights gained will increase understanding of common challenges to mealtime management in RACFs, provide insight into why current gaps in mealtime management may exist, and will assist in achieving a shared understanding across different service disciplines to facilitate multidisciplinary aged care and guide future mealtime care.

The content of chapter 5 consists of the manuscript entitled *"Perspectives on mealtime management in residential aged care: Insights from a cross disciplinary investigation*" which was published by the Journal of Nutrition in Gerontology and Geriatrics, in November 2014. The manuscript has been inserted as published including the section unique to this journal "Take away points" with the exception of formatting and referencing changes that have been made to align with the style guidelines of the American Psychological Association and to maintain consistency throughout this thesis. The references specific to this paper have been included in the overall reference list of this thesis.

5.1. Abstract

Meeting the medical, nutritional, and psychosocial mealtime needs of aged care residents requires a holistic, multidisciplinary approach. To date the perspectives of this multidisciplinary team have not been adequately explored. The aim of this study was to explore the perspectives of a range of service providers involved in mealtime management in residential aged care.

In-depth semi-structured interviews were conducted with 61 participants from five service disciplines. Four themes emerged: (1) mealtimes are highly valued; (2) service providers face common barriers to mealtime management; (3) communication among service providers is challenging; and (4) education in mealtime management is limited.

Data indicated service providers acknowledge the importance of mealtimes but recognise numerous shortfalls in current care. The need for interdisciplinary training and increased communication and collaboration among providers was emphasised, including the need for clarification of provider roles. Limited consideration of mealtimes in policy and funding documents was identified as a primary barrier in prioritising mealtime management and advancing care.

Keywords: ageing, eating perceptions, health care, intervention

5.2. Introduction

Skilled nursing facilities, known as Residential Aged Care Facilities in the Australian context, provide permanent and respite accommodation for both semi-dependent (low-care) and dependent (high-care) older people. Services provided in residential aged care settings include: meals; cleaning and laundry services; assistance with activities of daily living; social activities; and skilled nursing care. In the 1990's a number of seminal studies investigated the broad nature of mealtime services in aged care settings (Hotaling, 1990; Kayser-Jones, 1996; Kayser-Jones & Schell, 1997; Sidenvall et al., 1994). These early studies emphasised the importance of recognising "eating" as a *"complex biological, social, cultural, behavioural, and symbolic phenomenon"* (Kayser-Jones, 1996). What we eat, where we eat it, and how much we eat was shown to be dependent on individual choice and a lifetime of habit (Kayser-Jones, 1996). The influence of the mealtime environment on both resident nutritional intake and psychosocial wellbeing was highlighted and within this the key role that service providers' play in both facilitating resident intake and creating a positive mealtime experience (Hotaling, 1990; Kayser-Jones, 1996; Kayser-Jones & Schell, 1997; Sidenvall et al., 1994).

Although financing, organisation, and accreditation differences exist across residential aged care settings in an international context, the importance of mealtimes and the need for individualised management of mealtime difficulties is well recognised and has been emphasised in the literature (Crogan et al., 2004; Davis & Spicer, 2007; Hung & Chaudhury, 2011; McCullough et al., 2007; Miller & Patterson, 2014; Palacios-Cena et al., 2013; Reimer & Keller, 2009; The Speech Pathology Association of Australia Ltd, 2012). To align service provision with local and international ageing policy, mealtime management must be both multidisciplinary and consistent with a person-centered care approach (Aged Care Act, 1997; Commonwealth of Australia, 2012; WHO, 2002). Delivering optimal mealtime management in residential aged care therefore requires adherence to policy, evidence-based practice, and a high level of communication and collaboration among key service providers.

Translating research and policy recommendations into daily care practice in residential aged care has, however, historically been difficult to achieve. One factor known to facilitate translation is the prioritisation and inclusion of service provider perspectives (Blackford et al., 2007; Halcomb et al., 2009; Kaasalainen et al., 2010; Lindeman et al., 2003; Perry et al., 2011). Specifically pertaining to mealtime management, it is known that registered nurses and assistants in nursing perceive time and resource constraints, poor food quality, and lack of teamwork among facility staff to limit mealtime management in residential aged care (Crogan et al., 2001). However, implementation of mealtime management in aged care is not only dependent on nursing staff. In recognition of the wide range of service providers involved in mealtime management in this context, and to provide greater insight into the teamwork challenges identified in past literature, further exploration of the views and perceptions of all service provider perspectives about mealtime management is needed. There is also a need to examine service providers' perceptions of residents' medical and psychosocial mealtime needs in addition to their nutritional mealtime needs in order to explore issues impacting holistic mealtime care. Therefore, the aim of this study is to explore the perspectives of a range of service providers involved in mealtime management in aged care settings. By exploring the perspectives of multiple service providers involved in mealtimes and taking a holistic approach to mealtime management, it is the intent to identify common factors which could be targeted in the future to enhance mealtime management in residential age care.

5.3. Methods

5.3.1. Research Strategy

A qualitative descriptive methodology was adopted to explore the perspectives of a range of service providers involved in mealtime management in high-care Australian Residential Aged Care

Facilities. Qualitative descriptive methodology provides a comprehensive summary of an event or phenomena in everyday lay language while also providing valid and accurate accounts of the meaning attributed to identified events and phenomena by the research participants (Maxwell, 1992). Purposive criterion sampling was used to collect information rich data across cohorts, increasing the potential to identify issues of central importance to the aims of the study (Patton, 2002). Participants were recruited into five participant groups: (1) speech pathologists (SPs); (2) care managers (CMs); (3) nursing staff (NS); (4) assistants in nursing (AINs); and (5) care, domestic, and support staff (CDSS). SPs were included as an external provider of specialist mealtime management services contracted on an as needed basis. Care managers were included to provide a facility level management perspective, and nursing staff and assistants in nursing were included to provide two different nursing perspectives. The care, domestic, and support staff participant group was included to represent a range of other facility staff involved in mealtime management. This group included five kitchen staff, four lifestyle/recreation activity officers, four personal carers, two general support staff, and one volunteer. Participant demographic data is provided in Table 5.1.

Table 5.1 Participant demographics

Participant Group	Participants	Age (Yrs)	Yrs of Experience
		M(SD)	M(SD)
Speech Pathologists (SPs)	F = 10 M = 0	44.6 (11.12)	18.3 (11.88)
Care Managers (CMs)	F = 10 M = 0	48 (11.06)	23.5 (11.87)
Nursing Staff (NS) Registered Nurses, Endorsed-enrolled Nurses	F = 10 M = 0	48.6 (12.45)	23.3 (13.06)
Assistants in Nursing (AINs)	F = 14 M = 0	45 (13.01)	9.3 (8.00)
Care, Domestic and Support Staff (CDSS) Kitchen Staff, Recreation and Lifestyle Staff, Domestic Support Staff, Volunteer	F = 16 M = 1	47.4 (11.58)	9.2 (6.49)

SP participants were recruited through the public directory of speech pathologists provided on The Speech Pathology Association of Australia Ltd website (The Speech Pathology Association of Australia Ltd, n.d.). Care manager, nursing staff, assistants in nursing, and care, domestic, and support staff participants were recruited through 10 high-care facilities in rural and metropolitan New South Wales, Australia. These facilities were governed by two aged care providers: one large international for-profit entity, and one nationally operating not-for-profit religious organisation. Six of these settings were metropolitan and four were regional. All with bed capacity within the national average range (Australian Institute of Health and Welfare, 2012). All participants included in the study were required to: have functional English skills adequate for an interview, be working with residents at the time of recruitment, have at least six months prior experience in their current role and twelve months qualifying experience in their occupation.

5.3.2. Procedure

Data was collected through semi-structured in-depth interviews. Individual interviews were conducted with the SP, care manager and nursing staff participants. Focus groups (FG) of three to five participants were conducted with the assistant in nursing and care, domestic, and support staff participants. With assistant in nursing and care, domestic, and support staff participants holding a position of lesser authority within facility staff hierarchy, focus groups were chosen to provide opportunity for validation of participant responses through discussion of shared experience among a peer group (Kruegar & Casey, 2000; Madriz, 2000).

Open-ended questions within a semi-structured interview guide were used to gain participant perspectives of: prioritisation of mealtime management, level of confidence and training in mealtime management, the perceived impact of mealtime difficulties on resident wellbeing, and barriers and facilitators to current mealtime management. Individual and focus group interviews were conducted either face-to-face or via telephone, with the delivery method chosen to suit the location and availability of the participants. All interviews were audio-recorded and transcribed verbatim with the accuracy of transcriptions checked by a second analyst. Interview duration ranged from 15 to 67 minutes. The first author (MB), a speech pathologist with experience working in residential aged care, conducted all individual and focus group interviews. Permission for this study was granted by, the Behavioural and Social Sciences Ethical Research Committee of The University of Queensland, Australia and the participating aged care service providers.

5.3.3. Data Analysis

The framework approach to analysis (Ritchie & Spencer, 1994) was used as the basis for qualitative content analysis. The benefit of the framework approach is the use of clearly defined stages of data analysis (see Table 5.2) thereby increasing transparency in the process of analysis and strengthening the validity of the research findings (Pope et al., 2000; Ritchie & Spencer, 1994). Transparency in the analysis is also essential when aiming to influence policy direction and service change (Pope et al., 2000).

Table 5.2 Steps of data analysis

Step	Description
1	Initial reading and re-reading of the transcripts to familiarise the analysts with the data and gain an overall sense of key meanings and ideas within each interview.
2	Comparison was made across transcripts from the same participant group with the data charted to represent key themes and ideas relevant to that group. Themes and categories charted within each participant group were inclusive to represent the data in its entirety.
3	Comparison was made between the two analysts and subthemes were modified until consistency between the analysts was reached. Disagreement, overlap, or ambiguity in themes or subthemes not resolved by (MB) and (MW) were discussed with the second and third authors (EW) and (NS) until consensus was reached.
4	Comparison was made across participant groups and themes and subthemes rearranged to identify similarities and differences across groups.
5	Data from all participant groups was synthesised into a single analysis containing themes common across participant groups.

Following the analysis member checking was conducted to invite participant comments about each identified theme and subtheme specific to their participant group, and to answer a small number of open-ended additional questions arising from unexpected concepts evident in the data. Participant feedback was used to further refine the themes and subthemes increasing the validity of the analysis and accuracy in the interpretation of participant views (Hoffart, 1991). Completed member checking documents were received from 32 participants with the documents indicating overall agreement with the summary provided.

5.4. Results

Analysis of the interviews identified four themes common across participant groups: (1) mealtimes are highly valued; (2) service providers face common barriers to mealtime management; (3) communication among service providers is challenging; and (4) education and professional support in mealtime management is limited.

5.4.1. Theme 1: Mealtimes are Highly Valued

Mealtimes were highly valued across all participant groups with mealtime management rated in the top three of care tasks along with personal care and medication provision by the majority of participants. Multiple groups (speech pathologists; care managers; assistants in nursing; care, domestic and support staff) emphasised the importance of mealtimes in maintaining optimum nutrition and general health, specifically discussing the importance of adequate nutrition and hydration in maintaining weight, facilitating wound healing, and preventing infection. The importance of mealtimes as an opportunity for social interaction was highly valued by most groups. Comparing nutritional and psychosocial mealtime needs, one SP stated, *"I think people would give up optimum nutrition in order to have a meal that's less nourishing in the company of friends"* (SP01). Facility staff emphasised the opportunity that mealtimes offer for encouraging one-on-one and group social interaction among residents, and between residents and staff.

Many participants discussed the direct influence of mealtimes on resident QOL, *"I would say that in residential care it's perhaps right up there with priority number one or two… it is the one thing they wake up for most days"* (CM06). Mealtimes were described by care manager, nursing, and assistant in nursing participants as being "time keepers" in residential aged care, with residents planning their days around each meal rather than time itself. Participants reflected on how they would feel if they experienced difficulties during mealtimes or were subjected to an impoverished mealtime environment describing associated feelings of anxiety, depression, and embarrassment. Participants noted similar feelings among residents, *"You know their self-esteem is*

poor, if you have a stroke and you can't manage, to have someone, a young person feeding you must be terribly frustrating" (NS09).

5.4.2. Theme 2: Service Providers Face Common Barriers to Mealtime Management

Participants discussed numerous barriers to mealtime care and the provision of assistance to residents with mealtime difficulties including the impact of time pressure, limitations in funding for mealtime management, and a perceived divide between best practice and current care. The negative impact of low staff to resident ratios during mealtimes left assistant in nursing participants feeling pressured to complete resident meals quickly, at times resulting in less than optimal care practice, "*just the extra staffing so you're not under pressure to get that feed done to get to the next feed and the next feed"* (AINFG01). Kitchen staff discussed time pressure on meal service both in delivering meals and in ensuring meals were returned to the kitchen in a timely manner to allow adequate time for preparation of the next meal. SPs described the nature of SP service provision in residential aged care as largely an *"in and out"* (SP03) service due to time constraints. One SP stated, *"I'm aware of everything but there are time limitations, I know I've got to hurry up and get out of there"* (SP01). One-off SP assessment consultations were reported to be common, with review assessments or follow up contact limited. Care managers perceived lack of availability of SPs to be a key barrier to mealtime management.

SPs held strong views about current funding of mealtime management including facility willingness to allocate funds to mealtime management. SPs felt that current funding limited repeat services and the scope of services provided, *"on the whole you don't get that follow up phone call because it cuts into their budget"* (SP04). CMs agreed, commenting on the challenges of funding mealtime management under current governing legislation and with current staffing levels, *"As funding for swallowing goes, we have one registered nurse here, if we can claim funding for a person with swallowing, the registered nurse has to give them their whole meal, everything they consume which is impossible for one registered nurse to do for 61 people"* (CM05).

All participant groups expressed that current mealtime management did not always reflect best practice but all provided suggestions to improve both meal quality and the mealtime experience for the residents. Care managers and nursing staff expressed that they would like to enhance the presentation and variety of resident meals. Assistants in nursing felt that lack of variety and poor meal presentation had a direct negative impact on resident compliance during meals and meal intake. Kitchen staff stated that while they would like to implement recommendations to enhance meal presentation, inadequate kitchen space prevented the introduction of new equipment and additional procedures. Assistants in nursing, and care, domestic and support staff participants also

discussed the impact of inadequate space in dining areas to seat residents in wheelchairs and recliner chairs, meaning that many residents ate in their bedroom rather than in a social dining environment. Recreation staff discussed the need for menus written in lay rather than *"fancy"* (CDSSFG04) language, stating that on occasion they themselves had difficulty understanding the menus and therefore difficulty explaining the meals to residents to facilitate meal choice. Both assistants in nursing, and care, domestic and support staff participants also advocated for a return to a 'fine dining' atmosphere through the use of quality tablecloths, napkins, cutlery and crockery, and separate presentation of meal courses.

SPs commented that their role in mealtime management in aged care is very limited and inconsistent with speech pathology scope of practice (The Speech Pathology Association of Australia Ltd, 2003). SPs described a heavy focus on the management of 'swallowing' with 'swallowing difficulties' being the most commonly reported reason for referral to their service. Recommendations relating to texture modification and positioning were commonly described, with little active intervention discussed. Despite this, SP participants did express a desire to provide a greater range of services, in particular, to facilitate resident independence and enhance the naturalness of the mealtime environment. Profession specific issues were also noted by SP participants including lack of consistency in policy guiding SP services in aged care settings and a lack of SP assessment and therapy resources developed specifically for the resident population.

5.4.3. Theme 3: Communication among Service Providers is Challenging

Multiple issues drawing attention to professional roles and clarity in these roles were raised across participant groups. These issues stemmed largely from limited interprofessional communication. Participant discussion revealed a disparity between staff assigned with the overall responsibility for mealtime management and staff providing direct care during mealtimes. For example, care managers commented that while they are responsible for overseeing resident care plans, registered nurses are responsible for ensuring mealtime recommendations are appropriate and followed, while assistants in nursing are in reality those carrying out the recommendations. When asked who is primarily responsible for mealtime management, all participant groups said the *"registered nurse"*. All participant groups felt that disparity in role allocation and responsibility negatively impacted mealtime management. Communication breakdown among facility staff about mealtime management was reported to be a common occurrence, attributed to, shift changes, time demands, and on occasion poor relationship development among the staff body, *"The lack of communication sometimes, you know Arthur doesn't know what Martha's doing"* (AINFG04).

Discipline specific concerns relating to poor communication were also evident. Assistants in nursing felt they received little support in providing mealtime management, *"I'm not sure if we actually get support as much, were pretty much left to get on with it, fend for yourself"* (AINFG01). Assistants in nursing also commented that while they are alert for signs of mealtime difficulties, their reports of concern about resident difficulties were at times dismissed leaving resident difficulties unaddressed. Nursing staff commented that while they acknowledge they are responsible for mealtime management they cannot be in all places at once therefore it was difficult to ensure all staff followed recommendations consistently, *"Not every staff member follows the instructions the same way, even though they do read the report, the interpretation is sometimes different for different staff"* (NS08). SPs expressed a similar concern stating that with follow up consultation being rare, they had little knowledge of whether recommendations they made were read by relevant staff or the degree to which they were followed, *"There's just so many shifts that have access to the recommendations, making sure when you're not there that it information is followed, its very difficult"* (SP10).

Communication and collaboration between facility staff participants and SPs was discussed extensively across participant groups. Most facility staff viewed the role of SPs in aged care as limited to the management of 'swallowing' but valued the role of SPs in managing swallowing difficulties. A minority of care manager and nursing staff participants questioned whether speech pathology consultation was necessary on all occasions where residents experience mealtime difficulties. These participants felt that registered nurses had the skills to assess mealtime difficulties and modify the texture of diets in many cases, reporting that registered nurses in their facility readily made texture modifications to residents' diets. The most common change reported was to place residents on a puree diet and thickened fluids without specification of the degree of thickening.

Most facility staff indicated they would, however, like more involvement with SPs. Care managers indicated that they would like SPs to be more readily available and/or employed as internal staff to provide more frequent and ongoing services. Limiting this need, one care manager commented that they often had difficulty finding SPs with experience and interest in working in aged care, *"One of the difficulties I've had is finding someone who is interested in coming and doing the kinds of assessments that are required for our residents, they don't have the expertise or they're not interested in dealing with our population of people"* (CM01). Nursing staff, assistants in nursing, and care, domestic, and support staff participants commented that they would like to be present for and have greater involvement during SP consultations. This request included recreation staff who stated that while mealtime assistance was not technically in their job description, in

practice they do assist residents during mealtimes particularly on outings where nursing staff are not present. Recreation staff commented that they find this role particularly challenging, with one participant stating *"Some residents I don't want to take on an outing where there is food involved, because of the risk, I'm frightened, the risk is too high"* (CDSFG01).

Many SP participants were less complimentary in their descriptions of communication and collaboration. These participants did acknowledge barriers faced by facility staff including: limited staffing, high staff turnover and shift changes, commenting that these barriers had a negative impact of facility consistency in the preparation of texture modified diets and fluid consistencies and the following of SP recommendations. One SP described working in residential aged care as being akin to working in a "war zone" stating, *"You have to run in, its like triage, this is the one thing I really want you to do, please do it, and what's the best way to get that message across?"* (SP01). Another SP commented, *"I think the actual facilities don't always facilitate best practice, I mean that's not their core business to facilitate SP best practice"* (SP04). One SP did expressively highlight the role SPs as specialists in mealtime management must take in advocating for best practice mealtime care and in taking a lead role in communication and relationship development with facilities. This SP stated, *"We as SPs have the responsibility to talk to residents and family members, educate on what services we can provide, the cost and what we think would be a realistic outcome"* (SP08).

Where positive relationships between SP and facilities were described, participants commented they had invested large amounts of time over an extended period developing the relationship across staffing levels and roles. Care managers and SP described a positive impact on service provision resulting from this relationship development, associating the ability to provide new and innovative services in aged care with this collaboration, *"I have a relationship where I can go to people and see if I can set up new services because they know me well, they've seen me work with a number of residents and they've seen the improvement in the residents, all those things combined have made for a very positive atmosphere"* (SP08).

5.4.4. Theme 4: Education in Mealtime Management is Limited

All participant groups highlighted limitations in their training about mealtime management. Among facility staff, kitchen staff had received the most training with all kitchen staff having had received training on food hygiene and safe food handling. In addition, two kitchen staff participants had received training on meal preparation and presentation. This training provided by occupational health and safety officers and representatives for thickened fluids and pre-made texture modified meals. With the exclusion of one assistant in nursing participant who had received training on the preparation of texture modified foods and fluids by a SP, no other facility staff participant had

received any formal training in the workplace about mealtime management. Facility staff reported they gained most skills in mealtime management through on the job experience. This point was heavily emphasised by assistant in nursing participants, those carrying out the majority of mealtime recommendations. Care managers also discussed limitations in assistant in nursing training, "*We have a buddy system and rely heavily on that buddy to help, or assist, or point them in the right direction"* (CM07).

SPs also sought increased opportunity for profession specific education and training. They commented that the mealtime environment and global focus on mealtimes is very different in residential care settings compared to acute settings and therefore requires a different management approach. Specifically SPs expressed a need for increased knowledge of the systems of care and legislation governing aged care services, more dementia specific training, and greater understanding of expectations of resident outcomes. They also expressed a desire for increased availability of profession specific special interest groups and peer support opportunities for SPs working in aged care settings.

All participant groups felt that increased training may facilitate consistency of care, adherence to recommendations, and shared understanding and collaboration among service providers. Practical and hands-on training was valued by all RACF staff. Care managers rated education on mealtime management as a high priority but commented that ambiguous guidelines and/or limited mention of mealtime management in governing legislation made it difficult for facilities to allocate funds to this area, *"To the education department I don't think it's a priority because they work under legislation, but being an educator myself and a manager I think it's quite important"* (CM08). Most participant groups also noted they had limited knowledge of legislation, policy and funding initiatives influencing mealtime management, with care managers and SPs commenting this limited knowledge impacted both the frequency and scope of services sought. Lack of knowledge of in-house policy and documentation of mealtime management strategies such as in care plans by assistants in nursing and care, domestic, and support staff was also noted by care managers and nursing staff to have a negative impact on the appropriateness and consistency of mealtime care. SPs acknowledged they provide limited education to facility staff about mealtime management, with education that has been provided being limited to the use of texture modified foods and fluids, safe swallowing, and signs and symptoms of dysphagia. No SP participant had ever provided an in-service about managing the mealtime environment, providing rehabilitative intervention, or facilitating social interaction during mealtimes.

5.5. Discussion

This study is the first to explore mealtime management in residential aged care from the perspective of a wider range of service providers. While all service disciplines in this study recognised the importance of mealtimes as a biological, social, and cultural event, it is clear that service providers across disciplines face similar barriers in delivering mealtime care. Key barriers identified relate to: time and funding constraints, restricted scope of service provision, insufficient clarification of service provider roles, poor interprofessional communication, deficits in education and training, and limited policy guidance pertaining to mealtime management. These findings suggest that despite alignment between past research recommendations, aged care policy, and an international health focus on multidisciplinary care, PCC and QOL (Aged Care Act, 1997; Commonwealth of Australia, 2012; Davis & Spicer, 2007; Hung & Chaudhury, 2011; Miller & Patterson, 2014; Reimer & Keller, 2009; WHO, 2002) these premises and philosophies are yet to be effectively translated to daily care.

Findings from this study confirm that issues with interprofessional communication and collaboration persist (Blackford et al., 2007; Crogan et al., 2001; Halcomb et al., 2009; Kaasalainen et al., 2010; Lindeman et al., 2003; Perry et al., 2011). Perspectives of both facility staff and SPs confirm there are ongoing issues with multidisciplinary care in residential aged care settings (Davies et al., 2011; Halcomb et al., 2009) with a work environment that fosters open and equal communication and mutual respect across staffing levels and in decision making yet to be achieved. Poor role description, disparity between responsibility for mealtime management and hands on mealtime assistance, as well as difficulty communicating recommendations and concerns about residents across facility staffing levels and between facility staff and SPs were areas raised as being of particular concern in this study. The findings of this study support past recommendation for the explicit planning of multidisciplinary care in residential aged care settings and the use of direct strategies to increase understanding across disciplines about provider roles (Halcomb et al., 2009). These findings also support the call (Davies et al., 2011) for the development of service specific guidelines to facilitate collaboration and consistency in service provision.

It was evident from provider perspectives that a gap exists between current mealtime management and best practice, with deficits relating to the consistency of care, mealtime staffing and time requirements, meal quality and presentation, the physical mealtime environment, and the scope of SP services noted. SPs explicitly stated that current service provision was inconsistent with profession specific advancements, clinical guidelines, and research recommendations for best practice (Davis & Spicer, 2007; Hung & Chaudhury, 2011; Miller & Patterson, 2014; Reimer & Keller, 2009; The Speech Pathology Association of Australia Ltd, 2012). It was also evident that

limitations in education relating to mealtime management raised in past studies remain (Aselage & Amella, 2010; Crogan et al., 2001; Pelletier, 2004; Reimer & Keller, 2009). Participants in this study emphasised the need for interprofessional education to facilitate cross discipline communication and to clarify service provider roles and responsibilities for mealtime management, again illustrating the negative impact of poor communication and collaboration.

Adding new data, this study highlights the practical implications of poorly defined classification and descriptive guidelines, and policy and legislation pertaining to mealtime management. Limited definition of mealtime needs within funding guidelines was seen to have a direct negative impact on the frequency and scope of services sought and provided, and on the provision of education and training. Knowledge translation and consistency in terminology between policy and practice present a persistent problem across the health sector. This issue will remain until such time as increased collaboration between clinicians, researchers, and policy makers is achieved (Armstrong & Kendall, 2010).

This study extends knowledge of service provider perspectives about mealtime management in residential aged care settings, however, a number of limitations of this study must be acknowledged. This study incorporated a single external service discipline (speech pathology) involved in mealtime management. In future studies the perspectives of additional external service disciplines including dieticians should be obtained, as should the perspectives of family members and friends, and the residents themselves. In addition, further exploring which key strategies service providers believe could make the biggest improvements to service change would help provide greater insight into which issues should be prioritized in intervention and increased education and support for staff. Finally, it is acknowledged that all researchers involved in this study were SPs increasing the potential for bias in the interpretation of the data. Attempts were made to minimize this bias by having two clinicians' complete independent analyses of the data (one with and one without clinical experience in working in aged care). Member checking was also used to clarify participant views and the accuracy of the analysis.

5.6. Conclusion

Exploring the perspectives of providers involved in mealtime management in residential aged care it is clear that numerous barriers continue to limit daily care. In particular, time and funding limitations, limitations in education and interprofessional communication and collaboration, a narrow focus of intervention, and issues with restrictive policy remain. These are core issues faced by all facility staff and external service providers and are not specific to nursing alone. It is critical that all efforts are directed into exploring different ways to address these long

standing issues and systematically evaluate their efficacy. In doing so, appropriate and effective service provision models specific to mealtime management in aged care may be developed. When implemented such models may finally see more effective and sustainable translation of research and policy recommendations to care practice.

Take Away Points

- Mealtime management in aged care settings continues to be limited by numerous barriers to optimum care.
- The multiple service providers involved in mealtime management report similar service challenges and seek solutions to improve practice both within and across disciplines.
- Interventions designed to target long standing issues with mealtime management must be implemented across the range of service providers involved in mealtimes in order to address common challenges and affect change.

CHAPTER 6

SUMMARY, LIMITATIONS, IMPLICATIONS FOR CLINICAL PRACTICE AND FUTURE RESEARCH, AND CONCLUSION

6.1. Overall Summary

This thesis was submitted in a "thesis by partial publication" format, comprising four separate publications. Of these publications, one is provided in its published form (Chapter 2), one in its accepted form (Chapter 5), and two in their submitted form (Chapters 3 and 4). The four studies comprising these chapters revealed that service providers working in RACFs, including SPs, share a common love of working in the setting (Chapter 2). However, these service providers face numerous barriers to the provision of optimal care with many of these barriers common across care tasks and service disciplines (Chapter 2). The findings also demonstrate that there are vast differences between the breadth and scope of the management of communication difficulties in RACFs compared to mealtime difficulties. Neither current communication nor mealtime management in RACFs was found to be consistent with the principles of PCC, or the facilitation of active ageing and resident subjective wellbeing. In addition, evidence of explicit consideration of resident perspectives about their communication and mealtime needs, and evidence of multidisciplinary care was limited (Chapter 3, 4 and 5).

6.2. Chapter Summaries

A review of past literature in Chapter 1 provided a comprehensive background to the current thesis. It began with an overview of the complexity of working in RACFs and considered the influence of policy, reform, and specific terminology including, active ageing, PCC, and QOL, on service provision in RACFs. The use of specific terminology in this thesis was outlined including rationale for its use. The role of RACF governance and accreditation as well as the need for interprofessional communication and collaboration in RACFs was explored, followed by a discussion of considerations specific to speech pathology service provision in the setting. These included: funding of speech pathology services in RACFs; advocacy of speech pathology services in RACFs; and known challenges and considerations when working with older people, including the importance and difficulty of maintaining residents' right to autonomy and active decision making. These considerations were discussed to enable understanding of the wider influences on both broad service provision and speech pathology involvement in RACFs. An understanding of these influences is necessary to align care in the setting with current aged care sector

recommendations to enhance multidisciplinary care, work in a manner consistent with PCC, and facilitate resident QOL.

Following this discussion, what is known from past literature about the nature of communication and mealtime difficulties in RACFs and the impact of these difficulties on QOL was outlined before a discussion of the management of communication and mealtime difficulties in RACFs, including the role of SPs in providing this care. Literature review revealed that few studies have investigated the holistic management of either communication or mealtime difficulties in RACFs from either within the speech pathology field or broader health literature. Most research to date has focused on specific difficulties such as dysphagia, specific populations such as Dementia, or the broad influence of the RACF environment on residents as a collective group. Very few studies have explored either communication or mealtime management in the context of daily care, considerate of the nature and severity of individual resident need, and involving a range of service providers. Even fewer studies have attempted to gain resident perspectives about their own communication and mealtime difficulties and needs. These research gaps exists despite longstanding acknowledgement of the multi-factorial nature of communication and mealtime difficulties experienced by older people, and the known complexity of working in RACFs.

Both communication and mealtimes have a key influence on the QOL of older people, including residents of RACFs. Relating to communication, it is further argued, that without effective communication effective collaboration with older people cannot occur and therefore the principles of PCC cannot be upheld nor can active ageing be facilitated. Mealtimes, in addition to having a key impact on resident nutrition and medical status, also provide key opportunity for social interaction among residents of RACFs and between residents and staff, and provide residents with an opportunity to assert their independence and self-identify. As a result, mealtimes must also be prioritised in order to facilitate resident QOL, and to meet aged care policy and reform objectives.

The complex nature of service provision in RACFs is illustrated throughout Chapter 1, highlighting the specialist nature of care provided in the setting. To facilitate care in RACFs, including the advancement of communication and mealtime management, multidisciplinary models of care specific to the setting are needed. To develop such models, an understanding of current communication and mealtime management in RACFs is required including an understanding of known barriers to care and the influence of these barriers on communication and mealtime management. An understanding of the perspectives of service providers currently working in the setting as well as an understanding of individual and population level need for services by the inclusion of resident perspectives must also be obtained.

At present there is an insufficient research base to enable this understanding. This thesis has sought to begin to address gaps in previous literature by exploring current communication and mealtime management in RACFs considerate of: the context of care, documented recommendations, observation of resident-staff communication and mealtimes, individual resident need and resident perceptions, and staff perspectives and knowledge about residents' communication and mealtime difficulties and needs. Specifically this thesis aimed to: (1) obtain a more holistic and representative view of factors that influence optimal care in RACFs, identifying challenges and motivators to working in the setting for a range of service providers; (2) explore communication and mealtime management in RACFs examined in the context of daily care and considerate of documented, resident reported, and staff knowledge of residents' communication and mealtime needs; and (3) explore the perspectives of a range of service providers involved in mealtime management in RACFs to identify shared and disparate issues influencing care.

Chapter 2 aimed to explore the perspectives of five professional groups about challenges and motivators to working in RACFs. These included: (1) care managers; (2) nursing staff; (3) assistants in nursing; (4) care, domestic, and support staff; and (5) SPs. In total 61 participants were recruited from across these professional groups with data collected through semi-structured individual and focus group interviews. Data from these interviews was analysed using qualitative content analysis guided by the framework approach to analysis (Ritchie & Spencer, 1994). The results of Chapter 2 are consistent with previous studies (Davies et al., 2011; Halcomb et al., 2009; Reed et al., 2005) identifying a lack of multidisciplinary care in RACFs. Limitations in multidisciplinary care exist despite both policy and research advocating for increased interprofessional communication and collaboration in RACFs. This finding also demonstrates continued difficulty in translating research and policy recommendations to daily practice, reminding both researchers and policy makers that service change cannot be achieved without explicit planning, support, and consideration of known barriers to service provision and service change in the setting. Consistent with previous research both RACF staff and SPs felt that achieving service change, including implementing new services in RACFs, was directly related to the development of collaborative ongoing professional relationships among RACF staff as well as with external service providers and family members. Both RACF staff and SPs felt ineffective communication led to service provision *"falling apart"* and resident care diminishing, particularly for residents with communication difficulties who have a reduced ability to communicate their care needs. This places residents with communication difficulty in a position of increased vulnerability, vulnerability that could be reduced by the provision of appropriate communication intervention.

Extending previous research the results of Chapter 2 revealed a greater negative impact of ineffective staff communication and collaboration for RACF staff holding lower positions within the RACF staff hierarchy, in comparison to either more superior RACF staff or SPs. Assistants in nursing are one such professional group, however, they are those staff who provide the most frequent care to the residents including assisting residents during mealtimes. Assistant in nursing participants recognised that their own morale had a direct impact on resident morale such that when they struggled to present themselves with a positive persona to the residents, resident morale also decreased.

The inclusion of SPs as a participant group in Chapter 2 was integral to the extension of previous research about barriers to optimal service provision to external service providers. Like other RACF staff, SP participants reported they chose to work in RACFs largely because of a love of the work they do as well as a sense of giving back and caring for older people. SPs also shared very similar perceptions about the negative impact of limited time, staff, funding, and physical resources on service provision to those expressed by RACF staff. Further, consistent with RACF staff across all professional groups involved in this thesis, SPs expressed strong feelings that despite service provision in RACFs being a specialist area of care, this view remains largely unrecognised by health professionals working in other health care settings as well as by the community and health sector at large. SPs acknowledged there is a clear need for more discipline specific support, education, and professional development for those working in RACFs. This finding is particularly pertinent considering the lack of profession-specific guidance for SPs in RACFs highlighted in Chapter 1.

All participants felt that ageism continues to have a significant negative impact on the ability of service providers to deliver quality care in RACFs. In addition, despite the fact that participants regardless of professional group shared a love of working in aged care, participants from across all groups felt that differing motivations and priorities of care across service disciplines at times hindered optimal and effective multidisciplinary service provision. This finding again reiterates the need for increased interprofessional communication and collaboration to develop shared understanding across professional groups, and a united base for advocacy of service provision in RACFs.

Discussion of the impact of resident specific difficulties in Chapter 2 focused on the impact of resident cognitive and communication impairment on staff ability to provide consistent and quality care. RACF staff also emphasised the pivotal influence of resident-staff relationship development on the facilitation of resident QOL and staff workplace satisfaction. These findings reiterate the importance of effective resident-staff communication and therefore the need to

prioritise communication management. Despite participant emphasis on the need for effective communication with residents, communication management per se was not discussed by participants as being an explicit care task. These findings led to the study described in Chapter 3 exploring current communication management in RACFs. With mealtimes also providing a key time for socialisation and resident-staff communication in RACFs as well as having a key impact on QOL, the need to investigate current mealtime management in RACFs was also evident and was carried out in Chapter 4.

In both the studies described in Chapters 3 and 4, triangulation of data was used to generate a description of current communication and mealtime management as close to truth as possible (Patton, 2002; Thurmond, 2001). While previous research discussed in Chapter 1 highlighted a number of potential factors influencing communication and mealtime management in RACFs, very few studies had adopted a holistic approach to explore the impact of and interactions between these factors. In Chapters 3 and 4, analysing and comparing data across multiple data sources considered the interplay between: (1) documented recommendations, (2) the impact of context and situational influences on communication and mealtime management through direct observation of resident-staff communication and resident mealtimes, (3) resident perceptions, and (4) staff knowledge and perspectives about residents' communication and mealtime difficulties and needs. Using this methodology provided more comprehensive and holistic insight into the complex nature of communication and mealtime management in RACFs.

The specific aim of Chapter 3 was to explore the nature of and factors impacting resident-staff communication and communication management in RACFs. The clinical objective was to highlight areas that may be addressed by RACF staff and SPs to enhance communication management and better meet residents' communication needs. Analysis of data from review of resident files, observation of resident-staff communication, resident surveys, and staff surveys, were consistent with those of Chapter 2 in identifying that communication management per se is not viewed as an explicit care task in RACFs. Furthermore, the findings were consistent with previous literature discussed in Chapter 1 confirming current resident-staff communication is largely task-focused regardless of the broader topic of conversation and is not reflective of PCC. Strategies used to facilitate communication with individual residents were observed to be used inconsistently and were often poorly matched to the resident's specific communication needs. Documentation of strategies to facilitate communication were very limited and without rationale. In addition, RACF staff agreement about residents' communication needs and strategies to facilitate communication with individual residents was inconsistent. Discrepancy was also noted between staff and resident perceptions of resident desire for communication opportunity and participation. It was clear from

the study that resident desire for increased or reduced communication opportunity and participation was variable and unrelated to the resident's communication difficulties.

Despite over half of the resident participants in Chapter 3 subjectively categorised as having moderate/severe communication difficulties, not one of these residents had received any speech pathology services for these difficulties while in the RACF. Indeed, there was no evidence found in any resident's file to suggest that speech pathology or any other formal or informal assessment of the resident's communication needs had been undertaken by any service discipline. Given that communication management in the study was noted by the SP observer to be inadequate in meeting residents' holistic communication needs for all participants, it is possible that the true extent of the communication needs of resident participants in Chapter 3, far exceed that which were documented or reported by RACF staff.

For all residents, regardless of level of communication difficulty, resident-staff conversations were infrequent and too short to allow meaningful conversation and engagement with staff. Almost a quarter of all interactions observed in the study and described in Chapter 3 ended in communication breakdown. There was also inconsistency observed between staff knowledge of residents' communication strengths and the practice of fostering these strengths in daily care. In addition, residents were, by and large, observed to take a passive role in communication interaction with staff. With high levels of dependency many residents of RACFs are in a position where they rely on care staff for the vast majority of their personal care, emotional, and social needs. Staff were observed to initiate and terminate most conversations and to use a dominance of task-focused communication. Some staff were also observed to verbally dismiss resident attempts to communicate. This observed practice is in stark contrast to the principles of PCC and highlights the need for more holistic RACF staff training in communication management addressing the broad impact of communication difficulty on both residents and staff. Previous research as discussed in Chapter 1 suggests that staff training in communication management is beneficial in increasing staff awareness of communication difficulties and strategies to facilitate communication with residents. Staff training has also been shown to increase staff confidence in working with residents with communication difficulties.

Despite mealtime management being seen as an explicit care task in RACFs, similar to communication management, Chapter 4 highlighted a range of areas in which improvement in mealtime management is needed. The study described in Chapter 4 aimed to explore factors influencing mealtime management by comparing information from documented, reported, and observed care as well as from the perspective of the resident, an observer, and staff. The overall objective of Chapter 4 was to identify issues impacting mealtime management to inform practice

change and ultimately improve resident care. In the chapter, documentation of resident mealtime needs was compared with observational data, resident perceptions, and staff knowledge and perspectives about residents' mealtime difficulties and needs. Overall, mealtime management was found to be inconsistent both between residents and for individual residents, with disagreement noted between documented recommendations, observed management, resident reported needs, and staff reported management. Evidence of holistic mealtime management was very limited with resident psychosocial needs rarely addressed in documentation, discussed by staff, or observed as being met.

The findings of Chapter 4 indicate that RACF staff providing mealtime assistance had limited knowledge of residents' holistic mealtime needs. For residents that had documented speech pathology recommendations pertaining to mealtimes, adherence to these recommendations was poor. For four residents in the study described in Chapter 4, although these residents were legally required to be fed by a registered nurse given the severity of their mealtime difficulties, these residents were observed being fed by family members or assistants in nursing, and at times were left to feed independently. A mismatch between documented food textures and those provided to the residents was also noted. Together these findings raise notable concern for the welfare of residents who experience mealtime difficulty especially for those residents with severe mealtime difficulties, who in this study were among those residents for whom observed care was judged as the least adequate in meeting the resident's mealtime needs. These findings also demonstrate incongruence with policy and legislation, and highlight the practical implications of resource constraints on service provision in RACFs, as well as challenges relating to documentation and interprofessional communication and collaboration inherent in the setting.

Previous literature has emphasised the significance of mealtimes as a time for social engagement, yet the results of Chapter 4 demonstrate that in practice residents' psychosocial mealtime needs are not being adequately addressed, and resident-staff interaction during mealtimes is minimal and task-focussed. This finding is consistent with the nature of resident-staff communication identified in Chapter 3. Disparity was also observed between resident and staff perceptions of preferred dining styles and preferences highlighting discrepancy between the concepts of family and homelike dining in RACFs as described in past literature, with resident perceptions. It was also evident in Chapter 4 from both documented and observed care that current mealtime management does not adequately involve the resident in mealtime planning or care and is therefore inconsistent with the principles of PCC and the facilitation of active ageing.

It was noted in Chapters 3 and 4 that speech pathology involvement in RACFs was isolated to mealtime management, however, documented recommendations by SPs indicated a narrow focus

on compensatory intervention for dysphagia. Intervention addressing broader mealtime factors including environmental influences on the mealtime, and residents' psychosocial mealtime needs were rarely documented or observed. Given this focus on mealtime management, further exploration of the perspectives of both RACF staff and SPs regarding mealtime management in RACFs was sought to better understand provider prioritisation of mealtime management and shared and disparate issues in providing this care.

With methodology similar to that in Chapter 2 and involving the same participants, Chapter 5 aimed to explore the prioritisation and global perspectives of a range of service providers involved in mealtime management in high-care RACFs. The objective of the study was to identify common and disparate views about holistic mealtime management to better guide research and policy development, and to facilitate the translation of policy and research recommendations to daily care.

The results of this study indicated that both RACF staff and SPs recognise there are gaps in current mealtime management. Informing discussions about the quality and consistency of care, a distinct disparity was found between RACF staff assigned to be responsible for mealtime management (i.e., registered nurses) and those who provide the majority of assistance to residents during mealtimes (i.e., assistants in nursing). Furthermore, participants expressed that a distinct lack of communication about mealtime management exists between providers including between SPs and care staff, and between registered nurses and care staff. Both registered nurse and SP participants attributed a lack of adherence to mealtime management recommendations to ineffective interprofessional communication, in particular, with assistants in nursing. Conversely, assistants in nursing perceived that they had limited support in providing mealtime management and felt that concerns they raised about resident welfare were not always acknowledged, placing residents at risk of complications. It is clear from the results of Chapter 5 that a dysfunctional circle of poor communication and ineffective support exists relating to mealtime management, and led to participants from across professional groups describing mealtime management as *"sub-optimal"*.

Directly relating to ineffective interprofessional communication about residents' mealtime needs were discussions about challenges to working within a multidisciplinary team in RACFs (Chapter 5). Registered nurses in Chapter 5 commented that due to time limitations they could not supervise all mealtimes and as a result did not know whether mealtime recommendations were being consistently followed. Similarly, SPs acknowledged that due to their own time limitations they rarely initiated follow-up consultations with RACFs and therefore did not always know whether the recommendations they made were being read or followed by RACF staff. These reports again raise concern for the welfare of residents who experience mealtime difficulties. Of further

concern, the results of Chapter 5 indicate that the role of different service providers in mealtime management is not well defined. Marked disagreement about the role of different disciplines as perceived by participants, particularly relating to the role of registered nurses and SPs, was evident. This issue was first highlighted in Chapter 2, with SPs reporting that they felt RACF staff did not always value the service they provided. Poor role delineation and ongoing disagreement about the different roles of service providers will only inhibit multidisciplinary care, and result in further inconsistency in service provision and care quality.

The perspectives of all professional groups explored in Chapter 5 illustrate the high value of mealtimes in RACFs. Participants described the importance of mealtimes to resident QOL, nutrition, and medical status, as well as providing the residents with an opportunity for social interaction. Both RACF staff and SPs expressed an explicit desire to improve mealtime management in RACFs and to increase their own professional education in mealtime management relevant to the setting. SPs expressed considerable concerns stating that current speech pathology service provision in RACFs is inconsistent with evidence-based practice and fails to represent the full scope of speech pathology service provision. Speech pathology intervention in RACFs was largely described as the management of swallowing through compensatory interventions, with a lack of rehabilitative interventions or interventions to facilitate the mealtime environment described, consistent with past literature discussed in Chapter 1 and the findings of Chapter 4. While SPs recognised the need for and had a desire to broaden and increase speech pathology services in RACFs they felt they were limited in their ability to do so due to barriers inherent to working in the setting, a lack of guidance and policy in the speech pathology profession relating to working in RACFs, and a lack of speech pathology assessment and therapy resources developed specifically for the RACF population.

6.3. Limitations

One aim of this thesis was to explore the perspectives of a range of service providers who work in RACFs and in particular service providers who are involved in the management of communication and mealtime difficulties in the setting. A large range of RACF staff were recruited into the studies comprising this thesis, however, the inclusion of a single external service discipline (SPs) limits generalisation of the findings to other external providers. Future studies exploring communication and mealtime management in RACFs from a multidisciplinary perspective should include other external providers such as general practitioners, dieticians, and physiotherapists in to cross validate the issues raised by SPs in this thesis. Further, it is acknowledged that while increased involvement of SPs in RACFs would be of benefit in advancing communication and

mealtime management in the setting, to optimise this care, increased involvement across a wider range of service disciplines is needed. General practitioners were invited to participate in the studies comprising Chapters 2 and 5 of this thesis, however, an insufficient number of participants were recruited to enable data from this professional group to be included in the final analysis.

While the specific RACFs participating in the studies comprising this thesis were chosen to represent Australian RACFs of average national bed capacity and governed by providers with multiple facilities state wide, all facilities were from the one state and were governed by one of two specific aged care management organisations. It is acknowledged in Chapter 1 that care quality in RACFs is inconsistent across facilities and is also influenced by the philosophies of care and specific policies of different managing organisations and facilities. As such, the data obtained may not reflect the nature of communication and mealtime management across all Australian RACFs. The results of the studies in this thesis are, however, strengthened by triangulation of data sources, consistency of the results between sources, and consistency of the results with related past literature.

A further issue pertaining to RACFs included in the studies comprising this thesis was the fact that both were high-care facilities. During the period in which data was collected for this thesis Australian RACFs were divided into high-care and low-care facilities. With distinctly different funding and service arrangements existing between high-care and low-care Australian RACFs, generalisation of the findings should not be made to low-care facilities. In line with current aged care reform recommendations this delineation of level of care has though been removed as of the 1st of July, 2014. It is not yet known what impact this will have on service provision or care quality. It can only be postulated that providing services within the one facility across a wider range of resident needs will add further complexity to service provision in RACFs.

Data collection involving residents of RACFs has long been acknowledged as challenging. In this thesis, three limitations regarding resident participation should be noted. First, despite efforts to facilitate communication with all residents regardless of cognitive and/or communication difficulty, the depth of information provided by residents during resident surveys was limited. This was more so for residents categorised with moderate/severe communication difficulties. Hence, although attempts were made to gain the perspectives of the resident participants, the information gained was limited in scope and detail. Secondly, in this thesis investigation of communication and mealtime management aimed to consider the specific communication and mealtime difficulties and needs of individual residents. This process was hindered by both limited documentation of residents' communication and mealtime needs, and a lack of formal assessment of resident participants' communication and mealtime needs. Classification of these difficulties in this thesis

was based on ACFI classification of mealtime difficulties, and documentation of and staff perspectives of resident communication difficulty. Classification of these difficulties in this manner was found to be inadequate in identifying residents' specific communication and mealtime needs. Though future studies may consider formal assessment of residents' communication and mealtime needs as part of the recruitment process, it is acknowledged that to do so is challenging given the limited assessment resources developed specifically for this population (Hickson et al., 2005; Hopper et al., 2007; Pye et al., 2000). Thirdly, given known issues in resident recruitment in RACFs, in Chapters 3 and 4 maximum variation sampling was used to recruit resident participants. Although this approach has strengths in selecting participants of particular interest to the research aims, it is possible that including only a few residents per sampling criteria may have limited the perspectives gained, with the data reflecting the issues of only a subset of RACF residents.

One final limitation pertaining to the studies comprising Chapters 3 that must be noted is the use of a single observer rating communication and mealtime management. Although the observing researcher was independent to the participating facilities and unfamiliar to either the resident or staff participants in these studies, to validate the findings of this research the involvement of a second observer would have been of benefit. Ideally this observer would be from an alternate discipline involved in providing communication and mealtime management in RACFs to provide a multidisciplinary rating of current care.

6.4. Implications for Clinical Practice and Future Research

The findings of this thesis have several important clinical implications for both SPs and RACF staff involved in communication and mealtime management in RACFs. Past research (Davies et al., 2011; Halcomb et al., 2009; Kind et al., 2011; Reed at al., 2005) and the findings of this thesis identify ongoing difficulties with interprofessional communication and collaboration among RACF staff, as well as between RACF staff and external service providers including SPs. It is evident from this thesis that these difficulties limit multidisciplinary care and contribute to inconsistent and sub-optimal care quality. It is also evident that service providers across disciplines face many of the same barriers to the provision of optimal care in RACFs, adding to past discussion of barriers to service provision in the setting (Dwyer, 2011; Goodwin-Johansson, 1996; Heumann et al., 2001; Hopper et al., 2007; Lubinski, 2006; Mitchell & Pachana, 2013; Worrall & Hickson, 2003). The impact of lack of funding, time, and low staff-resident ratios as discussed in previous literature was also discussed in this thesis. The impact of these barriers across care tasks including communication and mealtime management highlights the need to explicitly consider these barriers when providing policy recommendations and developing models of service provision for the

setting. These particular barriers have been discussed in the literature for several decades. It is argued that service providers working in RACFs cannot overcome these barriers on their own. Explicit and sustainable solutions to reduce the impact of these barriers on service provision considerate of specific care task requirements and service discipline involvement must be explored.

All service disciplines explored in this thesis shared the same common desire to care for older people and improve care quality in RACFs. These findings demonstrate that despite different training backgrounds and at times differences in care task prioritisation and approaches to care, service providers across disciplines working in RACFs are perhaps more similar than previously thought. Bridging the gap between service provider perceptions and perceived priorities of care is an integral step in achieving more effective communication and collaboration among service providers, and in working within a multidisciplinary team to achieve shared objectives and optimise care (Halcomb et al., 2009; Kaasalainen et al., 2010; Reed et al., 2010).

Illustrated in each of the four studies comprising this thesis was the need for increased education for both RACF staff and SPs about communication and mealtime difficulties and management specific to the RACF setting. The need for increased training for RACF staff in communication and mealtime management has been reported in previous literature (Aselage & Amella, 2010; Bourgeois et al., 2004; Bowles et al., 2001; Bryan et al., 2002; Crogan et al., 2001; McGilton et al., 2006; Pelletier, 2004; Reimer & Keller, 2009; Williams et al., 2005). Although this body of research illustrates benefits of RACF staff training in communication and mealtime management, previous training initiatives have been criticised as failing to adequately consider knowledge translation to care practice and broader influences on training success and knowledge translation (Levy-Storms, 2008; Pelletier, 2004; Simmons et al., 2013; Vasse et al., 2010). There must be a stronger focus on the investigation and implementation of procedures to facilitate translation of knowledge gained through staff training to daily care. In addition, in response to past recommendations for increased RACF staff training and service provider calls for increased interprofessional and discipline specific training in this thesis, the availability of both discipline specific and interprofessional education must be increased, including for SPs. This includes discipline specific qualification training, specific to working with older people and to working in RACFs.

RACF staff in this thesis also called for increased involvement of SPs in RACF staff training. SP participants in this thesis and in past literature (Hopper et al., 2007) acknowledged they provide little training to RACF staff. Further, given that findings from this thesis and past literature (Hopper et al., 2007) also indicate uncertainty about the role of SPs in RACFs, the provision of increased education to RACF staff by SPs could be considered a vital tool in not only increasing

RACF staff knowledge but also in advocating for the role of SPs in the setting. SPs have the skills to facilitate RACF staff knowledge about the nature, presentation, and the wider impact of communication and mealtime difficulties, as well as to facilitate RACF staff understanding and involvement in a wider range of evidence-based interventions encompassing, medical, rehabilitation, and social models of service delivery.

The perspectives of SPs in this thesis provide valuable feedback to the profession regarding areas of need in profession specific policy development, professional development, ongoing support, and university level training. Policy development within the speech pathology profession in Australia for SPs working in aged care has recently progressed, with commencement of the development of a position statement for SPs working in aged care settings by The Speech Pathology Association of Australia Ltd. However, in order to advocate for speech pathology services in RACFs and increase funding for these services, the profession itself must have a comprehensive policy base upon which to lobby for change in RACF and aged care sector policy and legislation. Such policy will also assist in raising the profile of service provision in RACFs within the speech pathology profession, providing the policy needed to lobby for changes in speech pathology training specific to service provision in residential aged care settings. Increased focus in pre-professional training with specific indicators of new graduate skill level requirements in working with older people and in aged care settings in the *Competency-based Occupation Standards for Speech Pathologists* (The Speech Pathology Association of Australia Ltd, 2011) may assist in fostering greater interest in working in and conducting research into service provision in RACFs. In turn, this will increase the evidence-base for speech pathology services in RACFs and raise the profile of service provision in aged care settings as a specialist area of care, consistent with the perspectives of both SPs and RACF staff in this thesis and in past literature (Casper, 2013; Hopper et al., 2007; Lubinski, 2006; Worrall & Hickson, 2003). Furthermore, an increased presence of SPs in the setting would facilitate opportunity for peer support and increased availability of SPs in RACFs. This would also serve to address concerns raised by care managers throughout the studies described in this thesis that is difficult to find SPs with an interest in and the skills required to work in RACFs.

The need for increased interprofessional communication and collaboration in delivering communication and mealtime management in RACFs is highlighted throughout this thesis. Interprofessional communication and collaboration has been noted to be integral to both the delivery of consistent and quality care, and to achieving service change in RACFs (Blackford et al., 2007; Davies et al., 2011; Halcomb et al., 2009; Jeong & Keatinage, 2004; Kaasalainen et al., 2010; Lindeman et al., 2003; Reed et al., 2010). The implications of poor interprofessional

communication and collaboration revealed in this thesis are significant and wide reaching. Despite RACF staff and SPs expressing many of the same opinions regarding barriers to optimal service provision and the importance of communication and mealtime management in RACFs, division continues to exist between service disciplines including between different RACF staff groups. Increased communication among service disciplines involved in communication and mealtime management will provide a more unified base for advocacy of services for the residents. It will also provide common ground to begin to clarify professional roles in communication and mealtime management as well as to develop more effective multidisciplinary models of care specific to the setting.

Both RACF staff and SPs agreed that mealtime management is, at present, less than ideal. Both RACF staff and SPs recognised the importance of effective communication with residents despite communication management not being currently viewed as an explicit care task in RACFs. Both RACF staff and SPs discussed at length the importance of communication interaction and mealtimes in meeting residents' psychosocial needs and in facilitating resident QOL. These perceptions are consistent with exploration and discussion of the impact of communication and mealtime difficulties on QOL in past literature (Chan & Pang, 2007; Crogan et al., 2004; Cruice et al., 2000; Cruice et al., 2003; Ekberg et al., 2002; Evans et al., 2003; Hilari & Byng, 2009; Martino et al., 2010; Miller & Patterson, 2014; Morgan et al., 2002; Nijs et al., 2006; Nilsson et al., 1996; Palacios-Cena et al., 2013; Park et al., 2013). Despite this acknowledgement residents' psychosocial needs in this thesis were those needs most poorly met in the management of both communication and mealtime difficulties.

Participants also discussed the negative impact of resident communication difficulty on the ability of staff to complete care tasks and to provide care consistent with PCC. The impact of resident cognitive and/or communication difficulty on: staff ability to complete care tasks, resident-staff relationship development, and staff satisfaction in the workplace, has been discussed in previous literature (Bryan et al., 2002; Kato et al., 1996; Parsons et al., 2003; McGilton et al., 2006; McGilton et al., 2010). To provide services to better meet the communication and mealtime needs of all residents of RACFs SPs must reconsider their approach to management in the setting. There is a need to better align speech pathology services in RACFs with the principles of PCC and the facilitation of resident QOL, prioritising interventions aimed at facilitating resident participation and reducing activity limitations as well as interventions aiming to ameliorate impairment level difficulties. Such an approach is well supported by The Speech Pathology Association of Australia Ltd *Code of Ethics* (The Speech pathology Association of Australia Ltd, 2010) and aged care recommendations and legislation (Aged Care Act, 1997; Australian Government productivity

Commission, 2011; Quality of Care Principles, 1997; WHO, 2002; UN, 1991). To ensure recommendations are consistently followed greater attention must be paid to documentation of these recommendations, documentation of residents' communication and mealtime needs, and documentation of the assessment process by which resident perspectives and preferences regarding their care are collected. Procedures for communicating this information to all staff involved in communication and mealtime management in the setting must be explicitly included in future models of care. Without explicit attention and inclusion of practices to enhance this communication it is likely that long standing issues in documentation, handover, and interprofessional communication and collaboration will persist, and advancement in multidisciplinary care in RACFs will continue to be limited (Armstrong & Kendall, 2010; Blackford et al., 2004; Colon-Emeric et al., 2006; Reed et al., 2005).

Of particular relevance to communication management, if the profile of communication management in RACFs is not raised then all service providers working in RACFs will continue to struggle to meet current aged care recommendations, policy guidelines, and legislation. These objectives are focused on facilitating active participation of older people in their health care and in meaningful life activities and simply cannot be met without effective communication with residents. SPs as specialists in communication management have an obligation to increase recognition of residents' communication needs and to facilitate RACF staff management of communication difficulties. Communication management must be viewed as an explicit care task and as integral across all aspects of resident care and service provision. All residents have the right to engage in meaningful communication, however, for all residents in this thesis opportunities to engage in meaningful communication with staff were limited. There is evidence in the field of speech pathology of the benefit of targeted intervention for older people including for older people with cognitive and/or communication impairment (Davis, 2005; Genereux et al., 2004; Hopper; 2013, McGilton et al., 2010; Powell, 2000). Further research to trial and evaluate new and existing speech pathology assessment and intervention procedures in the RACF is, however, needed. In conducting these trials consideration must be given to the sensitivity of assessment procedures and interventions to the influence of the context of care in RACFs. Further, these resources must be able to capture the needs of residents of RACFs as a unique and diverse population group, including for residents with cognitive and/or communication difficulties. Furthermore, acknowledging the key role that RACF staff play in both assessing and providing intervention for resident difficulty in RACFs, the potential role of RACF staff in resident assessment, diagnosis, and intervention for communication and mealtime difficulties must also be addressed. Ultimately role delineation in the management of communication and mealtime difficulties in RACFs should be a collaborative process across professional groups and involving the residents themselves and family members.

Further exploration of resident perspectives regarding desired communication opportunities and participation is also required with the findings of this thesis suggesting disparity between resident and staff perceptions of resident desire for communication opportunity and participation.

With final reference to communication management, the findings of this thesis and past research (Casper, 2013; Hopper, 2007) indicate very limited speech pathology involvement in communication management in RACFs. As such, further exploration of the perspectives of SPs regarding communication management in this setting is needed. Determining the direction of the profession in working in RACFs should be based on thorough understanding of the potential need for and nature of the potential involvement of the speech pathologists in the setting, as this thesis has begun to inform. In addition, the perspectives of SPs about service provision in the setting must be thoroughly explored to address service specific concerns and barriers relating to communication management in RACFs.

In relation to mealtime management, participants in this thesis identified lack of adequate acknowledgement and reference to mealtime management in funding allocation documents and aged care policy as a key issue limiting the scope and frequency of mealtime management and RACF staff education relating to mealtimes. Without adequate support of mealtime management in policy documents and without adequate guidance in fund allocation for mealtime management, both RACF staff and SPs felt they had little basis to advocate for mealtime management in RACFs. Service providers must, therefore, in collaborating to raise the profile of mealtime management in the setting, explicitly advocate for increased recognition of mealtime management in funding allocation tools.

Findings from this study also suggest that discussion of the concepts of "home" and "family" style dining requires further refinement. This statement is supported by Adams et al. (2013) with disparity found between what residents viewed as a positive dining experience in the family home prior to admission and in the RACF. Philpin et al., (2014) have also recently begun to elucidate the complexity of the construct of mealtime experience in RACFs, discussing the inter-linked influence of physical and socio-cultural elements of the mealtime and the importance of shared understanding about mealtimes between residents and RACF staff. Increased understanding of resident perception of the concept of the "ideal" dining experience in RACFs will be pivotal in shaping mealtime management in RACFs, and in assisting SPs to align speech pathology services with PCC and the facilitation of resident QOL.

6.5. Conclusion

Older people present one of the most at-risk populations for both acute and chronic communication and mealtime difficulties. With an ageing population the need for communication and mealtime management in RACFs is only likely to increase. SPs are specialists in communication and mealtime management yet the results of this thesis indicate that at present speech pathology involvement in RACFs is limited and hindered by numerous barriers to optimal care, as is current communication and mealtime management provided by RACF staff. RACFs are a unique home and work environment, and as such, the specialist nature of care in RACFs must be recognised and taken into account in planning and implementing services in RACFs.

To facilitate resident QOL, to work in a manner consistent with PCC, and to achieve the broad aims of current aged care policy and reform, increased prioritisation and optimisation of communication and mealtime management in RACFs must be achieved. Both RACF staff and external service providers including SPs must work together and share their common perspectives and goals. Increased education for both RACF staff and SPs who work in RACFs must be provided including discipline specific and interprofessional education. Professional roles in communication and mealtime management must be clarified and multidisciplinary models of care developed for the setting. SPs as specialists in communication and mealtime management must increase prioritisation of service provision in RACFs within the speech pathology profession itself. SPs must also increase advocacy of the potential role of SPs in RACFs as well as increase education, policy, and service model development within the profession and specific to working in RACFs.

Key to these recommendations is the need for re-conceptualisation of both communication and mealtime management in RACFs. This re-conceptualisation must encompass the holistic and complex nature of communication and mealtime difficulties experienced by residents of RACFs, and the complex and multifaceted influence of the care environment (organisational, physical and relational) on service provision and resident outcome. Explicit consideration of residents' psychosocial needs and the impact of communication and mealtime difficulties on resident subjective wellbeing must also be considered, including increased exploration of resident perspectives about their communication and mealtime needs and communication and mealtime management.

For communication management specifically, aligning service provision models with PCC may have powerful benefits in providing a platform on which to highlight the importance of effective communication to resident participation and subjective wellbeing, thereby raising the profile of communication management and the role of SPs in RACFs. For mealtime management,

service provision consistent with PCC will explicitly support exploration and increased prioritisation of residents' holistic mealtimes needs, raising the profile of residents' psychosocial mealtime needs and the value of mealtimes in providing an opportunity for social interaction, resident expression, and interpersonal resident-staff interaction.

RACFs staff value communication, and they value mealtimes. They recognise the importance of communication to all facets of care, *"Communication is number one. Without knowing how people are feeling and where they're at how can you best provide the level of care that they need?"* (CM02). They recognise the importance of mealtimes to resident health and subjective wellbeing, *"If they're not eating they're not getting their nutrition and then they can end up with infections, sickness, and dehydration"* (AIN03), *"Mealtimes? Well to them it's the most important part of the day, mealtime is their social time, there's soft music in the background and the nurses can sit down with them and actually spend that time with them during their meal"* (NS09). SPs have the skills to lead and facilitate communication and mealtime care in RACFs. As passionately expressed by one SP in this thesis, *"we as SPs have the responsibility to talk to residents and family members, to educate on what services we can provide, the cost, and what we think would be a realistic outcome"* (Chapter 5, SP08).

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APPENDIX A

Behavioural & Social Sciences Ethical Review Committee Approval Letter – Stage 1

Approval granted 31st December, 2010

THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans Including Behavioural Research

Chief Investigator:	Ms Michelle Bennett
Project Title:	A Systematic Investigation Of Communication And Oral Intake Difficulties In Residential Aged Care Facilities (RACFs); Using The International Classification Of Functioning, Disability And Health (ICF) To Compare Resident Need To Current Intervention
Supervisor:	Prof Elizabeth Ward, Dr Nerina Scarinci
Co-Investigator(s)	None
Department(s):	School of Health and Rehabilitation Sciences
Project Number:	2011000546
Granting Agency/Degree:	PhD
Duration:	31st December 2014

Comments:

Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Associate Professor John McLean
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 3/6/2011 Signature

APPENDIX B

Behavioural & Social Sciences Ethical Review Committee Approval Letter – Stage 2

Approval granted 31st May, 2011

THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans Including Behavioural Research

Chief Investigator:	Ms Michelle Bennett
Project Title:	A Systematic Investigation Of Communication And Mealtime Management In Residential Aged Care Facilities (RACFs); Using The International Classification Of Functioning, Disability And Health (ICF) To Compare Resident Need To Current Intervention
Supervisor:	Prof Elizabeth Ward, Dr Nerina Scarinci
Co-Investigator(s)	None
Department(s):	School of Health and Rehabilitation Sciences
Project Number:	2012000480
Granting Agency/Degree:	PhD
Duration:	31st May 2015

Comments:

Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Associate Professor John McLean
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 17/5/2012 Signature

APPENDIX C

BUPA Care Services Pty Ltd – Letter of Approval

Approval granted 17th September, 2011

The Behavioural and Social Sciences Ethical Review Committee, University of Queensland.

Re: Michelle Bennett (Speech-Language Pathologist) PhD research: "A systematic investigation of the need for services and current service provision for residents of high care Residential Aged Care Facilities with communication and/or mealtime difficulties; Using the International Classification of Functioning, Disability and Health (ICF) to compare resident need to current intervention"

To the Behavioural and Social Sciences Ethical Review Committee,

I am happy, on behalf of Bupa Care Services Australia and the designated care homes, to participate in Michelle's research and to render her all possible support that we can.

Yours sincerely,

Glen Hurley Regional Director (North) Bupa Care Services Pty. Ltd.
Bupa Care Services Pty Ltd Level 19 201 Kent Street Sydney NSW 2000
T 02 8247 3000 F 02 9252 1003 www.bupacare.com.au

APPENDIX D

UnitingCare Ageing – Letter of Approval

Approval granted 3rd August, 2011

UnitingCare Ageing

Level 5, 222 Pitt St, Sydney

PO Box A2178 Sydney Sth 1235

T: (02) 8267 4372
F: (02) 9267 4842
E: unitingcareageinc@nsw.uca.org.au

www.unitingcareageing.org.au

3 August 2011

To Whom it may Concern

Re: PhD Project for Ms Michelle Bennett - A systematic investigation of the need for services and current service provision for residents of high care Residential Aged Care Facilities with communication and/or oral intake difficulties; Using the International Classification of Functioning, Disability and Health (ICF) to compare resident need to current intervention.

Michelle has approached UnitingCare Ageing to support her research project titled "A systematic investigation of the need for services and current service provision for residents of high care Residential Aged Care Facilities with communication and/or mealtime difficulties. Using the International Classification of Functioning, Disability and Health (ICF) to compare resident need to current intervention". UnitingCare Ageing has agreed to provide access and support for this project as outlined in the Ethics Application.

Speech Therapy is an area of clinical interest across the organisation and we welcome the opportunity to forge closer links between the aged care sector and speech therapy professionals Michelle will be conducting her research in our Hunter, New England and Central Coast Region.

Please contact me if you require any additional information.

Yours sincerely

Sirdhu Summers
Executive Manager, Service Excellence

Inspired Care... Enriching Lives... Together

UnitingCare Ageing is a ministry of the Uniting Church and a Service Group of UnitingCare NSW.ACT ABN: 78 722 539 923

APPENDIX E

Additional information collected during observations of resident-staff communication

Location of activity: e.g. bedroom, common space, garden

Communication partner: e.g., care manager, registered nurse, lifestyle activity officer, family member

Communication Interaction Initiated by: resident, communication partner

Means of initiation: verbal greeting, touch, facial expression, gesture, other

Purpose of utterance: express feeling, express personal information, express preference, request personal information, request person, request clarification, request activity, request object, give instruction, ask question, provide explanation, make a statement

Communication breakdown: yes, no

Was a communication repair attempted: yes, no (if yes by: resident, communication partner)

Number of utterances during conversation: total number of successive utterances about a single topic

Means of repair: speech, simplify sentence, check if resident has understood, gesture, re-formulating, demonstrating

Communication Interaction Terminated by: resident, communication partner

Means of termination: verbal farewell, touch, facial expression, gesture, physical exit, other

APPENDIX F

Mealtime observation form

MEALTIME OBSERVATION FORM																							
RES ID:					**OBS ID:**									**MT ID:**									
MEAL: Breakfast / Lunch / Dinner					**DAY:** Mon / Tues / Wed / Thurs / Fri / Sat / Sun									**STAFF PRESENT:**									
Location		Group dining room			**Seating**									**Meal Presentation**			All one tray				Separate Courses		
No. res. at each table		Bedroom at table			Bed		Wheelchair		Reg. Chair		Other			**Utensils**		Appropriate Normal		Appropriate Modified			Inappropriate		
No. Res. in room		Bedroom in bed			Appropriate				Inappropriate					**Crockery**		Appropriate Normal		Appropriate Modified			Inappropriate		
Lighting:	Adequate	Inadequate	**Noise:**	Noisy	WNL	Quiet/ Silent	**Smells:**	Adverse		Pleasant	None/ Minimal	**Physical Barriers:**	Yes	No	**Privacy:**	Minimal	Fair	High					
Attempt to change	Yes	No	Attempt to change		Yes	No	Attempt to change			Yes	No	Attempt to change	Yes	No	Attempt to change		Yes	No					
Privacy: Minimal – Resident in a public space or shared room with persons present not associated with the resident, or resident in a shared room in full view of passing people Fair – Resident in shared room with another resident or non-associated person present but with some degree of privacy e.g. bed curtain drawn, or resident in a private room in full view of passing people High – Resident in private room or shared room (alone or with persons associated with the resident) and out of site to passing people																							
Feeding Assistance Provided			Yes	No	**Nature of feeding assistance**																		
Who is assisting	RN/EEN	AIN	Other		Full Assist (Fully physically dependent on staff for intake)									Minimal Assistance Only (e.g. tray set up, verbal cue)									
Usual Assistant		Yes	No		Partial Assist (Some assistance required / some independent eating)									No Assistance Provided									
Should assistance be given		Yes	No																				
No. of Physical Prompts	None	Minimal	Multiple		**No. Verbal Prompts**									None		Minimal				Multiple			
Consistency in Assistance	Consistent	Variable			**Does res. respond appropriately to prompting**		Yes	Sometimes		No	**Assistance Appropriate**			Yes		No							
Nature of interaction between support person and resident											**Diet**												
Ongoing natural interaction throughout meal					No interaction during feeding other than occasional prompt						Thin Fluids		Level 150		Level 400		Level 900						
Minimal Interaction: Appropriate comments relating only to the feeding process					Minimal Interaction: E.g. Not always appropriate. Rushed, distracted conversation, talking over resident to others.						Normal Diet		Soft		Minced Moist		Smooth Pureed						

Mealtime observation form continued

Specific Assistance			**Recommendations**		
Resident is independent	Yes	No	Res. may benefit from strategies to ↑independence	Yes	No
Visual supervision is given	Yes	No	Res. may benefit from visual supervision	Yes	No
Physical assistance is given	Yes	No	Res. may benefit from physical assistance	Yes	No
Verbal prompts given	Yes	No	Res. may benefit from verbal prompts	Yes	No
Resident has special positioning	Yes	No	Res. may benefit from special positioning	Yes	No
Documented meal plan is observed	Yes	No	Res. may benefit from documented meal plan	Yes	No

APPENDIX G

Staff questionnaire

STAFF QUESTIONNAIRE					
FAC ID:	**STAFF ID:**	**RES ID:**	**Length of care:**	**Frequency of care:**	
			Frequently	**Sometimes**	**Never**
Resident requires visual supervision during mealtimes					
Resident requires verbal prompts					
Resident requires physical assistance					
Resident requires special positioning					
Resident eats their meals in their bedroom					
Resident has a specific mealtime management plan /recommendations					
Does the resident have any preferences about meal set-up or procedure?					
Are there any foods or fluids that the resident prefers or particularly likes?					
Are there any foods or fluids the resident refuses or particularly dislikes?					