Exploring the Effect of Aged Care Education on Quality of Care

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Abstract

Despite changes in legislation and increased funding and monitoring, there have been problems related to the quality of care in the aged care sector in Australia for several decades. An appropriately qualified aged care workforce is considered the key to improving aged care practices. Therefore, this study aims to understand the reasons for the ongoing problems in the aged care sector that relate to aged care education.

Since the 1990s, many studies have focused on care practices in nursing homes, now known as Residential Aged Care Services (RACS). The terms nursing homes and rest homes are still used in other countries. However, few studies examined the influence of aged care education on care practices in RACS. This thesis examines these issues considering John Dewey's (1859–1952) conceptual framework of pragmatism, which is employed in this qualitative study. The framework uses a mixed methods approach, including qualitative data from interviews and quantitative data from an online survey and document analysis of published documents. The document analysis includes the Department of Education and Training's aged care training packages and the Quality of Care Principles 2014.

The findings from the interviews were corroborated with the content analysis from the published documents and the descriptive analysis from the online survey. The results were presented in the context of aged care literature and current practices in aged care. Managers and care workers discussed five main themes: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to broaden educational topics on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges

of working in an aged care environment; and (5) the need for an application of knowledge through simulation and experiential learning by qualified mentors with experience and knowledge in aged care.

The conclusion presents a critical discussion of the results from a pragmatist perspective. It suggests a new pedagogical aged care education model Democratic Experiential Learning Aged Care Education Model that incorporates Dewey's writings on democracy and experiential learning.

Doctor of Education Declaration

I, Janet Josephine Lawrence, declare that the EdD thesis entitled 'Exploring the Effect of Aged Care Education on Quality of Care' is no more than 60,000 words in length including quotes and exclusive of tables, figures, appendices, and references. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my work.

Janet Lawrence-FACN

Doctor of Education Student

Date: 17 May 2019

The researcher received ethics approval ID number HRE16-149 from the Victoria University Ethics Committee to proceed with the research project to interview managers and Care Workers in Aged Care.

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List of Abbreviations

AACQA	Australian Aged Care Quality Agency
ACFI	Aged Care Funding Instrument
ANMC	Australian Nursing and Midwifery Council
AQF	Australian Qualifications Framework
AP	Approved Provider of Aged Care
AQF	Australian Quality Framework
ATSIs	Aboriginal and Torres Strait Islanders
CALD	Culturally and Linguistically Diverse
CDC	Consumer-Directed Care
EN	Enrolled Nurse
ICN	International Council of Nurses
PCA	Personal Care Attendant
PCW	Personal Care Worker
QoCPs	Quality of Care Principles
RACS	Residential Aged Care Services
RN	Registered Nurse
RTO	Registered Training Organisation
TAFE	Technical and Further Education
VET	Vocational Education and Training
WIL	Work Integrated Learning

Chapter 1: Introduction—Why Aged Care Training Needs Improvement

1.1 Introduction

I have worked in the aged care sector since 1987 and have experienced firsthand the disconnect between poor care practices and their effect on the quality of life of senior Australians. Aged care training needs to improve if we are to ensure quality in aged care. This thesis explores the issue of aged care training from the perspective of managers and care workers in Residential Aged Care Services (RACS).

Since the late 1980s, there has been an increase in the number of Registered Training Organisations (RTOs) to provide aged care training. RTOs are organisations that provide vocational education across all sectors; in the aged care and provide certificate level training. This certificate III is the requirement to work in aged care, and RTOs educate the largest number of workers entering aged care.

Education of the aged care workforce has been the subject of much scrutiny, and many consider it a key to improving aged care. There is a problem of skill shortages and a lack of further education for aged care workers (Mavromaras et al., 2017). There are critical gaps between aged care graduates and the workforce, and this is because the tasks in the workplace have become far more complex.

This thesis employs John Dewey's Pragmatism as the conceptual framework to investigate the problem of the variability of quality in aged care. The word 'pragmatism' derives from the Greek word 'pragma' (πρᾶγμα), meaning 'action' 'practice' and has 'practical' application (Martela, 2015). It comes from 'to do' 'to act' that has practical bearings or consequences of the action (Dewey, 1991a; Wells, 2000). Pragmatism is about solving problems practically, dynamically, and sensibly rather than

by fixed ideas, but does have some limitations for this research that are discussed in detail in Chapter Three: Conceptual Framework: Dewey's Pragmatism and Aged Care Education. According to Dewey's pragmatist perspective, knowledge comes from actions and learning from the experiences and outcomes of these actions (Demetrion, 2003; Dewey, 1991a; Morgan, 2014). Pragmatism in this study will focus on the problem of variability of quality in aged care logically and practically (Creswell & Plano Clark, 2007; Morgan, 2014; Wells, 2000). Pragmatism fits the focus of the study by understanding and reflecting on the problem of variability of quality in aged care, and if improving aged care education is the practical way to solve it.

Quality in aged care education is established through RTOs compliance with the Australian Quality Training Framework (AQTF) set of standards to assure quality training and assessment services for learners in Australia's vocational education and training (VET) system. The Standards for RTOs (2015) outline the responsibility of providers to adhere to the principles of teaching, such as 'access and equity' and 'fairness and currency'. However, variability in quality may occur when the standards are not followed, thus compromising the quality standards. Likewise, variability in teaching quality may occur when individual student needs are not recognised, nor students fully engaged with the subject matter.

Therefore, Dewey's (1991b) works and ideas are particularly useful for applied studies in aged care education that seeks to understand the problem of variability of quality in aged care through, in part, comparing published documents from aged care training packages and the federally legislated Quality of Care Principles 2014 (QoCPs) (Australian Aged Care Quality Agency [AACQA], 2018). This is important because there was a need to know if the QoCPs are adequately described in the training packages. This is likewise a vital means to understand the practices in aged care, which

is governed by the QoCPs. A total of 1,500 aged care facilities were contacted, and 360 managers and care workers in Victorian metropolitan and regional RACS responded. The online survey was followed by 22 semi-structured interviews with managers and care workers currently employed in RACS. The interviews used open-ended questions to seek interviewees' opinions, thoughts and feelings, and to develop a sense of their understanding of the situation. The data were thematically analysed to corroborate the findings from other data sources.

In this study, a pragmatist stance of 'what works', was taken (Wells, 2000). Pragmatism emphasises action and learning from experiences (reflection) and fits the focus of this study which is about vocational aged care education and understanding its limitations in an observable, work context. This research has developed an aged care education pedagogical model that is theory and practice-based that emphasises experiential learning, mentorship, simulation, and work placements. The model is designed to impact the delivery of aged care education.

It is envisaged in the research findings that Aged care education should involve not only the delivery of fit-for-purpose aged care training but also mechanism such as ongoing mentoring through work-integrated learning (WIL) to develop structured career pathways. The conclusion of this thesis presents the triangulation of findings (Figure 4.1. An Overview of the Data Collection Methods) in the following:

- Care workers have concerns regarding current aged care training and its ability to prepare them for the workplace and perform.
- Document analysis indicates that the QoCPs and Accreditation Standards are inadequately addressed in training packages (see appendix 1).

- Online survey participants suggested that additional onsite training was needed, and topics that are relevant to aged care should be included, such as caring for older adults with chronic health conditions.
- Semi-structured interviews with managers and care workers presented evidence of their concerns regarding gaps in aged care training.

The results establish the need for a long-term solution to ensure that RACS employ an appropriately qualified aged care workforce. A new pedagogical model of training is long overdue, and Dewey's theoretical ideas and works on democracy and education and experiential learning influence the proposed pedagogical aged care education model.

The critical challenge is to ensure that graduates are ready for the workforce in term of understanding personal care, nutritional knowledge, the management of challenging behaviour, risk management techniques, and thus the provision of quality care to older adults. However, the aged care industry has a long way to go to achieve this goal. This research will make a significant contribution to the literature by exploring how aged care education and training can be improved.

1.2 Aim of the Research

The study aims to understand how aged care education prepares graduates to work effectively in the aged care sector and whether the reasons for the ongoing problems in aged care that are caused by inadequate preparation.

1.3 Research Questions

1. How is the quality of care perceived by aged care workers and managers working in RACS?
2. How do RTOs teach the Quality of Care Principles legislated in the *Aged Care Act 1997* to aged care workers?

3. How do managers and care workers in RACS perceive gaps in the knowledge and skills of graduates?
4. How do aged care graduates view their preparation to work in aged care after gaining employment in residential aged care services?
5. What are the features of ‘good’ aged care training according to managers and care workers?

1.4 Statement of the Problem

The *Aged Care Act 1997* was implemented to raise the standards of care through an accreditation process to ensure that care services were of high quality. It was the result of ongoing community concerns associated with poor care services and training (Damiani, 2013; Productivity Commission, 2012a; Nolan et al., 2008). The Australian Government recommended strengthening accreditation and monitoring as a solution to improve services but did not include, for instance, evidence-based practice to monitor quality.

There is a problem of variability of quality in aged care in terms of the inconsistent implementation of standards of care, inadequate monitoring of standards of care, and differing interpretation of standards. These problems result in inconsistent standards in the delivery of care that is difficult to measure against a set of fixed standards. Quality indicators have the potential to expose inadequate care; however, the approach of objectively measuring quality by various agencies using consistent indicators is limited. Australia’s aged care sector has advanced haphazardly in response to the growing and fluctuating needs of older adults (Angus & Nay, 2003). These needs are that they are living longer, life expectancy in Australia is now 82.5 years, but longer life does not necessarily mean better health. This is because, at this late age, they are

much frailer with many organ failures such as the heart, lungs, and kidneys, that will need skilled medical and nursing interventions.

Successive governments have failed to recognise the need for quality and evidenced-based risk management, as well as effective aged care education that is robust. Further, there has been increased concerns regarding a lack of funding to support the future careers of aged care graduates. The *Aged Care Act 1997,* which was intended to assist approved providers (APs) in providing good-quality care, management and responsibility, has been the subject of debate because the standards of care in the Act are not clearly implemented and have been inadequately monitored.

The standards of care are a concern in the aged care sector because the guidelines are not specific. The guidelines should be care-specific and should be national to allow consistency to meet the minimum standards of care. The aged care standards are not a sufficient guide because they are too generalised and open to interpretation.

There have been several enquiries into the provision of care in the aged care sector across Australia (Clayton, Booth, Roy, Jenkins, & Sutcliffe, 2005; Department of Health and Ageing, 2005; Productivity Commission, 2011). This study focuses on aged care education and training, and it aims to provide a much-needed understanding of aged care education, as well as a strong stimulus to progress care training and practices.

The inadequate care practices and their adverse effect on residents for several years have been a concern. My interest in undertaking this research project resulted from the experiences of working in the aged care sector. I have worked in many roles, including registered nurse (RN), teacher, auditor, consultant, senior manager, expert witness, administrator and nurse advisor, chief executive officer, and director of studies.

Numerous discussions with staff and residents as well as academic literature have revealed ongoing concerns regarding aged care training and an inappropriately educated aged care workforce (Department of Health and Ageing, 2005; Nolan et al., 2008). This study explores these problems from a rigorous, research-based perspective. The researcher received ethics approval ID number HRE16-149 from the Victoria University Ethics Committee to proceed with the research project to interview managers and Care Workers in Aged Care.

1.5 Thesis Outline and limitations

This section outlines the post-introductory chapters presented in this thesis, including: (2) background and literature review; (3) conceptual framework using Dewey's pragmatism; (4) methodology using qualitative and quantitative approaches to data collection; (5) report of the findings of the study; (6) discussion of results, key issues, and themes arising from the data; (7) proposal for facilitating an innovative pedagogical aged care education model; and (8) conclusion.

In terms of the limitations of the study, there is limited knowledge as to what constitutes quality care for the elderly. There are likewise limited studies on how models of care improve the quality of care. There is also limited research on how an increase in government funding enhances the quality of care and the subsequent processes used to monitor standards of care. Therefore, there is a need to examine what constitutes quality of care, especially in everyday practice. There are several studies on the role of education in the quality of care and while reference to 'unqualified care workers' was noted in some of the literature, pragmatic ways of improving age care education for care workers was limited. This was especially the case with vocational education programs for aged care, where there are few studies on the delivery and impact of aged care programs on care practices. The researcher analysed and provided

an advanced integrated understanding of the complex body of knowledge about aged care and education. However, there is still much work to be done in terms of understanding what constitutes quality of care, especially in terms of education and monitoring standards of care.

Chapter 2 presents the background literature review that examines academic studies and state and federal government reports published in recent decades to provide an understanding of aged care training and its effect on the quality of care. It examines five key areas: (1) growing need for care services; (2) models of care; (3) legislative reforms and QoCPs; (4) challenges facing care workers; and (5) aged care and training in Australia. The literature review likewise highlighted the positive changes that have occurred in the aged care sector. Some of these included the amalgamation of nursing homes and hostels to prevent older Australians making a second move when their nursing, medical and personal needs increase due to chronic health conditions, frailty and highly dependent needs. The increased funding for aged care services, and models of care such as person-centred care, provide choices and improve quality of life for the older Australians in RACS.

Chapter 3 examines Dewey's principles and extensive body of work by outlining his ideas and their close connection with the central purpose of this study and aged care education. It explains Dewey's work (and examines the views of managers and care workers regarding problem-solving issues that arise in aged care education and their effect on the quality of care in RACS.

Chapter 4 outlines the qualitative approach used in this study. The model of pragmatism is the conceptual framework chosen for this study. Pragmatism is an approach that assists the understanding of the success of the application of education to professional practice. Document analysis of published documents is undertaken using

Aged Care Training Packages and QoCPs legislation. Second, an online survey was conducted with managers and care workers about aged care training. Third, in-depth semi-structured interviews were conducted with managers and care workers to obtain their views of graduates' training and their work in RACS. The data collection included five research questions, data analysis and sampling used to obtain participants. The justification for using qualitative analysis examines the data collected from the interviews to help explore and understand the phenomenon from the perspectives of managers and care workers. This chapter also addresses the validity and reliability of the data, as well as strategies to ensure trustworthiness and the researcher's reflection of the findings.

Chapter 5, the findings, contains a thematic arrangement of the data for each participant's responses to the questions to identify codes, categories, key issues and themes. It highlights issues of quality in care and education from the perspective of the participants. Three forms of qualitative data resources are collated: published data on Aged Care Training Packages, online survey and semi-structured interviews.

Chapter 6 discusses the findings of the five research questions. It details the key issues and central themes from the interviews arising from the findings considering Dewey's works and ideas.

Chapter 7 discusses a new pedagogical aged care education model considering Dewey's theory of democracy in education and experiential learning for ongoing professional development.

Chapter 8 proposes in conclusion: the implications, contributions, recommendations for future work for aged care education, significant findings of the study; contributions of this study to existing knowledge; a new aged care education model Democratic Experiential Learning Aged Care Education Model influenced by

Dewey’s works through his Democracy in Experiential Learning; application and implications for practice.

Chapter 2: Background and Literature Review

2.1 Introduction

This chapter examines research literature to provide an understanding of the debates and practices in aged care and quality of care. It examines five critical areas of aged care: (1) growing need for aged care; (2) models of aged care; (3) limits of aged care reforms: regulating quality; (4) key challenges facing aged care workers; and (5) adequacy of vocational education training for aged care workers.

2.2 Growing Need for Aged Care Services in Australia

This section examines the literature on the increasing demand for aged care in Residential Aged Care Services (RACS), and it addresses issues relating to an ageing population with chronic health conditions, a lack of funding, accommodation, and inappropriately trained staff to care for the older adults in aged care.

Harrington et al. (2000) and Australian government reports have highlighted the growing need for a highly skilled aged care workforce to provide quality care to a rapidly ageing population (Department of Health, 2010; Senate of Australia, 2017). In 2018, the current population stood at 25 million, of which 3.8 million Australians were aged 65 and over. Reports have forecast that Australia's population will increase to 43 million in 2056, with the ageing population growing proportionately (Department of Social Services, 2015). The Aged Care Financing Authority (ACFA, 2015) anticipates that 24% of the population will be over the age of 65 by 2036. Moreover, its forecasts will be 8.7 million older Australians by 2056 and 12.8 million by 2096 (Department of Social Services, 2014).

The increase in the ageing population is attributed to improved life expectancy and better medical technology, along with better health services (Department of Social Services, 2015). Sav et al. (2015) asserted that improvements in sanitation, housing and

education have resulted in a steady decline in mortality because of a reduction in infections. Medical technologies have improved immensely; they include vaccines that eradicate diseases, advancements in medical diagnostic equipment and medication that manages acute and chronic health conditions and health knowledge of medicines and treatments (Sav et al., 2015).

Chronic health conditions in older adults are rising, Hickman, Rolley and Davidson (2010) detailed that nearly 80% of older adults have chronic health conditions such as dementia and Alzheimer's disease, cardiovascular diseases, stroke, type 2 diabetes, lung cancer and chronic obstructive airway diseases. They claim that 37% of deaths in Australia are caused by chronic health conditions (Department of Health, 2012). As of 2016, according to the Australian Institute of Health and Welfare, the leading cause of death in older adults was coronary heart disease (AIHW, 2019)

Despite improvements in social, and environmental factors, concerns related to chronic health conditions continue to rise, particularly in older adults, because chronic health conditions have complex and multiple causes. They are generally long term and persistent, leading to the gradual deterioration in health and loss of independence, which compromises the quality of life (Department of Health and Human Services, 2017).

The ACFA (2013) reported that RACS in Australia provides care services to older adults. They are mostly operated by a mix of governmental and private operators (Department of Social Services, 2015). Most operators in Australia are not-for-profit organisations that manage high-care RACS (ACFA, 2013). The terms high-care and low-care were used in the 1980s. Nursing homes provided high-care services with high dependency needs. Hostels provided low care to older adults who require minimum support. The amalgamation of nursing homes and hostels occurred in the 1990s to prevent the older adults being transferred to Residential Aged Care Services that care

for both high dependent and low dependent elderly needs. Nevertheless, the reduced number of aged care facilities has been driven by the merging of high-care and low-care facilities in cities, as compared with regional areas of Australia. A limited number of RACS provide specialised services for culturally diverse people—predominantly those living in regional areas—such as Aboriginal and Torres Strait Islanders (ATSIs) (ACFA, 2013).

Given that most of Australia's population live in cities, the distribution of facilities between urban and regional areas appears to be reasonable on the surface. However, an analysis of funding by the ACFA (2013) suggests that an additional 74,000 places in RACS will be required over the next decade to achieve the target for residential services. Table 2.1 summarises the percentage of facilities per operator, type of operator, location of facility and type of care for 2014–2015.

2.2.1 Operators of Aged Care Facilities

Table 2.1 shows that most RACS are operated by not-for-profit organisations, and many of them offer services to older adults with high dependency care needs in the metropolitan region.

Nursing homes have been known as RACS in Australia since 1997 because of the changes in the *Aged Care Act 1997* in response to shifting attitudes towards charitable and benevolent organisations in favour of aged-care choice. Angus and Nay (2003) and De Bellis (2010) stated that RACS and other types of support assist care workers to help older people with activities of daily living under the management of approved providers. Under the *Aged Care Act 1997,* Approved providers are authorised to provide aged services and receive funding.

Pillemer and Moore (1989) claimed that in the 1980s and 1990s, older adults tried to avoid moving into aged care. They perceived aged care as 'places to die'

because many nursing homes were known to provide low-quality services. In fact, the 'dying in the home' practice was not common before 1997. The researchers explained that equipment and essential supplies were frequently unavailable, and nursing homes had no care planning to guide practice (Braithwaite, 1998; Donabedian, 1987).

Table 2.1

Residential Aged Care Facilities by Type and Per Cent (2014–2015)

Features of facilities	**Characteristic types**	**%**
Number of facilities per operator	Operates single homes	63
	Operates 2–6 homes	29
	Operates 7 or more homes	8
Type of operator	Not-for-profit organisation	60
	For-profit organisation	30
	State government	10
Location of facilities	City	58
	Regional	38
	In between urban	4
Type of care	High care	74
	Mixed care	24
	Low care	2

Source: Department of Social Services (2015)

Further, Eaton (2000) claimed that some residents laid in their waste because there were inadequate resources to meet basic needs. There were minimal social activities and physical exercises for rehabilitation to encourage independence or interaction with others, and the Government's response to poor practices was to increase funding to aged care services (ACFA, 2013).

The *Aged Care Act 1997* was intended to increase the number of government-subsidised services by aligning funding with the increase in the ageing population. The funding was expected to ensure a balance of services across Australian aged care facilities in regional areas (ACFA, 2013). Annual increases in financing are required to

meet the growing demand for aged care services. The Act shifted more responsibility and accountability upon the providers and accreditation was a means of ensuring they met requirements. They were certifying improved quality outcomes by measuring it against the standards of care outlined in the quality of care principles (ACFA, 2013).

Angus and Nay (2003), Clare, De Bellis and Jarrett (1997) and De Bellis (2010) stated that a reduction in financing resulted in a shift from a welfare system to a 'user pays' system whereby individuals make financial contributions towards the care they receive. The 'user pay' system was brought about by the amalgamation of nursing homes and hostels into Residential Aged Care Services. Nursing homes were for dependent older adults and hostels were for less dependent older adults, who were able to continue their social life independently. They also encouraged 'ageing in place' where they did not need to move even if their needs increased.

The amalgamation of the two into Residential Aged Care Services meant an increase in funding. However, funding was targeted and based upon financial means and those who were unable to pay were supported financially. This transformation from a 'welfare system' toward a 'user-pays' system was within the policy discourse of minimising labour costs and maximising profits' (Angus & Nay, 2003). While the Australian Government affords most of the financing (71%) for aged care services in conjunction with state and territory governments (ACFA, 2013; Productivity Commission, 2017), funding to service providers is primarily obtained from subsidy payments made by the Australian Government for additional services. ACFA (2013) reported that capital financing for homes is derived from investments, loans and accommodation bonds. It includes loans and grants in exceptional circumstances, such as the building of new RACS, the refurbishment of current facilities and additional

funding for culturally diverse clients and care services for Aboriginal and Torres Strait Islander (ACFA, 2013).

De Bellis (2010) and Ranasinghe and Miller (2007) voiced concerns that increased funding in the form of loans to approved providers is for building facilities and not for improving services or hiring more staff. The loans are often paid back through debt refinancing or other means. Moreover, the researchers argued that funding for RACS is inadequate because it does not cover flexible care, complex nursing care needs and additional staffing. Nursing staff manage complex needs for persons with specific chronic health conditions and other co-morbidities associated with end-of-life care (Ranasinghe & Miller, 2007).

Under the *Aged Care Act (1997),* funding is attached to compliance for the delivery of services (Angus & Nay, 2003; Ranasinghe & Miller, 2007). The Department of Health and Ageing is a regulatory body that plays a vital role in developing policies, managing programs, and providing administrative services to improve the quality of RACS in Australia. Researchers have stated that RACS are expected to be compliant in the delivery of care to receive ongoing funding (Angus & Nay, 2003; De Bellis, 2010; Ellis, & Howe, 2010; Rantz, Zwygart-Stauffacher & Flesner, 2005). Non-compliance, identified in the delivery of service, leads to a reduction in, or complete withdrawal of, funding (ACFA, 2013; Ellis, & Howe, 2010), which results in struggling services further compromising care and in some cases, closure of the RACS (Aged Care Crisis, 2010; Ranasinghe & Miller, 2006).

The Productivity Commission Reports (2017) on government services indicated that in 2015–2016, the Government's total expenditure on aged care services rose to $16.8 billion, of which 68.7% was spent on RACS (1.2% GPD). Australia spends a lower proportion of GDP on aged care (1.2 per cent) than Japan (3.6 per cent), the

Netherlands (3.4 per cent) the UK (1.5 per cent) and Canada (1.3 per cent) (Commonwealth of Australia, 2020).

Funding was based on frailty and dependency and time spent with the individual according to the rules of the Aged Care Funding Instrument (ACFI). The government funds covered items such as primary nursing, medical care services, information and assessment services, and home care and residential care (Algoso, Peters, Ramjan, & East, 2016; Productivity Commission, 2017). However, Algoso et al. (2016) claimed that the funding did not cover all aspects of care and considered it unrealistic both for the present and the future (Nay et al., 2010). Instead, the Productivity Commission report (2017) proposed an alternative in which the funding of aged care is based not on population size.

2.3 Models of Care to Assure Quality of Care

This section examines the literature on models of care that address the biomedical model in nursing homes, the social model of care in hostels and the current so-called person-centred model of care in RACS. It also addresses care workers who operate in models of care within the aged care workforce with unqualified staff.

In the 1980s, aged care facilities were divided into two models of care: nursing homes and aged care hostels. Nursing homes provided high-level care and hostels provided low-level care (Annear et al., 2014; Dwyer, 2011). Personal care workers (PCAs) primarily provided the care supervised by RNs (Angus & Nay, 2003).

Nursing homes employed the biomedical model of care (Annear et al., 2014; Brownie & Nancarrow, 2013; Nay & Garratt, 2004), which primarily focused on physical health and medical intervention, with care provided by RNs. Balding & Ibrahim (2009), Brownie & Nancarrow (2013), Nay and Garratt (2004) and Somerville (2006) argued that the medical model focused on a person's illness or dysfunction and

is not conducive to independence. The biomedical model relied on the ‘doing for’ approach towards older adults, which led to dependency, limited choices, lifestyle constraints and institutionalism through the ageing journey. This model lacked meaningful activity and rapidly led to isolation, depression, cognitive decline and hastened dysfunction (Billings, 2016; Marmot, 2005).

Billings (2016) and Marmot (2005) maintained that the biomedical model was geared towards supporting residents who had chronic illness and frailty. Residents did not have a choice of doctors, medical treatment, medication, allied health or personal nursing care. Further, Annear et al. (2014) and Brownie and Nancarrow (2013) claimed that the biomedical model was geared towards hierarchical decision-making by medical doctors through diagnosis, cure and treatment, rather than through an attempt to rehabilitate older adults to a healthy state of independence.

The advantages of the biomedical model are extended life expectancy and improved quality of life for individuals in term of medication, nutrition, and pain relief and comfort (Annear et al., 2014; Brownie & Nancarrow, 2013). The disadvantage is that, unlike the social model of care, the biomedical model did not always promote a holistic approach to good health, nutrition, activities and exercise (Davis et al., 2016).

Aged care hostels employed the social care model to accommodate those who are independent but not able-bodied enough to live in the community (Brownie & Nancarrow, 2013; Nay, Garratt, & Koch, 1999). The social care model enabled an older person to exercise social, cultural, environmental and financial independence (Brownie & Nancarrow, 2013; Marmot, 2005). Further, they could ambulate freely in and out of the hostel. They could make choices relating to care, medical treatment and allied health, including nursing services, nutrition, time and place for meals, personal hygiene and going out with their family for social functions.

Angus and Nay (2003) referred to the social care model as the concept of ‘ageing in place’, which describes residents who choose to remain in their current accommodation of choice, usually their own home, for as long as possible. This enables them to access support services as their needs change over time to that of dependency. The Government provides additional financial resources for elderly, frail people (Angus & Nay, 2003; Brownie & Nancarrow, 2013). The advantages of the social care model are that it has a health perspective that prevents infections and promotes overall wellbeing. This is because of diet, exercise, and leisure and health activities encourage the older person to remain socially connected and achieve as much independence within their capabilities (Marmot, 2005). The disadvantage of the model is that the development of medical technology and research driven, medical knowledge is diminished (Fairbrother, Chiarella, & Braithwaite, 2015).

In the late 1990s, the Australian Government reduced or ceased funding to many hostels as separate legal entities to prevent the demarcation of the biomedical model of care, which excludes psychological, environmental, economic and social factors (Angus & Nay, 2003; Nay et al., 1999). The social model broadly considers social, cultural, environmental and economic factors instead of disease and injury (Marmot, 2005).

According to Nay et al. (1999) and Angus and Nay (2003), the Australian Government’s policy on amalgamating services for nursing homes and hostels was ad hoc and reduced nursing staff hours. The lack of appropriate planning with APs, stakeholders, doctors and consumers resulted in neglect and poor health outcomes. These included an increase in pressure sores on bed-bound and residents who used wheelchairs, aggression resulting from mismanagement of medications, and a lack of dignity and respect as a consequence of poor hygiene and personal care (Braithwaite, 1998; Eaton, 2000; Pillemer & Moore, 1989).

Moreover, De Bellis (2010) and Ranasinghe and Miller (2006) claim that the reduction in RN hours means that residents are not adequately supervised. Supervision in this context means monitoring and guiding care outcomes were difficult to achieve because of reduced hours. This results in a high number of falls, as well as absconding and wandering residents because staff are unable to promptly respond to residents' needs (Davis et al., 2016; De Bellis, 2010; Ranasinghe & Miller, 2006). Further, the reduced number of RNs means that they work alongside unqualified staff who are considered incapable of carrying out doctors' orders (Angus & Nay, 2003; Brownie & Nancarrow, 2013). Unqualified care workers lacked appropriate education, such as Certificate III in Aged Care.

Wellness and retirement models of care have become progressively recognised for their contribution to the cognition and independence of older people (Billings, 2016; Dwyer, 2011). Types of care, such as the 'person-centred' approach allows a choice of care and services (Edvardsson, Fetherstonhaugh, & Nay, 2010; Brownie & Nancarrow, 2013). A 'Person-centred' approach is a model of care used in Residential Aged Care Services with an individualised structure, process, and outcome. For example, it focused on the person's needs, giving them a choice about nutrition, hygiene, activities, and comfort needs to meet desired health outcomes. It is a partnership with the resident and families, plus the medical and nursing staff (Donabedian, 1987; Ranasinghe & Miller, 2006).

RACS provides services for older people who require 24-hour maximum support. They are operated by private or not-for-profit APs, or by public organisations that receive funding provisions for RACS in Victoria (Productivity Commission Report, 2017). Angus and Nay (2003) and Brownie and Nancarrow (2013) said that the person-centred approach is not sustainable and cannot achieve quality of care, mainly because

of reduced nursing hours. The person-centred approach is a choice not only in Australia but also around the world (Edvardsson et al., 2010; Brownie & Nancarrow, 2013). The Australian Government supports person-centred care, even though it is not available to all older adult Australians (Parker & Geron, 2007). For example, aged care services are distributed unequally to ATSIs and culturally and linguistically diverse (CALD) clients. A report on disability claimed that clients aged 65 years and under who have a disability are accommodated in RACS because there are no other places for these special needs residents (ACFA, 2015; Bigby, Webber, Bowers, & McKenzie-Green, 2008; Department of Social Services, 2015). However, many personnel working with special needs residents are often not appropriately qualified to care for them because the basic certificate three level does not prepare them for residents for special needs and exceptional circumstances (State Government of Victoria 2019).

Since the Act was established, it has been open to interpretation and exploitation by APs that employ care workers to assume qualified RNs' duties (that hold a Bachelor of Nursing) (Algoso et al., 2016; Angus & Nay, 2003; De Bellis, 2010). Quality of care in RACS became a significant concern when the role of nurses in delivering care began to decline, and unregulated workers were asked to take on their duties (Angus & Nay, 2003; Clare et al., 1997; De Bellis, 2010; Dwyer, 2011; Nay et al., 1999).

Previously, the role of RNs in aged care was to manage direct care and undertake technical procedures and treatment prescribed by doctors for complex needs (Angus & Nay, 2003; De Bellis, 2010). The APs employed unregulated care staff, known as personal care workers (PCAs), who were more flexible and cost less. The PCAs are not accountable for the care they provide because they are inadequately covered by the Act (Angus & Nay, 2003; Clare et al., 1997; De Bellis, 2010; Dwyer, 2011; Nay et al., 1999).

Therefore, the aged care workforce in the late 1990s and early 2000s, more than 50% of the staff were unqualified to deliver care (Davis et al., 2016; Nay et al., 1999). Older adults are unaware that many of their carers have little formal nursing education or experience yet taking on RNs' complicated duties (Angus & Nay, 2003). These problems are exacerbated by management at the top level that is often antiquated and has no appropriate qualifications to understand and manage the care of older adults (Angus & Nay, 2003; De Bellis, 2010; Eaton, 2000; Ranasinghe & Miller, 2007).

The shift towards assigning unregulated non-nursing workers is an ongoing concern (Aged Care Crisis, 2010; Algoso et al., 2016). Plus, many APs have claimed that it is challenging to attract and retain qualified RNs to work alongside unregulated care workers (Aged Care Crisis, 2010; Algoso et al., 2016; De Bellis, 2010). The unregulated aged care workforce has been widely reported in the media, prompting people to demand better aged care services (Aged Care Crisis, 2018; Senate of Australia, 2017). However, this problem is not unique to Australia (Bartlett & Boldy, 2001). Researchers have found that issues of poorly trained staff, understaffing, and reduced healthcare outcomes also exist in other countries (Bartlett & Boldy, 2001; Clare et al., 1997; Eaton, 2000).

Further, Australian researchers in aged care have argued that unqualified staff are unable to care for residents with end-stage Alzheimer's disease and those who are highly dependent on staff (Angus & Nay, 2003; Boldy, Davison, & Duggan, 2015; De Bellis, 2010; Ranasinghe & Miller, 2006). In particular, older adults with little or no ability to communicate and those with terminal illnesses and complex needs are severely affected (Brownie & Nancarrow, 2013; Clare et al., 1997; De Bellis, 2010).

Further, nurses and care workers frequently report that they are not able to care for residents appropriately because of the conditions and time constraints imposed on

them (Aged Care Crisis, 2010; Ranasinghe & Miller, 2007). Care workers receive little or no supervision when performing their everyday jobs, and they receive no feedback on the effects of their work (King et al., 2012; Ranasinghe & Miller, 2007). Moreover, Ranasinghe and Miller (2006) asserted that care workers receive minimal instructions and information about the condition of residents. They are expected to manage care within a given timeframe while facing multiple simultaneous demands on their work (Angus & Nay, 2003; Brownie & Nancarrow, 2013; Eaton, 2000).

The Australian aged care workforce previously consisted of qualified RNs who worked alongside other health-related providers such as therapists, dentists, dietitians, podiatrists and speech pathologists (Angus & Nay, 2003; Davis et al., 2016). However, changes to funding have been perceived as encouraging the hiring of unqualified care workers (De Bellis, 2010; King et al., 2012; Radford et al., 2013). Several researchers have asserted the need for funding reforms to support suitably qualified and educated care workers (Chaplin, Crawshaw, & Hood, 2015; Courtney, O'Reilly, Edwards, & Hassall, 2007; De Bellis, 2010; Hogden et al., 2017). There are limits of aged care reforms, particularly reforms to regulate quality.

2.4 Limits of Aged Care Reforms: Regulating Quality

For decades, successive governments have made several failed attempts to regulate quality in aged care through targeted funding and legislative changes (Braithwaite, 1998; Donabedian, 1987; Nay et al., 1999). Funding has often focused on services over education, meaning that immediate services like medical, nursing and allied health procedures were funded. Still, education in terms of professional development and the identification of development needs was not supported. The education and training that is required under AP employer legislation requires that 'Management and staff have appropriate knowledge and skills to perform their roles

effectively' but is not specifics in terms of the qualifications needed (Aged Care Act 1997; Quality of Care Principles, 2014).

The ongoing depletion of human resources has adversely compromised care for older adults (Angus & Nay, 2003; Billings, 2016; Ranasinghe & Miller, 2006). For example, directors of nursing have reported that insufficient funds have reduced the number of nursing hours provided to older adults —particularly those with chronic and complex needs (Angus & Nay, 2003; Billings, 2016; Davis et al., 2016). These needs include dementia care, palliative care and other acute and chronic care needs (Angus & Nay, 2003; Ranasinghe & Miller, 2007). Substandard care and ongoing problems faced by older adults in the aged care sector are unacceptable, and further reforms are required to fund additional human resources for aged care services (Angus & Nay, 2003; Brownie & Nancarrow, 2013; De Bellis, 2010).

To alleviate these problems, the *Aged Care Act 1997* was introduced to regulate quality. It replaced the *National Health Act 1953* and the *Aged Disabled Persons Care Act 1954*. The *Aged Care Act 1997* introduced federal funding of aged care assessment teams and legislative changes to monitor the quality of aged care services (Angus & Nay, 2003; Clare et al., 1999; Donabedian, 1987; Nay et al., 1999). The Act was the first significant attempt to regulate the sector and address the problems that arose in the 1980s and 1990s (ACFA, 2013; De Bellis, 2010). It placed responsibility on APs to promote and be accountable for providing quality care to older adults (Angus & Nay, 2003). The Act defines 'care' as the types of services provided to a person with decreased physical, mental and social functioning when the person is unable to maintain themselves independently (Aged Care Act, 1997; Angus & Nay, 2003).

The QoCPs enacted in 1998 outlines the Standards of Care and Accreditation Standards. Clare et al. (1997), Damiani (2013); King et al. (2012) and Radford

Shacklock and Bradley (2012) observed that the Accreditation Standards require that there be 'an adequate number of appropriately trained staff' (Aged Care Act, 1997, p. 145; QoCPs, 1997). The Aged Care Act, 1997 and the Quality of Care Principles do not stipulate the number of nursing and care workers hours in RACS. The Department of Health also does not mandate minimum staffing levels for RACS.

The Aged Care Quality Standards is responsible for monitoring care in RACS that require all aged care services have 'sufficient, skilled and qualified staffing across all aged care services. The limited routine collection of clinical data makes it challenging to link quality outcomes and staffing levels. The National Aged Care Workforce Census (2016) shows the national average ratio of direct care workers to operational places was 0.78, with jurisdictional differences ranging from 0.66 (Northern Territory) and 0.69 (NSW) to a high of 0.91 (SA and ACT). These results do not show any evidence of variability in quality of care concerning staffing across RACS (Mavromaras et al. 2017). The Aged Care Crisis (2010) claimed that 'frail older people across Australia are at risk because APs are not meeting the minimum standards of care. There is a Charter of Aged Care Rights in the Aged Care Act stipulates that services must be of a high standard, safe, and respectful. Older adults in Australian Government funded aged care facilities have the right to high quality care and services. If providers are found to be in breach of the Charter, funding may be withdrawn. Funding is provided on the levels of care and time spent delivering services to each resident, depending on their needs (Australian Government, 2018).

Under the QoCPs, APs are accountable for Accreditation Standards and Standards of Care. The Accreditation Standards involve: (a) management systems, staffing and organisational development; (b) health and personal care; (c) care recipients' lifestyle; (d) physical environment and safe operations; and (e) home care

common standards, which deal with home care services (ACFA, 2013; Damiani, 2013; Fifield, 2014). Researchers and consumers have criticised the operation of the accreditation system (Aged Care Crisis, 2010; Angus & Nay, 2003; Damiani, 2013; Ranasinghe & Miller, 2006). Ranasinghe and Miller (2006) claimed that the auditors do not monitor for quality because they do not use clinical quality indicators as part of the assessments; therefore, the auditing is inadequate (Rantz et al., 2005). The Aged Care Crisis (2010) asserted that auditing by the AACQA focuses on processes and whether quality in care services are met rather than on measurable outcomes of adverse events such as falls, infections and polypharmacy.

According to Ranasinghe & Miller (2006), the accreditation system should monitor RACS to demonstrate continuous quality improvement in all four Accreditation Standards using carefully selected tools. However, this is not an easy task given that the level of understanding of measurement tools in aged care organisations may vary and is qualitative and subjective (Ranasinghe & Miller 2006). Several RACS are still unable to prove continuous quality improvement in all four standards (Fifield, 2014; Kaine, 2012) because of inadequate comprehension of the accreditation process and tools (Ranasinghe & Miller, 2006).

The approach of objectively measuring quality using clinical indicators, as part of the accreditation process, is used in other countries. England and Wales national standards and monitoring were implemented in 2002 and are regulated by the National Care Standards Commission (Greenfield et al., 2015). Certification of compliance is employed as a strategy to ensure that care providers deliver an adequate level of care (Bell, Robinson, & See, 2013). The United Kingdom's (UK) requirement for adequate quality monitoring includes monitoring of standards continuously through an accredited quality assurance scheme (Greenfield et al., 2015; Rantz et al., 2005).

In the US, comprehensive quality assessments, including quality indicators, are mandatory in nursing homes (Courtney et al., 2007). Quality indicators generally used in health care settings are a set of standardised, evidence-based indicators to measure health care quality. The data collated helps track clinical performance and outcomes and the number of infections, number of falls, and medication errors. It measures the safety and care provided to residents in RACS. They are deemed to improve care outcomes because the parameters form benchmarks that provide a target for excellence (Courtney et al., 2007; Rantz et al., 2005). Ranasinghe and Miller (2007), Rantz, et al., (2005) and Courtney et al. (2007) assert that clinical quality indicators expose inadequate care and facilitate accountability, transparency, quality improvement and measurement of outcomes.

Ranasinghe and Miller (2007) claimed that although accreditation teams assess RACS, non-compliance can occur at various stages throughout the three-year accreditation period. In the event of non-compliance, detailed review audits are undertaken of RACS that are suspected of being poorly run (Ellis, & Howe, 2010; Shanley, 2005). Those with issues of non-compliance receive a shorter period of accreditation between assessments and are funded accordingly (Productivity Commission, 2017). All RACS are obligated to maintain their three-year accreditation status to be eligible for funding the Australian Government, Department of Health (Hogden et al., 2017). However, researchers have argued that significant variations in quality go unnoticed during these three years (Aged Care Crisis, 2010; De Bellis, 2010; Ellis, & Howe, 2010; O'Reilly et al., 2007; Ranasinghe & Miller, 2006). For example, an abuse incident occurred in the Oakden facility in South Australia, prompting the Government to make sweeping changes to monitor RACS and to establish the Aged Care Quality and Safety Commission. Minister Ken Wyatt stated that RACS would be

assessed against the new single Aged Care Quality Standards from July 2019, with three times more unannounced visits (ICAC.OPI, 2018). This is quite a narrow approach to improving the quality of care because other underlying causes are not identified by increased monitoring. Other issues such as educational and professional development are often assessed in a cursory way and are not measured against their longer-term impact upon the quality of care. These are some of the issues that are explored in this thesis.

Reports have shown that AACQA has failed in its responsibility to oversee a quality improvement system in RACS (Productivity Commission, 2017; Annear et al., 2014; De Bellis, 2010; Ellis, & Howe, 2010; O'Reilly, Courtney, & Edwards, 2007; Ranasinghe & Miller, 2006; Rosewarne, 2002).). This is because Australia does not employ a consistent tool to measure care regularly. For example, measurable levels of performance of concern, such as bedsores, weight loss, injuries, falls, polypharmacy, rates of urinary tract infections and risk assessments, are not evaluated nor reported regularly (Courtney, O'Reilly, Edwards, & Hassall, 2010; Ranasinghe & Miller, 2006).

Those who are tasked with auditing and accreditation do not always have appropriate qualifications and knowledge in the fields of quality, education and aged care practices, which leads to a lack of consistency in the auditing process (Courtney et al., 2007; Ranasinghe & Miller, 2006). Poor auditing practices are often exposed through the media; for example, the appalling conditions for older adults in the Blue Care Bundaberg aged care facility (ABC, 2018). There are no comprehensive studies that identify best practices in quality that are consistent across all standards of care, including personal care, leisure and health, management, and safety.

2.5 Key Challenges Facing Aged Care Workers

The key challenges facing aged care workers include a lack of appropriate aged care training and insufficient nursing personnel to supervise and guide care workers. These challenges have been widely conveyed in several research studies (Angus & Nay, 2003; King et al., 2012; Nolan et al., 2008; Ranasinghe & Miller, 2006). They significantly affect the holistic care of older adults' emotional, physical, cultural and psychosocial needs (Ranasinghe & Miller, 2006).

Care workers provide direct care to older persons and therefore, must have formal aged care education (Mitchell & Cooper, 2006). However, the education and training of care workers are limited in the scope of practice meaning they can only perform specific tasks and often lack critical and problem solving skills (ACFA, 2013; Tisher, Dean & Tisher, 2009; van der Cingel, 2014). The Aged Care Workforce Strategy Taskforce (Department of Health, 2018; Senate of Australia, 2017) acknowledged that care workers' job descriptions are not on par with their training. Today, they are the largest-growing group of care workers and are considered extremely valuable, even though they have limited training in aged care (ACFA, 2013; Nolan et al., 2008).

In RACS in the 1990s, less than 50% of aged care staff were qualified (Nay et al., 1999). They worked in unsanitary conditions, worked alone after 10 pm and worked with residents who displayed aggressive and challenging behaviours or other mental health issues and communication difficulties (Aged Care Crisis, 2018). The Department of Health and Ageing (2012) acknowledged that providers wanted workers to have appropriate training in the areas of mental health, dementia, palliative care and communication with cross-cultural older adult residents (Department of Health and Ageing, 2012). Moreover, reduced flexibility to balance work and personal

commitments and the mismatch between roles and qualifications compared with duties and responsibilities caused job dissatisfaction among many care workers (De Bellis, 2010; Department of Health, 2018; King et al., 2012; Savy et al., 2017).
Also, persistent cost-cutting compromises the continuity of care (Aged Care Crisis, 2010; Karantzas et al., 2012; Sengupta et al., 2010). Hence, there is a shortage of skilled workers who are capable of managing the enormous workload challenges (ACFA, 2013; Aged Care Crisis, 2010; Sengupta et al., 2010).

Another challenge for care workers was a poor understanding of the legislative framework (Ranasinghe & Miller, 2007). The framework mainly involves the monitoring of personnel, which is difficult for PCWs to comprehend. Many care workers have reported that it is challenging to keep up to date with the changes to different types of care models while also meeting quality compliance (Brownie & Nancarrow, 2013; King et al., 2012). They described having to meet their organisation's requirements when they lack time, staff and resources to provide care (King et al., 2012).

Also, there are challenges involved in meeting regulatory compliance and managing teams to document the minute details of residents' activities, primarily for ACFI funding purposes (Australian Government, 2018). While documentation is an integral part of care, the time devoted to the task is out of balance because of staff shortages. Further, documentation activity does not appear to improve care (Aged Care Crisis, 2010; Angus & Nay, 2003).

McFarlane and McLean, (2003); King et al. (2012) and Ostaszkiewicz, O'Connell and Dunning (2016) argued that many care workers are unable to express their views openly because of their position within the hierarchy at work and their low education and training status. Care workers are anxious about being found to be non-

compliant with regulatory requirements and losing their jobs. Ostaszkiewicz et al. (2016) claimed that this fear causes care workers to only concentrate on issues that meet the accreditation standards and thus adopt an overly cautious control of residents (Ostaszkiewicz et al., 2016).

Care workers are caught in a maze of accreditation processes they do not fully understand because they have not received specific training about the Accreditation Standards and how they are implemented to achieve quality of care (Bell et al., 2013; Ranasinghe & Miller, 2007). The Government has acknowledged that much more needs to be done by APs and care workers to prevent pockets of poor standards that compromise the dignity and safety of older Australians in RACS (Bigby et al., 2008; Productivity Commission, 2008).

Moreover, previous studies and recent media discussions have reported that care workers are not appropriately trained to manage complex care, resulting in many older adults residents having to go to the hospital (Bigby et al., 2008; Productivity Commission, 2008; Ranasinghe & Miller, 2006; Stokoe et al., 2016). For example, in the absence of an RN or during staff shortages residents are transferred to hospital for minor technical procedures such as catheter insertions, wound management and removal of sutures, which are usually performed in RACS (Aged Care Crisis, 2018). Stokoe et al. (2016) claimed that there had been up to 40 transfers per 100 residents per year to the emergency department. The role delineation for care workers and restrictions of responsibilities cause difficulties because they are unable to manage complex care needs (Department of Health and Ageing, 2012; Dwyer, 2011). Plus, technology has advanced in aged care—particularly in the area of documentation—and care workers have not been trained or exposed to such technology (Department of Health and Ageing, 2017).

In the wake of complaints relating to aged care in RACS, education was not the first solution proposed; instead, more monitoring was suggested. The additional monitoring was to highlight quality concerns, quickly rectify issues and be responsive to critical incidents. This proposal is in response to the Oakden aged care facility's failure to provide care to its residents

There are currently no clear pathways for aged care graduates' careers through continuing education after they enter the aged care workforce (Department of Health and Ageing, 2017; Senate Inquiry, 2017). The basic level of education required is Certificate III in Individual Support (Ageing) or a Certificate III in Individual Support (Home and Community) Australian Qualification Framework (AQF). The adequacy of this level of training has been questioned.

2.6 Adequacy of Vocational Education Training for Aged Care Workers

There has been an enduring discussion about the adequacy of vocational training to meet aged care standards by several researchers (Angus & Nay, 2003; Hogden et al., 2017; Ranasinghe & Miller, 2006). This section addresses: (1) Vocational Education and Training (VET); (2) Australian Qualification Framework (AQF) and aged care training packages; (3) aged care training and funding; (4) delivery of aged care courses; (5) aged care placement and technology; and (6) aged care workforce and continuous professional development.

2.6.1 Vocational Education and Training

Researchers claim that a challenge facing aged care is the lack of appropriately qualified staff (Angus & Nay, 2003; De Bellis, 2010; Ranasinghe & Miller, 2007; van der Cingel, 2014). For many years, the Australian Government has provided support for aged care education (Productivity Commission, 2012b). Australia's VET system

approves training packages and is linked to five elements: (1) economics; (2) student outcomes in employment; (3) direct control over the curriculum; (4) reducing costs; and (5) increasing education (Eley et al., 2007; Hogden et al., 2017).

However, Wheelahan and Carter (2001) argued that education in the aged care sector—uses the minimalist approach (i.e. no work placements or simulation lab work) to implement aged care training with the bare minimum required knowledge.

2.6.2 Australian Qualification Framework and Aged Care Training Packages

The AQF sets the standard requirements for essential knowledge and skills. It has endorsed the VET sector to deliver nationally recognised courses since 1996. VET students choose to undertake a specific VET course—for example, aged care. Researchers have for many years argued that the VET education system is unwieldy and mainly addresses rigid core competencies rather than equip students with flexible skills to respond to changes in the work environment (Wheelahan & Carter, 2001).

Hogden et al. (2017) argued that the training packages developed by National Industry Training Advisory Bodies do not meet industry needs. For example, Certificate III and Certificate IV courses in aged care teach 'units of competency' that prescribe the roles that can be performed by a person working in aged care. However, because the roles are prescriptive, they do not meet the industry needs where roles are highly flexible and multiskilled.

2.6.3 Aged care training and funding

Funding for the VET system of education is provided by the states, territories and the Federal Government. In 2015 and 2016, the Australian Government announced extensive changes to improve aged care in Australia by simplifying funding and reducing regulations, increasing training and giving people rights and choices in quality aged care services (Cubit & Meyer, 2011; Department of Health and Human Services,

2017; Department of Social Services, 2014–2015). In 2017, the Australian Government additional funding was to support free aged care training through the Skills First program, for Technical and Further Education (TAFE) sector, Technical and Further Education (TAFE) is a government-owned college system. The free courses included health, nursing, aged care, community, mental health and disability. While Registered Training Organisations (RTO), are private colleges that provide nationally recognised training services in VET — vocational education and training were not given an additional funding boost to conduct free courses. The lack of funding to RTOs places more pressure on constructing learning programs that fit students' learning needs. The Department of Education and Training was confident in financing the TAFE sector because they claimed that TAFE was committed to providing high-quality training that led learners to real jobs. Yet, a seminar organised by the Education Department in 2018 proved that RTOs helped meet the current skills shortages in the workforce in high proportions, despite there being fewer funding incentives.

The courses are based on units of competencies that are assessed using skills-based tasks (Hogden et al., 2017; Wheelahan & Carter, 2001). Somerville (2006) and Hogden et al. (2017) argued that if the trend in RTO funding continues to decrease, training may result in poorer student learning outcomes. Bell et al. (2013) supported that aged care training is imperative to improve quality care. They argued that the US invests in the development of teaching nursing homes as part of its quality assurance systems. Federal requirements ensure that nursing assistants in the US receive continuing education as part of their annual registration (Bell et al., 2013). Sengupta et al. (2010) added that many states in the US provide additional training and continuing education to improve care workers' knowledge of the use of quality indicators.

Bartlett and Boldy (2001) and Han et al. (2014) claimed that training standards in the UK include management and administration (e.g., ongoing education and record-keeping). Training requirements cover induction programs and the practice of essential skills, as well as training days to achieve a National Vocational Qualification (Bartlett & Boldy, 2001; Han et al., 2014).

In Australia, appropriate training is required to improve care workers' confidence in providing specific and safe care (Department of Health and Human Services, 2017). The training does not address the responsibilities of care workers who manage challenging behaviours, palliative care, complex care needs and technical procedures in caring for older adults. Instead, aged care training has been criticised for being expensive and short, with courses covered in just 4–12 weeks. Moreover, in some cases, there are no work experience opportunities for students (Aged Care Crisis, 2010; King et al., 2012; Sengupta et al., 2010).

Sengupta et al. (2010) asserted that delivering training in a short period makes it difficult for students to understand the learning material, mainly when training programs focus on classroom instruction or online training rather than hands-on training in the workplace. The lack of training among care workers to care for older adult residents who suffer from chronic health conditions is detrimental to care (Sengupta et al., 2010). Bell et al. (2013) and Kåhlin, Kjellberg and Hagberg (2016) argued that regardless of the number of weeks in which aged care courses are delivered and assessed, units of competencies in training do not address the residents with complex needs, thereby leaving many care workers unprepared and forced to learn on the job. Alternatively, they learn through trial and error, particularly about caring for young disabled clients in RACS (Aged Care Workforce, 2012; Parliament of Australia, 2015; Ranasinghe & Miller, 2006).

Moreover, APs and consumers of aged care services deem 100–120 hours for practical placement was inadequate for care workers to gain experience in the workplace because it does not allow performance to be adequately assessed in different situations that arise in the workplace (Wheelahan & Carter, 2001). According to Wheelahan and Carter (2001), student learning is replaced by tasks-related activities. It does not allow students to reflect on the skills needed for future employment. Hogden et al. (2017) argued that students need to learn and develop new skills as needed, including general skills relating to literacy, numeracy, problem-solving, working in a team, and thinking critically and analytically (Ostaszkiewicz et al., 2016; Somerville, 2006; Wheelahan & Carter, 2001). Discussions for the delivery of aged care training by qualified trainers is vital to student learning.

2.6.4 Trainers' delivery of Aged Care courses

Trainers in aged care are required to deliver and meet the training and assessment requirements set by the AQF and endorsed by Australian Skills Quality Australia (ASQA) (Somerville, 2006). The AQF training packages provide for trainers a set of topics to be delivered and assessed for aged care worker as there is no national curriculum (Wheelahan & Carter, 2001). Instead, the essential knowledge and skills and curriculum are taught by the training provider (Somerville, 2006; Wheelahan & Carter, 2001). Although trainers who deliver training should have a teaching qualification, this is not always the case. There is inconsistency in the implementation of training packages, even though ASQA requires all trainers to have appropriate qualifications and industry experience to teach (Somerville, 2006; Wheelahan & Carter, 2001). Yet, teachers do not play a role in helping to formulate or develop training packages; therefore, they make no formal contribution to writing learning outcomes (Wheelahan & Carter, 2001). This is despite that teachers are theoretically responsible for learning

outcomes in training packages even though they did not write them (Wheelahan & Carter, 2001).

Researchers, Wheelahan and Carter (2001) claimed that teachers might not upgrade their skills because some courses in the VET system did not require qualifications for delivery. This has resulted in variability in the quality of student learning outcomes that do not meet the ASQA's requirements (Aged Care Crisis, 2010). Although, in 2017, ASQA stipulated the type of teaching and industry qualifications that aged care trainers must comply with by February 2019 (ASQA, 2015). However, the compliance did not extend far enough to describe the type of knowledge, skills and experience of aged care trainers, nor the knowledge and expertise required to understand current trends in aged care. For example, Ranasinghe and Miller (2007) and Ostaszkiewicz et al. (2016) observed that since the late 1990s, staff have had difficulty understanding and interpreting the *Aged Care Act 1997* and the Accreditation Standards and Standards of Care that direct the aged care industry. The teaching of Accreditation Standards was introduced in the revised Aged Care Training Packages in August 2015 and approved by the ASQA. The units of competency and the elements and criteria scarcely addresses the essential knowledge and skills required of care workers.

Moreover, researchers maintain that successful teaching requires trainers to have both aged care industry experience and a VET training and assessment qualification (De Bellis, 2010; Department of Health and Ageing, 2010; Ostaszkiewicz et al., 2016). This requirement has implications for aged care because trainers often enter aged care workplace for student placement without having aged care industry experience.

2.6.5 Aged care placement and technology

The workplace placement experience in aged care education is critical in preparing aged care workers to integrate theory and practice (Abbey et al., 2006; Gabb

& Keating, 2005; Johnson & Preston, 2001). Annear et al. (2014) observed that clinical placement allows learners to reflect upon their practice and thereby improve it in the workplace.

Learners have trouble accessing aged care work placements because of inadequate nursing staff and a lack of resources to mentor them (Abbey et al., 2006; Annear et al., 2014). Similar to the registered nursing programs, work placement for aged care courses is a mandatory component of the curriculum (Clare, White, Edwards, & van Loon, 2002). There are many challenges in securing aged care placements and no funding foraged care workplaces. Minimal research has been conducted on the challenges involved in clinical placements for aged care workers, and the impact of no funding models to support such programs. Clinical placement for students is a substantial pedagogical challenge because there is minimal mentoring of students to help them maximise their learning while on placement (Clare et al., 2002). For example, aged care and nursing programs have set types and hours of clinical experience that they are required to achieve in the curriculum, which may not be helpful for all students. Some students need more time to learn in the workplace to enable them to practice competently and safely.

Funding is not available specifically for clinical placements (Department of Education and Training, 2015). Thus, training organisations spend time and money seeking arrangements for their students (Ranasinghe & Miller, 2006). Students on clinical placements can assimilate concepts learnt in the classroom and develop problem-solving and interpersonal skills. They also become familiar with policies and procedures in the workplace (Annear et al., 2014). A lack of student engagement in placements within RACS is often associated with missed opportunities for the student to provide care under supervision (Annear et al., 2014).

The notion of giving hygiene care is considered low skilled by some and is not an inspiring task for students to undertake (Annear et al., 2014). Care workers are sometimes considered inferior because they provide rudimentary primary care to older adults. However, their work is crucial in helping older adults to continue their quality of life by assisting with personal hygiene and meals, continence and pain management and leisure activities for residents. Thus, care workers are valuable to the aged care workforce. Hence, supporting the education of care workers is significant in the work placement context (Abbey et al., 2006; Annear et al., 2014; Savy et al., 2017).

Aged care education is slow to overcome challenges faced by care workers in Australian RACS (Savy et al., 2017), and quality of care has been a growing concern since the 1980s. Government intervention is ineffective in many respects (De Bellis, 2010), and responses do not keep up with the chronic health conditions and complex needs of the increasingly ageing Australian population. These needs are still not being met by qualified care workers (Productivity Commission, 2017). (this paragraph is good but should be elsewhere)

The Aged Care Crisis (2010) has been critical of the teaching of technology in aged care, stating that it has languished behind for too long. Doctors are still required to type or handwrite notes in a system, which makes it challenging to collect and analyse information (Aged Care Crisis, 2010). A range of technology is used in aged care, including computers, iPads, eReaders, digital phones and TVs. Training aged care workers to use technology benefits both residents and staff in RACS. For example, some RACS record medication electronically by touching a button, entering a value using a slider, and writing and attaching any qualifying comments. A timecode ensures that the record is accurate.

Also, simple call lights send signals that are logged electronically by computers. The recording of call lights is one of the most sensitive measures of care—mainly if the call goes to the carer's pager or mobile phone to respond to a call bell. However, pager systems are not available to all care workers to respond promptly when a resident seeks help. Teaching care workers to use electronic notes assist uniformity and consistency of data collection and frees up time to care for residents (Aged Care Crisis, 2010). Further, data can be easier to capture in a format that is useful for communication between care staff.

The government wants aged care workers to use technology to respond to residents' health needs and document care electronically through the concept of telehealth and telecare services (Productivity Commission, 2017). Technologies that are in use in RACS include sensors and communication devices, electronic blood pressure and oxygen saturation, electronic documentation of assessments and vital signs, and dispensing and recording medications electronically. These technologies contribute to maintaining accurate information that can be used to assist with care and respond to emergencies (Productivity Commission, 2017).

Currently, telehealth and teleconferences are mainly used by doctors and dentists to communicate with specialists in regional and metropolitan areas to improve services across Australia. There is a need to expand education and training for care workers concerning using electronic communication devices to meet residents' care needs in RACS (McFarlane & McLean, 2003; Pearson et al., 2002; Productivity Commission, 2017). In the current environment, the diminished workforce and the geographical layout of new RACS make it impossible to promptly attend to residents' enquiries and care needs (Productivity Commission, 2017).

2.6.6 Aged care workforce and continuous professional development

The demand for a professional service for older adults exists in both urban and rural regions (Howe, 2009; Savy et al., 2017; Somerville, 2006). The PCW workforce is required to have formal aged care education to deliver care (Mitchell & Cooper, 2006). However, the education and training of PCWs provide a limited scope of practice (ACFA, 2013; Angus & Nay, 2003; De Bellis, 2010; Pearson et al., 2002; Ranasinghe & Miller, 2007; van der Cingel, 2014). Many PCWs are new entrants to the workforce and come from unrelated professions. Hence, work placements for students in the aged care setting are essential for students' training (Abbey et al., 2006).

The government needs to fully support an appropriate aged care curriculum to enable care workers to contribute to quality of care (Algoso et al., 2016; Chaplin et al., 2015). Moreover, they need to engage in ongoing consultations with aged care training institutions and APs in the aged care industry to develop aged care training to meet current trends and workforce demands (Mavromaras et al., 2017). As the number of care workers in aged care has grown significantly in recent years; however, many employed care workers receive very little formal training (ACFA, 2013). Given that they provide much of the direct care to older adults in RACS, there are concerns that care workers are not well supported in their training (Radford et al., 2012). The care workers are undertaking primary care in RACS (King et al., 2012). Their primary roles and responsibilities include assisting older adults with personal hygiene, continence management, meals and other related activities of daily living. However, Radford et al. (2012) and King et al. (2012) argued that the duties of PCWs should not include managing complex and chronic health conditions with minimal knowledge, skills and experience. Complex procedures that were previously performed by RNs are now being undertaken in by care workers RACS because nurses spend so much time on the

documentation that is required for funding and accreditation (ACFA, 2013; Mavromaras et al., 2017).

Researchers have long called for the adequate educational preparation of PCWs so they can operate and practice within their scope (Nay, Katz, Le Couteur, & Murray, 2009; Ranasinghe & Miller, 2006). This is the key to ensuring that care needs are identified, planned, implemented and evaluated (Mavromaras et al., 2017). Especially in areas of chronic care needs such as dementia, challenging behaviours, palliative care, chronic disease management, medication and wound management (Mavromaras et al., 2017; Nay et al., 2009; Ranasinghe & Miller, 2006). Educating care workers will support a better resident-focused approach and improve continuity of care for older adults (Mavromaras et al., 2017; Nay et al., 2009).

Although there has been some upskilling of non-nursing care staff (ACFA, 2013), very little has changed regarding quality of care because PCWs in aged care receive a minimum Certificate III in training (Aged Care Crisis, 2018). Also, there is limited continuing professional development among this group of care workers (Hogden et al., 2017; Savy et al., 2017). Increased support for further education and professional development of care workers will improve their effectiveness and confidence at work (King et al., 2012). In Australia, minimum hours of training for aged care graduates is 120 hours, as stated in the Aged Care Training Packages.

For many years, researchers have expressed dissatisfaction that professional development is lacking in aged care (Ranasinghe & Miller, 2007). Many providers do not consider professional development as a priority to improve quality care. Instead, the onus is placed on PCWs to attend professional development programs during work time, when they are already overworked (Ranasinghe & Miller, 2007). APs' responsibility to retrain aged care workers has been an ongoing concern (Ranasinghe &

Miller, 2007). Some APs offer on-the-job training using external training programs to provide better training and communication among managers and care workers (ACFA, 2013; Parker & Geron, 2007; Ranasinghe & Miller, 2006). Training should not be merely academic, but an opportunity to practice new skills by integrating training, quality improvement and care planning to refine communication and knowledge (Parker & Geron, 2007; (ACFA, 2013).

Ranasinghe and Miller (2007) argued that APs attempt to compensate for the minimum training of care workers through continuing education. However, this type of professional development is less meaningful because topics for training are chosen by management rather than care workers. As a result, some training is repetitive—for example, fire safety, continence care, manual handling, and infection control. The training does not cover new knowledge relating to managing chronic conditions and critical thinking (Ranasinghe & Miller, 2007). Moreover, the requirement for PCWs to attend training sessions annually is optional. The areas covered include palliative care, wound management, dementia, continence, nutrition and pain management. PCWs may be required to pay for their internal updated training. However, it is not a condition for ongoing employment, and it is not made compulsory by the government or managers.

The continuing education and training that are currently offered are fragmented because there are no formal teaching and assessment requirements following training. For example, in the areas of standards of care, quality indicators and care of chronic and acute health conditions (Bell et al., 2013; Courtney et al., 2010; De Bellis, 2010; McFarlane & McLean, 2003; Ranasinghe & Miller, 2007). Also, training can be costly, time-consuming and inconvenient for care workers, who are expected to fit the practice into their busy schedule (De Bellis, 2010; Hogden et al., 2017). Instead, Karantzas et al. (2012) and Radford et al. (2012) asserted that government incentives for care workers

are limited and do not provide a choice of pathways except to EN or RN nursing qualifications (Eley et al., 2007). Many care workers do not choose to become a nurse (Radford et al., 2012).

To summarise, this section demonstrated that the VET sector needs to understand current trends in practice. The Aged Care Training Packages require work placements to play a crucial role in students' learning. However, funding is minimal and does not cover aged care placements, thereby resulting in limiting students' learning concerning chronic health conditions, the regulatory requirement of Standards of Care, and the role of technology in RACS. Limitations in training packages affect the preparation of graduates to join the workforce; moreover, continuing professional development is not compulsory, even though APs attempt to provide on-the-job training to already overworked care workers.

2.7 Conclusion

The background and literature review undertaken considered five critical areas of aged care quality. The literature review demonstrated that there is insufficient academic research on aged care training and its effect on the quality of care. The review examined academic research and government reports published in recent decades to provide an understanding of aged care training and its effect on the quality of care. It examined the literature in five key areas: (1) the growing need for aged care; (2) models of aged care; (3) aged care reforms and QoCPs; (4) challenges facing aged care workers; and (5) aged care and training.

The escalating needs within aged care are well known. Still, funding remains a contention. Older adults who suffer from chronic health illnesses and who are dependent on others are not having their needs met as a result of staff shortages and unqualified staff (ACFA, 2013; Department of Health, 2010; Department of Social

Services, 2014–2015; Harrington et al., 2000). These older adults are in care facilities such as RACS and community settings such as special accommodation and health care facilities.

Models of care have changed over the years as a consequence of government policy and a reduced number of nurses working in RACS. The models of care are not easily understood and are not evaluated for their effectiveness (Annear et al., 2014; Dwyer, 2011; Hogden et al., 2017; Ostaszkiewicz et al., 2016; Savy et al., 2017), particularly in light of caring for ATSIs, diverse clients, disabled clients and clients with mental health issues. Also, the absence of training regarding the care of chronically ill residents in RACS has been an ongoing concern (Aged Care Crisis, 2010; Angus & Nay, 2003; Department of Health and Human Services, 2017; Hickman et al., 2010).

Few studies have explored the association between aged care training and its effect on the quality of care in RACS. The literature review revealed that legislative reforms and changes to accreditation have been insufficient in addressing appropriate aged care training and quality in aged care (Aged Care Act, 1997; Davis et al., 2016; Aged Care Crisis, 2018; De Bellis, 2010; Fifield, 2014; Kaine, 2012; Ranasinghe & Miller, 2007; Shanley, 2005).

The challenges encountered by APs and care workers significantly affect the emotional, physical, cultural and psychosocial needs of older adults. These challenges mainly relate to a lack of staffing and resources, budget constraints, insufficient qualified and trained carers, and the need to concentrate on documentation to meet compliance rather than provide care (Brownie & Nancarrow, 2013; King et al., 2012; Ostaszkiewicz et al., 2016).

Inappropriate training for care workers in RACS results in unnecessary transfers to hospitals. Recently, several RACS failed to comply with the Standards of Care. This

prompted changes to aged care, but limited attention was given to aged care education (Department of Health and Ageing, 2017). Currently, vocational education for aged care does not adequately prepare care workers because there is a disconnect between aged care education and practice. The current training packages in aged care do not prepare carers to operate in RACS because they did not consult APs and RTOs. A new aged care model is vital to prepare graduates entering the aged care workforce adequately. Some researchers argued that minimal education of care workers contributes to inadequate care (Aged Care Crisis, 2010; Billings, 2016; Ostaszkiewicz et al., 2016). Therefore, there is an imperative to change current teaching models and the education program to meet the quality of care standards and the challenges facing RACS (Aged Care Crisis, 2010; Billings, 2016; Ostaszkiewicz et al., 2016). Ongoing education and professional development are essential to maintain care workers' knowledge and skills (ACFA, 2013; Parker & Geron, 2007; Senate of Australia, 2017). It is essential to understand the perspectives of managers and aged care workers and the pathway to further education.

There is an interlinking of the most critical factors that contribute to aged care standards, that has again surfaced in the recent Royal Commission into aged care quality standards. However, the main thrust of the argument is that a lack of training, professional development and education is the key driver of the lack of quality, that is linked to other issues such as the nature of the provider and funding levels. The next chapter examines how the conceptual framework of the study 'pragmatism' assist as a tool to uncover many of the issues of aged care quality as they occur in the workplace. Pragmatism is a research paradigm useful to facilitate possible change as the issues are recognised in the daily work context through interviews and surveys.

Chapter 3: Conceptual Framework: Dewey's Pragmatism and Aged Care Education

3.1 Introduction

In this study, the paradigm of 'pragmatism' frames our understanding of the practical application of education in the professional practice of aged care. Pragmatism plays a significant role in guiding the research about aged care education and quality in RACS. Dewey's (1859–1952) important academic legacy establishes a base for this inquiry into aged care education and quality in RACS. This chapter describes the conceptual framework that supports the study. It addresses the foundation of pragmatism, explains the theory of pragmatism with its relevance to aged care education, and examines the use of pragmatism in other fields. The use of Dewey's pragmatism as a conceptual frame is justified at various junctures throughout the chapter.

3.2 Foundations of Pragmatism

The concept of pragmatism originated in the US in the nineteenth century and was driven by three prominent philosophers: (1) John Dewey (1859–1952); (2) Charles Sanders Peirce (1839–1914); and (3) William James (1842–1910). Dewey, Peirce and James claimed that knowledge is the product of inquiry and a problem-solving process through which people move from doubt to confidence (Devendorf, 2016; Twigg, 2010).

Peirce was born in Cambridge, Massachusetts and died in Milford, Pennsylvania. He wrote for 57 years from around 1857. Peirce developed pragmatic philosophies by illustrating their applied significance and their consequences for practice (Wicks & Freeman, 1998). James was born in New York and was a leader of pragmatism (Feilzer, 2010; Hall, 2012; Hooley, 2018(a); James, 1975; Wicks &

Freeman, 1998). His application of the pragmatic maxim focused significantly on theorising inquiry, meaning and the nature of truth.

Dewey's work is relevant to the study of aged care because his conceptual theories provide perceptive insights into daily practices and education (Dewey (1991b). A description of Dewey's work is discussed in Chapter 3 of the study. Demetrion, (2003) maintains Dewey was an educational theorist and social reformer who transformed essential methods of education and knowledge. His maxim was that undertaking progress in everyday life skills is central to education. This concept is applied in preparing graduates to work in RACS. Dewey's instrumentalism, also called pragmatism, helps to answer the research questions and justifies the methodology and methods of data collection and analysis (Demetrion, 2003; Mackenzie & Knipe, 2006; Morse & Richards, 2002; Wible, 1984). Dewey's influence lies along numerous fronts. His consideration of practice, democracy, reflection for learning has been influential. Practice is 'to do' and 'to act' that has practical consequences on the outcome.

Democracy is allowing the student to partly decide what they would like to learn and assist in the definition of the learning outcomes. And reflection is a process that engages continuous learning by examining practice and reflection upon its outcomes. Aged care education, involves theory, skills practice, and work placements. In the theory of pragmatism, Dewey rejected traditional dualisms such as realism v. antirealism. (Johnson & Onwuegbuzie, 2004). Instead, he used a process that viewed knowledge as arising from the people in their situation encountering problems (Dewey, 1997; Dewey, 1922).

Dewey's instrumentalism is a theoretical approach and set of tools used in the inquiry into daily actions, that favoured in fields such as science, law and education (Demetrion, 2003; Dewey, 1991b; Wible, 1984). Scientific inquiry best solves uncertain

questions. (Dewey, 1922) Dewey's theories are epistemology, metaphysics, naturalistic inquiry, active and dynamic adaptation, instrumentalism, human inquiry, and warranted assertability for truth (Wible, 1984). *Epistemology* is the philosophy of knowledge, especially regarding its approaches, soundness and opportunities, and the difference between acceptable belief and opinion. Dewey and other pragmatists claimed that knowledge is the construction of inquiry and a problem-solving process through which people change from uncertainty to certainty (Dewey, 1948; Devendorf, 2016; Sleeper, 2001; Twigg, 2010). Knowledge is regarded as being created on the truth that is experienced in life (James, 1975; Johnson & Onwuegbuzie, 2004).

Metaphysics is the division of viewpoints, including intangible thoughts such as being, knowing, identity, time and space (Dewey,1948).

*Naturalistic inquir*y is a method to interpreting situations, wherein, the researcher observes and understand the experiences of individuals and groups in a cultural and social context (Dewey,1948).

The concept of *active adaptation* includes seizing opportunities such as opportunities for learning. Dewey's pragmatism theory helps individuals to improve and manage their situations (Wells, 2000; Wicks & Freeman, 1998). Dewey favoured the truth method, which observes knowledge as rising from a dynamic version of the human creature to its situation (Cochran, 2012; James, 1975).

In *human organism*, humans use the ability to be artistically creative with technologies to develop a logical understanding of ourselves and the world (Dewey, 1916; Dewey, 1922; Dewey,1948).

Instrumentalism is a useful educational tool, regardless of whether concepts and theories are factual. It highly regards the reality and influence of the world of human experience (Dewey, 1991b; Johnson & Onwuegbuzie, 2004; Wible, 1984).

In *truth*, Dewey interprets meaning and knowledge as uncertain and changing over time. The researcher observes what is considered provisional truths. There is an absolute truth as well as provisional truths that we acquire (James, 1975; Johnson & Onwuegbuzie, 2004).

Warranted assertability refers to inquiry into a world that is not static instead of into things that are 'lived' by people. When knowledge is taken as an intellectual form of inquiry, it means warranted assertability of truth (Johnson & Onwuegbuzie, 2004).

An additional characteristic of pragmatism is 'practical theory', which is functional and informs active practice, or 'praxis'. It takes a value-oriented method to explore values such as equality, freedom, democracy and cultural values (Johnson & Onwuegbuzie, 2004).

3.3 Theory of Pragmatism and its Relevance to Aged Care Education

Dewey's theory of pragmatism is particularly relevant to aged care education. Theories can be used to solve problems and difficulties confronting inquiries (Cochran, 2012; Demetrion, 2003). Dewey's theory of knowledge distinguishes three phases of the learning process. First, the problematic situation is practical—that is, care workers provide varying levels of quality of care to older adults in RACS. The inconsistent implementation of quality of care, inadequate monitoring of quality care, and differing interpretation of standards result in inconsistent standards in the delivery of care; this is Dewey's 'problematic situation'. The second phase involves data collection, and the third phase is the reflective phase, which includes the cognitive and academic elements of inquiry of the problematic situation. Dewey defended the process of inquiry to understand how we attain both common sense knowledge and intellectual knowledge arising from scientific investigations. Dewey (1922) recognised the significance of the diverse richness of human experience and the need to understand and analyse the active

process of inquiry—for example, to discover facts by reflecting on the data (Dewey, 1910). Reflection involves a sequence of ideas from the data to determine the proper outcome of theory and practice (Dewey, 1910). His school of thought has become significant for informal educators in many areas of practice (Demetrion, 2003; Devendorf, 2016).

Dewey asserts that education must involve experience, knowledge, reflection, and a focus on interactions in learning environments (Demetrion, 2003; Devendorf, 2016). Dewey's progressive education and some of his writings, including *Democracy and Education*, as well as *Experiential Learning*, are explained further in this study (see Chapter 4 and Chapter 7). Care workers learn from experience and gain knowledge on how to manage different situations under the guidance of their teacher or nurses who supervise them. They learn from doing hands-on and reflecting on the outcomes of applying theory to practice.

Pragmatism is a balanced method to address the research questions regarding educational issues such as understanding how RTOs teach the Quality of Care Principles legislated in the *Aged Care Act 1997* and the preparation of aged care graduates for the workforce. The problem of variability of quality in aged care in terms of the inconsistent implementation of standards of care, inadequate monitoring of standards of care, and differing interpretation of standards could be because of educational deficiencies. The problem of variability of quality allows the researcher to see 'the other side', that is, it allows the researcher to see problems and possible solutions from the viewpoint of the participants.

The application of Pragmatism asks 'why?' and 'what works?' to highlight the problem and seek solutions (Wells, 2000). Johnson and Onwuegbuzie (2004) emphasised the benefit of using the theory of pragmatism in quantitative and qualitative

research. It is useful in quantitative research for testing and validating premises that are created before the data are collected. Pragmatism can generalise research findings when the data are based on random samples of sufficient size. It also generalises research findings using different populations and subpopulations, and it is particularly useful for predicting data. This process involves data collection, such as surveys, which are relatively quick to implement and provide specific numerical data that are less time-consuming to analyse. (Johnson & Onwuegbuzie, 2004). Pragmatism also has advanced trustworthiness with people in authority, such as managers, politicians, and funding bodies, because more significant numbers of participants can be included and its principles are well established (Johnson & Onwuegbuzie, 2004).

Sharma, Devi & Kumari (2018) discuss the application of Dewey's principles in other vocational fields, such as Engineering. The principle of utility, practicality and value that everything should be useful and relevant to the student lives. The principle of interest that students should be involved in the curriculum context, talking with one another, investigating things through experimentation, making things and being practical and creative. Principle of experience, learning through project-based learning and hands-on learning that focuses on keeping things practical. And the principle of holistic integration of concepts in the curriculum and the purpose of the subject being taught. These principles are prevalent in the thesis, partially in the interviews with participants and the proposed model in Chapter 7.

The use of pragmatism in this study is primarily based on gaining data that is not precise, quantitative, nor numerical. Instead, it is mainly qualitative data from interviews. To ensure that knowledge produced is for direct application and explicit to local circumstances, conditions and persons, the emphasis is on actions and consequences of the way the world is viewed (i.e., relativism) (Marshall, Kelder, &

Perry, 2005; Schwandt, 2003). From Dewey's educational point of view, this means that students must interact with their environment to adapt and learn thus, this study employs a mixed methods approach using pragmatism as its conceptual framework and theory to understand people in their workplace.

3.4 Use of Pragmatism in Other Fields

Pragmatism assists in the design of this research to give weight to the results. Pragmatism has been used in nursing and health. This is, for example, to identify better ways to manage palliative care and problem-solving the ethical challenges facing health professionals, for example, when treating brain-damaged patients. Pragmatism and the understanding ‘change’ have implications for nurses, nurse managers and nursing. A pragmatic approach in this study reveals problems that need changing in the personal, professional and organisational levels.

Pragmatism is closely associated with mixed methods data collection in research because it ‘sidesteps the issues of truth and reality’ (Feilzer, 2010, p. 8) and ‘focuses instead on “what works” as the truth regarding the research questions under investigation’ (Tashakkori & Teddlie, 2003, p. 713). One of the limitations of pragmatism is that it overlooks the cultural aspects of a problem in favour of the technicalities of ‘what works’ (Beista, 2007). In this thesis, the observations of the cultural as well as the technical are combined as they inform one another and are difficult to separate. Both perspectives must be used for informed professional and education action (Beista, 2007).

The use of mixed methods data collection is often used with pragmatism that involves collecting, analysing and integrating data from surveys and interviews (Creswell & Garrett, 2008; Creswell & Plano Clark, 2011; Lipscomb, 2008; Morse & Richards, 2002; Teddlie & Yu, 2007). Johnson and Onwuegbuzie (2004) argued that in

pragmatism mixed methods of data collection offer the best opportunities for answering research questions. For example, value-oriented education involves planned educational actions aimed at developing attitudes, values, emotions and behaviour patterns in learners. Hence, the pragmatic approach using mixed methods of data collection offers a comprehensive understanding of the research problem. Mixed methods data collection in pragmatism relies on the premise that pursuing the understanding of the research problems is central; thus, any research methods—quantitative or qualitative—can be used flexibly (Creswell, 2007a; Creswell & Garrett, 2008; Creswell et al., 2003; Creswell & Plano Clark, 2011; Lipscomb, 2008; Newby, 2013; Teddlie & Yu, 2007; Yin, 1984).

Dewey's (1991b) theory of experimentalism has been employed in fields of research such as nursing education. The idea of valuing application over theory is reflected in the philosophy of pragmatism used in the field of healthcare research. Long, McDermott and Meadows (2018) claimed that many healthcare workers identify with the real-world and realistic rather than the academic and ideal. In doing so, they judge the value of knowledge in addressing practical questions with action, thereby making knowledge meaningful (Bragg, 2005).

Pragmatism validates and evaluates actions, and this is necessary for a profession such as nursing or teaching that works in a real-world setting that focuses on consequences from actions (Marshall et al., 2005). Pragmatism, as a theory of knowledge, can be utilised in mixed methods approached so that the strengths of all methods can be used together (Wicks & Freeman, 1998). Similar to other research methodologies, Pragmatism in mixed methods data collection addresses enquiries about the credibility of evidence and enhancing the praxis of mixed methods evaluation

(Creswell & Garrett, 2008; Creswell & Plano Clark, 2011; Hall, 2013; Lipscomb, 2008; Schwandt, 2009).

Dewey's pragmatism is applicable as it seeks to address problems by finding solutions. Hall (2013) upheld Dewey's (1920) assumptions and asked researchers to 'discover the meaning of the idea' by asking 'for its consequences' (p. 163). Deweyan pragmatism 'embraces and promotes the mixing of methods' (Greene, 2007, p. 69) in which the researcher is the instrument (Hall, 2013; Mertens, 2010). Mixed methods demand a theoretical component to direct inquiry decisions (Creswell, Plano Clark, Gutmann, & Hanson, 2003; Creswell & Plano Clark, 2007; Creswell & Garrett, 2008; Lipscomb, 2008; Teddlie & Yu, 2007).

Pragmatism also develops a broad view of credibility, connecting it to practice. Dewey (1923) stated that pragmatism 'insists' upon the consequences (p. 8) and increases the role of credibility beyond investigations of methodological rigour to include reflections on practices and their results (Hall, 2013; Schwandt, 2009). In this study, the paradigm is a research framework centred on the experiences of aged care workers in RACS. Pragmatism in this study explicitly addresses issues of truth arising in aged care education to find a solution.

3.5 Dewey's Works and Ideas on Pragmatism in Education

Pragmatism as an educational philosophy has two crucial elements: (1) theory, or lessons delivered in the classroom; and (2) practice, which focuses on real-world applications of lessons that involve learning through experience and not through simple ideas. The central focus of Dewey's philosophical interests throughout his career is traditionally called 'epistemology' or the 'theory of knowledge' (Hooley, 2008). However, Dewey explicitly rejected the term 'epistemology' and preferred the 'theory of inquiry' or 'experimental logic' as more representative of his approach. A pragmatic

view of epistemology recommends that we know and understand the world through our experiences and senses (Hooley, 2018a, p.16). The word pragmatism originates from the Greek ‘pragma’, which means ‘to do’, ‘to make’ and ‘to accomplish’. In the twentieth century, progressive education emphasised the need to learn through a ‘hands-on’ approach, and Dewey’s primary point of pragmatism is that something is true and real if it works (Boucher, 1998; Howlett, 2013).

Dewey’s experimental school of thought is significant to this study because it explains both the theory and practice required to understand the truth of a situation. Dewey believed that it is better to teach critical thinking than rote learning (Devendorf, 2016; Dewey, 1997). Dewey was concerned with developing the minds of both students and teachers to develop their full potential as human beings (Dewey, 1922). Thus, students should gain knowledge and strengthen their skills, habits and attitudes to overcome problems (Devendorf, 2016). Dewey’s theory of experiential learning is the process of learning through reflection and experience (Devendorf, 2016; Itin, 1999). Pragmatic activity lies at the centre of all educative processes. Every continuous experience or event is educative because it is a constant reorganising or reconstructing of experience.

Problem-solving a core of all educative process becomes empirical, experimental and diverse: in a word, pragmatic. An example of the educative process is the enrolled nursing program in which theory is followed by skills demonstration and practice. The enrolled nursing program is a diploma level course that is accredited by the Australian Nursing and Midwifery Council. It is a VET course and is delivered by a registered training organisation or higher education training institution. An enrolled nurse must complete the diploma qualification of nursing requirements to be registered with the Nursing Midwifery and Board of Australia. An enrolled nurse, while working a

significant role, has less authority in a hospital. They work as part of a team, rather than in a supervisory role. They provide nursing care to patients in a variety of health, aged care, welfare, and community settings under the supervision of Registered Nurses.

To ensure they are ready to practice, students are required to demonstrate their knowledge in an objective structured clinical examination (OSCE). They then attend work placements, which enable them to apply their knowledge in practical situations in aged care, primary healthcare and mental health situations. Dewey recognised that individuals are unique and spontaneous and that their minds are active and naturally curious. Thus, students' interests are guided by educators as they gain knowledge of nursing and aged care and apply their skills in practical placements (Boucher, 1998; Devendorf, 2016).

In *Experience and Education*, Dewey (1938) explained his philosophy of experience and its relation to education. Dewey urged educators seeking a new movement in learning to regard the broader and more significant issues of education. We learn from reflecting on experience (Dewey, 1938). Dewey emphasised experiment, purposeful learning, freedom and other concepts we now consider progressive education (Howlett, 2013). The idea of experiential learning is the product of reflecting upon experience with different educational outcomes (Fowler, 2008; Howlett, 2013). For example, based on the pragmatic philosophy, individuals learn by observing the consequences of their experiential actions; thus, learning becomes continuous.

In 1920, Dewey recognised that when one first faces a problem, the primary task is to comprehend the problem by describing its elements and its relationship to the problem (Dewey, 1920). Dewey's principles of pragmatism as a methodology supports the approach in data collection and analysis to strengthen the overall study design

(Devendorf, 2016; Dewey, 1938a). A more comprehensive discussion of Dewey's work and its relationship to research methodology is presented in Chapter 4.

Pragmatism's philosophy of the search for truth is a scientific method and the power of the human belief system in what it is investigating (James, 1975). The theory of truth as an epistemological purpose and belief is associated with inquiry, which is an essential part of pragmatism. It is the ability to assimilate, validate, corroborate and verify the facts arising from the various data collected (Devendorf, 2016; Dewey, 1920; James, 1975).

The central principle of pragmatic philosophy is that people create their values during activity (Dewey, 1925). This is because pragmatism is an educational philosophy about life and growth within individuals (James, 1995). For example, aged care trainers teach students practical aspects of work in aged care to encourage them to grow into better workers when they provide care to older adults. This example of developing human values from social practice (i.e., caring for older adults) provides an empathetic understanding of what it means to be human (Dewey, 1922; Dewey, 1925; James, 1995). Values emerge from both local and general practice whereby human services such as aged care relate to appropriate human values that should align with caring for older adults. The philosophy of pragmatism helps to resolve practical problems, and it emphasises the importance of determining practical implications (Feilzer, 2010; James, 1995). For example, qualitative data collection and analysis strategies that are open-ended and exploratory (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Denzin & Lincoln, 2005; Elliott & Timulak, 2005). The qualitative data collection is useful when there is limited information to a complex problem such as the variability of the quality of aged care and to know if training will impact on the quality of care.

Using Dewey's (1916) *Democracy in Education*, the researcher sought to understand how aged care graduates can gain knowledge that will also advance the attitudes, customs and skills necessary for them to unravel a wide variety of problems (Boucher, 1998; Dewey, 1916, 1940). Education is broadly defined as enabling the acquisition of skills, knowledge, habits, beliefs and values (Howlett, 2013). Similarly, aged care training is defined as providing practice in a simulated environment and experience in a real-world setting (Somerville, 2006; Wheelahan & Carter, 2001). Dewey' educational philosophy of pragmatism encourages educationalists to deliver excellence that would inspire students' to learn and adapt and experience reality in their environment (Dewey, 1997a; Elkjaer, 2009).

Experiential learning is the development of learning through experience (Dewey, 1929)—especially when the student learns through reflecting on a task. An example is a student who learns how to use equipment more effectively (e.g., a blood pressure machine or a lifting machine). Aged care education takes place in formal and informal settings with formative and summative assessments whereby teachers can help assess students by presenting real-world problems and situations in aged care. Learning is most effective when learners want to reflect upon and absorb knowledge (Howlett, 2013).

In Dewey's (1920) *Democracy and Education*, his pragmatic philosophy is embedded with democratic theory and includes organisations that foster ideas that result in freedom. The real heroes of democracy are teachers who help people to achieve 'vision, method and knowledge' (Dewey, 1920, p. 131). Dewey's education philosophy aims to increase academic democracy in learning. Dewey stated that students must learn to conduct successful transactions with their environment in ways that integrate the operations into their experience (Demetrion, 2003). Satisfactory learning experiences

depend on the quality of learning and meaningful practice as determined by the student. Democracy and education are mainly concerned with the general perspective that gives them meaning (Chambliss, 2003).

Similarly, Hooley (2018a) asserted that democratic learning involves considering the views of others through observation of, possibilities, results, and developing an understanding of views to plan and direct new inquiries. Over time, general ideas based on this experience are accepted by communities as being appropriate guides for further action. Epistemology is fundamental to what it means to be human, where knowledge comes from, and how we learn. It is very much tied up with the political and economic forces of the day and can, therefore, distort the understanding of ourselves and others. It affects how we view our hopes and aspirations for a better world (Hooley, 2018b).

Dewey's core concepts are:

- Student Development
- Active Engagement
- The capacity of students to make inferences and judgements

Examples of the core concepts are particularly relevant and applicable to aged care training, as outlined below.

Student development: Aged care teachers provide supportive instruction to help students make a connection between their knowledge and practice. Aged care teachers link instructional content to the aged care experiences, expertise and interests of students. Teachers use an integrative approach to help students expand into new areas of knowledge acquisition and learn the skills required for aged care (Demetrion, 2003).

Active engagement: Aged care training courses involve practical placements whereby students are given instructional materials to help integrate their knowledge into

practice. The use of instructional materials to teach students the skills and knowledge they require to practise in a simulated environment depends on the trainers' expertise and experience. This enables students to use the materials to complete the tasks (Demetrion, 2003).

The capacity of students to make inferences and judgements: A simulated lab provides a formative and summative environment to help students develop their skills. It presents students with various scenarios using teaching resources that represent working resources. The resources stimulate active learning and enable students to independently master skills with the support of their teacher (Demetrion, 2003). It is crucial to encourage an interactive learning climate that links students' knowledge and interests through communication and language. Dewey 'emphasised human communication and language in learning' (Hooley, 2018a, p. 57). Participation that involves an understanding of communication is a way of replying to expectations, opportunities and requirements (Dewey, 2012)

The involvement of aged care managers and carers in this research provides a better understanding of the type of aged care education required to prepare care workers to work in the aged care sector and achieve a high quality of care. Trainers in aged care primarily impart knowledge by sharing their experience until it becomes a joint possession (Chambliss, 2003).

Dewey noted that the quality of the process has two interrelated phases: 'social and individual'. The meaning of experience is the 'social' side, while the agent of knowledge is the 'individual' side. Both aspects are part of the same process. Emphasising the individual as an agent in reconstructing experience increases the social value of the individual's expertise (Chambliss, 2013). For example, education is a lifelong process for students, who should be able to 'think through' problems. Aged

care students are given scenarios of situations that occur in aged care, and they are required to logically think about the steps they would take in each scene and learn from each other's experience.

Dewey and others presented the theory of truth as the 'power to work'. Dewey stated that the instrumental view of truth claims ideas become true with our experience (Devendorf, 2016; Dewey, 1997; Dewey, 1920; James, 1975). Dewey held the view that active and dynamic learning helps individuals develop their abilities and motivates them to reflect on the world around them critically. Aged care students engage in meaningful and appropriate activities that permit them to apply the notions of care learnt and hands-on projects create authentic learning experiences (Devendorf, 2016). For example, students practise their skills in simulated and work placement environments to gain experience in providing care.

Dewey claimed that the unique aims of education are to advance all the inherent capacities of the individual. Knowledge is a process of development and is essential in maintaining and establishing learning situations using student-centred methods of teaching (Simpson, Jackson & Aycock, 2005). Dewey believed that education is a continuous reorganisation, rebuilding and integration of experiences and activities. Experiences and experiments provide knowledge, and educational development is ongoing.

Dewey's philosophy of education involves 'lived experiences' and 'shared experiences'. The latter implies that a person 'lived experiences' learning with others (i.e., 'experiential learning'). 'Shared experiences' became a fundamental tenet of Dewey's viewpoint of pragmatism and the foundation of his philosophy of education (Elkjaer, 2009; James, 1995). The theory of experience as a fundamental tenet of the

philosophy of education brings together the practical lessons of theory and practice (Doyle, Brady, & Byrne, 2009; Feilzer, 2010).

It can be argued that Dewey's work is significant in vocational education because it is about 'doing'. Howlett, (2013), likewise claims Dewey's emphasised the need to learn by 'doing'. Indeed, aged care students undertake theory and clinical placements as part of their educational experience to provide real-world experience. The following chapters on the research paradigm, methodology and mixed methods examine the experiences of managers and care workers in RACS.

3.6 Conclusion

This chapter showed that Dewey's work on pragmatism is particularly crucial in this aged care study because Dewey's work helps us understand the views and understandings of the participants. This chapter briefly discussed pragmatism as a conceptual framework and its relevance to aged care education. Also, discussed was the use of pragmatism in other fields, Dewey's works and ideas on pragmatism in education, and its application in this study. Therefore, the chapter positioned pragmatism within a broader context. The model of pragmatism helps to determine the research design (James, 1995; Mackenzie & Knipe, 2006). This research approach offers a robust conceptual framework that aligns with investigating aged care education and its effect on quality in the context of this research.

The next chapter presents the position and justification for the philosophical and theoretical paradigm of pragmatism. The theory of pragmatism underlines the qualitative approach in the research design, which employs a mixed methods approach for data collection and analysis (Creswell & Plano Clark, 2011; Denzin & Lincoln, 2000; Denzin & Lincoln, 2005; Lipscomb, 2008; Teddlie & Yu, 2007). The methodological decisions are solely made on the research questions to reflect the

assumptions about the nature of knowledge and how such knowledge is attained (Bliesmer, 1993; Creswell & Plano Clark, 2011). This is because qualitative research methods generate ‘thick’ descriptive data that illustrate the interdependent relationship between individuals and the work context in which they reside (Creswell, 2003; Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Denzin & Lincoln, 2005; Morse & Richards, 2002; Newby, 2013).

Chapter 4: Methodology and Methods

4.1 Introduction

This chapter discusses how Dewey's conceptual framework is applied in the methodology by (1) justifying Dewey's pragmatism in a qualitative approach, (2) using pragmatism in a mixed methods approach to data collection and analysis and (3) validating the methods chosen for the study. The researcher received ethics approval ID number HRE16-149 from the Victoria University Ethics Committee to proceed with the research project to interview managers and Care Workers in Aged Care.

To recap, the research questions are: 1) how is quality of care perceived by aged care workers and managers working in RACS? 2) how do RTOs teach the Quality of Care Principles legislated in the Aged Care Act 1997 to aged care workers? 3) how do managers and care workers in RACS perceive gaps in the knowledge and skills of graduates? 4) How do aged care graduates view their preparation to work in aged care after gaining employment in residential aged care services? 5) What are the features of 'good' aged care training according to managers and care workers?

4.2 Justifying Dewey's Pragmatism in a Qualitative Approach

As discussed in the previous chapter, pragmatism is an appropriate paradigm in this research because it highlights the issues and concerns in the workplace; mainly how students apply their knowledge. Pragmatism relates to the practical nature of reality and finding truth in solutions to problems (Feilzer, 2010; James, 1975; James, 1995; Shaw, Connelly, & Zecevic, 2010). Problems are solved in real-world settings rather than making assumptions about the nature of knowledge (Hall, 2012).

The philosophical underpinnings of pragmatism reflect the ontological, epistemological, and methodological perspectives of this research (Creswell, 2003; Mayoux, 2007; Shaw et al., 2010). The paradigm influences the questions the researcher

proposes in the data collection (Doyle et al., 2009; Morgan, 2007). Table 4.1 outlines the researcher's application of pragmatism.

Table 4.1

Pragmatism—Pragmatic Diagram

Axiology	**Ontology**	**Epistemology**	**Methodology**	**Methods**
Values and ethics.	Nature of reality.	Nature of knowledge between the knower and what would be known.	Researcher gains knowledge through the process of research.	Mixed methods.
Researcher values the quality of care for the elderly in RACS.	Researcher seeks to understand aged care education from the perspective of managers and care workers' interpretation of the reality of the quality of care.	Researcher knows that good aged care education affects the quality of care by examining the participants' perspective and learning what is of value.	Researcher gains knowledge by using Dewey's pragmatism paradigm in a qualitative inquiry to explore education and quality.	Researcher employs data collected from document analysis, online survey and interviews with managers and care workers in RACS.

The justification for using pragmatism is that it provides insights into the significant issue in RACS. This study aims to understand the reasons for the ongoing problems in the aged care sector that relate to aged care education through researching age care workers and managers. The questions aim to understand and create a better education space for students' training in aged care by allowing care workers and managers to discuss what works best in their practice (Dewey, 1938b).

4.3 Pragmatism and a Qualitative Approach

Pragmatism is an approach that supports the use of mixed methods data collection in research. It 'sidesteps the contentious issues of truth and reality' (Feilzer,

2010, p. 8) and ‘focuses instead on “what works” as the truth regarding the research questions under investigation’ (Tashakkori & Teddlie, 2003, p. 713).

The qualitative research allowed the researcher to ask questions in a work setting and to explore topics relevant to the participants (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Elliott & Timulak, 2005). It provides a voice on sensitive issues that participants would not feel comfortable discussing in groups (Creswell, 2003; Creswell et al., 2007; Mayoux, 2007; Wilken, Walker, Sandberg & Holcomb 2002).

The critical aspects of using the qualitative approach in this study are: (1) data collection does not use pre-existing categories for organising data; instead, the focus is naturally driven by the research questions and participants’ responses; (2) qualitative interviews allow participants to take the lead and share their opinions and perspectives, for example, on aged care education and quality in RACS. The qualitative research approach aims to discover new insights into aged care education by interviewing participants in their natural setting—that is, their work in RACS (Creswell & Maietta, 2002; Lincoln & Guba, 1985).

Concerning the qualitative approach, Dewey’s (1938) concept of inquiry is a guide for action in qualitative inquiry. He believed that all inquiry arises from actions in the environment in which humans are directly involved. Qualitative relates to ‘concern or interest’ and ‘values’ when a problem arises, and a solution is planned using methods of inquiry. Pragmatism results in the formation of values from our social practice. We work out what is right and wrong, and values arise from action and reflection on action.

4.4 Pragmatism and Mixed Methods of Data Collection

Three methods of inquiry were chosen and triangulated to examine the phenomenon of aged care training and variability in the quality of care in RACS:

document analysis, online survey and semi-structured interviews. Figure 4.1 presents an overview of the data collection methods used in the research.

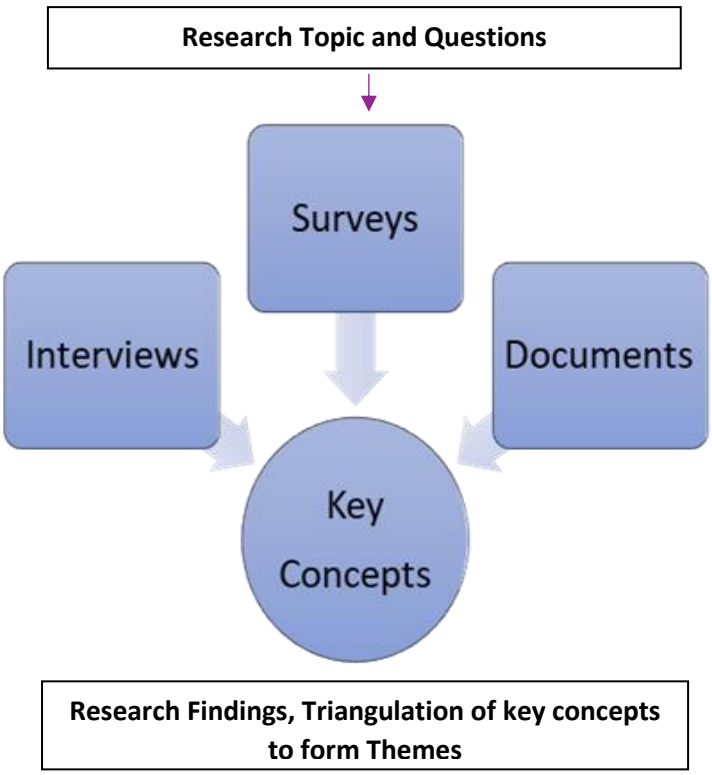

Figure 4.1. An Overview of the Data Collection Methods

Examination of the three data sets indicated that the interviews were more comprehensive and provided greater depth than the other two sets. For this reason, the methodology below has been arranged to focus on the interview data first, which are then triangulated with the other two data sets.

Purposive sampling of participants was used in the semi-structured interviews to explain and offer further insights into the phenomenon under investigation. The data collection included the published documents of the Quality Care Principles and the Aged Care Training Packages to establish whether the quality of care services have been adequately addressed when preparing aged care workers. The quantitative data from the online survey responses helped to develop the qualitative questionnaire to

collect additional data from participants to shed light on the phenomenon. All three data sets were valuable, and the interviews had more weight because responses took into account the voices of participants currently practising in the aged care sector, which enabled a connection to be made between theory and practice. Table 4.2 presents a summary of the mixed data resources used to answer the research questions.

Table 4.2

Mixed Data Resources

Document analysis of published resources	**Online survey resources**	**Interview resources**
Aged Care Training Packages. The following records were accessed: (1) Aged Care Certificate III in Individual Support Training Packages (2015), including CHC33015: Certificate III—Individual Support for Ageing, Home & Community; CHC33015: Certificate III in Individual Support—Disability; and CHC43015: Certificate IV in Ageing Support. (2) QoCPs 2014 (Federal Register of Legislation, 2014). *Appendix 1*: Summary of document analysis on Aged Care Training Packages and QoCPs	Number of respondents 360 An online survey using Qualtrics software. A total of 29 questions were asked: • 1–27: closed-ended questions; • 28: invited participants to provide contact details if they wanted to be interviewed; • 29: open-ended to ascertain participants' views and suggestions for improving aged care training. Questions 1–27 addressed: • participants' organisation • knowledge of quality • understanding of quality care indicators • aged care operations • accreditation and standards of care outcomes.	Twenty-two semi-structured interviews with personal care workers and managers.
Research questions: 1. How is quality of care perceived by aged care workers and managers?	Research questions: 3. How do managers and care workers in RACS perceive	Research questions: 1. How is quality of care perceived by aged care workers and managers?

2. How do RTOs teach the QoCPs legislated in the *Age Care Act 1997* to aged care workers and managers? 3. How do managers and care workers in RACS perceive any gaps in the knowledge and skills of graduates?	any gaps in the knowledge and skills of graduates? 4. How do aged care graduates view their preparation to work in aged care after gaining employment in RACS? 5. What are the features of good aged care training, according to managers and care workers?	2. How do RTOs teach the QoCPs legislated in the *Age Care Act 1997* to aged care workers and managers? 3. How do managers and care workers in RACS perceive any gaps in the knowledge and skills of graduates? 4. How do aged care graduates view their preparation to work in aged care after gaining employment in RACS? 5. What are the features of good aged care training, according to managers and care workers?

4.4.1 Document Analysis of Published Resources

Documents on the training packages were obtained from the Department of Education and Training's website, whereas the QoCPs were obtained from the Federal Register of Legislation website. The advantage of accessing this data source was that the researcher had practical knowledge because of her long experience in the aged care and education sectors. The disadvantage was that this was not the primary source of data analysis. The information from published documents was useful to data collected from other sources to verify the findings later in the study, such as the online survey and interviews.

4.4.2 Online Survey

An online survey using the Qualtrics software was sent to all aged care services in Melbourne and regional Australia to investigate critical areas of aged care knowledge and seek suggestions for improvements in aged care education. The online survey was distributed to participants currently working in the aged care sector in Victoria. The

advantage of the survey was that it facilitated the exploration of variables such as attitudes, opinions, behaviours and characteristics (Borrego, Douglas, & Amelink, 2009; Creswell, 2013). The perceived anonymity of respondents was a significant advantage when gathering information about their understanding of aged care training. A disadvantage was that there were no opportunities to clarify responses to specific questions provided by the participants.

Participants in the online survey were chosen from the publicly available contact details of RACS, obtained from the websites of the Department of Health and Ageing and the AACQA. Fifteen hundred residential care facilities (excluding community-based services) were selected from the Department of Health and Ageing's website.

Victoria University's (VU) Qualtrics online software package was used to develop and formulate the survey questions. The survey included a combination of closed-ended questions, multiple choice questions, checkboxes, dragging answers to relevant issues and open-ended questions. Before executing the survey developed by the researcher, the questions were given to the researcher's supervisors for feedback and clarity. An email was sent to invite potential participants to respond to the online survey. A link to VU's Qualtrics survey was provided and was kept open for two months (November 2016 to February 2017), and weekly reminders were sent via email. The questionnaire was sent to both managers and care workers.

The survey questions aimed to answer all five research questions. The survey obtained information on the research questions. The questions explored the following topics: organisation; knowledge; quality indicators; aged care operations; and participants' comprehension of the Accreditation Standards. Participants were invited to volunteer to be interviewed as part of the inquiry in aged care and education. Interested participants were asked to provide their contact details. The final question was open-

ended to enable participants to provide comments about aged care training and how it can be improved.

4.4.3 Semi-structured Interviews

Semi-structured interviews were conducted with managers and carers working in residential aged care services in Melbourne and regional Victoria. It was undertaken after participants completed the online survey. An invitation was sent to them that included a plain language statement about the interview (see Appendix 2). The qualitative in-depth interviews aimed to explore the five research questions.

Purposive sampling was used for participants who expressed interest in participating in the interviews. However, some could not be contacted or cancelled the interview appointment despite persistent phone calls and emails. The researcher used her knowledge of the aged care industry to invite other participants to be interviewed from regional Victoria and Melbourne metropolitan RACS (see Appendix 3). Purposive sampling aims to identify and select participants that are information-rich regarding the phenomenon under investigation (Creswell, 2013; Denzin & Lincoln, 2005). There were seven managers, twelve care workers and three TAFE trainers.

An interview schedule was prepared after considering responses from the online survey. The semi-structured interview schedule with open-ended questions developed by the researcher served as a guide during the interviews (see Appendix 4). The schedule was designed to allow for flexibility but within specific parameters. As new information arose during the interview conversations, the researcher further explored this information with subsequent discussions.

The researcher aimed to understand and document the day-to-day reality of managers and care workers by interviewing them in their work environment (Creswell, 2003; Patton, 1990). A relationship was established between the interviewer and

interviewees to facilitate the researcher's understanding of the minutiae of their experiences (Creswell, 2007a; Mayoux, 2007; Miles & Huberman, 1994; Patton, 1990). The interviews took place in a room of their choosing during work hours and were 30–60 minutes in length.

The interviews were conducted over three months with participants from Melbourne and regional areas of Victoria. The researcher stopped interviewing when saturation was reached, and no original data gained from the interviews (Creswell, 2013; Denzin & Lincoln, 2005). The use of anonymous, in-depth interviews allowed the participants to express their opinions open without fear of reprisal.

Participants' demographic details were obtained at the start of the interview, including roles and responsibilities, qualifications and voluntary disclosure of age and gender. Confidentiality and anonymity assurance were communicated to them, and written consent with permission to record the interview was gained (see Appendix 6).

The type of interview questioning helped to clarify and elicit information and cross-check perspectives, thereby cumulatively building on previous responses rather than adhering to a fixed set of questions and answers (Mayoux, 2007). The interviews included open-ended, descriptive and probing questions of previous statements to maintain an appropriate pace in the conversation (Creswell, 2003; Miles & Huberman, 1994; Patton, 1990). During the interviews, the researcher learnt of issues that had not been considered when constructing the questions (Creswell & Miller, 2000). Issues raised by participants was further explored.

Table 4.3

Number of participants in semi-structured interviews by Role and Gender

Role	**Number of females**	**Number of males**	**Total number**
Managers	8	2	10

Care workers	11	1	12
Total			22

More females than males were interviewed. This was expected given that the percentage of women working in the aged care sector is much higher (Productivity Commission, 2012a).

The purpose of identifying the number of years of experience was to determine whether the interview responses were different from those of managers and care workers who may have only recently joined the aged care sector.

Table 4.4

Type of Aged Care Sector Managers and Care Workers' Work

Role	**Residential experience (n)**	**Respite**	**Community experience (n)**	**Special residential accommodation (n)**	**Total number (n)**
Managers	4	0	1	2	7
Care workers	6		6		12
TAFE trainers	3				3
Total					22

Note: Residential = long-term and respite care; Community = special residential accommodation

The purpose of interviewing managers and care workers working across various aged care sectors was to determine the nature of services provided to older adults.

Managers were interviewed because they are responsible for employing aged care graduates. This was an efficient way of collecting qualitative data from people who were familiar with the research problems (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Merriam, 1998). The interviews sought to establish whether aged care training provided by RTOs meets the needs of RACS. Care workers were interviewed to allow them to discuss the nature of their experiences and expectations of aged care

education and employment in RACS. These interviews aimed to establish whether aged care training had prepared the care workers for the challenges of working in RACS and determine their views on the quality of care.

Table 4.5

Number of Interviews by Location

Role	Metropolitan experience (n)	Regional experience (n)	Total number (n)
Managers	5	2	7
Care workers	6	6	12
TAFE trainers	2	1	3
Total			22

Participants from both metropolitan and regional areas were interviewed to determine whether their responses to the research questions differed. Given that there are more RACS in metropolitan areas compared with regional areas, concerns may vary.

4.4.4 Additional Data Relating to the Interviewees

- The three TAFE trainers were former managers in aged care who currently deliver aged care courses. Thus, their perspective shed light on both education and practice in aged care.
- Two managers owned aged care services and accepted aged care students for placements.
- There were 12 care workers, including one quality coordinator who had a dual role in providing care and data related to quality.
- Managers were aged 30–60 and care workers were aged 24–50.
- The years of experience ranged from 12 months to eight years for managers and six months to 10 years for care workers.

- All managers and care workers currently worked in aged care.

The interview responses provided in-depth descriptions of the issues facing participants in their work setting (Creswell, 2003; Patton, 1990; Wilken et al., 2002). The researcher was open to all patterns and issues that emerged from the data collection to discover what was happening and then clarified issues arising from the interviews into themes (Patton, 1990; Wilken et al., 2002). Consent to audiotape the discussions allowed the researcher to capture the participants' exact words.

4.5 Approaches to Data Analysis

The data analysis in this study employed an interactive process from the three data sources (published documents, online survey and semi-structured interviews). Content data analysis of the published documents and descriptive analysis of the online survey data were used as additional information to support the content and thematic analysis of qualitative data.

4.5.1 Analysis of data from published documents

Content analysis of the three published document sources included the Aged Care Training Packages and the Accreditation Standards. This was to identify whether models of care, quality of care, quality of life and QoCPs in terms of Accreditation Standards and Standards of Care were addressed. Content analysis of the Aged Care training packages was undertaken of the elements in Certificate III in Individual Support (Ageing), Certificate III in Individual Support (Home and Community) and Certificate IV in Ageing Support programs. These programs are the minimum levels required to work in aged care were the focus of the content analysis. Notably, none of the core or elective units addressed the models of care and quality of care. However, one of the core units in Certificate IV in Ageing Support and the elective units in all three Aged Care Training Packages addressed the concept of quality of life.

Moreover, the QoCPs form a legislative framework that governs aged care practices. They are not covered in any of the three Aged Care Training Packages, whereas Accreditation is briefly addressed in one of the units in Certificate IV in Ageing Support. However, the Standards of Care are not addressed in any of the Aged Care Training Packages. Later in the analysis, information from the interviews with the participants confirmed their lack of knowledge of the above issues.

4.5.2 Analysis of the data from the online surveys

Preliminary descriptive data analysis of the responses provided in the online survey is presented in the form of numbers, percentages and mean deviations. This enabled the researcher to begin understanding what resulted from the data and to make sense of what might arise from subsequent interview data.

The online survey included data from a larger group of participants comprising managers and care workers currently working in RACS in the state of Victoria (n = 360). Once the online survey had been completed, data analysis commenced, which included checking for the reliability and exactness of the answers for each question. It was necessary to make corrections and choose whether some or all parts of a questionnaire should be discarded because of repetition, no response or a lack of relevance to the research question.

Data for the closed-ended questions were analysed using descriptive statistics summarised from the survey data. These included sample size, the mean age of participants, the percentage of males and females, and the range of scores on a study measure.

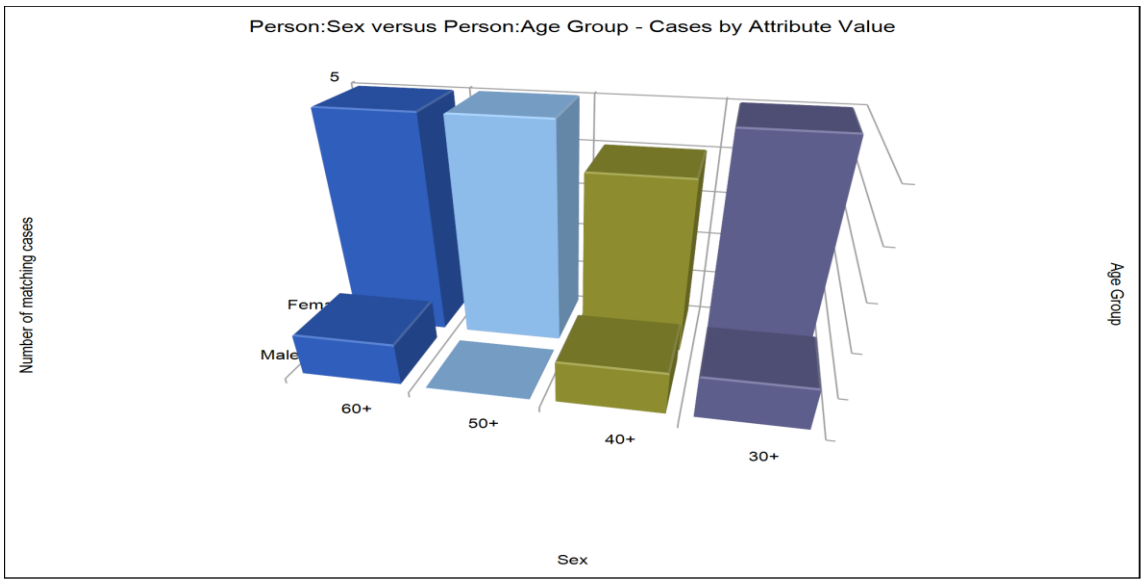

Figure 4.2. Participants Age and Gender

The open-ended questions invited managers and care workers to suggest improvements that could be made to aged care training. These responses were later used to support the findings with the online survey and document analysis.

4.5.3 Analysis of the interview data

The qualitative method utilised in-depth semi-structured interviews to describe, explore and understand the perspectives of the managers and care workers. Content and thematic analysis of the data was employed.

4.5.4 Use of NVivo software package

Content and thematic analyses were undertaken of the semi-structured interviews with managers and care workers. The interviews were transcribed verbatim to identify codes from direct quotations. These codes formed the categories, and then key issues were presented in the findings of the study. The recorded interview data were entered into the NVivo software package to speed up the process of managing the extensive data collected and for easy data retrieval. Also, using NVivo in the analysis process for the research questions enabled the data to be systematically deconstructed into meaningful units that were then coded to find groups of words, phrases, sentences

and themes, which were then searched and examined (Bernard & Ryan, 2010; Borrego et al., 2009; Creswell, 2013; Lauckner, Paterson, & Krupa, 2012).

The general framework for the qualitative research involved content analysis of the data obtained in the form of audio recordings (Creswell & Maietta, 2002; Merriam, 1998). This involved focusing on the research questions and examining the information from the interviews. The interview data were used to gain an understanding of participants' underlying reasons and opinions, and to provide insights into the research problem of variability of quality in aged care' in terms of the inconsistent implementation of standards of care, inadequate monitoring of standards of care, and the different interpretation of standards. The audio recordings were first transcribed verbatim to build a theoretical understanding of the data (Denzin & Lincoln, 2000; Denzin & Lincoln, 2005). This provided an opportunity to ask more questions in subsequent interviews because the researcher was able to critique and improve on the interview process.

4.6 Data Analysis Process of Interview Data

The process of data analysis involved listening to the audio recordings after each interview session. The qualitative data analysis involved three steps: (1) coding the data, (2) developing categories and (3) identifying issues that formed themes corresponding to the questions asked, as well as issues raised by the interviewees (Denzin & Lincoln, 2000; Miles & Huberman, 1994; Wilken et al., 2002). The participant's interview data were systematically recorded and electronically filed. Further, time was set aside to reflect on each interview response.

Preliminary analysis of all interview data was conducted as soon as practicable after each interview to give the researcher time to reflect on the data and identify new or different information that had been obtained (Creswell, 2003; Miles & Huberman, 1994;

Wilken et al., 2002). The process included the audio recordings were transcribed and labelled as soon as possible following the interview. A code number was allocated to every participant using the date, time and place of the conversation to protect the participant's identity. This code was converted to a pseudonym (see Appendix 3 p.235). During the analysis, the researcher examined the data to obtain a picture of the phenomenon under inquiry. The interviews were transcribed, systematically searched and analysed to illuminate what the data were saying (Feilzer, 2010). The qualitative data analysis involved the use of content and thematic analysis of the qualitative data obtained from the interviews (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Hunter & Levett-Jones, 2010). The purpose was to understand the central phenomenon under investigation—namely, aged care education and its effect on the training of care workers in RACS and thus its effects on quality of care. -

4.6.1 Content analysis

Verbatim accounts of the participants' interviews were transcribed using exploratory content analysis, which aimed to identify the codes and categories arising from the interviews as commonalities and themes developed. Codes, categories and themes were organised, conceptualised, refined and interpreted (Creswell, 2014). The process was essential to the analysis and development of ideas, and to clarify meaning and rework concepts as new insights emerged from the data (Nobel et al., 2013).

4.6.2 Thematic analysis

The thematic analysis aimed to identify patterns and themes arising from the interview data. This involved repeatedly moving back and forth between the complete data set in search of commonalities within a set of codes and categories across the different interviews to form themes arising from the analysis (Braun & Clarke, 2006). The analytical process was mapped to track relations across the data codes, categories,

and themes to visualise and lead to theory development (Nobel et al., 2013). This analysis was undertaken for each research question for each participant.

Verbatim transcriptions of the interviews were made, and each transcription was read numerous times when conducting the thematic analysis. The analysis involved data abstraction that was analysed inductively across the interviews to establish patterns of categories and themes for the information collected. The researcher interpreted the data and contextualised and made sense of them (Creswell, Plano Clark, Gutmann, & Hanson, 2008). The analysis was based on a standard set of principles (Noble et al., 2013). The principles in the interview data included allowing time for immersion and reflection after transcribing the interviews. In this step, each line of data was examined to code, categorised keywords and phrases to examine participants' words. The researcher's immersion in the data provided detailed insights into the phenomenon under investigation (Creswell, 2003; Creswell & Miller, 2000).

The information obtained from each interviewee was examined to identify their responses and then used for subsequent analysis (Creswell, 2003). Responses were grouped according to common questions and issues and were simultaneously analysed for similar and different perspectives on the topic of quality of care and education. The purpose of classifying the data was to facilitate the search for patterns and themes among the interviewees to obtain a clear understanding of their views. Extracts were taken from the interviews as the researcher tried to understand the responses to the interview questions. Descriptive line-by-line coding was undertaken in a Microsoft Word document to record the codes from keywords participants used and the context in which they were used. All interview sections that had multiple codes were copied and pasted into each code, along with some data surrounding the coded text to preserve the

surrounding context. The multiple codes were grouped to form categories that represented the participants' views of the key issues arising from the data.

The next stage of the data analysis involved bringing similar categories, key issues together into broader themes (Creswell, 2003; Noble et al., 2013). The categories from the interviews were placed together to identify and name the themes arising from the data. The themes were broader and involved active interpretation of the codes, categories and key issues in the data (Braun & Clarke, 2006). The researcher described the essence of each theme and what it was about, and then made discoveries in the study that had not been part of the investigation. Participants' quotations were used to present the themes to demonstrate the findings (Noble et al., 2013). Inductive reasoning was used to construct valid arguments from the responses to the research questions by moving from specific instances into a generalised conclusion (Thorne, 1997). The data from the study relied on inductive intellectual methods to understand and to construct meaning resulting from the interviews.

Documenting the movement from units of data to final themes resulted in transparent data analysis and demonstrated the findings (Nobel et al., 2013). Rigour, associated with openness, relevance to practice, and the methodological approach was employed. For example, the researcher used the data to generate concepts of aged care training and its effect on the quality of care. The thematic analysis and description were developed to understand the human aspects within the context in which the participants discussed their views and experiences to bring about findings to generate new knowledge (Morse, 1994; Nobel et al., 2013; Thorne, 1997).

The results of the data analysis were open and transparent. They were shared with the supervisors, along with the research process and method of analysis, to ensure the validity of the results and the research process. The data analysis of the published

documents, online survey and interviews was used to support the study findings. Initial editing of the interview data usually took place during or after the initial reading. Any repetitions and unnecessary digressions were omitted. However, the information provided during the interview, that was essential and relevant to the study was accepted.

The investigation was systematic based on the research questions regarding the phenomenon, and the researcher was able to quickly locate information in the data during the analysis of the data (Creswell & Clark, 2007a; Lingard, Albert, & Levinson, 2008; Patton, 1990; Xiao et al., 2014).

4.6.3 Trustworthiness, validity and reliability

The strategies for trustworthiness, validity and reliability included purposive sampling, a reflection of methods used to ensure enough depth, and significance of the data gathering and examination (Onwuegbuzie & Johnson, 2006). Results were validated by cross-checking them with other questions and information from other participants and data sources (Mayoux, 2007; Onwuegbuzie & Johnson, 2006).

The qualitative data provided personal opinions and enabled the individual viewpoints to be heard (Creswell & Maietta, 2002; Creswell & Clark, 2007a; Denzin & Lincoln, 2000; Lingard, Albert, & Levinson, 2008; Xiao et al., 2014). The stories and excerpts facilitated in-depth information, known as ‘thick descriptions’, from the voices, feelings and meanings that were illustrated by rich textual descriptions (Creswell, 2003; Patton, 1990; Wilken et al., 2002).

The record-keeping ensured that the interpretations of the data were consistent and transparent. Participants’ responses were compared by seeking similarities and differences across the interviews to ensure different perspectives were represented. This included copious descriptions of participants’ viewpoints to support the conclusions. Maintaining trustworthiness and credibility was vital as it leads to transferability,

dependability and confirmability (Denzin & Lincoln, 2000; Mayoux, 2007; Schwandt, 2009; Xiao et al., 2014). Credibility was established by ensuring that the data from the mixed approaches of data collection and analysis produced a more comprehensive set of findings (Creswell & Plano Clark, 2011; Lipscomb, 2008). In line with other researchers (Creswell, 2014; Fawcett, 2015; Tashakkori & Teddlie, 2003), the integration of different forms of data collection and analysis provided valuable insights into aged care education and practice. Transferability indicates that the findings can be applied to similar contexts and circumstances, similar populations and phenomena related to aged care (Mayoux, 2007; Xiao et al., 2014). Regarding dependability, other researchers can repeat this study on aged care education, and the findings would be consistent (Mayoux, 2007; Xiao et al., 2014).

In terms of confirmability, the researcher maintained a degree of objectivity in the research findings. The results are based on the participants' responses to reflect their perspective on each of the five research questions (Mayoux, 2007; Xiao et al., 2014). The integrity and accuracy of the findings are reflected in the data, and the validation strategy is congruent with the pragmatic theoretical assumptions underpinning the study's dominant qualitative paradigm (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Denzin & Lincoln, 2005). This methodology and methods in the research project provide the overall credibility of the research findings (Ring, Gross, & McColl, 2010; Schwandt, 2009).

4.7 Conclusion

This chapter aimed to justify: (1) the use of Dewey's pragmatism by employing the qualitative component of a mixed method approach; (2) the use of pragmatism in mixed methods data collection and approaches to analysis; and (3) the need for the validity of the methods chosen for the study through using document analysis, an online

survey and interviews. The primary qualitative data was the information collected during the interviews. Semi-structured, open-ended interviews permitted participants to discuss in-depth their perceptions, experiences and responses to the research questions without imposing too much structure into the inquiry. Instead, the flexibility allowed participants to discuss their views and experiences, which made each interview unique. The chapter also examined the validity of the methods chosen for the trustworthiness and credibility of the findings. The next chapter discusses the results of the research findings, which have been grouped into key issues and themes to address the research questions.

Chapter 5: Findings

5.1 Introduction

This chapter reports the findings from the five research questions. This research examines the relationship between education and quality of care in RACS and how aged care education can be improved. The findings are presented in a descriptive form using verbatim quotations and 'thick descriptions' (Patton, 1990). The data are connected and synthesised through explanatory text, figures and tables. However, the results of the findings are discussed in Chapter 6.

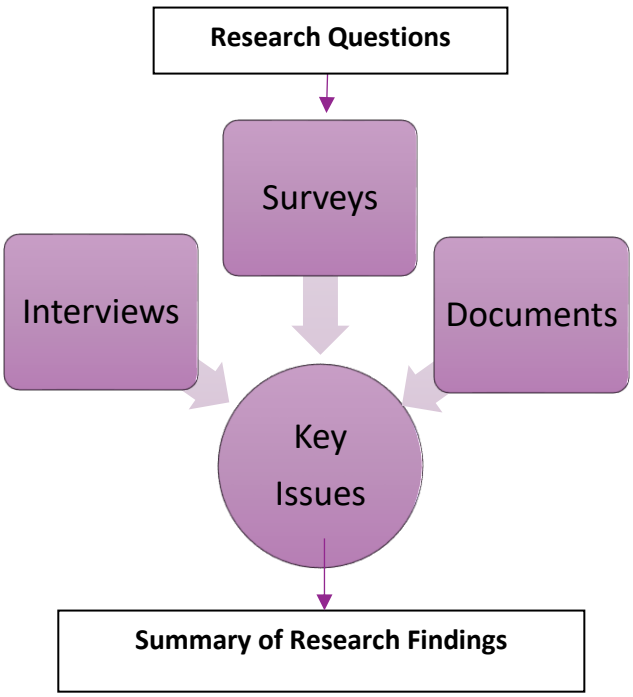

Figure 5.1. Methods of Data Collection

The primary form of data reported upon is the semi-structured interviews undertaken with managers and care workers. The participants' responses to the research questions revealed divergent views. Further, some interviewees did not answer the questions directly, but instead spoke of other problems, thereby revealing new insights. This section discusses the findings of each of the research questions, separated into codes, categories and key issues.

5.2 Discussion of Findings for Each Research Question

A total of twenty-two people were interviewed, comprising managers and care workers. There were ten managers and twelve care workers interviewed in the study. In each of the five research questions, participants discussed several topics, and these are highlighted in the findings.

5.2.1 How is quality of care perceived by aged care workers and managers?

To address the question 'how aged care workers and managers perceive quality of care', three types of data were collated: (1) semi-structured interviews; (2) online survey; and (3) document analysis. Eight participants directly addressed this question.

5.2.1.1 Semi-structured interviews

The participants own words in the interview discussed their (1) understanding of quality and the meaning of quality of care, (2) types of care, (3) and challenges of providing care.

Table 5.1

Semi-structured Interviews for Research Question 1

Participants	Codes	Categories	Key issues
Perception of quality			
2. Chanelle (care worker)	Quality of care is delivering care to the resident, giving a choice that comes from the resident's care plan. Our responsibility for giving them a quality of care to the clients. Strength to improve quality of life day-by-day. Quality of life is the independence maintained by themselves.	Understanding of quality giving a choice independence maintain quality of life making a difference in a persons' life care is individual giving quality of service	Quality of Care is perceived differently between managers and care workers and may pose a problem. Lack of staff, time and resources limited their
3. Kurt (care worker)	Quality of care provides a person what he or she wants to maintain a life without any issues; the person is living their life happily.		

Participants	Codes	Categories	Key issues
Perception of quality			
	To improve their quality of life is the main role. Quality of life, where a difference is made to the client's life. Quality of life as an individual thing. This is the quality of service you provide.	look after the person well comply with delivering care give what the client needs.	ability to provide quality of care.
16. Marion (care worker)	To me, the quality of care is making sure that the resident is looked after very well … making sure that their needs fully met. Quality of life means looking after them right through till the end.	Participants use descriptive terms to describe the meaning of quality, which is grouped into quality of care and quality of life.	Inability to explain models of care because of a lack of knowledge of models of care and because quality is perceived in different ways.
5. Elisa (manager)	So that people can still deliver quality care, but in so many different ways, depending on what the clients require and the type of people that are caring for. I have to comply with delivering quality care. Quality of life stems from that perspective.		
17. Lucky (manager)	They are checking on everybody … the individual quality of life.		
1. Terrie (manager/ educator)	Ensuring best practice. We are being responsive to the needs at the time. It is communicating effectively.	Meaning of quality of care described by participants as: Best practice Customer service Being responsive Communicating Effectively Giving your best to the customer	
2. Chanelle (care worker)	Quality meaning is actually like giving more than basic care.		
5. Elisa (manager)	[Customer service point of view]: want to see staff who understands my needs. We are about customer service. Are they satisfied with what you have done today? Are the residents happy?		
3. Kurt (care worker)	Quality means what best you can give to the customer.		

Participants	Codes	Categories	Key issues
Perception of quality			
2. Chanelle (care worker)	Care according to their care plan. Like excellent care to the resident. Maintain a standard of care for residents without harm and to improve their life.	Excellence in care is viewed as: Care according to the care plan Maintaining the standard of care Improving life Meeting requirements Giving them the best.	Challenges in giving care include balancing the needs of the organisation by making the customer happy. More knowledge and skills to understand residents' needs Concerns raised was the lack of knowledge on documenting care and the legal requirements.
3. Kurt (care worker)	[Perceive quality as] meeting requirements of that particular client. Give them the best.		
16. Marion (care worker)	Looked after very well.		
3. Kurt (care worker)	Giving him that holistic care a complete approach.	Discussed types of care such as: Holistic care Consumer-directed care.	
5. Elisa (manager)	And the consumer-directed care focus. The biggest challenge is to know what the consumer is looking for. Each of those consumers has come in with different needs, and what is it? The challenge of the worker is to balance what the organisation requires of them, versus making sure that the customer is happy.		
6. Bella (manager)	Accreditation is changing; it is more consumer-directed.		
	Documentation		
16. Marion (care worker) 12. Dorothy (manager)	Electronic documentation. Writing incidents. Know necessary documentation (e.g., no date, time, signature, name, designation). Write concisely, concise report writing. Documentation in dementia care (come to the ground level). Documenting incidents and care; these are legal documents.	Documentation of care.	

1. Participants' understanding of quality included: 'giving a choice to residents', 'maintaining independence', 'resident being happy', 'making a difference in a client's life' and 'treating them as individuals' (see Table 5.1). They associated the descriptive words with 'quality of care' and 'quality of life'.
2. Participants described quality of care as (a) 'holistic care' and (b) 'consumer-directed care'. They further defined it as 'giving more than basic care' and 'the best you can give to the customer'. The managers and care workers associated 'customer service' with understanding and satisfying individuals' needs.

   Three care workers (Chanelle, Kurt and Marion) explained care using the phrases 'excellence in care', 'meeting requirements' of the client and 'looked after them very well'. It is perhaps not surprising that care workers used descriptive words to explain care.
3. Participants noted challenges such as balancing the organisation's requirements with ensuring that the 'customer is happy'. Elsa (manager) stated that 'the biggest challenge of care workers is to balance organisation requirements' and 'to keep the customer happy'. Elsa referred to 'organisation requirements' because she is responsible for regulatory compliance as part of her role as a manager.

   Managers and care workers viewed documentation as problematic because they need to understand legislation, funding and residents' care needs. For example, progress notes, incident reports and dementia care require an enormous effort.

5.2.1.2 Online survey

The online survey captured data from 360 respondents, of which 199 (55%) claimed that they learnt about quality of care in aged care education. These encouraging numbers show that aged care education is vital in determining quality of care.

Table 5.2

Response Rate from Online Survey to Q12 that Addressed Quality of Care

Q12: Where did you learn about 'quality of care?' (You may tick more than one answer.)			
#	**Answer**	**%**	**Number**
1	In aged care education	55.28	199
2	In the workplace	37.78	136
4	I did not learn about 'quality of care'	1.39	5
3	Other (please explain)	5.56	20
	Total	100	360

5.2.1.3 Document analysis

Document analysis indicates that quality of care is inadequately addressed in Aged Care Training Packages (in Certificates III and IV). The aged care course includes core and elective units with elements and criteria to be taught.

Table 5.3

Published Documents on Quality of Care

Criteria and elements	**Elements in Certificate III in Individual Support (Ageing)**	**Elements in Certificate III in Individual Support (Home and Community)**	**Elements in Certificate IV in Ageing Support**
Quality of care	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Ageing).	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Home and Community).	Not addressed in any core and elective units of competency comprising Certificate IV in Ageing Support.

5.2.1.4 Key issues

In summary, the following key issues were found about Research Question 1, which examined how aged care workers and managers perceive quality of care:

- Managers and care workers agreed that the definition of quality of care is to improve the 'quality of life' for the individual. However, the participants stated that a lack of staff, time and resources limited their ability to provide quality of care.
- Managers felt that care workers needed more knowledge and skills to understand residents' needs.
- Participants considered documentation important in meeting residents' care needs and providing quality of care; however, they lacked skills in the area.

5.2.2 How do registered training organisations teach the Quality of Care Principles legislated in the *Aged Care Act 1997* to aged care workers and managers?

To address the question 'how RTOs, teach QoCPs from the perspective of managers and care workers', three types of data were collated: (1) semi-structured interviews; (2) online survey; and (3) document analysis.

5.2.2.1 Semi-structured interviews

The interviews sought to understand how the QoCPs, including accreditation and residential care standards, form the quality framework that governs the aged care sector and seeks to improve care practices. Accreditation is a process for monitoring quality and compliance with accreditation and residential care standards.

Table 5.4

Semi-structured Interviews for Research Question 2

Participants	Codes	Categories	Key issues
	Quality of Care Principles		
5. Elisa (manager)	I think working in an environment that has so much cultural diversity has taught me many things along the way when it comes to Quality of Care Principles. When it comes to Quality of Care Principles, it has forced me to look outside just the guidelines and look more at the individuals regarding what they require and what quality is to them. We could be compliant and fulfil everything that the Quality of Care Principles and accreditation requires to do without necessarily fulfilling the requirements of the residents … it is very task-oriented. So, I believe that the more knowledge they have, the more you tell them what the principles are all about. So, if you take a lot of time teaching and training them and giving them the knowledge, they require, they will do it. But if you do not spend that time, if you do not invest in education, then there is very little hope of that happening.	Accreditation is about ensuring quality, provision of education. It came about from poor standards of care. Residential care standards. It is to do no harm and improve quality of life. The effectiveness of monitoring quality appears to be a hindrance.	I am forced to look outside the legislative requirements. Accreditation drives one manager 'bonkers'. It is about participation and not about quality. It is about checking and ticking boxes; it is task-orientated. A lack of familiarity and understanding of the QoCPs' legislative framework and monitoring for compliance does not assure quality.
1. Terri (manager)	I am familiar with QoCPs … been changed quite significantly. We certainly highlight quality principles right throughout the course. [About accreditation], it drives me bonkers.		

	Because even with the quality team it is about evidence of participation, not about what quality you are delivering … It is much easier to audit against dates.		
3. Kurt (care worker)	Quality care principles are nothing, but as I told you before, to maintain the quality of the life of the person.		
	Accreditation		
3. Kurt (care worker)	They check if you, as an organisation, are meeting the requirements of particular clients. Are you doing it or not? That is what they do in accreditation.	Meeting requirements Quality care Teaching and training Checking on everybody Caring without harm	There is limited understanding of the legislative framework that governs aged care practices. Accreditation monitoring of standards is principally about 'compliance' and does not assure that 'quality in care' is provided.
5. Elisa (manager)	[Accreditation] looks at quality care, but its main function is compliance. I have to comply with delivering quality care. We could be compliant and fulfil everything that the Quality of Care Principles and accreditation requires to do without necessarily fulfilling the requirements of the residents … it is very task-oriented. So, I believe that the more knowledge they have, the more you tell them what the principles are all about. So, if you take a lot of time teaching and training them and giving them the knowledge, they require, they will do it. But if you do not spend that time, if you do not invest in education then there is very little hope of that happening.		
17. Lucky (manager)	Accreditation is about quality. They are checking on everybody … the individual … their quality of life.		

6. Bella (manager)	[Accreditation is] the 44 standards, so yeah, I think we just had to move with the times.
21. Bernadine (care worker)	Accreditation standards came about because of what the poor standards were in those days.
2. Chanelle (care worker)	Standard care is [caring for] the resident without harm and to improve their lifestyle … It is essential to give them standard care.

Seven managers and care workers discussed the legislative framework in terms of: (1) QoCPs and (2) their understanding of accreditation and residential care standards. Views differed between the managers and care workers because of their roles and responsibilities in the codes and categories. ‘Accreditation’ and ‘residential care standards’ are part of compliance in the aged care sector.

1. QoCPs
    a. Elisa (manager) claimed that the QoCPs have ‘forced me to look outside just the guidelines and look more at the individuals regarding what they require’. She explained that ‘we could be complaint … with the Quality of Care Principles and accreditation … without necessarily fulfilling the requirements of the residents’.
    b. Terrie (formerly a manager and now a manager of a training institution that conducts courses in aged care) reported that QoCPs have ‘changed significantly’. However, she did not expand on the significant changes.
2. Accreditation
    a. Terrie (manager) said that ‘accreditation drives her bonkers’, but she did not specify how it affects her. However, she stated that the quality team audit is not about ‘quality’; instead, it is ‘easier to audit against dates’

during the accreditation process. Fellow manager Elisa affirmed that although accreditation examines the quality of care, its ‘main function is about compliance’. She explained that one could achieve accreditation ‘without necessarily fulfilling the requirements of the resident’ because ‘it is a task-orientated’ exercise. Her comments were supported by Kurt (care worker), who stated that accreditation checks whether ‘you are doing it or not’.

b. Lucky and Bella (managers) confirmed that accreditation ‘is about quality’, but also referred to it as a process of ‘checking’. Managers must ensure that they meet compliance requirements in line with accreditation. In RACS, this process is usually undertaken in a series of quality assurance activities that involve checklists. This may be why managers used terms such as ‘ticking’ and ‘checking’.

c. Bernadine (care worker) claimed that ‘accreditation came about due to poor standards’ in earlier days. Bernadine had worked in the aged care sector since the 1980s when there was no such thing as ‘care workers’. There were only enrolled nurses in those days.

d. Chanelle (care worker) believed that ‘standard of care is [caring for] the resident without harm and to improve their lifestyle’. She asserted that ‘it is very important to give them standard care’. Chanelle has more than 20 years of experience in aged care and not only provides direct care to older adults but is also involved in the lifestyle program in the aged care sector.

e. As part of their principal role as managers, Elisa, Lucky, and Terrie are responsible for ensuring that compliance is met. However, they

expressed concerns that the exercise drives people ‘bonkers’ (Terrie) and that monitoring involves ‘ticking’ boxes. This view was shared by Kurt (care worker), who said that accreditation is about checking whether things are being done.

f. Managers stated that accreditation is about quality (Lucky) and referred to the 44 standards that are part of the process (Bella). Elisa voiced her concern that achieving accreditation involves ‘fulfilling requirements and [is] task-orientated’.

5.2.2.2 Online survey

The online survey showed that participants had excellent knowledge of the QoCPs through aged care education (52.62%) and the workplace (42.42%). However, only 1.10% understood the standards of care, which include management, health and personal care, resident lifestyle and physical environment, and safety systems. Many care workers were unaware of the management system, which includes staffing and organisational development. This result is concerning given that care workers provide the bulk of the care, while managers supervise and guide care workers in RACS.

Table 5.5

The Response Rate to Online Survey to Question 13 about the Standards of Care

Q13: Where did you learn about ‘standards of care’ as outlined in the Quality of Care Principles? (You may respond to more than one question.)			
#	**Answer**	**%**	**Number**
1	In aged care education	52.62	191
2	In the workplace	42.42	154
4	I did not learn about the ‘standards of care’	1.10	4
3	Other (please explain)	3.86	14
	Total	100	363

Note: Standards of care and Quality Principles 1

5.2.2.3 Document analysis

The QoCPs are not addressed in the analysis of published documents and surveys. However, accreditation is addressed in one of the units of competency in Certificate IV (CHCLEG003: Maintain Legal and Ethical Compliance—Performance Criteria and Knowledge Evidence), which involves maintaining and updating required accreditations or certifications. However, this knowledge may have come from employment in the RACS (see Table 5.6).

Table 5.6

Document Analysis on Quality of Care Principles Covered in the Aged Care Training Packages

Criteria and elements	**Elements in Certificate III in Individual Support (Ageing)**	**Elements in Certificate III in Individual Support (Home and Community)**	**Elements in Certificate IV in Ageing Support**
QoCPs	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Ageing).	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Home and Community).	Not addressed in any core and elective units of competency comprising Certificate IV in Ageing Support.
Accreditation	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Ageing).	Not addressed in any core and elective units of competency comprising Certificate III in Individual Support (Home and Community).	CHCLEG003 Maintain legal and ethical compliance. PC 4.2 Maintain and update the required accreditations or certifications. Knowledge evidence: accreditation requirements.
Standards of Care	Not addressed in any core and	Not addressed in any core and	Not addressed in any core and elective

	elective units of competency comprising Certificate III in Individual Support (Ageing).	elective units of competency comprising Certificate III in Individual Support (Home and Community).	units of competency comprising Certificate IV in Ageing Support.

Accreditation is covered in one of the units in Certificate IV—Aged Care Training Package. The standards of care are not addressed in any of the three aged care training packages. The document analysis confirms that the QoCPs, accreditation and residential care standards are mentioned in only one unit of competency in Certificate IV—Aged Care Training Package. The care workers who were interviewed had all undertaken Certificate III in Aged Care.

5.2.2.4 Key issues

In summary, the following key issues were found concerning Research Question 2, which examined how RTOs teach QoCPs to managers and care workers:

1. Accreditation monitoring of standards is principally about 'compliance' and does not assure that 'quality in care' is provided.
2. One of the central elements of the legislation—QoCPs—is not addressed in Aged Care Training Packages.
3. Managers and care workers had a limited understanding of the legislative framework that governs aged care practices.

5.2.3 How do managers and care workers in residential aged care services perceive any gaps in the knowledge and skills of graduates?

Managers and care worker discussed the gaps in knowledge and skills of graduates entering the aged care workforce, Three forms of data resources were collated to explore gaps: (1) semi-structured interviews; (2) online survey; and (3) document analysis. Nine participants directly addressed this question.

Table 5.7

Semi-structured Interviews for Research Question 3

Participants	Codes	Categories	Key issues
	Gaps in knowledge		
1. Terri (manager/ educator)	I do not think the units are sufficient. Palliative care unit, medication unit, quality of life, advocacy, wound care, nutrition, weight loss, malnourished, dementia.	More education needed in: • palliative care • medication • advocacy • weight loss • nutrition • wound care • dementia • mental health • cultural beliefs and needs • care plan • resident lifestyle • basic knowledge of care (making beds) • falls • all medical conditions • critical incidents • lack of understanding care planning.	Gaps in knowledge and skills create challenges for aged care graduates entering the workforce. Gaps in knowledge of basic skills and understanding chronic health conditions in relation to standards of care.
20. Virginia (manager/ educator)	One-on-one the knowledge and skills, there are gaps there.		
5. Elisa (manager)	Somehow bring that education into practice and change their mindset.		
11. Arnold (manager)	Gaps are more about how they deal with the person. Basic knowledge you need or require providing your care: disability, disadvantaged people.		
2. Chanelle (care worker)	I would include residents' cultural beliefs, medications, palliative care.		
4. Marion (care worker)	They do not get a lot on the standards, especially standard two at least. I think care is another thing that needs to be looked into.		
17. Lucky (manager)	They do not want to take responsibilities for the issues.		
	Care planning and documentation.		
3. Kurt (care worker)	Care planning. People do not know the word care plan. And they finished a certificate in aged care; that frustrates me a bit. They should know what a care plan is.		
12. Dorothy (manager)	I think documentation is very important. Basic documentation … date, time, signature, name, designation, these	Documentation: • care plans • legal requirements	

	are legal documents, write concisely. Documentation in dementia care. Manual handling unit has to be changed … manual handling has to be people-oriented not the object-oriented … people are quite unpredictable. Need to be taught basic cultural needs.	• incident reports • electronic documentation.	Lack of knowledge on use of equipment.

5.2.3.1 Semi-structured interviews

Six managers, three care workers and two managers now working as educators discussed several areas of knowledge for aged care graduates. The codes and categories in Table 5.7 outline the topics raised by the participants**.** Some participants referred to knowledge as 'gaps', while others said that care workers 'need to know' more. The managers suggested that their understanding of what aged care graduates 'need to know' has come about because of their many years of experience with aged care graduates (see Table 5.8).

Table 5.8

Response from Managers about Aged Care Graduates' Needed Knowledge

Terrie (manager)	**Arnold (manager)**	**Dorothy (manager)**
Palliative care, medication unit, quality of life, advocacy, wound care, nutrition, weight loss, malnourishment, dementia.	Basic knowledge to provide care for disabled, disadvantaged people.	Basic documentation on a date, time, signature, name, designation, write concisely. Documentation in dementia care. Need to be taught basic cultural needs.

The care workers also suggested topics that aged care graduates should understand (see Table 5.9). These suggestions came from their experience and expected job roles.

Table 5.9

Response from Care Workers about Aged Care Graduates' Needed Knowledge

Chanelle (care worker)	**Marion (care worker)**	**Kurt (care worker)**	**Joanne (care worker)**
Cultural beliefs, medications, palliative care	Standard two	Care planning	Most of the students come in, not knowing how to make a bed, which blows my mind.

Managers and care workers agreed that topics relevant to aged care practice include; the importance of documentation and caring for chronically ill residents, palliative care, medication, nutrition and weight loss, wound care, dementia care, mental health, care plan, lifestyle, basic knowledge of care, falls and responding to critical incidents. Some participants referred to advocacy and understanding diverse beliefs and needs.

5.2.3.2 Interviewing managers

- Terrie: 'I do not think the units are sufficient'.
- Elisa: 'Somehow bring education into practice and change their mindset'.
- Dorothy: 'I think documentation [legal documents] is very important'.
- Dorothy: 'Manual handling must be changed … to be people-oriented not the object-oriented'. She explained that residents with challenging behaviours are quite unpredictable.
- Lucky: Concerned that care workers 'do not want to take the responsibilities for the issues'. However, she did not elaborate on this comment.

5.2.3.3 Interviewing care workers

- Marion: ‘They do not get a lot on the standards, especially standard two at least’. Standard two is part of the four accreditation standards and is related to clinical care.
- Kurt: ‘People do not know the word care plan … And they finished a certificate in aged care; that frustrates me a bit. They should know what a care plan is’. Kurt is an EN involved in providing care to older adults. He is involved in mentoring new aged care graduates.
- Joanne: ‘Most of the students come in not knowing how to make a bed, which blows my mind’.

5.2.3.4 Online survey

The survey indicated that managers and care workers have an adequate understanding of conditions among older adults, including pressure injuries, falls, restraints, infections, weight loss, polypharmacy and pain. The surveys also indicated the need to provide more knowledge and training about managing older adults with chronic health conditions.

5.2.3.5 Document analysis

Analysis of the published documents on Aged Care Training Packages showed that they referred to some of the topics that managers and care workers.

5.2.3.6 Key issues

In summary, the following key issues were found about research question three, which examined how managers and care workers in RACS perceive any gaps in

- Managers and care workers agreed about the type of knowledge and practice that aged care graduates should have about standards of care.

- Aged care graduates lacked basic knowledge and skills (e.g., documentation and making beds).
- The currency of education to keep up to date with changes in practice and the use of equipment was a vital component for aged care graduates.

5.2.4 How do aged care graduates view their preparation to work in aged care after gaining employment in residential aged care services?

To question graduate care workers views on their preparation to work in aged care, data was primarily collated from the semi-structured interviews and the online survey.

Table 5.10

Semi-structured Interviews for Research Question 4

Participants	Codes	Categories	Key issues
	Challenges in aged care		
17. Lucky (manager)	I know it is confidential but staff ratio. The staff ratio is the most important in aged care.	• Staff ratio • Insufficient time • Lack of equipment • Facing reality in aged care • Dealing with family • Hard to break habits • Requirement for informatics • Need to develop attributes (e.g., work ethics, confidentiality) • Need the right training	Philosophical and educational limits in aged care education to prepare aged care graduates, thereby creating challenges for managers and care workers. Aged care workers are not prepared with the
3. Kurt (care worker)	Frustrates me, they do not know what is and explain what a care plan is. Aged care is time-bound. We do not have enough time, unfortunately. To have a glimpse of the care plan of the client who got a few behavioural issues.		
1. Terrie (manager)	Issues in a regional setting		
2. Chanelle (care worker)	Need more equipment. Need more staff.		
7. Chella (care worker)	They tell you, go to the aged care and have a wonderful time. They [residents] are all lovely … It is much more challenging than lovely. I mean like it is a bit hard for us.		

Participants	Codes	Categories	Key issues
	We have got nine, eight residents, and that is who we are stuck with every day. You cannot walk away from them, they are not a number, or it is not that you are palming them off, they are just in your face.	• Drastic decline in level of knowledge • Lack of responsibilities • Need good clinical skills	adequate knowledge and experience. Aged care workers do not have current education improve to meet the needs of the elderly. Care workers are not prepared to meet the challenges in real work situation.
14. Brodie (care worker)	Sometimes it is challenging dealing with family; cause there is such a big family, they do not agree with some things that you want, thinks best for an elder.		
18. Romayne (manager)	Time is the main challenge … it is tough to break the habits … they are used to certain things, and they want to continue like that.		
1. Terrie (manager)	[Challenges facing aged care workers and students in aged care]: The requirement for informatics and that sort of knowledge is key. Other challenges to develop attributes work ethics, maintaining confidentiality and not using social media such as Facebook, and being professional and responsible.		
5. Elisa (manager)	Including mental health, is it because you have, like, younger people also coming into aged care? And those people do come in with a lot of mental health issues. So, staff, if they are not geared or prepared for that … then providing quality care becomes very difficult. The services are quite overstretched, and I think some of the things they are called for could easily be managed at the facility level if the right training was there.		
3. Kurt (care worker)	I do not know what is wrong, what is going on, but I can see a drastic decline in the quality of the person who is coming out from the Certificate III. Based on the experience that the level of knowledge they are gaining is going down.		

	Clinical skills	Categories	Key issues
17. Lucky (manager)	Expecting that the graduates have to take more responsibilities … need to have a good clinical skill that is important. Need to know … the condition of the residents … the diagnosis is affecting the condition … skills are compulsory for the graduates.	• Hands-on experience • Practice as you learn • Not only theory but practice • More onsite training • Disconnect between learning and practice • Post-placement training • Face-to-face training • Need much guidance • Unaware of Aboriginal culture • Afraid of touching the elderly • Need to understand culture and history of residents' background • Just getting from one job to the next • It is daunting, but they get used to it.	Theory without practice is useless; practice without theory or experience is futile. Aged care workers need to be better prepared by obtaining adequate knowledge and experience. The currency of education needs to improve to meet the needs of the elderly Care workers should be better
3. Kurt (care worker)	I think they are getting much theory, but they are not getting enough hands-on experience.		
5. Elisa (manager)	They lack enough opportunities for hands-on experience. I think they should do theory as well as practical so they can translate what they are learning into practice as they proceed. There's a danger in training them, give them everything in theory in one hit and then send them out into for placement and they are expected to remember everything.		
7. Chella (care worker)	It probably needs to be a lot more onsite training. The [teachers tell you] it is all roses and rainbows and whatever. There was nothing rosy [about working in aged care].		
8. Chressa (care worker)	I found it a bit of a shock. It is not what is in the books to what is in real life. There was a disconnect between what you were learning and what you were practising … A bit more training.		
9. Arlinda (care worker)	I think those that have had post-placement training are more prepared than those that do it online. Doing a hands-on course that you need to have face-to-face training and be able to work with other people. We are looking for commitment … It is just a job … there is just no connection.		

11. Arnold (manager)	I would not say [that the graduates are prepared] … they needed much guidance … providing simple care … How to approach the person when someone is demented. [On understanding of Aboriginal islanders and cultural diversity]: No, no, absolutely not … they do not have that understanding. Most of who is here were never aware of the culture, the Aboriginal culture until started working here.	trained to meet challenges in real work situations. Aged care graduates are not trained to meet challenges in real work situations
12. Dorothy (manager)	Some people are frightened about the dementia residents, and some people have never seen someone dies … when they see, then they are frightened. I think as they learn the unit, they need to put it in practice. Some of the PCA trainee students come for placement; they walk with the gloves on because they do not like to touch people. They are frightened old people; especially they are not glamorous people, they are frightened they are going to get infected somehow touching people.	
13. Angelina (care worker)	Think many people would like to know are they [aged care graduates] prepared enough? For instance, the Italians or the Greeks, they are at an age where they have all had some war experience, conflict in their own country. PCAs are more for providing personal hygiene and feeding. Moreover, you know, and just getting from one job to the next.	
14. Brodie (care worker)	More information should be provided by Aboriginal/Torres Strait Islanders and diverse clients in training. The whole aged care training, there was not much about it.	

	A bit daunting at first, but you know, you get used to it over time, and it is just like second nature.	
15. Joanne (care worker)	Most of the students come in, not knowing how to make a bed, which blows my mind.	
	Legal ramifications	
15. Joanne (care worker)	Learning, knowing more about the legal ramifications of when you make a mistake in aged care. More information … legal side of it. It is all very well for us to write notes,	Legal ramifications: • more knowledge on the legal side of caring • not meeting course requirements • I need to meet work practice • work within the scope of practice.
20. Virginia (manager/ educator)	I think they are lacking in preparing the PCAs for the work … they are rushed through it. Very short … not adequate. They need to continue to develop and understand their work practice, the safety issues and infection control issues, that needs to be improved.	
4. Marion (care worker)	They do not go beyond their work of duty.	
	Documentation	
2. Chanelle (care worker)	Actually, once you are in the school you cannot provide proper documentation. You need to have the experience and it has come from your practice. The training must provide it. How to monitor appropriate documentation to gain that knowledge.	Documentation : the need to train on proper documentation and different software.
4. Marion (care worker)	Documentation is very necessary. Most aged care places have electronic documentation, and I am not so sure the training organisations are teaching about electronic documentation, the different software that they use … It is a big challenge actually.	
18. Romayne (care worker)	They should be focusing at the beginning of documentation a clear, concise manner but also what triggered what happened.	

	Teach people how to do electronic and paper-based documentation. Documentation is really important, and they do not do enough of it.	
	Quality and type of training	
1. Terrie (care worker)	They were unhappy with the quality of the education provider. Nurses that are educators in the higher ed [education] space that is not even allowed to supervise or sign off on assessments.	Quality and type of training.

5.2.4.1 Interviews

Managers and care workers discussed the preparation of aged care graduates to work in aged care after gaining employment in RACS. They said that graduates were unprepared to face challenges (see table 5.11). There were concerns about obtaining clinical skills using a hands-on approach.

Table 5.11

Responses from Managers about the Challenges for Aged Care Graduates

Managers			
Lucky	Terrie	Romayne	Elisa
Staffing ratio was an issue. Need to have excellent clinical skills.	Issues in the regional setting are different from that of working in metropolitan areas. The requirement for informatics. Challenges to developing attributes.	Time is the main challenge and tough to break habits. They should be focusing on documentation.	Inadequately prepared to care for people with mental health issues, particularly young people, so providing quality of care becomes difficult. Services quite overstretched. Lack of opportunity for hands-on.
Arnold	Dorothy		Virginia
They need much guidance in providing simple care. Dementia care. Understanding ATSIs.	Some people are frightened about dementia residents. Some people have never seen someone dies.		They are lacking in preparing PCAs. The course is concise and not adequate.

	Need to learn a unit and put it in practice. Misuse of gloves as they do not want to touch people for fear of getting infected. They do not understand people of other cultures, war and hard work, especially those with dementia.			
Care workers				
Kurt	Chanelle	Chella	Brodie	
Refer to being timebound because of lack of staff. Confused about what is going on and sees the decline of people coming out of Certificate III level. Level of knowledge is going down. Concern that students are getting much theory but not enough hands-on experience.	Need more equipment. Need more staff. To provide proper documentation, one needs experience, and it comes from practice. The training must provide it.	Been told one will have a wonderful time. It is more challenging than lovely. It is a bit hard. We are stuck with residents and no walking away. Needs to be a lot more onsite training.	Challenging dealing with family as they do not agree with what is best for an older person. There was not much about ATSIs. A bit daunting at first, you get used to it over time.	
Chressa	Arlinda	Angelina	Joanne	Marion
Found it a bit of a shock when commenced work. It is not all roses and rainbows.	Face-to-face training is better than online training. Need to be able to work with others. Looking for commitment, though not just a job, there needs to be a connection.	Not prepared enough. PCAs are just getting from one job to the next. I wish I knew about epilepsy, deep depression, chronic pain.	It knows more about legal ramifications.	They do not go beyond their work of duty. Documentation is necessary. It is a big challenge.

The three main findings from the interviews with the managers and care workers related to (1) documentation, (2) preparation of aged care graduates and (3) other challenges such as staff, overstretched services, difficulty completing work, need for more equipment. Care workers involved in direct care were able to articulate their

concerns regarding better preparation to work in aged care. Although most participants did not give specific examples, one reported on her preparation as an aged care graduate, while others spoke of their experiences with aged care graduates. For example:

1. Managers and care workers agreed that documentation is an essential aspect of their work:
    - Romayne (manager) believed that documentation is significant because it is part of justifying funding.
    - Chanelle and Marion (care workers) document care to provide evidence in support of funding and as part of their roles and responsibilities. Understanding the legal ramifications of documentation when something goes wrong in aged care is essential.
2. Aged care graduate preparation:
    - Elisa (manager): Care workers lack preparation to care for clients with mental health issues and young persons with disabilities in RACS.
    - Dorothy (manager): ‘Sometimes they do not understand people of other cultures, the war and hard life they have been through, especially when they are working with the dementia people’.
    - Arnold (manager): There is a need for training on dementia care, particularly for ATSIs. Arnold is the manager of an ATSIs RACS that mainly provides care services to residents from regional and metropolitan areas of Australia.
    - Virginia (manager): There is a lack of preparation because the course is short and inadequate. Elsa (manager) agreed that the course should be longer.

- Elisa (managers): Aged care students lack opportunities to practice hands-on care.
- Terrie (manager/educator): Some aged care places call the TAFE to retrain some of their care workers, stating that ‘they were not happy with the quality of the education provider’.
- Kurt (care worker): There has been a decline in knowledge among graduates of Certificate III. Concerned that students are getting more theory but not enough hands-on experience.
- Chella (care worker): Graduates needs more onsite training.
- Brodie (care worker): Training does not include much about ATSIs. Brodie claims to be Aboriginal but does not speak the language or understand the culture entirely.
- Angelina (care worker): Graduates are not prepared enough, and PCAs move from one job to the next. Angelina is trained as an aged care worker; however, she is more involved with lifestyle activities, and her perspective is from her current job. She explained the need to better prepare aged care graduates to help them develop an understanding of residents from culturally diverse backgrounds, such as Italians and Greeks, and to develop a commitment to work.

Joanne (care worker): Graduates should know more about legal ramifications in the event one makes a mistake in aged care.

3. Managers and care workers agreed on other challenges faced in their work:
    - Lucky (manager): There is a lack of staffing.
    - Elisa (manager): Services are overstretched.

- Kurt (care worker): Care workers have difficulty completing their work within a given timeframe.
- Chanelle (manager): More equipment is needed.
- Brodie and Chressa (care workers): Graduates are not prepared for the challenges and realities that face them when working in RACS.

5.2.4.2 Survey

Nevertheless, the survey participants indicated that aged care training adequately prepared them to work in aged care. The findings indicated that 162 of 180 respondents felt that they were adequately prepared to work in aged care.

In summary, Research Question 4 examined the view of aged care graduates regarding their preparation to work in aged care after gaining employment in RACS. This question was asked of care workers who had worked in aged care for a few years and would, therefore, be able to reflect on their past training. However, all managers and care workers discussed their opinions of other aged care graduates entering the aged care sector.

5.2.4.3 Key issues

In summary, the following key issues were found about Research Question 4, which examined the view of aged care graduates regarding their preparation to work in aged care after gaining employment in RACS:

- Aged care workers need to be better prepared by obtaining adequate knowledge and experience.
- The currency of education needs to improve to meet the needs of older adults.
- Care workers should be better trained to meet challenges in real work situations.

5.2.5 What are the features of good aged care training according to managers and care workers?

To explore the features of good aged care training, three types of data were collated: (1) semi-structured interviews; (2) online survey; and (3) document analysis of Aged Care Training Packages and the QoCPs, which is the legislative framework that governs aged care practice.

5.2.5.1 Interviews

Managers and care workers discussed the features of good aged care training. Participants' suggestions mainly addressed Aged Care Training Packages, trainers and practical work placements. Many suggestions included the phrases 'need to know' or 'would like to have' as features of good aged care training.

Table 5.12

Semi-structured Interviews on Research Question 5

Participants	Codes	Categories	Key issues
	Training packages		
18. Romayne (manager)	Need to know some basic computer skills … make sure in the training packages … have got computer skills. PCAs are from a language other than English. Sometimes the spelling, and it is often the tense of the word they use.	Training packages include basic computer skills and English language.	Ability of trainers to deliver aged care training must be enhanced to deliver the Aged Care Training Packages to meet the highest standards of practice and industry needs.
2. Chanelle (care worker)	[On review of training packages]: I think we should not wait until three years, should be one-and-a-half years. Because we can add new policy and procedures … Future training needs is always available from place-to-place because we need to review our knowledge, skills and experience … the bushfire example. Also, I would include residents' cultural beliefs and medications.	Review more frequently to have new policies related to emergencies. Include cultural beliefs and medications.	
5. Elisa (manager)	Training packages … I think it should be updated whenever there are changes within the aged care industry.	Packages included rapidly to	Training packages are not relevant and current to meet

	I always ask myself whether people when they are writing these training packages, they know what is going on in the field. Packages need to evolve rapidly. As rapidly as aged care's changing. Select the right electives to work in aged care. Staff in aged care are expected to be very all rounded … social aspects … lifestyle … mental health … manage specific behaviours. The course has to take a bit longer for this to be done properly.	involve changes in the field. Need for industry consultations with RTOs.	the needs of the elderly.
12. Dorothy (manager)	Should check every year, people who are the regulators should get the feedback from the RTOs and say is it working, which unit do you want to change? Get regular industry consultation and then change it. When the 2–3 years come … got all the information … to change it and this unit went to be changed. Think of the Australian demographics … Aboriginal culture is quite different from what they have been in the CBD or Melbourne. Individualised care tasks but the unit have not been changed isn't it?		
17. Lucky (manager)	Training packages, I would recommend yearly review and they can implement it straight away.		
1. Terrie (manager)	Training packages to meet the regional needs.		
	Trainers	**Categories**	**Key issues**
12. Dorothy (manager)	Not anyone can do training and have been saying that someone from industry, for example, aged care should be doing the training not someone outside the industry. You have to have some training qualifications. There are several changes happening in the aged care industry.	Need for qualified trainers with an understanding of changes to the industry. Need for trainers to have an understanding of the ATSIs.	Lack of appropriately trained staff.
12. Dorothy (manager)	Especially people come from another country; they need to learn the history of the Australian systems, number one. Because old people, our generation, at		

	this stage they have been through the war, the hard life. They are different. Sometimes they do not understand, especially when they are working with the dementia people; they do not understand that.	Trainers' qualifications, knowledge and experience and the disconnect between them.	
4. Marion (care worker)	Wound care—they need more training as they are going to get rid of the ENs. PCAs have to take that responsibility. They need to be doing more complex management … all these chronic health conditions. Needs to be instilled into them to have that passion for their job.	Know about, dementia and complex management of chronic health conditions.	
5. Elisa (manager)	About the trainers, what kind of qualification and experience do they have? There is a disconnect in their knowledge and experience.		
9. Arnold (manager)	More in dementia.		
3. Kurt (care worker)	Palliative care. Nobody can teach how to communicate with the family members after their death.		
	Practical work placements	**Categories**	**Key concepts**
18. Romayne (manager)	PCAs, we need to involve more skill sets and practicing. Things like one of the big ones is the oxygen.	More skills (e.g., oxygen). Ratio of mature staff to trainees. More funding.	Lack of resources to appropriately mentor and supervised on student placements.
21. Bernadine (care worker)	I would like to see just really one matured staff to two trainees. Buddy system. During practical placements, there is not enough trained staff to help the students.		
21. Bernadine (care worker)	Funding for education. I find that sometimes the money that we get from the government is not enough.		

	Required knowledge	Categories	Key issues
3. Kurt (care worker)	Mental health issues, dementia, physically aggressive, a bullying issue, need to be trained, manage those behaviours.	Need for additional knowledge and skills: • mental health • managing challenging behaviours • need to know the quality of life • necessary information on falls, medical conditions and emergencies • medications • epilepsy, depression and chronic pain.	Lack of knowledge on caring for chronically ill and persons with complex needs.
18. Romayne (manager)	Mental health, dementia and behavioural issues, fall in-depth.		
17. Lucky (manager)	Graduates are coming at least they need to know quality of the life and quality of care … need the basic information on falls, medical conditions, emergencies … Meet the industry needs, better-prepared aged care workers.		
16. Marion (manager)	In my opinion, they do not understand about medications; all they can do is count the medications.		
13. Angelina (care worker)	I feel it is good for them to know about the history of residents and to understand their backgrounds. I wish I knew more, like epilepsy, deep depression, chronic pain. The hardest thing is to try and put yourself in someone else' shoes … it comes with experience.		

5.2.5.2 Interviews

Interviews on the features of good aged care training for managers and care workers focussed upon; training packages, trainers who deliver the course, knowledge and skills in areas of practice, work placements, documentation, and continuing education.

Table 5.13

Response from Managers about Trainers Needed Knowledge

Managers

Romayne	Elisa	Dorothy
I need to know some necessary computer skills. Include it in the training packages. I am improving my English language skills. The need to know about mental health, dementia and behavioural issues, fall in-depth.	Training packages update whenever there are changes within the aged care industry. Select the right electives to work in aged care. Sometimes I wonder about trainers' qualifications and experience [of aged care]. There is a disconnect in their knowledge and experience.	Regular industry consultation to get feedback on the course. So, when 2–3 years come to have all the information to change a unit. Individualised care tasks but the unit have changed. Training qualifications and done by someone from the industry. People from other countries need to learn the history of Australian. PCA needs to involve in more skill sets and to practice. For example, oxygen care.
Terrie	**Lucky**	
Would like to see training packages to meet the local needs.	Graduates, they need to know quality of the life and quality of care. They need the necessary information on falls, medical conditions, emergencies'. To meet the industry needs, have better-prepared aged care worker.	

Care workers

Chanelle	Marion	Arlinda
Training packages. Do not wait for three years to review. Include about bushfire, cultural beliefs and medications.	Need to know more about wound care. The need for PCAs to do more complex management for chronic health conditions. The need to instil a passion for their job.	I would like to see more training in dementia care.

	Does not think care workers understand medication management.	
Kurt	Bernadine	Angelina
Palliative care. Nobody can teach how to communicate with the family members after their death. The need to know mental health issues, dementia, physically aggressive, a bullying issue, need to be trained, manage those behaviours.	Would like to see one matured staff to two trainees. Use of a buddy system. Not enough staff to help students. Funding for education. The money from the government is not enough.	It is good for them to know about the history of the residents' backgrounds. I wish I knew more, like epilepsy, deep depression, chronic pain.

The interviews covered four areas of aged care training: (1) training packages; (2) training qualifications; (3) type of knowledge and skills; and (4) practical work placements:

1. Training packages: Elisa and Dorothy (managers) are involved in teaching and therefore, questioned the ability of the training packages to meet current aged care practices. Lucky (manager) provided some examples: 'graduates are coming at least they need to know about the quality of the life and quality of care … need the basic information on falls, medical conditions, emergencies … meet the industry needs and have better-prepared aged care workers'. Training packages need to be reviewed more frequently and with industry consultation to keep up to date with changes in the aged care sector and to meet industry needs for better-prepared aged care workers.
2. Trainer qualifications: Dorothy and Elisa - managers of aged care, both questioned the qualifications of aged care trainers. They were interested to know if they had training and industry experience in aged care to address the changes occurring in the aged care sector. Elisa (manager) goes further to explain her

observation of students learning. That there is a disconnect between their knowledge and experience.

3. Type of knowledge and skills: This includes dementia care, palliative care, communicating with the family after the death of a resident, more skills such as oxygen care (Romayne, manager), mental health issues, dementia, physically aggressive, bullying, and the need to be trained to manage those behaviours (Arnold, manager; Kurt, care worker). Lucky (care worker) said there is a need to know about quality of care and quality of life, as well as necessary information about medical conditions, emergencies, cultural background of residents and their history.
4. Practical work placements: Romayne (manager) stated that there should be one mature staff member to every two trainees and suggested that a 'buddy system' be used during practical placements. She claimed that there are not enough trained staff to help students.

Participants expressed concerns regarding student placements as one of the key issues, wherein students needed to have more hands-on experience (see figure 5.2).

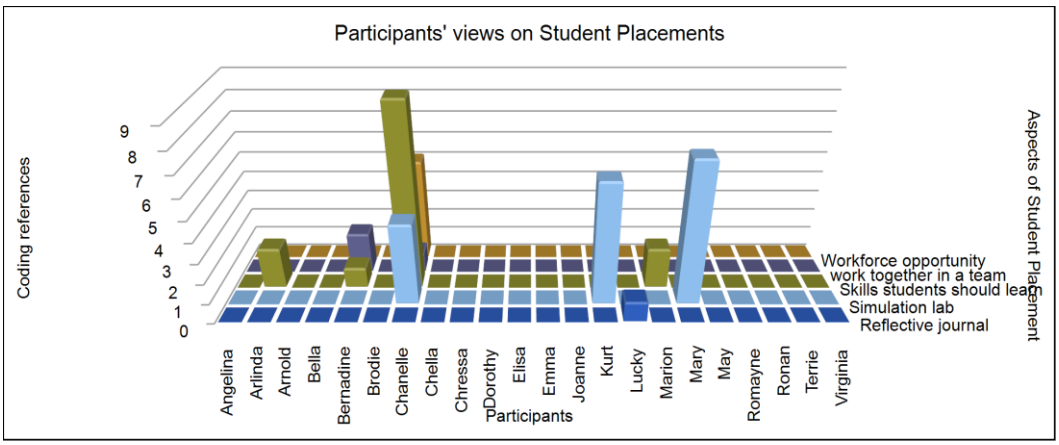

Figure 5.2 Participants Views on Student Placements

5.2.5.3 Online survey

Managers and care workers stated that additional knowledge is required about standards of care, lifestyle, environment and safe systems, consumer rights, literacy and numeracy, technology, cultural diversity, and documentation. The survey identified similar topics; chronic health conditions, specialised and complex care, skin integrity, medication management, palliative care, hydration, continence, challenging behaviours, mobility, rehabilitation, and dental care (see the table 5.13).

5.2.5.4 Document analysis

The findings of the analysis of published documents on training packages indicated that they do not address standards of care. The interviews brought to light areas that the researcher had not considered:

- Managers expected students to be all-rounders. They learn to provide personal care); however, they want to include the social, lifestyle, mental health and managing behaviours.
- The needs of ATSIs in Melbourne as an urban area are different compared with those in regional areas, and training packages should include the need to meet people's needs in regional areas in Victoria.
- Care workers need to be instilled with a passion for their job.

5.2.5.5 Key issues

In summary, the following key issues relating to the features of good aged care training were similar among both managers and care workers:

- Trainers must have the appropriate qualifications and experience of the aged care industry to ensure they make the connection between theory and practice.
- Clinical work placements should include a buddy system for trainees. However, there are not enough trained staff to help students.

- Graduates need to know how to care for chronically ill residents with complex needs.
- Training packages must be relevant to current needs in aged care.
- The education needs to address knowledge that is relevant to caring for residents who have chronic health conditions that have complex care needs.

5.3 Conclusion

This chapter reported the findings for the five research questions: (1) How is the quality of care perceived by aged care workers and managers? (2) How do RTOs teach the QoCPs legislated in the *Aged Care Act 1997* to aged care workers and managers? (3) How do managers and care workers in RACS perceive any gaps in the knowledge and skills of graduates? (4) How do aged care graduates view their preparation to work in aged care after gaining employment in RACS? (5) What are the features of good aged care training, according to managers and care workers?

The researcher examined the relationship between education and quality of care in RACS and how aged care education should be improved. Data were collected from document analysis, an online survey and interviews. The findings were presented using verbatim quotes and 'thick descriptions'. Content and thematic analyses identified the categories, codes and key themes. The primary data source was semi-structured interviews. The data were synthesised through explanatory text, figures and tables. Each section included a summary of the critical issues arising from the interviews, the online survey and the document analysis about each research question. The findings were corroborated and contextualised from the other data sources (online survey and document analysis).

The key issues arising from the five research questions suggest that changes must be made to aged care to improve quality of care in the long term. The critical issues raised by managers and care workers are summarised below.

RQ1: How is quality of care perceived by aged care workers and managers?

1. Quality of care aims to improve individuals' quality of life but is jeopardised by a lack of knowledge and skills among aged care graduates. Also, more staffing, time and resources are needed to support this.
2. Knowledge and understanding of the legal ramifications of proper documentation of care are imperative to meet care needs and provide quality of care.

RQ2: How do RTOs teach the Quality of Care Principles legislated in the *Aged Care Act 1997* to aged care workers and managers?

1. Accreditation monitoring of standards is principally about compliance and does not assure that quality of care is provided.
2. QoCPs are inadequately addressed in the Aged Care Training Packages.
3. Managers and care workers have a limited understanding of the legislative framework that governs aged care practice.

RQ3: How do managers and care workers in RACS perceive any gaps in the knowledge and skills of graduates?

1. Aged care graduates lack basic knowledge and skills (e.g., documentation and making beds).
2. The ability of education to keep up to date with changes in practice and the use of equipment is a vital component for aged care graduates.

RQ4: How do aged care graduates view their preparation to work in aged care after gaining employment in RACS?

1. Aged care workers need better preparation in terms of adequate knowledge and experience.
2. The currency of education needs to improve to meet the needs of older adults.
3. Training must better prepare care workers to meet the challenges and realities of real work situations.

RQ5: What are the features of good aged care training according to managers and care workers?

1. Doubts were raised about the appropriate industry qualifications and experience of trainers and whether they can make the connection between theory and practice.
2. There are not enough trained staff to help students during clinical work placements.
3. Aged care workers need knowledge and skills to care for residents who have chronic health conditions and complex needs.
4. Training packages are needed that are relevant to current needs in aged care.

The next chapter will examine the results for the five research questions and discuss the main issues considering the literature review, including Dewey's theoretical framework.

Chapter 6: Discussion of Results

6.1 Introduction

This chapter discusses the critical issues arising from the findings for each of the five research questions. It includes an interpretation, analysis and synthesis of the results of the findings. The chapter will present the key issues arising from the data by forming themes to make sense of participants' responses within the literature and the conceptual framework.

The approach to the analysis seeks new patterns among the findings and examines whether the literature corresponds with, contradicts or deepens the results. The researcher considers the differing and convergent views of managers and care workers in terms of their years of experience, roles and responsibilities, and education and background.

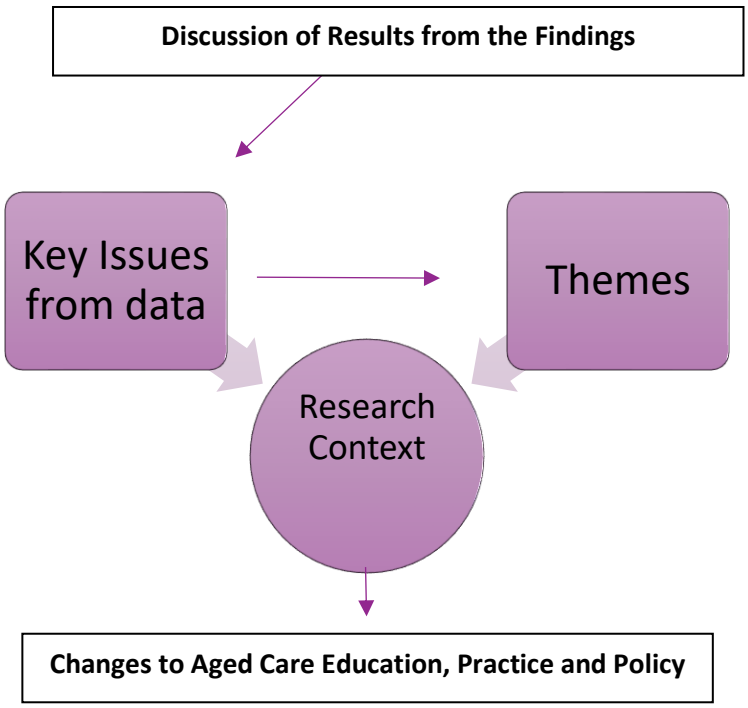

Figure 6.1 Discussion of Key Issues and Themes

6.2 Discussion of Results for Each Research Question

The issues are discussed about each of the research questions confirms previous concerns raised in the background and literature review offered in this study (see pp 8-49). The issues include quality of care perceived by aged care workers and managers; quality of care and its effect on the quality of life is jeopardised; and challenges in delivering holistic and consumer-directed care.

6.2.1 How is the quality of care perceived by aged care workers and managers?

The following issues arose in the findings: (1) quality of care and its effect on the quality of life is jeopardised; (2) there are challenges in delivering holistic care and consumer-directed care; (3) there is a lack of staffing, time constraints and resources, as well as inadequate funding. These issues are discussed in detail below:

6.2.1.1 Quality of care and its effect on the quality of life is jeopardised

The question on 'how quality of care is perceived by aged care workers and managers' is related to research question one (how is quality of care perceived by aged care workers and managers working in RACS?). For example, a manager defined 'quality' as 'being responsive', 'communicating effectively', 'ensuring best practice', 'gaining experience and knowledge' (Terrie), 'meeting of clients' and 'cultural diversity' (Elisa). A care worker defined quality as 'providing care according to the care plan and wishes', 'giving a choice', 'maintain client independence' (Chanelle), 'respecting the rights', 'give them the best' and 'individual care and make a difference' (Kurt).

Managers and care workers voiced concerns about the lack of resources and staff, which jeopardises the delivery of quality of care and affects the quality of life. It has long been known that a lack of staff is a problem in providing quality of care (Savy et al., 2017).

In the last 20 years, there has been a surge in the number of frail older adults entering aged care homes because they are unable to manage their chronic health conditions and require maximum assistance with personal care needs and treatment. The chronic staff shortage has had a domino effect, with aged care providers frustrated by the lack of staff and aged care residents not receiving care promptly. For aged care residents, low staff levels lead to a higher risk of fall incidents and an increase in medication errors, both of which can be fatal. For aged care providers, low staff levels lead to inadequate care practices, shortcuts in providing care, reduced job satisfaction and high attrition rates.

6.2.1.2 Challenges in delivering holistic and consumer-directed care

Participants described care as 'best practice', 'excellence in care' and 'quality of care' to affect the 'quality of life' of residents in RACS. Elsa (manager) discussed the models of care as 'holistic and consumer-directed care'. She explained the challenges in delivering these models of care:

> The biggest challenge is to know what the consumer is looking [for] sic. So, they could be functioning within a framework of what the organisation requires, but then they will find that each of those consumers [residents] has come in with different needs, and the challenge of the worker is to balance what the organisation requires of them versus making sure that the customer is happy (Elsa, Personal Communication, 16 June 2017).

Each resident has different needs. The holistic approach involves caring for the person's physical, mental, psychosocial and cultural wellbeing (Davis et al., 2016). However, many residents are frail and have chronic health conditions, and some are unable to express their psychological, cultural and social needs.

Another type of care is consumer-directed care, which provides more choice and flexibility of care to older persons living in the community with a home care package (Cardona, 2017; Department of Health and Ageing, 2013). Consumer-directed care ensures that consumers have control over forms of care and timely delivery of services (Cardona, 2017).

The concept of consumer-directed care is not used in many RACS because many frail residents are unable to articulate their needs or have a say in who should deliver their care services (Cardona, 2017). This was supported by Chanelle and Kurt (care workers), who stated that a 'lack of staffing' makes it impossible to meet residents' care needs even if they can express their needs. For example, the delivery of consumer-directed care involves planning and managing care in discussion with the individual and their family according to the funding provided to the individual (Cardona, 2017). Residents are not always aware of the type and amount of funding they can receive, and they have no say on how it should be spent on their individual care needs. Cardona (2017) warned that unless fundamental flaws are addressed, the most vulnerable people in society will continue to be neglected. Urgent need to address the lack of staffing and resources, as well as time constraints and more funding

6.2.1.2.1 Lack of human resources—staffing

A perceived lack of human resources was a significant hindrance to maintaining quality. Managers and care workers discussed the urgent need to address challenges in the delivery of quality of care, including 'time constraints', 'lack of resources and equipment' and 'the need for more funding'. The lack of resources includes human and physical resources such as staffing, supplies and equipment.

Lucky (manager), who works from 3 pm to 11 pm, stated that 'the staff ratio is the most significant in the aged care':

> One personal care worker on the night duty [is] given about 25 residents. There is an RN for one facility. It is impossible if a person has a fall or if a person has a seizure. By the time [the] RN reaches [the scene], the situation can change. I operate in an aged care facility that has 100 residents with four separate wings to it. Each wing has 25 residents with high care needs. These residents are dependent on … direct care that includes meeting hygiene needs, toileting, nutrition, comfort and medical needs (Lucky, Personal Communication, 27 May 2017).

Research shows that this has been an ongoing problem since the 1980s. This has prompted several studies into staffing in aged care (Angus & Nay, 2003; Chou, Boldy, & Lee, 2002; Dwyer, 2011; Ranasinghe & Miller, 2007), as well as media reports (ABC, 2018; Aged Care Crisis, 2018), increased monitoring supported by the minister for ageing (Aged Care Quality and Safety Commission Bill, 2018) and a Royal Commission into staffing levels in aged care.

Minimum staffing levels are not legislated for in the *Aged Care Act 1997* or supported by unions through workplace agreements in aged care. The practice of having three or four staff for every 25 residents between 3 pm and 11 pm, and two staff between 11 pm and 8 am, has been in place for more than 40 years. However, an individual's hygiene, toileting and comfort needs, as well as their frailty and chronic conditions, do not change over 24 hours. APs and the monitoring quality agency are aware of the ongoing problem of inadequate staffing in aged care (Australian Aged Care Quality Agency. 2018).

Consumer complaints and the media exposed years of inadequate staffing levels, which prompted an enquiry and sweeping changes. Aged Care Crisis (2018) stated that it was important that there is sufficient staff to provide care services. For many years,

APs, unions, quality assessors and governments have failed older adults. An excerpt from an accreditation report following an audit on a RACS showed that minimal staff were rostered between 8 pm and 6.30 am, and residents were not managed during this period, which resulted in residents absconding, wandering and falling (Aged Care Crisis, 2010). Minimum staffing after 6 pm has been a recurring problem for many years in RACS. It has prompted a Royal Commission into staffing levels in RACS across Australia, as well as media reports about the lack of delegated staff/resident ratios' compromising residents' care (Aged Care Crisis, 2010).

It is worth noting that the Accreditation Standards, outcome 1.3 legislated in the *Aged Care Act 1997* refer to 'an adequate number of appropriately trained staff'. The problem with this is that the staff ratio to residents is unknown. The word 'adequate' is unclear, and the phrase 'appropriately trained staff' is indistinct. The Oxford dictionary defines 'adequate' as 'satisfactory or acceptable in quality or quantity'. Managers and care workers are discouraged from asking about the quantity and quality of staff, which raises the question: What is a 'satisfactory or acceptable' number of staff?

6.2.1.2.2 Lack of resources—supplies and equipment

An EN who has worked for many years to provide direct care to residents explained that:

> Trained staffing was not a problem. It was a lack of staffing and resources. We did not have the proper supplies and equipment. (Bernadine, Personal Communication, 27 May 2017)

Resources such as consumable supplies and equipment are essential to support residents' care needs. Aged Care Crisis (2010) reported that a lack of resources has led to managers being pressured to provide services while simultaneously meeting profit targets. As a result, managers reduce staff numbers and place vulnerable residents at

risk. The ACFI's funding for additional resources was viewed as a 'rort and over-service' because funding is channelled for passive treatment to manage pain rather than evidence-based practice, thereby causing increased dependency and reduce functions, which affect residents' quality of life (Aged Care Crisis, 2010).

For many years, little has been done to address the rorting of the system (King et al. 2012, p. 151). Staff without adequate supplies and access to appropriate equipment are unable to provide safe care to residents.

6.2.1.2.3 Calls for more funding for staffing

Managers and care workers reported that a lack of staff availability is one reason for the inadequate prevention of falls and that the current ACFI has been inadequate in providing more staff. The ACFI is a funding tool that is based on residents' 24-hour care needs. Under the ACFI funding model, approved providers are limited to certain approved types of care (Australian Government, 2018; KPMG, 2012).

Regardless of the annual increase in ACFI funding to meet care needs, there was no increase in staffing. Lucky explained that on her evening shift, 'there [are] either two or three care workers with one enrolled nurse, who is busy administering medications for 25 residents. That takes three to four hours. The funding provided is supposed to be for the care needs of residents and adequate staffing'. Further, a resident who has fallen requires immediate attention, and:

> the one care worker on shift is not able to lift the resident on her own and without first the RN assessing the fall situation … the RN usually checks for any fractures and assesses the vital signs and general condition of the resident. She makes the call if the resident can transfer to his or her bed; she then calls for an ambulance to transfer the resident if injured (Lucky, Personal Communication, 27 May 2017).

Studies have been conducted on falls and the complications arising from falls, including hypothermia, fractures and bleeding, any of which can be fatal (De Bellis, 2010). Most residents in RACS are reliant on one or two care staff for their care needs and mobilisation. To provide quality of care, care workers need time to deal with not only frail older adults who need more time to get into bed but also residents with dementia who are more confused about their routine at night. In a recent example that has been discussed widely in the media, two care workers slapped the resident they were settling into bed in the Oakden aged care facility, which led to legal consequences for them.

Care workers are often blamed when they have no control over the budget to decide on staffing numbers for each shift. They are given a timeframe to complete their tasks, and failure to do so results in being reprimanded, suspended or even losing their job. The lack of staff on a shift—particularly after hours—means that they do not have the time and endurance to help residents who may be unable to cooperate because of a pathophysiologic condition such as dementia.

A lack of staff means that care workers do not have time to read individual care plans and treatments before approaching residents, to explain a procedure to a resident before carrying it out, or to translate if there is a language barrier (Ostaszkiewicz et al., 2016). These incidents often result in elder abuse while in care (Aged Care Crisis, 2018). APs are responsible for staff levels because they receive funding from the government and residents, and they should invest in more staff if the quality of care is to be assured (Ostaszkiewicz et al., 2016). Support for care workers is imperative to ensure that standards of care meet residents' needs and their quality of life are maintained.

Since the mid-1980s, concerns about poor standards of care have received considerable attention in several studies. Ranasinghe and Miller (2006) and Billings

(2016) showed that staff do not stay long if there is a lack of support. Recent practices prompted a response to the aged care crisis which resulted from nurses and carers unable to care for residents appropriately, given the circumstances and time constraints imposed on them as APs struggle to function with the least staff possible.

Lucky (manager) revealed: 'this is confidential: we need more staff'. Managers and care workers are hesitant to elevate the issue of staffing for fear of losing a shift or even their job. Care workers in the study reported 'being rushed to complete their work' because of a 'fear of getting into trouble', 'losing a shift or their job'. Care workers provide direct care, including personal hygiene care, assisting residents with meals, transporting residents to their room, the dining room or the lounge area, and preparing residents to settle into bed at night.

Many RNs are unable to help care workers in direct care because they are involved in administrative activities and need to work within a budget (Aged Care Crisis, 2018). For example, RNs respond to phone calls, seek and follow advice from medical doctors, advise family members on the care that is provided, call doctors to visit residents who need medical attention and answer queries from other care staff, residents and families.

Many managers are not nurses, and they incorrectly direct clinical care with no understanding of the resident's nursing, medical and personal care needs. The Australian Nursing and Midwifery Council, standards expect that nurses should take instructions from doctors and fellow nurses for issues relating to direct clinical care. In several aged care facilities, non-nurses with qualifications that are unrelated to nursing are advising and directing clinical care to other nurses, thereby placing residents at high risk.

Nurse managers who voice their concerns and request more staff and equipment are often vilified, deemed incompetent and performance-managed for their inability to cope. In many cases, they lose their job or leave the workforce out of frustration and fear of losing their license to practice. The Royal Commission is currently investigating staff levels in RACS, and there has been a growing call for more qualified RNs and appropriately qualified care workers (Commonwealth of Australia, 2020). The older adults who are residents must be protected from risks and abuse through adequate staffing levels. Education plays a significant role in assisting with an appropriately qualified aged care workforce.

6.2.2 How do registered training organisations teach the Quality of Care Principles legislated in the Aged Care Act 1997 to aged care workers and managers?

The QoCPs form a legislative framework that governs aged care practice and includes accreditation and residential care services. Several concerns have been raised relating to the QoCPs are: (1) limited understanding and implementation of the QoCPs; and (2) accreditation monitoring for 'compliance' rather than the quality of care.

6.2.2.1 Limited understanding and implementation of the Quality of Care Principles

The QoCPs are understood differently by managers and care workers because of their key roles and responsibilities. Most of the managers aged 40–50 with ten or more years of experience provided their views on the QoCPs. For example, Terrie explained that 'I am familiar with them [QoCPs] and I know [they] change quite significantly'. Implementation of the QoCPs changed Elisa is a manager's practice and perspective:

> when it comes to Quality of Care Principles, it has forced me to look outside not just the guidelines and looks more at the individuals regarding what they [staff] require and what quality is to them (Elisa, Personal Communication, 16 June 2017).

Elisa felt that she would have to teach staff about the QoCPs. Kurt (care worker) considered that the QoCPs involve ‘maintaining the quality of the life of the person’.

The QoCPs was developed in 1997 and amended in 2014 under section 96-1 of the *Aged Care Act 1997*. Managers and care workers found the QoCPs cumbersome and not easy to understand. The QoCPs address residential and home care services and set standards and schedules that must be compliant. Managers and care workers did not fully understand the Accreditation Standards and Standards of Care, which are part of the QoCPs. Therefore, QoCPs must be included in the education program to offer a better understanding and application of the principles for the benefit and protection of residents in aged care. The QoCPs are not adequately addressed in the Aged Care Training Packages.

6.2.2.2 Accreditation monitors for ‘compliance’ rather than ‘quality of care’

It is not surprising that managers and care workers have negative views of the Accreditation Standards. For example, Terrie (manager) said:

> It drives me bonkers. Because even with the quality team, it is about evidence of participation, not about what quality you are delivering. It is much easier to audit against dates and not what can be delivered (Terrie, Personal Communication, 27 May 2017).

There is no confidence in the AACQA, which is entrusted with monitoring the quality of care in RACS based on the Accreditation Standards. The literature review noted that several researchers (Angus & Nay, 2003; Ranasinghe & Miller, 2006) had criticised the AACQA for many years because of its inadequate ability to monitor the Standards of Care. The AACQA has been criticised for auditing for ‘compliance’ rather than ‘quality’. AACQA assessors evaluate the routine of care for residents against the

Care Standards and do not use objective data such as ‘clinical quality indicators’ (Aged Care Crisis, 2010; Ranasinghe & Miller, 2007).

The Accreditation Standards have been inadequately addressed in aged care education. The AACQA monitors four accreditation standards: Standard 1: management systems, staffing and organisational development; Standard 2: health and personal care; Standard 3: the resident’s lifestyle; and Standard 4: physical environment and safe systems (*Aged Care Act 1997*; Quality of Care Principles, 2014).

The literature review confirms the study participants’ belief that APs do the minimum amount required to meet the Accreditation Standards. It is vital for APs of aged care facilities to meet the Accreditation Standards to continue to receive government subsidies (see pp 8-49). The literature also confirmed the longstanding issue of AACQA assessors auditing for compliance rather than quality (Angus & Nay, 2003; De Bellis, 2010; Ranasinghe & Miller, 2007). Thus, monitoring for compliance with the Accreditation Standards is often a pretence to gain political acumen and was exposed by the media that criticised the accreditation processes’ failure to collect and publish objective data on the monitoring of the Standards of Care (Aged Care Crisis, 2010).

Assessors who were part of the monitoring team were not allowed to report deficiencies and issues arising during the audits because the team leader advised it was ‘not systematic’. However, these ‘not systematic’ issues came to the forefront, resulting in the Royal Commission’s investigation into the practices and monitoring of care standards in RACS (Commonwealth of Australia, 2020). The AACQA’s inadequate auditing processes have been reported in past and current literature, as well as by the participants of this study (Ranasinghe & Miller 2007). After 32 years, the AACQA has now recognised that it must concentrate on the quality of care. The newly developed

Aged Care Quality Standards, fully implemented in 2019, with emphasis on quality outcomes for residents rather than processes.

Since 1997, the QoCPs have aimed to monitor the quality of care for the recipient. However, it was common knowledge that the ‘quality’ agency favoured APs instead. For example, in 2017, a quality assessor raised concerns about an incident that occurred in an aged care facility in which poor management led to an unconscious resident being admitted to hospital. The assessor viewed an incident at the time of the audit and was asked to investigate the incident. Although the issue was addressed and documented by the facility, it was not done to the satisfaction of the next of kin. The team leader said it was not necessary to document the concern in the report because it was not considered a ‘systematic’ problem in the facility, given the short period allocated to monitor for compliance.

Feedback from the APs recommended that the assessor should use open-ended questions in future rather than closed-ended questions, even though the assessor had been auditing since 2000. The agency did not meet with the assessor but worked in favour of the AP and agreed with its comments to the detriment of the longstanding experience of the assessor in question. Several other assessors similarly reported that if the AP did not like them using both open-ended and closed-ended questions (depending on the issue), the AACQA ruled in favour of the AP, even though, the QoCPs always intended to have the quality of care at the forefront. Another criticism is that accreditation was supposed to be made more accessible to consumers and their representatives to help them know what to expect from a service.

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The most concerning aspect of the AACQA is the lack of demarcation of its roles and responsibilities. The AACQA should be an independent body to prevent

conflicts of interest. Currently, it provides education services, plays an administrative and advisory role, and consults on assessments of care practices and workshops. Aged Care Crisis (2010) identified that some RACS prepare for accreditation assessments with the help of contractors who work for the agency and are effectively working for two agencies.

More concerning, the 2015 Federal Budget announced a range of actions and planned to privatise the accreditation services to allow providers to choose an agency to accredit their facility (Aged Care Crisis, 2015). The government and the AACQA failed to identify the risk involved in compromising the objectivity of audits. Thus, it is not surprising that the QoCPs involving accreditation and residential care standards are problematic. It is difficult for managers and care workers to implement the Standards of Care appropriately. For example, Kurt (care worker) perceived the monitoring of accreditation by the AACQA as a checklist that is ticked off:

> They check if you … as an organisation are meeting requirements of particular clients, such as 'Are you doing it or not?' That is what they do in accreditation (Kurt, Personal Communication, 27 May 2017).

The literature review showed that researchers (Ranasinghe & Miller, 2007) have been scathing of the processes involved in monitoring the Accreditation Standards, stating that it is about ticking boxes for compliance rather than achieving objective and measurable outcomes using clinical quality indicators.

Elisa (manager) explained that 'accreditation, to a certain level, looks at quality care, but its main functionality is compliance'. She felt that she 'has to' comply. Still, she also viewed it from another perspective: 'I have to comply in delivering quality care to the residents depending on the kind of residents I have' (Elisa, Personal Communication, 16 June 2017).

Further, Eliza suggested that accreditation should determine whether the individual care needs of residents are met:

> We could be compliant and fulfil everything that the Quality of Care Principles and accreditation requirements wants us to do without necessarily fulfilling the requirements of the residents' needs (Elisa, Personal Communication, 16 June 2017).

Elisa extended her concern to aged care graduates and how they perceive accreditation in aged care:

> it all becomes a whole minefield for aged care graduates because it is different—how they understand it, how the organisation understands it and how the industry is looking at it—versus what the community or the customers are looking for (Elisa, Personal Communication, 16 June 2017).

Dorothy (manager) shared Elisa's views. Dorothy has worked for several years in the aged care industry in the capacity of a quality auditor and manager of aged care services.

Bernadine (care worker), who has worked in aged care since the late 1980s, claimed that 'accreditation standards came about because of … the poor standards in the 1980s and 1990s'. However, while there have been changes to living accommodation in RACS, little has changed about care practices—particularly for those who are unable to articulate their needs. Changes such hotel type of accommodation with single rooms with ensuites, large entertainment areas for the older adults in RACS.

Residents with a pathophysiological condition, affecting communication, should have their family included in the resident's upkeep. Quality of care is promoted if

adequate staffing, resources and education are provided, and all residents are included in decision-making.

6.2.3 How do managers and care workers in residential aged care services perceive any gaps in the knowledge and skills of graduates?

Managers and care workers identified gaps in aged care training that affect the quality of care such as: (1) aged care graduates lacking basic knowledge and technical skills; and (2) lack of understanding of the legal ramifications of inadequate documentation.

6.2.3.1 Aged care graduates lack basic knowledge and technical skills

Managers and care workers asserted that aged care graduates lack basic and complex knowledge and skills. The managers stated that basic knowledge includes 'documentation' (Dorothy), 'cultural needs' (Elisa) and caring for disadvantaged people and those with disabilities (Arnold) (Personal Communication, 18 July 2017). Joanne (care worker) said that 'most of the students come in not knowing how to make a bed, which blows my mind'.

Sophisticated knowledge and skills include 'palliative care unit, medication unit, quality of life, advocacy, wound care, nutrition, weight loss, malnourished, dementia' (Terrie, Personal Communication, 27 May 2017). The identified knowledge and skills refer to the Standards of Care for older adults in RACS. However, the care of younger people with disabilities in RACS is poorly addressed in practice and training packages.

It is critical to appreciate the social, cultural, religious beliefs and practices for residents receiving palliative care must be respected. Dorothy (manager) stated that graduates 'need to be taught palliative care and basic cultural needs'.

Social and cultural needs relate not only to people from other cultures or regions but also to their lifestyle. For example, if a person's habit is to have a shower or read the

newspaper in the morning, this social need must be accommodated to maintain the individual's quality of life. Social needs are inadequately addressed in the Aged Care Training Packages.

6.2.3.2 Lack of understanding of the basic legal ramifications for documentation

Many managers and care workers were concerned about gaps in knowledge about the legal ramifications for inadequate documentation. For example, Kurt (care worker) stated:

> Care planning: people do not know the word 'care plan'. They finish a certificate in aged care without knowing about documentation, and it frustrates me a bit. They should know what a care plan is (Kurt, Personal Communication, 27 May 2017).

Dorothy (manager) agreed and further explained:

> I think documentation is very important. Basic documentation, date, time, signature, name, designation, these are legal documents, write concisely, documentation in dementia care (Dorothy, Personal Communication, 27 May 2017).

Inadequate care documentation can have legal implications if documents are subpoenaed for court. Joanne (care worker) explained that 'learning, knowing more about the legal ramifications of when you make a mistake, is important'. Chanelle (care worker) explained that documentation is learnt on the job, even though it is provided in aged care education:

> Once you are in the school, you cannot provide proper documentation … You need to have the experience, so it has come from your practice (Chanelle, Personal Communication, 27 May 2017).

Marion (care worker) added:

> documentation is very necessary. Most aged care places have electronic documentation, and I am not so sure the training organisations are teaching about electronic documentation, the different software that they use. It is a big challenge actually (Marion, Personal Communication, 27 May 2017).

Romayne (manager) suggested that:

> they should be focusing at the beginning of documentation a clear, concise manner but also what triggered certain behaviours. What happened … teach people how to do electronic and paper-based documentation. It is really important, and they do not do enough of it (Romayne, Personal Communication, 27 May 2017).

The Aged Care Training Packages insufficiently address paper-based and electronic documentation undertaken in RACS. Students do not learn about the use of various documentation formats required of them.

Some participants reported documentation is vital for several reasons, including documenting residents' care needs, medical treatment, nursing care and allied health professionals. Managers and care workers refer to care plans, progress notes and monitoring charts to assess and plan future care. Documenting adverse reactions, incidents, and falls are essential for future reference (Romayne, Personal Communication, 27 May 2017). Documentation is vital for communicating residents' assessed needs and evaluating the care provided.

6.2.4 How do aged care graduates view their preparation to work in aged care after gaining employment in residential aged care services?

Concerning aged care graduates' preparation to work in aged care, managers and care workers found (1) a lack of preparation of aged care graduates and (2) a lack of preparing graduates to face the realities of working in aged care.

6.2.4.1 Lack of preparation of aged care graduates

This question was primarily directed towards care workers about their preparation to work in RACS. However, managers also provided their perspective. The researcher observed that only Angelina (care worker) stated her view rather than that of others: 'I wish I knew about epilepsy, deep depression, chronic pain'. Angelina was a care worker for a few years and now works in the lifestyle department, which assists residents with leisure and health activities. She identified issues that would be a barrier to residents participating in activities and stated that knowing more about epilepsy, depression and chronic pain, would enable her to identify signs and symptoms and help residents manage their conditions during leisure and lifestyle activities.

Kurt (care worker), who had undertaken aged care training and is now an EN, provided an objective view of current aged care graduates' training:

> I do not know what is wrong, what is going on, but I can see a drastic decline in the quality of the person who is coming out from the Certificate III … I do not know where they did the course. Based on the experience … the level of knowledge they are gaining is going down. I think in my opinion, at the moment, in the residential aged care sector, that people who are coming from the certificate in aged care, the level of passion, the level of knowledge is declining in my personal opinion. I do not know the specific reason. For example, there

> are so many observed, personally, but one particular example is the manual handling issues (Kurt, Personal Communication, 27 May 2017).

Kurt was a physiotherapist in his country of origin and recalled what he learnt when he was undertaking his aged care training:

> It helped me a lot, the basic knowledge of transferring of residents. I was [shown] what a standing machine is and what is a lifting machine and what is a transfer belt (Kurt, Personal Communication, 27 May 2017).

Manual handling presents a high safety risk to residents and staff. Injuries to both staff and residents can lead to financial and legal ramifications following an injury.

According to Arnold (manager), who manages an aged care facility for indigenous people:

> Graduates are not prepared well enough to provide direct care. Do not ask me the reason, but whatever I have seen in the last four or five years, whoever comes, they needed much guidance regarding providing simple care.
>
> How to approach the person when someone has dementia, persons with special care need requiring complex care, understanding the cultural diversity for Aboriginal islanders. Most of who is here were never aware of the culture, the Aboriginal culture, until started working here (Arnold, Personal Communication, 8 July 2017).

In line with this, findings in published documents have shown that there is incomplete information on the Aboriginal culture in the Aged Care Training Packages. Many people from indigenous communities live in Melbourne and away from their original homes, such as Alice Springs and Darwin (ABS, 2017). Managers and care workers discussed their concerns about graduates' lack of practical experience in caring

for people in these communities. Arnold (manager) had strong opinions about aged care graduates:

> I would not say [that graduates are prepared]. They needed much guidance [in] providing simple care [and] how to approach the person when someone is demented. They do not have an understanding of the Aboriginal islanders and cultural diversity … No, no, absolutely not (Arnold, Personal Communication, 8 July 2017).

Cultural diversity was an issue for many managers and care workers (ACFA, 2013). The ageing population includes many people who migrated from other countries. Arnold (manager), operates in a facility that meets the unique needs of Aboriginal and Torres Strait Islanders in the metropolitan region, was concerned that care workers were not aware of Aboriginal culture until they started working at the facility.

Brodie (care worker) works in a similar facility in regional Australia, and her views aligned with those of Arnold:

> more information should be provided by Aboriginal Torres Strait Islanders and diverse clients in training … the whole aged care training, there was not much. It was a bit daunting at first, but you know, you get used to it over time, and it is just like second nature (Brodie, Personal Communication, 8 July 2017).

6.2.4.2 Lack of preparing graduates to face the realities of working in aged care

Both managers and care workers discussed the need for more practical work placements to prepare aged care workers better. Most RTOs have simulation labs with supplies and equipment. However, they may vary in quality and quantity. For example, Terrie (manager) tries to ensure that her students have an opportunity to practice in a simulated lab that replicates an aged care setup:

> With the medication unit, regarding simulation, to make sure we have not got just the old dosette boxes, but that we have got the single-use containers and those sorts of things that you see in the aged care industry more so now (Terrie, Personal Communication, 27 May 2017).

Many universities and TAFE colleges receive financial support for simulation labs, but RTOs are expected to fund simulation labs without government support.

Kurt (care worker) was concerned that:

> I think they are getting a lot of theory, but they are not getting enough hands-on experience. Moreover, that is not necessarily to blame the colleges that are training them (Kurt, Personal Communication, 27 May 2017).

Many colleges and RTOs have simulated labs that may or may not be adequately equipped because of a lack of funding. Many managers and care workers discussed the need for 'hands-on' experience as a central component of aged care training. In the past, aged care training has been conducted online, with no practical experience for students. Arlinda (care worker) completed the online aged care course and stressed the need for 'hands-on' and 'face-to-face' training 'to be able to work with other people'.

Face-to-face training entails lectures, formative assessments and practice in a simulated environment at a training institution. 'Hands-on' refers to practical work placements, which enable aged care graduates to develop skills and learn to work with other staff in the aged care sector. Lucky (manager) explained that graduates are expected:

> to take more responsibilities, need to have good clinical skills that are important … need to know the condition of the residents, the diagnosis affecting the condition. [These] skills are compulsory for the graduates (Lucky, Personal Communication, 27 May 2017).

Dorothy (manager) suggested that people who are interested in working in aged care should undertake voluntary work before beginning their studies:

> I think that everybody should have some voluntary experience even when they go to school, or they register for this course. They should have volunteered and see if it is what is I want to do.
>
> I think they are frightened [of] old people, especially they are not glamorous people. They are frightened they are going to get infected, somehow touching people. Some people are frightened about the dementia residents, and some people have never seen someone die, you know, the palliative care people, so when the young people are doing this course and when they see, then they are frightened (Dorothy, Personal Communication, 27 May 2017).

Many aged care graduates do not have prior work experience or even voluntary experience working in the aged care sector. Dorothy (manager) advocated for training and practice as well as a better model:

> The 120–200 hours of practical experience should be staggered so the student can go back to the teacher [to] clarify areas they do not understand or do not know … The thing is that it is good to have theory and practice (Dorothy, Personal Communication, 27 May 2017).
>
> Dorothy was concerned that 'theory without practice is futile':
>
> You need to prepare them for tomorrow. People change, and industry constantly changes. I think the theory and practice, or traineeship would be better, though it is expensive (Dorothy, Personal Communication, 27 May 2017).

The expense involved in organising training and practice includes the trainer's salary and associated costs to follow up with students while they are on their placement.

Many students prefer placements that are closer to their home. However, trainers are unable to travel to certain areas because of time and transport issues.

Chella (care worker) was recently employed for a year following her aged care education and discussed her personal experience as an aged care graduate:

> They tell you, go to the aged care and have a wonderful time … They [residents] are all lovely. It is much more challenging than lovely. I mean like it is a bit hard for us. We have got eight to nine residents, and that is who we are stuck with every day. There is no walking away from them; they are not a number, or it is not that you are palming them off—they are just in your face (Chella, Personal Communication, 16 June 2017).

Chella suggested that there 'needs to be a lot more onsite training' and that 'there was not anything rosy and rainbows about working in aged care'.

Chressa (care worker) said:

> I found it a bit of a shock. It is not what is in the books to what is in real life. There was a disconnect between what you were learning and what you were practising. A bit more training in the workplace (Chressa, Personal Communication, 16 June 2017).

Following their training, Chella and Chressa found the aged care workforce challenging. They expressed their feeling of being upset and unhappy about their first experiences on the job and wished that they had a better preparation. Brodie (care worker) explained:

> Sometimes it is challenging dealing with family because there is such a big family. They do not agree with some things that you want, thinks best for an elder (Brodie, Personal Communication, 16 June 2017).

It is imperative to provide graduates workplace experience to prepare them better to understand work expectations and environment, to meet other staff working in aged care, and to meet residents and learn about their care needs. This would restore confidence in graduates and help them to cope with the realities and challenges of working in the aged care sector.

6.2.5 What are the features of good aged care training according to managers and care workers?

Managers and care workers were concerned that: (1) the training packages do not adequately address current trends in aged care; (2) aged care trainers do not have the relevant knowledge and experience that is required; (3) students' learning experiences are inadequately managed during work placements; (4) there is a lack of knowledge and skills in chronic health conditions; and (5) there is a lack of 'softs skills'.

6.2.5.1 Training packages do not adequately address current trends in aged care

Five managers and one care worker were concerned about the training packages. Romayne (manager) asserted that the training packages should include basic computer knowledge and skills:

> Students need to know some basic computer skills and … the Training Package should include computer skills to help PCAs [whose] language is other than English to help with their tenses and spelling (Romayne, Personal Communication, 27 May 2017).

The development of computer literacy skills is part of aged care training. Lectures, assessments and other related training information can be found on student learning management systems. Students are encouraged to use computers to conduct research or undertake self-directed studies and submit assessments online. Information technology personnel are on the premises, and remote access is available for students.

Chanelle (care worker) stated that training packages should be reviewed frequently—for example, every 18 months rather than every three years—and that changes in policy and procedures (e.g., 'responding to bushfires') should be added to the packages. Chanelle also suggested adding topics such as cultural beliefs and medications. Cultural beliefs are included in the training packages but may need to be broadened to include several cultures and beliefs that are relevant to Australian society.

Managers and carers had different views regarding whether training packages should be reviewed annually or every three years. Elisa (manager) said:

> I think it should be updated whenever there are changes within the aged care industry … I always ask myself, do they know what is going on in the field? Training packages need to evolve rapidly as aged care changes rapidly (Elisa, Personal Communication, 16 June 2017).

Aged care legislation, funding and monitoring of policies and practices are continually changing to meet the demands of the ageing population. Dorothy (manager) suggested that the training packages:

> should be checked every year. People who are the regulators should get the feedback from the RTOs and say is it working, which unit do you want to change, get regular industry consultation? Moreover, then change it (Dorothy, Personal Communication, 27 May 2017).

This process of ongoing consultation is part of the Australian Skills Quality Authority's (ASQA) requirements for RTOs to conduct regular industry consultations to ensure that the units that are taught are current and relevant. Industry consultation can occur informally on an ongoing basis by RTOs. However, when training packages are scheduled to be updated, notices are sent to RTOs to invite them to formally participate

in the industry consultation for training packages that are relevant to their scope of registration.

Lucky (manager) recommended a 'yearly review, so changes are implemented straight away', while Terrie (manager) suggested that 'the training packages need to meet the regional needs' because 'the needs of people in the country differ to those in the city'. Her opinion was reinforced by Dorothy (manager) who said that 'I think of the Australian demographic changes'. She used specialised facilities as an example, stating that 'the Aboriginal culture is quite different from regional to what they have in the CBD or Melbourne'. However, managers and care workers strongly believed that training should include appropriate knowledge of care for residents living in these specialised facilities.

6.2.5.2 Doubts that aged care educators have the relevant knowledge and experience

Dorothy and Elisa (managers) expressed concerns about aged care educators' knowledge and experience in the aged care industry:

> Not anyone can do training, and I have been saying that someone from industry, for example, aged care, should be doing the training—not someone outside industry … you have to have some aged care training qualifications and experience. As so many changes happening in the aged care industry (Dorothy, Personal Communication, 27 May 2017)

Dorothy felt that educators need to keep up to date with the rapid changes that occur in RACS if they are involved in aged care training. In particular:

> people come from another country … need to learn the history of the Australian systems, number one. Because old people, our generation, at this stage, they have been through the war, the hard life. They are different (Dorothy, Personal Communication, 27 May 2017).

With the rapid increase in migration, many older persons require care.

Regarding trainers, Elisa (manager) asked ‘what kind of qualifications and experience do they have? … There is a disconnect in their knowledge and experience’.

According to ASQA’s standards, trainers must have the necessary knowledge and experience in their field of training. This standard also applies to aged care trainers.

6.2.5.3 Deficiency of students’ learning experience during work placements

Managers and care workers discussed their issues with students’ learning and practice. Elisa (manager) stated that:

> I think they [student] should do theory as well as practical, so they can translate what they are learning into practice. There’s a danger in training them, by giving them everything in theory in one hit and then sending them out … for placement and they are expected to remember everything (Elisa, Personal Communication, 27 May 2017).

Managers and care workers had diverse views regarding when students should undertake work placements. One option is to give students the essential knowledge along with practice in a simulated work environment before their work placement. The second option is to provide training and work placements simultaneously to allow students to make better linkages between theory and practice.

Dorothy (manager) was concerned about students’ lack of exposure to aged care during training:

> I think as they learn the unit, they need to put it in practice. Some of the trainee students come for placement; they walk with the gloves on because they do not like to touch people. They are frightened [of] old people, especially they are not glamorous people. Students are frightened they are going to get infected, somehow touching people (Dorothy, Personal Communication, 27 May 2017).

Guidance during a student's placement is a joint effort between the training institution and the placement provider. Many aged care places do not accept students for several reasons. First, students may make mistakes that cause personal legal problems, including work health and safety issues. Second, unions strongly oppose the use of students in the fear that APs of aged care will routinely use students in the place of qualified and trained staff.

Romayne (manager) suggested that 'we need them [students] to be involved in more skill sets and practice. Also, things like one of the big ones are oxygen therapy'. Bernadine (care worker) said, 'I would like to see just really one matured staff to two trainees, a buddy system during practical placements and there is not enough trained staff to help the students'.

Enough trained staff to guide students is a more practical and efficient method of student learning. However, Bernadine (care worker) was concerned about 'funding for education. I find that sometimes, the money that we get from the government is not enough'.

Aged care facilities do not receive funding to provide extra staff to support students' learning. Therefore, staff who teach and support students are required to be supernumerary to have the time to guide students. However, there are not enough trained staff available to guide and mentor students in providing care to older adults in RACS.

Respondents in the online survey particularly expressed their frustration at being inadequately prepared for the workforce because of the absence or lack of work placement experience.

Securing work placements for students involves an enormous amount of time and resources because universities, TAFE and RTOs compete for aged care placements.

Issues include travel distance, cost and availability of trainers to supervise students at the workplace, lack of support from APs of aged care services, lack of training rooms to teach and debrief students, and lack of equipment and staff resources. Some training institutions receive government subsidies, and others do not; regardless, the funds do not adequately cover the costs of work placements.

6.2.5.4 Lack of knowledge and skills among aged care workers regarding chronic health conditions

Many managers and care workers agreed that aged care training should provide more knowledge and skills to aged care workers (see Figure 6.2).

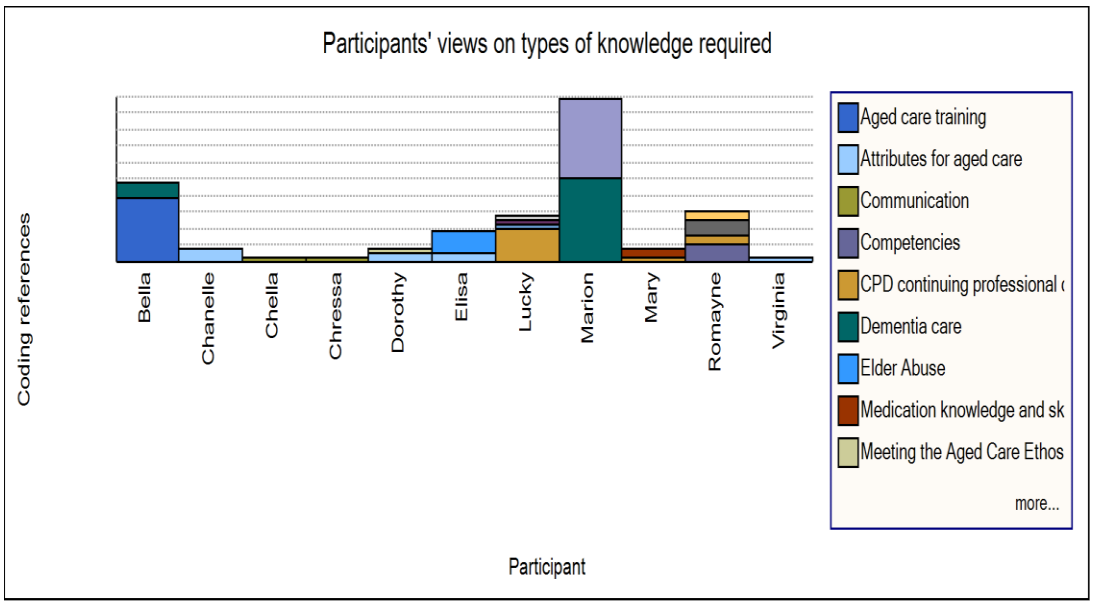

Figure 6.2 Participants Views on Types of Knowledge Required

Managers reported additional topics related to managing chronic health conditions would enable aged care workers to meet residents' individual needs. Lucky (manager) stated that if:

> graduates are coming, at least they need to know quality of the life and quality of care … need the basic information on falls, medical conditions, emergencies … Meet the industry needs and be better-prepared aged care workers (Lucky, Personal Communication, 27 May 2017)

Kurt, Marion (care workers) and Romayne (manager) suggested that added knowledge is required regarding mental health issues, dementia, managing physical aggression, bullying, managing challenging behaviours, falls, documentation, palliative care, medications, residents' history, cultural background, Aboriginal culture, epilepsy, deep depression, chronic pain and managing medical conditions and emergencies. Angelina explained that 'the hardest thing is to try and put yourself in someone else' shoes … it comes with experience'.

The knowledge and skills identified above can be addressed in aged care training through ongoing industry consultation. Currently, the Aged Care Training Packages are due for review by Skills IQ, an independent body, and industry providers and institutions have been invited to make suggestions for training.

There are calls for aged care training to be a separate package and conducted face-to-face. If changes are made, the above topics should be included in the program. However, although training packages are changed every three years, their structure and delivery do not change. This appears to be an exercise in listing wishes for specific units to be added to or deleted from the Aged Care Training Packages. If fundamental changes are to be made to meet current trends in aged care, then the method of delivery should also be addressed. A better model of aged care is needed to deliver training that is relevant, current, sustainable and meets the needs of the aged care workforce.

6.2.5.5 Lack of soft skills and the need to have them

Managers and care workers referred to graduates having 'soft skills' when interacting with older adults as residents in RACS. For example, Chanelle (care worker) observed a 'deficiency of soft skills to cope with the challenges facing aged care workers'. Soft skills, such as communications have developed because of self-reflection and experience. The participants provided examples such as 'responding to challenging

behaviours', 'being comfortable when caring for an older person', 'breaking of old habits', 'being open to change', 'acquiring more knowledge', 'having the right attitude to work', 'developing of skills' to deal with various situations, 'facing the realities of working in RACS' and 'being committed and passionate about their work'. The suggestion to build soft skills was supported by Marion (care worker), who said:

> They take it as a job and just getting money, and that is it. They do not put their heart and soul into the caring for the aged really, and I think maybe that needs to be instilled into them to have that passion for their job (Marion, Personal Communication, 27 May 2017).

Arlinda (care worker) supported this, stating, 'we are looking for commitment … It is just a job … There is just no connection'. Marion suggested that 'soft skills' need to be instilled in aged care graduates and that they are mainly developed through practice and experience (Dewey, 1910).

Care workers (Chanelle and Marion) and managers (Lucky) discussed the need for graduates to 'take more responsibility' to ensure that care needs are fully met. Elisa (manager) wanted 'to bring education into practice and change their mindset'. Terri (manager) viewed 'other challenges to develop attributes [such as] work ethics, maintaining confidentiality and not using social media such as Facebook, and being professional and responsible'. Romayne (manager) claimed that 'time is the main challenge; it is tough to break the habits' of care workers who were 'used to doing work their way and want to continue like that'.

Arlinda (care worker) further stated that 'we are looking for commitment … It is just a job … There is just no connection'. Brodie (care worker) added: 'just getting from one job to the next', while Marion (care worker) was concerned that 'they do not go beyond their work of duty'.

Managers and care workers had high expectations of what graduates should have in the way of ‘soft skills’. However, graduates will develop these communication skills over time as they continue to apply their knowledge to practice, and through experience and personal and professional development. For example, as Marion (care worker) explained:

> sometimes they do not understand, especially when they are working with the dementia people; they just do not understand that … there needs to be instilled into them to have a passion for their job (Marion, Personal Communication, 27 May 2017).

Given the discussion on all of the above key issues five themes arose to make sense of the participants' responses from the results of the data: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to broaden educational topics on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges of working in an aged care environment; and (5) the need for the application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care.

The next chapter will discuss the five themes concerning Dewey’s works and ideas.

6.3 Conclusion

The critical issues arising from the findings for each of the five research questions were discussed. It included an interpretation, analysis and synthesis of the findings presented the key issues arising formed themes to make sense of participants’ responses within the literature and the conceptual framework.

The approach to the analysis sought new patterns among the findings and examined whether the literature corresponded with, contradicted or deepened the results drawn from the analyses of the critical issues. This was undertaken by differentiating and associating the responses of the participants and exploring the 'how' and 'why' of the responses provided.

The key issues arising from the five research questions are summarised below.

RQ1: How is quality of care perceived by aged care workers and managers?

1. Quality of care and its effect on the quality of life is jeopardised.
2. There are challenges in delivering holistic care and consumer-directed care.
3. There are time constraints and a lack of staffing, resources and funding.

RQ2: How do RTOs teach the QoCPs legislated in the *Aged Care Act 1997* to aged care workers and managers?

1. Graduates have a limited understanding and implementation of the QoCPs.
2. Accreditation monitors for compliance rather than the quality of care.

RQ3: How do managers and care workers in RACS perceive any gaps in the knowledge and skills of graduates?

1. Aged care graduates lack basic knowledge and technical skills.
2. Graduates lack an understanding of the legal ramifications of inadequate documentation.

RQ4: How do aged care graduates view their preparation to work in aged care after gaining employment in RACS?

1. Aged care graduates lack preparation.
2. There is a lack of preparing graduates to face the realities of working in aged care.

RQ5: What are the features of good aged care training according to managers and care workers?

1. The training packages do not adequately address current trends in aged care.
2. Aged care trainers do not have the relevant knowledge and experience.
3. Students' learning experiences are inadequately managed during work placements.
4. There is a lack of knowledge and skills regarding chronic health conditions.
5. There is a lack of 'soft skills'.

From the discussion of the results concerning the five research questions, arising from the key issues are five themes. They are:

1. the need for consistent models of care.
2. the need for a better understanding of working within a legislative framework.
3. the need for experiential learning in which aged care workers can apply their knowledge to practice and develop their skills to cope in an aged care environment.
4. the need to broaden topics on chronic health conditions, documentation and elder abuse; and
5. the need for the application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care.

The findings and the discussion of the results show that the current aged care is inadequate. This is because it restricts students' learning to competency and task-related activities, instead of experience-based activities.

The issues and themes discussed in this chapter suggest that a new aged care education model needs to be developed and implemented to encompass the participants' views of improving aged care training. Using a pragmatist approach, a more democratic model of aged care education should be flexible in meeting graduates' learning needs. Society has an obligation to older Australians to provide the highest standards of care. Therefore, this study proposes using Dewey's writings on *Democracy in Education* and *Experiential Learning* to develop learners to gain knowledge through experience. Graduates must be adequately prepared to work in RACS and could cope with sudden changes in the sector. The next chapter draws upon Dewey's key works.

Chapter 7: Use of John Dewey's Influence in Aged Care Education

7.1 Introduction

This research employed an exploratory, descriptive qualitative inquiry into the problems that managers and care workers experience concerning quality in aged care. Five main themes arose from the research questions across the data: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to have knowledge on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges of working in an aged care environment; and (5) the need to apply knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care.

The results of the data identified the effect of aged care education on quality and unequivocally support the need to improve the present system of aged care education. The data provides evidence of the limits of the current aged care education model. This model provides training and assessments based on a set of topics, elements and criteria that must be taught in the classroom and during work placements. Still, it does not encourage aged care graduates to undertake professional development and a diversified career pathway to higher education. Currently, the only pathway to higher education for care workers is to undertake a diploma of nursing.

From a pragmatist perspective, this chapter addresses the five themes and considers Dewey's concept of learning and progressive education, and its influences of democracy in education and experiential learning (Howlett, 2013). This concept enables students to interact with their environment through critical thinking, reflection and

critical practice to develop the necessary skills, including soft skills, to meet the challenges in aged care.

This section also offers a brief critique of the current education model and advocates for a new aged care model to remediate aged care education, the Democratic Experiential Learning Aged Care Education Model (p.188). The chapter includes: (a) an overview of the current aged care model; (b) suggestions continuing education and professional development for graduates; (c) career pathways for aged care graduates; and (d) and a new model based on Dewey's democracy in education and experiential learning ideas.

The main themes in this study require students to engage in additional hands-on learning so they can experience the reality of working and link theory to practice. This includes adapting to the models of care, working within the legislative framework and understanding the chronic and complex technical care needs of the older adults in a culturally sensitive environment. The researcher argues that employing Dewey's education philosophy, which includes reflective learning, will enable aged care graduates to meet the challenges arising in RACS. This includes managing residents with challenging behaviours and coping with inadequate staffing and resources while simultaneously ensuring that the quality of care of individuals in RACS is not compromised.

Current aged care education and training is a grave concern because it does not teach students how to work pragmatically in the aged care environment. Further, it does not equip aged care graduates with the necessary knowledge to address the realities of working in a highly aged care sector. Therefore, the new education model, the Democratic experiential Learning Aged Care Education Model (p. 188), must form the fabric of contemporary aged care training. By incorporating WIL, it dramatically assists

the learning needs of students. Learning must include lasting knowledge and experience to meet the ‘reality’ and ‘truth’ of addressing problems and challenges in caring for the older adults in RACS. Therefore, students need to manage problematic situations in a supportive learning environment. The suggested model encourages reflective practice, and ongoing professional development motivates graduates to undertake higher education.

7.2 Discussion of Themes

7.2.1 Theme (1): The need for consistent models of care

There are no explicit models of care to guide care practices, which causes problems in terms of care workers being able to handle stressful situations. In an abhorrent case in Sydney in September 2018, a care worker assaulted a resident before settling him into bed for the night (ABC, 2018). The 35-year-old care worker repeatedly assaulted the 82-year-old resident by hitting him with a shoe and tugging at his clothing. The physical abuse caused the resident to lose balance and fall off the bed, resulting in bruises.

The AP claimed that it was ‘shocked and saddened’ by the incident and take the well-being and safety of its residents seriously. This statement is debatable. The incident revealed that the care worker was unable to handle the situation, perhaps because of a lack of critical incident training. Incidents such as this are not unusual in the aged care sector because the quality of care varies between providers. APs receive large amounts of funding from the government and resident accommodation fees; therefore, they must be held accountable.

Few models of care are taught in the Aged Care Training Package. The person-centred and consumer-directed models of care in the training packages provide inadequate information on their implementation. However, there are other types of care

not mentioned in the training packages, and these are applied sporadically across the aged care sector. These models include ‘Alzheimer’s Disease and Related Disorders Society’, ‘Eden Alternative’, ‘Early Neighbourhood’, ‘Household’, ‘Greenhouse’, ‘Wellspring’ and ‘Gentle Care’. Individual APs have developed these models of care; however, aged care workers across the sector do not understand the operations of these models of care, which can be confusing and can compromise care. It is essential to teach the person-centred model to enable workers to use a consistent approach to address the care needs and choices of older adults in care.

Aged care organisations are accountable for the funding they receive from the government and must responsibly invest it in the person-centred model approach regardless of their respective philosophies of care. The organisational, operational policies, staffing structures and related activities must encourage excellence in care.

The participants referred to two types of care, person-centred and consumer-directed care. Knowledge of the consumer-directed care model is appropriate for care workers assisting older adults living in the community. This model ensures the older person can decide when and who provides their care according to their choices. These choices involve doctors and other health services, types of meals and drinks, personal hygiene, leisure activities, family visits and other outdoor activities.

The older residents in RACS are limited to deciding when and who provides their care. They have limited choices about their medical and nursing care, as well as personal hygiene care (which must fit within the working hours of the facility), and they have no say on the type of staffing. Therefore, an understanding of person-centred care and consumer-directed care must be covered in aged care training to ensure the quality of care and quality of life of residents in RACS.

Other models are based on government requirements, the APs' mission and philosophy statements and the special care needs of an ageing population. These special care needs may include facilities that operate for religious denominations and specific cultures (e.g., ASTIs) and that operate for persons with Alzheimer's or dementia. The models for care are not widely known, and a lack of knowledge of how they work prevents carers from performing their responsibilities.

The training of graduates is a challenging task in terms of teaching quality, compliance, multi-denominational philosophies, ACFI funding and culturally specific practices that are relevant to aged care practice. An aged care model should be implemented that encompasses all the above intentions and philosophies of care in one person-centred care model.

Edvardsson, Fetherstonhaugh, & Nay, (2010) supports a person-centred care approach that enables care workers to place the individual as the most valued and essential person by allowing them or their representative to express their care-related choices. This enables the care worker to share the older person's ideas and past routines related to daily activities that are meaningful to them. It also encourages care workers to seek feedback to advance the individual's quality of life. Hence, regardless of the respective APs' philosophies, the care worker will place the individual at the centre of care and provide quality, meet compliance and deliver care within the available funding (Edvardsson et al., 2010). Regardless of where they work, care workers should respect residents' philosophies, religious beliefs and cultural and diverse needs in a sensitive and caring environment.

This study has shown that managers and care workers face challenges unless they have enough staff for residents who require 24-hour care, as well as adequate supplies and equipment that are fit-for-the-purpose of care. Most importantly, the

preparation of aged care workers must include the essential knowledge and skills to manage situations that confront them daily in an aged care setting.

The Democratic Experiential Learning Aged Care Education Model is essential to encourage care workers to build critical thinking skills to address various situations when they occur, as noted in the case of a care worker who assaulted an older person. The care worker demonstrated that he did not have the presence of mind to call in the 'troops' (i.e., fellow workers) to help; instead, he resorted to confrontation and inflicted a horrific assault on the 82-year-old man in a RACS. He had not developed the critical practice skills that would enable him to prevent abuse to the older person.

Teaching the models of care, regardless of which one is employed, must prepare aged care workers for difficult situations through the application of critical thinking, critical practice and facing realities of working in aged care (Dewey, 1938).

7.2.2 Theme (2): The need for a better understanding of working within a legislative framework

The QoCPs is a legislative framework that governs aged care. They have recently been updated to reflect the experiences of the older person in care. It is imperative to include the managers' and care workers' suggested topics that are relevant to care in the Aged Care Training Package. Coincidently, the current AQF Aged Care Training Package, is reviewed every five years. The next review is in 2020. Most of the topics, although oriented towards care and cultural sensitivity, show that a better understanding is needed of older persons' chronic health conditions and how to respond to better care for them.

The QoCPs and Accreditation Standards have changed to a single set of Quality Standards, which replace the Aged Care Quality Standards. The QoCPs were amended in 2014 and again in 2018. This legislative framework has never been part of the aged

care education. However, the Accreditation Standards in residential care will be replaced with the newly developed legislative framework in July 2019. The QoCPs should be included in the Aged Care Training package to ensure excellence in care and services across the sector.

The QoCPs outline the roles and responsibilities of APs in RACS, used as a guide for management. They also specify the Accreditation Standards with which APs must comply to achieve accreditation and receive ongoing funding (QoCPs, 2014). The Quality Care Principles Part 2 specifies the Residential Care Services, Division 1, for responsibilities of APs, and Division 2, for Accreditation Standards. The requirements are lengthy, complicated and not easily understood by care workers, who are part of the team delivering care to older persons in RACS.

The AACQA, which is responsible for monitoring the Accreditation Standards across RACS, failed in its responsibility to ensure quality across the aged care sector. For example, the quality agency was fully aware of staffing at every RACS because it was a compulsory requirement for providers to submit a list of their staff during each audit. The quality agency failed to recognise the types of residents and their care needs, despite the agency being given a list of the care needs. The inadequate staffing should have been investigated along with the increase in incidents occurring at the facility. The chronic shortage of staffing, especially after hours, and the lack of ongoing professional development have been issues since the 1980s. Whenever abuse to the older adults is exposed in the media, the APs, the Quality Agency and the sitting government go into damage control under the pretence of being appalled. These groups have been receiving complaints but have failed older adults and their carers through their inaction.

As a practitioner with many years of experience, I have dedicated my working life to make a difference in aged care. Since 1985 to present I have worked in the

capacity of aged care consultant, administrator and advisor of sanctioned facilities, director of nursing for several RACS, quality assessor, aged care consultant, legal expert witness, nurse educator and chief executive officer and director. It was extremely upsetting listening to the horrendous stories and cries regarding the maltreatment of persons in care and their carers at the hands of providers who supposedly claim that they care and the failure of the quality assessors to listen to residents' complaints. The management of the facility, the APs, the highest level of the Quality Agency and the sitting government must take responsibility and accountability and implement actions to prevent further mistreatment of the older adults in care. Care workers at the lowest level are the first to be blamed and exposed instead of management and higher levels of authority taking responsibility. Care workers do not have a say in whom they work with and how many carers are allocated on a shift, and they do not know the amount of funding available for resources and equipment. Instead, they are operating beyond what they have been trained to do. Hence, the top management, policymakers and decision-makers must take responsibility and be held accountable.

Over several years, many complaints on poor standards of care have been made by residents, their representatives, doctors and nurses to the Complaints Scheme, failures of several APs and occasional leaks of abuses to the media. It has taken more than 30 years and the initiative of the Morrison Government to set up a Royal Commission. We have failed our most vulnerable people in Australian society through a lack of respect and dignity.

A new pedagogical aged care education model Democratic Experiential Learning Aged Care Education Model for delivery, training and assessment must be implemented to ensure changes to practice and improved quality of care in RACS. This will empower aged care workers to learn through critical thinking and critical practice

to manage conflict situations. They will have a pathway to further education, and concerns that they raise with management, APs will be addressed promptly.

7.2.3 Theme (3): The need to broaden topics on (i) chronic health conditions; (ii) documentation and (iii) elder abuse

(i) Knowledge of chronic health conditions

The findings resoundingly showed that care workers should understand how to care for persons with chronic health conditions and complex care needs. This is because many older persons continue to suffer from chronic health conditions such as asthma, arthritis, cancer, obesity, diabetes, cardiovascular, mental health, neurological, gastrointestinal, genital-urinary conditions, muscular-skeletal and long-term mobility problems. Some of these can result in complications such as infections, stroke and impaired disability, and they can even be fatal. Care workers who provide direct care to residents must have a good understanding of the above conditions to accurately assess, provide and evaluate care, and to be able to report any observations during care to the RN, such as complications or adverse effects. This will ensure that if more specialised care is required, the RN can communicate with the doctor or allied health services for immediate care and relief for the resident. The care workers are essential in providing proper care and reporting to the RN who updates the nursing care plans.

Persons suffering from chronic health conditions often have complex needs that the care worker manages while providing care. These complex needs include oxygen therapy and other breathing apparatuses, catheter care, a combination of pain and comfort needs, palliative care, medication management, behaviour management, application of prosthesis, simple wound dressings, and managing falls and injuries. Care workers also undertake regular monitoring of vital signs, blood sugar levels, urinalysis

and documentation, as well as providing daily personal and hygiene care and other activities of daily living for the older person.

(ii) Documentation of care and reporting and managing of critical incidents

Documentation was hugely significant for both managers and care workers because it involves the choices and care needs of residents and their representative. This documentation is used as a guide for care workers to refer to when providing care. Care workers need to know the importance of documenting care and procedures to receive funding. They need to have an awareness that the documents are used as evidence of care given according to the Accreditation Standards of Care. They also need to be aware that the legal documents can be supplied to the courts as evidence of treatment and care in the event of legal action.

Care workers need to understand that there are various kinds of documentation, including hand-written or electronic documentation of care planning, implementation, evaluation, treatments provided, incidents such as injuries and falls, and monitoring of health conditions. Documentation also includes assessments, care plans and progress reports. Documentation helps to identify the resident's status and future medical and nursing care planning, as well as discharge planning.

Resident care documentation is considered a cornerstone of quality of care outcomes. It is a form of documentation between doctors, nurses, allied health services and care workers regarding residents' care needs. It allows for continuity of care and shared knowledge during shift handover for staff working to deliver care to residents. Care workers need to understand the importance of being accurate and timely in their documentation to meet legislative and ethical requirements. They also need to recognise the need for privacy and confidentiality of information and access to client records.

(iii) Compulsory reporting of elder abuse must be included in training packages

Concerns were raised in the findings regarding ‘elder abuse’ and ‘compulsory reporting’. These two areas are not well covered in aged care education. Elder abuse is an essential subject in the Royal Commission investigation into residents’ care in RACS. It has been a contentious subject for the past ten years, even though it was part of the *Aged Care Act 1997* to help protect residents. However, following reporting of elder abuse is not always taken seriously; hence, it is not reported. Further, abuse may not be reported by care workers because of a fear of reprimand and retribution, leading to the loss of their job.

Mandatory reporting to the Australian Government Department of Health—Ageing and Aged Care requires APs must report suspicious or alleged assaults within 24 hours to the authorities such as the local police and the health department. APs are also required to report residents who are absent or missing without explanation. This ensures that reports about missing persons are received promptly and that RACS have systems in place to prevent future episodes. It is vital that aged care training addresses this aspect of care to ensure a safe and protected setting for residents.

7.2.4 Theme (4): The development of soft skills to meet the challenges of working in an aged care environment

Managers and care workers often referred to graduates as having ‘soft skills’ when interacting with older adults in RACS. While the term may not be completely accurate, it is commonly used when people interact. It is often known as a person having attributes that allow someone to interrelate efficiently with other people. It is also seen known differently in various fields of practice. These may include a collection of personal abilities, behaviours, attitudes accepted and compatible at the workplace and in community. For example, in this study in aged care, the care workers perspective of attributes aged care graduates requires in caring for older adults. Some of the soft skills

conferred were the abilities to cope with challenging behaviours, caring, open to change, attitude, responsibility, and passion for their work. The participants also referred to attributes such as work ethics, maintaining confidentiality, time management, going beyond the call of duty, The participants acknowledged that these skills are mainly developed through practice and experience (Dewey, 1910; Eldridge, 1998).

The next chapter addresses problem-solving and ways to address it through reflective thinking, critical thinking and critical practice, through communication, teamwork, and reflect on practice and values on the notion of care. These generally fall under the central aspect of being human and wellbeing of the person and wellbeing of others. There is minimal literature on developing such skills and attributes in aged care.

7.2.5 Theme (5): The need for an application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care.

Care workers undertaking aged care training in RTOs are disadvantaged compared with those studying at universities and in the TAFE sector because many RTOs delivering aged care do not have a well-established simulation lab with contemporary equipment for students to practice. RTOs are not funded by the government to set up world-class simulation labs. Thus, they are compromised in the delivery of training. Students must have vast set-up areas to practice using scenarios in a simulation-based learning laboratory. It is costly to set up a lab for simulation, given the ongoing costs of consumable products and updated equipment for practice. The government funds student tuition fees and teaching costs and only for eligible RTOs. Universities and the TAFE sector receive funding to set up simulation laboratories even

though they deliver the same aged care program. Therefore, it is difficult for RTOs without funding to meet the same expected course requirements.

Moreover, there is much competition to access work placements in aged care because of the costs. Many places charge higher fees and still expect a qualified trainer to attend the workplace, even if it is for one student. Further, inadequate staffing and a lack of RNs to supervise student placements result in students informally becoming part of the staff ratio for the day, thereby missing opportunities to learn at their own pace while on work placements.

Further, the current fees structure and costs of RTOs do not support the added expense demanded of placement providers. RTOs are unable to compete with TAFE and universities running the same course and whose fees are too high. Also, tuition or course fees for education and training institutes are much higher, yet these institutes continue to receive support from the government for added equipment.

Additional funding is necessary for appropriately qualified facilitators and mentors to guide and mentor students who work alongside staff and are supervised by RNs. Students require their educational activities to be assessed for theoretical integration and application in the workplace. This process ensures that students meet the competency level of the skills required in the course to practice safely in a dynamic aged care environment.

7.3 Critique of the Aged Care Education Model Democratic Experiential Learning Aged Care Education Model

In addition to addressing the five themes arising from the study, the results showed the need to remediate aged care education by creating a new, supportive learning model that includes: (a) a brief overview of the current aged care model; (b) continuing education and professional development; (c) career pathways for aged

care graduates; and (d) the new pedagogical model aged care education model based on democracy and experiential learning.

7.3.1 A brief overview of the current aged care model

The current aged care training pedagogy model is not working effectively. It was developed from the training package requirements to deliver a course or unit of competency. The RTOs delivers the training according to ASQA standards and the requirement of the specific package (see Figure 7.1).

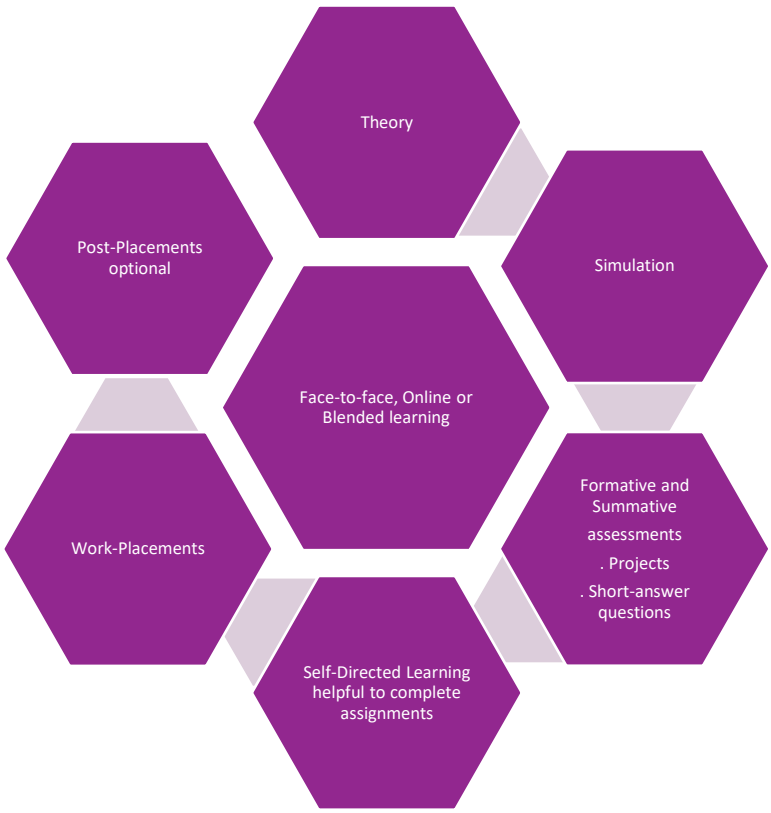

Figure 7.1. Current Aged Care Education Program.

Many RTOs have a standard model of delivery that is either face-to-face or online delivery. Others engage in blended learning, which is a mix of face-to-face and online delivery. Students much achieve asset competencies, which are undertaken through assignments with a series of short-answer questions or projects. A requirement for aged care training is work placements of no less than 120 hours or 4–5 weeks. Most RTOs provide a text that students may refer to for their lectures and assignments.

In contrast, others use a learning management program such as Moodle to upload lectures, learning activities for self-directed learning and short-answer questions to submit electronically or on hard copy. Students are required to undertake work placements after they complete their lectures and assignments and are deemed satisfactory, or lectures and work placements together, with educational activities to complete while on placements. Once the required lectures, assignments and work placements have been completed, the student is deemed ‘competent’ (have met the course requirements), and a qualification is issued. However, post-placements do not occur in every training institution. Students may not receive all the opportunities to practice their skills in the workplace because situations may not arise. Hence, post-placements are valuable to ensure that students who have been away on placements for 4–5 weeks are ready and confident to graduate. For example, many RTOs have been known not to have post placements as part of their aged care training model.

However, the current pedagogical model of aged care training is restrictive in terms of Dewey’s works and ideas. It does not allow students to decide their training needs in terms of their prior knowledge and experience. It allows RTOs to approve recognition of prior learning, which is often a tedious, expensive and time-consuming exercise. The student often gives up and prefers to repeat lectures and skills classes to complete the course without further delay. Further, the Aged Care Training Package provides a set program of core subjects decided by industry employers. The electives are chosen by training institutions that think what the industry may require an aged care graduate, even though industry consultation is part of the course development.

Dewey’s writings advocated the use of democracy in education, and this philosophy fits into the professional practice model for aged care education pedagogy. Dewey’s works and ideas, including experiential learning pedagogy, will be discussed

later in this chapter. This practice model encourages aged care students to understand the interests of older persons at work placements. Then they understand ‘the truth’ of responding to situations in the work environment, for example, the emotions involved in working in aged care with families, residents, and other care workers.

The significant gaps identified in knowledge can be filled by working with providers of aged care to deal with situations with critical thinking, reflective thinking and critical practice. The employers’ understanding of aged care students’ learning needs can help overcome the barriers that limit or impede their participation. They can encourage, assist and engage students in learning in the workplace.

7.4 Continuing Education and Professional Development

Continuing professional development refers to work-related knowledge during the career of aged care graduates. Professional development maintains, improves and broadens graduate’s knowledge, expertise and competence, and develops personal and professional qualities. Figure 7.2 provides a suggested model for continuing professional development for aged care graduates.

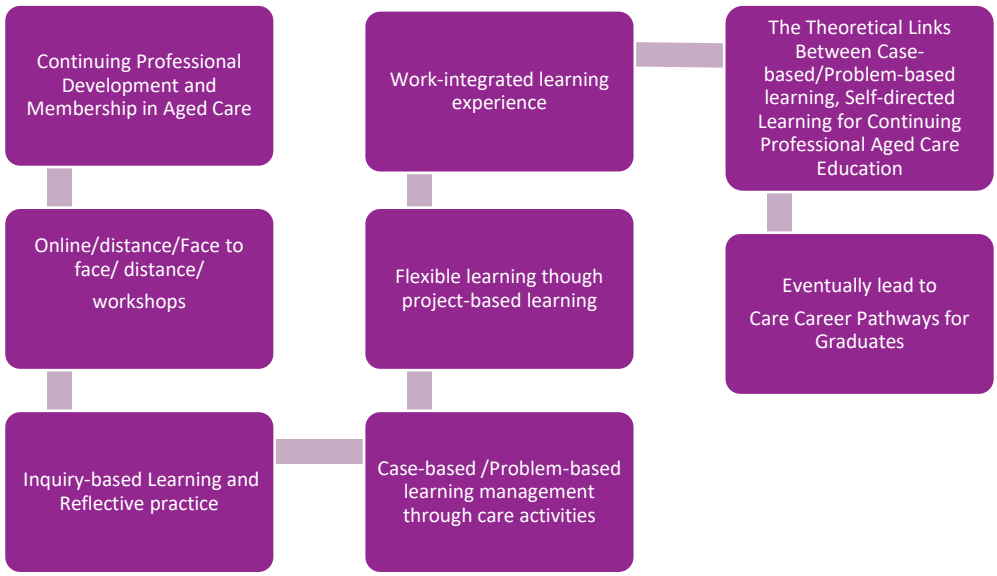

Figure 7.2. Continuing Professional Development.

This section argues the need for (i) professional development and professional membership; (ii) online, distance, face-to-face learning including seminars and workshops; (iii) inquiry-based learning; (iv) flexible learning through project-based learning; (v) case-based and problem-based learning management through care activities; and (vi) theoretical links between case-based, problem-based and self-directed learning for professional development in aged care education; and (vii) pedagogical aged care pathways for graduates.

7.4.1 Continuing professional development and professional membership

Aged care workers who are engaged in care practice should regularly participate in professional development that is relevant to their practice to maintain and enhance their knowledge and skills to help them deliver quality care. Professional development is a critical mechanism for safeguarding standards of professional practice.

Professional development may be formal or informal and involve activities. Formal professional development involves participation in short courses to enhance the graduate's skills, comprising activities such as courses and seminars, tertiary studies, including research (ACFA, 2013).

Informal professional development comprises learning additional skills in the area of aged care. Dewey's democracy in learning is ideal for aged care graduates take control of their education, which positions them to ensure it satisfies their personal and professional development.

Employers are increasingly looking for aged care graduates with industry experience. Aged care graduates can gain invaluable practical experience working with a mentor after graduation, and they can undertake units while working to achieve academic credits towards a diploma or a degree in aged care. The aged care graduate can gain experience while working and undertake projects as a great way to gain hands-on experience while they choose to study further and put their learning into practice.

Membership in Aged Care is characterised by:

- the responsibilities of service to other members of the public
- the understanding of a body of knowledge
- skills in a domain
- judgment and critical thinking
- workplace experiences
- a professional community (Shulman, 1998).

These characteristics are relevant to the aged care sector and its functions as a profession.

7.4.2 Online, distance, face-to-face learning including seminars and workshops

Many training institutions see face-to-face to online and distance education as a way to include more people in higher education (Turbill, 2002). This form of education is as a result of reduced funding and the ability to offer courses at a cheaper rate to attract students locally and from around the world. Administratively, offering courses online and distance education use fewer resources and are therefore cheaper. It also attracts new markets nationally and internationally, depending on the courses or units of competencies offered. However, in aged care, face-to-face training combined with online learning is considered more favourable because understanding the individual is not purely a technical exercise, but one that involves caring for people.

Moreover, some mature-aged students undertaking aged care training may not have completed year 12 schooling and be previously involved in working in unskilled jobs or raising children in a domestic context. Students who cannot obtain a job elsewhere find aged care attractive in terms of entering the workforce. These students have qualifications ranging from a diploma level to a PhD level or currently undertake higher education at a university. Moreover, students working in aged care possess higher education qualifications but are on a spouse visa with study and working rights. The current aged care program is not flexible in addressing the various cohorts of students. It is primarily because of inadequate resources and because those receiving government funding are restricted to 25% of the course being online.

Given that most of them are returning to the workforce after schooling, their computer skills are limited. Hence, developing an aged care program that accommodates these cohorts is challenging. Especially because overseas nurses and doctors undertaking the aged care course at a basic level do not find it stimulating. They do not even learn new knowledge because of the design of the aged care curriculum.

7.4.3 Inquiry-based learning

For several years, teaching and learning activities have employed inquiry-based learning, which involves active learning that presents questions, problems and scenarios of likely situations rather than just theory in the form of lectures (Dostál, 2015, Simpson et al., 2005; Twigg, 2010; Williams, 2001). An example is situations facilitated by the trainer that is likely to occur in aged care. Inquiry-based instruction was developed for students to practice their thinking skills.

Dewey's pedagogy of experiential learning through experiences encompasses the learner participating in personal experiences to make sense from them (Eldridge, 1998; Roth & Jornet, 2013). Experiential learning is encouraged through inquiry-based-learning engages students with the content material to question concepts and ideas.

Current nursing assessments and formative assessments in aged care training include scenario-based questions and are used in group discussions. Further, nursing uses the process of OSCE, which is a contemporary type of examination that is often used in health sciences (e.g., nursing, midwifery, medicine, and other health-related occupations). OSCE testing includes scenarios in clinical situations before students go on placements. However, the current aged care education program does not have an OSCE exam before students go on work placement (Rushforth, 2007).

The learning-centred model, known as student-centred learning, places the responsibility on the student by moving the responsibility from the teacher to the student (Jones, 2007; Pedersen & Liu, 2003). Further, it focuses on skills to enable independent problem-solving in the longer term (Young & Paterson, 2007; Williams, 2001). Student-centred learning emphasises the student's part in creating sense with new information and previous experience (Eldridge, 1998; Kraft, 1994). Student-

centred learning involves assessments wherein students participate in evaluating and demonstrating their knowledge in ways that support essential learning.

7.4.4 Flexible learning through project-based learning

Flexible learning using mixed mode education programs is commonly employed in Australian education. These include distance and online education programs (Gabb et al., 2005). For example, flexible learning can encourage students in remote areas or because of work or costs to access aged care education programs.

A dynamic method of education is the practice of project-based learning through activities. It helps students explore practical problems in managing challenging situations either in small groups developing skills to overcome difficulties arising in the individual environment (Williams, 2001). Project-based learning encourages students in their learning to obtain and retain in-depth knowledge of the subjects in their learning curriculum rather than through traditional learning, such as text-book learning. In project-based learning, students develop confidence and self-direction as they move through group learning to independent work. They also develop improved organisational skills through better communication, and they experience the positive outcome of their work.

Students are assessed on their projects rather than on exams, essays and written reports. Assessments in project-based are more meaningful to students as they can make a better connection between their academic work and real-life issues. Project-based learning is different from passive, repetition and memory learning; instead, it encourages students to explore, investigate and understand the field of study under the guidance of skilled trainers.

7.4.5 Case-based and problem-based learning management

Case-based learning presents new content through the application of case study using new information (Jones et al., 2010). For example, students will drive intellectual rational and logical problem-solving through planned learning objectives (Jones et al., 2010; Williams, 2001).

Problem-based learning provides the realities, dilemmas and problems that may be encountered in the workplace (Jones et al., 2010; Williams, 2001). A fundamental in problem-based learning is that students actively learn to contribute and recognise problems in groups rather than just their own (Jones et al., 2010). Problem-based learning encompasses the '5E' instructional model to promote a learning cycle. These include engaging, exploring, elaborating, evaluating and explaining problems in groups for a period of time to promote solving problems (Jones et al., 2010). This process enables students to develop personal and interactive skills to defend, critique and articulate decisions in problem-based activities.

7.4.6 Making a theoretical link between case-based and problem-based learning for continuing professional development in aged care education

Problem-based learning is a method that promotes an approach for connecting the gap between practice and theory. It is used in preparing students for practice, and it is useful for undergraduate aged care education programs that have a strong emphasis on the workplace. The goal is to prepare graduates that are competent to successfully transition to the world of professional aged care practice (Gabb et al., 2005).

7.4.7 Pedagogical aged care pathways for graduates

The model demonstrates that aged care graduates are moving from professional development to additional formal education to a university to achieve higher qualifications. Dewey (1904) focused on establishing professional education as

prerequisites learning and practice to well-educated adults in their own right (Shulman, 1998).

Dewey claimed that experience is paramount to learning and democracy a choice to learn is essential (Eldridge, 1998; Shulman, 1998). Dewey suggested that teachers must base their knowledge on a subject and be flexible in delivering the information that motivates students to learn by themselves (Shulman, 1998). Professionals must critically reflect on their teaching and their students' learning (Simpson et al., 2005).

Shulman (1998) claimed that topographies of professional education must place a strong emphasis on substantial theoretical preparation of students in their chosen areas of practice (Shulman, 1998). Professionals need to develop the ability to learn from the observation and reflection of their practice and to manage their actions as they progress in their career pathways.

7.4.8 Career pathways for aged care graduates

There is a limited career pathway for aged care graduates. There is no graduate year program to motivate students to specialise in any area of aged care. Nursing is the only career pathway for aged care graduates. Not all aged care graduates are interested in becoming a nurse, and other pathways are possible and can be available to aged care graduates. In Figure 7.3, is a model that displays proposed career pathways for aged care graduates.

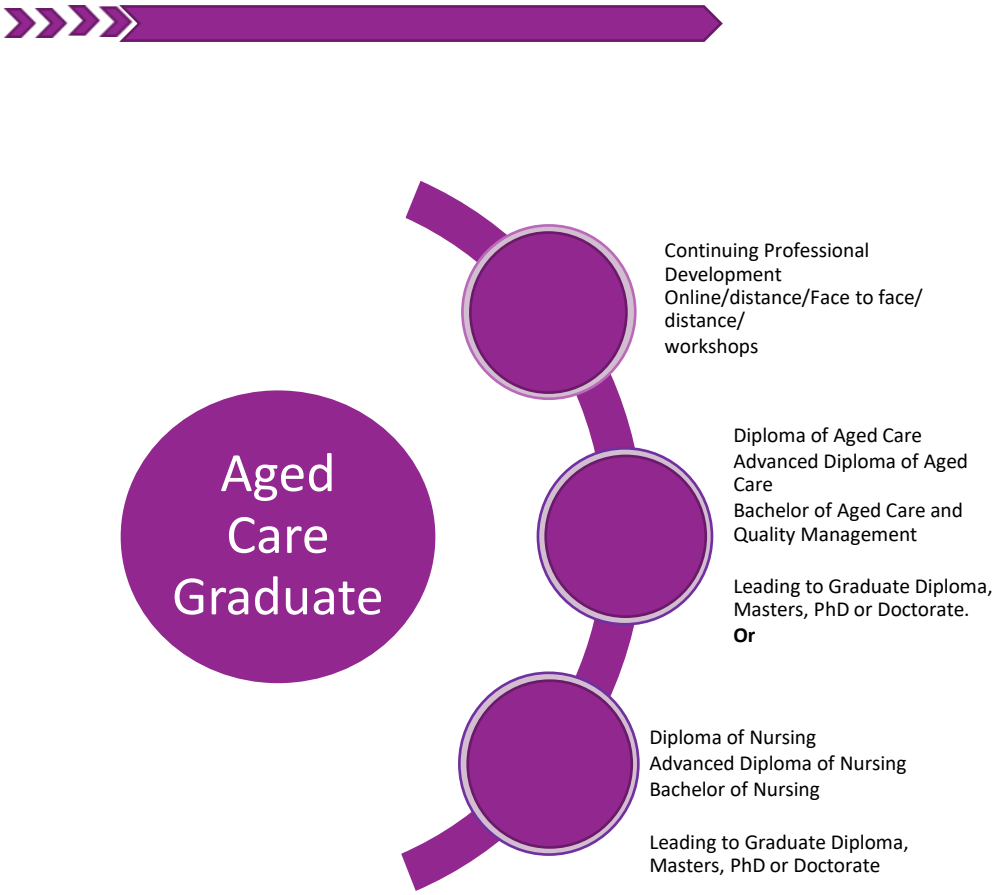

Figure 7.3. Aged Care Pathways for Graduates.

Aged care training should be followed up by a preceptorship and mentoring model. In the 1980s and 1990s, hospitals employed the preceptorship program for following their graduation. However, there is no formal program to follow up aged care graduates apart from a few weeks of orientation and professional development, which is not mandatory or assessed for its outcomes.

Dewey's notion of a reflective teacher noted that practitioners are considerately involved in changing their training to accomplish experiences for themselves and their students (Douglas et al., 2005). Ongoing learning and best practices among aged care graduates will eventually lead to excellence in aged care. Hence, A new pedagogical aged care education model based on democracy and experiential learning is proposed.

7.5 Proposed New Aged Care Education Model

Based on the discussion of the results of the findings, a more contemporary aged care model is required after more than 30 years of the old Aged Care education system. A new pedagogical Democratic Experiential Learning Aged Care Education Model for aged care graduates is suggested.

This section argues: (a) the need for a pragmatist democratic learning experience; and (b) the need for a Democratic Experiential Learning Aged Care Education Model comprising four domains: (i) professional communication and dialogue; (ii) interactive critical thinking; (iii) discourses of quality care; and (iv) democratic and learning-centred practice.

7.6 The Need for a Pragmatist Democratic Learning Experience

Dewey's education pedagogy uses pragmatism, whereby the student has the choice to learn, ask questions and learn from the trainer (Dewey, 1904; Shulman, 1998). It is an interactive approach between the trainer and the student. It is now proposed that a new model for aged care education be developed.

In Figure 7.4, the four domains in the circle represent Dewey's concept of knowledge and depict the four domains from a pragmatist perspective arising from the data. The domains cannot work without the others but must operate as one to affect the learner. The four domains are: (i) professional communication and dialogue; (ii) interactive critical thinking; (iii) discourses of quality of care; and (iv) democratic and learning-centred practice.

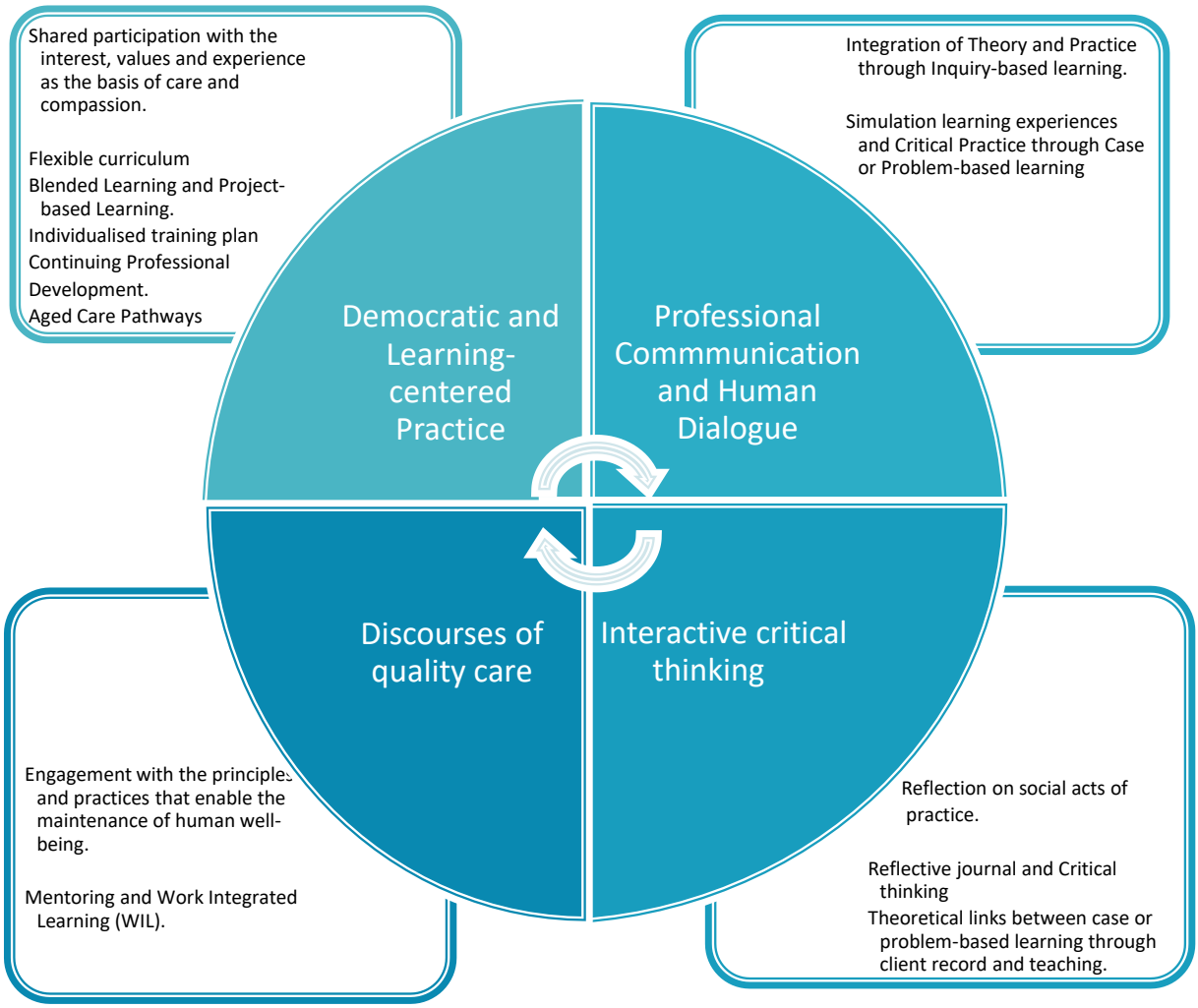

Figure 7.4. Democratic Experiential Learning Aged Care Education Model.

A fitting quote from Dewey's philosophy on education is relevant to this Democratic Experiential Learning Aged Care Education Model.

> Knowledge is humanistic in quality not because it is about human products in the past, but because of what it does in liberating human intelligence and human sympathy. Any subject matter which accomplishes this result is humane, and any subject matter which does not accomplish it is not even educational. — John Dewey (1916, online quote) Democracy and Education: An Introduction to the Philosophy of Education.

Below provides a brief explanation of the four domains in the Democratic Experiential Learning Aged Care Education Model is explained below. The model is comprising face-to-face learning and online and distance education for aged care workers. This is to develop a knowledge-building culture ensuring productive relationships between the teacher and the learner. The model uses the pragmatic approach to improve aged care is delivery based on Dewey's works in education and experiential learning.

The discussion that follows will draw upon the literature review and Dewey's conceptual framework, as outlined in Chapter 3. In the analysis below, the principles of pragmatism are applied to the model, based on understandings that have arisen during the process of research.

7.6.1 Domain 1: Professional communication and human dialogue

Professional communication and human dialogue in the model involve the Integration of Theory and Practice through Inquiry-based learning (Twigg, 2010; Williams, 2001). Examples include simulation learning experiences and critical practice through a case or problem-based learning (Williams, 2001).

Theory and practice, according to Dewey, are developed from his experience of reflection and interaction. Reflective practice gives one the ability to reflect on actions that engage the process of continuous learning. This assists in practical everyday actions by examining practice reflectively and reflexively (Dewey, 2016a). The educational strategy suggested in the aged care education, is problem-based learning and simulation-based learning that provides a framework for lifelong learning. In what follows the framework is further explained on how it could be implemented to prepare aged care graduates for lifelong learning.

In this Democratic learning experience model for aged care, reflective practice is an essential device in practice-based professional learning settings in aged care. Aged care students learning must be life-long, which can be achieved through simulation learning experienced and problem-based learning (Williams, 2001). It is a basis of personal, professional development through reflection on improving practice, skills, attitudes and knowledge. It adds to the learners' existing knowledge to influence a higher level of understanding.

Dewey's philosophical ideas are influential in progressive education and social reform. His theory of learning through experience focuses on experiential education that can encourage aged care educators to provide excellence in the educational experiences provided to students (Howlett, 2013). Experiences include the hands-on capability to influence aged care students' future learning and decisions through critical thinking and practice.

Communication is one of Dewey's central feature. Two of his concepts of empathy and foresight are critical to understanding Dewey's perspective on communication and society (Belman, 1977). Dewey's views communication, cooperation, and collaboration as necessary capabilities one must have in society. Dewey (1994) addressed these three characteristics directly in his philosophy when he referred to communication as instrumental, a means of establishing cooperation, control, and direction through shared experience (Coke, 2000).

The proposed new aged care model encourages teachers to communicate with students about their learning needs. Teachers have the power to effect change by communicating with their student to solely meet the needs of those students (Coke, 2000). For example, communicating with students during delivery of theory in the

classroom and practice in a simulation lab or work placements that encourages an 'inclusive situation for separate and independent performances' (Dewey, 1994, p. 231). Aged care educators will be more considerate and have an understanding of the student learning requirements where the educator can also grow through an understanding and working with the student.

Dewey asserts that educators need to be fully qualified in their area(s) of expertise. Likewise, educators in the field of ageing must provide expert teaching by joining in the activities of students (Simpson et al., 2005). It produces positive group work for students and puts the educator and students influences to the best possible use. (Coke, 2000). Learning is a form of communication and '[c]ommunication is a process of sharing experience until it becomes a common possession' (Dewey, 1997, p. 9). Students learning in aged care education must be seen in collaboration with the responsibility of educators, students, work placement approved providers to encourage communication for aged care graduates.

Human dialogue encourages the teacher and the student in the combined performance of knowing the object of study in a way that enables dynamic learning to generate and reproduce acts of knowledge. Dialogue encourages critical thinking without fearing the dangers of actions. Dialogue is the core of the educational method of Freire's educational philosophy is often called the method of dialogue (Firdaus & Mariyat, 2017, p.36). Firdaus and Mariyat (2017) claimed Freire's dialogical approach draws from the students' experiences and cultural values as co-contributors in their educational development.

Dialogue in learning is formal and refers to when two people are speaking to each other. Dialogue is a communication tool that allows the learner to understand other viewpoints without opposing them. In education, communication involves thinking

about what one wants to say before speaking. In education, this communication emerges from a student and teacher through inquiry and reflection (Twigg, 2010). This encourages the learner to work in collaboration with the teacher through an active discussion in the learning process. Examples of learning strategies in professional the communication and dialogue include the integration of theory and practice through inquiry-based learning, simulation learning experiences and critical practice through a case or problem-based learning (Breunig, 2009; Twigg, 2010; Williams, 2001).

Human dialogue is a popular approach in education, as it involves a humanistic approach. Firdaus & Mariyat (2017) states that Freire believes that education aims to develop human potential. Education approach must be humane using student-centred rather than a teacher-centred approach. In education, the principal purpose of the humanistic approach is for the benefit of treating the student as a 'human person' (Dewey, 1922).

Freire viewpoint on a humanistic approach in education is a process of liberating students from the traditional classroom teacher-centred learning and replace with critical thinking, student-centred process (Firdaus & Mariyat, 2017). It, therefore, enables teachers to motivate students to think critically and act according to the values of using a humanistic approach in education to improve student capabilities. Freire suggested that education is an integral part of a democracy.-His concept of a 'human being' recognises that it is because of human nature that people have the ability and potential to grow in a humanising education as a process of liberation from oppression in education (Firdaus & Mariyat, 2017). This means that students are subjects in their learning and the educator's, or 'facilitator's' role is to stimulate learning and self-development. For example, they work together in addressing significant problems in the process of learning through theory and practice (Firdaus & Mariyat, 2017).

Aged care students can develop critical thinking in aged care education through simulation labs and work placements. They are thereby using a humanistic approach to determine appropriate action. The method includes dialogue wherein teachers and students work together to determine suitable actions.

Dewey (1938) believes that each student is a unique learner, and his ideas influenced the teacher-student interests in providing instructions to students with background knowledge, experience and sets of beliefs shared in the student-centred learning. Students learn, engage and become reflective learners that respect and challenge the different opinions of others (Dewey, 1938, Hopkinson, 2007). Dewey described it as progressive education that includes socially engaging learning experiences.

Dialogue is a chance for the student to frame a learning problem collectively by independently voicing their perspective. Dewey believes in groups of people coming together to discuss, examine problems and make decisions (Dewey, 1938; Gutek, 2014; Morgan, 2007). Dialogue allows students to communicate and present their viewpoint. Dialogue encourages and engages the student to communicate their ideas about their learning need to develop knowledge and skills further.

Morgan (2007) claimed that Dewey's work supports the learner-centred model. In the learner-centred approach, the goal is to understand the student's perspective. Once the student has provided their perspective on learning, the teacher presents their thoughts to the student. Dialogue is a useful tool for communication, teaching and thinking. (Morgan, 2007). This is an effective way to encourage student engagement, resulting in a desire for enduring knowledge. Therefore, the use of professional communication and dialogue in the aged care education model will encourage the integration of theory and practice through simulation learning experiences.

7.6.2 Domain 2: Interactive critical thinking

In the model Figure 7.4, the ‘interactive critical thinking’ process involves reflection on practice. Dewey (1916) stated ‘We do not learn from experience... we learn from reflecting on experience.’ George Herbert Mead (1863-1931) along with Dewey, was a founder of Pragmatism. Mead's theory of the ‘social act’ states that the development of the mind is a social process of meaningful interaction. He considered two processes the ‘conversation of gestures’ and the ‘conversation of significant gestures’ where individuals are in interaction with one another (Elkjaer, 2009; Gillespie, 2005).

In ‘conversation of gestures’, the individual is unaware of his or her signs and gestures during communication. However, the individual may be unaware of the reactions of others observing their communication, thereby unable to respond to gestures from the other’s perspective (Gillespie, 2005). An example is an aged care worker meaningfully responding to a challenging situation through words and gestures towards a resident who is confused and displays unexpected behaviours.

Fook (2006) explains that critical reflection is explicitly used to improve professional practice. Reflective practice enables the power of thinking and reflection that might bring about change in social settings. For example, reflection on social acts empowers critically reflection on one's actions as a process of continuous learning (Fook, 2010; Hickson, 2011). In this Democratic Learning Experience model for aged care, the use of a reflective journal, critical thinking, theoretical links between a case-based or problem-based learning can be through client record and teaching (Williams, 2001). Hickson (2011) refers to Dewey in 1902 on reflective practice as a process of exploration of experience, interaction and reflection on one’s actions.

Dewey's education reform was based on the principle of learning through doing. His hands-on approach for humans to experience reality places him in the educational philosophy of pragmatism (Elkjaer, 2009; James, 1995). From a pragmatist perspective, the researcher believes that students need to interact with their environment. For example, students in aged care must interact in their future work environment to adapt and learn. Dewey theorised that learning is practical and active rather than passive and theoretical. Active learning is about critical thinking and reflective thinking that supports knowledge and where the knowledge leads.

Students reflect on social acts of practice through journal writing, client records, and teaching could be of benefit (Simpson et al., 2005). Therefore, the new aged care education model suggests that experiential learning through experience in a simulation laboratory and work placement problem-solving in aged care must include learning and reflection.

7.6.3 Domain 3: Discourses of quality care and mentoring

Dawish (2009) reported Aristotle, view on 'praxis' (theory and practice) is to further human well-being through education. This education view is also shared by Freire's that it concerns the obligation to freedom of the human soul (Dawish,2009). Pragmatism allows for developing and ongoing experience involving social acts to, over time, generate feelings and emotions of human satisfaction and well-being (Elkjaer, 2009; James, 1995). This comes about as humans consider problem situations and resolve them through cooperative activity and discussion.

The theory-practice model of aged care education program makes an explicit obligation to democracy and experiential in aged care education. For example, engagement with the principles and practices that enable the maintenance of human

well-being. This can be undertaken through Mentoring and Work Integrated Learning (WIL) and student support learning (see Figure 7.4).

According to the Department of Health (2011) encourages the concept of wellness to improve residents' life in RACS. This document covers many ways to enhance the well-being of an individual in RACS. For example, in the area of physical activity, nutrition and emotional well-being. It is aimed at facilitating discussion with staff identify barriers and challenges to older adult's emotional well-being and plan actions to address it. Providing quality care through models of care is one way to consider older adults physical and emotional well-being. However, the discourses of quality of care and the models implemented in RACS are not taught in aged care education nor well understood by people working in aged care. Since the 1980s, there have been several models of care that have been put forward in Australia. These include the biomedical model, social model, ageing-in-place model, person-centred model, consumer-directed care model, that are not taught in aged care education.

Most of Dewey's work in the discourse on the quality of care has been on education in early childhood, whereas the present study focuses on human well-being and the other end of the spectrum of life. While there are limited studies on discourses of quality of care in RACS, the topics on human-well-being are relevant to the current education model. Managers and care workers all believe in residents receiving quality of care, but this is jeopardised by a lack of staffing and resources and poor preparation of aged care graduates.

The inconsistent use of the various models of care may be related to the poor understanding and teaching of models of care in the Training Packages. Students do not receive hands-on experiential learning in this respect, and discourses of models of care

must be included in the new Democratic Experiential Learning Aged Care Education Model.

Little attention has been made to the link education and quality of care. For example, aged care graduates must understand the concepts of QoCPs in terms of the models of care to ensure the quality of care, to improve the quality of life for human-beings in RACS. Although changes are being made to the Aged Care Training Package to make it a standalone course, this is another band-aid solution to addressing aged care education with little empirical research into the aged care training model. If real and long-term change is to occur, then the researcher from a pragmatist perspective strongly recommends a new democratic and experiential learning model of theory and practice that involves mentoring and student support learning.

Current work placements in aged care education are considered ineffective because there is no formalised WIL. Gabb et al. (2005) explained that WIL is the global term for work-based activities undertaken by students.

7.6.4 Mentoring

The mentoring of aged care students on placements requires urgent attention. Many managers prefer industry placements and projects to be undertaken side-by-side during students' studies. Mentoring gives future aged care graduates in-depth experience in integrating theory with practice.

Students may find it challenging to navigate through aged care studies and into the working world. Receiving guidance from a mentor who has walked a similar path will make the student feel better equipped to make their next move in their future studies. This is because students will gain employable skills for future career development. The participants referred to these as 'soft skills' these include problem-

solving, working within teams, excellent interpersonal communication practices in work settings.

Mentoring in WIL provides many benefits for students, including an ability to create a professional and career-focused outlook that develops aged care graduates' employability skills. Further, they can apply these skills in specific areas of care that includes dementia, palliative care, young disabled clients, including mental health. Aged care graduates can establish or grow in their professional network, gain confidence in the context of professional relationships and settings, and gain career clarity to help them transition into higher education in their chosen field. Thus, students can expand their knowledge through higher education and enhance their resumes for job opportunities in the aged care workforce (see Figure 7.4).

Mentoring students is a collaborative learning relationship whereby the employer and the mentor share mutual responsibility and accountability for professional development. The goal is to help the student work towards the fulfilment of clear and agreed goals. To make this goal possible, the mentor should conduct a series of time-limited, confidential, one-on-one conversations, and other learning activities must occur with the student.

Mentors in the aged care industry are dedicated industry professionals who support future students in further aged care studies in the industry. For around 12–20 weeks, a student can work with a mentor to learn strategies for success in a supportive aged care environment.

Professional development encourages reflection for improvements in work, listening to and acting on feedback, being alert for opportunities, devoting time to career planning, and engaging in discussions with managers topics of interests and the organisation's needs. Future employers may be willing to invest in an individual's

professional development. They may support further studies at a higher level than the current qualification, which may lead to the completion of a university degree.

7.6.5 Work integrated learning

WIL uses several approaches that provide opportunities for students to integrate practice and theory (Patrick, 2011). Examples of WIL include internships and work placements, industry-based learning and project-based learning (see Figure 7.4).

Students undertake WIL activities such as the use of technology, equipment and activities throughout the program. They develop capabilities such as leadership, communication, teamwork, and values. Students develop an awareness of workplace culture and obtain skills in developing and applying their knowledge in practice.

7.6.6 Domain 4: Democratic and learning-centred practice

One of Dewey's most famous quotations concerns the nature of democracy as follows (Dewey, 1916):

> A democracy is more than a form of government; it is primarily a mode of associated living, of conjoint communicated experience. (p. 87).

According to Dewey, democracy is an essential aspect of a human being. That is, in our relations with others, events and problems are resolved together for mutual interest. This means that over time ways of acting with each other are clarified and ultimately are in the best interest of all. In this way, human values and ethical conduct emerges through the combination and experience of social acts. Humans, therefore, are democratic beings, both in relation to others and in relation to themselves. This goes to the heart of what it means to be human. In this regard, Domains 1, 2, and 3 are forerunners to Domain 4, in respect of how the philosophical approach described by the overall model attempts to establish humane and compassionate aged care (see Figure

7.4). The model locates aged care itself as an essential way of demonstrating and achieving what quality of care is all about.

A flexible curriculum that enables an individualised training program and shared experience must be part of the Democratic Experiential Learning Aged Care Education Model. The concepts include (a) critical thinking, (b) reflective thinking and (c) critical practice. It is essential to employ these forms of learning for safe work practices that are ineffectively addressed in the Training Packages. Some examples of democratic and learning-centred training include a flexible curriculum (blended learning and problem-based learning), individualised training plan, shared experience, professional development and membership, and aged care pathways.

7.6.7 Critical thinking

Aged care programs should promote critical thinking and develop critical reasoning skills. This is to be implemented in various situations encountered by care workers (e.g., skills to manage aggressive behaviour, falls and adverse effects of medications, food and treatment). Care workers can learn to objectively analyse and evaluate an issue and form a decision on the type of action to take.

Dewey (1933) defined thinking as:

> that operation in which present facts suggest other facts (or truths) in such a way as to induce belief in what is suggested on the ground of real relationships in the things themselves. (p. 12)

The purpose of thinking is to link things objectively and understand the truths (James, 1975). Incidents that occur in aged care can objectively be considered situations that must be understood to know why they occurred and to decide on how to manage and prevent them. Students can think and reflect on how they can address future incidents.

Dewey's thinking was founded on what could be considered a scientific and systematic method as a way of knowing and understanding (Garrison, 2006). Its focus is more on problem-solving than a philosophical contemplation of abstract ideas.

According to Clare et al. (2002), graduates need the characteristics of critical thinking and reflection. Researchers suggest that 'critical thinking and analysis' should be one of the core competency standards in the national competency standards for registered nurses (Gabb et al., 2005). Similarly, the aged care curriculum should include critical thinking, analysis and critical practice to help improve residents' care outcomes. Care workers need to be able to apply critical thinking and analysis in critical practice environments such as aged care (see Figure 7.4).

Garrison (2006) argued that critical thinking connected with adult education integrates aspects of problematic situations that can be solved with innovative thinking. The concept of critical thinking must emphasise the cognitive processes in knowledge expansion and the problem-solving approach. Critical thinking is a collaborative form that involves the use of a keen understanding in an educational context.

Critical thinking is useful as a problem-solving tool that is principally meaningful to student learning (Garrison, 2006; Pithers & Soden, 2000). An example is presenting a problem in the form of a scenario and asking the student to think critically about the objective information presented in the scenario, seek an explanation as needed, and make decisions based on the facts at hand. Garrison (2006) stated that this separation from the objective world is an essential feature of the critical thinking process.

7.6.8 Reflective thinking

Dewey (1933) used the term 'reflective thinking', to mean a way of engaging in thinking critically about the problem at hand and analysing though not necessarily to

accomplish a solution (Garrison, 2006). Critical thinking makes sense of complicated truths and realities, and knowledge of the facts guides a person's activities, both rationally and practically (James, 1975). Current aged care training (Figure 7.4), provides scenarios of potential situations with an emphasis on self-directed learning, but they provide no formal guidelines regarding the use of 'critical thinking and reflective practice' as a means and a goal of the learning (Brookfield, 1988; Simpson et al., 2005). Teaching critical thinking will help students at a basic level to develop their learning skills to analyse a situation using the given facts and respond to the situation appropriately.

7.6.9 Critical practice

Critical and reflective thinking in practice is a vital skill for care workers to learn through hands-on participatory learning experience (Simpson et al., 2005). Care workers should reflect on the influences of their own and other persons' thoughts before implementing change. Dewey (1933) referred to reflection as intellectually thinking about an issue, creating awareness of the subject and giving deep thought in active and experiential learning. It emphasises the self-determination and autonomy of the learner to be responsible for establishing and examining reflective practice (Simpson et al., 2005). Reflective practice on their own concerning situations arising and before implementing any interventions to manage a situation.

The reflective practice of students benefits from the presence of learning from others, such as a person who acts as a mentor to protect students from being drawn into unfortunate situations (Simpson et al., 2005). Tilley, Marsh, Middlemiss and Parrish (n.d.) argued that empowering learners to reflect on practice is the initial phase in developing critical and reflective thinking. Benefits are obtained from the guidance of educators and mentors who help students develop their skills in situations that are

specific to the work environment. For example, aged care graduates develop responses to sustainable challenges encountered in an environment that can be unpredictable, particularly in the event of challenging behaviour, accidents and falls.

Reflection is about aged care graduates giving careful thought to experiences at work to help them continue to improve their performance (see Figure 7.4). Performance can be improved through students thinking critically about the professional development activities that they undertake to evaluate their learning and its application to their current work role.

7.7 Conclusion

This chapter examined Dewey's influence on aged care education concerning the five main themes that arose from the research questions across the data: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to broaden topics on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges of working in an aged care environment; and (5) the need for the application of knowledge through experiential learning and simulations facilitated by qualified mentors with experience in aged care.

Theme 1 addressed the need for consistent models of care by highlighting one of the many incidents of carers assaulting older adults in RACS. The researcher argued that research had been conducted on substandard care for several decades. Yet, little had changed despite changes in governments and amendments to the legislative framework resulting in increased monitoring and more funding. Management, APs and governments must be held accountable instead of blaming care workers who have no control over the type and number of staffing over 24 hours and funding for resources and equipment.

Care workers working across several aged care services are not familiar with various models of care, and hence, it can be confusing for them. While managers and care workers mentioned the person-centred care model and the consumer-directed care model, they were unable to explain how the models work, as most of the work they do is providing primary care and undertaking task-oriented activities.

Training for care workers does not encourage critical thinking and reflective practice. Training that employs Dewey's works and ideas would enable care workers to develop skills in critical practice to handle untoward incidents. Regardless of the model of care used, basic knowledge and skills, as identified by Dewey, will engage care workers to provide safe care.

Theme 2 addressed the need for a better understanding of working within a legislative framework that governs aged care practice. For care workers to understand their responsibilities, in the accreditation process, the legislative framework must be included in the aged care training. While care workers do not have control of staffing, which may compromise care, critical thinking and reflective thinking would enable them to be assertive in raising concerns that affect their reflective practice and work in aged care.

Theme 3 addressed the need to broaden topics on chronic health conditions, documentation and elder abuse. Topics were suggested on conditions such as asthma, palliative care, dementia, respiratory and cardiovascular conditions, and other topics that care workers would benefit when providing care.

Also, many older persons with chronic health conditions require complex care and procedures, which are often conducted by care workers as a result of the lack of RNs on a shift. Complex care needs include oxygen therapy, wound management and fall incidents. Care workers conduct health monitoring activities of vital signs, blood

sugar levels and oxygen saturation. Understanding these parameters—that is, normal and abnormal levels and what to do if such a situation occurs—requires an RN's guidance. Again, Dewey's works and ideas can influence care practices.

Care workers' understanding of documentation and meeting legal requirements is not adequately addressed in the Training Packages. The managers and care workers suggested that documentation is essential from a compliance and funding perspective, and it helps guide care practices to meet residents' needs by referring to their care plans. Injuries and fall incidents must be documented to ensure the right treatment and future prevention of incidences.

Elder abuse has been raised for many years; however, little has been done despite legislation. Compulsory reporting and what constitutes elder abuse is not well covered in the Aged Care Training Package. Dewey's work on experiential learning should help care workers to identify, report and correctly prevent elder abuse through critical thinking and critical practice.

Theme four addressed the need for care workers to acquire soft skills to meet the challenges of working in an aged care environment. These soft skills will be developed gradually through hands-on experience in a simulated and workplace environment. Some of the soft skills raised by care workers (compassion, commitment, not being afraid of older adults) can be developed once the care worker is comfortable and confident in providing care. Confidence will come from the new education model that addresses WIL and supports, promotes and guides student practices while in training.

Theme five addressed the need for the application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care and how it supports the notion of instilling confidence in aged

care graduates. However, there is a need for Dewey's democracy in experiential learning, which will be addressed later.

Students' access to work placements in aged care has been a longstanding issue. It is essential that funding is provided for RTOs to build state-of-the-art simulation labs with adequate resources and contemporary equipment for students to use. Students from RTOs miss out on work placements because most of them have been booked by universities and TAFE colleges that can afford the high fees that placement providers demand.

This study brought to light the problems with mentoring and argued the need for facilitators and qualified mentors to guide students during work placements. Further, students should not be used to fill staff vacancies because they are unable to assimilate knowledge and practice in an aged care environment with no support and professional guidance.

Following the discussion of the themes, the researcher argued the need for a new aged care pedagogical model to replace the current rigid and broken aged care education model. Leading up to the model on democratic, experiential learning, the researcher argued that the current aged care education and training model does not prepare or encourage professional development, which leads to career pathways to higher education for aged care graduates.

This study covered the need to remediate aged care education by creating a new supportive learning model that includes: (a) a brief overview of the current aged care model; (b) continuing education and professional development; (c) career pathways for aged care graduates; and (d) is based on democracy and experiential learning.

First, a brief overview of the current aged care training model and argued that it deters students from developing ideas and thoughts because it is dependent on the

industry-based model that sets units of competencies to be taught according to the ASQA standards. Many activities are task-oriented and do not encourage critical thinking and reflective practice. The managers and care workers identified many gaps in the Training Package regarding the knowledge required to work in aged care. The current aged care training model does not encourage critical thinking, reflective thinking and critical practice. A model was provided to demonstrate the standard model that most RTOs follow. While the face-to-face approach is the preferred way to deliver a course, other RTOs choose to conduct the aged care course online for several reasons related to costs and time. Work placements are mandatory for aged care workers and paid facilitators, and mentors must be available to support them; however, this is compromised because of the high costs involved.

Second, the researcher discussed the importance of continuing education and professional development for aged care graduates through work-related learning activities that not only broaden the graduate's knowledge but also develop their expertise and professional competence.

Third, the researcher outlined a model to help graduates develop personally and professionally through: (i) professional development and professional membership; (ii) online, distance and face-to-face learning including seminars and workshops; (iii) inquiry-based learning; (iv) flexible learning through project-based learning; (iv) case-based and problem-based learning management through care activities; and (vi) theoretical links between case-based, problem-based learning and self-directed learning for professional development in aged care education, which will eventually lead to pedagogical aged care pathways for graduates.

For many years, there has been no formal graduate program for aged care workers. Given that aged care workers form a vital part of the aged care team, they must

be mentored and guided through professional development to access career pathways of their interest. These career pathways in aged care will enable them to develop further their critical thinking and reflective practice knowledge and skills.

The researcher provided a model for aged care pathways whereby students can reach their potential either as an aged care specialist care worker or in nursing. These specialist courses can include diploma, bachelor, masters and doctoral levels. Care workers need to exercise critical thinking and reflective practice that affects the quality of care and break the cycle of years of poor standards of care in the aged care industry. There must not be cause for another Royal Commission into the horrific and deplorable treatment of residents in aged care and their representatives. Our older Australians deserve better, and this is the time to consider a new aged care education model that inspires and reassures Australians of the ongoing quality of care delivered by well-prepared and educated aged care graduates.

Fourth, from a pragmatist perspective, the researcher considered Dewey's democracy in education, which developed intellectual influences and experiential learning to include critical thinking and critical reflection for graduates to develop the necessary skills for critical practice in an aged care setting.

The researcher detailed the Democratic Learning Experience Aged Care Education Model that must be further developed, implemented and evaluated if aged care education is to have a long-term effect on the quality of care in RACS. Therefore, from a pragmatist perspective, the researcher advocates the implementation of the Democratic Experiential Learning Aged Care Education Model, which comprises four domains: (i) professional communication and dialogue; (ii) interactive critical thinking; (iii) discourses of quality of care; and (iv) democratic and learning-centred practice.

Dewey's philosophies that can be implemented into practice in the new Democratic Experiential Learning Aged Care Education Model can contribute to building knowledge for shared benefit in an environment. For example, Dewey argues for open-plan classroom activities that encourage participation and dialogue by everyone through required reflection and practice. He challenged the traditional view of education and encouraged a more deep-seated way of thinking by keeping the learner central to the education system. Aged care education needs a change that will provide progressive education to those choosing to work in the aged care sector.

The researcher used Dewey's pragmatism to propose a Democratic Experiential Learning Aged Care Education Model based on Dewey's democratic and experiential learning (Elkjaer, 2009). Robust evidence has been presented in this study, which encompasses three methods of data collection. The findings and the discussion of the results have provided overwhelming evidence that the way aged care education is delivered to prepare graduates for the workforce must be changed. The aged care workforce must give older adults confidence in the quality of care that can be achieved through the Democratic and Experiential Learning Aged Care Education Model.

Chapter 8: Conclusion, Implications and Future Work

8.1 Introduction

This research set out to gain a better understanding of how aged care education influences the delivery of quality of care in RACS. The researcher conducted this extensive six-year study as part of her doctoral study because she works across two fields of practice: aged care and education. Education is crucial to helping resolve the substandard care affecting many older Australians in RACS. Over several years, many changes have been made to legislation, funding and monitoring of quality with varied impacts.

This chapter (1) revisits the aim, and research questions; (2) outlines the discoveries made to the research questions; (3) restates the significant findings; (4) discusses the contributions this study makes to the existing literature; (5) outlines future directions for research; and (6) recommends a new pedagogical model for aged care education using Dewey's democracy in experiential learning.

This study aimed to explore the quality of care in RACS and how aged care education can be improved through the use of Democratic Experiential Learning Aged Care Education Model. The five research questions in this study examined the issues with aged care education and quality in RACS. The study employed explorative, descriptive qualitative research that involved managers and care workers working in RACS. The five research questions were: 1) How is quality of care perceived by aged care workers and managers? 2) How do RTOs teach the QoCPs legislated in the *Aged Care Act 1997* to aged care workers and managers? 3) How do managers and care workers in residential aged care services perceive any gaps in the knowledge and skills of graduates? 4) How do aged care graduates view their preparation to work in aged

care after gaining employment in RACS? 5) What are the features of good aged care training, according to managers and care workers?

The study referred to Dewey's conceptual framework of pragmatism to investigate the problem of variability of quality in aged care. His works on education laid the foundation for my argument of inquiry into aged care education and quality in RACS. In particular, his work on knowledge was helpful and relevant to the research project. The researcher used the five research questions as a guide in each chapter to focus the investigation into aged care education and its effect on education. The researcher restated the significant findings in each chapter.

The background and literature review examined academic studies and government reports that provided an understanding of aged care training and quality in the aged care sector. The researcher critiqued five critical areas of aged care quality: 1) the growing need for aged care; 2) models of aged care; 3) limits of aged care reforms: regulating quality; 4) key challenges facing aged care workers; and 5) the adequacy of VET for aged care workers.

The literature established that there had been insufficient academic research into aged care training and its effect on quality. Given the growing Australian population, the demand for aged care services, accommodation and extra funding is insufficient. In particular, this affects accommodation to care for the frail older adults who suffer from chronic health conditions and who are dependent on their basic needs to be met (ACFA, 2013; De Bellis, 2010; Department of Health, 2010; Department of Social Services, 2015; Harrington et al., 2000).

There are no consistent models of care employed in RACS. The findings in the literature discussed the persistent shortage of nursing staff who are available to supervise care. This highlights a problem that has occurred for many years as a result of

poor government policy and a lack of direction (Ostaszkiewicz et al., 2016; Savy et al., 2017), particularly concerning the care of diverse clients and ATSIs, as well as intellectually challenged and young disabled residents in RACS (Parliament of Australia, 2015). The lack of training in the care of chronically ill residents is an ongoing concern (Angus & Nay, 2003; Department of Health and Human Services, 2017; Hickman, Rolley, & Davidson, 2010; Skatssoon, 2019).

The literature proved that limited research has examined the relationship between aged care training and its effect on the quality of care. It revealed that legislative reforms and changes to accreditation did not go far enough to address quality in aged care (Davis et al., 2016; QoCPs, 2014). Quality assessors audited for minimum standards and compliance rather than using clinical indicators (Aged Care Crisis, 2010; De Bellis, 2010; Fifield, 2014; Kaine, 2012; Shanley, 2005; Skatssoon, 2019).

The challenges encountered by managers and care workers included a lack of resources and insufficient qualified care workers (Brownie & Nancarrow, 2013; King et al., 2012; Ostaszkiewicz et al., 2016), which resulted in unnecessary transfers to hospitals (Department of Health and Ageing, 2012; Stokoe et al., 2016). These unnecessary transfers were exposed to the media along with other failures of non-compliance, which prompted changes to aged care; however, limited attention was paid to aged care education (ABC, 2018; Aged Care Crisis, 2010; Department of Health and Ageing, 2017; Savy et al., 2017; Skatssoon, 2019).

The literature has long-established that current vocational education for aged care graduates does not adequately prepare graduates because there is a disconnect between aged care education and practice. This is because Aged Care Training Packages do not include extensive consultation with APs and RTOs (Mavromaras et al., 2017; Wheelahan & Carter, 2001). Some researchers have argued that minimal

education of care workers contributes to inadequate care (Billings, 2016; Ostaszkiewicz et al., 2016). The literature confirmed the urgency of progressing current teaching practices to meet quality of care in a contemporary and growing aged care sector (Aged Care Crisis, 2010; Billings, 2016; Ostaszkiewicz et al., 2016).

Also, to maintain a robust aged care workforce, ongoing education and professional development were identified in the literature as essential in maintaining and updating knowledge and skills (ACFA, 2013; Parker & Geron, 2007). The background and literature review supported the investigation into aged care education and practice through an understanding of the issues confronting both managers and aged care workers.

The conceptual framework included the use of the pragmatism paradigm, which was significant in assisting the understanding of the practical application of the professional practice of aged care and education. Dewey's works and ideas on education established a precedent of inquiry into aged care education because his work on knowledge was relevant to the research project. Hence, the researcher described four areas: (1) the foundation of pragmatism; (2) the theory of pragmatism and its relevance to aged care education; (3) the use of pragmatism in other fields and its advantages and disadvantages in this study; and (4) Dewey's works and ideas on pragmatism in education.

Dewey's work on pragmatism was vital because it allowed the managers and care workers to express their views and experiences openly. Dewey's work was relevant to the study of aged care because his conceptual theories provided fresh insights into the daily practices and education of care workers entering the workforce.

As a result, the model of pragmatism helped to answer the research questions through the research design chosen in the methodology and the methods of data

collection and analysis (Johnson & Turner, 2003; Johnson & Onwuegbuzie, 2004; Mackenzie & Knipe, 2006). Although pragmatism, like all current philosophies, has some weaknesses, the researcher found it helpful in understanding the problems of managers and care workers.

For the methodology, the researcher justified the philosophical and theoretical paradigm of pragmatism, which underlined the explorative, descriptive approach (Creswell & Maietta, 2002; Morse & Field, 1995). The use of mixed methods of data collection and analysis was closely aligned with examining the research questions. The methodological decisions solely based on the research questions reflected the researcher's assumptions about the nature of knowledge and how such knowledge is achieved. The methodology explained the use of the conceptual framework and justified pragmatism, as well as the methods of data collection. The overall approach justified: (1) Dewey's pragmatism in a qualitative approach as a component of mixed methods; (2) the use of pragmatism in a mixed methods approach to data collection and analysis; and (3) the validity of the methods chosen for the study.

The methods included document analysis of published documents using the Aged Care Training Packages and QoCPs legislation regarding aged care training. An online survey was sent to 1,500 participants, and 360 responded to provide a broad understanding of the views on aged care education and practice. The in-depth semi-structured interviews provided in-depth knowledge from the perspective of managers and care workers about aged care graduates' training and their work in RACS. The use of qualitative analysis to examine the interview data helped to explore and understand the phenomenon from the perspective of the participants (Creswell & Maietta, 2002; Denzin & Lincoln, 2000; Morse & Field, 1995; Onwuegbuzie & Johnson, 2006). Validity, reliability and trustworthiness through the researcher's reflection of the

findings and discussion with her supervisors. The open-ended questions helped the researcher to focus the discussion without imposing too much structure. The inquiry was flexible and adapted to individual participants to enable them to communicate their experiences, thereby making each interview unique (Denzin & Lincoln, 2000; Elliott & Timulak, 2005).

The findings from the five research questions set out to examine the relationship between aged care education and quality of care in RACS. The data were collected and synthesised through explanatory text and visual displays of figures and tables. The data were thematically analysed to identify codes, categories, key issues and themes. The data highlighted the voices of the participants using three data resources: published data, an online survey and semi-structured interviews. The findings were presented in a narrative form using verbatim quotations from the interviews with the managers and care workers, which revealed divergent and competing views. The findings relating to each of the five research questions were separated into codes, categories, key issues and themes. The codes identified keywords and phrases; the categories were arranged to highlight the interrelationships between issues and themes.

8.2 Significant Findings of the Study

The significant findings from the data collected about the five research questions are outlined below:

- Quality of care is jeopardised by a lack of knowledge and skills among aged care graduates regarding understanding the types of care and the need for more staffing, time and resources.
- Aged care workers must have the knowledge and an understanding of the legal ramifications of proper documentation.

- Accreditation monitoring of standards is principally about ‘compliance’ and does not assure that quality of care is provided.
- QoCPs, which form a legislative framework that governs aged care practice, is inadequately addressed in the Aged Care Training Packages.
- Aged care graduates lack basic knowledge and skills to practice.
- The currency of education is critical to keep up to date with changes in aged care.
- Participants considered the need for better preparation for care workers.
- Currency in education needs to improve to meet the needs of older adults.
- Better-prepared care workers can meet challenges in real-world situations.
- Experienced trainers are needed to make the connection between theory and practice.
- Work placements need to include trained staff to help support student learning.
- Students need to understand how to care for persons with chronic health conditions and complex needs.
- There is an urgent need for training packages to be relevant to meet the current needs in aged care.

The discussion addressed the findings, which raised critical issues in each of the five research questions through the interpretation, analysis and synthesis of the findings. The discussion presented the key issues raised from the data in light of Dewey’s conceptual framework and his works and ideas. The analysis examined the critical issues of whether the literature corresponds with, contradicts or deepens the results drawn from the analyses of the critical issues arising from the above findings.

The literature confirmed that for research question one, the models of care and quality of care are not adequately addressed in the literature. Further, the ongoing

inconsistency in care, lack of staffing, time constraints, lack of resources and inadequate funding have been issues for many decades. Regarding research question two, the QoCPs has been amended three times since 1997 and yet are not adequately taught in the aged care training curriculum. This leads to limited understanding and implementation of the care standards. For research question three, managers and care workers in RACS perceived gaps in the knowledge and skills of graduates.

Moreover, training packages do not provide the technical skills required for persons with chronic health conditions and complex care needs. Documentation is not well addressed in the Training Packages, leading to a lack of understanding of the legal ramifications.

Regarding research question four, managers were concerned about the lack of preparation of aged care graduates to enter the workforce. Graduates do not receive enough experiential learning to prepare them to face the realities of working in aged care. For research question five, the Training Packages do not address the current trends in aged care. There were doubts about aged care trainers' capability and calls for them to have relevant knowledge and experience in the aged care sector. There was a concern that the learning experience of students at work placements was reduced as a result of costs, the lack of placement providers, the high cost of placing students and the lack of facilitators and mentors to guide students. There were calls from managers and care workers for graduates to have 'softs skills' to be able to work in aged care.

From the five research questions, five main themes arose from the discussion of the results: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to broaden topics on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges of working in an aged care environment; and (5) the

need for an application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care. These themes suggest that there is a need to improve the delivery of aged care education to meet the challenges and changes. The findings and the discussion of the results showed that the current aged care model does not work. It is restrictive for student learning and does not encourage flexibility in training, critical thinking, reflection and critical practice. Instead, students must complete task-related activities.

8.3 Contributions of This Study to Existing Knowledge

This research contributes to the existing literature and proposes the use of Dewey's writings on democracy in education and experiential learning. The existing literature highlighted that problems regarding a lack of trained staff and other issues surrounding quality in aged care have been ongoing, as reported in several studies and government reports. It also discussed some inadequacies related to the training packages. However, no studies have been conducted on aged care training and its effect on quality.

The results of this study identified that the effect of aged care education on quality supports the need to improve the current system of aged care education, which has been in place for 30 years or more. The data provided evidence of the current rigid and broken, aged care education model. This model conducts training and assessments based on a set of topics, elements and criteria that must be taught in the classroom and during work placements. Still, it does not encourage aged care graduates to undertake professional development or a career pathway to higher education. Currently, the only pathway to higher education for care workers is to undertake a diploma of nursing.

In using a pragmatist approach, a more democratic model of aged care education must be employed that is flexible in meeting graduates' learning needs. We have an

obligation to older Australians to provide the highest standards of care. My research contributes to the literature on the study of aged care education and quality by arguing that we must adequately prepare graduates for work in RACS to enable them to cope with challenges in the sector.

8.4 A New Pedagogical Aged Care Education Model Influenced by Dewey's Works

To address the main themes arising from the study, the researcher proposed a model for further aged care education. The main themes enabled the creation of a new pedagogical aged care education model based on Dewey's work in democracy and experiential learning. The themes developed from: (1) the need for consistent models of care; (2) the need for a better understanding of working within a legislative framework; (3) the need to broaden topics on chronic health conditions, documentation and elder abuse; (4) the development of soft skills to meet the challenges of working in an aged care environment; and (5) the need for the application of knowledge through simulation and experiential learning by qualified mentors with knowledge and experience in aged care.

From a pragmatist perspective, Dewey's discovery of learning and progressive education helped to develop the Democratic Experiential Learning Aged Care Education Model. The model allows students to interact with their environment through critical thinking, reflection and critical practice to develop the necessary skills, including 'soft skills', to meet the challenges in aged care.

The need to include a new aged care pedagogical model to support ongoing learning. The model includes: (a) a brief overview of the current aged care model; (b) continuing education and professional development; (c) career pathways for aged care graduates; and (d) is based on democracy and experiential learning.

The current aged care training model has deterred students from developing ideas and thoughts. This is because the model is dependent on the industry-based model that sets units of competencies to be taught according to the ASQA standards. Many activities are task-oriented and do not encourage critical thinking and reflective practice. The managers and care workers identified many gaps in the Training Package regarding the knowledge required to work in aged care. Significantly, current aged care training does not encourage critical thinking, reflective thinking and critical practice. A model was provided to demonstrate the standard model that most RTOs follow. While the face-to-face approach is the preferred way to deliver a course, other RTOs conduct the aged care course online for several reasons. Work placements are mandatory for aged care workers, and paid facilitators and mentors must be available to support them; however, this is compromised because of the high costs involved.

The researcher discussed the importance of continuing education and professional development for the aged care graduate through work-related learning activities that not only broaden the graduate's knowledge but also develop their expertise and professional competence. The researcher outlined a model to help graduates develop personally and professionally through: (i) professional development and professional membership; (ii) online, distance and face-to-face learning including seminars and workshops; (iii) inquiry-based learning; (iv) flexible learning through project-based learning; (iv) case-based and problem-based learning management through care activities; and (vi) theoretical links between case-based, problem-based learning and self-directed learning for professional development in aged care education, which will eventually lead to pedagogical aged care pathways for graduates.

For many years, there has been no formal graduate program for aged care workers. Given that aged care workers form a vital part of the aged care team, they must

be mentored and guided through professional development to access career pathways of their interest. These career pathways in aged care will enable them to develop further their critical thinking and reflective practice knowledge and skills. The researcher provided a model for aged care pathways whereby students can reach their potential either as an aged care specialist care worker or in nursing. These specialist courses can include diploma, bachelor, masters and doctoral levels.

8.5 Creation of a New Pedagogical Model for Aged Care Education Through Dewey's Democracy in Experiential Learning

To overcome the longstanding problems with aged care education, it is time to amend the current system as it is beset with problems as evident in the literature and the discussion of the research findings. Current aged care education does not equip aged care students with the necessary skills to work in a sophisticated aged care sector. Therefore, a new education model must form the fabric of contemporary aged care training to meet the need of the sector (see Figure 7.4 Democratic Experiential Learning Aged Care Education Model p 188).

Learning must include lasting knowledge and experience to meet the 'reality' and 'truth' of addressing problems and experience in managing situations in a supportive learning environment (James, 1975). The suggested model encourages reflective practice, and ongoing professional development motivates graduates to undertake higher education. Democratic, experiential learning is an alternative to fixing the system, which does not prepare or encourage professional development that leads to career pathways.

Care workers need to exercise critical thinking and reflective practice that affects the quality of care and break the cycle of years of poor standards of care in the aged care industry. There must not be cause for another Royal Commission into the

horrific and deplorable treatment of residents in aged care and their representatives. Our older adults deserve better, and this is the time to consider a new aged care education model that inspires and reassures Australians of the ongoing quality of care delivered by well-prepared and educated aged care graduates.

8.6 Recommendations and Future Directions

From a pragmatist perspective, the researcher considered Dewey's democracy in education to influence experiential learning. This includes critical thinking and critical reflection for graduates to develop the necessary skills for critical practice in an aged care setting.

The researcher detailed the Democratic Learning Experience Aged Care Education Model that must be further developed, implemented and evaluated if aged care education is to have a long-term effect on the quality of care in RACS. More research will be required once the new Democratic Experiential Learning Aged Care Education Model is trialled. The aged care model comprises four domains: (i) professional communication and dialogue; (ii) interactive critical thinking; (iii) discourses of quality of care; and (iv) democratic and learning-centred practice.

The four domains enable Dewey's philosophies to be transferred into practice in the new aged care model so that learners can contribute to building knowledge. The participation and dialogue required in reflection and practice are Dewey's challenges to traditional education. Instead, he encourages a more deep-seated way of thinking by keeping the learner central to the education system. Aged care education must change to provide progressive education to those choosing to work in the aged care sector.

The researcher recommends that aged care education policy, which includes government policies for aged care services and service providers, must support a change in aged care education and training. The suggested aged care education pedagogy will

need financial support and resources for further research to affect the quality of care in RACS.

8.7 Application and Implications for Practice

From a pragmatist perspective, the researcher referred to Dewey's work on democracy in education and experiential learning. There is overwhelming evidence that supports the need for change in aged care education delivery and training to prepare aged care graduates for the workforce. The aged care workforce must give older adults confidence in the quality of care that can be achieved through a more robust and better-designed Democratic and Experiential Learning Aged Care Education Model.

The implications for aged care education involve a much-needed change in the curriculum and delivery of aged care training. Change is essential to meet the current trends in aged care. A better model of aged care training must be employed and evaluated based on proven education pedagogies as part of the aged care curriculum.

8.8 Contributions of This Study to Research on Aged Care Education

This study has contributed new knowledge in the under-explored area of aged care education provided by RTOs and its effect on practice in RACS. The study informs aged care education policy for all RTOs that provide aged care training.

Aged care training must improve using the suggested pedagogical model based on Dewey's pragmatism of theory and practice to expand the knowledge of aged care graduates. This will provide sustainable ongoing education and support to aged care graduates working in Australian RACS. It will also provide a sustainable pathway that will encourage aged care graduates to specialise in an area of their choice relating to theory and practice in aged care.

8.9 Reflections of This Study for Researcher and Aged Care Education

This study has great significance for aged care education. The thesis focused on aged care training for care workers and its effect on the quality of care in RACS. The data confirmed that quality in aged care is an ongoing problem.

The managers and care workers overwhelmingly agreed that improvements in aged care training are a crucial component of improving quality in RACS. They also discussed the critical gaps in preparing aged care workers for the workforce. This study has achieved its purpose of providing knowledge from critical reflection and critical understanding of a complex field of learning and specialised research into aged care and creating a new model for the aged care curriculum. Through the reflection of the results in the findings, the researcher gained a better understanding of how aged care education influences the delivery of quality care in RACS.

The researcher analysed and provided an advanced integrated understanding of the complex body of knowledge. However, there was minimal literature on the effect of aged care education and the expectations of managers and care workers working in RACS.

The researcher was able to analyse and engage in critical thinking and reflection on the results of the research findings to enable the synthesis and evaluation of the complex information from the data using Dewey's conceptual framework. This framework was able to develop and adapt the methods of data collection approaches. Adapting Dewey's works and ideas were particularly useful in this applied study in aged care education. The researcher was able to extend and refine the existing knowledge of aged care and practice—particularly the influence of aged care education on quality of care in practice. Dewey's concept of pragmatism helped the researcher to

understand the current gaps in the aged care training paradigm and to interpret and transmit knowledge, skills and ideas for use in a specialised aged care education model.

The researcher generated original knowledge and understanding to make a substantial contribution to the discipline of education and professional practice in the field of aged care. An independent and sound judgement recommends that the new Democratic Experiential Learning Aged Care Education Model be implemented with the Industry Reference Committee to evaluate its effect on quality in aged care responsibly. This will fill the gaps identified in the study by managers and care workers in aged care and break the cycle of poor quality in RACS. It is envisaged that this new model will help aged care graduates improve the delivery of aged care training and will be sustainable for the aged care workforce.

Moreover, the model will provide ongoing support for aged care graduates and a pathway to develop further and provide challenges for those choosing to make aged care their long-term career. The researcher also sourced education concepts that are currently employed in Australian universities (e.g., WIL) and that can be adapted to the researcher's newly developed model. The study contributes to a way forward and has implications for future aged care education, policymakers in education and funding to ensure that the success of democracy and experiential education will have a flow-on effect on the quality of care practices in RACS. In using Dewey's works and ideas of knowledge and practice in aged care education, the future roles and responsibilities of care workers will enhance the effect on quality.

This study is timely given the commencement of the Royal Commission into aged care practices. Education is one of the terms of reference, but how to deliver it to ensure it has a long-term effect has not been raised. A band-aid approach to aged care education that is not built on working theories and practices is bound to fail. Therefore,

a new Democratic Experiential Learning Aged Care Education Model must be implemented in terms of the aged care curriculum, theory and practice. Education pathways for care workers and a mentoring approach to aged care graduates are the key to quality education that will affect the quality of care in RACS. Therefore, this research has much to offer and is highly relevant, given the Royal Commission into the education and practices of RACS.

Appendices

Appendix 1: Training Packages for Documents Analysis and Quality of Care Principles

The published documents 'Quality of Care Principles enacted in 2014 addresses the Accreditation and Standards and the Residential Aged Care Standards. To explore this question, three forms of data resources were collated: published data on the Aged Care Training Packages, an online survey and semi-structured interviews.

Criteria and Elements	Elements in Certificate III in Individual Support (Ageing)	Elements in Certificate III in Individual Support (Home and Community)	Elements in Certificate IV in Ageing Support
Quality of Care	Not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Ageing).	It is not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Home and Community).	It is not addressed in any core and elective units of competency comprising the Certificate IV in Ageing Support.
Quality of Life	**CORE UNITS** Not addressed in any core units of competency comprising the Certificate III in Individual Support (Ageing). **ELECTIVE UNITS** Addressed in the Elective unit. **CHCAGE001 Facilitate the empowerment of older people.** PC 1.4 Work with the person to identify physical and social enablers and disablers impacting on health outcomes and quality of life. PC 1.5 Encourage the person to adopt a shared responsibility for their own support as a means of achieving better	**CORE UNITS** Not addressed in any core units of competency comprising the Certificate III in Individual Support (Home and Community). **ELECTIVE UNITS** Addressed in the Elective unit. **CHCAGE001 Facilitate the empowerment of older people.** PC 1.4 Work with the person to identify physical and social enablers and disablers impacting on health outcomes and quality of life. PC 1.5 Encourage the person to adopt a shared responsibility for own support as a means of	**CORE UNITS** **CHCAGE001 Facilitate the empowerment of older people.** PC 1.4 Work with the person to identify physical and social enablers and disablers impacting on health outcomes and quality of life. PC 1.5 Encourage the person to adopt a shared responsibility for own support as a means of achieving better health outcomes and quality of life. Knowledge evidence: the impact of social devaluation on an individual's quality of life.

	health outcomes and quality of life. Knowledge evidence: the impact of social devaluation on an individual's quality of life. Not addressed in other Electives for the Ageing specialisation.	achieving better health outcomes and quality of life. Knowledge evidence: the impact of social devaluation on an individual's quality of life. Not addressed in other Electives for the Home and Community specialisation.	**CHCPAL001 Deliver care services using a palliative approach.** PC 1.3 Communicate with the person, carers and family about the person's quality of life, pain and comfort and report information to supervisor. Element 2: Respect the person's preferences for quality of life choices Not addressed in other Electives for the in Certificate IV in Ageing Support.
Quality of Care Principles	Not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Ageing).	It is not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Home and Community).	It is not addressed in any core and elective units of competency comprising the Certificate IV in Ageing Support.
Accreditation	Not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Ageing).	It is not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Home and Community).	**CHCLEG003 Maintain legal and ethical compliance** PC 4.2 Maintain and update the required accreditations or certifications. Knowledge evidence: accreditation requirements.
Standards of Care	Not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Ageing).	Not addressed in any core and elective units of competency comprising the Certificate III in Individual Support (Home and Community).	Not addressed in any core and elective units of competency comprising the Certificate IV in Ageing Support.

Appendix 2: Plain Language Statement

Information to participants involved in research

You are invited to participate in the research project titled:

Exploring the Effect of Aged Care Education on Quality of Care

This project is being conducted by a student researcher Mrs Janet Lawrence, as part of a Doctor of Education at Victoria University under the supervision of Dr Neil Hooley, College of Education (principal supervisor), and Dr Kerry Ryan, co-supervisor, Head of College Nursing: Victoria Polytechnic (TAFE Division Victoria University).

Project explanation

The variability of quality care provided by Aged Care Workers impacts on the quality of life for residents in Residential Aged Care Services (RACS). Despite structural, funding and legislative changes in RACS, and monitoring of standards of care since the year 2000, the provision of quality care is not available to all residents. Studies have identified the challenges in providing quality care to residents, particularly those with chronic health conditions in RACS. Aged Care graduates from Registered Training Organisations (RTOs) are employed by managers in RACS, who expect them to provide quality care. There are no studies that have specifically explored the Aged Care education delivered by RTOs and its impact on practice in RACS that will contribute to Quality of Care.

What will I be asked to do?

Participants will be asked to provide information in a face-to-face interview on their experiences of ages care training and whether it meets their particular needs. You will be asked open-ended questions related to your studies in terms of Quality of Care, in particular, what you learnt in terms of Quality of Care Principles and Accreditation Standards. You will be asked elaborate on how you were able to apply what in your work settings and reflect upon whether there are more subjects you could have more knowledge. Was there anything you wanted to learn, but it was not covered in the Aged Care training? You may choose a place to be interviewed, and you will be allowed to answer the questions at your own pace. You will be allowed to read the transcript and verify the data, and you can withdraw from the study at any time. Interviews will take about 45 -60 minutes

What will I gain from participating?

By participating in the study, you will get a more in-depth understanding regarding the impact of Aged Care education and training in quality care which is provided by Aged Care graduates in RACS. It will be valuable in informing both practitioners and policymakers of RTOs and RACS and the development of policy programs for Aged Care education. The research outcomes may open new channels of communications between RTOs and RACS, which could have an overall effect in improving the Quality of Care provided in RACS. The objective of this study is to generate knowledge about Aged Care training, is useful to understand and explore the phenomenon, mainly when no research has been undertaken to address the problem. The interviews will seek to establish whether the needs of Aged Care training provided by RTOs are being met.

How will the information I give be used?

The information provided will be analysed, interpreted and reported through the integration of different data forms and the analytical procedures in the analysis of each phase in this study. The researcher will compare the training syllabus to that of the Quality of Care principles and governance documents of RACS. The purpose is to reveal any patterns and discrepancies in the documents that may impact on practice about quality care.

What are the potential risks of participating in this project?

Participants will not be identifiable in the study, and their names and place of work will be removed from the transcripts, and final thesis and unique codes will be used instead. Participants will be able to review the transcript of the interview for accuracy. The record will be kept in a secure cabinet at Victoria University to be deleted at a later date. You may withdraw from the study at any time up to final writing of the thesis without any repercussions.

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form. The researchers will arrange a mutually convenient time for the interview.
Any queries about your participation in this project may be directed to the Janet Lawrence on janet@alacchealth.edu.au

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

Appendix 3: Summary of Participants Interviewed

Persons interviewed Code	Area of practice	Location	Occupation grouped	Occupation title	Profit or not-for-profit	Qualifications	Sex
1.Tar-01E Terrie	TAFE	Regional	Manager	TAFE Educator	TAFE	RN	F
2.Cha-010CW Chanelle	RACS	Melbourne	Worker	PCW	Profit	Aged Care	F
3.Kir-011CW Kurt	RACS	Melbourne	Worker	PCW	Profit	EN	M
4.Mar-012CW Marion	RACS	Melbourne	Worker	PCW	Profit	Aged Care	F
5.Eli-013M Elisa	RACS	Melbourne	Manager	CCM	Profit	RN	F
6.Bel-014M Bella	RACS	Regional	Manager	CCM	DHSRACS	RN	F
7.Che-015CW Chressa	RACS	Regional	Worker	PCW	DHS RACS	Aged Care	F
8.Chr-016CW Chella	RACS	Regional	Worker	PCW	DHS RACS	Aged Care	F
9.Arl-017CW Arlinda	RACS	Regional	Worker	PCW	DHS RACS	RN	F
10.Mau-018CW May	RACS	Regional	Worker	PCW	DHS RACS	Aged Care	F
11.Arv-019M Arnold	RACS	Melbourne	Manager	CCM	RACS	RN	M
12.Dev-02M Dorothy	SRS	Melbourne	Manager	Educator/ Owner	Profit	PhD OAM	F
13.Ann-020CW Angelina	RACS	Melbourne	Worker	PCW	RACS	Aged Care	F
14.Bro-021CW Brodie	RACS	Regional	Worker	PCW	DHS RACS	Aged Care	F
15.Jil-022CW Joanne	RACS	Regional	Worker	PCW	DHS RACS	Aged Care	F
16.Mari-03CW Mary	RACS	Melbourne	Worker	PCW	Not for profit	Aged Care	F
17.Lax-04M Lucky	RACS	Melbourne	Manager	Supervisor	Profit	RN	F
18.Ros-05M Romayne	RACS	Melbourne	Manager	CCM/ ADON	Profit	RN	F
19.Rob-06M Ronan	TAFE	Melbourne	Manager	TAFE Educator	TAFE	PhD	M
20.Vid-07E Virginia	TAFE	Melbourne	Manager	TAFE Educator	TAFE	RN	F
21.Ber-08CW Bernadine	RACS	Melbourne	Worker	PCW	Profit	EN	F
22.Est-09M Emma	SRS	Melbourne	Manager	Owner	Profit	EN	F
Key:							
RACS Residential Aged Care Services	SRS Special Residential Services	PCW Personal Care Worker RN-Registered Nurse	QC Quality Coordinator	CCM Clinical Care Manager	DHS RACS Department of Health Residential Care Services	ADON Assistant Director of Nursing	M-Male F-Female

Appendix 4: Semi-structured interview schedule

This interview questionnaire is looking at whether Aged Care training adequately prepares Aged Care graduates to meet the challenges of providing quality care to the older adults residing in RACS.

Sample questions:

Q 1. How does the RTO teach Quality of Care Principles legislated in the Age Care Act (1997)?

- 1.2 How do you perceive quality?
- 1.3 What is your understanding of the Quality of Care principles?
- 1.4 What are the Quality Care Principles you learnt from the trainer that you could apply in practice?
- 1.5 What was your overall perception of the type of Aged Care training you received?
- 1.6 What did you study about Accreditation standards?

Q 2. How do Aged Care graduates view their preparation to work in Aged Care after being employed in a RACS?

- 1.7 What knowledge, skills and experience do you think Aged Care trainers should have?
- 1.8 What are some of the skills, knowledge and experience did you acquire as an Aged Care graduate?
- 1.9 What type of preparation do you think an Aged Care graduate should receive before being employed in a RACS?
- 1.10 What knowledge and skills you learnt that assists you as an Aged Care graduate to provide quality care?
- 1.11 What knowledge, skills and experience do you think Aged Care trainers should have?

Q 3. How do you within RACS perceive the gaps in the knowledge and skills of graduates?

- 1.12 Do you consider your trainers were knowledgeable about Aged Care that they were able to provide you with adequate knowledge and skills to work in Aged Care?
- 1.13 How do you address the gaps in knowledge and skills to provide Quality of Care?
- 1.14 What are the Quality Care Principles you can apply in practice?
- 1.15 How does one identify the gaps in Aged Care graduate's knowledge and skills?
- 1.16 How does the RACS address the gaps in knowledge and skills for the Aged Care graduate?
- 1.17 What are the Quality Care Principles learnt that you could apply in practice?
- 1.18 Was there anything Aged Care graduates should learn in the Aged Care training?

Q 4. Are their gaps in the Australian Qualification Framework (AQF) Aged Care Training Packages delivered by RTOs in terms of quality and industry needs?

- 1.19 Given that you are working in RACS, what would you like to see added to future Aged Care training in terms of Quality of Care?
- 1.20 What would you like to see in the Training Packages that will better prepare Aged Care Workers for the challenges of working in a RACS?
- 1.21 Aged Care Training Packages are updated every 2-3 years, how often do you think it should be updated?
- 1.22 Recent changes in Aged Care packages have incorporated home and community and disability, are there any other packages you would like to see incorporated in Aged Care training?
- 1.23 Recent changes in Aged Care packages have incorporated home and community and disability, is there anything you would have wanted to learn that was not covered in the Aged Care training?

Q 5. Some demographic data will be undertaken:

- 1.23.1 What range best meets your age?
- 1.23.2 Where did you do your training?
- 1.23.3 What qualifications do you hold?
- 1.23.4 How many years' experience do you have working in aged care?
- 1.23.5 How many years' experience do you have teaching Aged Care students?
- 1.23.6 When did you undertake your Aged Care training?
- 1.23.7 How many months did you undertake each certificate relevant to you?
- 1.23.8 Did you get the opportunity to practice in a simulated environment in the training organisation before clinical placements?
- 1.23.9 Did you undertake clinical placements at the workplace?
- 1.23.10 If you did not do your clinical placement, what were the reasons?

Appendix 5: Online Survey

Improving training for Aged Care Services

Q1 What type of organisation do you currently work in?
Q2 What type of 'level of care' does your organisation provide?
Q3 Does your organisation have a relationship with a training institution?
Q4 What is your current position?
Q5 How many years have you been in your current role?
Q6 What is your age?
Q7 Gender?
Q8 Does your organisation have people with special needs?
Q9 Which best describes your current work status?
Q10 What are your qualifications?
Q11 What year did you complete your last qualification?
Q12 Where did you learn about Quality of Care?
Q13 Where did you learn about Standards of Care as outlined in the Quality of Care Principles?
Q14 Please indicate your knowledge of the following Quality of Care Indicators?
Q15 Please indicate your knowledge of the following topics.
Q16 Please indicate your knowledge of the following topics.
Q17 Please indicate your knowledge of the following Models of Care topics.
Q18 Please indicate your knowledge of managing chronic health conditions.
Q19 Please indicate your mode of study in your highest qualification.
Q20 Did you learn these topics on clinical care?
Q21 Did you learn topics related to lifestyle?
Q22 Did you learn topics related to safe environment and systems?
Q23 Did you learn topics related to consumer rights in aged care?
Q24 Did you improve your understanding in the area of aged care?
Q25 What extra educational needs do you require?
Q26 Do you agree that your training adequately prepared you to provide quality care to older adults?
Q27 How would you rate your satisfaction about your last qualification?
Q28 We are also conducting in-depth interviews about aged care training and Quality of Care.
Q29 How could age care training be improved? (please answer honestly and openly)

Appendix 6: Consent form for participants to be involved in research

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

We want to invite you to be a part of a study titled:

Exploring the Effect of Aged Care Education on Quality of Care

The project aims to analyse the extent to which RTOs' Aged Care education programs address the training needs of RACS in the context of a rapidly ageing population and the increasing need of quality skills in the area.
The research seeks to discover how Aged Care education programs provided by RTOs address the Aged Care training needs of RACS'?

CERTIFICATION BY PARTICIPANT

I, name _____of_____ certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the qualitative study: An exploration of the gaps between Aged Care training and practice: a Pragmatic paradigm using mixed methods research design, being conducted at Victoria University by Janet Lawrence, Doctoral student.

I certify that the objectives of the study, together, with the procedures listed below have been fully explained to me.

- The interview will take 45-60 Minutes
- The meeting will be held at my place of your choosing in a private room. The interview will be recorded for later transcription but will be made anonymous

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:_____ Date:

Any queries about your participation in this project may be directed to the research supervisor, Dr Neil Hooley neil.hooley@vu.edu.au
If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email Researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

Appendix 7: Ethics

The researcher received ethics approval ID number HRE16-149 from the Victoria University Ethics Committee to proceed with the research project to interview managers and Care Workers in Aged Care.

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