

# AUSTRALIAN INSTITUTE FOR SOCIAL RESEARCH

## **Implementing the Teaching Nursing Homes Initiative: Scoping Study**

### **BRIDGING EDUCATION, RESEARCH AND CLINICAL CARE – THE TEACHING NURSING HOME: DISCUSSION PAPER**

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REPORT PREPARED FOR:

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DISCLAIMER: This report describes current state of play and does not attempt to evaluate current practice.

## FOREWORD

### CONTEXT FOR THE DISCUSSION PAPER

In late December 2010, the Department of Health and Ageing (DoHA) commissioned the Australian Institute for Social Research (AISR) at The University of Adelaide to provide research and analysis to inform the implementation of the *Teaching Nursing Homes Initiative*.

### THE PROJECT TEAM

- Dr Kate Barnett, Deputy Executive Director, AISR (Project Leader)  
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- Professor Jennifer Abbey and
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### THE PROJECT MANAGEMENT TEAM

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### ACRONYMS

ACWC – Aged Care Workforce Committee

CRP – Community of Research and Practice

DEEWR – Department of Education Employment and Workforce Relations

DEST – Department of Education Science and Technology

DOHA – Department of Health and Ageing

HWA – Health Workforce Australia

NHWT – National Health Workforce Taskforce

TNH – Teaching Nursing Home

TNHP – Teaching Nursing Home Program

NTNH – Norway Teaching Nursing Home

NIA – National Institute for Aging

RACF – Residential Aged Care Facility

VET – Vocational Education and Training

## KEY FINDINGS

### The Model

Although there are many facets to a TNH, the essence of the model is the **linking of the separate spheres of research, clinical care and education and training** through an affiliation or partnership between a residential aged care facility (RACF) and an education or training provider. It is the research component that usually distinguishes a TNH from other RACFs. Most of the TNH models involve partnerships between university schools of nursing and RACFs, but some also include acute care hospitals.

The TNH model, with its focus on collaborative education and cooperation between clinicians, teachers, researchers, students and managers, can be designed to support interdisciplinary training for and delivery of aged care (particularly involving nursing, medicine and allied health professions). However, in practice, most of the initiatives reviewed have found it difficult to achieve this focus, or have pursued an affiliation based on a single discipline – usually nursing or medicine. This is a gap which new TNH models should seek to address, given current Australian aged care workforce evidence-based knowledge about the importance of holistic care of older people and the benefits of multidisciplinary team work.

Although there are certain ‘core’ features of the TNH model, its application can be expected to vary with local conditions, the expertise brought by its partnering organisations, and the needs of students and residents.

### Benefits of the TNH Model

The TNH provides the opportunity to simultaneously address multiple challenges that relate to the aged care workforce, aged care delivery, and education and training provision. The chart below summarises the key benefits that can be offered by a TNH, based on research and evaluation findings, and the key stakeholder groups affected by them.

Stakeholder	Benefits
<b>Education/ training provider</b>	<ul style="list-style-type: none"> <li>⇒ Increased involvement in ageing research that is based on clinical placement in a RACF. Greater opportunity to provide high quality education and training.</li> <li>⇒ The TNH model supports effective working relationships between aged care service and education providers, which is critical to effective clinical education</li> </ul>
<b>Aged care provider</b>	<ul style="list-style-type: none"> <li>⇒ Increased involvement in research and exposure to clinical practices that enhance quality of care.</li> <li>⇒ Increased professional development due to relationship with education provider.</li> </ul>
<b>Students</b>	<ul style="list-style-type: none"> <li>⇒ Enhanced learning opportunities based on clinical experience with an education and aged care provider affiliation committed to achieving greater quality of care, research and greater quality of education/training</li> </ul>
<b>Residents (&amp; Families)</b>	<ul style="list-style-type: none"> <li>⇒ Improved quality of care.</li> <li>⇒ Reduced turnover of staff, therefore, greater continuity of care.</li> </ul>
<b>Aged care workforce</b>	<ul style="list-style-type: none"> <li>⇒ Opportunity for the aged care workforce to be trained in a setting designed to meet the needs of older people (as opposed to an acute care setting). Enables aged care theory and practice to be integrated (when often is fragmented which has a negative impact on workforce preparation).</li> <li>⇒ The TNH has been found to enhance recruitment and retention of aged care workers because of the enhanced profile as a centre of excellence in research, training and care provision that many TNHs have achieved.</li> </ul>

There is an **interactive** effect between these sets of benefits as the TNH model is comprised of mutually influencing inputs. Benefits in one domain will enhance those in another - for example, a commitment to evidence-based clinical care supports, and is supported by, research that relates to the aged care environment and in turn, supports improved quality of care. Affiliated RACFs that achieve these outcomes will be more attractive to students and potential and current workforce members than will RACFs without this profile.

### **Impact on clinical education**

The TNH model supports effective working relationships between service and education providers and such relationships are critical to the design and delivery of clinical education. Given the shared responsibility for clinical education across the health and education and training sectors, mechanisms for effective engagement between the sectors are critical, and the TNH provides such a mechanism.

Research findings from a series of recent Australian studies reported in this discussion paper and illustrated in local case studies, strongly support the TNH model as a means of providing best practice clinical placement in aged care settings and thereby enhancing the training capacity of the aged care sector as a whole.

### **Critical Success Factors in achieving quality clinical placement in aged care**

#### ***Critical inputs at the preparation and planning phase***

- ✓ Adequate preparation of students prior to entry into a RACF clinical placement;
- ✓ A clear and realistic statement about the desired learning objectives together with information about assessment arrangements and the allocation of responsibilities and a briefing that explores expectations of students' role in the RACF setting;
- ✓ Clear information about student knowledge and skills and learning outcomes provided to the RACF;
- ✓ The need for clearer role and function definition, especially that of supervisors;
- ✓ Documentation of RACF and education provider roles and responsibilities;
- ✓ Information to students about the logistical organisation of the placement including (for example, transport and parking availability, site orientation, an introduction to site staff, details of the clinical teaching roles and responsibilities, arrangements for accessing clinical teacher/academic advisor, schedules for debriefing);
- ✓ Ensuring that adequate resources, including free time, are available for the supervisory/ teaching/ preceptor role.
- ✓ Provision of training in supervisor skills, where needed, and issues associated with access to training such as release and cost, and availability in some circumstances.
- ✓ Infrastructure and physical resources that are conducive to student learning (eg dedicated spaces for tutorials, lectures, feedback sessions etc).

#### ***Critical inputs at the implementation and evaluative phases***

- ✓ timely and objective feedback on performance;
- ✓ structured and regular opportunities to debrief and reflect during and after the placement;
- ✓ Promoting an understanding of the benefits for site staff from their involvement with the students and the training organisation.

At the broader **systems level** four key benefits have been identified in the literature:

- enhanced recruitment and retention is associated with TNHs that have effectively linked research, education and clinical care and achieved positive outcomes in all three domains;
- an enhanced profile is developed of the aged care sector as a location for clinical placement and ultimate employment, and an enhanced profile is developed for teaching and research focused on the care of older people and for education providers involved in these activities through a TNH;
- dissemination of TNH learnings to other RACFs can extend their impact and provide leadership for the aged care sector as a whole;
- prevention of hospitalisation and reduced length of stay in hospitals can arise from the increased capacity of RACFs to provide medical care and health prevention services (where the model has been extended to partner with acute care providers and/or has involved training and employing physicians in RACFs).

At the **service delivery level** (for both aged care and the education and training of the aged care workforce) a number of specific benefits and challenges have emerged from the literature review. These are discussed in detail in the report and are summarised below in terms of competing Incentives and Disincentives affecting the two key stakeholders – aged care service providers and aged care education and training providers.

### Benefits associated with a TNH

The research literature identifies a range of potential benefits and positive outcomes associated with Teaching Nursing Homes.

- The TNH model, with its focus on collaborative education and cooperation between clinicians, teachers, researchers, students and managers, can be designed to support **interdisciplinary** training for and delivery of aged care. This supports current directions in good practice in aged care.
- It can also play a role in addressing issues relating to the provision of **quality clinical education** opportunities, as this is one of its key purposes. Furthermore, the model supports effective working relationships between service and education providers and such relationships are critical to the design and delivery of clinical education. Evaluation has found evidence of improved learning conditions for students.
- The TNH enables faculty members to **identify practice issues, to research these and to feedback new knowledge into the education system**. By working within a RACF, the faculty member has the opportunity to enhance the quality of teaching, to identify research opportunities (including motivating aged care staff to undertake small scale research studies) and to improve patient care. Students benefit from being taught by faculty members with direct and recent clinical experience.
- **Enhanced quality of care** has been identified by researchers. RACFs and their residents have been found to benefit from the implementation of evidence-based practice and participation in clinical care focused research (for example, in the areas of continence management, falls prevention and wound management). In addition, improved decision making and care planning has also been identified in TNHs.



- Evaluation has found that **aged care staff's competence increases**, and RACFs share these learnings with other non-TNH facilities (for example, through conference presentations), thereby having a wider systems-level impact.
- The **profile of research into chronic illness and the specific needs of frail older people** may increase. Having access to high care need clients enables researchers to undertake controlled clinical trials. The United States TNH project sites funded by the Robert Wood Johnson Foundation were found to have achieved a five-fold increase in funded research activity. In turn, this contributes to increasing the education partner's standing in the academic community as a centre of excellence.
- The TNH can overcome ageist barriers to training and working in aged care, and instead generate **positive attitudes to older people and to working in aged care**, depending on positive clinical placement opportunities being enabled (that is, characterised by appropriate training and support in an environment focused on quality care).
- Evaluators have found marked **increases in TNH students taking up aged care post-graduate positions** and increased enthusiasm by participating staff to continue working in the facilities involved. **Recruitment and retention** have both been found to be facilitated by an effective TNH.
- Attitudinal changes have also been identified within schools of nursing participating in Teaching Nursing Home projects, noting a move towards **greater course content specialising in ageing and aged care, and increased clinical research and publications relating to care of older people** – all of which has a positive impact on students' attitudes to older people and to careers in aged care.
- Where the TNH collaboration has been extended to include local acute care hospitals, the model has been found to **prevent hospitalisation and reduce length of stay in hospitals** due to the increased capacity of RACFs to provide medical care and health prevention services.

### Challenges associated with the TNH model

The literature identifies more positive than negative outcomes arising from the TNH model. However, there are challenges associated with the model and there is a need to address these in both the planning and implementation phases of a TNH.

- There are a number of **ethical and legal issues** associated with a TNH. A key challenge for TNHs is balancing the rights of patients with the research and publishing requirements associated with teaching and education. There are also a range of ethical issues associated with undertaking research with residents of RACFs, particularly those with high level care needs and/or those not able to provide informed consent. In addition, the duty of care requirements of aged care providers and their legal liabilities mean that relatively untrained students can present a risk to fulfilling those requirements without specific supervision, orientation and other measures. Such issues require clarification in developing a teaching nursing home and underscore the importance of a formalised agreement between affiliation partners.
- A number of **disincentives** to participating in a TNH exist **for aged care providers**. Participating in a TNH involves four major challenges, the first three of which require dedicated resourcing in order

to be managed. The fourth involves a tension that will impact differently depending on the individual.

- The workload involved leads to reluctance by aged care providers to accept placements (in the absence of resources to enable them to do so).
  - There can be insufficient available aged care facility staff to mentor and supervise students.
  - It cannot be assumed that aged care providers will have the supervisory skills required, and hence resourcing is needed to provide access to training and associated costs (such as backfilling). Inappropriate physical infrastructure can also constrain the capacity for supervision.
  - An ongoing challenge has been found in pursuing two very different roles (clinical care and education/training) simultaneously.
- **Disincentives** also exist for **education and training providers**. Four main challenges have been identified that relate specifically to clinical placement.
- There is an ongoing trade off between the learning requirements of students and the need to find sufficient clinical places to meet the accreditation requirements of different professions.
  - The matching of students to placements requires significant individualised attention that education providers are increasingly unable to provide, and there is considerable potential for mismatch.
  - The complexity of the health and education and training sectors brings administrative and financial challenges in negotiating clinical placements.
  - Education and training providers have found that their clinical responsibilities at the affiliated RACFs conflict with their teaching and research responsibilities and the need to pursue these for tenure purposes.
- **Managing different cultures, capacity and expectations** is another challenge that faces any collaboration, including a TNH. Aged care providers and education and training providers operate in different environments, with different cultures and different sets of skills and experience. Combining these differences can bring significant benefits arising from the diversity of capacity involved, but the literature has also identified that those differences can cause difficulties if they are not addressed. In particular, there is a need to ensure that partners understand each other's goals, operational issues, expectations, career goals and experience in working with older people. Without a process to address gaps in this knowledge, difficulties will be faced as partners attempt to reconcile divergent roles. The issue of **communication** becomes extremely important in ensuring that different organisations with differing cultures, modes of operating and experience can work effectively together. The need for organisational stability and **continuity** of personnel has been identified by several other studies reviewed.

### Enablers of the TNH model

There are a number of factors that can be considered to be enablers of the TNH model. There was a trend in the research reviewed to identify the following ten:

- ✓ A number of features of *good practice in clinical placement* in aged care settings (of which there are many sub-features that also acts as enablers).
- ✓ *Attention to the planning stage* of the TNH.
- ✓ *Formalised affiliations* between those involved.

- ✓ *A shared commitment* by TNH partners to the goals of such a model.
- ✓ *Informed participation* by TNH partners.
- ✓ *Mutual understanding* by TNH partners.
- ✓ Ensuring that *clinical practitioners* are available to provide supervision and training for students.
- ✓ An *interdisciplinary focus* that supports a holistic view of care for older people.
- ✓ Choice of RACF sites with *sufficient critical mass* to offer diversity of learning experiences.
- ✓ *Appropriate physical infrastructure* for on-site training and education.

### Resourcing to support a TNH

Collaborations of any kind require skills, commitment to a shared purpose, and a significant investment of time – especially in the early stages when those involved are learning about each other’s operating conditions, drivers and constraints, and thereafter to ensure that the collaboration is sustained. It is difficult to achieve this without dedicated resourcing, and to meet other features of a TNH which the research literature has identified as essential. These involve:

- Education/training provider staff to train and support RACF staff (eg in supervision and teaching skills) and to visit the facility regularly.
- The RACF needs to backfill when their staff are providing training and support to students, or participating in meetings with their education partner.
- Supervisor training and resourcing is a critical enabler of best practice clinical placement, and therefore, of an effective TNH.
- Provision of appropriate physical infrastructure to support the linking of clinical care, research and education.

The research findings indicate that the TNH model holds significant potential to bring about enhanced quality of aged care, education and training of the aged care workforce, and research to provide an evidence base for these improvements. The model can benefit individual participants and stakeholders, as well as the broader aged care and education systems. Much depends on how it is planned, resourced, implemented and evaluated. However, sufficient evidence exists about lessons learned to date regarding enablers and barriers and this information is readily transferable to the Australian context.

## 1 THE TEACHING NURSING HOME: ORIGINS AND FEATURES OF THE MODEL

The Teaching Nursing Home (TNH) is most simply defined as an aged care facility in which there exists synergy between clinical care, education and research (Katz *et al* 1995: 507).

### 1.1 ORIGINS OF THE TNH MODEL

The origin of TNHs is usually traced to the early 1960s - particularly in relation to veterans' nursing homes (see *Section 1.1.3*) and affiliated veterans' hospitals (Rubinstein *et al* 1990: 74) - being associated with efforts in the United States to improve knowledge about long term care of older people and to increase the number of qualified aged care providers. However, it was the provision of funding through two major programs in the USA during the 1980s that led to recognition and focus for this model.

The first director of the National Institute for Aging (NIA), Robert Butler, established a teaching nursing home program that was research based and designed to increase knowledge about the ageing process and disease prevention, through multidisciplinary collaboration. Originally oriented to medical training, the program was broadened to affiliate with nursing schools and was designed to provide clinical placements for undergraduate students, foster collaborative research, and encourage continuing education among nursing home staff (Chilvers & Jones 1997: 464; DEST 2004: 16; Neville *et al* 2006: 4 citing DEST 2004; Wallace *et al* 2007: 5). Although focused on improving aged care training, the NIA program's primary purpose was to stimulate clinical research in nursing homes (Mezey & Lynaugh 1989: 773) and in the process, to build an interface between the aged care system and university schools in the training of aged care professionals. **It is this research focus which was seen to distinguish a TNH from other nursing homes** (Aronson 1984: 451-452).

Butler described the TNH model as a powerful "*institutional resource*" providing an "*organisational focus for geriatric research and training*" (1981: 1435). These four goals were articulated for the NIA program, and all remain relevant in the current care system:

- I. Foster systematic clinical investigation of disease processes in older people and develop diagnostic techniques and methods of treatment specific to their needs.
- II. Train different professions in geriatric care.
- III. Establish a research base for improving care in nursing homes, designing community and clinical services that defer or prevent institutionalisation, and rehabilitating and rapidly returning patients to their own homes.
- IV. Devise and demonstrate cost-containment strategies (Butler 1981: 1436).

Interestingly, although focused on nursing homes, Butler was clear that the majority of care for older people actually occurs outside of this setting, and expected the program to provide learning opportunities that covered a range of needs and services, including preventive health care and health promotion. The TNH was thus conceived as a 'hub' for a range of in-house and outreach services, rather than an exclusive focus on residential care services. The elements of the vision Butler expressed are often identified in the subsequent literature as critical success factors (this will be explored later in this literature review – see *Section 3*).

In the five years from 1982 to 1987, the Robert Wood Johnson Foundation (a private organisation in the USA) also funded a similar initiative - the *Teaching Nursing Home Program* (TNHP). Taking its inspiration

from the model of educating medical students by providing clinical training in teaching hospitals, the Program was designed to pilot clinical training for nursing students in residential aged care facilities (RACFs) while promoting research and improved care within these facilities (Bronner 2004: 2). However, in contrast to the NIA initiative, its primary focus was on restructuring and enhancing clinical care. Where the NIA model focused on physicians and linked with medical schools, the TNHP focused on nursing and linked with nursing schools (Mezey & Lynaugh 1989: 773; Kaeser *et al* 1989: 38; Liebig 1986: 199, 213).

The idea for the model is attributed to Linda Aiken, a nurse who had returned to study and obtained a doctorate, and who became a program officer at the Foundation in 1974. She had seen the success of affiliation arrangements between medical schools and veterans' hospitals and she and her colleagues believed that nursing education would be significantly improved through similar associations with nursing homes, while the latter would benefit from the linkage of academic nursing with actual care (Aiken *et al* 1985: 198-199).

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### 1.1.1 TNHP GOALS

The TNHP had these eight goals, which like those of the NIA program, remain relevant today:

- Exemplify the hallmark of a nursing home professional learning environment.
- Aspire to create an environment that models a culture of learning.
- Seek to transform perceptions and images in academia and the community as the potential of nursing homes to provide exemplary care and foster quality of life.
- Educate tomorrow's leaders and workforce in institutional long term care.
- Promote interdisciplinary education and practice.
- Test and disseminate evidence-based practices.
- Promote culture change that focuses on person-directed care.
- Leverage existing resources to improve competencies of direct providers, nursing home leadership, and faculty (Mezey *et al* 2008: 10).

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### 1.1.2 FEATURES OF AGED CARE FACILITIES PARTICIPATING IN THE TNHP INITIATIVE

Co-sponsored by the American Academy of Nursing, and administered by the University of Pennsylvania's School of Nursing, the TNHP initiative received applications from 53 schools and from these, 11 were selected for the pilot. The successful schools of nursing worked with 12 nursing homes, which although diverse, shared these characteristics:

- Provision of a higher than average level of care (also found in Australian research by Robinson *et al*: 2008).
- Provision of a greater than average proportion of skilled nursing facility beds.
- Were larger than average in size.
- Had 24 hour registered nurse coverage.
- All except one were not-for-profit organisations (Bronner 2004: 5-6; Aiken *et al* 1985: 199; Mezey *et al* 1997: 134).

### 1.1.3 FEATURES OF TNHS IN THE VETERANS CARE SECTOR

A survey of TNHs operating in the veterans care sector in the USA (Rubinstein *et al* 1990), where the model has been evident since the 1960s and evolved independently of the NIA and TNHP initiatives, found that compared with 'standard' veteran aged care facilities, the TNHs had the following features:

- They were significantly larger in size.
- They admitted and discharged significantly more patients per occupied bed.
- They placed a significantly larger proportion of discharged patients in non-institutional community settings.
- Care costs were slightly, but not significantly, higher despite significant increases in levels of professional staffing and amounts of training provided.
- There was a trend for TNHs to have higher staff to patient ratios in a number of staff categories including nurses, nurse practitioners, clinical specialists, physician residents and social workers.
- TNHs were significantly more likely to be receiving coverage from medical and surgical staff at the adjoining veterans' hospital (*note: this involvement with an acute care provider has always been part of the veterans' TNH model*).
- Academic activities of all kinds were more common in TNHs than non TNHs. This included having in-service education programs, formal staff lectures, staff who publish in the professional literature and present at scientific conferences, and research activities of various kinds (Rubinstein *et al* 1990: 75).

### 1.2 KEY FEATURES OF THE TNH MODEL

It is difficult to establish clear definitions of the TNH from the literature, however, a number of writers support the following features and show agreement on the fundamental concept of this model and its **linking of the separate spheres of research, clinical care and education and training** (Chilvers & Jones 1997: 463). Citing early work by Mezey *et al* (1984), Wallace (1984), Ciferri & Baker (1985), Huey (1985) and Kaeser *et al* (1989) they identify the following characteristics of TNHs:

- An affiliation between nursing homes and academic institutions
- Having the goals of –
  - ⇒ Promoting quality patient care
  - ⇒ Increasing knowledge in the care of older people requiring long term care
  - ⇒ Educating health professionals regarding long term care of older people
  - ⇒ Reducing the gap between theory and practice through research
  - ⇒ Providing education and clinical experience for students (Chilvers & Jones 1997: 463-464).

The TNH model provides the opportunity for the aged care workforce to be trained in a setting designed to meet the needs of older people. The training of the workforce providing this care varies from one profession to another, but among health professionals the **setting** in which clinical skills and knowledge are developed has been more likely to be in an acute care environment, rather than an aged care facility.

Traditionally, residential aged care facilities (RACFs<sup>1</sup>) have not played a central role in clinical development, and have not been closely or formally linked with the education and training providers responsible for the certification and development of their workforce. However, care for older people occurs in a range of settings – their own homes, community based services and aged care facilities, and to a far lesser extent, in acute care settings (Liebig 1986: 196).

Geriatric care has been criticised for being taught in a fragmented way with the consequent need for a place where the elements of **geriatric theory and practice can be integrated**. The acute-care hospital is a poor setting for such integration; the nursing home is considered to be far more appropriate (Liebig 1986: 199). Older people stay for shorter periods in acute care than they do in community or residential aged care services. For the student undertaking a clinical placement, the aged care service offers an opportunity to work with older people over an extended period of time and in a setting designed with their needs in mind. If that aged care service offers a diversity of programs the student can experience a range of service provision modes and a wider spectrum of aged care needs. Refer to *Section 0* for detailed discussion of enablers of the TNH model, including providing an interdisciplinary focus (*Section 3.7*).

### 1.2.1 INTENDED BENEFITS OF THE TNH MODEL

In reviewing the literature, it is apparent that the model can also be understood in terms of its four key stakeholders and the intended benefits for each. These are summarised in *Table 1*.

**Table 1: TNH Stakeholders and the benefits offered to each**

Stakeholder	Intended Benefits
<b>Education/training provider</b>	Increased involvement in ageing research that is based on clinical experience in a RACF, and greater opportunity to provide high quality education and training.
<b>Aged care provider</b>	Increased involvement in research and exposure to clinical practices that enhance quality of care.  Increased professional development due to relationship with education provider.
<b>Students</b>	Enhanced learning opportunities based on clinical experience with an education and aged care provider affiliation committed to achieving greater quality of care, research and greater quality of education/training
<b>Residents (and their Families)</b>	Improved quality of care

There is an **interactive** effect between these sets of benefits as the TNH model is comprised of mutually influencing inputs. Benefits in one domain will enhance those in another - for example, a commitment to evidence-based clinical care supports and is supported by research that relates to the aged care environment and in turn, supports improved quality of care. Affiliated RACFs that achieve these

<sup>1</sup> This paper will use the term RACF to denote the different levels of care, high and low, in most residential aged care facilities today. The term 'nursing home' will be used in reference to the early TNH examples.

outcomes will be more attractive to students and potential and current workforce members than will RACFs without this profile.

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### 1.2.2 IDENTIFIED BENEFITS OF THE TNH MODEL

The research literature identifies a range of potential benefits and positive outcomes associated with Teaching Nursing Homes.

- The TNH model, with its focus on collaborative education and cooperation between clinicians, teachers, researchers, students and managers, can be designed to support **interdisciplinary** training for and delivery of aged care (Chilvers & Jones: 1997).
- It can also play a role in addressing issues relating to the provision of **quality clinical education** opportunities, as this is one of its key purposes. Furthermore, the model supports effective working relationships between service and education providers and such relationships are critical to the design and delivery of clinical education (NHWT 2009: 4; Robinson *et al*: 2008).
- The TNH enables faculty members to **identify practice issues, to research these and to feedback new knowledge into the education system** (Chilvers & Jones 1997: 466). By working within a RACF the faculty member has the opportunity to enhance the quality of teaching, to identify research opportunities (including motivating aged care staff to undertake small scale research studies) and to improve patient care (Layng Millonig: 1986). Students benefit from being taught by faculty members with direct and recent clinical experience. Evaluation of the model in Norway has found that aged care staff's competence increased, and that they shared these learnings with other non-TNH facilities. It also found evidence of improved learning conditions for students (Kirkevold 2008: 284).
- The **profile of research into chronic illness and the specific needs of frail older people** may increase. Having access to high care need clients enables researchers to undertake controlled clinical trials. The United States TNH project sites funded by the Robert Wood Johnson Foundation were found to have achieved a five-fold increase in funded research activity (Aiken: 1988). In turn, this contributes to increasing the education partner's standing in the academic community as a centre of excellence (Mezey & Lynaugh: 1989).
- The TNH enables the generation of **positive attitudes to older people and to working in aged care** when it provides positive clinical placement opportunities (that is, characterised by appropriate training and support in an environment focused on quality care) (Wallace *et al* 2007: 5; Neville *et al* 2006: 3-4). Providing a variety of clinical experiences with older people and grading those experiences, starting with the 'well elderly' and finishing with the care of the sick and critically ill, seems to promote interest in working with frail older people (Abbey *et al* 2006a: 15 citing Haight *et al* 1994; Spier & Yurick 1992). Timing of the placement can also be critical to achieving this outcome, with negative views of aged care likely to develop if students are placed before they have developed advanced skills or knowledge, or if they are unable to access clinical settings where they can observe best practice in aged care (Neville *et al* 2006: 2).
- Attitudinal changes have also been identified within schools of nursing participating in Teaching Nursing Home projects, noting a move towards **greater course content specialising in ageing and**



**aged care, and increased clinical research and publications relating to care of older people** – all of which has a positive impact on students' attitudes to older people and to careers in aged care (Gamroth 1990: 151; Lindemann 1995: 79).

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### 1.2.2.1 INTERNATIONAL FINDINGS ABOUT TNH BENEFITS

International experience confirms that the above intended benefits have been translated into outcomes.

**USA** and **Australian** research studies have found TNH programs have resulted in –

- a marked increase in students taking up aged care post-graduate positions (LeCount 2004; Leppa 2004; Trossman 2003; Hollinger-Smith 2003; Burke & Donley 1987);
- implementation of evidence-based practice and participation in research in the areas of continence management, falls prevention and wound management (Kethley 1995: 99; Lindemann 1995: 79; Wallace *et al* 2007: 7 - citing Quinn *et al* 2004; Trossman 2003; Popejoy *et al* 2000; Mezey & Fulmer 1999).

Evaluation of the outcomes of the TNH model in the **Netherlands** has identified the following:

- enhanced quality of care in RACFs;
- provision of an ongoing patient-doctor relationship of the kind associated with general practitioners (this model was focused on physicians and located them in nursing homes);
- improved decision making and care planning;
- prevention of hospitalisation and reduced length of stay in hospitals due to the increased capacity of RACFs to provide medical care and health prevention services (Hoek *et al* 2003: 248).

Evaluation of the TNH model in **Norway** identified these positive outcomes:

- increased aged care staff competencies;
- increased quality of care;
- dissemination of TNH learnings to other RACFs thus extending impact and providing leadership for the aged care sector (the Norwegian application of the model established a network of TNHs, one in each region in order to achieve systemic change);
- improved learning conditions for students;
- increased enthusiasm by participating staff to continue working in the facilities involved (Kirkevold 2008: 284-285 and citing Hagen *et al*: 2002).

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### 1.2.3 GUIDING PRINCIPLES FOR A TNH

Important to the TNH model and its successful implementation, is a clear set of guiding principles that are accepted by both partners. Research undertaken by Mezey *et al* (2008: 10) has identified the following nine principles:

- Quality of care and quality of life for residents
- An ethical learning affiliation/partnership
- Mutual accountability
- Shared and sufficient resources to support the goals of the TNH
- Valuing, supporting and disseminating best practice learnings arising from the affiliation

- Reciprocity between partners – reflected in a formalised affiliation (that includes structures such as joint decision making and conflict resolution)
- Meaningful research, teaching and clinical roles are supported
- Commitment to transparency and quality improvement.

An Australian example of the TNH model, with the benefits its partners have identified, follows below in **Case Study 1 – Section 1.2.4**. This case study also illustrates the positive outcomes that can emerge when aged care research and practice are linked, with each informing the other – in line with TNH goals.

#### 1.2.4 CASE STUDY 1: ACU NATIONAL & RSL LIFECARE -EVIDENCE BASED ENHANCED CLINICAL CARE

##### **Case Study 1: Linking research, education and aged care**

###### **Affiliation partners: ACU National and RSL LifeCare**

The affiliation between RSL LifeCare and Australian Catholic University (ACU National) has been in place since 2004. RSL LifeCare is a not for profit organisation that is based in Narrabeen, New South Wales and now is a large provider of care for some 4,000 older people from the veteran community, delivering services across a continuum of care and for a wide range of needs.

There were a number of drivers for this affiliation. RSL LifeCare had long recognised the importance of providing learning opportunities for its staff as part of their employment, and access is provided for them to a range of programs delivered by a variety of education providers. There was also a goal to build upon clinical placement arrangements for undergraduate students and to develop research that would ultimately yield benefits for the veteran and wider community. A TNH model offered the mechanism to achieve these goals.

Negotiations were undertaken with ACU National that focused on developing a ‘full teaching and research partnership’ through the vehicle of an endowed chair. In mid 2005 the RSL LifeCare Chair of Ageing was established and Dr Tracey McDonald was appointed Professor of Ageing. The Chair is fully funded by RSL LifeCare, and is leading the development of a unique model of registered nurse practice in the aged care setting, the researching of links between residents’ quality of life and their functional capacity within an allied health therapy program. Additional areas of focus include mental health assessment and training of staff and students, effective communication with people with dementia, feeding and positive mealtime experiences for people with advanced dementia, wound care, falls prevention and injury reduction in confused older people, and the effects of recreation programs on sleep patterns.

The appointment of the Professor of Ageing has significantly extended RSL LifeCare’s links to the research community, both in Australia and internationally. For example, there are research based links to the University of Sydney’s Departments of Psychology and Rehabilitation, and the University of Technology Exercise Science Department. Industry linkages have also been established with aged care peak bodies and national nursing peak organisations. Internationally, links have been made with the United Nations Social Policy Division, with involvement in policy development on social integration and in implementing the Madrid Plan of Action on Ageing.

The affiliation provides a range of clinical learning opportunities for undergraduates in fields that include palliative care, mental health, community health, health promotion and rehabilitation, gerontology and sub-acute care nursing. Students have provided positive evaluative feedback about these opportunities. The learning needs of staff are also addressed. For example, a fully funded Graduate Certificate in Aged Care Nursing was offered to 12 RSL LifeCare registered nurses who completed their studies at ACU National in 2005, with two of these graduates then graduating with a Master of Clinical Nursing degree in 2008. The Chair of Ageing also provides supervision for Ph D students who conduct their research at the RACF.

Acknowledging that the costs to the RACF are substantial, the Board of RSL LifeCare has nevertheless committed to an eight year contract to fund the Chair of Ageing fully at around \$300,000 per annum (covering the cost of the Professor's appointment and that of a research assistant, plus various IT related inputs) with an option to review and renew the partnership for a further five years from 2013. Long term commitment of this nature supports innovation and a confidence to explore and trial better approaches to care. RSL LifeCare also considers that the benefits that can and are being achieved justify the investment being made. These benefits are documented in its strategic planning processes, and include the following:

- Focusing research on the health, care and treatment of older war veterans
- Establishing and sustaining RSL LifeCare as a leading aged care organisation
- Being regarded by staff as an employer of choice, with this being reflected in retention rates
- Being viewed positively by existing and incoming residents and their families, and the wider community.

The affiliation also sources funding from a range of other sources including the Department of Health and Ageing, the wider aged care industry, and charitable sources. A significant amount of expenditure has also been allocated to developing teaching physical infrastructure, including wireless connectivity throughout the RACF and providing students with laptops.

From the perspective of the University, the affiliation is seen as bringing a range of benefits in relation to its teaching and research activities, with a functional link in place between the RACF and the Faculty of Health Sciences. For both partners, the affiliation offers the opportunity for evidence-based improvement in capacity.

The achievements of the affiliation are reflected in RSL LifeCare receiving multiple national awards for its provision of care.

**Source: Interview with Prof Tracey McDonald and written case study information provided by RSL LifeCare.**

### 1.3 VARIATIONS OF THE MODEL

**Although there are certain 'core' features of the TNH model, its application can be expected to vary with local conditions, the expertise brought by its partnering organisations, and the needs of students and residents. For this reason, a 'one size fits all' approach is not appropriate to the implementation of the model.**

In reviewing different applications of the TNH model, Chilvers and Jones identified that typically the affiliation involved RACFs and either schools of nursing or schools of medicine (1997: 464), but that the method of affiliation appeared to be influenced by **financial** resources (citing Cifferi & Baker 1985 and Kaeser *et al* 1989). This has been found to produce two approaches – the one with funding involving *joint appointments* between the RACF and education provider and the one without such resourcing adopting an *exchange* approach. These two approaches were found to predominate, but with variations to each (Budden 1994; Layng Millonig 1986).

Exchange models have tended to operate informally and with limited funding support (Chilvers & Jones 1997: 466; citing Ciferri & Baker 1985). For a period of time, faculty members may work exclusively in the RACF and a member of the RACF staff works exclusively within the faculty. Roles are clearly defined with the faculty member responsible for the care of, and generating research opportunities, from a case load. The faculty member may provide a role model and catalyst for research, but the sustainability of this role is likely to be limited once the faculty member has left the RACF (Chilvers & Jones 1997: 466; citing Wykle & Kaufmann 1988). The main benefit of this approach is that it enables faculty members to identify practice issues, to research these and feedback new knowledge into the education system (Chilvers & Jones 1997: 466).

Most of the TNH models involve partnerships between university schools of nursing and RACFs, but some also include acute care hospitals (which has been the model of veteran specific TNHs since the 1960s – as discussed in *Section 1.1.3* (Rubinstein *et al*: 1990). See also *Section 1.4.1* describing the Netherlands application of the TNH, which also appoints physicians as part of the RACF workforce (rather than as visiting specialists). **Case Study 2 - Section 1.3.1**, exemplifies such a collaboration and is also unique by providing specifically for the needs of residents’ families. As such the collaboration also included social work practitioners and had a stronger multidisciplinary focus than many TNHs funded by the TNHP.

### 1.3.1 CASE STUDY 2: INCLUDING ACUTE CARE HOSPITALS AND FOCUSING ON FAMILIES, AN OHIO AFFILIATION

**Case Study 2: Extending the partnership to include acute care hospitals, and providing a focus on families**

**Affiliates: Carroll Manor & the Catholic University of America School of Nursing, Ohio**

**Funder: Robert Wood Johnson Foundation Program: Teaching Nursing Home Program (TNHP)**

Those involved in implementing the affiliation between Carroll Manor and the Catholic University of America School of Nursing found that six years after its initiation, the TNH project had been a catalyst for change bringing about the following –

- ⇒ Where previously attracting nursing students into aged care had been difficult, students competed for clinical placement at Carroll Manor.
- ⇒ A Research and Education Committee comprising nursing home staff, residents and school of nursing faculty was established to approve proposals for student placement and for clinical research at the facility.
- ⇒ The focus on research had seen facility staff increasingly using scientific methods in their work and early indications that research was enhancing decision making.
- ⇒ This TNH model also provided for the needs of family members of residential aged care facility clients. A program known as ‘*Family Circle*’ combined nursing and social work activities providing information, education and support to families. This interdisciplinary initiative also provided learning experiences for students on placement.
- ⇒ The collaboration was extended to include a local hospital which had provided the nursing home with greater access to a range of services, supported closer working relationships between physicians and nurse practitioners associated with the TNH. This had the broader impact of increasing the facility’s capacity to provide skilled care than would otherwise have occurred in a hospital (Burke & Donley 1987: 37-39; Donley 1986: 78).

#### **Critical Success Factors**

Retrospective analysis has identified these factors as being crucial to this TNHP affiliation. These factors are somewhat interdependent.

- ⇒ Broadening of the collaboration to *include a local hospital* which increased access to services and supported a wider range of working relationships.
- ⇒ The *appointment of nurse practitioners* to work with facility staff, students and physicians from local health services and the participating hospital.
- ⇒ *Commitment by stakeholders at all levels* – from senior management to front line delivery and teaching staff – to the TNH and its underpinning principles. These included valuing research and education as a means to improving nursing care of older people and supporting the rights of older people.
- ⇒ Expression of that commitment in a *formal agreement that specified mutual responsibilities and roles* (Clarke & Walsh 1988: 282-283; Burke & Donley 1987: 37-39; Donley 1986: 76-77).

**Sources:**

Burke, M & Donley R (1987) The educational experiment, a teaching nursing home, *Jl of Gerontological Nursing*, 13(1) 36-40

Clark H & Walsh M (1988) The linkage that worked: The Catholic University of America/Caroll Manor Teaching Nursing Home, *Jl of Nursing Education*, 27(6) 282-284

## 1.4 OTHER INTERNATIONAL EXAMPLES OF THE TNH MODEL

There are few other international examples of the TNH model in the literature reviewed. However, models which yield valuable lessons for Australia were found in the Netherlands and in Norway.

### 1.4.1 THE TNH IN THE NETHERLANDS – PHYSICIAN FOCUSED APPROACH

The Netherlands is identified as being the only country with a separate discipline of nursing home medicine as a medical speciality with its own training program (Hoek *et al* 2003: 244). This tradition has had a clear influence on the application of the TNH model in this country.

Prior to 1990, medical care in nursing homes was provided through general practitioners, but the increasing complexity of patients' health issues and general awareness of the need for specially trained physicians saw the introduction of a new medical speciality with a two year training program in nursing home medicine, the majority of which was delivered in nursing homes. This also led to the establishment of three Chairs in Nursing Home Medicine in the Netherlands and nursing homes employing physicians trained under this program as core (rather than visiting) staff (Hoek *et al* 2003: 244-245).

This approach has simultaneously seen the evolution of Teaching Nursing Homes that involve university schools of medicine providing the medical care in nursing homes training program and being selected and authorised by the Royal Dutch Medical Association. In the two decades since its implementation, this model has seen a growth in nursing homes employing these physicians and progress in the research associated with it. The initiative is seen as enhancing quality of care of nursing home residents, providing an ongoing patient-doctor relationship of the kind associated with general practitioners, improved decision making and care planning, and enhancing medical care in RACFs. Although employment of these specialists by nursing homes results in higher care costs, it is also considered to be offset by the prevention of hospitalisation and reduced length of stay in hospitals due to the increased capacity of TNHs to provide medical care and health prevention services (Hoek *et al* 2003: 248).

### 1.4.2 THE TNH IN NORWAY – THE NETWORK APPROACH

The Norwegian TNH program (NTNH) was implemented to address a similar set of issues that have been identified in the US aged care system (see *Section 1.4.2*). These involved concerns about the quality of care in RACFs, difficulties in recruiting qualified staff and high turnover of staff, the poor image of careers in geriatric care and under-developed collaboration between education and aged care providers (Kirkevold 2008: 282).

As in Western countries like the USA and Australia, strong links existed between medical schools in universities and the hospital sector to facilitate medical research and education, with this being represented in teaching hospitals. However, there was little collaboration between education and aged care providers to strengthen research, clinical practice and education for the care of older people. The

NTNH was thus developed to improve the education and recruitment of nurses in aged care and to support the professional and clinical development of existing aged care staff (Kirkevold 2008: 283).

The implementation of the model differed from those in the USA, with the government department responsible for health and aged care administering the program and establishing one TNH per region in Norway and one in the northern most part of the country to support the indigenous Sami people. In this way a national network of TNHs was established, and these meet several times a year to exchange information and support each other.

As discussed in *Section 1.2.2.1*, evaluation (local and national) has found that the NTNHS increased aged care staff competencies, increased quality of care, disseminated models of care outside of the network thus extending impact, and improved learning conditions for students. There was also evidence of increased enthusiasm by participating staff to continuing working in the facilities involved. These findings led to the Norwegian government establishing TNHs as a permanent part of the education and aged care sectors, under the leadership of the Department of Health and Social Services. Their continued success is attributed to this government support and its fostering of a network of TNHs which in turn provide leadership for the aged care sector (Kirkevold 2008: 284-285 and citing Hagen *et al*: 2002).

## 2 THE TEACHING NURSING HOME: CURRENT CONTEXT IN AUSTRALIA

The adoption of the TNH model in Australia has been largely triggered at government level by the need to address a range of issues in relation to the aged care workforce. At the level of aged care workforce education and training, and aged care delivery, a number of affiliations between these two sectors have evolved at the local level, driven by the incentive of improving workforce training and education (particularly the clinical placement component) and enhancing the quality of care delivered. Examples of these are provided in **Case Studies 1, 3, 4, 5, 6 and 7** and these were also the subject of detailed interviews being undertaken as part of the scoping study, of which this literature review forms one component.

The TNH model supports effective working relationships between service and education providers and such relationships are critical to the design and delivery of clinical education (NHWT 2009: 4). Given the shared responsibility for clinical education across the health and education and training sectors, mechanisms for effective engagement between the sectors are critical (NHWT 2009: 5).

**Effective clinical education for undergraduate students is not a task for any one agency: it takes two, bound by a well nurtured and constantly developing commitment to a partnership that is seen as delivering tangible benefits to all parties (Abbey et al 2006: 34).**

Research findings from a series of recent Australian studies – *Making Connections* (Robinson et al: 2002), *Building Connections* (Robinson et al: 2005), and *Modelling Connections* (Robinson et al: 2008) – see *Section 2.3.3, Case Study 3* - strongly support the TNH model as a means of providing best practice clinical placement in aged care settings and thereby enhancing the training capacity of the aged care sector as a whole.

**... the opportunity now exists to raise the training capability of the aged care sector by: instituting or renewing, enlarging and enhancing partnerships between the industry and the education bodies; moving the clinical placement experience, now something of a 'cottage industry', into the realm of structured, planned, resourced, education delivered through a collaborative quasi-contractual arrangement underpinned by an evidence-based model backed by careful planning and preparation, accountability mechanisms, appropriate staff selection and recurrent training regimes.**

**There is an urgent need to develop a robust and transferable model to facilitate quality clinical placements in aged care. The establishment of teaching nursing homes is central to supporting the implementation of the model and the development of an associated evidence base (Robinson et al 2008: 2, 4).**

### 2.1 AGED CARE WORKFORCE ISSUES: POTENTIAL RELEVANCE OF THE TNH MODEL

An unpublished report to the Aged Care Workforce Committee (ACWC: 2000) identified a number of strategies to improve nursing homes and facilitate the recruitment and retention of nurses in aged care, including the development of teaching nursing homes affiliated with a university. This approach was seen as attracting more qualified nurses to residential aged care facilities (RACFs) via clinical placements, enhancing the professional standards of RACFs, and increasing opportunities for RACF staff in continuing education and professional development (DEST 2004: 16).

This finding from the ACWC was reflected again in the report of the review commissioned by the Commonwealth Department of Education Science and Training (DEST). This review focused on nursing training in the aged care industry and identified a range of issues inhibiting this training, including difficulties faced by aged care providers in acting as clinical instructors for nursing students on placement with them. It was suggested that one way of addressing this challenge was to develop 'teaching' nursing homes as a model of practice (DEST: 2004). Apart from supporting greater collaboration between education and aged care providers, it was also recognised that incentives were needed to attract nurses to postgraduate courses, as was the need for employment of more aged care nurse specialists in universities and an increased emphasis on aged care in the undergraduate curriculum (Nay & Garratt: 2005; Neville *et al*: 2006: 3).

Both the ACWC and DEST reports incorporated findings from a literature review of teaching nursing homes that was undertaken by Chilvers and Jones (1997). The authors concluded that the concept of teaching nursing homes offered significant potential, both in terms of nursing education, and also in raising the profile of aged care.

Among the strategies identified in the literature to improve the education and training of nurses in aged care, the further development of collaboration between educational institutions and aged care facilities was highlighted as a key issue. In doing so, and encouraging the development of teaching nursing homes, a number of benefits were considered to be possible. These include further professional input for nursing curricula (Joy, Carter & Smith, 2000), improved opportunities for quality clinical experiences for nursing students and potential for greater recruitment (ACWC, 2000), opportunities for nursing homes to establish best practice based upon advancements in research and knowledge in the universities, and improvements in the status of aged care (DEST 2004: 15).

The relevance of the TNH model is apparent in the broader agenda of aged care workforce reform, and the challenges it addresses are briefly overviewed here. Workforce ageing and the recruitment and retention of qualified staff is a key issue for the sector which is characterised by low status (largely driven by ageist attitudes), relatively low pay rates, and high rates of turnover (Productivity Commission 2011: 270-271; O'Connell *et al* 2008: 412; DEST 2004: 26, 33, 34 citing Stein, Heinrich, Payne & Hannen, 2000; Macri 2000). The Productivity Commission (2011: 270-271), reflecting the views of the aged care industry as a whole, has identified the need for continuing skill development and promotion of career paths for workers as their skills develop and their careers progress.

In addition, there are insufficient incentives and opportunities for aged care staff in continuing education and professional development. This is seen as exacerbating recruitment and retention challenges. The TNH model, through its partnering of aged care and education providers, can address this issue for those involved in such an affiliation, and may provide leadership for wider industry opportunities.

**Currently, ... inconsistency exists in the recognition of advanced education and training. This inconsistency means that there are few incentives for nurses to pursue advanced education and training. A structured and well understood education and training profile in aged care will increase work satisfaction and could be an important marketing tool in recruitment (DEST 2004: 44-45).**

The Commission noted the limited number of specialist 'teaching aged care facilities' and that student clinical placements in aged care facilities had scope for improvement (2011: 369). The Commission identified the potential offered by the TNH model in providing positive placement experiences which significantly affect students' attitudes towards older people and the aged care sector as a potential



graduate destination as well as supporting a ‘much needed program of research’ (citing Abbey *et al* 2005; Robinson and See, Submission #231).

**The Australian Government recently announced it will support the establishment of teaching nursing homes over four years<sup>2</sup>. The Commission supports the direction of this commitment but considers the non-ongoing nature and the relatively small level of funding to be inadequate to address current and future workforce shortages in the sector (2011: 370).**

Noting the existence of a number of TNH models in Australia, the Commission further commented:

**Although these programs are only relatively new, submissions indicate that they have increased the recruitment of graduate nurses into the aged care sector and improved the variety of options available to registered nurses upon graduation (2011: 370).**

An earlier investigation by the Productivity Commission (2005) into the health workforce informed the formation of Health Workforce Australia, a cross sector national body with a key role in workforce reform and innovation (see *Section 2.2*).

## 2.2 GOVERNMENT INITIATIVES TO SUPPORT IMPROVED CLINICAL EDUCATION

A key challenge for the aged care industry, and for all industries, is designing education and training programs to maximise the development of professional competencies. For the health and aged care industries, this is usually referred to as ‘clinical education’ which can be defined as –

**... the training component that is undertaken in a clinical setting (broadly defined) for the purposes of building practical competencies relating to clinical practice.... clinical education is defined as compulsory placements in health and health related services, that are intended to ensure students attain the competencies that cannot otherwise be attained in a formal education setting (NHWT 2009: 2).**

The Australian Government invested \$157 million in clinical teaching and training infrastructure for undergraduate health professional students in 2010. This included an allocation of \$90 million for *Innovative Clinical Teaching and Training Grants (ICTTG)* over the four years from 2009-10 for capital projects that support health professional students and trainees across a range of health disciplines. The ICTTG Initiative is a key component of the Council of Australian Governments’ (COAG) commitment to investing in health workforce infrastructure. The grants support innovative approaches to addressing the increase in numbers of people undertaking health professional training and education; improved distribution and capacity for teaching and clinical training outside tertiary hospitals; and in settings not normally considered for Commonwealth funding. The Initiative is also designed to ensure that students and trainees have access to high quality facilities, especially in rural and regional areas. Joint proposals were sought from educational institutions and clinical training providers in both public and private health sectors (Media Release from the Minister for Health and Ageing, the Hon Nicola Roxon, 11/12/09).

A range of other initiatives have also been implemented in recent years. For example, in some states and territories, networks of health services were established to plan and negotiate postgraduate clinical

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<sup>2</sup> Australian Government Budget 2010-2011, Budget Paper # 2

training, and all states and territories have initiated systems development to better manage clinical placements (NHWT 2009: 9).

The **National Health Workforce Taskforce** (NHWT) was a national body created under the Australian Health Ministers' Advisory Council (AHMAC) committee structures, reporting directly to the Chair of AHMAC's Health Workforce Principal Committee to undertake projects informing workforce reform and innovation, and clinical education was a significant part of this program. Following a COAG announcement in November 2008, the NHWT and its work program was subsumed by a new national agency – **Health Workforce Australia** (HWA). This was conceived as operating across the health and education sectors, complementing jurisdictional responsibilities, and with governance arrangements to ensure a national approach.

HWA has implemented a number of initiatives designed to enhance clinical education. These include the *Clinical Supervisor Support Program* which aims to expand clinical supervision capacity and competence, and the *Clinical Training Funding Initiative* which includes a national network of *Integrated Regional Clinical Training Networks* (HWA 2010: 6). As announced by Health Ministers on 22 April 2010, a significant expansion of clinical training capacity for health and medical professionals is underway as part of the \$1.6 billion *Hospital and Health Workforce Reform National Partnership Agreement* announced by COAG in November 2008.

## 2.3 ISSUES ASSOCIATED WITH CLINICAL EDUCATION IN AGED CARE

Clinical placements are central to the education and training component of TNHs, and they bring a range of challenges which are well documented in both the peer reviewed and grey literature.

The National Health Workforce Taskforce (2008a: 5) and the Productivity Commission (2006: 100) have both identified the absence of a data base that quantifies clinical training load, distribution and any under-utilised capacity. This has inhibited analysis of issues relating to the planning and equitable resourcing of clinical education.

Apart from challenges associated with **supply and demand** for clinical education, and the **gap in data** to inform this, there are also **governance issues** that operate at different levels. The Federal Government, through the Dept of Education Employment and Workforce Relations (DEEWR), has primary responsibility for funding the higher education and VET sectors through an agreed number of places in set discipline clusters. In the case of medicine, new places are jointly determined by the Minister for Education Employment and Workplace Relations and the Minister for Health and Ageing. The provision of clinical placements is part of State and Territory Governments' responsibility for delivering public health services. They also contribute to VET (vocational education and training) funding (NHWT 2009: 2-3). The TNH model adds a further level of governance arising from the agreement made between participating education and training providers and aged care facilities. Historically, these arrangements depend on individual relationships, some of which have existed for many years. As such, they are highly variable and this contributes to a **lack of consistency** in clinical education provision (NHWT 2009: 6).

Clinical placements in hospitals and health and aged care services also involve a significant **cost** to those services, but that cost has not been accurately quantified and is difficult to quantify (NHWT 2009: 4). However, without dedicated resourcing and as demand pressures on health services increase, their capacity to support clinical training is constrained (NHWT 2009: 4).

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### 2.3.1 SYSTEM-LEVEL ISSUES

There are a number of challenges associated with clinical placement of health and aged care students, but the following three are of particular concern -

- The system suffers from the absence of a 'well integrated, purpose designed management information system' to coordinate and allocate placements.
- Different systems exist for clinical placement between schools, disciplines and jurisdictions, and these are neither linked, nor supportive of coordinated planning and resource management for clinical education.
- There is a lack of consistency in the education systems, standards and organisational practices which support health and aged care clinical education (NHWT 2009: 4-7).

A number of more specific challenges exist at the delivery level for both education providers and aged providers, and these need to be faced in implementing the TNH model. See *Section 4* for discussion of those issues.

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### 2.3.2 ADDRESSING NEGATIVE STUDENT ATTITUDES/AGEIST ATTITUDES/ NEGATIVE VIEW OF AGED CARE

A number of researchers have identified the barrier of ageist drivers of a negative view of aged care as a career – Xiao *et al* (2011) Abbey *et al* (2006); Fagerberg *et al* (2000); Beck (1996); Heine (1991); Manuel & Haussler (1994); Pursey & Luker (1995). A study that examined the impact of the clinical teacher (Fagerberg *et al* 2000) found that few in aged care were seen as able to inspire interest in the area. Furthermore, students perceived their clinical teachers as poor leaders lacking adequate medical knowledge (Abbey *et al* 2006a: 16). University staff have indicated that aged care staff tend to hold negative attitudes towards students, seeing them as a burden or challenge, and sometimes as a threat to their less trained staff members (Neville *et al* 2006: 20-21).

**Some students reported having gained the impression during their university studies that aged care nursing was not a demanding or attractive career option, not 'real nursing' but more a resting place on the path towards retirement .... Given the well-known bias in media representations of nursing towards critical and acute care, negative images of aged care held by role models within the university can only raise existing hurdles (Abbey *et al* 2006: 36).**

Conversely, recent studies have found that a positive clinical placement characterised by appropriate training and support in an environment focused on quality care, can produce positive attitudes to older people and aged care (Wallace *et al* 2007: 5). Robinson *et al* demonstrated a significant positive change in students' attitude following such clinical education (see **Case Study 3, Section 2.3.3**), indicating a possible interest in working in aged care following graduation (Robinson *et al* 2008: 101).

Placements designed as part of a course in gerontology appear to have the most positive impact on students' perceptions of elder care (Aday & Campbell 1995; Chen *et al* 2007; Burke & Donley 1987). Providing a variety of clinical experiences with older people and grading those experiences, starting with the 'well elderly' and finishing with the care of the sick and critically ill, seems to promote interest in working with frail older people (Abbey *et al* 2006a: 15 citing Haight *et al* 1994; Spier & Yurick 1992).

The literature indicates that much depends on the quality of the placement and how much positive encouragement for aged care is modelled from their university educators. Fagerberg *et al's* research

(2000) identified certain aspects of a placement as being likely to discourage students from seeking out a career in aged care, and this included working alone with no support or working in a setting with poor staffing and resource levels. Conversely, a positive clinical experience that addressed these factors and provided the opportunity to work with a range of residents with different needs and conditions was likely to encourage working in aged care (Neville *et al* 2006: 3-4).

US research studies have found that TNH programs resulted in a marked increase in students taking up aged care post-graduate positions (LeCount 2004; Leppa 2004; Trossman 2003; Hollinger-Smith 2003; Burke & Donley 1987), and the implementation of evidence-based practice and participating in research in the areas of continence management, falls prevention and wound management (Wallace *et al* 2007: 7 citing Quinn *et al* 2004; Trossman 2003; Popejoy *et al* 2000; Mezey & Fulmer 1999); (Kethley 1995: 99; Lindemann 1995: 79).

Attitudinal changes have also been identified within schools of nursing participating in Teaching Nursing Home projects, noting a move towards greater course content specialising in ageing and aged care, and increased clinical research and publications relating to care of older people – all of which has a positive impact on students' attitudes to older people and to careers in aged care (Gamroth 1990: 151; Lindemann 1995: 79). See *Section 4.6* for further discussion on the role of ageism as an inhibitor to the TNH model.

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### 2.3.3 CASE STUDY 3: QUALITY CLINICAL EDUCATION IN TASMANIA

#### **Case Study 3: The *Connections in Aged Care* initiative – Evidence-based approach to improving clinical education for aged care nursing**

**Affiliation: Tasmanian School of Nursing, University of Tasmania and various RACFs in Tasmania**

To date, there are three projects in this initiative.

**Project 1: Making Connections in Aged Care** began in 2001 when the School of Nursing collaborated with two aged care partners, the Park Group and Masonic Homes Launceston, which aimed to facilitate a positive experience for second-year undergraduate nursing students on placement in aged care, and in the process, to address students' negative experiences of aged care in order to promote the sector as a valued employment opportunity for graduates. It was also seen as a key strategy to facilitate the professional development of nurses already working in the sector."

Between 2001 and 2002 two cohorts of nursing students (n=26) involved in the study participated in three-week clinical placements in two RACFs, supported by nurse mentors (n=15). Using an action research methodology, students on placement and their mentors participated in weekly parallel meetings, where they explored their experiences (as mentor or mentee). A feedback loop between the two groups enabled participants to give non-threatening feedback on key issues. Prior to commencing the project mentors reported that they felt inadequate with respect to their capacity to facilitate student learning. However, participation in weekly Action Research Group (ARG) meetings helped both students and mentors to interrogate their practice and in the process develop, implement and evaluate strategies to foster teaching and learning. Participation in the research meetings represented the first time the mentors had the opportunity to explore issues in their practice. The project evaluation demonstrated a positive change in students' attitudes to working in aged care (36% on entry compared to 92% at completion of the placement), while their sense of feeling supported to learn was also enhanced. Further, the nurse mentors reported greatly increased confidence and capacity to effectively support students on clinical placement.

**Source: Robinson A et al (2002) *Making connections in aged care: the report on the residential aged care preceptor project*, Tasmanian School of Nursing, University of Tasmania in collaboration with the Park Group. Interview with Prof Andrew Robinson.**

### **Project 2: Building Connections in Aged Care**

The positive outcomes of this first project led the School of Nursing to seek funding from the Department of Health and Ageing to test the approach in other RACFs which had limited prior involvement with the university sector. The School received funding as a part of the Commonwealth Aged Care Nursing Scholarship Support Systems program.

The industry partners in Project 1 had a significant prior involvement with the School of Nursing and Midwifery and the second project sought to test the generalisability of the model and to develop quality clinical placements in aged care. Additional aims included developing sustainable support structures for undergraduate nursing students in practice within residential aged care; promoting aged care as an attractive working environment for student nurses; facilitating professional development among aged care nurses to increase their capacity to effectively support undergraduate students in aged care; developing linkages between the School of Nursing and the Tasmanian aged care sector; and building capacity in the participating RACFs to develop them as key sites for teaching and research in aged care in Tasmania.

The first phase of project 2 utilised a similar action research approach to that of Study 1 (above), while simultaneously scoping the issues that impacted on student learning to address identified deficits. The findings illustrated the limited capacity of RACF staff to effectively support students on placement despite their attempts to implement the program. They also highlighted students' lack of preparation for practice in aged care, inadequate orientation to the RACFs, poor learning experiences during the aged care placement, ill-informed support from mentors, and lack of opportunity to engage with residents over time, all of which had a negative impact. On entry, 50% of students indicated a possible/definite interest in working in the sector as an RN, but this figure did not improve on exit.

Phase 2 implemented a reconfigured program with a second cohort of students using the same methodology. Refinement included a comprehensive placement planning exercise, revision of information provided to RACFs by the university, development of a standardised orientation program, reconfiguring the placement to promote student continuity with both residents and mentors, and the development of resources to support student learning. These changes resulted in a marked improvement in student possible/definite interest (50% to 90%) in working in aged care. The percentage of students indicating a definite interest increased from 5% to 20% and those stating they were 'definitely not' interested decreased from 20% to 0%. Other changes included an improvement in orientation, student sense of feeling supported, and effectiveness of teaching and learning. It is notable that students also reported that having continuity with residents, rather than being rotated between areas within the RACF, increased opportunities for meaningful engagement. This challenged students' pre-existing ageist beliefs, with residents now being identified as the key 'draw card' to working in a facility. Staff also reported increased confidence as mentors, greater capacity to support students and facilitate teaching and learning, and that participation had improved the development of professional practice.

Phase 3 assessed the sustainability of gains achieved in the previous stage (above), where mentors implemented the model with a third cohort of students, with greatly reduced input from the research team. A subsequent follow-up evaluation involving both intervention RACFs and a control group (n=7) was then undertaken. The findings highlighted high-level sustainability in the context of limited research support and the vulnerability of RACFs to changing circumstances. A follow up study conducted at 6 and 12 months after the departure of the research team demonstrated that this improvement was sustained at 12 months post completion, with a significant difference between intervention and control groups.

Of note the above findings were consistent across settings despite significant heterogeneity between participating RACFs in terms of: (a) location (urban versus rural), (b) size (small <65 beds; to large >120 beds), (c) staffing/resident ratios (ranging from 2 RNs /65 residents per shift to 1 RN/120 residents per shift) (d) staff workloads, (e) intensity of care provision (high & low care) and availability of resources (stand alone and membership of a larger organisation). Further, the use of an action research method, which engaged participants as key players in the change process, was central to facilitating this level of sustainability. Participation in the ARG meetings encouraged mentors to develop insight into students' experiences, which in turn gave them the confidence to take on leadership roles to advance teaching and learning. It also enabled the development of a collaborative team ethic within the RACFs as well as the development of mentors' professional practice. At the same time students developed confidence in, and felt more supported by staff, appreciated enhanced opportunities for teaching and learning, and subsequently developed more positive attitudes to working in the sector.

**Source: Robinson A et al (2005) *Building connections in aged care: developing support structures for student nurses on placement in residential care: Final Report*, University of Tasmania. And Interview with Prof Andrew Robinson.**

### **Project 3: Modelling Connections in Aged Care**

In April 2005 a proposal was submitted to DoHA to conduct a four state demonstration project to develop a draft evidence-based /best practice model to facilitate quality clinical placements in aged care. The project received funding to undertake a systematic literature review, to consult with key stakeholders and collect base line data on the participating RACFs and develop a draft evidence based /best practice model (EBBPM) to facilitate quality clinical placements in aged care. The project established a research group in Queensland, South Australia, Western Australia and Tasmania, with each of these linked to a number of RACFs, and reporting to a Project Steering Committee. Quantitative and qualitative data were collected in late 2005 and early 2006.

The project aimed to: (a) determine the national applicability of findings from the two Tasmanian pilot studies, and (b) collate the evidence to develop the EBBPM. The project, conducted during 2005-6, involved undertaking the first systematic review of aged care clinical placements [33], and a program of surveys and focus group discussions with nursing students (n=52) and aged care staff (n=67) in 12 RACFs across the four states. Key findings included the following:

- The perception of a gap between academic preparation and clinical preparedness is recognised as a matter of concern to members of the public, government, the professions and students themselves.
- The systematic review revealed that there are no high level evidence-based models for undergraduate clinical placements in RACFs and that clinical education in nursing generally is informed by what is at best a low level evidence base.
- In the sphere of nursing, and most especially residential aged care nursing, the raising of the capabilities of student nurses has outstripped the quality of the clinical education and training available to them in the RACFs, not due to any failure of will or lack of commitment on the part of those involved. This was attributed to insufficient coordination between the education institutions and the sector and the residential aged care sector not being able to expand to meet the training responsibilities placed upon it.
- There is a need to provide clinical training opportunities that will encourage recruitment into the sector while fostering the interdisciplinary training needed.
- The training capacity of the aged care sector can be enhanced by: instituting or renewing partnerships between the industry and the education bodies; and redesigning the clinical placement experience as '*structured, planned, resourced*' education delivered through a formalised arrangement '*underpinned by an evidence-based model backed by careful planning and preparation, accountability mechanisms, appropriate staff selection and recurrent training regimes*'.

- The aged care workforce is inhibited by professional isolation and has a limited capacity for staff and student training, which may be exacerbated by a lack of training in the skills of preceptorship (that is, providing individualised training and support to students) and a failure to define teaching and supervision as falling within the scope of normal duties. Staff feedback identified a lack of adequate preparation for the experience and consequent anxiety about the ability to fulfil this role. Associated with this was concern about the added pressure on a demanding workload in a workplace that was often stressful; and feeling somewhat torn between the demands of students on placement and the needs of residents in their care.

**Source: Robinson A et al (2008) *Modelling connections in aged care: development of an evidence-based/best practice model to facilitate quality clinical placements in aged care, Report on Stages 1-3, Dept of Health and Ageing, University of Tasmania, Queensland University of Technology, University of South Australia, Edith Cowan University. And Interview with Prof Andrew Robinson.***

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### 3 ENABLING FACTORS

There are a number of factors that can be considered to be enablers of the TNH model. There was a trend in the research reviewed to identify the following ten:

- ✓ A number of features of *good practice in clinical placement* in aged care settings (of which there are many sub-features that also acts as enablers – these are discussed in *Section 3.1* and bolded in the text there and usually preceded by a ✓).
- ✓ *Attention to the planning stage* of the TNH.
- ✓ *Formalised affiliations* between those involved.
- ✓ *A shared commitment* by TNH partners to the goals of such a model.
- ✓ *Informed participation* by TNH partners.
- ✓ *Mutual understanding* by TNH partners.
- ✓ Ensuring that *clinical practitioners* are available to provide supervision and training for students.
- ✓ An *interdisciplinary focus* that supports a holistic view of care for older people.
- ✓ Choice of RACF sites with *sufficient critical mass* to offer diversity of learning experiences.
- ✓ *Appropriate physical infrastructure* for on-site training and education.

#### 3.1 ACHIEVING GOOD PRACTICE IN CLINICAL PLACEMENT

Consultation by Health Workforce Australia with a range of stakeholders, including Commonwealth, State and Territory Health Departments, health services (public sector, not for profit and private), accreditation bodies, specialist medical colleges, professional associations, and regulatory bodies has identified a number of areas requiring reform in clinical education, including:

- ✓ The need for clearer **role definition**, including better articulation of the role and function of supervisors and identification of generic core skills and competencies.
- ✓ The need for better **information about student knowledge and skills and learning outcomes**.
- ✓ The need for **training in supervisor skills**, and issues associated with access to training such as release and cost, and availability in some circumstances.
- ✓ The need to address the **tension between service delivery and supervision** roles.
- ✓ Constraints on **supervision capacity** imposed by infrastructure and physical resources and the need to provide incentives for supervisors.
- ✓ The need for explicit expectations and leadership around teaching and learning culture to embed clinical supervision as a core activity.
- ✓ The need to recognise, value and better support supervisors (HWA 2010: 10).

Literature searches have identified a scarcity of research on clinical experiences in aged care (Neville *et al* 2006: 2). However, recent Australian research yields valuable findings that have implications for the TNH model.

A study by Abbey and others (2006a) sampled the opinions of undergraduate nursing students and their clinical supervisors on the impact of clinical teachers, long-term care staff and the settings used, seeking any recurring themes that might indicate how these factors in Australian long-term care settings can incline students toward or against working in aged care on graduation. Participants in this study were critical of the way in which aged care was being taught, reflecting the findings of other Australian and overseas studies (eg Oberski *et al* 1999). In particular, inadequate **preparation** for aged care clinical



placements was a concern of both students and clinical teachers (see also *Section 3.2* for discussion on the importance of planning). One manifestation of this was students' reactions to the aged care environment which they found confronting. The study found that there was a need for **targeted preparation for aged care clinical placements and improved mentoring arrangements** (Abbey *et al* 2006a: 16-17).

The research goal of the *Modelling Connections* project (see **Case Study 3**, *Section 2.3.3*) was to produce for consideration a comprehensive evidence-based /best practice model stipulating all the ingredients needed for the introduction, maintenance and ongoing evaluation of quality clinical placements for undergraduate nursing students in aged care settings (Robinson *et al* 2008: 87). This project and research by Abbey *et al* (2006a) has identified a range of criteria of good practice in clinical placement, that are focused on nursing, but are transferable across professions and therefore of relevance to the clinical education component of the TNH model. These emphasise the **importance of the planning and preparatory phase** and a summary follows.

#### **Critical inputs at the preparation and planning phase**

- ✓ **adequate preparation of students** prior to entry into the RACF clinical placements was a frequently recurring factor in the evidence obtained;
- ✓ **a clear and realistic statement about the desired learning objectives** together with **information about assessment arrangements and the allocation of responsibilities** and a briefing that explores **expectations** of their role in the RACF setting;
- ✓ **information relevant to the logistical organisation** of the placement including (for example, transport and parking availability, site orientation, an introduction to site staff, details of the clinical teaching roles and responsibilities, arrangements for accessing clinical teacher/academic advisor, schedules for debriefing);
- ✓ **Documentation** of roles and responsibilities;
- ✓ Ensuring that adequate **resources**, including free time, are available for the supervisory/teaching/ preceptor role.

#### **Critical inputs at the implementation and evaluative phases**

- ✓ **timely and objective feedback** on performance;
- ✓ **structured and regular opportunities to debrief and reflect** during and after the placement;
- ✓ the **'cultivation of an understanding of what constitutes a stimulating and supportive learning environment'**
- ✓ **Promoting an understanding of the benefits for site staff** from their involvement with the students and the training organisation  
(Robinson *et al* 2008: 94-99; (Abbey *et al* 2006: 35-40).

It is also important to note that while the TNH model can increase the capacity of the aged care system to better prepare its workforce, the RACF is increasingly seen as a site for the clinical preparation of those, especially nursing students, who will ultimately work with older people, but not necessarily in a RACF environment (Xiao, Kelton & Paterson 2011: 3, citing the work of Chen *et al*: 2007, Brown *et al*: 2008 and Bernsten & Bjorklida 2010). Chen *et al*'s survey of 53 nursing schools in the US identified a range of advantages perceived to lie with locating clinical placements in RACFs, including the slower pace (relative to acute care settings) that allows students to learn from one on one teaching, opportunities to work with older people with complex needs, and the development of positive attitudes to ageing (2007: 909).

As Xiao and her colleagues point out, clinical placement in RACFs is characterised by two interrelated paradoxes. First, despite being specialists in aged care, they have suffered from not being regarded as a choice of placement (particularly for nursing training). Second, clinicians from RACFs have had less influence on gerontological nursing education compared to their colleagues from acute care settings. Dealing with these socially and historically constructed paradoxes is a challenge, and one that will affect TNHs (Xiao *et al* 2011: 5-6). The affiliation involving Xiao and others is presented in **Case study 4**.

### 3.1.1 CASE STUDY 4: PACE: GOOD PRACTICE IN CLINICAL EDUCATION

#### **Case Study 4: PACE (Partnership in Aged Care Education) - Improving clinical education for aged care nursing**

**Affiliation: Flinders University of SA and 5 aged care providers**

An equal partnership between the Flinders University of South Australia, School of Nursing and Midwifery, and five large South Australian aged care providers – Helping Hand Aged Care, Resthaven Inc, ECH Inc, Southern Cross Care and Bupa Care Services (involving a total of 8 sites) was developed to ensure quality clinical placements for 179 undergraduate nursing students (across three year-levels). Critical action research was adopted as its methodology thereby enabling its stakeholders to be both co-researchers and co-subjection, using a process of action-reflection.

In addition, multiple methods were used to collect data to support collaborative critical reflection. Stakeholders were invited to contribute to a quarterly Newsletter which was disseminated to all students, academics and nursing staff in the RACFs. The research fellow assigned to the project undertook weekly participant observations in student debriefing, focus groups were held and students were invited to voluntarily submit reflective learning logs (RLLs) on clinical learning. In addition, students and nursing staff were invited to participate in a self-administered evaluation survey of clinical placements in each semester.

The study sought ethics approval from the structures of both the university and the RACFs. Duration of clinical placement varied across year-levels – involving one week for first year students, three to four weeks for second years, and six weeks for third year students. The program included an on-site orientation day and tailored pre-clinical sessions for students.

Among the barriers to clinical placement identified were the lack of organisational structures, resources and guidelines to support and govern clinical teaching and learning. RNs also felt that they were under-prepared for supervising students. An on-site staff development program was developed for RN preceptors, supported by a project-designed Clinical Supervision Kit.

Consequently the PACE project developed a structure that included RN facilitators from the RACFs, academic facilitators (employed specifically to facilitate student learning) and teaching staff in nursing practicum topics to support student learning. In each participating facility a manager was appointed as a clinical convenor and RNs in each unit who work across shifts were appointed as preceptors for students. This ensured that students were supported in all shifts by either a nursing manager or an RN. Core documentation was developed to guide placements, covering clinical orientation, and roles and responsibilities.

Student evaluations showed that students were generally satisfied with their placements and that this satisfaction level increased incrementally (but was statistically significant) over the period of placement. Any problems identified in these evaluations were then addressed by the project Advisory Committee (for example, increasing the time allocated to debriefing students).

During the 30 month period of the PACE project the University in dollar terms, contributed approximately \$90,000 and each of the five RACFs contributed approximately \$10,000 each.

The PACE project addresses the enablers and facilitators of clinical education for the aged care setting identified in the research literature. It also supports the TNH model because it brings together the key stakeholders involved in the education and training of the aged care workforce.

Source: Xiao L, Kelton M & Paterson J (2011) *Critical action research applied in clinical placement development in aged care facilities*, *Nursing Inquiry*, forthcoming and Interview with Prof Jan Paterson and Dr Lily Xiao, and Interviews with representatives from each of Helping Hand Aged Care, Resthaven Inc, ECH Inc and Southern Cross Care.

### 3.2 ATTENTION TO PLANNING

Just as the preparatory phase of clinical placement has been found to be critical (see *Section 3.1*), so too has planning the TNH affiliation been found to be ‘of paramount importance’, ensuring that respective roles and expectations are clearly defined and able to meet the needs of both partners (Mezey *et al* 1997: 139). The establishment phase has been found to be complex and challenging, and those involved need to have a clear vision, a reasonable workload (to avoid the burnout identified by several researchers) and sufficient experience to meet the demands involved (Chilvers & Jones 1997: 465; citing Joel 1985; Kaeser *et al* 1989).

This phase also needs to be structured to increase partners’ mutual understanding of each other’s goals, operational issues and approach to aged care. Without a process to address gaps in this knowledge, difficulties will be faced as partners attempt to reconcile divergent roles (Berdes & Lipson 1989).

Another finding of the evaluation of the US *Teaching Nursing Homes* program was the importance of setting manageable clinical outcomes in the planning phase. One of the TNHP funded projects initially sought to produce positive clinical impacts for all nursing home residents (some 570 residents) but found that they could not do this. When they reduced their target to 120 residents located in two residential units, setting these aside as experimental centres, they found they were able to achieve the changes they sought. They were then able to slowly increase the clinical strategies employed to other units in the facility (Bronner 2004: 5-10).

### 3.3 INFORMED PARTICIPATION AND MUTUAL UNDERSTANDING

As discussed, education and aged care providers operate in very different organisations, with different career goals and expectations. Essential to a TNH affiliation is mutual understanding by partners of each other’s goals, methods of operating and so on, and that each understands their respective differences as well as similarities (Mezey *et al* 1997: 139; Ciferri & Baker 1985: 28). **At the same time, it is also important that partners share similar values and philosophical approaches, in particular, a commitment to improving quality care for older people** (Ciferri & Baker 1985: 29).

While collaboration is essential at the leadership level, the TNH is ...

**... really acted out by people doing their daily work. It is at the level of the individual nursing home staff member and the individual faculty member that the merger or joint venture takes place (Mezey *et al* 1984: 148).**

In the TNHP in the USA this often saw joint appointments described as ‘... *the human bolts or linchpins that tie the joint venture together*’ (Mezey *et al* 1984: 149). A number of lessons about joint appointments have emerged from reviews of the TNHP –

- ✓ The mission of the TNH must be clear to the joint appointee.
- ✓ Their role must involve a reasonable workload.
- ✓ Demands on them must be commensurate with their level in the organisation.
- ✓ They must be sufficiently experienced and prepared to withstand the stresses of a dual role.
- ✓ They should not be asked to protect the autonomy of one or both of the partnering organisations.

**Case Studies 1, 5 and 6** all involve joint funding by universities and aged care providers of Chairs with an ageing related focus, and all have produced a range of positive outcomes.

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### 3.3.1 UNDERSTANDING THE IMPACT ON PARTNERS OF THE TNH AFFILIATION

Although they retained separate organisational structures, as the TNHP projects in the USA progressed it was found that nursing schools had to assume some degree of accountability for clinical practice in the RACFs, while the nursing homes had to accept some accountability for the clinical training of students. This also meant that both partners needed to be conversant with each other's personnel and programs (Mezey & Lynaugh 1989: 773). **This is not surprising because over time, the TNH partnership will change the participating organisations.** Some of the specific changes involved have been identified by TNHP program directors and include –

- RACF staff can expect to need to work differently, to accept new leadership, to change methods or take on new responsibilities, including working with students, and with researchers. They may need to collect different data, and may feel vulnerable in the face of change.
- Education providers may need to assume ongoing clinical responsibilities, and in the process balance this with requirements relating to promotion and tenure. They will need to work with changed curriculum requirements and need to learn how to work effectively with RACF staff.
- For both partners, there will be changes in policies, processes, and structures (such as, committees).
- Ultimately affected will be RACF residents and their families who need to be informed about what the TNH will mean for them (see **Case Study 2, Section 1.3.1** which included a specific family focus).
- The successful TNH will raise the profile of its partners in their respective professional communities and with other professional networks that will arise when new services are added to the existing provision. For example, most of the TNHP sites in the USA initiated clinical affiliations with hospitals and community nursing services, and several developed model teaching units within hospital settings. Those that become regional centres for gerontological education and research, while raising their profiles, had to meet the expectations that this can bring (Mezey *et al* 1984: 149-150).

**On the one hand, substantial changes occur in the relationships between the two partners .... equally important, and less often stressed, is the readjustment of relationships within each participating organization....**

While the original mission and the values of each partner are important and must be retained, the effect of the affiliation on the inner workings of each organization must be acknowledged. There will be an ongoing need to separate issues growing out of relationships between the organizations from issues growing out of change within either institution (Mezey *et al* 1984: 149, 150).

### 3.4 SHARED COMMITMENT BY TNH PARTNERS AND STRONG LEADERSHIP

Effective participation in a TNH collaboration requires shared commitment by its partners to the goals and principles of the model, and to its implementation for which the resource of time is critical (Mezey *et al* 1997: 139). Education staff need to provide time to train RACF staff and to visit the facility regularly while the RACF needs to backfill when their staff are providing training and support to students, or participating in meetings with their education partner.

Those in management and leadership roles in participating organisations will also need to commit time and a willingness to make the initiative a success. Consequently, clarifying expectations about time and other resource inputs that reflect commitment is important, and needs to occur in the **planning** phase of the initiative (Ciferri & Baker 1985: 30). (See *Section 3.2* for discussion on the importance of planning.) **Navigating these demands requires stable and strong leadership of the TNH underpinned by a commitment to the principles and goals of a TNH** (Mezey *et al* 2008: 13; Berdes & Lipson 1989: 20).

**The TNH requires ... a new type of leadership and a commitment to the chemistry of team development (Berdes & Lipson 1989: 20).**

**When the nursing school and the healthcare provider see both their roles and their interests as inextricably intertwined and accord a high priority to grounding the relationship firmly within their operating arrangements and organisational culture, collaboration becomes more embracing and more fruitful for, it seems, all parties. (Abbey *et al* 2006: 34).**

#### 3.4.1 CASE STUDY 5: HAMMONDCARE AND UNSW – LINKING RESEARCH AND MULTIPLE CARE SECTORS

**Case Study 5: Positive health and ageing and an alliance that includes ageing, health and sub acute care**

**Affiliation partners: HammondCare in collaboration with the University of New South Wales (Medicine and Allied Health), the University of Wollongong (Nursing) and Western Sydney Institute of TAFE (Certificate III and IV in Aged Care)**

The affiliation between the University of New South Wales (Medical & Allied Health students) & HammondCare & University of Wollongong (Nursing students) and Western Sydney Institute of TAFE (NSW) (Cert III and IV) provides an increasingly wide range of learning opportunities that are also multidisciplinary. This focus is being extended by the establishment of a multi-disciplinary teaching and research centre at HammondCare's Hammondville campus in south west Sydney. HammondCare has received numerous national awards for its provision of care making it an ideal learning environment for students and staff.

Drivers were multiple, relating to the need for quality clinical placements in aged care for medical, nursing and allied health students, and for research to support enhanced care of older people. There was also a goal to provide sub-acute care experience and a focus on specialist areas like mental health and restorative and palliative care. It was considered that the education opportunities would have benefits for the broader health workforce, acknowledging that 90% of people in hospital are over 65 years old, many with complex health needs as well as aged care needs. Expanding student training beyond the acute care setting and into an aged care setting was considered to provide more relevant learning opportunities.

A feature of the affiliation is conjoint teaching and conjoint academic positions, involving a collaboration between HammondCare and the University of NSW. The first conjoint position is based in the UNSW School of Public Health and Community Medicine (previously the School of Community Medicine), a post held by Assoc Professor Andrew Cole since 1986. The further appointment of a new Chair was announced in February 2011 - the inaugural Hammond Chair of Positive Ageing and Care - which will commence in mid March of 2011. Both require clinical skills and a strong background in teaching and research and are funded by HammondCare.

HammondCare currently collaborates with the Western Sydney Institute of TAFE to provide training for Certificate III and Certificate IV in Aged Care but is in the process of itself becoming a Registered Training Organisation. It is a very large provider of aged care in NSW, supporting more than 2000 older people with services spanning the care spectrum, as well as providing health care and hospital services for more than 600 people. HammondCare's sub-acute hospital services include 54 inpatient palliative care beds, and accompanying these inpatient services 450 people are receiving palliative care community services. The affiliation thus provides an excellent example of the value of extending the TNH concept to include the health and particularly, sub acute care sector.

The affiliation with UNSW is formalised through a MOU of five years' duration which focuses on the roles and responsibilities of the Chairs. The project has also received funding from the Department of Health and Ageing (an Innovative Clinical Teaching and Training Grant) to construct the newly-completed Clinical Training Centre, located at the Hammondville campus, where medical, nursing and allied health students will undertake clinical training placements.

The range of learning opportunities provided mean that students can experience care through health services in the community as well as in residential and sub-acute hospital care settings, guided by principles of restorative care under a model of wellness and positive ageing.

**Sources: Interviews with Mr Stephen Judd, CEO of HammondCare; Conjoint Associate Professor Andrew Cole, Chief Medical Officer of HammondCare and School of Public Health and Community Medicine, University of NSW and HammondCare website**

### 3.5 FORMALISATION OF AFFILIATIONS BETWEEN EDUCATION AND AGED CARE PROVIDERS

The administrative structure to support the projects funded by the TNHP in the USA was defined in formal affiliation contracts. These saw financial and operational authority retained by the participating nursing home and special costs attributable to the project being shared with participating nursing schools. This included recruitment (noting that this also included the addition of nurse practitioners to the nursing homes), and the salaries of nurses jointly appointed (Aiken *et al* 1985: 198-199). Early literature (Lynaugh *et al* 1984: 28; Berdes & Lipson 1989: 19) points to the importance of a written agreement specifying a mechanism for joint decision making, clinical staff recruitment and allocation of clinical resources. Recent Australian research has also identified a formalised agreement as constituting an **essential** component of the TNH model (Robinson *et al*: 2008).

The formalisation documentation should also include agreement on which discipline will lead the TNH program, and how leadership will be selected from the participants (Berdes & Lipson 1989: 19). **This is an important strategy when multidisciplinary participation is involved.**

Mezey and others who were directors of the TNHP describe the affiliation documentation as 'legal contracts 'binding the participating organisations and serving two purposes – the first recording the 'facts of the relationship', and the second specifying the ' components of the relationship', including where autonomy is retained and where responsibility is to be shared (1984: 149). They have identified the following enabler for effective partnership in a TNH, separating *institutional* from *individual* levels of responsibility (1984: 148-149).

At the institutional level, responsibility is shared through budgets, joint policy making bodies and personal collaboration between leaders such as Deans of faculty and RACF executive officers. Risk of loss of autonomy has been found to be reduced by providing parity for each partners, for example, by shared membership of key committees, mutual sign-off on budgets relating to the TNH, and communication processes that are inclusive.

### 3.6 CLINICAL PRACTITIONERS AND SUPERVISORS

The Robert Wood Johnson Foundation program (TNHP) was implemented with two key features –

- 1) Every project placed one or more clinical specialists – in this case, because of the TNHP focus on nursing - nurse practitioners (including geriatric nurse specialists, gerontological nurse specialists and psychogeriatric nurse specialists) from the nursing faculty in the nursing home to work with staff and care for patients.
- 2) Every participating nursing home restructured its approach to clinical decision making and delivering nursing care – with the clinical practitioners providing leadership for this.

The clinical practitioners had a variety of titles (such as, director of nursing, nurse practitioner/clinician, or director of quality assurance) and their appointment was a condition of funding. The model depended on them becoming integrated into the nursing home, and it was assumed that this would lead to the nursing home becoming a more acceptable site for clinical practice, research and interdisciplinary education that would attract nursing students to clinical placements (Mezey *et al* 1988: 285).

Evaluation of the program found that these two strategies were essential to improving care outcomes and quality of care, and this was found to be due in part to the fact that students and staff benefited from the role modelling provided by these practitioners.

Essential to an effective TNH is supervision in the RACF. The literature is clear in the need for resourcing that frees supervising RACF staff (by providing backfill for their usual position) to mentor and supervise students, that provides training in supervision, and opportunities for supervisors to debrief and meet with education and training staff involved in the TNH. It is often the case that RACF staff feel a lack of confidence in their ability to supervise, in part because of a lack of training to do so (Xiao *et al* 2011:18; HWA 2010: 10; Abbey *et al* 2006: 40) and in part, because of the relatively few opportunities for ongoing skill and professional development in most RACFs. As discussed in *Section 3.1*, supervisor training and resourcing is a critical enabler of best practice clinical placement, and therefore, is crucial to an effective TNH.

### 3.7 INTERDISCIPLINARY FOCUS

Although the early USA pioneers funded by the NIA and TNHP initiatives identified the importance of multidisciplinary training and care, in reality, the NIA remained focused on medical professionals and the TNHP on nursing professionals (Mezey & Lynaugh 1989: 773; Kaeser *et al* 1989: 38; Liebig 1986: 213). As discussed in *Section 1.1*, Butler specifically noted that the multiplicity of needs of older people required a multidisciplinary approach to their care. However, the two major TNH funding programs in the USA have been criticised for evading ‘... *the challenge and potential of the interdisciplinary approach*’ (Berdes & Lipson 1989: 19). The failure to embed such a focus is antithetical to the care of older people, as Liebig points out –

**This unidisciplinary focus seems asynchronous with one of the major models and tenets of long-term care, the multidisciplinary/interdisciplinary team approach (Liebig 1986: 215).**

Although there are no specific studies evaluating this aspect of the TNH model, it would appear the absence of outcomes identified in relation to achieving multidisciplinary training and clinical care means that this had been difficult to achieve. Reporting on findings from research with TNHP participants, Mezey *et al* (1988: 288) identified a range of difficulties experienced in achieving interdisciplinary goals of the program –

**Scheduling problems, differing student educational levels, competing purposes and goals, and time allocation for TNH experiences may have frustrated attempts to achieve interdisciplinary links.**

An inadequate interdisciplinary focus can also reflect program design and funding criteria. For example, the NIA initiative designated the involvement of disciplines other than medicine and nursing as ‘desirable’ only (Liebig 1986: 213). It may also be a consequence of affiliations involving a particular school (eg nursing) rather than a number of schools linked to different professions. However, at least one of the TNHP projects appears to have achieved a multidisciplinary focus, no doubt due to the fact that this had been a central part of one of the partner’s existing structure and practice. This is discussed in *Section 5.2.2 - Case Study 8* (an early USA example) and below in *Section 3.7.1 - Case Study 6* (a current Australian example).

#### 3.7.1 CASE STUDY 6: INTERDISCIPLINARY FOCUS: A TNH AFFILIATION IN SA

##### **Case Study 6: Interdisciplinary-focused aged care training**

##### **Affiliation: University of SA and Helping Hand Aged Care**

This collaboration is supported by a \$1.8 million grant from the Department of Health and Ageing which is supporting 110 students from the disciplines of nursing, physiotherapy, pharmacy, podiatry, occupational therapy and exercise physiology at UniSA to undertake placements across seven Helping Hand Aged Care facilities – three of which are in rural South Australia. (Helping Hand is a large not for profit provider that pioneered the ageing in place model.) A focus of the initiative is interdisciplinary care and team work, working within a client-centred approach to care.



Students will also be given the opportunity to practise from a mobile health clinic in a regional setting, with outreach to other rural areas. Their training will include rehabilitation, mobility training, medication management, lifestyle assessment and the use of equipment and aids. The training is designed to increase students' understanding of older people's social support needs as well as physical care needs, as well as issues faced in providing care in rural settings.

The affiliation builds on an existing collaboration between Helping Hand and the Division of Health Sciences at UniSA that over time had developed gradually as a community of research and practice (CRP). Among the activities this generated was the joint appointment of a Professor of Ageing, and the co-location of an existing university research centre with Helping Hand's own Research and Development Unit, joint sharing of staff and resources including co-location of University teaching staff. The resulting research centre also linked with other research partners including an overseas university, to create a wider range of opportunities for participants.

Another outcome of the CRP was the development of 'Research Intensives' – jointly developed opportunities for staff development and the linking of research with clinical practice. Those involved point to the consequent evolution of a strong research culture within the RACF, and a framework for conducting clinical research that includes a 'robust ethics approval process', a committee structure to support practice research. One of the factors described as critical to the initiative's success has been strong and visionary leadership. The CRP has provided a strong foundation for the interdisciplinary training collaboration.

**Source: Cheek J, Corlis M & Radoslovich H (2009) *Connecting what we do with what we know: building a community of research and practice*, Helping Hand Aged Care, Adelaide and Interview with Ms Megan Corlis, Helping Hand Aged Care and Prof Esther May, University of South Australia.**

The need to provide an increased interdisciplinary approach (particularly involving nursing, medicine and allied health professions) to aged care delivery is a theme in recent Australian aged care workforce policy and research, and is seen as enabling holistic care to older people and combining knowledge, research and best practice from a range of disciplines (DEST 2004: 40). The TNH model, with its focus on collaborative education and cooperation between clinicians, teachers, researchers, students and managers, can be designed to support interdisciplinary training for and delivery of aged care.

In their review of the literature, Chilvers and Jones (1997) concluded that the originally intended multidisciplinary focus of a TNH should be re-emphasised in developing the model in Australia. Liebig's analysis of the TNH programs in the USA supports this view, noting the need to expose students to a range of disciplines and a team approach to care (1986: 213). A similar conclusion was reached by Mezey *et al* (2008: 12) in reporting the findings of a TNH summit of geriatric care and education experts.

**Such a collaborative approach would provide a holistic approach to research and knowledge development exploiting the talents of all professionals in increasing the profile of care for the elderly (Chilvers & Jones 1997: 468).**

### 3.8 PHYSICAL INFRASTRUCTURE

Most aged care facilities are designed to provide care rather than education and training environments. To be effective, TNHs require physical infrastructure that supports teaching, for example, lecture and tutorial rooms. It is essential that there is sufficient space for teaching and research activities, and that those spaces are designed with these purposes in mind (ACWC 2000: 4; Liebig 1986: 206).

This might mean that new infrastructure needs to be built at or near the teaching institution (ie building a nursing home on the campus) or alternatively involves building a teaching facility at an existing nursing home (ACWC 2000: 4).

The Case Study which follows relates to a developing TNH which is being purpose-built with a design that supports interdisciplinary research, teaching and care, as well as links to sub-acute and acute care.

### 3.8.1 CASE STUDY 7: ACH GROUP AND FLINDERS UNIVERSITY OF SA – PURPOSE DESIGNED QUALITY LEARNING ENVIRONMENT

#### **Case Study 7: Multidisciplinary care and care across the aged and sub acute sectors.**

##### **Affiliation: Flinders University of SA and the ACH Group, Adelaide**

The ACH is a large not for profit organisation that has been a pioneer in consumer centred care and care in the community, having trialled the care package concept which has since become a central part of the Australian aged care continuum of services. It has also pioneered a number of sub-acute care services, one of which is part of the TNH affiliation which is being developed at the time of writing.

This affiliation is being supported by multiple funding sources that include the SA Government, Health Workforce Australia. A purpose designed facility, involving rebuilding of the veterans Repatriation Hospital which is closely located to Flinders University, will house a state of the art teaching facility in the floors above the sub acute/transition care service operated by ACH. Significant resources such as interactive TV screens and an e-learning channel will support teaching activities. The new \$17 million *Teaching Aged Care and Rehabilitation Facility* will be funded by ACH Group and Flinders University with the SA government providing \$32.27 million for the remaining component of the redevelopment.

The 120 beds in the new Teaching Aged Care and Rehabilitation Facility will comprise 60 new residential aged care beds to be operated by ACH Group, plus 40 existing transition care/flexible care places to be operated by ACH under contract to the Adelaide Health Service, which will provide medical and allied health services. These include 24 flexible 'step-up, step-down' care beds and 16 transition care beds for patients preparing to return home. An additional 20 rehabilitation beds will be operated by the Department of Health. The new building will also include teaching and research spaces for university students and staff. The expansion of the existing rehabilitation facility will provide additional consulting rooms, therapy gyms and rehabilitation areas, laboratory services and staff/student shared spaces.

The disciplines of nursing and allied health (primarily physiotherapists and occupational therapists) are the focus of this collaboration. There will be 100 students, 60 RNs, 40 Allied Health staff by 2013, and numbers are expected to grow from this. Focus of the care and therefore education of students will be restorative and holistic.

Drivers are multiple and include a goal of providing quality learning environment and a source of workforce recruitment, as well as contributing to the existing strong learning culture of the organisation and fostering further innovation. ACH envisages this as a centre for excellence.

**Sources: Interview with Prof Jan Paterson, Flinders University of SA, Interview with Mr Jeff Fiebig, the ACH Group and SA Minister of Health Press Release 11/1/11**

### 3.9 ADEQUATE AND SUSTAINED RESOURCING

The TNHP in the USA provided five year grants which were not renewed. TNH representatives indicated that at least another five years of funding was needed to stabilise partnerships and to build other working links needed for the TNH (Bronner 2004: 4). Stable funding is critical to the success of a TNH (Xiao *et al* 2011: 20; Berdes & Lipson 1989: 19) if the affiliation is to be sustained beyond the goodwill of individuals, and is to deliver quality education and clinical care outcomes. It is concluded from the literature review that most of the features of a TNH require dedicated resourcing, and in particular the following:

- The supervising of students (in both the academic and care settings) and backfilling of RACF staff involved in teaching and support.
- Supervisors in the RACF may well need training (see *Section 4.2*) and there is a need to resource the opportunity for staff professional development that is offered by a TNH.
- As discussed in *Section 3.8*, there will be a need to build or modify physical infrastructure to create a learning environment suitable for training students in an aged care setting.
- It is necessary to create dedicated positions in both facilities (see *Section 3.6*) and these bring cost consequences (Berdes & Lipson 1989).
- It also needs to support the time investment (at management and service delivery levels for both education and aged care participants) that is required to establish and sustain a collaboration.

**Resourcing issues are somewhat marginalised in the literature, although the information and analysis available indicates that adequate numbers of well trained staff is a fundamental requirement for the successful induction, education and development of undergraduate students in the healthcare site. Students, the literature reminds us, are not to be regarded as cheap labour and staff cannot both teach and carry a full load of normal duties (Abbey *et al* 2006: 40).**

As discussed in *Section 1.1.2*, there was a trend for TNHs in the USA to have higher staff to patient ratios in a number of staff categories including nurses, nurse practitioners, clinical specialists, physician residents and social workers. However, just what that ratio should ideally be is not clearly articulated in the literature reviewed.

**A number of the studies reviewed raised the question of the appropriate ratio of teachers : students in nursing clinical practice but we are as yet without hard, contestable evidence of what is necessary. Given the place adequate resourcing was found to occupy in studies conducted in Australia and overseas ... this is important (Abbey *et al* 2006: 36).**

Because of its cost implications, some researchers believe that TNHs should be seen as '*centres for education and research*' rather than the norm for all RACFs (ACWC 2000: 3; Chilvers & Jones 1997: 467 citing Fretwell & Katz 1985). This complements the 'hub' approach and the 'Lighthouse' TNH network in Norway, discussed in *Sections 5.2.1* and *5.2.3*.

Viewed for their wider and system-related impact, these costs may be offset by the benefits associated with improved quality of care and savings in unnecessary admissions to acute care settings (Aiken 1988; Aiken *et al* 1985), especially if the affiliation is extended to acute care providers. However, these savings will not be measured within the Australian aged care sector unless specific data collection systems are designed and integrated into TNH accountability processes.

By being part of a TNH model, RACFs and education providers can also enhance their own profile, a benefit which can offset some costs by focusing on their investment potential (Mezey *et al* 1984; Berdes

& Lipson 1989). Convincing RACFs in particular of these benefits has also been found to be essential to establishing a TNH (Chilvers & Jones 1997: 467 citing Kaeser *et al* 1989).

### 3.10 CRITICAL MASS

The RACFs participating in the USA TNH facilities were large in size (see *Section 1.1.2*), as were those in the veterans aged care sector (see *Section 1.1.3*) and some of the studies reviewed argued that a degree of critical mass is essential so that participating RACFs can offer diversity in residents' care needs and services to support those needs. Those that were found to be most successful in the early USA initiatives were providing for between 250 and 300 residents (Liebig 1986: 205, citing the work of several researchers).

**...a TNH will not succeed unless it can achieve a critical mass in volume of cases, clients or patients; diversity of diagnoses; ... number of students attracted to the program ....(Berdes & Lipson 1989: 19).**

## 4 CHALLENGES AND ISSUES ASSOCIATED WITH A TNH

The literature identifies more positive than negative outcomes arising from the TNH model. However, there are challenges associated with the model and there is a need to address these in both the planning and implementation phases.

In a survey of the original eleven TNHP sites, Mezey *et al* (1997: 137) identified 13 barriers to TNH affiliations, which in order of frequency, are presented in *Table 2*. This shows that the major barriers are insufficient resourcing and insufficient commitment by partners.

**Table 2: Barriers to TNH affiliation (Mezey et al 1997)**

Barrier identified	% of survey respondents
Insufficient funding	53.0
Lack of aged care partner commitment	39.0
Lack of education partner commitment	36.0
Aged care partner's lack of readiness for affiliation and innovation	18.0
Time constraints for education partner and aged care partner	13.0
Insufficient RACF located preceptors to mentor students	11.0
Inadequate physical infrastructure (not conducive to education and training)	9.0
School of nursing lack of readiness for affiliation and innovation	9.0
Imbalance of power between affiliation partners	7.0
Poor proximity between school of nursing and RACF locations	7.0
High RACF staff turnover	7.0
Unclear allocation of responsibility between partners for student supervision	4.0
Lack of mutual understanding of each partner's purposes and operations	4.0

### 4.1 ETHICAL AND LEGAL ISSUES

A key challenge for TNHs is balancing the rights of patients with the research and publishing requirements associated with teaching and education (ACWC 2000: 2). There are also a range of ethical issues associated with undertaking research with residents of RACFs, particularly those with high level care needs and/or those not able to provide informed consent (Liebig 1986: 199).

In addition, the emphasis on consumer centred care as a key principle of aged care is not matched by equivalent attention in the research methodology literature and a reliance on traditional 'ethical principles' persists (McCormack 2003: 179). These are difficult to apply to many RACF residents, particularly those with dementia, and ethics procedures for the research component of TNHs thus require careful and sensitive consideration.

**Research in western society is preoccupied with a rational discourse of informed consent (Johnstone, 1989). Indeed, the increasing control being exerted by ethics committees and research governance**

frameworks excludes approaches to consent that are not objective and rational. ... The result of this is that large sections of populations are excluded from giving consent other than through 'proxies'. Existing evidence suggests that proxy consent is unreliable as it assumes that an individual's values are known and understood by another person (Buchanan & Brock, 1989). Because of this dominance, client groups such as people with dementia are largely excluded from the consent process or, worse, are sidelined as a suitable population to study directly. Much research with older people with dementia is conducted via 'reliable informers' on the basis that they are able to represent the person – an unreliable position to adopt ....

.... The challenge for academic communities is to explore ways of linking in a more proactive way, the agendas of researchers with the agendas of practitioners (McCormack 2003: 184,187).

In addition, the duty of care requirements of aged care providers and their legal liabilities mean that relatively untrained students can present a risk to fulfilling those requirements without specific supervision, orientation and other measures.

The work of McCormack is useful here in its discussion of the issues and the provision of a framework of guiding principles for undertaking research in an aged care setting (McCormack 2003: 185-187). The TNHP funded Carroll Manor & the Catholic University of America School of Nursing affiliation in Ohio established a Research and Education Committee comprising nursing home staff, residents and school of nursing faculty which had the dual role of approving proposals for student placement and requests to conduct clinical research at the facility (**Case Study 2, Section 1.3.1**).

**Such issues require clarification in developing a teaching nursing home and underscore the importance of a formalised agreement between affiliation partners that includes a focus on ethical issues and implications** (ACWC 2000: 3; Liebig 1986: 204-205).

## 4.2 DISINCENTIVES FOR AGED CARE PROVIDERS

Aged care providers participating in a TNH face four major challenges, the first three of which require dedicated resourcing in order to be managed. The fourth involves a tension that will impact differently depending on the individual.

- i. The workload involved leads to reluctance by aged care providers to accept placements (in the absence of resources to enable them to do so).
- ii. There can be insufficient available aged care facility staff to mentor and supervise students.
- iii. It cannot be assumed that aged care providers will have the supervisory skills required, and hence resourcing is needed to provide access to training and associated costs (such as backfilling). Inappropriate physical infrastructure can also constrain the capacity for supervision (HWA 2010: 10; NHWT 2009: 4-7).
- iv. An ongoing challenge has been found in pursuing two very different roles (clinical care and education/training) simultaneously (Chilvers & Jones 1997:465; Mezey *et al* 1984: 149).

As discussed in *Section 3.6*, recent Australian research has identified the aged care sector's professional isolation as limiting capacity for staff and student training, including a lack of training in the skills of preceptorship (that is, providing individualised training and support to students). In addition, teaching and supervision is not usually defined as falling within the scope of normal duties and aged care staff have identified a lack of adequate preparation for the experience and consequent anxiety about the

ability to fulfil this role. Associated with this is concern about adding to workload and stress levels, and the tension created by responding to the dual demands of students on placement and the needs of residents in their care (Robinson A et al :2008). Training roles and responsibilities in RACFs for registered nurses and other staff are very often not formalised, a situation that compares unfavourably with teaching hospitals used for other nursing specialities(Robinson *et al* 2008: 95).

### 4.3 DISINCENTIVES FOR EDUCATION AND TRAINING PROVIDERS

For participating education and training providers, four main challenges have been identified that relate specifically to clinical placement.

- i. There is an ongoing trade off between the learning requirements of students and the need to find sufficient clinical places to meet the accreditation requirements of different professions.
- ii. The matching of students to placements requires significant individualised attention that education providers are increasingly unable to provide, and there is considerable potential for mismatch.
- iii. The complexity of the health and education and training sectors brings administrative and financial challenges in negotiating clinical placements (NHWT 2009: 4-7).
- iv. Education and training providers have found that their clinical responsibilities at the affiliated RACFs conflict with their teaching and research responsibilities and the need to pursue these for tenure purposes (Bronner 2004: 4; Lindemann 1995: 81).

**Many faculty, who did not understand the teaching nursing home concept, perceived the affiliation with a nursing home as conflicting with university facilities or with existing clinical affiliations. Furthermore, the off-campus site had no immediate visibility. In general, senior faculty tended not to be interested in the program while doctorally-prepared assistant professors were pressured by the pull between service needs and scholarly activities (Lindemann 1995: 81).**

### 4.4 MANAGING DIFFERENT CULTURES, CAPACITY AND EXPECTATIONS

Aged care providers and education and training providers operate in different environments, with different cultures and a different set of skills and experience. Combining these differences can bring significant benefits arising from the diversity of capacity involved, but the literature has also identified that those differences can cause difficulties if not addressed. In particular, there is a need to ensure that partners understand each other's goals, operational issues, expectations, career goals and experience in working with older people (Ciferri & Baker 1985: 28; Chilvers & Jones 1997: 465; citing Joel 1985; Kaeser *et al* 1989). Without a process to address gaps in this knowledge, difficulties will be faced as partners attempt to reconcile divergent roles (Berdes & Lipson 1989). The examples which follow, drawn from those with experience in TNHs, illustrate the intensity of these challenges.

In a retrospective analysis of the outcomes of the TNHP in the USA, Bronner made this observation -

**Nursing home staff often seemed to resent the outsiders, viewing them as intruders who thought they knew better and who were going to create unnecessary work. Meanwhile many faculty members were typically unfamiliar with the regulatory difficulties in nursing homes and the small profit margin on which they operated. Relations eased after the first year or two in most cases and were even harmonious in some cases (Bronner 2004: 4).**

Commenting on the TNHP funded project at the Oregon Health Science University School of Nursing, Lindemann noted –

**The university schools of nursing and the nursing homes often had difficulties in appreciating the external and internal pressures faced by the other. Finance, values, beliefs and goals were among the major areas of misunderstanding. Developing the school/home relationship required extensive time and energy.... The schools and the homes found that establishing mutual trust and lines of communication was difficult and time-consuming (Lindemann 1995: 82).**

Berdes & Lipson (1989: 20) made these observations of the TNHP funded project at the Health Care Institute in Washington DC -

**There was little understanding of the respective competencies of university-based and nursing home-based staff. University-based staff had little hands-on experience in care provision in the nursing home setting and little management expertise. The university did not reward experiential expertise of the nursing home staff with university roles or titles. People who bridged the gap between university and nursing home... were hard to find, expensive, and likely to experience stress through the attempt to reconcile their divergent roles.**

For both aged care and education partners the involvement in a TNH involves a significant workload (that can lead to burnout without appropriate resourcing and support) and requires sufficient experience to meet the demands involved (Chilvers & Jones 1997: 465; citing Joel 1985; Kaeser *et al* 1989).

The issue of **communication** becomes extremely important in ensuring that different organisations with differing cultures, modes of operating and experience can work effectively together. This in turn is most difficult in the early stages when partners have not had the benefit of learning about each other, and this presents significant risks in the delicate negotiation of the affiliation agreement. Quoting from one of the TNHP project stakeholders –

**Contract negotiation was beset by a series of misunderstandings and deficiencies in the art of compromise on the part of both institutions. The academic interests of faculty members predominated over any responsibility for clinical care, and administrators in the home were hesitant to give authority to individuals who were external to their own system. Only mutual respect and trust between nursing leaders in both arenas allowed the basic philosophy of the project to prevail and to find permanent protection in the resulting affiliation agreement (Bronner 2004: 6).**

#### 4.5 THE IMPORTANCE OF CONTINUITY OF PERSONNEL

A key finding of the evaluation of the US *Teaching Nursing Homes* program of the mid 1980s was the importance of retaining as many as possible of those involved in the development of an affiliation. The reversal of positive clinical outcomes in a particular project identified by the evaluation was linked to the county administration's decision to address budget deficits by changing management to an investor-owned corporation. This saw the replacement of registered nurses with non-professionals and the exclusion of the academic partner from its role in the operation of the RACF concerned. Other key personnel were also reduced to achieve economic efficiencies, leading to the university partner withdrawing from the affiliation (Bronner 2004: 10-11).

The need for organisational stability and **continuity** of personnel has been identified by several other studies reviewed (Bronner 2004: 4-5; Berdes & Lipson 1989: 19-20). Apart from the time involved in



orienting new arrivals to the TNH program, there is also the risk that they may be replaced by individuals lacking the same commitment to the model (Bronner 2004: 5).

**In order to survive and grow, a TNH requires a high level of organizational stability in both parent organizations, the nursing home and the university. High turnover in nursing home management positions meant that the individuals who made the affiliation agreements were not always there to implement them. The four administrators who guided the Health Care Institute TNH in its first four years had widely varying levels of commitment to the concept of TNH, yet they may have had more influence than any other group in its success or failure (Berdes & Lipson 1989: 20).**

**Guaranteed long term funding is an enabler for continuity of personnel because participants have a degree of employment stability.**

#### 4.6 OVERCOMING AGEIST ATTITUDES

As discussed in *Section 2.3.2*, ageism constitutes a significant barrier to clinical placement in aged care services. Equally this is a significant inhibitor for the development of a TNH – but not necessarily a lasting inhibitor once a TNH has achieved positive results (also discussed in *Section 2.3.2*). The negative impact at the planning stage is illustrated in these two examples from the TNHP initiative in the USA.

**The lingering mistrust between education and service and the hurdles of contract negotiation that this created seem small compared to the entrenched attitudes toward the aged, most particularly the institutionalized aged. Undergraduate students were less than exuberant about a clinical placement in the home. Staff members were blind to the fact that there could be more quality of life for residents .... (Bronner 2004: 6 quoting Lucille Joel, director of the TNHP project at Rutgers University).**

**The faculty were uninterested and unmotivated. It was hard to get them to redirect their interests and carve out space in the curriculum. Gerontology has never been as sexy as critical care or oncology nursing (Bronner 2004: 6, quoting Joan Lynaugh, Associate Director of the TNHP project at the University of Pennsylvania School of Nursing).**

## 5 OTHER LESSONS LEARNED FROM THE LITERATURE IN APPLYING THE TNH MODEL

### 5.1 PROVISION FOR EVALUATION

The importance of including evaluation as an integral part of the model is to ensure that the effect of implementation is continually monitored (Robinson *et al* 2008: 101-102).

**The importance of collaborative relationships makes it imperative that the nature of these relationships should be evaluated on a regular basis. Evaluation is needed to ensure that the scheduled organisational arrangements do take place and there is a systematic audit of the implementation of the university and RACF partnership agreements eg Is the communication working? Has personnel changed? Do there need to be different arrangements put in place? (Robinson *et al* 2008: 102).**

Evaluation is also important for ensuring that learnings arising from the TNH are disseminated. Evaluation of the TNHP in the USA found that its evaluation had –

**...played a role in sharpening the way care of the elderly is evaluated (Bronner 2004: 16).**

### 5.2 CRITERIA FOR SELECTING A NURSING HOME SITE FOR A TNH

TNH focused research undertaken with representatives of five clinical disciplines (dentistry, medicine, nursing, pharmacy and social work) identified the importance of the following characteristics of RACFs participating in a TNH initiative. As can be seen, one group of indicators relates to human resources, another to adherence to quality and regulatory standards, another to having a philosophy of care that upholds the rights of residents, another to having an organisational culture that is committed to learning, and the fifth to having a generally good reputation (which will evolve from the preceding groups of factors). A sixth criterion – critical mass – has also emerged from the review of the literature.

#### Human resource indicators

- Sufficient preceptors who can provide clinical training, support and guidance to students, and more widely, staff who are receptive to student participation in care planning and delivery.
- Sufficient trained registered nurses.
- Staff who are receptive to student participation in care planning and delivery.
- An interdisciplinary team willing to teach and collaborate with an education provider (Mezey *et al* 2009: 199-200; Chen *et al* 2007: 911).

#### Quality related indicators

- A robust quality assurance program.
- Meeting industry accreditation and regulation standards (Mezey *et al* 2009: 199-200).

#### Rights-based or consumer-centred philosophy of care

- Having in place, or being willing to establish, an ethics committee to protect the rights of residents and their families in relation to research (ACWC 2000: 2).

### Learning culture

- Although difficult to quantify, TNH aged care facilities should also be selected because their culture is that of a learning organisation. Some indicators of this would include a commitment to providing ongoing learning and training opportunities for staff, and a willingness to collaborate on research studies that support continuous improvement of clinical care (Robinson *et al* 2008: 94).
- Willingness to, or application of, evidence-based clinical care (Mezey *et al* 2009: 199-200).
- Related to this is a willingness to disseminate to other aged care providers the learnings of the TNH collaboration (Mezey *et al* 2008: 8).

### Reputation

- a facility with a good reputation (Mezey *et al* 2009: 199-200)

### Critical mass and diversity of services

As discussed in *Section 3.10*, a TNH aged care provider needs to be of a certain size and offering diversity of services in order to provide students with experience in a range of care services designed for older people. This means that RACFs operating in isolation and lacking such linkages are not suitable for a TNH (Liebig 1986: 206).

As discussed in *Section 5.2.1*, the TNH can be conceptualised as a ‘hub’, connecting students to a range of services within the RACF and beyond, as well as joining education, research and clinical practice. This requires critical mass and established working relationships with a range of stakeholders.

### Additional criteria

**Case Study 8**, *Section 5.2.2* documents how the University of Texas sought affiliations with a network of RACFs, and application of the following criteria in selecting them.

- ✓ The potential offered for faculty and students to increase their knowledge about long term care of older people.
- ✓ Qualifications and commitment of facility personnel.
- ✓ Capacity of the facility to support the program with finances, staff and patients.
- ✓ Willingness to participate in shared decision making with the university.
- ✓ Willingness to jointly fund clinical practitioner appointments.
- ✓ Opportunities offered for the potential development of products, services, programs and policies.
- ✓ Opportunities offered in service provision, education and research – and the quality, focus, extent and depth of those.
- ✓ Physical suitability of the facility for residents, staff, students and faculty.

### Monitoring and review

It is also important to review the RACF from time to time to determine their continuing suitability (the same can be said for education and training partners).

**Acceptance of a site as a training location must be periodically reviewed in the light of evidence ... of how standards and culture may vary over time as a result of unforeseeable events exhausting the slim buffer that protects most aged care residential facilities from adverse changes (Abbey *et al* 2006: 35).**

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### 5.2.1 THE TNH AS A HUB

Although many of the affiliations identified in the research literature involve a single, albeit large sized nursing home, there are a number of examples that highlight the potential to leverage impact when the RACF has sufficient critical mass to provide a range of services, and when the affiliation extends its linkage to include the health sector. Even in its earliest configuration, the TNH model was conceptualised as supporting a service hub.

**Consequently, the teaching nursing home goes beyond its own walls. Conceived as a hub of services to the independent as well as institutionalized elderly, the teaching nursing home would show the student a spectrum of patient needs and services.... Because the geriatric patient often has multiple medical and psychosocial problems, interdisciplinary training patterns would be encouraged ... and ... [different] professionals would participate in clinical teams. They would learn about health promotion as well as disease treatment (Butler 1981: 1436).**

The affiliation between the University of Texas Health Science Center and a network of nursing homes illustrates the impact of a network approach, involving multiple RACFs – echoing the model in Norway.

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### 5.2.2 CASE STUDY 8: AN INTERDISCIPLINARY NETWORK OF TNHS IN TEXAS

#### **Case Study 8: The University of Texas Health Science Center and Nursing Home Network Affiliation – an Interdisciplinary Focus**

The Center on Aging at the University of Texas Health Science Center at Houston (UTHSC-H) is administratively housed in the School of Nursing and has an Advisory Group that is drawn from six component schools within the UTHSC-H (medicine, nursing, dentistry, allied health science, public health and biomedical sciences), from other UTHSC-H units, from other academic institutions and from community groups. These form the Council on Aging which is committed to developing interdisciplinary clinical resources in the long term aged care sector. The TNH model which they developed reflects the TNHP model in its focus on practice, education and clinical research but also identified nursing, medicine and social work as the essential disciplinary components of their approach (with nursing assigned the lead role). It added to the clinical care focus, attention to policy and management issues.

The UTHSC-H application of the model also differed in developing affiliations with a network of nursing homes, rather than a single facility. It sought proposals from interested organisations, asking them to address the following issues associated with collaboration and shared decision making in relation to:

- Residents, program and service mix
- Admissions, discharges and transfer policies and procedures
- Access to residents
- Contracts and agreements with other health service providers
- Design and allocation of space
- Selection and retention of key staff
- Standards of practice
- Qualifications, functions and mix of professional staff
- Joint appointments
- In-service education
- Fiscal planning.

Those selected were assessed against the following **criteria** (*all of which have emerged throughout this literature review as important factors, and should be seen as generalisable*):

- ✓ The potential offered for faculty and students to increase their knowledge about long term care of older people.
- ✓ Qualifications and commitment of facility personnel.
- ✓ Capacity of the facility to support the program with finances, staff and patients.
- ✓ Willingness to participate in shared decision making with the university.
- ✓ Willingness to jointly fund clinical practitioner appointments.
- ✓ Opportunities offered for the potential development of products, services, programs and policies.
- ✓ Opportunities offered in service provision, education and research – and the quality, focus, extent and depth of those.
- ✓ Physical suitability of the facility for residents, staff, students and faculty.

The appointment of key personnel to positions within the nursing home and one of the participating health profession schools was considered to be critical to effective communication and implementation of the TNH model.

**Source: (Kaeser *et al* 1989: 37-41)**

### 5.2.3 LESSONS FROM NORWAY: THE TNH 'LIGHTHOUSE NETWORK'

There is also much to be learned from the Norwegian application of the TNH model, which located one TNH in each region and built into their role the dissemination of learnings arising from this network of 20 centres of excellence. Led by government but addressing the goals of the aged care sector, individual TNHs have been designated as 'Lighthouse' projects focusing on specific areas of clinical care, for example, dementia care and palliative care. At the same time, they support locally driven practice oriented projects – balancing national and local reform. The research which they have carried out is fed back into the policy process. Evaluation of the NTNH has concluded –

**In this way, the TNHs have become vehicles for implementing national policies for improved care of the elderly. At the same time, the TNHs continue to support locally driven practice development projects that the staff and leadership of the participating institutions deem necessary.... The TNHs have gradually become institutions that other institutions turn to for support. They are also increasingly being seen as competent institutions by researchers interested in doing research in collaboration with nursing homes....**

**The program has created substantial enthusiasm within the nursing home sector and has increased the prestige of these institutions (Kirkevold 2008: 285).**

The application of the model in Norway takes the network approach one step further by designing the participating TNHs as centres of excellence who must disseminate their research findings and clinical expertise, in the process, having a positive impact on the wider aged care sector.

## 6 CONCLUSIONS

The TNH model supports effective working relationships between service and education providers and such relationships are critical to the design and delivery of clinical education. Given the shared responsibility for clinical education across the health and education and training sectors, mechanisms for effective engagement between the sectors are critical, and the TNH provides such a mechanism.

Research findings from a series of recent Australian studies strongly support the TNH model as a means of providing best practice clinical placement in aged care settings and thereby enhancing the training capacity of the aged care sector as a whole.

At the broader **systems level** four key benefits have been identified in the literature:

- enhanced recruitment and retention associated with TNHs that have effectively linked research, education and clinical care and achieved positive outcomes in all three domains;
- an enhanced profile of the aged care sector as a location for clinical placement and ultimate employment, and an enhanced profile for teaching and research focused on the care of older people and for education providers involved in these activities through a TNH;
- dissemination of TNH learnings to other RACFs thus extending their impact and providing leadership for the aged care sector as a whole;
- prevention of hospitalisation and reduced length of stay in hospitals due to the increased capacity of RACFs to provide medical care and health prevention services (where the model has been extended to partner with acute care providers and/or has involved training and employing physicians in RACFs).

At the **service delivery level** (for both aged care and the education and training of the aged care workforce) a number of specific benefits and challenges have emerged from the literature review. These are discussed in detail in *Sections 1.2, 1.4 and 2.1, and in the Case Studies*. Challenges are discussed throughout *Section 4* and the Case Studies also exemplify how these have been addressed.

As with any exercise in policy analysis, the introduction of TNHs in Australia through a dedicated program with associated funding requires identification of the competing Incentives and Disincentives involved. Both benefits and challenges have been summarised in the CHART 1 in terms of competing Incentives and Disincentives affecting the two key stakeholders – aged care service providers and aged care education and training providers – with enabling factors that address both identified in the third column.

CHART 1: TNH Incentives, Disincentives & Enablers

Incentive	Disincentive	Enabling or Mediating Factor
<b>Shared Incentives and Disincentives</b>		
The TNH partnership connects those involved with research and education opportunities, and associated networks, that would otherwise not have.	Education and aged care providers operate in very different organisations, with different cultures, career goals and expectations.	Essential to a TNH affiliation is mutual understanding by partners of each other’s goals, methods of operating and approach to aged care, and that each understands their respective differences as well as similarities. It is also important that partners share similar values and philosophical approaches, in particular, a commitment to improving quality care for older people.  Research findings emphasise the importance of the planning and preparatory phase of a TNH. Planning the TNH affiliation must include clear definition of respective roles and expectations and strategies to meet the needs of both partners. A <b>formalised agreement</b> is an essential component of the TNH model.
	It is necessary to create dedicated positions in both facilities (and these bring cost consequences)	Specific and stable resourcing is needed to stabilise partnerships and to build other working links needed for a successful TNH.
	Significant time investment (at management and service delivery levels) is required to establish and sustain a TNH collaboration. This is difficult for sectors noted for tight resourcing and heavy workloads.	The successful TNH will raise the profile of its partners in their respective professional communities and with other professional networks that will arise when new services are added to the existing provision.
TNHs offer the opportunity to link research, education and clinical care and for all three to be mutually supportive.	Inadequate physical infrastructure and associated resources militate against teaching and learning in aged care.	Resourcing is needed to support the building or redevelopment of physical infrastructure for on-site training and education, and to support the linking of research, clinical care and education.
TNHs support the provision of inter-disciplinary care and education/training.	Interdisciplinary education and training can be challenging to provide.	RACF sites with sufficient critical mass to offer diversity of learning experiences are essential.  Identifying a lead discipline is important.

Incentive	Disincentive	Enabling or Mediating Factor
<b>Incentives and Disincentives specific to Education and Training Providers</b>		
<p>The TNH enables faculty members to identify practice issues, to research these and to feedback new knowledge into the education system. By working within a RACF the faculty member has the opportunity to enhance the quality of teaching, to identify research opportunities and to improve patient care.</p>	<p>Ageist attitudes act as a barrier to student participation in a clinical placement, and to attracting new graduates to the aged care sector.</p> <p>Ageist attitudes have also been found to reduce enthusiasm for aged care education, including clinical placement in an RACF among the broader faculty.</p>	<p>Providing a positive clinical placement (see chart) characterised by appropriate training and support in an environment focused on quality care can produce positive attitudes to older people and aged care. TNH programs resulting in a marked increase in students taking up aged care post-graduate positions.</p> <p>Certain aspects of a placement are likely to discourage students from seeking out a career in aged care, and this includes working alone with no support or working in a setting with poor staffing and resource levels. Conversely, a positive clinical experience that addresses these factors and provides the opportunity to work with a range of residents with different needs and conditions is likely to encourage working in aged care.</p> <p>The TNH has been found to significantly change negative attitudes by education providers to the aged care sector. Attitudinal changes have been identified within schools of nursing participating in Teaching Nursing Home projects, noting a move towards greater course content specialising in ageing and aged care, and increased clinical research and publications relating to care of older people – all of which has a positive impact on students’ attitudes to older people and to careers in aged care.</p>
<p>The profile of research into chronic illness and the specific needs of frail older people may increase. Having access to high care need clients enables researchers to undertake controlled clinical trials. In turn, this contributes to increasing the education partner’s standing in the academic community as a centre of excellence.</p>	<p>Education and training providers have found that their clinical responsibilities at the affiliated RACFs conflict with their teaching and research responsibilities and the need to pursue these for tenure purposes.</p>	



Incentive	Disincentive	Enabling or Mediating Factor
Evaluations have identified improved learning conditions for students in a TNH.	The complexity of the health and education and training sectors brings administrative and financial challenges in negotiating clinical placements	An effective collaboration facilitates the negotiation of clinical placements between those involved in a TNH affiliation. RACFs can be motivated by the positive impact of a TNH on students undertaking a placement with them and upon graduation, seeking employment with them.  Evaluation has identified a marked increase in students taking up aged care post-graduate positions, and being attracted to work in aged care as a result of an effective clinical placement.
<b>Incentives and Disincentives specific to Aged Care Providers</b>		
The TNH offers a range of potential benefits including recruitment & retention of staff, opportunities to establish best practice based on research, enhanced quality of care, improved decision making and care planning, increased aged care staff competencies, and a subsequent raising of RACF profile.	The aged care sector usually has limited capacity for staff and student training, including a lack of training in the skills of preceptorship that can result in anxiety about the capacity to fulfil this role.  There are insufficient incentives and opportunities for aged care staff in continuing education and professional development.  With limited staff resources, it can be difficult to release staff for supervision and teaching purposes. In addition, teaching and supervision is not usually defined as falling within the scope of normal duties.	By being part of a TNH model, RACFs and education providers can also enhance their own profile, a benefit which can offset some costs by focusing on their investment potential.  Supervisor training and resourcing is a critical enabler of best practice clinical placement, and therefore, of an effective TNH.  There is a need to resource the staff professional development that is part of a TNH, and for the backfilling of staff involved in teaching and supervision.
The TNH encourages the implementation of evidence-based practice and participation in research in a number of clinical areas of concern to aged care providers eg continence management, falls prevention and wound management	The workload involved leads to reluctance by aged care providers to accept placements.  Being unable to meet workload commitments is seen as a risk to providing effective clinical care.	Resourcing is needed to remove the disincentive of compounding an already heavy workload.  The TNH model, through its partnering of aged care and education providers, can lead to improve clinical care, and research has found that informing RACFs of this outcome can minimise this disincentive.

Incentive	Disincentive	Enabling or Mediating Factor
	The duty of care requirements of aged care providers and their legal liabilities mean that relatively untrained students can present a risk to fulfilling those requirements without specific supervision, orientation and other measures.	The TNH model, when supported by resourcing of staff involved in teaching and supervision, reduces this risk.  In addition, the formalised agreement developed for a TNH model can and should address this and other potential risks, and strategies that ensure participating RACFs can fulfil their duty of care.

### Resourcing to support a TNH

Collaborations and partnerships of any kind require skills, commitment to a shared purpose, and a significant investment of time – especially in the early stages when those involved are learning about each other’s drivers and constraints, and thereafter to ensure that the collaboration is sustained. It is difficult to achieve this without dedicated resourcing, and to meet other features of a TNH which the research literature has identified as essential. These involve:

- Education/training provider staff to train and support RACF staff (eg in supervision and teaching skills) and to visit the facility regularly.
- The RACF needs to backfill when their staff are providing training and support to students, or participating in meetings with their education partner.
- Supervisor training and resourcing is a critical enabler of best practice clinical placement, and therefore, of an effective TNH.
- Provision of appropriate physical infrastructure to support the linking of clinical care, research and education.

The research findings indicate that the TNH model holds significant potential to bring about enhanced quality of aged care, education and training of the aged care workforce, and research to provide an evidence base for these improvements. The model can benefit individual participants and stakeholders, as well as the broader aged care and education systems. Much depends on how it is planned, resourced, implemented and evaluated. However, sufficient evidence exists about lessons learned to date regarding enablers and barriers and this information is readily transferable to the Australian context.

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