AUSTRALIAN INSTITUTE FOR SOCIAL RESEARCH

Implementing the Teaching Nursing Homes Initiative: Scoping Study

FINAL REPORT

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Report prepared for:

AISR Informing Decisions

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ABBREVIATIONS

ACAA - Aged Care Association Australia Ltd

ACWC - Aged Care Workforce Committee

ACRRM - Australian College of Rural and Remote Medicine

ACSA - Aged &Community Services Australia

AHMAC - Australian Health Ministers' Advisory Council

AISR – Australian Institute for Social Research

AMA - Australian Medical Association

ANMC – Australian Nursing and Midwifery Council

COTA – Council on the Ageing (COTA Australia)

COAG – Council of Australian Governments

DEST - Department of Education Science and Training

DOHA - Department of Health and Ageing

HWA - Health Workforce Australia

NHMRC - National Health & Medical Research Council

NIA - National Institute for Aging

NHWT - National Health Workforce Taskforce

NTNH - Norwegian TNH (program)

RACF – Residential Aged Care Facility

RACGP - Royal Australian College of General Practitioners

RCNA - Royal College of Nursing Australia

RTO – Registered Training Organisation

SPACW - Supporting a Professional Aged Care Workforce

TNH - Teaching Nursing Homes Initiative

TNHP - Teaching Nursing Home Program

VET – Vocational education and training

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

1   INTRODUCTION

1.1   THE SCOPING STUDY

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 began in early January 2011 and will be completed at the end of March 2011. Findings from the scoping study will inform the funding process to be conducted in 2011.

1.1.1   THE PROJECT TEAM

➢ Dr Kate Barnett, Deputy Executive Director, AISR (Project Leader)
   working in collaboration with AISR Research Associates

➢ Professor Jennifer Abbey -Honorary Clinical Professor, Faculty of Health Sciences, University of Adelaide; Adjunct Professor, Queensland University of Technology; Honorary Research Fellow, Menzies Institute, University of Tasmania.
   and
➢ Ms Jonquil Eyre, Principal, Jonquil Eyre Consulting.

1.1.2   THE PROJECT MANAGEMENT TEAM

A small team from the Department of Health and Ageing's Better Practice Section of the Aged Care Workforce & Better Practice Programs Branch, Office of Aged Care Quality and Compliance is managing the project.

➢ Ms Eliza Hazlett, Director, Better Practice Section
➢ Ms Anandhi Raj, Assistant Director, Better Practice Section
➢ Ms Trish Deane, Better Practice Section.

1.1.3   BROADER CONTEXT FOR THE PROJECT

This project is occurring as part of a wider and ongoing process of reform within the Australian aged care system.

The *Teaching Nursing Homes Initiative* is a key component of the *Supporting a Professional Aged Care Workforce (SPACW)* Program, introduced by the Commonwealth Government to strengthen the aged care workforce to ensure that older people continue to receive quality care.

Government-led workforce development in aged care includes addressing projected shortfalls in workforce numbers (for example, in registered and enrolled nurses in residential aged care) and responding to the needs of an ageing population, as well as improving quality care through increased training opportunities. A particular focus is being placed on improving clinical care, enhancing recruitment and retention and creating career paths

in aged care. Different models of practice for nurse practitioners in aged care are being trialled in order to identify models that are effective and viable and that build a better career path for aged care nurses.[1]

As part of the SPACW Program, funds have been allocated to support the establishment of teaching nursing homes over the period 2010-11 to 2013-14. Funding will be provided to support a number of teaching nursing homes to build staff capacity to meet the increasing demand for services particularly for residents with complex health conditions. The Initiative will also strengthen links between the aged care sector and research and training institutions (including the Dementia Collaborative Research Centres and Dementia Training Study Centres) across a broad range of student disciplines and the Local Hospital Networks (as these are established).

1.1.4 KEY REQUIREMENTS OF THE SCOPING STUDY

The key focus of the scoping study is to examine critical enablers and barriers to establishing and operating a Teaching Nursing Home (TNH) in Australia. The scoping study is designed to identify the range of models and key characteristics that contribute to excellence within Teaching Nursing Homes by:

⇨ analysing Australian and international peer reviewed and grey literature; and

⇨ documenting various models of teaching nursing homes currently operating in Australia.

1.1.5 METHOD

There are two key components to the scoping study method –

1. A review of the literature
2. Structured interviews with key stakeholders.

1.1.5.1 LITERATURE REVIEW

The literature review analysed Australian and international peer-reviewed and grey literature on teaching nursing homes to identify:

⇒ key characteristics of successful teaching nursing home models as applicable to the Australian aged care setting;

⇒ enablers and barriers to the successful operation of teaching nursing homes;

⇒ the range of health professionals typically participating in teaching nursing home training programs;

⇒ types of affiliations established; and

⇒ resource requirements for successful operation.

1.1.5.2 CONSULTATION WITH CURRENT TEACHING NURSING HOMES AND AFFILIATED TEACHING / RESEARCH FACILITIES

Structured interviews were undertaken with two groups of stakeholders –

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[1] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-agedcare-13

1. Representatives from residential aged care facilities (RACFs) and teaching and research providers involved in TNH affiliations (current, planned or lapsed). This has resulted in consultation with **17** TNH affiliations and **38** individuals (**15** teaching and research providers and **23** people from 22 RACFs). Two of the university interviewees are conjoint appointments with a RACF. 14 of the education providers are from universities and the remaining provider is a private VET (vocational education and training) provider (ie a Registered Training Organisation). A further two affiliations also involved VET providers as well as university providers. The purpose of these consultations was to document Teaching Nursing Home models currently operating in Australia. ***The AISR team is extremely grateful to the generosity of those interviewed in giving their time and for the valuable information which they have provided***. (For details refer to APPENDIX I: PEOPLE INTERVIEWED)

2. CEOs and other executive management from relevant national peak bodies and from the Department of Health and Ageing to explore broader system level issues in health and aged care workforce development, aged care service provision, and broader reform in both of these areas. Interviews were undertaken with the following organisations (for details refer to APPENDIX I: PEOPLE INTERVIEWED).

   ➢ Aged &Community Services Australia (ACSA)
   ➢ Aged Care Association Australia Ltd (ACAA)
   ➢ Australian College of Rural and Remote Medicine (ACRRM)
   ➢ Australian Medical Association (AMA)
   ➢ COTA Australia
   ➢ Council of Deans of Nursing
   ➢ Health Workforce Australia (HWA)
   ➢ National Health & Medical Research Council (NHMRC)
   ➢ Royal College of Nursing Australia (RCNA)
   ➢ The Royal Australian College of General Practitioners (RACGP).

The findings from these two sets of interviews have been woven through this report from *Section 2.3* onwards.

1.1.5.3 REPORTING

A separate Discussion Paper was prepared to bring together the findings from the Literature Review. The findings from the Literature Review have been incorporated into this Final Report, and compared with the findings from the consultation process. The Discussion Paper is presented as an accompanying report.

The findings from the consultation interviews were analysed by the AISR team, comparing trends across and within affiliations, associated with specific sectors (aged care or education and training), and against previous research findings. Findings have been structured to reflect the scoping study objectives.

2 THE TEACHING NURSING HOME MODEL: CONTEXT

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).

2.1 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 distinct 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. This means that aged care workforce training, particularly for nurses, has lacked an integration of theory and practice (Liebig 1986: 199).

Traditionally, residential aged care facilities (RACFs[2]) 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).

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 setting offers an opportunity to work with older people over an extended period of time and in a service environment designed with their needs in mind. In addition, patients in an acute care setting increasingly are in hospital for a very short time and may be too acutely ill to cope with the extra examinations teaching students may wish to undertake. Residents in an aged care setting, in contrast, may have multiple co-morbidities but be medically stable and able to comfortably manage student attention.

One interviewee commented that they were aware of Nursing Homes already being used for teaching medical students.

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[2] 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.

"For bedding down, for example, 4th year medical students' assessment and diagnosis skills, work in Nursing Homes can be useful. The environment is different to that in an acute hospital. The residents have found that having the medical students sit around and chat to them has been a positive thing and it has been useful for the students as well. It has consolidated foundation skills such as assessment and history taking. Many residents have co-morbidities."

If an 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 3.4* for detailed discussion of enablers of the TNH model, including providing an **interdisciplinary** focus*.*

2.1.1 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
Education/training provider	Increased involvement in ageing research that is based on clinical experience in a RACF, and greater opportunity to provide high quality education and training.
Aged care provider	Increased involvement in research and exposure to clinical practices that enhance quality of care. Increased professional development due to relationship with education provider.
Students	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
Residents (and their Families)	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 outcomes will be more attractive to students and potential and current workforce members than will RACFs without this profile**. This is a key finding of the literature review, and is supported by interviews undertaken for the scoping study.** For further discussion on the benefits arising from the TNH model, refer to *Section 3.2.*

2.2 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 2.2.3*) 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 –

a.   The National Institute for Aging program
b.   The Teaching Nursing Home Program.

Both programs have yielded a significant amount of research, the findings of which are relevant to contemporary TNHs. These findings have been reviewed for the scoping study and analysed against those arising from the study's consultation processes. They are presented in *Sections 3 and 4*.

2.2.1   THE NATIONAL INSTITUTE FOR AGING PROGRAM

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).

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. This concept continues to have relevance and is discussed in more detail in *Sections 2.2.5 and 4.1.2.*

2.2.2   THE TEACHING NURSING HOME PROGRAM

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 (originally) 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).

2.2.3   TEACHING NURSING HOMES IN THE US VETERAN CARE SYSTEM

The TNH model had been evident in the veteran care system of the USA since the 1960s and evolved independently of the NIA and TNHP initiatives. Affiliation with an acute care provider was always part of the veteran care TNH model, with nursing homes receiving significant input from medical and surgical staff at the adjoining veterans' hospital. In addition, this model placed a significantly larger proportion of discharged

patients in non-institutional community settings, compared with the NIA and TNHP initiatives (Rubinstein *et al* 1990: 75).

This application of the model, by linking with hospital providers, can also be relevant in Australia where some examples exist. This is discussed further during this report, including in relation to addressing challenges associated with locating a TNH in a rural setting – see Section 3.4.1.

2.2.4   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, and provides useful lessons for consideration in Australia.

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 are affiliated with 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).

This approach to a TNH, with its training of physicians in an aged care setting, has relevance for Australia, reinforced by some of the interview feedback obtained for this scoping study. This is discussed in this report, and also in **Case Study 6,** *Section 3.1.8.1 which presents the HammondCare affiliation's application of the TNH model.*

2.2.5   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 2.2*). 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). *These are all issues that are relevant to Australia's aged care system and the training of its workforce.*

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.

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).

This model, with leadership from government and the application of a regional network of TNHs, also has lessons that are relevant to the development of TNHs in Australia. These are discussed further in Section 4.1.2.

2.3   THE TNH MODEL IN AUSTRALIA

A number of TNH affiliations between the aged care workforce education and training, and aged care delivery sectors, have evolved at the local level. These have been driven largely by the incentive of improving workforce training and education while enhancing the quality of care delivered. Examples of these are provided in the six case study examples included in this report and representatives from all known and current affiliations have participated in detailed interviews that were undertaken as part of this scoping study.

2.3.1   DRIVERS FOR A TNH MODEL

The literature review identified multiple drivers for the application of the TNH model in Australia. In particular, these involve:

o   A range of aged care workforce issues and challenges.

o   The ongoing need to enhance clinical training and placement and challenges associated with this.

o   Ongoing pressures to improve the quality of care for older people.

These are reflected in the drivers for the TNH affiliations studied for this scoping study – as discussed in *Section 3.1.1.*

2.3.2   AGED CARE WORKFORCE DEVELOPMENT CHALLENGES

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).

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.

The relevance of the TNH model is apparent in the broader agenda of aged care workforce reform, and the challenges associated with this 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).

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, is seen as addressing this issue for those involved in such an affiliation, and may provide leadership for wider industry opportunities (DEST 2004: 44-45).

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 to move through as their skills develop and their careers progress. 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). It 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[3]. 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. The work being undertaken by this organisation is of direct relevance to TNHs, both in terms of broader aged care workforce development and in relation to specific features of the model, particularly enhanced clinical placement opportunities.

Feedback from the scoping study interviews has identified that close collaboration will be occurring between HWA and the Department of Health and Ageing in relation to the Teaching Nursing Homes Initiative.

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[3] Australian Government Budget 2010-2011, Budget Paper # 2

2.3.3   ENHANCING CLINICAL TRAINING AND PLACEMENT

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 National Health Workforce Taskforce (NHWT) was a national body created under the Australian Health Ministers' Advisory Council (AHMAC) committee structures, and 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 subsequently implemented a number of initiatives designed to enhance clinical education – for details refer to *Section 2.2* of the Discussion Paper prepared for this scoping study. *(HWA was one of the key stakeholders interviewed for the scoping study.)*

HWA has indicated it will provide support and development for TNH in the following ways*:*

- o   funding for clinical training
- o   funding for simulated nursing environments and clinical supervision support
- o   a targeted reform program – Caring for Older People in Community and RACFs.

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 (NHWT 2009: 4-5).

> **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* 2.3.3.1, **Case Study 1** - 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.

> **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).**

There are a number of issues and challenges associated with the clinical education of the aged care workforce. These are discussed in detail in *Section 2.3* of the Discussion Paper which presents the findings from the literature review informing this report. Interviews undertaken for this scoping study also highlighted the importance placed by both education and aged care sector representatives on meeting the challenges associated with clinical placement, and drew attention to the range of efforts designed to address those challenges. **TNHs can be focal points of good practice in clinical placements, but they are, and should be,**

differentiated from other such initiatives and from the usual RACF, by their linking of research, education and clinical care. As one of those interviewed noted -

> *In a TNH people would experience good role modelling and demonstration of scope of practice.….. The TNHs should be part of a proactive development movement which offers a model of clinical collaboration and research. This will require both sides [universities and RACFs] to recognise each other's expertise.*

There is a diversity of opinions about who would take the main teaching role responsibilities in a TNH. For example, one interviewee was of the opinion that –

> *'… care delivery has to be within a framework of clear roles and responsibilities with everyone aware of their part to play.'*

And that nurses should be -

> *'…leaders and teachers in any kind of model as they have the most global and holistic perspective.'*

Representatives of GPs indicated in their interviews that most GPs are interested in teaching but need the incentive of being paid 'an attractive rate' to enable them to teach in RACFs. An additional, cost-neutral incentive identified involves providing teaching GPs with academic status – for example, an appointment as Adjunct Professor or Associate Professor.

Some interviewees discussed sharing teaching among clinical practitioners and academics and indicated that the coordinator of clinical placements was the 'lynchpin' for this process.

The need for competencies, agreed assessment tools and clinical standards was also identified. Various competency assessment tools were discussed and, although this is still a matter for each professional group, the development of national curriculum guidelines and competency assessments for use within aged care settings was seen as an important role for any TNH. For example, the Council of Deans of Nursing has supported the development of a clinical assessment tool (CAT) for assessing nursing students on practicum, for use in all Universities across Australia. The tool has 8 core assessments to be undertaken within the course of a program, plus an evaluation of each student against Australian Nursing and Midwifery Council (ANMC) competencies on each placement. It reflects the direction of a coalition of Australian Universities which has been advocating for the development of clear and universally accepted competencies.

The Australian Learning and Teaching Council funded the development of this initiative with project funding and Health Workforce Australia is now interested in supporting the roll-out of its use across the sector. It was put to the AISR team that if this could be connected to a TNH and act as a mandatory part of clinical placement assessment, it would promote consistency and collaboration.

Three Allied Health professions (Occupational Therapy, Speech Pathology and Physiotherapy) have also developed competency assessment tools. It seems likely that Health Work Force Australia will ask nurses and these groups to form an advisory group around competency tool development for other professions to ensure consistency of graduates. The Council of Deans of Nursing indicated that they would be supportive of this.

2.3.3.1 CASE STUDY 1: CONNECTIONS IN AGED CARE - EVIDENCE BASED IMPROVED CLINICAL EDUCATION

Case Study 1: 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. And 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. (REFERENCES RELATING TO THIS RESEARCH CAN BE FOUND IN APPENDIX II OF THIS REPORT)**

2.3.4 IMPROVING THE QUALITY OF CARE OF OLDER PEOPLE

There are numerous studies and reports focusing on the ongoing challenge of improving the quality of aged care and there is not scope to do them justice in this report. However, of relevance to this sector wide issue, is the role of clinical research that creates an evidence base for improved clinical care. This is a key feature of the TNH model, and there is substantial evidence in the literature and arising from the consultations undertaken for this scoping study, of the valuable contribution a TNH can make to achieving this outcome.

As discussed in *Section 3.2*, the literature review and findings from the scoping study consultation processes have identified a number of benefits arising from the TNH model. These benefits are mutually reinforcing and among those that focus on enhanced clinical research and care are the following:

o   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;
o   an enhanced profile of the aged care sector as a location for clinical placement and ultimate employment;
o   enhanced recruitment and retention associated with TNHs that have effectively linked research, education and clinical care and achieved positive outcomes in all three domains;
o   dissemination of TNH learnings to other RACFs thus extending their impact and providing leadership for the aged care sector as a whole.

Education partners in a TNH have the opportunity to undertake clinically-relevant research in a setting with older people needing clinical care, while aged care partners have the opportunity to influence research design and to provide input into the research process. Mutual learning for both partners is a key outcome, provided there is willingness on the part of the aged care provider to apply evidence-based clinical care, and on the part of the education provider to work collaboratively with the aged care provider, tailoring the research to address the care needs of residents and ethical and legal issues associated with the research (Mezey *et al* 2009).

Case Study 2, below, like all of the case studies presented, provides one example of this.

2.3.4.1 CASE STUDY 2: ACU NATIONAL & RSL LIFECARE -EVIDENCE BASED ENHANCED CLINICAL CARE

Case Study 2: 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.

3   APPLYING THE TNH MODEL

The scoping study has involved structured interviews from both education providers and RACFs involved in a TNH affiliation. Information sought included details of the features of these affiliations – where they have been located, the size of the RACF, key services provided by the RACF, the disciplines involved, the types of resources involved and as much information about operational features as could be obtained.

More detailed discussion was based on how the affiliation came about, the strategies put in place to promote a good learning environment for students, method of delivering training, method of formalisation of the affiliation and associated governance arrangements, and any monitoring against agreed standards.

3.1   MAPPING THE TNH AFFILIATIONS

A note on Terminology

The term 'teaching nursing home' is broadly understood but approximately half of the people interviewed commented that they see the term as restricting (implying high level and facility based care only, whereas the model has relevance to both residential and community care). However, there was no commonly used alternative term, and examples of the terminology being used included *'learning organisation', 'teaching aged care', 'clinical training academic and research unit'* and *'aged care provider that provides training opportunities'.*

It will be important to develop a term that indicates the model in Australia has moved beyond the US pioneering form, but retains the tradition of teaching and research focused on the well-being of older people. For example, it could be called a *Teaching Aged Care Facility* (TACF) to distinguish it from other RACFs, or to reflect a wide range of services (beyond residential care) and its three defining roles, *Teaching Research Aged Care Service* (TRACS). For the remainder of this report, the term 'TNH' is used.

Some of those consulted pointed to the need not only for a defining name, but also for this to be part of a wider marketing exercise designed to promote TNHs and in the process, to contribute to addressing negative and ageist stereotypes associated with a career in aged care – as discussed in *Sections 2.3.2 and 3.5.*

The AISR team were given details of 17 affiliations incorporating TNH features, that is, collaborations between education and training providers and aged care providers designed to improve the quality of student training and education and to enhance the quality of care of older people. *Table 2* summarises the current status of these affiliations. It can be seen that seven are currently operating and five are in the early stages of development. Four have lost momentum (often because key individuals driving them had moved on, and often because a lack of dedicated resourcing made it difficult for them to continue). Without evaluating each of these, however, it is difficult to be more precise about the reasons for their decline. One affiliation, involving a VET provider and a RACF, did not have a research component, and therefore, should more accurately be categorised as a 'student placement collaboration'.

Table 2: Status of the TNH affiliations studied

Status of the TNH	No of affiliations
Current and operational	7
Evolving/early stage development	5
Lapsed	4
Not fitting TNH criteria (no research component)	1
Total	**17**

Table 3 provides examples of the type of affiliations involved in a TNH partnership (that is, close working relationships with a common purpose and for mutual benefit). As can be seen, these usually involve Universities and RACFs, but it is also possible for vocational education and training (VET) providers to be involved. For example, two affiliations studied included VET providers because they were making provision for Certificate III or IV Aged Care Workers.

Table 3: Some examples of TNH affiliations in Australia

University/RTO partner	RACF partner/s
Australian Catholic University	RSL LifeCare, NSW
Flinders University of SA	Helping Hand Aged Care + Resthaven + Southern Cross Care (includes RTO partner for SCC only) + Bupa + ECH
Flinders University of SA	ACH Group
University of SA	Helping Hand Aged Care
University of Canberra	Calvary Retirement Comm + Kangara Waters Illawarra Ret.Trust + Morshead Home for Vets
University of Western Sydney	Chesalon Living, NSW
University of New South Wales + Western Institute of TAFE	HammondCare, NSW
Flinders University of SA	ACH Group + Resthaven
Deakin University	Chestnut Gardens + Domain Principal Group, Vic
University of Tasmania	A wide no. identified, building on previous affiliation
University of Wollongong	Uniting Care Ageing, NSW
Murdoch University (Plus Notre Dame University + Curtin University)	St Ives Group, WA
James Cook University	Good Shepherd Home, Townsville
Australian Catholic University	Lilian Wells NH + Chesalon Living + Marian NH, Benevolent Society, Parramatta, NSW
La Trobe University	Ian Brand NH (new care model being developed to support a new affiliation)
University of Newcastle	Warabrook Centre for Aged Care
– 4 LifeSA (RTO) (no research component)	Masonic Homes, SA

RTO = Registered Training Provider (ie VET sector)

3.1.1 DRIVERS FOR THE TNH AFFILIATIONS

The reasons identified in the literature review (see *Section 2.3.1* and *Table 1)* for forming a TNH were reflected in the interview findings. The first driver is usually associated with education providers, the second and third are shared by education and aged care providers, while the fourth and fifth are usually RACF-initiated.

1.   **To develop effective clinical placements**.

See **Case Study 3**, *Section 3.1.1.1,* for an example of this driver leading to a TNH affiliation. All of the affiliations studied had this as a key driver for their formation.

2. **To undertake collaborative and clinical care focused research, and related to this, to support a learning culture in the RACF**. Some RACFs identified a synergy between the TNH model and their organisation's own *learning culture,* and a wish to sustain that culture.

3. **To enhance the quality of care provided by evidence (research) based methods.**

   One small RACF sought only a *research* focus for its work, and has never pursued a teaching role. It was driven by the goal of enhancing clinical care through an evidence base, and realised that this was dependent on collaboration with a university. For some RACFs, involvement in evidence based practice is seen not only as having a positive impact on care but was as making the workplace more interesting and attractive for existing and future staff, as well as increasing overall profile with residents and their families.

   'We expect research to be part of evidence based practice which makes the organisation a magnet because of its best practice.'

4. **To increase aged care workforce recruitment by attracting students and graduates involved in placements**. Related to this driver, is that of reducing negative and ageist attitudes on the part of some students to working in aged care.

   'To address future issue of the availability and ageing of the current aged care work force.'

   'We believed it could and can provide valuable learning for students and staff about what aged care really means. It addresses the accusation of aged care being a backwater/cottage industry.'

   RACFs who have been initiators identify the need to *enhance their recruitment processes or address workforce shortfalls*, seeking to engage students while on placement, and provide a positive learning experience that would encourage them to see employment with the RACF after graduation. One RACF in this situation established an affiliation with a Registered Training Organisation in order to provide a Certificate III Aged Care for its staff and to encourage recruits in this stream. It reported substantial success in doing so.

   'We need to build a more advanced strategic way of working to build the workforce of the future. The key thing is finding placements across a range of health care with sufficient quality.'

   'The driver is to better address workforce needs in aged care through innovative models that support growing your own staff, having better prepared staff for the aged care sector, and creating an environment of ownership of roles in aged care. '

In identifying how their TNH had come about, those interviewed often pointed to long standing but loose associations that were typically geared to facilitating student placement.

   '[name of university]… has a long and extensive aged care linkage with [name of aged care provider]; over 10 years of taking students and lots of research activity… a very good example of affiliation.'

Although not asked to date the implementation of their TNH (because it was understood that these usually evolve gradually and slowly), a number of people provided approximate dates for the formation of a TNH affiliation, and the period from 2005 onwards stands out as a time of activity for several. Two dated their affiliation to around the year 2000. One Victorian affiliation received funding to build a 'greenfield' aged care

facility that would also promote a particular and innovative model of care. A number of those interviewed identified a wish to be innovative as driving their participation.

3.1.1.1 CASE STUDY 3: PACE -IMPROVING CLINICAL EDUCATION FOR AGED CARE NURSING

Case Study 3: 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.

3.1.2 GEOGRAPHICAL LOCATION

The majority of the affiliations studied were located in metropolitan locations, followed by outer metropolitan sites. None were in a remote setting, and only five people identified a rural location. There are a number of challenges associated with delivery in rural and remote settings, and these are discussed in *Section 3.4.1 and Section 3.5.*

3.1.3 SIZE OF THE RACFS: THE IMPORTANCE OF CRITICAL MASS

There was a clear trend identified in the research literature for participating RACFs to be **large** in size, reflecting a literature finding that a certain critical mass is necessary to provide sufficient learning opportunities for students and to ensure sufficient well trained staff to supervise and interact with students. From the interview information provided, approximately –

- o 27% of the RACFs studied can support between 51 and 100 residents;
- o a further 27% support between 101 and 500 people; and
- o 23% support between 501 and 1000 clients.
- o A further two organisations (9.1%) have more than 1000 people in their care.

In the few cases where this trend did not occur, a number of smaller RACFs were involved with in networks that rotate and share clinical placements in order to broaden learning opportunities, and share the load of placement on facilities. One representative from a smaller size RACF noted that their lack of critical mass had been a substantial barrier to continuing with the affiliation.

RACFs were also asked if they provide **care packages**, as one indicator of possible breadth of care experience they can offer to students. Only 27% of RACFs studied do *not* also provide care packages, indicating that the majority can offer a range of learning opportunities for students in care provision, both facility and community based. Most of the packages being provided are CACPs (low level care) and EACH (high level care), followed by EACH Dementia packages.

3.1.4 SPECIAL NEEDS OF RESIDENTS: BREADTH OF LEARNING OPPORTUNITY

Also critical to the diversity of learning experience that can be provided in a TNH are the different types of resident need for which specialist services are offered. The overwhelming majority of those studied are supporting older people with a variety of special needs. In order of frequency, these involve people:

- ⇒ With significant dementia
- ⇒ With complex care needs
- ⇒ With challenging behaviours
- ⇒ Receiving palliative care
- ⇒ Receiving end of life care
- ⇒ From a CALD background
- ⇒ With severe mental illness
- ⇒ From an Indigenous background (very few facilities).

3.1.5 DISCIPLINES INVOLVED IN THE TNHS

In both the literature review and the findings from the scoping study interviews, **nursing** was the predominant discipline involved in a TNH and providers of education were usually schools of nursing. However, some of the affiliations studied involved collaborations with VET providers (both public, that is, TAFE and private registered

training organisations) for the purpose of training Certificate III and IV Aged Care Workers. Not all of these were part of a TNH affiliation. There was also a trend for **allied health** involvement, particularly involving physiotherapists and occupational therapists. In a few instances, medical practitioners were part of TNH training. *Table 4* provides details.

Table 4: Disciplines involved in TNH training program

Discipline	No of RACFs
Registered Nurses	20
Enrolled Nurses	12
Aged Care Workers	12
Allied Health – Audiologists	0
Allied Health – Dietitians	7
Allied Health – Physiotherapists	15
Allied Health – Occupational Therapists	13
Allied Health – Podiatrists	4
Allied Health – Psychologists	5
Allied Health – Social Workers	3
Allied Health – Speech Pathologists	3
Allied Health – other (Exercise Physiologist)	2
Allied Health – 0ther (dental)	1
Allied Health – 0ther (Pharmacy)	4
Dementia specialists	5
Medical practitioners – generic	4
Medical practitioners – geriatric specialists	1
Indigenous specific staff	1
CALD specific staff	3
Specialists in managing challenging behaviours	8
Specialists in managing complex health needs	6
Specialists in wound management	7
Specialists in continence care	8
Mental health specialists	4
Palliative care staff	9
Other	
Not answered	4
Total	**22**

As the literature review identified, proponents of the TNH model identify multidisciplinary collaboration as ideal, but in practice, it is less of an occurrence. This is likely to be due to the challenges involved in coordinating education provider disciplines and those working in the aged care facility. One of those interviewed identified the importance of agreeing on a lead discipline as one strategy for managing multidisciplinary involvement.

Some of the developing TNH affiliations have deliberately structured a multidisciplinary focus into their model – as is illustrated in **Case Study 4** below.

Case Study 4: Interdisciplinary-focused aged care training

Affiliation: University of SA and Helping Hand Aged Care, Adelaide

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.**

3.1.6 RESOURCING OF THE TNHS

It is clear from the literature review and from interview findings, that TNHs require dedicated and ongoing resourcing in order to meet their goals of quality care, quality teaching and clinical research. Funding is needed to support two key types of resources, both of which emerge as essential to TNH effectiveness –

1. **Human resources** – typically this involves Clinical Educators who are located in the RACFs and are responsible for clinical placement teaching, Clinical Placement Coordinators who undertake the administrative responsibilities associated with placements, trained mentors (sometimes also fulfilled by the Clinical Educators) who support and guide staff – many of whom will lack confidence in their ability to teach by example or to supervise students – and who support and guide students (again, the Clinical Educator may fulfil this role). Some affiliations have appointed a workforce development officer, others a project officer, and others an overall coordinator. It is also apparent that a sufficient number of Registered Nurses will be needed, especially when nursing students are involved. Some of those consulted identified that they had withdrawn from an affiliation because of insufficient RN numbers in a facility.

There is variety in the way human resources are defined and utilised, but there was a strong trend for Clinical Educators and Clinical Placement Coordinators to be funded by participating universities - see for example, **Case Study 3** *Section 3.1.1.1.*

There are some RACFs who have invested in human resources, drawing on their own funding sources. For example, by funding or co-funding the appointment of a Chair - see **Case Study 4** (*Section 3.1.5.1*), **Case Study 2** (*Section 2.3.4.1*) and **Case Study 6** (*Section 3.1.8.1*).

Critical to the amount of human resourcing required, is the ratio of students to teaching and aged care staff. It has been difficult to obtain precise figures for this – either in the literature or through interviews. However, a few affiliation representatives have offered ideal examples, such as –

⇒ 8 students: 1 Clinical Educator
⇒ 2 students : 1 RACF
⇒ 1 student: 1 RACF staff involved in teaching
⇒ 1 student : 4 – 6 Personal Care Workers.

Interviews undertaken for this scoping study sought information from education providers about the number of students involved in each affiliation. Indicative numbers ranged from 10 to 258 students in first year; from 10 to 540 students in second year; from 10 to 50 or 60 in third year, and from 2 to 12 in fourth year. Very few post graduate students were identified. (The courses undertaken were consistent with the disciplines identified in *Table 4.*)

2. **Physical resources** – most RACFs are designed solely with care functions in mind, and lack the physical infrastructure required to be an effective teaching facility. Apart from buildings that are designed to provide lecturing, tutoring, simulation laboratories, support and administrative functions, there is also a need to resource a range of teaching aids and equipment to ensure that students can apply theory to practice. Some of the affiliation representatives consulted have designed state of the art infrastructure that includes new technologies such as, interactive TV screens and e-learning aids – see **Case Study 5**, *Section 3.1.6.1*. One RACF representative pointed out that physical design must support a range of learning methodologies, and can also reflect philosophies of care –

'… space must not be limiting; it must be the least restrictive and reflect wellness.'

Those affiliation representatives providing information about **current funding sources** (for both human resources and physical infrastructure) have identified several:

➢ Health Workforce Australia (mainly clinical training initiatives)
➢ State government health or ageing agencies
➢ Department of Health and Ageing
➢ RACF internal funding
➢ University funding.

Case Study 5 illustrates that a range of funding sources can support different aspects of a TNH, and therefore, the TNH Initiative, when implemented, will rely on policy level collaboration and cooperation as much as on local level collaboration at the TNH level. It also exemplifies a focus on multidisciplinary care and care across the aged and sub-acute sectors, as well as integrating state of the art teaching infrastructure and resources.

Case Study 5: 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 with Mr Jeff Fiebig, the ACH Group and SA Minister of Health Press Release 11/1/11

3.1.7   FORMALISATION OF THE AFFILIATION

Most, but not all of the TNHs studies, involved the use of a Memorandum of Understanding (MOU) to formalise the affiliation and associated governance arrangements. These trends are quantified in *Table 5.*

Table 5: Formalisation of TNH affiliations

Type of partnership	No of affiliations
MOU in place	14
Informal collaboration (includes one developing an MOU)	3
Total	**17**

Some of those interviewed noted the value of the MOU in establishing clear lines of communication, roles and responsibilities. Others also provided clear guidelines for students, for example, in relation to ethical issues, rights of residents and accompanying detailed information with an operational focus (for example, wearing of uniforms).

In some cases, university partners identified that it was their responsibility to undertake criminal record checks on students prior to clinical placement.

In the case of one affiliation that had lapsed following the departure of a key person, one partner commented that the MOU had been imbalanced, focusing on the needs of one with little attention to the other partner. **This illustrates (and is reflected in the research literature) that it is not sufficient to have an MOU in place, but to have an MOU that addresses the needs of all stakeholders and reflects their expectations and motives for involvement. Similarly, collaboration will be driven by the meeting of mutual needs, otherwise the incentive to do so is minimal. MOUs should reflect this.**

The content of a MOU will vary but some of those consulted pointed to the importance of it reflecting best practice in clinical care –

> *'…clinical standards underpinned by clinical best practice established in learning environment and relevant governance and insurance managed as agreed through MOU.'*

Those who provided details about governance arrangements identified the need for structures and processes relating to ensuring clinical standards and addressing curriculum, administration, and ongoing funding. Structures usually took the form of Steering Committees, with some dedicated to specific issues such as Research Ethics or Clinical Education. Difficulties were occasionally identified in relation to sharing intellectual property, which is a challenge faced by partnerships of all kinds.

> *'Intellectual property was a "show stopper" and a key thing to negotiate. [the university] had a clear policy on IP that had to be navigated to address their concerns about research results. The plan is to address this on a case by case basis addressing the legitimate concerns of the Uni.'*

Very few indicated that they had formalised dispute resolution provisions, with most indicating that this was not seen as necessary, and was addressed on a case by case basis. One person interviewed suggested that governance structures could address disputes, for example, through a project management group of major stakeholders to oversight key aspects of development and implementation. Most appear to rely on aged care and higher education sector methods of quality control, for example, accreditation and associated approaches.

3.1.8   INVOLVEMENT IN RESEARCH

Most of those interviewed are participating in a TNH affiliation that involves clinically focused academic research, undertaken collaboratively. One affiliation has appointed a full time research fellow dedicated to the TNH, and who works with university partner researchers –see **Case Study 3,** *Section 3.1.1.1*. Another has appointed a Chair with a Research Assistant – see **Case Study 2,** *Section2.3.4.1*, while those involved in the affiliations presented in **Case Study 4**, *Section 3.1.5.1* and **Case Study 6**, *Section 3.1.8.1* have funded conjoint Chairs.

Examples of clinical research undertaken due to a TNH affiliation involved projects relating to –

- ⇒ pain management
- ⇒ dementia, including sensory therapy, music therapy, and behaviour management
- ⇒ management systems
- ⇒ veterans' health and rehabilitation,

- ⇒ quality of life
- ⇒ mental health, including post traumatic stress syndrome
- ⇒ Falls management
- ⇒ Person centred care
- ⇒ Oral health in aged care
- ⇒ Social isolation of older people.

Case Study 6: 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.

3.1.9 STRATEGIES DEVELOPED FOR A GOOD LEARNING ENVIRONMENT

A TNH should be a place that excels in its teaching of students, and affiliation representatives were asked to identify the strategies they had put in place to promote a good learning environment.

'The model is not only about teaching services, it is about changing aged care services.' **(RACF provider)**

Usually multiple strategies were involved, with the following range identified (in order of frequency) –

- ✓ Purpose-built infrastructure
- ✓ A structured learning plan for students
- ✓ Designated Clinical Educators in the RACF
- ✓ Structured and comprehensive orientation by the education partner for both students and RACF staff
- ✓ Provision by the education partner of mentoring for RACF staff to engage and support them in their teaching or supervision role
- ✓ Provision by the education partner of ongoing training and supervision opportunities for Clinical Educators and other staff, including specific encouragement of staff to further their studies
- ✓ Involvement of the RACF in curriculum design and development
- ✓ 'Buddying' of students with RACF staff
- ✓ Multidisciplinary involvement and holistic focus.

Less commonly identified were the following strategies –

- ✓ Peer learning and mentoring of younger students by older students
- ✓ Establishment of clear lines of communication between education provider, aged care provider and students
- ✓ Low staff to student ratio in the TNH
- ✓ Use of e-learning
- ✓ Application of adult learning principles
- ✓ Demonstration of clinical care that is a) holistic b) consumer focused c) restorative
- ✓ Exposing students to multiple care philosophies and practices, and different types of aged care – eg community, hospital-community interface or transition care
- ✓ Payment of students by the RACF (one RACF using this approach argues that this is effective when accompanied by a strategy of integrating students into the clinical team – in an apprenticeship type of model).

'Students are integrated into the work force. They are there to make a difference, not off to the side. It is an inclusive model. Goal is get them to feel part of the team with a purpose. "You have a value to us, not just learner and teaching."'

3.1.9.1 ATTENTION TO ORIENTATION

It was clear from the literature and the interviews, that structured orientation is critical to effective clinical placement. This is seen as essential to prepare students, and also RACF staff and requires significant thought by the education provider. A common strategy is to provide a one or two day workshop that brings students and both sets of staff together.

One affiliation has orientation process that includes the following:

⇒ An orientation pack that included information on aged care, the role of the Registered Nurse in aged care, a brief description of each facility involved, and of the funding model of aged care, information on standards and accreditation, and information on manual handling. The booklet was posted on the university access site for students.

⇒ In addition students meet with facilitator as part of a group to discuss the placement.

⇒ Students and their facilitator are brought together for one day of orientation and this session has had positive feedback.

Another affiliation uses this orientation approach:

⇒ A pre-clinic meeting with a focus on aged care as well as the learning objectives etc. for the clinical placement, and the manner in which the student will conduct themselves during a clinical placement. This is delivered to the students by the academic facilitator at the university.

⇒ The RACF organises a one day orientation workshop with a focus on communication lines in the RACF (the need for this arose from needing to get consent from residents), the implications of being in the resident's home, and operational information.

In some cases, orientation includes 'buddy shifts' in which the mentoring staff member of the RACF works with the student to orient them to standards of practice.

3.1.10 TRAINING DELIVERY METHODS

The usual method of delivering training, not surprisingly, is face-to-face in the aged care setting, with some theoretical input at the education or training provider's site. This is considered to be essential for skill and knowledge transfer. However, some TNHs provide a range of online resources to support and supplement, but not replace, the face to face delivery. These take advantage of new information and communication technologies.

> *'By the end of the project there will be a series of quite sophisticated e-learning tools which are new to aged care.'*

> *'There is now more ability to supervise distance learning e.g. ipads.'*

Case Study 5, *Section* 3.1.6.1 exemplifies a developing TNH affiliation where significant attention has been paid to physical infrastructure and teaching resources in order to maximise the learning environment.

3.2 POTENTIAL POSITIVE AND NEGATIVE OUTCOMES

Both the literature review and the structured interviews sought specific information about the positive and negative outcomes that can arise from a TNH, with the interviews also examining unintended consequences – both positive and negative – as they specifically relate to the four key stakeholder groups (aged care residents, aged care providers, aged care students, and aged care education and training providers).

The majority of the affiliations appear to have undertaken evaluations but these vary in terms of their focus and whether or not the evaluation was internal or independent. However, throughout the interviews it was clear that those involved in a TNH affiliation were clear about the possible benefits and the challenges involved. In addition, one of the questions in the interviews asked affiliation representatives to rate, using a five point likert

scale, their level of agreement with 10 statements, each of which represented a consistent finding in the research literature about TNH benefits. The sixth dimension of the scale offered the option of not being able to assign a rating.

Figure 1 provides a summary of the average ratings assigned to each benefit. It can be seen that there is consistency in a very strong level of agreement with the benefits that relate to *achieving a positive learning environment* and for the *synergies enabled between research, education and care* – these received average ratings of **4.9** out of a possible '5'.

The benefits seen as less likely, but still receiving average ratings of **4.3**, relate to enhancing the capacity of aged care staff to address complex health and care needs, and increasing staff retention. Interestingly, the TNH model is seen as slightly more likely to increase staff recruitment, with an average rating of **4.4**. This is attributed to the likelihood of a quality clinical placement encouraging students to enter aged care, particularly with the provider hosting their placement. Details about ratings for each benefit appear in *Figure 2* through to *Figure 11.*
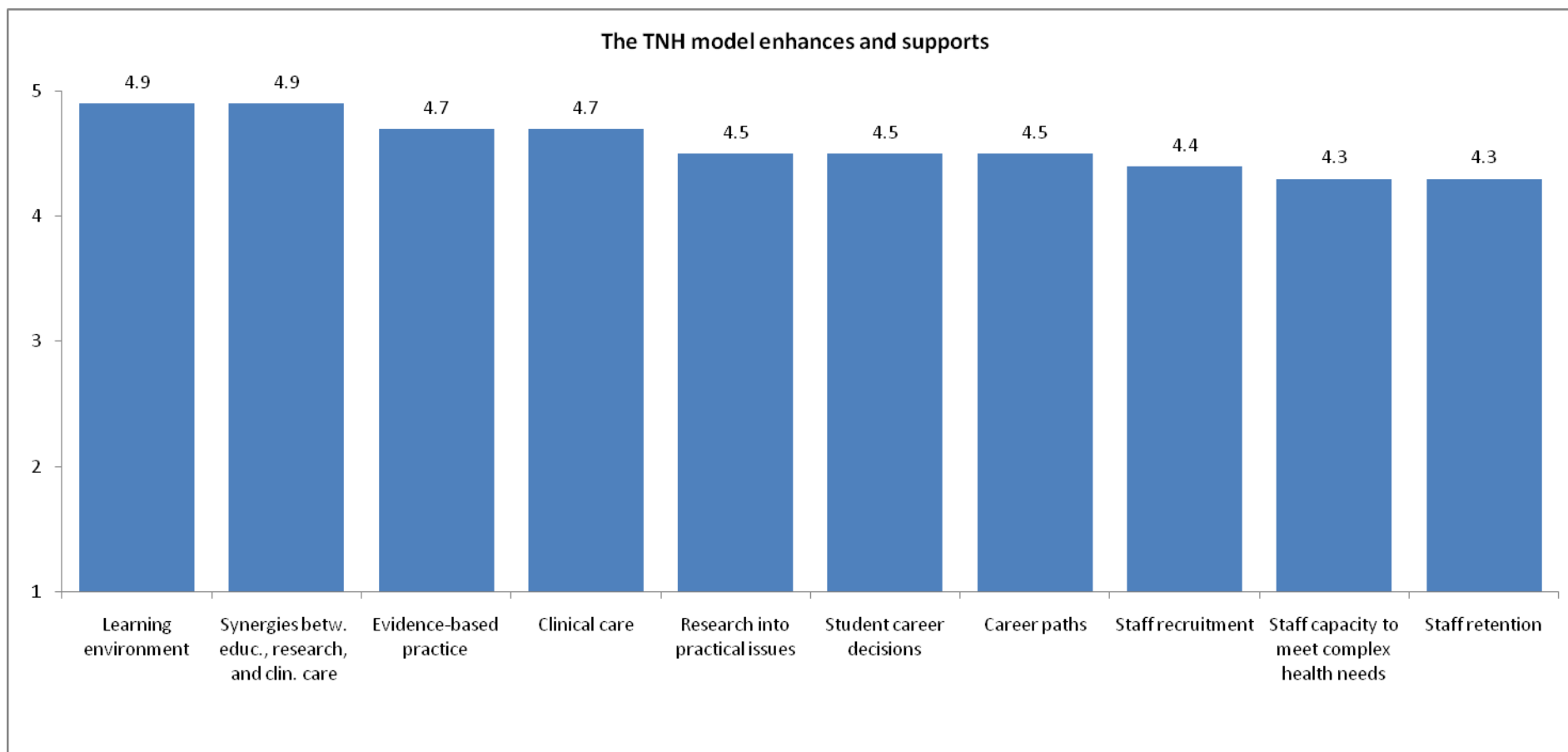
Figure 2: The TNH can provide a good learning environment for students

Learning environment

- Strongly Disagree:
- Disagree:
- Neutral:
- Agree: 5.7%
- Strongly Agree: 91.4%
- Unsure/unable to say: 2.9%
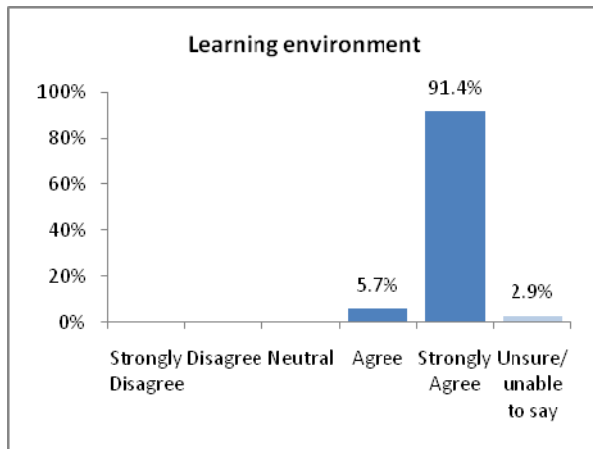
Figure 3: The TNH creates synergies/builds linkages between education, research & clinical care

Synergies betw. educ., research, and clin. care

- Strongly Disagree:
- Disagree:
- Neutral:
- Agree: 14.3%
- Strongly Agree: 82.9%
- Unsure/unable to say: 2.9%
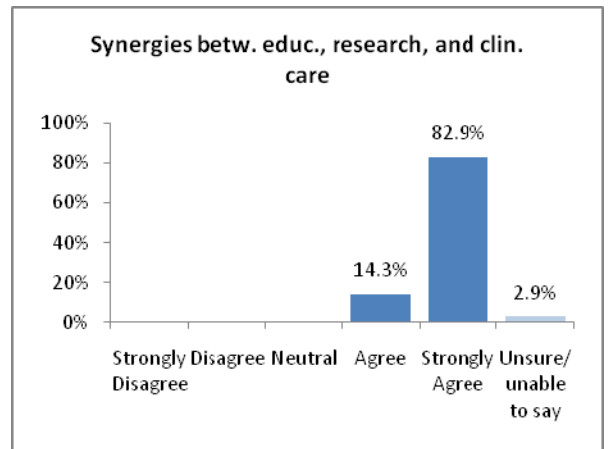
Figure 4: The TNH is likely to increase evidence-based practice within aged care homes

Evidence-based practice

- Strongly Disagree:
- Disagree:
- Neutral: 2.9%
- Agree: 25.7%
- Strongly Agree: 68.6%
- Unsure/unable to say: 2.9%
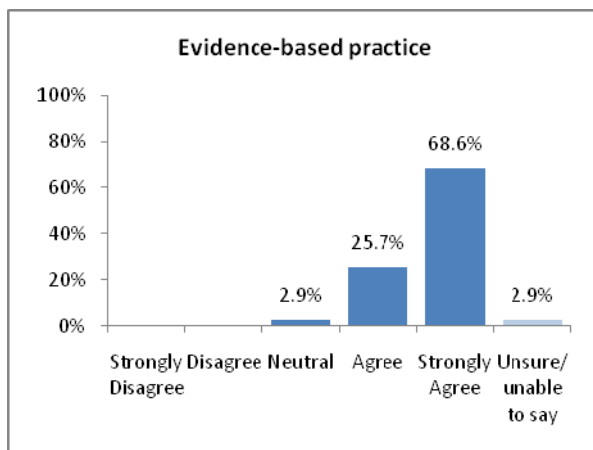
Figure 5: The TNH supports clinical care of older people

Clinical care

- Strongly Disagree:
- Disagree:
- Neutral:
- Agree: 22.9%
- Strongly Agree: 62.9%
- Unsure/unable to say: 14.3%
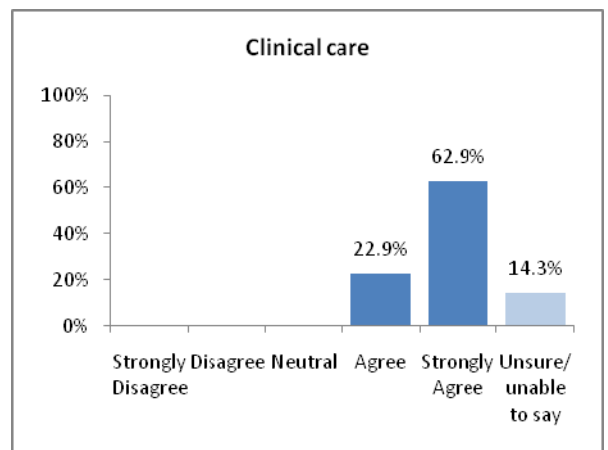
Figure 6: The TNH supports research into practical issues of concern within aged care

Research into practical issues

- Strongly Disagree:
- Disagree:
- Neutral: 11.4%
- Agree: 28.6%
- Strongly Agree: 57.1%
- Unsure/unable to say: 2.9%
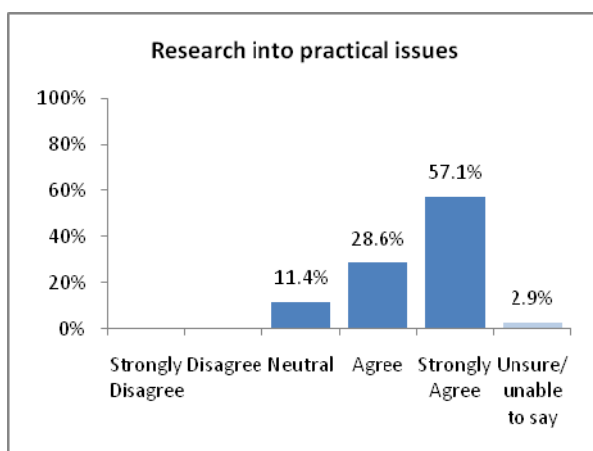
Figure 7: The TNH is likely to positively affect student decisions about whether to pursue a career in aged care

Student career decisions

- Strongly Disagree:
- Disagree:
- Neutral: 14.3%
- Agree: 22.9%
- Strongly Agree: 60.0%
- Unsure/unable to say: 2.9%
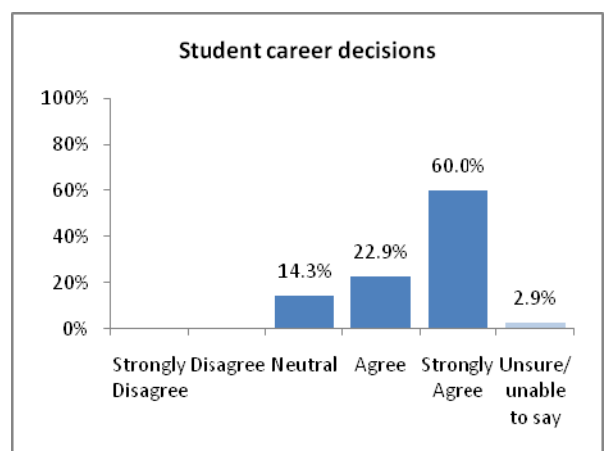
Figure 8: The TNH can build career paths in aged care

Career paths

Strongly Disagree: (none)
Disagree: 2.9%
Neutral: (none)
Agree: 42.9%
Strongly Agree: 48.6%
Unsure/unable to say: 5.7%
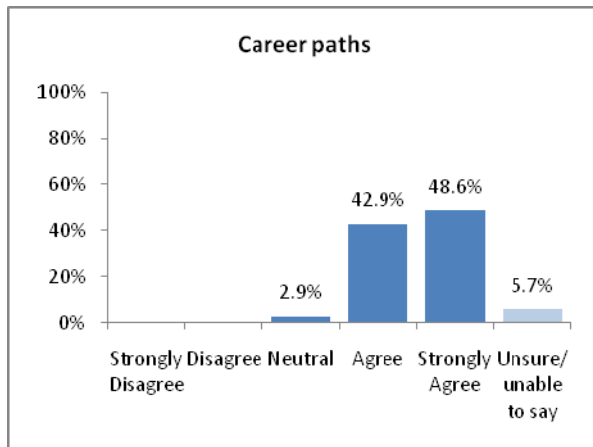
Figure 9: The TNH can enhance the recruitment of aged care staff

Staff recruitment

Strongly Disagree: 2.9%
Disagree: 5.7%
Neutral: (none)
Agree: 40.0%
Strongly Agree: 51.4%
Unsure/unable to say: 0.0%
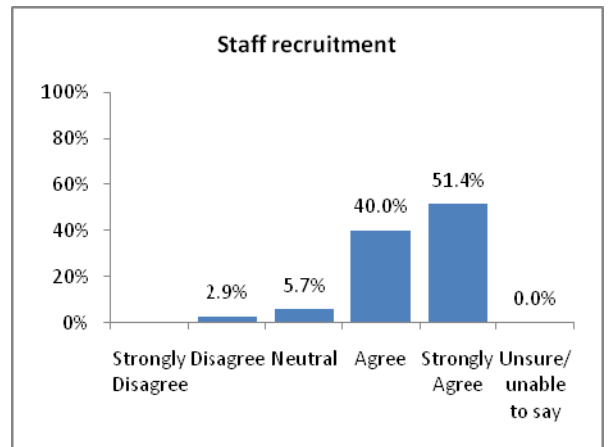
Figure 10: The TNH helps build staff capacity to meet the needs of aged care residents with complex health conditions

Staff capacity to meet complex health needs

Strongly Disagree: 2.9%
Disagree: 14.3%
Neutral: (none)
Agree: 28.6%
Strongly Agree: 48.6%
Unsure/unable to say: 5.7%
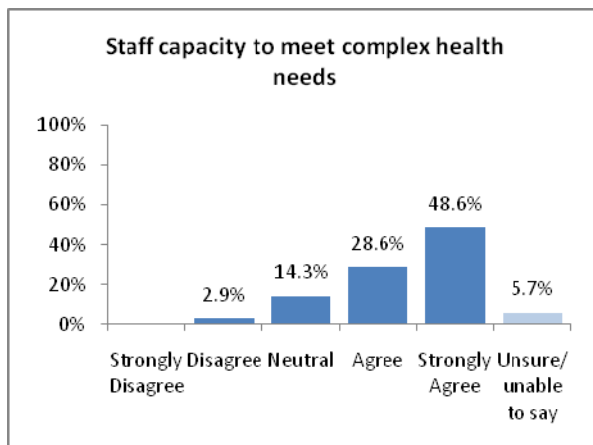
Figure 11: The TNH can enhance the retention of aged care staff

Staff retention

Strongly Disagree: (none)
Disagree: 8.6%
Neutral: (none)
Agree: 45.7%
Strongly Agree: 31.4%
Unsure/unable to say: 14.3%
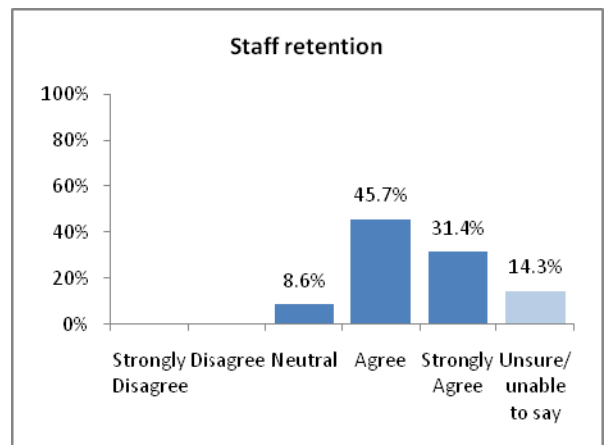
Open-ended comments that illustrate some of these benefits are included below.

'Research is an absolute added value – one door opens and another opens beyond it.'

'Makes the facility a jewel in the crown.'

'Service benefits by making the field more attractive, helps with recruitment and services improve when delivered by people with the right attitude – and the word gets around.'

'Usually get older staff now new graduates who are full of ideas, have generosity of spirit of sharing.'

'Will help to remove stigma that staff are under, "I work in a TNH" will be able to be said proudly.'

3.2.1 ADDITIONAL BENEFITS IDENTIFIED

Apart from the benefits rated above, those interviewed identified other benefits associated with a TNH. These were:

➢ Changing of negative attitudes to the care of older people and the education of their workforce, with positive shifts noted among students and university staff not associated with the TNH but from other departments.

➢ A TNH encourages existing staff to increase their own skills, knowledge and learning, with some noting that their involvement with students had inspired staff to increase their qualifications. This impact appears to be most pronounced among Personal Care Workers. Some identified the two-way learning that can occur between RACF staff and students -

'Students are a good learning resource for staff – fresh eyes for an old routine – there is mutual learning.'

'IT capacity has been increased and staff now match student IT ability.'

➢ Benefits that arise from bringing different skills, knowledge and experience together – supporting innovation and exposure to a wider range of learning opportunities than normally occurs.

'Because it brings into focus working together in partnerships and encourages working across boundaries which in other areas are barriers.'

'Has raised new opportunities – e.g. RACF has included architectural students looking at design faults.'

➢ Enables increasingly relevant training for the aged care sector because education providers are working closely with aged care providers. In several instances those interviewed noted that the RACF was consulted by the education provider in designing curriculum.

'Having an aged care practitioner have input makes sure that the course is relevant.'

➢ The training and education offered by a TNH ensures that students learn about the needs and care of older people in an aged care setting (when usually the acute care setting has been the source of this learning). This means that a range of professions and the broader health workforce benefit, regardless of whether their career destination lies in aged care. With the ageing of our population, there is an increasingly urgent need for health and other providers to be well trained in working with older people.

'Aged care is an area where students can practice really important relationships with people and practice basic skills, helping people with personal hygiene, activities of daily living, practice communication skills, in a less stressed environment, a foundation for their skills.'

3.2.2 BENEFITS TO THE BROADER AGED CARE SECTOR

Those interviewed were also asked if the positive outcomes identified have the potential to benefit the broader aged care sector. **All** of those interviewed who provided a response agreed that the TNH model

can have a positive impact on the wider aged care sector. A number of interventions were seen by them as enabling such a sector-level impact:

⇒ Provision of initial and recurrent funding
⇒ A marketing program to disseminate the positive outcomes possible and arising from a TNH.
⇒ An initiative to disseminate the research and clinical care findings arising from a TNH.
⇒ Evaluation of the initiative – methods included resident surveys, staff and student feedback, monitoring of workforce statistics (especially vacancy rates, retention rates and turnover).

3.2.2.1 INCLUSION OF ALL AGED CARE OCCUPATIONS

Both the research literature and almost all of the TNH affiliations studied for this scoping study involved universities and focused on the nursing, medical and allied health professions and therefore, on the occupations relating to these disciplines. However, despite the growth in the occupation of Personal Care Worker and their dominance in the aged care workforce over other occupations, TNH affiliations do not reflect this.

Our interviews identified three affiliations that involved a partnership with a VET provider, or Registered Training Organisation (RTO) to provide clinical placement opportunities for Certificate III or IV Aged Care students. These involved:

a) HammondCare which is partnering 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). This affiliation is presented in **Case Study 6**.

b) Masonic Homes in SA and 4Life SA, a local RTO, are involved in the early stages of a partnership designed to improve the training provided to students completing a Certificate III in Aged Care. Masonic Homes has provided input into the course, and up to 10 students are able to complete work placements at Masonic Homes' three residential care facilities in SA over a three month period. Students are 'buddied' with a care worker and senior staff. However, because there is no research component to the collaboration, and it is essentially a quality-focused clinical placement initiative, it has been excluded as an example of a TNH affiliation.

c) Southern Cross Care which is one of the aged care providers participating in the PACE affiliation described in **Case Study 3.** Although not part of the PACE affiliation, the partnership between Southern Cross Care and TAFESA and private RTO Celtic Training, is focused on Personal Care Workers (targeting between 130 and 200 first year students) and others (eg Enrolled Nurses) who are trained in the VET system. The partnership with TAFESA has been occurring for the past six years and was initiated to develop an extended Certificate III in Aged Care, and in the process, to address workforce shortfalls.

    Interestingly, the initiative involves treating students like workforce members and this includes paying them for a 30 hour a week contract and providing them with a uniform. The person interviewed argued that this cost has been justified by the enhanced retention and reduced cost of replacing and training staff as well as reduced reliance on agency staff. The strategy is also seen as enhancing continuity and quality of care.

Two of the three affiliation representatives noted that one of the challenges associated with targeting Personal Care Workers is developing culturally inclusive learning strategies, given the relatively high

proportion of these workers who come from culturally diverse backgrounds. This includes addressing language barriers. Interestingly, the Southern Cross Care-TAFESA partnership has achieved its highest retention rate among students from culturally diverse backgrounds. This is no doubt due to the specific additional support provided for these students to address language, literacy and numeracy needs, and for which separate funding was obtained. There was also a need to address initial resistance by some residents to working with CALD background students and to provide mentoring to assist these students to understand key cultural issues associated with aged care in Australia.

Consequently, where a VET provider is part of a TNH affiliation, the examples identified have also involved collaboration with a university partner in order to include a research focus. (However, one example did not include a university partner and was not research focused, and consequently is more accurately described as a partnership to facilitate student placements.) Research is not normally a VET provider activity whereas for university partners, research is a central and long established tradition of their work. Given the trend for increasing numbers of Personal Care Workers in the aged care workforce, it will be important for TNH affiliations to include VET providers. This will also enable a holistic cross-occupational focus that is largely missing from past and existing Teaching Nursing Homes, both in Australia and internationally.

3.2.2.2 ENSURING THAT THE IMPACT OF TNHS HAS SECTOR-WIDE REACH

It is important that the learnings arising from individual TNHs can be shared in order to maximise their impact and to achieve the goal of enhancing the care of older people. Achieving this outcome cannot be assumed as occurring and requires specific interventions, some of which have been identified from the literature review and from interviews with TNH representatives.

In addition, it is important to consider incentives and disincentives to disseminating TNH learnings and to develop strategies which build on the former and take into account the latter. For individual affiliation partners, incentives exist in the form of individual and organisational profile, as occurs with research publications, presentations at conferences and similar venues. Such incentives are particularly strong for university partners as publications, particularly in refereed journals, are linked to promotion and these and conference type presentations add to reputation. The key incentive of being seen as a centre for excellence in aged care is a powerful one for RACFs, and it is in their interests to promote this, which those interviewed recognise as important.

One affiliation (see **Case Study 2**, *Section 2.3.4.1*) noted that their heightened profile has seen them becoming involved in international policy forums, such as, through the United Nations, and in national policy development. The key disincentives would appear to relate to sharing of intellectual property, and wishing to retain competitive edge.

It is possible to conceive of a network of TNHs, as occurs in Norway (see *Section 2.2.5*) and which involves TNHs being 'hubs' with 'spokes' connecting them to other aged care providers (see *Section 4.1.2* for further discussion on this approach).

3.3 UNINTENDED CONSEQUENCES OF THE TNH

Those interviewed were also asked to identify any unintended consequences that had emerged from their TNH affiliation, and to separate these for each of the four key stakeholder groups. These findings are summarised in *Table 6.*

Table 6: Unintended consequences of the TNH

For aged care residents	For aged care providers
Unintended positive consequences	
Enjoyment achieved from working with students *'Run conversational cafes … students have a conversation over tea and find out that older people are really interesting, wise, have stories to tell.'*	Raised profile in the aged care sector
	Growth in learning culture. Increased staff interest in formal study.
Older people can be part of the students' learning experience. *'Most residents love the students interface … appreciate the learning environment and are very willing participants in supporting their learning … have a sense of assisting the students to achieve their qualification.'*	Some students return to work in RACF - Higher CALD student retention rate (1 RACF). Usually PCWs
	Better practice, evidence based
	Unexpectedly positive relationship with training provider
	Student presence leads to change in practice, bring new knowledge to RACFs. Increased staff motivation when students are seen to learn from them.
Unintended negative consequences	
Resistance by some to having CALD students work with them	Initial resistance by staff (resolved by mentoring to help staff see benefits of TNH)
Missing the attention when students leave	
For students	**For education/training providers**
Unintended positive consequences	
Changed attitudes to working in aged care *They never really understood that aged care was so dynamic and complex. Some were keen to come and commence their career in aged care.*	Better understanding of needs etc of partner *'Already had strong partnership but this has given a greater understanding of each other's issues and more confidence in raising issues.'*
Students often find part time work in the RACF to support them through their studies.	Other academic staff appreciate the learning opportunities presented in a RACF. *'There needs to be championing of the aged care sector within the university sector – aged care is the Cinderella sector with few people having expertise in this area.'*

For aged care residents	For aged care providers
Unintended negative consequences	
Difficulties adjusting to demands of aged care	Expected recruitment increases not achieved
Some students require additional support eg CALD students require language, literacy input	Addressing the additional learning needs of CALD background students, and resistance by some residents to working with them.
Negative impact of poor clinical placement on continuing a career in aged care.	

3.4   ENABLING FACTORS

Interviews were designed to identify the enabling factors that determine the effectiveness of a TNH, and these findings were examined against those arising from the literature review. Where relevant, enablers were separated where they applied to the *establishment* as opposed to the *ongoing operation* of a TNH. These have been listed in order of frequency in Table 7.

It can be seen that critical enablers in the **planning and early development** of a TNH involve:

⇒   Obtaining and designating funding to support the physical infrastructure and human resources required for the TNH. This includes funding dedicated positions relating to student teaching and supervision and placement coordination, and for backfilling of staff providing training, supervision and support to students. It also includes developing appropriate physical infrastructure to support teaching and learning opportunities (noting that most RACFs are designed for providing care not for teaching purposes.)

⇒   Development of clear and agreed communication lines and processes, underpinned by efforts to ensure each partner has an understanding of the other's operating environment; and designing of clear links and feedback loops connecting research, education/training and clinical practice and supporting coordination generally.

⇒   Strong and effective leadership by both partners, underpinned by a clear commitment to the TNH model. This leadership is important to ensuring the TNH is supported by staff in each partnering organisation. It should be noted that leadership alone is not sufficient to ensure the sustaining of a TNH – this should not rely on individual goodwill and commitment, but should involve the engagement of groups of champions within the organisation with the underpinning of a formalised agreement.

'A strong underpinning and will to collaborate is essential to be able to work through this.'

⇒   Clarification of mutual expectations and values, and details of how the TNH will be implemented, preferably through a formalised agreement such as, an MOU

⇒   Design of structures and processes to address resident rights and ethics associated with research and other aspects of the TNH. For example, Research Ethics Committees can be established to

approve research projects in the RACF and these can include resident representation. This helps to address one of the concerns raised about the TNH, namely, that it needs to acknowledge teaching is occurring in a person's home and that there are a number of rights that must not be overridden.

Interview and literature findings also indicate that the establishment phase requires **time**, in order to support developing relationships and to take into account all of the enabling factors that must be addressed. Similarly, the impact of a TNH in areas such as enhanced clinical care or workforce development will also take time and requires longitudinal monitoring and evaluation.

Sustaining a TNH is also essential, and the interviews and literature findings have identified a range of enabling factors for ongoing implementation. These involve:

➢ Provision of recurrent funding to support ongoing costs, including clinical educators and RACF staff providing teaching and supervision, with backfilling for them to do so. Such funding also recognises the time involved for all partners in collaboration and effective communication.

'If there was a funding line, we would have RNs who would say "pick me" but they do not want to leave other nursing staff short by being drawn into teaching.'

'People have enormous interest in providing opportunities for students but do not have the resources.'

'Workload holds people back – it is hard to do research and make time and resources available to clinicians to enable them to participate other than theoretically.'

➢ Provision of opportunities to maximise student learning, including multidisciplinary and holistic care, exposure to a range of care services and philosophies as well as to specialisations (such as dementia or palliative care).

➢ Design and delivery of a positive placement experience for students, that includes a sound orientation program for students, and participating RACF staff. It also includes a sufficiently flexible learning program that can be customised to meet changing student need, changing aged care sector need and workforce trends.

➢ Providing opportunities for clinically-relevant learning and upskilling for RACF staff.

➢ Training of RACF staff in supervision, as well as the provision of structured mentoring and other forms of support for supervisors by the education partner.

➢ Processes to shape clinical research (eg structured input by RACF staff) and to feedback research findings to clinical practice (eg workshops between education and RACF staff).

➢ Development of strategies to disseminate learnings and outcomes arising from the TNH, for the benefit of the aged care sector as a whole and to raise the profile of affiliation partners, leading in turn to attracting more students and graduates.

➢ Ensuring that monitoring and evaluation processes are built in to the TNH and that the information from these is used to address difficulties that arise as well as to quantify outcomes.

➢ Providing a model of full IT literacy for the Industry to follow.

"The second most important enabler to quality would be to make the whole Industry IT literate".

➢ Providing a conduit to setting standards in the future.

'A process for quality clinical input is needed. This is where a TNH model could be used as an influence in setting standards and supporting benchmarking, allowing Industry and clinical input into Accreditation. '

Table 7: Enabling factors for a TNH

ENABLING FACTORS
Enablers specific to the Establishment of a TNH
Provision of start up funding to support the establishment costs of a TNH – these include the design of appropriate physical infrastructure and human resources to support learning
Establishment of an MOU that reflects detailed discussion about mutual expectations, challenges, benefits sought, and related issues
Design of clear communication lines and processes between the partners and all key stakeholders
Design of structures and processes to address resident rights and ethics associated with research and other aspects of the TNH.
Strong and effective leadership by the RACF and education/training provider, under-pinned by strong commitment to the TNH model
Enablers specific to the Ongoing Operation of a TNH
Provision of recurrent funding to support ongoing costs of a TNH, including appointment of dedicated clinical educators, RACF staff providing teaching and supervision (and backfilling for them to do so)
Provision of a positive placement experience for students. This includes designing a sound orientation program for students and participating staff.
Provision of clinically-related learning and upskilling opportunities for staff
Provision of training in supervision for RACF staff, and structured mentoring and other forms of support for supervisors
Provision of opportunities that maximise student learning, including multidisciplinary care teams, a range of needs and services for older people, and different approaches to care provision.
Design of processes to shape clinical research and feedback findings to clinical practice
Design of processes to customise the learning program according to changing student need, and to changing demands arising from broader aged care sector and aged care workforce trends.
Design of strategies to disseminate learnings arising from the TNH affiliation, for the benefit of the broader aged sector, and to raise the profile of the affiliation partners, thereby attracting more students and graduates.
Inbuilt monitoring and evaluation processes
Enablers applying to all stages of a TNH
Commitment of funding to support human (dedicated staff, backfilling of participating RACF staff) and physical (buildings, equipment) resources needed for a TNH
Appointment of dedicated Clinical Educators in the RACFs
A TNH affiliation that is formalised through a MOU or similar structure
Purpose built or modified infrastructure to support teaching in a RACF setting

ENABLING FACTORS
Commitment by RACF executive and other senior managers, and RACF staff to the TNH
Commitment by senior managers and teachers from the education/training partner to the TNH
Provision of opportunities and support for collaborative research with a clinical focus that is linked to clinical care
An RACF with sufficient critical mass to support a range of learning opportunities and with sufficient staff to participate in student teaching and supervision
A TNH affiliation that is characterised by collaboration, flexibility and responsiveness
Appointment of a coordinator to support the affiliation and its activities
Involvement of an RACF with a 'learning culture' or one that is striving to achieve this.

3.4.1 ENABLERS FOR TNHS IN RURAL SETTINGS

Those interviewed were also asked to identify enablers that address difficulties associated with locating a TNH in a rural setting. As none were providing in a remote location, enablers for this setting were not identified. The key challenges of small size of most rurally located RACFs and the logistics of accommodating and supporting students away from their usual environment were seen to be addressed by –

➢ Providing resources for student accommodation and support for them during their placement.

The challenge of critical mass was seen as being addressed in three ways-

➢ Building on the care model that exists in most rural (and remote) settings of incorporating aged and health care services into local hospitals, it was suggested that TNHs also include affiliation with hospital and other medical providers.
➢ Two affiliations are using mobile clinics to deliver TNH services, one of them noting that the hub for this was the nearest regional centre.
➢ Two affiliations suggested that rural TNHs are part of a network that is linked to a larger facility, along the lines of a 'hub' and 'spoke' strategy.

Details appear in *Table 8.*

Table 8: Enablers for TNHs in rural settings

Enablers
Provision of physical infrastructure and funding to accommodate students
Co-location and affiliation between local hospital and RACF/TNH and education/ training provider – addresses issue of small critical mass
Provision of support of various kinds to students undertaking a clinical placement away from home and their usual support sources
Use of mobile clinics
Making rural TNHs part of a network, linked to a larger facility

3.4.2   ESSENTIAL CHARACTERISTICS OF TNH ORGANISATIONS

Based on the information yielded by the literature review and the interviews undertaken, the following RACF features have been identified consistently as critical for an effective TNH, and therefore, for enabling a RACF to participate in such affiliations. Obvious indicators, such as, meeting aged care accreditation and related standards are taken as given.

✓   An organisation with *critical mass* covering different services and client need, sufficient staff to be involved in teaching and supervision. It also includes use of multiple sites where individual RACFs lack such mass.

✓   An organisation with a *learning culture* – that is, one that regards learning as a positive process that is valued, provides opportunities and encourages its staff to continue to learn, is innovative and open to change. Existing relationships with researchers are also part of this criterion. The aged care provider participating in a TNH is either committed to being, or has already become, an organisation with a learning culture, and this too is central to an effective TNH (Robinson *et al* 2008).

✓   An organisation that is *committed to the goals of a TNH*, that is, linking education, research and clinical practice, and to ongoing improvement in the delivery of care.

✓   *Staff* who have kept up to date with clinical practice developments, have good clinical skills and knowledge, and are willing to work with students and are interested in learning.

3.5   BARRIERS AND CHALLENGES

Interviews were also designed to identify the barriers and/or challenges that limit the effectiveness of a TNH, and these findings were examined against those arising from the literature review. Where relevant, these were separated where they applied to the *establishment* as opposed to the *ongoing operation* of a TNH. These have been listed in order of frequency in *Table 9*.

Critical barriers and challenges associated with the **planning and early development** of a TNH involve:

➢   Lack of funding to support the establishment costs of a TNH – that is designing physical infrastructure and developing the human resources required.

➢   Failure to clarify key issues of governance, education, research, clinical care between partners, as well as to clarify mutual expectations, and to formalise these in a MOU.

➢   An absence of strong and effective leadership by both partners, underpinned by a significant commitment to the TNH model.

➢   An absence of clear communication lines between the partners, and within their organisations. This is crucial at all stages of a working relationship, and is most difficult to achieve in the earliest stages of such a relationship before trust and familiarity has been established.

➢   Resistance by staff and/or residents to having students working with them, which can be a result of a failure to consult with residents, their families and staff in the development of a TNH. It can

also, in the case of staff, reflect a heavy workload to which the TNH is perceived as an additional burden, rather than an opportunity.

➢ To a lesser extent, TNHs can be impeded (especially in being recognised as teaching centres of excellence) by the absence of a tradition, (comparable to that of the acute care sector and teaching hospitals), where RACFs are learning organisations designed to provide both care and learning opportunities. **As such, TNHs are pathfinders who need to create reputation rather than rely on tradition to do this for them.**

The interviews and literature findings have identified a range of challenges associated with the **ongoing implementation and sustaining** of a TNH, in particular:

➢ Lack of dedicated and recurrent funding to support human and physical resource requirements.

➢ A major barrier to TNHs arises from negative and ageist perceptions associated with the care of older people and with ageing more generally, with RACFs suffering by association. Paradoxically, TNHs whose profile is lifted because they develop a reputation for sound research, education and clinical care help to shift such perceptions, and are less affected by such a challenge.

➢ Absence of RACF critical mass to support a range of learning opportunities and to enable some staff to participate in student teaching and supervision is a major impediment.

➢ Difficulties faced by the RACF in recruiting and retaining their workforce, with high turnover of staff having a particularly negative impact on a TNF.

➢ Loss of key individuals who have been champions in a TNF is also significant, with some having lapsed because of the gap left by such people. Associated with this barrier is a reliance on the commitment of individuals to sustain a TNH, so that when they leave their positions, a void is created and the TNH struggles to survive**.**

➢ Many RACF staff lack the confidence and skills needed to teach and supervise students, and a failure to address this (eg through specific training and support) will act as a barrier to the effectiveness of a TNH. Exacerbating this barrier is that RACFs tend to not have the capacity, personnel or budgets to support and train students, and their workload can make the addition of teaching responsibilities onerous.

➢ Related to this is a failure to provide dedicated Clinical Educators and other key personnel in the RACF to support and sustain the TNH.

➢ Failure to create a positive learning experience for students is also identified as detrimental to the sustaining of a TNH, and this is related to a failure to provide a range of opportunities to learn about different care needs and different approaches to providing care. This includes opportunities for multidisciplinary learning and care, although it is recognised that some TNHs may be designed to enable specialisation, for example, in dementia or palliative care provision.

➢ Several of those consulted have identified the absence of career pathways for both participating RACF and education provider staff arising from their involvement in a TNH. For example, academic staff involved in a TNH may not have their role recognised when the usual university benchmarks for success predominate. Those providing clinical education, supervision and teaching of students

appear to lack a career structure for teaching related activities in a RACF. The lack of a career structure in aged care is also seen as a barrier for clinical staff.

Table 9: Barriers and challenges for a TNH

BARRIERS AND CHALLENGES
Barriers and challenges specific to the Establishment of a TNH
Lack of start up funding to support establishment costs of a TNH
Failure to formalise through a MOU that reflects detailed discussion about mutual expectations, challenges, benefits sought, and related issues
Lack of strong and effective leadership by the RACF and education/training provider, under-pinned by strong commitment to the TNH model
Lack of clear communication lines and processes between the partners
Residents' resistance to having students working with them
Staff resistance to working with students – often driven by a heavy workload
The absence of a tradition, comparable to that of the acute care sector, where RACFs are learning organisations designed to provide care and learning opportunities
Barriers and challenges to the Ongoing Operation of a TNH
Difficulties faced by many RACFs in recruiting and retaining their workforce, in particular, high turnover has a negative impact on TNHs
Lack of recurrent funding to support ongoing costs of a TNH, and failure to resource staff leading to burnout
Negative and ageist attitudes to older people and their care and more broadly to aged care careers and the aged care sector
Lack of funding or willingness to support clinically-related learning and upskilling opportunities for staff
Many RACF staff lack the confidence and skills and capacity (due to workload) required to supervise students
Turnover and loss of key personnel involved in driving the affiliation. Reliance on the commitment of individuals to sustain a TNH, so that when they leave their positions, a void is created and the TNH struggles to survive.
The absence of career pathways for participating RACF and education/training provider staff
Barriers and challenges applying to all stages of a TNH
Lack of funding to support human (dedicated staff, backfilling of participating RACF staff) and physical (buildings, equipment) resources needed for a TNH
RACF with insufficient critical mass to support a range of learning opportunities and with insufficient staff to participate in student teaching and supervision
Lack of dedicated human resources, in particular, Clinical Educators, a Coordinator to support the affiliation and its activities, and Clinical Placement Coordinators. Not being able to release RACF staff for teaching and supervision.
Lack of dedicated resources for purpose built or modified infrastructure to support teaching in a RACF setting
Lack of commitment by RACF CEO and other senior managers, and RACF staff to the TNH
Lack of commitment by senior managers and teachers from the education/training partner to the TNH
RACF that does not have a learning culture, or is unwilling to develop one
Negative and ageist attitudes militate against students seeking to develop careers in aged care

Insufficient opportunities that maximise student learning, including multidisciplinary care teams, a range of needs and services for older people, and different approaches to care provision

Other issues identified by some of those interviewed relate to the logistics of a TNH, and the bringing together of two very different organisational cultures and involve:

- A range of challenges arising when joint appointments are made, for example – dual accountability, and managing dual roles simultaneously.

- Bringing together different cultures and organisations, with different core purposes (eg teaching, research, service provision). Some described a tension between education and service delivery roles that can be difficult to balance.

As discussed in *Section 3.2.2.1,* the review of research and consultations undertaken for this scoping study have identified a predominant trend for TNHs to involve the higher education and not the VET sector, and to be focused on disciplines related to the nursing, medical and allied health professions. This reflects the tradition associated with TNHs and not the more recent growth in the occupation of Personal Care Worker and their dominance in the aged care workforce over other occupations. It also reflects the research tradition of the higher education sector contrasting with the almost exclusively teaching focus of the VET sector.

Given the trend for increasing numbers of Personal Care Workers in the aged care workforce, it will be important for TNH affiliations to include VET providers. This will also enable a holistic cross-occupational focus that is largely missing from past and existing Teaching Nursing Homes, both in Australia and internationally.

Representatives of the affiliations that involved a partnership with a VET provider have identified two further challenges that need to be addressed in making provision for Personal Care Workers, both of which reflect the relatively high proportion of these workers who come from culturally diverse backgrounds. This includes addressing language, literacy and numeracy barriers. There can also be a need to address initial resistance by some residents to working with CALD background students and to provide mentoring to assist these students to understand key cultural issues associated with aged care in Australia.

4   IMPLEMENTING THE TNH INITIATVE

Both the literature review and interview findings yield a number of lessons that are extremely valuable for the Australian Government's *Teaching Nursing Homes Initiative*. The factors identified regarding enablers and challenges also represent critical success factors and reflect the accumulated wisdom of those who have been involved in a TNH in a significant way.

Another lesson that arises from this information is the need to avoid the inflexibility of a single model, allowing for local differences, and varied applications of the TNH model. This is important in terms of fostering innovation, broadening the range of learnings possible, and maintaining relevance to local needs and issues.

It will also be important that the *Teaching Nursing Homes Initiative* includes a formative evaluation strategy, guided by an over-arching evaluation framework that reflects the principles and goals of the TNH model, while allowing for individual variation at the level of each TNH. In the scoping interviews with Industry and Professional organisations the question of the necessity of a structured and effective evaluation of TNHs was given a very high priority, and several of those interviewed from affiliations also emphasised the importance of an evaluation to capture the lessons learned.

The evaluation should include a database that is designed to assist TNHs to monitor their outcomes, and in a way that minimises reporting burden. As with other DoHA programs, the evaluation strategy would be based on consultation with participating TNHs, and would be designed to engage their commitment to capturing the lessons of their efforts. Given the culture of most existing and developing affiliation participants, such engagement would not be expected to be challenging. Instead, the evaluation can be designed to build on that commitment to innovation and better practice. Due to the time involved in establishing a TNH and in achieving measurable impact, evaluation should also be longitudinal so that a range of outcomes can be quantified and captured.

4.1   EXTENDING THE IMPACT OF TNHS

In an environment where the aged care sector is committed to workforce growth and development and to ongoing advances in quality care, it is essential that the learnings of TNHs are shared. This is also important in an ongoing climate of resource restrictions arising from growing demand levels, and leveraging the findings from TNHs means that the resources invested in them can be magnified in their impact. Two key strategies for achieving this outcome have emerged from both the literature and interview findings. One relates to linking to the sub-acute and acute care sectors, and the other relates to designing TNHs to be 'hubs' that are linked to other aged care services.

4.1.1   JOINING THE EDUCATION AND TRAINING, AGED CARE, AND SUB-ACUTE AND ACUTE CARE SECTORS

There are examples in the literature and among affiliations studied for the scoping study (see **Case Study 6**, *Section 3.1.8.1*) that involve training, and sometimes locating, medical personnel in RACFs while at the same time extending the partnership to include local hospitals. This has been the approach characterising veterans' care in the USA (see *Section 2.2.3*) where evaluation has found it has had a positive impact in

lifting the quality of care and reducing overall acute care costs due to RACFs having better capacity to treat residents who would otherwise be admitted to hospital.

The model applied in the Netherlands, as discussed in *Section 2.2.4*, funds the appointment of physicians in TNHs, supported by physician training and partnerships with medical educators and RACFs. This too has identified an improved capacity to provide medical care in RACFs, with a consequent reduction in hospitalisation entry and stay rates. There is a significant amount of research pointing to the cost savings achieved by avoiding unnecessary hospitalisation and reducing length of stay, including through the participation of RACFs. The TNH model can support such outcomes but requires medical partners to do so, and in particular, partners from the sub-acute sector. **Case Study 5** - *Section 3.1.6.1,* includes such an affiliation. Furthermore, the expansion of the model to include hospitals has significant relevance for rurally located TNHs, as discussed in *Section 3.4.1.*

This report has identified the need for the wider health workforce to develop the capacity to work effectively with older people, especially in the face of continuing population ageing. The TNH can support the achievement of this goal by providing education opportunities that extend beyond the aged care workforce. This includes General Practitioners and other medical providers. As one of those interviewed commented -

'Even doctors and rehab specialists will never spend more than part time in an RACF. For the future – a new kind of aged care doctor (e.g. a GP with extra qualifications) will be … [needed]…. [There is a] need to train GPs with special skills as registrars in aged care disciplines, which doesn't happen at present.'

'GPs are the backbone of Aged care – they need better support and exposure to Aged care during training.'

4.1.2 THE 'HUB' AND 'SPOKES' NETWORK APPROACH

As discussed previously, consideration should be given to establishing a network of TNHs (as occurs in Norway, and in some USA-based TNHs that were discussed in the literature review Discussion Paper – eg the University of Texas Health Science Center model). There are different ways to structure a network but in the Australian context, the concept of TNHs acting as Hubs, linking to individual RACFs through structured Spokes, appears to have merit.

This approach also supports the notion of a TNH being a centre for excellence, radiating its influence. TNHs can be seen as 'Lighthouses' providing guidance and leading by example in best practice. The stronger their individual reputation, the more likely it is that they then attract the best in education and research and clinical care, adding further to that profile. As explored in *Section 0*, a *Hub and Spoke* approach needs to be structured, and should not rely on chance.

It is likely that the most effective dissemination of findings, and promotion of the value and outcomes of TNHs, requires national and state level coordination, involving both government agencies and sector peak bodies. Not only does this enable the utilisation of existing communication networks, but it enables a proactive approach. Specific TNH seminar and conference series could be part of a TNH initiative, as could opportunities for other aged care providers to buy in support and teaching from a TNH (for example, by sending staff for work experience, or by commissioning TNH staff to offer staff training and development). Given the strong support that the scoping study has identified for the TNH, it will be important that the Initiative balances the need for individual interpretation of the model with a coordinated approach to sharing its learnings and maximising its impact at the sector level

A: SCOPING INTERVIEWS WITH THE DEPARTMENT OF HEALTH AND AGEING

PERSON INTERVIEWED	ORGANISATION
Russell de Burgh A/Assistant Secretary	Office for an Ageing Australia Dept of Health and Ageing
Andy Paras Director, Palliative Care Section	Office for an Ageing Australia Dept of Health and Ageing
Fiona Nicholls Assistant Secretary	Aged Care Workforce and Better Practice Programs Branch, Dept of Health and Ageing
Sue Hunt Senior Nurse Advisor	Office of Aged Care Quality and Compliance Dept of Health and Ageing
Eliza Hazlett Director, Better Practice Section	Office of Aged Care Quality and Compliance Dept of Health and Ageing
Anandhi Raj Assistant Director, Better Practice Section	Office of Aged Care Quality and Compliance Dept of Health and Ageing
Trish Deane Better Practice	Aged Care Workforce & Better Practice Programs Branch Office of Aged Care Quality and Compliance Dept of Health and Ageing

B: SCOPING INTERVIEWS WITH PEAK ORGANISATIONS AND OTHER KEY STAKEHOLDERS

PERSON INTERVIEWED	ORGANISATION
Ms Lesley Dredge	Aged &Community Services Australia (ACSA)
Mr Rod Young	Aged Care Association Australia Ltd (ACAA)
Prof Richard Murray	Australian College of Rural and Remote Medicine
Dr Wayne Herdy	Australian Medical Association (AMA)
Ms Jo Root	COTA Australia
Prof Patrick Crookes	Council of Deans of Nursing
Mr Mark Cormack	Health Workforce Australia
Prof James Best	National Health & Medical Research Council (NHMRC)
Ms Debra Cerasa	Royal College of Nursing Australia (RCNA)
Prof Claire Jackson	The Royal Australian College of General Practitioners (RACGP)

C: INTERVIEWS WITH REPRESENTATIVES FROM TNH AFFILIATIONS

PERSON INTERVIEWED	ORGANISATION
Ms Barbara Andracchio Education and Resident Liaison	Morshead Home for Veterans, NSW
Mr Michael Bendyk CEO	Southern Cross Care SA & NT Adelaide
Ms Lynne Bickerstaff Director of Operations for Rehab and Aged Care Services	Chestnut Gardens Southern Health Nursing Research Centre Doveton, Vic
Ms Deborah Booth General Manager	Calvary Retirement Community, ACT
Ms Angela Brown Associate Head of School	University of Wollongong, NSW
Ms Catherine Brown Clinical Nurse Consultant	Northern Territory Health, NT
Dr Peter Brown Assoc Professor	School of Health Sciences Charles Darwin University, NT
Mr Bruce Cameron Trainer Director	4 Life SA Pty Ltd Adelaide
Dr Andrew Cole Chief Medical Officer	HammondCare, NSW and School of Public Health & Community Medicine, Univ of NSW
Ms Judi Coombe GM Residential Care	ECH Inc Adelaide
Ms Megan Corlis Director Research & Development	Helping Hand Aged Care Adelaide
Ms Sharyn Cumming Manager	Chesalon Care Beecroft, NSW
Mr Jeff Fiebig Manager, Program Development	The ACH Group Adelaide
Dr Sharyn Hunter Lecturer	School of Nursing and Midwifery The University of Newcastle
Dr Stephen Judd CEO	Greater Southern Area Health HammondCare, NSW
Ms Dawn Kroemer General Manager Residential Care	Kimberley House St Ives Group, WA
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