

# **‘I’m a Person not a Job!’**

## **Establishing Core Competencies for Change in Brotherhood of St Laurence Residential Aged Care**

A study for the BSL–RMIT TRACS (Training and Research in Aged Care Services) partnership project

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## **About the BSL–RMIT TRACS project**

Teaching and Research Aged Care Services (TRACS) was a Commonwealth initiative funded by the Aged Care Workforce Fund. Its main aim was to better prepare the workforce to care for and support older adults in residential care. From 2011–12 to 2014–15 the Workforce Fund allocated a total of \$8.3 million across 16 projects. One of these, a partnership between the Brotherhood of St Laurence (BSL) and RMIT, was designed to develop Sumner House (a 42-bed facility operated by the BSL) as a Centre of Excellence, enhance resident well-being and improve support for aged care staff and students.

## **Acknowledgements**

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## Summary

The Core Competencies for Change in BSL Residential Aged Care was one of the five studies that made up the research program of the BSL/RMIT Teaching and Research in Aged Care Services (TRACS) 'Sumner House<sup>1</sup> Centre of Excellence' project (2012–2014). The study sought to identify core competencies for excellence in aged care which would drive change in how care is delivered and so enhance the lives of Sumner House residents. The research was constructed to find consensus on the core competencies for high quality care and support among four stakeholder groups – residents, their families and friends, BSL aged care managers and Sumner House direct care staff. The results can be used by staff to adapt their service delivery and supports, by management to adapt policies and procedures, by residents in making claims of the service and by educational establishments in developing courses which reflect the competencies identified by four working groups.

## Key findings

Of the thirteen core competencies identified by this study, only one was found in the top ten of every stakeholder group:

*Treat residents as people, not a job.*

'Knowing the person' is essential if skills are to be applied in ways that reflect personal choice and to understand the approach to delivery of care and support which for the person constitutes dignity and quality. These ideas span human rights, personalised care and the principles associated with relational services. They anticipate a [number of corollaries](#):

- Care and support should be delivered in a thoughtful and considerate way. People should be treated with respect and the delivery should be predictable and reliable.
- Care and support that is not respectful and considerate simply adds to the challenges the person faces and creates additional angst, fear and resentment.
- 'Trust' is required for the delivery of high quality of services. Trust builds relationships, helps in getting to know the person and allows much more collaboration.
- The resident is the person at the centre of the care and support relationship. Relational approaches demonstrate that a person is cared about as well as being cared for.
- Use of a transactional approach in which staff 'get through the job' is often seen as 'cold' and 'uncaring'. A 'relational' approach where care and support are reflected in knowing each other is far better.

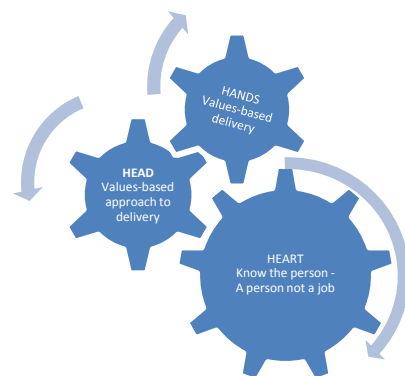
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<sup>1</sup> Sumner House is a 42 bed residential aged care facility at the Brotherhood of St Laurence.

The study found the values above important as well as staff skills or competencies. However, staff and managers talked in 'organisational speak' about competencies with an emphasis on training and skills. Clients and families talk more about the qualities of care and its delivery. Sometimes the gap between these two discourses can prevent communication between the groups. It is vital to link values and skills with a detailed knowledge of the person.

The thirteen core competencies identified were thought about by the stakeholders in terms of three categories.

- 'know the person' (sphere of influence)
- 'skills and applied knowledge' (skills)
- 'approach to delivery' (characteristics of delivery).



It is essential to achieve dignity of risk. It is only through risk that people become resilient and achieve the lives they choose by struggling to overcome those challenges preventing them from these goals. However, all delivery of care and support takes place in spaces and environments and under policies that have the potential to create or limit opportunities. Therefore,

- Skills must be delivered to optimise the conditions under which a person can function and flourish and are therefore a servant to the person's goals and aims.
- The substantiation for any procedure or intervention lies in its contribution to the person's will for living, and their own self-authored lives.

Knowledge and skills should be seen as 'conversion factors', that is, in their application they *support changes that accomplish goals*. The personalised characteristics of care therefore represent an essential 'conversion factor' that transforms cold transactions into warm and

trusting caring and support relationships. Accomplishing relational care is therefore intimately tied to these conversion factors.

- There were gaps between the idea of the competency and its practice.
- To anchor the core competencies in practice, staff and management need to examine and reflect on concrete examples of care drawn from the stakeholder groups.
- The core competencies identified can be used to adapt BSL services, policies and practices to promote relational care. They can also be used to describe skills and attributes in the BSL Capabilities Workforce framework.

## **Background**

Given the growing ageing population, it is estimated that there will be a need for 75,000 additional aged care beds by 2022. This will necessitate not only a larger workforce but one that is to deliver responsive and high quality services and support to meet changing consumer expectations.

### **The BSL–RMIT University TRACS project**

The sixteen TRACS projects funded by the Department of Social Services for the period 2012–2015 aimed to:

... combine teaching, research, clinical care and service delivery in one location to operate as a learning environment, to support clinical placements and professional development activities in various disciplines (Department of Health, 2014).

In this context it was envisaged that the Core Competencies for Change research would contribute to RMIT VET course development in aged care and inform formal training as well as influencing BSL practice. It represented a way to link teaching, research and practice.

### **BSL Aged Services principles**

The principles underpinning the Brotherhood of St Laurence aged services are built on the Capabilities Approach which holds that every person should have the opportunity to live a life they have reason to value and to be and do those things which enable a valued life. The Core Competencies project explores how staff competencies might influence the operationalisation of this approach and some of the processes through which BSL care and support services can enable residents in their care to achieve the capabilities they aspire to.

### **The research methodology**

The research design was based on the work of Hatton et al. (2005) in the use of a job element method to identify skills, attributes, knowledge, attitudes and qualities that are key to the role of the support workers in enabling a good life for Sumner House residents. The definition of ‘competence’ in this study takes on a broad definition. The design also

recognises the importance of understanding the needs and preferences of people using services as well as of those administering and providing them. The RMIT research team consulted with four expert groups: residents, care support staff, managers and family and friends of residents. The study used an adapted Delphi technique, which was carried out in three phases.

### **Phase 1 – Developing a list of skills, attitudes and qualities**

Reflecting the definition of competency adopted by the study, the aim of Phase 1 was to generate from participants in each stakeholder group a comprehensive list of the skills, attitudes and qualities that constituted such competency. They were asked the question: *What qualities and skills should staff have to work with Sumner House residents to enable them to live better lives?*

### **Phase 2 – Rating and identifying the top-rated core competencies**

The aim of the second phase was to seek ratings on each of the 79 staff competencies identified in Phase 1 and identify in consultation with the four stakeholder groups the top-rated core competencies. A questionnaire was developed from the refined list of competencies with a corresponding statement developed for each item. Ranking and aggregating participant responses identified 13 core competencies.

### **Phase 3 – Anchoring the core competencies in everyday practice**

The aim of this phase was to *anchor* at the extremes each of the 13 identified core competencies by asking the stakeholder groups to identify best case and worst case examples for each of the 13 competencies.

## **Findings**

### **Phase 1**

The main finding from this phase was the identification of 79 skills, attributes and practices, which were constituted as competencies. Significant differences across the four stakeholder groups were observed. Management and staff tended to place stronger emphasis on training and skills, whereas residents, their families and friends preferred to talk about qualities of care and its delivery. The differences were further explored by examining the differences in language used by each group.

The first phase found that different stakeholders use different terms to describe their preferred characteristics of staff competencies. Residents and their families spoke more about the qualities of care and its delivery while staff and managers talked more about training and skills and tended to use professional and managerial terms to describe staff competencies. Residents and their families were concerned that information could be lost through formalised and professional jargon. While there was often an equivalence of

thought the difference in language, sometimes obscures communication and creates a divide between staff and residents.

The gap between the two discourses and the need to identify shared terms and ideas led the researchers to consider the distinction between transactional and relational approaches to care. Responses from stakeholders, particularly residents, suggest that the transactional approach, which supports rigid roles and a task focus, is often experienced as 'cold' and 'uncaring'. In contrast, a relational approach built on trust and emphasising interest in the resident as well as their care is preferred.

## Phase 2

Through stakeholder rankings of the 79 competencies and subsequent aggregation of the rankings, 13 core competencies were identified. Only one of the core competencies was rated in the top 10 across each group. This was 'Treat residents as people not a job.' For the researchers this finding reinforced the distinction between transactional and relational approaches to care. Moreover, of the 13 competencies a significant number focused on the person and the goals they want to achieve.

There were significant differences among the priorities accorded the various competencies by staff and management. Given that organisations are more likely to flourish where there is agreement on priorities, the researchers then considered the ideas, values and terms that were shared across the groups and discovered that the competencies identified by staff and management were in fact directed towards optimising residents needs thus lending additional weight to a relational approach to care. They concluded that:

- Skills are delivered to optimise the conditions under which a person can function and flourish and are therefore a tool for resident to pursue their life goals.
- Care and support should be delivered in a respectful and considerate manner. Not doing so simply adds to the challenges the person faces and creates additional angst fear and resentment.

## Phase 3

To ground the core competencies in practice, the four stakeholder groups were asked to draw on personal experience or anecdotal evidence to provide an example of 'good' and 'bad' practice for each of the top 13 competencies.

Contrary to expectations getting examples of core competencies was not straightforward. The researchers therefore concluded that:

- Competencies are broad and general and it is not easy to adapt them without any clear sense of what needs to be done to accomplish them in practice. There is a gap between the idea of the competency and the practice.



- The complexity of people’s lives makes any single competency hard to identify as any single competency is interconnected and interdependent with others.

To address these issues, the data was re-examined for and re-categorised into three themes that might apply generically to each interaction and to the delivery of support and care:

1. ‘Heart – know the person’
2. ‘Head – have an informed approach to delivery’
3. ‘Hands – knowledge and skills’

By adopting these conversion factors that transform cold transactions into warm and trusting caring and support relationships could be built. Accomplishing relational care is therefore intimately tied to these conversion factors. In this, knowledge and skills can be seen as both key resources or inputs and conversion factors that build capacity to accomplish personal lives and goals. Thus services should be delivered with good will such that they maintain individual agency and choice and contribute to the person’s ‘will for living.’

Service delivery should reflect the principles of fundamental human rights encompassed by principles such as dignity, respect, equality. Care and support should be influenced by personalisation, individualisation, individual preferences and choices. In other words, residents and their continued growth should be at the centre of services, management practice and policies.

## Conclusion

The findings of the Core Competencies for Change research support those of the Brotherhood’s study, *Valuing capabilities in later life: the Capability Approach and Brotherhood of St Laurence Aged Services* (2012) which drew on the capability approach to construct the Brotherhood’s Capability Framework for Aged Services. The core competencies articulated by this research can be used to set the conditions for residents to be offered the opportunities to enable them to move towards personal and collective goals.

## Recommendations

It is recommended that

- BSL consider the possibilities of using the findings of this report to elaborate their emergent capability framework.
- In every interaction, in every plan or intervention staff need to know the person sufficiently, to apply skills meaningfully for the person to achieve their goals and to do so in an ethical way. It is the role of management to establish the conditions that are designed to produce freedom.

- BSL ensure that all language around competencies is understandable and useable by all stakeholder groups.
- BSL widely display the primary competency around BSL: *Treat residents as people not a job*.
- BSL ensure that relational approaches inform aged care policies and set the conditions which enable staff to develop such relationships in their work.
- Relational approaches be adopted as an indicator of quality services and should be measured as part of quality assurance.
- The findings of this report be incorporated into RMIT VET programs and courses as appropriate.
- BSL use these research finding as a compass to point the way to delivering quality services and supports for residents of Sumner House.

# 1. Background to the study

## 1.1 The TRACS project

This is a final report to the Brotherhood of St Laurence (BSL) of the research project, Establishing Core Competencies for Change in BSL Residential Aged Care. This project was funded by the Department of Social Services as part of the wider BSL TRACS (Training and Research in Aged Care Services) Project. The intention of TRACS is

*'...to provide funding to help establish a variety of TRACS models, and share the lessons learnt in establishing these models with the wider industry to inform current and future developments', (Department of Health, 2014).*

BSL viewed the TRACS funding as an opportunity to develop a Centre of Excellence in the provision of aged care services at Sumner House. In this context it was envisaged that a research project undertaking work on mapping core workplace competencies would contribute to RMIT VET course program development, inform formal training as well as influence BSL practice. In this way the research represented one way in which to link teaching, research and practice, as reflected in the TRACS aim to:

*'... combine teaching, research, clinical care and service delivery in one location to operate as a learning environment, to support clinical placements and professional development activities in various disciplines' (Department of Health, 2014).*

*Establishing Core Competencies for Change in BSL Residential Aged Services (Core Competencies project for brevity) is the final report of the study.*

This report is accompanied by a practice guide developed from the findings and designed to support staff and residents to adopt values and actions that align and accomplish these core competencies in everyday work life and interaction at Sumner House.

## 1.2 Background to the Core Competencies project

Several factors set the complex and dynamic context in which this study was undertaken.

Demographic changes forecast that the number of Australians aged over 85 years will increase from 400, 000 in 2010 to 1.8million by 2050 (Productivity Commission, 2011, p.37).

It is estimated that there will be a need for 75,000 aged care beds by 2022 and the Treasury's 2010 Intergenerational Report 'Australia to 2050' estimates that government spending on aged care alone will increase from 0.8% to 1.8% GDP by 2050 (The Treasury, 2010, p.37). A growth in the number of residential places required in the future implies the need for more staff able to deliver quality services and support to the residents.

This means workforce issues have been a priority for government as exemplified through TRACS and Health Workforce Australia funding.

*'The funding support being provided by the Australian Government supports the sector as a growth area for employment and provides opportunities to work in innovative environments'* (Department of Health, 2014).

In order to bed these innovations into the growing workforce there is a requirement to bring together industry and research and learning to work collaboratively to inform practice excellence. This is particularly important given orientations and expectations of the baby-boomer generation when they access aged care services. A significant move towards personalisation (SCIE, 2012) in which personalised funding, and planning combine with emergent models around human rights and capabilities make the context within which this report is written highly complex.

Independent of these individualised approaches, pressures for change are mirrored by important moves to empower consumers of services and, in this context, residents of BSL aged care facilities to themselves contribute to the co-design and production of service which better reflect their needs and wishes. Such moves to a co-production model (Dunstan et.al, 2009; Hunter and Ritchie, 2007; Needham and Carr, 2009) see those in aged care services as part of the solution rather than the 'problem', respect what they offer as they construct their communal and individual lives and respect these contributions as equal in

importance to those of the organisation. These agendas have been progressively mirrored in BSL's strategic approach and direction,

*'The Brotherhood's aged care services have progressively rejected...deficit constructs in their movement towards models that foster agency, opportunity and choice ... To this end, over the last five years the BSL has already incorporated person-centred care, self-directed care and active services models into its program delivery', (Kimberley, Gruhn and Huggins, 2012, p.3).*

In both the magnitude and nature of delivering care and support, the workforce in aged care services is subject to the vicissitudes and dynamics that the change outlined above may progressively impose. In such a multifaceted context the new roles occupied by those delivering formal care and support in the sector are more open to question. Not surprisingly then significant work is being undertaken to strategize and plan the development of the workforce for the future. In relation to such workforce reform Health Workforce Australia (HWA) set out a broad-based 'Framework' for action responding to the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (Health Workforce Australia, 2011). The 'Framework' established 'five domains for action ... that provide the foundation for an integrated, high performing workforce':

- Domain 1: Health workforce reform for more effective, efficient and accessible service delivery
- Domain 2: Health workforce capacity and skills development
- Domain 3: Leadership for sustainability of the health system
- Domain 4: Health workforce planning; and,
- Domain 5: Health workforce policy, funding and regulation  
(HWA, 2012, p.7).

The future is therefore dependent upon the adaptability of the workforce, not just in relation to the health workforce, but also in relation to others working within the system such as Personal Care Workers), Lifestyle Coordinators, and a host of external professions and agencies likely to be involved in the delivery of care and support to residents of aged care facilities.

The development of workforce capacity and skills might be approached in *disciplinary* terms or in terms of *role* or '*scope of practice*'. However, such approaches tend to be *unidisciplinary* in orientation since they are constructed out of what *distinguishes* certain professions and grades within professions, and they are likely to be 'top down' and often operationalised at the expense of interdisciplinary working, role overlap and common values and principles. A concomitant neglect of the voice of non-disciplinary stakeholders, particularly residents and family carers is also a feature of the literature, (Hatton et al., 2006).

The focus on disciplinary role clarity also produces the potential for conflict and division on disciplinary lines and together with the voices of residents and carers, produces a constant flux that leaves those involved 'protecting the boundaries' of their disciplinary roles and practices. Venturato, Kellett and Windsor, speaking as early as 2007 about the reform agenda in aged care services, suggest in their study of 14 nurses in a long term care facility that,

*'The data revealed a sense of tension and conflict between nurses' traditional values, roles and responsibilities ... [and they] ... struggled to renegotiate both their practice roles and values' (p.4)*

Within small nursing teams in some organisations such tension can be debilitating and may accentuate the protection of a scarce resource, skilled nursing practice.

Walking around some organisations delivering aged care services and supports, unspoken and yet palpable boundary-marking is evidenced through distancing around task obligations. At the same time the specification of core disciplinary roles which lie at the heart of the problem remains unaddressed, a '*Voldemort effect*' (i.e. that which should not be mentioned). Breaking down the resulting boundaries among staff groups who feel threatened does not work because the sense of threat is not easily excised by reassurance nor by seeking to divide ownership of unclaimed tasks.

Further, pointing to habituated behaviour among staff, difficult environments for care delivery and the iatrogenic effects of some interventions, Cohen-Mansfield and Ray (2014) point to the 'multi-level need for change',

*'These include change in priorities of policy-makers, change in institutional structures and physical design to allow accommodation of different needs, changes in job designations and responsibilities to make someone accountable for following through ... The fact that these changes are related and contingent on each other makes good care a challenge ... and the care of the person with dementia will not be adequate without synergy on all of these ...'* (p. 1232–33).

These issues will be revisited later in this report.

The tensions around disciplines are themselves potentially destructive; and yet a report from the Caring for Older People Program points out that,

*'Client needs are an effective way to determine the nature and scope of workforce design and drive the system changes required ... [and] three-quarters of competencies in care of older people are common across disciplines and service themes ...'* (HWA, 2012, p.10).

A question therefore emerges about the extent to which there are cross-disciplinary, cross-stakeholder principles, competencies and attributes on which there is consensus and which might form a foundation able to survive the dynamic change in the contemporary ageing care residential sector. Such 'core competencies' would have relevance to policy, to recruitment, practice and, indeed, to the delivery of training to those who aim to work in the aged care sector. Such core competencies may also provide common principles and practice over which collaboration and trust can be established as the grounds for delivering the best care and support to improve the lives, well-being and capabilities of those who use aged care services.

The present study explores what is shared by different stakeholders and, through a process of consultation, to search for consensus between them on what are the core competencies for care and support in BSL. The core competencies project was constructed to examine the perspective of these four stakeholder groups; its design is further outlined below. A Delphi study was adopted because, from its inception as a method, a key benefit has been its capacity to draw links or 'build bridges' (Pill, 1971) between different groups (Bowles, 1999).

## 2. Methodology – how we designed and conducted the study

The present study draws to a significant degree on the thinking laid out by Hatton et al., (2006) in relation to the core competencies of support staff working with people with intellectual disabilities in residential settings. Similar to that study, but in a different context, it is important to note that:

- The vast majority of studies which examine the core competencies of professionals fail to take account of the views of consumer groups and family carers. In an era of personalisation, consumer-directed care, choice, control, human rights and capabilities, all too real in BSL strategic frameworks, it is vital that these stakeholder views are reflected in the core competencies of staff working in the aged care sector.
- Exploring what makes an effective worker may be one way of identifying essential skills give the complexity of, and flux within, the sector (disciplines, diverse people served, and diverse settings).

In adopting the Delphi technique as our core methodology it was not the intention to be overly prescriptive about the definition of ‘competency’. Such over-prescription imposed by fiat ideas likely to direct experts contributing to the process to respond in ways they might not otherwise have chosen to do. So a broad definition was adopted, allowing this to inform the construction of our questioning of stakeholders in Round 1 of the Delphi (*see below*),

*‘Competency is the ability to perform well. Knowledge provides a basis for competency, but may not be enough by itself. A desire to improve and practice help build competency. Competencies may also be thought of as standards or measures of behaviour. The competencies for good dementia care are the standards or measures of care giving behaviour that best support the person in one’s care.’* (Michigan Dementia Coalition, 2006: 1)

It will be noted that while the definition points to the importance of both skills, and the knowledge that informs such skills, the reference to behaviours also suggests that qualities and attitudes of staff are important in demonstrating competence. These elements are reflected in the following section in which the study design and methodology are detailed.



## 2.1 Ethics approval

The RMIT research team submitted an ethics application for the project to the Brotherhood of St Laurence Human Research Ethics Committee and permission was granted to proceed. The researchers then met with residents, staff, managers and family and friends at separate meetings to explain the research aims and method and to invite participation and ensure informed consent sheets were completed. With residents we sought to have informed consent sheets completed at the many meetings that were held with residents over the project period. This ensured ongoing consent from those who had originally agreed to participate and had done so in a previous phase and consent for those taking part in each of the phases as they eventuated.

## 2.2 Research design

The project design aimed to elicit and synthesise the perspectives of the four expert or stakeholder groups at Sumner House regarding core competencies for those providing care and support for residents at Sumner House. The four expert groups were residents, care and support staff, managers, and family and friends of residents. The study design reflected the work of Hatton et al. (2005) in the use of a job element method to identify the skills, attributes, knowledge, attitudes and qualities most central to the roles of the range of support workers to enable a good life for Sumner House residents. These characteristics are reflective of the broad definition of competence adopted for the study. Furthermore, the design recognises the importance of understanding the needs and preferences of people using services as well as of those administering and providing them, particularly in the case of potentially vulnerable groups such as older people and people with disabilities (Abbott, Fisk and Forward, 2000; Dodevska and Vassos, 2013).

Following Hatton et al. (2005) a three stage adapted Delphi technique was employed to identify a consensual set of competencies across the four expert groups. The Delphi technique is a well-recognised, and now long-established, method of systematically gathering and refining, over at least two iterations, diverse expert opinions to ultimately develop a consensual position (Helmer, 1967). The method was facilitated by the RMIT research team and it was envisaged originally as offering an anonymous method for

engaging feedback and ideas thus freeing participants from concerns about conformity, influence or conflict. The present study involved three iterations as outlined below.

### **2.3 Phase 1 – Developing a list of skills, attitudes and qualities**

Reflecting the definition of competency adopted by the study, the aim of Phase 1 was to generate from participants in each stakeholder group a comprehensive list of the skills, attitudes and qualities that constituted such competency.

The research team spent some time making links in staff, management and family meetings to explain the research and to request participation. A letter was sent to each participant with a copy of the Plain Language Statement and consent sheets. The participants were asked to respond as fully as they could to the following Round 1 Delphi question using a pro forma and to post or email their responses back to the researchers:

***What qualities and skills should staff have to work with Sumner House residents to enable them to live better lives?***

This question was developed by the RMIT research team in conjunction with the course developers from the RMIT Vocational Education Team Certificate III in Aged Care development team. Because of potential literacy, comprehension and access barriers, BSL facilitated researchers to meet with residents in small groups and individually to elicit responses which were audio recorded. Some residents also prepared detailed written responses.

Responses were aggregated and collated for each expert group under the categories of Skills, Attributes and Practices yielding a list of 79 skills, practices and qualities.

### **2.4 Phase 2 –Rating and identifying the top-rated core competencies**

The aim of the second phase was to seek ratings on each of the 79 skills, practices and qualities identified in Phase 1 in order to then identify the top-rated core competencies within and across each of the four expert groups. A questionnaire was developed from the refined list of competencies with a corresponding statement developed for each item. The questionnaire was piloted with a group of two staff and adapted prior to being distributed to participants in the four expert groups.

Participants were asked to rank each statement in order of importance from 1 (*not important*) to 10 (*extremely important*). (They was also given a '*don't know*' option). The questionnaire was emailed or sent by post to the staff, managers, and family and friends groups subsequent to a meeting with each group to explain the aims and process of this second phase. Once again, the researchers met with small groups of residents several times to complete the questionnaire. Difficulties in accessing residents led to reliance upon two BSL staff members to assist with data collection at this time. Although not ideal it was felt that the benefits of this approach outweighed associated issues.

The responses from all groups were rated taking into account the number of respondents who had answered each question. The results are summarised to enable exploration of the relative importance of each of the 79 items. The calculation of the rating was made by adding up the value given to each competency by participants in each group. This total value was then divided by the number of participants in each group. For example, if 3 residents rated competency A as 8, and 4 residents rated competency A as 5, the total value for that competency for the resident group would be 6.2, i.e. 44 (total score) divided by 7 (number of residents scoring).

For the purposes of this research however, we were primarily interested in the top-rated competencies about which there was also some agreement between stakeholder groups. In this respect we identified 13 core competencies which became the focus for Phase 3 of the Delphi which is outlined below.

### **2.5 Phase 3 – Anchoring the core competencies in everyday practice**

The aim of this phase was to *anchor* at the extremes each of the 13 identified core competencies by asking the expert groups to identify best case and worst case examples of each. To achieve this, a questionnaire was posted or emailed to managers, staff, and family and friends requesting, for each of the 13 competencies examples of practice at each end of the continuum. Once again the research team met with the residents to identify examples and also organised a meeting with staff to facilitate the feedback process. The examples were collated for each group into one master document.

The original intention of this stage was to build a compendium of examples to help staff to see exactly what each competency would look like in practice. However, as will be described in the research findings this did not transpire for a number of reasons. Instead it was necessary to undertake a rather different analysis to translate these examples into a practice-relevant format.

### 3. Research findings and commentary

#### 3.1 Response rates

Ordinarily Delphi studies ask the same participants to take part in the different phases of the study. We had intended to recruit up to 12 people from each of the four stakeholder groups; however, despite significant attempts through meetings, letters and emails, the response rate was lower than expected and did not have the consistency over time that would have been ideal. Participant numbers are documented in Table 1.

**Table 1:** Response rates over the three phases of the project.

Expert group	Phase 1 (n=)	Phase 2 (n=)	Phase 3 (n=)
Residents	6 individual and group responses	7	Several group sessions over the course of the project and written submissions. (gathered from earlier group discussions and 'the thesis')
Care and support staff	7	9	5 individual and group responses
Managers	5	5	5 individual and group responses
Family and friends	8	6	2

As can be seen, participant numbers within each group fluctuated over the three phases of the project. There was a significant experience of non-response; many attempts were made before data was finally sent or researchers had to resort to collecting data in groups (which had only been anticipated for the resident participants). Although not ideal, the researchers had to make a fitting adjustment between exerting pressure to participate against the vicissitudes of staff and management availability and the wavering motivation levels of residents and family and friends. To adapt to these constraints group sessions were held with residents and, with their permission, by sitting in on their pre-existing meetings. Several group sessions were also run with staff in an effort to capture data which might not

otherwise have been forthcoming. The research team were supported at various stages in finding this balance by key BSL managers and others to whom we express gratitude for their support over the course of the research.

### 3.2 Phase 1 Findings and commentary

Phase 1 sought to explore with members of the four groups their answers to the following question:

***What qualities and skills should staff have to work with Sumner House residents to enable them to live better lives?***

Significant data was yielded from the 26 participants. A 'master collation' was then developed with responses from each group coded in a different colour to maintain separation of source.

The responses were explored and some collapsing of similar responses into single categories was undertaken. Additionally, using analysis of the categories, six thematic groupings were identified within which skills, attributes or practices could be placed. These six groupings were as follows:

- 1) Orientation to work – qualities and attributes
- 2) Orientation to work – skills and practices
- 3) Orientation to residents – qualities and attributes
- 4) Orientation to residents – skills and practices
- 5) Orientation to residents – resident health and well-being
- 6) Orientation to environment, community, family and culture

In placing the responses into these groups, similar responses were further collapsed to reduce and refine the number of overall items. This yielded 79 categories for use in Phase 2

Analysis of the contributions of the four stakeholder groups is worthy of comment.

Management and staff discourse often differed from that of most residents and family carers. Among the former there seemed to be a higher emphasis on training and skills development alongside use of terms neither of which readily appear in the lexicon of families and resident, *inter alia*: clinical supervision, person-centred approaches, care notes,

social determinants, emotional intelligence, respecting professional boundaries, management skills, clinical skills and observational skills.

Orthodoxy would suggest that the emphasis on everyday life of residents and family is 'translated' by staff and management into 'organisational forms' taken to produce best outcomes. If better lives and accomplishing capabilities (Kimberley, Gruhn and Huggins, 2012) is the BSL aim then it must be assumed that these organisational forms do indeed accomplish these outcomes.

Critical perspectives suggest the above professional and management categories might seem like 'alien' categories to those who receive care and support from BSL. Cynically, these alien terms might arguably be seen as what Foucault terms 'dividing practices' in which a group is separated out using a discourse of 'life, labour and language' with professional staff using processes that are legitimised by power structures (see Rabinow, 1984). In short it is not clear that what is encompassed in concepts esoteric to the supposed beneficiaries, is translated into positive practice and better outcomes.

What is clear is that maintaining the divide in discourse has the propensity to *be perceived* as an attempt to maintain power over, rather than to empower residents. This has the propensity to mask the 'goodwill' of organisations to improve the lives of those for whom they provide care and support. The gap between the two perspectives represents a potential space in which 'Voldemort terms' flourish and which are therefore never addressed. If some consensus can be found in this space it provides the grounds for a common engagement in an area of primary importance.

*Different stakeholders use different terms of emphasise different characteristics of staff competencies.*

*Staff and managers talked in 'organisational speak' with an emphasis on training and skills.*

*Clients and families talk more about the qualities of care and its delivery.*

*Sometimes the gap between these two discourses can prevent communication between the groups.*

*More is needed to highlight terms and ideas that can be shared and that are positive.*

As well as these alien concepts, there are also seemingly a number of similar concepts but stated in a different language. For example: ‘awareness of symptoms of illness and particular health problems’ and ‘knowing about the effects of medication’ might be encapsulated under ‘clinical skills’; ‘calming skills for distressed residents’, ‘learning to walk in the shoes of a resident’, ‘having time to chat’, may all be considered under the rubric of ‘communication skills’. Similarly, the managerial term, ‘person-centred approaches’ although described above as alien, actually houses similar content to that which residents describe as ‘responds to residents needs and preferences’. There is then an *equivalence of thought but a difference of language* in many instances.

While the use of clear language is perhaps important to residents and family carers using BSL services and supports, the worry that something is lost through formalised and professional discourse is rather more important. It marks a distinction between managerialist utilitarianism designed to ‘get through the work efficiently’ as compared with a ‘virtue ethics’ or particular ‘ethic of care’ in which trusting relationships play a more significant role.

*Use of a transactional approach in which staff ‘get through the job’ is often seen as ‘cold’ and ‘uncaring’.*

*The resident is a person at the centre of the care and support relationship. Relational approaches demonstrate that a person is cared about as well as being cared for.*

Others have referred to this distinction as taking place between ‘transactional’ models based on throughput of tasks, rigid roles, technology dominated approaches and depersonalisation, as opposed to ‘relational’ approaches in which work roles are structured through everyday relationships built out of empathy, knowledge of the other and trust built over time (Williams, Nolan and Keady, 2009).

This distinction and associated words and actions across levels within BSL will feature in the discussion to this report. At this stage it is necessary to point out that without ‘trust’ no relationships can flourish (Ramcharan et al., 2009). And if the interaction between BSL staff and clients is to be cast in terms of a relationship rather than a ‘transaction’, then it will not



flourish without such trust. It is hypothesised that, particularly from the 'baby-boomer' generation through to Gen X and Y, that the right to question authority and to search out alternatives is likely to grow (Tolbize, 2008). This further raises the need to build trust through interaction.

### **3.3 Phase 2 Findings and commentary**

Table 1 shows that 27 people participated in phase 2 of the study; most were residents and staff.

The RMIT research team, together with the VET Course Development Team then analysed the data to identify the top ten rated core competencies for each group. The data was then ranked within each group based on raw scores, i.e. reflecting importance to *each* group. By comparing these it was possible to identify those ranked in the top 10 that were common across more than one group as well as those peculiar to each group. Ultimately 13 core competencies were identified as representing those most common across all or most groups as these exhausted the categories shared by at least two of the stakeholder groups. Table 2 below shows these 13 competencies and their overlap among the 4 groups.

**Table 2 – Core competencies and which groups identified these as important.**

	<b>13 core competencies</b>	<b>Residents</b>	<b>Staff</b>	<b>Managers</b>	<b>Family &amp; friends</b>
1	<i>Treats residents as people not a job</i>	☺	☺	☺	☺
2	<i>Is reliable and keeps commitments to residents i.e. does what they say they are going to do.</i>		☺	☺	☺
3	<i>Shows care in approach to working with residents</i>		☺	☺	☺
4	<i>Understands and attends to residents' individual needs and preferences</i>	☺	☺		☺
5	<i>Prioritises residents' quality of life</i>		☺	☺	☺
6	<i>Skills to manage difficult behaviours with compassion by trying to understand the underlying causes of difficult behaviour</i>	☺			☺
7	<i>Has a good understanding of mental health issues and care, particularly dementia</i>	☺			☺
8	<i>Is sensitive to residents' emotional and social well-being</i>	☺			☺
9	<i>Skills that actively promote resident independence and social participation</i>	☺			☺
10	<i>Shows responsibility in approach to working with residents</i>		☺	☺	
11	<i>Is focused on the medical, social and emotional needs of the residents</i>			☺	☺
12	<i>Provides personal care in a respectful and sensitive manner</i>			☺	☺
13	<i>Is considerate and thoughtful</i>	☺		☺	

As can be seen, only one of the core competencies (cc for brevity) was rated among the top ten of each of the four stakeholder groups to 'Treat residents as people not jobs'. This further reinforces the distinction mentioned earlier between transactional and relational approaches. Items 25 in which there was agreement among three of the four groups may be read as elaborating this distinction even further. These are more to do with the 'sphere of influence' and 'characteristics of delivery' leaving the 'skills focus' in rows 6, 7, 9 and 11.

*By looking at the top ten rated core competencies as rated by each groups involved, thirteen core competencies were identified.*

*Only one core competency was found in the top ten of each group – Treat residents as people, not a job.*

*This finding emphasises the importance of relational approaches.*

It is interesting to note the extent to which the lists from management and staff differed: they shared few of the core competencies as priorities (core competencies 4, 11, 12, 13). It is not clear the extent to which alignment is necessary, but it does seem to indicate a staff group with different priorities to management. Organisations generally flourish best where there is agreement on priorities and some work might be done to explore how this gap might be addressed.

It is vital to recognise the person at the centre of many competencies (core competencies 1, 4, 5, 8, 9). It is their hopes, dreams, needs, wishes and aspirations that are most important. These also imply achieving goals relating to life quality, well-being, independence and social participation. Personalised and goal oriented competencies therefore feature in the identified competencies.

*Of the thirteen core competencies a significant number focused on the person and the goals they want to achieve.*

Skills deployed in support of accomplishing these outcomes are dependent upon skills to support the person to be healthy (medical, social and emotional needs ends: Core competencies 6, 7, and 11) and to bring specialist skills relating to dementia, disability and managing challenging behaviours. These skills seem to act in such a way as to create the 'optimal conditions' in which people can function and flourish. A healthy person not affected by emotional issues is more likely to be able to pursue their lives unhindered by avoidable obstructions.

*Skills are delivered to optimise the conditions under which a person can function and flourish and are therefore a servant to the person's goals and aims.*

And if care and support are delivered in a respectful manner and a kind and considerate way (core competencies 2, 3, 12, 10, and 13) the interruption to life that they represent, the challenge to the cadence of every expectation about the day and about life, the frustration they pose to achieving outcomes are, at the very least minimised. In contrast, the obverse, as represented in bad quality and disrespectful care simply adds to personal challenges of residents and has the potential to accentuate any negative effects of these challenges to the person's life.

*Care and support should be delivered in a respectful and considerate manner. Not doing so simply adds to the challenges the person faces and creates additional angst, fear and resentment.*

### **3.4 Phase 3 Findings and commentary**

In order to ground the core competencies in practice, each of the four stakeholder groups was asked to contribute examples of 'good' and 'bad' practice for each of the top 13 competencies using a *pro forma*. These examples could be based on their experience and/or anecdotal evidence and potentially provided differing perspectives of similar events. We received contributions in this round from 5 managers and staff but only 2 from family carers. Given the way data had been collected from residents', examples for this group drawn from across the three research phases in which groups discussions with residents had been held, it was not possible to be precise about the number of resident participated in this part of the research. However we estimate around 10 residents contributed to Phase 3 which would give a total Phase 3 response rate of 22.

It was anticipated that once core competencies had been identified, getting examples of each would be straight forward and that this would give clear advice about good and bad practice for each competency. This is not what happened.

For example look at the core competency: 'Shows responsibility in approach to working with residents' is complex. Look at the 'Poor practice' column.

'Non-responsive approach to clients' needs around duty of care issues – hygiene, care, safety'.

It includes issues to do with the approach to clients (non-responsiveness), to do with the sense of professional duty (duty of care) and in relation to the goals, 'hygiene, care and safety'. It should be noted that the response was not a sole referent to 'responsibility in approach': it might just as easily have been used in relation to other competencies such as '*treating residents as people and not a job*' or '*shows care in approach to working with residents*'. Many of the extended examples identified for each of the competencies had similar complexity.

Looking through the other examples it is clear that many are complex and many can be seen as examples relating to more than just one of the identified competencies. This was a conundrum and not what had been expected. It produced some perplexity for the research team and pointed to the need for further analysis of the data.

What was concluded was that 'competencies' cannot be easily broken down into discrete definable entities in the eyes of the stakeholders, as indicated by the cross-cutting examples. A result is that they are unlikely to be easily recognised and adopted by the stakeholders in their work, or by residents and family in their expectations. Because they are general and broad it is easy to adopt them without any clear sense of what needs to be done to accomplish them in practice. There is therefore a vacuum or gap between the idea of the competency and the practice. Concomitantly training to deliver such competencies is also obfuscated and runs the risk of not producing intended outcomes with consequences for all stakeholder groups and the broad organisational agenda.

*Our data indicate that 'competencies' were thought about by the participants in terms of three categories: skills, a focus for these skills (what they achieve and their sphere of influence) and characteristics relating to their delivery.*

Like human rights, then, ‘competencies’ were shown to be interconnected and interdependent and therefore not easily identified as discrete and dismembered entities. In interpreting the data the question therefore became whether there were any intrinsic categories that respondents were using when they offered the examples of good and bad practice. After all, if they are to be useable, they must be based on the ideas that are understandable to stakeholders.

*The concept of ‘competency’ is complex and individual competencies are hard to identify as discrete entities. They are interconnected and interdependent.*

To resolve this, the data were explored again with a view to identifying underlying assumptions and concepts. The three themes that seemed to be implied in many of the complex examples were:

- A recognisable skill
- A sphere of influence and outcome
- Characteristics of delivery.

These seemed to be the unspoken concepts that informed many of the examples. It will be noted that these categories have already featured in reporting Phase 2 results (see Table 3) and they were retro-fitted from the present Phase 3 analysis.

These categories were then applied to the original 13 core competencies, Table 3.

**Table 3:** Showing the breakdown of the 13 core competencies into skills, spheres of influence and outcome and characteristics of delivery.

<b>Skills</b> (Know, understand, think)	<b>Spheres of influence and outcome</b> (Contribute, create, lead, facilitate, access the resources; for what end, in what environment, setting, community or in relation to what personal preference or need?)	<b>Characteristics of delivery</b> (Dignity and respect for Being, belonging, becoming)
<ul style="list-style-type: none"> <li>• Skills relating to difficult behaviours (cc6)</li> <li>• Mental health and particularly dementia (cc7)</li> <li>• Skills to meet medical, social and emotional needs (cc11)</li> </ul>	<ul style="list-style-type: none"> <li>• Person first, not a job (cc1)</li> <li>• Individual needs and preferences (cc4)</li> <li>• Quality of life (cc5)</li> <li>• Emotional and social well-being (cc8)</li> <li>• Independence and social participation (cc9)</li> </ul>	<ul style="list-style-type: none"> <li>• Cares about the person (cc3)</li> <li>• Reliable and keeps commitments (cc2)</li> <li>• Personal care respectfully delivered (cc12)</li> <li>• Shows responsibility (cc10)</li> <li>• Considerate and thoughtful (cc13)</li> </ul>

More will be said of the skills, sphere of influence and characteristics of delivery in the following section.

*Care and support should be delivered in a thoughtful and considerate way. People should be treated with respect and the delivery should be predictable and reliable.*

*These ideas span human rights, personalised care and the principles associated with relational services.*

What can be said here is that there seems to be a greater consensus among the four stakeholder groups in relation to characteristics of delivery. Respect, kindness, consideration and reliability are hugely important values and principles and there is agreement across groups that this should be the case. Residents are people first and care delivery should reflect fundamental human rights principles such as dignity, respect, equality and freedom (FRED) (see VALID, n.d.). Skills should be delivered according to these principles and in ways that are influenced by personalisation, individualisation, individual preferences and choice, and some end point designed to maximise resident capability. They should reflect agreed values such as participation, inclusion and independence.

In short the personal aims of residents and their continued growth should structure all other action on their behalf, whether that be through services, supports, management practice or through the organisation's policies. More will be said shortly about the relevance of a 'capabilities approach' in accomplishing this end.

Additionally the cross-cutting themes suggested that the original 13 core competencies across the four groups may not have indicated people's values and how they were actually working and employing their skills. This was also emphasised in the observations and informal conversations the research team had during the study period.

To resolve this, it was felt that that the data needed to be revisited through a finer level of analysis which would capture more of the overlap and interconnectedness so overt in the examples. It will be remembered that the analysis of Phase 2 data used aggregate scores for each group. Even while doing so it was clear that this approach had its difficulties. Some participants simply scored each of the 79 competencies identified in Phase 1 at the highest level; there were non-responses; where the competency was not applicable no mark could be given to add to the aggregate score; and, it was clear that people did not complete the later parts as well as the earlier, perhaps because there were so many competencies to rate.

With this in mind it was decided to run the analysis again, but this time taking the mean scores, i.e. the average based upon the number of respondents who had rated each of the 79 competencies. There are problems with this approach also, not least that the numbers responding to some categories were low, that it was not clear whether to include the 'don't know' responses and, like the previous analysis, that some people had given a blanket high score for all and had tired towards the end of the schedule. However, this new analysis yielded thirteen shared competencies additional to those already identified and these are shown in Table 4.



**Table 4:** Additional competencies taking account of mean scores for each of the 79 competencies identified in Phase 1:

	Competency	Resident	Staff	Managers	Family/friends
14	Has up to date knowledge of drug protocols and administration		☺		☺
15	Nursing skills and qualifications to cover the needs of all residents (nurses only)		☺	☺	☺
16	Be a care giver not a care taker		☺	☺	☺
17	Resident and person-centred in approach	☺			☺
18	Has necessary and high level of clinical skills (nursing staff only)		☺	☺	☺
19	Has knowledge and skills to cover care and support needs of all residents		☺	☺	
20	Has good conversational skills	☺	☺		
21	Is willing to advocate on behalf of residents when required		☺	☺	
22	Can provide clinical supervision as required in the role (Senior nursing staff only)		☺	☺	
23	Skills for managing and resolving conflict	☺	☺		☺
24	Has required nursing skills for the job	☺	☺		☺
25	Is skilled in calming distressed residents	☺	☺		
26	Has skills and knowledge of specific disabilities and aged care issues	☺	☺		

As can be seen, by approaching the analysis in this way a number of ‘skills’ were highlighted (core competencies 14, 15, 18, 19, 20, 22, 23, 24, 25 and 26) that did not originally feature in the thirteen core competencies. Additionally, willingness to advocate for residents (21) also featured. The resultant 26 competencies were allocated to the three identified categories: skills and applied knowledge, sphere of influence and characteristics of delivery, Table 5. This was not a ‘precise’ avenue but one that was used heuristically and for the purposes of further analysis. At this point too we began to think about how best to express these categories in language that speaks directly to those providing support and care and identify each category with the seat of its motivation. Thus, ‘sphere of influence’ was superseded by ‘Heart – know the person’, ‘skills and applied knowledge’ by ‘Hands – skills’ and ‘characteristics of delivery’ by ‘Head – approach to delivery’.

**Table 5:** 26 identified competencies categorised as know the person (sphere of influence), skills (applied knowledge and skills) and head (approach to delivery).

Heart – Know the person (sphere of Influence)	Hands – Skills (applied knowledge and skills)	Head – Approach to delivery
<ul style="list-style-type: none"> <li>• Understands and attends to residents’ individual needs and preferences</li> <li>• Resident and person-centred in approach/skills that promote resident autonomy and choice</li> <li>• Prioritises residents’ quality of life</li> <li>• Is sensitive to residents’ emotional and social well-being</li> <li>• Is focused on the medical, social and emotional needs of the residents</li> <li>• Skills that actively promote resident independence and social participation</li> <li>• Willing to advocate on behalf of residents when required</li> </ul>	<ul style="list-style-type: none"> <li>• Nursing/clinical skills for all needs</li> <li>• Knowledge of drug protocols and administration</li> <li>• Understands when to offer clinical referrals/ knowledge and skills to cover all care and support needs</li> <li>• Clinical supervision as required</li> <li>• Skills to manage difficult behaviours with compassion by trying to understand the underlying causes of difficult behaviour</li> <li>• Skills for managing and resolving conflict</li> <li>• Skilled in calming distressed residents</li> <li>• Has a good understanding of mental health issues and care, particularly dementia</li> <li>• Skills and knowledge around disability and aged care</li> </ul>	<ul style="list-style-type: none"> <li>• Treats residents as people not a job</li> <li>• Caregiver not caretaker</li> <li>• Good conversational skills</li> <li>• Is reliable and keeps commitments to residents i.e. does what they say they are going to do</li> <li>• Shows care in approach to working with residents</li> <li>• Shows responsibility in approach to working with residents</li> <li>• Provides personal care in a respectful and sensitive manner</li> <li>• Is considerate and thoughtful</li> <li>• Is interested in residents’ life stories and uses them to enrich daily interactions</li> <li>• Is gentle with residents and colleagues</li> <li>• Is helpful and supportive of students on placement</li> </ul>

The ‘know the person’ column points to the importance of knowing the resident’s individual needs and preferences. These cover the social, emotional and medical needs as well as their independence and social participation. Further, the competencies highlight the importance of these being a product of informed choice and autonomous decision-making. Person-centred care is highlighted as well as care that promotes outcomes associated with improved well-being and quality of life. In short person-centred practices are at the heart of achieving better lives.

Exploration of the data also made it clear that many of the examples of good practice of the top-rated and shared core competencies were only possible where the member of staff really knew the person and explored who the person was through dialogue;

‘Staff member listening to my mother’s problems and offering her ways to cope and deal with these issues’,

'Goes over resident's care plan with resident and/or family to make sure information is accurate and that strategies and plans are appropriate. Monitors outcomes and adjusts strategies and plans as required',

'Care/support that takes into account a resident's lived experiences, that they are more than simply their age and disability',

'Knowledge of social history. Awareness of current medical issues. Awareness of family situation',

'Talks to residents about their lives and daily interests',

'Staff who understand, respect and facilitate interests and preferences particularly in an innovative way'.

Like in any good relationship, knowing the person is a prerequisite to responding more intuitively in ways that reflect the person's known choices and preferences, that appeal to the person's sense of self and their future aspirations, and that convey the unique 'small touches' that show they have been a focus for another person's interest and care. Such relationships support the choices and the pursuit of outcomes to which residents personally aspire.

*'Knowing the person' is essential if skills are to be applied in ways that reflect personal choice and to understand characteristics of delivery which for the person constitutes dignity and quality.*

This sense of movement and continued growth, engagement and fulfilment gives life its purpose. Moreover the 'trust' that builds up in relationships is a necessary precursor to the delivery of an enabling form of care and support. Residents are unlikely to want to place their lives in the hands of people they do not trust. They are unlikely to be compliant or to collaborate where no such trust exists. Or, conversely, their compliance will be achieved through oppression and disregard for their choices. Similarly family members, if provided with choice, will entrust the well-being of their loved ones to those organisations with which they can develop a trusting relationship. The care and support relationship is intimately tied to trust and, in turn, maximising that trust is dependent upon knowing the person well, and through continuity of care.

*'Trust' is required for the delivery of high quality of services. The relationship of trust builds relationships, helps in getting to know the person and allows much more collaboration.*

This personalised approach has knock on effects at the boundary between knowing the person and the skills and approach to delivery. The 'conversion factors' are played out in several ways.

For example, in the column relating to the approach to delivery of the competency 'treating residents as people not a job' can only be achieved if the person is actually known and understood in a deep way. For example, understanding how people construe their privacy and issues of touch, how to respond to a person's concept of being cared for and about, understanding their interests and values are important to accomplishing respectful and sensitive care delivery. Only by knowing the person will services and workers be able to provide the nuanced forms of care that the person wants and needs.

'Sometimes in the evening when my mother takes the last of her medication for the day a particular nurse will give her shoulders a massage. Mum loves this and it is such a nice touch.'

'Staff see the whole person, understand their personal history and can have meaningful conversations with the person while attending to their care needs'.

Treating people with respect, understanding their sense of personal space and their privacy, those factors that populate the characteristics of delivering care and support, is intimately tied to the depth of knowledge held about that person's life preferences and sense of self. The gift residents give of access to this otherwise personal world is the 'privileged space' into which care and support staff are invited. Such 'privileged spaces' must be respected or trust is broken and the 'relationship' is lost.

The personalised characteristics of care therefore represent an essential 'conversion factor' that transforms cold transactions into warm and trusting caring and support relationships. Accomplishing relational care is intimately tied to these conversion factors.

*The personalised characteristics of care therefore represent an essential 'conversion factor' that transforms cold transactions into warm and trusting caring and support relationships. Accomplishing relational care is therefore intimately tied to these conversion factors.*

And while the situated interactional elements are essential, so too are those relating to the longer term hopes and aspirations of each resident. To know the person, their history, their background, the things they love, provides the very clay that can be moulded into 'lives worth living' and a means to maximise self-authored lives. Care plans, leisure pursuits, social networks, cultural and spiritual choices, finding common interests with others, along with an infinitely diverse range of preferences, effectively constitute the resident's 'will for living':

'Can read the resident's file notes – personal interests/history is able to listen attentively about their preferences – e.g. what they like to eat, the clothes they'd like to wear, the type of activities they would like to engage with',

'Staff who understand respect and facilitate interests and preferences particularly in an innovative way',

'Understanding what is happening in the resident's life, i.e. loss of a friend, upset over issues, acknowledge upset'.

The will for living is no trivial matter. It implies both an attention to risk, to hope and to resilience. Parsons (2008) summarises this well,

*'Central to the notion of recovery is the notion of hope. Every choice involves both the possibility of failure and the possibility for success. Every choice involves hope. Overprotection by taking away people's choices and not allowing them to take risks or try new things crushes hope. This can be seen in many people who have been institutionalised or hospitalised for any great length of time' (Parsons, 2008).*

As Nay (2002) asserts,

*'There is no life without stress: we cannot eliminate risk without eliminating the person. Life is a risk. It is through struggling and overcoming challenges and taking risks that we become fully human' (p. 33).*

The effort to achieve this dignity of risk can be seen in some of the examples of good and bad practice:

'allowing people to have a particular food brought in from their family',

'Resident is blind and loves food ... not allowed to have soft-boiled eggs due to food safety plan'

'Staff that can assist residents to get used to unfamiliar environments and can work to relieve residents' anxiety and social isolation',

'give people control in ADL, even if it is just holding soap'.

*It is essential to achieve dignity of risk. It is only through risk that people become resilient and achieve the lives they choose by struggling to overcome those challenges preventing them from these goals.*

The purpose of using knowledge and skills, the second column (Table 5), should be as *servant* to these longer term preferences and this 'will for living'. The application of skills is therefore a product of another conversion, from personal life goals to supporting the accomplishment of those goals. As one person put it:

'Work with residents to do things only assisting where it adds value to the *resident*'.

Knowledge and skills should therefore be seen as both key resources or inputs and conversion factors in building capacity to accomplish personalised lives and goals. The list in Table 5 points to skills that: keep the person as fit as possible to be able to pursue life goals; they point to systems in which expertise is used to protect residents from fear or harm when there is difficult behaviour; to deliver quality in terms of clinical skills and administering medications; and to in-depth knowledge in a number of areas: disability, dementia, mental health and challenging behaviour.

*Knowledge and skills should be seen as 'conversion factors', i.e. in their application they support changes that accomplish goals.*

*The substantiation for any procedure or intervention lies in its contribution to the person's will for living.*

*The person's will for living is, in turn, subject to 'origination', i.e. that the idea came from them and was pursued with a good will.*

In line with arguments about 'conversion' factors so far, any skill should be utilised with recognition of the characteristics of delivery each resident wants and its aim should to maintain the life choices of the person. The substantiation of any procedure or intervention lies in its contribution to the person's 'will for living'. That in turn is subject to 'origination' (Honderich, 2008), that is, the original idea upon which all following actions are based has come from the person themselves (Ramcharan et al., 2013). If argued from this perspective, it does address some of the radical critiques identified earlier in which what residents receive is seen as dictated simply by professional discourse. It does so insofar as it can be said that the subservience is of professional practice to individual choice.

The conversions discussed above take place within a particular set of structures. For example, a leisure program represents an opportunity structure for choice; the plan of a building represents an opportunity structure in which a person can or cannot move; a policy (say on behaviours that challenge) represents a limit and boundary to a person's actions. In many ways the structural features are a product of the powerful making decisions over those whose opportunities and actions are being shaped by their decisions.

Time spent by researchers in Sumner House as a space pointed to a number of observations: there were several restrictions on movement between floors; many rooms were locked during the day but could have provided useful spaces for residents to meet up; computers provided for resident use were not working; bedrooms were sometimes not given the level of privacy required; locked doors to the outside meant blanket restrictions on the movement of people who might easily have benefited from freedom. The space had a major effect on the opportunities available for residents.

These observations suggest that there is a need to plan and design to: achieve 'freedom'; to 'maximise the choices' available to residents; to view policy as handmaiden to accomplishing 'lives worth living'; and as a means of reflecting diversity among the resident population. These observations are particularly important for managers and Boards seeking to make policies and decisions which will have the effect of accomplishing the opportunity structures through which the person expresses their personhood. Policy, regulation,

governance and planning should primarily be premised on 'creating freedom' by expanding opportunity rather than controlling behaviour, movement and thought.

*All delivery of care and support takes place in spaces and environments and under policies that have the potential to create or limit opportunities.*

*The underlying principles within the setting require the creation of opportunity structures that maximise freedom.*

*This implies employing 'positive practice' principles.*

There is often a lack of conversion from management to those staff who deliver care and support and from them to those who receive that care and support. Earlier it was suggested that one thing preventing such conversion was use of language. Another as shown here is couching decisions in terms of limiting the bad and troublesome rather than 'supporting the good' and personal freedoms. 'Positive management and staff practice' is therefore a hugely important starting point for any form of discussion or action. In turn the accomplishment of freedoms can only take place through knowledge of the people for whom the service is being provided. In this respect a number of questions need to be addressed. What is the individual and collective 'will for living' and how can the organisation be organised around that? Where are the voices and advocacy informing this? And how are characteristics of delivering care and support aligned with the human rights principles of freedom, respect, equality and dignity?

The findings of this research provide some modest insights into how this may be achieved. At the heart of the model we have developed are the 'spheres of influence', the characteristics of care and support delivery' and the place of 'skills and knowledge' (the Heart, hands and head) and how each relates to the other. The findings point to the importance of positive models of management practice and to maintaining conversion factors which lead to the 'will for living' among the residents. In the following short discussion these ideas are explored in terms of their contribution to the emergent capabilities framework being operationalised by the Brotherhood of St Laurence.



*The data proves instructive and can be used at the very least as a generic list of good and bad practice. Staff, managers, family and residents might be made aware of this list. The list can be used and adapted as a free-standing learning resource also that will help people to recognise and use good practice, to question their own assumptions and ways of working. The list is not exhaustive. It is a 'compass' for practice and not a prescription.*

The examples identified by each of the stakeholders can be used independently as a 'compass' for practice.

## 4. Discussion and implications

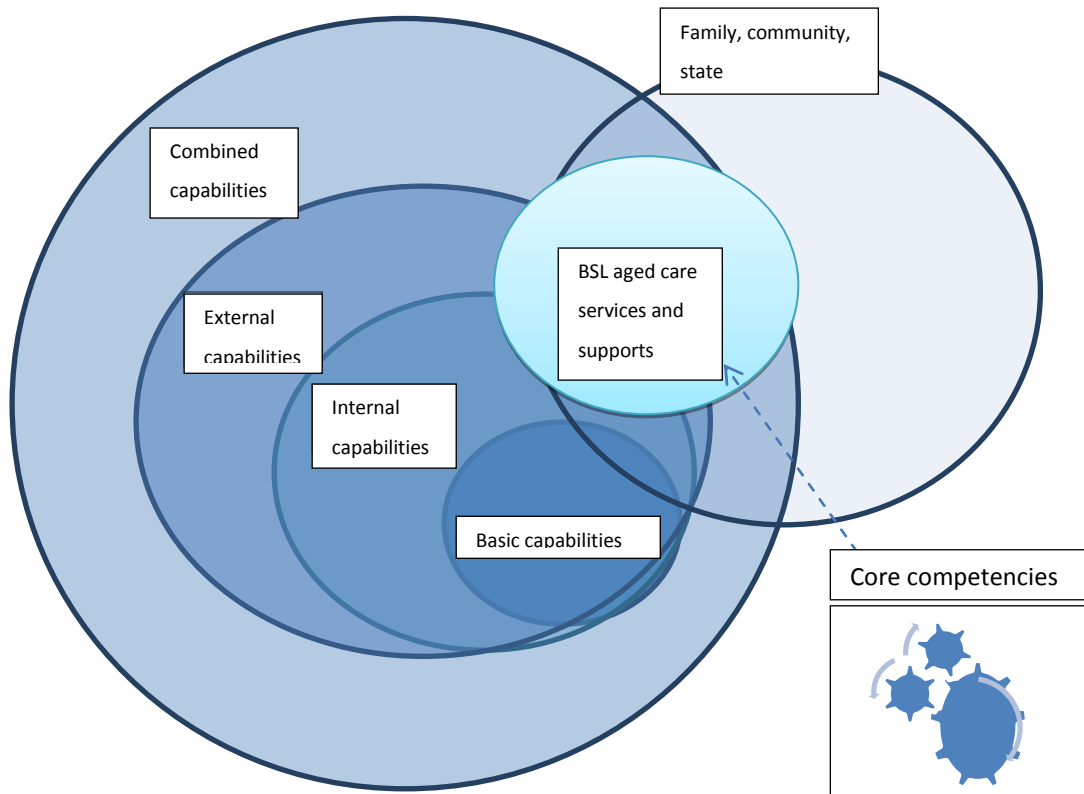
The findings of this study have a marked similarity to the recent study on the capability approach undertaken within the Brotherhood of St Laurence (Kimberley, Gruhn and Huggins, 2012),

‘The connections between the concepts of social inclusion, person-centred care, consumer-directed care and active service models are based on increasing agency, the belief that people should be able to actively think about, shape and control their lives according to their values and in the context of their society’, (p.45).

In like fashion they suggest a series of questions that staff and services should ask, for example, ‘how would you choose to be?; what would you choose to do?; what can we do towards achieving this?; what in aged service program guidelines facilitate or preclude this service?; what policies or elements of policies, either external or internal, serve to constrain capability advancement?’ (ibid: p.44).

So too does the report usefully explore elements of a capabilities perspective (Nussbaum, 2003) in identifying those things most important in the lives of over 200 people using BSL: aged care services (Kimberley, Gruhn and Huggins, 2012: 26). In answering questions about what services can do to support these outcomes they argue that innate equipment (basic capabilities) can be enhanced through socialisation, education, exercise (internal capabilities) and that these are limited or freed by environments and opportunity structures (external capabilities). The role of services and supports are to facilitate the combined capabilities, to set the conditions for their accomplishment and to draw upon and access other resources that might help in achieving this move towards personal and collective goals (Figure 1, below).

**Figure 1:** The Brotherhood aged services and capabilities framework (from: Kimberley, Gruhn and Huggins, 2012: p.20)



There are clear similarities between the findings of that study and those in this report.

*The findings of the present study support those of the Brotherhood of St Laurence capability study (Kimberley, Gruhn and Huggins, 2012).*

*The focus of the present study is on the processes through which the competencies of staff can be applied by BSL. The study therefore elaborates some of the processes through which BSL care and support services can accomplish capabilities for each resident in their care.*

What the present study does is to explore in more detail how staff core competencies might operate across the various capability domains and, therefore, some aspects of how the capabilities model can be operationalised. In particular it drills down on the box labelled 'BSL aged care services and supports' (see Figure 1 above) within which three key aspects of these services and supports are identified. The centrality of starting with and knowing the person has been emphasised. Moreover, three core underlying elements have been

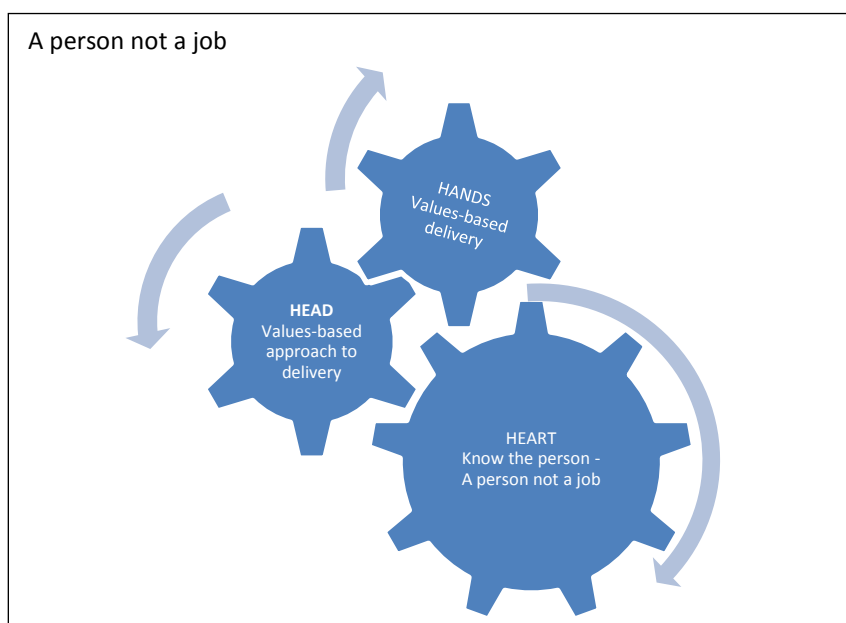
identified as combining to constitute each competency. It is recommended that these concepts be adopted and used to elaborate the BSL capability framework. These are ‘Heart – know the person (sphere of influence)’, ‘Hands – skills and application of knowledge’ and ‘Head – approach to delivery’. ‘Conversion factors’ are those aspects that ensure the delivery is tied to personal choice and to the ‘will to live’, the portent of richer lives accomplished through the struggle of living them.

### Recommendation:

*It is recommended BSL consider the possibilities of using the findings of this report to elaborate their emergent capability framework.*

It is essential that all staff across BSL have some easy way of organising their thoughts, their interactions with residents and the planning and delivery of care. Within (though not exhausting all that should take place in that space) the ‘BSL aged care services and supports’ box (Figure 1) are three important strategies relating to ‘competencies for capabilities’, as shown in Figure 2.

**Figure 2:** BSL Aged Care Services and supports – Applying competencies for capabilities.



It is therefore recommended that in terms of the application of competencies that BSL staff apply these three ideas in all interactions, plans, and interventions. These should be applied in such a way as to ensure the conditions within which care and support are delivered maximise the opportunity structures set by environment, policy, and by accessing resources external to BSL, including family, friends and community among others.

### Recommendation:

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*In every interaction, in every plan or intervention, staff need to know the person sufficiently, to apply skills meaningfully for the person to achieve their goals and to do so in an ethical way. It is the role of management to establish the conditions that are designed to produce freedom.*

It will be noted that the terms used in the cogs are slightly different from those used in the report. Earlier it was argued that language can often obfuscate meaning and that language that can be shared is much more useful. It is recommended that the terms used in the cogs be adopted as they convey a more common and grounded meaning to stakeholder groups.

### Recommendation:

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*Ensure that all language around competencies is understandable and useable by all stakeholder groups.*

The sole core competency common to the top ten competencies identified by each stakeholder group was to; 'treat residents as people not a job', the title adopted for this report. It is recommended that this notion be more broadly used in advertising around Brotherhood of St Laurence. It encapsulates an important reminder for staff and a source that potentially empowers residents and carers.

### Recommendation:

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*Widely display the primary competency around BSL: 'Treat residents as people not a job'.*

Related to this there was a very clear commentary in the data that quality services are based on relational principles and not upon transaction. It is recommended in this light that 'relational' approaches be bedded into policy and practice as essential conditions and that these be monitored and added to quality measures.

### Recommendation:

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*BSL management should ensure that relational approaches inform their policies and set the conditions which allow staff to develop such relationships in their work.*

*Relational approaches are an indicator of quality services and should be measured as part of quality assurance.*

Personalised and individualised approaches require respect for diversity and this diversity in turn has implications for how care and support are delivered. The concept of social justice is a useful way of thinking about such diversity. Treating people the same is not treating people as if they are the same but, rather, treating them with the same respect and recognition as a person. Respecting diversity also has an impact on the communities to which people seek membership. So as well as recognising individuality it is important to recognise collective identities also.

### Recommendation:

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*It is recommended that management need to create an authorising environment around 'creating freedom' in terms of environment, governance and policy. Closing the gap with staff may rest on exploring alignments such as those featuring in this consensus study*

It is important to recognise that competencies can only be as successful as the context within which they are operationalised. The environment, policy and, governance all have an impact on creating freedom. It was shown earlier that there seemed to be a gap between staff and management in recognition of the core competencies identified in this study. There needs to be more work done to close this gap. Part of this might be the extent to which there is an authorising environment which is based upon shared and common values. Some of the findings of this project can be used to close the gap using common and agreed concepts. Furthermore all policy, governance and the wider systems factors such as environment should be based on 'creating freedoms'

This report feeds back into VET training in a number of ways. The examples of good and bad practice can be used to illustrate expectations in the workplace; the three way conceptualisation of competencies can be adopted to help students focus on how to think about their practice, role and the principles and skills that inform quality practice.

### Recommendation:

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*It is recommended that RMIT VET use this report to inform their programs and courses as appropriate. Sometimes the gap between these two discourses can prevent communication between the groups.*

We anticipate that the findings of this project should be welcomed by people across BSL, not least because the project was based upon finding consensus. The report is a 'compass' and not a 'prescription' seeking to point the way to quality practice. It is hoped this report is a helpful contribution though recognise it leaves all the work to be done by the management and staff of BSL in collaboration with residents and families.

### Recommendation:

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*That BSL uses this finding of this research as a compass to point the way to delivering quality services and supports for residents of Sumner House.*

## 5. References

- Abbott, S., Fisk, M., and Forward, L. (2000) Social and democratic participation in residential settings for older people: realities and aspirations. *Ageing and Society*, 20, pp 327–340.
- Bowles, N. (1999) The Delphi technique. *Nursing Standard*, 13(45), 32–36.
- Cohen-Mansfield, J. and Ray, C.A. (2014) Guest Editorial: Whose responsibility is it to make life worth living?, *International Psychogeriatrics*, 26, 8, 1231–1233.
- Department of Health (2014) Training and Research in Aged Care Services. Downloaded from <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-dynamic-sector.htm>, last accessed 23.9.2014.
- Dodevska, G. A. & Vassos, M.V. (2013) What qualities are valued in residential direct care workers from the perspective of people with intellectual disability and managers of accommodation services? *Journal of Intellectual Disability Research*, 57, pp.601–615
- Dunston, R., Lee, A., Boud, D., Brodie, P., & Chiarella, M. (2009) Co-Production and Health System Reform: From Re-Imagining To Re-Making. *Australian Journal of Public Administration*, 68(1), 39–52.
- Hatton, C., Craig, J., Wigham, S. and Gudgeon, E. (2006) *Developing measures of job performance for housing support staff working with people with learning disabilities: Final Report*. Lancaster: Institute for Health Research, Lancaster University.
- Health Workforce Australia (2011) *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*, Adelaide: HWA.
- Health Workforce Australia (2012) *National evaluation of HWA Aged Care Workforce Reform Program*. Adelaide: HWA.
- Helmer, O. (1967) *Analysis of the Future: The Delphi Method*; Santa Monica California: RAND Corporation.
- Honderich, T. (2003) Free will. In J. Baggini and J. Stangroom (Eds) *What Philosophers Think*. London, Continuum Press: 197. Hunter, S., & Ritchie, P. (Eds.). (2007). *Co-production and personalisation in social care. Changing relationships in provision of social care*. London: Jessica Kingsley.



- Kimberley, H., Gruhn, R. and Huggins, S. (2012) *Valuing Capabilities in Later Life: The capability approach and the Brotherhood of St Laurence aged services*. Melbourne: Brotherhood of St Laurence.
- Michigan Dementia Coalition (2006) *Knowledge and Skills Needed for Dementia Care: A guide for direct care workers*. Detroit: Michigan.
- Nay, R. (2002). The dignity of risk. *Australian Nursing Journal*, 9(9), 33.
- Needham, C., & Carr, S. (2009) Co-Production: An Emerging Evidence Base For Adult Social Care Transformation, *SCIE Research Briefing*. London: Social Care Institute.
- Nussbaum, M. (2003) Capabilities as fundamental entitlements: Sen and social justice, *Feminist Economics*, 9, p. 35–59.
- Parsons, C (2008) 'The dignity of risk: challenges in moving on', *Australian Nursing Journal*, 15 (9), p. 28.
- Pill, J. (1971) The Delphi Method: Substance, context, a critique and annotated bibliography, *Socio-Economic Planning and Science*, 5, 57–71.
- Productivity Commission (2011) *Caring for Older Australians, Report Number 53, Final Inquiry Report*. Canberra.
- Rabinow, P. (1984) *The Foucault Reader: An introduction to Foucault's thought*. Harmondsworth: Penguin.
- Ramcharan, P., Nankervis, K., Strong, R. and Robertson, (2009) *Experiences of restrictive Practices: A view from people with disabilities and family carers*. DHS Melbourne, Office of the Senior Practitioner.
- Ramcharan, P., Leighton, D., Moors, R., Laragy, C., Despott, N. and Guven, N. (2013) *It's My Choice: RMIT and Inclusion Melbourne*.
- SCIE (2012) *Personalisation: A Rough Guide*. London: Social Care Institute of Excellence (SCIE)
- The Treasury (2010) *Australia to 2050: Future Challenges*. Canberra.
- Tolbize, A. (2008) *Generational Differences in the Workplace*. Minnesota: Research and training Centre on Community Living.
- VALID (n.d.) Charter of Human Rights and Responsibilities, <http://www.valid.org.au/resources/posters/32.pdf>

Venturato, L., Kellett, U. and Windsor, C. (2007) Nurses' experiences of practice and political reform in long-term aged care in Australia: Implications for retention of nursing personnel, *Journal of Nursing Management*, 15, p. 4–11.

Williams S, Nolan M, Keady J. (2009) Relational practice as the key to ensuring quality care for frail older people: discharge planning as a case example, *Quality in Ageing*. 10 (3), p. 44–55.