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Support workers can develop the skills to work with complexity in community aged care: An Australian study of training provided across aged care community services.

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ABSTRACT

Enhancing support workers' (SW) role is timely given increasing demands on human and financial health care resources. This article presents outcomes of a program, delivered to 140 participants from five community aged care providers in Australia, designed to enhance knowledge, skills, and confidence of community aged care SWs, building their practical skills in understanding, recognizing, and responding to complexity. Evaluation training modules on communication, complexity, behavior change, and chronic condition self-management support involved pre/post surveys with SWs and their supervisors. SWs reported greater awareness, skills, and confidence in working with complexity, reinforcing the value of their existing practices and skills. Coordinators reported greater appreciation of SWs' skills, and greater awareness of gaps in SWs' support and supervision needs. Educators, policy makers, and services should account for these contributions, given growing fiscal restraint and focus on reablement and consumer-directed care.

KEYWORDS

Behavior change; care workers; community aged care; complexity; education and training; support workers

Introduction

Health and aged care systems internationally are experiencing significant demands on their limited human and financial resources, and these pressures are likely to grow as the burden of chronic disease increases with the growing needs of the aging population (Narasimhan et al., 2004; Productivity Commission, 2011; Segal & Bolton, 2009; World Health Organization [WHO], 2006). The Australian aged care system comprises a network of care options including community aged care and residential aged care. The goal of this system is to maximize older persons' capacity to remain in their own home and to live as independently as possible for as long as possible. This service sector is variously funded by state and national government, with services provided by a combination of state health and nongovernment private organizations. All aged care services and their workforce are governed by national standards of service delivery (Australian Institute of Health and Welfare, 2015). However, in Australia, aged care is an intersectorial health and aged care

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system but is hampered by a disconnected workforce across many boundaries, perpetuating duplication and inefficiency (Health Workforce Australia [HWA], 2012). Agencies providing services to these clients often work independently within their own scope of services and practices to achieve their own organizational objectives. This results in suboptimal outcomes for older people and their carers, underpinned by multiple disconnected “systems” that are difficult to navigate to get the right service provided by the right person, the first time, whenever and wherever they need care (HWA, 2012). Clients with more complex care needs are particularly disadvantaged within such systems. Complexity, as used within this article, means the situation arising from persons’ needs that mean that engagement with them, assessing their needs and service provision to meet those needs is not straightforward. This can be due to the presence of a range of comorbid physical and mental health conditions and/or psychosocial circumstances surrounding the person.

The Australian government’s response to the above issues has been to promote the uptake of more effective self-management support and collaborative care within health and social services. These processes aim to maximize people’s motivation and engagement in their own health care, and their reablement to maximize their independence in the community and defer their placement within higher care settings. Together, these objectives form central components of the Australian National Chronic Disease Strategy (National Health Priority Action Council [NHPAC], 2006), and further national initiatives and state-based chronic disease strategies developed to address the growing burden of chronic disease in Australia. Such strategies rely heavily on enhancing the skills of the health workforce in the areas of communication, collaboration, behavior change, and managing complexity. However, focus has tended to be on the professional or specialist workforce. Broadening the scope of support worker (SW) roles in the community, to respond to complexity, releases professional staff time to undertake more specialized roles with clients. This might then lead to optimal utilization of the support and professional/ specialist workforce (Moran, Nancarrow, Enderby, & Bradburn, 2012). It might also engage whole teams of SWs in community care, being actively involved in hospital avoidance and better client outcomes. However, building these roles for SWs requires a paradigm shift in how the workforce is structured (HWA, 2012; Stone, 2004).

We propose that the SW workforce can play an increasingly important role in enacting chronic condition care plans and rehabilitation regimens developed by service professionals, and in supporting clients to improve self-management of their chronic conditions. This is because, arguably, SWs see and work with clients in their natural environment on a more routine basis than other health care providers, for extended periods. They are therefore likely to have a greater opportunity to develop trust and close working relationships with clients. They are also highly attuned to clients’ daily needs, routines, and practices and changes in their physical and psychosocial health and well-being as a consequence of their contact with clients (Martin & King, 2008; Mellor et al., 2010; Menne, Ejaz, Noelker, & Jones, 2007; Ryan, Nolan, Enderby, & Reid, 2004).

SWs make up 82% of workers within community aged care environments (King et al., 2012). Hence, they are in an ideal position to identify adverse changes in clients’ health and well-being and provide motivational support that is client centered and realistically targeted to clients’ identified needs, goals, and circumstances. They could communicate

clients' needs to others in their services in a more timely way, leading to more positive outcomes for client care. Clients' perceived value in the SW extends to their expressed expectations that SWs have intimate knowledge of their circumstances, as a representative of the organization providing the service. This sometimes creates an assumption that the SW is an integrated part of the care team (Southern Adelaide Local Health Network [SALHN], 2013). It can place the SW in sometimes quite stressful situations when clients choose to disclose personal and sensitive information (which they commonly do) to them. However, it is of concern that SWs' training does not provide them with the necessary skills to address these complex and sensitive needs of clients (Menne et al., 2007).

There is now a large body of international research and practice evidence for the effectiveness of chronic condition management and self-management support approaches. Yet SWs have largely been excluded from such training and have undertaken their roles with little formal training in these approaches, particularly in the area of supporting behavior change. Their life experience and their personal qualities of care, patience, and tolerance have historically guided their work with clients (SALHN, 2013). In the dominant discourse, they have been represented as a low-skilled, inexpensive workforce undertaking predominantly practical labor (i.e., hands-on, everyday personal care tasks with and for clients) (Neysmith & Aronson, 1996). However, with the increasing complexity of clients' chronic conditions and comorbidity, and the future demands on the health workforce, it is timely that SWs be supported to have more formal understanding of how to maximize their interactions with clients with complex physical and psychosocial needs, and to maximize their interactions with professional staff within more collaborative service delivery structures. Stone (2004) argues that, "The future of home care will depend, in large part, on this 'third rail' of long-term care policy" (p. 521).

Complexity is multifaceted and requires a multilayered workforce approach to enable shared responsibility and early intervention across sectors and agencies (Adelaide Health Service, 2011). "Without integration at various levels [of health systems], all aspects of health care performance can suffer. Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes" (Kodner & Spreeuwerberg, 2002, p. 2). As a result of services working in isolation, clients are often overserved but underserved (i.e., people are receiving more services than they need but receiving services that do not necessarily target their actual needs) with issues resulting in crises that are not effectively identified and/or addressed by conventional approaches (Peek & Baird, 2014). As a result, there are admissions to hospital and escalation to case managers that could be potentially prevented (McLean, Mendis, & Canalese, 2008). Additionally, an integrated and coordinated workforce response across systems to identify and respond to early deterioration in health status is not currently in place.

This article reports on the evaluation of training that aimed to enhance the role that SWs can play in supporting clients from within their community aged care services to effectively self-manage their chronic conditions; thereby improving the capacity and capability of the health and aged care workforce to work with complexity (HWA, 2014a, 2014b). To attain the aim of this study, statistical analyses were performed to test the following hypothesis:

Phase 2

Hypothesis 1: There is a significant difference between the perceptions of trained coordinators and SWs about SWs' knowledge, skills, and confidence in managing complexity.

Phases 1 and 3

Hypothesis 2: There is a significant difference between the perceptions of trained coordinators and nontrained coordinators about SWs' knowledge, skills, and confidence in managing complexity.

Hypothesis 3: There is a significant difference between the perceptions of trained SWs and nontrained SWs about SWs' knowledge, skills, and confidence in managing complexity.

Method

Setting and rationale

This research was conducted for an HWA-funded project: Aged Care Workforce Reform: Building a Complexity Competent Support Workforce (HWA, 2014a; 2014b). HWA is the Australian government-funded national workforce agency tasked with driving change, collaboration, and innovation in Australia's health care services to meet the rapidly rising demands for health care. The aim of this project was to identify and test SW functions, associated competencies, and system enablers (the parts of the system that support the development and enactment of the competencies) via targeted training for the management of complexity across the care continuum for older people. Its focus was on enhancing the role of SWs to support coordination of care for older people with complex needs, building their capacity to support client self-efficacy, and to identify and respond to risk associated with complexity.

The project involved collaboration between five community services tasked with care coordination and direct service provision for older people with complex needs who were living in the SALHN community, in metropolitan and rural South Australia. SALHN is the state government-funded body working toward improving the design, coordination, and integration of patient care in the southern region of Adelaide, serving a population of approximately 500,000 South Australians. It oversees the delivery of government-funded hospital and community health services. The services included a Community Complex Care team (based at the Local Health Network), two community nongovernment providers of aged care packages, a community domiciliary care service, and a remote country health service providing domiciliary-type services and aged care packages. The client group targeted was older people (65 years or older or 50 years or older for Aboriginal or Torres Strait Islander people) living in the community who were frequent users of hospital and other acute care services as a result of multiple comorbidities and other psychosocial complexities. Clients were living independently in the community in their own homes or within clustered housing units and receiving a range of supports such as personal care, physiotherapy and occupational therapy aide support, social support, transportation and shopping assistance, and house cleaning support. Two Victorian and

one New South Wales (NSW) community aged care services were also involved, as part of a wider HWA Workforce Innovation Group formed to share project resources and promote learning.

Community aged care service providers from across the project region identified that the workforce was not currently organized to provide streamlined care for older people with complex needs. This involved the following identified service gaps: early intervention, integration, and cross-sectorial or interagency working in ways that were coordinated, consistent, systematic, and flexible toward clients' needs or standardized to evidence-based practice (Neal & O'Connor, 2008). Paid SWs, in particular, were identified as not currently working to the full scope of their practice (Bird, Kurowski, Dickman, & Kronborg, 2007). In the South Australian project region, 74% of older residents experience one or more chronic diseases, and 10.1% experience three or more (SALHN, 2013).

In 2011, a 2-month audit was also undertaken of the top 200 most frequently presenting patients to the Emergency Department of the major hospital servicing the region in which the project was undertaken. This audit was undertaken to gain a better understanding of this population group and their needs, and the issues facing services in relation to this population. Seventy patients were excluded who had a mental health diagnosis, required palliative care, were age younger than 18 years or primarily had an addiction. Of the 130 patients remaining, 30 were older than age 65 and had an average presentation rate (to hospital seeking admission) of eight presentations per year. The most common reason for presentation was chest pain, followed by chronic obstructive pulmonary disease and syncope/collapse. In addition to chronic conditions, there was also a range of psychosocial complexities that impacted clients' health and their rate of Emergency Department presentation (SALHN, J. O'Connor, June 30, 2013, personal communication). These figures indicated a need for more health education, prevention of deterioration, early intervention, and lifestyle management of this population by community health services. They also indicated a need for innovative approaches to enhancing SW workforce skills and capacity.

Ethical considerations

Ethics approval was granted by the relevant Clinical and University-based Ethics Committees. All data reported was deidentified by person and service. Completion of the surveys was voluntary and anonymous, asking only that participants nominate their role as either SW or coordinator. Participant information sheets and consent forms were provided, with signed consent received from every participant with the return of their completed surveys.

Participants

Participants were paid SWs working in the community who provided a range of services to the aged care population. This included personal care, home-based delivery of rehabilitation support, assistance with shopping and cleaning, and welfare check visits. Coordinator participants were those providing direct supervision to SWs or who inter-acted directly with SWs because they provided health professional case management to the client group. In addition to the participants from the South Australian community aged care services described above, participants also included a small number of SWs and

Table 1. Number of participants.

Participants	Pre-training	Immediately post-training workshops	3 months post-training
Coordinators/supervisors/other	15	26	12
Support workers	35	76	52
Total	50	102	64

coordinators from Victorian community aged care services who travelled to South Australia to attend workshops (n = 4) and NSW (n = 20) community aged care services linked to the project. The researcher travelled to NSW to deliver a workshop to these participants. Table 1 presents the number of participants and their distribution in each phase.

Here, it is important to mention that numbers of participants were not the same in different phases. Also, there were no identification numbers to match the participant who took part in more than one phase.

The training

The training involved four modules that could be delivered as a total single workshop or in distinct, shorter sessions to accommodate service needs and SW availability. For this project, they were delivered as a one-day workshop, with breaks and lunch provided. All modules involved a range of learning activities delivered as whole group, small group, paired activities, or individual reflection, with large-group discussion and feedback to share insights and consolidate the learning. The focus of the modules was on adult learning principles (Burns, 1995) that is, providing highly interactive and practical learning activities perceived by learners to be relevant and important, to ensure active participation, appropriate pitch and relevance to SWs' experience, with regular opportunities for reflection/application cycles. Didactic delivery was minimized, with the focus heavily placed on shared dialogues that drew on participants' existing experiences. The lead researcher was the workshop facilitator and an experienced educator who had previously worked as a SW for 10 years and who therefore brought credibility to the process. The learning materials were compiled into a train-the-trainer manual to foster sustainability and reach of the training for the broader SW workforce in each service, in the orientation of their new staff, and for dissemination more broadly. The workshop content was developed by the lead researcher in collaboration with the project team and its reference group of representatives drawn from across the services involved in the project:

- Module 1: Introducing Communication, Motivation and Behaviour Change covered core skills for communicating with clients around behavior change. This provided participants with the opportunity to discuss behavior change in the context of themselves, others, and clients and asked them to draw on the personal and practice experiences.
- Module 2: When Complexity Makes Providing Support Hard covered strategies for facilitating cooperative behavior and dealing with difficult family dynamics, using a series of developed case studies to prompt small group discussion and brainstorming.

Module 3: *Motivating People for Change* covered an introduction to motivational interviewing principles and skills, using video clips to demonstrate and role play to practice the skills, in addition to a Problem and Goal Setting exercise using an established tool for identifying the clients' main problem (the problem, its impact, and how it makes them feel) and setting a SMART goal (Specific, Measurable, Actionable, Realistic and Timely) (Lawn, 2013; Lawn, Westwood, Jordans, & O'Connor, in press).

Module 4: *Chronic Condition Care Planning and the Support Worker Role* provided an introduction to the concepts of self-management and self-management support. Participants explored the SWs' role in supporting self-management by using developed case studies to complete a self-management care plan (identified issues, aims, steps to get there, who is responsible, review date) (Lawn, 2013; Lawn et al., in press).

Data collection and measures

The impact of the training was evaluated via surveys to participants, distributed at three phases that delineated different activity points in the study and different timing of data collection corresponding to those activity points:

- Phase 1: Beginning of project/pre-training survey—December 2012, with return to the researcher by the beginning of March 2013.
- Phase 2: Post training survey—June/July 2013 immediately following completion of training workshop or given option to return within one week of workshop completion.
- Phase 3: End of project survey—Three months postworkshop (October 2013) once participants had the opportunity to use and reflect on their new skills in practice, with return to the researcher by the end of November 2013.

For Phases 1 and 3, separate surveys were provided to SWs and coordinators, to reflect their differing position in relation to the Likert-rated and open questions asked (approximately 20 minutes to complete). The SWs' survey looked at their expectations and their perceived challenges, opportunities, and issues with working with clients with complex needs prior to implementation of training to support their work with such clients, and then once the training had occurred. The coordinators' survey looked at the same question areas from their perspective of the SW role to compare and support an understanding of the issues and needs of SWs. The researcher provided batches of hardcopy surveys to key contact staff of each of the services, along with return stamped envelopes to enable confidential return, or via e-mail directly to the researcher if participants preferred. The research project managers provided reminder prompts to each service via the key contact person at each site.

For Phase 2, training workshop participants were asked to complete a post evaluation survey at the end of the workshop. This included Likert-rated questions about each of the four modules: whether the information was useful and of assistance in their current role (very useful, of some use, not at all useful), easy to understand (very easy, mostly easy,

difficult), whether there was additional information that they would have liked included (yes, no, explain), and whether the length of the presentation was suitable (yes, no). It also included a series of Likert-rated questions (agree, unsure, disagree, unchanged or not answered) about their confidence, knowledge, and skills across each of the workshop content areas in relation to their role. SWs and coordinators completed the same survey, with coordinators asked to complete questions about confidence, knowledge, and skills based on their perceptions of how useful the material was for SWs (approximately 5–10 minutes to complete).

At the conclusion of the project, SWs and coordinators also took part in a series of focus groups, separately, to ensure that they could speak freely. Case study examples of the impact of the training on SW practice were also elicited. Matched pre- and post-in-depth interviews with a sample of clients from each of the five services were also undertaken (i.e., the same person was interviewed at the beginning of the project and then interviewed again at the end of the project to determine if his or her views had changed). The results of the focus groups and interviews, and case studies, are reported elsewhere.

Data analysis

All survey data were managed and analyzed using SPSS 21 to evaluate the training impact on participants. Most questions used Likert-type scale rating to scoring the responses in all phases and the responses were largely skewed. Hence, nonparametric tests were used for data analysis (Salkind, 2014). In particular, responses of coordinators and SWs collected through Phase 1 (pre-training) and Phase 3 (post training) were compared through bi-variate analysis (Salkind, 2014) to test the two hypotheses. As the participants were different in numbers in Phases 1 and 3 and also unidentifiable, the Mann-Whitney U Test was employed to compare responses between pre and post training groups (Garson, 2012). On the other hand, univariate analysis was attempted to summarize the responses of Phase 2 (evaluation of the training). Inferential statistics were also attempted (bivariate chi-square and McNemar Test) to see if coordinators and SWs evaluated the training session differently. The alternate hypothesis was accepted for all the tests if the p value was less than or equal to 0.05 (Hair, Black, Babin, & Anderson, 2009; Salkind, 2014). General discussion points and conclusions from across the surveys were then drawn to highlight the key ideas pertinent to the role, confidence, knowledge, and skills of SWs. These appear in the results section below.

Results

A description of the preliminary workshop outcomes is presented first (Phase 2), then a summary of the comparative results of the pre-training and 3-month post training surveys (Phases 1 and 3) are presented to demonstrate the broader impact of the training.

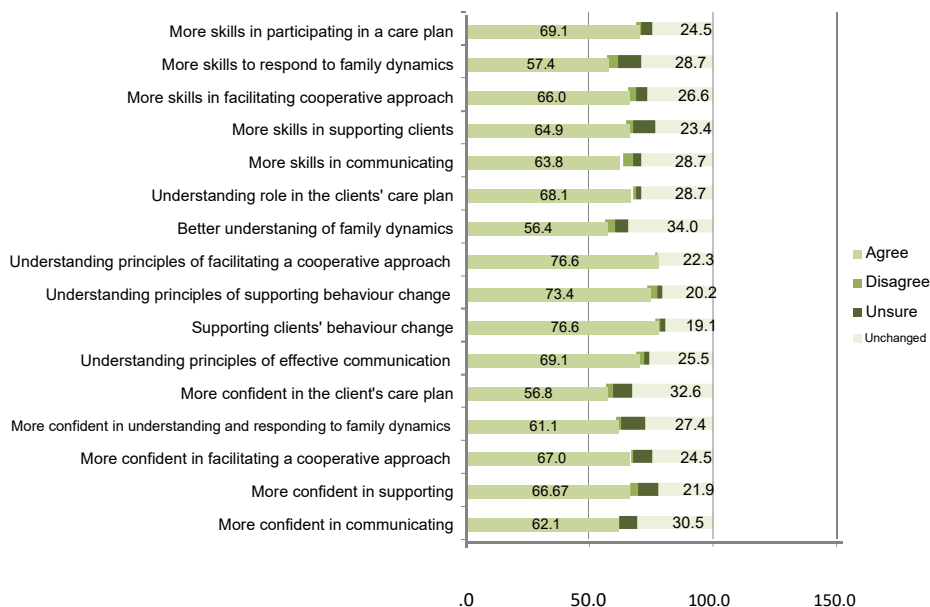


Figure 1. Overall evaluation of workshop training session (in valid percentages).

Phase 2 results

One-hundred and forty participants attended the Complexity Workshop training during June, July, and August 2013. Of these, 72.8% (n = 102) across all workshops provided survey feedback. Among these 102 participants, 76 were SWs and 26 were coordinators. Participants were asked to evaluate the overall training sessions. This section of the article focuses on their responses that reflected their confidence, knowledge, and skill levels after the training. Figure 1 captures their overall responses in valid percentages.

The majority of the participants “agreed” (minimum-56.4% and maximum-76.6%) that the training sessions had improved their confidence, knowledge, and skills in different sections. They reported that it had boosted their confidence (67%, n = 68) in “facilitating a cooperative approach with clients and supporting clients to change their behavior” (66.67%, n = 68). Also, 69.1% (n = 70) of participants believed that they acquired “more skills in participating in a care plan for clients.” Finally, most of the participants perceived that their knowledge had been enhanced in different learning areas after the training session (“realising their role in supporting clients’ behaviour change”: 76.6%, n = 78; “better understanding of the principles of how to support clients to change their behavior”: 76.6%, n = 78).

SWs and coordinators appeared to benefit from the learning experience, regardless of their previous training and job roles. As mentioned earlier, bivariate chi-square and McNemar Tests were applied to see if the two groups’ responses to the survey questions were significantly different. For this purpose, variables were collapsed (agree and disagree/unsure/unchanged) to meet the assumptions of the tests. However, none of the variables showed significant differences in views between the two groups (Table 2). Therefore, alternate Hypothesis 1 was rejected.

Table 2. Comparison between pre-training and post-training surveys for coordinators.

	Groups	N	Sum of ranks	Percentiles			Mann-Whitney U	Asymp. Sig. (2-tailed)
				25th	50th (Median)	75th		
Coordinators have satisfaction with the support they provide to SW	Pre-training	15	168.5					
	Post-training	12	209.5					
	Total	27		5.00	5.00	6.00	48.500	.034
SW enjoy working with these clients	Pre-training	14	138					
	Post-training	12	213					
	Total	26		5.00	6.00	7.00	33.000	.005
SW feel confident in providing health information to these clients	Pre-training	15	164.5					
	Post-training	12	213.5					
	Total	27		4.00	5.00	5.00	44.500	.021
SW ability to provide practical examples and ideas to these clients	Pre-training	10	77.00					
	Post-training	12	176.00					
	Total	22		5.00	6.00	6.00	22.000	.006
SW confidence in their ability to provide effective support to these clients	Pre-training	11	84.00					
	Post-training	12	192.00					
	Total	23		5.00	6.00	6.00	18.000	.002
SW are clear about their roles and responsibilities across the continuum of care	Pre-training	12	105.00					
	Post-training	12	195.00					
	Total	24		5.00	5.00	6.00	27.000	.004
SW have opportunities to work collaboratively with other services	Pre-training	12	114.50					
	Post-training	12	185.50					
	Total	24		5.00	5.00	6.00	36.500	.033

Likert-type scale scores: 1 (strongly disagree), 2 (disagree), 3 (somewhat disagree), 4 (neither agree/disagree), 5 (somewhat agree), 6 (agree), 7 (strongly agree). Asymp. Sig. = Asymptotic significance. SW = Support workers.

Phase 1 and phase 3 results

Thirty-five SWs and 15 coordinators completed Phase 1 surveys. Fifty-two SWs and 12 coordinators completed Phase 3 follow-up surveys.

SWs and coordinators generally agreed that the project activities had made a positive contribution to enhancing the SW role and its impact on clients' care. SWs and coordinators wanted to sustain the interventions developed within the project. Both groups were keen to learn more, and both groups identified working with clients with mental health issues as an area of ongoing unmet learning need.

Coordinators

Fifteen and 12 coordinators participated in Phase 1 (pre-training) and Phase 3 (post-training) surveys, respectively. Comparative results (those that were significantly different) from pre/post surveys from coordinators are provided in Table 3.

Firstly, as can be seen from Table 3, a total of seven items showed significant differences between pre- and postsurvey responses out of twenty items. Mean rank and median show that postsurvey responses were ranked higher than the presurvey ones, which confirms a positive impact of the training on the coordinators. The majority of coordinators agreed that they were "satisfied with the support provided to support workers" ($p = .034$). Coordinators also mentioned that "support workers better enjoyed their work" ($p = .005$) and "felt more confident in providing health information" ($p = .021$). Their ability in "providing practical examples and ideas" ($p = .006$), "confidence in providing effective support" ($p = .002$), and their realization of "roles and responsibilities across the continuum of care" ($p = .004$) were also improved after the training session. Overall, coordinators perceived that SWs' "opportunities to work collaboratively with other services" ($p = .033$) had increased. As some of the items showed significant differences between Phase 1 and Phase 3 responses for coordinators, the alternate Hypothesis 2 was accepted.

Support workers

Thirty-five and 52 SWs participated in Phase 1 (pre-training) and Phase 3 (post-training) surveys, respectively. Comparative results (those that were significantly different) from pre/post surveys for SWs are provided in Table 4.

As can be seen from the table, six items showed significant differences in pre/post surveys out of 20. Mean rank and median provide evidence that postsurvey responses were ranked higher. In some cases ("satisfaction with the support received," $p = .022$ and understanding "role of providing support to clients with complex care needs," $p = .003$), the responses were ranked highest as SWs strongly agreed (mean rank = 7) that the training had a positive impact on those factors. SWs agreed (mean rank = 6) that they were "satisfied with how they supported clients" ($p = .004$), with "effective coordination of support across services" ($p = .023$) and that their "views on the client needs are listened by other services" ($p = .043$), SWs largely agreed that they were "able to identify emerging risks/issues" ($p = .015$). As some of the items showed significant differences between Phase 1 and Phase 3 responses for SWs, the alternate Hypothesis 3 was accepted.

It is notable that coordinators and SWs agreed that the SWs were satisfied with the support provided to them. Both parties also agreed that SWs understand better and realize

Table 3. Comparison between pre-training and post-training surveys for support workers.

	Groups	N	Sum of Ranks	Percentiles			Mann-Whitney U	Asymp. Sig. (2-tailed)
				25th	50th (Median)	75th		
Satisfied with how I currently support clients	Pre-training	34	1167.50					
	Post-training	52	2573.50					
	Total	86		5.00	6.00	7.00	572.500	.004
Satisfied with the support received from coordinators	Pre-training	35	1292.00					
	Post-training	52	2536.00					
	Total	87		6.00	6.00	7.00	662.000	.022
Effective coordination of support across services	Pre-training	35	1285.50					
	Post-training	52	2542.50					
	Total	87		5.00	6.00	7.00	655.500	.023
My views on the clients' needs are listened to by other services	Pre-training	30	1377.00					
	Post-training	48	2364.00					
	Total	78		4.00	6.00	6.25	529.000	.043
Confidence in my role of providing support to clients with complex care needs	Pre-training	35	1218.50					
	Post-training	51	2522.50					
	Total	86		6.00	7.00	7.00	588.500	.003
I am able to identify emerging risks/issues for clients	Pre-training	35	1278.00					
	Post-training	52	2550.00					
	Total	87		6.00	6.00	7.00	648.000	.015

Likert-type scale scores: 1 (strongly disagree), 2 (disagree), 3 (somewhat disagree), 4 (neither agree/disagree), 5 (somewhat agree), 6 (agree), 7 (strongly agree). Asymp. Sig. = Asymptotic significance.

Table 4. Comparison of responses between support workers and coordinators for evaluation immediately following training workshops.

		Participant's role		Pearson chi-square	Asymp. Sig. (2-sided)
		Support worker	Coordinator/supervisor/other		
More confident in communicating	Agree	41	18	1.411 ^a	.235
	Disagree/Unsure/Unchanged	29	7		
More confident in supporting	Agree	48	16	.422 ^a	.516
	Disagree/Unsure/Unchanged	22	10		
More confident in facilitating a cooperative approach	Agree	45	18	.079 ^a	.778
	Disagree/Unsure/Unchanged	23	8		
More confident in understanding and responding to family dynamics	Agree	43	15	.170 ^a	.680
	Disagree/Unsure/Unchanged	26	11		
More confident in the client's care plan	Agree	37	17	1.065 ^a	.302
	Disagree/Unsure/Unchanged	32	9		
Understanding principles of effective communication	Agree	46	19	.260 ^a	.610
	Disagree/Unsure/Unchanged	22	7		
Supporting clients' behaviour change	Agree	53	19	.248 ^a	.618
	Disagree/Unsure/Unchanged	15	7		
Understanding principles of supporting behaviour change	Agree	50	19	.002 ^a	.965
	Disagree/Unsure/Unchanged	18	7		
Understanding principles of facilitating a cooperative approach	Agree	53	19	.248 ^a	.618
	Disagree/Unsure/Unchanged	15	7		
Better understanding of family dynamics	Agree	37	16	.388 ^a	.533
	Disagree/Unsure/Unchanged	31	10		
Understanding role in the client's care plan	Agree	46	18	.022 ^a	.883
	Disagree/Unsure/Unchanged	22	8		
More skills in communicating	Agree	42	18	.454 ^a	.500
	Disagree/Unsure/Unchanged	26	8		
More skills in supporting clients	Agree	42	19	1.056 ^a	.304
	Disagree/Unsure/Unchanged	26	7		
More skills in facilitating cooperative approach	Agree	43	19	.811 ^a	.368
	Disagree/Unsure/Unchanged	25	7		
More skills to respond to family dynamics	Agree	38	16	.246 ^a	.620
	Disagree/Unsure/Unchanged	30	10		
More skills in participating in a care plan	Agree	46	19	.260 ^a	.610
	Disagree/Unsure/Unchanged	22	7		

Asymp. Sig. = Asymptotic significance. ^a0 cells (.0%) have expected count fewer than 5.

their roles and responsibilities more than they did prior to the training. However, coordinators were more positive about the overall increase of “confidence” in SWs’ roles than were SWs themselves (statistically insignificant). Of note, 32% of SWs reported that confidence in their role was unchanged; though it is unclear this meant that they already felt confident in how they provided care to clients or whether their lack of confidence was unchanged (see Limitations).

Discussion

Across all sources of data used to evaluate the training, results were overwhelmingly positive. SWs, regardless of their role, were keen to learn. They valued the opportunity to be involved in the learning activities and wanted to continue to develop their skills. They were particularly keen to be given opportunities to reinforce their learning, and to have more opportunities to debrief with their peers and supervisors as a means to reflect on their role and experiences of providing support, and to consolidate their learning. A national survey of the direct care workforce found that it has a strong commitment to training and upskilling (King et al., 2012).

For coordinators, the workshops provided a clear opportunity to revisit core concepts such as person-centered care, motivation, and behavior change. For SWs, it introduced new concepts for them to consider and reinforced the value of their existing practices and skills. SWs clearly demonstrated their capacity to understand many core concepts surrounding behavior change. Although they did not always acknowledge their skills (with many assuming them as “intuition” or not overtly naming them), the activities within the training workshops allowed them to recognize the complexity of the care they deliver. This was affirming but also challenged their knowledge base. The motivational exercises generated thinking about what the client actually wants and that SWs can play an integral part in supporting clients’ behavior change. They recognized that behavior change support is not about the worker’s authority but about encouraging clients’ control over their own situation, and that this can be built regardless of the client’s level of complexity. The training provided SWs with the opportunity to reflect on and understand better the holistic needs of clients with more complex comorbidities and psychosocial circumstances and how these might affect clients’ capacity to engage with services and with behavior change. SWs became even more aware of the need to listen to and create opportunities to empower these clients. A significant shift in thinking occurred, from “doing for” to “doing with” clients.

There was clear value in combining SWs and coordinators within the same learning workshop space, to share ideas and to learn with, from and about each other as part of an effective Interprofessional learning process (Centre for the Advancement of Interprofessional Education, 2002). This was perceived to enhance collaborative working, build respect for the SW role, and provide an opportunity for service teams to consider (as a group) how they might embed some of their learning into their service structures. Coordinators were also able to better realize and appreciate the skills of their workforce, the relationship SWs have with clients, and to recognize gaps where SWs needed more support and supervision.

SWs felt more knowledgeable, skilled, confident, and valued by their services as a consequence of the project activities delivered to them. Many SWs’ comments also demonstrate that they had changed their practice to be more motivational toward their clients as part of supporting clients’ self-management behaviors and maximizing clients’

autonomy and independence. There were several anecdotal examples of improved client health and self-management outcomes through this change in approach during the project. It seemed that the trusted interaction and a change in the perspective of the SW from a “do for” attitude to a “do with” attitude had a very positive effect. Providing opportunities for SWs to develop their skills leads to greater job satisfaction, reduced stress, and lower workforce turnover (King, Wei, & Howe, 2013). King et al. (2013) found that SWs are confident in their skills but that their skills were underused and not fully respected. Kemper et al. (2008) found that SWs reported feeling appreciated, respected, and listened to as important to their job satisfaction.

Coordinators confirmed that they felt more understanding toward, and confidence in, the SW role and SWs’ capacity to work effectively with clients with complex care needs. Across several areas, their shifts in perception were even more marked than those observed from SWs. Radford, Shacklock, and Bradley (2013) found perceived supervisor support was an important predictor of SW retention and job satisfaction.

A large review of research into health workforce skill-mix found that “factors promoting successful changes in that skill mix include introducing ‘treatments’ of proven efficacy; appropriate staff education and training; removal of unhelpful boundary demarcations between staff or service sectors” (Sibbald, Shen, & McBride, 2004, p. 28). The current study effectively met a range of these criteria. It developed and delivered training in proven approaches: motivational interviewing, behavior change, and self-management support. It appeared to match the learning needs of SWs in ways that built their confidence and skills; though mental health remained an area of unmet need for both groups. The project learning activities also brought SWs and health professionals together in ways that built awareness of SWs’ skills and respect for their contribution to client care and care coordination more broadly.

Study limitations

The original surveys did not incorporate any identification number or code to match pre/ post survey responses. This limited the application of crucial statistical tests such as the “related samples test” (Salkind, 2014). Also, the total number of participants was inconsistent across all three phases. In the surveys, participants were not asked about any personal characteristics such as age, sex, or education qualification, which might have influenced the responses rather than the training itself. This limitation restricted any multivariate analysis where the above-mentioned factors could be controlled to see their effects (Hair et al., 2009). Also, the fairly low sample size for coordinators (pre-15 and post-12) might have influenced the statistical power of the study. Besides the low sample size, there were some unanswered responses (treated as missing values) due to the self-administered responses. Finally, the Likert-type scale responses in Phase 2 failed to clarify the difference among the terms unsure, unchanged, disagree that might have hampered the responses (Likert, 1932).

Conclusion

The project activities increased the ability and confidence of SWs to identify and respond to clients with complex needs at risk of decline. SWs and coordinators stated that service

coordination, communication, and relationships had been strengthened as a consequence of the project activities. Project activities appeared to have brought SWs and coordinators even closer together, improving their working relationships and being more aware and respectful of each other's roles. Overall, all project activities appeared to facilitate a collaborative, coordinated service with all parts of the team working together with the client. The study findings (perceived improved understanding, confidence, and coordination) might translate to improved care for older people, greater job satisfaction, and workforce retention for SWs through an expanded scope of practice and greater recognition of their skills and contributions, and more efficient use of health professionals' skills and time on more specialized roles. The findings of this project suggest that SWs have many existing yet untapped skills for supporting complexity and can make a valuable contribution to health care services. This represents a significant enhancement of the SW resource for minimal cost to the organizations, but significant value for all concerned. Health care policy makers, educators, and services should account for these contributions, given the growing climate of fiscal restraint and calls for a greater focus on reablement and consumer-directed care.


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