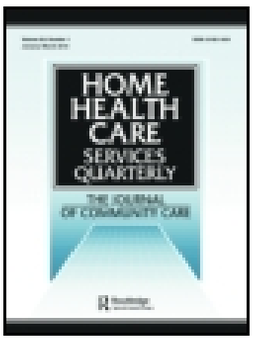

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Australian home care work: an integrative review

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Australian Home Care Work: an Integrative Review

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Abstract

The home care sector comprises one of Australia's fastest growing workforces, yet few papers capture the overall landscape of Australian home care. This integrative review investigates home care work with the aim of better understanding care recipients and their needs, funding and regulation, care worker skills, tasks, demographics, employment conditions and training needs. Over 2,700 pieces of literature were analysed to inform this review. Results suggest sector fragmentation and a home care workforce who, although well placed to improve outcomes for care recipients, are in need of better training and employment support. Suggestions for future research regarding Australian home care include studies that combine both aged and disability aspects of care, more research around care recipients, priority needs and strategies for addressing them, and how best to prepare home care workers for their roles.

Key words:

Home care, care worker, home care work, paid care, aged care, disability, training

Introduction and background

The home care sector comprises one of Australia's fastest growing workforces, yet little has been written that truly captures the overall state of play in Australian home care and informs future direction. This integrative review investigates home care work with the aim of better

understanding care recipients, funding and regulation, and care worker skills, tasks, demographics, employment conditions and training needs.

In keeping with global trends, the Australian population is ageing (Chomik & MacLennan, 2014a). In 2014, 15% of Australians were aged 65 and over compared to 8% in 1964, and in the past 20 years there has been a ninefold increase in the number of people aged 85 and over, up to 1.9% of the population in 2014 (Australian Bureau of Statistics [ABS], 2015). This longevity is potentially associated with increased years of chronic illness, disability, physical and cognitive decline, and is driving the need for aged and disability care at an unprecedented rate (Chomik & MacLennan, 2014a).

Home-based care affords social support and assistance for individuals with various health care needs to live as independently as possible in their own homes and communities (Chomik & MacLennan, 2014a; Clarke, 2015; Iacono, 2010; Martin & Healy, 2010; Meagher, Szebehely, & Mears, 2016). This model is a viable option for policy makers, as it promises greater cost-efficiency and respects the preferences of an increasing number of people to remain in their own homes rather than move to residential care facilities for support (Chomik & MacLennan, 2014a; Martin & Healy, 2010).

By 2050, it is anticipated that around 80% of Australian aged care services will be delivered in the community and the paid care workforce will need to more than quadruple (Productivity Commission, 2011). Data about the size of standalone disability sector which provides support for Australians under the age of 65 who have a permanent and significant disability is less specific (Alcorso, 2017). However, reports from this sector indicate that the demand for disability services is also increasing, with an associated workforce growth of approximately 3.6% per quarter (Alcorso, 2017; Baker, 2016), and industry expectations that demand for workers will rise further with the introduction of the National Disability

Insurance Scheme (NDIS). Consequently, paid home care is one of Australia's largest employing industries and fastest growing sectors (AIHW, 2015).

The home care workforce comprises licensed health care professionals such as nurses, physiotherapists and occupational therapists, and unlicensed home care workers (HCWs). In Australia, these HCWs typically account for more than three-quarters of the home care workforce (King, Mavromaras, Wei, He, Healy, Macaitis, Moskos & Smith, 2013; Martin & Healy, 2010). While the workforces for home-based aged and disability care may be considered as quite distinct, they share many characteristics, including their demographics, skills and tasks associated with their role and employment conditions (Alcorso, 2017). Moreover, there may be some merging of the two roles as people with disabilities age (Iacono, 2010).

Aim

The aim of this review is to identify and analyse research on Australian home care work. The central premise is that the home care sector is rapidly expanding, yet few papers capture the overall landscape of Australian home care. The following research questions were informed by the central premise and used to guide this review:

1. Who are the home care recipients in Australia and what are their care needs?
2. How is home care currently funded and regulated?
3. What tasks comprise the home care role?
4. What are typical Australian HCW worker characteristics and employment conditions?
5. What are the training needs of Australian HCWs?

Literature collected and analysed in relation to these questions sketch the landscape of home care in Australia and propose key recommendations to support quality sustainable home care provision in the future.

Methods

Design

Whittemore and Knafl's (2005) methodology informed this integrative review. This five-phased process relies on: (i) clear identification of an answerable and searchable question(s); (ii) a rigorous search strategy and audit trail; (iii) an iterative, critical appraisal of the selected studies; (iv) data extraction; and finally (v) interpretation and dissemination of findings (Whittemore & Knafl, 2005). This methodology was chosen as the most appropriate to capture assorted sources of information allowing for a rich and comprehensive understanding across the landscape of home care health care.

Search methods

A systematic inclusive approach was used to identify included papers. Electronic databases CINAHL, PsycINFO, Medline, EMBASE and Scopus were searched using terms incorporating various titles and terms describing home care workers, for example disability support workers, direct care workers etc. Inclusion criteria were: published after 2000, paid care, home care, individual care, Australian research, and written in English. Exclusion criteria were: informal caregiving, group facilities, respite or community based centres, nursing homes or residential care facilities, international studies. Papers included peer reviewed journal articles, government reports and papers and some grey literature. Reference lists of relevant papers and authors' collections were also searched.

Search outcome

Following removal of duplicates, two researchers reviewed titles and abstracts. Sixty-three papers were shared among the researchers for full text review against a data extraction tool detailing inclusion and exclusion criteria. Due to the inclusive nature of this review and the heterogenetic forms of literature, both peer reviewed and grey, it was decided not to use a

specific quality appraisal tool. The result was 27 papers for inclusion in the integrative review (Figure 1, Table 1).

Data abstraction

The Whittemore and Knafl (2005) approach requires analytical and systematic methods throughout to provide unbiased and comprehensive interpretation of included papers. The reviewers independently extracted data from the papers, onto a shared worksheet allowing for transparency between each reviewer. This process generated a tabulated form ready for analysis and synthesis.

Synthesis

In keeping with thematic analysis, data was read and reread carefully identifying emerging themes (Liamputtong & Serry, 2017). The first author completed the analysis, using reflexivity, in consultation with other reviewers maintaining a strong rigorous and transparent process. Through this course of interpretation, the reviewers, at times, looked past each paper's primary objectives to draw out material relating to the aim of the review: the landscape of Australian home care.

Results

Characteristics of the included literature

Twenty-seven pieces of literature were included in the review process. All papers originated in Australia and included Government reports (5), peak body reports (3), research papers (17), a discussion paper (1), and a letter to the editor (1). The research papers were an assortment of qualitative, quantitative and mixed methods (Table 1).

Insert Table 1 here.

Themes

Data were identified against the five research questions guiding this review: home care recipients, home care funding and regulation, home care worker role/tasks, home care worker

characteristics and employment conditions, education and training. These data are presented in the key findings section of this review.

Insert Figure 1 here.

Key findings of the review

Key findings in relation to the five research questions: home care recipients, home care funding and regulation, home care worker role/tasks, home care worker characteristics and employment conditions, education and training, are now presented in the following sub-sections.

Home care recipients

Table 2 sets out the key findings from the review in relation to Australian home care recipients. The left-hand column outlines the key finding and the right-hand column identifies the literature source.

Insert Table 2 here.

In overview, precise data about Australian home care recipients and their care needs are not always available. What is known, however, is that an ageing Australian population is associated with an increase in chronic illnesses such as depression, which is often undetected in the elderly (McCabe, Davison, Mellor, & George, 2008; Mellor et al., 2010). Additional challenges for home-based care include people with complex needs, such as those with disabilities who are ageing (Iacono, 2010; Wark, Hussain, & Edwards, 2014). However, these 'needs' are not well articulated in the papers reviewed. Home care 'tasks' are outlined (see Table 3) which may be aligned to care needs e.g., personal hygiene, mobilization, domestic duties, although these tasks are mostly discussed in the context of the HCW role rather than the needs of the recipient.

More generally, the papers reviewed emphasize independence as a fundamental need of Australian care recipients. Today's home care programs are consumer-directed,

characterised by the increasing expectations of the Australian population in relation to care, including their personal capacities and financial resources for achieving them (Chomik & MacLennan, 2014a). Within this model, the governance of care provision is enacted in a way that encourages the independence of ageing/disabled Australians and seeks to give consumers a political voice. Moreover, this policy trend favours programs which focus on preventative, re-enabling and capacity-building programs (Chomik & MacLennan, 2014a). Consequently, there is a need to better understand care recipients, in terms of demographics, health conditions and specific care needs, in order to determine the kinds of programs and workforce most appropriate for Australian home care.

Current funding and regulation

The Australian Federal Government administered Home Support Program (HSP) is the mainstay for older Australians requiring home-based care. This program offers support to people aged 65 years or older, or for Indigenous Australians aged 50 years or older with chronic illnesses, disability, or physical and cognitive decline (Chomik & MacLennan, 2014a). The HSP funds basic services that complement independent living in the community, including meal preparation, domestic assistance and personal care.

In contrast to aged care, Australian home-based disability support has different funding and administrative structures (AIHW, 2015). Aged care services are administered by the Federal Government, while disability services fall under the administration of Australian States and Territories, or a mix of both Federal and States (AIHW, 2015). This fragmented funding, especially when HCWs (and clients) may move between sectors, lends itself to problematic planning, coordination, communication and training (AIHW, 2015) primarily due to state and federal governance structures and systems being largely disconnected.

Further compounding these problems are the various organizations that provide aged/disability care. Services may be provided by larger, government-run organizations,

local councils, community health centers or by small, less known private agencies. In 2012, 81% of the providers of home-based aged care packages were non-profit organisations (e.g., organisations catering to a specific ethnic, cultural or local community, religious and charity organisations) (Chomik & MacLennan, 2014b). Consequently, regulation of services may also be challenging. Commonwealth legislation, regulations and standards exist for community-based care (e.g., Aged Care Act 1997, Disability Services 1986; Home Care Standards 2013) and their compliance is monitored through accreditation, reaccreditation and pre-arranged visits by auditors. However, for the most part, service providers are encouraged to participate in their own quality assurance processes to ensure uniformity and quality of service provision (ANF, 2009; Chomik & MacLennan, 2014b), and to meet their own organizational objectives (Lawn, Westwood, Jordans, Zabeen, & O'Connor, 2016). Insufficient formal performance monitoring may result in suboptimal outcomes for some care recipients and their carers, as they attempt to navigate duplicitous, inefficient and disconnected care systems (Lawn et al., 2016).

A range of Australian Government reforms and initiatives targeting the improvement of service delivery in both aged care and disability sectors are currently in progress. For example, the 2012 introduction of Federal Government's 'Living Longer, Living Better' program aims to provide greater choice and control to consumers, sets means-tested co-contributions from consumers for care, proposes increased funding for the home care workforce and implements stricter quality control measures (Chomik & MacLennan, 2014b). The NDIS which has been gradually rolled out in Australia since 2013, offers disability support packages which are more flexible and tailored to individual consumer needs, provide people with increased control over what and how support services are delivered (Baker, 2016).

In summary, Australian home care has been characterized by fragmentation and ad hoc reform (AIHW, 2015; Chomik & MacLennan, 2014a). However, today's care is inclined towards consumer-directed, independence-focused home care which also delivers value for money (Chomik & MacLennan, 2014a). Central to this provision of consumer-directed care support are HCWs. Therefore, it is necessary to better understand the home care worker role, the home care worker demographic, and the means by which the home care workforce can be improved and sustained.

The home care role

The HCW role typically comprises personal care, domestic duties and social support, dependent upon the skills of the HCW, the ambition of the home care organization, and the needs of the consumer (Meagher et al., 2016). Table 3 provides an extensive list of tasks routinely performed by Australian home care workers in aged care and disability support, as described in the reviewed literature. The left-hand column numbers the task in order of most frequently reported, the centre and right-hand columns locate the task within either aged care or disability support.

Insert Table 3 here

In overview, the HCW role is multifaceted and requires a diverse skill set. While it is difficult to attach a weighting to each task described, Table 3 suggests that personal hygiene assistance, domestic duties and social support are the most commonly performed tasks across both aged care and disability sectors, while tasks such as household management and skills development were exclusively reported in disability support. Noteworthy also is that the HCW role supports high levels of autonomy (Clarke, 2015; King et al., 2013). So, these tasks and associated skills are carried out without the close supervision or guidance of others. After informal (unpaid) carers, HCWs form the core of home-based support, spending more time with care recipients than any other group of health professionals (AIHW, 2015). This

situation emphasizes the need to understand HCW characteristics and employment conditions which may better support them in their roles.

HCW characteristics and employment conditions

Table 4 sets out the main characteristics and employment conditions outlined in the reviewed literature. The left-hand column identifies each specific element, the right-hand column elaborates on each element in more detail.

Insert Table 4 here

In essence, the majority of home care work in Australia is performed by female, middle-aged, low paid workers, with a significant proportion from minority backgrounds (AIHW, 2015). This demographic is also represented internationally e.g., in the United States (AIHW, 2015; Stone, Sutton, Bryant, Adams, & Squillace, 2015), the United Kingdom (Manthorpe & Martineau, 2008), and some European countries (Boerma, Kroneman, Hutchinson & Saltman, 2013). Understanding this demographic is important as it may inform strategies to recruit and retain a robust home care workforce. Noteworthy in Table 4, is that despite high turnover rates in the home care sector, Australian HCWs report significant job satisfaction and positive association with the role (e.g., King et al., 2012; Meagher et al., 2016; Shepherd et al., 2014). This contradiction also suggests that attracting and sustaining a stable home care workforce is possible. One such strategy may be effective education and training initiatives to improve the quality of home care work and support HCWs in their roles.

Education and training

A typical Australian HCW has 12 years of schooling and has undertaken some kind of post-school study relevant to their role e.g., Certificate III in Aged Care or Home and Community Care (AIHW, 2015; ANF, 2009; Austen, McMurray, Lewin, & Ong, 2013; Martin & Healy, 2010). These certificates are the most common qualifications for new entrants to the home care sector (ASQA, 2013), designed to assist HCWs to become 'work ready' with a range of

subjects focused on working safely with consumers and providing individualized care. However, formal qualifications are not mandatory for entry into home care work (ANF, 2009) and even when offered, the suggestion is that formal training programs vary between training providers in terms of course content and delivery, are largely too short, and allow insufficient time in a workplace for sufficient skills development (ANF, 2009; ASQA, 2013; Lawn et al., 2016). In these instances, they rely on their life experience and personal qualities such as dedication, patience and tolerance to fulfil the requirements of their roles (ANF, 2009; Lawn et al., 2016). Indeed, an underlying assumption has prevailed that these experiences and qualities are sufficient for effective practice. This in turn affects the amount of on-the-job training, professional supervision and support offered to HCWs by various organizations (ANF, 2009).

Nonetheless, HCWs report a strong commitment to training and up-skilling for their roles (King et al., 2013; Lawn et al., 2016). Beyond formal qualifications, a range of other learning experiences that enable HCWs to handle the complex issues and problems encountered in their work are suggested, although these suggestions are neither uniform nor mandated in the sector (ANF, 2009). Still, targeted training and preparation for the HCW role has been linked to better quality of care for consumers (Clarke, 2015), improved emotional wellbeing of HCWs (Clarke, 2015), greater job satisfaction and workforce retention (Lawn et al., 2016). Table 5 provides a list of HCW training needs arising from the literature reviewed. The left-hand column numbers the training topic in order of most frequently reported, and the right-hand column provides the rationales for training and aligns these with the literature reviewed.

Insert Table 5 here

Table 5 identifies mental health disorders, dementia and person-centred planning and care as the three most commonly reported training priorities for HCWs. Other suggested topics

included stress management (McCluskey, 2000) and training around client management systems in response to new models of care and funding arrangements such as the NDIS (AIHW, 2015). On-the-job coaching and supervision (Iacono, 2010), opportunities to debrief with peers and supervisors (Lawn et al., 2016), and formal supervision (Shepherd, Meehan, & Humphries, 2014) were identified as ways of effectively conveying information to HCWs. Generally, it was agreed that HCWs are well-placed to respond to the increasingly complex needs of aged/disabled Australians in home care settings. An overall summation and discussion of the key findings from this review follows in the next section.

Discussion

Review findings suggest that Australia has an ageing population and people with chronic/complex conditions e.g., disability, dementia, depression, all with a range of individual task requirements that focus largely on living well and independently. Current funding and regulation to support these requirements is characterized by fragmentation, with various levels of government and a large number of different organisations providing home care services such as personal hygiene assistance, mobilisation, domestic duties, medication management, administrative duties, health planning, monitoring and assessment. The workforce for home care is growing exponentially, comprising predominantly middle-aged women with entry-level qualifications, who earn below the average Australian wage in their part-time or casual role. Training, preparation and workplace support for the range of tasks that HCWs are required to perform varies significantly between organizations. Further, as the demand for HCWs increases (AIHW, 2015), Australia's HCWs are also ageing (Clarke, 2015; King et al., 2013; Meagher et al., 2016). Not surprising then, are the challenges associated with retaining a stable home care workforce, intensified by existing high turnover rates, particularly in the disability sector.

The impact of home care workforce shortages and instability are significant. For care recipients, high turnover of workers is associated with less time to develop therapeutic relationships and increased stress (Meyer, Donelly, & Weerakoon, 2007). Care disruptions and uncoordinated approaches to training may lead to poor health and safety outcomes e.g., bruising, skin tears, pressure sores and emotional trauma reported as a consequence of poor care techniques (ANF, 2009; Iacono, 2010). For the HCW, role ambiguity and poor preparation/support for their role may lead to poor psychosocial health and worker burnout (Vassos, Nankervis, Skerry, & Lante, 2013). Recruiting and training high volumes of workers is also costly for organizations (Chomik & McLennan, 2014b), diverting funds from the various stakeholders (e.g., clients, families, care staff) that they aim to support.

Nevertheless, there are four main gaps in the reviewed literature. Firstly, the authors note that most of the papers reviewed dealt with each workforce (i.e., aged care and disability) as a separate entity. Of the 27 pieces of literature reviewed, only one (AIHW, 2015) included data on both aged care and disability HCWs. However, these workforces share many characteristics, and as the Australian population lives longer, there may be some merging of the two roles (Iacono, 2010). Second, the authors acknowledge challenges in extracting data about HCWs from the all-encompassing 'direct care workforce', which comprises a range of licensed health care professionals and unlicensed workers. Yet, HCWs form the core of home-based care (King et al., 2013; Martin & Healy, 2010). Therefore, home care research that combines both the aged and disability aspects of care, and focuses only on the HCW, may better facilitate understanding of this unique cohort. Third, we can see discrepancies between the commonly performed HCW tasks (i.e., personal hygiene, domestic duties and social support) and identified training priorities (i.e., mental health disorders, dementia care and person-centred care). More research around how HCWs are prepared for everyday tasks, and/or how the highlighted training areas can be incorporated into

preparation for these everyday tasks might assist in developing targeted training resources for HCWs. Finally, we note the difficulty in obtaining data about actual care recipients. The literature suggests that home care needs are complex, vary significantly between individuals and are consumer-driven. However, beyond this information, there is some uncertainty about the health risks, lifestyle factors and more precise care needs of recipients. Preventing falls in elderly Australians has been identified as a priority, to reduce fractures and other injuries, loss of confidence and admissions to institution-based care (Chomik & McLennan, 2014b). Dementia, poor mobility, incontinence and polypharmacy have also been flagged as major issues (Chomik & McLennan, 2014b). Therefore, as the largest component of the direct care workforce, HCWs may be well-placed to implement a range of early health interventions for home care recipients e.g., exercise programs, assistance with maintaining a positive outlook for home care recipients, medication monitoring (Chomik & McLennan, 2014b). Consequently, in order to respond appropriately, more research is needed around care recipients, priority needs and strategies for addressing them (including the role of HCWs).

Conclusion

As an increasing number of aged/disabled Australians are choosing to receive care in their own homes, the immediate challenge is to build and retain a home care workforce large enough, and with the necessary skills, to meet this demand. Addressing this challenge requires the development of a cohesive and transparent system that can clearly articulate the needs of Australian aged/disabled care recipients, a core set of HCW tasks and skills, and targeted training to support positive outcomes for both HCWs and those for whom they care.

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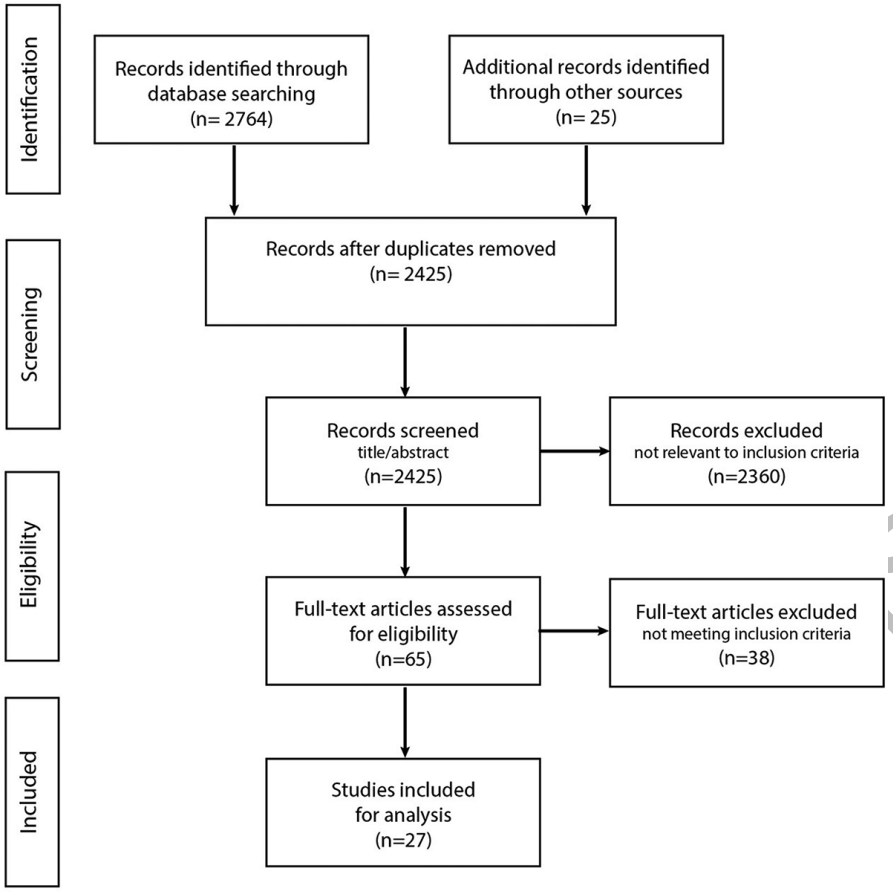
Figure 1 ***Search outcome***



Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e100097. doi: 10.1271/journal.pmed1000097

Table 1 ***Included Studies***

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(AIHW, 2015)	Describes demographics of paid welfare workforce	Multiple settings e.g., aged care, disability, child care	Reports on data from ABS Labour Force Survey 2014. Sample size 27,000. Data also included from National Aged Care Workforce Census and Survey 2012	Government Report	Welfare workforce experiencing faster than average growth, facilitated by increasing workforce participation of females in general plus migration. Identifies key issues as workforce shortage, changing needs, sector fragmentation.
(Alcorso, 2017)	To track the national disability workforce data.	Disability		Sector Report	Reports on a rapidly growing workforce that is trending to a more casual employment structure. Casual workforce turnover rates are higher than permanent part-time. The workforce is made up of 70% female with 21% aged 55 years and older.
(ANF, 2009)	Examines the many titles and work that unlicensed health care workers partake in. Considers issues around skills and training preparation. Impetus for paper was nurses' concern about unlicensed workers performing "nursing" work, and the potential risks to the community.	Multiple settings e.g., aged care, disability, schools		Discussion paper/ report by Australian Nursing Foundation	Describes demographics consistent with other literature (e.g., Martin & King). Makes key recommendation of licensing of paid care workers, along with preservation of title.

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(ASQA, 2013)	Focuses on existing training in Aged Care; Home and Community Care. Response to the Productivity Commission's (2011) concerns about: (a) quality and variability of training; (b) different durations for training by RTOs for same qualification; (c) amount of practical; (d) industry experience of trainers and assessors; (e) regulation of training.	Aged care		Government Report	Key messages: (a) Cert III in Aged Care the most common entry qualification of aged/community care workers; (b) Most RTOs have difficulty complying with assessment requirements; (c) training programs largely too short and have insufficient time in a workplace for skills development; (d) changes to national standards are required.
(Austen et al., 2013)	Identification of the patterns of employment retention that need to be addressed in the development of workforce strategies in the aged care sector	Aged care	De-identified staff record data (Silver Chain) 1997-2007	Research Paper	63% of carers employment ended within 2 years; 57% of nurse employment ended in within 2 years. Retention was poorest among younger, , males and workers on casual contracts (43%)
(Baker, 2016)	Mapping the state of the disability sector in Australia	Disability		Sector Report	Report provides an overview of the disability sector including those employment statistics and requirements of clients. Almost 36000 individuals work in the disability sector providing homecare and other services. Service quality maybe at risk as workers are mainly employed on a casual basis.
(Chomik & MacLennan, 2014a)	Describes the Australian aged care policy landscape, as well as the demand for and funding of formal and informal aged care.	Aged care		Research Brief	
(Chomik & MacLennan, 2014b)	Describes the aged care sector from the "bottom up" - care recipients, providers, the workforce, access and quality issues.	Aged care		Research Brief	High level of job satisfaction, lower turnover than previously thought.

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(Clarke, 2015)	Exploration of community aged carers evaluation of job quality using a job quality framework	Aged care	Five focus groups (35 participants) and 13 face to face semi-structured interviews-one aged care provider	Research Paper	Issues identified for remuneration, career structures, skill and skills based career structures important for organisational capacity and recruitment.
(van Dooren, Dean, Boyle, Taylor-Gomez, & Lennox, 2016)	Letter to the editor outlining outcomes of 2013 study of disability support workers and their perception of health assessment	Disability		Letter to the editor	Support workers (i) suggested that the health assessment resulted in improved health awareness for both GPs and support workers; (ii) articulated that the health assessment assists not only as a clinical checklist but also as an advocacy tool for individuals and their supports; (iii) identified the role that the health assessment might play for the GPs and themselves as collaborative, professional supports for individuals with intellectual disability; and (iv) understood how the process of undertaking a health assessment might impact on the daily life of individuals.
(Iacono, 2010)	Investigate the range and complexities of tasks involved in providing direct care and support to people with intellectual disability, and strategies to increase the capacity of DSWs to meet these demands.	Disability	Discussion of several specific areas	Discussion paper	Organisational leadership and coaching of DSWs to support them to implement training and to utilise input from professionals is a possible means of increasing the capacity of disability organisations to make meaningful changes for people receiving their services and to adequately support their staff.
(King et al., 2013)	Presents data from the National Aged Care Workforce Census Survey 2012.	Aged care		Government Report	>240,000 workers in direct care roles in aged care sector - 147,000 in residential facilities, 93,350 in community outlets.
(Lawn et al., 2016)	Presents outcomes of a training program designed to enhance practical skills in understanding, recognising and responding to complexity.	Aged care	140 support worker participants from 5 community aged care providers in South Australia	Research paper	Positive responses re training - perceived improved understanding, greater job satisfaction, workforce retention. Support workers were particularly keen to be given opportunities to reinforce their learning, more opportunities to debrief and reflect with peers and supervisors.
(Martin & Healy, 2010)	Profiles community services sector. Disability services are the focus for this paper.	Multiple settings e.g., child protection, juvenile justice, disability except aged care		Government Report	68,700 people employed in Australian disability services sector, 58,200 people providing direct services. Non-profit or charitable organisations fund the bulk of disability services (73% of employees). 76% of disability services employees are "non-professional" i.e., personal carer, home care worker, disability support worker etc.

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(McCabe, Russo, Mellor, Davison, & George, 2008)	Evaluate the effectiveness of a training program to assist carers to better recognize depression among older people	Aged care	52 formal carers (26 in community care, 26 in RACF) completed a 4 session (for personal care attendants) training program to identify/ respond appropriately to signs of depression.	Research paper	Training was effective in increasing carers' knowledge of depression and self-efficacy in detecting depression and reducing the barriers to care at both post-test and 6-month follow-up
(McCluskey, 2000)	Exploratory study set out to define the key roles of paid carers of people with brain injury.	Disability	10 semi-structured interviews - five people with a traumatic brain injury and five paid carers.	Research paper	Five major roles identified: Attendant, Protector, Friend, Coach, negotiator. Friendship important aspect of care relationship. Carers were required to negotiate frequently with clients and their families, and with other service providers.
(Meagher et al., 2016)	Compares job characteristics of home care work in Australia and Sweden.	Aged care	318 Australian HCWs completed NORDCARE survey re job characteristics in 2010 to enable comparisons with Swedish model of care.	Research paper	
(Mellor et al., 2010)	Evaluated the efficacy of the beyondblue Depression Training Program	Aged care	148 staff from low level and community care facilities; Pre and post program and follow-up questionnaire data were collected and referrals for depression by staff were recorded.	Research paper	Training improved carers' knowledge about depression, their self-efficacy in responding to signs of depression and their attitudes towards working with depressed aged care recipients. Training also increased the number of referrals for depression made by carers.
(Meyer et al., 2007)	To understand and describe the experience of people receiving assistance and people's interactions with personal care attendants from the perspective of the person receiving personal care assistance.	Disability	In-depth, semi-structured, telephone interviews were conducted over 5 months (June–October 2002) with seven men and four women	Research paper	Participants wanted their personal autonomy facilitated when they received carer assistance. This was achieved when the carer replaced the participant's 'hands' and followed the choices and preferences of the participant when providing assistance.

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(Mutkins, Brown, & Thorsteinsson, 2011)	To investigate the level of burnout among disability support staff in relation to client behaviour and level of support received	Disability	Disability support staff - working in homes - some office staff also included	Research Paper	Disability support workers level of burnout was similar or less than personal services staff. Staff emotional response and personal resources not necessarily related to levels of burnout. Client behaviour was not related to levels of burnout More social support satisfaction had a moderate relationship with burnout levels.
(Productivity Commission, 2011)	Systematic inquiry into social, clinical and institutional aspects of aged care, provides recommendations for regulatory and funding options, future workforce requirements etc.	Aged care		Government report	Key points from inquiry. Possibly a precursor to the "my aged care" gateway.
(Radford, Shacklock, & Bradley, 2015)	To examine factors influencing personal care workers' intensions to stay or leave Australian aged care employment.	Aged care	206 participants from community and long term aged care (4 organisations)	Research paper	Supervisor support, on the job embeddedness and type of employment were identified as predictors of intention to stay or leave. Community care workers reported more support than long-term care workers.
(Robinson et al., 2009)	To scope issues surrounding availability of information for service providers about dementia clients living in the community; service providers information needs and information transfer among service providers	Aged care	7 GPs, 20 community health nurses, 23 home carers, 18 residential aged care facility staff, 16 aged care assessment team members	Research paper	Home carers gain initial information from clients/families but sometimes unreliable. Limited information available from service providers. Home care workers would like diagnostic information from GPS and medical information. A large amount of information is available around these issues for home care workers and community nurses.
(Shepherd et al., 2014)	To highlight challenges faced by in-home psychiatric support workers in implementing the vision of recovery in their work with clients with severe psychiatric disability	Disability	27 support workers and 10 managers of support service organisations	Research paper	Challenges include balancing the need to provide care with the requirement to promote autonomy and also developing an effective working relationship while working in the client's home.
(Treuren & Frankish, 2014)	Focuses on client embeddedness - embeddedness theory and its use in more effective recruitment and retention programs	Disability	153 personal care workers - disability service	Research paper	Home care workers feelings toward their clients impacts their intention to leave

Citation	Aim	Setting	Sample/Method	Paper Type	Relevant Findings
(Vassos et al., 2013)	To explore work engagement and job burnout within the disability support worker population	Disability	258 disability support workers	Research paper	Role ambiguity was associated with both work engagement and burnout. Workload and challenging behaviour were also associated with engagement and burnout. Workplace resource of job feedback was also closely associated with engagement and burnout.
(Wark et al., 2014)	to identify the key training issues for staff that support people ageing with an intellectual disability.	Disability	31 disability support workers Rural areas of NSW	Research paper	Themes include: Generic Issues, Medical Issues, Emerging ageing issues requiring changes in support, Mental health issues and quality of life. These are broken down further into categories

Table 2 ***Australian Home Care Recipients***

Key Findings	**Source**
Frail aged (i.e., over 65 years if non-Indigenous, over 50 years if Indigenous Australian) access bulk of home care services	Austen et al., 2013; Chomik & McLennan, 2014b; King et al., 2013; Meagher et al., 2016
Many also have chronic illness e.g., depression, dementia;	Chomik & McLennan, 2014b; McCabe et al., 2008; Mellor et al., 2010; Robinson et al., 2009
Disability (e.g., intellectual, physical or psychiatric;	AIHW, 2017; Iacono, 2010; McCluskey, 2000; Meyer et al., 2007; Shepherd et al., 2014
Any combination of frail aged, chronic illness and disability	Lawn et al., 2016; Wark et al., 2014
Around 5% of older Australians utilise basic home care services through the 'Home Support Program'	Chomik & McLennan, 2014b
An additional 60,000 older Australians receive home-based aged care packages at predetermined 'low', 'intermediate' and 'high' care levels, and additional services (e.g., dementia) as required	Chomik & McLennan, 2014b
Older women, singles, lower income earners, Indigenous Australians and regional/rural Australians most frequent users of home-based aged care services	Chomik & McLennan, 2014b
In 2015-2016, around 146, 000 Australians received home-based disability care	AIHW, 2017
Recipients of home-based disability care predominantly male (59%), with a median age of 35 years	AIHW, 2017
Care received in regular episodes of short duration e.g., three – four hours	Chomik & McLennan, 2014b; Meagher et al., 2016; Meyer et al., 2007; Shepherd et al. 2014
Increasing expectations in relation to care – Australians want consumer-driven, individualised services	Chomik & McLennan, 2014a; Baker, 2016

Table 3. ***Australian Home Care Tasks***

	Task	Aged Care	Disability Support
1.	Personal hygiene assistance (e.g., bathing, toileting)	ANF, 2009; AQSA, 2013; Chomik & McLennan, 2014a; King et al., 2013; Lawn et al., 2016; Meagher et al., 2016; Productivity Commission, 2011; Radford et al., 2015	Baker, 2016; Iacono, 2010; McCluskey, 2000; Meyer et al., 2007; Vassos et al., 2013; Wark et al., 2014
2.	Domestic duties (e.g., cleaning, shopping, meal preparation)	ANF, 2009; Chomik & McLennan, 2014a; Clarke, 2015; King et al., 2013; Lawn et al., 2016; Meagher et al., 2016; Productivity Commission, 2011; Radford et al., 2015	Iacono, 2010; McCluskey, 2000; Meyer et al., 2007; Shepherd et al., 2014
3.	Community inclusion, social support, recreational activities	ANF, 2009; Lawn et al., 2016; Meagher et al., 2016; Productivity Commission, 2011	Baker, 2016; Iacono, 2010; McCluskey, 2000; Shepherd et al., 2014; van Dooren et al., 2015; Vassos et al., 2013
4.	Lifting or assisting with mobilisation	ANF, 2009; Clarke, 2015; King et al., 2013; Meagher et al., 2016; Productivity Commission, 2011	McCluskey, 2000; Meyer et al., 2007; Wark et al., 2014
5.	Assistance with accessing and/or navigating the health care system (outside the organisation)	Clarke, 2015; Lawn et al., 2016; Meagher et al., 2016; Productivity Commission, 2011; Robinson et al., 2009	Iacono, 2010; McCluskey, 2000; van Dooren et al., 2015
6.	Health assessment, planning and/or promotion	ANF, 2009; Lawn et al., 2016; McCabe et al., 2008	Iacono, 2010; McCluskey, 2000; van Dooren et al., 2015; Vassos et al., 2013; Wark et al., 2014
7.	Behavioural support and management	King et al., 2012; Productivity Commission, 2011	Baker, 2016; Iacono, 2010; McCluskey, 2000; Mutkins et al., 2011; Wark et al., 2014
8.	Medication monitoring and/or administration	ANF, 2009; AQSA, 2013; Meagher et al., 2016	McCluskey, 2000; van Dooren et al., 2015; Wark et al., 2014
9.	Advocacy (e.g., ensuring rights of care recipients are upheld; facilitating equitable community access)	Clarke, 2015	Baker; 2016; Iacono, 2010; McCluskey, 2000; Shepherd et al., 2014; Wark et al., 2014
10.	Household management (e.g., finances)		Iacono, 2010; McCluskey, 2000; Shepherd et al., 2014
11.	Skills development (e.g., employment assistance)		Baker, 2016; Iacono, 2010; McCluskey, 2000
12.	Therapeutic relationships	Meagher et al., 2016	Shepherd et al., 2014; Treuren & Frankish, 2014
13.	Administrative tasks (e.g., organising daily and weekly schedules; booking appointments)	Meagher et al., 2016	McCluskey, 2000

Table 4. ***Australian HCW Characteristics and Employment Conditions***

Element	Description
Gender	Predominantly female, representing 90% of HCWs in aged care Chomik & McLennan, 2014b; Clarke, 2015; Meagher et al., 2016) and 70% of HCWs in disability (Alcorso, 2017)
Age	Predominantly middle-aged. 45-54 years age group represent over two-thirds of aged care workers (King et al., 2012; Meagher et al., 2016) and one-quarter of disability support workers (Alcorso, 2017)
	Great proportion of workers in both sectors aged over 55 (Clarke, 2015; King et al, 2013; Meagher et al., 2016); likely to exit workforce within the next ten years (Alcorso, 2017; King et al., 2012)
Ethnicity	Majority are Australian-born; 28% report migrating to Australia (AIHW, 2015; King et al., 2013)
	Most migrant HCWs from English-speaking countries such as United Kingdom, South Africa and New Zealand (AIHW, 2015)
	An increasing number from India, China and the Philippines where English is not the first language (AIHW, 2015)
Employment type	Typically casual or part-time (Alcorso, 2017; Austen et al., 2013; King et al., 2013; Meagher et al., 2016)
	Permanent part-time more common for aged care HCWs (King et al., 2013)
	Almost half of HCWs in disability sector employed on a casual or contract basis (Alcorso, 2017)
Working hours	Regular daytime shift (Austen et al., 2013; Meagher et al., 2016)
	Approx. 16 – 24 hours per week (Alcorso, 2017; Austen et al., 2013; King et al., 2013; Meagher et al., 2016)
Average earnings	In 2014, in both sectors $AU679/weekly; approximately 43% below average Australian wage of $AU1182/weekly (AIHW, 2015)
Turnover	In aged care, somewhere between 6.9% (Meagher et al., 2016) and 16% (Chomik & McLennan, 2014b) employed in sector 12 months or less; 37% remain in HCW role after two years (Austen et al., 2012)
	Higher turnover in disability sector – 25% of HCWs replaced every 12 months (AIHW, 2015)
	Turnover in disability sector likely due to casual workforce (Alcorso, 2017)
	Poor pay and job insecurity most commonly reported reasons for turnover in both sectors (Alcorso, 2017; Radford et al., 2015)
	Mature-aged females are more likely to remain in the role than younger workers (Austen et al., 2012; Radford et al., 2015)
Job satisfaction	Most Australian HCWs happy in their roles (Chomik & McLennan, 2014b; King et al., 2013; Meagher et al., 2016)
	Sociable working hours, manageable workload, good supervisor support and role autonomy reported as positive aspects of role (King et al., 2012; Meagher et al., 2016; Radford et al., 2015; Vassos et al., 2013).
	Client attachment, HCW role esteem, personal satisfaction in helping others and the view that home care is a 'calling' are also positively associated with the role (Martin & Healy, 2010; Meagher et al., 2016; Radford et al., 2015; Shepherd et al., 2014; Treuren & Frankish, 2014).
	Limited opportunities for career progression – rather than moving 'up', HCWs tend only to be able to move horizontally, to either administrative or coordination roles (Clarke, 2015).
	Stress and burnout also commonly reported in disability sector (Mutkins et al., 2011; Vassos et al., 2013)

Table 5. ***Training Needs of Australian HCWs***

Training Topic	Rationale
1. Mental health disorders e.g., depression	Increasing number of Australians with mental health disorders e.g., depression, anxiety (ANF, 2009; Productivity Commission, 2011) HCWs and their organisations also identified the need to upskill in this area (AQSA, 2013; King et al., 2013) Only 22% of older Australians with major depressive disorders detected in home care settings, HCWs well placed for early detection and referral (McCabe et al., 2008; Mellor et al., 2010)
2. Dementia care	In view of ageing population, increasing number of Australians with dementia. (ANF, 2009) Given that HCWs are in regular, direct contact with their consumers, they play an important role in recognising and responding to cognitive decline (ANF, 2009; Wark et al., 2014). HCWs and their organisations also identified the need to upskill in this area (AQSA, 2013; King et al., 2013) Training needed around dementia information access and exchange between various health providers (Robinson et al., 2008)
3. Person-centred planning and care	To meet quality standards for the home care sector (ANF, 2009) Ensure that care is flexible and responsive to needs of individual (AIHW, 2015; ANF, 2009; Meyer et al., 2007; Wark et al., 2014)
4. Assessment, recognition, response and monitoring of health status	Given that HCWs are in regular, direct contact with their consumers, they play an important role in assessing, recognising and responding to various health conditions e.g., diabetes (Lawn et al., 2016; van Dooren et al., 2016; Wark et al., 2014).
5. Managing challenging behaviours	High levels of verbal and physical abuse experienced by HCWs, from consumers as well as their loved ones. Leads to absenteeism and burnout (ANF, 2009) Skills required for specific consumer groups (e.g., acquired brain injury) who may display aggressive outbursts or inappropriate sexual advances (McCluskey, 2000); and people with intellectual disabilities who are ageing (Wark et al., 2014)
6. Communication – reading, written and verbal	Skills needed in liaising with consumers and loved ones – diffusing difficult situations (ANF, 2009; McCluskey, 2000) Specific needs for HCWs from non-English speaking backgrounds to ensure instructions are followed correctly (ANF, 2009) Accurate record keeping to assess consumer changes over time (Wark et al., 2014)
7. Palliative care	Response to the longevity of Australian population (Productivity Commission, 2011) HCWs and their organisations identified the need to upskill in this area (AQSA, 2013; King et al., 2013)
8. Management and leadership	Increase skill mix amongst HCW cohort (Productivity Commission, 2011) HCWs and their organisations identified the need to upskill in this area (AQSA, 2013; King et al., 2013)
9. Planning and facilitating recreational activities	Response to 'healthy ageing' programs for older Australians (ANF, 2009) For HCWs in disability support, activities may facilitate social networks for consumers which may prevent over-involvement of HCWs in consumers' lives (McCluskey, 2000)
10. Wound management	HCWs and their organisations identified the need to upskill in this area (AQSA, 2013; King et al., 2013)