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RESEARCH ARTICLE

'REDI TO CHAT?' Evaluating the effect of two structured tools on the confidence of nursing and care staff working in residential aged care facilities in Australia: A pre-post survey design

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Abstract

Objective: The objective of the study was to evaluate the effect of two self-designed structured clinical tools on overall self-perceptions of confidence in the assessment, management and communication of acutely unwell residents in nursing and care staff of residential aged care facilities (RACFs).

Methods: Quasi-experimental pre-post design using surveys in 22 RACFs in Metropolitan Sydney, Australia. A convenience sample of 254 nursing and care staff were recruited. Two structured tools were developed to enhance confidence: (1) RACF Emergency Decision Index (REDI) and (2) Clinical Handover Assessment Tool (CHAT). The REDI is a clinical decision guide for treatment implementation and escalation, and the CHAT is a structured communication aid. Surveys were administered to participating nursing and care staff working within the RACFs prior to the implementation of the two structured tools (T0) and 6 months later (T1).

Results: There was a significant increase in reported overall confidence in assessing and managing acutely unwell residents 6 months after the implementation of the REDI and CHAT ($p = 0.003$ and $p = 0.006$, respectively). Baseline Confidence in Assessment Scale and Confidence in Management Scale scores differed significantly 6 months following the implementation of the REDI and CHAT tools ($p < 0.001$). There was improvement across all surveyed communication domains.

Conclusions: Preliminary data suggested that the two structured tools are effective in increasing confidence in the assessment, management and communication of acutely unwell residents for nursing and care staff working in RACFs.

KEYWORDS

clinical handover, geriatric nursing, nursing assessment, nursing homes, self-efficacy

1 | INTRODUCTION

The number of older people living in Residential Aged Care Facilities (RACFs) has shown an increase of 17% between 2010 and 2020.[1] Australian RACFs provide accommodation and personal care 24 h a day as well as access to nursing and general health services.[2] The clinical workforce mix in RACFs comprises Registered Nurses (RNs), Enrolled Nurses (ENs) and Health Care Assistants (HCAs). In Australia, both RNs and ENs are registered and regulated by the Nursing and Midwifery Board (NMBA).[3] HCAs are unregulated and work under the guidance of RNs and ENs to provide basic care, such a feeding and bathing.

Over half of people living in RACFs in Australia have five to eight long-term conditions, while 21% have nine or more conditions.[4] Such co-morbidities add to the complexity of management by RACFs' nursing and care staff.[5,6] Currently, in Australia, the Department of Health does not mandate minimum staffing levels and since 2003, RACFs are employing a higher proportion of HCAs than RNs and ENs.[7,8] HCAs are often the most senior staff on duty overnight and on weekends at some RACFs within Australia. HCAs are responsible for contacting and communicating with an RN in the event of resident deterioration. This, coupled with limited access to medical support, resources and appropriate equipment and increasing pressure to reduce the rate of hospital transfer, has created a stressful working environment.[9–11] The literature has identified that nurses and care staff in RACFs are fearful of being criticised or sued for their decision not to transfer a resident to hospital.[9,12] RACFs nurses and care staff frequently have negative interactions and criticisms when communicating with ED and paramedics, further contributing to an already-stressful situation.[9,13,14] This has resulted in nursing staff in RACFs reporting a lack of confidence in their own abilities and decisions.[10]

1.1 | Rationale for study

The evidence highlights the need for specialised training and resources for nurses and care staff working in RACFs.[7,9,13,15] The Royal Commission into the Quality and Safety of Aged Care has highlighted that residential aged care staff are under-skilled and under-educated to adequately assess older people.[8] A focus on the development of skills to enhance confidence and competence will ensure adequate assessment and management of the deteriorating, acutely unwell resident.[8,9,13] It appears that nurses in RACFs are more confident and decisive when equipped with a tool, resource or procedure to follow when managing acutely unwell residents.[9] Evidence also suggests that standardised communication tools may improve information transfer between RACFs and hospital services.[16] However, the majority of studies to date have focused on reducing hospitalisations rather than having a focus on upskilling RACFs' nursing and care staff.[16–19]

Practice Impact

This study demonstrated that structured tools helped to improve confidence and self-efficacy among RACF staff in the assessment, management and communication of acutely unwell residents. This should provide an impetus for further research on the effects of such tools on staff performance in the management of these residents.

1.2 | Objectives

The primary aim of this study was to evaluate the effect of two self-designed structured clinical tools on overall self-perceptions of confidence in the assessment and management of acutely unwell residents by RACFs' nursing and care staff. The secondary aims were to evaluate self-perceptions of confidence in communication and the perceived usefulness of the tools. It was hypothesised that the two structured tools would enhance self-perceptions of confidence in assessment, management and communication. Additionally, it was envisioned that nursing staff would regularly utilise the two structured tools in their clinical practice.

2 | METHODS

2.1 | Research design

Quasi-experimental pre-post survey design using a convenience sample was used to evaluate the effect of the two structured clinical tools on nursing and care staffs' self-perceptions of confidence in the assessment, management and communication of acutely unwell residents.

2.2 | Participants and setting

The study was designed and implemented by a rapid response outreach team covering 35 RACFs, home to approximately 3000 residents in Metropolitan Sydney, Australia. The study was based on a pilot study which involved eight RACFs in 2017. Of the 27 RACFs not involved in the pilot study, 22 were recruited based on their willingness to participate. Nursing and care staff were eligible to

participate if they were Tier One (RN or EN) or Tier Two (HCAs). For the purpose of this study, an HCA is a non-registered healthcare worker who provides personal and supervised clinical care to residents. HCAs were included in this study as staff who regularly provide handover to the RNs about noted changes in residents' conditions. All eligible nursing and care staff working within these facilities were invited to take part in the survey. The recruitment and intervention were staggered across the RACFs between August 2018 and April 2019.

2.3 | Ethical considerations

Ethical approval was obtained from the South Eastern Sydney Local Health District Human Research Ethics Committee prior to recruitment (ethics approval number 17/357). A participant information sheet was distributed with the survey to provide further information about the study and with contact details of the lead researcher. In addition, the information sheet emphasised the voluntary nature of the study. Completion of the survey implied the individual's consent to participate in the study. Consent to participate in the education session was implied by participants' attendance. All nursing and care staff at the facilities were eligible to attend the education, whether or not they participated in the study and completed the surveys.

2.4 | Structured tools and education sessions

Two structured tools were developed by the research team (1) RACF Emergency Decision Index (REDI) (Appendix S1) and (2) Clinical Handover Assessment Tool (CHAT) (Appendix S2). The REDI is a clinical decision guide for treatment implementation and escalation. The REDI consists of 10 scenarios; respiratory distress, chest pain, acute abdomen, dehydration, new confusion (delirium), urinary tract infection (UTI), constipation, blocked feeding tubes, falls and palliative care. The REDI was adapted from the Nursing Home and Hostel Emergency Decision Index (NHHEDI) flip chart, developed by the Geriatric Rapid Acute Care Evaluation Service (GRACE) at Hornsby Ku-Ring-Gai Hospital, New South Wales, Australia. Permission was granted from the creators for the GRACE NHHEDI flip chart to be modified to reflect the common presentations of acute illness in the author's service and for use in this research project. The CHAT is a structured communication aid based on the Identify, Situation, Background, Assessment and Recommendation (ISBAR) handover method. Both tools underwent face validity and were trialled in a pilot study (unpublished).

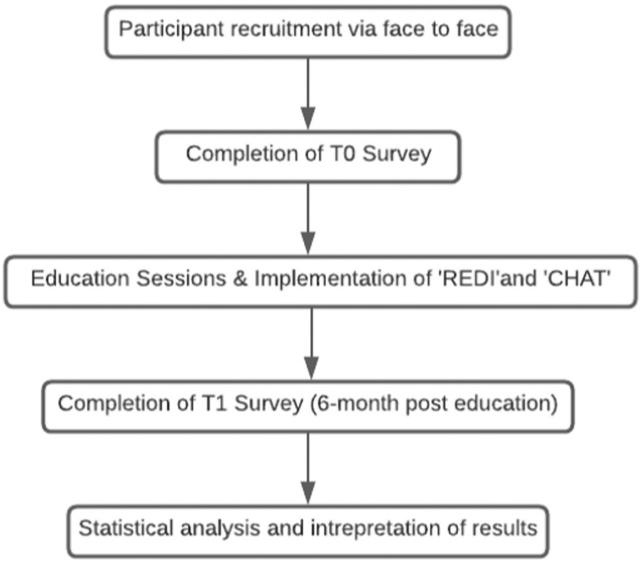

FIGURE 1 Study timeline

All eligible nursing and care staff were invited to attend two face-to-face 1-h education sessions: (1) REDI Flipchart and (2) Assessment of the Acutely Unwell Resident: A to G Approach. Session One provided education on the use of the REDI and CHAT tools. Session Two provided education on the A to G approach to clinical assessment and use of the CHAT tool. The A–G approach is a systematic approach to assessment, that considers Airway, Breathing, Circulation, Disability, Exposure, Fluids and Glucose.[20] Both sessions used problem-based learning through the use of case studies. The sessions were rolled out sequentially across the participating facilities and the tools were made available in each facility following the completion of the education sessions at each site. Both nursing and care staff were encouraged to use the tools to assess residents in the event of acute deterioration and to communicate this assessment to relevant clinicians.

2.5 | Data collection

Data were collected between August 2018 and October 2019. Prior to the education sessions, all participants were invited to complete a baseline (T0) survey (Figure 1). The survey was designed by the research team, underwent face validity and was tested in a pilot study (unpublished). Based on the pilot study, the formatting of the questions was modified to increase usability. The survey was emailed to the research team three times until a consensus of the questions and structure of the survey was agreed upon. The theoretical underpinning of the survey was self-efficacy theory.[21–24]

The T0 survey consisted of six sections (a total of 38 questions). Section One consisted of five demographic

questions. Section Two consisted of two questions asking participants to self-rate their level of overall confidence in assessing and managing acutely unwell residents. Section Three consisted of five questions evaluating self-perceptions of confidence in communication about a resident's condition. The questions in sections two and three used a six-point Likert scale, from 0 (none) to 5 (very high). Section Four consisted of a 10-item Confidence in Assessment Scale aligning with the 10 domains of the REDI flipchart. Each item used a six-point Likert Scale, from 0 (no confidence) to 5 (very high level of confidence). The total score on the combined scale ranged from 0 to 50, where higher scores indicated greater confidence. Section Five consisted of a 10-item Confidence in Management Scale and followed the same scoring as Section Four. Section Six consisted of six 'yes' or 'no' questions and two open-ended questions relating to recent education, barriers and use of clinical tools and guidelines.

Six months (T1) post-intervention, participants who completed the T0 survey were invited to complete a modified version of the T0 survey, where Section Six was changed to consist of 10 open-ended and closed questions regarding the usefulness of the REDI and CHAT tools (total of 42 questions).

2.6 | Data analysis

The data were analysed through IBM SPSS Statistics for Windows, version 27.0.[25] The participants' demographics and secondary outcomes were explored through descriptive statistics. The results are reported as median and interquartile range. Mann–Whitney *U* was used to evaluate the differences in self-perceptions of confidence in assessment and management of acutely unwell residents pre- and post-implementation of the REDI and CHAT tools. The level of statistical significance was set at $p = 0.05$.

3 | RESULTS

3.1 | Demographic characteristics of participants

A total of 282 eligible staff attended at least one of the education sessions. Two hundred fifty-four of them participated in the T0 survey (response rate 90%): 46% Tier One staff and 54% Tier Two staff (Table 1). A total of 51 participants completed the T1 survey (response rate of 20%): at least 12% of participants had resigned during the study period; 22% ($n = 57$) of participants were aged 25–30 years old; 33% ($n = 84$) had 1–5 years of clinical experience; 35% ($n = 90$) had worked at the RACFs for 1–5 years; 50% ($n = 128$) held a bachelor's degree and 50% ($n = 127$) of participants reported that they had received education on assessing acutely unwell residents in the 12 months prior

TABLE 1 Demographic characteristics of participants

	Total ($n = 254$) *n* **(%)**
Clinical position	
Tier 1	117 (46)
Tier 2	137 (54)
Age range (years)	
<20	1 (<1)
20–24	11 (4)
25–30	57 (22)
31–35	22 (9)
36–40	15 (6)
41–45	16 (6)
46–50	29 (11)
51–55	8 (3)
56–60	26 (10)
>60	18 (7)
Missing	51 (20)
Clinical experience (years)	
<1	45 (18)
1–5	90 (35)
6–10	48 (19)
11–15	28 (11)
16–20	16 (6)
21–25	11 (4)
26–30	3 (1)
>30	1 (<1)
Missing	12 (5)
Service at RACF (years)	
<1	45 (18)
1–5	90 (35)
6–10	48 (19)
11–15	28 (11)
16–20	16 (6)
21–25	11 (4)
26–30	3 (1)
>30	1 (<1)
Missing	12 (5)
Highest level of education	
High school	48 (19)
TAFE	45 (18)
Bachelor's degree	128 (50)
Postgraduate degree	28 (11)
Missing	5 (2)

to the implementation of the REDI and CHAT. Of those who completed the T1 survey, 45% ($n = 23$) had attended one of the two education sessions and 45% ($n = 23$) had attended both of them.

3.2 | Confidence in assessment and management of acutely unwell residents

There was a significant increase in reported overall confidence in assessing and managing acutely unwell residents' 6 months post the implementation of the REDI and CHAT ($p = 0.003$, $r = 0.17$ and $p = 0.006$, $r = 0.16$, respectively; Table 2). Baseline Confidence in Assessment Scale and Confidence in Management Scale scores differed significantly 6 months post the implementation of the REDI and CHAT tools ($p < 0.001$, $r = 0.22$ and $p < 0.001$, $r = 0.24$, respectively; Table 2).

3.3 | Confidence in communication of acutely unwell residents

As depicted in Figure 2, there was improvement across all surveyed communication domains (maximum score of 5). The greatest improvement in confidence was in communicating with the hospital outreach service from mean 3.37 (SD = 0.94) to mean 3.86 (SD = 0.61).

TABLE 2 Self-perceptions of confidence in assessment and management

	T0 survey		T1 survey		
Statements	**Mdn**	**IQR**	**Mdn**	**IQR**	***p***
Overall confidence in assessing acutely unwell residents[a]	4.0 (n=245)	1	4.0 (n=51)	0	0.003
Overall confidence in managing acutely unwell residents[a]	3.0 (n=241)	1	4.0 (n=50)	1	0.006
Clinical Confidence in Assessment Scale Score[b]	35.0 (n=220)	10	39.0 (n=50)	4	<0.001
Clinical Confidence in Management Scale Score[b]	35.0 (n=214)	10	40.0 (n=51)	4	<0.001

[a]Maximum score 5.0.

[b]Maximum score 50.

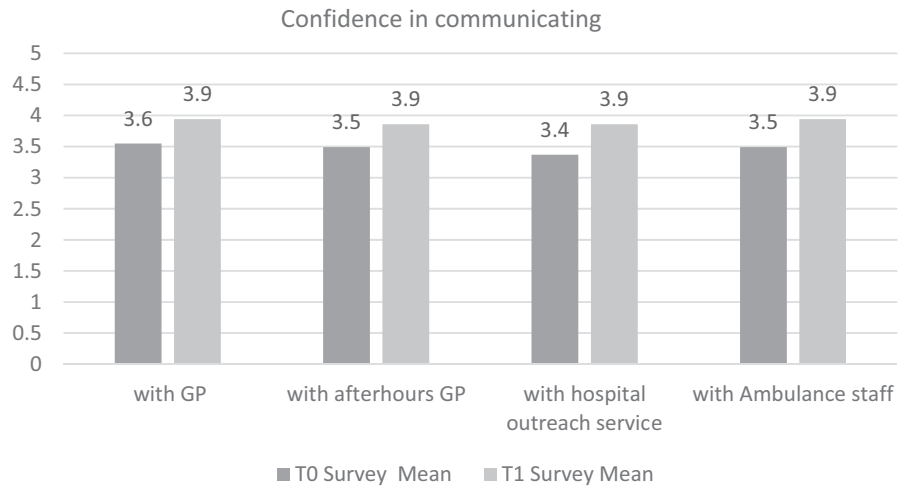

FIGURE 2 Confidence in communication. GP, General Practitioner

TABLE 3 Use of the REDI and CHAT

Statements ($n = 50$)	Never	Rarely	Sometimes	Often	Always
How many times have you used the REDI flipchart?	3 (6.0)	5 (10.0)	26 (52.0)	9 (18.0)	7 (14.0)
How many times have you used the CHAT?	2 (4.0)	5 (10.0)	22 (44.0)	13 (26.0)	8 (16.0)

3.4 | Perceived usefulness of the REDI and CHAT tools

The majority of participants stated that they 'sometimes' used the REDI and CHAT tools (52% and 44%, respectively; Table 3). In addition, 62% ($n = 31$) of participants reported that their confidence in assessing an acutely unwell resident after using the REDI was either high or very high; 70% ($n = 35$) reported that their confidence in managing an acutely unwell resident after using the REDI was either high or very high; 68% ($n = 34$) report that their confidence in communicating information about a resident's condition was either high or very high after using the CHAT. Most participants ($n = 45$, 88%) reported that the CHAT helped in communicating their concerns about an unwell resident.

4 | DISCUSSION

This study indicated that the REDI and CHAT tools have a positive effect on self-perceptions of confidence in the assessment, management and communication of acutely unwell residents in RACFs. The development of confidence for nurses and care staff in RACFs is vital to assist them to overcome the numerous challenges they face. Self-perception of confidence is known as self-efficacy. Self-efficacy is the belief in one's personal capabilities to perform a specific task.[21,22] The greater the individuals perceived self-efficacy, the more likely they are to successfully engage in and perform that behaviour.[21,22] The use of the REDI and CHAT tools was less frequent than hoped, with the majority of participants reporting that they used the tools 'sometimes'. Despite this, the majority of participants did report their level of confidence as high or very high after the implementation of the REDI and CHAT. As confidence with assessing, managing and communicating increases, the reliance on REDI and CHAT will be expected to reduce.

Confidence is subjective and highly individualised, based on factors such as role, self-esteem, sense of self and experiences related to the setting.[26] Negative attributes such as doubt, uncertainty and negativity can be detrimental to a person's self-confidence.[26] Ongoing criticism by ambulance and ED staff is likely to continue to have a negative impact on the self-confidence of RACFs nursing and care staff, and ultimately, their performance or competency.[26] While there was an improvement in confidence in communicating with ambulance staff, there needs to be a greater understanding amongst emergency and hospital services of the constraints of managing acutely unwell residents in RACFs. The stigma surrounding the workforce and working in RACFs needs to be addressed in order to attract, retain and enhance confidence of RACFs nursing and care staff.[13,27]

Similar studies that have implemented decision and communication tools have evaluated reduction in hospitalisations and have not focused on staff outcomes.[17–19] Interventions to Reduce Acute Care Transfers (INTERACT), a randomised study comparing control RACFs and RACFs who received training and implemented a quality improvement program, found no statistical difference in hospitalisations and ED presentations of residents.[17] The INTERACT study included a set of tools and interventions to identify, assess and manage conditions proactively to prevent residents being transferred to hospital.[18] Management should include hospitalisation of residents when required. The purpose of the REDI is not solely to prevent hospital transfer but to ensure that the right care is provided in the right place at the right time. Research should focus on increasing nursing and care staff knowledge, competence and confidence to achieve this purpose.

Studies evaluating self-efficacy in RACFs' nursing staff identified that knowledge and training intensity is a predictor of confidence.[28,29] However, as only 50% of participants attended both education sessions, it is likely that the extent of the education and support for this study may have been insufficient. While the research team provided ad hoc support and encouragement to utilise the REDI and CHAT, there was a lack of onsite champions and considerable turnover in facility leadership teams and staffing during the 6-month period. Such turnover makes the implementation of quality initiatives challenging. Thus, the utilisation and embedding of the REDI and CHAT tools into practice was likely dependent on barriers and facilitative factors within each RACF. This is an expected finding, with several studies involving RACFs also finding a high turnover of facility leadership and staff which affected implementation of initiatives.[11,17,18,30] Future research needs to consider and explore these barriers when implementing and designing tools for RACFs. Unfortunately, participants were not allocated a unique identifying number and we were unable to pair the pre-post survey data, thus data was treated as independent. The small response rate and effect size is a limitation of this study, and the generalisability of the findings is limited. Furthermore, as the follow-up survey was conducted 6 months after the implementation of the REDI and CHAT tools, the sustainability over longer periods of time is uncertain.

5 | CONCLUSIONS

Preliminary data suggest that the two structured tools could be effective in increasing confidence in the assessment, management and communication of acutely unwell

residents for nursing staff working in RACFs. This could have a positive impact on RACFs' nursing staff competence. However, we cannot infer with certainty that higher self-efficacy leads to improved performance here. Therefore, future research could focus on the relationship between self-efficacy and performance in the assessment, management and communication of acutely unwell residents by RACFs' nursing staff.

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CONFLICTS OF INTEREST

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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