Curtin School of Nursing

A Mixed-Methods Investigation of the Experiences of Migrant Care Workers Caring for People with Dementia in Australian Residential Aged Care Facilities

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Author's Declaration

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any degree or diploma in any university.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statements on Ethical Conduct in Human Research. The research study received human research approval from the Curtin University Human Research Ethics Committee (EC00262). Approval Number HRE 2017-083.

Omobola (Bola) Abake Adebayo

Date:

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Abstract

Background: The ageing population and the exponential increase in the prevalence of dementia in Australia and other high-income countries have contributed to a reliance on residential aged care facilities (RACFs) and a high demand for care workers. Similar to the pattern in other high-income countries, migrant care workers have been recruited from middle and low income countries to address staff shortages and to meet the increased care demands in the aged care sector.

International and Australian studies have focused on the experiences of migrant care workers in the community aged care and acute care settings. However, this study focused on the level of knowledge of dementia and dementia care experiences among migrant care workers. Additionally, the work-related stressors associated with caring for residents with dementia in conjunction with migrant care workers' resettlement challenges was examined in this study.

Aims: The aims of this study were to investigate the level of knowledge of dementia among RACF migrant care workers and to determine the impact of the resettlement challenges on their well-being, work, and retention in RACFs. The study objectives were to investigate migrant care workers:

- knowledge of dementia,
- experiences of dementia care in RACFs,
- psychosocial well-being, and
- working conditions.

Methods: An explanatory sequential mixed-methods research design was used to explore the aims of this research study. A national cross-sectional survey (Phase One) followed by qualitative semi-structured interviews (Phase Two) were conducted. Purposive sampling was used to recruit participants in both study phases. Participants were recruited from RACFs and multicultural organisations and through social media and the researcher's networks.

Phase One was conducted between March 2018 and April 2019 to gather quantitative data among RACF migrant care workers employed across Australian States and Territories. Three existing and validated questionnaires – the Dementia Knowledge Assessment Tool Version 2 (DKAT 2), Riverside Acculturation Stress Inventory (RASI), and the Depression, Anxiety, and Stress Scales (DASS) were used to measure RACF migrant care workers' knowledge of dementia, their levels of acculturation stress, and their psychosocial well-being respectively.

Phase Two was conducted between May and December 2019 among migrant care workers of

Filipino, Indian, and Nigerian backgrounds employed in RACFs in Perth, Western Australia. The purpose was to elaborate on the key findings from the national cross-sectional survey. Semi-structured interviews were conducted using face-to-face and telephone methods to collect the qualitative data.

Findings: A total of 272 migrant care workers from 46 nationalities across five continents namely Asia, Africa, Europe, North, and South America participated in the national cross-sectional survey. The top five countries of birth are Nigeria (13.4%), India (9.4%), Philippines (7.8%), Nepal (5.6%), and China (2.8%). Quantitative findings highlighted that migrant care workers had dementia knowledge deficits relating to the cause of dementia, its progression, and the physical symptoms associated with dementia co-morbidities. Acculturation stress was high (M=38.4; *SD*=14.1; 38.9% scored $\geq$ 40 out of 75). Respondents self-reported good mental health scoring in the normal to mild ranges (85% to 93%) on the DASS 21 scale. Ethnicity ($F [4, 254] = 11.0, p < .001$), occupational roles ($F [3, 254] = 3.0, p = .03$) and self-reported English proficiency ($F [1, 254] = 4.17, p = .04$) were statistically significant with acculturation stress.

A total of 20 migrant care workers employed in RACFs in Perth Metropolitan in Western Australia participated in semi-structured qualitative interviews. Nine participants were from a Nigerian background, six from an Indian background and five from a Filipino background. Six telephone and 14 face-to-face semi-structured interviews were conducted according to the participants' preferences. Thematic analysis of the qualitative data showed that migrant care workers' resettlement challenges intersected with work-related stressors, including experiencing discrimination from residents, family members, and colleagues from dominant cultures. Migrant care workers utilised coping strategies that supported their psychosocial well-being. Some groups of migrant care workers, especially newcomers and students on temporary visas were more vulnerable and required additional support when compared to other groups of migrant care workers. In relation to participants' knowledge of dementia, the majority accurately identified associated risks factors for dementia but attributed the risk factors with the main cause of dementia which is biomedically unknown. Migrant care workers understood the principles of the person-centred approach to dementia care and utilised these principles in caring for residents with advanced dementia.

Conclusion: A highly skilled, well-rewarded, and valued aged care workforce is vital to the success of high-quality aged and dementia care. Addressing migrant care workers' dementia knowledge deficiencies would enhance their capacity to engage in collaborative and informed care planning with residents, their families, and other healthcare workers. Understanding the negative effects of acculturation processes and the demands of resettlement challenges on migrant care workers' productivity and well-being can inform policy in sustaining a quality migrant aged care workforce.

Organisation

This thesis is a hybrid thesis consisting of the typescript thesis and published papers.

Chapter One provides background information about the study. Discussed are the contextual factors of the migrant dementia care workforce in residential aged care settings. A review of research gaps and challenges, and the rationale for conducting this research, including the study significance was presented. The chapter concludes with a description of the aims and objectives of the research and the significance of the study.

Chapter Two presents a review of the literature around migrant aged care workers' dementia care experiences in high-income countries, including the enablers and challenges that influence their retention in RACF. It also contains a published peer-reviewed scoping literature review of dementia care experiences in the migrant aged care workforce.

Chapter Three discusses the research methodology, design, and rationale of the sequential explanatory mixed-method design. It also explicates the ethical considerations of the study.

Chapter Four describes findings on the psychosocial well-being of RACF migrant care workers from the national cross-sectional survey. A published paper based on the quantitative findings of the impact of acculturation stress and the level of their mental health is incorporated in this chapter.

Chapter Five presents the results from the national cross-sectional survey relating to migrant care workers' the knowledge of dementia in Australian RACFs across metropolitan areas.

Chapter Six provides an account of dementia care experiences of migrant care workers of Nigerian, Filipino, and Indian backgrounds

Chapter Seven describes the qualitative findings of the psychosocial well-being and working conditions of migrant care workers from Nigerian, Filipino, and Indian backgrounds.

Chapter Eight presents the major study findings, recommendations, limitations, and final concluding statement of the thesis.

Publications Included as Part of the Thesis

For each of the peer-reviewed publications included in this PhD thesis, the scope, design, and objectives of the research studies were conceptualised by the researcher (Bola Adebayo). The researcher also conducted data collection, data analysis, and interpretation of findings, and prepared drafts of the manuscripts. The following publications are included as part of this thesis:

1. **Adebayo, B**., Nichols, P., Heslop, K. & Brijnath, B. 2020. A scoping review of dementia care experiences in migrant aged care workforce. *The Gerontologist*, *60*(2), pp.e105-e116.

2. **Adebayo, B.,** Nichols, P., Albrecht, M. A., Brijnath, B., & Heslop, K. (2020). Investigating the impacts of acculturation stress on migrant care workers in Australian residential aged care facilities. *Journal of Transcultural Nursing*, 1043659620947810.

Conferences and Presentations

Adebayo, B., Heslop, K., Brijnath, B., & Nichols, P. *Dementia care experiences in migrant aged care workforce*. Australian Dementia Forum Hobart, Tasmania. June13-14th, 2019

Adebayo, B., Heslop, K., & Nichols, P. *Culture, dementia care and institutions: the experiences of migrant care workers.* Curtin Ageing Research Network (CARN) Forum, Perth. December 7th, 2018.

Adebayo, B., Heslop, K. & Nichols, P. *Culture, Institutions and Dementia Care: The Experiences of Migrant Care Workers from Culturally and Linguistically Diverse Populations*. Australian College of Mental Health Nurses Western Australia Branch Symposium, Perth. July 27th, 2018.

Brijnath, B., Haralambous, B. & **Adebayo, B.** *Cultural understandings of dementia: Implications for care. Professional development workshop for aged service providers*. National Ageing Research Institute (NARI), Parkville, Melbourne May 10th, 2018.

Invited Seminars

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Adebayo, B., Heslop, K. & Nichols, P. *Culture, institutions and dementia care: The experiences of migrant care workers in residential aged care facilities*. WA Dementia Alliance Meeting, Perth. June 26th, 2018.

Table of Contents

Author's Declaration ... ii
Acknowledgements ... iii
Abstract ... iv
Organisation ... vi
Publications Included as Part of the Thesis ... vii
Conferences and Presentations ... viii
Table of Contents ... ix
List of Tables ... xiii
List of Figures ... xiv
List of Abbreviations Used in the Thesis ... xv

Chapter One Introduction and Research Context ... 1

1.0 Overview of the Chapter ... 1
1.1 Introduction ... 1
1.2 Dementia ... 4
1.2.1 Dementia a Global Health Issue ... 4
1.2.2 Cost of Dementia Care in Australia ... 5
1.3 Dementia and Culture ... 6
1.4 Australian Residential Aged Care ... 8
1.4.1 Profile of Australian Residential Aged Care Facilities ... 8
1.4.2 Australian Residential Aged Care Workforce ... 9
1.5 Migrant Care Workers in Australian Residential Aged Care Facilities ... 10
1.5.1 Historical Context ... 10
1.5.2 Migration Pathways ... 11
1.5.3 Profile of Migrant Care Workers from Culturally Diverse Backgrounds in Australian RACFs ... 12
1.5.4 Employment Benefits to Australian Aged Care Sector ... 13
1.5.5 Migrant Care Workforce Challenges ... 13
1.6 Study Rationale ... 15
1.7 Research Gaps ... 16
1.8 Aims and Objectives ... 16
1.9 Personal Context ... 17
1.10 Summary of the Chapter ... 18

Chapter Two Review of the Literature ... 19

2.0 Overview of the Chapter ... 19
2.1 Summary of the Scoping Literature Review Process and Findings ... 19
2.2 Manuscript-Paper 1 ... 20
2.3 Gaps in literature and Literature Published After the Literature Review ... 32
2.4 Summary of the Chapter ... 32

Chapter Three Methodology ... 34

3.0 Overview of the Chapter 34
3.1 Mixed Methods Research 34
3.1.1 Research Objective 35
3.1.2 Study Phase 35
3.1.3 Identify and report the current evidence on the knowledge of dementia among migrant care workers in RACFs 35
3.1.4 Phase One- National cross-sectional survey 35
3.1.5 Investigate the levels of acculturation stress and mental health of depression, anxiety and stress of migrant care workers in RACFs 35
3.1.6 Phase One 35
3.1.7 Examine the general well-being of RACFs 35
3.1.8 Phase Two- Qualitative Semi-structured interviews 35
3.1.9 Measure the impacts of acculturation stress and mental health on migrant care workers in relation to their working conditions in RACFs 35
3.1.10 Phase One 35
3.1.11 Explore the working conditions of RACFs migrant care workers 35
3.1.12 Phase Two 35
3.1.13 Explore the understanding of dementia and dementia care experiences of Indian, Filipino, and Nigerian residential aged care workers 35
3.1.14 Phase Two 35
3.1.1 Rationale for Using Mixed-Methods Sequential Explanatory Design 35
3.1.2 Factors Influencing the Mixed Methods Design Process 37
3.2 Phase One: National Cross-sectional Survey 39
3.2.1 Study Design 40
3.2.2 Reliability and Validity of the Questionnaires 41
3.2.3 Questionnaire Readability 41
3.2.4 Study Population 42
3.2.5 Piloting and Pretesting of Questionnaire 42
3.2.6 Sampling and Recruitment 42
3.2.7 Data Collection 44
3.2.8 Data Organisation and Analysis 46
3.3 Phase Two: Qualitative Semi-structured Interviews 47
3.3.1 Study Setting 48
3.3.2 Participants 48
3.3.3 Sampling and Recruitment 48
3.3.4 Data Collection 49
3.3.5 Data Analysis 51
3.3.6 Report on the Analysis 53
3.4 Rigour 54
3.4.1 Triangulation 55
3.5 Ethical Considerations 55
3.5.1 Informed Consent and Perceived Coercion 55
3.5.2 Privacy and Confidentiality 58
3.5.3 Harm Minimisation 58

3.6 Data Storage ... 58
3.7 Summary of the Chapter ... 59

Chapter Four The Psychosocial Wellbeing of Migrant Care Workers of Residents with Dementia ... 60

4.0 Overview of the Chapter ... 60
4.1 Background ... 60
4.2 Results ... 62
4.2.1 Sociodemographic Characteristics of Phase One Participants (N=272) ... 62
4.2.2 nglish Proficiency ... 63
4.3 Manuscript – Paper 2 ... 67
4.4 Overview of the findings ... 77
4.5 Summary of the chapter ... 77

Chapter Five Knowledge of Dementia in Migrant Care Workers in Residential Aged Care Facilities ... 79

5.0 Overview of the Chapter ... 79
5.1 Background ... 79
5.2 Survey Results on Respondents' Knowledge of Dementia ... 81
5.3 Discussion ... 86
5.4 Summary of the Chapter ... 88

Chapter Six Knowledge of Dementia and Dementia Care Experience: An Exploration of the Qualitative Interviews ... 89

6.0 Overview of the Chapter ... 89
6.1 Background ... 89
6.2 Findings ... 91
6.2.1 Sociodemographic Characteristics of the Study Participants ... 91
6.3 Expanding on Quantitative and Quantitative Data on Knowledge of Dementia and Dementia Care Experiences ... 92
6.3.1 Understanding of Dementia ... 94
6.3.2 Dementia Care Experiences ... 95
6.3.3 Caring for Residents with Advanced Dementia ... 96
6.3.4 Facilitating Better Quality Dementia Care ... 98
6.3.5 Improving Dementia Care ... 98
6.4 Discussion ... 99
6.5 Summary of the Chapter ... 100

Chapter Seven Migrant Care Workers' Perceptions of Work Experiences in Residential Aged Care Facilities ... 101

7.0 Overview of the Chapter ... 101
7.1 Background ... 101
7.2 Findings ... 103
7.3 Overview of the Findings ... 114
7.4 Summary of the Chapter ... 115

Chapter Eight Discussion and Conclusion ... 116

8.0 Overview of the Chapter ... 116
8.1 Key Findings ... 116
8.1.1 Knowledge and Understanding of Dementia in RACF Migrant Care Workers ... 116
8.1.2 Dementia Care Experience ... 120
8.1.3 Physical and Psychosocial Health ... 122
8.1.4 Working Conditions of RACF Migrant Care Workers ... 125
8.2 Study Significance ... 128
8.3 Strengths and Limitations ... 131
8.4 Recommendations for Further Research, Aged Care Policy, and RACF Management ... 133
8.4.1 Research ... 133
8.4.2 Aged Care Policy and Practice ... 134
8.4.3 Residential Aged Care Facility Management ... 136
8.5 Conclusion ... 138

References ... 139

Appendix A License to Reuse Published Article in Thesis ... 156
Appendix B Human Research Ethics Approval Letter ... 157
Appendix C Phase One Recruitment Flyer ... 160
Appendix D Phase One Participant Information Sheet ... 161
Appendix E Survey Questionnaire ... 164
Appendix F Phase Two Participant Information Sheet ... 174
Appendix G Participant Consent Form ... 178
Appendix H Interview Guide ... 180
Appendix I Codes and Categorisation of Qualitative Data ... 183
Appendix J Impacts – Media Reflections on the Current Research ... 184

List of Tables

Table 3.1 Research Objectives and Study Phases 35
Table 3.2 Readability indices for the RASI, DASS and DKAS questionnaires 42
Table 3.3 Phases of thematic analysis 52
Table 4.1 Respondents' countries of birth 64
Table 5.1 Selected sociodemographic characteristics and their relationship to dementia knowledge (N=272) 82
Table 5.2 Assessment of dementia knowledge: Percentage of respondents that answered individual DKAT2 correctly. 84
Table 5.3 Dementia knowledge deficiencies 85
Table 5.4 Investigating the predictors of the level of knowledge of dementia 85
Table 6.1 Elaborating survey findings in qualitative interviews 92
Table 6.2 Codes subthemes and themes 93
Table 7.1 Sociodemographic characteristics of qualitative study participants according to nationality (n=20) 105
Table 8.1 Summary of the key findings in relation to the research questions 117

List of Figures

Figure 3.1 Sequential Explanatory Mixed-Methods Approach 35
Figure 3.2 Graphical illustration of the explanatory sequential mixed method design used in the study 57
Figure 4.1 Respondents Level of understanding in English 65
Figure 4.2 Respondents Level of English Fluency 65
Figure 4.3 Respondents level of communication in English 66
Figure 4.4 Respondents level of comfortability in English 66
Figure 5.1 Dementia Knowledge Assessment Tool Version 2 (DKAT 2) Total Frequency Scores 81

List of Abbreviations Used in the Thesis

ABS	Australian Bureau of Statistics
AD	Alzheimer’s disease
AHPRA	Australian Health Practitioner Regulation Agency
CALD	Culturally and Linguistically Diverse
COVID-19	Coronavirus Disease 2019
DASS	Depression Anxiety Stress Scale
DKAT 2	Dementia Knowledge Assessment Tool Version 2
EN	Enrolled nurse
HREC	Human Research Ethics Committee
PCA	Patient care assistant
RACFs	Residential aged care facilities
RASI	Riverside Acculturation Scale Inventory
RN	Registered nurse
NACWCS	National Aged Care Workforce Census and Survey
NHMRC	National Health and Medical Research Council
NSW	New South Wales
SA	South Australia
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UN	United Nations
WA	Western Australia
WHO	World Health Organization

Chapter One Introduction and Research Context

1.0 Overview of the Chapter

This chapter provides background information to the current research study, including the ageing Australian population, the current and projected needs of people with dementia, and the migrant care workforce. It presents health and social issues associated with dementia and explains the costs of dementia care in Australian residential aged care facilities (RACFs). A discussion of migrant care workers' contributions in RACFs and workforce challenges are also included. The research gaps, the rationale for conducting this study, aims, objectives, and research questions are also discussed.

1.1 Introduction

Population projections indicate that the global population of people aged 65 and over will increase to 10 million by 2066 (United Nations 2020). Evidence shows that older adults aged 80 and over, are the main users of aged care services and their numbers are estimated to reach 426 million by 2050 (United Nations, 2020), which predicts a greater demand for aged care workers. Major policy discussions in high-income countries have focused on the implication of population ageing on economic growth and development, and strategies to attract and retain a strong workforce within the future aged care sector (Burgess, Connell, Nankervis, Dhakal, & Fitzgerald, 2018; O'Shea & Walsh, 2010) in the past years. [1]

Chronic age-related medical conditions increase as people live longer, resulting in multiple medical conditions that require reliance on formal or informal support services (Abdi, Spann, Borilovic, de Witte, & Hawley, 2019). It is estimated that by 2050 over 3.5 million older Australians will access aged care services annually (Productivity Commission, 2011; Wilson, Temple, Brijnath, McDonald, & Utomo, 2021) as a result of the decline in the availability of family caregivers and informal care arrangements (Burgess et al., 2018). Thus, the aged care workforce will need to increase by over 300% to meet the varied and increasing demands of aged care services by 2050 (Wilson et al., 2021).

The number of people living with dementia in Australia is projected to increase from 472,000 in 2021 to approximately 1.1 million by 2058 (Dementia Australia, 2020). People with dementia

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[1] Based on the World bank 2017 classification, high-income countries including Australia, Canada and the United Kingdom are countries with a gross national income per capita United States (US) $12,536 (Fantom & Serajuddin, 2016).

generally require increased assistance with daily living and care activities as their symptoms progress (Australian Institute of Health and Welfare [AIHW], 2016). Thus, the rising prevalence of dementia necessitates an increase in care workers to support their needs (AIHW, 2016).

Dementia is one of the main reasons for admission to RACFs (Australian Bureau of Statistics, 2017). Over 50% of residents have a diagnosis of dementia in Australian RACFs, and almost 90% of residents with dementia are expected to develop significant changed behaviours, which are commonly referred to as behavioural and psychological symptoms of dementia (BPSD) (Loi & Lautenschlager, 2017; Westaway et al., 2020). According to the International Psychogeriatric Association, the term BPSD describes the symptoms of disturbed perception, thought content, mood, or behaviour that usually occur in people with dementia (Feast, White, Candy, Kupeli, & Sampson, 2020).

The main cause of BPSD is unknown evidence suggests that people with dementia usually exhibit BSPD when their physical or psychological needs and environmental factors are unmet (Westaway et al., 2020). In recent years, expressions such as *responsive behaviour* or *changed behaviour associated with dementia* are used rather than BSPD (Clifford & Doody, 2018). The premise is that BPSD is not the pathology of dementia, but rather it is an expression of emotions and/or unmet needs, such as pain, frustration, loneliness, confusion, or fear, that the person with dementia expresses differently (Dementia Australia, 2020). Therefore, the expression " changed behaviour associated with dementia" will be used in this thesis.

The changed behaviours can be classified into five domains: (1) cognitive/perceptual (delusions, hallucinations); (2) motor (pacing, wandering, repetitive movements, physical aggression); (3) verbal (e.g. yelling, calling out, repetitive speech, verbal aggression); (4) emotional (e.g. euphoria, depression, apathy, anxiety, irritability); and (5) vegetative (disturbances in sleep and appetite) (Cloak & Al Khalili, 2020). The changed behaviours may not only predispose people with dementia to have high care needs (Ervin, Pallant, & Reid, 2015), but also increase the physical and psychological care demands on workers (Ervin et al., 2015). It could interrupt RACFs routines, and hinder the overall delivery of care (Hazelhof, Schoonhoven, van Gaal, Koopmans, & Gerritsen, 2016). Difficulties associated with caring for residents with significantly changed behaviours can also lead to increased absenteeism and sick leave among nursing staff property damage, decreased productivity, security costs, litigation, workers' compensation, reduced job satisfaction, recruitment and retention issues (Hazelhof et al., 2016).

The ageing population and the increase in the prevalence of dementia in Australia and other high-income countries have contributed to a reliance on RACFs to provide care services for people living

with dementia (Fleming & Purandare, 2010). The projection is that formal care workers will need to increase from 3.27 million in 2014 to 4.56 million in 2024 (Gilster, Boltz, & Dalessandro, 2018) to be able to meet the care demands in RACFs. However, attracting and retaining staff in the aged care sector continues to be a challenge in high-income countries (Oppert, Keeffe, & Duong, 2018) as aged care workers' roles are psychologically and physically demanding (Ervin, Pallant, & Reid, 2015) regardless of care workers' cultural backgrounds. Additionally, aged care is often under-appreciated and associated with low job satisfaction and limited career development opportunities (Oppert et al., 2018). These negative factors often contribute to low workforce retention in RACFs.

Workforce retention challenges are complex as workers' intentions to stay in the sector are often influenced by a number of organisational, personal, and professional factors (Burgess et al., 2018). Similarly, strategies to address these challenges are multi-faceted (Chan, Tam, Lung, Wong, & Chau, 2013). For example, the complexity of diversity in the workplace such as the RACFs in terms of size, staff roles, employee composition, industrial relations, and the organisation's culture present challenges for aged care management to implement policies and strategies that would facilitate job satisfaction and staff retention (Trenerry, Franklin, & Paradies, 2012).

Strategies to enhance job satisfaction could reduce staff shortages (Chan et al., 2013) as highly engaged and enabled employees are more likely to provide better services to care recipients, contribute to improved business performance, and remain with their organisations (Commonwealth of Australia, 2018). The aged care workers that this current study focuses on are registered nurses (RNs) and enrolled nurses (ENs – equivalent to an Associate Degree) and patient care assistants (or personal care assistants). The identified three categories of care workers that the current study focused on constitute the major care workers in the overall composition of the RACF direct care workforce (Australian Government Department of Health, 2021).

To meet the growing demand for care in high-income countries, RACFs there have seen a trend toward an increasing reliance on both new and existing populations of migrants from low and middle-income countries (Charlesworth & Isherwood, 2020). It is well documented in the literature that migrant workers are vulnerable members of society and often engaged in dirty, dangerous, and demanding (3-D) jobs. These workers are often hidden population groups or can be ignored by government policies (Moyce & Schenker, 2018).

Additionally, migrant workers may experience psychological and cultural changes as a result of their continuous exposure to a second culture, a process known as acculturation (Miller, Kim, & Benet-Martínez, 2011). Acculturation is defined as a process of cultural and psychological changes that occur as a result of contact between two or more cultural groups and their members (Berry,

2005). These psychological changes can lead to stress known as “acculturation stress” in some migrants (Berry, 2005). Acculturation stress affects migrant care workers’ well-being and may negatively affect their capacity to provide quality care to residents (Pung & Goh, 2017).

Acculturation stress in conjunction with migrant care workers’ working conditions (Pung & Goh, 2017) and the level of job satisfaction could negatively affect the provision of quality care (Charlesworth & Isherwood, 2020) in aged care settings. The Royal Commission into Aged Care Quality and Safety March 2021 final report states “a need for policies and practices to drive a “virtuous circle”, where good working conditions, supportive and visionary management, and empowering work culture, collaborative teams, relevant education and training, structured career progression, and job satisfaction among care workers underpin high quality, person-centred care” (Royal Commission into Aged Care Quality and Safety, 2021 pg. 124).

Low job satisfaction among care workers does not only impact the continuity and consistent quality of formal care for older Australians but also presents a major barrier to the attraction and retention of aged-care workers (Charlesworth & Isherwood, 2020). Therefore, understanding and implementing changes to improve migrant care workers’ well-being and their employment experiences should be considered as both a human right and an economic obligation for aged care management and government policymakers in designing and implementing aged-care reforms.

Although migrant care workers have made significant contributions to the aged care sector by filling the gaps in staff shortages, there is a dearth of literature on how migrant care workers from different cultural backgrounds are able to understand and respond to challenges associated with caring for a resident in residential aged care settings, especially residents with complex needs such as those with dementia. This knowledge gap needs to be urgently addressed given the rising proportion of multicultural older Australians who are increasingly been cared for by a multicultural workforce (Mavromaras et al., 2017).

The remainder of this chapter will provide some background information on dementia, the intersection of culture with dementia care, and the migrant aged-care workforce in residential aged care facilities.

1.2 Dementia

1.2.1 Dementia a Global Health Issue

Dementia is a medical syndrome characterised by deterioration of mental functioning (Devshi et al., 2015). Dementia is usually chronic or progressive and can affect an individual’s memory, thinking, behaviour and ability to perform daily activities (Devshi et al., 2015). Compelling evidence shows

ageing, particularly 65 years and above, as the main predictor of dementia (Livingston et al., 2020). However, dementia is not a normal ageing process, although it is common in older adults. It can also affect younger people, a condition known as "young-onset dementia" (World Health Organization & Alzheimer's Disease International, 2012). It thus cannot be categorised solely as an older age-related condition.

There are several types of dementia, the most common being Alzheimer disease (Teo, 2020). Other types of dementia are vascular type, multi-infarct dementia, frontotemporal dementia, dementia with Lewy bodies, and other types of dementia including Korsakoff's disease, Creutzfeldt–Jakob disease (CJD), HIV-associated dementia and younger onset dementia (Clifford & Doody, 2018). There are approximately 9.9 million new cases of dementia annually worldwide, implying one new case every 3.2 seconds (Teo, 2020).

The World Health Organization (WHO) has classified dementia as a public health priority, due to its significant negative social and economic impacts on family and society (World Health Organization & Alzheimer's Disease International, 2012). Globally, the total number of people with dementia is projected to reach 82 million by 2030 and 152 million by 2050 (Livingston et al., 2020; Maiese, 2019). The global cost of dementia increased by 35% over 5 years to US$ 818 billion in 2015 (Teo, 2020). Additionally, the global impact of dementia on individuals, their families, and the economy has been estimated to cost USD$1 trillion annually, and this was predicted to rise to USD two trillion by 2030 (Livingston et al., 2020). These costs comprise direct medical and social care costs, such as paid and professional home care, residential and nursing home care and loss of carer's income due to caring responsibility (Braun, Kurzmann, Höfler, Haber, & Auer, 2020; World Health Organization & Alzheimer's Disease International, 2012).

Explicitly, the rising dementia prevalence has a significant impact on the health and social care sector and, importantly, can negatively impact the overall quality of life of a person with dementia and their caregivers (Hodiamont et al., 2021).

1.2.2 Cost of Dementia Care in Australia

In 2018, dementia was the second leading cause of death after cardiovascular diseases in Australia and the leading cause of death among Australian women (AIHW, 2020). The 2016 Dementia Australia report indicated that the average cost of dementia care of a resident annually in a residential aged care setting ($23,810.00) is 86% more than the community home care setting ($12,835.00) (Brown et al., 2017).

Given the Australian RACFs consists of a large proportion of residents with dementia, the cost of formal care for advanced dementia symptoms and co-morbidities, which are commonly seen in the

residents with dementia, partly explained the significant gap in total costs between residential and community aged care services (Brown et al., 2017). An Australian 2017 report indicated that the direct costs, including hospitalisation, general practitioners and medical specialist consultations, care, pharmaceuticals, transport, and other direct costs, contributed to 62% of the total costs of dementia (Brown et al., 2017). The indirect costs through the lost productivity of both persons with dementia and carers were 38% of total costs (Brown et al., 2017). Overall, the estimated total cost associated with dementia care was more than $15 billion in 2018, and the total cost of dementia is predicted to increase to more than $18.7 billion by 2025 and over $36.8 billion by 2056 (Brown et al., 2017).

1.3 Dementia and Culture

The intersection of culture and dementia is well documented in the literature (Brooke, Cronin, Stiell, & Ojo, 2017; Cipriani & Borin, 2015). The discourse explicitly states that dementia extends beyond cascades of signs and symptoms, and should be viewed as attribution of cultural values that shapes the experience and interpretation of cognitive decline in people with dementia (Cipriani & Borin, 2015).

Culture has been described by Hanssen (2013) as shared symbols and beliefs that constitute a way of life for individuals. Culture supports an individual's sense of security, integrity, and belonging (Hanssen, 2013), and shapes how individuals make decisions on their lifestyle choices and perceive death (Hanssen, 2013). Although there could be varied lifestyles and ideas among members of cultural groups, they still share similar symbolic traditions and cultural identity (Cipriani & Borin, 2015; Hanssen, 2013). For example, independence and autonomy are valued in individualist cultures and are predominant in societies with nuclear living arrangements for single people, couples, or couples with young children (Burholt, Dobbs, & Victor, 2018; Nguyen, Levkoff, & Nguyen, 2021). Comparatively, collectivist cultures value interdependence among families, including community cohesion and commitment (Nguyen et al., 2021). This is often associated with extended family living arrangements (Nguyen et al., 2021). There is a culture shock when individuals from collectivist cultures migrate to Western countries and see older adults being cared for in long-term care institution settings such as RACFs (Brooke et al., 2017).

Culture may also shape how an individual perceives and defines some medical conditions (Cipriani & Borin, 2015)). For instance, older adults with cognitive decline are stigmatised in many cultures (Brooke et al., 2017). Elements of denial, shame, and sensitivity are usually associated with dementia in these cultures, which places people with dementia in an unfriendly environment (Cipriani & Borin, 2015). In Sub-Saharan African cultures, the cause of dementia is perceived to be

witchcraft rather than a medical condition (Mkhonto & Hanssen, 2018). Given the negative connotations around witchcraft as a power to create evil or cause tragedy and unfavourable or destructive incidents, people with dementia in these cultures are seen as evil and they are not only stigmatised but may be bullied, beaten, stoned, burned, or even killed (Mkhonto & Hanssen, 2018). Additionally, a similar concept of stigma was reported among Pakistani Muslim families in the United Kingdom, in which family carers and their relatives with dementia were stigmatised by the wider Muslim community members as being cursed or possessed by evil powers (Hossain, Crossland, Stores, Dewey, & Hakak, 2020; Mackenzie, 2006).

Culture may provide an additional layer of complexity for the care workers and management in delivering appropriate dementia care (Brijnath et al., 2022) in residential aged care settings. Residents with dementia, especially those in the advanced stage, usually have difficulty with language and communication (Runci, Eppingstall, van der Ploeg, & O'Connor, 2014). This challenge is usually exacerbated in residents with dementia whose English is their second language, due to deterioration of their second language (Runci et al., 2014). Language reversion is a common experience in older people from culturally and linguistically diverse backgrounds (CALD)[2]. Language reversion is referred to as the declination of an individual's second language communication skills and languages acquired subsequent to their first language (Tipping & Whiteside, 2015). Evidence shows that neurological conditions and the gradual cognitive decline as seen in people with dementia can cause language reversion (Tipping & Whiteside, 2015).

When residents revert to their first language, the quality of care may be hindered (Xiao et al., 2021) especially if care workers lack the skills and understanding of how to provide care for such residents. A previous study reported that family members of residents with dementia in Australian ethno-specific RACFs were more satisfied with the care provided to their relatives when compared to the satisfaction of family members who had relatives from multicultural backgrounds in the mainstream RACFs (Runci et al., 2014). Residents' families from culturally diverse backgrounds attributed this to the ability of management to meet the language and cultural needs of their relatives, the social activities, and the types of food provided (Runci et al., 2014) in the facility.

Cultural perceptions of the care workers could also influence the quality of care that residents receive (Runci et al., 2014; Yong & Manthorpe, 2016; Xiao et al, 2021). An increasingly diverse workforce, especially migrant care workers with a variety of cultural norms and attitudes towards

[2] The terms 'Culturally and Linguistically Diverse' (CALD) is commonly used in the research, practice, and policy discourse to refer to all of Australia's non-Indigenous ethnic groups other than the English-speaking Anglo-Saxon majority. The Australian Bureau of Statistics (ABS) defines the CALD population mainly by country of birth, language spoken at home, English proficiency, or other characteristics (including year of arrival in Australia), parents' country of birth and religious affiliation

older adults with a diagnosis of dementia, may also struggle to understand the resident as an adult and an autonomous person that has the right to make choices (Egede-Nissen, Sellevold, Jakobsen, & Sørlie, 2017). According to Egede-Nissen et al. (2017), these care workers use mild coercion through their tones and body language when engaging with the residents. They attribute their behaviour to their cultural perceptions that people with dementia are adults without the ability to care for themselves and should be treated as children with the use of a firm voice when communicating with them (Egede-Nissen et al., 2017). Therefore, it is essential to examine cultural perceptions of the care workers considering the influence of culture on the quality of dementia care (Cipriani & Borin, 2015) that the care worker provides.

1.4 Australian Residential Aged Care

A residential aged care provides services for medical needs, personal care and assistance for people with continuing dependencies due to their health care needs (Dyer et al., 2020). Aged care in Australia is largely funded by the national government, which supports aged care providers through subsidies, capital grants and fundings through aged care programs such as Dementia and aged Care Service Fund (Australian Government Department of Health, 2020).

Institutional long term care recipients are those receiving formal long-term care in institutions other than hospitals and these care-recipients are referred to as residents in this thesis. The Australian Government provides institutional long-term care for almost 20% of the population aged 80 and over (Dyer et al., 2020).[3] Compared to some other high-income countries, such as Japan, Netherlands, and Canada, Australia has the highest use of institutional aged care services compared to home or community aged care services, with 51.5% of care recipients aged between 65 and 80 years and 58.5% aged over 80 living in institutional care (Dyer et al., 2020).

This contrasts with 21.6% in Japan to 34.6% in the Netherlands for institutional care recipients aged between 65 and 80, and 23.1% in Japan to 41.8% in Canada for those 80 years and above (Dyer et al., 2020). The difference in these proportions between Australia and the three countries is that these countries support a greater number of older adults in non-residential programs through home and community care (Dyer et al., 2020).

1.4.1 Profile of Australian Residential Aged Care Facilities

The Australian aged care system comprises public, private, and not-for-profit organisations whose main aim is to provide personal care services to the aging population who might be living with

[3] The Organisation for Economic Co-operation and Development (OECD) defines institutional long term care as specifically designed nursing and residential care facilities that provide accommodation and care as a package, with the predominant service being care (Dyer, Valeri, Arora, Tilden, & Crotty, 2020)

chronic illness or physical and cognitive decline (Burgess et al., 2018). Australian aged care consists of three main types of service delivery, namely residential care system, community care system, and flexible care services (Australian Institute of Health, 2012). Residential aged care is used interchangeably as long-term care or nursing home care in the literature. This thesis refers to "residential aged care facilities" as RACFs, which is a common abbreviation in the Australian context. Residential aged care is available on a permanent or temporary (respite) basis (Smith, 2019), and low and high levels of care are also available in RACFs (Australian Institute of Health, 2012). Low-level care includes daily routine assistance, accommodation, personal and social care, and domestic assistance, while high-level care includes intensive nursing services in addition to daily assistance. Residents who require complete assistance with most activities of daily living are offered 24-hour care (Smith, 2019).

The Australian Federal Government expenditure on aged care services has exponentially increased over the years. Aged care expenditure was approximately $15.8 billion between 2013 and 2014 and increased by 27% to $20.1 billion between 2018 and 2019. In 2018–19, two-thirds of the expenditure was on residential aged care (66% or $13.3 billion), compared with community-based care (29% or $5.9 billion). Individuals were eligible for residential aged care services following a comprehensive assessment conducted by the Aged Care Assessment Teams (Commonwealth of Australia, 2020). The 2020 report indicated that 244,363 people received permanent residential aged care during the year, an increase of 1,751 from 2018 to 242, 612 in 2019 (Commonwealth of Australia, 2020).

RACFs consist of a diverse population of residents and workers and a mix of medical institutions and home-like environments for the residents (Bennett, Ward, Scarinci, & Waite, 2015). The residential aged care environment is influenced by several factors, including the physical setting, availability of resources, staff skills, management, and staff attitudes towards ageing and resident care (Bennett et al., 2015). Additionally, the complexity of care provision in RACF is exacerbated by a high proportion of residents with high co-morbidity and a high prevalence of cognitive impairment and associated communication difficulties and behavioural and mental health issues, which often makes care provision in this setting challenging for care workers (Bennett et al., 2015).

1.4.2 Australian Residential Aged Care Workforce

The direct care workforce in Australian residential aged care settings consists mainly of personal care workers (PCAs) and licensed nurses, such as registered and enrolled nurses (Mavromaras et al., 2017) . The International Standard Classification of Occupations (ISCO) defined nurses as providing long-term care at home or in institutional settings other than the hospitals. While PCAs are formal care givers, they are not qualified or certified as nurses who provide long-term care

services at home or in institutions other than hospitals.

According to the recent Australian aged care workforce census, the total number of workers in RACFs in 2020 were 277,671 with 208,903 being direct care workers (Australian Government Department of Health, 2021). The report showed that RACF direct care workers comprised 70% PCAs, 23% nurses, and 7% allied health professionals (Australian Government Department of Health, 2021). The remaining 68,768 staff included 52,801 working in ancillary roles, such as cleaners, cooks, and laundry assistants management, (n=14,021) working in administrative roles, and 1,946 working in pastoral care and professional educational roles (Australian Government Department of Health, 2021).

Approximately 1.9% (n=3,298) of RACF direct care workers identified as Aboriginal and/or Torres Strait Islander and 35% (n=49,4750) identified as being from a CALD background in 2020 (Australian Government Department of Health, 2021). This current research focuses on Australian RACF migrant carers from culturally diverse backgrounds. Information on their migration pathway, profile, and contributions to the aged care and challenges are discussed below.

1.5 Migrant Care Workers in Australian Residential Aged Care Facilities

Howe et al. (2019) defined the migrant care worker as an individual "born outside the country in which they are employed in frontline care work" (Howe et al., 2019, p.6). This definition will be used in this thesis, and the main focus of this study is on migrant nurses (enrolled and registered) and personal care assistants. The migrant aged care workforce is not a homogeneous group (Isherwood & King, 2017), and it is essential to consider the different characteristics of each migrant care worker cultural group as they differ in countries of origin, cultural values, migration pathways, education, and work experience (Hugo et al., 2011).

According to the 2016 ABS census, over a quarter (29%) of the population was born overseas (Australian Bureau of Statistics, 2013). Australia's migration program has evolved post the Second World War in response to the political, social, and economic priorities of the government (Thomson, 2014). This has resulted in Australia being a culturally diverse nation (Thomson, 2014). Individuals of foreign nationality working outside their home country in skilled and unskilled jobs are referred to as migrant workers (Noor & Shaker, 2017).

1.5.1 Historical Context

Australia's migration program post the Second World War expanded in response to the political, social, and economic priorities of the government (Thomson, 2014), which encouraged the influx of migrant workers. Historically, migrant workers in Australia have concentrated in low-skilled and low-paid jobs, in which Australian workers would not choose to work (Willis et al., 2018). In the

1950s, migrant workers were predominantly employed in car, food, and clothing manufacturing industries. However, the occupational trends changed in the early twenty-first century and most migrant workers predominantly engaged in low-skilled jobs, mainly in service industries, such as taxi driving and community and residential aged care (Thomson, 2014; Willis et al., 2018). The high turnover and higher job vacancies in the aged care industry has meant that aged care has become one of the major likely sources of employment for migrants (Thomson, 2014). Over the last two decades, the government focus has been on recruiting skilled migrants, particularly migrant registered nurses, to address the staff shortage in the health care sector due to an ageing population and skills shortages (Willis et al., 2018).

1.5.2 Migration Pathways

Migrant residency status in Australia can be permanent or temporary. Australian migration programs have offered permanent residency to skilled migrant workers born overseas (Howe, Charlesworth, & Brennan, 2019) and to people that experienced forced migration from their countries of birth, such as humanitarian entrants and refugees, in the last decades. There are also myriads of temporary labour migration pathways in Australia; however, the main labour migration pathway is the Temporary Skill Shortage (TSS) visa (Howe et al., 2019).

The TSS has two streams: the first stream provides a pathway to Australian permanent residency and is designed for occupations that have been identified as of high value to the Australian economy and in alignment with the government's longer-term training and workforce strategies (Howe et al., 2019). The second stream is a short-term and temporary stream, designed for occupations with an immediate need, with the visa expiring after two years and with no access to permanent residency (Howe et al., 2019).

Australia's skilled migration policy is heavily regulated, with migrants required to navigate complex entry requirements and demonstrate recognised qualifications (Tan & Cebulla, 2022). Migrant care workers employed in aged care often enter Australia through broad-based temporary work visas or the employer-sponsored subclass 482 visa (2017–present) (Department of Home Affairs, 2021). They might also enter Australia through permanent migration pathways such as family sponsorships or humanitarian entrants' visas. However, not all overseas qualifications are recognised by Australian health regulation agencies such as the Australian Health Practitioner Regulation Agency (AHPRA) and Nursing and Midwifery Board of Australia (NMBA). Migrant nurses often need to pass clinical or technical assessments to have their overseas qualifications recognised and/or be accredited to practice their profession in Australia (Tan & Cebulla, 2022).

There have been no explicit visa pathways for non-professional frontline care workers to enter Australia. The Characteristics of Recent Migrants Survey indicate that 38 per cent of overseas-born non-professional care workers first entered Australia on an international student visa (ABS 2017). Nursing students on international student visas (subclass 500) are allowed to work on a part-time (40 hours in a fortnight) basis during their studies. They are eligible to apply for a temporary graduate visa (subclass 485) after graduating which permits them to four years of entitlement to live and work in Australia (Department of Home Affairs, 2021). A temporary visa known as Pacific Labour Scheme stream was recently replaced by the Pacific Australia Labour Mobility (PALM) stream. The PALM scheme allows Australian businesses to hire workers from Pacific Island countries to address staff shortage (Department of Home Affairs, 2021) in the aged care sector.

1.5.3 Profile of Migrant Care Workers from Culturally Diverse Backgrounds in Australian RACFs

A large proportion of migrant care workers in the Australian aged care sector are long-standing migrants with permanent residence in Australia (Charlesworth & Isherwood, 2020; Morrison-Dayan, 2019). Additionally, there has been a significant increase in the numbers of international students in the Australian aged care sector in the last two decades (Howe, Charlesworth, & Brennan, 2019, Morrison-Dayan, 2019).

The Australian aged care sector is one of the most ethnically diverse employment sectors in Australia (Howe, 2009; Australian Government Department of Health, 2021). The 2016 Australian Aged Care Workforce Census and Survey (NACWCS) reported that 32% of RACF care workers were born overseas (Mavromaras et al., 2017). The survey further indicated that 39% of migrant care workers in RACFs used another language in their work. The recent report showed a further increase in the proportion of migrant care workers, with the 2020 Aged Care Workforce Census data showing 35% of the RACF direct care workforce identifying as being from a CALD background (Australian Government Department of Health, 2021). [4]

Australian RACFs consist of a higher proportion (50.6%) of PCAs born overseas, compared to (30.6%) of the total RACF workforce (Eastman, Charlesworth, & Hill, 2018). . In 2020, the Aged Care Workforce Census also reported that the majority of staff from culturally diverse backgrounds are PCAs (72%), with 24% nurses and 4% allied health professionals (Australian Government Department of Health, 2021). This statistic is in concordance with the overall composition of the

[4] The 2016 data excluded agency and/or subcontractor roles who are direct care workers in RACF from CALD backgrounds whereas 2020 did not differentiate these roles.

RAC direct care workforce (Australian Government Department of Health, 2021).

Similar to the aged care sectors in other high-income countries, migrants employed in the Australian aged care sector are predominantly women (Mavromaras et al., 2017) and often have higher educational qualifications than native-born patient care assistants (Stone, 2016). Migrants care workers in Australian RACFs are mainly from Indian and Filipino backgrounds (Mavromaras et al., 2017). The top ten countries of birth for those born overseas are India, the Philippines, England, Nepal, New Zealand, China, Sri Lanka, Fiji, Vietnam, and South Africa (Eastman et al., 2018). Recently, there has been an increased representation in the aged care workforce from new migrant communities; for example, a 2009 survey of over 600 care workers in Perth, Western Australia indicated that a higher proportion of migrant care workers were from African countries (Nichols, Horner, & Fyfe, 2015) such as Zimbabwe, Nigeria and Zambia. Western Australia, the state where Phase Two of this current research was conducted, had the highest proportion of migrant care workers in the Australian aged care and disability sector with 51% of the workforce being foreign-born (Negin, Coffman, Connell, & Short, 2016).

1.5.4 Employment Benefits to Australian Aged Care Sector

There are benefits to employing migrants care workers from culturally and linguistically diverse backgrounds. These benefits include their resilience, willingness to work across all shifts, and ability to learn new skills (Bourgeault, Atanackovic, & LeBrun, 2011). Migrant care workers have addressed the gap of staff shortages in the health and welfare sector particularly in RACFs and remote areas (Howe, 2009).

The national aged care workforce statistics also show that migrant care workers contribute additionally to the aged care sector. For instance, bilingual migrant PCAS in RACFs often use their native language skills to facilitate cross-cultural understandings (Morrison-Dayan, 2019) and offer more diverse cultural activities for the residents, as well as link older people and RACFs to diverse ethnic communities (Mavromaras et al., 2017). Their loyalty to their employer could lead to reduced rates of staff turnover (Isherwood & King, 2017) in RACFs. Furthermore, migrant care workers have been reported to be better care workers when compared with native-born care workers because of their cultural norms, which include caring for and respecting elders (Bourgeault et al., 2011).

1.5.5 Migrant Care Workforce Challenges

Despite their positive contributions to the sector, studies show that migrant care workers in high-income countries are significantly disadvantaged in the long-term care workforce (Bourgeault et al., 2011; Spencer, Martin, & Bourgeault, 2013). They have shorter job contracts, frequent irregular

work hours, and lower payments when compared to the non-migrant care workers. For instance, in the United Kingdom, migrant care workers are more likely to earn less than the minimum wage (Charlesworth & Isherwood, 2020; Walsh & O'Shea, 2009). Similarly, in Australia, migrant status may affect opportunities for securing quality jobs in the Australian aged-care sector (Charlesworth & Isherwood, 2020). An Australian study revealed poor working arrangements and conditions as a key area of job dissatisfaction for migrant care workers (Isherwood et al., 2018). Participants in this study mentioned poor salary as another reason for low job satisfaction, especially in comparison to jobs such as cleaning and retail industries, which require a lower skill set and offer higher pay rates than aged care (Isherwood et al., 2018).

Migrant care workers from culturally diverse backgrounds usually face challenges in adjusting to their new country's workplace culture (Chen, Xiao, Han, Meyer, & Müller, 2020; Jeon & Chenoweth, 2007). One such challenge is language and communication difficulties, which can create tension in relationships among staff and between migrant aged care workers and the residents (Timonen & Doyle, 2010). For example, difficulties in comprehending regional accents, colloquial language, and slang used by co-workers and residents from the dominant culture can result in migrant care workers being vulnerable to discrimination and racial comments (Timonen & Doyle, 2010). Previous studies also showed that migrant care workers often experience discrimination, prejudice, and stereotyping from residents with dementia, as a result of the worker's skin colour, language (Nichols et al., 2015; Pung & Goh, 2017) or temporary migration status (Lovelock & Martin, 2016). Such challenges often lead to social isolation and job dissatisfaction (Chen et al., 2020). Additionally, these challenges could affect their career advancement, relationship with their colleagues and care-recipients, and their psychosocial well-being (Pung & Goh, 2017).

Generally, direct care workers, especially PCAs, often have close contact with residents with dementia and may have a knowledge of their preferences, behaviours, and functioning (Gilster, Boltz, & Dalessandro, 2018). They are often the first workers to notice physical changes, signs of illness, and pain in residents with dementia (Gilster, Boltz, & Dalessandro, 2018). An additional challenge for migrant care workers is the lack of knowledge of dementia before they arrive in Australia (Nichols et al., 2015). Thus, the limited knowledge of dementia and the related symptoms, in conjunction with limited dementia care experience in institutional settings and their resettlement challenges, may hamper the ability of migrant care workers to provide quality care for people with dementia (Adebayo, Nichols, Heslop, & Brijnath, 2019; Yong & Manthorpe, 2016). A higher proportion of the Australian residential aged care workforce are PCAs from migrant backgrounds. PCAs spend the majority of their shift (77%) providing direct care to residents (Mavromaras et al., 2017). Therefore, it is crucial to examine migrant care workers' knowledge and experiences of

dementia care and how culture shapes their understanding of care work.

1.6 Study Rationale

The rising prevalence of dementia in the aged care sector highlights the need to have well-equipped aged care services and quality care workers who are sufficient in number and are motivated to provide safe, high-quality care for people with dementia (Brown, Hansnata, & La, 2017). The Australian aged care sector will need to expand its workforce from 366,000 to 980,000 by 2050 to meet the needs of older adults accessing aged care services (The Senate Community Affairs Committee Secretariat, 2017;). Given the current skills shortage in aged care, strategies that could attract and improve workers retention should be considered.

There are important cultural variations in the understanding of dementia (Brijnath, 2014; Leibing & Cohen, 2006) among people from culturally diverse populations. Studies have shown that migrant carers had no knowledge or experience of dementia care before they arrived in Australia (Nichols et al., 2015; Brooke et al., 2017). Considering that the majority of migrant care workers are primarily engaged in personal care with residents, it is crucial to examine their knowledge and experiences of dementia care and how culture shapes their understanding of care work in a long-term institutional setting such as RACFs.

Furthermore, there are demands for direct care workers in other care sectors, particularly in the disability sector) (Isherwood et al., 2018). The disability sector requires care workers with similar qualifications and skillsets to the aged care sector (Isherwood et al., 2018). Therefore, an increase in demand and competition for care workers is expected to be greatest between these two sectors as a result of the expansion of the workforce in the disability sector following the establishment of the National Disability Insurance Scheme (NDIS) (Isherwood et al., 2018), which provides direct funding to people with a permanent and significant disability. Consequently, staff shortages and high turnover rates among care workers at RACFs can lead to increased costs in terms of recruitment and reduced quality of care with incompetent care workers (Gao, Tilse, Wilson, Tuckett, & Newcombe, 2015) if strategies to implement care workers are not implemented.

Additionally, cultural and linguistic diversity in the community and workforce can be challenging for both employers and workers (Armache, 2012). Understanding the key acculturation stressors that drive the productivity of migrant care workers in RACFs can help employers in the aged care sector to better identify the staff at risk of their psychosocial well-being being affected and further inform the design of interventions to address these stressors.

Challenges to migrant care workforce retention in the Australian aged care sector were identified in the 2016 national aged care workforce study (Mavromaras et al., 2017). These challenges were

directly related to the migrant care workers' resettlement issues (Isherwood et al., 2018). Building on these findings, this present study will further expand knowledge around the factors that may hinder and/or improve their working conditions in the Australian aged care sector.

1.7 Research Gaps

Previous international studies have reported that the detrimental impacts of acculturation stress on migrant care workers (Jenkins & Huntington, 2016; Pung & Goh, 2017) in hospital settings. Care provision in RACFs differs to in hospital settings. Hospital care workers usually deliver short-term treatment services, including general medical services. On the other hand, in RACFs, long-term care including accommodation, personal and social care, domestic assistance, and intensive nursing care are provided to residents whose care needs are unable to be met at home (Howe, 2009). Thus, RACF care workers often tend to develop a meaningful relationship due to the long-term care of residents. However, little is known on this topic in the Australian context, with just a few studies having examined migrant care workers' care experiences, generally focusing on registered nurses in acute care settings (Kishi, Inoue, Crookes, & Shorten, 2014) . There is a paucity of research of this cohort's care experiences in RACF.

Additionally, this current study expands on the limited knowledge in research on migrant care workers that are employed to provide care for residents with dementia in institutional settings. Previous studies focused largely on dementia care experiences and family caregivers from migrant backgrounds in community settings (Xiao, Habel, & De Bellis, 2015). However, there is a dearth of literature on how cultural understanding of dementia shapes care provision among migrant care workers in institutional settings. This knowledge gap needs to be urgently addressed given the rising proportion of older Australians from the dominant culture and culturally diverse backgrounds in RACFs who are increasingly being cared for by a multicultural workforce.

1.8 Aims and Objectives

Recognising the challenges associated with an increasingly multicultural age care workforce caring for an increasingly multicultural ageing Australian population, the overall aim of this study was to investigate the level of knowledge of dementia among RACF migrant care workers and to determine how their resettlement challenges impact their well-being, work, and retention in RACFs.

The study objectives were to:

1. investigate the knowledge of dementia among migrant care workers employed in RACFs
2. examine RACFs migrant care workers' dementia care experiences
3. explore the general and psychosocial well-being of RACF migrant care workers

4. understand the working conditions of migrant care workers in RACFs.

The objectives and corresponding research questions (RQ) are provided below.

Objective 1: To investigate the knowledge of dementia among RACF migrant care workers

RQ 1: What are the current literature findings on the knowledge of dementia among RACF migrant workers in high-income countries?

RQ 2: What is the level of knowledge and understanding of dementia among migrant care workers in Australian RACFs?

Objective 2: To examine RACFs migrant care workers' dementia care experiences

RQ 3: What are the experiences of dementia care among migrant care workers in Australian RACFs?

Objective 3: To explore the general and psychosocial well-being of RACF migrant care workers

RQ 4: What is the level of acculturation stress among RACF migrant care workers?

RQ 5: What is the psychosocial well-being of migrant workers caring for people with dementia in Australian RACFs, using mental health measures of depression, anxiety, and stress?

RQ 6: What are the effects of acculturation stress on the general health and psychosocial well-being of migrant care workers?

Objective 4: To understand the working conditions of migrant care workers in RACFs

RQ 7: What are the challenges and benefits of working in RACFs for migrant care workers?

RQ 8: What are the enablers and barriers to migrant care workers retention in the Australian aged care sector?

1.9 Personal Context

This research aligns with my work experiences and career aspirations. I am an overseas-trained dentist and I migrated to Australia from Nigeria over 10 years ago. Following my arrival in Australia, I graduated with a Master of Public Health from a Western Australian university. I experienced some post-migration challenges as a migrant working in the Australian health and community service sectors, and this experience informs my understanding of how post-migration challenges, and the acculturation process (both positive and negative experiences) can impact an individual's well-being.

The inclusion of the minority population groups in research, in this instance migrant care workers,

is an underpinning principle in this current study, which aligns with my career principles. In my professional life, I often utilise my skills in capacity building and implement skill development projects targeting disadvantaged populations. I have also contributed to policy development that has resulted in positive outcomes for disadvantaged populations in government organisations. For example, I assisted in a Multicultural Framework Initiative in a local government organisation and an Authorisation Policy on restrictive practices in disability service settings in a State Government department.

In my county of birth, I have personally witnessed people with dementia being subjected to stigma and treated negatively, due to a lack of knowledge of conditions affecting cognition, such as dementia. Past experience and limited formal or medical knowledge of dementia could potentially influence migrant care workers, particularly those from culturally and linguistically diverse backgrounds (Ayalon, 2009).

In my previous work experience as a research officer, I investigated the oral health needs in older adults in RACFs by exploring the dental care perceptions of migrant care workers from African backgrounds (Adebayo, Durey, & Slack-Smith, 2017). In my engagement and consultations with migrant care workers, I learned of some of the challenges that care workers from migrant backgrounds were experiencing in providing care in RACFs, especially in the context of oral health. It was challenging to recruit this population group for the research study. Some migrant care workers were reluctant to participate in research and did not understand the importance of generating evidence-based findings through quality research studies. However, their voices need to be heard to support them in delivering their roles effectively and to improve the quality of care for the residents. Therefore, I anticipate that the findings and recommendations provided in this thesis will contribute to reforms that will increase migrant care workers' confidence in care delivery and also improve job satisfaction for the migrant workforce in the aged care sector.

1.10 Summary of the Chapter

This chapter has provided an overview of dementia as a global public health issue and the economic implications associated with dementia care in Australia. The intersection of culture with the knowledge of dementia and care provision, especially among migrant populations, was highlighted. The profile of RACF migrant care workers, their contributions to the Australian aged care sector and the challenges that impact their care delivery roles were also discussed. The next chapter reviews the existing research literature on the knowledge of dementia among migrant care workers in RACFs.

Chapter Two Review of the Literature

2.0 Overview of the Chapter

This chapter describes the literature review undertaken as part of this study. The published article examines the literature published between 2000 and 2018 on migrant care workers' knowledge of dementia, their dementia care experiences, and working conditions in residential aged care facilities (RACFs). It summarises the process undertaken in the review and the findings from the review analysis. A manuscript published in the peer-reviewed journal *The Gerontologist* is included in this chapter (Paper 1: Adebayo, B., Nichols, P., Heslop, K., & Brijnath, B. [2020]). A scoping review of dementia care experiences in migrant aged care workforce. (*The Gerontologist*, 60(2), e105-e116).

2.1 Summary of the Scoping Literature Review Process and Findings

The findings in this chapter relate to the followings research questions.

RQ 1: What are the current literature findings on the knowledge of dementia among RACF migrant workers in high-income countries?

RQ 2 ; What is the level of knowledge and understanding of dementia among migrant care workers in Australian RACFs?

RQ 3: What are the experiences of dementia care among migrant care workers in Australian RACFs?

RQ 7: What are the challenges and benefits of working in RACFs for migrant care workers?

RQ 8: What are the enablers and barriers to migrant care workers retention in the Australian aged care sector?

The literature search criteria included migrant care workers and their knowledge of dementia, with a focus on research conducted in residential aged care settings and high-income countries. Three main themes emerged from the analysis of the literature. The first theme highlights the intersection of culture and the knowledge of dementia among migrant care workers. The second theme explains how the relationship between migrant care workers and care recipients, co-workers, and employers impact their care delivery in RACFs. The third theme delineates enablers and challenges to the retention of the migrant care workforce in the aged care sector. The literature around "Acculturation and wellbeing" has been discussed in chapters 4 and 7. It was not included in chapter 2 to avoid repetition.

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A Scoping Review of Dementia Care Experiences in Migrant Aged Care Workforce

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Abstract

Background and Objectives: In high-income countries, an increasing number of people living with dementia in residential aged care facilities are being cared for by an increasingly multicultural workforce. The purpose of this review was to investigate migrant aged care workers' dementia care experiences and to identify enablers and challenges that influence their retention.

Research Design and Methods: Utilizing Arksey and O' Malley's approach, PubMed, Scopus, CINAHL, Web of Science, and EMBASE were searched for peer-reviewed studies published from 2000 to November 2018. Selection criteria were studies with original research, focusing on dementia care among migrant aged care workers, and conducted in high-income countries.

Results: Seventeen articles were identified incorporating 13 (76.47%) qualitative, 1 (5.88%) quantitative, and 3 (17.65%) mixed method designs. A limited understanding of dementia and experiences of dementia care were reported among some migrant care workers in residential aged care facilities. The identified enablers to retention were the availability of organization support services; professional development opportunities; reciprocity and mutual respect between migrant care workers, care recipients, and coworkers; and good working conditions. Factors such as discrimination from care recipients and coworkers and limited understanding of workplace culture were identified as barriers to migrant care workforce retention.

Discussion and Implications: Migrant care workers are valuable contributors to the aged care workforce. It is important to consider their cultural perceptions of dementia in relation to care provision. In addition, their exposure to occupational psychosocial risk factors in conjunction with the challenges associated with resettlement and dementia care needs to be addressed.

Keywords: Culture, Cognitive impairment, Residential aged care facilities, Staff retention

Dementia is the main reason for admission into residential aged care facilities (RACFs), and over 50% of residents have a diagnosis of dementia (Cubit, Farrell, Robinson, & Myhill, 2007). Almost 90% of these residents are expected to develop significantly changed behaviors associated with their dementia (Cubit et al., 2007), including anxiety, irritability, eating disturbances, sleep disorders, aggression, delusions, psychosis, and hallucinations (Devshi et al., 2015). These behaviors that challenge not only have a detrimental impact on the person with dementia and their

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family but can also disrupt other residents and staff and hinder the delivery of care (Cubit et al., 2007). Among RACF staff, the stress of dementia care can lead to increased absenteeism and sick leave, decreased productivity, and reduced job satisfaction. For RACF management, the challenges associated with managing staff stress associated with dementia care can include litigation, workers' compensation, security costs, and staff recruitment and retention difficulties (Cubit et al., 2007).

The rising prevalence of dementia in the aged care sector highlights the need to have well-equipped aged care services and care workers who are sufficient in number and are motivated to provide safe, high-quality care for people with dementia (Brown, Hansnata & La, 2017). However, aged care has conventionally been regarded as a less prestigious profession as a result of factors such as low wages, high work-related injury, stress, and lack of career progression in the aged care sector (Fujisawa & Colombo, 2009). Consequently, the sector consistently reports difficulties in recruiting and retaining aged care workers (Fujisawa & Colombo, 2009).

Migrant care workers have been recruited in high-income countries such as the United Kingdom (Shutes, 2012), United States (Martin, Lowell, Gozdziak, Bump, & Breeding, 2009), Canada (Bourgeault, Atanackovic, & LeBrun, 2011), and Australia (Nichols, Horner, & Fyfe, 2015) to address staff shortages and to meet the increased care demands in the aged care sector. In Australia, about 32% of RACF workers were born overseas (Mavromaras et al., 2017). Similarly, in the United Kingdom, London, and other major cities, the proportion of care staff who are migrants has been found to be as high as 40% (Hussein, Stevens, & Manthorpe, 2013). Though migrant care workers have made significant contributions to the aged care sector by filling the gaps in staff shortages, their understandings of dementia and care need to be better understood as research shows that culture shapes perceptions and behavior toward dementia care (Brijnath, 2014; Leibing & Cohen, 2006). For instance, some cultures view dementia as part of the normal aging process, whereas other cultures view dementia as an embarrassment or dishonorable (Brooke, Cronin, Stiell, & Ojo, 2017). Evidence shows that culture provides an additional layer of complexity in delivering appropriate dementia care and it may influence the type of care migrant workers deliver (Ow Yong & Manthorpe, 2016).

In addition, migrant care workers, especially those from cultural backgrounds different from their host countries, often experience challenges in adjusting to the workplace culture (Jeon & Chenoweth, 2007). These challenges include discrimination and difficulties associated with communication (Nichols et al., 2015). Stress related to dementia care in tandem with resettlement challenges, such as language and communication barriers, discrimination from residents, families, and coworkers (Miller, Kim, & Benet-Martínez, 2011), may lead to social isolation, job dissatisfaction, and poor mental health outcomes, which in turn may affect staff turnover in the aged care sector. To meet the rising challenge associated with the increasing prevalence of people living with dementia in aged care who are being cared for by an increasingly multicultural workforce, our scoping review aimed to (i) review the literature on how culture influences the dementia care experiences of migrant care workers in aged care settings and (ii) identify enablers and challenges that influence retention of migrant care workforce in the aged care sector.

Research Design and Methods

Study Design

A five-stage interpretative scoping review proposed by Arksey and O'Malley provided the framework for this review. The rationale for selecting a scoping review is that a systematic review addresses a narrowly defined research question (Arksey & O'Malley, 2005), whereas the scoping study can be used to identify gaps in the existing literature (Arksey & O'Malley, 2005). In addition, this interpretive scoping review approach allows an in-depth and critical analysis of the findings from the existing literature (Arksey & O'Malley, 2005). The research question guiding the review is as follows: What is known from the existing literature about the experiences of dementia care among migrant care workers working in institutional settings, such as the RACFs? These findings will inform future research, policy, and practice.

Identifying the Relevant Studies

A comprehensive search for relevant literature was conducted in PubMed, Scopus, CINAHL Web of Science, and EMBASE. Internet searches were also conducted to identify government reports and other relevant gray literature (e.g., doctoral dissertations). Medical Subject Headings (MeSH) and specific subject headings searched were "migrant" (immigrants*, ethnic minority*, overseas*), "care workers," dementia," culturally diverse," "aged care" (nursing homes*, residential aged facilities*, long-term-care*), "turnover" (staff retention and attrition*), and "culture" (cultural*, norms*). The search was further expanded by examining the reference lists of articles for additional articles.

Selecting Studies and Charting the Data

Inclusion criteria

Inclusion criteria were peer-reviewed articles published in English, between 2000 and November 2018, focusing on dementia care, focusing on migrant care workers, conducted in institutional aged care settings, and conducted in high-income countries. Migrants were defined as people born overseas and are from diverse populations that differed in culture, religion, language, and ethnicity from the majority populations in their host country. According to the World

Bank criteria, countries with a gross national income per capita U.S.$12,056 or more in 2017 are defined as high-income countries (Fantom & Serajuddin, 2016). Institutional aged care settings were defined as long-term care settings such as RACFs, where migrant care workers might be employed.

Studies with original research of quantitative, qualitative, and mixed methods designs that focused on care workers from migrant backgrounds in aged care sector in high-income countries were included. Articles focusing on the working conditions of migrant care workers and/or the relationship between migrants care workers, their coworkers, employers, and care recipients were also included in the review.

Exclusion criteria

Studies that focused on the role of migrant care workers in hospital settings, articles published in languages other than English, and publications that comprised nonoriginal research (e.g., commentaries, editorials) were excluded. Also, excluded were studies where the primary focus was on family caregivers of people with dementia, studies that exclusively focused on native-born care workers and/or residents from the dominant culture, and studies that reported older adults with other medical conditions without dementia.

Data extraction and charting

The researcher (B.A.) independently identified studies that fulfilled the selection criteria, discussed, and agreed on article selection with the other researchers (B.B.) and (P.N.) to ensure methodological rigor in the review process. Inclusion and exclusion criteria were established through an iterative process by four researchers. Figure 1 shows the literature search and selection process.

A total of 3,565 records were identified. Duplicated records (*n* = 1,220) were removed. Titles and abstracts were screened and full-text articles (*n* = 347) were assessed for relevance to the review. During this process, 330 articles were excluded, as they did not meet the inclusion criteria and 17 articles were retained. Table 1 provides a description of the 17 articles. The articles were charted in Microsoft Excel 2011, using the following column headings: lead author/s; year of publication; study method; ethnicity; immigration status; sample size; study setting, and major findings.

Results

The selected articles included 13 (76.47%) qualitative, 1 (5.88%) quantitative, and 3 (17.65%) mixed method studies. The studies were conducted in Australia (*n* = 6), Sweden (*n* = 2), Ireland (*n* = 2), Canada (*n* = 1), Norway (*n* = 1), England (*n* = 1), New Zealand (*n* = 1), Hawaii (*n* = 1), and Israel (*n* = 1), and one study was conducted in both the United Kingdom and Ireland (*n* = 1).

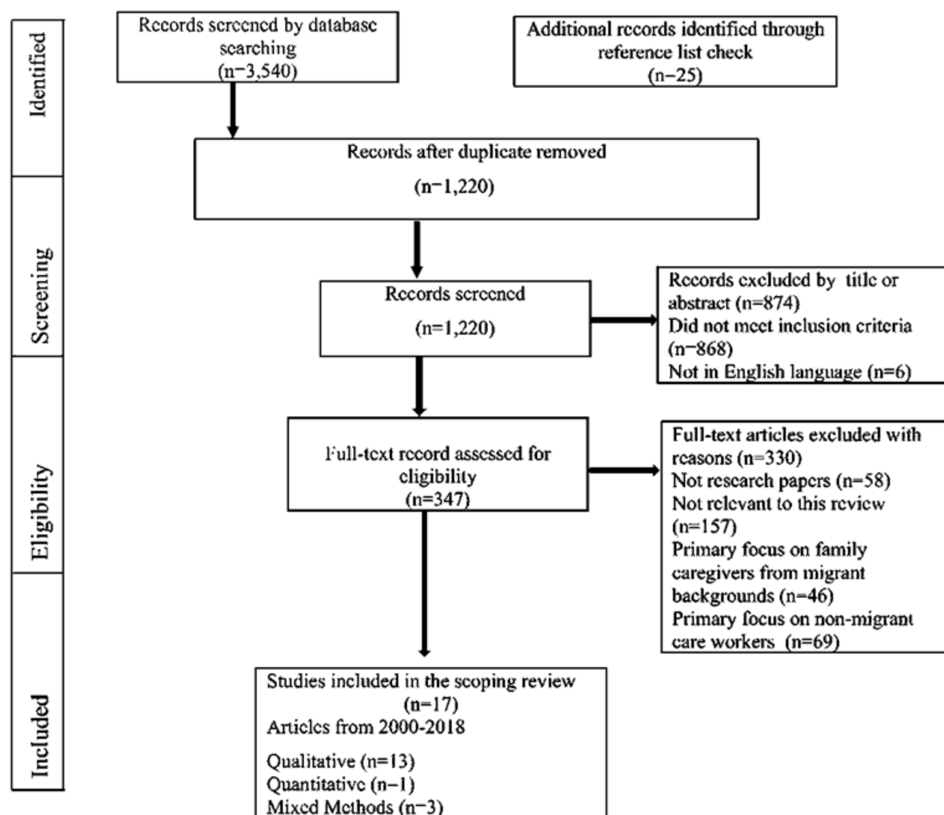

Figure 1. Flow chart: literature search and selection.

Table 1. The Selected Reviewed Studies

Authors	Country	Methods	Participants	Findings
Antelius and Plejert (2016)	Sweden	Qualitative	10 participants. Migrant care workers from the Middle East countries, such as Iraq, Turkey, Syria, and Iran (n = 10)	Participants mentioned that no definitive description of dementia in Middle Eastern culture. Dementia care is a family responsibility.
Ayalon (2009)	Israel	Mixed methods	Questionnaire survey completed by 184 Filipino migrant care workers and qualitative interviews with 29 Filipino home	Workers who were not informed about the care recipient's medical conditions were more likely to report beliefs that were inconsistent with current scientific knowledge.
Boughtwood et al. (2011)	Australia	Qualitative	24 participants. Bilingual care workers of Arabic (n = 6), Italian (n = 4), Chinese (n = 7), and Spanish (n = 7) speaking communities	Three main themes identified were as follows: (i) cultural and familial norms pertaining to illness and older people; (ii) understanding and the definition of the term "carer"; (iii) patterns in family giving.
Bourgeault et al. (2011)	Canada	Mixed methods	Qualitative: 127 participants migrant care workers (n = 75) care recipients (n = 29) and employer (n = 23). Quantitative: 149 participants online survey; employers only	The themes identified in the study were as follows: (i) working conditions of migrant care; (ii) relations with an older person and quality of care. Three major types of relationship identified were as follows: (i) professional relationship; (ii) friendly relationship; (iii) discriminatory relationship.
Browne et al. (2006)	Hawaii	Quantitative	173 participants. Migrant care workers of Filipino background	Almost 20% felt discriminated because of their position as a care worker. Almost 90% planned to continue with care work. Almost 87% participants stated that their children or grandchildren are less likely will be become care workers.
Doyle and Timonen (2009)	Ireland	Qualitative	40 participants. Migrant care workers of African (n = 11), South Asian (n = 16), and European (n = 13 backgrounds)	A specific group of migrant care workers was confronted with different obstacles and barriers that affected care delivery. The level was discrimination and prejudice was different among migrant care workers from the three population groups.
Egede-Nissen et al. (2017)	Norway	Qualitative	5 participants. Migrant care workers from Brazil, the Philippines, Serbia, and Montenegro employed in the Norwegian nursing home	The main theme identified was challenges associated with in understanding the quality of care for persons with dementia among migrant care workers. Complex and compound verb and nonverbal communication can be challenging for migrant care workers.
Gao et al. (2015)	Australia	Qualitative	16 participants. Migrant care workers from diverse cultural backgrounds (n = 6), Native-born care workers (n = 10)	Determinants of migrant care workers retention in RACFs include cultural awareness of the management, English-language support, a sense of family and appropriate job responsibility.

Table 1. *Continued*

Authors	Country	Methods	Participants	Findings
Goel and Penman (2015)	Australia	Qualitative	7 participants. Migrant care workers	Participants expressed mixed experiences. Satisfaction came from positive and encouraging client feedback, enriching work experience, flexible hours, and having a job. Dissatisfaction came from constraints with time, workload, staffing, poor peer relations, discriminatory practices, and the nature of the job itself. Migrant workers do not experience a strong support infrastructure.
Lovelock and Martin (2016)	New Zealand	Qualitative	29 migrant care workers from Filipino background	Being a temporary migrant was a source of stress for all participants. This placed pressure on some to accept low wages and to work long hours to retain their job as a condition of residency. Participants perceived to be desirable care workers because of their hardworking abilities and be willing to do "dirty" and "demanding" work.
Nichols et al. (2015)	Australia	Qualitative	58 participants. Migrant care workers (n = 35). Family members (n = 5), staff from the main culture (n = 7), and employer (n = 11)	Almost 60% (migrant care workers) had experienced negative reactions from the residents with dementia due to their visible cultural difference. The main findings identified in the study were communication issues, prejudicial treatment between migrant care workers, coworkers, and residents with dementia.
Ow Yong and Manthorpe (2016)	England	Qualitative	11 participants. Migrant care workers of Indian background (n = 11)	Participants experienced insecurity, lower self-esteem, and the lack of knowledge of local policies and language difficulty in their first 6-month period of life and work in England. Between 2.5 years of postarrival in England, participants developed a sense of competence in their work and integrated into workplace culture and they developed hope for career progression.
Strandroos and Antelius (2017)	Sweden	Qualitative (interviews) Participant observation and video recording	26 participants. Migrant care workers of Finnish, Hungarian, Polish, Kurdish, and Arabic backgrounds (n = 7). Residents with dementia from culturally diverse groups (n = 19)	Communication measures such as body language, artifacts, embodiment, and time were essential in establishing the relationship between migrant care workers and residents with dementia, rather than shared spoken language between them.
Timonen and Doyle (2010)	Ireland	Qualitative	40 participants. Migrant care workers of African (n = 11), South Asian (n = 16), and European (n = 13 backgrounds)	The study findings revealed positive relationships between migrant care workers and care recipients. A significant racial and cultural tensions were evident in the relationship between migrant care workers, coworkers, and employers/supervisors.

Table 1. *Continued*

Authors	Country	Methods	Participants	Findings
Walsh and Shutes (2013)	Ireland and United Kingdom	Mixed methods	Migrant care workers. U.K. sample (70); Irish sample (12). Care recipients from the main culture (*n* = 4). U.K. sample (26); Irish sample (15)	Cultural and institutional differences in care approaches were evident. The relational aspects, such as being caring, kind and patient, superseded the technical skill-sets. High workloads and staff shortages hamper care relationship between migrants care workers and residents and often affects staff turnover.
Willis et al. (2018)	Australia	Qualitative	16 migrant care workers from Bangladesh, El Salvador, Fiji, Holland, India, Indonesia, Italy, Iran, Kenya, Nepal, Philippines, and Sri Lanka	Positive management strategies and value systems will enable migrant care workers-resident relationship building.
Xiao et al. (2015)	Australia	Qualitative	13 participants. Migrant care workers (*n* = 7) and family carers (*n* = 6) of Vietnamese backgrounds	The themes identified in the study were as follows: (i) a need for culturally and linguistically appropriate dementia education programs; (ii) the willingness and unwillingness to seek help; (iii) poor knowledge of health care service availability related to dementia; (iv) the effect of language barrier in accessing services; and (v) the main sources of aged care services utilization differed between migrant care workers and family carers of Vietnamese background.

Three broad themes were identified from the analysis of the literature: (i) culture, dementia understanding and care; (ii) the relationship between migrant care workers, care recipients, coworkers, and employers; and (iii) barriers and enablers to retention of migrant care workforce in the aged care sector.

Culture and Understanding of Dementia

Evidence shows that some migrant care workers understanding of the dementia is inconsistent with the current medical perspectives of dementia (Ayalon, 2009). Particularly, their beliefs around symptoms associated with dementia, age-related memory changes and memory loss, and perceptions of dementia care (Ayalon, 2009). For example, Antelius and Plejert (2016) reported that migrant care workers from Middle Eastern backgrounds working in a Swedish aged care setting stated that there was no definitive description of dementia in their culture (Antelius & Plejert, 2016). Over 70% of participants in Ayalon's (2009) study stated that forgetfulness was a sign of Alzheimer's disease in all individuals aged over 75 years. Changed behaviors associated with dementia were found to be considered by some migrant care workers as part of the aging process (Ayalon, 2009; Nichols et al., 2015), and many had no knowledge or experiences of dementia care prior to their arrival in their host countries (Ayalon, 2009; Nichols et al., 2015). Ayalon's (2009) study of migrant care workers in Israel reported that 33% of participants believed that agitation in people with dementia is deliberate and intended to annoy care providers and family members. The *stigmatizing* view expressed by this study participants might be as a result of not being provided adequate information about the medical condition and needs of the care recipients (Ayalon, 2009). Ow Yong and Manthorpe's (2016) participants implied that the negative cultural perceptions of dementia and the limited understanding of dementia hampered the ability of migrant care workers of Indian background to provide quality care for people with dementia (Ow Yong & Manthorpe, 2016).

Some migrant care workers perceived dementia as a family responsibility (Antelius & Plejert, 2016; Boughtwood et al., 2011; Nichols et al., 2015; Xiao, Habel, & De Bellis, 2015). This perception was identified as one of the barriers in the utilization of RACFs among some migrant communities due to stigma and cultural obligation toward caregiving (Boughtwood et al., 2011; Xiao et al., 2015).

People with a cognitive disability such as dementia usually have difficulties with the use of language (Egede-Nissen, Sellevold, Jakobsen, & Sørlie, 2017; Strandroos & Antelius, 2017), which can make communication between people with dementia and care workers challenging (Strandroos & Antelius, 2017). This challenge becomes more profound when people with dementia and the care workers lack similar linguistic and/or cultural backgrounds as may apply in the

case of migrant care workers (Egede-Nissen et al., 2017; Strandroos & Antelius, 2017). A shared native language between migrant care workers of Finnish, Hungarian, Polish, Kurdish, and Arabic backgrounds and residents with dementia in a Swedish RACF facilitated communication and increased well-being among the residents (Strandroos & Antelius, 2017). However, a shared language was not sufficient in itself to establish an understanding between migrant care workers and residents (Strandroos & Antelius, 2017). Other forms of communication such as embodiment, body language, the use of objects, and the physical environment were observed to be equally important in establishing these relationships (Strandroos & Antelius, 2017).

The Relationship Between Migrant Care Workers, Care Recipients, Employers, and Coworkers

Residents and migrant care workers' employers perceived cultural diversity in RACF settings as a benefit rather than a problem (Bourgeault et al., 2011). Residents were satisfied with the services provided by the multicultural team (Goel & Penman, 2015; Walsh & Shutes, 2013). The positive relationships between residents and staff in cross-cultural care settings were the result of reciprocity and respect for each other (Walsh & Shutes, 2013). In addition, employers identified their preferences for hiring migrant care workers. Migrants care workers were often perceived by employers to have the "right" skills requirements, which included a good work ethic, loyalty to the organization, and a willingness to work all shifts (Bourgeault et al., 2011).

Care recipients in the Irish RACFs valued principles that were associated with family care, for instance, compassion, kindness, trust, respect, and effective communication skills, more so than the formal training of the care worker (Walsh & Shutes, 2013). Migrant care workers were reported to be better care workers when compared with the native-born care workers because of their cultural norms, which involve caring for and respecting elders (Bourgeault et al., 2011). The relationship migrant care workers developed with care recipients varied by setting; Timonen and Doyle (2010) reported that migrant care workers of African, South Asian, and European backgrounds employed in the Irish community aged care settings developed personal and social interaction with people with dementia that extended beyond formal care relationships, whereas personal attachments between migrant care workers and care recipients in Irish RACFs were less evident (Timonen & Doyle, 2010). Factors such as high workload and a large number of care recipients with dementia in RACFs contributed to limited personal and social interactions between migrant care workers and the residents (Nichols et al., 2015; Timonen & Doyle, 2010; Walsh & Shutes, 2013). However, workers still recognized the value of using a person-centered approach, nonverbal communication, and empathetic body language to build a positive relationship with residents with dementia (Timonen & Doyle, 2010).

Migrant care workers in aged care frequently encountered discrimination and racism. According to Nichols and colleagues (2015), 21 of 35 participants who were migrant care workers employed in Australian RACFs had experienced negative reactions from the residents with dementia due to their visible differences, particularly workers from African backgrounds. Migrant care workers experienced racism not only from residents with dementia but also from residents without cognitive impairment (Goel & Penman, 2015; Timonen & Doyle, 2010). Migrant care workers from African backgrounds experienced the highest levels of discrimination and prejudice when compared with migrant care workers from other backgrounds such as South Asian or European (Doyle & Timonen, 2009; Walsh & Shutes, 2013). Care workers from European backgrounds encountered the least prejudice and discrimination and were more optimistic about their career progression compared with migrant care workers from other cultural and ethnic groups (Doyle & Timonen, 2009).

Migrant care workers rationalized that negative reactions from residents with dementia may be a result of the neurodegenerative disease process and past experiences (Nichols et al., 2015), a lack of interaction with people from other cultural backgrounds, and intergenerational factors that reflect dominant beliefs in older cohorts toward different ethnic groups (Walsh & Shutes, 2013). Migrant care workers developed coping strategies such as ignoring racism and discrimination, being emotionally resilient, and avoiding situations at work that might elicit such responses (Nichols et al., 2015; Walsh & Shutes, 2013).

Some migrant care workers felt discriminated against due to the manner in which coworkers from the dominant culture interacted with them (Goel & Penman, 2015). Also, participants reported that they perceived being allocated heavy workloads and difficult tasks as discriminatory practices (Goel & Penman, 2015). Factors such as the lack of trust in the work abilities of migrant care workers and the belief that jobs are being taken by foreign-born workers partly explained the native-born care workers' prejudice toward migrant care workers (Bourgeault et al., 2011). In the study by Bourgeault and colleagues (2011), only 28% of migrant care workers viewed their relationships with their coworkers as positive (Bourgeault et al., 2011). Tensions were reported to emerge between them and the native-born care workers (Bourgeault et al., 2011), as a result of the difficulties in understanding migrant care workers' accented English (Nichols et al., 2015), culturally specific way of delivering care, and the use of native language among migrant care workers in the workplace (Bourgeault et al., 2011). The use of native language between migrant care workers of similar cultural backgrounds in the presence of care recipients and coworkers from the dominant culture was considered disrespectful (Boughtwood et al., 2011) and often led to a distrustful care relationship between migrant care workers and the care recipients and their coworkers (Walsh & Shutes, 2013). In a survey conducted

among employers, 65% of respondents in Ireland and 66% of respondents in the United Kingdom indicated that poor English-language proficiency was a significant challenge in employing migrant care workers (Walsh & Shutes, 2013). This finding is consistent with studies from Canada (Bourgeault et al., 2011) and Australia (Nichols et al., 2015). Factors such as regional accents, and colloquial language and slang (Nichols et al., 2015; Walsh & Shutes, 2013) used by coworkers and employers from the dominant culture also contributed to communication difficulties between them and the migrant care workers (Bourgeault et al., 2011; Walsh & Shutes, 2013). Strategies used to address communication difficulties between residents and migrant care workers included migrant care workers using their smartphones for interpreting residents' languages, and nonverbal communication such as responding to the residents' body language (Willis et al., 2018).

Caring roles in aged care sector are physically and psychologically demanding for all workers (Gao, Tilse, Wilson, Tuckett, & Newcombe, 2015). Migrant care workers face additional work stressors from work-related psychological factors such as discrimination from colleagues and residents (Nichols et al., 2015). Furthermore, those on temporary residence visas particularly are often under pressure to accept low wages and to work longer hours to retain their job as a condition of residency (Lovelock & Martin, 2016). The need to care for their relatives in their country of origin by remitting money is another driving factor to work longer hours among some migrant care workers (Lovelock & Martin, 2016). For example, study participants employed in the New Zealand RACFs organized care arrangement for their families in their home country through regular remittance to the Philippines (Lovelock & Martin, 2016). Bourgeault and colleagues (2011) also reported that migrant care workers are working more than one job due to a lack of full-time work provided by employers. Some migrant care workers reported feeling isolated at work and home as their busy work schedules often hindered their social relationships with family and friends (Bourgeault et al., 2011). The combination of work-related stressors with the family-related issues and financial pressure had a negative impact on their physical and mental health (Goel & Penman, 2015).

Enablers and Barriers to Retention of Migrant Care Workers Workforce

Reciprocity and mutual respect between migrant care workers, residents, and their families appear to facilitate retention in the aged care workforce (Gao et al., 2015). Acknowledgment and recognition of the caring role of migrant care workers had a positive impact on migrant care workforce retention in RACFs (Gao et al., 2015). For example, some migrant care workers mentioned that being appreciated by the care recipients and their family members fostered a feeling of accomplishment and achievement (Walsh & Shutes, 2013). Friendship and a familial-like relationship between migrant care workers and care recipients can also facilitate retention of the migrant care workforce (Gao et al., 2015). Attachment to the care recipient is common, particularly among migrant care workers with fewer family members in host country (Gao et al., 2015; Timonen & Doyle, 2010). The perceived meaning of care work was another contributory factor in retention of migrant care workers. Gao and colleagues (2015) reported that migrant care workers ascribed special meaning to care work including religious beliefs such as karma (the belief that good intents and actions will result in happy life in the future, and bad intents and actions will lead to difficult future life), and intergenerational benevolence (Gao et al., 2015). These factors enhanced the willingness of migrant care workers to provide quality care and motivated them to continue in their caring job (Gao et al., 2015).

The availability of organizational resources to support migrant care workers was linked to retention. These resources included supervisor support, coworker interaction, opportunities for personal development, physical amenities, and appropriate staffing levels (Gao et al., 2015). Participants in an Australian study noted that the organization's English-language support service facilitated their retention in their current workplaces as did a positive relationship between migrant care workers and coworkers from the dominant culture (Gao et al., 2015). The perceived benefits identified by some migrant care workers included the flexibility associated with care work, self-satisfaction from caring, and regular income (Bourgeault et al., 2011; Goel & Penman, 2015).

The benefits of working in the aged care sector were identified among some migrant care workers (Browne, Braun, & Arnsberger, 2006). The identified benefits included the flexibility associated with care work, self-satisfaction from caring, and regular income (Bourgeault et al., 2011; Goel & Penman, 2015). Over 90% of study participants, predominantly migrant care workers of Filipino backgrounds employed in Hawaiian RACFs, planned to continue in this role (Browne et al., 2006). However, due to the challenges associated with working in the aged care setting such as dealing with residents' care, legislation demands from government officials, and inadequate wages, 87% of the study participants would not recommend working in the aged care sector to their progeny (Browne et al., 2006).

Barriers to retention such as perceptions of prejudicial treatments from care recipients and coworkers from the main culture linked to skin color, accented English, cultural approaches to care provision, preexisting cultural biases, and belief that migrant care workers threaten the job security of native-born care workers have already been discussed (Nichols et al., 2015; Walsh & Shutes, 2013). Additional barriers such as the lack of control over their work duties, lack of organizational support, high rates of

occupational injuries, irregular shifts, low pay rates from hiring agencies, frequent night shifts, and casual work contracts negatively affected the working conditions of migrants care workers (Bourgeault et al., 2011; Goel & Penman, 2015). Limited understanding of workplace culture was a barrier to migrant workforce retention. Ow Yong and Manthorpe (2016) found that most participants in their study experienced a high level of insecurity as a result of the lack of awareness of culturally appropriate social behavior and work protocols, especially among newly arrived migrants (Ow Yong & Manthorpe, 2016). The use of unfamiliar technology and documentation processes were also identified as an impediment to their abilities to perform their role (Ow Yong & Manthorpe, 2016).

The migration status of the care workers has a significant effect on their employment opportunities, working conditions, and job retention (Bourgeault et al., 2011). Canadian participants explained that employers perceived migrants as lacking Canadian work experiences required to carry out their duties (Bourgeault et al., 2011). Participants further explained that the lack of permanent status often restricted migrants with temporary visas from exploiting professional advancement that may result in a better-paid job (Bourgeault et al., 2011).

Discussion and Implications

Migrant care workers are valuable contributors to the aged care workforce (Gao et al., 2015; Shutes, 2012). However, concerns have been raised regarding the quality of their care provision. Although there is a shift in high-income countries including Australia for community-based dementia care (World Health Organization and Alzheimer's Disease International, 2012), RACFs still provide significant long-term care for people with dementia especially in situations when the family caregiver is sick or can no longer manage on their own at home. Although several studies have been conducted on the dementia care experiences of family caregivers from migrant backgrounds, relatively few studies have been conducted on how cultural understanding of dementia shapes care provision among migrant care workers in RACFs. It may be that family carers and migrant care workers from a similar cultural background share similar views of dementia; similarly, the views of migrant care workers may also be held by other care workers (and relatives). In either case, many of the recommendations discussed below would be salient to these cohorts. Ultimately, given that a large proportion of residents in RACFs have changed behaviors associated with their dementia (Cubit et al., 2007) and are being cared for by a migrant workforce with different cultural perceptions of dementia, it is important to consider the role of culture in dementia care in RACFs.

To summarize the broad themes from our review, there are divergent understandings of dementia care among migrant care workers in RACFs compared with conventional medical understandings of dementia; cultural diversity is viewed as strength in the RACFs. There are significant communication difficulties between migrant care workers and residents and between migrant care workers and coworkers and employers, which are related to proficiency in the dominant language. The identified enablers to retention were the availability of organization support services; professional development opportunities; reciprocity and mutual respect between migrant care workers, care recipients, and coworkers; and good working conditions. Factors such as discrimination from care recipients and coworkers and limited understanding of workplace culture were identified as barriers to migrant care workforce retention (Stevens, Hussein, & Manthorpe, 2012).

These findings have important research and policy implications. First, it is imperative to upskill dementia training all staff by providing resources and support for education, training, and orientation programs to enhance the quality of dementia care in the aged care sector (De Siún & Manning, 2010). Dementia education and training that includes basic information about dementia, the progression of the condition, and developing a working relationship with carers and families are recommended (De Siún & Manning, 2010). Other training contents such as responses to dementia-related changed behaviors, communication skills, and application of principles of person-centered care in daily activities and care are also recommended for all staff (De Siún & Manning, 2010). In addition, support structures such as language support services; information on health care resources; and training on workplace culture should be incorporated into dementia education package to assist migrant care workers in their dementia care duties.

Appropriate human resource (HR) and regulatory support should be provided (World Health Organization and Alzheimer's Disease International, 2012) in community and RACFs to prevent, and effectively manage, instances of exploitation, discrimination, and abuse often experienced by migrant care workers during their engagement with residents, families, and coworkers (World Health Organization and Alzheimer's Disease International, 2012). Embedding principles of effective HR practices in aged care management will have a positive impact on migrant workforce retention (Willis et al., 2018), particularly HR practices and management policies that effectively address work-related psychosocial risk such as discrimination (Willis et al., 2018).

Providing cultural diversity training and education for both staff from culturally diverse backgrounds and the dominant culture in RACFs (Willis et al., 2018) can enhance staff knowledge about the benefits of cultural diversity and foster a positive relationship between migrant care workers and staff from the dominant culture. Also, provision of multicultural social activities and festivals in RACFs could contribute to multicultural awareness and acceptance of migrant care workforce among residents (Willis et al., 2018).

Finally, population aging in tandem with global migration means we are increasingly confronting an aging and multicultural world. Thus, it is pertinent to consider how cultural and linguistic diversity influence the planning and delivery of appropriate aged care service (The Senate Community Affairs Committee Secretariat, 2017). Cultural competence training is an important educational strategy to enhance the understanding of the aged care workforce around the relationship between cultural beliefs, behavior, and care provision. Cultural competence is defined as a "congruent set of behaviors, attitudes, and policies that come together in a system, agency or among professionals and enables these to work efficiently in cross-cultural settings" (Chenoweth, Jeon, Goff, & Burke, 2006).

Evidence shows that some aged care workers are aware of the elements of cultural competence (Gillham et al., 2018). However, the competing demands for time and residents' complex care needs often hinder them to provide comprehensive care, including culturally appropriate care to the recipients (Gillham et al., 2018). Future strategies at both the organizational and sector levels addressing concerns around high workloads and inadequate staff to residents' ratio should be considered. Addressing these barriers would allow greater time and resources to implement comprehensive quality care, including culturally appropriate care, into routine practice.

In addition, the limited educational attainment among some care workers might be a barrier to engaging in the cultural competency training (Gillham et al., 2018). Thus, the provision of culturally sensitive language and literacy learning opportunities in verbal and written formats will facilitate communication processes that are sensitive to the literacy skills of the whole aged care workforce and not only migrant care workforce (Nichols et al., 2015).

Some interventions have been developed to address these training needs; for example, Gillham and colleagues' multicultural workforce development education package was designed with multiple interventions that targeted all staff at different levels in the aged care sector and can be provided in different formats such as online materials, hard copy booklets, and face-to-face education and peer teaching in the workplace (Gillham et al., 2018). Similarly, Dupuis and colleagues' (2012) authentic partnerships toolkit was developed among people with dementia, their families, and health care professionals in Canadian aged care settings to improve dementia care, support, and services. The toolkit values diversity, open communication, regular critical reflection, and dialogue with partners (Dupuis et al., 2012). The evaluation process demonstrated the importance of all the key stakeholders' involvement in decision making relating to dementia care (Dupuis et al., 2012).

Opportunities for discussion and reflection regarding migrant care workers' perceptions, assumptions and concerns, and communication needs should be encouraged (Chenoweth et al., 2006). A culturally inclusiveness program that allows migrant care workers to contribute their knowledge, skills, and positive cultural norms to needs assessment, care planning, and service evaluation of care recipients; particularly those with similar cultural backgrounds might improve the quality of dementia care in the aged care sector.

Limitations

The review was limited to peer-reviewed articles published from 2000 to November 2018. Although a rigorous process was undertaken to perform a thorough search, it is possible that evidence might have been missed. In addition, only studies that examined the experiences of dementia care among migrant care workers in aged care settings were considered. Studies investigating the experiences of dementia care among this cohort in an institutional setting such as the hospital may add value to understanding related needs.

Conclusion

In high-income countries, there is an increasing prevalence of people living with dementia in aged care that are being cared for by an increasingly multicultural workforce. Given this dynamic, it is essential to have the knowledge of how the migrant workforce delivers dementia care in cross-cultural settings. According to the 2012 World Health Organization and Alzheimer's Disease International report on dementia, a better understanding of migrant care workers' experience of caring for people with dementia, particularly in long-term care is required (World Health Organization and Alzheimer's Disease International, 2012). This scoping review provides an insight into the existing literature on dementia care experiences of migrant care workers in aged care settings and enablers and barriers to migrant workforce retention. There is an insufficient evidence to describe how culture shapes dementia care among migrant care workers in an institutional setting. Further research is required in this area. In addition, more studies are required in understanding migrant care workers' exposure to work-related psychosocial risk factors and the impact of these factors on their general and mental health condition, and the quality of care that they deliver to the residents.

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Conflict of Interest

None reported.

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2.3 Gaps in literature and Literature Published After the Literature Review

Previous research focused on knowledge of dementia of family members from culturally diverse backgrounds providing care to people with dementia in community settings (Brooke et al., 2017). . Future research examining the knowledge and predictors of dementia among RACF migrant care workers is required. Additionally, research studies exploring RACF migrant care workers' cultures and how their acculturation process affects care delivery to the residents with dementia from the dominant culture are also required.

A systematic review and meta-synthesis study was recently published on challenges and opportunities for the migrant care workforce in the aged care sector (Chen, Xiao, Han, Meyer, & Muller, 2020) The results of this study adds insight into the important role of cultural competence for successful multicultural teamwork in aged care settings (Chen et al., 2020). The results identified cultural diversity awareness as a crucial element that shapes team building, peer support opportunities, and positive cross-cultural experiences among the migrant aged care workforce.

Additionally, the Royal Commission into Aged Care Quality and Safety (Royal Commission) 2021 final report highlighted the low-quality care in RACFs that stemmed from workforce issues (Royal Commission into Aged Care Quality and Safety, 2021). The Royal Commission is a statutory agency established by the Australian Government to enquire about the quality of aged care services for people living in RACFs. The main aim of this report was not about the migrant care workforce but rather on how to deliver respect, dignity safety, and care for older adults living in residential aged care settings (Royal Commission into Aged Care Quality and Safety, 2021). In light of public submissions and hearings, the Royal Commission, in their final report, provided recommendations on the current and future challenges, including workforce issues. Factors impacting residents' quality care, including older adult abuse, neglect, and staff shortages, were identified in the report (Royal Commission into Aged Care Quality and Safety, 2021). Recommendations to better deliver aged care services to the vulnerable cohort living in RACFs, especially people with dementia, people with disabilities, and younger people, were highlighted in the report (Royal Commission into Aged Care Quality and Safety, 2021). Furthermore, the fundamental importance of the workforce for enabling quality care in the aged care sector was also emphasised in the final report (Royal Commission into Aged Care Quality and Safety, 2021).

2.4 Summary of the Chapter

The continued growth of the ageing population in conjunction with an increase in age-related conditions highlights the need for a better understanding of the aged care sector (Oppert et al., 2018) and the dynamics of the multicultural aged care workforce to provide quality care delivery.

The published paper (Paper 1) examined the earlier literature published between 2000 and 2018. The paper has been cited seven times in peer-reviewed papers and featured in the peer-reviewed *Gerontology Special Issue on Immigration and Aging* (Volume 60, Issue 2, March 2020).

This chapter has reviewed the major factors that influence migrant care workers' knowledge of dementia, and their dementia care experiences in RACFs, along with the enablers and barriers to retention. The research methods and design used in the current study will be discussed in the next chapter.

Chapter Three Methodology

3.0 Overview of the Chapter

This chapter presents the study design and describes the mixed methods research design selected for this current study. The rationale for a sequential explanatory mixed methods approach is discussed, followed by an explanation of the quantitative and qualitative components of the study, and then the strategies utilised to enhance the rigour of quantitative and qualitative studies.

3.1 Mixed Methods Research

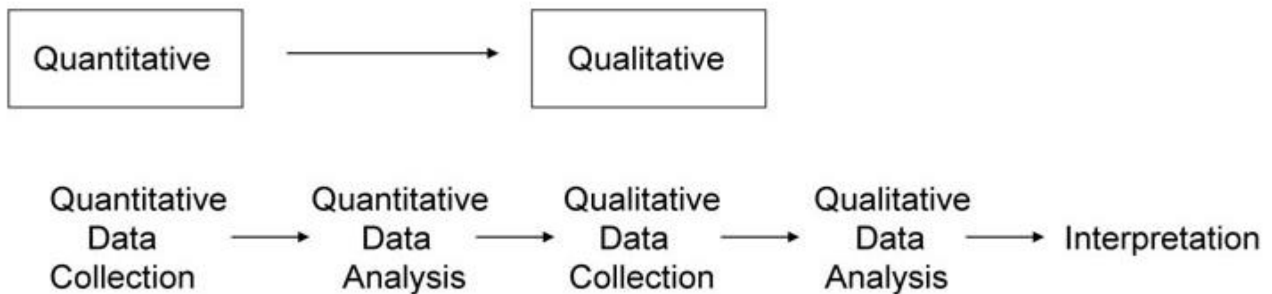
Several research questions are best and fully answered through a mixed research approach due to its inclusive, pluralistic, and complementary nature in utilising multiple research approaches in answering the questions (Johnson, Onwuegbuzie, & Turner, 2007). The sequential explanatory mixed-method design typology was chosen for this study because it allows the researcher to elaborate on the findings of one method with another method (Creswell, 2003). As illustrated in Figure 3.1, the quantitative (numeric) data was first collected and analysed followed by the collection and analysis of qualitative (text) data, which is analysed second in the sequence (Ivankova, Creswell, & Stick, 2006). The two phases are connected in the result interpretation stage (Halcomb & Hickman, 2015; Ivankova et al., 2006). Table 3.1 presents information on the research objectives that were addressed in each study phase.

The main advantage of the sequential explanatory mixed-method design is that both qualitative and quantitative data capitalises on the strength of the data, and compensates for the limitations of particular methods by providing an integrated understanding of the research topic (Halcomb & Hickman, 2015). The explanatory sequential mixed-method approach is time-consuming, which is the main disadvantage, as time is required to collect data in two separate phases (Ivankova et al., 2006).

Qualitative and quantitative methodologies both have their strengths and limitations (Johnson & Onwuegbuzie, 2004), depending on the research focus and desired outcomes. The qualitative approach may provide insight into the unique perspectives of individual migrant care workers, however, there is the limitation of weak generalisability to the larger population (Castro, Kellison, Boyd, & Kopak, 2010). Conversely, the quantitative approach has the capacity to conduct group comparisons, examine the strength of association between variables of interest, and test research hypotheses (Castro et al., 2010). The limitations of the quantitative approach are that the researcher may focus on the theory or hypothesis testing and may overlook the occurring phenomena (Johnson & Onwuegbuzie, 2004). Additionally, the knowledge generated through a quantitative approach may be abstract and too broad for direct application to specific population groups (Johnson &

Onwuegbuzie, 2004). Using a mixed-method approach will facilitate more comprehensive balanced research findings (Johnson et al., 2007) and can enhance validity in the research results (Halcomb & Hickman, 2015).

Figure 3.1 Sequential Explanatory Mixed-Methods Approach



Source: Terrell (2012, p.261) Mixed-Methods Research Methodologies: The Qualitative Report

Table 3.1 Research Objectives and Study Phases

Research Objective	Study Phase
Identify and report the current evidence on the knowledge of dementia among migrant care workers in RACFs	Phase One- National cross-sectional survey
Investigate the levels of acculturation stress and mental health of depression, anxiety and stress of migrant care workers in RACFs	Phase One
Examine the general well-being of RACFs	Phase Two- Qualitative Semi-structured interviews
Measure the impacts of acculturation stress and mental health on migrant care workers in relation to their working conditions in RACFs	Phase One
Explore the working conditions of RACFs migrant care workers	Phase Two
Explore the understanding of dementia and dementia care experiences of Indian, Filipino, and Nigerian residential aged care workers	Phase Two

3.1.1 Rationale for Using Mixed-Methods Sequential Explanatory Design

The researcher's ontological and epistemological standpoint is important in research study as it can influence the research questions, design and the methodology (Timans, Wouters, & Heilbron, 2019). From ontological (nature of reality) stance, migrants are often excluded from research

study, particularly those from culturally diverse backgrounds (Low et al., 2009) due to factors such as cultural appropriateness, communication barrier, additional time to develop the relationship, and additional costs of translation services (Spring et al., 2003; Sulaiman-Hill & Thompson, 2011). However, these challenges were addressed as the researcher in this current study is from a migrant background and had established relationships with some migrant care workers while conducting a previous study that examined migrant care workers' perceptions of oral health in RACFs (Adebayo, Durey, & Slack-Smith, 2017). Therefore, the researcher used her established networks to recruit migrant care workers for this current study. The researcher also spent some time visiting RACFs within the state and interstate to explain the purpose of the study to migrant care workers.

Epistemological (the nature of obtaining knowledge) stance of mixed method research is grounded in pragmatism (Johnson & Onwuegbuzie, 2004), as it utilises pluralistic approaches including postpositivism and constructivism to obtain an in-depth knowledge about an ocurrness or situation (Timans et al., 2019). The positivistism supports quantiative method by asserting an objective knowledge through examination of empirical evidences and hypothesis testing (Kaushik & Walsh, 2019) ,while constructivism emphasises on qualitative method by proposing that knowledge is relative and focusing on the complexity of reality (Kaushik & Walsh, 2019). However, pragmatism embraces the two extremes and offers a flexible and more reflexive approach to research design in its mode of inquiry (Kaushik & Walsh, 2019).

This current study utilised the pragmatism aproach of an intelligent action approach proposed by Dewyer (1998) which recognises that inquiry takes place within communities of dynamic demographics with a complex interaction of diverse perspectives and experiences. It is essential to communicate responses necessary to address complexiety around the diverse communities (Hall, 2013) . From this pragmatism viewpoint , the research problem is viewed as an important issue through the lens of both subjective and objective observations to reveal findings (Halcomb & Hickman, 2015).

In addition, Deweyan pragmatism embraces mixed-methods design by offering a descriptive approach on how methods are to be considered with the understanding that the method is being utilised to address a specific research problem, and to provide information that will help to make evaluative judgments (Hall, 2013). For example, , the sequential explanatory mixed-method design used in this current study aligned with six research questions outlined in chapter one to obtain answers to these questions. The research questions two, four and five were addressed based on quantitative data gathered via survey questionnaires, while research questions one and six were addressed qualitatively, based on data gathered via semi-structured interview. The mixed-method

approach can guide the exploration of the predictors of variables in understanding migrant care workers' dementia care knowledge in residential aged care settings and further examine a deeper understanding of experiences and perceptions of individual migrant care workers. While quantitative measures, such as survey questionnaires, can address the research question through statistical analysis, participants' responses cannot be explored in greater depth. Following up with a qualitative approach, which provides insight and a deeper understanding of the concepts contained in the research question, is required. For instance, the quantitative method can generalise findings to a larger population and predict factors (Drake & Jonson-Reid, 2008) associated with acculturation stress, dementia knowledge, and care experiences among migrant care workers. However, the qualitative approach allows an in-depth analysis of the complexity around participants' normal and cultural experiences in a manner that cannot be fully captured with quantitative measurement scales and multivariate models (Castro et al., 2010).

Statistical data analysis could be inadequate to explore migrant care workers' understanding of dementia and their post-migration experiences. For instance, the Likert-type response categories used in the quantitative questionnaires could encourage uncertainty in the responses, whereas participants are often confident of their knowledge in their qualitative responses (Flaskerud, 2012). Conversely, the qualitative approach could not be solely used in this study because of its difficulty in assessing associations and relationships between variables of interest (Castro et al., 2010).

Furthermore, using the sequential explanatory mixed-methods approach allows the researcher to examine participants' dementia care and working experiences statistically, through the quantitative lens, and also provides an overview and context for a qualitative approach to further address the research questions (Grbich, 2013). Thus, the combination of quantitative and qualitative designs in this current study can be used to build on the strengths of the two designs and can also be used to address the evident weaknesses in both designs. Additionally, the explanatory sequential mixed-method approach provides an opportunity for the research questions to be answered in different ways, therefore strengthening the overall research findings.

3.1.2 Factors Influencing the Mixed Methods Design Process

Factors influencing the design and procedures of the sequential explanatory mixed-methods study outlined by Creswell (2003) included timing, priority or weighting, and integration or mixing (Creswell, 2003).

3.1.2.1 Priority

Priority refers to the study phase that researchers give the most attention to in the data collection and analysis process of the study (Ivankova et al., 2006). Priority may be given to the quantitative

or qualitative phase. At times, both phases may receive equal priority (Ivankova et al., 2006). Priority was given to the quantitative study in this present study because it was anticipated that the large sample size required for robust findings from a nationwide cross-sectional survey would take a considerable amount of time. Additionally, the quantitative findings were required as preliminary data to guide the qualitative semi-structured interviews.

3.1.2.2 Timing

Timing refers to the sequence of data collection and analysis in the mixed-methods design (Ivankova et al., 2006). In light of the explanatory sequential mixed-method approach, the two phases were conducted separately and connected in an intermediate stage, in which the analysed data from the first quantitative findings were corroborated with the second qualitative findings. Overall, it took approximately 18 months to complete the quantitative phase. The recruitment and data collection process that will be discussed in detail in this chapter lasted for 12 months (March 2018-April 2019). The researcher, with the support of the principal supervisor and the biostatistician, conducted the quantitative data analysis over the following six months.

The qualitative phase of the study was conducted for 12 months. It was less challenging for the researcher to recruit participants for the qualitative phase because the researcher had developed professional relationships with participants who completed the cross-sectional survey and the key stakeholders that supported the quantitative recruitment process. The qualitative data analysis was conducted concurrently with the recruitment to allow the researcher to be familiar with the data and to ensure the research questions were addressed.

3.1.2.3 Integration of quantitative and qualitative data

The integration process involves the coalescing of quantitative and qualitative components of the mixed methods approach (Siddiqui & Fitzgerald, 2014). The notion was to develop interdependent components that would generate a profound picture and deeper understanding of the research phenomenon (Fetters, Curry, & Creswell, 2013).

This study utilised Fetters et al. (2013) approach to integrate qualitative and quantitative research procedures and data at the three stages of the research process: (1) design; (2) methods; and (3) interpretation and reporting levels of research.

3.1.2.3.1 Methods

Integration of the quantitative and qualitative data occurs through linking the methods of data collection and analysis of the two research designs in different ways (Fetters et al., 2013). In this current study, methodological integration occurred through “connecting” as the three main

population groups (Filipino, Nigerian, and Indian) in the quantitative study were selected as participants for the qualitative study.

The quantitative results regarding participants' psychosocial well-being, particularly their post-migration challenges and mental health, were also explored in the qualitative study

3.1.2.3.2 Interpretation and reporting

A staged narrative approach was used to integrate the qualitative and quantitative data at the interpretation and reporting levels (Fetters et al., 2013). A staged narrative approach is an integration of qualitative and quantitative data at the interpretation and reporting level of the overall study (Fetters et al., 2013) . Three methods to the staged narrative approach are the weaving, contagious and staged (Fetters et al., 2013). The weaving method involves the concurrent writing of both qualitative and quantitative findings together on a concept-by-concept basis (Fetters et al., 2013). The contiguous method involves the presentation of findings within a single report, with the qualitative and quantitative findings being reported in different sections (Fetters et al., 2013). The staged method is frequently use in multistage mixed methods studies, the results of each step are reported in stages as the data are analyzed (Fetters et al., 2013).

The contiguous s method was used in this current study, quantiative findings is reported in chapters four and five, while chapters six and seven reports the qualitative findings and both findings are reported as a single report in chapter eight. The merging of the qualitative and quantitative findings produced a comprehensive, multifaceted description of cultural factors influencing migrant care workers' knowledge, as well as the factors affecting their working conditions in the Australian aged care sector. The results of each phase were reported sequentially as the data were analysed.

3.2 Phase One: National Cross-sectional Survey

A national cross-sectional survey was conducted among migrant care workers employed in Australian RACFs. The following four objectives addressed in Phase One were to:

1. Identify and report the current evidence on the knowledge of dementia among migrant care workers in RACFs.
2. Determine the experiences of work-related psychosocial risk factors and work-related stressors experienced by RACF migrant care workers.
3. Assess the self-reported mental health status of migrant care workers of people with dementia in RACFs.
4. Measure the impacts of acculturation stress on migrant care workers in relation to their effectiveness in performing their roles in RACFs.

.A cross-sectional survey method was chosen to address the study objectives in Phase One due to a lack of agreed data standards and collection mechanisms for monitoring the aged care workforce (The Senate Community Affairs Committee Secretariat, 2017), especially the migrant aged care workforce. The main source of aged care workforce data is the NACWCS conducted by the National Institute of Labour Studies (NILS) at Flinders University, on behalf of the Australian Department of Health. Data on aged care workforce is also available from other sources, including the ABS and datasets created by the National Aged Care Data Clearinghouse (The Senate Community Affairs Committee Secretariat, 2017). However, it has been argued by some researchers that data collected from both the NACWCS, and ABS are inadequate and has numerous deficiencies (The Senate Community Affairs Committee Secretariat, 2017). For instance, the NACWCS classified direct care employees in the residential aged care workforce by country of birth as two groups 'Australia and others. The need to conduct a survey that would provide robust findings on migrant care workers' working experiences in RACFs and examine their knowledge of dementia and care experiences, was thus apparent.

3.2.1 Study Design

A cross-sectional national survey was conducted among migrant care workers employed in Australian RACFs. Their dementia knowledge and dementia care experiences were examined. Additionally, their mental health and the effect of acculturation stress on their working conditions were investigated. All the measurements were obtained at a single point in time in accordance as per a cross-sectional study, although recruitment occurred across the 12 months (Sedgwick, 2014). A cross-sectional survey is useful for providing information about different population groups at a single point in time (Song & Chung, 2010). It is also inexpensive and easy to administer. However, its limitations are the lack of an inherent temporal dimension (it cannot be used to determine cause-and-effect relationships between different variables) and an inability to reflect past or future findings (Song & Chung, 2010).

Existing validated questionnaires were used to gather quantitative data. These questionnaires were the Dementia Knowledge Assessment Tool Version 2. (DKAT 2), Riverside Acculturation Stress Inventory (RASI), and the Depression, Anxiety and Stress Scales (DASS).

The DKAT 2 was selected because of its successful outcomes in measuring dementia knowledge among nurses and patient care assistants in Australian RACFs (Toye et al., 2014). The RASI can also relate to different culturally diverse populations, and it focuses on culture-specific challenges among migrant populations (Miller et al., 2011).

The RASI questionnaire was selected for this study because it has been successfully used and validated in a quantitative study examining the impact of acculturation stress in migrants from Asian backgrounds in the United States (Miller et al., 2011).

The DASS questionnaire was chosen because it has been used previously across different cultural groups (Oei, Sawang, Goh, & Mukhtar, 2013). It has been validated in use with several population groups, such as Hispanic, US, and UK adult populations (Oei et al., 2013).

3.2.2 Reliability and Validity of the Questionnaires

Rigour in Phase One was achieved through measurement of validity (the extent to which the variables are accurately measured) and reliability (accuracy of the instrument or measuring tool) (Heale & Twycross, 2015).

The DKAT has undergone psychometric analysis and is also reported to have acceptable internal consistency reliability (Cronbach's alpha = 0.79) with established content validity (Toye et al., 2014).

The RASI is a valid and reliable measure of acculturative stress (Benet-Martinez, 2003) with Cronbach's alpha .87 (K. Chen & Sheldon, 2012). A study conducted to assess the psychometric characteristics across four racial groups (African American, Caucasian, Hispanic/Latino, and Asian) indicated that the psychometric properties of the DASS 21 have high reliability and high convergent validity (Norton, 2007). The internal consistency of the DASS-21 scales across these four racial groups was acceptable with Cronbach's alpha .82, .77 and .87 respectively in depression, anxiety, and stress subscales.

3.2.3 Questionnaire Readability

Considering that the reading ages of the validated tools (RASI, DKAT2 and DASS 21) were tested in the pre-test phase of the research study. The readability indices such as the Coleman Liau index, Flesch Kincaid Grade Level, Flesch Kincaid Reading Ease, Gunning Fox Score, SMOG, and Automated Readability Index (ARI) were used to determine the reading ages of the validated tools that we administered in the questionnaire. The reading ages of the tools are as follows:

- The Riverside Acculturation Stress Inventory (RASI) text has an average grade level of about 8. It should be easily understood by 13- to 14-year-olds.
- The Depression, Anxiety, Stress Scales (DASS) text has an average grade level of about 12**.** It should be easily understood by 18- to 19-year-olds.
- The DKAT 2 text has an average grade level of about 7**.** It should be easily understood by 11- to 13-year-olds.

Table 3.2 Readability indices for the RASI, DASS and DKAS questionnaires

Questionnaire	Flesch Kincaid Reading Ease	Flesch Kincaid Grade Level	Gunning Smog Fox	Coleman Liau index	Automated Readability Index	SMOG Index
RASI	54.3	7.3	7.6	11.8	4.7	6.7
DASS	52.2	13.8	16.8	10.7	8.4	13.4
DKAT 2	61.5	6.3	9.7	10.9	3.3	6.7

3.2.4 Study Population

The study population was migrant care workers born overseas, aged 18–65 and above, currently or previously employed in an Australian RACF in metropolitan areas and major cities. Care workers included enrolled and registered nurses and patient care assistants. These groups of care workers were considered because they are the direct care workers who are often known as "hands-on" workers as they assist with all aspects of residents' physical care (Gilster et al., 2018). The rationale for selecting this study population was also based on the recent Australian report on RACF aged care workforce which indicates that direct care workers comprise of 70% PCAs, 23 % nurses and only 7 % allied health professionals (Australian Government Department of Health, 2021).

3.2.5 Piloting and Pretesting of Questionnaire

The survey questionnaire was piloted with migrant care workers (n=20) across different ethnicities in the pre-test phase of the research study. Respondents were asked to provide feedback in relation to the content of the questionnaire. They provided positive feedback and described the questions as easy to understand. Minor changes were made in the questionnaire formatting.

3.2.6 Sampling and Recruitment

3.2.6.1 Sample selection

The desired survey sample size was 350 as determined from a priori power analysis. The overall sample size was calculated based on an acceptable sampling error of 5% (de Vaus, 1991), and at a 95% level of confidence. The desired sample size of the quantitative phase was not achieved because of the additional time required to develop a relationship with migrant care workers before the research study could be conducted. Barriers such as low response rates, community suspicion of research, language barriers, and status differences between interviewers and respondents have hampered earlier research conducted among migrant populations (Pernice, 1994), and these factors

may have affected the recruitment process in this present study.

Geographical location was also a constraint in achieving the desired sample size. The researcher was located in Perth, Western Australia and the data were collected nationally. As such time was required to engage with interstate stakeholders, such as the aged care management for distribution and collection of paper questionnaires to be conducted across Australian states and territories Given that the current study was a sequential explanatory mixed-methods design and was designed to be completed within a certain timeframe, the researcher could proceed to the second phase of the study after extending the time allocated to the national cross-sectional survey (Phase One).

3.2.6.2 Recruitment

Purposive sampling was employed to recruit respondents across major Australian cities including Perth, Sydney, Brisbane, Canberra, Melbourne, and Adelaide. The researcher sought support from residential aged care services, ethnic groups, and peak bodies in the aged care sector, such as Alzheimer WA, the Australian Association of Gerontology, and multicultural support service organisations across Australian states and territories. To enhance migrant care workers' participation nationally, the researcher travelled and attended interstate conferences to engage with key stakeholders in the aged care sector and migrant care workers, especially in Melbourne, Sydney, and Hobart.

The researcher engaged with other researchers at the National Ageing Research Institute (NARI), Bolton Clarke in Melbourne, and HammondCare in Sydney to assist in recruiting participants. Emails, social media, including Facebook, WhatsApp mobile apps and LinkedIn, were used to recruit respondents.

Selection criteria

The following inclusion criteria were used to select the survey participants:

- Women and men aged 18-65
- Migrant care worker born overseas
- Currently or previously employed in RACFs within the last five years
- Self-reported high to moderate level of English proficiency
- Migrant care workers that consented to participate in the survey

Exclusion criteria included:

- Migrant care workers with less than six months of work experience in RACFs
- Second migrants (Australian-born individuals with at least one overseas-born parent) and

third-plus generations (Australian-born people whose parents were both born in Australia)

- Migrant care worker with no working experience in RACFs
- Migrant care workers with little or no English proficiency

3.2.6.3 Cross-Sectional Survey Process

For online participation, an invitation email containing a project flyer and a survey link was sent to potential participants by the researcher and facility managers. A reminder email was sent by the researcher fortnightly to participants who had started but not yet completed the survey. Participants were given one month to complete the questions.

Paper-based questionnaires with post-paid envelopes were posted to participants who requested this format. Similarly, to the online respondents an email was sent to remind them to complete and return their questionnaires. The questionnaires were collected four weeks after the distribution. Detailed information outlining the survey process were provided on the first page of the questionnaire including: study purpose, potential benefits, risks and associated discomforts; and statements about participants' confidentiality and rights, involvement of the participants, and informed consent. The Curtin Human Ethics Research Office contact details, as well as the researcher and supervisors' contact details, were also included on the information sheet for respondents that wish to ask questions about the study. Respondents were asked to provide their consent before proceeding to the questions by ticking "Yes, I consent to proceed with participation" or, to decline participation, "No, I do not consent".

Questions relating to inclusion and exclusion criteria were asked to ensure that the respondents met the criteria. For example, validated questions from a US study examining English fluency as a predictor of acculturation stress among international student respondents (Yeh & Inose, 2003) were included to enable respondents to self-report their English proficiency. Respondents also provided demographic data, such as age, gender, date of birth, education and occupational information about their roles in RACFs, duration in their RACF role and in the aged care sector, current visa status, and education qualification.

3.2.7 Data Collection

A 75-item structured questionnaire was used to collect quantitative data, including the level of English proficiency (fluency, understanding, speaking, and comfortability), socio-demographic data, and data on migrant care workers' dementia knowledge, acculturation stress, and mental health status. To enhance survey participation respondents were given two options as to how to participate in the survey: (1) online participation and (2) a paper questionnaire (see Appendix E for survey questionnaire sample).

Filtering questions to determine eligibility for study participation were presented on the first page of the survey questionnaire. To ensure that the respondents met the selection criteria, questions relating to inclusion and exclusion criteria (section 3.2.6.2 above) were asked. Respondents were asked to tick a box to indicate their eligibility before accessing the survey. The following questions relating to English proficiency were asked: (1) "*How fluent are you in speaking English?"* (2) *"How good are you at understanding spoken English?"* (3) *"How often do you communicate in English?"* (4*) "How comfortable are you in communicating in English?*". The Individual item scales range from *0 (e.g. not fluent)* to *3 (e.g. very fluent).* A total score of 0 to 1 were restricted on the Qualtrics and participants would not able to proceed with the online survey. These questions were used in the United State study to examine English fluency as a predictor of acculturation stress among international students (Yeh & Inose, 2003). The purpose of these questions was to determine participants' capacity to understand the study materials.

The second section of the questionnaire included the demographic questions. Questions relating to sociodemographic characteristics of population groups were developed based on the current research study aims and objectives. Respondents were asked to share their age group, sex, duration in Australia, country of birth, ancestry, role in RACFs, whether they speak other languages than English at the workplace, their highest level of education qualification, their duration in the aged care sector, and current visa status.

Using the Riverside Acculturation Stress Inventory (RASI), the third section of the questionnaire investigated the acculturation stress and resettlement challenges of the respondents. The RASI is an acculturation scale developed by Benet-Martinez and Haritatos (2005) and comprises 15 items that focus on culture-related challenges in five life domains (Miller et al., 2011). These include (1) language skills (e.g. being misunderstood because of one's accent); (2) work challenges (e.g. having to work harder than non-immigrant/majority peers); (3) intercultural relations (e.g. having disagreements with others because of behaving in ways that are ''too ethnic'' or ''too mainstream''); (4) discrimination (e.g. being mistreated because of one's ethnicity); and (5) cultural isolation (e.g. workplace that is not culturally diverse) (M. J. Annear et al., 2015). The responses were measured on a 5-point Likert scale ranging from *1 (strongly disagree)* to *5 (strongly agree).*

The fourth section used the Dementia Knowledge Assessment Tool Version 2 (DKAT 2) to examine respondents' dementia knowledge and their general dementia care experiences. DKAT 2 is a 21-item questionnaire developed by Toye et al. (2014) to assess the knowledge of dementia among care workers and family members of people with dementia. It can evaluate knowledge of dementia and dementia care rather than any specific dementia-related illness (e.g. Alzheimer's disease), making it more broadly applicable (Toye et al., 2014). Response options are *"agree,"*

“disagree”, or “don’t know”. Scores range from 0 to 21, with higher scores indicating greater dementia knowledge (Toye et al., 2014).

The psychosocial well-being of the respondents was measured using the Depression, Anxiety and Stress Scales (DASS) in the fifth section of the questionnaire. The DASS is a self-report measure in which participants rate the frequency and severity of experiencing negative emotions over the previous weeks (Oei et al., 2013), namely depression (DASS-D), anxiety (DASS-A), and stress or tension (DASS-S) (Oei et al., 2013). The shorter version of the DASS is the DASS-21 (Oei et al., 2013). The DASS-21, developed by Lovibond and Lovibond (1995), was selected for this study because of its effective psychometric properties for measuring psychological distress with good reliability and validity (Lovibond & Lovibond, 1995; Oei et al., 2013). The DASS-21 scales contain seven items, divided into subscales with similar contents (Parkitny & McAuley, 2010). The DASS-Depression focuses on reports of low mood, motivation, and self-esteem; the DASS-anxiety focuses on physiological arousal, perceived panic, and fear; and the DASS-stress focuses on tension and irritability (Parkitny & McAuley, 2010). The response options include *0–Did not apply to me at all; 1–Applied to me to some degree or some of the time; 2–Applied to me to a considerable degree or a good part of the time; and 3–Applied to me very much or most of the time.*

3.2.8 Data Organisation and Analysis

3.2.8.1 Data Organisation

The process of data analysis involves identifying the independent and dependent variables, appropriate attributes, and types of statistical measurement (Wetcher-Hendricks, 2014). Quantitative data from the questionnaires were exported from the Qualtrics software program (Qualtrics, Provo, UT) into a Microsoft Excel datasheet. Data were cleaned and checked for errors. The data were imported from the Excel spreadsheet into the Statistical Package for the Social Sciences (SPSS) database Version 25 (IBM Corp., 2017). Data were coded and entered for analysis into SPSS, a file was created, and all variables and response choices were labelled. Recoding of variables was done to convert continuous variables into ordinal and nominal data analysis. Data coding, sorting, filtering, and splitting of variables occurred in the SPSS software as part of the data organisation process, and this guided the beginning of the data analysis process (Wetcher-Hendricks, 2014).

3.2.8.2 Data Analysis

Descriptive statistics analysis was conducted and frequencies analysis of all the variables were undertaken. An analysis of variance (ANOVA) test was used to compare whether the means of two or more groups were significantly different from each other (Wetcher-Hendricks, 2014). The

assumptions of homogeneity of variance were tested using Levene's test. There were 13 categorical independent variables as measured by the demographic questionnaire and multiple continuous dependent variables in the current study. For instance, ANOVA was used to determine if there were differences between the total DKAT 2 and RASI scores for the respondents' sociodemographic characteristics.

Associations and the strength of the relationships between the variables were determined using Spearman's (rho) tests to find out whether there were correlations between the independent and dependent variables of main interest. In addition, a standard multiple linear regression analyses were conducted to determine relationships between independent and dependent variables of main interest. Preliminary analyses were carried out to ensure that the assumptions were not violated. The regression model was assessed for outliers using Cook's distance. Tests for multicollinearity, Levene's test for homogeneity of variance and normality and/or other patterns in the residuals using plots of the residuals versus predicted and Q-Q plots, were also conducted. To increase test sensitivity, an analysis of covariance (ANCOVA) was further used to test the main and interaction effects of categorical variables on a continuous dependent variable and to remove the effects of covariates.

3.3 Phase Two: Qualitative Semi-structured Interviews

Using semi-structured interviews, a qualitative descriptive approach was utilised to explore the knowledge of dementia and dementia care experiences and resettlement challenges of migrant care workers from Indian, Filipino, and Nigerian backgrounds to build upon the responses obtained from Phase One. The interviews further explored their work experienced in RACFs and exposure to worked-related psychosocial factors. The qualitative descriptive approach is useful in providing a comprehensive description of individuals' experiences and facilitating a greater understanding of the area that is being explored (Sandelowski, 2010). This approach is particularly relevant in nursing and healthcare research that focus on increasing changes and quality improvement in healthcare settings (Doyle, McCabe, Keogh, Brady, & McCann, 2020). This design is also frequently used in mixed-methods design which allows qualitative data to explain quantitative findings in explanatory sequential method and also validate and corroborate findings in the overall study (Doyle et al., 2020).

The following objectives addressed in Phase Two were to

1. Examine the factors contributing to understanding of dementia and the dementia care experiences in RACF migrant care workers.
2. Explore migrant care workers' perceptions of working in Australian RACFs

3. Explore migrant care workers perceptions of job demands in RACFs and the impacts on their psychosocial well-being
   Determine migrant care workers' employment intentions to leave or stay in their jobs

3.3.1 Study Setting

Phase Two of this research study was conducted in the Perth metropolitan area in Western Australia. This major city accounts for approximately 78% of the Western Australian population and 11% of Australia's overall population (Australian Bureau of Statistics (ABS), 2013). The ABS 2011 Census reported that WA had the highest proportion of migrant care workers in the Australian aged care and disability sector with 51% of the workforce being foreign-born (Negin et al., 2016).

3.3.2 Participants

A purposive sampling method was adopted to recruit migrant care workers from Indian, Filipino, and Nigerian backgrounds. These three population groups were selected based on the 2016 National Aged Care Workforce statistics (Mavromaras et al. 2017) and from the Phase One results of this current research. The 2016 workforce statistics reported that migrant care workers in RACFs are mainly of Indian and Filipino backgrounds with a recent increased number of migrant care workers from African communities (Mavromaras et al. 2017).

3.3.3 Sampling and Recruitment

Approximately, 30 semi-structured interviews were initially planned to be conducted by the researcher, with approximately 10 interviews per each three-population group. The interviews were intended to continue if required until the data reaches saturation, and no new themes were emerging from the data. A purposive sampling approach to maximise sociological diversity by age, gender, locality, level of education, and job title was chosen to recruit participants. Purposive sampling was selected for this study because it has been successfully used to recruit ethnic minority groups for health research (Adebayo, Durey, & Slack-Smith, 2017).

Participants recruited included women and men aged 18–65 years who are migrant care-workers from the three study population groups employed in Perth RACFs. The selection and exclusion criteria outlined in section 3.2.6 were used in the recruitment process with the additional inclusion criterion of participants being from the three identified nationalities.

Participants from the three identified population groups who completed the national survey were invited to participate in the qualitative . Participants were also recruited through the researcher's community networks, RACFs, multicultural events, and ethnic organisations, such as the Filipino Communities Council of Australia, the Indian Associations in Western Australia, the Nigerian

Association of Western Australia, and universities in Perth. Print media (including flyers, newspapers, and newsletters) containing information about the study, participation recruitments, and statements on ethics were distributed at the RACFs, multicultural events, and ethnic organisation meetings. Interested migrant care workers contacted the researcher directly. The researcher screened interested migrant care workers to determine their eligibility for this study. . Some participants that completed the national survey (Phase One) also indicated interest to be interviewed in the second phase of the study. .

3.3.4 Data Collection

A semi-structured interview method was used to gather qualitative data from RACF migrant care workers from the identified three population groups from April 2019 to December 2019. This interview method is commonly used in qualitative research as it involves the use of predetermined questions and provides an opportunity for the researcher to seek clarification (Holloway & Galvin, 2016).

A set of questions was developed based on the research questions, literature review and quantitative survey findings in alignment with the explanatory sequential mixed-method design to guide the interviews questions, which can be found in Appendix K. A semi-structured interview approach was chosen as it allows a participant's experience or thoughts to be deeply probed (Taylor, 2005) and to identify and better understand the underlying concepts of their knowledge of dementia and care experiences. A semi-structured interview may also allow them to communicate freely and provide detailed information about their working conditions in Australian RACFs.

While the national survey conducted in Phase One consisted of closed-ended questions that limited the extent of the responses provided by the survey respondents, the individual interviews allowed the participant to elaborate more comprehensively on their understandings and knowledge of dementia, dementia care experiences, and mental health. The survey findings also assisted in highlighting specific relevant issues and concerns of interest to the researcher (Hesse-Biber, 2010) among participants. For example, the researcher further explored the factors exacerbating acculturation stress based on the survey findings. Given the participants were from culturally and linguistically diverse backgrounds, the researcher explained and rephrased the questions cautiously to ensure that participants understood the questions.

3.3.4.1 Interview Process

The researcher's skills and experiences were key elements to collecting quality data in the qualitative data process (Whiting, 2008). The researcher has the skills and has conducted qualitative interviews in her previous roles as a research assistant. Additionally, it was imperative to consider

participants' comfort in an interview environment because factors such as background noise, weather, and room temperature may have negatively affected the data collection process and the quality of data gathered (Doody & Noonan, 2013). The interviews were conducted face-to-face and over the telephone at participants' preferred locations, including their workplaces, homes, and the university library and seminar rooms.

Building on previous literature findings, a telephone interview was used in conjunction with a face-to-face interview in this current study to allow participants who wished to participate in the study but did not have time to meet the researcher because of their work schedule or geographical location (Smith, 2005) to do so. Findings on the quality of qualitative data obtained through telephone interviews when compared with face-to-face interviews are inconsistent in the literature and there is no evidence to show significant differences between the two methods (Glogowska, Young, & Lockyer, 2011; Smith, 2005).

Prior to commencing face-to-face interviews, the researcher gave information sheets to participants and encouraged them to ask questions relating to their participation and the research study before signing the consent form. A week before the phone interview, the researcher emailed the information sheets and consent form to participants that requested to be interviewed over the telephone. Verbal consent was provided by participants over the telephone on the day of the interview. The researcher asked participants if the interviews could be audio-recorded to ensure accuracy and to complete verbatim recording of the researcher's questions and participant's responses and all participants agreed.

Consistent with Whiting (2008) recommendations, interviews lasted between 30 and 60 minutes. The researcher utilised the time to maximise the collection of quality data through the phases of rapport building, reducing apprehension, exploring participants' views through prompting, and facilitating cooperation and full participation (Whiting, 2008). While participants were informed that the interview would take a maximum of 60 minutes, the researcher ensured that this timeframe was maintained by using open-ended questions and prompts, which encouraged participants to elaborately express their experiences (Whiting, 2008). Using open-ended questions also encouraged in-depth conversations with the participants (Doody & Noonan, 2013). Some interviews (two) exceeded 60 minutes because the researcher needed to create a good rapport with the participants to allow them to express their feelings in greater depth.

Data saturation is a criterion for discontinuing data collection in qualitative research (Saunders et al., 2018). Data saturation occurs when data collection reaches a point where no new information emerges from the data collection process and participant accounts become repetitive (Saunders et

al., 2018). However, data saturation was not the only guiding principle for the qualitative interviews, as the purpose of the qualitative interviews was to corroborate the national cross-sectional survey findings. The researcher ensured that the research questions were thoroughly explored by initially conducting 16 interviews to elaborate on the quantitative findings and then conducting an additional four interviews to explore participants' perceptions of the Royal Commission Aged Care Quality and Safety enquiries on the level of care in RACF and its impact on their care delivery in RACFs.

3.3.5 Data Analysis

All recorded audio interviews were transcribed verbatim. Identifying information was removed from transcriptions and participant numbers were allocated to each transcript. The interviews were transcribed by a professional transcription service (Triple A Transcription Service).

A thematic analysis approach was utilised to analyse the qualitative data (Braun & Clarke, 2006). "Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke 2006, p. 79). The researcher utilised an inductive approach in analysing the data. In the inductive approach themes identified are strongly linked to the data (Braun & Clarke 2006). This approach uses detailed readings of raw data to derive concepts and themes (Braun & Clarke, 2006). The analysis was conducted according to the six steps of thematic analysis outlined by Braun and Clark (2006) as shown in Table 3.3.

The qualitative data were coded using NVivo 12 software. The researcher independently reviewed all transcripts under the guidance of the supervisors. All the transcripts were coded into themes. Theme development was informed by the research questions using keywords, phrases, and sentences. An iteration process involving a discussion between the researcher and the supervisors occurred in resolving discrepancies that emerged during the phases of thematic analysis. Constant comparison was applied to examine similarities and differences between groups (Glaser & Strauss, 1967).

Table 3.3 Phases of thematic analysis

Phase	Description of the process
1.	**Data familiarisation**: transcribing data, reading and re-reading the data, noting initial ideas from data
2.	**Generating initial codes**: systematic coding of the data, collating data relevant to each code
3.	**Themes searching** collating codes into potential themes, gathering all data relevant to each potential theme
4.	**Reviewing themes**: Checking if the themes work aligns with the coded extracts and the entire data set, generating a thematic map of the analysis
5.	**Defining and naming themes**: ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme
6.	**Report of the analysis**: selection of compelling extract examples, the final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Braun & Clarke. Using thematic analysis in psychology. Qualitative research in psychology. (2006, p. 87)

3.3.5.1 Familiarisation with the data

Understanding the interview transcripts is essential in the data analysis process (Braun & Clarke, 2006). The researcher (PhD candidate) listened to the audio interviews several times and reviewed the transcripts to be immersed in the data before searching for themes and patterns after transcription of the six in-depth interviews were completed. The whole transcripts were read line by line several times to gain familiarity with the data and to align with an inductive data analysis process (Braun & Clarke, 2006). Additionally, short phrases were noted, as well as where ideas for coding occurred. The transcripts were compared with the reflective notes that were gathered during the interviews, and inconsistencies found in the typed transcripts were corrected.

3.3.5.2 Generating initial codes

The typed transcripts were imported into NVivo12© (QSR International Pty Ltd) to assist with the process of analysing the data. The analytical categories were created while reading the words, sentences, and expressions from the transcripts. This process, referred to as "coding", enabled the researcher to reduce the dataset into several meaningful sections. Coding involves a systematic and cautious reading of the transcribed text to identify the description and meaning of data in different

segments (Tuckett, 2005). It is used to identify similarities in participants' experiences. Reading and re-reading the transcripts allowed the researcher to retain the original nuances of the participants' words. Additionally, the researcher identified data relevant to the research questions from each transcript and coded them by highlighting the phrases in the transcripts. Two supervisors (BB and PN) with expertise in qualitative research read the first five transcripts to ensure quality data were gathered, and they further read the remaining transcripts and provided constructive feedback to improve the breadth and depth of the analysis.

3.3.5.3 Searching for the themes

Consistent with Braun and Clark's (2006) approach, the researcher organised the coded data into potential sub-themes and themes. The themes that captured significant topics discussed by participants during the interviews were searched and identified. These included the participants' knowledge of dementia, pre-arrival dementia care experience, and decisions to stay or leave their jobs. Some of the codes fit together to form a sub-theme. For example, post-migration challenges such as the lack of social support and communication difficulties were collated into the sub-theme referred to as "work-related stressors". All codes were collated into broader sub-themes relevant to the in-depth interviews, discussions, and research questions to enable the researcher to explore the findings from Phase One (cross-sectional survey) in more depth.

3.3.5.4 Reviewing the themes

The data were re-read to determine the existing relationships both between other data and within the coded data (Tuckett, 2005). The created themes and sub-themes were also reviewed to ensure that they were representative of the coded data. Additionally, to ensure accuracy, the themes and sub-themes were also reviewed and agreed upon by the supervisors.

3.3.5.5 Defining and naming themes

This step involves recognising the context that each theme articulates and providing clear and concise names for the themes (Braun & Clarke, 2006). The core of each theme and sub-theme was identified and the aspect of the data that the themes and/or subthemes have captured was determined.

3.3.6 Report on the Analysis

This step entails the presentation of the findings to communicate the story of the analysed data collected and analysed. This process was achieved in the current study by selecting data excerpts from the transcripts that reflected the themes defined. The data excerpts were provided in an analytic narrative to provide a coherent and concise account of the participants' views and opinions on interview questions.

3.4 Rigour

Different qualitative researchers have rationalised the notion of conducting rigour in the qualitative study through different philosophical explanations and have argued that the rigour process in qualitative research should differ from quantitative research (Golafshani, 2003). The rigour of the qualitative component of this current study was assessed with the criterion of trustworthiness (Guba, 1981; Seale, 1999). The assessment of trustworthiness criteria was based on Lincoln and Guba's Four-Dimensions Criteria (FDC) (Forero et al., 2018). The FDC are credibility, confirmability, dependability, and applicability (Forero et al., 2018; Noble & Smith, 2015).

The FDC informed the process of conducting rigour in the qualitative study. The purpose of *credibility* is to establish the true value of the results based on participants' perceptions (Forero et al., 2018), while *dependability* aims to ensure consistency of the findings within the same cohort of participants or contexts (Forero et al., 2018). The purpose of *confirmability* is to ensure that interpretations of results are not influenced by the researcher's subjective interpretations and personal bias (Guba, 1981, p. 80). *Applicability* refers to the extent to which the results can be generalised to other contexts or settings (Forero et al., 2018).

To further enhance the trustworthiness of the qualitative study, the researcher utilised Creswell's (1998) essential strategies used widely by qualitative researchers to verify the criteria of trustworthiness. These strategies include: (1) prolonged engagement and persistent observation in the field; (2) triangulation; (3) peer review or debriefing; (4) negative case analysis; (5) clarifying researcher bias: (6) member checks; (7) rich, thick description; and (8) external audits' (Creswell, 1998, pg. 201-203). The two rigorous strategies used were external audits and peer debriefing.

In this current study, the researcher utilised a *peer debriefing* strategy by having the transcripts assessed by the two supervisors to verify the consistency of the results and accuracy of interpretation. *External audit* strategy was also used, where the researcher established an audit trail by keeping clear documentation of all research activities, developing a data collection process informed by the quantitative findings (Phase One).

C*larifying researcher bias* was another strategy used to enhance trustworthiness in this study. The researcher kept a reflective diary to constantly record assumptions made and to document interview details, particularly participants' behaviour. The content of the reflective notes was regularly discussed with the supervisors to clarify personal assumptions that might affect data collection and interpretations. This procedure enhanced the creditability and confirmability of the data collection and interpretation processes.

It is important to be rigorous in using this research design (Halcomb & Hickman, 2015). A rigorous

approach to mixed-method design is to illustrate and explain all phases of the mixed methods research process in a logical flow (Halcomb & Hickman, 2015) and demonstrate justifications in integrating both quantitative and qualitative processes (Creswell, 2003). The benefit of providing a visual model of the procedures that has a notation system that can document and explain the mixed-methods procedures has been expressed in the literature (Ivankova et al., 2006). Based on Ivankova and colleagues' recommendations (2006), the ten rules presented in Figure 3.2 illustrates a graphical logical flow and explanation of processes involved in the sequential mixed method design used in this study.

3.4.1 Triangulation

The researcher utilised triangulation of qualitative and quantitative findings to increase the validity and rigor of the research findings. Methodical triangulation uses more than one research approach in a study and can be considered across research methods or within methods (Bans-Akutey & Tiimub 2021). Methodological triangulation has been found to be beneficial in improving the rigor of findings, increasing validity and enhancing understanding of the studied phenomenon (Bekhet & Zauszniewski, 2012). Using the explanatory sequential research method and triangulation allowed more than one research approach to be used in this study and further allowed the researcher to validate findings from these two different study phases.

3.5 Ethical Considerations

An ethics approval (HRE 2017-0863) was obtained from the Curtin University Human Research Ethics Committee that classified this research study as low risk

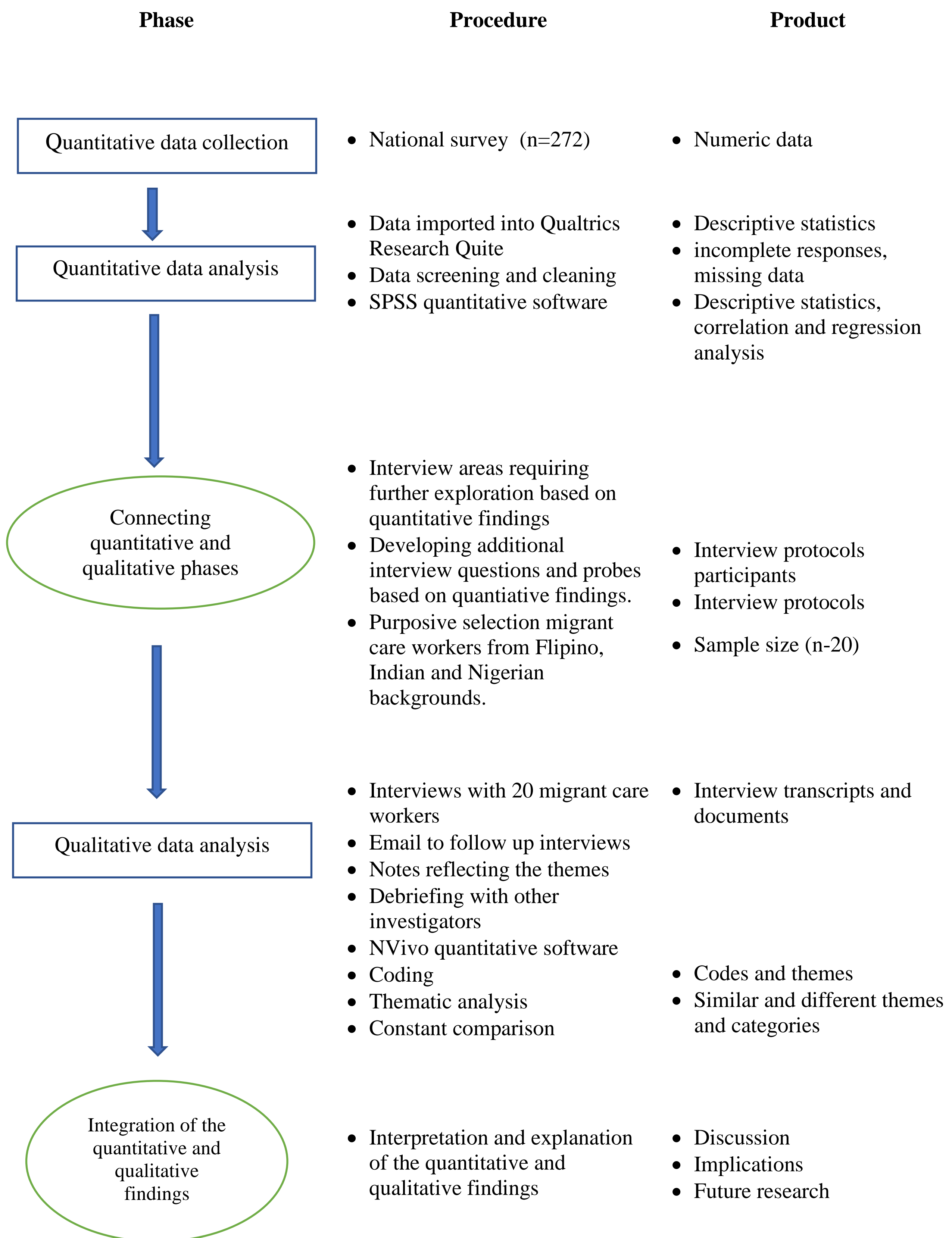
3.5.1 Informed Consent and Perceived Coercion

Voluntary informed consent is an integral ethical principle to research practice (Brear, 2018). It is a process of providing unbiased information to the study participants on the foreseeable risks and benefits of being involved in the research and allowing them to decide without coercion and undue influence (Brear, 2018). The researcher recognised that coercion or undue influence could arise from recruiting participants through RACF facility managers and university lecturers who hold figurative power. To address this issue, it was clearly outlined in participants' information sheets that participation is voluntary, and that the participants' identities and information would be kept confidential. Phase One participants' information sheet can be found in Appendix D and Phase Two in Appendix F.

Additionally, respondents that completed the survey via a paper questionnaire were asked to email their questionnaires back to the researcher (and not to their RACF supervisors or lecturers) using Curtin University pre-paid envelopes.

Written consent was impractical with online surveys. Consent was received from Phase One respondents by setting up an information sheet as the first page of the online survey and asking participants to tick a box to indicate consent before accessing the survey. Phase Two participants were provided with an information letter detailing the study design and activities, their rights as participants, confidentiality, and the contact details of the research and other investigators. Signed informed consent was obtained from the participants (see Phase Two participant's consent form in Appendix G).

Figure 3.2 Graphical illustration of the explanatory sequential mixed method design used in the study



Adapted from Ivankova, Creswell and Stick (2006). Using Mixed-Methods Sequential Explanatory Design: From Theory to Practice

3.5.2 Privacy and Confidentiality

Quantitative data were collected without the respondents' names to ensure anonymity. The completed paper questionnaires were stored in a locked drawer in the researcher's private office during the data collection process . Completed paper questionnaires were coded to maintain the confidentiality of data. The data were entered into a password protected computer.

For the qualitative data, participants' personally identifiable information was removed from the transcribed files. Personal information of participants was not used in the publications. To respect participants' privacy participants were asked to contact the researcher directly to express interest in participation and to select the venue for an interview. The qualitative interviews conducted in the participants' workplace (RACF) took place in a private room. Participants' colleagues and supervisors were not present during the interviews, which allowed participants to express their opinions freely.

3.5.3 Harm Minimisation

The study is a low-risk research study; minimal potential harm or risks were foreseen in this study. However, potential risks of distress and embarrassment when discussing questions with some participants was foreseen. If this situation occurred, participants were advised to call a free and confidential helpline (Lifeline 13 11 14). This number is for crises support and suicide prevention.

3.6 Data Storage

Electronic data were stored on a secure Curtin University server (Research R: drive). Access to all electronic data, including data obtained from the national survey and qualitative interviews, was restricted to research team members only. All electronic data (quantitative data in Qualtrics and qualitative data in NVivo12© databases) were stored on a password-protected computer without identifiers and were accessible to the researcher. The hard copies of signed consent forms and completed demographic questionnaires were scanned into electronic form and stored on the password-protected computer in a secure Curtin University server R drive accessible to the researcher and Curtin University-based supervisors. The hard copies were destroyed according to the Australia Code for the Responsible Conduct of Research and Curtin University Research Data and Primary Materials Policy for seven years after the completion of the study. The data gathered will only be used for the purpose of this study as consented to by participants.

3.7 Summary of the Chapter

This chapter has provided the rationale for the study design and the qualitative and quantitative methods used in the study. The process of integrating quantitative and qualitative studies was delineated. In addition, different strategies and criteria applied to enhance the study rigour were discussed. The next chapter describes the results of the quantitative data from the RASI and DASS self-administered questionnaire to highlight the impacts of acculturation stressors on the well-being of migrant care workers.

Chapter Four The Psychosocial Wellbeing of Migrant Care Workers of Residents with Dementia

4.0 Overview of the Chapter

This chapter includes a manuscript published in the peer-reviewed *Journal of Transcultural Nursing*.

Paper 2: Adebayo, B, Nichols, P, Albrecht, AM, Brijnath, B and Heslop, K (2020). Investigating the Impacts of Acculturation Stress on Migrant Care Workers in Australian Residential Aged Care Facilities. *Journal of Transcultural Nursing*. 1043659620947810.

In this chapter, a brief discussion of the concept of acculturation stress and mental health is delineated. This chapter summarises respondents' sociodemographic characteristics and their levels of English proficiency, including their level of fluency, understanding, communication, and comfort communicating in English. Additionally, the levels of acculturation stress and mental health of the study participants are determined. Associations between acculturation stress and mental health are also explored to examine the impact of acculturation stress on migrant care workers' well-being.

4.1 Background

Acculturation is a crucial adaptation process for migrants in their settlement countries. The process of acculturation often requires the acquisition of the language, behavioural norms, and values of the settlement countries (Rogler, Cortes, & Malgady, 1991). This process can be stressful (Berry, 2005) for some individuals and can offer life-enhancing opportunities for others (Lorraine Brown, 2009). Factors associated with higher levels of acculturative stress include lower levels of education, lower levels of engagement in a second culture, lower levels of language competence, the level of acceptance of diversity of the host country, pre-immigration history, socioeconomic status of the migrant, social and family support, and one's perceived ability to deal with the culture-specific life stress (Berry, 2005).

The concept of acculturation originated from anthropological studies on Indigenous peoples and sociological research on migrant cohorts. According to Redfield et al. (1936) cited by Caplan (2007), "Acculturation is defined as the process of social and psychological exchanges that take place when there are ongoing encounters between individuals of different cultures, with subsequent changes in either or both groups" (Caplan 2007, p. 2).

According to Caplan (2007), acculturation stress has three domains that are interrelated and should not be viewed as discrete entities. These three domains are (1) instrumental/environmental stressors;

(2) social/interpersonal stressors; and (3) societal stressors (Caplan, 2007). Instrumental or environmental acculturation stress relates to difficulties in obtaining daily essentials, including financial needs, language proficiency, employment, and safe working conditions (Caplan, 2007). Social and/or interpersonal stressors include changes in relationships, roles, behaviours, and cultural norms occurring as a result of the migration process. For example, loss of social networks and social status, and loss of family cohesiveness or family support and intergenerational conflict (Caplan, 2007). The third acculturation stress domain, which is societal stressors, included discrimination, political and historical events, and stressors related to undocumented migrants or asylum seekers (Caplan, 2007).

Migrant care workers could experience different types of acculturation stressors; for instance, environmental stressors such as communication difficulties and negative employment outcomes (McGregor, 2007) have been widely documented in the literature. Social stressors such as loss of social network and the lack of family support are common among migrants, and not only those working in the aged care sector (Goel & Penman, 2015). Previous studies show that migrant care workers experienced discrimination, which is a form of societal stressor in their workplaces (Timonen & Doyle, 2010; Walsh & Shutes, 2013). Additionally, contextual factors influencing the domains of acculturation stress are migrants' psychological characteristics and coping mechanisms, migration and socioeconomic status, and level of acculturation (Caplan, 2007). Thus, the experiences of acculturation stress vary across each migrant population and individuals, and the impact of acculturation stress and health outcomes is therefore multifaceted.

Acculturation stress can have negative effects on the mental health of some migrant workers. Research shows an association between acculturation stress and a range of negative health outcomes, such as depression, suicide ideation, alcohol abuse, and self-reported physical health problems (Doucerain, Varnaamkhaasti, Segalowitz, & Ryder, 2015). Internationally, research has focused on the acculturation experiences of nurses mainly from Asian backgrounds and working in hospitals, with findings showing high acculturation stress in this population group (Ma, Quinn Griffin, Capitulo, & Fitzpatrick, 2010). However, there is a dearth of literature on the impacts of acculturation stress on migrant care workers from other nationalities, especially those employed in RACFs.

Additionally, studies reporting the impact of acculturation stress on the mental health of migrant populations in Australia and internationally are few and show inconsistent results (Liddell, Nickerson, Sartor, Ivancic, & Bryant, 2016) (Xiao, Liu, Yao, & Wang, 2019). Liddell et al. (2016) found that migrants that chose to migrate to other countries, such as skilled migrants, have better health compared to native-born individuals. The reasons are that this group of migrants undergo

health screening before migrating to their resettlement countries (Liddell et al., 2016). On the other hand, Saraga et al. (2013) argue that migrants are less likely to have good mental health because of their pre-migration negative experiences.

The main aim of this study was to examine the psychosocial well-being of migrant care workers in RACFs. The objectives were to investigate the levels of mental health and acculturation stress of migrant workers caring for people with dementia in Australian RACFs and to determine the impacts of acculturation stress on migrant care workers' well-being in Australia. This chapter addresses research questions 4, 5, and 6 outlined in chapter one.

4.2 Results

4.2.1 Sociodemographic Characteristics of Phase One Participants (N=272)

Three hundred and nineteen respondents participated in the national cross-sectional survey. Forty-seven (14.7%) of surveys were incomplete and contained missing data, where the respondents started the survey but did not complete it or provided no responses to some questions. When the data from completed surveys (n=272) were compared to uncompleted surveys, there were no differences in demographic characteristics, which indicated no group differences. Only the 272 completed surveys were included in the final analysis

Respondents originated from 46 nationalities across five continents, namely Asia, Africa, Europe, and North and South America. The top five countries of birth were Nigeria(15.9 %) , India (11.1%)4), Philippines (9.2%) () and Kenya(8.5%) Table 4.1 shows the nationalities of all respondents that participated in the national cross-sectional survey. The sociodemographic characteristics of the participants is outlined in Table 1 of the published manuscript (Paper 2). There were few responses from some nationalities; therefore, to obtain a robust result, the researcher collapsed the sparse data into a single category (DiStefano, Shi, & Morgan, 2020) labelled as "others" as shown in Table 4.1in the published manuscript. The "others" category (n=25, 9.2%) included Anglo-Saxons/Europeans Oceania/Pacific Islanders and South and North Americans. Participants from European countries including Croatia, Lithuania, Poland, and Yugoslavia, where English is not their first language, identified their ancestry as Anglo-Saxon.

Twenty-one identified their occupational role as "others". These included social worker (3), specific dementia carer (4), occupational therapist (2), physiotherapist assistant (4), student nurse (2), clinical facilitator (1), lifestyle assistant (1), facility manager (2), geriatrician (1), and aged care workplace trainer (1).

In relation to respondents' self-reported highest education qualifications, almost half (40.4%)

possessed a bachelor's degree and 17.6% had a post-graduate degree. Nearly one-fifth (18.8%) of the respondents had certificate (Cert 111 and IV)[5] qualifications. Nearly 40% had lived in Australia for less than five years and 17.6% had lived in Australia between 11 to 15 years. Over half of the respondents (56.7%) had worked between one and six years in the aged care sector. Less than 2% had worked in this sector for over 21 years. Nearly half of the respondents (48.5%) were Australian citizens and less than a quarter (15%) were on a student visa, and less than 5% were on temporary skilled visas.

4.2.2 English Proficiency

The self-reported level of English proficiency of the study respondents that completed the survey are presented in Figure 4.1 - Figure 4.4. As shown in Figure 4.2, over half (51.1%) of the respondents reported that they were very fluent in English, 37.5% were mostly fluent, and 10% reported being slightly fluent in English. Over two-thirds (65.3%) reported "mostly understanding English". Nearly half of the respondents could communicate in English (46.9%) "all the time". While a similar percentage (48.7%) communicated in English "mostly often". Less than 1% (0.4%) did not often communicate in English. In relation to the respondent comfort in communicating in English, two-thirds (60.7%) were comfortable, less than 5% were slightly comfortable, and less than 1% reported not being comfortable in communicating in English (Figure 4.4)

The current study findings relating to the levels of acculturation stress and mental health of the study participants, and the associations between acculturation stress and mental health, are discussed in the published manuscript.

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[5] Certificate qualification qualify individuals to undertake skilled work, in this context aged care, and apply a broad of knowledge and skills. Certificates are available in four levels with Certificate 1 being most basic and Certificate IV most advanced with in-depth content.

Table 4.1 Respondents' countries of birth

Country of origin	Frequency (n)	Percent (%)
Bangladesh	1	0.4
Bhutan	1	0.4
Botswana	1	0.4
Burundi	1	0.4
Chile	1	0.4
China	9	3.3
Colombia	1	0.4
Croatia	1	0.4
Ethiopia	7	2.6
Fiji Island	5	1.8
Ghana	6	2.2
Guinea	1	0.4
Hong Kong	1	0.4
India	30	11.1
Indonesia	7	2.6
Ireland	2	0.4
Israel	1	0.4
Italy	1	0.4
Japan	5	1.8
Kenya	23	8.5
Liberia	6	2.2
Lithuania	1	0.4
Malaysia	2	0.7
Mali	1	0.4
Nepal	18	6.6
Nigeria	43	15.9
Peru	1	0.4

Country of origin	Frequency (n)	Percent (%)
Philippines	25	9.2
Poland	1	0.4
Rwanda	1	0.4
Scotland	1	0.4
Senegal	1	0.4
Sierra Leone	11	4.1
Singapore	1	0.4
South Africa	3	1.1
South Korea	2	0.7
South Sudan	8	3.0
Sri Lankan	1	0.4
Sudan	5	1.8
Taiwan	1	0.4
Thailand	1	0.4
Tongan	1	0.4
UK	1	0.4
Ukraine	2	0.7
Yugoslavia	3	1.1
Zambia	8	3.0
Zimbabwe	18	6.6
Total	272	

Figure 4.1 Respondents Level of understanding in English

Figure 4.2 Respondents Level of English Fluency

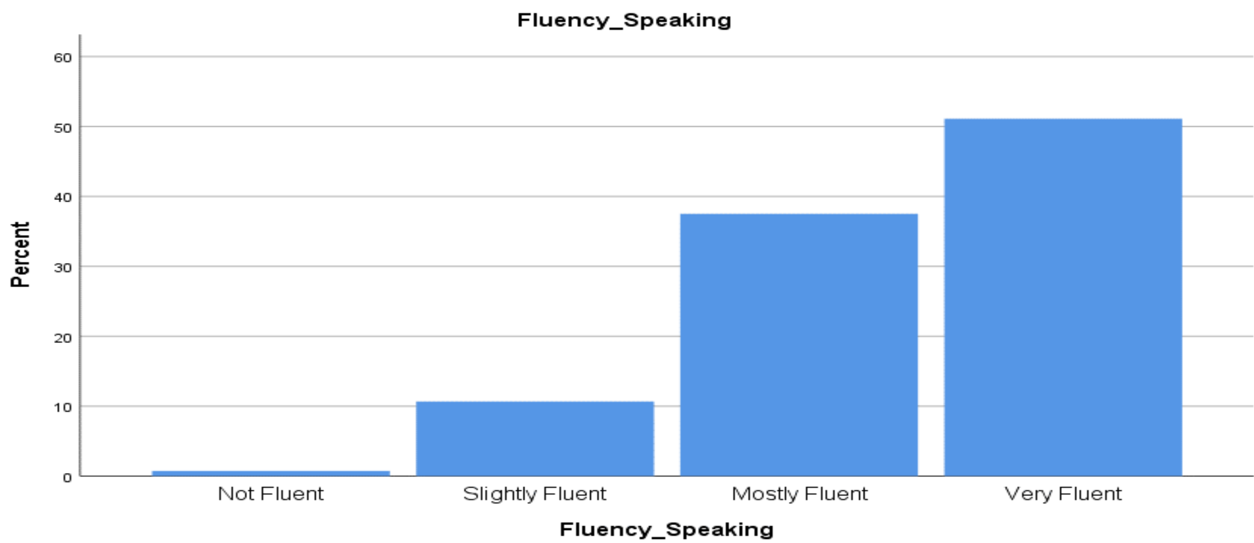


Figure 4.3 Respondents level of communication in English

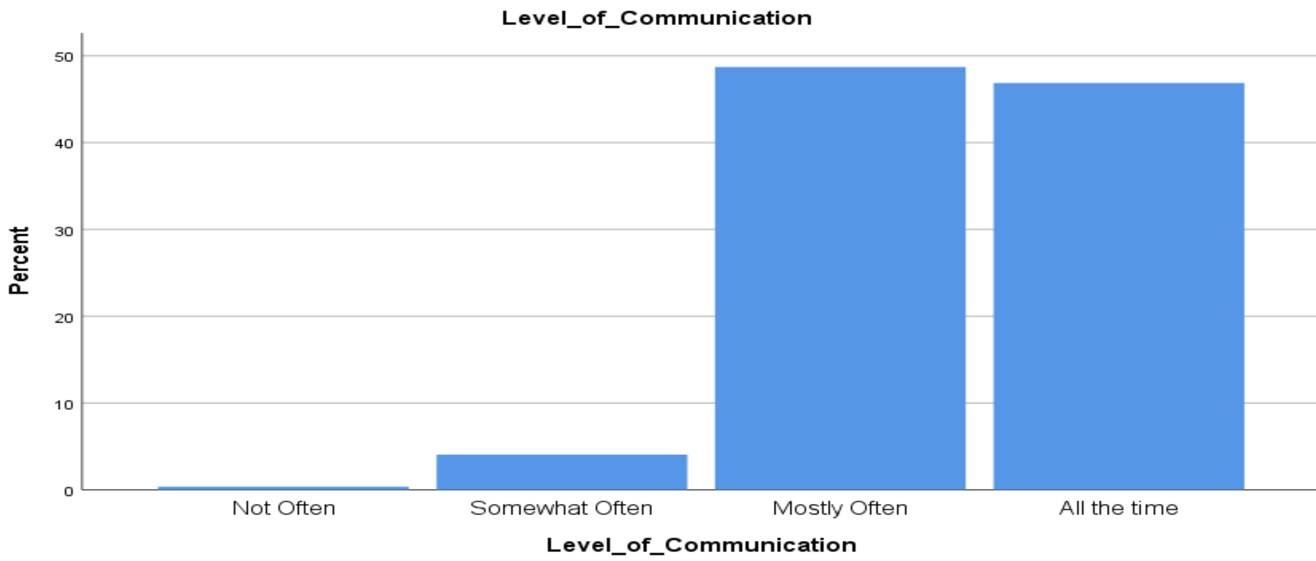
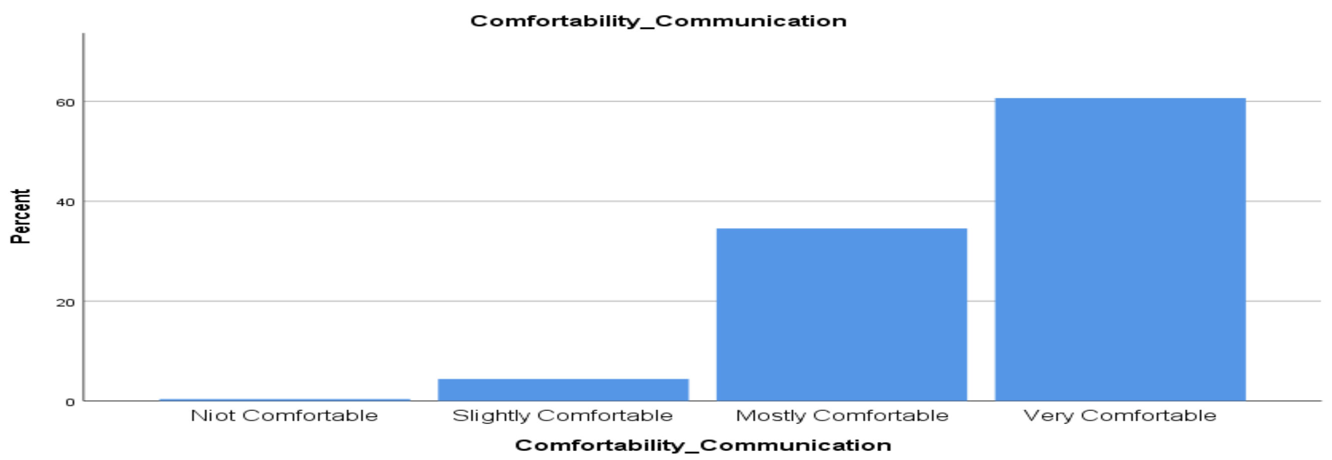
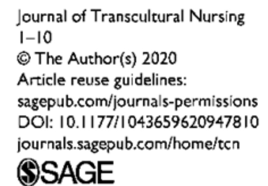


Figure 4.4 Respondents level of comfortability in English



4.3 Manuscript – Paper 2

Research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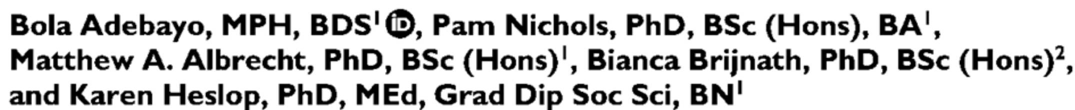
Investigating the Impacts of Acculturation Stress on Migrant Care Workers in Australian Residential Aged Care Facilities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Abstract

Introduction: Migrant care workers are a growing portion of the aged care workforce in high-income countries. This study investigated the impacts of acculturation stress on the well-being of migrant care workers. **Method:** A cross-sectional national survey was conducted among migrant care workers (n = 272) across five Australian states and one territory using the Riverside Acculturation Stress Inventory (RASI) and Depression Anxiety Stress Scale (DASS 21). **Results:** Acculturation stress was high (M = 38.4; SD = 14.1; 38.9% scored ≥40 out of 75), but respondents scored in the normal to mild ranges (85% to 93%) on the DASS 21 scale. Enrolled and registered nurses had the highest acculturation stress levels when compared with other occupational roles. Ethnicity, $F(4, 254) = 11.0$, $p < .001$; occupational roles, $F(3, 254) = 3.0$, $p = .03$; and self-reported English proficiency, $F(1, 254) = 4.17$, $p = .04$, were statistically significant. **Conclusions:** Addressing acculturation stress may improve job satisfaction and retention among migrant care workers.

Keywords

transcultural health, work force diversity, gerontology

Introduction

Migrant workers are individuals of foreign nationality working outside their home country in skilled and unskilled jobs (Noor & Shaker, 2017). Care workers from migrant backgrounds have made significant contributions to the aged care sector in high-income countries such as Australia, the United Kingdom and the United States by addressing the gaps in staff shortages in this sector (Stone, 2016). Evidence shows that approximately one in five care workers in the United States, and one in four care workers in Canada and Australia are foreign-born (Fujisawa & Colombo, 2009; Stone, 2016). According to the 2016 Australian aged care workforce statistics, the occupational distribution of the migrant care workforce in residential aged care facilities (RACFs) is broadly similar to that of the overall Australian RACF direct care workforce. They are predominantly women comprising registered (19.8%) and enrolled (6.8%) nurses as well as patient care assistants (70.3%; Mavromaras et al., 2017).

Migrants may experience psychological and cultural changes as a result of their continuous exposure to a second culture, a process known as acculturation (Berry, 2005; Miller et al., 2011). Acculturation can be a stressful process for some migrants (Berry, 2005), as a result of culture-specific stressors such as low levels of engagement in a second culture, limited language proficiency, and low levels of acceptance of diversity in the settlement country (Miller et al., 2011). Other contributing factors include preimmigration history, socioeconomic status of the migrant, low levels of education of the migrant, social and family support, and an individual's perceived ability to deal with the stressful conditions (Berry, 2005).

The ageing population in high-income countries concomitantly with an increase in the number of residents in aged care facilities with cognitive impairments such as dementia have contributed to increased dependency on RACFs (Fleming & Purandare, 2010). This has resulted in an increased demand for care workers who, regardless of their backgrounds, are considered the backbone of RACF due to their roles in providing essential care and support for residents (Fleming & Purandare, 2010). Caring for residents with cognitively impaired such as dementia can be challenging for workers due to the physical and mental demands associated with care provision for these residents and may affect staff job

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satisfaction (Etters et al., 2008). In conjunction with their dementia care role, migrant care workers may experience additional stressors such as acculturation stress, which may affect their psychosocial well-being, capacity to provide quality care to residents and the level of their job satisfaction, as well as the rate of staff turn-over in RACFs. However, both internationally and in Australia, few studies have investigated the impact of acculturation stress on RACF migrant care workers' well-being.

Migrant care workers, particularly overseas-trained health practitioners such as general practitioners, nurses and other allied health workers, face challenges in adjusting to their settlement countries' workplace culture (Jeon & Chenoweth, 2007). They often experience prejudice and stereotyping because of their cultural differences, from residents and coworkers from the dominant culture as well as stressful working conditions (Nichols et al., 2015). For example, a U.K. study reported that more than 30% of migrant care workers in RACFs worked more than 40 hours per week, compared with 18% of U.K.-born care workers (Shutes, 2012). Participants in this U.K. study also reported working overtime and having limited control in choosing their shifts (Shutes, 2012). A higher proportion (74%) of migrant care workers were also engaged in shift work compared with U.K.-born care workers (60%; Shutes, 2012). These challenges often lead to social isolation, and job dissatisfaction (Jeon & Chenoweth, 2007). The demands of immigration, such as challenges to identity, values and loss of family support, may further contribute to a greater amount of cumulative stress for migrant care workers not born and not educated in the settlement country (Connor & Miller, 2014).

Migrant care workers from culturally diverse backgrounds are not a homogenous group and are differ by factors such as birthplace, cultural values, education, and work experience (Hugo et al., 2011). Therefore, it is essential to consider these differences between migrant groups. The purpose of this study was to investigate the impacts of acculturation stress on the well-being of migrant care workers in residential aged care facilities. The research questions were as follows:

> **Research Question 1:** What are the levels of acculturation stress in RACF migrant care workers' and how does it relate to their sociodemographic characteristics?
> **Research Question 2:** What is the state of RACF migrant care workers' mental health and how it differs by sociodemographic diversity?
> **Research Question 3:** What are the predictors of acculturation stress?

Method

Study Design

This study is part of a large mixed-methods study examining migrant care workers' knowledge of dementia, care experiences, psychosocial well-being, and working conditions in RACFs. A cross-sectional national survey of migrant care workers was conducted between March 2018 and April 2019. Findings related to the psychosocial well-being of RACF migrant care workers are reported in this article.

Sample

Respondents across five Australian states (Western Australia, South Australia, New South Wales, Victoria, and Queensland) and one territory (Australian Capital Territory) participated in the national survey. Respondents were recruited through a purposive sampling method from RACFs, ethnic groups, peak bodies in the aged care sector and multicultural support service organizations across Australian metropolitan major cities. RACF workers from migrant backgrounds, born overseas, aged 18 years and older, and currently employed, or having previously worked in the past 5 years in an Australian RACF were invited to participate in the survey. Care workers who were second- or third-generation migrants (i.e., Australian-born individuals with at least one parent or grandparent born overseas) were excluded from the study.

Data Collection

The researchers sought support from residential aged care services, ethnic groups, and peak bodies in the aged care sector such as Alzheimer WA, Australian Association of Gerontology and multicultural support service organizations across Australian states and territories. Advertisements were distributed via emails and social media, including Facebook, WhatsApp mobile apps, and LinkedIn. Respondents completed the survey through an online format or paper questionnaire. A survey link was sent to participants that requested an online survey. At the beginning of the survey was a short explanation outlining study purpose, potential benefits and discomforts, statements on participants' confidentiality and rights involvement of the participants. Respondents were asked to read the information and indicate their consent by ticking a box, "Yes, I consent "to proceed with participation." Those who declined to participate were asked not to complete the survey.

The paper questionnaires were posted to the participants who requested this format. The questionnaires were collected 2 weeks after their distributions. Data were collected without the respondent names to ensure anonymity. Hard copies were stored in a locked filing cabinet and electronic data were stored on a secure server, only accessible to the researchers. The survey questionnaire was tested with RACF migrant care workers (n = 20) across different ethnicities in the pretest phase of the research study. Respondents were asked to provide feedback in relation to the content of the questionnaire. They provided positive feedback and described the questions as easy to understand.

Measures

Sociodemographic Characteristics. Respondents provided sociodemographic information including age, sex, ethnicity, state of residence, duration in Australia, education qualifications, and current visa status. Occupation-related questions, including respondents' role in the RACF, duration in the occupational role, and their length of employment in the aged care sector were measured.

English Proficiency. In Australia, frontline aged care workers are predominantly patient care assistants (PCA), registered and enrolled nurses. The minimum vocational qualification to work in the aged care sector as a PCA is a Certificate 3 in aged care (Mavromaras et al., 2017). This qualification is delivered in the English Language and its prerequisite is a capacity to communicate in English to a professional standard. Concerning, the overseas trained registered and enrolled nurses, they are required to pass an English test before they can register as a practicing nurse in Australia. For these reasons, our study participants were expected to be proficient in English Language and an interpreter was not deemed necessary for this study.

Nevertheless, respondents' levels of English proficiency was assessed using self-reported English proficiency questions previously used among international students to assess their levels of English proficiency (Yeh & Inose, 2003). Respondents were asked to self-report their English proficiency according to four items, measured on a 4-item scale: (1) " How fluent are you in speaking English," (2) "How good are you at understanding spoken English," (3) "How often do you communicate in English," and (4) "How comfortable are you in communicating in English." The item responses ranged from 0 (*not fluent*) to 4 (*very fluent*) for Item 1; Item 2 from 0 (*not good*) to 4 (*very good*); Item 3 from 0 (*not often*) and 4 (*all the time*), and Item 4 from 0 (*not comfortable*) to 4 (*very comfortable*).

Acculturation Stress. The Riverside Acculturation Stress Inventory (RASI) is an acculturation scale developed by Benet-Martínez and Haritatos (2005). It comprises 15 items, which focus on culture-related challenges in five life domains (Miller et al., 2011). These are (1) language skills, (2) work challenges, (3) intercultural relations, (4) discrimination, and (5) cultural isolation (Annear et al., 2015). Responses are measured on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores indicate greater acculturation stress. RASI can relate to different culturally diverse populations and focus on culture-specific challenges among migrant populations (Miller et al., 2011). The RASI questionnaire has been successfully used and validated in a quantitative study that examined the impact of acculturation stress in migrants from Asian backgrounds (n = 793) in the United States with a total score internal consistency estimate of .84 (Miller et al., 2011).

Depression, Anxiety, and Stress. Depression, anxiety, and stress were measured by Lovibond and Lovibond's short version of the Depression Anxiety Stress Scale (DASS 21). The DASS 21 is a self-report measure that allows participants to rate the frequency and severity of experiencing negative emotional states, namely depression (DASS-D), anxiety (DASS-A), and stress or tension (DASS-S; Oei et al., 2013). Each category consists of seven questions about symptoms experienced over the past week and scoring is on a 4-point scale from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*). Higher subscale scores indicate more severe symptoms in each dimension. The DASS 21 has been used in general population studies and culturally diverse population studies including four prevalent racial groups in the United States, which are African Americans, Asians, Caucasians, and Hispanics (Norton, 2007) and migrants from South Asian backgrounds in Hong Kong (Tonsing, 2013). Psychometric properties of the DASS 21 reported high reliability and high convergent validity with the reliability of the scale ranging from .81 for depression, .73 for anxiety, and .81 for stress (Lovibond & Lovibond, 1995).

Data Analysis

Data were entered into SPSS version 25.0 (IBM Corp., 2017). Descriptive statistics were used to report demographic items. The mean total RASI scores for age, gender, occupational role in RACFs, duration in Australia, ethnicity, educational qualifications, and duration in the aged care sector were compared using one-way analysis of variance tests. The assumptions of homogeneity of variance were tested using Levene's test. In order to better understand factors that could be related to the acculturation stress, the nonparametric Spearman's rho (ρ) was determined to identify correlations between the selected sociodemographic and RASI subscales. Following this, Spearman's correlation tests were conducted to identify associations between DASS and RASI subscales as DASS scores were skewed (Mukaka, 2012). Finally, a multiple linear regression analysis was conducted to determine the association between acculturation stress as the primary outcome variable and the selected sociodemographic characteristics such as age, gender, duration in the aged care sector and in Australia, highest education qualification and the levels of English proficiency as predictors. Gender, occupational roles in RACFs, and ethnicity were treated as categorical factors, while the effects of age, duration in the aged-care sector, duration in Australia, level of education, and English competency were treated as ordinal variables using linear contrasts. The regression model was assessed for outliers using Cook's distance, multicollinearity by examining pairwise correlations, homogeneity of variance using Levene's test, and the residuals were inspected for normality and other patterns using plots of the residuals versus predicted and Q-Q plots. All data were considered statistically significant at the $p < .05$ level.

Ethical Considerations

The Curtin University Human Research Ethics Committee (HRE 2017-0863) approved the study.

Results

Characteristics of the Study Respondents

A total of 272 migrant care workers participated in the survey. The response rate was difficult to determine as the survey was distributed through multiple avenues across the nation and the total number of survey recipients was unknown. Respondents were from 46 nationalities across five continents namely Asia, Africa, Europe, North, and South America with the top five countries of birth being Nigeria (13.4%), Indian (9.4%), Filipino (7.8%), Nepal (5.6%), and China (2.8%). More than one third (39%) of respondents had lived in Australia for less than 5 years. More than 70% were 25 to 45 years of age, predominantly women (73.5%) and 72,8% were employed as patient care assistants (PCAs) with 11.8% employed as registered nurses (RNs) and 5.9% as enrolled nurses (ENs). A large proportion (40.4%) of the respondents possessed a bachelor's degree with 17.6% having postgraduate qualifications. These figures are consistent with the 2016 Australian aged care workforce statistics (Mavromaras et al., 2017) and also reflect the demographic profile of migrant care workers in high-income countries (Stone, 2016). More than 55% had worked between 1 and 6 years in the aged care sector. Respondents reported a high level of understanding of the English language (93.1%), and half (51%) reported to be very fluent in English.

Research Question 1: What are the levels of acculturation stress and how does it relate to their sociodemographic characteristics?

The overall mean score of acculturation stress as measured by the RASI was 38.4 (SD = 14.1) with a median score of 38, and 38.9% scoring 40 and higher out of 75. Table 1 presents the mean total RASI scores across each demographic variable. The nurses had the highest acculturation stress as indicated by higher mean scores on the RASI (ENs = 43.8 and RNs = 40.4) when compared with the mean scores for other occupational roles (PCAs = 37.8, Others = 37.1). Ethnicity, $F(4, 254) = 11.0$, $p < .001$; occupational roles, $F(3, 254) = 3.0$, $p = .03$; and self-reported English proficiency, $F(1, 254) = 4.17$, $p = .042$, were statistically significant as indicated in Table 1.

Table 2 illustrates the mean scores for the RASI subscales of work challenges, language skills, intercultural relations, discrimination, and cultural isolations. The Spearman's correlation analyses in Table 3 indicated negative correlations between duration of work experiences in the aged care sector with language skills ($\rho = -.12$, $p = .04$) and cultural isolation ($\rho = -.12$, $p = .04$). There were also negative correlations between age and discrimination ($\rho = -.12$, $p = .04$).

Research Question 2: What is the state of RACF migrant care workers' mental health and how it differs by sociodemographic diversity?

The majority of respondents scored in the normal to mild ranges (85% to 93%) on the DASS 21 subscales, as shown in Table 4. Few respondents reported moderate/severe/extreme levels of depression (7.2%), anxiety (12.1%), and stress (4.5%) respectively. Table 2 presents the total mean scores of depression, anxiety, and stress and the three subscales as measured by the DASS 21. There were no statistically significant associations between the sociodemographic variables and total DASS 21 scores or the three subscales.

Research Question 3: What are the predictors of acculturation stress?

Table 5 presents the results of multiple linear regression analysis for predicting acculturation stress as a function of demographic variables. The overall model was significant, $F(4, 254) = 10.9$, $p < .001$, indicating that demographic characteristics were associated with acculturation stress and accounted for approximately 18% of the total variance (adjusted R^2). Ethnicity and self-reported English proficiency were significant contributors to acculturation stress as shown in Table 5. There were no statistical significances in other demographic variables such as gender, age, education qualifications, duration of work experiences in the aged care sector and Australia.

There were statistically significant associations between the total DASS 21 score and total RASI scores ($\rho = .18$, $p = .003$), indicating that increased acculturation stress was related to the greater negative affective state. Looking more closely at RASI subscales, RASI-language skill stress was associated across all DASS 21 subscales, with Spearman's correlations ranging from .22 to .25 ($p < .001$). Additionally, there were weaker associations between cultural isolation and DASS-depression ($\rho = .13$, $p = .03$), anxiety ($\rho = .13$, $p = .02$) and stress ($\rho = .16$, $p = .009$). Intercultural relation also showed weak associations with DASS-depression ($\rho = .24$, $p < .001$), -anxiety ($\rho = .14$, $p = .02$), and -stress ($\rho = .13$, $p = .03$). There were no statistically significant associations between work challenges and DASS 21 subscales.

Discussion

The increased reliance on migrant care workers in high-income countries demands an explicit understanding of the dynamics of the current ethnically diverse aged care workforce and highlights the need to address challenges in this workforce. One such challenge in the migrant aged workforce is acculturation stress as a result of their exposure to the settlement country culture.

In this present study, the nurses (ENs and RNs) had the highest acculturation stress levels when compared to other occupational roles in RACFs. These findings support the

Table 1. Selected Sociodemographic Characteristics and Their Relationship to Acculturation Stress (N = 272).

Background characteristics	N (%)	RASI M (SD)	F	dfn	dfd	p
Sex			0.02	1	254	.86
Men	72 (26.5)	38.9 (14.0)				
Women	200 (73.5)	38.2 (14.2)				
Age, years			0.25	1	254	.61
18-25	27 (9.9)	37.7 (14.2)				
25-35	194 (71.3	39.2 (14.1)				
45-55	33 (12.1)	41.1 (13.1)				
≥56	18 (6.6)	25.4 (9.8)				
Ethnicity			11.04	4	254	<.001*
Sub-Saharan African	141 (51.8)	42.9 (13.4)				
South Asian	50 (18.4)	34.3 (13.1)				
Southeast Asian	38 (14.0)	33.6 (12.2)				
Northeast Asian	18 (6.6)	40.2 (12.7)				
Others	25 (9.2)	27.4 (13.6)				
Anglo-Saxon						
Oceania/Pacific Islander						
South and North American						
Role in RACF			2.89	3	254	.03*
Patient care assistants	198 (72.8)	37.8 (13.9)				
Registered nurses	32 (11.8)	40.4 (14.4)				
Enrolled nurses	16 (5.9)	43.8 (17.0)				
Others	26 (9.6)	37.1 (13.6)				
Facility manager						
Occupational therapist						
Dementia care specialist						
Highest education qualification			0.004	1	254	.95
Postgraduate degree	48 (17.6)	38.2 (14.7)				
Bachelor degree	110 (40.4)	37.8 (11.9)				
Diploma	49 (18.0)	39.8 (15.1)				
Certificate qualifications	50 (18.4)	36.7 (15.4)				
Completed year 12 and <year 12	15 (5.5)	45.2 (18.5)				
Duration in aged care sector			1.99	1	254	.15
6-12 months	41 (15.3)	37.6 (16.5)				
2-10 years	152 (56.7)	40.4 (13.1)				
11-20 years	70 (26.1)	36.2 (14.2)				
≥21 years	5 (1.9)	23.4 (7.87)				
Duration in Australia			0.53	1	254	.46
0-6 months	2 (0.7)	39.5 (2.1)				
1-5 years	106 (39.0)	38.1 (14.5)				
6-10 years	81 (29.8)	40.6 (14.2)				
11-15 years	48 (17.6)	38.7 (12.6)				
≥16 years	35 (12.9)	33.7 (14.5)				
Self-reported English proficiency (total scores)			4.17	1	254	.04*
Fluency		3.4 (0.70)				
Understanding		3.5 (0.62)				
Communication		3.4 (0.59)				
Comfortability in Communication		3.5 (0.59)				

Note. RASI = Riverside Acculturation Stress Inventory; RACF = residential aged care facility.
*p < .05.

U.S. studies that reported that migrant nurses' adjustments to their work routines in the settlement country can negatively affect their productivity (Ea, 2007; Jose, 2011) in their workplaces. Factors including the lack of familiarity with medical technologies and equipment, overwhelming paperwork and documentations and loss of confidence due to inability to finish nursing tasks and the hand over process to the incoming shifts were contributing stressors reported in a previous study (Ea, 2007). Nonwork stressors that could negatively affect their acculturation process include securing affordable

Table 2. Means, Median, and Standard Deviations of the Respondents RASI and DASS 21 Subscales.

Measure	*M*	*SD*	*Mdn*	Range
Acculturation stress				
Total RASI scores	38.4	14.1	38.0	0-75
RASI subscales				
Work challenges	9.5	3.7	10.0	0-15
Language skills	6.3	3.1	6.0	0-15
Intercultural relations	6.4	3.2	6.0	0-15
Discrimination	8.6	3.8	9.0	0-15
Cultural isolations	7.4	3.5	7.0	0-15
Mental health				
Total DASS 21 scores	7.1	8.1	5.0	0-46
DASS 21 subscales				
Depression	1.8	2.8	0	0-20
Anxiety	2.3	2.8	1.0	0-16
Stress	2.9	3.1	2.0	0-14

Note. RASI = Riverside Acculturation Stress Inventory; DASS 21 = Depression Anxiety Stress Scale.

accommodation, and negotiating routine tasks, for instance navigating the local transportation system (Jose, 2011) and difficulties in engaging with professional organizations were reported in the previous studies (Ea, 2007; Jose, 2011). The negative impact of stressors is not unique to migrant care workforce only, however, the intersection of nonwork stressors as a result of postmigration challenges and workplace stressors may affect their productivity (Goel & Penman, 2015).

A large proportion of our respondents have bachelor and postgraduate qualifications (58%) and are working as PCAs earning a salary level lower than their reported education qualifications and training. This finding is consistent with a Canadian study that reported that some migrant care workers employed as PCAs were previously trained as nurses or physicians in their native countries (Bourgeault et al., 2011). Participants in the Canadian study expressed their frustration at their inability to apply their medical qualifications acquired in their countries of birth. Although the PCAs scored lower on the RASI than the nurses in our study, these care workers are likely to be cognizant of their lower salary and lower work status and this could be a stressor that may negatively affect their socioeconomic status in Australia, their settlement country.

Our findings indicate English proficiency as one of the predictors of acculturation stress in RACF migrant care workers. This finding concurs with previous studies, which reported that communication difficulties between migrants, staff and residents from the dominant culture hampered their abilities to perform their duties in workplaces (Liou & Cheng, 2011; Ma et al., 2010). According to Liou and Cheng's (2011) U.S. study, the main sources of frustration and unhappiness in the workplace among migrant nurses of Taiwanese background stem from language and communication barriers. Language barriers included written and verbal communication difficulties, particularly in their interactions with other health care staff and with care provision, which eroded their self-confidence and ability to function in their managerial roles (Liou & Cheng, 2011).

In addition, our study findings indicate ethnicity as a predictor of acculturation stress. Notably, respondents from sub-Saharan backgrounds had the highest levels of acculturation stress when compared to other ethnicities (Table 1). This finding concurs with Irish (Doyle & Timonen, 2009) and U.K. (Alexis, 2015) studies that reported migrant care workers experiences of acculturation stressor in the form of discrimination was higher among specific groups in RACF, particularly those from African backgrounds compared with migrant care workers from Asian and European backgrounds. Discrimination is often expressed as racism, verbal abuse and professional isolation (Ma et al., 2010). Similarly, McGregor's (2007) U.K. study highlighted the difficulties among migrant care workers from Zimbabwe in obtaining aged care work and workplace discrimination after securing employment in that sector (McGregor, 2007).

Of particular note, our findings indicate a good level of mental health among migrant care workers in RACFs. The majority (85% to 93%) of the respondents reported having normal to mild levels of depression, anxiety and stress. The hypothesis of "healthy migrant effect and migration selection effect" (Liddell et al., 2016) could explain the good mental health of our study respondents. This hypothesis refers to migrants from low- and middle-income countries having better general health and mental health than the settlement country local populations, which are usually high-income countries (Renzaho, 2016). The hypothesis attributes immigration requirements, including good health status, economic potential, and educational qualifications to the positive adaptation to their new cultural and social environment (Kennedy et al., 2006). Potential migrant workers who are ill and chronically disabled are less likely to be granted work or permanent residence visa (Renzaho, 2016). However, there are mixed research findings on the healthy migrant effect hypothesis, as evidence also shows that the health advantage in migrant populations is inconsistent and not permanent (Renzaho, 2016).

Furthermore, our findings indicate weak associations between cultural isolation, discrimination, intercultural relations and mental health measures of depression, anxiety, and stress. However, these associations did not indicate clinical anxious-depressive and work-related stress symptoms, as our respondents indicated good mental health. Our finding concurs with previous studies that reported acculturation stress as a contributor to depression and stress in migrant workers (Anikeeva et al., 2010; Lee et al., 2012). However, our results did not show strong associations between acculturation stress, depression, and stress in migrant care workers as indicated in Lee et al.'s (2012) study. Their study

Table 3. Spearman's Correlations (ρ) Between Riverside Acculturation Scale Inventory Subscales and Respondents' Sociodemographic Characteristics.

	Riverside Acculturation Scale Inventory Subscales				
Sociodemographic	Lang skills	Discrimination	Cult isolation	Work challenge	Intercult relations
Age	.02 (.69)	−.12 (.04*)	−.08 (.18)	−.46 (.44)	−.03 (.56)
Highest education qualification	−.05 (.34)	.03 (.53)	.01 (.86)	−.19 (.75)	.01 (.89)
Duration in aged care sector	−.12 (.04*)	−.03 (.54)	−.12 (.04*)	−.10 (.09)	−.01 (.77)
Duration in Australia	−.11 (.06)	−.03 (.62)	−.90 (.10)	−.03 (.60)	.09 (.10)

Note. Values are presented as Spearman's rho (p value). Lang skills = RASI—Language skills; Discrim = RASI-Discrimination; Cult isolations = RASI—cultural isolations; Work challen = RASI-work challenges; RASI = Riverside Acculturation Stress Inventory.
*Correlation is significant at the .05 level (2-tailed).

Table 4. The Total DASS 21 Scores of the Respondents Who Completed the Survey.

Subscale	Normal	Mild	Moderate	Severe	Extremely severe
Depression	226 (84.7)	22 (8.3)	12 (4.4)	5 (1.8)	2 (0.8)
Anxiety	199 (74.5)	36 (13.4)	16 (6.0)	6 (2.3)	10 (3.8)
Stress	240 (89.9)	15 (5.6)	7 (2.7)	5 (1.8)	0

Note. Values are presented as number (percentage). DASS 21 = DASS 21 = Depression Anxiety Stress Scale.

Table 5. Summary of the Multiple Regression Parameter Estimates for Sociodemographic and English Proficiency Predictors of Acculturative Stress.

Variables	B	*SE*	*T*	*p*
Intercept	48.97	7.87	6.21	.000
Age	−.45	.93	−.48	.63
Gender—Male[a]	−.12	1.85	−.06	.94
Ethnicity—Sub-Saharan African[b]	16.05	3.15	5.08	<.001*
Ethnicity—Southeast Asian[b]	6.14	3.62	1.69	.09
Ethnicity—Northeast Asian[b]	12.97	4. 36	2.97	.003*
Ethnicity- South Asian[b]	6.87	3. 57	1.93	.05
Roles in RACF—Patient care assistants[c]	1.33	.88	1.49	.13
Roles in RACF—Registered nurses[c]	3.91	3.57	1.09	.27
Roles in RACF—Enrolled nurses[c]	1.38	4.27	.32	.74
Highest education qualification	−1.30	.80	−1.63	.10
Duration in aged care sector	−1.17	1.37	−.86	.39
Duration in Australia	.12	.99	.12	.90
Self-reported English proficiency	−.85	.42	−2.042	.04*
R^2 = .18				

Note. B = the standardized coefficient. Dependent variable is acculturation stress as measured by the RASI. RASI = Riverside Acculturation Stress Inventory; RACF, residential aged care facility.
[a]Base level for contrast = Female. [b]Base level for contrast = Others (see Table 1). [c]Base level for contrast = Others (see Table 1).
*$p < .05$ (statistically significant).

showed that Korean Chinese migrant workers in South Korea with high levels of acculturation stress were highly likely to experience depressive symptoms.

Our respondents self-reported good mental health could be as a result of migrant care workers' coping strategies such as overlooking racism and discrimination from the residents and being emotionally resilient to prejudice from their native-born colleagues, which was reported in a previous study (Nichols et al., 2015). This might have contributed to their low levels of depression, anxiety and stress despite the high acculturation stress they are experiencing. For example, an Italian study reported that migrant workers who had experienced racial discrimination and utilized avoidance coping strategies were less likely to suffer anxious-depressive disorders and work-related stress (Capasso & Zurlo, 2015).

Policy and Practice Implications

The aged care sector is one of the most ethnically diverse employment sectors in Australia (Mavromaras et al., 2017) with high rates of recruitment of migrant care workers aimed at addressing staff shortages in this sector. Awareness of migrant workers' resettlement challenges could facilitate improved interaction and engagement between employers and work colleagues from the dominant culture and migrant care workers.

Language and communication skills are integral to the acculturation process and one of the main causes of acculturation stress (Doucerain et al., 2015). Therefore, it is recommended that vocational occupation-specific communication training be provided to aged care workers. This training could incorporate effective writing approaches specific to their caring roles in the aged care sector and communication strategies with colleagues and residents' family. In addition, role-play and practical demonstration of effective verbal communication skills could be included in the training. It is also important to evaluate and review the effectiveness of the training regularly, particularly with staff from migrant backgrounds.

Cultural and linguistic diversity in the workforce offers benefits and challenges for both employers and employees (Armache, 2012). Understanding the key acculturation stressors that contribute to the productivity of migrant care workers in RACFs can help to identify those at higher risk of being affected by the stressors. This will further inform the design of interventions. These interventions could assist employers to support the well-being of migrant aged care workers and may also improve staff retention in the aged care sector.

Strength and Limitations

This study addressed a paucity in the literature relating to acculturation stress and mental health of migrant care workers from diverse ethnicities in RACFs. The inclusion and participation of migrant care workers in this cross-cultural research study is another strength. A potential limitation of this study is the selection bias, as our respondents may be a group of migrants who are less stressed or have adjusted well into Australian society. Another limitation is the nonrandom sample and the purposive sampling method, which could have affected the generalizability of the study findings as some migrant care workers from ethnic groups may not be represented in the sample. However, purposive sampling is the most effective method when there are individuals in the population who possess the specific traits that are being studied, such as migrant care workers. Additionally, it is possible that some respondents intentionally omitted some items in DASS 21 due to their cultural beliefs and stigmatization associated with mental health. However, the missing data had no effect on the results, due to its small proportion (n = 5, 1.8%).

Conclusion

Migrant care workers provide valuable contributions to the aged care sector, particularly in residential aged care settings. Their health and well-being should be considered as both a human right and an economic obligation for aged care management and government policy makers. The present study supports existing findings in the literature on acculturation stress among migrant care workers in the aged care sector. Notably, self-reported mental health among our study respondents was good, suggesting that acculturation stress can occur without having a measurable impact on the more common mental health measures of depression, anxiety, and stress. However, it is crucial to address these acculturation stressors to enhance residents' quality care, increase job satisfaction, and retention in the migrant aged care workforce.

Declaration of Conflicting Interests

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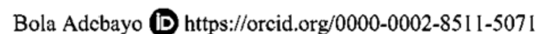
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4.4 Overview of the findings

The objective of this paper was to examine the impacts of acculturation stress on the mental well-being of RACF migrant care workers. Respondents reported moderate to high levels of acculturation stress on the RASI scale (M = 38.4; SD = 14.1; 38.9% scored ≥40 out of 75). Bivariate analysis was conducted with one-way ANOVA to explore associations between the five RASI subscales with the respondents' demographic characteristics. The ANOVA results showed significant differences between ethnicities, occupational roles in RACF, and total mean RASI scores.

. Age is also negatively correlated with discrimination. This is not surprising, given age at the time of migration has been considered to be a critical factor influencing the acculturation process in migrant cohorts (Ma et al., 2010). The negative correlation results in this current study could be because of variations in perceived discrimination among younger and older migrant care workers.

Additionally, the multiple linear regression analysis results indicated that ethnicity is a predictor of acculturation stress, suggesting that migrant carers from different ethnicities are likely to experience acculturation stressors in the form of discrimination, work challenges, cultural isolations, and intercultural relations.

Despite the respondents self-reporting good level of understanding of English (91% reported a high level of understanding), the multiple linear regression results indicate language skill as the major predictor of acculturation stress in this current study. This finding is consistent with the literature that reported migrant care workers' language skills as a predictive factor of acculturation stress (Ma et al., 2010).

Self-reported mental health among the respondents was good. There were no statistically significant associations between the sociodemographic variables and total DASS 21 scores and the DASS subscales (depression, anxiety and stress). Contrary to previous studies (Anikeeva et al., 2010; Lee, Ahn, Miller, Park, & Kim, 2012), this research found that despite the presence of acculturation stress among migrant workers, self-reported mental was good.

4.5 Summary of the chapter

This chapter explored the relationship between levels of acculturation stress and mental health in 272 migrant care workers working in RCFs across five Australian states. The socio-demographic data and levels of English proficiency among the 272 respondents were presented. This current study concludes that migrant care workers can experience acculturation stress without having a measurable impact on the more common mental health measures of depression, anxiety, and stress.

The next chapter describes the national cross-sectional survey findings of the knowledge of dementia among RACF migrant care workers.

Chapter Five Knowledge of Dementia in Migrant Care Workers in Residential Aged Care Facilities

5.0 Overview of the Chapter

This chapter presents the results from a self-administered questionnaire on knowledge of dementia among migrant care workers (n=272) employed in Australian residential aged care facilities. It reports on the findings from the DKAT2 among RACF migrant care workers who participated in the cross-sectional national survey.

5.1 Background

The number of people with dementia in Australia is expected to exponentially increase by 2058 (Australian Institute of Health and Welfare [AIHW], 2021). In 2021, 472,000 people were estimated to have dementia in Australia, and this is expected to rise to approximately 1.1 million by 2058 (Dementia Australia, 2020). A recent report shows that more than two-thirds (68.1%) of aged care residents have moderate to severe cognitive impairments (Dementia Australia, 2020). The reduced cognitive ability, functional capacity, communication, and reasoning in residents with dementia frequently result in behavioural and psychological disturbances (Mallon, Krska, & Gammie, 2019). Consequently, caring for residents with dementia can be challenging for the direct care workers and requires a specific set of skills, knowledge and understanding, and the ability to respond to a complex range of physical, behavioural, and psychological challenges associated with dementia (Brooke et al., 2017; Mallon et al., 2019).

Care worker knowledge and attitudes towards people with dementia and dementia care could be influenced by their cultures, the societal views from their countries of birth, interpretation of behaviours and symptoms of a person with dementia (Yaghmour, 2022), and limited knowledge of the medical condition (Yong & Manthorpe, 2016). Therefore, factors such as workers' knowledge, attitudes, and perceptions need to be considered when considering the skills of workers that are providing care for residents with dementia (Yaghmour, 2022).

Additionally, a continuing evidence-based knowledge of dementia is essential for those involved in care planning and delivery (Toye et al., 2014). Knowledge is an essential component in health literacy that underpins an individual's capacity to interact effectively with health care systems and make key decisions about their health and the health of those they care for (Eccleston et al., 2019). Limited or inaccurate knowledge of dementia may contribute to inadequate dementia-related symptom management, overuse (or underuse) of medications to manage responsive behaviours associated with dementia, and inappropriate care (Robinson et al., 2014). Furthermore, limited

knowledge in caring for residents with challenging behaviours associated with dementia may result in staff burnout and low retention in care settings (Mallon et al., 2019).

The growing demand for high-quality care and an increasing number of people with dementia in RACFs requires evidence-based dementia training interventions and that care workers possess knowledge, skills, and appropriate attitudes to achieve the highest level of quality of life (Barbosa, Nolan, Sousa, Figueiredo, & Sciences, 2014). Barbosa et al. (2014) further suggested that the development of effective training interventions could be enhanced through acquisition of previous knowledge and experience from care workers' experiences.

The importance of the acquisition of care workers' knowledge on dementia was demonstrated in an Australian study (Eccleston et al., 2019). This study reported that the baseline of participants' knowledge of dementia was positively related to their previous learning about dementia from various types of exposure to the condition, including having family members and/or working with people with the condition and having undertaken dementia education (Eccleston et al., 2019). However, knowledge of all participant groups showed substantial improvements after the completion of the dementia training Understanding Dementia Massive Open Online Course (UDMOOC). Their study concluded that effective training would improve dementia knowledge regardless of care workers' educational background and previous experience of dementia care, either in family or workplace settings (Eccleston et al., 2019).

There is a paucity of research on the knowledge of dementia among RACF care workers across ethnic and migrant backgrounds in Australia. Previous studies have examined the knowledge of dementia for the general aged care workforce (Jones, Moyle, & Stockwell-Smith, 2013; Smyth et al., 2013), family members of people with dementia (Robinson et al., 2014), and nursing students (Eccleston et al., 2015). However, the studies do not state the participants' nationalities. International studies are also limited in this area. For example, Jones et al. (2013) examined the level of knowledge of dementia and training among aged care workers from migrant backgrounds and dominant cultures employed in three different Australian RACFs in Brisbane, Queensland. Their study reported that ethnicity and the length of residency in Australia were predictors of RACF migrant care workers' knowledge of dementia (Jones et al., 2013). However, their results were limited by the small sample size (n=35) and specific geographical context as the study was conducted only in one Australian metropolitan area (Jones et al., 2013). In addition, as demonstrated in the published scoping literature review, there is a dearth of research on knowledge of dementia among migrant care workers employed in high income RACFs (Adebayo et al, 2020). Therefore, there was insufficient evidence to determine the levels of dementia knowledge in migrant care workers employed in high incomes RACFs.

Research Question 2 “What is the level of knowledge and understanding of dementia among care workers?” is addressed in this chapter.

5.2 Survey Results on Respondents’ Knowledge of Dementia

The level of knowledge about dementia in the 272 respondents was assessed using the Dementia Knowledge Assessment Tool Version 2. (DKAT 2 items). A summary of DKAT 2 total scores is presented in Figure 5.1. The overall mean score for dementia knowledge in the 272 migrant cares workers as measured by the DKAT 2 was 13.8 (*S.D* 4.1) out of 21, with a median of 15. This suggests that respondents reported a moderate level of dementia knowledge as shown in Figure 5. 1.

Descriptive analysis indicated that men had higher total DKAT 2 mean scores (*M*=14.1, *S.D*=3.8) when compared to women (*M=13.6, S.D=4.3*). However, the result of the independent sample *t*-tests indicated that this difference was not statistically significant (t (270) = 0.74, p= 0.4). The enrolled nurses as a group appeared to have better dementia knowledge as indicated by higher mean scores on the DKAT-2 (*M*=15.0, *S.D*=1.8, N=16) when compared to other occupational roles in RACF (PCAs: *M*=13.6, *S.D*=4.2, N= 198; RNs: *M*=13.7, *S.D*= 4.9, N=32). The results of the ANOVA indicated no statistically significant differences between the sociodemographic characteristics and the total DKAT 2 scores as shown in Table 5.1.

Figure 5.1 Dementia Knowledge Assessment Tool Version 2 (DKAT 2) Total Frequency Scores

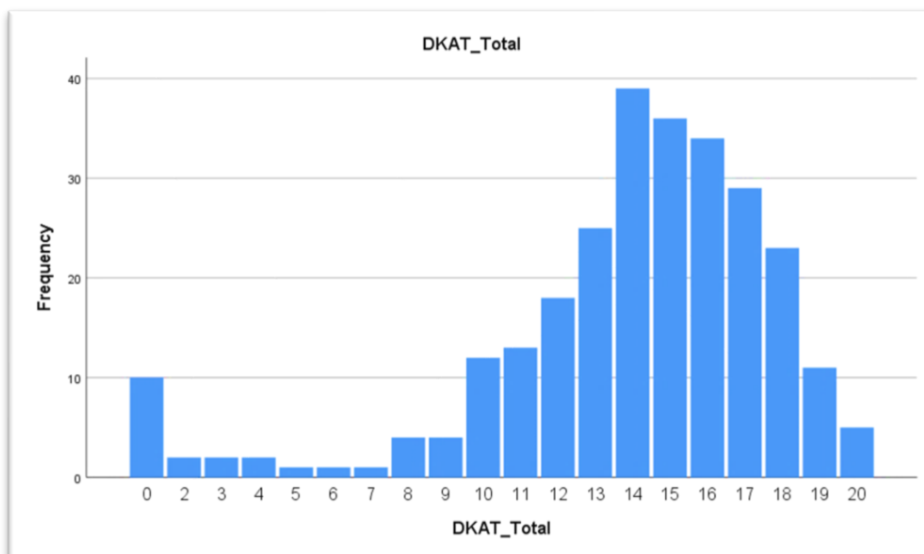

Table 5.1 Selected sociodemographic characteristics and their relationship to dementia knowledge (N=272)

Sociodemographic	n (%)	DKAT 2 Mean (SD)	F	df	P
Gender			.69	1	.40
Men	72 (26.5%)	14.1 (3.8)			
Women	200 (73.5%)	13.6 (4.3)			
Age			1.86	1	.17
18-25 years	27 (9.9%)	14.4 (3.6)			
26-35 years	110 (40.4%)	14.9 (3.8)			
36- 45 years	84 (30.9%)	13.5 (4.3)			
46- 55 years	33 (12.1%)	13.1 (4.9)			
55 years and above	18 (6.6%)	13.4 (5.0)			
Ethnicity			.48	4	.75
Sub-Saharan African	141 (51.8%)	13.6 (3.8)			
Southern Asian	50 (18.4%)	14.2 (3.7)			
South-East Asian	38 (14.0%)	13.7 (4.7)			
North-East Asian	18 (6.6%)	14.6 (4.8)			
Others Anglo-Saxon Oceania/Pacific Islander South and North American	25 (9.2%)	13.5 (5.5)			
Role in RACF			.69	3	.55
Patient Care Assistants	98 (72.8%)	13.6 (4.2)			
Enrolled Nurses	32 (11.8%)	13.7 (4.9)			
Registered Nurses	16 (5.9%)	15.0 (1.8)			
Others Facility Manager Occupational Therapist Dementia Care Specialist	26 (9.6%)	14.2 (3.7)			
Highest education qualification			.004	1	.95
Postgraduate degree	48 (17.6%)	14.2 (4.0)			
Bachelor degree	110 (40.4%)	13.7 (4.3)			
Diploma	49 (18.0 %)	13.3 (4.2)			
Certificate qualifications	50 (18.4%)	14.0 (3.8)			
Completed year 12 and < year 12	15 (5.5%)	13.4 (5.3)			
Duration in the aged care sector			1.99	1	.15
6-12 months	41 (15.3%)	12.9 (4.3)			
2-10 years	152 (56.7%)	14.0 (4.2)			
11-20 years	70 (26.1%)	13.7 (4.0)			
21 years and above	5 (1.9 %)	15.2 (2.8)			
Duration in Australia			.53	1	.46
0-6 months	2 (7.0%)	14.0 (1.4)			
1-5 years	106 (39.0%)	13.9 (4.2)			
6-10 years	81 (29.8%)	13.6 (4.0)			
11-15 years	48 (17.6%)	13.7 (3.5)			
16 years and above	35 (12.9 %)	13.7 (5.2)			

Table 5.2 shows a large proportion of the respondents selected the correct response to the DKAT2. However, low levels of knowledge were apparent in specific questions. The DKAT2 items with more that 50% incorrect responses are reported in Table 5.3. Items measured include knowledge of dementia progression (item 7), recognition of acute confusion (item 12), and pain recognition in residents in the later stages of dementia (item 20).

As shown in Table 5.3, 89.5% of the study respondents provided incorrect responses to question 7, which examined respondents' knowledge on how the likely causes of dementia can help to predict its progression. Over 80% responded incorrectly to Question 12 and did not appear to understand that a sudden increase in confusion is unlikely to be a characteristic of dementia.

Approximately two-thirds (62.5%) reported that it is not possible to recognise pain in a person who is in the later stages of dementia. These items were identified by the researcher and the supervisors as addressing issues of clinical significance to the knowledge of dementia and care in RACFs.

Table 5.2 Assessment of dementia knowledge: Percentage of respondents that answered individual DKAT2 correctly.

	Dementia knowledge assessment scale-statements	% Correct responses	% Incorrect responses
1	Dementia occurs because of changes in the brain.	92.2	7.8
2	Brain changes causing dementia are often progressive.	88.4	11.6
3	Alzheimer's disease is the main cause of dementia.	69.4	30.6
4	Blood vessel disease can also cause dementia.	60.9	39.1
5	Confusion in an older person is almost always due to dementia.	57.8	42.2
6	Only older adult develops dementia.	78.3	21.7
8	Incontinence always occurs in the early stages of dementia.	50.4	49.6
9	Dementia is likely to limit life expectancy.	70.5	29.5
10	When a person has late-stage dementia, families can help others to understand that person's needs.	86.4	13.6
11	People who have dementia may develop problems with visual perception (understanding or recognising what they see).	85.3	14.7
13	Uncharacteristic distressing behaviours may occur in people who have dementia (e.g. aggressive behaviour in a gentle person).	85.7	14.3
14	Difficulty swallowing occurs in late-stage dementia.	64.0	36.0
15	Movement (e.g. walking, moving in a bed or chair) is limited in late-stage dementia.	66.7	33.3
16	Changing the environment (e.g. putting on a CD, opening or closing the blinds) will make no difference to a person who has dementia.	64.3	35.7
17	When a person who has dementia is distressed, it may help to talk to them about their feelings.	77.1	22.9
18	It is important to always correct a person who has dementia when they are confused.	56.6	43.4
19	A person who has dementia can often be supported to make choices (e.g. what clothes to wear).	88.8	11.2
21	Exercise can sometimes be of benefit to people who have dementia	86.4	13.6

Table 5.3 Dementia knowledge deficiencies

	Dementia knowledge Assessment Scale-Statements	Correct responses	% Correct responses	% Incorrect responses
7	Knowing the likely cause of dementia can help to predict its progression.	F	10.5%	89.5%
12	Sudden increases in confusion are characteristic of dementia.	F	19.0%	81%
20	It is impossible to tell if a person who is in the later stages of dementia is in pain.	F	37.6%	62.4%

Multiple Linear Regression

Multiple linear regression analysis was conducted to evaluate the collective effect of sociodemographic variables relating to overall knowledge of dementia to ensure that there were no suppressor effects or negative confounders. The results of the regression are presented in Table 5.4. There was no collective significant effect of sociodemographic characteristics on the knowledge of dementia (F (12, 259) =.68, p = .77 R^2 = .03, $R^2_{Adjusted}$ = -.014), with no individual variable being a significant predictor of dementia knowledge.

Table 5.4 Investigating the predictors of the level of knowledge of dementia

Predictor	B	B 95% CI [LL, UL]	sr^2	sr^2 95% CI [LL, UL]	Fit
(Intercept)	14.59**	[12.19, 17.00]			
Age	-0.40	[-0.99, 0.18]	.01	[-.01, .03]	
Female	-0.50	[-1.67, 0.67]	.00	[-.01, .01]	
Role – Registered Nurse	0.06	[-1.66, 1.79]	.00	[-.00, .00]	
Role – Enrolled Nurses	1.57	[-0.63, 3.78]	.01	[-.01, .03]	
Role – Others	0.43	[-1.37, 2.23]	.00	[-.01, .01]	
Duration in Australia	-0.20	[-0.75, 0.34]	.00	[-.01, .01]	

Ethnicity – South -East Asian	0.07	[-1.51, 1.65]	.00	[-.00, .00]
Ethnicity – North-East Asian	1.33	[-0.82, 3.48]	.01	[-.01, .02]
Ethnicity – Southern Asian	0.60	[-0.78, 1.98]	.00	[-.01, .01]
Ethnicity – Others	0.23	[-1.78, 2.24]	.00	[-.00, .00]
Education qualifications	-0.02	[-0.37, 0.34]	.00	[-.00, .00]
Duration in the aged care sector	0.35	[-0.14, 0.84]	.01	[-.01, .03]

$R^2 = .03$

Note. A significant b-weight indicates that the semi-partial correlation is also significant. b represents unstandardised regression weights. sr^2 represents the semi-partial correlation squared. LL and UL indicate the lower and upper limits of a confidence interval, respectively

5.3 Discussion

In this study, migrant care workers demonstrated moderate levels of knowledge of dementia as measured by the validated knowledge measure tool – the Dementia Knowledge Assessment Tool 2 (DKAT2) (M=13.8 (*S.D* 4.1) with a median of 15 out of 21. There is a high proportion of correct responses to an individual DKAT 2 with their responses to 18 items ranging from 64% to 92.2% as presented in Table 5.2.

There were significant knowledge deficiencies in some areas (DKAT 2 items 7, 12, and 20 as reflected in Table 5.3). The dementia knowledge deficits were evident in two key areas: (1) aetiology of dementia and its progression; and (2) physical symptoms associated with dementia.

Respondents lacked knowledge around the aetiology of dementia and its progression with few (10.5%) correctly identifying that the knowledge of likely causes of dementia would not help to predict its progression. Understanding the complexity of dementia causation and being able to predict its progression has been an evolving process in biomedical research (Kenigsberg et al., 2016) as dementia is a syndrome with multiple aetiologies (Kenigsberg et al., 2016). It is not surprising that the respondents demonstrated knowledge deficiency in this topic, considering our respondents were direct care workers. With the majority being PCAs (72.8%), a detailed knowledge of neurological science and causes of dementia in relation to its progression could be beyond their scope of training.

The findings of this study are similar to a previous study that utilised the DKAT2 tool to explore the knowledge of care workers in RACF (Robinson et al., 2014). The previous Australian study

investigated the knowledge of dementia in Australian RACF among RN, EN, and PCA, including family members of residents with dementia, using the DKAT 2 (Robinson et al., 2014). Participants' cultural backgrounds were not identified in their study.

This current study and the previous Australian study (Robinson et al., 2014) identified knowledge deficiency around a sudden increase in confusion in residents with dementia. In this current study, only 19% responded correctly (Table 5.3) that sudden increases in confusion is not a characteristic of dementia. Similarly, only 26% of the RACF aged care workers in Robinson et al. (2014) study provided correct responses to this question.

Sudden confusion which could be an indicative of delirium usually superimposed with dementia and is common in older adults with a prevalence ranging from 22% to 89% (Bull, Boaz, & Sjostedt, 2014). People with dementia are at increased risk of developing delirium (Bull et al., 2014). Delirium is a life-threatening and reversible condition characterised by sudden onset and fluctuations in orientation, memory, disorganised thinking, and perceptual disturbances (Bull et al., 2014). Evidence shows that it could be challenging for care workers in both RACFs (Robinson et al., 2014) and acute care settings (Jackson et al., 2017) to recognise sudden confusion in people with dementia. This is because both dementia and delirium are disorders of cognitive function that are intricately linked, and as such could be difficult to effectively recognise, investigate, and manage by health practitioners due to the lack of validated clinical processes for accurate diagnosis (Jackson et al., 2017).

The majority of participants in the current study were PCAs who might not have adequate training and skills to recognise delirium in residents with dementia as demonstrated in their high proportion of incorrect responses to DKAT item 12. However, it is important for the direct care workers (nurses and PCAs) to recognise changes in residents' behaviour, which could be an indicator of physiological change in their health status. In particular, PCAs assist residents with their personal care and are often the first care workers to notice physical changes or signs of illness in residents (Gilster et al., 2018). Prevention of delirium is the preferred outcome (Ford, 2016). Being observant to changes in residents' behaviour and reporting these changes to clinicians such as GPs for further investigation is one of the delirium prevention strategies that could improve residents' health outcomes (Jackson et al., 2017).

This current study and Robinson et al.'s findings also identified knowledge deficiency around pain recognition among residents in an advanced stage of dementia. A large portion (62.4%) of the migrant care workers in this current study incorrectly answered that pain recognition in people with advanced dementia was not possible. The finding concurs with 65.3% incorrect responses in

Robinson et al.'s (2014) study. Due to the inability of people with dementia to effectively communicate their pain to the care workers, pain is frequently under-detected and poorly managed in residents with advanced dementia (Dening, 2020; Giménez-Llort et al., 2020).

Contrary to Robinson et al.'s findings, the majority of participants (70.5%) in this current study had a good knowledge of the life-limiting nature of dementia as reflected in item 9 in Table 5.2. Only 49.5% participants, however, in Robinson et al.'s study provided correct responses to this question. This finding suggests that migrant care workers have a good knowledge that dementia is a terminal medical condition with a life-limiting nature. The differences in our findings could be a result of respondents' higher education qualifications as more than half of the participants (58%) possessed a bachelor or post-graduate degree. It has also been reported in previous Australian studies that migrant care workers are more likely to hold bachelor qualifications (Adebayo, Durey, & Slack-Smith, 2017) and generally possess qualifications higher than Australia-born direct care workers (Nichols et al., 2015).

As identified above, there were no significant differences between the select respondents' sociodemographic characteristics and the total DKAT 2 scores in this current study. Further regression analysis also indicated no collective significant effect between sociodemographic characteristics and dementia knowledge. However, the small number of participants who had worked in the sector for a long time (over 20 years) had a higher mean DKAT score. Considering that more than half of the survey respondents (56.7%) had worked less than five years in the Australian RACF aged care sector, respondents' knowledge deficiencies around dementia symptoms (DKAT2 items 12 and 20) as discussed above could be a result of their limited dementia experiences prior to their migration to Australia (Nichols et al., 2015). Participants' pre and post migration dementia care experiences will be discussed in detail in the next chapter

5.4 Summary of the Chapter

The level of knowledge of dementia among RACF migrant care workers and the sociodemographic predictors of knowledge of dementia were investigated in this chapter. In alignment with the explanatory sequential mixed-method design, the survey findings are expanded in Phase Two and discussed in the next chapter.

Chapter Six Knowledge of Dementia and Dementia Care Experience: An Exploration of the Qualitative Interviews

6.0 Overview of the Chapter

This chapter presents qualitative findings from Phase Two of this explanatory sequential mixed-methods study, which were generated from the semi-structured interviews undertaken with migrant care workers (n=20).

6.1 Background

The two main factors driving increased demand for aged care are the ageing population concomitantly with the increasing number of people with dementia (Smith, 2019), which has placed unprecedented demand on RACFs (Roe, Coulson, Ockerby, & Hutchinson, 2020).

The residential care system provides care and support for older adults whose care needs cannot be met at home (Roe et al., 2020). In 2018, 51.2% of residential aged care recipients had a diagnosis of dementia based on the Aged Care Funding Instrument assessment (Smith, 2019). Although there is a shift in high-income countries, including Australia, towards community aged care service for dementia care provision (World Health Organization & Alzheimer's Disease International, 2012), RACFs still provide significant long-term care for people with dementia where other aged care services, such as outpatient hospital care and community and home aged care services, are unable to provide aged care sufficiently. The limitation of community aged care services may occur as a result of the illness of family caregivers, rapid progression of challenging behaviours associated with dementia, safety issues, inappropriate accommodation, or an increase in severity of dementia (World Health Organization & Alzheimer's Disease International, 2012).

In Australia, the RACF aged care workforce is culturally diverse because of the recruitment in the past decades of care workers from Asian, African, and European countries (Mavromaras et al., 2017). Exploring the perceptions of migrant care workers on dementia care is crucial as their approach to care is complicated by the dynamics of their adaption to the host society and the provision of culturally congruent care to the local patients (Egede-Nissen et al. 2017). For instance, an Egede-Nissen et al. (2017) study reported that some migrant care workers struggled to maintain ethical care practices alongside their challenges to adapt new cultural norms in order to provide quality dementia care in an unfamiliar workplace. One of the most identified resettlement challenges among migrant care workers is communication difficulty, which often becomes profound when they engage with residents with dementia (Egede-Nissen et al. 2017). Residents with dementia, especially those in the advanced stage, may not be able to understand to express

their needs, or ask for help, or correctly interpret their emotions in verbal communication due to cognitive function decline (McGilton et al., 2017).

In addition to migrant care workers' limited communication skills, an understanding of residents' culture and knowledge of workplaces are essential to provide person-centred care for residents with dementia (Mullay, Schofield, Clarke, & Primrose, 2011). The theory of a person-centred care approach was developed in the context of dementia care by Kitwood (1997). This care approach extends beyond the traditional medical model of care that focuses on residents' daily care routines and organisational needs (Fazio, Pace, Filnner & Kallmyer, 2018) to underscore a relationship-centred care philosophy between care workers and persons with dementia (Fazio et al, 2018). In delivery of person-centred care, an individual's well-being required a holistic, not just a focus on their medical condition. Residents' respect, choice, dignity, safety, and meaningful living must be considered and affirmed. Research shows that effective communication between care workers and residents, the flow of information exchange and on residents' care plan between care workers in RACFs to understand the needs of the residents will improve delivery of person-centred care (Kolanowski et al., 2015). Migrant care workers, especially those who are new to this role, may lack these skills, creating challenges concerning their ability to communicate with residents with dementia and to provide the quality of dementia care the residents required (Mullay et al., 2011).

There is significant research related to transcultural nursing (Chen et al., 2020), the migration of direct care workers (Charlesworth & Isherwood, 2020), and their work experiences in healthcare institutions (Xiao, Willis & Jeffers, 2014). But studies related to migrant care workers' challenges in caring for people with dementia is very limited.

The main aim of this chapter is to address the following research questions:

Research Question 2: What is the level of knowledge and understanding of dementia among migrant care workers in Australian RACFs?

Research Question 3: "What are the experiences of dementia care among migrant care workers in Australian RACFs?"

To address these research questions, the study aimed to explore the understanding of dementia and dementia care experiences of Indian, Filipino, and Nigerian residential aged care workers.

6.2 Findings

6.2.1 Sociodemographic Characteristics of the Study Participants

Six telephone and 14 face-to-face semi-structured interviews were conducted among 20 migrant care workers employed in RACFs in Perth metropolitan area. Nine were from a Nigerian background, six from Indian, and five from Filipino. Participants were mainly women (n=15, 75%), with the ages of the participants ranging from 25 to 45 years. The majority of the participants who participated in the qualitative interviews were personal care assistants (PCAs) (n=14, 70%). Four (20%) were registered (RN) and two (10%) were enrolled nurses (EN). All the RN and EN participants had their nursing qualifications registered under the Australian Health Practitioner Regulation Agency (AHPRA). Two RNs held managerial positions in the RACFs with one (Filipino background) being a care manager and the other (Nigerian background) a clinical nurse. The RN of Filipino background had extensive work experiences in the Philippines and worked as a clinical nurse for two years in a hospital in Saudi Arabia before migrating to Australia. The Nigerian clinical nurse initially worked as a PCA in an Australian RACFs while undertaking a nursing bachelor's degree and later obtained an Australian postgraduate degree in geriatric nursing.

The other two RNs were new graduate nurses with six months to three years of aged care experience. The EN participant initially trained as an accountant in his country of birth and had an Australian postgraduate degree in accounting before obtaining a Diploma in Nursing from an Australian Technical and Further Education (TAFE) College, which qualifies him to work as a nurse in the Australian aged care sector.

The PCA participants obtained a qualification of Certificate IV in Aged Care through Australia accredited training organisations. Similar to participants that completed the cross-sectional survey in the quantitative study, most of the PCAs (65%) in the qualitative study have bachelor and postgraduate degrees and had completed higher education qualifications in their countries of birth before migrating to Australia. For example, two participants had a bachelor's degree in banking and finance in their countries of birth, and three were trained teachers with a bachelor's degree in education.

Most participants (85%) had lived in Australia between six and ten years. Participants' duration of work experience in the aged care sector ranged from 12 months to 10 years. Over three-quarters (80%) of the participants had permanent resident status with 12 participants (60%) identifying as Australian citizens. All five participants (25%) on student visas were studying for a nursing degree in Australian universities in Western Australia. Most participants (60%) speak a language other than English at work and often speak their native languages with co-workers from a similar cultural background. The languages they speak are Hindi, Yoruba, Malayalam, Igbo, and Tagalog.

6.3 Expanding on Quantitative and Quantitative Data on Knowledge of Dementia and Dementia Care Experiences

These findings further explained and expanded on the results from the DKAT2 questionnaire from the cross-sectional survey conducted in Phase One. In alignment with the sequential explanatory mixed-methods approach (Halcomb & Hickman, 2015), the semi-structured interviews enabled a deeper exploration of participants' understanding of the concepts linked to the DKAT2 items that had indicated a knowledge deficit. Namely, items 7, 12 and 20 in Table 6.1 provide the semi-structured interview questions used to prompt further discussion relating to the DKAT2 items that had a high rate of incorrect responses.

Table 6.1 Elaborating survey findings in qualitative interviews

	Quantitative Questions DKAT 2 Items	Percentage of correct responses	Qualitative Statements/Questions
12	Sudden increases in confusion are characteristic of dementia.	19.0%	What do you expect to see in a person with dementia?
7	Knowing the likely cause of dementia can help to predict its progression.	10.5%	Do you think knowing the cause would help you in any way?
20	It is impossible to tell if a person who is in the later stages of dementia is in pain.	37.6%	How you will recognise pain in residents with dementia in advanced disease conditions who cannot verbalise their pain?

The emerged themes were participants' understandings of dementia as expressed in their explanations of causes, risk factors, and symptoms of dementia. Another identified theme indicates that participants' dementia care experiences are influenced by their pre-migration understanding of care as a cultural norm.

Skill requirements approaches to care, perceptions of caring for residents with advanced dementia, and facilitators and barriers to quality dementia care for residents also emerged as themes. Quotations from the migrant care worker' interviews are referenced by their sex, country of origin, role in RACF, and the interview number ascribed to each interview. A summary of themes and subthemes is provided in Table 6.2.

Table 6.2 Codes subthemes and themes

Codes	Sub-themes	Themes
Brain disease	Definition of dementia	Understanding dementia
Ageing process	Associated risk factors	
Mental health		
Hereditary		
Family responsibility	Pre-arrival dementia care experiences	Dementia care experiences
Discomfort		
Cultural values	Post-arrival dementia care experiences	Skill requirements
	Communication	
Person-centred care	Relationship with residents with advanced dementia	Caring for residents with advanced dementia
Residents' body language		
Empathy		
Good rapport		
Training	Dementia Training	Facilitators of quality dementia care
Work experience in aged care		
Inadequate staffing		Approaches to care
		Barriers to dementia care

6.3.1 Understanding of Dementia

In alignment with the survey findings in which 92.2% correctly responded that dementia is as result of sudden changes to the brain (Table 5.2). The majority of participants (19 out of 20) described dementia as a neurological disorder. "*Dementia is a collective name for a group of symptoms that involves degeneration of the brain, sometimes they are aggressive, not complying with activities of daily living, so we are to assist them with what they should be doing in their daily life activities"*– Female Indian PCA #3. They further explained that a person with dementia requires constant personal care because of the co-morbidities and challenges associated with the dementia.

It was challenging for two participants to define dementia, but they recognised that dementia is a loss of cognitive function. *"I do not know the definition of dementia... well just people losing their cognitive abilities."* Male Nigerian PCA #1. A small number of participants (including two registered nurses and four personal care assistants) identified the cause of dementia as unknown.

Associated risk factors of dementia were identified by the participant; however, the majority of participants (17 out of 20) attributed dementia to the normal ageing process. Other causes of dementia identified by participants include trauma, mental disorder, genetics, consumption of high carbohydrate and canned food, stressful lifestyle, alcohol, smoking, and loneliness.

"Mostly, I said it's more common within the aged ………. it's more of a stereotype like the symptoms of aging, Oh, grandma has forgotten again." Female Nigerian PCA #4

"I think it is age, sometimes maybe mentally condition, sometimes maybe depression." Female Indian PCA #3.

"One thing that I see though that is common in these people is psychiatric problems. It usually runs in *the family as well."* Female Filipino PCA #1

"Maybe drug users as well and then long-term alcohol use." – Male Indian PCA #5

"If someone has brain trauma, it can lead to dementia." – Male Nigerian PCA #1

One participant perceived dementia as a progression of Parkinson disease. *"I think first you get Alzheimer's, you get Parkinson's."* – Female Filipino PCA #2.

It was evident that the majority of participants had a basic understanding of a range of risk factors associated with dementia even though most perceived dementia as a normal ageing process.

Some participants had pre-conceived understanding about people living with dementia before migrating to Australia. Migrating to Australia and being employed in Australian RACFs changed the perceptions and understanding of dementia.

"The first time I had experience with someone with dementia was in Africa, but then I did not know it was dementia I thought it was another thing entirely. It was when I migrated to Australia that I now know that was dementia. Back home, my grandma had dementia and she used to wander around, did not know what she was doing. Then we thought maybe she was a witch because of the level of education that I had then, I did not know what was wrong with her. But when I came to Australia and I did some courses relating to dementia, that was when and I realised what happened to her then was dementia." Female Nigerian PCA #1.

Participants also recognised that the shorter life expectancy of the population in their countries of birth when compared to the life expectancy in Australia may have contributed to their poor awareness of dementia. "*In India, the condition is not coined as dementia… life expectancy is usually between 60–70 years, so it is not a big thing."* Female Indian RN 1. The participant further explained that the negative impact of chronic medical conditions, such as diabetes and heart-related diseases, usually affect longevity of the population in her country of birth.

Confusion and forgetfulness in residents were equated with dementia-related symptoms by most participants. Two participants were able to differentiate between age-related memory changes and memory loss in residents with dementia. These participants correctly described memory loss in residents with dementia as short-term.

"All the signs are short term memory loss and inability to understand things, lack of insight, diminished capacity for thinking." – Male Indian PCA #3

However, the majority of participants perceived confusion as a normal symptom of dementia and did not identify other factors associated with confusion in residents that could indicate other issues or comorbidities.

6.3.2 Dementia Care Experiences

Caring for non-family members with dementia in an institutional setting was a novel experience for all participants. They all described dementia as a family responsibility. None of the participants had previous institutional dementia care experiences before migrating to Australia. All participants mentioned that their countries of birth do not have long-term institutional care for people with dementia, so caring for the older person with dementia in an institutional setting such as RACFs was a learning experience for many of them.

"If you just come from the Philippines, like me, I did not know what I was doing at first. I really did not know how to deal with people with dementia." – Male Filipino RN #1.

Most of the participants' dementia care experience began in Australia when they were employed or

undertaking student placement in RACFs. All described their initial post-migration dementia care experiences as challenging. Witnessing residents with dementia with a lack of bowel control or aggressive responses was very disturbing for some participants. Most felt very uncomfortable and initially felt they lacked the competence to provide care for residents with dementia.

"The first time was when I was employed in an aged care facility… I saw a resident walking aimlessly not knowing where he was going and tried to dip his hand in his pooh (faeces) and eat his pooh. It was such a shocking experience for me." – Female Nigerian PCA 1

"The first day I cried a lot. I went home because I have not seen people behaving like this before." – Female Indian PCA #2

Participants were used to caring for their family members in their countries of birth. Caring for residents in a cross-cultural institutional setting was challenging for one participant. *"It was stressful because that was my first time caring for someone from a different nationality because I was just from Africa at that time. I was so stressed, so scared because back home I was caring for my family with dementia."* – Female Nigerian EN #2.

A participant described her first experience of providing personal care to a male resident as shocking and confrontational. *"In my first experience working in aged care, I thought the female carer would assist the female residents and the males would assist the male residents. When I was asked to shower this resident, I was like, 'I am a female, how can I shower a male resident?'* – Female Filipino PCA #4.

Given most participants were from cultures where care for older people is perceived as a family responsibility, it was distressing for them to witness loneliness in residents, particularly those that were visited infrequently by their friends and family members.

"On Christmas day they are alone (residents), you are their family, things like that were challenging for me, because where I came from everything revolve around families." – Female Nigerian RN #3

Participants perceived this as "elder abandonment". They were uncomfortable with the lack of family obligation and compassion towards the older family member as a detrimental norm of Western societies.

6.3.3 Caring for Residents with Advanced Dementia

As highlighted in the national survey findings (Table 5.3) in Chapter Five regarding pain recognition in people with dementia, participants acknowledged that pain recognition in residents with advanced dementia or with aphasia (loss of the ability to verbalise or to understand speech)

could be challenging.

"It is difficult to recognise pain or engage with residents with dementia at times, no matter how much you talk to them, they still do not respond." – Male Indian PCA 2

"Sometimes you really can't tell because they're frozen, you can't tell the difference between pain anymore especially if they been in pain for so long and has become normal to them." – Female Filipino PCA 1

Although participants expressed the challenges in recognising pain in people with advanced pain, they recognised that a meaningful relationship with residents would assist them in identifying unusual changes in residents' behaviour.

"Getting to know your resident well will make you know if he/she is having any pain. I think someone who interacts with them every day will know if there is something wrong with the person." – Female Filipino PCA #2.

The majority of participants (16 out of 20) explained that they often used residents' body language to recognise pain. Such changes in body language can include agitation and facial expressions. Moreover, most participants highlighted that having an ongoing care relationship with residents will help them to recognise pain in residents with advanced dementia.

"If you touch a particular part of the person's body when cleaning them, you will see the reaction on the face, then you know something is wrong with that part of the body." – Female Indian PCA #3.

Participants mentioned that having substantial work experiences in aged care contributed to their ability to recognise pain in a resident who was unable to verbalise pain.

"I would just say it's through the experience of working in the aged care that has given me the experience to know their [residents with dementia] attitude you can reason along with them to know what they want." – Female Nigerian PCA #2.

Regular dementia training was also identified by four participants as beneficial in supporting care workers to recognise and manage pain in residents with advanced dementia.

"Training also is part of it because if you are not trained you will not be able to recognise those body languages." – Female Nigerian PCA #2.

Some participants perceived residents with dementia as little children that constantly require care. A participant felt being a mother positioned her to relate better with residents with dementia, and she often treat such residents as babies.

"These residents are like babies. I find it a bit easier now to deal with them because I've had babies, so I just treat them like babies if they can still understand and communicate." – Female Filipino PCA #2.

6.3.4 Facilitating Better Quality Dementia Care

All participants acknowledged that dementia training enhanced their skills and confidence in delivering care to residents with dementia. *"I am more comfortable now because I've been doing it for so long. The things that are making me comfortable is education and talking about dementia."* – Female Nigerian PCA #4.

A participant explained that her skills acquisition in relation to dementia care was through the support of her team members. *"I think is teamwork…. my team support actually let me get used to it earlier"* –. Female Nigerian PCA #5. Some mentioned that the combination of dementia training and team support increased their confidence in care provision.

Participants were concerned that staff dementia training was irregular and inadequate, despite the benefits of the education. *"That is the first challenge because three months induction program or bridging program doesn't really cover much ground when you're dealing with something so new to you, such as dementia."* – Male Filipino RN #1.

All participants recommended that dementia training should be provided regularly to the staff.

"Dementia training is a good way to expand our knowledge, to know more about dementia, it's a broad topic. The five-day course is not enough, some people go to the university to study this. They talk about the frontal lobes, all that stuff, you know. It is a lot…. knowing what happens, what symptoms you need to see in people with dementia." – Male Nigerian EN #3.

6.3.5 Improving Dementia Care

Based on their daily interactions with the residents, participants recommended strategies to improve quality care for residents with dementia based on their daily interactions with them. The participants discussed their dissatisfaction at the lack of environmental signals in RACFs, which otherwise would benefit residents with dementia. The participants were aware that a dementia friendly environment should include such items as clear signage, colour co-ordination, and clocks for orientation purposes. A participant recognised that poor environmental design could impede the quality of care, noting that some residents found it challenging to negotiate their way in the RACF environment as a result of their short-term memory loss.

"Residents with dementia cannot identify where a toilet is because the colours of the door of the toilet and the walls are the same. Making it very bold and unique, like making it a very bright

colour, putting very big signage could help them. It would help them with the incontinency aspects. Because we all know dementia might result in incontinence because of confusion." – Female Nigerian PCA #4

Another participant recommended that RACFs should be built to accommodate social infrastructure, especially recreational facilities, to alleviate a sense of institutionalisation in residents.

"I think if a facility has coffee shops and a bit of a shopping centre inside where they do not feel like they are in a facility, that would be better for them." – Female Filipino PCA #1.

Further discussion about the environment of care led to the importance of creating a sense of familiarity and homeliness and not an institutionalised environment for residents with dementia.

6.4 Discussion

Similar to previous Australian study (Nichols et al., 2015) the current study participants had no pre-migration dementia care experiences in a formal institutional setting. Dementia care was a new experience for migrant care workers who had received their education in their countries of birth. Therefore, the initial dementia care experiences were challenging and confronting. This current study findings concur with Brooke et al., 2017 study that migrants care workers' preconceived ideas of dementia informed their care delivery and their understanding of residents' dementia-related changes in behaviour. For example, resonating with Ayalon's study (2019), some migrant care workers in this current study considered the challenging behaviours associated with dementia to be a part of the normal ageing process.

Importantly, our participants in this current study recognised the benefits of dementia staff training in enhancing their skills to provide quality care for residents with dementia. Benefits of training include an increase in staff confidence in delivering care, reducing staff work-related stress in understanding and responding to symptoms associated with dementia (De Siún & Manning, 2010). As identified by the current study participants and participants in previous study several challenges may hinder the implementation of effective staff training programs including low staff attendance at training, insufficient funding, a lack of training facilities, and a lack of organisational support for change in best practice (Gilster et al., 2018).

Notably, staff dementia training was described as not being sufficient. This suggests that training should be regular and co-designed with migrant care workers to address their dementia deficiencies. However, these findings should be interpreted with caution as consistent knowledge in current medical perspectives of dementia and dementia training does not necessarily translate into

improved care outcomes for residents with dementia (Surr, Smith, Crossland, & Robins, 2016). Evidence shows that while dementia training could be effective in changing care workers' attitudes it might be insufficient to change the efficiency of caring for people with dementia as translating knowledge and skills acquired in training into practice takes time (Surr et al., 2016).

Based on the integrated findings from the quantitative and qualitative responses to questions relating to the knowledge of dementia, participants have some understanding of dementia as a neurological condition. However, their pre-conceived ideas around the normal ageing process and dementia have not changed. Various associated risks that could lead to dementia were outlined by migrant care workers. However, some identified risk factors, for instance, trauma and Parkinson disease, were inconsistent with current biomedical perspectives of risk factors associated with dementia.

Despite the high false response rates to question relating to pain recognition (DKAT2 -item 20) in people with advanced dementia as reported in Phase One (Table 3.3), participants in Phase Two recognised that care developed as a result of the contingent knowledge of unique individuals through good interpersonal relationship is important. Notably, for caring and recognising (Fazio et al, 2018) symptoms, such as pain in residents with advanced dementia that have communication difficulties.

The complexity of ethical considerations regarding understanding residents with dementia as adults and autonomous people was apparent in some participants. Relating to the residents with dementia as if they are a baby, or a person with a mental health illness, or a violent person (Stangl et al., 2019) implies that language can negatively affect approaches to care (Fazio et al., 2018). Labels depersonalise individuals and could lead to disempowerment and infantilism of residents with dementia (Fazio et al., 2018), which is contrary to person-centred care. Relating to a previous study (Yaghmour, 2022), it was apparent in this current study that the provision of care for residents with dementia extends beyond the confines of care workers' education and overlaps with additional factors, such as attitudes and perceptions of the medical conditions of the residents they are caring for.

6.5 Summary of the Chapter

In summary, this chapter explored RACF migrant care workers' knowledge of dementia and their dementia experiences in RACFs. It combined a quantitative study from the first phase of the study with relevant data from the qualitative interviews to gain a deeper understanding of the study objectives relating to migrant care workers' knowledge of dementia and dementia care experiences.

The next chapter reports and discusses the findings of the migrant care workers' experiences of working in residential aged care settings in metropolitan Perth.

Chapter Seven Migrant Care Workers' Perceptions of Work Experiences in Residential Aged Care Facilities

7.0 Overview of the Chapter

This chapter presents a summary of perceptions of migrant care workers' experiences as reported by Filipino, Indian, and Nigerian care workers in semi-structured interviews. The chapter provides a detailed explanation of their working conditions that may contribute to acculturation stress, as identified in Chapter Four. Migrant care workers' motivation to work in RACF and employment intentions are also discussed in this chapter.

7.1 Background

Care work consists of activities involved in meeting the physical, psychological, and emotional needs of individuals of all ages and abilities (King-Dejardin, 2019) across a range of cultural backgrounds. Care workers differ in terms of cultural background, education, skills, sector, and pay. They are employed in a range of roles from skilled healthcare workers, including doctors and nurses, to less skilled care workers, such as childcare workers and aged care workers (King, Randolph, & Floro, 2020).

RACF care workers often work in less favourable working conditions compared to other care workers and are generally low-income earners (International Labour Organisation [ILO], 2017). For example, in 2017 the International Labour Organisation reported that in 2014 aged care workers in Australia, the United Kingdom, and the United States earned around half (55–57%) of the average earnings of other occupations (King-Dejardin, 2019).

Challenging behaviour exhibited by people with dementia can cause staff fatigue, interrupt facility routines, and may hinder the delivery of care at RACFs (Cubit et al., 2007; Roe et al., 2020). The complexity of caring for residents with dementia and the potential incidents that can arise could lead to increased absenteeism and sick leave of nursing staff, property damage, decreased productivity, security costs, litigation, workers' compensation, reduced job satisfaction, recruitment, and retention issues (Cubit et al., 2007).

With the declining availability of family members and informal carers and the shortages of relatively low skilled personnel in aged care services, some aged care employers have raised concerns about increased migration to help meet current and future care demands in the Australian aged care sector (Adamson et al., 2017). The discourse focuses mainly on the recruitment of migrant care workers as a strategy to address labour shortages and to have a culturally diverse

workforce appropriate for Australia's ageing CALD population. It does not focus on the needs of the migrant workforce. However, migrant status such as their visa status, a lack of overseas qualifications and skills may affect opportunities for securing quality jobs in the Australian aged-care sector (Charlesworth & Isherwood, 2020). For example, an Australian study exploring the experiences of migrant workers found that PCAs from Southern Asia were more likely to be employed on a casual contract while migrants from both South-East Asia and Southern Asia were more likely than Australian-born workers and other migrants to be underemployed (Isherwood & King, 2017),

The 2016 report on Australian aged care workforce statistics (Mavromaras et al., 2017) indicates that migrant care workers in RACFs constitute about one-third of Australia's direct care workforce, which includes nurses, allied health workers, and personal and community care workers (Mavromaras et al., 2017). Migrant workers are significantly disadvantaged in the RACF aged care workforce (Charlesworth & Isherwood, 2020). They are more likely to work overtime, have limited control in choosing their shifts, and may engage in a higher number of night shifts when compared to their native-born co-workers (Shutes, 2012; King-Dejardin, 2019). These changes can negatively affect migrant care workers' health and well-being. Evidence shows an association between negative health outcomes, such as depression, suicide ideation, alcohol abuse, and self-reported physical health (Doucerain, Varnaamkhaasti, Segalowitz, & Ryder, 2015). These challenges often lead to social isolation, and job dissatisfaction (ref) and affect their retention in RACFs (Overgaard, Withers, & Mcdermott, 2022).

Given the need to expand the workforce in the aged care sector (Spencer et al., 2013) and to meet the demands of the increasing multicultural ageing population in Australia, it is essential to explore migrant care workers' challenges in adapting to cross-cultural care practices in their settlement countries. Factors affecting their retention in the aged care sector also need to be understood to mitigate the issues of staff shortage in this sector. Building on the results from the national cross-sectional survey in Phase One, which showed the effects of acculturation stress on the well-being of migrant care workers, this chapter further investigates migrant care workers' perceptions of the job demands in RACFs, their suggestions for improvement, and future employment intentions to leave or stay in the sector.

The chapter addresses Research Question 7 "What are the challenges and benefits of working in RACFs for migrant care workers?" and Research Question 8 "What are the enablers and barriers to migrant care workers retention in the Australian aged care sector?"

7.2 Findings

Table 7.1 presents the summary of key sociodemographic characteristics of participants with a focus on their education and work experience.

An analysis of the interview data revealed a number of themes relating to care workers' perceptions of working in RACFs as a migrant. These include motivation to work in RACFs; relationships with residents, their families, co-workers, and management; work-related stressors and re-settlement challenges; and coping strategies deployed to mitigate these stressors and barriers to providing quality dementia care. These themes may explain the high levels of acculturation stress and intentions to leave or reasons for having left employment in residential aged care.

Motivation to Work in RACF

Some participants' cultural values influenced their decisions and motivation to work in RACF. Migrant care workers from culturally diverse backgrounds often perceive care provision for older adults as the responsibility of the family and community (Pharr, Dodge Francis, Terry, & Clark, 2014). This is referred to as "filial piety" in some Asian communities (Xiao et al., 2015). Drawing on their cultural values, our participants perceived residents as similar to their grandparents. Twelve participants, mostly women, indicated that they loved caring for their grandparents in their countries of birth and their compassion for caring for older people influenced their decision to work in RACF.

"My grandma stayed at my house, so I used to take care of her with my siblings. I love her very much. I love her so much, so that is what I have transferred to the residents here." – Female Nigerian PC#3

"I had the experience of taking care of human beings, so when I came here actually, I wanted to do Child Care,. But I think the first training that came to my mind was to do Aged Care." – Female Nigerian PCA #5.

The availability of caring roles in RACFs, and being able to train as a personal care assistant within a short duration, also motivated some participants to work in RACFs. Some migrants will inevitably experienced challenges such as unemployment during their adaptation and integration into their settlement country (McGregor, 2007). Two participants, a skilled worker and a professional in the finance sector in their countries of birth, identified unemployment as a challenge when they first arrived in Australia. They explained their difficulties in securing employment in their professions because of their lack of work experience in Australia. Both participants decided to work in RACF because it was work they could more readily secure.

"Well, at first that was my gateway to come here. So let me just be honest with you that was the available work." – Male Filipino RN #1

Some participants were overseas-qualified nurses working in Australian RACFs in lower-skilled roles (for example, patient care assistants) because their overseas qualifications were not recognised and they were unable to practise in Australia. "*I do not have my registration as a nurse, so I cannot work as a nurse, this is the closest thing."* – Female Filipino PCA #2

These participants found care work in RACFs a useful stepping-stone to gaining practical knowledge and experiences in the Australian healthcare system before obtaining formal registration in the country. For some participants working in a RACF was a starting point for their future employment goals in the Australian healthcare sector, such as nursing in hospital settings. *"It's also helpful to me because it's a good training ground in terms of culture and the healthcare system. I get familiar with things that I need to know before I become a nurse."* – Female Indian, PCA #4

Relationships with Residents and Families

In order to better understand the employment situation of migrant care workers, care work should not be considered as only a set of tasks or activities, but rather involves a network of relationships between the individuals and institutions involved in caring for the needs of individuals and families (King-Dejardin, 2019).

Most participants described their relationships with residents as being positive. Participants recognised communication and social interaction with the residents and families as crucial in fostering a positive relationship with them. A friendship and familial-like relationship existed between them and the residents, especially when they had continuous professional interactions with the residents and families.

"This is how the residential or the aged care sector is different from working in the hospital in acute care because, in acute care, the turnover is quick. You take care of them for three to five days, a maximum of two weeks. If they are in intensive care, they could be there for a month. In aged care, you take care of them for those years and they become your family." – Male Filipino RN #1

Table 7.1 Sociodemographic characteristics of qualitative study participants according to nationality (n=20)

Nationality	Gender F=Female M=Male	Role in RACF	Highest education qualification	Average age ranges (years)	Average years spent in Australia	Average years of work experience	Current visa status
Nigerian	F=7 M=2	RN=2 EN=1 PCA=6	Postgraduate=3 Bachelor=3 Diploma=3 Cert 111 & IV= 0	25–36	6–10	7–10	Australian citizen=6 Permanent resident=0 Student visa= 3
Indian	F=4 M=2	RN=1 PCA=5	Postgraduate=1 Bachelor= 4 Diploma=1 Cert 111 & IV= 0	25–36	6–10	1–3	Australian citizen =5 Permanent resident=0 Student visa= 1
Filipino	F=4 M=1	RN=1 PCA=4	Postgraduate=1 Bachelor=1 Diploma=1 Cert 111 & IV= 2	36–45	1–5	1–3	Australian citizen =4 Permanent resident=0 Student visa= 1
Total	F=15 M=5	RN= 4 EN=1 PCA=15	Postgraduate=5 Bachelor=8 Diploma=5 Cert 111 & IV= 2	25–36	6–10	1–3	Australian citizen=15 Permanent resident=0 Student visa= 5

RN= Registered nurse; EN= enrolled nurse; PCA=Patient care assistant)

The importance of building positive relationships with family members was highlighted by some participants. Limited engagement between residents' family members with the residents can also negatively affect their relationships with care workers, as expressed by a participant.

"I would say generally nine out of 10, I have a good rapport with the family as well. The more you get familiar with the family member, the more they become familiar with you, because they know that you look after their parents very well. They are quite happy with the care that we give. Some residents [family members], like the other 10%, do not really come often. So you do not really get to interact with those ones." – Female Filipino PCA #3

For some participants, interaction and engagement with family members from a different cultural background was challenging and stressful. For example, a Nigerian participant narrated the racial abuse she experienced from a resident's daughter.

"There are some relatives, they are really very difficult… really do not appreciate what you are doing… she called me big XXX and she said that 'black pig'. I do not like her." Female Nigerian PCA #3

Relationship with Co-workers, Supervisors, and Employers

Similarly, some participants experienced negative working experiences with their Australian colleagues. These participants expressed a belief that their contributions were not valued in the workplace. They experienced disrespectful behaviour from Australian colleagues, which was expressed through demeaning comments and body language. The majority of participants attributed their ethnicity and their migrant status as the reasons for the treatment they received.

"Oh, you are Indian, you don't know what to do. They don't want to listen to us and sometimes we feel it. They disrespect us, with body language." – Female Indian PCA #1

Findings from the survey in Phase One indicate that experiences of discrimination and racial treatment from co-workers from the dominant culture were more frequently reported from participants from African backgrounds when compared to participants from Asian backgrounds. This perception was supported by one of the participants who was interviewed.

"When I first started my role in aged care, I was bullied… by Australian-born colleagues, because you are new in the sector… Then you start asking yourself if this how this country is? Is this racism? Of course, you are new to the system, they [Australian born workers] have over 10 years' experience, they know a lot of things. Newcomers like us are vulnerable and the culture shock is there. You're thinking is this the norm?" – Female Nigerian RN #7

Participants recognised the importance of organisational support in fostering a positive relationship

with their employers. Nearly all participants stated that they had a positive relationship with their supervisors. They felt they were supported to deliver their duties effectively through the training provided by management. "*They are good. They're helping us to learn something so that we can help the residents. That's good.*"– Female Indian PCA #3

However, a few participants (three out of twenty) reported negative experiences with management. These participants felt the management was not cognisant of their contributions to the workplace, and they felt devalued due to the lack of organisational support.

"You are doing a great job, trying to clean somebody and somebody tells you off for a minor mistake . . . The facility is more concerned about the resident or the money they are making. They can get rid of the care worker and get a new one, but for them to get rid of a client, it costs more than to get rid of the carer." – Male Nigerian EN #2

Discrimination was one of the key themes described by the majority of participants. However, discriminatory treatment varied across ethnicity, with migrant care workers from Nigerian backgrounds experiencing discrimination more frequently. Most Nigerian participants (seven out of eight) reported having experienced discrimination and racism from residents, families or work colleagues, and attributed the racist treatments to their skin colour and accent.

"Everything happens to Africans, by the time you wonder who these things happen to, you find out it's Africans, why is it only the Africans?" – Female Nigerian PCA #2

However, discriminatory treatment was not limited to migrant care workers from African backgrounds. Participants from Asian backgrounds also reported discrimination and prejudice in their workplaces. "*You can't really erase cultural prejudice, or discrimination. It's still there, but it's not as blunt. It's not as offensive. Sometimes it can be offensive, especially when your colleagues say that the company prefers Asians, and they should give the jobs back to the white people*." – Female Filipino PCA 3

Stressors Related to Working in RACFs

Stressors such as post-migration and acculturation stressors were specific to migrant care workers. These stressors hampered their ability to efficiently perform their roles in RACFs. One such stressor identified by most participants is communication difficulty. Residents and non-migrant care workers' accents, as well as their colloquial language and slang, impeded effective communication for most participants.

Some participants explained that some residents complained about their accents and inability to understand them, which eroded their self-confidence in communicating with other residents and

non-migrant staff. Racist comments by residents generally took the form of verbal abuse towards migrant care workers. *"I was trying to explain the plans for the day to a resident and I was trying my best to speak louder, but the resident was showing an unpleasant attitude. Another carer came in to intervene and he [resident] said, 'Because of her bloody accent, I could not hear what she was saying'. I was affected. I do not have the choice to choose my accent, this is who I am".* – Female Nigerian PCA #3

Communication difficulties were more profound in newly arrived migrant care workers. Most participants were able to overcome these challenges with a longer duration in their occupational roles. For instance, participants who had worked for over two years in RACFs expressed more confidence and the ability to communicate effectively with residents and staff.

"At the start, it was like the language was a problem. It was like a barrier… The first year was a little bit difficult to understand the language or the accent here, but once you settle here, you know the jargon they use." – Female Indian RN #1

Participants who experienced negative attitudes from residents, especially those with challenging behavioural symptoms, tended to ascribe the residents' negative attitude to their medical condition. They recognised that having a good knowledge of residents' medical conditions assisted them to establish a meaningful relationship with the residents.

"It can get very challenging if they start getting aggressive. But, well, the first few months I was affected. I really felt bad for them, as I understood their condition better because they don't know they don't recognise their children, their husbands, and it's like a prison. They're a lock … they're locked in that body." – Female Filipino PCA #3

Another stressor that impacted care provision was a lack of familiarity with workplace routines. Routine care provision for residents, such as preparing a cup of tea and placing the right towels for the resident's needs, was initially challenging for one participant. As explained by this participant, the adjustment to the caring role in Australian RACFs was shaped by cultural differences between her country of birth and Australia rather than skill sets.

"It's like from birth they are used to their afternoon tea. I did not even know how to make white tea. I did not know that. Well, the first difficulty that I had was differentiating between dinner, afternoon tea, morning tea. I felt really stupid at first, and I did not know the differences between a bathmat, face towel, and face wash. Because they all looked like towels to me." – Female Filipino PCA # 2

Working with residents with challenging behaviours, especially those with dementia, was another stressor identified by participants. As noted earlier, the majority of participants had no previous

dementia care experience. Working in residential aged care was a foreign concept before they arrived in Australia. Additionally, their knowledge of dementia and the associated physical and physiological symptoms were limited before their arrival. Most participants described their initial experiences of caring for residents with challenging behaviour as being confronting and disturbing.

"I was on the dementia wing; I was just sitting alone doing my documentation on the laptop. A resident just came out. I do not know where he found the knife, probably in the kitchen. He ran towards me. I thought he was going to hurt me and there was no exit … he did not hurt me. I realised that he came to the kitchen to get a knife and then went back to his room. I was scared to go back to work the next day." – Male Indian PCA # 4

Managing residents with dementia was particularly challenging for participants who were overseas trained nurses because of their limited dementia care experiences and being required to take on the responsibilities of additional supervisory and leadership duties.

"When I got promoted to a clinical nurse position, that made it more challenging. You are not dealing firsthand with residents with dementia anymore, but you have to make things better for them, to advocate for them. You have the power to suggest what they need, to implement changes in their environment and make changes in the care that they are receiving." – Male Filipino RN #1

Students on temporary visas are a disadvantaged group within the migrant aged care workforce. Three participants who were on student visas described how a lack of social network supports concomitant with their inability to access subsidised health treatment (Medicare), benefits such as childcare support, and restrictions on working hours (maximum 20 hours per week) amplified their financial difficulties. One participant explained that she was worried about paying her hospital bill when she was sick and admitted to the hospital.

Being an immigrant and not yet a permanent resident, it is very difficult. When I was in the hospital, one of the major things that made me wept was how do I clear my hospital bill? … The childcare fee is expensive here in Australia. I cannot compare it to what I have got at home…. A happy person will deliver more quality care, somebody that got so many things going on in his or her mind would have a limit to what they can deliver. Female Nigerian PCA #3.

She recommended that RACF management provide loans and re-payment arrangements as a strategy to support staff in this situation.

Coping Strategies and Psychosocial Well-Being

A diversity of coping strategies was adopted by participants to alleviate their work-related stressors.

Ignoring the stressors was the most common coping strategy that participants used to manage stressors, particularly when engaging with residents with negative attitudes or challenging behaviours associated with dementia.

"Part of the coping strategy I have used in the past and most of the time was to ignore and move on." – Male Nigerian PCA #2

Other participants who have family members working in a similar role in a RACF supported each other.

"My husband also works in aged care, so every night when I come home, we sort of debrief each other." – Female Filipino PCA #2

All participants described their caring roles in RACFs as physically and psychologically challenging. Strategies used to relieve stress at work and after work included meditation and spiritual practices. Prayers and attending religious worship sessions, such as church services, were described as a means to manage stress.

"Mostly here we have a Tai Chi session where we invite the staff or anyone to join. I think meditation is like yoga, at least five minutes before coming to work." – Female Indian RN #1.

"I believe in Jesus Christ, and I think that he gives us the power to overcome things." – Male Filipino RN #1

Self-care measures were also utilised by some participants to restore energy and reduce stress. Although the majority of participants were aware that a RACF is a challenging environment, they understood the importance of self-care. Their self-care measures included working on a part-time job contract and separating work from home life.

"To improve my general health, I tried to take a day off from my work so I can work better. That's why we are supposed to be working just two or three days, especially in this kind of environment, because when you are working daily in this environment after three or four days you feel like you need a rest." – Female Indian PCA #3

"Every time I go to work, I believe, it is just a job. Then I finish and leave work, it ends there. I don't take it home; I don't think about it at all. Then I go back the next day and pick it up again." – Male Nigerian EN #3

The participants reported having good mental health, which aligned with the findings from the quantitative data, in which over 90% self-reported good mental health. Most participants (18 out of 20) in this qualitative study also mentioned having good general health despite the work-related

stressors. Participants attributed their good general and mental health to aged care training.

"My general health has been very good. This work did not have any impact on my mental health. Do you know what helped me? During the Certificate 111 and IV training, they already told you what you're going to meet. So, whenever I was coming to work, I know what I'm coming to. So, I was prepared for it." – Female Filipino PCA #3

Perceived Barriers to Quality Care

Factors impacting the residents' quality of care in RACFs included inadequate staffing, which limited the capacity to engage with the residents as expressed by participants. Meaningful engagement with residents with dementia was described as an important element in delivering person-centred care. Participants further explained that the lack of interaction or communication between them and residents could exacerbate distress and loneliness, and for some residents may trigger negative changes in their behaviour.

"In my honest opinion, I think residents are less cared for because of the workload assigned to the carers. Their main objective is just to carry out the tasks. The care, the supports, the emotion, the empathy are all lacking. Speaking with dementia patients makes them feel valued, makes them feel loved." – Female Nigerian PCA #4

Participants further expressed that the high workload due to inadequate staffing often deterred care workers from being able to devote sufficient time for meaningful engagement and companionship.

"The residential support workers in the aged care facility do not have the luxury of time, they do not have that time." – Female Nigerian PCA #4

One participant explained the detrimental effect on the residents' quality of care in RACFs from not having sufficiently skilled staff nurses to coordinate care. This participant attributed this to staff shortages and the aged care management strategy to reduce staffing costs.

"There is a lot of skill-mixing in aged care. By skill-mix, I mean roles that nurses should do, PCAs are being trained to also perform. No matter how we sugar-coat this, the quality of care is going to be affected. You cannot exchange someone well-trained in that area for someone trained for a few days to perform the same duties… That is the reason why incidental falls, incidental medications, and negligence often occur." – Female Nigerian RN #7

The regulatory requirements of the Australian Royal Commission into Aged Care Quality and Safety were described as cumbersome by two participants who were clinical nurses in leadership positions. These participants expressed the challenges associated with adapting to emerging policies and regulations associated with aged care practices.

"Another challenge would be this whole debacle of the Royal Aged Care Commission. If you are an RN on the floor, it doesn't really bother you that much. But when you are in middle and upper management, it is different. There are big changes to the policies, big changes in the way you work and deal with the residents and their families. So that is the biggest challenge I can see at the moment, one of the changes that you try and adapt to and that's the next challenge as well. Aged care is an ever-evolving trade. I meant a policy or mandate may come out this week and then the following week, another mandate will come out as well. It's hard to keep up with these challenges." – Male Filipino RN #1

Employment Intentions

Despite the work-related challenges that participants experienced, nearly two-thirds (12 out of 20) indicated their intentions to continue their employment in RACFs. The benefits of working in RACFs, including being a family-friendly workplace and flexibility with working hours, were driving factors for participants to continue working there. Women with children described the shift work arrangements in RACF as compatible with meeting their family responsibilities. The shift work arrangements also provided opportunities for some to complete their studies, particularly those on student visas.

"The aged care sector is family-friendly and because I have a family… Yes. It is very easy to talk to people to arrange your shift." – Female Filipino PCA # 2

Adequate organisation support is another factor driving the retention of migrant care workers. A participant who had worked for 14 years in one RACF described her prior intention to train as a registered nurse and work in the hospital setting. She was unable to complete university assignments as a result of her limited computer skills. However, the barrier to progressing her career did not affect her intention to continue working in RACFs. She described organisation support and good working conditions, including mutual respect and support among team members, as the main reason to continue working in RACF.

"If you can see me as an African working in one place for 14 years, it means the management is taking care of not only their residents but even their workers." – Female Nigerian PCA #4

However, five participants, all of whom were pursuing nursing qualifications at university, intended to leave the residential aged care workforce. They provided reasons, including a perceived lack of career options. RACF tasks were also described as repetitive. One participant who had also worked in banking and finance in his country of birth perceived his current role in RACF as a low-status job and preferred to utilise his nursing skills in a multinational health organisation, such as the World Health Organization, when he completed his nursing degree. Others expressed a preference to work

in hospital environments.

"I love to work in an acute care environment. I want to learn new things. That's's why I'm going to work in the hospital as well, so I can get to know about more things." – Female Indian PCA #4

Compassion for the caring needs of older adults and a desire to help others had initially motivated one participant to work in RACF. However, she worked for only eight months and left because of tension and perceived racially motivated treatment from non-migrant workers, as well as disloyalty from some migrant care workers from different cultural backgrounds, which impacted her general and mental health.

"I love to work and look after older people, and I did not have a problem with the residents. I am always patient and tolerant and I know they (residents) need care… What I hated was colleagues talking behind me. I was constantly having heartache and couldn't sleep well, even after work. I had to quit? If I had stayed there, I would go mad." – Female Filipino PCA 3

Another factor that contributed to leaving or intending to leave the sector was a perception of poor quality of care for residents. Organisational resources such as low staffing levels were seen as negatively impacting residents' quality of care. Three participants perceived residents' level of care as being inadequate. They described care as frequently rushed with minimal time for interaction and communication with the residents. For these three participants, their decisions for leaving the aged care sector was influenced by a sense of social justice.

"I cannot handle the way the residents are treated. It's not the workers' fault; they have been told by the managers to rush their duties and finish at a specific time… The RACF is too money-oriented. For me, not treating someone right is wrong. I cannot work in that environment I had to leave." – Female Filipino PCA #4

Two out of the three participants had already resigned from their full-time positions in RACF to work in the disability sector. The participants described greater career fulfilment working in the disability sector, due to a reduced workload, which enabled an opportunity to engage meaningfully with the care recipients.

The majority of participants (14 out of 20) expressed good personal relationships with the management and will continue to work in this setting. However, this might not be sufficient for some participants, as they perceived the quality of care provision as being compromised by the high workload that often deters good relationships between care workers and residents.

7.3 Overview of the Findings

Work-related stress resulting from insufficient time to provide quality care and working with residents with chronic medical conditions and behavioural changes associated with cognitive decline and dementia were identified by the participants. Other sources of stress related to communication difficulties, occupation-related injuries and prejudice from residents' families and work colleagues from dominant cultures. The majority of participants (18 out of 20) experienced negative relationships in the form of prejudice and discrimination from some residents and from co-workers.

Stressors such as high workload, low remuneration and lack of career projection (Gao, Tilse, Wilson, Tuckett & Newcombe, 2015), complex regulatory care requirements, deprivation of personal time, deteriorating health, aggressive behaviours and violence from residents are some challenges faced by aged care workers, and not only migrant care workers (Cheng, Nielsen, & Cutler, 2019). However, our study reveals that the complexity of additional resettlement stressors including communication difficulties, the lack of familiarity with the host culture and social support may impede migrant care workers' ability to perform their duties effectively.

Participants' ethnicity was reported as a predictor of acculturation stress in the Phase One. Respondents from Sub-Africa that completed the national cross-sectional survey had the highest acculturation stress when compared to those from other ethnic backgrounds. The survey results did not show discrimination as the main cause of acculturation stress among this cohort, however, expanding on the survey results (Phase One), a large proportion of participants (7 out of 8) from Nigerian backgrounds expressed discrimination as a stressor in Phase Two. These findings resonate with previous studies that reported that migrant care workers from non-Caucasian backgrounds expressed racism in their workplaces (Behtoui, Boréus, Neergaard, & Yazdanpanah, 2020; Storm, 2018).

Additionally, occupational role was shown as a predictor of acculturation stress in Phase One of this current study. The national cross-sectional survey conducted in Phase One revealed nurses had the highest acculturation stress when compared to other occupational roles (Chapter Four). Consistent with the survey results, the RN participants in Phase Two expressed profound challenges in their roles. Challenges included onerous regulatory requirements, supervising the care team, meeting the residents' needs, and family expectations. The combination of these challenges and other resettlement challenges that migrants often further faced explained higher acculturation stress in RACF migrant nurses.

Expanding on the quantitative findings, the participants self-reported good general and mental

health. They ascribed this to aged care training, self-care activities, and a wide range of emotion-focused coping strategies, despite the acculturation stress and their resettlement challenges.

A wide range of factors included flexibility with working hours and being a family-friendly work environment, motivated participants to continue to work in RACFs. However, organisational support was the main driving factor for most participants to continue working in RACFs. Barriers to staff retention as highlighted by staff included lack of career progression, low care level for residents, and negative attitudes from co-workers.

7.4 Summary of the Chapter

This chapter presented an insight to migrant care workers' work experiences in RACF and how this influences their intentions to stay or leave RACFs. It summarised the characteristics of the 20 interviewed participants and key themes that emerged from the qualitative data related to their work experiences in RACFs. The final chapter will summarise the overall study results as they align with the research questions. The strengths and limitations of the study, the conclusion, and the potential for future research are provided.

Chapter Eight Discussion and Conclusion

8.0 Overview of the Chapter

The final chapter highlights the study findings from Phase One and Phase Two in alignment with the four research objectives. The key findings are discussed in relation to these objectives. In accordance with an explanatory sequential mixed methods design, the findings from the two phases of the study strengthen or corroborate the key findings. The strengths and limitations of the research are described, and the recommendations for aged care policy and practice are identified and discussed.

8.1 Key Findings

This research study examines the existing knowledge and contributes new findings to the body of knowledge research relating to migrant care workers' knowledge of dementia and their dementia care experiences in Australian RACFs. The study highlights the link between migrant care workers' working experiences and their general and psychosocial well-being. Table 8.1 summarises the key findings in relation to the research questions outlined in chapter one.

8.1.1 Knowledge and Understanding of Dementia in RACF Migrant Care Workers

This section addresses Research Questions 1 and 2 . Participants in this study demonstrated moderate levels of knowledge of dementia (median DKAT total scores of 15 out of 20). As noted in Chapter Five, the majority of migrant care workers in Phase One (92.2%) understood dementia as a brain-related disease, as did a similar proportion of participants (19 out of 20) in Phase Two. This basic understanding may assist care workers when attending to the needs of people with dementia and ensure they do not inflict burdensome interventions that may be of limited benefit to the care recipients, or that could be inconsistent to a palliative approach to care (Mitchell et al., 2009) and could ultimately lead to poor care outcomes for residents with dementia

Table 8.1 Summary of the key findings in relation to the research questions

Research Questions (RQ)	Key Findings
RQ 1: What are the current literature findings on the knowledge of dementia among RACF migrant workers? **RQ 2:** What are the levels of knowledge and understanding of dementia among migrant care workers? **RQ 3:** What are the experiences of dementia care among RACF migrant care workers?	• There is a paucity in the literature regarding the knowledge of dementia in migrant care workers employed in residential aged care facilities. • Migrant care workers have a moderate level of knowledge of dementia (**new findings**). • There are deficiencies in knowledge of the cause of dementia and physical symptoms associated with the comorbidities of dementia. • Migrant care workers' preconceived beliefs around dementia has a greater influence on their knowledge of dementia as a normal ageing process than their sociodemographic characteristics.
RQ 4: What are the levels of acculturation stress among RACFs? **RQ 5:** What are the levels of mental health measures of depression, anxiety, and stress? **RQ 6:** What are the impacts of acculturation stress on the psychosocial well-being of migrant care workers?	• Acculturation stress is high in RACF migrant care workers. Their work roles, ethnicity, and self-reported English proficiency are significant contributors to their acculturation stress (**new findings**). • Migrant care workers have good mental health measures for depression, anxiety, and stress (**new findings**). • Migrant care workers can experience acculturation stress without having a measurable impact on their mental health (**new findings**).
RQ 7: What are the challenges and benefits of working in RACFs for migrant care workers? **RQ 8:** What are the enablers and barriers to migrant care workers retention in the Australian aged care sector?	• Some groups of migrant care workers, especially those on temporary visas and new arrival cohorts, are likely to be highly disadvantaged when compared to other groups of migrant care workers. • An intersection of work-related stressors and post-migration challenges are significant contributors to migrant care workers' job satisfaction and retention in RACFs. • Despite a combination of post-migration and workplace challenges often experienced by

migrant care workers, the majority (60%) of migrant care workers that participated in the qualitive interviews still intend to continue working in RACFs **(new findings)**.

- Organisational support and positive relationships with co-workers are crucial factors enhancing migrant care workers retention.

Knowledge deficiencies among RACF migrant care workers who completed the national cross-sectional survey (Phase One) were evident in two main areas: (1) physical symptoms associated with dementia and (2) causes of dementia and its progression. The current study finding is consistent with comparative international studies, which identified deficiencies among migrant care workers in their knowledge of symptoms associated with dementia and age related dementia (Ayalon, 2009). It was apparent in this current study and previous cross-cultural dementia studies that some migrant care workers perceive dementia as part of the normal ageing process (Brooke et al., 2017; Nichols et al., 2015).

While age has been recognised as the strongest risk factor of dementia, especially year 65 and above, dementia is not a projected part of ageing (Gerritsen, Oyebode, & Gove, 2018). The belief that dementia is part of the normal ageing process could negatively impact migrant care workers' understanding, as they may perceive that residents require support due to their age, rather than the symptoms associated with dementia (Egede-Nissen et al., 2017). This could affect the quality of care provided for residents. Care could be compromised when dementia is considered a normal part of the ageing process rather than a neuropathology condition, and this could subject residents to ageism (Gerritsen et al., 2018). Ageism is a negative stereotypical and prejudicial perception that older adults are forgetful (Ayalon, 2009), less deserving, incapacitated, and in need of protection (Gerritsen et al., 2018). This could further result in the lack of comprehensive coordinated care support for the residents (Gerritsen et al., 2018).

Explicitly, residents' quality care would be affected when care workers rely on the philosophies of care based on their personal beliefs rather than evidence-based knowledge (Stangl et al., 2019). Ageism and stereotyping arises when care workers fail to see the person behind the medical condition (Digby, Lee, & Williams, 2017) or when they associate dementia with a mental health disorder (Stangl et al., 2019). The perceptions of residents with dementia as having a mental health condition can lead to labelling the person as violent, dangerous, and incompetent (Stangl et al., 2019). Research shows that such labelling could depersonalise a person with dementia and subject

them to disempowerment and infantilism (Fazio et al., 2018), which could affect their overall well-being. Evidence-based understanding of the residents' medical conditions (Stangl et al., 2019) and dementia care philosophies among direct care workers is essential to providing quality care for residents with dementia.

Modifiable risk factors, such as excessive alcohol consumption, chronic medical conditions, diabetes, and cardiovascular diseases, have been widely recognised in research as factors that could increase the risk of cognitive decline and dementia in individuals (Baumgart et al., 2015). Consistent with previous qualitative findings (Antelius & Kiwi, 2015; Ayalon, 2009; Nichols et al., 2015), Phase Two study participants accurately identified associated risks factors for dementia and further mentioned additional modifiable risk factors, such as trauma, alcohol, mental illness, hereditary, and Parkinson disease. However, most participants confused the associated risk factors of dementia with the cause of dementia. To date, the cause or aetiology of dementia is unknown, but risk factors associated with dementia have been scientifically established (Kenigsberg et al., 2016).

Notably, the three DKAT 2 items with a higher proportion of incorrect responses (7, 12, and 20) have *false responses* as reflected in Table 5.3. Similarly, participants in a previous Australian study (Robinson et al., 2014) that measured RACF care workers' knowledge using DKAT2 also had larger incorrect responses in DKAT 2 items 12 and 20. This raises concerns whether respondents' incorrect responses were an accurate reflection of knowledge deficiencies in these items or were influenced by how the questions were structured, which might have hampered respondents' ability to accurately interpret the questions and provide accurate responses. (Investigation of this concern was outside the scope of this current study.)

For example, over two-thirds of the survey respondents in Phase One incorrectly reported that it is impossible to recognise pain in residents with advanced stages of pain. However, in elaborating on this question in Phase Two, the majority of participants (18 out of 20) emphasised the importance of a person-centred approach in recognising pain in residents with dementia. Additionally, the majority of participants (81.5%) in Phase One showed knowledge deficiency in understanding the cause of dementia in relation to its progression. Further expansion of the topic among Phase Two participants indicated their good understanding of the associated risks of dementia and their good knowledge of dementia as a terminal neurological condition. In summary, the explanatory sequential mixed method utilised in this current study provided an opportunity to better understand participants' baseline knowledge of dementia.

The quantitative analysis in this study did not demonstrate any statistical significance between

migrant care workers' sociodemographic characteristics and their knowledge of dementia. Previous studies that examined differences in knowledge of dementia across racial and ethnic groups showed inconsistent findings in this area (Carpenter, Zoller, Balsis, Otilingam, & Gatz, 2011). Some found minor differences in the knowledge of dementia among Hispanic, African American, and Caucasian groups (Connell et al, 2009), while others reported significant differences between knowledge of dementia and ethnicity (Carpenter et al, 2011).

Overall, findings from this current study show that migrant care workers have similar knowledge of dementia compared with results from other studies that include care workers from the dominant culture. The positive impact of staff dementia training was highlighted by study participants in Phase Two, which suggests that education on dementia has a similar impact on knowledge of dementia, regardless of cultural diversity among care workers.

8.1.2 Dementia Care Experience

This section addresses Research Questions 3. The qualitative component in this current mixed-method study allowed the researcher to have a greater understanding of migrant care workers' pre- and post-migration dementia care experiences. A deeper expression of participants' beliefs and values emerged through in-depth discussions (Hesse-Biber, 2010).

As highlighted in Phase Two, the majority of participants had no pre-migration dementia care experiences in institutional aged care settings. Comparative qualitative studies that explored migrant care workers' dementia care experiences reported similar findings (Nichols et al., 2015; Yong & Manthorpe, 2016). The challenge of care provision in residential aged settings varied among study participants. Newly arrived migrant care workers were more likely to experience challenges in providing dementia care to the residents. This finding is not surprising, given newly arrived migrant care workers have limited dementia care experiences and dementia training prior to their arrival to their host countries (Adebayo, Nichols, Heslop, & Brijnath, 2020; Brooke et al., 2017).

Organisation culture plays a significant role in the quality of dementia care in RACFs (Stanyon, Griffiths, Thomas, Gordon, & ageing, 2016). For example, a RACF with a person-centred care organisation approach is likely to provide quality care to residents with dementia (Gilster et al., 2018). Migrant registered nurses often face resettlement challenges, such as limited English proficiency and a lack of understanding of the host's workplace culture (Ma et al., 2010). Additionally, challenges including care coordination, administrative duties, management of residents and families' care expectations in an ethical manner, and continuous professional development education (Gilster et al., 2018) have also been identified among RACF workers in

leadership roles. Challenges such as onerous and evolving aged care regulations and residents' advocacy duties associated with supporting quality care for residents with dementia and additional supervision in tandem with RACF migrant nurses' resettlement challenges were identified in this current study

Previous studies have investigated migrant nurses' work experiences and analysed the impacts of their resettlement challenges on their care practices in hospital settings using both qualitative (Jose, 2011; Kishi et al., 2014; Zhou, 2014) and quantitative approaches (Goh & Lopez, 2016; Ma et al., 2010). These studies identified challenges that hampered their ability to perform their duties, including the level of English proficiency (Ma, Quinn Griffin, Capitulo, & Fitzpatrick, 2010) and the influence of their cultural perceptions on some medical conditions, (Xiao, Willis, & Jeffers, 2014).

According to the World Health Organization (cited in Ratcliffe et al., 2020, p. 5), high-quality care is defined as "care that is safe (minimises risks and harm), effective (provides services based on evidence guidelines), timely (reduces delays), efficient (uses resources in the best way possible), equitable (delivery of care should be the same despite personal characteristics), and person-centred (taking into account the unique preferences, values and needs of the individuals accessing" care. Participants in this study reported that residents with dementia were not receiving high-quality care. They identified barriers to quality care for residents with dementia in RACFs. These barriers included inadequate staffing (Timonen & Doyle, 2010), a non-user-friendly care environment (Garcia & Slaughter, 2012), and onerous government regulatory care requirements (Mariani et al., 2017).

In Australia, the Aged Care Quality Standards outlines new quality standards for RACFs in relation to residents' dignity, care planning, individualised services and supports, organisational environment, and governance (Australian Government Department of Health, 2018; Hamiduzzaman, Kuot, Greenhill, Strivens, & Isaac, 2020). However, the quality of aged care provided to older Australians, especially those with dementia in residential aged settings, is still of major public concern (Ratcliffe et al., 2020). Consistent with the 2016 Australian aged care workforce statistics (Mavromaras et al., 2017), the majority (73%) of this study's participants were PCAs from minority backgrounds. PCAs provide most of the care for residents with dementia as they are responsible for supporting residents' physical care, offering meaningful activities, and promoting their emotional well-being (Gilster et al., 2018; Morrison-Dayan, 2019). However, the PCAs may not have the authority to address organisational barriers hindering residents' quality care or to advocate to relevant government agencies to address systemic barriers hampering residents' quality care.

The goal of dementia care to provide residents with high-quality person-centred care that incorporates both physical and psychological care through interpersonal relations between staff and residents (Fazio, Pace, Flinner, & Kallmyer, 2018) was expressed by participants in this current study. Direct care workers, especially PCAs, caring for residents with dementia often understand the residents' preferences, behaviours, and functioning and may be the first to notice physical changes, signs of illness, and pain in residents with dementia (Gilster et al., 2018). However, organisational challenges such as workload pressures due to poor staffing levels, which result in insufficient time to engage with residents, and the limited allocation of time for training could hamper their ability to develop person-centred care with the residents (Timonen & Doyle, 2010).

Thus, the views of migrant care workers on the quality of dementia and recommendations to improve such quality should be considered because the majority of this cohort are direct care workers that provide personal care and are in regular contact with the residents (Morrison-Dayan, 2019). This was the reason why the researcher was contacted by the Royal Commission into Aged Care Quality and Safety (the Royal Commission) to invite migrant care workers to attend hearings on the current levels of quality care in RACFs. The Royal Commission was interested in the perceptions of migrant care workers in relation to the residents' quality care and workforce issues impacting the residents' care.

8.1.3 Physical and Psychosocial Health

This section addresses Research Questions 4, 5 and 6. The process of adapting to a different culture in a new society, referred to as "acculturation" (Berry, 2005), could lead to a certain level of stress in some migrants because of the differences between their culture and the new host culture (Kim & Kim, 2013). While previous studies have focused on acculturation stress among migrant care workers in hospital settings (Jose, 2011; Ma et al., 2010), few have focused on acculturation stress such as discrimination among RACF migrant care workers (Goel & Penman, 2015; Doyle & Timonen, 2009).

This current study not only provides empirical findings on the levels of acculturation stress among RACFs migrant care workers in Phase One, but also identifies predictors of acculturation and work-related stress among this cohort. The predictors include migrant care workers' ethnicity, occupational roles, and English proficiency. Data gathered from the interviews provided an opportunity to gain a greater understanding of daily routine issues that can contribute to acculturation and work-related stress for migrant care workers.

These predictors were corroborated in the qualitative findings. For instance, the quantitative analysis shows that the migrant nurses (RNs M=40.4, *SD* = 14) had higher acculturation stress

levels when compared to the PCAs (M=37.6, *SD*= 13.9). This can be explained by the additional challenges that RN participants in the qualitative interviews identified, including additional roles involving implementation of care requirements by the aged care regulatory body, supervisory, and advocacy roles.

Linguistic and communication dimensions have always been an important aspect of the acculturation process for migrants in their resettlement countries (Goh & Lopez, 2016). Participants' English proficiency screening questions were administered alongside the other instruments in the cross-sectional survey. A majority of the participants self-reported good levels of English proficiency in terms of *fluency, comfort in communication* and *ability to understand* as discussed in Chapter Four. Approximately half of the respondents reported being very fluent (51.1%) in English. Previous findings indicate English language proficiency is an acculturation stressor even among migrant care workers who had passed host country English proficiency tests (Ma et al., 2010) . Therefore, a decision was made to investigate the impact of respondents' language proficiency on their acculturation process in Phase Two, despite their self-reported good level of English proficiency.

In the current study, language as an acculturation stressor emerged both in the quantitative and qualitative findings (Phase One and Phase Two). Statistical analysis (via multiple linear regression tests) demonstrated English proficiency as a predictor of acculturation stress. Communication difficulty was also identified as one of the most challenging aspects of acculturation and a source of acculturation stress among some participants in Phase Two, especially at the initial stage of their employment in RACF. Consistent with previous relevant cross-cultural studies (Liou & Cheng, 2011; Nichols et al., 2015), participants' communication difficulties negatively affected their relationships with the residents and colleagues from the dominant culture. Participants in this present study expressed that to integrate better in their workplaces and have meaningful relationships with residents and co-workers, they had to learn the local idioms and jargon in conjunction with the host country's culture-specific verbal and non-verbal communication styles.

Kolanowski et al. (2015) found that RACF care workers identified oral and written information and formal meetings as the main sources of sharing information around residents' care plans and changed behaviour associated with residents' dementia. However, their study also found that PCAs perceived that the oral method of exchange was more effective than the written information in medical charts or resident care plans due to time constraints (Kolanowski et al., 2015). Thus, it is important for direct care workers in RACFs to understand that they need to provide both accurate documentation and timely verbal communication to facilitate quality care in RACFs (Adebayo, Durey, & Slack-Smith, 2017). While participants' ability to communicate fluently in English was

investigated in this current study, it did not investigate participants' abilities to convey medical information to co-workers as it was outside the scope of this study.

The influence of migrant care workers' ethnicity on acculturation stress was demonstrated in both phases of the study. The levels of acculturation stress varied among migrant care workers from different cultural backgrounds. Participants from Sub-Saharan backgrounds had the highest levels of acculturation stress when compared to other cultural groups. Sub-Saharan Africans as a group had the highest mean RASI scores (M= 42.9.0, *SD* =13.4) when compared with South-East Asian (M= 33.6, *SD*= 12.1), and South Asian (M= 34.3, SD= 13.1) migrants. A similar result was obtained in Phase Two, where the majority of participants of Sub-Saharan background (Nigerians) expressed experiencing discrimination and racial comments more frequently than other participants from South-East Asian (Filipinos) and South Asian (Indians). This finding is consistent with previous qualitative studies (Alexis, 2015; Doyle & Timonen, 2009; McGregor, 2007).

Despite evidence of acculturation stress, participants in this study had good mental health according to their DASS-21 total scores. A high proportion (87% to 98%) of the respondents had normal to mild levels of depression, anxiety, and stress. There were no statistical relationships between respondents' sociodemographic characteristics and their mental health, which was supported by qualitative findings where most (19 out of 20) participants expressed good general and mental health. This suggests that acculturation stress can occur without having a measurable impact on the more common mental health measures of depression, anxiety, and stress. Additionally, this finding could also suggest that RACF migrant care workers who have learned coping skills are able to withstand the impact of acculturation.

. In alignment with previous study (Bodeker, Pecorelli, Choy, Guerra, & Kariippanon, 2020), the current study participants' good mental health can partially be attributed to their coping strategies which included viewing stressors from a religious perspective and self-care activities include listening to music, meditation and relaxation exercises such as yoga. According to Folkman and Lazarus (1984), "coping" is referred to as the cognitive and behavioural efforts that are constantly changing to manage specific external and/or internal demands that are appraised as exceeding the resources of the person. Coping strategies can be problem-focused or emotion-focused (Folkman & Lazarus, 1984). Problem-focused coping includes problem-solving activities and seeking information, while emotion-focused coping includes seeking others' company and cognitive activities, such as the denial of facts to distort the real situation or being unreasonably optimistic (Healy & McKay, 2000).

In the current study, participants' resilience was demonstrated in their abilities to deploy various

coping strategies to manage these stressors. Resonating with previous qualitative related studies (Nichols et al., 2015; Walsh & Shutes, 2013), participants in this present study expressed emotional-focusing strategies, including avoidance, overlooking racism and discrimination from the residents, and being emotionally resilient to prejudice from the Australian colleagues. These coping strategies might have contributed to their low levels of depression, anxiety, and stress and enabled them to mitigate their stress and maintain good mental health. However, this may not be the case for those who have left this sector, as reported by two participants.

Capasso and Zurlo (2015) also found that migrant workers who had experienced racial discrimination and utilised emotional-focused coping strategies were less likely to suffer anxious-depressive disorders and work-related stress. However, Boumans and Landeweerd, (1992) reported problem-focused coping strategies are positively related to job satisfaction and negatively to poor health conditions when dealing with workplace stress. Problem-focused and emotion-focused coping strategies were successfully used by the participants to limit the impact of discrimination in workplaces, indicating that RACF migrant care workers could be supported to use both forms of coping strategies to mitigate acculturation and work-related stressors. Providing organisation support such as culturally relevant psychological or counselling services could enable new migrant care workers to recognise and manage the impact of stressors and to further enhance their well-being.

8.1.4 Working Conditions of RACF Migrant Care Workers

This section addresses Research Questions 7 and 8 The process and quality of care involves a myriad of factors, not only for the care recipients but also for the care workers, such as the working conditions under which they are employed and perform their roles (King-Dejardin, 2019). These factors are indispensable in ensuring that residents access quality care (King-Dejardin, 2019). Workplace stress is a multi-factorial condition involving the relationship between the individual and the environment, which has certain aspects that they perceive as stressful in relation to their coping resources (Saarnio, Sarvimäki, Laukkala, & Isola, 2012). Heavy workloads and managing residents with changing behaviours and chronic medical conditions are prevalent issues identified by aged care workers as contributing to work-related stress (Lovelock & Martin, 2016).

The relationships between care workers, families, and residents are important determinants of successful care outcomes in RACFs (Jones & Moyle, 2016). Participants' cultural norms, beliefs, and values associated with caring for older people were evident in the relationships they formed with the residents. The strenuous workload that care workers often experience did not deter positive relationships between the study participants and the residents. Friendship and familial-like relationships were also reported in Phase Two between some migrant care workers and the residents

in this present study. These participants equated the residents to their grandparents and older family members in their home countries and thus transcended their required duties to care for the residents. Their premise was based on their cultural norms and religious beliefs. This is particularly evident for carers from collectivist cultures in which familial care is perceived as obligatory (Nguyen et al., 2021).

The influence of cultural norms of familial care for the provision of quality care for residents should not be underestimated, as evidence shows that familial-like care builds morally obligated and emotionally devoted workers that will exceed beyond expectation to care for residents (Dodson & Zincavage, 2007). However, Spencer et al. (2013) argue that quality care could not be simply perceived as being influenced by cultural or religious norms and that other factors, including effective communication, also play an important role in residents' quality care.

Factors influencing care workers' motivation to work are complex (Xiao et al., 2021) and includes personal, institutional, and societal factors (Matarese, Lommi, Piredda, Marchetti, & De Marinis, 2019; Xiao et al., 2021). In this current study, some migrant care workers motivation to work in RACFs was shaped by positive factors including RACFs being family-friendly workplaces with flexible working hours and shifts, compassion in caring for older adults, and a sense of helping others, the availability of aged care jobs compared to other jobs was another motivation factor for some migrant care workers.

Negative factors identified by the participants included a lack of recognition of migrant care workers' overseas nursing qualifications and an inability to obtain employment in a previous profession, forcing them to consider working in RACFs. Consistent with previous findings (Bourgeault et al., 2011; Goel & Penman, 2015), overseas trained nurses currently working as PCAs perceived aged care as a steppingstone to working in the future in the Australian healthcare system as a nurse and registering with the practising body in Australia.

Aged care is physically and psychologically demanding for all workers regardless of their ethnicity (Gao et al., 2015). High workloads, low remuneration, lack of career projection, complex regulatory care requirements, deprivation of personal time, deteriorating health, and aggressive reaction and violence from residents are some challenging stressors faced by aged care workers, and not only migrant care workers (Cheng, Nielsen, & Cutler, 2019). This current study findings align with previous study findings (Yong & Manthorpe, 2016) that reported that the complexity of additional post-migration stressors, including communication difficulties, a lack of familiarity with the host culture, and a lack of social support, may impede migrant care workers abilities to perform their duties effectively.

Attracting and retaining skilled care workers to the aged care sector to meet the care needs of older adults is challenging for high-income countries such as Australia with a growing ageing population (Xiao et al., 2021). However, the qualitative analysis in this current study shows that most migrant care workers (60%) intend to continue working in RACFs despite their experiences of acculturation stress and workplace challenges. Positive workplace culture and organisational support are key factors to migrant aged care workers' retention (Willis et al., 2018), as highlighted by participants in this study.

Although over two–thirds (13 out of 20) of Phase Two participants expressed a willingness to continue to work in RACFs, this may not necessarily reflect a positive outcome. It could indicate that some migrant care workers are unwilling to leave because they cannot obtain their preferred jobs. They may feel trapped in their jobs, a situation referred to as "job lock" (King, Wei, & Howe, 2013). Job lock in this instance could also be due to migrant care workers having financial dependents and needing to send remittances to family members in their birth countries (Lovelock & Martin, 2016), or being an older worker (King et al., 2013) with established skillsets in the aged care sector and are scare to change careers. However, this job lock can be turned into a positive experience for migrant care workers and job satisfaction can be enhanced while workers are unable to leave their jobs (King et al., 2013) if barriers to their job dissatisfaction are addressed and effective strategies are implemented to improve their retention.

Consistent with comparative findings (; (Isherwood, Mavromaras, Moskos, & Wei, 2018)Timonen & Doyle, 2010), participants who intended to leave RACFs identified challenges such as poor quality of care for residents because of the limited organisational resources and low staffing levels in RACFs. Notably, all participants (six) pursuing nursing qualifications at a university perceived tasks in RACF as repetitive and expressed their intentions to leave the residential aged care workforce due to the lack of career progression in the RACFs.

The increased presence of international students, especially the nursing students in the aged care sector, was evident in the COVID-19 pandemic where they filled in the gaps in workforce shortages in Australian residential RACFs (Xiao et al., 2021). Thus, it is important to identify the barriers and to consider factors that can attract this cohort and enhance their job satisfaction in order to retain them in the residential aged care workforce. For example, in this present study, participants who were on student visas expressed a lack of social network support, which was compounded with the inability to access subsidised social support services, for instance, childcare The inability to access childcare rebate allowances and healthcare coverage through the universal healthcare system, Medicare, created post-migration challenges for migrant care workers on student visas. This negatively affected their well-being and productivity as highlighted in Chapter seven.

Yong and Manthorpe (2016) reported that the most challenging period for migrant care workers was their initial employment period when they first started their roles in RACFs. Participants in his study are from Indian backgrounds employed in aged care settings in England. Similarly, participants in this current study identified challenges when they first started working in the sector as initial stressors, including communication difficulties, the lack of familiarity with workplace culture, inability to manage workplace harassment and discrimination from colleagues from the dominant culture, limited understanding of residents' medical condition, and the lack of confidence to response to such residents' care needs. Positive relationships with co-workers and organisational support are crucial to retaining newly arrived migrant care workers as evidence shows that they are highly likely, compared to other groups of workers, to report that such support from managers was a major contributor to their job satisfaction (Isherwood et al., 2018).

8.2 Study Significance

The success of the future aged care system is determined by a highly skilled, appropriately remunerated, and valued aged care workforce (Brown et al., 2017). The final report of the recent Royal Commission (2021) revealed that the quality of dementia care in the aged care system, especially in RACF, require significant and immediate improvement.

To the researcher's knowledge, this was the first Australian study that examined the level of knowledge of dementia among RACF migrant care workers nationally. Previous studies examined the level of dementia knowledge among RACF aged care workers, family members of people with dementia (Robinson et al., 2014), and nursing students (Eccleston et al., 2015). Jones and her colleagues (2013) also investigated the level of knowledge of dementia and training among care workers from the dominant cultures and migrant backgrounds employed in three different Australian RACFs in Queensland only. Their study reported that cultural and ethnic origin and the length of residency in Australia were predictors of knowledge of dementia in RACF migrant care workers (Jones et al., 2013). However, their results were limited by a relatively small sample size (n=35) and geographical constraint as the study was conducted only in one Australian metropolitan area (Brisbane), which ultimately limited the generalisability of their research findings. This current study addressed the gap in the limited knowledge in this area and provided an understanding by investigating the level of knowledge of dementia among RACF migrant care workers from 47 different nationalities across Australian States and Territories.

Given the increasing reliance on the multicultural workforce in the Australian aged care sector (Mavromaras et al., 2017) the research is timely and important. Migrant care workers have received little attention in Australia-focused research (Fine & Mitchell, 2007), and they have not been

considered in any significant way in Australian aged care policy and practice. Migration strategies to support an increasingly multicultural aged-care workforce have received limited attention (Charlesworth & Isherwood, 2020), despite this cohort constituting over a quarter of the Australian residential aged care workforce (Mavromaras et al., 2017).

The current projection shows an increase in the numbers of older adults and those with dementia in Australia over the next 30 years, which will result in a substantial increase in people relying on different types of aged care, including RACFs (Annear, 2020). The impact will be evident in the number of people required to deliver aged care, including the aged care workforce in RACFs. Australia will likely continue to encounter a shortage of aged care workers if pragmatic workforce planning is not implemented to address these forecasted issues in the aged care workforce.

Due to a high proportion of older workers in the aged care sector, the Australian Aged Care Workforce Strategy Taskforce recommended targeting migrant care workers from culturally diverse backgrounds (Commonwealth of Australia, 2018). However, strategies specific to retention were not outlined in the report. This study addressed this gap by identifying enablers and barriers to job satisfaction and retention among the migrant aged care workforce.

It is well documented in the literature that challenges (Gilster et al., 2018) exist for direct care workers caring for residents with dementia. These challenges are further compounded by families and the aged care regulatory bodies. Chapters seven and eight highlighted the challenges of dementia care provision in conjunction with acculturation stress among RACF migrant care workers. The understanding of the impacts of the additional acculturation stressors juxtaposing with other work-related stressors on the well-being of migrant care workers can inform aged care policy and practice. Addressing these issues can further support and enhance migrant care workers' skills and confidence in delivering high-quality service. The findings provided a detailed understanding of ways in which dementia care, acculturation stress, and the workplace culture in RACFs affects migrant care workers' well-being.

This study expands the limited scholarship on migrant care workers' knowledge of dementia in institutional settings. Inadequate skills among RACF staff are one factor identified as a barrier to quality dementia care in the Royal Commission's 2021 report. The report notes that the aged care workforce must have the appropriate education and training, skills, and attributes to provide quality care for people with dementia with complex care needs. Staff training in dementia care is thus essential for aged care workers, including migrant care workers. The identified knowledge deficiencies could inform aged care management on critical areas for training and education for migrant care workers, to better equip them to provide care for residents with dementia.

Like other nations globally, Australia faces challenges responding to the COVID-19 pandemic, particularly with regards to protecting the health of vulnerable populations, including older Australians (Commonwealth of Australia, 2020), and the social and health care especially of the aged care workforce. In the first wave of the pandemic in Australia, three-quarters (75%) of total deaths have occurred in RACFs, giving Australia one of the highest rates worldwide of deaths in RACFs (Cousins, 2020). A lack of preparedness for infection control in pandemic situations was attributed to the high transmission rates for the COVID-19 infection in RACFs (Davidson & Szanton, 2020). It has become apparent that the residents and staff could not be kept safe because care workers have not been adequately supported to provide safe and quality care (McGilton et al., 2020).

Prior to the COVID-19 crises, the Australian aged care sector had been grappling with the chronic shortage of skilled nursing staff, high staff turnover, and staff ageing (Qian, Yu, & Hailey, 2016). PCAs, who comprise the majority of the workforce in Australian RACFs, are not adequately trained to manage the complex care needs of residents, particularly in the context of a pandemic (Davidson & Szanton, 2020). Thus, in the early days of the pandemic, it was not surprising to see the quality of residents' care outcomes being compromised as a result of the lack of skilled care workers and inadequate resources (Davidson & Szanton, 2020). The Royal Commission's special hearing into the aged care sector's response to COVID-19 found that existing and ongoing staffing and skills mix shortages incapacitated the ability of the RACF management to provide quality care for the residents (Peters, Marnie, & Butler, 2021).

Furthermore, staff who earn low wages or are on a part-time employment contract may work at multiple nursing homes to earn a liveable wage, putting themselves, residents, and staff at increased risk of spreading the virus. The current aged care workforce consists of a high proportion of PCAs, the majority of whom are migrant care workers on low incomes, working on part-time employment (Mavromaras et al., 2017). Thus, the consequences of the COVID-19 pandemic crisis in RACFs have revealed and accentuated the need to support the vulnerable cohort of residents and staff in the aged care sector (McGilton et al., 2020).

Although this current study was conducted before the emergence of the COVID-19 pandemic, findings and recommendations from this current study in relation to how RACF migrant care workers can be supported will be useful for informing and guiding the implementation of successful aged care workforce reforms and pandemic preparedness training to improve migrant care workers' confidence and skills in delivering quality care.

Additionally, the COVID-19 crisis has exacerbated the ongoing staff shortages in RACFs in high-

income countries (Vanhaecht et al., 2021). Staff shortages, high staff turnover, and high resident-to-staff ratios were reported in RACFs during the COVID-19 pandemic (Dorritie et al., 2020). Fear, grief, fatigue, and moral distress from losing residents they have cared for for several years contributed to staff shortages (McGilton et al., 2020; Vanhaecht et al., 2021) and likely had a negative impact on staff mental health (Vanhaecht et al., 2021). A recent study conducted in Belgium found associations between COVID-19 and poor mental health among care workers (Vanhaecht et al., 2021). The associations were strongest for the age group 30–49 years, females, nurses, and RACFs (Vanhaecht et al., 2021). This suggests that strategies are required to attract new care workers and retain the existing workers in the RACFs in high-income countries.

8.3 Strengths and Limitations

One of the strengths of this current research was the application of a comprehensive mixed methods research design to address the research questions. The explanatory sequential mixed-method approach facilitated a thorough exploration of data and a more in-depth understanding of employment experiences of RACF migrant care workers in high-income countries and factors that could be influencing their well-being. Additionally, to the best knowledge of the researcher, this thesis includes the first study in Australia to investigate the knowledge of dementia among migrant care workers in RACFs nationally.

A diversified, national sample of migrant care workers employed in Australian RACFs is another strength of this study. Migrant care workers across five States and Territories participated in the national survey (Phase One). The inclusion and participation of migrant care workers in this cross-cultural research study is another strength. Migrants are often excluded from research, particularly those from culturally diverse backgrounds (Low et al., 2009) due to factors such as cultural appropriateness, communication barriers, and the additional time required to develop relationships (Spring et al., 2003; Sulaiman-Hill & Thompson, 2011). Therefore, an additional strength is the considerable efforts made to recruit migrant care workers from different nationalities to participate in the national cross-sectional survey

The mixed-methods design and the pragmatic paradigm approach used in this study were also of great significance. The current study participants were from culturally and linguistically diverse backgrounds, and to capture their values and assumptions only through a survey questionnaire would be inadequate (Panda & Gupta, 2013) as individuals' values and fundamental assumptions are best explored through the qualitative method (Hesse-Biber, 2010). Moreover, it would not have been possible to conduct a comparative assessment of the influence and/or associations of factors (Panda & Gupta, 2013) such as their sociodemographic characteristics on the research questions if

the qualitative method was used only in this study. Therefore, the research design allowed the multi-level analysis of the data in relation to the research questions and also facilitated the understanding of the complexity around culture and care provision among RACF migrant care workers.

The purposive sampling method employed in this study might have affected the generalisability of the study findings as migrant care workers from some ethnic groups may not have participated in the study. However, purposive sampling is the most effective method when there are individuals in the population who possess the specific traits that are being studied and their opinions in a particular field is the topic of interest (Martínez-Mesa, González-Chica, Duquia, Bonamigo, & Bastos, 2016), such as migrant care workers.

While a validated dementia knowledge measuring tool DKAT 2 was utilised in this Phase One, there is a possibility that the way some DKAT 2 items were phrased might have skewed participants' responses. Evidence shows four main stages that respondents undergo in answering survey questions. The first stage, *comprehension*, involves interpretation of the question (Aday & Cornelius, 2006). In the second stage, *retrieval*, the respondent examines relevant information from memory (Aday & Cornelius, 2006). In the third stage, *estimation or judgment*, the respondent evaluates the retrieved information and its relevance to the question and utilises information to respond (Aday & Cornelius, 2006). The final stage, *responsive*, is where respondents consider factors such as the sensitivity or threat level of the question and the social acceptability of the answer and then decides to respond (Aday & Cornelius, 2006). Therefore, ambiguous questions could lead respondents to understand the question differently than was intended (Choi & Pak, 2005).

The sample of respondents that self-reported good mental health may indicate that this group have adjusted well to the Australian culture, or it could be that some respondents intentionally omitted some items in DASS 21 in the survey questionnaire due to their cultural beliefs and stigmatisation associated with mental health (Dow, 2011).

Researcher bias may have occurred during the qualitative interviews as the researcher who conducted the interviews is a migrant from a Nigerian background. Thus, it is possible that Nigerian participants felt more comfortable expressing their experiences of racism than participants from Indian and Filipino backgrounds. However, regular discussions with the supervisors who are from different cultural backgrounds were conducted to clarify the researcher's assumptions that could have affected the data collection and interpretations.

Qualitative interviews were conducted in one location (Perth, WA) and it is possible that migrant

care workers in other locations and working in community aged care may provide a different set of experiences. Future research incorporating the views of migrants aged care workers working in community and home-based aged care is required to have a better understanding of factors contributing to migrant aged care workers' acculturation stress and post-migration challenges in different aged care settings.

Finally, the data in this current study were collected before the COVID-19 pandemic crisis that had a devastating impact on the residents and residential aged care workforce in Australia. It is likely that if the study were conducted during or after the COVID-19 pandemic, research findings would be different. Therefore, post-COVID-19 future research with a diversified sample, including from regional and rural areas and incorporating community aged care workers, may provide additional relevant information.

The contribution of this research to the aged care workforce has already resulted in interest from some sectors. The reflections based on the results of the literature review were published in the *Aged Care Insite* magazine, an Australian E-newsletter that focuses on the current trends and issues in the aged care sector (Appendix 0). The researcher was contacted by government agency Australian Royal Commission into Aged Care Quality and Safety requesting to engage with RACF migrant care workers. A non-government agency, Polaron Language and Citizenship Services, Melbourne, Victoria also consulted the researcher during the COVID-19 crisis to seek information on how RACF migrant care workers can be supported to deliver quality care.

8.4 Recommendations for Further Research, Aged Care Policy, and RACF Management

Based on the findings from the research, the following recommendations for ongoing research and improving policy and practical management strategies in RACFs are given.

8.4.1 Research

Migrant care workers are strongly represented in Australian residential aged care facilities and are likely to continue to constitute a significant proportion of the Australian aged care workforce in the future. A paucity of literature regarding the knowledge of dementia among RACF migrant care workers was identified in the current research. More research examining migrant care workers' understanding of dementia and attitudes towards dementia care in RACFs is required to improve the quality of care provided in RACFs. In addition, future research should consider examining the predictors of migrant care workers' knowledge of dementia by expanding on the existing findings in this current research and further investigating the influences of culture and dementia training on

their knowledge of dementia.

While data relating to migrant care workers' knowledge of dementia was collected as part of a national cross-sectional survey within this exploratory study, similar data were not collected from a comparator group. Therefore, it was not possible to directly compare the knowledge of migrant care workers with care workers born in Australia. A comparator research study focusing on the knowledge of dementia of care workers among non-migrants is required to assist in designing appropriate education and training strategies that would be beneficial and relevant to address the gaps in the knowledge deficits in both migrant care workers and native-born care workers in RACFs.

Further research should examine migrant care workers' expectations of quality dementia training and their perceived challenges in engaging in dementia education and training as some migrant care workers in this current research, particularly in the qualitative study (Phase Two), identified dementia training as being beneficial in enhancing their knowledge and skills to deliver quality dementia care in RACFs.

To achieve a representative sample for a population survey, the best method is to randomly select participants from a sampling frame (Coughlan, Cronin, & Ryan, 2009). However, there is a lack of a sampling frame for migrant care workers and agreed data standards and collection mechanisms for workers in the Australian aged care sector. The main source of data on the aged care workforce is the National Aged Care Workforce Census and Survey (NACWCS), conducted by the National Institute of Labour Studies (NILS) at Flinders University, on behalf of the Australian Department of Health (Charlesworth & Isherwood, 2020). Data on the aged care workforce is also available from other sources, including the Australian Bureau of Statistics (ABS). It has also been argued by some researchers that the data collected from both the NACWCS and ABS are inadequate and have numerous deficiencies (Charlesworth & Isherwood, 2020). For instance, the NACWCS classified direct care workers in the residential aged care workforce by country of birth as two groups 'Australia and others' (Mavromaras et al., 2017). The 2016 NACWCS only provided data on employed PCAs in RACFs who spoke a language other than English. Thus, future research is recommended for the collection of data from a larger sample size of migrant care workers in Australia RACFs.

8.4.2 Aged Care Policy and Practice

These current findings have implications for policy and practice. Firstly, regular dementia education and training would increase migrant care workers' confidence and capacity in caring for residents with dementia. Staff who understand dementia and have undertaken regular dementia education are

likely to respond better to changes in symptoms, behaviours, or cognitive abilities (Dementia Australia, 2020). In alignment with Dementia Australia recommendations, all staff working in aged care should receive a minimum level of mandated dementia education (Dementia Australia, 2020) regardless of their cultural backgrounds. Dementia education could be incorporated as a compulsory unit in vocational or tertiary health education (Dementia Australia, 2020), and individuals should pass or demonstrate competency in the unit to be able to work in the aged care sector.

Dementia training should target the dementia knowledge deficits in migrant care workers and the training method should be co-designed with skilled healthcare trainers from a range of migrant backgrounds to determine suitable training approaches that could be more culturally meaningful, engaging, and interactive. Tailoring dementia training to migrant care workers needs is essential as their approach to care is influenced by the dynamics of their cultural backgrounds, adaption to the host society's workplace culture, and the requirements of aged care policies.

Aged care is physically demanding and perceived as repetitive, dirty, or comprising demeaning tasks (Gao et al., 2015). Availability of jobs in the aged care sector was one of the motivating factors for some migrant care workers to work in RACFs in this current research. There is a likelihood that such migrant care workers with this notion might choose to work in another occupation when an opportunity arises, particularly if working conditions are not improved in RACFs. Additionally, those on temporary visas such as the students or those on working visas who are using the aged care sector as a pathway to obtain permanent residency are likely to seek jobs in other industries if they are not satisfied with their work conditions and wages (Howe et al., 2019). Therefore, strategies and reforms to attract and retain migrant care workers are recommended. These strategies include improving care workers' pay rates in accordance with the complexity of the role and tasks (Commonwealth of Australia, 2018; Royal Commission into Aged Care Quality and Safety, 2021), opportunities for career advancement, and migration policies that address the systemic precarity of temporary migrant care workers by allowing them to access subsidised support services, such as healthcare and childcare, to enhance better working and living conditions in their resettlement country.

The Australian aged care regulatory government agency (the Australian Commission on Safety and Quality in Health and Aged Care) should mandate that approved RACF providers meet a statutory requirement on a minimum ratio of care staff to residents and monitor the staff skills mix and numbers regularly through reports to be submitted to the relevant government department. Additionally, the published report should be clear and available for residents, their families, and carers to access and understand. Migrant care workers should be encouraged and supported to join advisory groups that works with policy makers to address on aged care issues and guides the

implementation of aged care reforms .

Given the majority of migrant care workers in RACFs are PCAs, the Australian Health Practitioner Regulation Agency could establish a registration scheme for PCAs (Royal Commission into Aged Care Quality and Safety, 2021). The mandatory scheme should include a minimum qualification, ongoing training and professional development, minimum requirement of levels of English language proficiency, criminal history screening requirements, and the power for the registering body to investigate complaints into breaches of the Code of Conduct by care workers, as recommended by the Royal Commission (Royal Commission into Aged Care Quality and Safety, 2021) Implementing these recommendations could address the high workload among staff, enhance quality care, and facilitate greater transparency in care delivery.

Additionally, the Australian Health Practitioner Regulation Agency should work collaboratively with Fair Work Australia to ensure that enforcement actions are taken to address racism and discrimination at workplace. Furthermore, to address the issue of communication difficulties, vocational occupational-specific communication training should be provided to workers. Training could incorporate effective writing approaches specific to their caring roles in the aged care sector and communication strategies with colleagues and residents' families.

8.4.3 Residential Aged Care Facility Management

The establishment of a dementia champion role for suitably skilled migrant care workers would benefit RACF management and residents. A dementia champion has been described as a self-motivated individual with excellent knowledge and skills in caring for people with dementia (Mayrhofer, Goodman, & Smeeton, 2016). A dementia champion is generally an advocate for people with dementia, a source of information and support for a co-worker, and often motivates others by acting as a role model in the delivery of person-centred dementia care (Mayrhofer et al., 2016). Dementia champions in hospitals in Sweden (Banks et al., 2014) and in Australia (Travers, Graham, Henderson, & Beattie, 2017) support staff in delivering person-centred care to patients with dementia, and in the UK in fostering dementia awareness and dementia-sensitive care among the health and social care workforce (Mayrhofer, Goodman, & Holman, 2015).

Migrant care workers who have dementia training and organisational support could support other migrant care workers to engage in professional training that will upskill their knowledge of dementia. Organisational support should be provided for identified migrant care staff to mentor other migrant care workers in providing person-centred dementia care, especially newly arrived migrants with limited work experiences. Organisational support could include funding their attendance at dementia-related conferences and seminars and recognising their contributions at staff

events. Additionally, residents' family involvement in dementia care can be enhanced through support from dementia champions from migrant backgrounds. Migrant dementia champions from similar cultural backgrounds to residents and families can communicate and pass on information regarding care in a culturally appropriate manner and can relate family concerns to management.

Migrant populations' acquisition of new cultural traditions and their integration into new social networks can be achieved through establishing regular communication activities with members of the host cultural group (Doucerain et al., 2015). Residential aged care management should encourage participation in social events among migrant and non-migrant care workers as well as the residents and their families. Multicultural social activities and festivals can provide an opportunity for non-migrant care workers' residents and their families to value cultural diversity in the RACF setting and foster intercultural relations between migrant care workers and members of the host country (Willis et al., 2018).

As previously discussed in Chapter Two, the migrant aged care workforce is not a homogenous group. The needs of the identified disadvantaged cohorts within the migrant aged care workforce, especially new arrivals and those on temporary visas, should be considered and addressed. For instance, the provision of mentoring support for newly arrived migrant care workers with limited work experience is recommended to build their confidence in performing their roles efficiently. Furthermore, workplace health promotion programs, such as general health checks, mental health promotion, and provision of health information, should be implemented for those on student visas who may not be able to afford preventive healthcare services.

The aged care sector is one of the most ethnically diverse employment sectors in Australia (Mavromaras et al., 2017). Awareness of resettlement challenges and their impact on migrants' health and information about migrant care workers cultural backgrounds would support employers and colleagues from the dominant culture in their interaction and engagement with migrant care workers. Therefore, training sessions, especially cultural awareness training, should be provided regularly for staff regardless of their cultural background. In addition, RACF management should provide forums for migrant care workers to share and discuss their experiences of the acculturation process and resettlement challenges and to suggest improvement for residents' quality care. These forums could include the provision of suggestion boxes and the conducting of anonymous surveys targeting migrant care workers' concerns about their working conditions.

Support must be provided to alleviate work-related stress at the organisational level. Support should include supervisor support, respect, and professional development opportunities. Finally, inter-sectoral collaborations involving RACF management, the public sector trade unions, and the Fair

Work Commission could assist migrant care workers in achieving positive settlement outcomes by tackling issues related to lack of familiarity with work rights policies. Migrant care workers should be encouraged and supported to join advisory groups that work with policy makers on aged care issues and implementation of aged care reforms.

8.5 Conclusion

This study contributes to the understanding of dementia care from the perspective of migrant care workers' caring for people with dementia in a residential aged care setting. Insights to challenges experienced by migrant care workers in care provision in RACFs were identified. Key issues include the intersection of the post-migration challenges with work stressors among migrant care workers in residential aged care, especially caring for residents with dementia. Organisational support is critical to the delivery of quality care in RACFs and should include ongoing dementia training, health promotion, and stress reduction initiatives. A review of staffing levels and the creation of best quality care environments for residents with dementia is essential for the well-being of both staff and residents. The numbers of migrant care workers are increasing and their rights to be safe and supported in the workplace is as important as attracting and retaining this cohort.

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Appendix A License to Reuse Published Article in Thesis

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Mary Ann Price (she/her/hers) <permissions@sagepub.com> to me

—-—-—-—

Reply above this line.

Mary Ann Price (she/her/hers) commented:

Dear Bola Adebayo,

Thank you for your email. You may include the Final Published PDF (or Original Submission or Accepted Manuscript, if preferred) in an Institutional Repository or database as specified in our journal author reuse policy.

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Kind regards,

Mary Ann Price

(she/her/hers)

Appendix B Human Research Ethics Approval Letter

Office of Research and Development

GPO Box U1987 Perth Western Australia 6845

Telephone +61 8 9266 7863

Facsimile +61 8 9266 3793

Web research.curtin.edu.au

12-Dec-2017

Name: Karen Heslop

Department/School: School of Nursing, Midwifery and Paramedicine

Email: K.Heslop@curtin.edu.au

Dear Karen Heslop

RE: Ethics Office Approval number: HRE2017-0863

Thank you for submitting your application to the Human Research Ethics Office for the project Culture, institutions and dementia care: The experiences of migrant care workers from culturally and linguistically diverse populations.

Your application was reviewed through the Curtin University Low-risk review process.

The review outcome is: **Approved**.

Your proposal meets the requirements described in the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007).*

Approval is granted for a period of one year from **12-Dec-2017** to **11-Dec-2018**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Heslop, Karen	CI
Adebayo, Omobola	Student
Brijnath, Bianca	Supervisor

Approved documents:

Document

Standard conditions of approval

1. Research must be conducted according to the approved proposal.
2. Report in a timely manner anything that might warrant a review of ethical approval of the project including:
    - proposed changes to the approved proposal or conduct of the study unanticipated
    - problems that might affect continued ethical acceptability of the project
    - major deviation from the approved proposal and/or regulatory guidelines serious adverse events.
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants).
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project.
5. Personnel working on this project must be adequately qualified by education, training, and experience for their role, or supervised.
6. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project.
7. Changes to personnel working on this project must be reported to the Human Research Ethics Office.
8. Data and primary materials must be retained and stored in accordance with the Western Australian University Sector Disposal Authority (WAUSDA) and the Curtin University Research Data and Primary Materials policy.

9. Where practicable, results of the research should be made available to the research participants in a timely and clear manner.
10. Unless prohibited by contractual obligations, results of the research should be disseminated in a manner that will allow public scrutiny; the Human Research Ethics Office must be informed of any constraints on publication.
11. Approval is dependent upon ongoing compliance of the research with the Australian Code for the Responsible Conduct of Research, the National Statement on Ethical Conduct in Human Research, applicable legal requirements, and with Curtin University policies, procedures and governance requirements.
12. The Human Research Ethics Office may conduct audits on a portion of approved projects.

This letter constitutes a low risk/negligible risk approval only. This project may not proceed until you have met all of the Curtin University research governance requirements.

Should you have any queries regarding consideration of your project, please contact the Ethics Support Officer for your faculty or the Ethics Office at hrec@curtin.edu.au or on 9266 2784.

Yours sincerely

Amy Bowater

Acting Manager, Research Integrity

This study has been approved by the Curtin University Human Research Ethics Committee (HRE 2017-083)

Appendix C Phase One Recruitment Flyer

The experiences of migrant care workers in residential aged care facilities

Are you?

- A care worker from migrant background, born overseas and from culturally and linguistically diverse background (speaks other languages than English)
- Aged 18-65 and currently working (or have previously worked) in an Australian residential aged care facility

The researchers at the School of Nursing, Midwifery and Paramedicine, Curtin University, Western Australia would like to know your experiences of caring for people with dementia in residential aged care facilities.

What do you need to do?

- Complete an online survey or questionnaire (10–15mins).
- You may also be invited to talk more about your experiences directly with the researcher.

Participation is voluntary

For further information, please contact:

Coordinator: Bola Adebayo

Omobola.Adeba@postgrad.curtin.edu.au

(08) 9266 2090

OR

Dr Karen Heslop	Dr Bianca Brijnath	Dr Pam Nichols
K.Heslop@curtin.edu.au	Bianca.Brijnath@curtin.edu.au	P.Nichols@curtin.edu.au

Thank you.

Appendix D Phase One Participant Information Sheet

Culture, institutions and dementia care: The experiences of migrant care workers from culturally and linguistically diverse populations

Participant Information Sheet

Purpose of the Study

The purpose of this research is to find out about your knowledge of dementia, your experiences of dementia care, and your working conditions as a migrant care worker in residential aged care facilities.

Process

It will take about 10 –15 minutes to complete the survey. The survey will ask about your general knowledge of dementia, your experiences in caring for people with dementia as a migrant, your health conditions in the past weeks, and your relationships with other workers in residential aged care facilities.

At the end of the survey, you will be asked if you are willing to be contacted for a follow-up. If you agree to be contacted, you may receive an email in the future.

Potential Risks and Discomforts

You may stop the survey at any point if you experience some negative feelings in responding to some of the survey questions about difficulties and issues that you might have experienced as a migrant care worker. Also, if any questions in the survey raise any negative feelings for you, please call a free and confidential helpline (Lifeline 13 11 14).

Potential Benefits

There will be no direct benefit to you. However, the results of the study may help the investigators understand the experiences of migrant workers that are caring for people with dementia in residential aged care facilities.

The results of this study may also provide information about the working conditions of migrant care workers in residential aged care facilities, which might be useful to government departments and other professionals.

Confidentiality

You will not be required to provide any information that will expose your identity. We will maintain your confidentiality. Your responses will be collected and stored in the survey provider's database, which will be accessed with a password.

The information that is collected will be kept private and stored securely and safely on the researchers' computer. Only the research team and the Curtin University Human Research Ethics Committee will have access to the information that will be collected in this survey. Your name will not appear on any information. The information that is gathered in the study will be kept for seven years. After this time, it will be destroyed.

Your rights as a participant

Taking part in this research is completely voluntary. You may choose not to take part at all. Your relationship with your employer or the investigators will not be positively or negatively affected by your decision to participate or not participate in this research study.

If you decide to take part in this research, you may stop participating at any time by closing your web browser. However, if you decide not to participate in this study or if you stop participating at any time, you will not lose any benefits.

If you have questions, concerns, or complaints, please feel free to contact **rgo@hammond.com.au** or (02) 8788 3957. You may also contact the non-HammondCare on the below addresses for any information regarding the research project.

Researcher

Bola Adebayo: Omobola.Adeba@postgrad.curtin.edu.au

Chief Investigators

Dr Karen Heslop: K.heslop@curtin.edu.au;

Dr Bianca Brijnath: Bianca. Brijnath@curtin.edu.au

Dr Pam Nichols: P.Nichols@ curtin.edu.au

Participant Consent Form

Human Research Ethics (HRE) Project Number:	2017-0863
Version Number:	Version 1
Version Date:	03/DEC/2017

- I have read the information statements and I understand its contents.
- I understand the purpose, my involvement and any potential discomforts in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by the Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of this Information Statement and Consent Form.

Participant Signature	Date:

I have supplied an Information Letter and Consent Form to the participant who has signed above and believe that they understand the purpose, extent and possible risks of their involvement in this project.

Appendix E Survey Questionnaire

Migrant Care Workers Survey

Are you at least 18 years?

- Yes
- No

Please end the survey if your answer is NO

Are you a migrant, born overseas?

- Yes
- No

Please end the survey if your answer is NO

Are you a care worker currently working (or have worked) in a residential aged care facility?

- Yes
- No

Please end the survey if your answer is NO

Please select the answer choice that best describes your level of English Proficiency

How fluent are you in speaking English?

- Not Fluent
- Slightly Fluent
- Mostly Fluent
- Very Fluent

How good are you at understanding spoken English?

- Not Good
- Slightly Good
- Mostly Good
- Very Good

How often do you communicate in English?

- Not Often
- Somewhat Often
- Mostly Often

- All the Time

How comfortable are you communicating in English?

- Not Comfortable
- Slightly Comfortable
- Mostly Comfortable
- Very Comfortable

Below are the demographic questions. Please answer all the questions. Your responses will not be used to identify you in any way.

What age group are you in?

- 18-25 years
- 25-35 years
- 36- 45 years
- 46-55 years
- 55-65 years
- 65 years and above

Gender

- Male
- Female

Which country are you originally from?

Please specify ______________________

Which state are you located?

- New South Wales

How long have you been living in Australia?

- 0-6months
- 1- 5 years

- 6 -10 years
- 11- 15 years
- 16-20 years
- 21- 25 years
- 25 years and above

How would you like to be identified?

- White/European (inclusive of Western (French, German), Northern (Finnish), Southern (Italian), South Eastern (Bosnian, Croatian) and Eastern European
- Sub-Saharan African (inclusive of People of Sudan (Nuer, Bari) Central and West African (Ghanaian, Nigerian), Southern and East African (Kenyan, South African, Ethiopian, Oromo)
- North-East Asian (Chinese, Japanese, Taiwanese, Korean)
- Southern Asian (Indian, Pakistani, Nepalese, Tamil)
- South East Asian (Filipino, Burmese, Indonesian, Singaporean)
- South American (Argentinian, Brazilian, Chilean, Ecuadorian)
- North American (African American, French Canadian, Hispanic)
- Central American (Mexican, Costa Rican, Salvadoran)
- Caribbean Islander (Cuban, Barbadian, Jamaican, Trinidadian)
- Oceania (Solomon Islander, Papua New Guineans)
- North African and Middle East (Kuwaiti, Syrian, Egyptian, Jordanian)
- Others (please specify) ______________________________

What is your role in a residential aged care facility?

- Registered nurse
- Enrolled nurse
- Patient care assistant

Others (please specify) _______________________________________

How long have you been in this role?

- 6-12months
- 2-5 years
- 6-10 years

- 11-15 years
- ❍16-20years
- 21-25 years
- 25 years and above

Do you speak other languages than English at work?

- Yes
- No

What language (s) do you speak at work?

Please specify ___________________________________

What is your highest level of education qualification?

- Never attended school
- Less than Year 12
- Completed Year 12
- Certificate 111/IV
- Diploma
- Trade/apprenticeship
- Bachelor degree
- Postgraduate degree
- Others

Others (please specify) _____________________

How long have you been working in the aged care sector?

- 6-12 months
- 1-3 years
- 4-6 years
- 7-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 25 years and above

What is your current visa type?

- Australian citizen
- Permanent resident
- Temporary skilled migrant worker visa
- Student
- Other

We are interested in understanding your experience of adjusting to Australian culture as a migrant care worker in a residential aged care facility. Using the 1-5 scale below, please indicate your level of agreement with each of the statements below.

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
1. I feel because of my cultural background, I have to work harder than most Australians.	○	○	○	○	○
2. I feel the pressure that what "I" do will be seen as representative of my abilities based on my cultural background.	○	○	○	○	○
3. In looking for a job, I sometimes feel that my cultural background is a limitation.	○	○	○	○	○
4. It's hard for me to perform well at work because of my English skills.	○	○	○	○	○
5. I often feel misunderstood or limited in daily situations because of my English skills.	○	○	○	○	○

6. It bothers me that I have an accent when I am speaking English.	○	○	○	○	○
7. I have had disagreements with other people (e.g. friends or family) from my cultural background for liking Australian customs or ways of doing things.	○	○	○	○	○
8. I have had disagreements with Australians for liking my cultural ways of doing things	○	○	○	○	○
9. I feel that my particular practice has caused conflict in my relationships.	○	○	○	○	○
10. I have been treated rudely or unfairly because of my cultural background.	○	○	○	○	○
11. I feel that people very often interpret my behaviour based on their stereotypes of what migrants from different cultural backgrounds are like.	○	○	○	○	○
12. I feel discriminated against by mainstream Australians because of my cultural/ethnic background.	○	○	○	○	○
13. I feel that there are not enough people from my cultural background in my workplace.	○	○	○	○	○

14. When I am in a place or room where I am the only person from my ethnic/cultural background, I often feel different or isolated	○	○	○	○	○
15. I feel that the environment where I work is not multicultural enough; it does not have enough cultural richness.	○	○	○	○	○

There are some statements about dementia. Please read each statement carefully and place a tick in the box to show if you agree or disagree with the statement, or if you don't know

	Yes (1)	No (2)	Don't know (3)
1. Dementia occurs because of changes in the brain.	○	○	○
2. Brain changes causing dementia are often progressive .	○	○	○
3. Alzheimer's disease is the main cause of dementia.	○	○	○
4. Blood vessel disease can also cause dementia.	○	○	○
5. Confusion is an older person is almost always due to dementia.	○	○	○
6. Only older adults develop dementia.	○	○	○
7. Knowing the likely cause of dementia can help to predict its progression.	○	○	○

8. Incontinence always occurs in the early stages of dementia.	○	○	○
9. Dementia is likely to limit life expectancy.	○	○	○
10. When a person has late-stage dementia, families can help others to understand that person's needs.	○	○	○
11. People who have dementia may develop problems with visual perception (understanding or recognizing what they see).	○	○	○
12. Sudden increases in confusion are characteristic in dementia.	○	○	○
13. Uncharacteristic distressing behaviours may occur in people who have dementia (e.g. aggressive behaviour in a gentle person).	○	○	○
14. Difficulty swallowing occurs in late-stage dementia.	○	○	○
15. Movement (e.g. walking, moving in a bed or chair) is limited in late-stage dementia.	○	○	○
16. Changing the environment (e.g. putting on a CD, opening or closing the blinds) will make no difference to a person who has dementia.	○	○	○
17. When a person who has dementia is distressed, it may help to talk to them about their feelings.	○	○	○
18. It is important to always correct a person who has dementia when they are confused.	○	○	○
19. A person who has dementia can often be supported to make choices (e.g. what clothes to wear).	○	○	○
20. It is impossible to tell if a person who is in the later stages of dementia is in pain.	○	○	○
21. Exercise can sometimes be of benefit to people who have dementia.	○	○	○

Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the

statement applied to you over the past week. There are no right or wrong answers.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree or a good part of time

3 Applied to me very much or most of the time

	0	1	2	3
1. I found it hard to wind down	○	○	○	○
2. I was aware of dryness of my mouth	○	○	○	○
3. I couldn't seem to experience any positive feeling at all	○	○	○	○
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	○	○	○	○
5. I found it difficult to work up the initiative to do things	○	○	○	○
6. I tended to over-react to situations	○	○	○	○
7. I experienced trembling (e.g. in the hands)	○	○	○	○
8. I felt that I was using a lot of nervous energy	○	○	○	○
9. I was worried about situations in which I might panic and make a fool of myself	○	○	○	○
10. I felt that I had nothing to look forward to	○	○	○	○

11. I found myself getting agitated	○	○	○	○
12. I found it difficult to relax	○	○	○	○
13. I felt down-hearted and blue.	○	○	○	○
14. I was intolerant of anything that kept me from getting on with what I was doing	○	○	○	○
15. I felt I was close to panic	○	○	○	○
16. I was unable to become enthusiastic about anything	○	○	○	○
17. I felt I wasn't worth much as a person	○	○	○	○
18. I felt that I was rather touchy	○	○	○	○
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	○	○	○	○
20. I felt scared without any good reason	○	○	○	○
21. I felt that life was meaningless	○	○	○	○

Thank you for taking part in this survey. Results will be based on all the information that we collected and reviewed as part of the research. We would like to inform you about the results of our research study.

Would you like to be contacted at the end of this study?

○ Yes (Email address) ____

○ No

Appendix F Phase Two Participant Information Sheet

Culture, institutions and dementia care: The experienc
culturally and linguistically diverse

HREC Project Number:	HRE2017-0863
Project Title:	Culture, institutions, and dementia care: The experiences of migrant care workers from culturally and linguistically diverse populations
Chief Investigator:	A/Prof Karen Heslop, A/Prof Bianca Brijnath Dr Pam Nichols
Student researcher:	Omobola (Bola) Adebayo
Version Number:	Version 1
Version Date:	03/DEC/2017

What is the project about?

Evidence shows that care workers from migrant backgrounds are contributing positively to the Australian aged care sector. Caring for people with dementia in residential aged care facilities can be stressful for care workers, especially those from different cultural backgrounds.

This study aims to find out about your experiences of dementia care and working conditions as a migrant care worker in residential aged care facilities

Who is doing the research?

This study is being conducted by Bola Adebayo, under the supervision of A/Prof Karen Heslop and Bianca Brijnath and Dr Pam Nichols at the School of Nursing, Midwifery and Paramedicine, Curtin University, Western Australia.

The purpose of this research is to find out about your knowledge of dementia, your experiences of dementia care, and your working conditions as a migrant care worker in residential aged care facilities.

Why am I being asked to take part and what will I have to do?

I am inviting you to participate in this research project because you are at least 18 years old and

have been identified as a migrant, born overseas, and employed as a care worker (nurse/patient care assistants) in an Australian residential aged care facility.

Your involvement in the study will be at your convenient location and time. You will be invited to take part in an interview; I will conduct the interview with you. On the day of the interview, you will be asked to sign a consent form and return the form, so that we know you are interested in taking part in the study. Please take your time and ask any questions before you decide on what to do. You will be given a copy of this information form to keep.

I will ask questions about your experiences of caring for people with dementia and working conditions in residential aged care facilities. The interviews will last for 30–60 minutes and will be audio-recorded.

There will be no cost to you taking part in the study. We will give you $20 gift card to thank you for taking part after you have completed the interview.

Are there any benefits to being in the research project?

There will be no direct benefit to you. However, the results of the study may help the investigators understand the experiences of migrant workers that are caring for people with dementia in residential aged care facilities.

The results of this study may also provide information about the working conditions of migrant care workers in residential aged care facilities, which might be useful to government departments and other professionals.

Are there any risks, side effects, discomforts or inconveniences from being in the research project?

Apart from giving your time, we do not expect that there will be any risks or inconveniences in taking part in this study. However, you may stop taking part in the interview if you experience some negative feelings in responding to some of the questions about the difficulties and issues that you might have experienced as a migrant care worker. Also, if any questions raise any negative feelings for you, please call a free and confidential helpline (Lifeline 13 11 14).

Who will have access to my information?

You will not be required to provide any information that will expose your identity. We will maintain your confidentiality. The information that is collected will be kept private and stored securely and safely on the researcher’s computer.

Only the research team and the Curtin University Ethics Committee will have access to the

information that will be collected in this interview. Your name will not appear on any information. The information that is gathered in the study will be kept for seven years after the research has ended. After this time, it will be destroyed.

Will you tell me the results of the research?

If you provide us with your contact details, we will write to you at the end of the research and let you know the results of the research. Results will be based on all the information that we collected and reviewed as part of the research.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented

Do I have to take part in the research project?

Taking part in this research project is voluntary. It is your choice to take part or not to take part. You can withdraw from the project without giving us reasons. Please let us know if you want to stop.

If you choose not to take part or stop taking part in the study, it will not affect your relationship with the University, staff or the researchers. If you chose to leave the study, we will not use any information collected unless you tell us to.

What happens next and who can I contact about the research?

If you decide to take part in this research, we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

If you have any questions about the study, you may contact the researchers on the address below

Researcher

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T: (08) 9266 2090

Supervisors

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T: (03) 8387 2294

Dr Pam Nichols
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T: (08) 9266 2737

Curtin University Human Research Ethics Committee (HREC) has approved this study (HRE2017-0863). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix G Participant Consent Form

Culture, institutions and dementia care: The experiences of migrant care workers from culturally and linguistically diverse populations

HREC Project Number:	HRE2017-0863
Project Title:	Culture, institutions, and dementia care: The experiences of migrant care workers from culturally and linguistically diverse populations
Chief Investigator:	A/Prof Karen Heslop, A/Prof Bianca Brijnath Dr Pam Nichols
Student researcher:	Omobola (Bola) Adebayo
Version Number:	Version 1
Version Date:	03/DEC/2017

- I have read the information statement version listed above and I understand its contents.
- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of this Information Statement and Consent Form.

Participant Name	
Participant Signature	
Date	

Declaration by researcher: I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

Researcher Name	
Researcher Signature	
Date	

Appendix H Interview Guide

Introduction

Thank you for coming along and agreeing to participate in this interview. We would like to ask you some questions about your experiences of caring for people with dementia in a residential aged care facility. We will have a discussion and find out your experiences of dementia care and what you understand about dementia. Your responses will be useful in designing support for researchers and professionals in the aged care sector.

With your permission, we would like to tape-record the discussion as writing is a bit slow and we don't want to miss anything you say.

1. Understanding of dementia

- What is dementia?
- How do you think people get dementia?
- When and where did you first engage with people with dementia?
- Has your view on dementia changed since you have started your role as a care worker?

2. Experiences of dementia care in RACF

- Have you ever worked as a care worker of a person with dementia before you arrived in Australia?
- If yes, in what way was it different from your experiences in Australia?
- Please tell us your experiences of taking care of people with dementia in an Australian residential aged care facility.
- How motivated are you to work with people with dementia in residential aged care facilities?
- What activities in terms of care do you perceive will make a difference to a resident with dementia? (prompts e.g changing CDs or window blinds)
- What are your opinions on how people with dementia are being cared for in residential aged care facilities?
- How comfortable are you in providing care for people with dementia in your role as a care worker in a residential aged care facility?
- Please tell us how you will recognise pain in resident with dementia in advanced disease condition and who cannot verbalise their pain.

3. General and mental health conditions

- How do you feel about taking care of a resident with dementia? (Do you feel burn-out or stressed?)
- Have you ever felt down/low or had a sense of anxiety (nervous /worried/uptight) in caring for residents with dementia? If yes, when, how and what are you doing to address these negative feelings?
- Have you noticed any significant changes in your health since when you started taking care of residents with dementia?
- Have you sought support for this health issue, if there is any?
- Has your view on dementia changed since you have started your role as a care worker?

3. Acculturation and work relationships

- Can you tell me your relationship with residents with dementia and their families?
- What is your relationship with your co-workers?
- Please tell me about your relationship with management.
- Do you feel being a migrant from different cultural background affects your relationship with the residents with/without dementia/ families/ and co-workers? How?
- Please tell me how you feel about having more migrant care workers from your cultural background? Would it make a difference and how?
- What do you think staff from other cultural backgrounds bring to the work?

4. Working conditions and retention

- Do you enjoy your role as a care worker in the residential aged care facility?
- What are your views regarding the support that you get from your supervisors and co-workers in carrying out your duties efficiently?
- Do you receive enough support from family/friends/ community members?
- Will you consider changing your profession as a care worker in residential aged care in future?
- Do you have any comments or suggestions regarding your work conditions in a residential aged care facility?

5. Training and Royal Commission

- What training do you think would benefit migrant care workers in carrying out their duties effectively in RACF?
- How often should training, particularly dementia training, be provided to staff?
- What are your views regarding cultural competency training for staff?

- What do you think about the Royal Commission Aged Care Quality and Safety reports on the level of care in RACF? How does this report affect your work in RACF?

We really appreciate the time you have given to take part in the discussion. Thank you for your contributions.

Prompts

Understanding of dementia

1. What is the meaning of dementia?
2. What do you expect to see in a person with dementia?

Experiences of dementia care

1. Do you feel residents with dementia are receiving adequate care?
2. What are your views regarding the level of dementia knowledge among workers taking care of residents with dementia?
3. Please share your experiences of caring for residents with dementia, it could be positive or negative.

Acculturation, discrimination and work-related stress

1. Has your work affected your health in any way?
2. Will you be willing to seek help, if yes, where and how?
3. Have your cultural views or knowledge about dementia changed since you have started working in this role?
4. What coping strategies do you have in reducing the negative effects of caring for residents with dementia if you think it has a negative impact on any aspect of your welfare?

Working conditions

1. What kind of support are you expecting from supervisors and co-workers?
2. Please tell me the level of support for you that is being provided by the management.
3. What is your view on workplace racism and discrimination; have you ever experienced any of these issues at your workplace?
4. Are you satisfied with your current working conditions in terms of your work shifts, relationship with residents, co-workers, and supervisor?
5. What would you like to change or remain in your workplace?

Appendix I Codes and Categorisation of Qualitative Data

Category/ Theme	Code
Knowledge of dementia	• Definition and understanding of dementia • Associated risk factors • Pre-arrival knowledge of dementia
Dementia care experiences	• Pre- and post-arrival dementia care experiences • Caring for person with advanced dementia in pain • Communication • Enablers and hindrances to dementia care in RACFs
Psychological well-being	• Mental health • Coping strategies • Work-related stressors • Non-work-related stressors
Working conditions	• Relationship with residents and their families • Relationship with employers and co-workers • Reasons for choosing to work in the role • Retention/turnover 1) Continuity 2) Leaving

Appendix J Impacts – Media Reflections on the Current Research

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How cultural background affects dementia care

By: Conor Burke in Top Stories, Workforce May 31, 2019 0

In high-income countries like Australia, nursing and aged care workforces are increasingly multicultural. In Australia it is estimated that 32 per cent of RACF workers were born overseas. In similar nations, such as the UK, figures are as high as 40 per cent.

These workers have been essential to the aged care workforce, filling significant staff shortages and reflecting the multicultural make-up of aged care residents.

However, migrant workers bring with them differing levels of dementia understanding and this can affect many facets of care.

Some literature has found differing perceptions of dementia in different cultures. For example, some cultures view dementia as an embarrassment or dishonourable, or even just a part of normal ageing.

Some cultures, such as those in the Middle East, have no definitive definition of dementia at all.

Bola Adebayo, a migrant herself and Curtin University academic, has recently published a paper looking in the dementia care experiences of the migrant workforce.

"The culture and perception of someone having dementia is very different to the perception in the Australian setting. People think people with dementia are witches, or it's a normal ageing process," she said.

"But when I migrated to Australia, I thought it's very different. Dementia is really a medical condition… and relating back to my experience in Africa and with people I've talked to, I realised that culture might affect the way people provide care."

Through a series of interviews for her PhD, Adebayo found that some migrant aged care workers had no prior knowledge of dementia as a formal medical condition and as well as affecting the level of care they are able to give, can frustrate the worker and cause migrant workers to leave the sector.

"When they are frustrated, and they lack the knowledge, they don't really know how to work with someone with dementia. This can lead to frustration and can affect their retention, their turnover in residential age care facilities," Adebayo said.

Some migrant workers also experience challenges adjusting to workplace cultures, and they can often face discrimination from other staff and residents.

The paper referenced a study that found "21 of 35 participants who were migrant care workers employed in Australian RACFs had experienced negative reactions from the residents with dementia due to their visible differences, particularly workers from African backgrounds".

Language and accents also act as barriers to care for these group of workers, as it can make understanding and communication with colleagues difficult.

Adebayo suggests more needs to be done to provide support for migrant workers. Her study found that organisational resources to support migrant workers was strongly linked to retention.

"I think we need to be majorly providing language support and educating not only the migrant care workers but the native-born care workers from the mainstream communities to be tolerant, to be patient," she said.

"And also, the age care management providing support will diffuse the issue of communication difficulties in the age care sector."

Providing this support and education is key to improving retention of this vital aged care resource. Adebayo's study found that migrant workers bring with them positive and desirable cultural norms too, such as "caring for and respecting elders".

"There are cultural norms of caring, cultural values of caring for people. This really impacts on how they work… being kind, being gentle to them. So, in that cultural value, it's a good factor."

And through her research she has found that some residents prefer migrant workers as they are from similar backgrounds and share cultural identities.

The research also reported that employers like to hire migrant workers due to "good work ethic, loyalty to the organisation, and a willingness to work all shifts".

Overall, Adebayo and her colleagues believe it is imperative for the sector to improve dementia and cultural diversity training of all staff, including its migrant workforce.

"Studies have shown and people have seen that migrant care workers bring different value and contribution to each care centre," Adebayo said.

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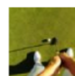
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