Communicating work health and safety in the context of cultural and linguistic diversity in aged care

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Prepared by Asia Pacific Centre for Work Health and Safety Research Centre for Languages and Cultures University of South Australia
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Executive summary

The project brought together a focus on communication in contexts of linguistic and cultural diversity and on work health and safety (WHS) in aged care organisations. For the aged care sector, this combination raises a complexity of issues that are conceptual as well as practical. To address this complexity the report provides a conceptual framing that informs the findings and the recommendations.

The aged care industry in Australia is facing unprecedented growth. The population is aging, traditional sources of care such as the extended family are less readily available, and there is a shortage of skilled personnel in the labour market. A workforce strategy to fill this gap for services in the aged care sector has been to employ aged care workers from overseas. In consequence, and combined with the changing demographic of the Australian workforce in general, there has been a significant increase in the number of aged care workers for whom English is a second language. The research literature suggests that these workers are at greater risk of injury due to difficulties in understanding a new language and their status as new workers. In preparing these workers, little attention is given to differences in cultural background; however, in this study we found differences in cultural beliefs and practices to have an important impact on migrant workers’ work health and safety (WHS).

The findings are drawn from two analyses taken from the perspectives of WHS and language and culture. They highlight the complexity of communicating safety in the context of linguistic and cultural diversity. The overarching message of the identified major themes is that this complexity arises not only from the relational nature of communication in general but also from the intercultural nature of communication in aged care. There is a different order of complexity to communication between people who do not share a language and culture. It requires the exchange of meanings among people who bring different linguistic and cultural resources to how they interpret what each other means and to how they respond to and act on the basis of their interpretations. The findings highlight the need for understanding that it is the interplay of languages and cultures that influences how people interpret what others mean. What was made very clear is that this understanding cannot be taken for granted as it usually is among people who share linguistic and cultural backgrounds. If it is assumed, then mutual communication is put at risk, the chances of misunderstandings increase, and safe practices are jeopardised.

The findings revealed that language differences alone did not create the barriers that might be expected to occur during work. It was the combination of linguistic and cultural differences that presented greater challenges, for example when participants misunderstood colleagues based on their assumptions. These assumptions tended to emphasise differences among workers for whom English is a second language as deviations from what is normal and appropriate, and were seen to have compounding, negative effects on safety communication and psychosocial well-being. They perpetuated preconceived ideas and led
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to over-generalisations, tensions and loss of trust. These effects included second-guessing the reasons for reticence among such workers, which prevented understanding of why they would not speak up. Safety could then be compromised due to workers’ not participating or sharing information that may benefit their co-workers.

From the findings and implications of the research study, we make the following recommendations.

**Recommendations**

Given the findings and implications of the research study, we make the following recommendations:

1. That aged care organisations put in place mechanisms to capture the linguistic and cultural profile of their workforce and analyse the changing profile to inform in an ongoing way both their human resources management policy, planning and practice and their health and safety policy, training and practice.

2. That aged care organisations reconsider the use of the term ‘CALD’ (culturally and linguistically diverse), recognising that all participants in the organisation are linguistically and culturally situated and the term applies to all. To separate one group from another by differentiating them as CALD can misrepresent that group as a particular source of risk compared to others, whereas the reality is that all are involved in accomplishing safety.

3. That a whole-of-organisation approach to understanding linguistic and cultural diversity recognise the value of the local methods formulated by workers. These evolve through practice to accomplish WHS, together with the regulatory requirements and expectations of WHS. Such an approach would aim to shift current practice from a transactional to an interactional and intercultural orientation to communicating WHS, incorporate learning to work with an intercultural stance in contexts of linguistic and cultural diversity, and be underpinned by management support, participation, and continuous learning based on the power of example.

4. That strategies be put in place to improve risk management systems so that they recognise the reality of linguistic and cultural diversity in managing both psychosocial and physical risks in the work environment by including the perspectives of all care workers.

5. That human resource management strategies be implemented to enhance the skill development and induction of new workers into care work, particularly those of different linguistic and cultural backgrounds. These should include formalised approaches to mentoring and opportunity to commence work by undertaking supernumerary shifts.

6. That a pre-service system to prepare new workers for work in the aged care environment in the Australian context be put in place, with priority given to the development of an intercultural stance as part of the formal training provided for all care workers (Certificate III).
7. That sector-wide interventions be developed to support a shift from a transactional to an interactional and intercultural approach to communicating WHS. This will enhance the psychosocial work environment by not only alerting workers to the need for mutual understanding, care and communication in domains of safety, but also motivating workers to make this an ongoing part of their routine work practices and interactions.

8. That further research be conducted that builds on the findings of this study by developing a sector-wide evidence base to enhance the relationship between WHS regulation and the practical accomplishment of WHS within the range of aged care organisations.

The findings of this project highlight the need for further research that

- develops a sector-wide understanding of the local methods enacted by workers as they perform their work and how these can be aligned and integrated with existing regulatory requirements
- examines how WHS regulation may be clarified and explained in its application and translation to practical processes and procedures within the range of aged care organisations in the sector, particularly in the context of linguistic and cultural diversity
- builds on the findings of this study to provide a sector-wide evidence base for the development, implementation and evaluation of interventions designed to enhance communication and interaction in accomplishing WHS. This should focus on the effective implementation of reflective practice techniques and assessment of their impact in improving WHS outcomes, particularly in culturally and linguistically diverse contexts.
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1. Introduction

1.1 Background

The aged care industry in Australia is growing rapidly due to an increasingly ageing population and the decline in familial and informal sources of care (Productivity Commission, 2011). Keeping up with the demand for skilled workers in this industry is emerging as a ‘crisis in aged care’: the industry is labour-intensive nature; the aging population is causing the labour market itself to tighten (Hugo, 2007); Productivity Commission, 2011); and increased competition for skilled workers has not translated to higher wages in this sector. A workforce strategy to fill the gap for services in the aged care sector has been to employ workers from overseas. In consequence and combined with the changing demographic of the Australian workforce in general, there has been a significant increase in the number of workers in the aged care industry for whom English is a second language (Productivity Commission, 2011).

Relative to other industries, aged care work carries high health and safety (WHS) risks. Particular issues include high levels of musculoskeletal injuries, mental stress, and exposure to violence. With the increase in the number of workers for whom English is a second language, it is important to take a fresh look at WHS to ensure that workers from all backgrounds are able to deliver quality care safely. Alcorso (2014) says that such workers are considered vulnerable as they ‘may not receive equity, access, or participation or rights to work and as a result may face discrimination and an elevated health and safety risk’. She refers to evidence that suggests that these workers experience more injuries and may be more vulnerable than others because of issues with understanding and communicating safety messages, being exposed to unknown risks, being exposed to a poor work environment and conditions, being excluded from workplace participation and representation, and fear of reporting hazards and injuries (e.g. concerns of deportation, causing trouble). Most Australian jurisdictions, including South Australia, adopted harmonised WHS legislation in 2011-2012 that stipulate that a primary duty of care is owed to all workers. Notably, WorkCover NSW (2014) makes explicit that persons controlling a business or undertaking have a legal obligation to provide a safe workplace, giving special attention to the needs of vulnerable workers, including those from diverse backgrounds.

This study explores the contexts of aged care work (the external regulatory framework, the labour market and economic factors) and organisational factors (e.g. the organisational culture and its safety climate and their dynamic relationship to health and safety). Because health and safety is accomplished ‘on the ground’ its effectiveness is dependent on interactions between managers, workers and residents. Consequently, this study uses an ethnographic approach to understand how social meaning is given to WHS issues in the residential aged care industry by local workers and those for whom English is a second language (e.g. nurses, care workers, and residents). In taking this approach we sought to reveal how and why the participants communicate, take up and act on WHS information in
the way they do, making visible how language, culture and communication matter to people in the communication of WHS. A fine-grained understanding will facilitate the development of WHS practices that will be relevant not only for the aged care industry but also other industries with workers for whom English is a second language.

To achieve this, the study:

1. profiles the linguistic and cultural composition of the workforce and draws out the implications for safety practice
2. examines safety information and training from the perspectives of local workers and those for whom English is an additional language
3. explores day to day practices including the use of safety feedback systems
4. develops, implements and evaluates an intervention based on (1), (2) and (3), and makes recommendations in these areas.

1.2 Strategic alignment

This research study is funded by SafeWork SA. It addresses two priorities of the WHS strategic framework for South Australia:

- To improve the capacity of workplace partners, stakeholders, government, and community to manage WHS effectively to improve and influence outcomes.
- To protect new workers. This study focuses on a largely under-researched group, workers for whom English is an additional language.

1.3 Research approach: Multi-disciplinary, collaborative research

The research team used several process principles to guide the discovery and intervention phases of the study. These were:

- Senior management support
- Participatory processes
- Feedback mechanisms
- Continuous learning
- Multi-dimensional observations and interpretations
- Using the power of example
- Paying attention to the influence of language and culture.

If change is to occur in the organisation, senior management concern about the issue is important. In the discovery phase, senior management support was a necessary condition for access to the worksites, to the workers, and to the residents. During this phase, to ensure that the study and its findings were grounded in the understandings and experiences of the participants and were of ‘practical relevance’ (Roberts & Sarangi, 1999) to the aged care sector, the research approach drew on principles of ethnography and participatory action.
research (PAR). In PAR, stakeholders (researchers, managers, and workers) participate in a cyclic process of:

1. Defining the issues
2. Developing the method and data collection to inform the problem
3. Making sense of the data
4. Defining the interventions
5. Helping to implement interventions

In a continuous learning opportunity, PAR participants move through a plan, act, observe and reflect on process (Kemmis & McTaggart, 1988). Feedback is continuous and improvements can be made in the work environment and in health and safety processes by cycling through the PAR processes. At every stage of the process stakeholders are closely involved to ensure a shared understanding of issues and that the interventions or changes proposed are fit for purpose (Dollard et al., 2007). Beyond simple outcomes such as whether to modify a policy or not, PAR is a form of inquiry that seeks to understand why, highlighting values, beliefs and assumptions. It often takes time for new understanding to occur because the actor’s worldview must be altered and underlying assumptions, values and goals changed in so-called double-loop learning (Argyris & Schon, 1974; Gronhaug & Olson, 1999).

In PAR it is important to develop co-appreciative relationships, to assist in the development of shared understanding and interest in actions that are required for organisational change.

During the discovery (primary data collection) phase, researchers observed a wide range of routine practices and gathered multiple data sets, including observation notes, interviews, training materials and profiling information. The analyses of these data guided the design of a ‘narrative intervention’ (Crichton & Koch, 2007, 2011). Researchers and staff of the organisation collaborated closely to (1) co-create the intervention, (2) ensure the intervention was grounded in the evidence emerging from the research, and (3) increase the participation, ownership and uptake of solutions (Dollard, Le Blanc & Cotton, 2007).

Based on our guiding principles, the intervention phase involved collaboration and participation from all voices in the organisation, from senior management to workers (Landsbergis et al., 1993). The intervention also involved the collaborative redesigning, trialling and evaluation of existing online safety training materials in light of the ethnographic findings of the project. This participatory approach informed the theoretical knowledge and expertise of the researchers (Hughes, 2003), enabling a more comprehensive and relevant understanding of the organisational setting (Schensul, 1994) and ensuring that the interventions were contextually grounded and rooted in accumulated organisational knowledge (Schurman, 1996). Participatory approaches are empowering as they give workers a sense of control (Rosencrance & Cook, 2000) and an increased sense of ownership of ideas, responsibility, and legitimacy to their enlarged role (Pasmore & Friedlander, 1982).
In this way they help to build organisational capacity for future problem identification and solution as the cycle continues (Hughes, 2003).

The research team also engaged in feedback processes (e.g. presentations at SafeWork SA Week and national and international conferences) to test the veracity of the work in the professional and public arena.

The main principles that were used to guide the discovery and intervention phases parallel those thought to comprise the essential elements of organisations with a strong health and safety climate. These continuous learning organisations have top management support and organisational priority for health and safety, strong worker participation in understanding and resolving threats to health and safety, and strong communication systems. In enacting these principles within this study, which inquired into deep aspects of the organisation, we emulated what is required to build an organisation with a strong health and safety climate.

Consistent with an approach to change world views, the study drew on a multidisciplinary team of experienced qualitative researchers from psychology, WHS and applied linguistics. The psychology perspective considered psychosocial factors at work, organisational systems and functions, and implications for WHS policies, practices and procedures. The WHS perspective brought understandings of the WHS policy framework, regulation, processes and procedures. The applied linguistic perspective brought particular expertise of languages, cultures and communication in the context of linguistic and cultural diversity.

1.4 The project team

The project team comprised:

- Dr Jonathan Crichton, Senior Lecturer, Research Centre for Languages and Cultures, University of South Australia
- Professor Maureen Dollard, Director, Centre for Applied Psychological Research, University of South Australia
- Ms Kate Loechel, Research Assistant, Research Centre for Languages and Cultures, University of South Australia
- Dr Valerie O’Keeffe, Research Assistant, Centre for Applied Psychological Research, University of South Australia
- Mrs Fiona O’Neill, Research Assistant, Research Centre for Languages and Cultures, University of South Australia
- Associate Professor Angela Scarino, Director, Research Centre for Languages and Cultures, University of South Australia.

1.5 Aims

The aims of this research study were:
1. To understand WHS amongst culturally and linguistically diverse (CALD) and non-CALD workers by:
   a. critically examining WHS training and procedures
   b. critically examining the psycho-social/cultural drivers of WHS
   c. identifying the tensions between systems (science, procedures, policy) and perceptions (psychological, social, linguistic, cultural) of WHS as realised through languages and communication
   d. identifying the ways in which workers can identify and report hazards more readily.

2. To understand linguistic and cultural diversity by:
   a. developing an understanding of the diversity of CALD workers and their interactions with residents and non-CALD workers
   b. identifying the challenges and opportunities for CALD workers.

3. To reduce injuries in the workplace by:
   a. trialling and evaluating interventions in WHS processes that are developed through a participatory process.

4. Additional outcomes:
   a. Identify policy implications for the regulator
   b. Enable the capacity building of individual and team research skills, project development skills and collaborative opportunities with industry
   c. Identify further research opportunities.

1.6 Research questions

The primary research question addressed in the study was:

1. How do CALD workers disseminate, interpret, and understand WHS information and carry out WHS instructions in the aged care industry?

The following sub-questions guided the research:

2. How prevalent are CALD workers in the research sites?

3. What are the WHS procedures and what training is provided?

4. What are the psychosocial and WHS needs of CALD workers?

5. What features of the workplace help or hinder WHS for CALD workers?

The procedural sub-questions were:

6. How is safety information communicated?
7. To what extent is safety information implemented by CALD workers and non-CALD workers?

8. How can the psychosocial work environment inform the provision of WHS information to CALD workers and the implementation of WHS interventions?

9. How can the implementation of WHS interventions reduce injury rates, but increase reporting of incidents in this industry?

1.7 A note on terminology

The term ‘CALD’, originally given to the study, reflects the prevalence of the term in current policy and practice. It has become commonly used to acknowledge the immense linguistic and cultural diversity that now characterises the aged care environment. In the study brief, the term framed the focus of the study by defining one group of people as CALD in contrast to those people who do not share this characteristic. The study was to focus on the former group, not the latter.

At the outset of this report, however, it is important to clarify the problems with labelling people as CALD. In reality the boundaries between what is CALD and not CALD are unclear. Everyone has some CALD profile. The larger population is itself not linguistically and culturally homogenous, but comprises a diversity of groups from different linguistic and cultural backgrounds. This profile will vary depending on which segment of the population is the focus of attention. The profile of the Australian aged care sector is a subset of the larger population of Australia, but has a particular and changing profile of linguistic and cultural backgrounds among staff, managers and residents. The upshot is that in identifying a subset of the population as CALD, the term assumes an unsustainable distinction. The reality is best captured not by a distinction between diverse and non-diverse groups but by the notion of a ‘diversity of diversity’, a phrase that reflects the fact that all people come from particular linguistic and cultural backgrounds and that, collectively, the groups with whom they share these backgrounds are diverse.

Moreover, in identifying a particular group with a characteristic that is assumed to raise communication problems, the CALD category is normative: it carries expectations of how ‘CALD’ people will behave in contrast to others (Sacks, 1992). By association, the category pigeonholes one group as the source of the ‘problem’, thereby distracting from the relational reality of communication. Communication is mutually accomplished among individuals by interpreting and exchanging meaning within the interaction at hand. This includes the communication of safety.

Rather than assuming a distinction between CALD and non-CALD, the study has been designed and implemented around the way communication is actually accomplished, interactively and mutually, within a ‘diversity of diversity’ of staff, managers and residents. This has raised the question within the study of how to refer to people who are second
language users of English as opposed to people from other linguistic and cultural backgrounds. It should be acknowledged that a similar tension arises from categorising particular groups while focusing on diversity among people in general. Wherever relevant, the languages spoken by particular people are used to refer to their background. However, in order to reflect more closely the nature of the diversity involved, where relevant, people have been identified as ‘people for whom English (or the dominant language) is a second (or additional) language’.

Similarly, the original title of the study included the term ‘migrant worker’. This is a common phrase that seeks to acknowledge those staff in the sector who have recently migrated to Australia. However, within the context of the study it risks identifying these people uniquely in terms of their migrant status. It also fails to acknowledge the large proportion of people who work in the sector who are less recent migrants. Based on these considerations, the title of the study was reworded to maintain the focus on linguistic and cultural diversity while avoiding these problems of categorisation.

Within this report WHS refers to work health and safety, the term adopted to replace occupational health and safety in South Australia. Some participants quoted in this report refer to ‘safety and wellness’, being the term applied within Helping Hand to describe work health and safety. In addition, the WHS Regulations (SA) 2012 refer to ‘manual tasks’, which replaces the previously used ‘manual handling’. In this report the terms the two terms may be used interchangeably. The term ‘manual handling’ is a verb form and is often referred to by participants as they describe the handling of residents. It is also used in discussion of the actual performance of manual tasks, which are discrete activities that involve manual handling.
2. Literature review

2.1 Introduction: context and purpose of the literature review

Like other developed Western nations, Australia is faced with an unprecedented need for aged care workers in the coming decades owing to a dramatic increase in the expected number of people who will require aged care and a projected shortfall of available workers to meet this need. Hugo (2007) signalled the ‘crisis in aged care’ in his analysis of the Australian Bureau of Statistics’ estimated resident population and projections from 2005 data. More recently, a Productivity Commission Report (2011) predicts the number of people aged over 85 years will increase fourfold to some 1.8 million people by 2050. In addition, the report forecasts a 43 per cent increase in the number of culturally and linguistically diverse aged care recipients by 2026, with a shift from the current demographic of post-war European migrants to an increasing number of ageing Asian migrants. In an extensive review of the literature, Orb (2002) identified a knowledge deficit for the appropriate care of linguistically and culturally diverse residents in aged care. What is known is that such people often revert to their primary language, particularly if they are affected by dementia (Martin & King, 2008; Productivity Commission, 2011).

Although the Aged Care Workforce Final Report 2012 for the National Institute of Labour Studies (King et al., 2013) has indicated that the residential aged care workforce has grew by approximately 20,000 workers between 2003 and 2012, it acknowledges that the sector still faces a serious workforce shortage in the coming decades. Increasingly, migrant workers of diverse linguistic and cultural backgrounds are being considered as a solution to this shortage (Fine & Mitchell, 2007). According to King et al. (2013), 35 per cent of residential aged care workers in Australia were born overseas, and a third of these workers come from countries where English is not the primary language. This significant increase in the number of aged care workers from culturally and linguistically diverse backgrounds has added to the complexity of the situation. The implications for both those cared for and the carers themselves are not well understood and an emerging body of literature seeks to explore the issues and developments around the growing linguistic and cultural diversity of both aged care residents and healthcare workers (Diallo, 2004; Fine & Mitchell, 2007; Hugo, 2009).

The purpose of this literature review is to establish what is known about communicating WHS in the context of linguistic and cultural diversity in aged care, focusing particularly on the experience of healthcare workers from migrant backgrounds, and to identify the gap in current understanding. To accomplish this, the literature review first considers the current research around the phenomenon of human migration and linguistic and cultural diversity in healthcare settings. Secondly, it discusses WHS risks in general. Third, it considers WHS and workers for whom English (or the relevant dominant language) is a second language. Fourth, it explores the sites of communication in which linguistic and cultural diversity manifest, and identifies issues in the current literature. Finally, the review considers the implications of
these issues for the safety and well-being of healthcare workers and the residents they care for in aged care settings.

2.2 Why we are seeing an increase in linguistic and cultural diversity

A growing global phenomenon is being acknowledged. People are on the move more than ever before due to new technologies in communication and travel. Despite this apparent mobility, not everyone experiences such movement and its perceived opportunities in the same way. While people are moving to find better work and living conditions, or ‘capital’ (Bourdieu, 1986), not everyone has the same access to this capital that such mobility would seem to afford (Bauman, 1998). In addition, this increased mobility leads to greater and more complex connections between people of increasingly diverse backgrounds (Blommaert & Rampton, 2011), and these connections are augmented by new technologies that affect financial, political, linguistic and cultural aspects of their lives (J. Collins & Slembrouck, 2009; Crichton, 2010; Jensen, 2003; Jordan & Duvell, 2006; Robertson & White, 2007). Language and communication are central to how people experience these complex connections. There is now a growing literature across multiple disciplines that explores what it means for individuals to move between languages and cultures in their life and work. This highlights the risks and opportunities of moving outside of one’s primary language and culture. In understanding this literature, it is important to consider what is meant here by the term ‘culture’.

2.3 Work health and safety risks in aged care

The academic literature on the WHS risks experienced by care workers in the Australian aged care sector is limited. However, the potentially negative impact of exposure to hazards in aged care work has long been recognised by government agencies responsible for the delivery of care and the protection of worker health and safety (B. Cole & Foley, 1996; Department of Health and Ageing, 2000). Providing care to the impaired elderly is becoming increasingly physically and mentally demanding and that care is delivered in a context of low reward and recognition (Myers, Silverstein, & Nelson, 2002). Aged care workers perform physically intensive activities such as moving and handling heavy and cumbersome loads, including resident transfers, working in awkward postures, and with time constraints (Trinkoff, Johantgen, Muntaner, & Le, 2005; Yeung & Chan, 2012). Increasing resident-to-staff ratios and the growing fragility and clinical acuity of the residents add to these demands (Palumbo, McLaughlin, McIntosh, & Rambur, 2011).

Regulators have been concerned by the increasing risks to safety in aged care, as evidenced by the growth in workers’ compensation statistics. In the USA, the Occupational Health and Safety Administration (OSHA) first released ergonomic guidelines for the aged care industry in 2003, recognising the unacceptably high rates of musculoskeletal disorders in the industry (Occupational Health and Safety Administration, 2009). Concurrently, the South Australian regulator, SafeWork SA (http:www.safework.sa.gov.au), was also active in implementing
strategies to assist aged care facilities to improve their WHS practices. Areas of focus have included the prevention of occupational violence, incorporation of safety into the design of facilities, the implementation of ‘no lifting’ programs and the prevention of musculoskeletal disorders.

Strategies adopted by regulators target some of the major risks experienced by aged care workers. In 2012, falls comprised 16% of all workers’ compensation claims lodged in the residential care services sector; other frequent causes of injury were muscular stress from pushing and pulling (15%) and being assaulted by other persons (14%) (WorkCover SA, 2012a). Working as a personal care worker is a risky occupation. In South Australia during 2010–2011, personal care workers lodged 14% of the total workers’ compensation claims. They were the most highly represented occupation among injury occurrences. These claims cost the community nearly $35 million, accounting for 15% of the total cost of work-related injury claims (WorkCover Corporation South Australia, 2012b). The major mechanisms of injury in the aged care sector can be identified by the proportion of claims requiring time absent from work. Of these claims in 2010–2011, body-stressing caused 55% of the injuries. Although fewer in number, the 64 claims that arose through mental stress contributed the greatest duration of work absence. Stress claims averaged 154 days lost, representing close to double the duration of absence from work resulting from other injury mechanisms (WorkCover Corporation South Australia, 2012a).

International research also reflects concern over worker injury outcomes in the aged care sector and draws attention to staffing ratios (Castle, Engberg, Mendeloff, & Burns, 2009; Trinkoff et al., 2005). Insufficient staffing contributes to injury risk by increasing worker exposures to biomechanical risk factors, while also adding to psychosocial risks such as work pressure and stress (Leka & Jain, 2010). Trinkoff et al. (2005) examined relationships between the staffing levels and worker injury rates in 445 nursing homes in the United States. Using regression models, they examined relationships between worker injury rates, facility staffing levels and organisational characteristics. The results indicated that the total number of care hours per resident day was significantly associated with worker injuries, once adjusted for resident acuity and the total number of residents. Further modelling highlighted that for each additional hour of nursing care available, the injury rate decreased by nearly 16 per cent. In addition, higher injury rates were found in for-profit nursing homes, which typically also have lower staff ratios (Castle et al., 2009; Trinkoff et al., 2005), although Stanev et al. (2012) found injury rates to be higher in not-for-profit facilities. These findings have implications for the retention of aged care workers. Trinkoff et al. (2005) suggest that the intention to change jobs may stem from care workers’ desire to reduce their exposure to the high frequency of transfers necessary in caring for more dependent residents.

Care workers have been reported to sustain the highest levels of shoulder and back injuries across all industries in the USA (Myers et al., 2002). A prospective study of 18 months’ duration assessed the predictive value of resident characteristics, such as cognitive, physical
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and behavioural status, on injury outcome. Findings revealed only small positive associations, particularly with those residents without leg mobility (Myers et al., 2002; Stanev et al., 2012). The study by Myers, Silverstein and Nelson (2002) also highlighted a possible link between psychosocial conditions and injury outcomes. The authors positively associated the amount of ‘social disarray’ in the aged care facility with the incidence of injury. Social disarray was defined as the sum of two factors – the number of care workers commencing work in the past 30 days and the number of care workers who ceased work in the past 30 days. The net number of new workers provided an indicator of injury risk; new workers are unfamiliar with the work itself, the residents they care for and their colleagues, and as such are prone to injury. In addition, social interaction is disrupted by staff turnover and access to resources previously provided by now absent workers is also diminished. These factors create a lack of connectedness in social and instrumental support that may be harmful to workers (Myers et al., 2002).

Musculoskeletal injury risks to aged care workers are well recognised. Over recent years, much effort has been devoted to improving resident-handling practices and providing equipment, with significant reductions in injuries (J. W. Collins, Wolf, Bell, & Evanoff, 2004). A survey study of 898 Ohio nursing homes sought to examine the impact of facility characteristics and the availability of safety equipment on injury rates (Stanev et al., 2012). Whereas 95% of facilities had resident lifting policies, only 22% of these were ‘no lift’ policies. Portable total-lift hoists were provided in 96% of facilities; ceiling-mounted hoists were infrequently available (7% of facilities). Facilities without a policy on resident lifting experienced higher estimated injury rates than those facilities with policies. The presence of equipment was not associated with significant changes in injury rates, suggesting that more sensitive data examining accessibility and actual use of available equipment is warranted to better understand its impact on injury patterns.

Musculoskeletal injuries sustained by care workers result not only from exposure to manual lifting and handling. A study of workers’ compensation data from six nursing homes in the USA found that care workers experience more slips, trips and falls incidents than workers across all other industries (Bell et al., 2013). Many of the causes of these injuries, such as wet floors or small obstacles, are easily mitigated; however, other causes can be more difficult to control. The inherent risks of the work, such as providing daily living assistance to residents with mobility and cognitive impairments, often in wet environments, magnify the risk. Because slip, trip and fall incidents are largely preventable, facility-wide programs to address their causes, focusing on design solutions, are justified (Bell et al., 2013).

The literature on the health and safety risks involved in the provision of care highlights the physically and emotionally demanding nature of the work. An American study examined practical nurses’ self-ratings of health and emotional well-being. Practical nurses are licensed ‘hands on’ providers of care, most closely equivalent to the Australian enrolled nurse. Palumbo and colleagues (2011) reported that practical nurses working in aged care
perceived their health to be worse than those working in other settings. Compared to 24% of their counterparts working in other facilities, only 16% of practical nurses working in aged care rated their health as excellent. In addition, aged care–employed practical nurses rated their emotional health as significantly poorer than that of other practical nurses. Only 9% of practical nurses in aged care rated their emotional health as excellent, compared to 19% of practical nurses employed in other care settings (Palumbo et al., 2011). Coping effectively with these physical and emotional demands points to the need for care workers to communicate and work effectively as a team to safely deliver care and support each other. Safety culture represents the shared perceptions toward health and safety within a work team, derived from attitudes, behaviours and workplace situational factors (Cooper, 2000). A poor WHS culture is associated with adverse events that are likely to result in harm to workers and in turn negatively affect the residents and the quality of care they receive (Yeung & Chan, 2012).

2.4 Work health and safety and workers for whom English is a second language

The literature addressing WHS in relation to culturally and linguistically diverse workers focuses on marginalised groups in unskilled and high-risk industries, with construction and agriculture being most represented. Although there has been an increasing representation in health care of workers for whom English (or the dominant language) is a second language, studies of their WHS experiences are scant. Several systematic reviews of such workers’ health and safety outcomes have been conducted but health care has not been one of the industries studied.

2.4.1 Injury rates

Ahonen, Benavides and Benach (2007) found that such workers reported general feelings of displacement, loneliness and stress, which affected their psychological health and well-being. They described studies from the United States that found that fatal occupational injuries increased among migrant workers, despite injury rates falling among native workers. For non-fatal occupational injuries, the research is less consistent. One study from Singapore showed that workers for whom the dominant language is a second language experienced slight increases in injury rates that required longer recovery times (Carangan, Tham, & Seow, 2004).

Bollini and Siem (1995) reported that epidemiological studies from the Netherlands, Germany, Switzerland and France suggest that workers for whom English is a second language have a rate of occupational injury that is about twice as high as that of native workers. Data from the US demonstrate that the agriculture and construction industries, recognised for their high degree of risk, are also employers of large numbers of workers for whom English is a second language (McCueley, 2005). These findings are consistent with work undertaken in Italy (Salvatore, Baglio, Cacciani, Spagnolo, & Rosano, 2013), which reports that in the years 2004–2008, the injury rates sustained by non-Italian-speaking
workers increased by 13 per cent compared to a decrease of 10 per cent in the injury rate for the entire Italian population. The authors attribute this difference to significant proportions of such workers being employed in the high-risk industries of construction and agriculture.

A more recent Finnish literature review of migrants and their risk of occupational injury examined 72 studies from around the world (Salminen, 2011). A calculation based on 31 of these studies revealed that ‘foreign-born’ workers have 2.13 times the rate of occupational injury of native workers. The highest rate Salminen discovered estimated an injury rate ten times that of local workers for US workers for whom English is a second language. Seven studies showed that such workers actually had lower rates of occupational injury and three studies consistently showed that these workers experienced higher rates of injury than native-born workers during their first five years in the workplace. After five years the rate decreased to below that of native workers, consistent with the findings of an older Australian study by Corvalan, Driscoll and Harrison (1994). This reduction in injuries over time has been attributed to growing familiarity with the work and improvement in language skills.

Overall, it is clear that evidence for higher rates of occupational injury and illness for workers for whom the dominant language is a second language is inconclusive, although on balance it is likely that foreign-born workers do experience enhanced risks owing to greater exposure to dangerous work. Evidence suggests that accidents and incidents involving these workers tend to be under-reported in the official datasets (Boden & Rees, 2009).

The poorer WHS outcomes for these workers are often attributed to language differences (Lindhout, Swuste, Teunissen, & Ale, 2012). Effective communication of health and safety information is central to achieving safe and healthy work (WorkSafe Victoria, 2008), with communication barriers expected to have a negative impact. The study by Lindhout et al. (2012) highlighted the presence of multiple languages in European construction workplaces as a barrier to effective health and safety because of the absence of a shared language and shared meanings about safe practice.

### 2.4.2 Language differences

The potentially negative impact of language differences on worker health and safety has long been acknowledged. The International Labour Organisation (International Labour Organisation, 1975) of the United Nations requires workplaces to protect workers’ occupational health and safety. The *Occupational Health Safety and Welfare Act 1986* (SA) embodied these principles by placing duties on employers to provide a safe workplace for their employees. Where workers speak different languages, then fulfilling that duty required the employer to provide information, instruction and training in a form that can be reasonably understood by the workforce. The revised *Work Health and Safety Act 2012* (SA)
makes these requirements less clear, obligations to address language differences are not addressed within the duty of care principles.

Many communication problems in the multilingual and multicultural workplace arise from misunderstandings. In their survey study of 400 workers for whom English is a second language in the Australian construction industry, Trajkovski and Loosemore (2006) reported that nearly half (48.7%) of their respondents had misunderstood a work instruction owing to their lack of English skills. Furthermore, 66.7 per cent of these workers attributed making a mistake at work to a misunderstanding arising from their poor English proficiency. The relative likelihood of having a misunderstanding that leads to a mistake potentially has serious consequences for health and safety practice. While language is central to communication at work, it is only one issue that may impede understanding of health and safety information. Difficulty in understanding English may mask other barriers to communication such as literacy (WorkSafe Victoria, 2008), which may be a problem for both native and English as second language workers, particularly if they come from disadvantaged backgrounds.

2.4.3 Cultural differences

Notwithstanding the importance of perceived language barriers, language is an expression of culture. Cultural factors determine the ways in which workers interpret information, the meanings they attribute to messages and the conditions under which information will be noticed, interpreted and given importance (Trajkovski & Loosemore, 2006). Language is not only an instrument for expressing ideas but also a mechanism for shaping the formation of those ideas. Consequently, people who speak different languages are likely to understand the world differently (Trajkovski & Loosemore, 2006). Therefore it is not just language that comes into play in communicating at work. Workers for whom the dominant language is their second language understand that they have to learn new language conventions, but they must also develop a new working identity through interpreting the norms for interacting with colleagues and clients (O’Neill, 2011). Consequently, cultural beliefs and practices may deter such workers from actively participating in processes for improving health and safety in the workplace (Bahari & Clarke, 2013).

Australian WHS legislation provides mechanisms for workers to be consulted about health and safety issues that affect them. Mechanisms such as the Work Health And Safety Act 2012 (SA) and WorkSafe Victoria’s (2008) compliance code include elected WHS representatives and health and safety committees. Walters (2011) draws the link between the presence of elected health and safety representatives and improvements in workers’ psychosocial conditions. Consultation provisions recognise that workers are intimately acquainted with their work and therefore have experience in its inherent hazards, risks and idiosyncrasies. However, workers from different cultural backgrounds may be reluctant to raise workplace issues, perceiving it as disrespectful to question authority, ‘speak up’ or voice concerns (Mearns & Yule, 2009; S. B. K. Scollon & R. Scollon, 2001). This is particularly
so for workers who come from cultures characterised by high power distance as a consequence of hierarchical structure and collectivism (Hofstede, 1984, 2001). Such workers may also be reluctant to offer divergent views for fear of reprisals (Bahari & Clarke, 2013), particularly if they have not yet obtained residency status. Therefore, communication in culturally and linguistically diverse workplaces can be affected as much by cultural norms and beliefs as by the understanding of language.

Against this background, the increasing representation in the workforce of workers for whom the dominant language is their second language points to a need for better understanding of intercultural communication practices and potential barriers to cooperative working. In terms of policy and practice, this is likely to require adjustments at the organisational, management and worker levels to ensure effective communication. In the National Aged Care Workforce Census and Survey, 2007 (King & Martin, 2008), 70 percent of aged care facility managers identified communication as the most pressing issue for their workers for whom English is a second language. The report draws attention to the possibility of potential WHS consequences resulting from miscommunication (King & Martin, 2008 pp. 53-4). As previously established, the aged care industry is recognised as being high risk because of frequent exposures to hazardous tasks, often involving frail and resistive residents. The combination of these job-specific risk factors and compromised communication is likely to be synergistic, exacerbating the risks present in the work itself.

### 2.5 How linguistic and cultural diversity affects communication

In understanding what is meant by culture in the context of globalisation and mobility, Liddicoat (2005, p. 201) explains that moving between one’s primary language and an additional language requires more than learning its vocabulary and grammar; it demands ‘an engagement with culture’. Some aspects of culture such as food, dress and festivals, the practices of a culture, are readily visible, but Weaver’s (1999) iceberg analogy illustrates how a great deal of culture is not visible, and includes how people think, their values, attitudes and beliefs (Claire Kramsch, 1998). Although speakers of a second language may be formally taught how to control the words and grammar, and be taught about the visible aspects or practices of the second language and culture, it is the hidden aspects of culture that are more difficult to learn. Learning how different language choices can be used to establish one’s cultural and professional identity and become integrated within a speech community often happens outside of formal language instruction through a process of discovery (Blommaert, 2005; Liddicoat, 2005; Saville-Troike, 2003).

In addition, Bauman (2004) argues that, rather than the world becoming more homogenous and easier to navigate as a result of the increasing contact between languages and cultures, the things that once defined us are no longer ‘solid’ but ‘liquid’, constantly moving and changing in a globalised environment. An individual’s sense of belonging and identity are no longer predictable, and interaction with others who do not always share the same primary language and culture has become increasingly complex (Blommaert & Rampton, 2011). Thus,
both native speakers and individuals who are second language speakers of the dominant language will experience misunderstandings in intercultural interactions, not simply because of a language barrier, but because of a lack of awareness of how communication norms reflect cultural values and attitudes involving the establishment of identity, roles and relationships (Lemke, 2002; Nelson, Carson, Al Batal, & El Bakary, 2002; Ochs, 2002).

2.6 Why understanding linguistic and cultural diversity is important

There is a large amount of research in the area of cross-cultural communication that looks at how cultural influences embedded in language lead to misunderstandings between speakers of different languages. For example, people with different first languages may use different politeness strategies, different conversation strategies and diverse ways of respecting roles and relationships. The research of Wierzbicka (1991, 1994) reveals the diverse ways in which cultural values and attitudes become encoded in languages, and shows how taking first language norms of communication into the second language can result not only in misunderstandings but also negative perceptions of the speaker. In a professional context, co-workers and clients may interpret such perceptions as rudeness or even professional incompetence, leading to negative stereotyping (Candlin & Crichton, 2010). In her report on improving aged care training for speakers of English as a second language, He (2012) illustrated how some native workers formed such stereotypes of specific cultural groups, considering them as complacent, lazy or disinterested.

In addition to managing misunderstandings and negative perceptions, culturally and linguistically diverse individuals in Australia may also have to deal with negative attitudes resulting from a ‘monolingual mindset’ (Clyne, 2005). According to this mindset, speaking another language may negatively impact on their ability to learn in the dominant language and may create social and professional disharmony (Blackledge & Creese, 2010). Thus second language speakers who are trying to adapt to the dominant culture’s communication norms may experience feelings of social and professional isolation and loss (Blackledge & Pavlenko, 2001; Blommaert, 2008; Liddicoat & Crichton, 2008; Watkins-Goffman, 2006).

2.7 What does linguistic and cultural diversity look like in healthcare?

Turning now to the context of healthcare, the literature reveals that language and culture do matter for such individuals, both as the recipients of care and as care providers. Elderly people from culturally and linguistically diverse backgrounds are known to find it more difficult to communicate in English and often return to using their first language, which can lead to communication issues between healthcare workers and residents and adverse health outcomes for both groups, stress being high on the list (Heikkila, Sarvimaki, & Ekman, 2007; Jeffries, 2006; Ulrey & Amason, 2001). Although the recent increase in migrant healthcare workers could be argued to improve communication with these residents in aged care (Heikkila et al., 2007), at the current time in Australia, many newly arrived health workers
come from different linguistic and cultural backgrounds from those of the elderly clients for whom they care.

Descriptions of language as a barrier are not uncommon in the literature concerning migrant healthcare workers, where shift handovers, patient assessment and interactions with residents and colleagues are some of the potential communication hurdles to be navigated (Crawford & Candlin, 2012). As previously shown in this literature review, when considering how language matters to people it must not be conceptualised merely as a system of words and grammar but as a linguistic and cultural framework through which people interpret and make meaning. The following literature exemplifies the types of issues that are being explored in communicating WHS in culturally and linguistically diverse healthcare settings, in both acute and in aged care contexts.

In the USA, Olson (2012) conducted a critical review of the literature in this area and concluded that language and communication is an important roadblock to the successful integration of migrant health workers into the healthcare system. The participants in these studies described a fear of not being understood by clients and colleagues because of the complexities of learning not just one second language, but also its medical, nursing and layperson’s language, as well as the cultural aspects of communication, such as how and when to make small talk with patients or ask for clarification with colleagues. These issues culminated in the participants’ experiences of social and professional isolation.

Also in the USA, Bosher and Smalkoski (2002) identified communication in the clinical setting as highly problematic for these people, leading to anxiety, errors when performing their clinical role, and fear of negative evaluations. Their findings were incorporated into the training of these workers, to address a perceived shortfall in assertiveness skills, therapeutic communication and the part culture plays in healthcare communication. In Australia, He (2012) draws attention to the consequences of miscommunications due to language and cultural differences in aged care workers, describing errors in serving foods, carrying out care practices and using household equipment with which they were unfamiliar. In the UK, Gandhi and French (2004) found a lack of research around the success of adaptation programs for migrant healthcare workers. Their paper outlined the need to educate such individuals in how to participate in group work, brainstorming and self-reflection, in addition to the regular induction training that new staff already receive. Interestingly, native English-speaking workers were not required to attend such cultural communication training. The authors describe a process during this course in which the migrant health worker is mentored and observed for ‘performance problems’. Failure to correct these ‘performance problems’ would not only lead to failing the program, but also being asked to leave the UK and return to their home country. The representation of such workers in the healthcare literature as CALD, rather than the healthcare context itself being culturally and linguistically diverse, could encourage a perception that the issue somehow lies with these people (Garrett, Dickson, Klinken Whelan, & Whyte, 2010).
This brings us to an important point about linguistic and cultural diversity and WHS in healthcare made by Ulrey and Amason (2001): in today’s increasingly globalised world it is essential to remember not to focus solely on ‘the individual present in foreign cultures’ or indeed the foreigner as the ‘other’ in the host culture, but also to be aware that intercultural communication is something that host culture members as well as migrants and visitors are all increasingly called to do. If language and communication are pivotal to the effective care of clients and the well-being of culturally and linguistically diverse individuals in healthcare, then research is needed that considers the multiple perspectives of all stakeholders (clients and carers from all language and culture backgrounds) to better understand how people experience and manage linguistic and cultural diversity in healthcare settings.

An extensive systematic review of the international literature that takes such a multi-perspective approach to cultural diversity in health care was conducted by Pearson et al. (2007) in Australia. Its purpose was to identify the features of healthcare organisations that promote cultural diversity, culturally competent practices and a healthy workplace. From a starting point of 659 papers, they narrowed their review to just 19 papers that identified these features. They defined cultural competence as ‘the knowledge, skills, attitudes and behaviours required of a practitioner to provide optimal health care services to persons from a wide range of cultural and ethnic backgrounds’ (Pearson et al., 2007, p. 59). Supporting the notion that the increasing diversity of healthcare teams creates a complex environment for culturally and linguistically diverse health workers, their native-speaker colleagues and their clients, the authors highlighted organisational structures and processes drawn from findings of their systematic review, which would augment the cultural competence of diverse health care teams. Their objective was not only to improve the care provided to healthcare clients, but also to demonstrate that cultural competence education that improves the skills and attitudes of all workers would have positive outcomes for all. The authors concluded that both physical and psychosocial factors are important for well-being. For the healthcare institutions employing these workers, well-being was defined in terms of staff retention, good team relationships, and a reduction in absenteeism, burnout, illness and injury. For healthcare workers, these factors included positive feelings about the workplace, having a good work–life balance and job/role satisfaction, and having input into their sphere of professional practice. Congruent with the conclusions of the studies mentioned previously (Bosher & Smalkoski, 2002; Gandhi & French, 2004; Ulrey & Amason, 2001), workers for whom English was a second language faced issues of stereotypes, social isolation and cultural differences in managing conflict (cf He, 2012).

Much of the research considered so far looks at the phenomenon of linguistic and cultural diversity of teams in general healthcare settings, but not particularly the types of teams found in aged care settings. In the USA, Dreachslin, Hunt and Sprainer (2000) have explored the issues from the multiple perspectives found specifically in aged care. Their study investigated how nursing care teams made up of licensed carers such as registered nurses (RNs) and non-licensed carers function together, and how role and race contribute to how
communication and conflict management are dealt with. Their conclusions highlight the significant role of leaders to ‘validate alternative realities and appreciate different perspectives’ (Dreachslin et al., 2000, p. 1408). They argue that although popular thought would suggest that diversity in teams is desirable, the potential misunderstandings and negative evaluations that arise because of linguistic and cultural diversity must be attenuated by effective leadership. Such leadership encourages people to go beyond the stereotypes in order to understand that people from culturally and linguistically diverse backgrounds see the world from different viewpoints.

Returning to the Australian context, King and colleagues (2013, pp. 48-49) state that just over 97 per cent of aged care facilities surveyed in their study perceived the employment of culturally and linguistically diverse health workers as beneficial, particularly in enhancing cross-cultural understanding amongst staff and recipients of care. In addition, a third of migrant-background aged care workers not only used their additional languages in their work, but also saw themselves as having an increased cultural sensitivity to culturally and linguistically diverse aged care residents and their families (King et al., 2013, p. 141). Nevertheless, 40 per cent of these facilities and just under a quarter of such workers themselves identified issues with employing such people, issues principally of communication and cultural knowledge.

Johnstone and Kanitsaki (2007) argue that even though Australia has had 30 years of multicultural policy, the healthcare system is still not coming to terms with the increasing linguistic and cultural diversity in the field of aged care. The notion of cultural competence as being important in the education and credentialling of healthcare workers is supported in principle by the Australian Nursing and Midwifery Accreditation Council, and yet there is a lack of detail to underpin policy and educational and workplace practices. In addition, qualified overseas healthcare workers are expected to conform to Anglo–Australian cultural practices rather than being seen as a ‘rich resource’ of cultural knowledge (Chenowethm, Jeon, & Burke, 2006, pp. 35, 39). In a study on how trans-cultural competency is incorporated in nurse education in Australia, Pinikahana, Manias, & Happell (2003, p. 151) found that of 28 universities offering nurse education, only three provided dedicated courses in trans-cultural or cross-cultural nursing. Likewise, while a plethora of registered training organisations offered online training for carers in Certificate III in Aged Care, few incorporated specific units on cross-language and cross-cultural competency.

In a South Australian study of aged care workers who had completed the Certificate III training in aged care, many stated that although they had completed the course without difficulty, they felt unprepared for the reality of aged care work (He, 2012). Some of the differences reported were: the use of unfamiliar equipment and terminology, exposure to dementia clients, needing to participate in conversation with clients, and unfamiliarity with common items of clothing, Australian foods and their combinations. None of these topics were covered in the training. Graduates of the training also reported experiencing confusion
about the different ways in which instructions were given in the workplace and how they felt too vulnerable to clarify. In one case, a care worker recounted an example in which he was told to report for training between 9.00 a.m. and 12.00 noon. When he arrived at 11.00 a.m. he was told he had missed the training.

Resources developed to support CALD workers undertaking the Certificate III training in aged care also highlight the need for different modes in delivering training. CALD workers perform better in the classroom where there is the opportunity to work in cross-cultural small groups. Interactive approaches allow students to explore meaning in the context of their own experiences and expectations. Providing students with the opportunity to pre-read the learning materials and become familiar with new words also improved learning. Such preparation enables CALD students to concentrate on the content of the training rather than puzzling over specific words. Training that provides an early introduction to actual aged care services through supervised site visits also assists CALD students to better understand the aged care work environment, easing their transition from student to worker (South Australian Health and Community Services Skills Board, 2012).

Migrant healthcare workers are at risk. As they attempt to improve their knowledge of Australian culture and English language on the job, they experience discrimination and compromised WHS in the workplace (Johnstone & Kanitsaki, 2007, p. 252; King et al., 2013, p. 48).

2.8 Summary

We note that in the literature a range of different terms are used to describe communication and the capability to communicate in the context of linguistic and cultural diversity: cross cultural communication/understanding/competency, ‘cultural competence’ (Pearson et al. 2007), ‘transcultural competency’ (Pinikahana, Manias & Happell, 2003). For the purposes of this study we use the terms ‘intercultural communication’ and ‘intercultural understanding’, highlighting the interactive nature of communication across diverse linguistic and cultural worlds and that it necessitates reciprocal understanding.

The literature on WHS risks in aged care and on the role of language and culture in aged care highlights that there are challenges to providing quality care for clients and workers. Faced with increasing numbers of people who will require aged care and a lack of available local workers to meet this need, the linguistic and cultural profile of the sector is becoming increasingly diverse as recently migrated workers are recruited to make up this shortfall. The implications for both those cared for and the carers themselves are not well understood. However, the consensus in the literature is that increasing linguistic and cultural diversity brings with it increasing complexity in communication for all involved in the sector, which increases risks to physical and psychosocial safety. In particular, misunderstandings arising from different perceptions of workplace roles and norms, and practices potentially have serious consequences for health and safety practice. Safety culture depends on shared
perceptions of health, safety and communication within the organisation as a whole. Without them, adverse events are likely to result in harm to workers and residents and the quality of care they receive, impacting on the quality of jobs and the quality of care.

The literature on WHS risks emphasises that even without this increasing complexity, the aged care sector is high-risk because of frequent exposure to hazardous tasks and situations, often involving residents who are frail and resistive. These job-specific risks are reflected in growing workers’ compensation statistics for injuries associated with both bodily and mental stress. These risks are compounded by staffing ratios and high staff turnover, which compromise the routine patterns of social interaction that develop over time and on which social and instrumental support depend. The combination of job-specific risk factors and the complexity of communication associated with increasing diversity among staff and residents is likely to exacerbate these risks for all concerned. It has also been reported that workers from diverse linguistic and cultural backgrounds who need to adapt to the mainstream have poorer health outcomes, including feelings of displacement, loneliness and stress, which can affect their psychological well-being (Victorian Health Promotion Foundation (VicHealth), 2007). As well, injury rates may be under-reported and may be as much as twice as high as that of longer term local workers.

The literature on language and culture in care emphasises that such complexity reflects the relational nature of communication. In other words, successful communication is something that is accomplished between people both within and across languages and cultures. It is not an attribute of particular individuals or groups. It arises in the process of interaction among people, in how people interpret reciprocally what each other means and how they respond and act on the basis of their interpretations. It therefore brings together both language and culture: language as the primary cultural framework through which the individual creates and interprets what the other means, including how they think, their assumptions, values, attitudes and beliefs. This means that linguistic and cultural diversity is not about a particular group of people who are ‘diverse’ in their interactions with others; rather, it is about how people from all backgrounds understand themselves and each other in their interactions. Successful communication involves the shared interpretation and exchange of meaning, and draws on and fosters mutual linguistic and cultural understanding. When communication occurs across diverse languages and cultures, the process of exchanging meaning is intercultural. Successful intercultural communication reduces the risk of misunderstanding and thereby enhances safe practices; failure to communicate jeopardises this understanding and safe practices.

Like the WHS literature, the language and culture literature emphasises the risks faced by people trying to adapt to majority languages and cultures. It also foregrounds another key consideration: that the issue does not lie with these people but in the fact that the healthcare context itself is culturally and linguistically diverse. Improvements in how people experience and manage the associated complexity in safety communication will depend on
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understanding the multiple perspectives of those involved and how they successfully interpret and exchange meaning in safety communication in the context of linguistic and cultural diversity.
3. Methodology

3.1 Approach

To better understand how WHS information is disseminated, interpreted and implemented, and in keeping with the study's qualitative methodology, the researchers adopted 'an interpretive and naturalistic approach' (Denzin & Lincoln, 1994, p. 2) to explore how people make sense of their experience of the communication of safety and well-being in residential aged care. The researchers also acknowledged the multi-dimensional nature of the phenomenon under study, placing strong emphasis on how the individual participants understood their experience from their own point of view and in their own terms. Drawing on principles of ethnography (Cresswell, 2007), multiple data sets were gathered, the primary data being interviews with relevant participants. They were analysed in the light of extended researcher observations of routine practices and training sessions, relevant training and policy documents, and profiling data.

The interview data were analysed from the perspectives of both applied linguistic and health and safety. In order to explain how these people interpret their experience, and to acknowledge the multiple perspectives involved and the complexity arising from this particular context (Crichton & Koch, 2011), the applied linguistic analysis drew on narrative inquiry methods (Riessman, 2002; 2008, p. 53) to identify themes that account for the whole of participants’ experience, rather than fragmented categories. The researchers specialising in WHS adopted broadly similar conceptual principles to thematic analysis, using an inductive approach. Inductive coding is also referred to as ‘open coding’ or ‘data-driven coding’ and describes a process of themselves assigning codes to categories that arise from the data rather than attempting to fit the data to a pre-determined coding frame (Braun & Clarke, 2006). The key difference in analytical approach was that the WHS researchers used the NVivo 10 software (QRS International) to assist in organising the data into categories and themes. The findings of both these analyses informed the design of the intervention that is the focus of Chapter 8 of this report.

The overarching consideration in the study has been to understand how and why participants themselves communicate, understand and accomplish safety within the linguistic and cultural diversity of the aged care sector, while ensuring the ‘practical relevance’ (Roberts & Sarangi, 1999) of the study to the sector. This emphasis on developing a mutual understanding of the participants’ diverse perspectives within the complex larger context, and on interpreting their professional practices in a meaningful way, requires ‘thick participation’ (Sarangi 2005). This means close and extended immersion by the researchers within the life of the organisation and its everyday practices; in particular, it requires ongoing collaboration and dialogue among the researchers and the participants and within the organisation more broadly, and among the different disciplines represented in the research team. This approach was followed through the design, data collection and analysis and in the development and evaluation of the ‘narrative intervention’ (Crichton & Koch,
2007, 2011; Koch & Crichton, 2007). There were regular meetings with key participants and ongoing dialogue with those involved in checking understandings, eliciting feedback and negotiating the design and implementation of the study.

3.2 Design

The participants of the study included 43 nurses and carers, 9 managers and 22 residents from two sites of Helping Hand’s residential aged care services. The participants represented a diversity of linguistic and cultural backgrounds. Each participant took part in a semi-structured interview that was designed to elicit their experience of how WHS information is disseminated, interpreted and implemented in the context of linguistic and cultural diversity in residential aged care. Each interview was digitally recorded and transcribed in full without modifying the language used. In addition to the data collected in the interviews, the researchers took extensive observational field notes, observing how WHS information was exchanged, understood and accomplished ‘live’ in the natural setting of two of Helping Hand’s residential aged care sites.

3.2.1 Data Collection

Data collection took place in two residential aged care sites within Helping Hand. At site A, the researchers commenced data collection in November 2012, completing it in March 2013. At site B, data collection occurred between March and July 2013. Data collection involved the following processes:

(a) Briefing of all managers and key participants at each site and interviews (5–10) with management, health and safety representatives and WHS committee members

Initial meetings were undertaken with the Residential Services Managers at both sites before commencing the field research. Information bulletins were distributed and displayed at both sites. These set out the study aims and the researchers’ photographs and contact details. The researchers met with the Clinical Nurse Consultants as part of an induction and introduction process at each site. This enabled them to discuss the study with key personnel and develop rapport with staff. Eight interviews with managers were recorded.

(b) Observations of WHS committee meetings and training to gain an understanding of the procedures and content of the workplace induction and training, in particular from the perspective of workers for whom English is a second language (e.g. accessibility, translation)

Members of the research team attended several meetings and forums for communicating and sharing WHS information. At both sites this included the RNs’ daily meeting and care staff handovers. At Site 2, members of the research team were given access to additional meetings. These meetings included:
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- Two WHS training sessions (4 hours each)
- One WHS Committee meeting
- One carers’ meeting
- One nurses’ meeting
- One residents’ meeting

(c) Observations of workplace practices

The researchers completed 24 observational visits at Site 1 (each of 3–7 hours’ duration) and 33 visits at Site 2. These observations included activities within each care unit, including high care, low care and secure care. Most observations were conducted in the high care unit because care delivery was more obvious and more personnel were allocated to meet the workload demands. Activities observed included meal times, delivery of care, handovers and incidental interactions arising from the work, such as corridor conversations.

(d) Interviews with workers

One-to-one interviews were conducted with 21 workers for whom English is a second language (including nurses and care workers) and 22 native English-speakers across the two sites.

(e) Interviews (22) with residents across the 2 sites.

3.3 Process of analysis

The applied linguistics researchers analysed the ensuing interview and observational data using a process of multiple close readings and note-taking which, in keeping with Riessman’s (2002, 2008) methods of narrative inquiry, attended not only to what the researchers observed in the field and the content of what participants related in their interviews, but also to the manner in which the participants chose to describe their experience. Thus close attention was given to both what the participants talked about and how they described their experience of communicating WHS. This approach required a close focus on the language participants used, including evaluative language, metaphor, elaborations, and the indexicality of words such as ‘us’ and ‘them’, language with which participants revealed understandings of themselves in relation to one another when communicating safety in the context of linguistic and cultural diversity. In taking this approach, the analysis sought to reveal how and why the participants communicate, take up and act on WHS information in the way they do. It sought to make visible how language and culture come into play in communications across languages and cultures, and how intercultural communication matters to people in the communication of WHS in the residential aged care.

The WHS researchers also performed multiple close readings, focusing on the content of the participants’ interviews and their WHS experiences in work practice involving interaction.
with managers, co-workers, residents, equipment and documentation. Key phrases were grouped to highlight relationships between concepts related to the participants’ understanding of and day-to-day WHS practice. In adopting this approach, the analysis sought to reveal participants’ understandings of health and safety as a daily practice arising from and integrated within performance of the work.

3.4 Ethics

This study was conducted in line with the ethical guidelines of the University of South Australia to protect all those involved and maintain the integrity of the research process (Israel, 2006).
4. Framing the findings

Given the complexity of communicating WHS in the context of linguistic and cultural diversity in organisations that are themselves complex in their structure and practices, and in the context of needing to be responsive to a highly regulated external environment, we use two key constructs to frame the analysis and discussion of the findings. These are (1) sites of communication, and (2) an interactional approach to communicating WHS.

4.1 Sites of communication

The construct ‘sites of communication’ recognises that the process of communication is situated in multiple and diverse contexts (Candlin, 2000). Participants with different linguistic and cultural profiles perform distinctive roles in diverse relationships with each other. The notion of ‘communication’ highlights that accomplishing health and safety at work involves talk, texts and processes of communication through which participants exchange meanings. The participants interact, communicating information, ideas and practices to accomplish health and safety at work.

To capture the range of work accomplished in aged care, we identified two sets of sites of communication. One set pertains to ‘acting’; that is, ‘doing’ safety and care. The other pertains to ‘managing’; that is, training and auditing safety and care. In the context of this study, these sites of communication in aged care are as follows:

Acting:
- Day-to-day interactions in safety/care
  - Handovers
  - Staff and resident interactions
  - Informal conversations between staff
  - Care plans, records and notes
- Domains of safety and care
  - Manual handling
  - Psychosocial
  - Reporting of hazards and incidents
  - Physical/chemical
  - Infection control
  - Food handling
  - Emergency response

Managing:
- Reporting and auditing
  - WHS training days, intranet resources, memos and noticeboards
- Trainings and meetings
Communicating work health and safety in the context of linguistic and cultural diversity in aged care

- Health and safety committee, clinical nurse/manager meetings/carer meetings.

This listing provides a scoping of the different sites where the communication of WHS is crucial. The use of verbs is intended to highlight the notion of safety and care as processes that are actively and interactively accomplished through the use of language across a range of sites of communication. The interactional nature of sites of communication is depicted in Figure 1.

![Figure 1: Framing sites of communication](image)

In Figure 1, acting involves the work performed on a daily basis that constructs safety and care. It is dynamic, responsive and immediate. All workplace participants, including care workers and managers, act to create the environment in which there are domains of safety around hazards and risks. Acting and managing are required to respond effectively to the hazards and risks inherent in work that undermines safety and care. Managing acts to coordinate and refine the process of care delivery by consciously monitoring, reviewing and adjusting action to effectively respond to threats to safety and care. Acting is performed all day, every day by all workplace participants and is constant in nature, as depicted by its larger representation in Figure 1.

Managing is also a cyclic activity that aims to control and improve practices. The aged care work environment is highly regulated from the perspectives of client care and worker safety. Managing has an important overarching role in reconciling acting with regulation in
producing safety and care. In communicating health and safety within and across cultures, CALD workers cannot be isolated from their clients, colleagues or the management system that technically defines how work is performed. Hence framing the research as presented in Figure 1 enabled a structured approach to the research question that acknowledges the interactive nature of CALD workers’ engagement with WHS as they interpret, disseminate and understand WHS, and act in performing their work.

4.2 An interactional approach to communicating work health and safety

Figure 2 depicts an interactional approach to communicating WHS. At the centre of the diagram is the process of interaction. People interact with each other to ensure that WHS is accomplished. Interaction is central to the safety and care of all participants in the organisation. In interacting, people bring their own framework of knowledge, experiences, understandings, assumptions, perceptions and values, which are mediated through their languages and cultures. It is through this framework of interpretive resources that people interpret and create meanings when communicating with others. This communication may occur within a particular language and culture, or inter-culturally, across languages and cultures. In the diagram, safety and care are linked, through interaction, to depict an understanding that safety and care are not one-off accomplishments. They are not accomplished in a singular site or in isolation, and they are not determined by the broader sector or legislative context. Rather, they are accomplished with reference to this context through ongoing interaction among people. In aged care this encompasses a continuous process of caring for self, colleagues, residents, managers and families.
Communicating work health and safety in the context of linguistic and cultural diversity in aged care

Figure 2: An interactional approach to communicating safety and welfare
The self is central because it represents the individual unit of participation in creating a safe and caring organisation. Every self is linked to all other participants and brings with him/herself a framework of knowledge, understandings, experiences, perceptions and values. These are mediated by language and culture to shape their interpretation and the creation of meanings in interactions. Every self has agency and contributes to the fabric of the organisational culture that ensures that WHS are integral values, practised daily by all. The individual ‘self’ is understood as (a) interacting with diverse individuals in the various sites of communication and across different domains of safety and care, and (b) reflecting on his/her actions and interactions and what meaning these have for their own practice in caring for themselves and others. In this way, individuals develop not only a set of WHS practices, but also an ongoing understanding of the different meanings and significance they may hold for others, either within the same language and culture or across different languages and cultures in the organisation. Thus, safety and care become not only a matter of compliance, but also safety, for all, every day.

The penultimate circle of the diagram depicts the organisational culture and the psychosocial climate of safety and care that can be created and changed by participants in their different roles. The outer circle depicts external factors that include legislation and the regulatory environment. The aged care environment and WHS are necessarily highly regulated. These external factors are relevant at every point in the functioning of the organisation, its policies, procedures, management, philosophy and practices. They impact at the whole-of-organisation level and may extend to the whole-of-sector level. In this way the model depicted in the diagram can reflect the broader context in which care and safety operate.

While emphasising that health and safety is ultimately accomplished ‘on the ground’ and that its effectiveness depends on the understandings of, and interactions between managers, workers, and clients within organisations, the model also reflects that this ongoing accomplishment is framed by the larger context. Organisations are not islands separate from the regulation and economic reality in which they exist. In its model to explain the complexity of health and safety management, the US National Institute of Occupational Health (NIOSH) highlights the important relationship between the organisation and its regulatory and economic context (Saurer et al., 2002). Factors arising in the economic and regulatory domain have a direct impact on the nature of exposure to hazards and risks, for example through work intensification and level of control. In aged care this manifests as excessive paperwork arising from accreditation, work pressure arising from inadequate staffing or caring time, and the high risk of musculoskeletal disorders arising from resident handling (King et al., 2013). The link between the external regulatory and social environment and organisational work conditions is clear from interviews with nearly 29,000 senior OHS managers, who reported legal requirements and requests from employees or their representatives as the main reasons for dealing with psychosocial risks (Dollard & Neser, 2013; European Agency for Health and Safety at Work, 2009). Research shows that
organisational workplace policies, practices and procedures implemented in relation to work stress, violence, and bullying (the so-called psychosocial safety climate) vary between nations. This indicates that clusters of contextual factors at a national level, such as national occupational health and safety frameworks, welfare state regimes, and unionisation levels, all influence the health and welfare of the workforce through the functioning of the organisation. The organisational psychosocial safety climate reflects the extent to which health and safety is given priority over economic imperatives (i.e. welfare vs profit). Evidence shows that organisations with high levels of psychosocial safety climate have lower levels of work pressure and emotional demands (Dollard & Bakker, 2010), higher levels of worker control (Dollard & Neson, 2013), lower levels of workplace bullying (Bond, Tuckey, & Dollard, 2010), lower levels of emotional exhaustion (Dollard et al., 2012) and lower levels of sickness absence (Dollard & Bakker, 2010). Safety climate, a related construct, is also related to safer physical working conditions (i.e. reduced physical hazards) and injury rates (Zohar, 2010).

Although interaction between individuals is crucial in creating a safety culture, to focus exclusively on the interactional construction of health and safety between the actors within individual organisations might lead to ‘glossing over’ the powerful influences of the external environment. To focus only on the issues arising in individual workplaces can be counterproductive to promoting worker health and safety, as it may create an emphasis on workers coping with arduous job demands that actually have their origins in economic and regulatory pressures. A failure to cope with demands can be easily interpreted as a worker deficiency and lead to simplistic approaches to WHS that ignore the broader landscape (Barnetson & Foster, 2012).

There are also dynamic interactions in the interface between the environment and the organisation. In her study of Toronto aged care workers, Charlesworth (2010) drew attention to the fact that social processes, such as care, are affected by multiple regulatory influences, particularly market forces, social norms, and the social architecture in which the care services exist. As an example of the latter in Australia, aged care facilities are typically classified by their funding arrangements – for profit, not-for-profit or government-funded. In two US studies, the type of funding provided for delivery of care has been shown to influence the health and safety outcomes of the workforce (Castle et al., 2009; Trinkoff et al., 2005). These effects have been attributed to differences in the funding provided for staffing and equipment to promote efficiency and health and safety.

In addition to economic factors, during the past 20 years society’s expectations of care have altered dramatically, with a shift toward deinstitutionalisation and increasing client and human rights (Baines, 2006). New public management principles have underscored policy changes, promoting greater efficiency, accountability and lean service delivery, and ambiguities between bureaucracy and professionalism (Kamp & Hvid, 2012). This policy shift has effected a fundamental change to the service ethos, moving community-based organisations away from their origins toward business models that have had negative
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consequences for the caring sector mission, culture and labour practices (Charlesworth, 2010). In this space, the nature of care has changed, devolving from ‘hands on’ nursing care to the work of less skilled and lower trained care workers (De Bellis, 2010).

The highly gendered nature of the aged care workforce, consisting mainly of women, with most of the workers casualised and working part-time hours, also influences worker health and safety (King et al., 2013). These factors allow work and other life responsibilities to blend, encroaching on the work–life balance and exacerbating the stresses of caring work in both the workplace and the home (Charlesworth & Chalmers, 2005).

As reflected in the diagram, work in organisations does not exist in a vacuum. Health and safety is a fundamental factor in the complex relationship between the organisation and the regulated environment. To ignore these important yet complex interactions may risk shifting onto the workers much of the responsibility for solving their own problems. Notwithstanding the complex interplay of external factors, the organisational culture that shapes the delivery of safety and care is expected to shape conditions associated with worker health (Dextras-Gauthier, Marchand, & Haines III, 2012). The positive safety climate that arises from effective and satisfying interactions between workers, clients and managers promotes worker health and well-being and enables many hazards to be quickly and efficiently controlled at the source (Kaine, 2012; Zohar, 2010). In considering the interface between individual organisations and their broader environment, it must be recognised that many of the external factors are difficult to control, and change is slow and complex. It then falls to individual workers at the day-to-day carer interface to construct health and safety by engineering their own solutions to the effects of larger scale policy and economic influences. Hence, interactional communication is central to successfully negotiating and crafting changes to work processes that make the system work ‘on the ground’ so that safety is an ongoing daily accomplishment.
5. **Profiling**

To understand the nature and extent of linguistic and cultural diversity within an organisation it is necessary to capture its profile. This can be a complex undertaking because of a range of considerations, including:

- issues of disclosure (that is, the willingness of workers to provide such information)
- the difficulty of specifying languages spoken or used, e.g.
  - whether the language stated is the worker’s first, second, or third language
  - the domains in which the language is normally used
  - the level of proficiency that is deemed appropriate for attesting that one is a competent user of that particular language
- the cultures associated with particular languages spoken or used (e.g. a person who speaks Spanish may have a cultural affiliation with one of many different Spanish-speaking cultural groups)
- the relationship between the languages spoken and English (e.g. the relative strength of the two languages, the linguistic and cultural distance between the two languages)
- the need, in the absence of a language test, to base responses on self-reporting.

There are also considerations related to the capture and use of the data. To establish a meaningful profile of the organisation as a whole, all people engaged in the organisation must declare their linguistic and cultural profile. Not all participants are necessarily willing to do so.

It is intended that linguistic and cultural profiling data sensitize the organisation to the nature and extent of diversity that it encompasses. At the same time, it needs to be acknowledged that appreciation of the nature and extent of the linguistic and cultural diversity of the organisation does not address matters of safety directly. Because it provides a context for recognizing the different kinds of diversities that are at play in the organisation, profiling information can be useful, but taken alone it is not sufficient for acting for and managing safety.

A profiling protocol in this study was developed (see Appendix 1). It captures the languages spoken, a self-assessment of competence in English, questions about the use of English in the workplace, and migration background (where applicable). Workers at both sites in the study were invited to complete the protocol. In total, 30 were returned from Site 1 (North Adelaide) and 46 were returned from Site 2 (Parafield Gardens). The participant self-identified the language group. Tables 5.1 and 5.2 depict the number of languages spoken at the two sites.

Table 5.1 shows that of the group of respondents from Site 1, 19 claimed to use English as their first language, with all respondents claiming to be speakers of English. A total of 11
different languages were represented among workers. Of the group, 12 were monolingual English speakers and 18 were multilingual.

Table 5.2 shows that of the group of respondents from Site 2, 34 claimed to use English as their first language, with all respondents claiming to be speakers of English. Together, the workers spoke a total of 19 different languages. Of the group, 24 were monolingual English speakers and 22 were multilingual.

These tables indicate some of the ways in which it is possible to profile workers. They reveal complex profiles of diversity and a relatively high level of multilingual capability (which may or may not be in use as a resource). They also reveal a self-reported capability in English, although where respondents had taken an IELTS test the overall score achieved ranged from 5.5 to 8.5 (N = 7) at Site 1 and from 6 to 7.5 (N = 8) at Site 2. The data gathered in this study could be used to identify languages spoken by position/role and migration history, as relevant.

The protocols developed for this study (Appendix 2) provide a starting point for the profiling that might be undertaken in an aged care organisation. Notwithstanding the fact that the capture was not comprehensive, the data do provide a picture of the nature and extent of linguistic and cultural diversity. Understanding this diversity – an ever-expanding diversity – must be a starting point for ensuring safety. Of course, such profiling could also be extended to include residents and other participants in aged care.

**Table 5.1: Site 1 – self-identified first and subsequent languages spoken**

<table>
<thead>
<tr>
<th>Language</th>
<th>Frequency as L1 N = 30</th>
<th>Frequency as subsequent language</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Swahili</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Nepali</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Visayan</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Filipino</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Krio</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Hindi</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sinhalese</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gujarati</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Punjabi</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>German</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 5.2: Site 2 – self-identified first and subsequent languages used

<table>
<thead>
<tr>
<th>Language</th>
<th>Frequency as L1 N = 46</th>
<th>Frequency as a subsequent language</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>34</td>
<td>12</td>
</tr>
<tr>
<td>Gujarati</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Spanish</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Swahili</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kalen Jin</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Punjabi</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mandingo</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Hindi</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Zulu</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Tagalog</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Kiswahili</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Italian</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Dutch</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sanskrit</td>
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<td>1</td>
</tr>
<tr>
<td>Maltese</td>
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<td>1</td>
</tr>
<tr>
<td>Khmer</td>
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<td>1</td>
</tr>
<tr>
<td>Norwegian</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
6. Major themes

6.1 WHS Perspective

6.1.1 Introduction

The analysis reveals four major work communication themes: communicating health and safety, perceptions of cultural identities, managing health and safety while caring, and working well together. However, the fourth theme overarches the first three themes, highlighting the relational nature of health and safety in the workplace and its integration with service delivery to promote holistic care. Each theme is now discussed in turn, together with its impact on implementing safe and healthy work practices.

6.1.2 Communicating health and safety

Interviews with managers, care workers and residents revealed that despite language being cited as a barrier to communication in the literature, it presented few problems in day-to-day work. Rather than resulting from lack of English knowledge, issues were more likely to arise from misunderstanding accents and pronunciation, as illustrated in the following quote:

My experience here in Africans, they have an alright accent. Here I can understand them but there are also some who are African, they have different accents and even Indians too, so and even me, I’m not sure if everyone who listens hears my pronunciation because sometimes I keep on saying things, I keep on saying the English word but they, like, can you repeat it?, so yeah it’s very hard but once we just clarify it, so everything is alright. It feels OK to clarify.

Site 2-Filipino Carer-05

Despite some frustration in being understood, workers largely cooperated to resolve confusion, with little consequence for health and safety, even at times finding humour in the confusion. The workers acknowledged that residents may have difficulty in communicating with care workers, particularly in understanding accents and pronunciation, arising from residents’ own limitations in hearing, speaking or comprehension.

Well sometimes it’s not a language thing, like there are some residents they cannot speak very well clearly, sometimes I have to get senior staff and ask them what exactly he is saying to me I don’t really understand what he’s saying.

Q. Because they may have slurred speech or not very clear?

A. Yeah some clear speech.

Q. So it’s not the language?

A. No they’re having like speech therapy yeah.

Q. Ok alright so that’s not a difficulty with English is it?

Site 1-Carer-Indian-10
Q. Do you think that their spoken English and their understanding or their listening skills are good or?
A. Well it’s partly us, also our hearing is not as good, and they don’t speak as clearly.
Q. And accents maybe?
A. Yes and we could mistake what they are saying just as easily as they could mistake what we’re saying.

Site 1-Anglo-Australian Resident-01

Overall, language did not pose a significant problem for workers in enacting WHS, and with cooperation and clarification, issues were readily resolved. However, in terms of actually completing work cooperatively, cultural factors were more likely to impede communication and understanding of WHS. Participants commented on the difficulties encountered when colleagues failed to actively listen and pre-empted discussion, or from not giving colleagues sufficient time to process what they want to say and to express themselves. There might be an underlying assumption that a worker with an accent will be difficult to understand. Such miscommunications often arose from workers being rushed due to heavy work pressure or dismissing others’ opinions because of their perceived lesser experience. The following quote from a manager describes her interpretation of workers’ reticence:

Some of the staff we’ve had issues with in terms of like the staff that have been here a long time saying oh well he comes in he doesn’t seem to know what he’s doing ... so we’ve had them down here and we’ve chatted to them to find out and quite often it’s not that they don’t know what to do, they’re a little bit hesitant to sort of push themselves forward not a lot of confidence in what they’re doing, don’t want to be seen as pushy or out there and you know so when you talk to them and you find that there’s probably a little bit of miscommunication you know rather than them deliberately trying to or as one person said ‘They’re always trying to get out of things’.

Q. So is it that they understand but they don’t have the confidence to do it or is it that they don’t understand but they say yes because they want to please, like it’s not ok culturally to say no to a superior?
A. They smile at you. No that’s right and they don’t sometimes feel its right to say ‘I don’t know’ and I say to them it doesn’t matter how many questions you ask you can ask as many as you like nobody’s going to say you’re silly or you’re stupid we would rather you ask the question than make a mistake and I think that’s important that they understand that.

Site 1-Anglo-Australian Manager-18

As a result, Anglo-Australian co-workers often perceived workers for whom English is a second language as being reticent, or unwilling to ‘speak up’ and clarify any misunderstandings (cf Bahari & Clarke, 2013). This perceived lack of assertiveness or competency often led to frustration and at times to negative perceptions of the work ethics of migrant workers. This is a significant impediment to effective implementation of health and safety practice, where work is not coordinated, cooperation is difficult to achieve and there are mismatches in expectations about what is to be done. Because the residential aged care environment is both physically and emotionally challenging, these interruptions to the
flow of work have adverse effects on compliance with safety procedures and trust between co-workers. The same manager highlighted the need to give time for processing and to clarify nuances in language:

Well I think one of the things that we need to make sure is that when an instruction is given that they actually understand the instruction, I think you know even whether it’s and I do ask the question do you understand what I’ve just asked you to do yes and I’ll say well you tell me how you’re going to go about it and when they flounder a little bit you know that they haven’t and I say well let’s work through it again and I think it’s just going through it again and again and eventually and they do know, they do understand and they will understand.

Site 1-Anglo-Australian Manager-18

Handover was a particularly important site of communication about aspects of care. Handovers provided important opportunities for information exchange about specific residents and more general management issues relevant to efficiently performing the work and planning and managing the shift. In some units, the handovers were tape-recorded and played back to the oncoming care workers. Taped handovers were problematic from a health and safety perspective, because they suffered from the problems of poor fidelity and misunderstanding of accents. Importantly, taped handovers did not provide an opportunity for clarifying information in a timely way. In addition, not all care staff attended the handovers; to ensure that staff were available to attend to residents, attendance at handovers was staggered. This further compromised the information exchange, with different workers potentially receiving different information. The following carer response highlights the limitations of current handovers:

Q. When shifts change at handover, how do you find the communication here?
A. Communication is not so very good and not bad, it’s in the middle and it’s just when they give handover to the carer they just give us like, not thoroughly, just the highlight. You know they say what the resident has.

Q. Is it enough information or would you like more?
A. Maybe ... I’m feeling in my way maybe other people, like the staff who come here regularly, they know better. But for the casual staff, or staff who comes not very often sometimes ... they don’t know what’s going on. That’s the reason ... yeah like, sometimes, like, if you are giving some handover you can say ‘oh this resident is having ...’ as you know like that ... rather, you can start from the beginning yeah, what happened, how it happened ... that would be good.

Site 2-Indian Carer-10

Handovers are an ideal opportunity to convey important and timely health and safety information that is directly relevant to the shift, particularly where it affects both the residents and the workers. Examples include the changing status of residents and the impact on the care (e.g. changes in handling procedures) and changes in the status of equipment, staffing, and procedures. Handover should not be seen as a substitute for training but as a regular mechanism for ensuring a safe and efficient shift by focusing on the holistic nature of worker and resident safety in the process of delivering care.
6.1.3 Perceptions of cultural identities

The second theme that emerged from the WHS analysis emphasised the importance of different perceptions of cultural identities. These differences played out in practice through, for example, having different attitudes and values toward aging. In some cultures, elders are cared for by extended family in the home and the concept of an aged care industry is unfamiliar. As a consequence, many of the nursing staff for whom English is a second language have only worked in the hospital setting in their home countries, which contributes to their perceptions of professional behaviour. For many of these workers it is not considered acceptable to engage in banter with residents, so common in Australian aged care facilities where it is considered important to create a home-like environment. Having care work understood as paid work meant that many of these workers were unfamiliar with the formality of health and safety arrangements required in Anglo-Australian workplaces (cf Bourgeault, Atanackovic, Rashid, & Parpia, 2010), meaning they were less likely to report problems through formal channels.

As discussed in relation to communication, due to their cultural backgrounds, these workers were less likely to clarify misunderstandings about work procedures and as a result were more likely to be perceived as incompetent or unintelligent. These workers were often perceived to be more reserved and quiet and did not question superiors, considering this to be disrespectful. This issue is common in some cultures. However, working in this manner is contrary to contemporary health and safety practice, where strategies such as non-technical skills (Flin & Mitchell, 2009; Flin, O’Connor, & Crichton, 2008; Flin & Yule, 2006) involving communication and teamwork are taught to workers. The purpose of such training is to facilitate respectful communication for challenging colleagues, including superiors, in order to minimise risk in normal work operations. These strategies are commonly taught in high-risk industries such as aviation operations, the nuclear and chemical industries and increasingly in health care, and also have relevance to work practices in the aged care environment. TeamSTEPPS is an example of a program implemented in healthcare settings that has developed and utilised specific tools and techniques to integrate non-technical skills in care delivery in acute-care hospital settings (Clancy & Tornberg, 2007; Guimond, Sole, & Salas, 2009). These tools include the use of mnemonics for structuring handovers of information and problem-solving, the use of huddles to bring team members together for ad hoc problem-solving, and the use of non-technical communication skills for ‘speaking up’ with colleagues.

In terms of contrasts in cultural practice, care workers and nurses reported differences in, for example, the technique for giving showers and dispensing medications, differences that could hamper cooperation in applying effective work practices ‘on the ground’ or lead to perceptions of incompetency, as shown by this simple example offered by a migrant carer:

'It's just that when I first came here the shower back in the village you would have your hair washed but here shower doesn't mean to have your hair washed right you have to ask if the
hair is to be washed or not so sometimes you do just shower we wash their hair and then its oh very different ...

Site 2-Filipino-Carer-08.

6.1.4 Managing health and safety while caring

Care workers recognised care work as being physically and emotionally demanding and that the demands of the work created risks to residents and workers (cf King, 2013). They understood that safe care practices would promote safety for the residents and safety for themselves and that, fundamentally, safety had its origins in the design of their work. Specific characteristics of the work that put carers’ health and safety at risk included manual handling of very dependent, frail and sometimes heavy and awkward residents; dealing with aggression and resistive behaviours; slips, trips and falls; and exposure to chemicals and biological hazards such as body fluids. Carers spoke often of the emotional demands of the work and their desire to provide personalised and supportive care. Carers mostly found intrinsic value and reward in delivering care, but acknowledged that the work environment was time-pressured and that their residents’ needs were becoming greater and more complex, creating higher workloads, as reflected in the following observation:

Five minutes later the same male resident gets to his feet unsteadily ... a female resident rushes to the nurses’ station counter and hits the bell to alert staff ... EN quickly attends to resident and he is resettled into his wheelchair ... EN explains to RAs ‘He’s restless ... every afternoon from 3 o’clock onwards he’s like this ... that’s when falls happen.

Site 2-Observations-Reference-9

Many workers in aged care work part-time and the work is generally low paid. Carers may struggle to secure sufficient hours to meet their financial responsibilities. As a result, many work in multiple jobs, reflecting the state of wages and conditions in the aged care sector. Consequently care workers are likely to experience fatigue and stress, and because many of them are women, are likely to also juggle their paid care work with unpaid caring work in the home (Charlesworth & Chalmers, 2005). These sentiments were echoed in the following carers’ responses:

I love my job but you know it’s not like a very, very hard work but you have to love this job to do it, the money is not good but you have to love it.

Site 1-Arabic-Carer-02

Q. Do you get off on time because I notice some of the people we have talked to like they say you’re not going to get off on time I haven’t had time to do the paperwork and it seems to be quite a lot of pressure?

A. Because the paperwork takes time and if we don’t finish it we are not allowed to go.

Q. So you have to stay over time?

A. Yeah and finish yeah make sure we finish everything.

Q. How much time does the paperwork take normally?

A. It depends how busy we have been.
Managing health and safety in this context requires that hazards, risks and incidents are reported and addressed promptly. In this aged care organisation, care workers reported issues directly to the RN or enrolled nurse on duty, who completed the formal documentation and investigation. A typical example described by participants was completing maintenance requests for broken equipment or building repairs, the most commonly reported hazards. However, action was not always prompt. The following comment came from a carer who had been hit by a resident:

Q. So if there’s an injury or an incident here what happens then?
A. You report it.

Q. How do you do that?
A. On the incident form.

Q. There’s an incident form?
A. You fill it out and what happens like depends on your injury sometimes you explain a little bit why we fell or were hurt and they respond to you what they will do. It really gets me annoyed you know, like it happened to me before when we wanted to move the resident and she hit me, like in my ear my right ear.

Q. She hit you in the ear?
A. So I fill in the incident form and the RN asked if I needed to take a couple of days off and I say I’m not too sure and I went home. I like took, I think maybe a month, months, 3 months before I got a call. On this day, at this time you was hit by this resident and how did it go, did you go to the hospital, did you do this, did you do that, no I didn’t go anywhere I’m ok blah blah blah.

Q. So you had been coming to work anyway?
A. Yeah I had been coming to work but what really annoys me was that it had taken place and it was ignored. They usually take a day or two to follow up what happened to the staff you know.

Q. So you didn’t get any feedback?
A. I didn’t get any feedback after 3 months yeah.

Staff recognised the need for compliance with health and safety procedures designed to protect the health and safety of both themselves and their residents. Participants also recognised the important role of the RN in reinforcing safe practice through supervision and promoting the use of correct procedures during handovers.

Essential to effectively managing health and safety practice is managers’ and workers’ access to accurate and current information. Care workers were familiar with accessing information on the intranet, though in practice they tended to seek information directly from the nurse on duty. The policies and procedures available through the intranet were found to be dense
with information, written for managers with the emphasis on legal rather than practical requirements, and were not current, with many not having been reviewed for more than five years. The presentation, style of language and format of the health and safety policies and procedures are consistent with policies and procedures in most organisations; however, they would be difficult for new workers, those for whom English is a second language or those who did not have the literacy skills to comprehend them.

6.1.5 Working well together

The final theme emerging in the WHS analysis was ‘working well together’. This theme overarched the preceding three themes and highlighted the relational nature of health and safety as an enacted practice that arises from producing care work on a daily basis. This theme encompassed perceptions of how effectively nurses, carers and residents cooperated and collaborated to effectively achieve the necessary outcomes for the benefits of residents, their families, the management and workers. It included concepts like teamwork, friendliness, feeling ‘safe’ to raise issues or clarify expectations and be treated fairly. It was important to workers to feel supported by their management and colleagues; to have a sense of belonging; to be able to rely on colleagues for help, particularly when task demands are excessive; to receive constructive and respectful feedback; and to be able to discuss and solve problems together. The willingness and ability of carers to problem-solve by communicating and developing solutions was important in overcoming disruptions and allowing work to proceed. The ability to overcome disruptions and continue with the work is critical in the time-pressured environment of aged care. Problem-solving was illustrated by working together, talking through and deciding together how to do things the best way with minimal effort; that is, in a way that is efficient and safe for both carer and resident. Such problem-solving was observed when carers performed manual handling with residents, planned multiple work tasks, responded to resident behaviours, and worked out strategies for providing effective clinical care. Participants’ ideas of working well together were reflected in the following statements:

I’m pretty passionate about my work here anyway. I don’t like it when people aren’t passionate about their job which is why I get stuck right into manual handling training and I let everybody know that I’m an equal opportunity officer too because we’ve got lots of young new staff coming through and because a lot of the older staff, you know that have been here 20 odd years, will often use bully-boy tactics, you know to use the wrong method in lifting or using the lifting machines and all that sort of stuff and so I always say to them new staff you know then if you’re getting harassed then you need to come to me, and then I can approach the Site Manager and then we can give these people added training because they will always do the right thing in front of you in manual handling training they will always do it then they walk away and because they want to cut corners they don’t actually adhere to Helping Hand’s policies and procedures.

Site 1-Anglo-Australian-Nurse-16

This is a big facility there’s always issues, some issues staff will report, some issues staff won’t report they go and cry in a corner or just talk behind your back or something which is not
good, I think we should talk about it in the open but in the human nature you know we all different how we deal with that but I find the communication even you know in your own family it is very, very important that you move on because if communication is not good everything goes wrong.

Site 1-European-Nurse-02

Q. How and where would you find the information you need on safety and wellness so some of it comes from training but are there other ways?

A. Well there are actually because we all help each other so in other words it will be if say you don’t raise the bed high enough we’re all very close here they’ll say don’t you think you need to raise the bed so and so did their back in don’t forget so it’s more of a support the other team, that’s what we do. If you haven’t got a good team together that helps each other, good luck.

Site 2-Anglo-Australian-Carer-04

Recurring throughout the analysis, the idea of ‘speaking up’, referred to participants’ willingness to raise issues, voice concerns or clarify understandings about how the work is done or is to proceed. The need for all workers to participate in speaking up, offering their perspectives and agreement on how work is to be performed is at the heart of safe practice and working well together. Examples observed included challenging co-workers, carers or residents on care techniques such as infection control or manual handling, asking co-workers to clarify statements or instructions and responding to perceived rudeness or unclear medication instructions. Speaking up is essential for preventing adverse events for residents and carers. The perceived unwillingness to speak up of workers for whom English is a second language was a source of frustration to colleagues and a possible source of safety risk. However, this did not apply to all such workers, as is reflected in the following extract:

A. Like if for example like if someone asked me to do it in a wrong way I just straight away tell them no I can’t do that I’m sorry.

Q. So you feel ok to say so?

A. Yeah because if I’m quite aware that this is not correct way I’m not afraid to say it.

Q. So you feel quite comfortable to say this is not the right way?

A. Yeah I’m sorry this is not what I been taught and what I been taught was this way so could you please. It’s not in a like crude way but I nicely explain to them this is the correct way which I learnt and I’m not quite happy to follow this new way.

Q. And on those occasions where you’ve needed to do that, are the others carers respectful and do it the right way?

A. Yes sometimes they’ve been, not all the time but sometimes but.

Q. What happens on the times that they don’t agree?

A. Sometimes I keep quiet because if they’re like senior, very senior to me I can’t argue with them so in that case I just keep quiet but I don’t follow that way.

Q. You don’t do it?
A. No no I don’t because I know for sure if I’m not quite sure about it I go and double check with the procedure manual.

Q. With the procedure manual, would you ask a co-worker, another worker?
A. No I didn’t get a chance, no or I talk to EN or RN.

Q. So someone senior?
A. Yes

Site 1-Indian-Carer-10

6.1.6 Opportunities for improving communication from a WHS perspective

There is ample opportunity to improve intercultural communication within the workplace by fostering a relational approach to WHS that embraces the safety of all. However, of itself this will not be sufficient to achieve WHS improvements unless there are clear implications for policy. The Work Health and Safety Act 2012 (SA) and the Work Health and Safety Regulations 2012 (SA) make provisions for consultation and participation of workers in health and safety matters that affect them. In this case-study facility, there was no carer representation on formal committees at either site. Carers are not represented in the formal structures that exist for workers to communicate and participate in formal health and safety decision-making. Because the formal structures allow for an elected representative on a formal committee, non-representation may result from not understanding the importance and purpose of participation, having inadequate knowledge, or lacking confidence to participate or credibility in representing a diverse group. In addition, the structural arrangements of such committees may have been a barrier to participation; that is, the time of day meetings were held and the elected representative having the time to attend.

Training is also an important process for sharing health and safety information and teaching skills for care. Training could be used as a vehicle for developing intercultural understanding. Training approaches such as interactive computer-based methods will allow greater flexibility for delivery, but must not be seen as a substitute for practical training and the opportunity for participants to test understanding with facilitators and co-create knowledge with peers. In particular, the health and safety training requires greater focus on practical application of knowledge and the building of competencies, particularly for skills such as manual handling and team-based problem-solving.

The time-pressured environment in aged care and the part-time nature of the workforce may necessitate alternative and innovative arrangements to foster consultation and participation. Working towards identifying and establishing consultative processes is a priority for improving health and safety in this organisation and in the industry more generally. Teaching non-technical skills in communication and teamwork (Flin, O’Connor & Crichton, 2008) and applying techniques like huddles, drawn from patient safety programs like TeamSTEPPS (Clancy & Tornberg, 2007; Guimond et al., 2009) are likely to be useful processes for encouraging communication that harnesses worker participation and commitment to safety. In fostering better communication, participation, collaboration and
consultation, there are likely to be associated improvements in psychosocial safety climate. The psychosocial conditions in an organisation reflect its commitment to the health and safety of its workers and clients, and have been associated with improved health and safety performance (Zohar, 2010).

Finally, working well together and communicating effectively are important for improving health and safety ‘on the ground’ and promoting more positive working relationships. However, as highlighted in the foregoing discussion on the relationship between organisations and their broader environment, so-called ‘higher order controls’ (Behm & Powell, 2014) such as improvements to job, equipment and facility design, are required for real gains in health and safety practice. Job design arising from the design of the aged care system is the source of the pervasive hazards that continue to place the health and safety of workers and residents at risk.

6.2 The languages and cultures perspective

6.2.1 Introduction

The primary aim of the study was to investigate how WHS information is disseminated, interpreted and implemented in residential aged care in the context of increasing linguistic and cultural diversity. As the literature review has revealed, while the experience and needs of aged care residents who come from non-English speaking backgrounds has often been the focus of research in this area, there is limited understanding of the experience of residential aged care workers in this context. This section reports on the analysis. First, we explain how linguistic and cultural diversity was found to affect communication and therefore care. Second, we explore the tensions and possibilities for communicating safety for management, the workers and the residents in aged care. With delivery of care central to the work being done in the aged care setting, existing models fail to capture the complexity of transmitting and communicating WHS information when multiple linguistic and cultural knowledge systems are in play. We provide data that illustrates the interactional nature of the communication of safety between residents and their families, workers and management. Third, this report considers ways of reconceptualising communication in culturally and linguistically diverse settings to guide the development of future policies, resources, and procedures for WHS training, reporting and practice.

6.2.2 What does the communication of safety currently look like?

At the heart of the broader external and organisational WHS contexts already outlined in the NIOSH report by Sauter et al, (2002), is the work being done to deliver care to aged care recipients. This care is provided under the supervision of management by workers such as personal care assistants, enrolled nurses and registered nurses. Current conceptualisations of how WHS is communicated and conducted present a model in which information flows from the top down, with state and federal legislation positioned at the summit of the flow chart, followed by organisational regulatory forces, then workplace policy and practices,
finishing at the bottom with the worker (Sauter, et al., 2002). The analysis has revealed that such a conceptualisation has consequences for how WHS information is disseminated, thought to be understood and ultimately, how it is implemented, because it underestimates the relational aspects of communication.

To better understand how WHS information was disseminated to workers and how they then made sense of this information, the researchers conducted interviews and undertook extensive fieldwork over a period of six months in two sites of a residential aged care facility in South Australia. The scope of the investigation included ethnographic observations of WHS training sessions, multiple sites of interaction (including meetings, handovers across the various shifts, clinical care delivery, and incidental ‘corridor’ communication), and documentation and reporting practices. Domains in which safety was a focus included the policies, procedures and practices involving manual handling, reporting of hazards (psychosocial, physical and chemical), emergency responses (fire, evacuation, bomb threat, intruder), infection control and food handling.

A thematic analysis of the data encompassing all of these domains revealed that the current transmission model that disseminates information, and that shapes workers’ understandings and practices around WHS and communication, is problematic in the context of increasing linguistic and cultural diversity. This is because people from different linguistic and cultural backgrounds bring with them different expectations and perceptions of what communication of WHS should actually look like. Three major themes emerged from the analysis:

- The role of languages and cultures in communication
- Perceptions of professional and cultural identities (including roles and responsibilities)
- Participation and possibilities in communicating WHS.

This report highlights and discusses the consequences for the communication of safety, taking into account the growing complexity arising from increasing linguistic and cultural diversity and the different perspectives of those involved, presenting excerpts from the data to illustrate these multiple points of view.

6.2.3 The role of languages and cultures in communication: Is language a barrier?

Residential aged care managers, workers and residents participated in interviews in which they shared their points of view on the role of language in communicating WHS. The notion that language could be a barrier (as reported in the literature) was mentioned by all of the participant groups, but there were differences in how this barrier was perceived and in what way it was considered consequential for communicating WHS (Bosher & Smalkoski, 2002; Cangiano, Shutes, Spencer, & Leeson, 2009; Crawford & Candlin, 2012; Olson, 2012).
Training

The researchers attended WHS training sessions and observed that information was delivered to a large group of housekeeping and administration staff, nurses and carers in a time-pressured environment, with little opportunity for the workers to clarify information or for trainers to effectively evaluate understanding. The question ‘Has everyone got that?’ (Field notes, Site 2, p. 15, line 21), although often asked by the trainer, did not provide a safe or conducive setting for clarifying understanding. The workers present did not respond to the trainer, but instead checked with the co-worker next to them if they were unsure. The resources used in the training sessions did not cater for speakers of non-English speaking backgrounds. For example, during the DVD presentation on safe food handling, it was difficult for workers to divide their attention between the DVD and the workbook in which they had to write responses to questions. The language of the DVD was rapid and contained idiomatic and technical language with little or no scaffolding for people of non-English speaking background. The emphasis was on transmitting a large volume of information to workers, who in turn would complete a workbook to submit for assessment, with little evidence that the information had been understood sufficiently to assimilate into their everyday practice. In the practical manual handling session, the groups were smaller. There was more opportunity for interaction between participants and the trainer, although the trainer/assessor intervened very little and seemed to let the group manage themselves, only occasionally stepping in to resolve disagreements. At no time in the practical sessions did there appear to be misunderstanding caused by language.

Interactions in the clinical setting

Workers for whom English was a second language sometimes reported encountering a language barrier in the form of unknown words and expressions, as this carer described:

Yeah sometimes the language barrier could affect sometimes because we don’t know exact word for like if ... for bed pan for example ... bed pan we don’t know that is being called as bed pan ... so I don’t exact word to that particular thing so I should have to ask ‘What is that? Could you please explain it ... what bed pan is ... what it looks like or show me?’ So then they explain it so it takes a bit of time.

(Sub-continental carer, Site 1, p. 137, lines 189–196)

For such workers, these language issues were considered inconsequential and could be overcome in the early stages of adapting to work in aged care in Australia. Generally they described feeling confident to ask residents or co-workers when they didn’t understand a word or expression in the clinical setting or during handover, or to ask people to repeat what they said if they couldn’t understand someone’s accent. Some, however, felt that it was better not to ask and just to ‘figure it out’ than risk disapproving looks from busy co-workers who were ‘all the time rushing and doing work and they don’t have time to explain it so they want to finish their job also’ (c.f.O’Neill, 2011). These workers found that residents in particular were helpful in explaining unknown words, slang or idiomatic expressions, and this
was confirmed in interviews with residents. Residents found communicating with such workers sometimes required more effort and could occasionally be frustrating because they had to explain how things ‘ought’ to be done, or ask them to repeat what they said because of difficulties with accent, but very few reported language as risk to their safety and well-being. This resident pointed out:

… they’re [workers for whom English is a second language] very good at explaining if you can’t quite understand and you give them a bit of help. ‘Do you mean this or do you mean that?’ Oh no they will tell you straight away and there’s no difficulty there. I can’t think of any trap I fell into by misinterpreting any question, I can’t think of any …

(Australian resident: Site 1, p. 173, lines 29–33)

As this excerpt illustrates, residents placed much less emphasis on language as a barrier or a risk to their health and safety. They were also more likely to acknowledge their own part in tensions arising around language and communication, which was often characterised by their poor hearing, speech difficulties or broad UK accents.

Interviews with Australian workers revealed a sense that language could be problematic and a possible source of tensions. Here is one such response from a manager:

They [Australian staff] always just come up and say ‘Look I’ve been working with so and so and I’ve asked them [non-English speaking background staff] to do a couple of things and they’ve actually gone and done this and I’m wondering if they understand what I’m saying’ … so, with the safety and wellness aspect of things we’re very quick to pick up if we think someone’s got an English barrier.

(Australian manager: Site 1, p. 18, lines 208–212)

Here, language is perceived as a barrier that must be dealt with promptly to manage a potential WHS risk. This excerpt highlights how managers and workers on the floor collaborate in identifying, monitoring and reporting language and communication problems of staff for whom English is a second language. Taking the perspective that language was a barrier or hindrance, this Australian carer recounted the tensions she feels in a time-pressured, task-oriented workplace:

… with the language barrier sometimes if they don’t understand what you’re saying yeah that can slow you down too … it does frustrate me because I you know … working with people that don’t understand what we’re doing or if they haven’t done a routine before and you’ve got to explain it and explain it and explain it and then you know you just sort of … they’re following you around and so you’re telling them what to do as you go that sort of thing but it can take a lot longer you know and they don’t understand what you’re trying to tell them.

(Australian carer, Site 2, p. 97, lines 154–156, 173–178)

She explained her understanding of language as a hurdle that handicaps and frustrates her efficiency in accomplishing her daily tasks. Such workers already contend with a heavy workload and the feeling of not being able to deliver optimal care, factors that are argued to contribute to significantly elevated stress levels for aged care workers (Martin & King, 2008,
While acknowledging language as an issue, this carer also suggested that another factor might be at play: these workers do not know the routine or their role. This will be considered in more depth in exploring the theme of perceptions of professional and cultural identity.

**Documentation, auditing and reporting**

The analysis did not reveal any major issues in the language of documentation, auditing and reporting, and in interviews all workers consistently stated that they made use of documentation and reporting pathways. For example:

> We have an incident form for staff and clients. If it’s about the clients I fill it for them. If it’s about the staff then anyone who is working under my supervision I would be writing what happened and all that they will fill the form primarily and then I will be enquiring and writing my notes and that form goes next morning to the manager the CNC and they take appropriate action because it goes to Work Cover and everything else any incident … near miss … whatever happens we have to report it and it goes further from there.

*(Indian EN, Site 1, p. 61, lines 94–100)*

No matter what their linguistic and cultural background, workers demonstrated awareness of reporting procedures (informing the RN on duty was usually the first step), the paper trail (incident, hazard or action forms) or computer software (PeoplePoint, RiskMan) for documenting for management information about hazards, near misses or incidents. Nevertheless, the analysis also revealed that workers from non-Australian backgrounds were described as less likely to report incidents and injuries, as the next two excerpts illustrate:

> I guess the fact that probably 40% of our staff are from different backgrounds, I guess it’s 30-40%. I think you’re looking at hazards and workplace injuries and you see that CALD staff are under-represented. What’s interesting is that they are not reporting them.

*(Australian manager, Site 1, p. 6, lines 201–204)*

> Sometimes I think they (migrant background workers) might be a bit shy in putting up their hand and saying look … or filling out a form … or shy to ask someone to help them with a form or even getting another staff member say ‘Well look this is what I found … can you help me fill out the form?’

*(Australian manager, Site 2, p. 23, lines 342–348)*

Here, there is awareness that there is a reduced rate of reporting by workers for whom English is a second language that may be explained by factors other than a language barrier. In the latter example, reticence in reporting is explained as shyness. Attempts to explain why workers did not speak up will be explored further in the next section.

To summarise this section, participants had different perceptions of language as a barrier, which ranged from language differences (most commonly accents) causing minor frustration, to language differences being an issue for the safety and well-being of workers and residents. Although language differences were perceived as potentially problematic, they were largely
overlooked in WHS training and resources, although there was evidence of collaboration between different participant groups to make communication work in the clinical setting.

6.2.4 The role of languages and cultures in communication: Is culture a barrier?

Turning now to the role of culture in interactions in the clinical setting, the analysis revealed that interpretations of cultural differences could create barriers to communication. Such differences could include communication practices relating to body language, the use of space, attitudes to time, relationships and the activity of care giving. For example, Australian workers cited differences in cultural practices involving hygiene, touch and care of the dying as a possible reason why workers appeared not to understand when given instructions, as demonstrated in the following example:

I would probably say a cultural thing you know and they've got all different religious backgrounds and rules and regulations that aren’t the same as ours ... well even the basic showering they do it a lot different than what we would you know totally different ... we do them normal you know what is normal you know what I mean the washing and that you know they do it totally different but that’s what they know.

(Australian carer, Site 2, p. 111, lines 186-187, 199–202)

This carer highlights a common perception amongst Australian workers that frames diverse cultural practices not just as different, but as deviations from normal. Taking the perspective of workers from cultures other than Anglo-Australian, an African worker recounted an experience of misunderstanding when, to show respect to a resident, he sat on the floor to place himself in a lower position than someone older and therefore more senior to him, resulting in confusion for the resident and workers concerned. Other workers of both African and Asian background explained how it was difficult for them at first to call senior staff and residents by their first names, as this was not respectful in their first language and culture. The following statement illustrates how cultural differences can create tensions in interactions across languages and cultures:

... you see there is this problem here in Australia because in my country if you are like a year older than me, I have to respect you, I don’t have the right to look you straight in your eyes while I’m talking to you ... yeah, so when I came to Australia it was very difficult like in Australia here if you’re talking to someone and you don’t maintain the eye contact they look at you like you’re lying to them but in my country it is quite different ... when you’re talking to me like I’m talking to you now, I don’t have the right to look at you straight in the eyes ... it’s disrespectful.

(African carer, Site 1, p. 105, lines 112–119)

As this worker explained, he discovered that not looking someone in the eye can give Australians the impression that he is lying. Here it is apparent that different cultural practices in communication could be misinterpreted by Australians as rude or inappropriate, resulting in tensions and a sense of mistrust (Wierzbicka, 1994). Discovering these differences, making sense of them and adjusting to them is a difficult and gradual process for
such workers, as new ways of communicating often conflict with their primary cultural practices and underlying systems of values.

Although the analysis revealed a growing awareness amongst workers that language and culture differences could create barriers to effective communication, the interpretations of why this was so were many. An Australian nurse recounted:

So I find that some of them will nod their head as if they are listening and understand but sometimes they don’t really understand what you’re actually trying to get across to them ...

I also find that some cultures will not speak up; they will just like stand back and just watch, but you don’t really understand whether or not ... you don’t really know if they’re actually understanding what’s happening, or if that’s just their way of being polite.

(Australian nurse, Site 1, p. 35, lines 355–363)

Here, not speaking up was attributed to cultural significance and recognised as a way of expressing cultural values, demonstrated here in politeness routines as deference (R. Scollon & S. Scollon, 2001, pp. 143-144). Reticence amongst workers for whom English is a second language emerged as a strong element that caused tensions in the workplace. This was variously explained by the different participant groups in the study. The following perspective is from an Australian nurse:

Safety is a big concern especially with some of the cultures that we deal with they don’t understand maybe how to do something and they won’t ask.

(Australian RN, Site 1, p. 28, lines 38–39)

From this perspective, reticence amongst workers for whom English is a second language is interpreted as a reluctance to seek information or a lack of assertiveness, which leads to concerns amongst Australian staff around WHS communication. This notion is supported by the misunderstanding that linguistic and cultural diversity is situated within the individual who is not a member of the dominant culture, rather than linguistic and cultural diversity creating the context within which all individuals, regardless of their first language and culture, find themselves having to interact in today’s context of ‘super diversity’ (Vertovec, 2007). This is compounded by the manner in which migrants are represented in health literature, by labelling people rather than context as CALD or culturally and linguistically diverse (Garrett et al., 2010). This contributes to an ethnocentric focus in training such workers to be ‘more assertive’ and therefore more like their western colleagues (Bosher & Smalkoski, 2002). The consequences of taking such a viewpoint, which sets up an ‘us’ and ‘them’ mindset, are further developed in the following statement by an Australian manager:

It’s not that they don’t know what to do ... They’re a little bit hesitant to sort of push themselves forward ... not a lot of confidence in what they’re doing ... don’t want to be seen as pushy or out there and, you know, so when you talk to them and you find that there’s probably a little bit of miscommunication, you know, rather than them deliberately trying to or one person said: ‘They’re always trying to get out of things’.

(Australian manager, Site 1, p. 27, lines 333–340)
This exemplifies the tendency that emerged in the analysis to second guess why such workers were reticent, preventing Australian workers and managers from understanding the diverse reasons why workers from other languages and cultures would not speak up. Misinterpretations around not speaking up could then evolve into negative evaluations and assumptions that reticence was linked to avoiding work. However, as one RN of European background explained, it took a long time for her to adjust to the idea of reporting things because it was not something that was done in her first culture:

This is a big facility there’s always issues … some issues staff will report … some issues staff won’t report … they go and cry in a corner or just talk behind your back or something which is not good […] you feel better when you say something you’re going to feel better and if you get to this point and if get someone who is going to listen to you it’s good because very often you can hear staff ‘Yeah I report it but she won’t do anything about it anyway’… you know but some they will but I’m telling you they’re pushing really hard regarding the safety and wellness.

(Australian–European RN, Site 1, p. 55, lines 168-170, 177–181)

She explained that, coming from a cultural background where you were just expected to fix things yourself and get on with work, it took time and training to understand that speaking up about issues, reporting and documenting were worthwhile for the safety and well-being of staff and residents, and that it was now her responsibility as an RN to encourage others to do it too.

6.2.5 Perceptions of professional and cultural identities: Tensions around roles and responsibilities

Misinterpretations of workers’ reticence and reluctance to report, and second guessing in an attempt to understand why, were compounded by different perceptions of professional and cultural identities and their respective roles and responsibilities. In terms of professional identities, registered and enrolled nurses were perceived as those responsible for managing WHS issues, particularly in the first instance, while carers were just busy getting the job of caring done:

It’s not a knowledge gap it’s just a bit of a reluctance in their busyness of the day. You sat in a meeting when we talked about action forms … it’s about reporting things and we find things broken and we find things damaged but we accidentally come across them and I don’t mean all the time, it’s just sometimes staff aren’t that willing to fill in things like action forms, hazard reports even maintenance requests sometimes and I’m not sure that I’ve got to the bottom of what the barrier is for them other than they perhaps don’t see it as their job. It’s somebody else’s job or they’re so busy they just think I’ll do that later and they forget.

(Australian manager, Site 2, p. 28, lines 125–133)

Carers were often cast as task-orientated, seeing the nurses not only as their first port of call when dealing with WHS reporting and documentation, but as those ultimately accountable to management. Registered nurses cast themselves as ‘in charge’ and felt that they were not always actively informed by carers of WHS issues:
Being an RN I think you do have a bit more ... you know ... because if I give a directive well that’s what’s to be done so you know ... it’s quite a big responsibility really to make sure the staff are safe.

(Australian RN, Site 2, 116–118)

In terms of cultural identities, the reticence of workers from non-Australian backgrounds was interpreted as resistance or reluctance, and the analysis revealed tensions amongst staff about their co-workers’ integrity and work ethic. Consequently such workers from non-Anglo-Australian backgrounds were sometimes cast as less efficient, less professional or simply letting the team down and this led to issues of trust (Candlin & Crichton, 2010). Although largely refuted by residents, who expressed a high level of satisfaction with the standard of care from all workers, this was a recurrent theme in the interviews with Australian workers:

Lazy, just laziness, that’s all it is and a lot of them, I’m sure and I can understand, use aged care as a stepping stone you know like some of them are studying some of them are doing this and that and the other, but if you don’t want to be here, don’t be here, you know, don’t say you’re here for the residents when you’re not, you know, if you don’t want to come to work to work, don’t come to work, you know, there’s plenty of people out there that are looking for jobs that really would like the opportunity to work here.

(Australian nurse, Site 1, p. 48, lines 254–260)

This excerpt makes explicit the perceptions amongst some workers that the reticence of workers from other linguistic and cultural backgrounds demonstrated that they were less hardworking, less motivated, and less professional. In explaining his experience of being misinterpreted because he is quiet, this African worker highlights the consequences of not taking time to understand how language, culture and different perceptions of professional roles and responsibilities affect how an individual perceives and acts in the world:

Q. You’re not shy but people interpret you as shy?
A. Yeah just because of my culture, but now I’ve been trying to get along with a lot of things so and I’m sure I’ll be alright ... The only thing I could add is a lot of people still need to like listen closely to you before they answer quickly ... like if they ... it’s not like a racist or something ... some people, they see that you’re black, they’ve already made up their mind that they won’t understand whatever I’ve got to say so you know people need to listen first before they judge.

Q. So for you, you feel sometimes that people are judging?
A. Sometimes before I speak they are like: ‘What are you saying?’ I say: ‘Why don’t you just listen first so then we understand what I was about to say’, so you have to listen before you understand. Yeah, there is no way you understand something if you don’t listen.

(African carer, Site 1, p. 100, lines 185–200)

Here it is apparent that newly arrived workers are not just adapting to linguistic, cultural and professional differences, but they are doing so in challenging circumstances, in which
preconceived ideas held by others can lead to being categorised (Sacks, 1992) as somehow deficient, which in turn limits their opportunities to communicate effectively with others.

In addition, there was a strong hierarchical element in the distribution of roles and tasks that was complicated by conflicting expectations of roles and responsibilities. Field work demonstrated that personal care workers were often not included in the full handover attended by enrolled and RNs, and yet they were expected to understand ‘the nursery things’ (Australian nurse, Site 2. p. 58, line 192) and report clinical changes in residents, which were not part of their training and expertise. In addition, they were not well represented on workplace committees or at meetings where they could voice their perspectives and contribute to decision-making around hazard and incident reporting, and WHS training, policy and practice, as this excerpt highlights:

We have the RN and EN meetings we have the carers’ meetings. We don’t at this stage have carers that come to our safety and wellness meetings we would love them to be there. We would love them to come onto the safety because they’re the ones at the end of the day going back to the floor and putting into practice … but I don’t know whether there’s a stigma that they can’t join or because we’re too … you know like the managers are […] I won’t say they’re not interested I just think maybe they’re a bit frightened.

(Australian manager, Site 2, p. 20, lines 177–182, 186)

Here it seems that the offer is there, but no-one is sure why it is not being taken up. As identified in the literature, workers from different linguistic and cultural backgrounds described feelings of not having a voice, of being sized-up, categorised and negatively evaluated before they could even begin to express themselves (Bosher & Smalkoski, 2002; Gandhi & French, 2004; O’Neill, 2011; Ulrey & Amason, 2001). Along with misperceptions of the reasons for their reticence, this perpetuated preconceived ideas and led to over-generalisations about workers from linguistic and cultural backgrounds other than Anglo-Australia. This had consequences for how these workers were able to participate in communication. These tensions were compounded when such workers received negative comments. They felt there was a lack of support in these situations, particularly from residents, even though they felt that the residents’ diminished cognitive states or age contributed to their attitudes, as an Indian nurse explained:

There is a perception that nurses are busy. I’m very busy here. I’m not that busy in hospital but there is a code. There is a client code which is defined there. In hospital if you are good, it’s good … if you are rough if you swear to me I’m not coming to you: ‘I’m sorry, you calm down, then I’ll talk to you’ … as a nurse I don’t take any shit there … in hospital, it’s written, if you behave properly you’re being treated; if you don’t ‘I’m sorry I can’t do it, somebody else can’ … I’ll say ‘Look he called me a “black Indian”, go away, I’m not going there’ and nobody will question me … that’s it alright ‘Look after yourself mate somebody else will go there’ but in aged care it doesn’t happen … oh, they can call you anything, and we to do counseling with them but they keep on doing those things.

(Indian nurse, Site 1, p. 61, lines 320–329)
This nurse articulated the feelings of workers of linguistically and culturally diverse backgrounds who felt that there was not the same support at an institutional level in aged care as that given to newly arrived workers experienced in acute care settings. However, there was some solidarity from co-workers. For example:

A lot of our residents, you know, grew up in time when they had a White Australia Policy and things like that, so we do find sort of racism does rear its ugly head every now and again, and, you know, you can’t tell someone that is not acceptable now because, you know, we can’t put our feelings on somebody else, we can’t tell somebody else how they should feel about something, so if it does rear its ugly head and we have a resident who particularly objects to, you know, a member of staff based on their colour or culture, you know, we will try to avoid sending that member of staff in to that resident because you know, it’s unpleasant, you know, the member of staff and plus, you know, you have to take into [account] the resident’s feelings so we try to be sensitive to everybody’s feelings, and you certainly don’t want to, you know, upset a member of staff either, so you have to be fairly careful how you arrange things and normally we do amongst ourselves.

(Australian carer, Site 1, p. 70, lines 189–201)

This revealed an approach to managing psychosocial stress in which Australian workers tended to juggle how residents were allocated to carers on a shift-by-shift basis to minimise migrant workers’ exposure to such attitudes and remarks. This sometimes created tensions when Australian workers had to come from other areas to cover for a worker who might be exposed to verbal abuse from a resident because of their ethnicity. Although workers from all linguistic and cultural backgrounds perceived that changing residents’ attitudes and behaviour was not realistic because residents were ‘set in their ways’ or had dementia, such negative comments and the tensions created between staff had consequences. In the following excerpts two perspectives are juxtaposed to highlight how reticence can be misinterpreted, with negative consequences:

I think they’re just used to it ... they don’t take it to heart or anything, they just know what it’s like, but if that happens they usually get someone from a different area just to attend to that resident at night ... it doesn’t seem to ... it’s not a ... it doesn’t affect it, I don’t think, you just work it out.

(Australian carer, Site 2, p. 93, lines 263–267)

If you know what not to do then you will be in less trouble then ... be proactive, open-minded, if somebody upset you, alright, they will not stop for you, you have to catch up with them and if you are a bag on their back they won’t like you, so try to do it that way ... every time, if you’re new, then you have to do extra.

(Indian nurse, p. 63, lines 216–219)

In the first excerpt the Australian carer interpreted reticence as coping, whereas in the second excerpt the Indian nurse voiced the perspective of workers like himself, who are faced with the choice of keeping quiet and getting on with the job or speaking up and potentially being perceived as inconveniencing other workers who have to cover for them with ‘difficult’ residents – aware of the risk of fulfilling some co-workers’ preconceived ideas that they were trying to avoid responsibilities. As a consequence, these workers related
experiencing tension and keeping such stress to themselves. They described leaving their culture ‘at home’, in order to somehow separate their cultural identities from their professional identities.

6.2.6 Participation in communicating work health and safety: Overcoming tensions

Notwithstanding these tensions, possibilities for communicating WHS do emerge from the analysis. They highlight a collaborative effort to mediate linguistic and cultural differences, to deal with preconceived ideas, to develop new, shared understandings and to discover the opportunities that can result from embracing a linguistically and culturally diverse work environment. This Indian nurse explained his experience of overcoming perceived barriers and adapting to new ways of communicating at work:

Nothing ... you can’t do anything about it ... it’s this way I will explain ... there is a highway ... everyone else is going over the speed of 100k per hour and you’re just trying to enter this highway and your speed is probably 45. What do you do? You can’t take your car there and let them smash into you. So what do you do? You just drive carefully around the corner and try to get to the speed 100k, and then, when you have 100k you manipulate yourself. You can’t fight with everyone can you?

(Indian nurse: p. 63, lines 195–201)

His metaphor of entering the fast-moving stream of traffic illustrates the time and effort such workers need to get up to speed and to be able to keep pace with co-workers in a busy and stressful setting. This difficulty is not often recognised by co-workers. He described it as a process of careful positioning, choosing one’s moments and picking one’s battles that refutes notions that such workers’ reticence is due to passivity or laziness. He reveals an intercultural competence that understands the close relationship between language, culture and identity in interaction (Kramsch, 2011). Such a competence looks beyond the face value of language as merely words or grammar, and the notion of culture as merely practices, and shows an awareness that language and culture are inextricably linked to the values and attitudes that influence how we see ourselves in relation to others. Knowing that values and attitudes may be differently encoded in diverse languages and cultures enables a deeper understanding of how tensions may arise in intercultural communication, how they can be explored and mediated, and how new perspectives and possibilities can be considered. The following two excerpts from interviews with an Australian nurse and an Australian resident show an understanding that shifts the perspective from the tensions to a greater focus on the possibilities that can be achieved through empathy and tolerance:

Being brought up in Australia and being born as Australian (of Asian heritage) I can still feel ... I don’t know ... like I can still relate to other cultural backgrounds that have just come over to Australia and at a younger age I dealt with all that, you know, indifference and the stereotyping, and all the ... racism basically ... so being there and now there’s a real big difference and a lot of changes, now so I can still feel for the other people that have just come aboard.
I always try and be as helpful as I can because I put myself in their shoes and I know how difficult it would be for me to start a job, you know, and have to use a language that I’m not familiar with ... Yes I think it’s up to us Australians to be patient and try and help them with what we can.

Consistent with Vertovec’s (2007) notion of the diversification of diversity, a significant number of workers who had self-identified as Australian subsequently mentioned their ethnic heritage and additional languages in interviews. Much like this Asian nurse, these people spoke of the empathy and multiple perspectives they had developed from their own experiences of moving between languages and cultures, which enabled them to bridge the gap for others and help their Australian co-workers understand and empathise with newly arrived workers. Some Australian workers who self-identified as Anglo-Australian also demonstrated an emerging awareness of the need to move beyond the tensions, to catch up with the dynamic and changing context and see the world from other perspectives, not because of, but by means of, the increasing linguistic and cultural diversity in the residential aged care context. This Australian carer explained:

I think us Australians have to learn a little bit more about different cultures; I think that other cultures have to learn more about us because we’ve all got different opinions, we’ve got different viewpoints, we’ve got different religious beliefs, and maybe, if we had a kind of an understanding and a balance between them, we could see each other’s point of view, so there wouldn’t be so many misunderstandings.

From this perspective, cultural differences are not seen as deviant or abnormal but as alternative ways of understanding reality (Pearson et al., 2007). Here the onus is not solely on the new arrivals to learn and assimilate to Australian culture, or to leave their language and culture ‘at home’ because it is not appropriate to bring it to work. There is a shift in attitude: everyone has a responsibility in building shared understandings by learning about others and valuing linguistic and cultural diversity as a resource (Chenoweth et al., 2006). The following excerpt from an interview with a worker explains how this shift from focusing on the tensions to considering the possibilities, might be accomplished:

Putting your culture second doesn’t mean that you are putting yourself down it’s more of just taking a step back and seeing where that person is coming from, you know, it’s not saying ‘OK I’m not right’. It’s more of going: ‘Oh Let’s see where he’s going’ and try to understand and then I can say: ‘Let’s find a common ground’ and work from there ... so we’re not taking a step back. If you keep pushing your culture forward, then you get that block. Then you will never know how to work with someone of a different culture ... so, I think it’s more of just taking a step back and observe and then find the common ground to just gel.

From this perspective, finding common ground requires taking a step back to think about what is really going on in a situation, reflecting not just on the culture of the other but on
one’s own cultural standpoint (Xakellis et al., 2004, p. 139), and then choosing not to focus on the differences or concede to others who put forward their opinions more vocally, but rather to seek out first what is shared and build on that. This perspective recognises that tensions arise not from the linguistic and cultural differences in themselves, but from focusing on and promoting one way of conceiving reality without taking into consideration other possibilities.

I speak up if I think something is not quite right and so they need two people to attend to me to lift me up in the lifter and into my chair on the shower chair and if they're not doing it correctly for safety for their back for their body and as well as me well I say so.

(Australian resident, Site 1, p. 154, lines 40–43)

6.2.7 Possibilities in communicating safety: Linguistic and cultural diversity as opportunity

Some Australian workers were open to the opportunities that linguistic and cultural diversity in residential aged care might offer, particularly in enhancing the care of residents for whom English was an additional language:

I actually like working with a lot of the ... like we’ve got a South Korean guy on tonight and an Indian girl, and yeah, the other one’s from Serbia, like she was born in Australia but she’s Serbian background and the Indian girl ... we’ve actually got an Indian resident that can’t actually speak. He can speak English but not a lot so we’ve an Indian that can actually translate ... that works well and one of our other residents is Croatian and the Serbian girl can actually communicate with her; mind you, the one that’s Croatian, she speaks English but, because of her illness, she sometimes diverts back to ... so it works really well.

(Australian carer p. 82, lines 122–131)

In field observations and interviews it was apparent that residents of non-English speaking background often reverted to their primary language and culture and could experience stress or poor health, safety and well-being when they couldn’t communicate with Australian workers. When a worker was able to speak with residents in their first language it was seen to provide therapeutic possibilities: residents’ behaviours improved and tensions were relieved for those giving and receiving care (Heikkila et al., 2007; Jeffries, 2006; Ulrey & Amason, 2001; Xakellis et al., 2004). The ability of migrant workers to act as linguistic and cultural mediators was seen to be a valuable resource in the delivery of care, and with a projected 320 per cent increase in the number of 80-year olds from non-English speaking backgrounds in Australia between 1996 and 2026 there is clearly a need to harness this resource (Howe, 2009).

But this resource was not considered beneficial only for residents for whom English was an additional language. Interviews with residents of Australian background and field observations of residents and workers interacting revealed that linguistic and cultural diversity was perceived as an opportunity to broaden the horizons of Australian residents in their interactions with migrant workers:
Q. So for you it’s quite an enriching and enjoyable thing to have different cultures?

A. Oh it is! Look, I do I enjoy it.

Q. Is there anything in terms of safety and wellness and their communication that’s of concern or interest to you?

A. Not with safety, no, safety well, for me it’s falling and I have to think of ways to stop myself from falling and I don’t think that the carers know that I could fall and they would help me but that’s a fairly obvious … in any language and culture … and wellness … I can’t think of anything … I enjoy meeting them and mixing with them, I think that helps my wellness!

(Australian resident, Site 1, p. 172, lines 112–122)

Not only were workers and residents enriched and informed about one another’s cultures, but the interview and field data overwhelmingly supported the idea that communicating WHS is about more than just passing on information; it is also about complex relationship-building between all participants: management, workers and residents (Dreachslin et al., 2000). Residents frequently demonstrated sensitivity to the relational aspect of communication, often performing a mediating role in interactions with workers from non-Anglo-Australian backgrounds, as the following excerpts illustrate:

I try to get them talking … usually I can talk sport with them you have to find some common … but with the girls I can talk to them about their children and they love talking about them […] so I can communicate with them and it seems to break down any barriers.

(Australian resident, Site 1, p. 171, lines 73–78)

It’s a bit shattering at first especially when you get to the stage where you’ve got to be showered by other people … especially if a great big six foot ten Nigerian comes in to shower you and you’ve never met him before … I make him laugh and I say to him ‘Look just pretend you’re washing a car … scrub my back’ I said ‘You’re doing the bodywork on the car now your arms and legs they’re the four wheels so give them all a good scrub … now.’ I said ‘Just give me the sponge I’ll be doing my face while you clean the windscreens.’ Well, they finish up laughing and enjoying themselves instead of they being embarrassed as I was you see … they’re more embarrassed than you, especially when they start … after they’ve done me a few times, we just have a good laugh.

(Australian resident, Site 1, p. 177, lines 121-129, 134–135)

Residents often took an interest in building relationships with workers through such reciprocity, finding out about their cultures, putting them at ease and inducting them into Australian cultural practices in supportive ways, recognising that they were not only learning how to work in another language, but also discovering cultural differences and learning new roles and routines.

As Aries (2004) argues, until all groups reach a shared understanding of linguistic and cultural diversity as a valuable resource rather than a risk in the provision of health care, the optimum provision of care, including the communication of WHS, is not reached. As articulated in this excerpt, by mediating interculturally competent communication and care, residents did not just feel enriched; they saw themselves as making a useful contribution to
the lives of others. In this way, the residents described their experience of safety and well-being through a sense of active participation. Through their empathy and efforts to make communication work in the increasingly complex context of linguistic and cultural diversity, they both received and provided care to others.

6.2.8 Possibilities in communicating safety: Communicating WHS relationally

The analysis has demonstrated that the ‘common sense’ view that workers should simply speak up in the workplace fails to acknowledge the complexity arising from the increasing linguistic and cultural diversity in residential aged care. Although there is a plethora of ways of passing on information, and instructing people to speak up would seem self-evident, the data has revealed that there are varied and complex reasons why some individuals don’t participate in communicating WHS. Workers from different linguistic and cultural backgrounds are simultaneously learning language(s) and culture(s) for communicating with others on social, professional and institutional levels. They need time to process and adapt to new ways of communicating, but they are concerned about being a burden to their busy co-workers. Often the close relationship between language, culture and identity is poorly understood by all involved, and when people carry the communication practices of their primary language and culture into the Australian setting they may be misinterpreted. As a consequence, there can be negative evaluations of one another, which seem to reinforce negative perceptions. To add to this complexity there can be different expectations of roles and responsibilities, which lead to tensions when certain workers feel they carry a greater load in terms of responsibility, when in fact everyone involved has a responsibility in WHS communication.

There is a need to develop intercultural understanding so that diversity is valued as enriching, rather than different, deficient or risky. It is vital to recognise that one cannot simply leave one’s primary culture at home, even when speaking English only in the workplace. Deeply held cultural values will still be evident in communication; they are part of each individual’s sense of cultural and professional self and they impact on rapport and relationships in interactions. Simply passing on WHS information does not acknowledge the relational aspect of communication, so vital when working as part of a team. Environments in which it is less face-threatening to clarify, such as small group training, the ‘huddle’ model and buddy relationships, are potential spaces for people to navigate diverse ways of speaking and taking up professional roles and responsibilities. When people feel valued as contributing to a team, when they feel that their different cultural perspectives and ways of looking at the world are just as valid as another’s, they will be more likely to take up roles and responsibilities that enhance WHS communication. As the analysis has revealed, this feature of communication that is already in the worksite could be further developed to encourage broader participation across perceived barriers created by differences in languages, cultures and perceived roles and responsibilities, thus moving away from a notion of communication as transmission to one of communication as relational.
6.3 Summary of major themes

The themes identified in the two analyses, from the perspectives of WHS and language and culture, highlight the relational nature of safety communication in aged care and how it is substantially more complex when it involves the exchange of meaning across more than one language and culture. The relational complexity results from the different linguistic and cultural backgrounds that staff, managers and residents bring to the way they interpret what is going on; to what they each say and do; and to how they respond and act on the basis of their interpretations and their perceptions of each other’s professional roles, relationships, motives and expertise. The complexity is seen in the diverse ways in which staff, managers and residents mutually and locally accomplish safety communication in an ongoing way in their interactions. This was evident, for example, in perceptions of staff for whom English is a second language as ‘resistant’ of ‘reluctant’ to report incidents or speak up despite all workers demonstrating familiarity with safety systems and procedures. These and other perceptions were seen to reflect misinterpretations about behaviour, motives and expertise, which in turn compounded negative assumptions and exacerbated tensions, reducing psychosocial safety and compromising safety communication. Perceptions of language and culture played prominent roles in this complexity. Language was seen as a potential ‘barrier’ that could be a cause of minor frustrations and lead to broader concerns for the safety and well-being of workers and residents. Perceptions of cultural differences were wide-ranging. Differences were seen as deviations from what was expected as normal and appropriate; this perpetuated preconceived assumptions and led to over-generalisation, tension and loss of trust. The perceptions of differences in language and culture as problems, and of the ‘different’ staff as responsible, tended to compound perceptions of lack of support and isolation among those staff, reducing their psychosocial safety and further compromising their participation in safety communication. These effects were yet further complicated by strong hierarchic divisions of role, tasks and responsibilities that tended to reinforce division and reduce opportunities for the different groups to address misconceptions. However, clear evidence also emerged of staff and residents routinely and successfully navigating and managing this complexity, working together to anticipate and mediate perceptions of linguistic and cultural difference and overcoming perceived barriers and misconceptions. There was clear evidence of the benefits that linguistic and cultural diversity can bring to the quality and safety of care practices.
7. **An intervention**

7.1 **Introduction**

The intervention developed and evaluated as part of this study was designed both to ensure relevance to Helping Hand’s policy and practice and to be emblematic of the proposed interactional approach to communicating safety arising from the research. It is a formative intervention in the sense that it was designed through collaboration between researchers and practitioners in situ, to address a practice problem arising within an activity system (M. Cole & Engestrom, 2006). As Gutierrez and Penuel (2014) state:

> Studying the social life of interventions moves us away from imagining interventions as fixed packages of strategies with readily measurable outcomes toward more open-ended social or socially embedded experiments that involve ongoing, mutual engagement. (p. 20)

In a collaborative partnership researchers and practitioners work together in such a way that the researcher becomes a participant observer who is able to make visible the practices, their meanings and their significance to those for whom the practices have become routine and invisible. As in this case, such collaboration also allows for bringing together the diverse expertise needed; namely, experts in safety as well as experts in the linguistic and cultural dimensions of communication in the context of diversity.

7.2 **Rationale**

Based on the findings of the study and drawing on data gathered from participants, the intervention trialled a model of training designed to facilitate an interactional approach to safety communication that acknowledges that it is mutually accomplished among individuals in accordance with how they understand each other and the interaction at hand.

As noted in the literature review and underscored in the findings of this study, increasing complexity and diversity raises significant challenges and risks for healthcare workers and their clients (Pearson et al., 2007) and is associated with decreased reporting of safety incidents (NSW, 2002; WorkSafe Victoria, 2008) and higher injury rates/psychological risk (Johnstone & Kanitsaki, 2007; King et al., 2013).

Current approaches to safety communication in the sector and more generally emphasise the auditing and provision of information about safety procedures and safe work practices. This ‘transactional’ approach (Clarke, 2013) is limited by not being sensitive to diverse understandings of safety among staff or to the complex social, linguistic and cultural environment in which they understand and interact with each other and with residents. Moreover, the fact that these groups are from different linguistic and cultural backgrounds further risks the mutual understanding on which meaningful communication depends (Candlin & Crichton, 2013; Fryer, Mackintosh, Stanley, & Crichton, 2013).
To address this limitation, researchers collaborated with staff, residents and managers to develop an intervention in an online safety training module developed by Helping Hand Aged Care. The intervention sought to foster shared understanding, learning and communication about safety among staff and residents and to promote a ‘safety culture’ (Westat et al., 2011).

The methodology was qualitative, drawing on the approach to narrative intervention developed by Crichton and Koch (2007, 2011; 2007) in which narratives of experience gathered through interviews with the participants themselves are used to understand, reframe, enhance and change existing practices. Selected extracts from narrative interview data gathered from participants during the study were included in a training module on ‘manual handling’. These extracts were included within the module as vignettes, which were designed to frame how the modules would be read by participants in light of:

- the understandings and experiences of safety communication of the diverse groups in the organisation as whole
- the fact that safety among staff and residents depends on how they routinely understand, interact with and care for each other.

The outcomes include the revised training materials and the intervention as an approach to enhancing and developing further training materials, and as a model for safety training more generally.

### 7.3 Design and process

The intervention was designed and developed collaboratively by the research team and Helping Hand Aged Care’s research and training teams. It is one exemplar of a micro-enactment of how the communication of WHS can be enhanced and how staff sensitivity to the diverse understandings of safety can be increased in the growing complexity of linguistic and cultural diversity amongst both staff and residents. Members from both organisations came together on four occasions to discuss and develop the design and implementation of the intervention, and its evaluation. The following principles informed this collaborative process:

- The recognition of the significant influence of language and culture on people’s understanding of, and responses to, WHS information
- The power of example (modelling as well as telling)
- Continuous learning
- The feedback mechanism of returning the data to the intervention
- A multidimensional approach to observations and interpretations
- An active and participatory approach.
The two teams agreed that the scope and timeframe of the current study limited the scale of the intervention. However, during these collaborations further potential was recognised for integrating the research findings, in line with the principles listed above, into other types of interventions in the future.

At the first meeting, the Helping Hand research and training team showed members of the applied linguistics team an e-learning program being developed to replace the current annual WHS ‘training and testing’ day for all staff. This new e-learning program would serve both training and auditing roles, requiring the scheduled and successful completion of multiple choice questions. Although this met Helping Hand’s aims of changing organisational culture to think of ongoing importance of safety rather than once a year, in light of the study’s findings, the research and training team recognised that the e-learning program in its present form was still very much focused on the transaction and auditing of WHS information and practice. It made little reference to the significant role of language and culture in the way the communication of safety is mutually accomplished in interaction between people. The implications of recognising and attending to the influence of language and culture on how people understand and respond to WHS information are profound when it is understood that without such attention to language and culture, assumptions are made, misunderstandings arise, people evaluate one another negatively and vulnerable people are less likely to speak up. The applied linguistic researchers worked with Helping Hand’s research and training team to discuss how the e-learning program could be complemented to change the focus from a transactional model to a relational and interactional model of communicating WHS information.

The powerful role of the report’s narrative extracts in increasing the Helping Hand research and training teams’ awareness of the highly relational and interactional aspects of communicating safety suggested that these narratives would be a good starting point in developing the intervention. A series of narrative vignettes would be integrated into the manual handling module of the e-learning program with the aim of expanding the focus from simply ‘passing on information’ and ‘knowing’ about WHS procedures to understanding the diverse relationships on which such procedures depend. In keeping with the principle of using the power of example, the integration of such narrative vignettes was seen as a profound way of showing rather than merely telling workers how the communication of safety was indeed relational, as it foregrounded how safety mattered to people, especially those who might be considered more vulnerable and less able to speak up. In addition, as a narrative intervention (Crichton & Koch, 2011) it would reinforce the not insignificant role of language and culture in influencing how people take up and act upon WHS information, by foregrounding in their own words the diverse ways individuals experience the communication of safety. This would facilitate reflection on individual WHS practice, sensitising people to how their (in)attention to linguistic and cultural difference contributes significantly to how WHS information is disseminated, interpreted and put into practice,
both individually and across professional and organisational cultures. It sensitises them to act as a catalyst for change around organisational safety culture and practice.

The two teams met with the researchers in a further three meetings to design and plan the implementation of the intervention and to develop a tool for its evaluation, including the collaborative selection of a series of narrative vignettes from the data. This allowed the data to be returned to the source, in line with the principle of providing a feedback mechanism for improving the existing training materials. Ensuring that such a principle was upheld meant that any changes to the existing training materials were relevant and meaningful for both the individuals and Helping Hand as an organisation. The selected vignettes illustrated critical moments in communicating WHS and exemplified the multiple perspectives of nurses and carers, residents and management, highlighting the significant role of language and culture in both enacting and managing safety in the context of linguistic and cultural diversity. The vignettes were then collaboratively edited to ensure they were representative of people’s experience but did not identify particular individuals. The narrative vignettes and associated prompts and questions for reflection were incorporated in a reflective journal that was designed with a further principle in mind; that is, to provide the opportunity for continuous learning, giving people a sense of the diverse ways in which individuals make sense of WHS information, and to invite them to question their own assumptions about how they and others interpret and implement such information. More specifically, the narrative vignettes and prompts and the questions for reflection were selected and designed to address two organisational priorities: firstly, to encourage people to speak up; and secondly, to enhance the way people work together by encouraging them to reflect on the implications for their own practice of how they care for one another and how they communicate safety and well-being for themselves, their colleagues and their clients, every day.

Together, the two teams chose the following narrative vignette to appear at the very beginning of the e-learning program as a ‘headline’ quote, to emphasise the shift of WHS training from a focus of telling people about safety, to one of showing the complexity and diversity of perspectives around the communication of safety, such as in the following headline quote:

Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’, because not many people answer ‘No I don’t understand’, they just go off and try to figure it out for themselves. This is really important when lifting or transferring, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured. (Nurse)

In subsequent screen ‘pages’ other narrative vignettes were incorporated to highlight the relational and interactional nature of the communication of safety, with the Helping Hand research and training team playing a significant role in the decision-making around where to place the vignettes to best complement the existing WHS information. Once the vignettes
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had been integrated into the program, however, the Helping Hand training team recognised how the language of the existing program remained highly transactional. This prompted strong collaboration between the two teams to modify such language to better reflect the relational and interactional nature of communicating safety. As they became sensitised to the powerful influence of language and culture and more confident in changing the existing text to better reflect an interactional approach to the dissemination of WHS information, the organisation’s research and training team demonstrated continuous independent learning. Selected pages from the e-learning program showing before and after pages are included in Appendix 3.

In order to evaluate the new training materials the applied linguistics researchers, with input from the Helping hand research and training team, developed a reflective journal for participants who had completed the e-learning manual handling module (Appendix 4). This provided another feedback mechanism through which participants could report on the impact of the e-learning program on their own practice. The journal, to be completed over five shifts, included five prompts for reflection, one for each shift and each with two narrative vignettes from the e-learning program. For each journal entry, the first vignette repeated the headline quote and was paired with a second headline quote. After each shift the participants were asked to reflect on and write a short response about their experience of the communication of safety in relation to the narrative vignettes, prompts and questions for reflection, as shown in the following example:

During today’s shift, please consider these quotes and the question below:

‘Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, “Do you understand?”, because not many people answer “No I don’t understand”, they just go off and try to figure it out for themselves. This is really important when lifting or transferring, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured.’ (Nurse)

‘I could see the carer was embarrassed about helping me in the shower, but I needed him to stay so I didn’t fall, so I told him jokes. In the end this made us both feel better about it, and I certainly felt safer because he stayed and helped me.’ (Resident)

Reflecting on these experiences, how would you change the way you care for yourself, your colleagues and residents?

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients?

In keeping with the principle of continuous learning, the final section of the journal invited participants to reflect more broadly on any ways in which the narrative vignettes, prompts and questions from the e-learning program had changed how they understood, and subsequently how they would practise, communicating safety with colleagues and clients in
their work. This would provide another feedback mechanism that would allow further improvement to the training.

Another important principal that informed the design of the intervention was its multidimensional approach, in keeping with the design of the research study itself, in which the relationship between safety, communication and the context of linguistic and cultural diversity was recognised and attended to. This resulted in understandings that led to the creation of innovations to the existing manner in which WHS information had hitherto been communicated and enacted upon, innovations that may otherwise have been overlooked. Throughout the design and development of the intervention and in line with the principle of taking an active and participatory approach, the research team and Helping Hand research and training teams collaborated on every aspect of the design of the intervention. The intervention was not imposed on the organisation in any way, but came very much from within. It was therefore developed to be relevant and meaningful to those who would be participating in it.

7.4 Implementation

Ten staff members who had participated in interviews earlier in the study took part in the intervention. These participants included one RN, four enrolled nurses and five carers. Four of the nurses and one of the carers were from an Anglo-Australian background; one of the nurses and four of the carers were from diverse linguistic and cultural backgrounds. These participants completed the jointly developed e-learning program (manual handling module) with the incorporated narrative vignettes. On completion of the e-learning package, the participants completed the reflective journal over their next five shifts over a maximum period of two weeks. The ensuing qualitative data was collected and analysed by the applied linguistic researchers, providing a feedback mechanism by which to assess the effect of the intervention itself on people’s attitudes to the communication of safety in the context of linguistic and cultural diversity.

7.5 Findings

The findings are based on a thematic analysis of the journals of eight participants. Three people who initially agreed to participate withdrew in the early stages for personal reasons. Of the eight nurses and carers who completed the e-learning module (with vignettes) and completed the reflective journal, five were from an Anglo Australian background and three were from other language and culture backgrounds.

Four key findings emerged from the analysis of the journal entries. The first finding was that the participants emphasised the value of understanding communication as interactional in their experiences on the shifts. These experiences were elaborated through four findings that highlight the interactional nature of communicating safety: mediating languages and
cultures, oneself as an example of difference, speaking up and working together. Each finding is explained in the following sections with exemplifying data.

Communication as interactional

The training resource (the e-learning module with narrative vignettes) used in the intervention was designed to move the framing of the communication of safety from transactional to interactional, and the same interactional framing can be seen in the experience of the participants in their feedback after the intervention in the following examples:

I worked with a carer, she was a new employee and it was her third shift. I told her she is going to shower one the residents, when I looked at her face, I found it looked like she was not sure how she was going to do it. I thought it’s better the first time to be with her and explain to her what to do and make sure she is doing the right manual handling and safe working. I told her how she needs to do things, we did them together and at the end she told me how she was confident for the next resident. That was a good experience for the shift. She learned she needs to ask if she is not sure, before making mistakes.

(Middle Eastern carer)

‘I’ve had this happen, a new carer had started and was struggling with how to do things. After sitting down and discussing what they were struggling with, the nurse and myself then showed her. After a few doubles (two staff working together) she got the hang of it. I encouraged her to ask questions if she was unsure. After the shift I asked them if they wanted some clarification. I answered questions for her.’

(Australian carer)

‘I had to work with a carer who struggled (slightly) with English, especially when spoken quickly. A resident in this carer’s list had some changes to their care needs and I found it easier to go through the care plan page by page explaining the differences. I asked if she felt OK with this and she said that it was very clear.

(Australian nurse)

‘I discuss with the carer what we are going to do and how we are going to do it. I ask the carer to acknowledge they understand by clearly going through what they have understood so we both have the same thing in mind.’

(Australian nurse)

These quotes exemplify the range of responses that participants gave in their feedback and emphasise the importance they place not simply on complying with and passing on WHS information, but actively ensuring that there is a shared understanding amongst all involved. The first quote illustrates how the carer recognised that simply telling the new employee what to do would not be enough, and so they worked and talked through tasks together until she was confident that the new employee had not only learned what to do, but also learned how to ask questions when she wasn’t sure what to do. The other quotes underscore this theme of creating a dialogue or interaction around the communication of safety, while showing the variation in individual responses.
Mediating languages and cultures

The theme of mediating languages and cultures which emerged from the analysis of the intervention data resonates strongly with the local methods identified in the parent study, suggesting that the intervention supports the practices developed by staff and residents to mediate linguistic and cultural differences in ways that anticipate and manage preconceived ideas and potential miscommunication and misunderstandings, as the following examples highlight:

‘If staff have not worked together before it’s useful to talk through the manual handling procedure by explaining the next steps to the resident by the senior carer. This method saves assuming knowledge, pre-empts any differences in manual handling practices which could be hazardous, encourages the resident to participate in their care and feel cared for, encourages staff to communicate with the resident leading to a greater rapport and awareness of them as individuals rather than jobs to be completed.’

(Australian nurse)

‘Australia is a multicultural country where people from different backgrounds would get to work together and obviously speak with different accents but the most important thing is to build the ability to listen to each other. People should not just conclude that I don’t understand or I will not understand what he/she has to say. I have heard people saying “I don’t understand her accent”, some people saying “Did you understand what he said?”, but I believe that if people listen more they will understand. Because most people have already made up their minds that they will not understand, usually lost them at the middle of the conversation. When people listen more and take time to understand one another there would be safety for all.’

(African carer)

‘This (narrative vignette) reminded me that assuming familiarity with terms can be a mistake. After taking a resident’s blood pressure as I’d requested, the carer told me the result which was on the low side, I automatically queried “Lying?” (as in lying/standing position) and her horrified response was “No I’m telling the truth”. This occurred in front of the other carers and after brief embarrassment and laughter a discussion with the relieved carer about understanding English language with all its sayings, slang and colloquialisms. I often feel I may be patronising in querying understanding if language is an issue and have occasionally sensed resentment if I reiterate or oversimplify. I have used this anecdote and other examples to ensure colleagues understand that I do not mean to demean them in so doing.’

(Australian nurse)

‘On this shift the carer came to the nurses’ station in a panic, requesting me to come to Mrs XYZ’s room as she was feeling ill I had to ask her to repeat the name several times to no avail. I asked her to tell me the room number and then I was able to go to the room. We talked about this later in the night and both agreed to use the room number instead to allow for less confusion. The carer found several surnames on the floor very difficult to pronounce and was relieved to avoid this in future conversations.’

(Australian nurse)

‘The quotes (in the new training module) reminded me to think of both sides.’

(Australian nurse)
These quotes highlight how staff use local methods that enable them to bridge the gap that arises from linguistic and cultural differences, and different levels of experience. Such methods include taking the time to listen, building confidence in others as they get up to speed and finding practical solutions when accents or expressions might lead to misunderstandings. They also point to attitudes and practices that build rapport and enhance others’ self-esteem. The ways in which they do this point to the next theme, understanding oneself as an example of difference.

Oneself as an example of difference

Difference as a theme was framed quite differently in participants’ journals than in the parent study. In the journals, participants emphasised difference as normal – not something to be concealed, but something that is a natural part of life, to be discovered, appreciated and taken into account when communicating safety, as the following quotes exemplify:

‘People tend to listen and understand that we are not the same and also our ability to find solutions to problems are not the same as well. One thing that I noticed was people from non-English speaking backgrounds need more time to express themselves because they have a lot to contribute. Some people still don’t like to listen to migrants; they think it’s a waste of time listening to them as it takes time to understand some accents. I believe communication would be so effective when other points of view are fully understood and acted upon.’

(African carer)

‘A lot of carers in this industry are much younger and even if I were not senior to them would possibly feel disrespectful in asking me to repeat myself. I also work quickly and this can suggest inferior skills and impatience which could erode confidence so I try to be encouraging and positive. I also use my hearing deficit to identify with staff from different language and culture backgrounds, as I often have to ask people to repeat themselves and have sensed irritation at times. I certainly know I have assumed that I have heard correctly and not asked for repetition for fear of seeming “dense”. I do have the confidence to ask for clarification where safety may be compromised and have explained my hearing deficit and the speaker accent combined are a problem. I find this deflects the tension and clears the air for much safer communication. Clients can be influential in persuading staff to perform unsafe manual handling. We need to give each other strategies to refuse without causing offense or tension.’

(Australian nurse)

‘It is important to remember that each individual has different background, culture, education, commitment to safety, policy and procedure. I have found it valuable to demonstrated correct techniques by this it takes in how different people learn. Some learn by seeing it done, rather than reading a procedure or instruction.’

(Australian nurse)

‘Obviously our backgrounds have a lot to do with how we live our lives every day and how we care for people. For example the way I talk to residents is a bit different. Most of the time I speak to them in a low voice and this has something to do with my background and my personality, as I see all of them as my grandparents and in my culture you are never allowed to yell at elderly ones and maintaining eye contact with them is considered being rude and disrespectful. So I take my time and I’m extra careful while communicating with my
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colleagues and residents because it’s always good to treat people the same way you will love to be treated.’

(African carer)

‘When people realise or understand how to celebrate differences, communication will become more effective rather than people jumping to conclusions and assumptions. Me as an individual I believe that we are just so different, we have different personalities and beliefs but if we take time to listen to each other and try to see each other’s points of view, people will work together with love and harmony and make a working place a safe environment for all.’

(African carer)

These quotes highlight how the participants acknowledge that difference is not just something found in others, but is a feature of everyone’s experience, whether it be age, experience in the job, language or culture, and it does not have to be an impediment to communication. This increased sensitivity to difference was something everyone shared and is something that can be managed, leading to the fourth finding, speaking up and working together.

**Speaking up and working together**

When there is sensitivity to the fact that individual differences arise from different perspectives and understandings and these inform how people communicate and act, there is less risk of making assumptions, misunderstanding and judging one another. As a consequence, an environment is created that makes it possible to manage individual differences, and people are encouraged and supported to speak up and work together, as these quotes show:

‘I have found it is very important to allow everyone in the team to be involved in day to day decisions and have the opportunity to voice their ideas, opinions. Some staff from different cultural backgrounds do not feel comfortable doing this in the group setting so it is important to spend one-on-one time with these individuals to ask them for input or gain understanding of their level of knowledge.’

(Australian nurse)

‘Body language is very important in our work generally, particularly in situations where language is complicated; body language may be interpreted even more closely. If new staff are lacking in confidence and obviously new to the role it is particularly important to modify your body language, tone of voice and facial expression (for example rolling your eyes when they don’t understand you) and this can not only offend but also make it difficult for the staff member to ask for clarification for fear of ridicule.’

(Australian nurse)

‘When 12 years ago I started working as a carer I was very shy, but I remember one sentence in my book, “Before you make a mistake always ask” That’s my experience and I always tell to new staff “Please it’s not embarrassing to ask, it’s embarrassing to make a mistake not asking”. We are from different cultures and backgrounds, but it doesn’t mean we can’t learn from each other and ask questions, nothing to do with culture and background you have to
be confident in your job otherwise you’re not going to be a good carer or other job. I love to get to know new staff and found it’s what’s in common rather than them “I’m better than you”, which makes them to hate me. I made lot of friends in years working with people in different cultures and background. Communicate with each other, it makes you a good person.

(Middle Eastern carer)

‘Other staff members have approached me and said they were not sure that she could understand them, and that they had difficulty understanding her. When I asked them why they said she spoke very quietly and when they asked her something she would respond with very short answers or nod. When I worked alongside her I found I would have to initiate conversation, ask her understanding of what tasks we were about to do so as to see clarification she understood. Once I offered her some prompts I found she would offer more in her conversation on that one-on-one basis. I asked other carers to discuss more with this carer what tasks they were doing, assist her to understand, ask her to speak up a bit more so clients could hear her and engage her in other conversations so she felt more included in the team.’

(Australian nurse)

7.6 Conclusion

The journal data from the intervention participants consistently emphasised the value of understanding the communication of safety not only transactionally, but also interactionally. Transactional communication is concerned with transmitting, learning and complying with information about safety processes and requirements, but safety is accomplished locally, between people. It is dependent on how people care for each other’s safety, and how people interpret each other’s understanding of safety and risk in any given situation. Participants’ journal entries highlight their awareness of the need for ongoing alertness to the potential for different or unexpected understandings; the need for ongoing communication about safety issues that is not based on preconceptions about the way others understand them, especially in contexts of linguistic and cultural diversity. From these findings and the principles outlined above, we suggest that the intervention provides one possible model for reframing current transactional approaches to safety communication to emphasise the interactional nature of effective safety communication. It will be important to then develop the broader applications of this model of intervention. It will be important to consider, with particular reference to linguistic and cultural diversity, how such interventions can be used in training and safety communication more generally, how they can been developed to benefit further sites, and what other models of intervention might be used to support the development of interactional approaches to safety communication.
8. Findings and implications

8.1 Linguistic and cultural profile

Finding 1

Many organisations in aged care recognise the changing linguistic and cultural profile of their workforce and communities and that this has an impact on how the organisation as a whole communicates and works with WHS. Most organisations have no mechanism in place to capture the linguistic and cultural profile of their organisation.

It is of value for organisations to know and understand the linguistic and cultural profile of their people as a basis for planning and development of their workforce, its practices and its professional learning, including how to respond to cultural differences. In addition, workers from linguistically and culturally diverse backgrounds are considered vulnerable in the context of WHS legislation because they are new to the workplace and bring with them different ways of understanding work practices and workplace conventions. Although such profiling is necessary, it is not sufficient to ensure sound WHS within the organisation as a whole. Recognising the diversity provides a basis for understanding the nature of the organisation’s people and this may prompt an interest in finding out and exchanging cultural ‘facts’. It must be recognised that exchanging this kind of knowledge and eliciting mutual interest is a useful first step in communication. However, it does not address the central need for the kind of communicative interaction that ensures mutual care in the exchange of meanings within and across languages and cultures. Furthermore, it does not consider the meaning and significance that particular concepts or practices hold for different people.

Given the need to better understand the dynamic linguistic and cultural profile of the organisation, organisations should capture their overall linguistic and cultural profile as a basis for planning and action. This should be done regularly for the entire workforce.
8.2 Categories and naming

Finding 2

To support work health and safety, the ‘CALD’ category needs to be understood not as a trait just of particular minority groups, but as a trait of all people. All participants in the organisation are linguistically and culturally situated and, by definition, CALD. Communicating WHS is an act that is interpreted and accomplished among all people in the organisation. Communication is a relational, interactional process among people in the context of linguistic and cultural diversity, a diversity that influences their understanding and work practices.

There is a need to reconsider the use of the term ‘CALD’ even though it is a convenient tag used in everyday practice. It is important to understand how such categories are understood by different people, and the consequences of such categorisations.

To separate one group from another by differentiating them as CALD can misrepresent that group as a particular source of risk compared to others, whereas the reality is that all are involved in accomplishing safety. As a result, the concept of CALD can hinder understanding of the interactional nature of effective communication about safety and draw attention away from the need for responsibility across the whole organisation.
8.3 Complexity, cultural assumptions and organisational change

**Finding 3**

The communication of safety is complex because of the framework of knowledge, understandings, experiences, perceptions and values; that is, the interpretive resources that each participant brings and the assumptions all participants make about how knowledge and actions will be interpreted by others. This complexity needs to be seen as an ongoing project of understanding and working with the different organisational roles and functions, including management, and the ways in which linguistic and cultural diversity impacts on these. This complexity increases significantly in contexts of linguistic and cultural diversity. A whole-of-organisation approach is needed to develop an organisational culture that supports communication in the context of linguistic and cultural diversity, along with other forms of diversity.

Organisations are diverse not only in terms of languages and cultures, but also in a myriad of other ways. The structure of the organisation informs how things are done, such as how professional roles are carried out, how hierarchies are established and maintained, and how people are held accountable. All of these dimensions contribute to the organisation as a complex whole. These differences need to be considered when changing any aspect of the organisation. Working to enhance WHS practices using the complexity brought by linguistic and cultural diversity needs to be an integral part of the culture of working in the organisation.

This requires leadership in the development of sophisticated ways of ensuring that organisational members are aware of, able to anticipate and engage with and remain open to diverse interpretations of concepts, behaviours, situations and phenomena – and ultimately that they are able to act and interact within and across languages and cultures in responsive ways. There is also a need to recognise that the dynamic nature of the profile of organisations makes the effort towards understanding and working with this complexity an ongoing project of engaging with change. Huddles, handovers and formal meetings, such as WHS committee, careers’ meetings and nurses’ meetings, provide existing sites of communication where such awareness and reflection could be encouraged. Another way in which this can be achieved is by including awareness-raising and reflective practice activities in daily work and in training programs for managers, nurses and care workers.
8.3.1 Local methods

Finding 3.1

Individuals and groups acknowledge and develop local methods to communicate and implement safety as a way of managing the context of diverse knowledge, understandings, prior experiences, interpretations of values, and practices. These local methods bring consequences that need to be acknowledged within organisations.

To better understand their use and where they help or hinder the communication and enactment of WHS, greater attention needs to be given to the local methods of accomplishing WHS that evolve in practice. In so doing, it must be acknowledged that there can be a tension between regulation and diversity. Regulation speaks of systems and structures that are often devoid of the sociocultural nature of the work environment to which they apply. Local methods are of value because they are responsive; they arise as a consequence of the immediate situation at hand. Nevertheless, these local methods also need to evolve around the regulatory requirements and the WHS expectations of the organisation.

Informal methods that are responsive ‘on the ground’ are also needed to encourage all workers to participate in health and safety every day. In particular, workers (especially those for whom English is an additional second language) need to be supported to ‘speak up’ about the uncertainties, problems, hazards and risks they encounter during their work. In practice this means workers whose second language is English speaking with their co-workers and supervisors about creating safety as a regular part of everyday work. At the local level, existing mechanisms for this form of interaction include huddles, handovers and ‘corridor conversations’. In addition, effective teamwork strategies could be promoted. The development of local methods is important because WHS itself is local. It is through local interactions that understanding, collaboration and cooperation are maintained. External macro-environmental factors such as regulation and the economy are enacted, materialised and solved by local interpretations and actions so that work can proceed despite tensions between macro and micro environments, regulation and diversity.
8.3.2 From transactional to interactional communication

Finding 3.2

In managing linguistic and cultural diversity in aged care's planning, auditing, managing and training procedures, organisations tend to rely on transactional methods of transmitting information and procedures, rather than acknowledging that safety is accomplished between people and therefore depends on how they understand their own and each other's knowledge and know-how.

There is need for a shift from a transactional to an interactional approach to communicating WHS. Such a shift recognises that (a) daily interaction among people at all levels is crucial to accomplishing safety, and (b) such interaction depends on ongoing mutual care and shared interest in understanding the diverse perspectives of those involved. This in turn depends on how people successfully interpret and exchange meaning in safety communication in the context of linguistic and cultural diversity.

Making handovers more inclusive, participative and focused on how the work is to be accomplished, and the training and use of non-technical skills for care staff and managers, can all contribute to promoting interactional communication.

An important opportunity for developing communication is through the mandated WHS training. As the intervention revealed, there is need to rebalance the emphasis on regulation and managing structures and processes, with enacting safety as daily practice. The use of reflective practice in training of all staff is helpful in achieving this shift.

The foundation for interactional communication is established through understanding WHS as a practical daily accomplishment that is integral to successful completion of the work, rather than as an inconvenient additional activity to be managed. In addition, managers and supervisors need to make themselves visible and accessible so that they actively participate with their staff in the ongoing project of creating safety ‘on the ground’.
8.3.3 Intercultural communication

**Finding 3.3**

In the context of increasing linguistic and cultural diversity in aged care, communication necessarily involves the interplay of languages and cultures. In aged care environments it is not just a single culture that is present – multiple cultures are present and operate simultaneously, including the workers’ and residents’ cultures and the organisational culture. Knowledge of cultures is important in this environment, because this cultural framework affects what is communicated and how.

It is language use in its cultural context that creates meaning – creating and interpreting meaning is accomplished within a cultural framework. Communicating successfully in this environment, however, is not just a question of gaining knowledge about the cultures that circulate in that environment, useful though this is. Rather, each participant must learn to understand him- or herself in relation to other cultures and developing an intercultural stance towards communicating. This means recognising that one’s own culture shapes perceptions of the world, actions, relationships with others and perceptions of oneself. Taking an intercultural stance means that participants are able to decentre from their own linguistic and cultural context. It means that communicating across cultures involves recognising and accepting ourselves and others as being culturally conditioned, and that these conditioners are at play in communicating.

A main difference between a cultural and an intercultural orientation is that a cultural perspective considers only the culture of the other person rather than the cultures of both the other person and the person making the judgment. An intercultural orientation, on the other hand, recognises that the participants’ cultures are a fundamental part of engaging with linguistic and cultural diversity in ways that support WHS practices.

There is a need to develop such an intercultural stance to working with linguistic and cultural diversity in aged care. The notion of ‘stance’ (Cochran-Smith & Lytle, 1999) is intended to highlight the fact that this intercultural way of working cannot be reduced to a few practical prescriptions. Rather, it represents a holistic way of working that recognises that people’s practices are a part of their own personal, social, linguistic and cultural makeup and that their experiences, beliefs, ethical values, motivations and commitments shape their actions, relationships and professional identities (Scarino & Liddicoat, 2009). Cochran-Smith and Lytle (1999, pp. 288-289) describe ‘stance’ in the following way:
We use the metaphor of stance to suggest both orientational and positional ideas, to carry allusions to the physical placing of the body as well as the intellectual activities and perspectives over time. In this sense, the metaphor is intended to capture the ways we stand, the ways we see and the lenses we see through.

Developing an intercultural stance includes:

- noticing cultural similarities and differences
- comparing one’s own cultural practices and understandings with those of others
- reflecting on one’s experience of linguistic and cultural diversity, how one reacts, how one feels, and how one will find ways of engaging constructively
- interacting from the basis of ongoing experience and reflection on linguistic and cultural diversity.

In the aged care context in Australia interactions are likely to be mediated in English. It is a context that is heavily documented and characterised by procedural language. Wherever possible it will be valuable to incorporate some use of the languages of the participants. In all interactions that involve communicating in English, when recognising that other languages and cultures are at play it will be necessary to pay attention to the use of language. This may involve rephrasing or elaborating on a phrase to make it clearer to a person for whom English is an additional language. It may also involve taking care not to use colloquial expressions.
8.4 A principled approach to learning, managing and enacting the communication of safety

**Finding 4**

*Interaction is central to learning, managing and enacting the communication of safety. In keeping with the principles that informed this study, and following Finding 8.3, the development of ways of working within a context of linguistic and cultural diversity must recognise at all levels of the organisation the significant influence of language and culture on people’s understanding of, and responses to, WHS information and practices. Interventions to address this need should provide opportunities for continuous learning in which best practice is achieved through active participation and the power of example at the levels of management, training and the enactment of safety information and communication.*

As an example, an intervention could be designed to keep the dialogue going that was begun by the narrative intervention of this study, in such a way that the multiple perspectives and interpretations around the communication of safety are kept in the forefront of people’s minds. This would ensure ongoing learning from the experience of others, modelling rather than telling, and educating workers in their day-to-day practice how to be attentive to language and culture in communicating safety. In this way intercultural awareness becomes a normal part of working, through listening, acting and reflecting. This could be achieved by discussing anecdotes around the communication of safety, including when safety communication goes well and when it doesn’t go well, and particularly in terms of how it matters to the people involved.

Additional ways of improving the communication of safety in keeping with the principles of the research study could include adjusting the language of training resources, including the Intranet, so that it is less ‘systems’ orientated and more focused on the relational aspect of the communication of safety. This could be achieved by incorporating a range of textual, audio and visual techniques that foreground the interactional nature of safety communication, particularly when it occurs across languages and cultures. These could include posters, audio- and/or video-modelling of enactments of safety communication and practice, and environmental signs with information displayed in carefully crafted language, supported by visuals to illustrate key procedures.

In recognising the important role of language in how people make sense of what is going on in interactions, another way of enhancing communication and demonstrating that linguistic and cultural diversity are an integral part of working in the particular organisation could be
the translation of key safety procedures, notices and signs into multiple languages. However, with the vast array of safety information available in an organisation, the diversity of languages represented and the difficulty in maintaining the accuracy and currency of the information, translation is not the easy solution it may appear to be. Nevertheless, it may be appropriate to translate key documentation as far as it is reasonable to do so, keeping in mind the risks involved in the work concerned. Linguistic and cultural differences are now a rapidly growing feature of the aged care industry. Ultimately, this reflects what is happening more broadly in our social and professional world. Although it brings added complexity to the communication of safety, this study has highlighted how it also brings many positives to the lives of all involved, including greater intercultural understanding, and therefore any new resources or approaches should frame this as a positive feature rather than a problem. The development of such intercultural understanding is an ongoing process. One way of achieving it would be through the design of professional learning resources that invite reflection rather than judgement on the linguistic and cultural differences at play in the management and enactment of the communication of safety. Such resources would ideally need to be developed collaboratively with those who are in the workplace and therefore directly involved in the delivery of care and the communication of safety. They must also reflect the linguistic and cultural diversity involved.
8.5 Improving internal safety training

**Finding 5**

*Internal safety training is fundamental to addressing the complexity of safety communication in contexts of linguistic and cultural diversity. The research makes evident the need for development of specific areas of internal safety training.*

As evidenced by the outcomes of the intervention undertaken during this research, training improvements within aged care organisations should be implemented that support skill development in the context of linguistic and cultural diversity.

In practice this means internal training should incorporate multiple methods for transmitting information, including the use of reflective practice techniques, multiple media, small group activities, opportunities for learners to clarify meaning, and opportunity to practise and receive feedback on practical skills. Reflective practice WHS training should also be viewed as an on-going learning activity, rather than a once per year obligation required to meet WHS legislative compliance.
8.5.1 Improving the management of risks

Finding 5.1

In contexts of linguistic and cultural diversity, psychosocial and physical risks increase for all participants because of the complexity of interactions and understandings between people. In managing psychosocial and physical risks in this work environment, the perspectives of all care workers should be included. Management must address psychosocial risks with the same concern shown towards physical risks.

Combined with the complexity of linguistic and cultural diversity, the nature of interacting with frail residents with increasingly complex health, psychological and emotional needs makes care work physically and mentally demanding. Care work is time-pressured, involves shift work and is often casualised, increasing the risk of fatigue and stress, with associated increased risks of injuries from manual handling, slips, trips and falls and errors. Existing mechanisms for risk assessment and control need to be sensitive to addressing these risks for all care workers on an ongoing basis. Risk management procedures, particularly for risk assessment, incident investigation and incident reporting should be clarified, made readily accessible and address the full range of hazards and risks present in care work. In particular, the risk management system, including the work of formal representative structures, should address psychosocial hazards and risks with the same priority given to physical risks.

Care workers should be represented in workplace committees such as WHS and other consultative forums. Care workers (including those for whom English is a second language) should be encouraged to become involved as committee members and elected health and safety representatives. Successful consultation and participation in committees requires more than training in hazards, risks and the material aspects of WHS. In addition, organisations need to train and support participants in representing their work groups, building skills in communication, problem-solving and assertiveness. Furthermore, existing barriers to participation in these forums need to be investigated and addressed, providing innovative solutions that address the nature of shift work and the interface with work–life factors. As care work already exists in a time-pressured environment, this is a likely barrier to care worker participation. Managers also require training to support and facilitate such a participative approach.
8.5.2 Creating a learning environment in aged care workplaces

**Finding 5.2**

The level of training among care workers varies. A whole-of-organisation approach is needed to ensure all workers learn effective practice to ensure safe work and safe care.

Local level training should address the development of skills in care delivery and WHS. A base level of skills and knowledge is attained during formal vocational training during Certificate III. However, not all care workers have completed Certificate III. Becoming a proficient care worker requires ongoing opportunities to improve knowledge and skills through practice and over time.

Implementing formal mentoring programs would provide such opportunities, allowing new workers to gain skills with the support of an experienced co-worker, who in turn would be supported by a broader network of co-worker and management cooperation and encouragement. Formal mentoring programs should include processes for identifying suitable mentors and formal training on the purposes of and skills required to successfully mentor. Mentoring programs should be provided to participants for up to the first three months of their employment.

In supporting the induction of new workers, particularly those for whom English is an additional language, organisations should provide the opportunity to commence work by undertaking supernumerary shifts. Working in a supernumerary capacity means that the new worker supplements the allocated workers on a given shift. Such a practice enables the new worker to become familiar with the work without the pressure of being assigned a workload. In addition, organisations could structure workloads so that new workers have the opportunity to increase their competency over time by being allocated fewer clients or clients who have less intensive care requirements. Other strategies that will allow new workers to gain familiarity with clients will also assist in forging positive relationships. As an example, in their first few shifts new workers could be allowed to spend more time in the dining or activity room, becoming familiar with clients before progressing to more personally intrusive care procedures.
8.5.3 Building a reporting and feedback culture

Finding 5.3

A reporting and feedback culture is vital to the management of safety communication, especially given the complexity raised by linguistic and cultural diversity. A whole-of-organisation approach is needed to enhance the culture and processes for reporting hazards, risks, injuries and opportunities for service improvement.

Organisations that are sensitive to the potential for failure in their practices perform better in WHS (Reason, 1997). To support a reporting culture as part of a whole-of-organisation approach, there need to more opportunities for all workers to report issues and to put processes in place that are easy for care workers to use. For example, handovers could be opportunities for reporting and recording problems with work processes and equipment. To support a reporting culture, there must be timely feedback about the nature of issues reported, progress on resolving them and sharing the lessons learned. A reporting culture must be underpinned by a no-blame philosophy where investigations focus on finding (and correcting) systemic causes rather than assigning blame to individuals (Reason, 1997).

Feedback could be provided to workers through handovers, emails, and WHS committee bulletins. Such an approach promotes organisational learning and participation in reporting, as workers see relevance in making a contribution.

The findings and implications of promoting communication should be considered the foundation for achieving greater participation and reporting; however, managers need to create a culture where it is safe to report, and they need to build workers’ confidence to report. Importantly, there needs to be timely follow up and the provision of feedback to reinforce the value of reporting.
8.5.4 Preparation for work in Australian aged care workplaces

Finding 5.4

The preparation for work of aged care workers does not adequately address the linguistic and cultural complexity of working in aged care. The research makes evident the need for preparation of new workers for work in the aged care environment in the Australian context.

There is scope to influence training providers to improve the development of an intercultural stance as part of the formal training provided for care workers (Certificate III). This could include specific aspects of differences across cultures, for example, attitudes towards showing respect; touching and personal care; eating, food, and nutrition; death and dying. Not only should training address the attitudinal aspects of these features of aged care work in Australia but also provide practical examples. In particular, Certificate III training participants would benefit from becoming familiar with common items of equipment, such as hoists; clothing, including how, when and where it is worn; common food types and their combinations; and how to engage in conversation with elderly clients. Exposure to these issues would facilitate the entrance of all new care workers to the workplace and enhance the nature of care that can be provided to residents and clients.

Certificate III in aged care training could also include integrated English training and more hours in vocational placement to enable new workers to develop practical skills as they apply in real workplace settings.

There is also value in creating a broader familiarity with the world of work, particularly for newly arrived migrants as they transition to becoming workers in Australia. Government agencies like SafeWork SA, who have responsibilities for promoting and enforcing work standards in organisations, may find value in forging relationships with multicultural agencies that provide support to newly arrived migrants. These relationships should influence the development of programs that prepare new arrivals for work in Australia. This preparation may involve familiarisation with Australian working systems, such as providing simple information about work contracts and workplace protections, principles of legislation applied to practice (e.g. equal opportunity, sexual harassment, WHS), and conventions about being a worker. Examples may include providing information about what to expect in the workplace, including notions about punctuality, participation at work, and worker responsibilities.
9. Conclusion and recommendations

9.1 Conclusion

This research set out to better understand how workers from culturally and linguistically diverse backgrounds interpret, share and utilise WHS information and apply instructions in their work within aged care. Together, the findings highlight the complexity of communicating safety in linguistic and cultural diversity. The overarching message is that communication of safety in aged care needs to be understood as relational, and as taking place both within a dominant language and culture and increasingly across languages and cultures. Communicating safety within just one language and culture is challenging; however, the exchange across languages and cultures is substantially more complex.

The relational nature of safety communication was observed in the ongoing ways in which it was mutually accomplished by staff, managers and residents in their interactions. Communicating relationally was informed by participants’ particular experiences and perceptions, including assumptions about each other’s professional roles, relationships and expertise, and interpretations of each other’s past, current and potential behaviour. Examples included interactions among staff when clarifying safety requirements, interactions among staff and residents being sensitive to each other’s safety, and interactions among managers and workers in identifying, monitoring and reporting language and communication problems. This local accomplishment of safety communication by people working together, grounded in their interpretations of each other and the immediacy of the interaction at hand, is consequential for both the implementation of safe practices and the way safety information is disseminated in the sector. In particular, it highlights the need to move from current top-down approaches to the provision of information that reflects a policy and regulatory framework orientation, to approaches that also acknowledge the interactional nature of communication in safety practices and training. There is a need to see this as an ongoing study focused on care for all concerned, but particular situations in which the need for interaction in safety communication was at a premium included handovers; manual handling of residents; dealing with challenging behaviours; slips, trips and falls; and exposure to chemicals and biological hazards such as body fluids.

The relational aspects of safety communication become far more complex in situations where people do not share a primary language and culture, because communication then involves the exchange of meanings among people who bring different linguistic and cultural backgrounds to how they interpret what is going on, what they each say and do, and how they respond to and act on the basis of their interpretations. As an example, this complexity is borne out in the analysis by the fact that no matter what their linguistic and cultural background, workers demonstrated awareness of reporting procedures but workers for whom English was a second language were perceived as less likely to report incidents and injuries, and to be ‘resistant’ or ‘reluctant’ to speak up about safety issues. More generally (and this is also reflected in the perceptions around reporting and reasons for not speaking
up), this complexity created tensions arising from the diverse assumptions participants made about each other, and the conclusions they drew about each other’s expertise, behaviour and motives. These tensions create an environment that impacts negatively on psychosocial aspects of health and safety, where participants may feel misunderstood, isolated and under-valued, leading to reduced participation and motivation, which can compound negative perceptions and consequences for psychosocial safety.

Themes concerning perceptions of language and culture played a prominent part in the complexity of communication. Whereas all participants viewed language as a potential ‘barrier’, these perceptions ranged from minor frustration resulting from language differences (most commonly accents) to issues affecting the safety and well-being of workers and residents. Overall, it was clear that formal checking of understanding during training was less likely to acknowledge that clarifying understanding of language by ‘speaking up’ is itself a demanding and complex linguistic and cultural act. Problems of comprehension were resolved most effectively in conversation among fellow workers or in small groups, in the work context and with residents. This was marked in the case of residents, who placed less emphasis on language as a ‘barrier’ or a risk to their safety and well-being, being more likely to acknowledge their own part in tensions arising around language and communication.

Perceptions of cultural differences emerged as particularly influential and included perceptions of body language, the use of space, attitudes to time, relationships, the activity of caregiving, hygiene, touch, care of the dying, and professional expertise and identity more broadly. These perceptions tended to emphasise differences among workers for whom English is a second language as deviations from what is normal and appropriate, and were seen to have compounding, negative effects on safety communication and psychosocial well-being. They perpetuated preconceived ideas and led to over-generalisations, tensions and loss of trust. These effects included second-guessing the reasons for reticence among such workers, which prevented understanding of why they would not speak up. Such misinterpretations could then reinforce assumptions that these workers were avoiding work, less motivated and less professional than those for whom English was the first language. From the perspective of workers for whom English is a second language, such misinterpretations tended to compound perceptions of lack of support and isolation, reducing their psychosocial safety and further compromising their participation in safety communication. Adding to these effects, the strong hierarchic divisions of role, tasks and responsibilities tended to reinforce these divisions and reduce opportunities to address misconceptions among the different groups involved.

Amidst this complexity, evidence emerged of opportunities to work together to mediate perceptions of linguistic and cultural difference and so refute and overcome perceived barriers and misconceptions. Evidence also emerged of the benefits that linguistic and cultural diversity can bring to the quality and safety of care practices. These ways of working
are ‘intercultural’: they look beyond perceptions of linguistic and cultural barriers or differences, and emphasise close, sensitive and ongoing attention to discovering, understanding and judiciously responding to the assumptions, attitudes and values of all concerned. This is not a question of being sensitive to differences of language or culture, as if it were possible to separate them in making sense of what people say and do. Rather, it is a matter of understanding that the interpretation and exchange of meaning draws on languages as the primary frameworks through which cultures are encoded, articulated and reproduced, and that this is mutually accomplished moment-by-moment by people in interaction. Crucially, this understanding cannot be taken for granted in contexts of linguistic and cultural diversity as it usually is among people who share linguistic and cultural backgrounds. If it is assumed, then mutual communication is put at risk, the chances of misunderstandings increase, and safe practices are jeopardised.

In all workplaces, promoting workplace health and safety requires continuous learning and leadership that prioritises health, safety and care over productivity and profit goals. To understand and resolve threats to health and safety requires strong participation, consultation, representation, and communication systems. In workplaces with increasing linguistic and cultural diversity, implementing these mechanisms is more challenging because of different perceptions and cultural meanings involved in communicating. A positive safety climate arises from effective and satisfying interactions between workers, clients and managers, and promotes worker health and well-being. It enables safety behaviours to be enacted and hazards to be quickly and efficiently controlled at their source. Interactional communication that involves all workplace participants is central to successfully negotiating and crafting changes to work processes that make the system work in practice so that safety is an everyday accomplishment.

Contributing to these outcomes, the intervention provided evidence that such interventions offer the potential to raise awareness of the interactional nature of safety among workers, in particular in contexts of linguistic and cultural diversity, enhancing the psychosocial work environment by not only alerting workers to the need for mutual understanding, care and communication in domains of safety, but motivating workers to make this an ongoing part of their routine work practices. The findings suggest that interventions based on this model can encourage people to speak up about issues of safety and enhance the way people work together by encouraging them to reflect on the implications for their own practice for how they care for one another and communicate safety for themselves, their colleagues and their clients, every day. From these findings, we suggest that the intervention provides one possible model for how current transactional approaches to safety communication may be reframed to emphasise safety communication as also interactional. By promoting mutual understanding and communication in domains of safety such as manual handling, the broader adoption of such interventions has the potential to improve care and safety by reducing psychosocial and physical risk and hence reducing injuries/illnesses and encouraging increased reporting rates.
9.2 Recommendations

From the findings and implications of the research study, we make the following recommendations:

**Recommendation 1**

*That aged care organisations put in place mechanisms to capture the linguistic and cultural profile of their workforce and analyse the changing profile to inform in an ongoing way both their human resources management policy, planning and practice, and their health and safety policy, training and practice.*

Aged care organisations currently collect data on the linguistic and cultural profiles of their clients; for example, the languages spoken and religions practised. However, such data is not generally collected from the wider workforce. This information is helpful as a human resources management strategy to improve recruitment and retention; and to improve service delivery by better planning for and aligning staffing, induction, training, mentoring and practice with the changing profiles of workers and clients.

**Practical application**

- **Human resource management policies for recruitment, induction and training**
  Gather anonymous information from workers to assist in raising awareness and understanding of the different languages and cultures that they represent. For example, workers for whom English is an additional language may feel intimidated in group interviews and therefore not contribute to their full potential.

- **Inductions**
  Design inductions to be more comprehensive and implemented over longer periods, utilising reflective learning principles and peer support from experienced co-workers.

- **Training methods**
  Make greater use of small groups for problem-based learning and the use of reflective practice in developing skills. Such an approach creates greater opportunity for all workers to clarify and co-create their mutual understanding of relevant information and processes.
Linked to Recommendation 1 is the need for greater understanding and recognition of the complexity of communicating in the context of linguistic and cultural diversity. To separate one group from another by differentiating them as CALD can misrepresent that group as a particular source of risk compared to others, whereas the reality is that all are involved in accomplishing safety. As a result, the CALD concept can hinder understanding of the interactional nature of effective communication about safety and draw attention away from the need for responsibility across the whole organisation.

**Practical application**

- Put in place a whole-of-organisation approach to develop an organisational culture that supports interactional communication in the context of linguistic and cultural diversity. This requires leadership at management level to promote the development of sophisticated ways of ensuring that members of the organisation are aware of, are able to anticipate and engage with, and remain open to diverse interpretations.
Recommendation 3

That a whole-of-organisation approach to understanding linguistic and cultural diversity recognise the value of the local methods formulated by workers, methods that evolve through practice to accomplish WHS as well as and together with the regulatory requirements and expectations of WHS.

Recommendation 3.1

That such an approach shift current practice from a transactional to an interactional and intercultural orientation to communicating WHS.

This approach is based on practising two-way communication and understanding between workers and managers, and between workers. Such communication is reflective and cyclic and responds to hazards, risks and problems with immediacy, enabling monitoring and learning from those changes as a basis for continued action.

Recommendation 3.2

That such an approach incorporate working with an intercultural stance that includes learning to notice, learning to compare, learning to reflect and learning to interact in contexts of linguistic and cultural diversity.

This means increasing the awareness of managers and workers so they consider the effectiveness of their own communication and understanding, and adapt their interactions accordingly.

Practical application

- Use reflective practice techniques in training programs, meetings (e.g. WHS Committee) and in performance evaluation.
A whole-or organisation approach should identify, recognise and analyse local methods to ensure they do not conflict with legislative requirement, and encourage workers to identify improvements that complement the formal management system and be incorporated into practice.

Methods such as those listed below demonstrate local level participation and learning through practice, which contribute to organisational learning. The learning takes place locally to resolve tensions between the need to comply with rules and to accomplish work safely in ways sensitive to the situation at hand. Local methods reflect initiative, understanding and professional expertise, and are necessary to facilitate the continuity and efficiency of care work.

They can support safety but should be monitored and integrated where appropriate to minimise potential gaps between policy and practice.

**Practical application**

- Set up informal ‘buddying’ arrangements
- Encourage spontaneous group interactions during training sessions
- Encourage mutually supportive interactions about specific aspects of care between experienced and less experienced care workers
- Train staff to manage their interactions with residents sensitively.
Recommendation 4

That strategies be put in place to improve risk management systems so that they recognise the reality of linguistic and cultural diversity.

Recommendation 4.1

That in managing both psychosocial and physical risks in the work environment, the perspectives of all care workers be included.

Practical application

- Establish or amend existing formal structures for WHS representation (e.g. WHS committees and representatives) to include care workers, particularly workers of varied linguistic and cultural backgrounds.
- Train care workers in the skill of representation and ensure that practical arrangements for representation (e.g. meeting times) enable worker participation.
- Simplify risk management procedures for identifying and assessing hazards and controlling risks, in particular hazard and incident reporting. This is a particular priority in light of the increasing complexity of safety communication in context of linguistic and cultural diversity.
- Amend the risk management system, including the work of formal representative structures, to address psychosocial hazards and risks with the same priority as physical risks.
- Incorporate psychosocial hazards and risks into WHS training to promote awareness and demonstrate the importance that management places on the effective management of these risks.
**Recommendation 4.2**

*That a whole-of-organisation approach be put in place to enhance the culture and processes for reporting hazards, risks, opportunities for service improvement and prevention of workplace injuries.*

**Practical application**

- Build a learning culture that values reporting as a learning opportunity. Where reporting is everyone’s responsibility, reporting is easy to do, reports are promptly addressed, feedback is provided that protects the confidentiality of those concerned, and the management actions taken are fair.

**Recommendation 4.3**

*That within aged care organisations training improvements be implemented to support skill development in the context of linguistic and cultural diversity.*

**Practical application**

- Incorporate into internal training multiple complementary methods for transmission of information, including the use of reflective practice techniques, multiple media, small group activities, opportunities for learners to clarify meaning, and the opportunity to practise and receive feedback on practical skills. WHS training should be viewed as an ongoing learning activity, rather than a once a year obligation to meet WHS legislative compliance.
**Recommendation 5**

*That human resource management strategies be implemented to enhance the skill development and induction of new workers into care work, particularly those of different linguistic and cultural backgrounds.*

**Recommendation 5.1**

*That formal mentoring programs be implemented to ensure that new workers, particularly those for whom English is an additional language, become familiar with the practice of care work over time and with the support of an experienced co-worker within a broader network of support from other co-workers.*

**Practical application**

- Establish formal approaches to mentoring for up to the first three months of employment, such as the appointment of a mentor to work regularly with the new worker.
- Train mentors in the purposes of and skills required for mentoring.
- Supplement formal mentoring programs with buddyng, a less formal arrangement for providing support and guidance to the new worker. Buddyng has the advantage of minimising power imbalances between workers while promoting positive relationships.

**Recommendation 5.2**

*That to support the induction of new workers, particularly those for whom English is an additional language, organisations should provide the opportunity to undertake supernumerary shifts when commencing work.*

**Practical application**

- Allow the new worker to supplement the allocated workers on a given shift. This enables the new worker to become familiar with the work while on a minimal workload.
- Structure workloads so that new workers are allocated fewer clients or more clients with less intensive care requirements, thus having the opportunity to increase their competency over time.


**Recommendation 6**

That a pre-service system to prepare new workers for work in the aged care environment in the Australian context be put in place.

**Recommendation 6.1**

That formal training for care workers provided as part of Certificate III incorporate an improved development of an intercultural stance using improved and multiple modes of delivery.

Training for work in aged care is fundamental to ensuring quality of care and safe practice on the job.

**Practical application**

- Foster an intercultural stance: this includes a focus on learning to notice, learning to compare, learning to reflect and learning to interact in contexts of linguistic and cultural diversity.
- Extend training content to address specific aspects of differences across languages and cultures within the training content (e.g. attitudes towards showing respect; touching and personal care; eating, food, and nutrition; death and dying).
- Structure training to include reflective practice technique, better opportunities for early supervised placement in actual aged care work settings, the adoption of multiple modes of training delivery using small groups, and integration of aged care and language training courses to develop workplace-based language skills.
Communicating work health and safety in the context of linguistic and cultural diversity in aged care

**Recommendation 6.2**

*That opportunities for early familiarisation with the context of work in Australia be made available to people for whom English is an additional language.*

Early familiarisation with the context of work in Australia would be valuable; for example, as migrants begin their transition from new arrival to worker.

**Practical application**

- Establish relationships between multicultural support organisations and organisations with responsibilities for employment and training, such as SafeWork SA, SafeWork Australia and the Department of Further Education, Employment, Science and Technology.
- Provide information on what to expect in Australian workplaces, including workplace principles such as equal opportunity; employment arrangements (e.g. the forms of employment and the protections in place), standards for work (e.g. WHS), and conventions practised at work (e.g. notions of punctuality, participation and worker responsibilities).
Daily interaction among people at all levels is crucial to accomplishing safety. Such interaction depends on ongoing mutual care and shared interest in understanding the diverse perspectives of those involved. This, in turn, depends on how people successfully interpret and exchange meaning in safety communication in the context of linguistic and cultural diversity.

An interactional and intercultural approach to communicating WHS will:

- enhance the psychosocial work environment by not only alerting workers to the need for mutual understanding, care and communication in domains of safety, but motivating workers to make this an ongoing part of their routine work practices and interactions.
- encourage people to speak up
- enhance the way people work together by reflecting on the implications for their own practice of how they care for one another and how they communicate safety and well-being for themselves, their colleagues and their clients, every day.

**Practical application**

- Provide opportunities for continuous, reflective learning in which best practice is achieved through active participation and the power of example in management, practice, training and induction.
- Draw on vignettes voicing real-life safety communication experiences that reveal the multiple perspectives involved. Follow up with reflective practice activities that
  - support personal and professional learning
  - provide a feedback mechanism to inform the evaluation of the interventions
  - yield further vignettes to include in training and induction

**Recommendation 7**

*That sector-wide interventions be developed to support a shift from a transactional to an interactional and intercultural approach to communicating WHS.*

**Recommendation 7.1**

*That these interventions draw on the principles that inform the intervention in this study to encourage ways of working that recognise at all levels of the organisation the significant influence of language and culture on people’s understanding of, and responses to, WHS information and practices.*
Incorporate strategies in training and induction in the organisation more broadly, which promote the interactional and intercultural communication of safety through
  - audiovisual presentation/demonstration
  - translation
  - signage in multiple languages
  - exemplification from the experience of staff and residents in training and induction.

**Recommendation 7.2**

*That interventions to support the development of interactional approaches to safety communication, with particular reference to linguistic and cultural diversity, be used in training and safety communication in the sector as a whole.*

**Practical application**

Develop interventions sector-wide for managers, nurses and care workers by the provision of, for example:

- Online training modules and induction modules that include interactional perspectives in all key areas of WHS
- Training and induction modules with specific focus on communicating safety in the context of diversity, incorporating awareness-raising and reflective practice activities in daily work and in reflecting learning activities
- Intercultural communication training to help staff to learn not only about other languages and cultures, but also to decentre themselves and recognise how our language and culture shapes our perceptions.
The findings of this project highlight the need for further research that builds on this research by:

- developing a sector-wide understanding of the local methods enacted by workers as they perform their work and how these can be aligned and integrated with existing regulatory requirements
- examining how WHS regulation may be clarified and explained in its application and translation to practical processes and procedures within the range of aged care organisations in the sector, particularly in the context of linguistic and cultural diversity.

**Practical application**

- Develop a sector-wide evidence base for the development, implementation and evaluation of interventions designed to enhance communication and interaction in accomplishing WHS.

These interventions should focus on the effective implementation of reflective practice techniques and assessment of their impact on WHS outcomes, particularly in culturally and linguistically diverse contexts.
Appendix 1. Profiling Protocols

Communicating safety and wellness in the context of linguistic and cultural diversity in aged care industry project

This survey is part of a research project that examines safety and wellness in the workplace, particularly where different languages and cultures are involved. The findings from this project will help to improve the workplace environment for staff and residents. This form is designed to enable us to understand the range of languages and cultures that are represented at Helping Hand Aged Care.

We invite you to answer the questions below. If you are unable to answer any of the questions, please leave it blank.

1. Name: ______________________________________________________________________________

2. Site: ______________________________________________________________________________

3. Position/role: _________________________________________________________________________

4. Languages spoken:
   (List all the languages you use)
   First language ______________________________________________________________
   Other language(s) _______________________________________________________________

5. Competence in English:
   (a) (On the scale 0 [very little] to 10 [very good], mark how well you think you speak English
   ______________________________________________________________________________
   
   0   1   2   3   4   5   6   7   8   9   10
   Very little English ____________________________________________ Very good English

   (b) Have you completed an English language test? If so?
   Name of test: _______________________________________________________________________
   Year in which it was completed: _______________________________________________________
   What was your score? ______________________________________________________________


(c) How easy do you find it to understand verbal instructions in the workplace? Give examples.
____________________________________________________________________________________

(d) How easy do you find it to understand written instructions in the workplace? Give examples.
____________________________________________________________________________________

6. English in the workplace
   How many years have you worked in an English-speaking workplace?

7. Migration background (if applicable):
   (a) Are you a migrant to Australia? YES □ NO □
   (b) Please indicate: I migrated from: ____________________________
   (c) When did you arrive in Australia? ________________

8. Interview
   We are planning to conduct interviews to find out more about health and safety practices.
   Would you agree to participate in a workplace interview?
      YES □ NO □
Appendix 2. Research Protocols

Resident Interviews
Advising the participant of the research – we are from the University of SA and are interested in the experiences of people in Helping Hand of working with people from different linguistic and cultural backgrounds. We are particularly interested in the effects on workers’ (and residents’) health and safety.

Advise participant of confidentiality arrangements and obtain consent.

1. Allocate a participant code/identifier
2. Sex
3. How long have you lived at Helping Hand?
4. What cultural group do you identify with?

Resident Questions
Thinking about the effect of different languages and cultures used by people working at Helping Hand . . .

1. How do you experience the care given at Helping Hand? Can you give me an example?
2. Have you experienced anything that makes you concerned for the safety and wellness of staff or residents? Can you tell me about that?
3. What do you think are the causes of those concerns?
4. What is your experience of how staff communicate with you and you with them, particularly in regard to health and safety?

Thank participant for their time and sharing their experiences.
**Worker Interviews**

Advise the participant of the research – we are from the University of SA and are interested in the experiences of people in Helping Hand in working with people from different linguistic and cultural backgrounds. We are particularly interested in the effects on workers’ (and indirectly residents’) health and safety.

Advise participant of confidentiality arrangements and obtain consent. For interview participants, the following demographic questions should be asked at the commencement of the interview:

5. Allocate a participant code / identifier
6. Sex
7. Age
8. What is your job title at Helping Hand?
9. How long have you worked at Helping Hand?
10. What cultural group do you identify with?
11. What languages do you speak?
12. How long have you lived in Australia?
13. What is your educational background?

**Worker Questions**

1. What is your experience of Safety and Wellness?
2. What training (formal and informal) have you had in Safety and Wellness? How does that training help you to do your work at Helping Hand?
3. Where and how do you find the information (policies, practices, procedures) you need on Safety and Wellness?
4. Can you tell me about a time when you were concerned about yourself or someone else being hurt at work? What happened when you identified this health and safety problem?
5. What happens if there is an injury or incident on this site? How does management know about incidents that occur on site?
6. How are you involved in decisions (policy or practice) to make working here safe?
7. How do you experience day-to-day communication at Helping Hand, particularly in relation to Safety and Wellness? e.g. between managers and workers, between workers, within teams, between shifts?
8. How do you experience working with people who are from different language and cultural backgrounds at Helping Hand? e.g. work colleagues and residents? Can you give me an example – positive and negative?
9. In what ways does your own cultural background influence your work at Helping Hand, particularly in terms of Safety and Wellness?
10. Can you describe an incident where you had difficulty or felt unable to carry out a task because of language or cultural difference?
11. Can you describe an incident where you successfully carried out task because of language or cultural difference? Why was it successful?
12. Which tasks do you manage easily in English?
13. Which tasks do you manage with some difficulty in English?
14. Please tell me about your skills in English in general, in terms of carrying out your work?

Thank participant for their time and sharing their experiences.

**Manager Interviews**

Advise the participant of the research – we are from the University of SA and are interested in the experiences of people in Helping Hand of working with people from different linguistic and cultural backgrounds. We are particularly interested in the effects on workers’ (and indirectly residents’) health and safety.

Advise participant of confidentiality arrangements and obtain consent. For interview participants, the following demographic questions should be asked at the commencement of the interview:

1. Allocate a participant code /identifier
2. Sex
3. Age
4. What job title do you hold at Helping Hand?
5. How long have you worked at Helping Hand?
6. What cultural group do you identify with?
7. What languages do you speak?
8. How long have you lived in Australia?
9. What is your educational background?

**Manager Questions**

1. What is your role in the management of Safety and Wellness?
2. What training and experience do you have in Safety and Wellness?
3. How do you evaluate Helping Hand’s Safety and Wellness performance? How do you know whether you are doing a good job with Safety and Wellness?
4. What are the risks at Helping Hand / this site and how do you manage them?
5. How are risks reported and dealt with?
6. What changes have you seen or facilitated regarding Safety and Wellness at Helping Hand / this site? What was helpful or challenging when making these changes?
7. How do you involve the workforce in decision making about Safety and Wellness?
8. How do people on this site gain the skills they need to meet Safety and Wellness requirements?
9. How do you experience day-to-day communication at Helping Hand, particularly in terms of safety and wellness? e.g. between managers and workers, between workers, within teams, between shifts?
10. What is your experience of working with people who are from other cultures or speak other languages, particularly related to Safety and Wellness? Can you give me an example?
11. How does the training you receive at Helping Hand assist you in doing your work, given the linguistic and cultural diversity in the workplace?
12. What suggestions do you have for how Safety and Wellness should be managed in the context of linguistic and cultural diversity?
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13. In what ways does your own cultural background influence your work at Helping Hand, particularly in terms of Safety and Wellness?

Thank participant for their time and sharing their experiences
Appendix 3. Intervention Screenshots

Page 1: Introduction

Before

After

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Identifying hazards and eliminating or minimising risk?

Before:

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<td>Identifying hazards and planning work tasks to reduce risk</td>
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Just about all work tasks involve the application of manual handling principles. But is this what we need to plan our work tasks to reduce risk?

- There are risks involved.
- Under the work environment.
- Planning for ergonomic hazards:
- the client is protected.
- The client is protected.
- The client is protected.
- The client is protected.
- The client is protected.

Ask yourself these questions before any work task:

- Can I do the task without using my back?
- Is it possible to do the task without using my back?
- Can I do the task using appropriate manual handling principles?
- Can I do the task using appropriate manual handling principles?
- Can I do the task using appropriate manual handling principles?

After:

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It’s helpful to think about the different ways of approaching things so that the different we can become the most of what things is ‘normal’ for everyone. They often talk about all the different ethnicities and they may not even know where to start or what to do, and may be confused about things differently. We also have different ethnicities and so we explain it to each other and try to understand each other’s doing things in a different way, with the clients, with different clients, so we can use the different ethnicities and so that is helpful for everyone to adapt and understand.

Ask yourself these questions before any work task:

- Can I do the task without using my back?
- Can I do the task without using my back?
- Can I do the task with appropriate manual handling principles?
- Can I do the task with appropriate manual handling principles?
- Can I do the task with appropriate manual handling principles?
Communication and prevention of resistive behaviours

Before

Before moving or performing personal care for any client, it's important to communicate clearly what you are going to do. A number of incidents can arise when transferring clients and they may become resistive. If a client does not want to have personal care at the specific time that you are ready to, it's OK to leave them and return a later time in consultation with the client. Talking to other carers about the type of communication that works best for each client is a great way to engage with clients and can assist to minimise resistive behaviour. It may be a good strategy to set up a behaviour chart to identify and assess the best time for doing personal care.

After

I didn’t realise that you should look people in the eye when you speak to them or they will think that you are not trustworthy. In my culture that’s really disrespectful to seniors. So I was calling seniors by their first name - it really shocked me when I saw people doing that here. I understand there are different ways of saying and doing things and I'm trying to adapt, but I think it will take me some time to adjust to them, because doing those things is so wrong in my culture.

Before moving or performing personal care for any client, it's important to say clearly what you are going to do, and help everyone be safe. A number of incidents can arise when transferring clients and they may become resistive. If a client does not understand or want to have personal care at the specific time that you are ready to, it's okay to leave them and return at a later time in consultation with the client. Talking to other carers about the type of communication that works best for each client is a great way to engage with clients and can assist to minimise resistive behaviour. It may be a good strategy to set up a behaviour chart to identify and assess the best time for doing personal care.
Use correct manual handling procedures at all times

The end

Congratulations, you have now completed all of the learning package for manual handling. You can revisit this as much as you like.

What now?
If you haven't already, do the assessment on the home page. See if you can get 100%. If you can not then you can always come back and have another go!

After

Use correct manual handling procedures at all times

Summary

Congratulations, you have now completed all of the learning package for manual handling. You can revisit this as much as you like.

Safety is all about caring for myself, colleagues and clients, and to do this we need to communicate effectively. I try to slow down and say things differently now instead of repeating the same thing over and over. Often people look annoyed when I ask them to explain or repeat something. I am tempted to not bother them and just look it up in the manual or ask the client. I'm trying to get up to the same speed as everyone else, but it's going to take some time and understanding.

Safety is all about caring.

Thank you!
Appendix 4. Intervention Journal

After you have completed the trial e-learning manual handling module, this journal gives you the opportunity to reflect on your experience of how safety is communicated during five shifts.

How to use the journal

For each shift, there is a page in the journal to complete.

Each page of the journal has two quotes from the trial e-learning manual handling module and a question to consider.

There is space on each page for you to write about your thoughts.

For each shift please reflect on your experience of the communication of safety with others on the shift and write a paragraph or two comparing your experience on your shift with the experiences described in the quotes.

For example, were there any similarities or differences in the way you cared for colleagues and clients?

There is a sixth page in the journal for you to reflect more broadly and write about anything else that is important to you in regard to the communication of safety and wellness in your work.

Your feedback will be completely anonymised.

If you have any questions regarding this journal, please e-mail Fiona O’Neill

Fiona.Oneill@unisa.edu.au
Shift 1

Date: ________________

Please consider these quotes and the question below:

‘Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’ because not many people answer ‘No I don’t understand’, they just go off and try to figure it out for themselves. This is really important when lifting an item or transferring a client, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured.’ (Nurse)

‘I could see the carer was embarrassed about helping me in the shower, but I needed him to stay so I didn’t fall, so I told him jokes. In the end this made us both feel better about it, and I certainly felt safer because he stayed and helped me.’ (Resident)

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients? What would you do differently when caring for yourself, your colleagues and residents?

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**Shift 2**  
*Date: _______________*

Please consider these quotes and the question below:

‘Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’; because not many people answer ‘No I don’t understand’, they just go off and try to figure it out for themselves. This is really important when lifting an item or transferring a client, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured.’ (Nurse)

‘I always listen to what the client prefers and explain to them when it is not safe to do something. We have to be careful about everyone’s safety, so sometimes I need to explain why we do things in a certain way.’ (Carer)

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients? What would you do differently when caring for yourself, your colleagues and residents?
Shift 3  

Date: ________________

Please consider these quotes and the question below:

‘Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’ because not many people answer ‘No I don’t understand’, they just go off and try to figure it out for themselves. This is really important when lifting an item or transferring a client, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured.’ (Nurse)

‘Safety is all about caring for myself, colleagues and clients, and to do this we need to communicate effectively. I try to slow down and say things differently now instead of repeating the same thing over and over. Often people look annoyed when I ask them to explain or repeat something, I am tempted to not bother them and just look it up in the manual or ask the client. I’m trying to get up to the same speed as everyone else, but it’s going to take some time and understanding.’ (Carer)

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients? What would you do differently when caring for yourself, your colleagues and residents?

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Shift 4       Date: ________________

Please consider these quotes and the question below:

‘Sometimes when there's a misunderstanding I'm not sure if it's a language issue or a cultural difference. I've found it's more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’, because not many people answer ‘No I don't understand’, they just go off and try to figure it out for themselves. This is really important when lifting an item or transferring a client, because that's one of those moments when everyone needs to know what's happening so no-one gets injured.’ (Nurse)

‘It's helped me to take a step back and think about our different ways of speaking and doing things as just that, they're different. We can't assume that our way of doing things is ‘normal’ for everyone. Many of our colleagues and clients have different backgrounds and they may not understand us as well as we think they do, or they may be used to doing things differently. It helps when we listen to each other and try to understand why they want to do things in a certain way. With the clients, when we understand why, we can see the difference it makes to their behaviour, they're less resistant, and this is better for everyone's safety and well-being.’ (Nurse)

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients? What would you do differently when caring for yourself, your colleagues and residents?

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Shift 5  Date: _____________

Please consider these quotes and the question below:

‘Sometimes when there’s a misunderstanding I’m not sure if it’s a language issue or a cultural difference. I’ve found it’s more helpful to ask questions to clarify or to get the carer to explain what it is they are going to do, rather than ask, ‘Do you understand?’, because not many people answer ‘No I don’t understand’, they just go off and try to figure it out for themselves. This is really important when lifting an item or transferring a client, because that’s one of those moments when everyone needs to know what’s happening so no-one gets injured.’ (Nurse)

‘I noticed that people were making assumptions that a carer didn’t understand a safety instruction. A lot of people jumped to this conclusion because she was quiet, didn’t always respond to questions, and came from a different cultural background. When I took the time to really listen to her, I discovered that she did know what to do and wasn’t shy at all. When we got to know each other, we started to focus on what we had in common rather than the differences, so we communicated really well.’ (Nurse)

Reflect on your experience of communicating safety with others on the shift and write a paragraph or two comparing your experience with the experiences described in these quotes. For example, were there any similarities or differences in the way you cared for colleagues and clients? What would you do differently when caring for yourself, your colleagues and residents?

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Please reflect more broadly on any changes that you have noticed in the communication of safety and wellness in your work since completing the e-learning manual handling module and this journal. Write a few paragraphs here about your experiences.
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