SOCIAL CONNECTION TOOLKIT FOR RESIDENTIAL AGED CARE:

DEVELOPMENT AND EVALUATION

JANE FARMER, JASMINE KNOX, LUCIO NACCARELLA, JAYME VERHAGEN, SHERRIDAN EMERY

ACKNOWLEDGEMENT OF COUNTRY

We respectfully acknowledge the Wurundjeri People of the Kulin Nation, who are the Traditional Owners of the land on which Swinburne's Australian campuses are located in Melbourne's east and outer east. We pay our respects to leaders and Elders past, present, and emerging, for they hold all their Peoples' memories, traditions, culture, and hopes.

We express our gratitude for sharing this land, our sorrow for the personal, spiritual, and cultural costs of that sharing, and our hope that we may walk forward together in harmony and the spirit of healing.

We also acknowledge and respect the Traditional Owners of lands across Australia and recognise the continuing sovereignties of all Aboriginal and Torres Strait Islander Nations.

ETHICS STATEMENT

Swinburne's Human Research Ethics Committee approved this project per the National Statement on Ethical Conduct in Human Research, reference number 20237216.

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CONTRIBUTIONS

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We thank all the aged care staff and residents who participated in this project and the members of the project's Governance Committee, Tom McClean, Patrik Ekstrom, Vanessa Ogborne, Edwina Gow and Andrea Mabalo.

To preserve the anonymity of participants in this research, stock photographs are used throughout this report.

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Foreword from Aged Care Industry Partners

Dr Tom McClean
Head of Research and Social Policy,
Uniting NSW.ACT

We at Uniting NSW.ACT are delighted to have been part of the development and evaluation of the Social Connection Toolkit for Residential Aged Care.

As one of the largest providers of aged care in New South Wales and the ACT, we see the need for this kind of Toolkit every day in our work. Australians are living for longer, and for many this means more years of good health. However, we also know that people often struggle with loneliness as they age and that this can deteriorate rapidly when people enter care. Aged care services and the system as a whole are not well-adapted to promoting connectedness or holistic wellbeing. In fact, they often make the problem worse despite the best efforts of the people actually providing care.

We saw the need for a set of tools that would help direct care teams to identify when a resident may be experiencing loneliness, and to respond. We needed these tools to do three things. First, to help us work respectfully with our residents, to talk about the relationships and activities that are important to them. Second, to be easy to use and actually useful for care teams who are already busy meeting the needs of many residents at a time. And third, to be easy to introduce into a care environment with complex existing processes and mandatory existing indicators like the QOL-ACC.[1]

At Uniting, we think that we as a society can and should do better. And we think that things like the Toolkit are one way to do that. Our experience of developing and using Tools suggests that, when staff are trained and supported to use them properly, they lead to much richer conversations with our residents. Our staff feel they know our residents better, and that they're better equipped to help them see the people and do the things that bring meaning and purpose to their lives. There's more work to do, but we're heading in the right direction.

1 Quality-of-Life-Aged Care Consumer measure.

Patrik Ekstrom
Executive Manager Business Improvement,
The Salvation Army Aged Care

This report describes the essence of the second phase of a social connection initiative where we partnered with other providers and researchers. We set out to codesign a Social Connection Toolkit, principally to aid in engaging aged care residents in conversations about their preferences for realising social connection.

Social connection plays an important role in combatting social isolation, loneliness, and depression. The impact on one's healthy emotional, physical, and spiritual wellbeing can be significant. In an aged care setting – where people may have lost their life partner; been distanced from their children, grandchildren, other family and friends; been displaced from the familiar surroundings of their home; and, been disconnected from their usual activities - this potential impact is often amplified and, therefore, the importance of aged care residents' social connections, informed by personal choice, becomes deeply meaningful and critical to their wellbeing.

Residential aged care providers, in Australia and beyond, have both statutory and moral obligations to ensure residents' rights to be treated with dignity and respect. From the perspective of the Australian Aged Care Quality and Safety Commission, this is safeguarded via a suite of Quality Standards. The work in our social connection initiative can make an important contribution to aged care residents' experience, supporting the goals of the Standards.

During this project, and here I write from the experience within The Salvation Army Aged Care, we engaged internal stakeholders to build awareness and support, both operationally and strategically. We participated in project governance meetings, and codesign sessions, amongst many activities. We succeeded in using the Tool in conversations with residents involving both lifestyle and chaplaincy staff. Now, we have the opportunity to build further on our learnings and we look forward to continuing the conversations with our partners in this initiative – looking at how we might expand our collaboration. I thank the many project participants for their contributions towards enhancing the wellbeing of residents in aged care.

Executive Summary

Social isolation in Residential Aged Care (RAC) is associated with depression, self-harm, cognitive decline and reduced physical health. Helping people to be socially connected is a growing priority. In this project we developed, implemented and evaluated a Social Connection Toolkit. The Toolkit aims to assist RAC staff to discuss with residents, the kinds of social connection activities that will best meet their preferences.

Codesigned with RAC residents and staff, the Toolkit has: e-learning modules about social connection; a conversation-style set of questions ('Tool'); a guide for use; and a digital data collection interface. Once created, the Toolkit was implemented in four RAC facilities across New South Wales and Victoria. Impacts for residents, staff and organisations were evaluated. Ethical approval for the project was from Swinburne University Ethics Committee (ref. 20237216). This project was funded by Aged Care Research & Industry Innovation Australia (ARIIA) and took place in 2023-24.

EVALUATION

Surveys, interviews and observations were carried out. Eighty residents and 29 staff members (lifestyle coordinators, pastoral care staff and direct care staff) completed short surveys before- and after- use of the Social Connection Tool. Sixteen residents and 15 staff were interviewed after using the Tool. For the organisation-level implementation evaluation, 22 managers and lifestyle coordinators and a group of senior staff members of participating organisations (who served on a Project Governance Committee) were interviewed. Eight resident-staff pairs were observed using the Tool to discuss resident social connection.

FINDINGS

Residents: Survey results showed no significant change in satisfaction with rapport with staff, social activities or quality of life after using the Tool. The mean score of satisfaction that residents have with control over their social connection and choice about social connection declined, but it's unclear if this was related to Tool use. Only one resident remembered using the Tool. This stimulated him to participate in more activities. Others emphasised the value of social connection for them and expressed wide dissatisfaction with the social interaction opportunities currently available. Residents discussed their own efforts to generate more interesting activities including gardening.

Staff members: Survey results showed no significant differences in the median scores between pre- and post-use of the Toolkit including on satisfaction with social connection knowledge, rapport with residents, and understanding of needs. Interview findings showed positivity about using the Tool and Toolkit. Staff thought that training was important, and the conversational style of the Tool helped to elicit more useful information from residents. Recommending adoption, staff identified particular uses for the Tool/Toolkit e.g. for direct care staff, new staff, and staff with a language other than English.

Organisational level: There was enthusiasm for using the Toolkit, but there were also multiple challenges to implementation including varying leadership and 'championing' across different facilities, lack of staff time, prioritisation of residents' personal care tasks, and challenges with embedding the Tool into usual care. Some duplication with existing Tools was reported, highlighting a need for clarity about the Tool/Toolkit purpose vis a vis other existing data collection.

CONCLUSIONS: ISSUES, IMPLICATIONS & HOW TO IMPLEMENT THE TOOLKIT YOURSELF

This project found wide recognition that better responses to resident social connection are needed, and there is an appetite for change. However, implementing the Toolkit raised considerable issues in terms of organisational readiness, as well as issues about the Toolkit. If your organisation wants to use the Toolkit, we conclude you need to address the following issues:

Toolkit: An audit of existing Tools should be conducted prior to implementation to identify duplication. The Tool's purpose needs to be clear. This will guide data collection and which staff groups use the Tool. Guidance about what data to collect should be shared. Who will access the data that is produced needs to be identified and data security and privacy needs to be addressed. Training and staff meetings prior to implementation are needed so all staff understand the goals and buy-in. Implementation requires trusted, influential leaders. Procedures for dealing with issues raised from the Tool's use should be established.

Organisation context: Adoption of the Toolkit beyond a project, needs widespread discussion, codesign and a plan for rolling out work on improving social connection. Leaders and champions at all levels need to be identified. Ways to integrate work on social connection into organisation processes and staff roles, and ways to measure social connection work need to be identified. Resources, including time, need to be allocated. Our Implementation Planning Framework – included in this report - could be used to guide strategic and operational planning.

What happens next? The project identified improvements and next steps. Project partners Uniting NSW.ACT and The Salvation Army Aged Care, are using findings to inform enhanced RAC resident social connection.

For further information, contact Professor Jane Farmer at jcfarmer@swin.edu.au

Introduction

Addressing social isolation by helping people to be socially connected is a growing health priority in Australia and internationally. Older adults living in RAC are at particular risk of social isolation, which is associated with depression, self-harm, cognitive decline and reduced physical health. Practical ways to foster social connection in RAC are urgently needed.

We worked as a partnership of researchers and RAC providers to develop, implement and evaluate a Social Connection Assessment & Enablement Toolkit ('Social Connection Toolkit').

The Toolkit aims to assist RAC staff to discuss with residents, the kinds of social connection activities that will best meet their needs and wants. Using the Toolkit is intended to help optimise a resident's opportunities to build, maintain and strengthen their social connection.

Codesigned with RAC residents and staff, the Toolkit produced has:

- E-learning modules about social connection, for staff;

- A conversation-style set of questions ('Tool') for discussing social connection in staff-resident interactions;

- A guide to social connection and using the Tool, for staff; and

- A digital data collection interface.

Building on a previous feasibility study (Knox et al., 2022), the Toolkit was implemented at four RAC facilities in New South Wales and Victoria, Australia. Surveys and interviews were used to understand the impacts of using the Toolkit on RAC staff and residents, and at the organisation (RAC facility) level. The project had approval from Swinburne University Ethics Committee (reference 20237216) with agreement from The Salvation Army Aged Care and Uniting NSW.ACT.

This report describes the Toolkit and its design, presents findings from evaluating its impacts, and raises implications and considerations for future work.

Social connection and older people in residential aged care

Being socially connected

Being socially connected means having a range of satisfying relationships with others that meet a person's needs for social and emotional support, and that give access to a diverse range of interactions as well as helping people to feel they belong (Farmer et al., 2021). Social connection doesn't just involve interactions with people and doing activities with others, it also involves having various spaces and places where people can meet, and that are safe and accessible. It can involve interactions with animals and nature that give people a sense of joy, comfort and security. Being socially connected supports a person's overall health and wellbeing (Dunbar & Spoors, 1995; Huxhold, 2020; Seppala, 2014).

For older people, social connection has been linked to positive health outcomes, such as feelings of hope, lower mortality rates, better physical health and cognitive functioning (Thomas et al., 2013). It may be more effective than other psychological therapies such as cognitive behavioural therapy or reminiscence therapy in treating depression (Davison & Bhar, 2024).

Engagement with other residents, staff members, family, friends and contacts with people and places in the wider community is important for social connection of RAC residents. Research shows that relationships with staff and other residents can play an integral role in compensating for the loss of social networks that occur when a person moves into a RAC facility (Grenade & Boldy, 2008; Sumaya-Smith, 1995; Thomas et al., 2013).

Being connected in RAC settings

In Australia, RAC facilities provide accommodation and supports for older people who are deemed no longer able to live independently at home, due to increased care needs. In post-industrialised countries, it's been estimated that approximately two to five per cent of the older population resides in RAC (or long-term care as it is more commonly known internationally) (Gardiner et al., 2020). In Australia, 20% of the population aged 80 years and over lives in RAC – one of the highest rates compared with other OECD countries (Dyer et al., 2020).

The median length of stay in an Australian RAC facility is 25 months (AIHW, 2024). The World Health Organisation (WHO) found that residing in long-term care is one of the highest population risk factors for experiencing social isolation (WHO, 2021). A recent systematic review found approximately 61% of older people living in long term care may be moderately lonely, and around 35% may be severely lonely (Gardiner et al., 2020). An Australian study found half the population of older people living in RAC have significant levels of depression (Hughes et al., 2024), with high use of anti-depressant medication in aged care

environments internationally (Arthur et al., 2020;Hughes et al., 2024). This has been linked, at least partially, to social isolation and loneliness (Hughes et al., 2024; Paque et al., 2018).

There is growing acknowledgement that social isolation in RAC needs to be addressed and that greater social connection for residents would improve their quality of life. The Australian Royal Commission into Aged Care Quality and Safety (2021) stated that "the current aged care system leaves too many older people isolated and disconnected" (p. 71). The Commission Report made recommendations to improve social connection, such as increasing staffing levels and greater access to social activities. Australian Aged Care Quality Standards, introduced in 2019 (Aged Care Quality and Safety Commission, 2019), specified that aged care providers must support residents to maintain their relationships of choice and participate in their community. The National Aged Care Mandatory Quality Indicator Program (Commonwealth of Australia, 2021) requires RAC facilities to regularly report on resident social engagement and feelings of loneliness.

Challenges to improving social connection in RAC settings

While the significance of social connection is increasingly recognised in aged care policy, there are challenges to implementing practical improvements. These include:

Lack of capacity to provide personalised activities:
There are organisational and staffing resource implications of moving from the customary practice of fitting residents into existing mass programs (such as bingo or craft activities), to developing varied activities that residents want to do in different sized groups, pairs or individually with a volunteer or community member (Theurer et al., 2015).

Difficulties in recruiting and retaining sufficient staff:
The aged care sector is chronically understaffed, with staff underpaid and high staff turnover rates (Batchelor et al., 2020; Peters et al., 2021; Royal Commission, 2021). This contributes to a 'disconnected and isolating' living environment for residents, where low staff continuity prevents stable and satisfying longer-term staff-resident bonds (Royal Commission, 2021). Due to lack of staff time, essential tasks of personal care tend to be prioritised over interactions that would influence psychosocial wellbeing (Ludlow et al., 2020; Royal Commission, 2021). A high proportion of the current workforce was born overseas, and this presents challenges for staff-resident communication due to differences in language and cultural understanding (Biddle & Makkai, 2021).

Insufficient staff training:
With overall levels of training considered insufficient to retain a skilled aged care workforce (Batchelor et al., 2020; Royal Commission, 2021), there are few resources to educate aged care workers about social connection, its benefits and activating social connection with residents.

Gaps between measurement and increasing social connection:
One way to influence change in care settings is to implement measurable indicators that signal the outcomes considered important. One social connection question is included in QOL-ACC, the new validated quality of life indicators. However, having just one question limits the instrument's capacity to capture the range of issues associated with a lack of social connection. While measurement is a start as it indicates the desired trajectory, there is a lack of guidance about how to improve connection outcomes. There is currently a gap in resources to support organisations to respond to any deficits in resident social connection they might identify.

The project and the Toolkit

Project overview

The project developed, implemented and evaluated the impacts of a Social Connection Toolkit on residents, staff members and at the organisation (RAC facility) level across four RAC settings in Victoria and New South Wales. The project involved RAC staff receiving some training about social connection and then implementing the Social Connection Tool (explained below) with residents.

Project phases were:

1 Toolkit DESIGN

At the start of the project, residents and staff from one of the included RAC settings participated in a 90-minute workshop to codesign a Tool (set of questions) to enable conversations about social connection between staff and residents. Participants were informed about the project goals and interacted with a version of the Social Connection Tool designed in a previous feasibility study (Knox et al., 2022). Participants helped to improve the Tool by suggesting design ideas, including wording of questions and instructions that should be newly included or cut from the previous version. The result was a revised codesigned Social Connection Tool and guide. Five e-learning modules were created using information from the codesign sessions and including resident and staff voices.

2 Toolkit IMPLEMENTATION

The Toolkit (e-learning modules, Tool, guide and data collection interface) was implemented with 86 residents, and 29 staff across four diverse RAC settings.[2] Implementation involved staff receiving training (via e-learning modules, a guide and Toolkit introduction sessions) and then using the Social Connection Tool with residents. This involved a one-to-one staff member-resident conversation based around 11 questions about social connection. These conversations aimed to find out more about residents' preferences for ways to connect, places and spaces to connect, and activities and to talk about residents' social interaction experiences and preferences. Notes were recorded by staff using a digital interface (a version of the Tool) on iPads.

3 FOLLOW-UP BY LIFESTYLE COORDINATORS

Following the Toolkit implementation, lifestyle coordinators met with residents to try to activate their interests and preferences (expressed when using the Tool) e.g. if a person wanted to go for walks around the local community or participate in gardening activities, the lifestyle coordinators explored this more with the resident and considered the feasibility of engaging the resident in these activities.

2 The four RAC facilities were selected by project partners, Uniting NSW.ACT and The Salvation Army Aged Care, to provide a variety of settings: one was regional while others were located in major population centres; one specialised in people experiencing challenges with homelessness and/or alcohol and other drugs.

4

Toolkit EVALUATION

Evaluating the impacts of using the Toolkit involved short pre- and post- "using the Tool" surveys completed by residents and staff, and interviews following the implementation. Interviews were also held with lifestyle coordinators to explore their reflections about using information from the conversation about social connection (i.e. the interaction with the Tool), to drive more tailored activities for residents.

5

IMPLEMENTATION EVALUATION

The impacts of implementing the Social Connection Toolkit at organisation management (i.e., setting/facility) level were also explored. An implementation science methodology was used, involving interviews and discussions with facility managers. This evaluation aimed to understand the readiness and capability of the RAC settings to adopt the Social Connection Toolkit as part of the usual business of care.

The Social Connection Toolkit

We aimed to create a Toolkit that helped RAC staff to:

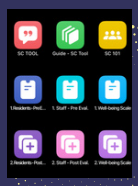
- understand evidence about social connection in the context of RAC;
- have standardised conversations with residents about social connection;
- generate information to complement quality of life data collection that could be used to connect residents with activities they value.

The Toolkit created and evaluated has four components:

THE SOCIAL CONNECTION Tool

THE SOCIAL CONNECTION Tool GUIDE

E-LEARNING MODULES



DATA COLLECTION INTERFACE

The Social Connection Tool

A **set of 11 questions designed for staff** to engage residents in discussion of their social connection experiences, needs and preferences. The Tool offers staff a consistent set of questions, in conversation-style language, to talk with residents about social connection. It enables residents to voice their feelings about their social connections, including their wants and needs, and for staff to find out about these.

The Tool was codesigned with residents and staff. The included questions cover topics raised by residents and staff and key topics from the literature (Bagnall et al., 2018; Farmer et al., 2021). Questions ask about what social interactions residents have and want, preferred places and activities for connection and about ways residents might want to interact outside a RAC setting with different communities they belong to. Importantly, the questions are conversational in style, with the idea being to prompt a comfortable chat rather than completing a formal-style tick-box questionnaire. The Tool can be completed in 10-20 minutes, but in a relaxed and comfortable situation, it can take up to 30 minutes for a staff member to cover all the questions. The Tool can be used by a staff member while carrying out other routine tasks, if time is limited. Information collected can be used to complement existing data collection about quality of life and inform care planning. Information can be used to help activate new or enhanced connection activities by forming the basis for further conversations, for example by lifestyle coordinators.

The Social Connection Tool Guide

A guide for staff, explaining how to use the Social Connection Tool with residents. The guide has information about why social connection is important for resident wellbeing. It raises the significance of ensuring resident (and staff member) comfort and emotional state, when using the Tool, and discusses reading a Duty of Care Statement to residents so they can decide about consent to participate.

E-Learning Modules

Five short (3-6 minutes) e-learning modules about social connection. These are to give staff some knowledge about social connection, its benefits and to alert staff to key considerations when using the Social Connection Tool with residents. For a link to the e-learning modules online, visit: The Social Connection E-learning modules (social-connection.au)

Data collection interface

A digital version of the Social Connection Tool created using Qualtrics, to enable easy and quick collection of residents' social connection information via an iPad.

Evaluation

Evaluation of Toolkit use by staff & residents

Methods summary

Short surveys and interviews were used to collect data from residents and staff members who used the Tool, including lifestyle coordinators who were interviewed after they held a follow-up session with residents after Tool use.

The evaluation aimed to find out impacts of using the Tool on residents' perspectives about social connection, including their control and agency in relation to their social connections. For staff, the evaluation explored experiences using the Tool, impacts on ways of working and perspectives about residents' social connection. This part of the evaluation was conducted by Swinburne University researchers.

Participant selection

A mix of participants was selected from across the four included RAC facilities. Staff initially identified residents that they assessed had the cognitive capability to engage with consent processes and using the Tool, and then researchers selected residents to approach for participation from lists supplied by staff. Residents included were all those who volunteered, following approaches from researchers, and who consented to participate. Staff members included were lifestyle coordinators and lifestyle staff, pastoral care staff and direct care staff[3] from the four settings who volunteered to participate following the initial provision of information about the project.

Data collection

- Survey data was collected from staff members and residents at two time points: pre-Tool use – i.e. approximately 1-3 months before use of the Tool; and post-Tool use – i.e. approximately one month after its use. (Surveys were given to all participating staff and residents. 29 staff and 80 residents completed the pre and post surveys).

- Interviews were conducted with: residents (four from two settings, five from one setting and three from one setting, total = 16 residents); and a mix of lifestyle and pastoral care staff and direct care staff (three from two settings, two from one setting and four from one setting, total = 12 staff members).

3 For the purpose of the research, staff are grouped into two categories: (i) lifestyle coordinators, lifestyle staff members and pastoral care, referred to as 'lifestyle staff' to avoid identification (ii) direct care staff, which includes personal care assistants and home makers.

- Lifestyle coordinators (one from each of three settings, total = three lifestyle coordinators) were interviewed at 2- 4 months after use of the Tool. Despite multiple attempts, it was not possible to interview a lifestyle coordinator from the fourth setting. These interviews explored the feasibility of using data collected from using the Tool to engage with residents to activate more personalised social connection activities.

All interviews were voice recorded with the consent of participants. The following section explains the surveys used. Surveys were completed before and after use of the Tool.

Staff Survey

The Staff Survey has five questions designed to assess the level of staff members' satisfaction with their rapport with residents, ability and comfort in discussing social connection, and their knowledge about social connection. Staff who engaged with the Toolkit were asked to tick a response on a 5-point Likert scale from '1 - very dissatisfied' to '5 - very satisfied' for the following:

How satisfied are you with…

• …how well you get along with residents?
• …your ability to talk about social connection with residents?
• …your understanding of resident's social connection needs?
• …your level of comfort discussing social connection with residents?
• …your knowledge and understanding of social connection and its benefits?

Resident Survey

The Resident Survey has five questions designed to assess residents' satisfaction with their rapport with staff, social activities, level of control and feeling listened to in relation to social connection, and quality of life. Residents who used the Social Connection Tool with staff were asked to tick a response on a 5-point Likert scale from '1 - very dissatisfied' to '5 - very satisfied' for the following:

How satisfied are you…

• …with how well you get along with staff?
• …with the level of control you have over who you connect with socially?
• …with the social activities that you do with others?
• …about feeling listened to when expressing choice in relation to social connection?
• …with your life as a whole?

Data analysis

Survey responses of individual residents and staff members pre- and post- using the Tool were matched and compared. Appropriate statistical tests were used to identify any statistically significant changes between pre- and post- survey responses.

Wilcoxon signed rank tests were used to analyse the difference in the median between the pre- and post-implementation Staff Evaluation Survey questions. This nonparametric test is robust for small sample sizes with skewed data (McCrum-Gardner, 2008), accommodating the negative skew and high kurtosis observed within each of the staff questions in the relatively small dataset (n=29). This analysis was conducted using SPSS v29.0.

The pre-implementation Resident Evaluation Survey question 'How satisfied are you with how well you get along with staff?' also displayed negative skew (S=-2.40) and high kurtosis (K=10.07). Consequently, a Wilcoxon signed rank test was also used to test the difference between the median of the pre- and post-implementation answers for this question.

The four other Resident Evaluation Survey questions had skewness and kurtosis within an acceptable normal range (-2 to 2 for skewness, -7 to 7 for kurtosis) (Hair et al., 2010). As the data for these questions was approximately normally distributed, paired sample t-tests were conducted via SPSS v29.0 to determine any significant differences between the average results of the four pre- and post-implementation Resident Evaluation Survey Questions.

For all tests, a p-value <0.05 was used to assess statistical significance.

Interview data was analysed for themes. NVIVO was used to manage qualitative data.

For further details about Staff and Resident Evaluation Methods, see Appendix A. For Methods of organisational-level implementation, see the section on this evaluation below.

Findings: staff member and resident impacts

Staff members

Short surveys were completed by 29 staff members at both pre- and post- Tool use stages. As detailed in the Methods above, these covered staff satisfaction with their rapport with residents, ability and comfort in discussing social connection, and knowledge about social connection. Interviews were held with 15 staff members, including lifestyle coordinators, lifestyle staff members, pastoral care staff and direct care staff, to discover their experiences of the Social Connection Toolkit.

Staff survey findings

In relation to changes in 29 staff members' self-reported satisfaction with their rapport with residents, their ability and comfort discussing social connection with residents, their understanding of residents' social connection needs, and their knowledge of social connection, no statistically significant differences were found between the medians pre- and post- use of the Tool (see Table 1). The median score of 4-5 (on a Likert scale ranging from 1 to 5) indicates that staff were very satisfied with all areas.

Table 1. Staff satisfaction with social connection knowledge and resident rapport: Wilcoxon signed rank test on pre- and post-implementation survey responses.

Question			Mean	Std. Dev.		Median	Z	Wilcoxon Signed Rank Test (P-value)
How satisfied are you with...								
...how well you get along with residents?	Pre		4.45	0.91		5.00	1.03	0.30
	Post		4.62	0.82		5.00		
...your ability to talk about social connection with residents?	Pre		4.45	0.91		5.00	0.41	0.69
	Post		4.52	0.87		5.00		
...your understanding of resident's social connection needs?	Pre		4.31	0.89		4.00	0.94	0.35
	Post		4.45	0.87		5.00		
...your level of comfort discussing social connection with residents?	Pre		4.45	0.91		5.00	-0.20	0.84
	Post		4.41	0.95		5.00		
...your knowledge and understanding of social connection and its benefits?	Pre		4.45	0.87		5.00	-0.27	0.79
	Post		4.34	1.08		5.00		
* Significant at ≤ 0.05 (two-tailed test)								
** Significant at ≤ 0.01 (two-tailed test)								
*** Significant at ≤ 0.001 (two-tailed test)								

Staff interview findings

Staff were generally positive about using the Tool. Positive themes arising are summarised in Table 2 below and then explored thereafter, with illustrative quotes given. A small number of staff raised challenges, and some suggestions for improvements were made. These are also described below in this section.

Themes from staff interviews

Table 2. Positive aspects about the Tool/Toolkit consistently raised by staff in interviews

Themes raised by staff in interviews	Staff (N=15) Made positive comments
Social connection is important for residents' wellbeing	14
It's important to have training about social connection	13
Using the Tool helped to get to know residents better	13
The Tool is useful for responding to residents' needs	11
I would recommend using the Tool	11

Social connection is important for residents' wellbeing

Most staff commented that social isolation and loneliness are problems for many residents, making fostering social connection vital. Getting to know residents and knowing about their social interactions was considered an important part of this.

> It's important for staff to know who they're caring for, what they need, what social connections they do have. We've got residents who have family come in every day… We also have residents who have no visitors whatsoever. I think it's important for the ones who have no visitors, that we're making sure they are staying socially connected somehow.
>
> (Lifestyle staff member 1)

Training about social connection is important

Staff said they appreciated the training about social connection provided through the project. They thought such training would help all staff to understand the relevance of addressing residents' social needs, and give them evidence-based information about how to respond appropriately.

One staff member commented they had previously had some training about social connection, but most noted they had not had specific training prior to this project.

> And then if we train [staff] with the Social Connection [Tool], I think you don't forget what [residents] like or what they dislike… and you know that she likes this, because it was done with them itself, [staff] will always remember the residents.
>
> (Direct care staff member 1)

The Tool helped to get to know residents

Most staff reported that a key benefit of using the Tool was having more in-depth conversations with residents. This helped to build staff-resident understanding and connection.

> It helped improve our bond, really. For me, personally, it helped me know my residents more… the Social Connection Tool… is more of an improved way of us getting to know the residents. It's simplified, but the questions are more engaging.
>
> (Direct care staff member 2)

The Tool is useful

Staff often favourably compared the Social Connection Tool with other Tools they use. From further exploration with Uniting and The Salvation Army, it appears these other Tools are more tick-box or short answer in style, and include in-house questionnaires and formal validated instruments. Staff who commented said the conversational style of the Social Connection Tool made residents feel at ease, helping to have comfortable, in-depth discussions about social connection rather than responses to tick-box questions. They suggested this helped to generate useful information about residents' preferences, helping to understand, for example, what activities residents enjoyed, people they liked spending time with and the types of music and books they liked. Such information can be used to help get residents connected with more personalised activities they want to do.

> "we have that kind of questionnaire where we say, oh, what kind of activities do you like to do, but the Social Toolkit I notice has, it's the way the questions were phrased, gets a deeper answer from the resident."
>
> (Lifestyle staff member 2)

One staff member said that the smaller number of questions in the Social Connection Tool contrasts with some instruments they currently use:

> "the current one we have for a start is 34 questions long. So that's a turn off before anything. It's a turn off for the staff, but forget about the staff. It's a turn off for a resident to be asked that many questions."
>
> (Lifestyle staff member 1)

The Tool helps to logically structure a conversation about social connection and can be particularly useful for helping new staff to start to get to know residents. One staff member (with a language background other than English) found the Tool useful as it gave them consistent wording and a guided conversation so they could explore resident interests without straining communication between them.

In this project, the Social Connection Tool was used by staff members with various roles. However, one lifestyle coordinator suggested the Tool is perhaps specifically useful for direct care staff. The participant said lifestyle coordinators tend to have had training, already, in how to talk with residents about activities and interactions.

Aligned with that observation, one direct care staff member expressed that the Tool was useful for her role, highlighting the potential to improve relationships between care staff and residents, and contributing to greater job satisfaction.

> We're not just here to toilet people, and give them food, medicines, you know, a lot of it is giving support. So I think this could really improve and help people - with the Tool - because, you know, some staff are not as outgoing or, you know, they might be shy but this could sort of help improve their relationships, and actually, the needs and wants of the residents, like we can achieve more and then that improves your job satisfaction.
>
> (Direct care staff member 2)

Another staff member noted direct care staff don't typically get access to the information about residents collected by other Tools used in their facility. They saw an opportunity for sharing information, gathered from using the Tool, across different staff in the wider team.

Recommend Tool adoption

Most staff recommended continuing the use of the Tool, and three staff members suggested it could replace existing Tools used for collecting information about resident social connection.

Challenges

A small number of staff members raised some challenges. These included that it was difficult to find the time to have even 10–20-minute conversations about social connection. One noted that time constraints meant using the Tool with each resident could only realistically happen once a year. Some staff indicated that there were already many surveys that residents had to complete, making comments like *'we had just finished our consumer survey… It was like, oh, again!' (Lifestyle staff member 4)* and *'residents here don't like to keep being asked for surveys' (Lifestyle staff member 5)*. Three staff members perceived overlap with existing in-house questionnaires and formal validated instruments such as 'Key2Me'.

It was noted that the Tool isn't appropriate for all residents. Highlighting that some residents don't want to talk about these topics, two staff members reported residents who said no to participating in using the Tool. Sometimes using the Tool could lead to confronting discussions. A lifestyle coordinator reported that, in the Social Connection Tool conversation, a resident disclosed that she was a victim of historical abuse. The staff member said she had been able to support the resident suitably through the conversation. However, this instance shows that implementing the Social Connection Tool brings the possibility of residents disclosing unanticipated information that will require appropriate responses.

Improvements suggested

Some improvements were suggested. These included simplifying wording, reducing perceived duplication with other Tools used and making the Tool relevant for residents from diverse language and cultural backgrounds. One staff member suggested that the term "social connection" might not be readily understood by residents.

Follow-up interviews with lifestyle coordinators

Interviews were held with three lifestyle coordinators who had undertaken follow up sessions with residents using the data collected through using the Tool. In all three interviews, the lifestyle coordinators indicated that they were able to use information collected from using the Tool to develop new social connection opportunities for residents.

One supported a resident with vision impairment to participate in existing activities within the facility:

> "Since the social connection [Tool], I followed her up and… this lady's partially blind, so that's the reason that she doesn't want to go to many things - but I've got her to come to gardening. I've got a podcast group that we have… Now she loves that.
>
> (Lifestyle staff member 1)"

In another facility, the lifestyle coordinator spoke of plans to set the resident up with some craft activities for her to carry out with other residents:

> …she's done those courses on arts and crafts, she got the ideas for montage and using magazines or dry leaves and this and that. So I'll say, would you be keen on, conducting it with other residents, like give a little bit of responsibility.
>
> (Lifestyle staff member 3)

The lifestyle coordinator in a third setting reported that the resident with whom she conducted a follow up session, had initially expressed interest in participating in more bus trips and games. However, his health declined, so the follow up initiatives were scaled back, and activities were brought to his room instead.

Residents

Short surveys were completed by residents pre- and post- Tool use. These covered questions on residents' satisfaction with their rapport with staff, social activities, their feelings of control over their social connection opportunities, and their quality of life. Interviews were held with residents to explore their reflections about social connection and their experiences of engaging with the Tool.

Resident survey findings

Eighty residents completed both pre- and post- using the Tool evaluation surveys. No statistically significant differences were found between residents' satisfaction with their **rapport with staff, social activities, or quality of life** before and after using the Tool (see Table 3). However, the mean level of resident satisfaction with the **level of control** they have over their social connections in residential aged care and **feeling listened to when expressing choice** about social connection actually **decreased** at the post- use of the Tool survey, compared with the pre- survey, and this result was found to be statistically significant (see Table 3).

Table 3. Resident satisfaction with staff rapport, social activities, quality of life, level of control over social connection, feeling listened to when expressing choice: Wilcoxon signed rank test & paired samples t-test on pre- and post-implementation survey responses.

Question		Mean	Std. Dev.	Median	Z	Wilcoxon Signed Rank Test (P-value)		
How satisfied are you...								
... with how well you get along with staff?	Pre	4.58	0.65	5.00	-1.40	0.16		
	Post	4.44	0.76	5.00				
Question		**Mean**	**Std. Dev.**	**Mean Difference**	**Paired Std. Dev.**	**T**	**df**	**P-value (2-tailed)**
How satisfied are you...								
...with the social activities you do with others?	Pre	4.21	0.98	0.113	1.222	0.82	79	0.41
	Post	4.10	0.98					
...with your life as a whole?	Pre	4.24	0.94	0.225	1.263	1.59	79	0.11
	Post	4.01	1.08					
... with the level of control you have over who you connect with socially?	Pre	4.45	0.67	0.300	0.960	2.80	79	0.00**
	Post	4.15	0.78					
...about feeling listened to when expressing choice in relation to social connection?	Pre	4.36	0.77	0.463	1.078	3.84	79	0.00***
	Post	3.90	1.05					
*** Significant at ≤ 0.05 (two-tailed test)**								
**** Significant at ≤ 0.01 (two-tailed test)**								
***** Significant at ≤ 0.001 (two-tailed test)**								

Resident interview findings

Sixteen residents were interviewed between four to 16 weeks after using the Social Connection Tool with a staff member. At interviews, residents were asked a series of open-ended questions about their experiences of using the Tool, as well as their broader perceptions of their social connection experiences in RAC settings.
Interestingly, most residents could not remember using the Tool nor could they remember having conversations about their social connection with a staff member. This is perhaps understandable as interviews sometimes took place a considerable time after the Tool was implemented due to Christmas breaks, a Covid-19 outbreak and organisational issues at facilities meaning researchers were unable to arrange timely interviews with residents. While they couldn't remember details about using the Tool, residents did share information on their attitudes to social connection while living in RAC settings. In the section below we summarise themes arising, illustrated with quotes. Interview findings highlight some of the challenges and restrictions in RAC facilities that create barriers to supporting social connection. We also provide more extended information from the sole resident who remembered using the Tool.

Themes from resident interviews

Social connection is important

Almost all residents (15 out of 16) stressed the importance of social connection for their mental health, wellbeing and quality of life. The value of being able to share thoughts and talk with others was raised, as well as the significance of having someone you can trust and who will listen:

> "You feel secure if you've got a friend, a good friend... That's all you need. Someone you can rely on, depend on, and spend time with."
>
> (Resident 1)

However, challenges with creating deep connections were also raised. These challenges included dealing with residents' own physical health issues, such as impaired vision and mobility, or another resident's cognitive issues such as dementia, or fears about emotional pain from getting close to other residents who may pass away. As one resident said:

> "… that hurt can take a while, so you don't get too attached."
>
> (Resident 1)

Discussing social connection with staff members

The majority of residents (14 out of 16) said it was appropriate for staff to know about their social connection experiences and preferences, including knowing which residents they are close to, and about their visitors. Residents thought this would help staff to know them as individuals, and to care about and for them:

> "I know that [staff] wonder how to relate to [residents]. And I know, they ask questions of other [residents] sometimes, but I volunteer, not only answering but offering them things because they like to know us, and it makes their caring for us more suitable if they know a bit more about us."
>
> (Resident 2)

Some residents regretted a lack of opportunities to talk to staff about their social connection, sometimes feeling that they should "just hold it in". There was a wider perception of a lack of staff time for interaction and a feeling that staff were "always busy". High staff turnover and a consequent lack of continuity of relationships with staff was identified as challenging for trying to build rapport as one resident explained:

> "I didn't even have a conversation with [agency staff] as I knew I was never going to see them again."
>
> (Resident 3)

Limited opportunities to connect

Most residents (12 out of 16) wanted to do activities that were not currently available at their RAC setting. These included gardening, cooking, volunteering, discussion groups, exercise or spending time with people outside of the facility. A small number of residents had independently started vegetable patches at their facilities, using their own money to purchase soil and gardening equipment. One said:

> "I try to get as many residents [involved]… and they're keen enough, even if they are only pulling a few weeds out, that's something in their book that's probably great."
>
> (Resident 4)

Discontent with current social programs was common, including with bingo, balloon tennis, and “singalongs”. Arts and crafts sessions that were limited to “colouring in” were highlighted as demeaning and frustrating. Connecting with people outside the RAC setting was noted by some residents as limited. Not being able to do this was attributed to safety issues or policies. Several residents mentioned wanting to go for walks in the neighbourhood, accompanied by staff and other residents, or wanting to travel by taxi to visit close friends. However, this was restricted due to the level of risk assessed by staff – or their families. The resulting feelings were summed up by one resident:

> “sometimes I feel like I might as well be in a prison, because you can’t do certain things… I feel like I’m in prison, but the only crime I’ve committed is getting old.”
>
> (Resident 5)

John's experience of using the Social Connection Tool

Of the sixteen residents, one person (we've called him John here) remembered using the Tool and this is what he said about the experience.

Since using the Social Connection Tool with a staff member, John said he had reflected on his own engagement in the activities offered at his RAC setting. He said the ***"questions of what we discussed made me think about things more in depth... what would I like to do in regards to recreation."***

This reflection prompted John to join activities that he had previously ignored, including bingo and balloon tennis. His experience engaging with the Tool ***"made me think how I can socialise more and do the activities."*** He had been reluctant to join these activities as ***"I don't find bingo very entertaining"***, but - through the conversation about his social connection - he arrived at the realisation that activities were often about the people he might meet. He reflected it was more about social interaction, than about interest in the activity itself: ***"I might not really like hitting the balloon around like a tennis ball, but you know a different set of people do that."***

John mentioned a noticeable change in his relationship with the staff member since using the Tool, ***"she knows me a little bit better. That makes me feel a little special and now we communicate if I see her when I go out."*** Since using the Tool, John was asked to represent the residents from his facility in a meeting with organisation executives about his lived experience residing in the facility. This gave John a sense of pride and enablement.

These aspects, raised by John's reflections, highlight impacts of using the Tool beyond informing staff about residents' preferences. In this instance, using the Tool had prompted the resident - John - to reflect about the value of social connection, and to interact differently. Simultaneously, it had enabled a relationship to develop between staff and a resident where he was recognised for distinctive capabilities, enabling John to participate in more ways and to enable him to feel valued, with consequent wellbeing benefits.

Evaluation of Toolkit implementation at the organisational level

As part of the evaluation, researchers from The University of Melbourne examined aspects of the implementation of the Social Connection Toolkit, at an "organisational level", at the four RAC facilities. Organisational level refers broadly to considering the implications for the management of facilities and the evaluation at this level focused on the Toolkit as a whole, rather than just on the Social Connection Tool. The implementation evaluation was informed by implementation science approaches and frameworks (Damschroder et al., 2009; Shea et al., 2014). Key organisation level evaluation questions included: 'To what extent has the Toolkit been implemented as intended?' (Implementation Process); and 'What contextual factors (enablers, barriers) have influenced the Toolkit's implementation?' (Implementation Context).

Multiple qualitative methods were used to collect data including: 1) reflections of project team members collected at six Project Governance Committee Member [4] meetings; 2) 22 semi-structured interviews with RAC staff (facility managers (n=10) and lifestyle coordinators (n=12)) at three time points: pre-, during and post-Toolkit Implementation; and 3) observations conducted during Toolkit implementation, of eight RAC direct care staff using the Tool questions with eight residents.

Organisation-level implementation findings

Evaluation findings are presented below in relation to: Toolkit Implementation Readiness; Implementation Fidelity; and Implementation Context.

Toolkit Implementation Readiness

Overall, there was a high level of reported organisational and staff readiness to implement the Toolkit. Governance Committee members commented that there was "collaborative readiness" based upon the existing working relationships created through the Toolkit's prior codesign process and a plan that the social connection data, collected from residents through using the Tool, was to be embedded into existing IT systems.

4 Governance Committee meetings were held approximately every 6 weeks throughout the project and the committee comprised senior management personnel from each of the four participating residential aged care facilities as well as the university-based research team members.

> **Even some of the residents that we did the [codesign] workshop with, are asking their staff when's this starting? When are they coming? So, the appetite is definitely there from the people that we will be impacting.**
>
> (Governance Committee Member)

However, Governance Committee members also commented on a key implementation readiness challenge – namely, *"that the project was going against the tide of the aged care reforms"* which were viewed as largely clinically focused and not targeted at psychosocial wellbeing. Pre-implementation interviews with RAC managers and lifestyle coordinators also revealed an eagerness to implement the Tool with residents, as there was perceived value in engaging with residents about their social interactions. During- and post-implementation interviews revealed, however, that while staff were eager to implement the Tool, the existing high workloads and increasing demands on their time led to skepticism about their capability to embed using the Tool into their roles:

> **every aged care facility is under increasing demands. There's a lot of stuff going on... We are already bombarded with so much paperwork and what we do already. I think, anywhere in health care, stuff in lifestyles is being cut. So maybe we have two lifestyle people a day for 103 beds. So, [using the Tool is] something that we wouldn't be able to do regularly, but maybe on admission, or something like that.**
>
> (Lifestyle coordinator- Pre-implementation interview)

One staff member said that the Tool questions duplicated part of the existing 'Key2Me' and 'Spirituality Assessment Form' used by lifestyle and pastoral care staff - leading to staff resistance to engage and implement the Tool.

Toolkit Implementation Fidelity

Overall, there were differing viewpoints in relation to implementation fidelity. Governance Committee members largely commented that the implementation of Toolkit components was going as planned, whereas manager and lifestyle coordinator interviews suggested variable clarity about the Toolkit's components and planned implementation processes. Interviews at facilities further revealed that staff absences and workloads contributed to some staff missing information about involvement in Toolkit implementation and education about using the Tool:

> **...I was not able to attend training as I was on leave and so not clear about next steps**
>
> (Lifestyle coordinator- Pre-implementation interview)

Variable access to all Toolkit components (e.g., delays in access to iPads so that data from using the Tool could be collected) was reported. The observations of the staff-resident pairs revealed that some staff were asking the social connection questions in a formulaic and non-conversational style – resulting in confusion and annoyance amongst both residents and staff. Staff commented on some needed improvements, including flexibility of questions to resident (and staff) cultural differences and staff literacy levels, and the need to examine how to embed the Tool into day-to-day work, current processes and existing data collection.

Toolkit implementation context

Organisation-level evaluation data from Governance Committee members and manager and lifestyle coordinator interviews highlighted several factors critical to implementation, arising from internal (to organisation) and external contexts.

Internal to the RAC facilities, critical factors included:

Implementation Climate – that is, aspects relating to: variability in facility management support; variability in communications about the Toolkit's strategic and operational implementation priority; variability in staff resourcing to implement the Toolkit; the general time-poor nature of staffing in RAC; the differing perceived Toolkit-RAC values fit; variability in Toolkit implementation champions at RAC strategic and operational level; variability in RAC policies to support the Toolkit's implementation; and
Implementation Participants – including aspects relating to: diversity in resident profiles e.g., gender, cognition/dementia; variability in workforce readiness and capacity for innovation/change and increasing competing demands on workforce.

External to the RAC facilities, several key implementation contextual factors emerged. Governance Committee members commented that "in RAC, leisure is likened to cruise ships - one size fits all, but that the Toolkit was individual - personalised care, hence going against the tide". This mismatch created strategic and operational implementation challenges. Governance Committee members also commented on the misalignment between the aged care policy context and aged care practice context. They indicated that while the new Aged Care Quality Standards recognised the importance of older people's social wellbeing, increasing staff workloads were resulting in push-back from direct care staff involved in Toolkit implementation.

> **"In RAC there are all these other pressures - time pressures, the funding that you only get is you perform certain tasks. It's very task driven...it's not funded, because other areas are funded. So, you can see why things like social connections don't get a look at, because it's not a priority for staff, and then for residents it's not the most important thing they want – they want a shower done."**
>
> (Governance Committee member)

Data from the evaluations of resident, staff member and organisational implementation perspectives led us to highlight a set of considerations and implications in the final section of this report.

Implementing the Social Connection Toolkit in RAC: Issues and Implications

In this section we highlight key issues and implications for the RAC sector, of introducing the Social Connection Toolkit. We also cover limitations of the evaluation.

Significance of the Social Connection Toolkit for RAC

It seems clear that - *generally* – RAC facility managers and direct care staff have been habituated to prioritise satisfactorily completing the essential technical tasks of personal health care. This is, arguably, an entirely rational response to deeply-embedded structural incentives, which are reinforced by funding constraints.

Because of this, more holistic and relational aspects of care, that prioritise resident psychosocial wellbeing, gain less attention. Staff members are hard-pressed to complete all their tasks in their allotted hours and it is challenging to recruit and retain staff. In such an environment, less attention than would be optimal, has been paid to raising staff skills in aspects of psychosocial care. Instilling knowledge about social connection for staff, through training, is likely therefore to come well down on the list of necessities from an organisation perspective.

Similarly, it is possibly new for aged care providers to think about how spaces and places in buildings and gardens can be part of fostering social connection, and how to connect residents with people living in the communities surrounding RAC facilities. Further to this, while many staff members do 'connect' daily with residents, this social interaction may have tended to go unconsidered explicitly. This could be because it is hard to delineate boundaries between 'caring' and 'connecting'. It could also be because trying to provide tailored opportunities for social connection in an environment where – to paraphrase one staff member– *a 10–20-minute conversation about social connection is only likely feasible once a year* – is just like opening a world of expectations that cannot hope to be met.

Into this environment, as a partnership of social connection researchers and aged care providers, we codesigned and implemented a Social Connection Toolkit

consisting of training and a conversation-style Tool for collecting information about individual residents' experiences and preferences. We also introduced a template for collecting this information. Results of the evaluation show that implementing the Social Connection Toolkit is not the answer to meeting residents' social connection needs - rather, it offers most promise as a way to start a conversation with residents about social connection wants and preferences. Our implementation and evaluation of the Social Connection Toolkit exposes a range of issues that need to be addressed to systematically optimise social connection for the diverse people that live in RAC.

Below, we first cover issues raised in the Toolkit evaluation, and implications of the initiative, from residents and staffing perspectives and then from an organisational perspective. We hope the RAC sector can build off this work to transform facilities into socially connected places where older people's psychosocial wellbeing can come more to the fore.

Issues and implications for residents

It's important to discuss social connection

Most residents think their social connection is important. We encountered a range of perspectives on connection during the project. Some residents expressed being happy, content and feeling at home in RAC, while others expressed feeling trapped and isolated. Resident participants in the codesign workshop were enthusiastic to participate to improve action on social connection and continued to ask about the status of the project after their initial involvement. It seems clear that the topic of resident social connection is a significant one to be considering right now, particularly in the context of a globally aging population.

Discussing social connection can prompt residents' agency and enablement

The case of John (who remembered using the Social Connection Tool) highlights that using the Tool can prompt residents to reflect on their own social connection and take actions to self-help. John realised that balloon tennis wasn't about balloon tennis, but more about interacting with others when he made efforts to overcome his distaste and got involved! Simultaneously, the staff member that interacted with John got to know him as an individual and then acted to encourage him into other situations that allowed John to show his communication and engagement skills. This 'partnership' working was a win-win with John gaining fulfilment and confidence and the RAC facility utilising his skills to inform organisational goals. This shows that – while the initial goal was to help staff have conversations with residents - actually the Tool can also be empowering from the residents' perspective.

Residents are already engaged in pro-social activities

Some residents discussed establishing gardens and asking others along. Other residents talked about proactively trying to engage other residents in conversations and activities. In ways, residents are recognising and already doing things about social connection in RAC. It is important that further work by RAC should supplement and support this initiative of residents and not hinder it.

Issues and implications for staff

How to signify social connection as important

Most staff also acknowledged that working on residents' social connection is important, but this issue seems in constant tension with lack of staff time, the many pressures on staff time and a focus on completing objectively measurable/auditable essential 'technical' tasks like showering, feeding and toileting. On the one hand, having the Social Connection Tool turns talking about social connection into a measurable/completable task – although it still doesn't help to capture ongoing social connection work of staff – i.e. in warm and connective conversations and activities with residents. This non-captured element of social connection inevitably means it is seen as less important.

Training

Most staff appreciated learning about social connection, its benefits and having a framework for thinking about and talking about social connection. This is what the e-learning modules, Tool and guide provided. Only one staff member said they had previously had training on social connection. Given staff time constraints, it is clearly beneficial to provide training, while simultaneously impractical and unlikely to be valued, given the current work environment. Some issues could perhaps be covered more in the Toolkit e-learning and guide we created. The area of boundaries between care practitioner role and caring 'relationship' seems particularly significant for discussion and training. Recent research has found that direct care staff and clinical care staff view supporting social connection as the responsibility of lifestyle coordinators and not necessarily part of their role (Ludlow et al., 2020). According to the literature, direct care staff often resist engaging in social and lifestyle activities with residents. However, our evaluation found that many direct care staff want to do more for/with residents. Signalling that social connection is a legitimate topic and skills area – via training - would acknowledge the important work of RAC staff in support, interaction and emotional attachment for residents (van der Borg et al., 2017).

Despite training about the Social Connection Toolkit being provided, many staff required additional discussions with researchers and managers to grasp the Tool's purpose and potential. In the sites where facility managers as well as

lifestyle coordinators attended regular meetings, training sessions or workshops about the Social Connection Toolkit during the project, direct care staff tended to be more positive about the Tool. This underscores the importance of leadership and spending time to engage management before implementing Tools in residential aged care.

Targeting the Toolkit where it is most valuable

Staff members involved in 'direct care work' such as personal care workers or home makers may have benefitted more from engaging with the Tool, than other staff such as lifestyle or pastoral care staff. Direct care workers reported that the Tool facilitated conversations about social connection that allowed them to 'get to know residents' or deepen their connection to the resident. It was highlighted by direct care staff that this type of information is often collected by management or lifestyle staff and direct care staff do not often get the opportunity to use these Tools with residents. Although they can read residents' files to learn this information about residents, it was reported that it was through having conversations about residents' social connections that a deeper understanding and connection was facilitated with the resident.

Language- and culture- appropriate Tools

Several staff raised the issue that the Tool is in English language and that this makes it difficult for them to use – if the staff member has a different first language, or to use with a resident, if they have a different first language. This is an important issue, since words for social connection, relationships, bonds, interaction etc. will differ between languages as will the meaning and significance of these ideas between different cultures. However, this must also be an issue for other topics discussed in RAC, so it is pertinent to understand how other Tools and training are translated and used. It would be useful, as part of future work, to try to codesign with cultural and language groups to 'translate' the Social Connection Toolkit for other languages/cultural backgrounds to see what is revealed about different cultural understandings and preferences around social connection practices, and so that the Tool can be more widely used.

Purpose(s) of the Tool and links with data collection

Several issues arose linked to clarity about the intended purpose and possible potential roles of the Tool. In the project explanatory statement provided to staff and resident participants, the Tool was explained as: helping to have conversations with residents about social connection; helping to collect data so that residents' preferences could be better addressed; and providing information to complement existing quality of life data collection. We did not carry out an audit of existing Tools used in participating RAC facilities. As implementation progressed, different staff members and managers mentioned other, existing Tools used to, for example, find out about residents' preferences for social activities, or to collect quality of life data. Some staff said there was duplication with existing Tools. Others said it was difficult to introduce yet another Tool when residents are already 'over-surveyed'.

As it turns out, the three goals of the Tool highlighted above (from the explanatory statement), are potentially quite distinct while originally understood as complementary. The Tool can be a gateway to conversations about social connection. It can also help to collect data about preferences. It could possibly highlight social connection status over time – if standard ways of collecting data were established.

To avoid duplication or perceived duplication, future work should compare the Social Connection Tool questions with existing/other Tools used. The purpose(s) of using the Social Connection Tool should be clear and known by staff.

Data collection and use

Linked to the above issue about clarity of purpose, data collection from using the Tool was quite a challenge. While the Tool provided a standard, codesigned set of questions and a digital interface for collecting data, it became clear that some staff asked the questions 'in a formulaic way' while others made the Tool part of a conversation. This generated different responses i.e. short yes/no or longer conversational data. At the same time, there were differences in how staff recorded responses, ranging from yes/no statements to trying to write verbatim notes of resident conversations. Clarity about the purpose and role of the Tool would help to drive consistent collection of 'the right kind of data', along with training and including information about recording information in the Toolkit Guide.

Collecting data from resident conversations, perhaps while also carrying out other tasks, might be too big an ask for hard-pressed staff, so consideration needs to be given to how to collect data. Another issue that arose was the extent to which data collected might be available across the whole team. Some staff said data relating to social connection is currently collected, but they don't have access to it.

Potential to raise difficult issues

Only one staff member reported that using the Tool with a resident had raised a distressing issue – in this case, a remembrance of historical abuse. Nonetheless, this illustrates the potential of the Tool to raise difficult issues and the need for organisations to be prepared for this by having robust procedures in place. Similarly, the findings from the resident surveys of dissatisfaction with their agency over their social connection, as well as the finding from John who positively acted to change his social connection following using the Tool, could indicate the potential for the Tool to have a range of effects. This was positive for John in that his reflection caused him to act to increase his social connection; however, for others, using the Tool could make them think there had been no response or to reflect negatively about their social connection status in RAC.

Again, providers need to be alert to possible consequences of using the Tool, and prepared to deal with these.

Start of a process

Using the Social Connection Toolkit and Tool is really just the start of a process of imbuing a more psychosocially-alert culture into RAC. The Toolkit can stimulate thinking about social connection and gives staff and managers a framework for conceptualising a nebulous topic. The Tool gives entry to a conversation that breaks down barriers of talking about this potentially personal and sensitive topic, in a consistent way, between staff and residents. Lifestyle coordinators interviewed all said that information collected from using the Tool helped to stimulate new ideas for resident social connection. However, the project reported here is just a start and further work is required to understand how to fulfil different residents' social connection needs, including as they change over time.

Organisational-level issues and implications

Implementation Readiness

Considering implementation readiness across the RAC facilities, the organisation-level evaluation confirmed that there were individuals (including lifestyle coordinators, managers and senior managers on the Governance Committee) who were ready and committed. However, widespread commitment and capacity – to implement the Social Connection Toolkit at the operational level – was challenging. Some managers were distracted and busy dealing with emergent issues, others didn't know (enough) about the project. This meant that, at the level of individual RAC facilities, implementation and commitment to the initiative, was patchy.

This finding resonates with known factors from the literature about influences on organisational readiness for change (Shea et al., 2014), including the need for 'change commitment' – i.e. the shared resolve to implement an innovation; and 'change efficacy' - shared belief in the collective capacity to implement an innovation. It also resonates with identified factors contributing to innovation readiness in healthcare organisations (Van den Hoed et al., 2022) including: strategic course for innovation, climate for innovation, leadership for innovation and commitment to innovation.

Reflecting upon these factors, the evaluation supports the idea that there is: a strategic course for innovation and a commitment to innovation present in participating organisations. This could be seen from the commitment of more senior managers to the Project Governance and the enthusiasm of some RAC facility managers. However, two elements require further work: leadership for innovation - especially the middle managers' roles (e.g. facility managers, regional managers and specialist roles such as practice leads and quality leads) in implementation leadership; and the climate for innovation – especially the culture for innovation and learning - within RAC facilities. This latter is challenging as dealing with day-to-day exigencies like finding sufficient staff and 'putting out fires' of emerging priorities, inevitably detracts from good intentions around education and training.

Implementation Context

In relation to Implementation Context, the evaluation revealed key implementation challenges within and external to RAC. These findings resonate with known determinants to implementing innovations (Helfrich et al., 2007), including: management support and innovation-values fit, which contribute to an organisational "climate" for implementation.

A key issue here is resolving the dissonance between a technical 'check-list' approach to aged care provision focused on ticking off and counting tasks and functions completed, with a more holistic pro-social orientation where considering psychosocial wellbeing imbues all interactions and tasks.

While acknowledging there are other frameworks to assist with implementation of innovations in aged care, to assist with planning how to implement the Social Connection Toolkit, we provide a specific framework. Here, we draw on existing literature and findings from this evaluation to generate an Implementation Planning Framework (see Figure 1) that provides a set of considerations and talking/planning points.

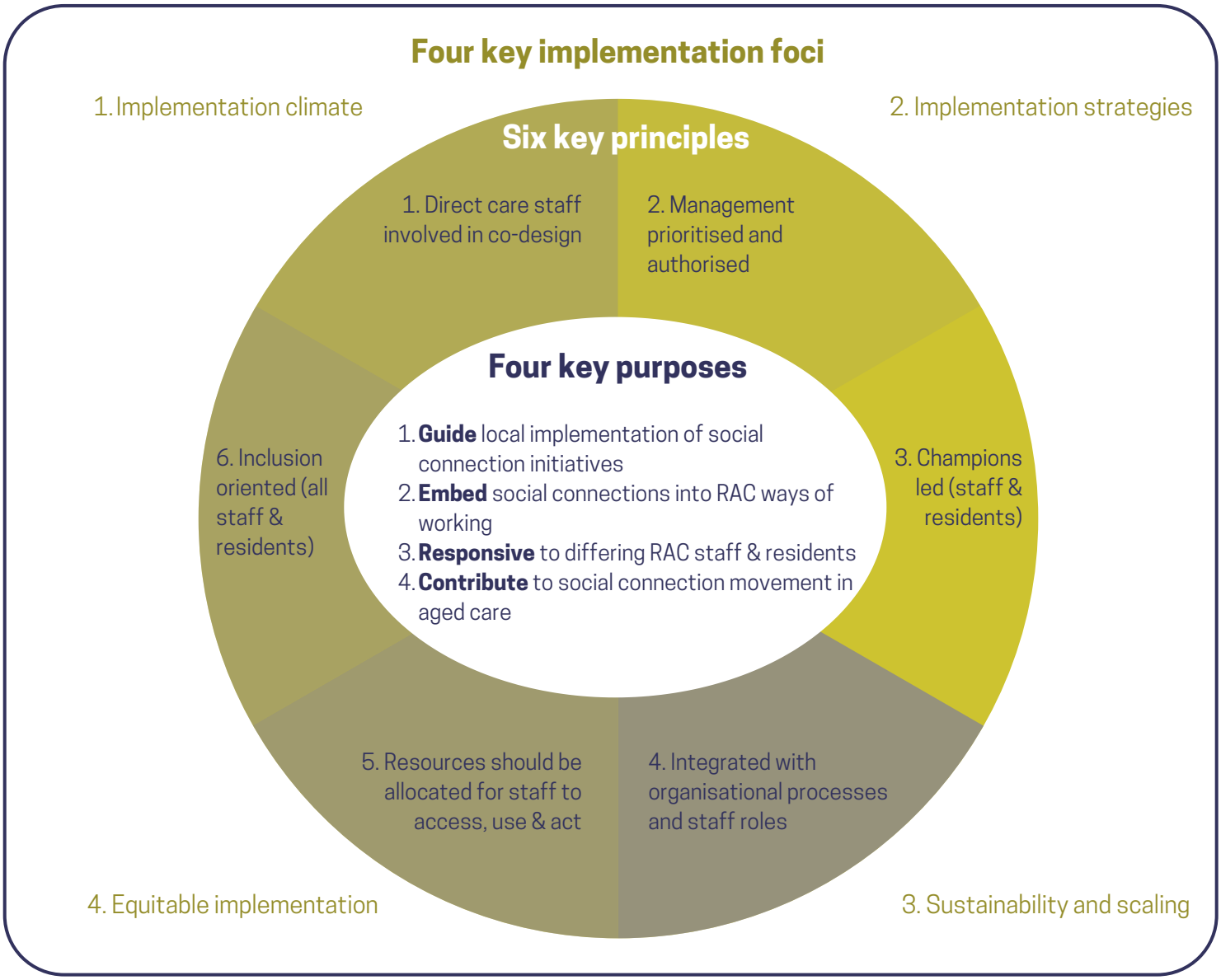


Figure 1. Social Connection Initiative Implementation Planning Framework

The potential of the Social Connection Toolkit to be adopted, implemented and scaled in RAC and to enable social connection for residents, requires key implementation internal and external factors to be addressed. The draft Social Connection Initiatives Implementation Planning Framework (Implementation Foci, Principles and Purposes) could provide a way forward to address the complex implementation contextual challenges that exist for social connection initiatives within RAC, that also have broader aged care policy, practice and research implications. For more details about this framework and how it was created, see Appendix B.

Limitations of the evaluation

The evaluation raised limitations that should be considered when interpreting the findings and considering future evaluations in the residential aged care context.

Both staff and residents appeared to struggle to respond to the short pre- and post- use of Tool surveys. This resulted in responses like ticking all of the same scores for all questions (e.g. all highest possible score). Researchers gave insufficient thought to the 'power dynamics' of the context for both sets of respondents. Residents were potentially afraid to give frank responses due to fear of repercussions from staff/'the organisation' and staff potentially did not always give frank responses due to their (high) appraisal of their own performance in context of potential repercussions from management.

Residents' lack of recall of using the Tool was a challenge when interviewing them about their experiences. This could be interpreted positively as the Tool being accepted and not causing memorable disruptions to their life. On the other hand, it would have been useful to follow-up with the interviews just after staff-resident Tool interactions to gain immediate responses. The organisational implementation did carry out observations of staff-resident Tool use, but immediate feedback, reflecting on the experience, was not collected.

Findings of the resident survey post-Tool use indicated decline in the level of control the residents have over their social connection and feeling listened to when expressing choice about social connection. These findings are intriguing. However, we did not ask residents to link their responses to using the Tool, so we are unable to make associations between these results and Tool use. It is possible that using the Tool raised residents' awareness about social connection and their choice and control.

Originally, we were interested in measuring change in resident wellbeing in relation to the implementation of the SCT. However, as the project rolled out, it became clear that it was unrealistic to attempt to measure change in resident wellbeing in relation to the implementation of the Social Connection Tool. Using the Tool itself is unlikely to impact on wellbeing – rather, staff acting on findings from using the Tool – i.e. to implement new social activities – might have affected wellbeing over time. This may be a focus for future research.

These limitations underscore the need for evaluation methodologies – for future work - that are appropriately attuned to the challenges of researching in RAC environments.

Conclusion and Next Steps

Overall, better responses to social connection in RAC are needed and there is an appetite for change. This project shows the value that the Toolkit can have as a gateway to conversations about social connection between residents and staff in RAC and considering the importance of social connection. Through the Toolkit evaluation, we can see the benefits that the Toolkit can have for collecting data about preferences and potentially highlighting social connection status over time (if standard ways of collecting data are established). The Toolkit was generally received positively by staff and residents, however, as detailed, there are important considerations around organisational readiness and aspects of the Toolkit itself that should be explored if using the Toolkit within your organisation / RAC facility.

To conclude this report, we summarise some of the considerations your organisation should explore before using the Tool. These considerations relate to both the Toolkit itself and organisational readiness:

Toolkit

- Conduct an audit of existing tools to identify potential duplication before implementation.
- Clearly define the Tool's purpose to guide data collection and determine which staff groups should use it.
- Provide guidance on data collection methods and identify who will have access to the resulting data.
- Organise training sessions and staff meetings prior to implementation to ensure all staff understand the goals and to help secure their buy-in.
- Identify trusted, influential leaders to champion the implementation process.
- Establish procedures for addressing issues that may arise from the Tool's use.

Organisational Context

- Engage in widespread discussion and co-design to plan the rollout of initiatives aimed at improving social connection.
- Identify leaders and champions at various levels of the organisation to drive change.
- Develop strategies to integrate social connection work into existing organisational processes and staff roles.
- Establish metrics to measure the social connection work being done.
- Allocate necessary resources, including staff time, to support the initiative.
- Use the Implementation Planning Framework provided in this report to guide strategic and operational planning.

The next steps for the Social Connection Assessment and Enablement Toolkit include project partners Uniting ACT.NSW and The Salvation Army Aged Care using the evaluation findings to inform enhanced RAC resident social connection.

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Appendices

Appendix A
Evaluation Methods: Resident and Staff Evaluation

Sample & Selection

Two residential aged care organisations, The Salvation Army and Uniting NSW.ACT, each chose two residential aged care settings to participate in the Social Connection Toolkit project, for a total of four sites. These settings were selected based on stability of staffing and structure plus residents' diversity.
Table 4 presents the number of interview participants for the Social Connection Toolkit evaluation for each site.

Table 4. Social Connection Toolkit evaluation interview participants by site

	Number of participants				
Participant Group	***Site 1***	***Site 2***	***Site 3***	***Site 4***	***Total no of participants***
Residents	3	5	4	4	**16**
Aged Care Staff	3	3	2	4	**12**
Lifestyle Coordinators	1	1	1	0	**3**

Residents were selected on the basis of being aged 65 years or over and not experiencing cognitive challenges that would detract from capacity to understand the project requirements or consent. Diversity of CALD groups, genders, length of time in the residential aged care facility and care needs were also sought.

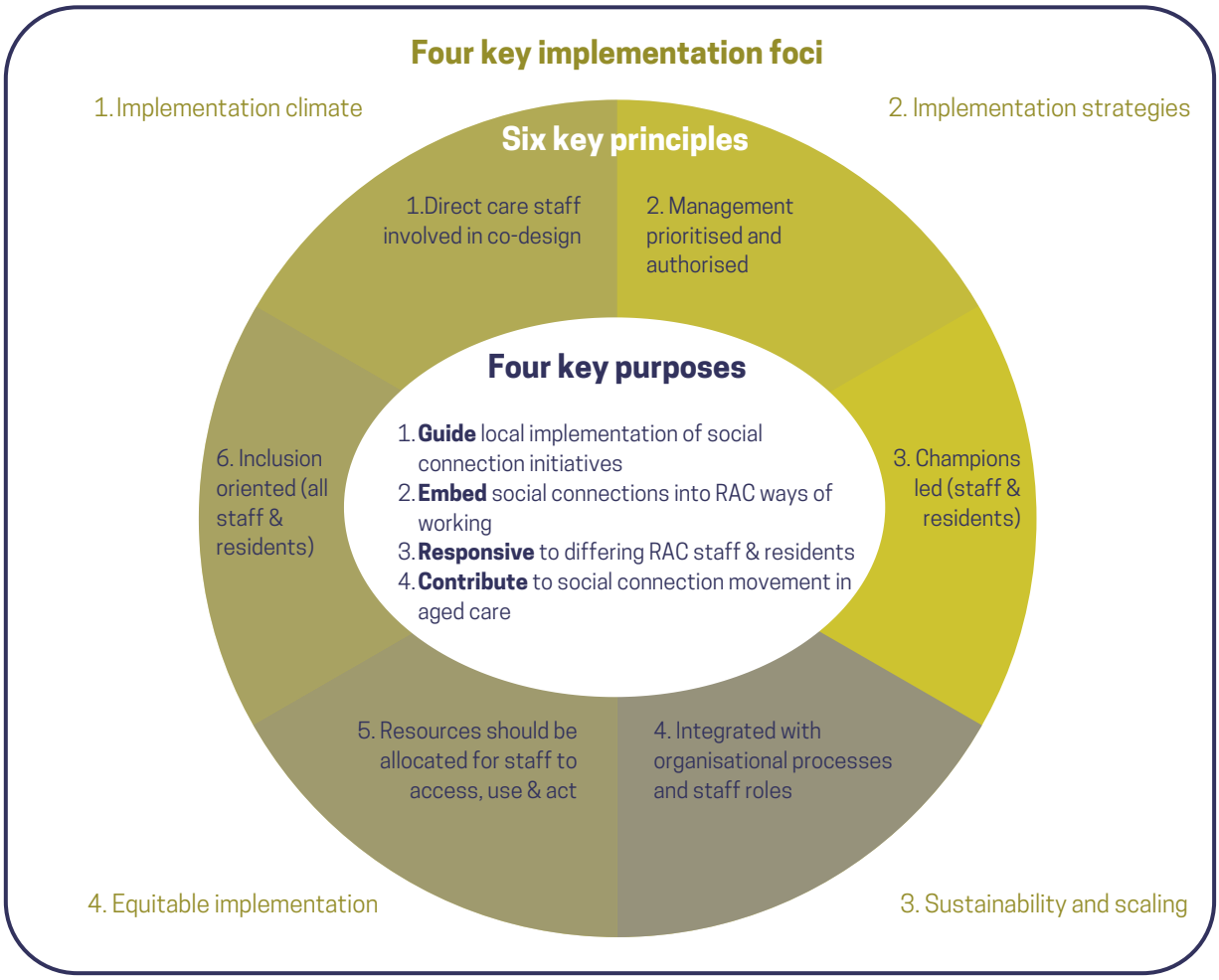
The selection criteria for staff interview participants for the Toolkit evaluation included aged care staff who were in direct care roles, pastoral care roles and lifestyle coordinator roles; who were willing to participate; and were able to meet the time requirements for participating. A broad representation of gender and ethnicity was sought.

The Implementation evaluation outlined in Section 2 of the report involved interviews with 22 RAC staff members including 10 facility managers and 12 lifestyle coordinators. For further details, refer to 'Implementation Evaluation of the Social Connection Toolkit' report available on the www.social-connection.au website.

Further information about the instruments used in the research are available from the Chief Investigator.

Appendix B
Social Connection Initiative Implementation Planning Framework

The Framework was drawn together from analysis of data from the organisational-level implementation evaluation. For the full implementation evaluation report which gives more information about the context and creation of this framework visit the www.social-connection.au website.



Social Connection Initiative Implementation Planning Framework

1.Implementation Climate: refers to staff shared perceptions of the extent to which their use of the innovation (e.g., Toolkit) is rewarded, supported, and expected. Implementation climate is specifically influenced by Implementation leadership – hence increased investment in implementation leadership for Social Connection initiatives is required.

2.Implementation Strategies: refers to HOW TO enhance the adoption, implementation, and sustainability of Social Connection initiatives in aged care. Multiple implementation strategies (Implementation process; Dissemination; Integration; Capacity building and Scale up) are required to address key implementation challenges for implementing social connection initiatives in RAC.

3. Implementation Sustainability and Scalability: given the investment in the Toolkit's implementation and future social connection initiatives in RAC – we focus on Scalability – and draw upon the growing evidence base that the process of scaling social innovations to achieve systemic impacts involves a combination of three key types of scaling: Scaling out - spreading the initiatives to more RAC facilities, staff and residents via knowledge dissemination; Scaling up - changing RAC facility policies and procedures to facilitate social change efforts in RAC via policy development and advocacy; and Scaling deep - changing relationships, culture, values, beliefs and ways of working within RAC via networks & communities of practices.

4. Equitable Implementation: defined as an explicit and intentional integration of implementation science and equity that attends to what is being delivered, for whom, and under what conditions, and how delivery should be tailored to best meet the needs of the focus population. To avoid perpetuating inequities, equity needs actions at both the 'What' (Social Connection Interventions') and the 'How' (RAC Implementation context) for any future social connection initiatives in RAC or broader aged care settings.

CONTACT

Professor Jane Farmer
Chief Investigator
Professor of Health & Social Innovation
Centre for Transformative Innovation
Swinburne University of Technology

Email: jcfarmer@swin.edu.au
Web: www.social-connection.au (for E-learning modules and a Community of Practice discussion of the Toolkit with Jasmine Knox and Edwina Gow)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