

Research Article

Education Program Delivered to Community Aged Care Employees Based on a Diversity Conceptual Model: A Preliminary Evaluation Using Qualitative Methods

J Michael¹, V McDonald², R Ogrin¹, J Fraser², T Roysmith², K Harvey¹

¹Royal District Nursing Service Group, 31 Alma Rd, StKilda, 3182, Victoria, Australia

²Diversicare, 49-51 Thomas Street, West End, 4114, Queensland, Australia

ABSTRACT

Introduction: Increasingly, community aged care employees need to respond to multiple aspects of diversity to meet the care needs of older community members. Guidance to incorporate diversity into workplace education is an unmet need.

Materials and methods: A diversity education program was developed for the Australian context, based on a Diversity Conceptual Model. A focus group and semi-structured interviews were undertaken, after the diversity education was delivered, to

explore participants' thoughts and experiences of the education and its impact on their practice. Data analysis was based on grounded theory, using constant comparison method.

Results and conclusion: The diversity education positively influenced knowledge, built on participants' skill, and influenced participants' care practice.

Keywords: Aged care; Diversity; Diversity conceptual model; Policy; Workforce education

Introduction

Background

Australians enjoy the highest levels of health and wellbeing in the world¹. The life expectancy of Australians is 79.5 years for males and 84 years for females, and 82% of Australians are satisfied with their quality of life.¹

However, there are subgroups within Australia's population that have significantly poorer health and wellbeing compared to the rest of nation. For example, almost half (46%) of people with a disability report poor or fair health compared to 5% people without a disability.¹ The life expectancy of Aboriginal and Torres Strait Islander people is 12 years shorter than other Australians¹. People who are socioeconomically disadvantaged are twice as likely as those who are least disadvantaged to have a long-term health condition.² People providing informal care are more likely to live in low income households (26%) compared to non-carers (15%), have lower participation in the labour force (54% versus 79% of non-carers), and report high rates of disability themselves.³ The low levels of health literacy in Australia—59% of Australians assessed at having below the minimum standard of health literacy; a figure that increases to 83% for Australian's aged 65 to 74 years—also influences how successfully one can interact with the healthcare system and manage their health.⁴ More broadly, the heightened physical and mental health risks for people from lesbian, gay, bisexual, transgender and intersex (LGBTI) communities and lower rates of accessing healthcare are being increasingly acknowledged as a major driver of inequity amongst Australians⁵. These findings identify some of the range of characteristics that are associated with health disadvantages and inequities for some Australians.

Person-centred care is pivotal to the provision of community

aged care services in Australia in order to meet the needs of older community members⁶. To provide person-centred care, we must consider all of the diversity characteristics that may impact the ability of individuals to access care that addresses their needs⁷. A diversity characteristic refers to an individual or population group characteristic such as a condition or situation that can make it difficult for a consumer or a group of consumers to participate in their healthcare and wellbeing⁷.

Much work has been undertaken to increase the understanding of employees on individual diversity characteristics of the older community members they work with, mostly in the transcultural and education fields⁸⁻¹⁷. By increasing understanding, it is thought that employees would be better able to identify the needs of older individuals, facilitating improved access to appropriate services, and thereby lead to improved wellbeing^{8,18,19}. However, individuals rarely comprise of one diversity characteristic alone²⁰. Instead, individuals are a medley of diversity characteristics, and as such, employee education in the workplace that considers individuals through the lens of one diversity characteristic no longer adequately reflects the individual needs of older community members²¹. As such, employees need to be equipped with the necessary knowledge and skills to consider all diversity characteristics of an individual. Workplace education that addresses diversity more broadly will help aged care businesses and their employees to consider the multiple needs of individuals in a holistic way; and support greater participation of older people in their care, thereby leading to improved wellbeing⁷.

Whilst the focus on diversity is in its infancy, much can be gained from efforts directed at overcoming barriers in access and equity to aged care, most notably derived from the cultural competence and transcultural field. Systematic reviews have

been published on the effectiveness of cultural competency training, with the strongest evidence of a positive effect on the following points: cultural competence programs improve provider knowledge^{8,9}, awareness⁸, cultural sensitivity⁸, cultural self-efficacy⁹ and skills, mostly commonly represented as communication skills⁹. Client satisfaction is heightened in response to health practitioner participation in these programs⁹. Cultural competency education programs have been shown to have a positive effect on individuals' outcomes such as health status⁸ and treatment adherence⁹. There is lower level evidence linking higher trust and perceived respect and dignity by providers with improved adherence to medical regimens¹⁸ and health care satisfaction with more continuous health care, treatment adherence and better health¹⁹.

To date, no research has been undertaken to assess the impact of workplace diversity education and training for community aged care employees, nor on the older community members in their care. To better understand the complexity of diversity and diversity characteristics, the Diversity Conceptual Model was developed as a visual tool that aims to assist aged care employees to think, understand and solve problems associated with individual and population diversity and possible associations with disadvantage in policy and care practices. It's development is described in another publication⁷.

This paper describes the development, delivery and qualitative evaluation of diversity education underpinned by a Diversity Conceptual Model to community aged care employees from three aged care businesses in Queensland and Victoria.

Aim

The study aims were to evaluate the perceptions of community aged care workers receiving the diversity:

1. Their understanding of diversity, and
2. The application of new diversity knowledge and skills into practice.

Materials

Development of the diversity education

The development of the diversity education program involved professional educators from two aged care organisations. An existing diversity training program, based on a Diversity Conceptual Model, already in use by one of the organisations was refined and developed into an electronic interactive Diversity Education program, entitled 'Working with Diversity in Health and Aged Care'.

Diversity conceptual model

Diversity education resources developed for this study are based on a Diversity Conceptual Model. The visual Model provides practical guidance to support aged care businesses to understand and resolve problems associated with diversity and associated benefit or disadvantage in policy and practice⁷. As shown in Figure 1, the Diversity Conceptual Model is a visual circular tool within which 28 diversity characteristics are articulated to act as prompts to aged care employees. The



Figure 1: The diversity conceptual model contains 28 diversity characteristics to prompt employees to think about all the diversity characteristics of an individual.

central diversity characteristic is cultural group (self-identity) and 27 other diversity characteristics are presented that are common to and shared by older people. The model encourages a focus on all diversity characteristics,⁷ that may be creating benefit or disadvantage for a consumer in participating in their health care⁷. Client narratives are used together with the (DCM) to support concept learning for the aged care workforce. This can help aged care employees to identify, understand and classify an individual's diversity characteristics which can be critically analysed for connection and disadvantage and applied to assessment, care planning and service delivery practices⁷.

Blooms²² increasing complexity of knowledge acquisition and skill development informed the development of the education program to be delivered to employees in two levels. Level one, an introduction level, was delivered over 45 min and involved the introduction of new diversity concepts such as the DCM, Diversity, Diversity Characteristics, the identification of diversity characteristics based on a client narrative using the DCM and a description of some organisation good practice samples that support equity in policy. Level two, an advanced level, was delivered over 90 min and involved using the constructs of Campinha-Bacote's cultural competence theory²³ including: cultural awareness, cultural encounters, cultural knowledge, cultural skill and cultural desire, for participants to identify appropriate ways for engaging with consumers to critically analyse methods for assessing areas of health and wellbeing as illustrated in a given client narrative. A range of teaching and learning methodologies were used based on Knowles adult learning theory²⁴ such as, direct instruction, activities using individual, pair and group work, real life client narratives and sharing of experiences by participants.

Delivery of the diversity education program

Delivery of the diversity education program occurred in three different service settings of two different businesses:

1. **Diversicare:** is the Community Services division of the Ethnic Communities Council of Queensland delivering services to aged and disabled people predominantly from culturally and linguistically diverse backgrounds. Diversicare also provides information and education services through the Multicultural Advisory Service and Partners in Culturally Appropriate Care. Diversicare employs over 230 employees and has nearly 2000 clients from diverse (Qld Aged Care).
2. **RDNS (Royal District Nursing Service)** is an aged care business providing nursing, Home Care Packages and domestic and personal care in Victoria (Vic Home Care) and across Australia through its subsidiary company RDNS HomeCare. Employees from the RDNS HomeCare Queensland service participated in this study (QLD Home Care). RDNS employs over 2,500 employees across Australia, including Registered nurses, Enrolled nurses and personal care workers. During the last financial year, 2.7 million home visits were made to over 100,000 clients.

The diversity education program was delivered by one facilitator to 43 participants from the three service settings as four separate education sessions to cater for locations and

number of participants.

Methods

Research design

This was a qualitative study guided by Elliot and Timulak's interpretive description technique²⁵.

Sample

All attendees of the diversity education were invited to participate in the evaluation. The employees within these businesses consisted of predominantly a female workforce. Staff from the Victorian and Qld Home Care organisations were predominantly of Anglo-Australian background. The Queensland Home Care organisation staff predominantly included people from culturally and linguistically diverse backgrounds.

Recruitment

Employees were invited to participate in the education sessions through existing dissemination methods of the three businesses including emails to employees and promotion on the intranets of the workplaces involved. The education was provided free of charge and at a time and location convenient to employees. All attendees of the diversity education were verbally invited to participate in the evaluation at the end of each education session by the facilitator, with written information about the evaluation handed out. Further invitations were sent via emails disseminated by each workplace.

Ethics approval was obtained from the relevant human research ethics committee, and each participant provided written consent.

Data collection

Evaluation was to include four semi-structured focus groups at one month after education, to identify early impact of education on participants, with a follow up interview of participants at three months after the education (method structure shown in Table 1). This would contribute to understanding of how long it might take participants to embed diversity principles in practice, an unknown factor²⁶, while working within the constraints of the 12 month project timeline.

An experienced Ph.D. qualified female qualitative researcher who had no relationship with the interviewees undertook the focus groups and interviews. Participants were advised that the interviews were to ascertain the key issues and factors related to diversity education and its impact on knowledge and practice, with the focus group and interview guide created to achieve this.

RESULTS

Sample

Of the 43 attendees of the education, eleven (26%) consented to participate in the evaluation, see for detailed information on the methods and the number of participants engaged in the evaluation. Participant aspects are further discussed (Table 1).

All participants were female and six were born overseas.

Table 1: Focus group and interview schedule and structure post diversity education.

Timing	Qualitative method	Participant Number	Method of data collection	Organisation
Within 6 weeks after diversity education	Focus Group	3	Face to face at their work place	3 Vic Home care
	Interview	5	Face to face at their work place	2 Vic Home care 3 Qld Aged care
Within 14 weeks after diversity education	Interview	6	Telephone	3 Qld Aged Care 2 Qld Home care

Five participants worked as registered nurses, three as enrolled nurses and three as domestic and personal care workers. All participants considered themselves to have an extensive amount of experience working within the community aged care sector.

Analysis

The focus group and interviews were conducted in English, audiotaped and independently transcribed verbatim. An author checked the transcript for accuracy against the recording.

The focus group duration was for 60 min and interviews ranged from 22 min to 56 min, with an average of 36 min overall. Timing was longer in the earlier interviews (mean 43 min); with follow up interviews being shorter (mean 31 min).

Data analysis was managed manually with electronic and hard copy manuscripts. Three researchers read the transcripts separately and divided the data into distinctive meaning units²⁵. The three researchers then met face to face and collectively organised the data into domains, followed by categorising the meaning units within each of the domains into which they had been organised²⁵. This involved a constant comparison of meaning to each other and to the emerging categories, until all the data were sorted. The categories were then themselves categorised and relationships between the categories was described²⁵. Differences in categorisation, where evident, were resolved by consensus.

Given the small number of participants in the evaluation, and as the focus group and interview questions were focussed, the focus group and interview data were merged.

Qualitative analysis

Three major themes were identified, from the participants' responses relating to the impact of the diversity education on attendees: improved knowledge of diversity, building on skills and changed care practices.

Improved knowledge

a) Diversity defined

Participants stated that the diversity education changed their thoughts regarding what diversity means to them.

'I'm surprised you know. Diversity...cover so many areas. Not just different language but you know like lesbian people [and] disability.' QLD Aged Care 6 weeks #2

b) Raised awareness

A major theme underpinning all of the participants' responses was the increase in awareness of diversity as a result

of the education.

'I'm walking in to a new residence looking for cues, already got that radar going for anything that maybe relates to the characteristics. That maybe you should address, or leave alone, or be observant of.' QLD Home Care #1

Built on skills

Participants conveyed that they gained new skills as a result of the diversity education, which helped them to apply diversity principles into practice. This included using conversation to draw information from community members, and adapting the conversation so that it is more positive and leads to better interactions.

a. Using conversation was seen by participants as a better way to elicit information and history from the individual, rather than formally going through specific questions from a list. Conversation was used as a way to build rapport and reduce the intrusiveness of the care provider.

'You have the general conversation and well you know which questions you have to focus on but do it in a conversation type of way...so you can build a rapport' VIC Focus group #3

b. Listening to what the person is saying and acting on it rather than doing what the care worker thinks is best for the individual was identified as a key skill to support older individuals with diverse needs.

I more listen to - and also their environment or so more sensitive, more listening to whatever is there, in every sense in front of me, rather than just concentrate on...the regular things and just think everyone is quite similar... VIC Home Care 14 weeks #1

It also included active listening, even if the participants didn't agree with the choices made by older people, the act of listening was identified as being important to better support older community member's needs.

'I just listen to him, what he - he need someone come and listen to him...For him, someone that listen to him, understand him. While I report back to my corner to work, I'm listening...I'm not allowed to have some advice or whatever, because that is his own choice. I just, yeah, okay I understand.' QLD Aged Care 14 weeks #2

c. Observation Participants expressed they were able to increase their capacity to observe the homes of individuals, and this allowed them to increase their ability to recognise what was important to their clients. This included how the house was set up, to personal objects

and aspects that provide clues to client's personalities and preferences. This was a supplement to the verbal and listening communication techniques.

'I think one particular one which I did but I wasn't aware of is things like going into someone's house and seeing their photos and getting a sense of who they are through the photos before we actually go any further.' Vic focus group

d. Don't judge the individual's decisions about how they wish to live better lives.

Participants began to realise that their client's lives involved more than following clinical guidelines and thereby the need to not impose their own value judgements. It involved the client making their care decision based on what is more important to them and their circumstances. This understanding led to participants withholding their value judgement on the decisions their clients made.

'Before that [diversity training] I think, oh, that man crazy... Why he make that choice. But now, I understand that's his choice, that's his decision' QLD Aged Care 14 weeks #2

Changed care practices

The understanding of the broader concept of diversity led participants to understand that the only reason they are going to peoples' homes is to help in the way they wish to be helped

'I think in a general kind of way, it makes you slow down and think of the bigger picture. So sometimes we have to go in there for medications or hygiene and the client isn't complying with it. It's just there's something not right and we can't do [that task] - and they're focusing on something else, so sometimes you have to actually go with that focus, what they're focusing on, so that you can resolve that and then get back to what you actually need to do... I can see how it's helping.' VIC focus group #4

While many participants expressed that the education helped them improve their awareness and increased their understanding of individuals' lives, the examples provided regarding the impact on their work practices were few.

'...if you've got that client you still are provide a service for them. You couldn't say no, I'm female; I'm not going to shower for a male. I'm not going to do that for the lesbian or gay whatsoever. Diversity means you provide service for every people. You don't judge people for the outside, where they come from, their male or female or whatsoever...' QLD Aged Care 6 weeks #2

Further, for one participant, this raise in awareness of the broader concept of diversity was overwhelming as there were so many things to consider.

'... [DCM], really big, really really big [concept, with] so many characteristics, so many' QLD Aged Care 6 weeks #2

a) Use of the diversity conceptual model

Overall participants agreed that the DCM is a tool to prompt employees to understand and look for characteristics that may be creating or contributing to disadvantage for older community members and impacting on care delivery.

'I think that the breakdown into the diversity characteristics

that we were given, and those extra ones we think of ourselves, they put the meaning into the work we do and gives us an idea on where we're going and what we need to address and what we may not have been aware of.' Qld Home Care #1

b) Education content

Overall, participants perceived the strength of the diversity education program was being able to share experiences with others. Going through the case studies while using the DCM tool was also found to be very useful.

'...each group did a different case study and so then it was interesting to listen to the other groups and what they had identified in their case study.' VIC Home Care 3 month #4

Participants suggested that diversity education be provided to all staff as part of their orientation. Further, they considered that staff needs regular refreshers, to continue to learn about the topic, particularly as the community is evolving and diversity is expanding.

'Anyone who works out there in the community [should consider doing the diversity education]. It would assist them to make those initial engagements meaningful, productive first up' Qld Homecare 6 weeks #1

'I think it can be more ongoing with the individual characteristics being updated or brought to light as changes occur.' Qld Homecare 6 weeks #1

Discussion

Diversity education underpinned by a Diversity Conceptual Model was developed and delivered to community aged care employees. Their participation in this education positively influenced their knowledge, skills and practices.

Our results confirm previous findings from the cultural competence and transcultural field, which showed a positive effect of cultural competency training on provider knowledge^{8,9}, awareness⁸, cultural sensitivity⁸, cultural self-efficacy⁹ and skills, mostly commonly represented as communication skills⁹. The aged care employees who participated in the study felt a positive influence of the diversity education on their knowledge through awareness, and greater understanding of diversity. They also built on their skills of observation and communication through conversations, rather than questions, as well as listening. This led to participants in our study to change their care practices by engaging in activities that considered the needs of the person for whom they were caring.

Diversity is about what makes a person unique and different and includes identity, life experience and beliefs. At the same time it is about the shared characteristics and values that connect a person to groups and communities⁷. Given that individuals are more complex and are not defined by their gender or cultural background alone, education to facilitate community aged care employees becoming more aware of the multiple aspects of diversity is necessary. The aim of the education is to reduce bias and prejudice while increasing the capacity of employees to more appropriately interact with community members who have a variety of characteristics in order to improve care delivery²⁶. This preliminary work identifies the positive

response of the attendees to the broader concepts of diversity and the increased complexity within the community members they serve. Diversity education and training has been studied in the fields of business management, health, sociology and education, however community aged care is a new field. To date, the community aged care sector has undertaken extensive work in certain diversity fields such as culture^{27,28} and LGBTI²⁹. However, these diversity characteristics have been treated as separate characteristics when some community members may in fact have a background of both a different culture and be gay, and likely additional diversity characteristics that make them who they are. Individuals are complex and it has become increasingly clear that simply viewing individuals from one lens is inadequate: workplace education and training needs to consider all aspects that make up an individual to be able to understand their needs fully. The diversity education provided here endeavoured to build the knowledge and skills for community aged care employees to understand the concept of diversity. In this way, community aged care employees were encouraged to see the individual as a whole, rather than through one diversity characteristic lens.

Additional research is required to confirm the findings of this project with a larger number of participants. Further, evaluation is needed to ascertain whether diversity education has measureable benefits for knowledge, skills and practice, and how care delivered by employees participating in the education impacts on the individuals receiving the care.

While it was outside the scope of this study, there is a need to consider an organisation-wide approach to diversity, so that all employees consider diversity as part of their work⁷.

Limitations

This evaluation included 11 (26%) participants in total, across three business settings. The responses of participants may not be reflective of all of those who attended the diversity education or of the workforce at their respective businesses. The education was voluntary, and those who attended may have been positively biased to include only those who have an interest or who had deficits in this area. Despite having funding to provide time for participants to be involved in focus groups, there was great difficulty to find employees willing to take the time away from care delivery to engage in these interviews and focus groups. Given the sensitivities of the broader diversity subject, participation in the evaluation may have been impacted by specific biases of the workforce. The addition of an option of an anonymous questionnaire may have exposed some potential biases. Appropriate evaluation methods to adequately engage the aged care workforce needs further study. Those that attended may have been particularly affected by the Diversity Conceptual Model education.

In addition, for some employees, English was not their first language, and this made conveying of the complex concepts to the interviewer more challenging. The interviewer worked with the participants to draw from them the meaning that they were expressing in terms all could understand. Given that all employees had at least certificate III training, the researchers assumed that all employees had strong English language skills, sufficient to convey their experiences of the

education. Participation and communication of the complex themes involved in this project may have been improved had professional interpreters been offered and used.

Conclusion

Participants of diversity education gained recognition that diversity is a broader concept than gender and culture. The Diversity Conceptual Model tool facilitates employees to recognise additional aspects of individuals' lives that impact on their ability to access and participate in their healthcare and achieve wellbeing. Although some examples where diversity education changed work practice were identified, participants stated that they felt it changed their attitudes.

More work is required to assess whether there was a quantitative impact on the knowledge, skills and practice of participants who attended the diversity education program, and whether equity of access to care for older consumers improved when they were seen by aged care employees who undertook diversity education.

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ADDRESS FOR CORRESPONDENCE

Jaklina Michael, RDNS (Royal District Nursing Service) Group,
31 Alma Rd, StKilda, Vic, 3182, Australia, Tel: 0410561068;
E-mail: jmichael@rdns.com.au

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