AGEING WELL:
NEGOTIATING LEARNING IN AGED CARE FACILITIES

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1. Introduction

 This pilot project investigates ways staff in aged care facilities (ACFs: formerly referred to as nursing homes and hostels) learn in their workplace. It was funded by a University of Melbourne *Special Initiative Grant*. The researchers come from different paradigms: the qualitatively-informed Education tradition, and the quantitatively-informed Medical model. Yet this is simplistic, since all three share a professional interest and expertise in experiential and particularly problem-based learning (as used in Newcastle and McMaster Universities). The project team has three major areas of relevant expertise: geriatric medicine, clinical epidemiology and medical education (Darzins); adult education (Beckett) and professional development/training (Gough). The aim of this research is to gain an understanding of the factors that influence the learning needs of staff in ACFs and whether workplace learning is possible in these settings.

We report on the project to date, particularly on the negotiation of the research. We illustrate the enactment of these negotiations in two of the six ACFs with which the project team is most involved.

2. Background: Educating Cinderella

Cinderella has featured in the emergence of adult learning on the stage of Australian education policies. Many share the hope that the time is nigh for Vocational Education and Training (VET), the 'upstairs' high-profile player on the stage, to be genuinely influenced by the 'downstairs' low-profile understudy, adult and community education (Come In Cinderella 1991; Beckett 1993; Beyond Cinderella 1997). ACFs are community-based, but unlike neighbourhood houses or local learning centres, they are not voluntaristic, nor are they ostensibly sites of learning. Yet the need to address learning needs within ACFs is increasingly urgent.

In the reformed Federal aged care policy arena, there is a new emphasis on the quality of care provided by ACFs. An acceleration of demand for accommodation as the baby-boomer demographic heads into the so-called 'Third' and 'Fourth' Ages (Hurworth and Crombie 1995) is anticipated. Community anxiety about the ACFs and Federal funding contributed to policy reformulations during 1998. Aged care policy was prominent during the Federal election campaign, In several 'crisis' stories, *The Age* Insight team provided an expose of an 'increasing number of nursing homes...plagued by serious deficiencies' (The Age 1998; p1).

This paper is not about the prospects of Cinderella going to the ball. At least Cinderella looked forward to a glamorous future. There is nothing glamorous about most ACFs. Our research centres, not upon the residents of an ACF, but upon the staff.

Nevertheless, while our paper does not concern the needs of residents in ACFs, this is a vast and under-recognised field, with connections to health and well-being yet to be explored. It may be the greatest policy challenge facing governments in the Western world as their populations age, and the costs to the public purse of health care and a declining revenue base collide. Here the rhetoric on 'lifelong learning' gains a poignancy not even the Cinderella of adult and community education has yet come to terms with. Cinderella does, after all, have her whole life in front of her. Aged care has, by contrast, an image problem. Experts in the field have recently stated (*Education and Ageing* 1998; p9), in reviewing UK lifelong learning policy:

> Later life is only associated with conditions of ill-health, dependency, frailty, poverty and lack of dignity. There is nothing about the freedom, activity, challenges, altruism and positive contributions to society which characterise the lives of many older people, and which, while being in themselves educational, also call for support from a national learning culture.

Given the above aged care and lifelong learning policies' nexus, more than ever before, the adult learning - the 'professional development' really - of the regulated, unregulated and managerial staff within both nursing homes and hostels across Australia should be a priority. Yet perceptions of unglamorous contexts, and unglamorous work, tend to render invisible the learning needs of such workers.

Who are the workers in an ACF? The profile is shaped not only by nursing (both Division 1, traditionally known as Registered Nurses, and Division 2, traditionally Enrolled Nurses), but also by health care work of widening variety: physio- and other therapies, welfare and other agencies, and a growing number of 'patient care attendants' (PCAs), 'nursing assistants', and the like. Various stages of residents' medical dependency necessitate 24 hour care (especially the high dependency of the 'nursing home'), so shift work is a feature, and so is the part-time, female composition of the workforce. Clearly the nursing/non-nursing divide is up for re-negotiation as patient care attendants take up some of the jobs which ENs and many RNs would traditionally have done. In some low-care ACFs these 'unregulated workers' provide the whole workforce, but in others none are employed at all. All of these aspects require managing and leadership (especially with heightened public expectations and media attention, and with accountability to regulatory bodies). Sophisticated local capabilities are much in demand but are often lacking, and 'directors of nursing' are expected to meet this demand.

Nurses and allied health professionals have a strong initial and evolving post-initial raft of professionalised, credentialled and registration requirements. However, in the area of continuing professional education, gerontic nursing is not well served. . Recent innovations for PCAs include TAFE and Australian Nursing Federation courses. Some tertiary graduate diplomas also target ACFs as generic workplaces. Despite this, little formal education or training is available for most of this part-time, female workforce. Indeed, most of those who are not nurses or allied health professionals have little formal qualifications, but may have years of experience. Low levels of literacy are common. Yet these women who work 'down-stairs' are now expected to adapt to local and national versions of new, higher community expectations.

3. Negotiating Workplace Research

Since 1995, the National Ageing Research Institute (NARI) (an affiliate of The University of Melbourne) in collaboration with the North West Hospital (NWH) in Royal Park, has conducted a seminar series for health care professionals working with older people. This program has provided insights into the conduct of continuing education in the aged care field. The approach so far appears to be marked by:

➢ what is *ad hoc* rather than planned;
➢ little attention being given to on-site/off-site transfer of education;
➢ involvement by clinicians (eg medical practitioners, nurses, allied health professionals, psychologists, social workers, research scientists);
➢ cursory attention to contemporary adult learning theory and practice;
➢ insufficient awareness of vocational pathways or of accreditation ;
➢ no basis in known learning or specific clinical practice needs;
➢ little effective use of contemporary educational/communication technologies or contemporary professional practice structures such as competence .

The aged care sector comprises a large number of small facilities (many with fewer than 20 staff) where education and training expertise rarely exists. Like most small businesses (Karpin 1995), individual ACFs require assistance to analyse education and training needs, explore optional solutions, and design and evaluate effective educational opportunities. Facility managers are beginning to seek assistance from education and training providers to design effective educational interventions. The new regulatory environment makes this an imperative. Twelve ACFs in the inner northern and western suburbs of Melbourne were identified from the larger number with which NARI has contact, covering both those with hostel and nursing home orientation. Six of those twelve form a Control group; six comprise the Intervention group. A questionnaire was devised to survey the formal and informal education and training experiences of up to about ten staff in each of the twelve ACFs, when the Project commenced. There is a follow-up questionnaire for the same staff when the Project

concludes. Combining this data with observational and conversational data, we want to ascertain how the intervention described below made a difference to the staff in the latter six ACFs, compared to the Control group of ACFs where there was no intervention. Since August 1998, we have been working with the six ACFs in this Intervention group as follows:

➢ At a meeting at NARI we invited the six ACF managers to consider some practical ways they can encourage their staff and themselves to take 'workplace learning' on board;

➢ We encouraged those managers to take these ideas back to their own workplace, and develop a modest 'on-site' staff development plan, in consultation with key staff and ourselves;

➢ We facilitated the implementation of these site-based plans, concluding towards the end of 1998, whereby we met with each of the local learning groups (ie. at each ACF) regularly, to monitor and assist with the implementation of the learning plans, identify and record progress, observe and report impediments and successes, assist with problem solving as appropriate, and to ensure deadlines can be met. (This work is now concluding)

We will evaluate this approach early in 1999 to find out if our approach is feasible in other, similar workplaces, giving attention to the learning needs of different groups of staff and managers, criteria for selection of appropriate learning solutions, and recommendations for structure, implementation and evaluation of learning plans. What was crucial in this sequence was the emphasis on the 'ownership' of the local learning need for each ACF, and the structuring of that need as a workplace 'problem', which all relevant staff could identify with. In this way we wanted to redress some of the difficulties in workplace learning listed above arising from NARI activities with ACFs since 1995, and which have been discussed more generally in VET scholarship in recent years (eg. Beckett and Hager 1998, Boud and Garrick 1999). Negotiation took place at each of the six sites, involving between 8-12 staff and the ACF's manager or representative, and one of us, so that the learning plan had relevant content for that site. What follows are two examples from the range of six negotiated local learning plans. Both plans are, we believe, process-driven, because they are shaped by the opportunities, constraints and contingencies of the specific workplace itself, even although, of course, the larger policy context outlined earlier, and NARI's own experiences, shape the very need for such workplace learning in the first place.

TWO EXAMPLES OF SUCH LEARNING PLANS WERE:

Title: "Improving the Management of Residents with Dementia"

Workplace Problem

Challenging behaviours amongst the residents in the dementia unit at Pleasantville (pseud.) require a sharing of staff experience in addressing these behaviours. This is difficult when staff work patterns (shifts and other responsibilities) engage individual resident behaviour patterns in many different times and ways.

Learning Needs to be Addressed

Communication skills (inc both initial documentation and verbal discussion between staff)

Teamwork in analysing 'critical incidents'

Reporting of implementation of responses to such 'incidents'

Format and Structure

Unit staff to meet fortnightly (Wednesdays at 2 pm, which is as much as possible a common time), outside the unit, with DB as facilitator.

On the alternate Wednesdays, each staff member to meet with her 'pair' to swap experiences of any challenging behaviours in the preceding few days, and what was done to address these at the times these arose. Each 'pair' to collect brief notes about such incidents and table a verbal report each fortnight with the unit staff as a team. DB to record these discussions.

Two months of this structure, then an evaluation, and summary of workplace learning.

> **Title**: "Using Handover to enhance Holistic Care of Individual Residents at Sunnyside Nursing Home"
>
> **Workplace Problem**
>
> Daily 'Handover' from one shift to the next is not efficient: the type and volume of information and the way it is presented often leave untouched important background to or changes in an individual resident's condition or needs.
>
> **Learning Needs to be Addressed**
>
> Researching resident history and current concerns
>
> Presentation of Resident of the Week -volunteer RN Div 2
>
> Facilitating group discussion - volunteer RN Div 1, including record keeping
>
> Responsibility for the project - Charge Nurse (CN)
>
> **Format and Structure**
>
> Wednesday 2.45-3.30 - night shift staff are encouraged to participate, offered extra 30 minutes' pay. Staff attend if they are interested and available
>
> At the conclusion of the 30 min education session, traditional handover takes place for 15 minutes.
>
> The CN maintains a journal during the project
>
> **Evaluation:**
>
> After two months of this structure, an evaluation session to be facilitated by JG to get first hand input from staff involved. A modified nominal group technique will be used, including questions provided by the CN. This evaluation session will include group discussion and suggestions to the management regarding their preference for continuing/discontinuing the sessions. The CN and JG will separately reflect on the management learning as reflected in her journal and as it emerges in the discussion.

4. Enacting the Process

4.1 EPISTEMOLOGICAL ENACTMENT:

"Improving the Management of Residents with Dementia"

Seven staff, both nurses and PCAs, all females, who work in the dementia unit at Pleasantville ACF met with DB regularly. Meetings #1 and #2 were mainly involved with sharing experiences with certain residents, but across meetings #3, #4 and #5, the adult learning perspective was made more explicit. Consider these notes, taken by DB, and verified by those seven staff.

Meeting #3 Oct 7 1998

Resident B***
Update: Barbara: B***** has been hospitalised with a broken femur. Maree visited her - drinking with syringe etc, and with family support at meal times. Susan: not on IV now

Resident C**
Update: Judith: C**** back from hospital 30 mins ago (Susan: quite dopey too) - balance problems, some aggression. B and S both astonished to see her returned so soon - medical matters still present

Resident B*

Update: Judith: goes to bed fully-dressed. Marj: B*** required full change of clothes this morning. S: use a lip-plate for lunch, some wandering the unit. Marj: agreed - moves furniture, 'dusts', B. better at night now, and S agreed, as B*** heads straight for toilet in the morning, yet today's incontinence is less typical. Maree and Marjery agree recognition is quite good. S: hairdresser return trip is significant - sees the door! J and Marjery agree that patterning B***'s days is difficult

Resident M*

Update: Barb: the medical advice was to 'modify' the TLC, and change the medication. J: still weepy, even howling. B wondered if M*** liked being a resident. M noted M*** can shower OK, reluctant to come in the door (can see reflection?). J: noted M*** strong on teeth-cleaning. S wondered if there was a lot of frustrated communication there, B wondering if a firmer line was called for.

General points to emerge in discussion agreed on by participating staff:

1. Changes in staffing, and family visits (etc) are significant for these residents: they may see these as 'interference' with their lives - there's an ownership tension always present for them.

2. Its essential to have a wide range/repertoire of responses to engage 'challenging behaviours' - must constantly try out things, since across the 24 hrs and several staff, a resident in this unit will vary in behaviour often dramatically.

3. Hospitalisation turns residents into patients - off-site, they tend to become medical diagnoses, and then are liable to the 'throughput' priorities of a hospital, arriving back at Pleasantville prematurely, and disoriented, and without the prospect of high-level medical care continuing.

➢ Structures and patterns are essential for these residents, but they frequently struggle to re-invent these.

Meeting #4 Oct 21 1998

Resident B****

Update: still hospitalised, and w/listed for a nursing home (S)

Resident C**

Update: (B) aggression, deterioration req a full medical review esp psych aged care assessment (Maree) and possible re-placement: but (B) 'Where do they go …?'

Resident B*

Update: (M) mumbling, incommunicable: 'What on earth is going on?'

(Janice via Maree) toileting problems, some agitation: discussion of continence-related reasons (B, J, S: 'I'm finding….'). Good support from medico, and medication is effective; family back and involved.

Maree: soft food leads to knife on the tongue: 'I think she should have spoon'

(J) 'I provide a spoon for savoury mince'

(M) reversed the utensils to see if that helps

Resident M*

Update: (J) sociable - passed the 'nuts and bolts' around; (L) any medication changes? Very lucid. (B) no changes so far. But J and M: different over the weekend, very teary. (S) She wants to stop in, so 'Go and sit in the lounge…'. Maree: lots of touching, crying: 'If you stop, I'll take you for a walk'. Janice (via Maree): kept occupied folding bin bags, but (L) concentration diminished - only folded two towels.

(Marjery) M*** told B*** to 'shut up' when she was excited!!! (B) medico ordered some medication changes from today.

DB asked staff:
Consider what you do in such 'challenging' situations as the above. Is it:

➢ 'guessing' (WHY is Resident doing this?) OR
➢ 'trying' (WHAT IF we do this?) OR
➢ 'showing' (WHEN we do this…)

Which of these more accurately describes what you find yourself doing?

General points to emerge in discussion, agreed on by participating staff:

➢ 'Trying' (including both now - eg. 'I think she should have spoon' - & going away and trying later) is most apt. This is followed by

➢ 'Guessing' ('What on earth is going on? Inc. looking for other evidence e. g. urine smell). This indicates that

➢ 'Showing' is the least apt (requires the most reflection: staff wouldn't find themselves 'showing' because of the ethical implications eg. bottom-washing has a dignity aspect).

Meeting #5 Nov 4 1998

What do I <u>find myself doing</u> which expresses empathy?
The group then reflected again on their own learning (cf. previous meeting):

Discussion produced agreement that staff 'talk on their [residents'] level' (Maree), which is hard until you get to know residents, and talk in such a way that humours residents: eg. 'I feel good today/you look good today' to start them off, rather than ask 'How are you…?' Staff not likely to get at a resident's condition directly: recognise there's a telling and re-telling of stories, so look for signs of a 'new story' emerging (Barbara). The stories are indications of 'residents' realities' - essential for empathetic staff in dementia units to come to understand.

Analysis

These Pleasantville staff are able to articulate a process of workplace learning shaped by epistemological considerations. In particular, they are able to share their learnings of what works with individual residents' 'challenging behaviours' (or 'hot action': Beckett 1996) within frameworks that are *chronological* (times of the day or night, events like visits and meals), *medical* (dosages, clinical matters, hospitals), *psychosociological* (relationships with staff, families, each other) and so on. Here the goal for the staff is pattern-making and re-making, 'reading' a critical situation or challenging behaviour such that it then can be better understood. This instantiates Dewey's view (in Garrison 1999) that the ends of practical action and judgement emerge in a creative effort to overcome a 'disrupted context' - and a dementia unit is eminently disruptable. These staff, it will be noted, engage in practical reasoning, in attempts to shape stability within the unit. This is fundamentally an Aristotelian epistemology, since it is concerned with the dynamism of means and ends, the respect for practical (as opposed to theoretical) action and for the embodied subject. As history tells us, this confronts much of Western education, with its traditional focus on Platonic epistemology, and by Cartesian ontology.

Yet the fieldwork represented by Pleasantville reveals a deeper analysis. When pressed to identify what they find themselves relying upon in the moments of greatest workplace challenge, the staff opted for 'trying', rather than guessing or showing. Guessing and showing are candidates because they represent, respectively, 'double-loop learning' (hypothesising, or 'what if…) and the artistry of practice. Argyris and Schon, in the late 1970s, and Schon in the 1980s, have advanced these two epistemological considerations as ways to understand organisational and workplace learning - at least for individuals.

But in these more postmodern times, we are attuned to the diversity of voices (or narratives) represented amongst a workforce. How do PCAs and nurses understand their practical workplace challenges? By acknowledging their own sensitivity to the value of empathy, the staff at Pleasantville showed that pattern-making and re-making had a more profound epistemological significance. They do 'try' - but not merely to re-stabilise a situation. Their 'trying' is expressed in discourse (that is, speech, actions, meanings) which invites and elicits residents' own narratives. Caring for the dementing is thus regarded by staff involved as anticipating the need to enter into marginalised discourses, that is, it has an ethical purpose, which is, nonetheless up for re-shaping each day, or rather, each shift.

Here then we see entwined in one profound epistemological enactment not only Aristotelian practical judgments, but also a privileging of what some prominent postmodern adult educators have called the 'local, personal and the particular' (Bryant and Usher 1997).

4.2 ORGANISATIONAL ENACTMENT

"Using Handover to enhance Holistic Care of Individual Residents at Sunnyside Nursing Home"

A small organisation with a traditional hierarchical structure and procedures, Sunnyside Nursing Home highlights the impact of organisational variables on workplace learning as suggested by the Hayton and Loveder model in 1992, cited in Hager (1997 p. 21). The Sunnyside workplace learning project demanded sensitive enactment through a tiny maze of paths and crevasses.

The Agreed Learning Plan

The DoN and CN agreed that an 'education session' would meet for 30 minutes each Wednesday prior to the usual daily Handover, that it would be open to all RNs Div 1 and Div 2, and would be structured around a presentation on a selected 'Resident of the Week'. One volunteer Div 2 would research the resident in the week prior and a discussion would be chaired by a Div 1 volunteer. It will be called an 'education session' to give it equal status with other inservice activities, attendance will be recognised by a NARI Certificate and will be recorded in the staff education records. Participating staff will be paid for the extra 30 minutes beyond their shift.

The Other Learning Plan

The CN was told she had responsibility for the project, as an opportunity for her to take more of a management role in the organisation. Upon my suggestion, she agreed to keep a journal recording her journey in this project, an opportunity for management learning in the context of her work (Beckett in Boud 1998)

The Action On Stage

It was immediately clear that the initial plan to let the site project run without further intervention was not feasible; the first phone conversation indicated that the first session "Went well but ... got off the rails", and had become "bigger" than the DoN intended. The DoN issued a staff memo that delineated the timeframe for the sessions. I became more active in observing the sessions and meeting with the DoN and CN.

The first education session I observed ran smoothly. The volunteer Div2 reading verbatim the many pages of notes she had made about the Resident's history, her needs and suggested a number of strategies. She took 25 of the 30 minutes to give this presentation, no one interrupted or made any attempt to change the way the time was being used. A crammed two minutes of discussion concluded that this was a good holistic picture of the Resident to have drawn, but that the case was so difficult and complex that everything had been tried before in some form, and staff should be comforted that they are doing the best they can do. The presenter was congratulated for her thorough presentation. This seemed to be a passive group, unaccustomed to group process and group decision-making. It was traditional content-focused and "teacher"-centred approach that opened up to discussion which was quite open and crossed the hierarchical divides in information and ideas sharing.

Upon invitation to comment, I suggested that a 5 minute presentation means about 500 words to prepare and I reiterated that the rest of 30 minutes can then be used for discussion, problem-solving and planning for the next session.

The group was basically working as the CN and I had envisaged it, and she and the participants were pleased that the research and presentations were new and good development opportunities for the individual staff.

The Learning Plan was proceeding quietly and productively. Sessions appeared to make more use of the available 30 minutes and discussion across the Div /Div2 divide was constructively approaching solutions to resident care and management issues.

Back Stage

What was going on between the sessions since the early implementation of the project, however, was important.

I arranged that prior to the session with staff I would meet with the DON and CN, a meeting which revealed that. It had been difficult and "cathartic" according to the CN, apparently explosive drama. The content of the very first session had touched some forbidden territory of care and management,

and the staff had assumed that part of the purpose of the workplace learning group was some room to make decisions about the Resident of the week.

A Slice of the Action

Resident of the Week 'Cliff' (pseud.) - The dialogue:

Issues of concern raised: malfunctioning hearing aids, worsening visual impairment, increasing incontinence, arguments with other residents, not attending recreation activities

Agreement to focus on one issue: increasing reclusiveness

Presentation focused on discussion RN had with Cliff in preparation for the session that identified that embarrassment associated with incontinence and visual impairment were the issues affecting his social participation; Cliff suggested things he would like to do that staff agreed can easily be put into place. Staff comments in the evaluation session (see below) imply that without this learning group, the research and the time set aside to look at the whole person of Cliff, his problems and reclusiveness would have lingered unattended to. While in this case it was the RN doing the research and presenting the case, the whole group was involved in listening to the story, suggesting specific strategies and agreeing on implementation and trials

The session is working as a learning group in so far as the picture of the resident as whole person facilitates holistic thinking about the care.

DISCUSSION

➢   "The power of the WBL [work-based learning] approach is that it explicitly integrates organisational learning with individual learning" (ANTA 1996, p18). This project carried the weight of some organisational tensions and in experimenting with something new which ultimately gained staff and management support, the organisation seems to have learned/developed.

➢   Individual learning occurred in the learning sessions, as well as for the managers. Luckily, the learning journal provides a good record of this.

➢   Staff development: the decision the staff had made in the very first session about the management of the Resident was actually implemented after the furore, so they were rewarded for taking the power and initiative.

➢   In addition to the complexity of Sunnyside's workplace culture, the industry is characterised by shifts, part-time employees doing a 'second' job and residents who are always right outside the door for the direct care worker. The learning group contends with the unpredictability of shift changes and relentless resident demands.

➢   The project would have benefited from involvement of the staff in setting the Learning Plan and the arrangements for the Learning Group.

➢   The CN requested assistance with conducting the evaluation session, and provided the questions which she wanted asked:

> *What did you expect to get from the project? Were your expectations met?*

> *Did the sessions have the right focus? If not, what should the focus have been?*

> *What, if anything, has this project revealed about the skills among the staff group and the use of these skills?*

> *Should Sunnyside keep this program of education sessions going? If so, what should change to make it better?*

 I asked questions like:

> *Given that the purpose of the project that the DoN agreed to was: "....", what do you think it has achieved?*

> *What did you learn that you didn't expect to learn?*

What aspect/incident/role did you learn most from?

One staff member's comments on what the project achieved: "Encouraged communication, facilitated teamwork; opportunity for everyone to have input on range of issues; increased awareness that handover needs to be precise and not lose direction"

Another: "Opened lines of communication; various levels of knowledge were valued in the group building a team between the junior and senior staff; less intimidating now:

Yet another: "Staff participate more in the care of the residents and some of the strategies have been implemented and some are working".

And finally: "It gave us an opportunity to generate ideas for interventions when we thought we had tried everything"; "see resident care as a whole now, not just a few items"

This selection of responses (hurriedly gathered in a 20 minute modified nominal group technique) suggests that this workplace learning group, has been a good experience for the staff at Sunnyside and the CN and DoN will most likely sustain it in some form. Workplace learning will probably become part of the structure at Sunnyside, (ANTA, p.18) and will continue to affect the culture and operation of the organisation.

➢   In this project, development of the Key Competencies emerge as one of the most likely enduring outcomes: collecting, analysing and organising information; planning and organising activities; working with others and in teams; solving problems through group processes. The value of the project as identified by the participants in the evaluation session highlights these competencies.

➢   In addition to the frequent cry in the literature (Hager, 1997, ANTA 1996) for management endorsement of workplace learning in particular and staff development generally, workplace learning also requires a 'manager as learning enabler' to smooth the path for the players.

5. Conclusion

There are many barriers to workbased learning in ACFs. These barriers include staff issues, physical plant issues and work-place culture issues.

The staff-related barriers include the fact that the work-force is largely a part-time work-force, there are low literacy levels, and there is a wide-spread perception that the job consists of "menial" physical tasks rather than tasks that require content knowledge, thought and reflection. There is no tradition of ongoing continuing professional education among the staff of ACFs and there are no opinion leader role models of ongoing professional education. It is also possible that the jobs themselves have a relatively low importance beyond the income they provide to the staff of ACFs. The work in ACFs may just be convenient ways of earning income rather than vehicles whereby staff attain self actualisation, which they seek and obtain in different venues eg in their roles in their family or in other social organisations. At a personal level there may be many disincentives to ongoing education. For example, the PCA who misses shifts to attend off-site education sessions will lose pay and will incur expenses (cost of the seminar registration) and will not gain any additional pay for the effort expended or improved skills or knowledge.

The physical plant issues that hinder continuing professional education in ACFs include such problems as the lack of a designated staff room, the paucity of up to date health-care text-books or educational videos (if any) that the staff could access. Furthermore, there is rarely an area that is obviously purpose built or at least designed to accommodate education in small groups (eg has blackboard or whiteboard, screen for overhead projector (OHP) or has the electronic equipment commonly used for education eg OHP and a television and video tape player. Needless to say in these environments where even the most basic of teaching and learning resources are seldom found, more advanced potential information sources such as current subscription nursing and gerontology journals (as opposed to "throw-away" journals) and internet access via computer is hardly ever available.

There are many work-place culture issues that hinder ongoing continuing professional education. These include the absence of professional requirement for maintenance of professional competence among the least trained of the ACF health care staff (eg cooks, cleaners, bed makers, and personal care attendants). Even among the more educated staff (enrolled and registered nurses) there is negligible requirement for demonstrated maintenance of competence. There is no clear reward for

additional mastery. Indeed in work places where there is little apparent intellectual aspect to the work, individuals who undertake further education may be ostracised by their colleagues. In this work force there is little to "trade" other than physical work - information has little apparent value. For most groups, there are no financial incentives for ongoing education.

Despite these barriers our pilot project showed that we could provide / encourage work-place based learning. Our interventions were achieved with modest means. The fact that our approaches were readily received suggests there is a great need for work-based education. Perhaps like Cinderella's slipper there is a close fit between the educational needs of staff in ACFs and the education that can be provided by relatively modest work-place based learning initiatives.

Finally, we can conclude that negotiating research in ACFs has been interesting. The different backgrounds, training and professional experience of the members of the project team contributed to the richness of the project. The actual process of researching the workplace learning of certain ACF staff, was, however, particularly intense. After the initial negotiation of the 'learning plans', their enactment turned out to be rich in workplace dynamics. The plans themselves can be put to sound education usage, but more importantly, the negotiation associated with the project has the potential to change attitudes to acquisition of relevant knowledge.

Thus, at Pleasantville, staff constructed their experiential knowledge gained from work with dementia residents. Initially, this was by pattern-making and re-making. This could be more fundamentally understood as a process of reading and re-reading residents' 'stories'. There are ontological and ethical underpinnings for the epistemological enactment of the staff learning plan. These are amenable to postmodern, as well as Deweyan, scholarship.

At Sunnyside, staff constructed their experiential knowledge amongst a contested organisational culture. Here power and authority were significant parameters. When staff realised their traditional expectations need no longer pertain, and that there was a window of opportunity through which to glimpse new learning, then this influenced existing power structures. This both displays and interrogates the nexus outlined in mainstream business and management literature between the workers and the culture by which they are shaped.

In both settings, individual staff members' experiences are the 'raw data' for their workplace learning. The way staff interact and share their "raw data" is vital, but hard to capture. Some staff may believe they 'know' nothing since their formal education and training experiences are limited, or because their location in a hierarchy is such that they 'should know nothing'.. Yet we have shown that staff can be encouraged to alter their perceptions of their own knowledge, and convert their "raw data" into knowledge. This is a precondition to engagement in workplace learning. Once some of the traditional structures are side-stepped or negotiated, valuable learning in the workplace becomes possible. In all of this, it is important to respect the context-specificity of workplace-based educational research. The better provision of aged care is a national policy priority for Australia. The educational development of the staff in aged care facilities represents a massive, modernist investment in lifelong learning. This is important for the ageing Australian population. The attempt to structure learning out of local settings and experiences is a powerful, postmodernist strategy.

Our experience suggests that the approaches to work-place based learning that we implemented would most likely be readily accepted in other ACFs. This is an important consideration for the approximately 3000 ACFs in Australia, the organisations that attempt to police (at worst) or maintain (at best) the standards of care in the ACFs. Finally, those of us who might end up in ACFs or who have relatives who are forced to go to ACFs, would be less troubled by these events if we knew that the educational needs of the Cinderellas who work in the ACFs have not been ignored.

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