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ARTICLE

Modelling the communication challenges of care workers from multilingual and multicultural backgrounds

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Abstract

Effective communication is central to the majority of activities in care settings. In many English-speaking countries, carers working in care settings are increasingly from multilingual and multicultural backgrounds, with many growing up in countries where English is not the primary language. Communication difficulties may impede carers creating meaningful relationships with residents or successful working relationships with colleagues. Misunderstanding may also result in safety issues. To date, however, few studies have investigated what aspects of communication carers from culturally and linguistically diverse (CALD) backgrounds find difficult; nor have these difficulties been modelled theoretically. This article presents the findings of an interview-based study exploring communication difficulties in care settings in Australia. Three groups of participants were interviewed: (1) 30 personal care assistants (PCAs) from CALD backgrounds, (2) 20 supervisors of PCAs and (3) 18 older people who were receiving care and/or nominated support people who participated on behalf of an older person. The data were thematically analysed. The findings show that the communicative challenges facing new PCAs from CALD backgrounds are numerous, ranging from specific linguistic challenges to more workplace-specific problems. Based on the findings, the article proposes a model of communicative competence of personal care workers. The study has implications for the training of personal care workers from CALD backgrounds.

Keywords: communication difficulties; communication in care settings; English language proficiency; personal care assistants

Introduction

With an increasingly older population globally, the number of people living in residential care facilities or those requiring in-home services is likely to increase substantially

over the coming years. This is the same case in Australia, where in the past decade alone the number of older Australians living in residential care has increased by 11 per cent and those accessing home care by more than threefold (Australian Institute of Health and Welfare 2022). As the number of older people accessing care grows, the workforce attending to older people will also need to grow.

More than 70.3 per cent of staff members caring for older people in Australia across these contexts are personal care assistants (PCAs) (Mavromaras et al. 2016). This proportion is even higher in home care settings (Australian Government Department of Health 2020). Personal care assistants, otherwise referred to as nursing assistants in the United States and care workers in the UK, as the name suggests, spend more hours than any other professions working with older care recipients. Their day-to-day tasks differ from those of nurses or allied health staff in that they are employed to assist with the personal care and daily activities of older people. The work requirements in these roles have changed in recent years, with more time pressure, 'more multi-tasking, the introduction of new technologies and a more textualised workplace' (Jansson 2014, 202). Older Australians' care needs are also becoming increasingly diverse (Fetherstonhaugh et al. 2020), with 60 per cent of those in residential care facilities being aged 85 or older and 54 per cent of Australia's care home residents having dementia (Australian Institute of Health and Welfare 2022).

Effective communication when caring for older people is central to the majority of activities in residential and in home care settings (Bennett et al. 2016). Being able to communicate effectively is key to older people maintaining meaningful relationships with others and asserting their independence. For older people, ageing can mean losing autonomy and facing the prospect of needing assistance with basic and often intimate tasks which they have performed independently since early childhood. Relying on others for help can feel 'both physically and mentally intrusive' (Heinemann 2009, 103). Effective communication is key to making such situations less uncomfortable or, as Marsden and Holmes (2014) wrote, 'much of the interaction between caregivers and older residents can be construed as a negotiation, designed to manage the unavoidable and discomforting face threatening acts involved in care, with as much face-saving as possible for both participants' (18). Furthermore, effective communication between staff working in care settings enables efficient completion of tasks, and successful working relationships with colleagues.

Difficulties with communication, on the other hand, can affect the performance of care workers, their relationships with the older people they care for and their interactions with other team members (Chen et al. 2020). Trouble with communicating can lead to misunderstandings that may place residents and PCAs at 'increased risk of incidents, leading to injury or illness at work' (O'Keeffe 2016, 131), or may prevent PCAs from socially integrating into their workplaces. From an older person's perspective, a PCA's language difficulties can impact their perception of that carer's ability to offer care and their relationship can suffer as a result (Bourgeault et al. 2010). The language competence of carers is key to 'creating a trustful relationship between carers and residents, which positively affects the identity and well-being of the older people being cared for' (Jansson 2014, 202). As PCAs spend the most time with an older person, they are in the best position to engage in everyday conversations, that is, talk that includes making plans, gossip, small talk, reflecting on events and so on, and where workers are not

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confident to engage in these conversations, older people can miss out on the opportunity to engage in the daily conversation that can have a positive effect on their quality of life and cognitive function (Fukaya et al. 2023; Hartmann et al. 2018).

Problems with the reading and writing skills of both PCAs from culturally and linguistically diverse backgrounds (CALD) and local workers can also be an issue. Where a service's funding is dependent on documenting an older person's care needs or reporting incidents, inappropriate documentation can risk that a care service will be judged non-compliant against aged care standards and jeopardize their funding. Equally, information about an older person's care needs can rely on written communication and where a carer has low literacy skills, this can present problems in recording and acting on that information. Furthermore, low literacy can present problems for care staff when it comes to participating in training to improve or update required skills, again putting them at a disadvantage and risking the organization's compliance against the required standards. It is vital, therefore, for employees with limited language or literacy skills to engage in effective communication training (Shrestha et al. 2023).

A recent Aged Care Workforce Census report (Australian Government Department of Health 2020) showed that 36 per cent of PCAs in residential care are from CALD backgrounds, defined as people born overseas in countries other than the 'main' English-speaking countries (*i.e.* Canada, Ireland, New Zealand, South Africa, the UK and the United States) (Ethnic Communities' Council of Victoria 2018). The most common background of those were Indian and Filipino (Mavromaras et al. 2016). In home care settings, the proportion is slightly lower, at about 20 per cent. The increased reliance on migrants to supplement the workforce supporting and caring for older people is not just an Australian phenomenon and has long been acknowledged in other OECD (Organisation for Economic Cooperation and Development) contexts such as the UK, the USA and Europe (Browne and Braun 2008; Leeson 2010; OECD 2020; Shrestha et al. 2023). Gaining an understanding of the types of communication difficulties facing CALD care staff can form an important basis for future training of new PCAs and their supervisors and can create a more supportive workplace.

Literature review

Communication difficulties in care settings

Communication difficulties in care settings have been described by several researchers to date. These studies have generally focussed on carers from any background, rather than only those from CALD backgrounds. Studies conducted in a range of contexts (*e.g.* Denmark, Australia, US) have, for example, identified a lack of interpersonal communication and a high reliance on task-focussed communication on the side of carers (Bennett et al. 2016) and difficulties in communication when face-threatening tasks such as helping older people to have a shower and go to the toilet are conducted (Heinemann 2009) or when caring for residents living with dementia (further described later). Similar research has also been conducted in the contexts of Sweden (Jansson 2014), New Zealand (Marsden and Holmes 2014), the UK (Cangiano and Shutes 2010) and Ireland (Walsh and O'Shea 2009). In these contexts, communication is often marked by elderspeak, commonly shown to share key features of baby talk or motherese (Jansson 2016; Jansson and Plejert 2014; Lombard 2021; Marsden

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and Holmes 2014), and is not in line with the principles of person-centred care (Carpiac-Claver and Levy-Storms 2007; Savundranayagam 2014).

A prominent line of research has been on communication with people living with dementia, owing to the large increase in residents living with this condition (Fetherstonhaugh 2016). People with dementia often experience difficulty in word finding, and constructing and maintaining coherent conversations. Interaction between carers and residents with dementia has been shown to be task-oriented, patronizing and often overly directive (Savundranayagam 2014). Interactions are also infrequent (much more so than with residents without dementia) and often very short. Savundranayagam (2014) argued that the reason for this is often a lack of awareness amongst staff about the importance of interaction with people living with dementia and their assumption that such interactions have limited impact on residents with cognitive impairment. Studies of interactions between carers and people living with dementia point to the importance of social interaction, including while conducting care-giving activities, in providing emotional support and managing agitation amongst people living with dementia (Jansson and Plejert 2014, 30). Jansson (2014) was also able to show the importance of body language for effective communication with persons living with dementia (see also Carpiac-Clever and Levy-Storms 2007).

The body of research investigating communication difficulties experienced by carers from CALD backgrounds caring for older people is relatively small. Martin and King (2008), for example, conducted a national survey of care providers in Australia, with 70 per cent of those participating mentioning communication as the most important issue for staff from non-English-speaking backgrounds. Linguistic and cultural differences were identified as concerns during patient interaction and shift handovers. Mackey (2018) listed a range of second language skills that carers from CALD backgrounds need to master when working in English-speaking care workplaces, including pragmatic competence, grammatical accuracy, pronunciation, and understanding of cultural assumptions of the host country and workplace. She collected interviews and role-play data from nine personal carers working in Australian care homes (three native-English-speaking PCAs and six from non-English-speaking backgrounds) and identified three main differences between the use of language of these two groups of carers: the use of (1) 'small talk' and social talk, (2) humour and (3) endearments. Carers from CALD backgrounds spent less time on relational social talk with residents before starting to discuss specific tasks they wanted to undertake. Humour and endearments were much more frequently used by native-English-speaking carers.

Nichols et al. (2015) conducted interviews with staff, managers and family members to gain a better understanding of communication processes in care homes in the Australian context. The interviews revealed that staff from CALD backgrounds experienced issues with communication, including difficulties with spoken language (both production and reception), colloquial language and slang, understanding cultural norms of communication and interpersonal communication. One manager mentioned that the daily work of carers included collecting and documenting information about residents. Inappropriate documentation may result in loss of funding to an institution. Participants in Bauer et al.'s (2014) study, which focussed on staff–family relationships in Australian care homes, reported that a lack of English language proficiency tested such relationships and inhibited the development of trust between staff and families.

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A more recent study conducted by Shrestha et al. (2023) investigated similarities and differences of caring behaviours of two groups of carers – those from culturally diverse backgrounds and those from similar cultural backgrounds from the perspective of the older people receiving care. Their interview-based study showed that the interview participants identified a number of challenges of being cared for by culturally diverse PCAs, including issues with communication, in particular spoken communication. Also, PCAs not being familiar with residents' cultures and traditions was identified as challenging for both parties.

Collectively, the studies show that PCAs from CALD backgrounds may experience communication difficulties when entering workplaces in destination countries; however, it is not clear how comprehensively these difficulties have been captured by the research to date. These studies have also not always elicited these difficulties from a range of stakeholders in the care sector. To this end, this study set out to capture the range of communication difficulties encountered by PCAs from CALD backgrounds.

Modelling communication in care settings

This study aimed to describe how PCAs from CALD backgrounds can communicate successfully in the care settings using a language teaching model that incorporates communicative competence (originally proposed by Hymes 1967). Such a model would be helpful to inform workplace communication training for those from CALD backgrounds or to screen potential employees for workplace roles. While other tools and models have been developed in the context of health care, particularly from a person-centred approach (Lombard 2021), the aim of this study is to cater to a population of PCAs from CALD backgrounds and focus on their communicative competence in this very specific workplace context. A potentially useful model of communicative competence was proposed by Celce-Murcia (2008) to be used in the language teaching context (*e.g.* to be used as the basis for language curriculum design). While it is unclear how well this model accounts for workplace communication in care settings, previous work by one of the authors of this study focussing on CALD nurses (Mackey 2018) identified many aspects in Celce-Murcia's model as relevant. It was a secondary aim of this study to examine how well this model accounts for communication difficulties experienced by PCAs from CALD backgrounds. Celce-Murcia's (2008, 45) model comprises several components, including:

- discourse competence (selection, sequencing of words and utterances to achieve a unified message)
- socio-cultural competence (speaker's pragmatic competence – how to express messages appropriately within a context) with three variables:
  - social contextual variables (participants' age, gender, status and social distance)
  - stylistic appropriateness (politeness; sense of genres and registers)
  - cultural factors (cross-cultural awareness; background knowledge of target language group, including regional differences)
- formulaic competence (knowledge of fixed and prefabricated chunks of language that communication relies heavily on, such as idioms and linguistic routines)

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- linguistic competence, including phonological, syntactic and lexical knowledge and knowledge of word forms
- interactional competence with three sub-components
  - o actional competence (knowledge of how to perform common speech acts such as complaining, apologizing, etc.)
  - o conversational competence (understanding the turn-taking system, including how to open and close conversations, change topics, interrupt, etc.)
  - o non-verbal competence, including body language, gestures, use of space, touching, role of silence, pauses and non-linguistic utterances such as *ahh!, uh-oh!*, etc.
- strategic competence (strategies for language use, including self-repair, self-monitoring, asking for clarification in the case of a communication breakdown, etc.)

While the model is comprehensive, it was not developed for communication in work contexts, and it was therefore not clear whether all aspects listed were relevant to professional communication or whether additional components needed to be added. We hoped that focussing on communicative difficulties encountered in workplace communication would be helpful for interrogating and possibly revising this model for workplace communication contexts.

Research aims

The study aimed to gain a picture of the kind of communicative difficulties CALD PCAs encounter in Australian workplaces and to ascertain whether Celce-Murcia's (2008) model of communicative competence could sufficiently capture the different aspects of communication issues identified in the study.

The specific research questions we set out to answer were:

1. What are the communicative challenges faced by PCAs from CALD backgrounds in Australian workplaces?
2. Does Celce-Murcia's (2008) model of communicative competence sufficiently capture components of communication used in care settings?

This article reports on only a subset of the wider project, which also focussed on understanding the communicative tasks PCAs engage in regularly, and the role of communication in avoiding various risks in the care setting. The current project focussed on identifying communicative events that are barriers to successful interactions with colleagues, health professionals, older people and families. The study was interview-based and three participant groups were recruited: (1) CALD PCAs working in Australian care settings, (2) supervisors of PCAs and (3) older people and/or their families. While all PCAs may experience communication challenges at work, this article focusses only on the challenges specific to PCAs from CALD backgrounds.

The data collected were rich, and, owing to space reasons, we have chosen to focus only on the communicative challenges encountered by PCAs. Apart from the challenges we focus on in this article, the data also showed many instances of PCAs

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adapting, learning and gaining confidence. It is important to note that it is our intention not to negatively portray in this article the work that PCAs do but rather to identify challenges to inform future training and support for new CALD members of this profession. Also, PCAs from CALD backgrounds bring many communication and interpersonal skills to their roles and are highly valued members of the workforce.

Methodology and methods

Design

The study was an exploratory qualitative study drawing on semi-structured interviews with the three participant groups described earlier. This approach was taken to enable the study to capture participants' perspectives in depth (Miles et al. 2020). Ethical approval for this study was granted by the Human Ethics Research Committee of the University of Melbourne.

Context of the study

In Australia, aged care providers are funded by government to offer services that vary according to the older person's support needs. The levels of care range from in-home support to personal care in the home, with respite and residential aged care homes offering the highest levels of care. The majority of care is offered in the person's home; however, residential care attracts the highest level of government funding owing to the intensity of support offered (Australian Institute of Health and Welfare 2024). This study was carried out in both residential care and in-home care settings in 64 locations across 3 Australian states (South Australia, Victoria, New South Wales) and the Australian Capital Territory.

The study was carried out when Covid-19 pandemic response measures were in place, including social distancing and restrictions on face-to-face contact in care settings. The impact of these measures on participant recruitment processes and conduct of the interviews, respectively, is set out in what follows under 'Participant recruitment' and 'Interviews'.

Participant recruitment

As mentioned earlier, this study focussed on three participant groups: (1) PCAs from CALD backgrounds working in Australian care settings, (2) supervisors of PCAs and (3) older people and/or their families. The majority of workers and just over half of the older people came from residential care settings, with the remainder working in or receiving in-home care. These groups were selected because we considered them best placed to comment on the communication challenges encountered by PCAs from CALD backgrounds from a range of perspectives. Owing to the disruptions this sector faced during and immediately following the Covid-19 pandemic, we relied on a 'convenience' sample within these groups rather than aiming for a stratified sample of participants (*e.g.* a sample representative of ages, genders and country of origin for the PCAs). The majority of participants were recruited through social media

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(44 per cent) and the rest through professional networks (20 per cent), personal networks (19 per cent) and snowballing (17 per cent). Supervisors and PCAs were recruited through contacts in care settings by the research team, who approached potential participants and provided them with a QR code to sign up for the project. We also posted advertisements for the project on various relevant social media sites, which invited participants to sign up using an online link or a QR code. Older people and/or their support person(s) were recruited through the personal networks of the researchers and through recruitment advertisements circulated to staff and students of the University of Melbourne. Potential participants or their family members were sent an online link which invited them to sign up for the study. Any participants who registered their interest on the online link were then approached via their preferred contact method (phone or email) to arrange a time for the interview.

In line with ethical protocols, we interviewed only people who had the capacity to provide informed consent. We ensured that older people living with dementia were included through the participation of family members who spoke in the interview on their behalf.

Procedure

Consent procedures

All interviewees provided written consent prior to the interviews. Consent was sought by the interviewer prior to each interview by providing the participant with an information sheet and the consent form and, if necessary, answering any questions that the participant asked.

Interviews

Each interview was conducted by one of the authors. Owing to the Covid-19 restrictions, all interviews with care staff were conducted using an online video-conferencing platform at a time suitable for the participants. Some interviews with older people or their support person were held in person in the care setting of the older person (depending on the preference of the participants and the Covid-19 restrictions in place at the time of the interview). The duration of each interview with care staff was approximately 60 minutes, and with older people or their support person, 30 minutes.

The interview protocols for the three groups followed the same structure, starting with a section on the background of the participants, a focus on regular communicative tasks occurring in the care setting, and communicative difficulties experienced by all PCAs and those particular to PCAs from CALD backgrounds. This article focusses only on the final sections of the interviews. The questions differed slightly depending on the group interviewed.

Data analysis

Following the completion of the interviews, the audio files were transcribed verbatim; however, names of participants and institutions were not transcribed. The qualitative analysis of the data was supported by NVivo 12 (Lumivero 2022) software. During the

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data analysis, we followed the six steps for thematic analysis proposed by Braun and Clarke (2006, 2019). First, we familiarized ourselves with the data by carefully reading the transcribed interviews. A preliminary list of possible codes was developed based on the literature review and the interview questions prior to the commencement of coding. The interview transcripts were then carefully re-read, and new coding themes were created during this process. Themes were refined over time and merged where necessary. The interview transcripts were re-read until no new themes emerged.

The main themes and the Level 1 sub-themes relating to communication difficulties experienced by PCAs from CALD backgrounds are listed here:

- Challenging aspects of language or communication
  - o linguistic difficulties
  - o lack of socio-cultural knowledge
  - o lack of medical knowledge/lack of training or experience impacting communication
  - o lack of strategic competence
- Challenging communicative tasks
  - o with older people
  - o with other interlocutor groups.

In line with Lincoln and Guba's (1985) trustworthiness criteria, the credibility and the confirmability of the themes and sub-themes were enhanced through an intercoder reliability check. This involved a meeting with a second coder followed by double-coding of a subset of 10 per cent of the interviews. Intercoder reliability was established by comparing the agreement on the various codes by the two coders. Intercoder reliability was above 0.8 for all themes.

Findings

Interviews were conducted with a total of 68 participants across three groups: PCAs from CALD backgrounds (n = 30), supervisors of PCAs (n = 20), older people and/or support people (n = 18). The characteristics of the participants in each group are shown in Table 1. Across all three participant groups, the care settings were in various locations across Australia, both metropolitan and regional. Amongst the participants in the PCA group, the following home languages were represented: Azeri, Bisaya, Burmese, Chinese/Cantonese/Mandarin, Filipino/Tagalog, Hindi, Japanese, Korean, Malayalam, Portuguese, Punjabi, Sinhalese, Spanish, Vietnamese, Twi and Yoruba. Compared with the language groups reported to be most commonly spoken amongst CALD PCAs working in Australian care settings (*i.e.* Indian, Filipino, African, Pacific Islander, Chinese, Italian, Greek and South East Asian) (Mavromaras et al. 2016), participants' home languages were to some extent representative of those in the wider population of PCAs from CALD backgrounds, noting that Pacific Islander languages, Italian and Greek were not represented, and additional languages were represented (Azeri, Japanese, Korean, Portuguese, Spanish). The interviews with participants in the older people and/or support people group were conducted according to the older person's

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Table 1. Participant characteristics

Group	Care setting	Years working as a PCA	Years living in Australia
CALD PCAs (n = 30)	Care home (n = 26) In-home services (n = 4)	Range: 0.17–16 Average: 5.42	Range: 0.25–44 Average: 11.75
Group	**Care setting**	**Years in supervisor role**	
Supervisors (n = 20)	Care home (n = 18) In-home services (n = 2)	Range: 0.33–20+ Average: 6.92	
Group	**Care setting**	**Age (years)**	**Years receiving care**
Older people/ support people (n = 18)	Care home (n = 9) In-home services (n = 9)	Range: 65–99 Average: 82.89	Range: 0.67–7 Average: 3.92

capacity to give consent and/or their preference to have a support person (*i.e.* family member) in attendance. Of the older people who had cognitive capacity to consent to an interview, six participated themselves (with a support person present in all cases but one) and two chose to be present in the interview while a support person spoke on their behalf. Each of the remaining ten interviews for this group was conducted with a support person who participated on behalf of an older person with cognitive impairment.

In what follows, we describe the themes developed through the analysis of data. We illustrate the findings with extracts from the interview data. Participants are identified by the following abbreviations followed by the participant number: OP – older person, OPSUP – older person support person, SV – supervisor, PCA – personal care assistant. For example, Older Person 3 is indicated as OP03.

Challenging aspects of language or communication

The first main theme, Challenging aspects of language or communication, includes four Level 1 sub-themes: (1) linguistic difficulties, (2) lack of socio-cultural knowledge, (3) lack of medical knowledge/lack of training or experience impacting communication and (4) lack of strategic competence. Each of these is described in more detail next.

Linguistic difficulties

Participants reported a range of linguistic difficulties of CALD PCAs working in Australian workplaces. We identified six further Level 2 sub-themes relating to the Level 1 sub-theme of 'linguistic difficulties': (1) general English proficiency, (2) comprehension, (3) speaking, (4) writing and reading, (5) vocabulary and (6) grammar. Each of these sub-themes is further described next.

A number of comments made by participants focussed on the PCAs' *general English language proficiency*. For example, OP02 described one carer who had been providing care at her house for two to three years:

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> And I think we've never had a full conversation with her because her English seems very limited. Very. She can speak just a few words here and there, broken English. So that's been sometimes …. Because you're inviting them in your home and you have a certain routine and way of doing things, for example, where to put the towels, how to use the sink in the laundry, all these things. So sometimes I've had to demonstrate myself things. (OP02)

The *comprehension* of PCAs from non-English-speaking backgrounds was frequently mentioned as a problem. For instance, SV06 noted the following challenges:

> So residents sometimes get very frustrated. They are already in pain, they are already bedridden, they already have depressive episodes. They try to tell PCA, 'Okay, today I'm not feeling well. I would like to have breakfast in bed. I don't want to have a shower. I would just like a little sponge in bed. Can you please give me my newspaper that's at the front desk, and then also can you let the nurse know that I'm having this thing?' All these things, if a resident telling a PCA and if she's feeling, 'Oh my God, what he's talking about? Too much information and so quickly,' she would ask him again and again and again. And residents they get frustrated. 'I don't want this staff member. She doesn't understand what I'm talking about. She's just not listening properly.' (SV06)

Ten PCAs mentioned that they had struggled to understand the accent of residents when they first started working in Australia. On this subject, PCA07 explained that this was owing to her not being used to the Australian accent, having been exposed to American accents during her schooling in the Philippines. Apart from the difficulty understanding accents, residents or colleagues talking too fast was also mentioned as a reason for difficulties with comprehension (PCA11, PCA16).

Participants noted that PCAs from CALD backgrounds often required demonstration to understand instructions (*e.g.* OP02) or were reluctant to ask for clarification (OP03, OPSUP03, SV02) (see also the Level 1 sub-theme 'lack of strategic competence'). The explanation SV02 gives illustrates this issue:

> This can be difficult, obviously, because if they [the residents] are in pain and then they are asking for something and it kind of goes over the worker's head. No fault of them but they don't want the resident to think they don't understand but they also don't understand. I also think there is a little bit of, 'Oh, I better not show that I don't know what you are saying because that is going to make me look bad,' kind of thing. (SV02)

Difficulties with *speaking* or the *comprehensibility of the spoken language produced by PCAs* were frequently reported. As part of the interviews, older people/support persons and supervisors were asked whether they ever had any problems understanding the spoken language of PCAs from non-English-speaking backgrounds. The PCAs were also asked whether they thought that older people or colleagues ever had problems understanding them. Almost all participants reported the spoken language of CALD PCAs to be a problem.

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Many PCAs in the sample reported experiencing problems with their speaking when they first started in their role. For example, PCA16 described her first few weeks working:

> In the initial days, I was very scared to talk. I was too much thinking about maybe my communication is not at all good. I wanted to communicate. I had a lot of inferiority complex. So I couldn't really communicate much with the relatives. But that times it was different because every day I have to communicate with them to meet their needs. So I was using very simple language that they can understand and not to make it very complex. Maybe a hundred times, I have to repeat it two, three times for them to make it understand. (PCA16)

Some PCAs described remaining quiet owing to speaking difficulties; for example, 'I couldn't say what I want to tell or what I want to talk, so I was so quiet, so people think I'm just a quiet person' (PCA21). Problems with speaking resulted, at times, in supervisors receiving complaints from residents (*e.g.* SV03) as well as PCAs feeling that residents were racist by not accommodating their language when needed (PCA01).

Participants offered several reasons for these difficulties with speaking. The most common reason was a PCA's accent causing problems. This was reported by 18 participants across all participant groups. Three participants mentioned that PCAs often spoke too quickly and were therefore difficult to understand (OP04, PCA20, SV04). Not speaking loudly enough was mentioned by two participants (OPSUP11, PCA22), as were issues with pronunciation (PCA14, PCA22). Also, PCA18 mentioned that she was not able to make full sentences when she first started and PCA22 reported using incorrect grammar.

Problems with writing and reading as part of care work were not mentioned frequently by PCAs in our interviews. Writing was brought up as an issue by only three PCA participants. For instance, PCA9 mentioned that initially he did not know what he was expected to write when completing various forms. And PCA21 and PCA22 mentioned that they had had problems at first with producing the required medical terminology. Eight other PCAs mentioned that writing and reading did not pose much of an issue for them when they first started.

Supervisors, on the other hand, identified a number of problems with the reading and writing of PCAs from CALD backgrounds. In respect of writing, SV11 reported that PCAs often did not understand that different notes needed to be written in different ways. She suggested that this should be included in training packages for new PCAs. Specifically, SV04 reported issues with spelling and SV01 mentioned that she found it hard to understand some entries made by PCAs:

> When you read the [PCA] notes you think, 'Oh, my gosh!' You know it is all sort of very difficult to understand what the point they are trying to make. Probably [problems with] vocabulary. I don't know whether I need to put a spell check on the computer for them. You know even if it is not a big word sometimes they make a very big mistake on very small regular words. (SV01)

Reports of *difficulties with vocabulary* were quite common in the interviews. The most common vocabulary issues were with PCAs not understanding certain words.

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Relately, SV04 described how incorrect use of terminology could have a large impact. For example, a PCA wrote that a resident had become aggressive. When quizzed on whether the resident had indeed been aggressive, it turned out that they had offered some resistance. The word 'aggression' had triggered follow-up actions, including monitoring of the safety of those involved. Such nuances in terminology were therefore seen as crucial in documentation.

Specific vocabulary used in the care setting also posed problems for new PCAs. For example, PCA03 reported not understanding 'scooter' in the care context (*i.e.* he knew the term only as a children's toy rather than as a motorized vehicle for adults with mobility problems). A similar example of not understanding specific vocabulary is provided by SV19:

> Like he's just standing there and he doesn't even know what he's doing because I said, 'Can you go and get the commode? This person wants to go for a shower.' And then he came back, he was holding a chair with, it's not with the wheels, a commode, but there's no back rest. I did not tell him that, but how can the resident who has a stroke sit up in a chair without a backrest and without wheels? So I just went to get it. And when I came back, I said, 'This is the commode.' (SV19)

Problems with *grammar* were reported by two participants. For instance, SV12 reported on her earlier experience starting as a PCA from a non-English-speaking background. Her use of incorrect grammar confused her co-workers and made her responses sound rude to others. Also, SV17 described grammatical problems in PCAs' writing, in particular the incorrect choice of tenses or pronouns in incident reporting.

Lack of socio-cultural knowledge

Issues with PCAs' 'lack of socio-cultural knowledge', the second Level 1 sub-theme, were also mentioned in many interviews. The following further Level 2 sub-themes were identified in the data:

- problems understanding humour
- problems understanding slang/idiomatic language
- lack of cultural and pragmatic knowledge.

Respondents in six interviews reported PCAs not understanding Australian *humour*. This sub-theme was mentioned by several older people and/or support persons in particular. For instance, OPSUP09 reported at-home carers struggling to understand her father's humour:

> So they might struggle with my father's sense of humour. He's very old world and I think some of the things that he might say to them might go over their head. Not in an offensive way or anything like that, but they just, they may not understand some of his expressions which are …. He's 85 years old. Some of his expressions might be alien to them. (OPSUP09)

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Table 2. Examples and explanations of idiomatic language identified in the study

Example	Explanation
'I need a slash' (OPSUP10)	'slash' means to urinate (from the UK)
'Can you get jocks and socks' (PCA09)	'jocks' is a general term for underwear (Australian usage; similar to 'jockeys' in the UK)
'Can you put my knickers down' (PCA09)	'knickers' is a general term for women's underwear (from the UK)
'being a boost' (PCA14)	meaning a heavy drunk
'being a bugger' (PCA15)	depending on the context, 'bugger' could be a humorous/affectionate term or a negative one referring to an unpleasant/difficult person (from the UK)
'I'm a pommie' (PCA22)	'pommie' refers to a British person and can be offensive (Australian and New Zealand usage)
'being a spring chicken' (PCA22)	idiomatic expression referring to someone who is young, and usually used negatively as 'no spring chicken'
'I'm going to have a fag' (PCA23)	'fag' refers to a cigarette (from the UK)

Similarly, OPSUP07 reported that her father, at times, did not like the carers who came into his room because they did not understand his jokes. She noted, however, that some of his humorous comments could easily have been considered offensive.

> He, I guess, assumes that he's funny … And I think it's absolutely fair that someone may actually find it offensive what he's saying, rather than funny. Especially if it's not the usual banter that they receive or if they feel like it's a personal comment. (OPSUP07)

As this comment shows, it may be possible that this kind of 'humour' may be experienced as racist or sexist by the carers, although this was not directly reported by the PCAs in our study. However, while not encountered in our data, misunderstanding of humour could be an instance where communication problems can occur in the interaction in both directions.

Many participants in our sample reported PCAs from CALD backgrounds struggling to understand *Australian idiomatic language*. Most used the term 'slang' for these expressions, but others called it 'older person's language' (PCA09) or 'old Aussie slang' (PCA19). Most offered specific examples of the type of language and not all these can be classed as being truly Australian – some may be expressions used in other English-speaking countries, particularly the UK. Regardless of the origin of the expressions, problems were reported by 19 of the participants. Specific examples are listed in Table 2.

Closely related to PCAs' lack of knowledge of certain idiomatic language is PCAs' *lack of cultural and pragmatic knowledge*. Sub-themes included (1) not knowing/understanding general cultural practices, (2) not knowing how to act in a culturally appropriate way and (3) coming across as rude/lacking politeness. Each of these sub-themes is illustrated next.

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Three participants reported PCAs from CALD backgrounds not knowing or understanding cultural practices or inferences. For instance, OPSUP05 mentioned that some PCAs did not understand references to Australian-rules football, and SV03 reported that one PCA she supervised did not understand the idea of having breakfast in bed on a resident's birthday. Further, OPSUP09 described her father often making religious (specifically Catholic) references that were often lost on the in-home carers.

Not knowing certain conventions for doing things was reported by two participants. The first, OP05, talked about PCAs not always understanding standards of personal hygiene and therefore not knowing how to apply these to residents. And the second, PCA12, an in-home carer, explained that in every home she attended, she needed to learn the 'cultural way of doing things'. In particular, she referred to how mopping was done and how the bucket was used for cleaning.

A theme mentioned by ten participants, older people/support persons and the supervisors in particular, was that of PCAs lacking politeness or coming across as rude or cold. The following is an example of what these participants said in relation to this sub-theme:

> I think there are obviously, there are cultural differences in the way people interact. Some cultures are more direct and that can be seen as being rude. (OPSUP01)

Only two PCAs mentioned the sub-theme of rudeness. They were made aware of their communication coming across as rude by a supervisor (in the case of PCA23) or because of a complaint made by family (PCA24). Here is PCA23's description of what can occur:

> So I think there was a time I had a problem with my RN [registered nurse supervisor] because she didn't understand what I was saying. So she thought I was insulting a resident. She thought what I was saying was an insult. I thought she didn't understand what I was trying to say. So in her mind, she interpreted it as me being aggressive or insulting the resident. (PCA23)

The fact that this sub-theme was so much more prominent in the supervisor and older/support person interviews than in the interviews with the other participant group will be further discussed later in this article.

Lacking medical knowledge/lack of training or experience

Within the third Level 1 sub-theme of lacking medical knowledge/training or experience, we identified two further Level 2 sub-themes: (1) lack of knowledge of medical and health terminology, acronyms and abbreviations, and (2) lack of medical knowledge, training and experience leading to communication challenges. We describe these two sub-themes further with examples from the interview data.

The PCAs' lack of knowledge of medical and health-related terms was the most frequently mentioned aspect of this sub-theme (seven participants). For example, OP05, who was a supervisor of PCAs before she retired, described some of these after being asked what terms may be difficult:

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> The language, well, starting from the head down, what do we mean by cataracts? We've had cataract surgery. What, what is that? What are hearing aids? What are the batteries? What are you talking about? Batteries in hearing aids? What are dentures? … What's a pacemaker? What am I looking at? They're on P tube feeding. What's that? (OP05)

Health-related terminology, such as the names of different types of diet, was also mentioned by some participants (*e.g.* SV20). One PCA, PCA11, described when she first started and struggled with some of the terminology for equipment used in the care setting (*e.g.* four-wheel walker). This problem was also reported by some of the supervisors in the interviews.

Abbreviations and acronyms also posed a problem for several new starters. For instance, PCA13 described her experience when she first started (prior to studying nursing):

> I think in the beginning, … it was all this abbreviation. I couldn't really grip it straight away. For example, SOB. It should be shortness of breath, but they cut it in short. So yeah, it's challenging, but now I'm used to it. You just have to get used to certain abbreviations. (PCA13)

Concerns about lack of training and experience in PCAs was mainly raised by older people/support people and the supervisors. Medication errors were described by OPSUP03, who relayed a story about an in-home PCA making a mistake with medication for her father and also accidentally throwing away medication that had not yet been used and then trying to cover up what had happened.

Another example is OPSUP04, who employed in-home carers for her mother with dementia, and was also concerned about the lack of training of PCAs (combined with the lack of experience and information from head office given to PCAs). She described a situation where a carer took her mother living with dementia for a walk that was beyond her mother's ability. The informant's mother then fell and hurt herself and the carer tried to conceal what had happened. She argued that the care worker knew far too little about dementia in general and her mother's case in particular, and also felt that the head office had not provided enough information.

Lack of strategic competence

Strategic competence refers to the ability to use language to communicate, even in situations of communicative breakdowns or difficulties. The fourth Level 1 sub-theme, a lack of strategic competence in communication, was raised in seven interviews. These participants, who were all supervisors or older people/support persons, noted that PCAs from CALD backgrounds often did not ask for clarification when they had not understood what was said to them. This was an issue raised both in communication with residents and in staff–staff communication, for example at handover time. Participants also proposed some reasons for PCAs from CALD backgrounds not asking for clarification. These included being shy, saving face and worrying about job security. For instance, OPSUP03 described how her father became frustrated with their in-home carer:

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> There is a tendency sometimes with people from the Asian cultures to be very respectful of you, and rather than making you feel bad that they haven't understood, they just nod. Which is great, but Dad interpreted that as she knows what I wanted to do. … And then she wouldn't do it, and he would get frustrated. (OPSUP03)

Also, SV01 noted that many PCAs from CALD backgrounds were very quiet at handover time and reluctant to ask questions in the group situation.

In summary, our data showed a range of challenging aspects of language and communication facing CALD PCAs in care settings, including a range of linguistic difficulties, challenges with socio-cultural knowledge, a lack of medical knowledge, training and experience impacting communication and a lack of strategic competence.

Challenging communicative tasks

The themes and sub-themes described so far point to specific aspects of language and communication that pose problems for PCAs from CALD backgrounds. The data also showed that there were a range of communication tasks that were considered difficult. In relation to these, here we describe two Level 1 sub-themes: (1) challenging communicative tasks with older people, (2) challenging communicative tasks with other interlocutor groups.

Challenging communicative tasks with older people

Interviewees described a range of specific communication tasks with older people (first Level 1 sub-theme) that some PCAs might find difficult. The following tasks were identified in the data as difficult (all Level 2 sub-themes): asking for permission, explaining, offering choices and building connections with older people.

Asking for permission before performing specific tasks was mentioned as an issue by two supervisors. For example, SV19 noted that asking for permission is required in her work context and that this may at times be forgotten by the care staff from CALD backgrounds who may force a resident to have a shower or to complete a certain care task.

Also, SV21 reported at times investigating incidents that resulted in aggression from older people (often those living with dementia) and noted that this occurred because permission was not properly sought from older people for care tasks.

Explaining care tasks to older people was considered by several PCAs as being challenging, regardless of whether the older people had cognitive limitations or not. For instance, PCA10 described how she found this challenging when she first started as a carer:

> So I think depend on the patient, whether how much they, let's say some people have their dementia and then maybe not much communication can be involved, but at least you have to explain what you try to do. But if the patient's fully cognitive, of course they are going to chit-chat a lot, and especially, they love to talk, so has to listen and have to explain what you're going to do for the day or something. So it was pretty challenging, especially the beginning. (PCA10)

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Offering older people *a limited number of choices* was mentioned by supervisors as an important strategy when communicating, particularly when communicating with people living with dementia. However, one supervisor participant, SV21, mentioned how staff from CALD backgrounds do not offer such choices frequently enough, resulting in communication difficulties.

Building connections with older people was a theme that came up frequently in the interviews. Support persons and supervisors mentioned reasons or occasions when PCAs from CALD backgrounds failed to build connections with older people. For example, OPSUP03 mentioned lack of communication as one reason why a PCA from a CALD background had failed to build up a connection with their relative:

> I think Dad is a person who has always taken pride. He will still wear a tie and a tie bar, and that kind of thing. Being clean and well-presented is important to him. And so that's something that has to happen every day. And if the person who's preparing you for the day is just there treating you like a job … And when there's no conversation, I think he feels more naked. (OPSUP03)

Similarly, OPSUP01 reported how carers from various backgrounds came into the home care setting to look after her mother and did not try to establish a connection with her mother. Instead, her mother felt that she was being 'bossed around', particularly around shower time when she felt vulnerable.

Further, SV21 noted that new carers, in particular CALD carers, often failed to find out key information about a resident and therefore did not gain the older person's trust. For instance, SV17 noted that one reason for having problems making connections with them was that carers from CALD backgrounds struggled to engage in small talk while undertaking caring duties. She noted that doing these two things at the same time was quite hard and therefore posed challenges for carers.

It is, of course, not always easy or even possible for carers to build a connection with the older people they are caring for, and a lack of connection could equally be because of the older person not being willing to reciprocate. Our data, however, showed many examples where the participants described instances of very successful building of connection by staff from CALD backgrounds, as well as many instances where language and possibly cultural differences stood in the way of such connections.

Challenging communicative tasks with other interlocutor groups

Participants also noted that there were, at times, problems of communication between CALD PCAs and other interlocutor groups (Level 1 sub-theme), specifically with their colleagues, older people's families and management (all Level 2 sub-themes).

Problems communicating with colleagues was described as occurring both while working and socially, such as when on breaks. Several PCAs reported issues communicating with other carers. For example, PCA3 noted that she struggled when communicating with one colleague in particular and that they often had to solve this by pointing to the particular equipment they needed. Misunderstandings also often happened on the telephone. Carers frequently need to use the DECT (digital enhanced cordless telecommunications) phone to call for assistance with particular tasks and

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cannot leave an older person alone (*e.g.* when they are sitting on the toilet). [We later cover the task of using the telephone in more depth.]

Futher, PCA4 noted that there were often communication problems amongst staff and that this sometimes resulted in anger and impatience between co-workers. Similarly, PCA13 described often asking for clarification, which could cause co-workers to become impatient. Frequently, vocabulary and accents were given as reasons for communication difficulties. Describing why he struggled when he first started as a PCA, PCA15 says:

> I have … like trouble because the accents and the words they're using, like small, short words which we don't know, like toileting or how you say bowel and bowl, like few, few things, it was hard for us as well. We learn as we go. (PCA15)

Social interactions during break time resulted in difficulties as well as workplace communication. For instance, PCA18 reported on her experiences when first starting:

> Some of them are from Philippines or Indians. So even the accent is really different. So until I understand the different accents, it was hard. So sometimes, for example, during our breaks, I was avoiding to talk. I was just listening until I understand what they are saying. So around two months I was just listening and not communicating with them, avoiding some breaks together. Because I was, oh my God, it's so many things to understand. So I will focus on, understand the client first and then to talk with simple conversation with my colleagues and during the breaks. So in the beginning I wasn't too confident to talk with them. (PCA18)

Similar problems were mentioned by a number of PCAs in our sample. Some reported feeling overwhelmed at how fluently others spoke and not having the courage to talk.

Communication with families was also mentioned as being difficult in several interviews. For instance, PCA09 described how, when she first started, she was particularly worried about how her employer would respond to her 'broken English'. Several supervisors also mentioned problems when PCAs talked to family members. For example, SV03 described a situation where a family member asked a PCA from a CALD background a couple of simple questions about an older person, but she could not answer these and referred the family to the supervisor, which she said 'was not good'.

Examples of *communication problems with management* were also provided by our participants. Supervisors described two types of communication issue: (1) breakdown of communication owing to English language proficiency and (2) PCAs from CALD backgrounds not communicating key information (or downplaying key information). Regarding the former, SV13, herself from a CALD background, noted her communication problems with certain carers:

> I got a lot of problems like that. Sometimes I really do not understand what this carer says sometimes. I try to clarify and again, again. So if that happen, or after, because some important instant I need to know from the beginning to end. I don't know, is that my listening problem or her language problem? (SV13)

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Both SV17 and SV21 were concerned about PCAs from CALD backgrounds at times downplaying (or exaggerating) an issue a resident was experiencing (*e.g.* reddened skin) or not informing supervisors about a problem early enough.

Using the telephone was a communication task that PCAs engaged in with various communication partners. Supervisors and family members reported at times not understanding CALD PCAs when they spoke over the phone or left messages. One supervisor (SV13) complained that PCAs sometimes did not have efficient phone conversations. On the other hand, PCAs noted that they did not always understand their colleagues when they gave instructions or made requests on the DECT phone. For example, PCA03 attributed her lack of vocabulary when she first started work to her problems using the phone. Several PCAs referred to the telephone as something they were scared of and avoided where possible. For instance, SV12, a former PCA from a CALD background, described being scared when she once had to call the family of a resident, and asking a colleague who she thought spoke better English to do it instead. And PCA16 described her fear of having to use the phone:

> I was so, so scared. My biggest worry was in case if I have to call the ambulance, how I'm going to call the ambulance? What if they don't understand? I have [since] gained that confidence. Even though I can communicate with people, I think my confidence level was so low at that time because I'd never been surrounded by people who only speak English. (PCA16)

Also, PCA07 described how she avoided answering the phone when it rang because she was worried that she would not understand the person on the other end.

In summary, the analysis of the interview data showed that CALD PCAs encounter challenges with a range of communication tasks that involve interaction with a number of different interlocutor groups.

Discussion and conclusion

With an increasingly ageing population, more people accessing residential and in-home services, and an increasingly multicultural and multilingual workforce in many developed countries (Mavromaras et al. 2016; Turnpenny & Hussein, 2022; Walsh & Shutes, 2013), it is important to draw attention to the importance of supporting care workers from CALD backgrounds in developing their communication skills. Gaining a better understanding of the specific challenges encountered by these carers can help with the development of specific interventions to help those already in the workforce and those planning to enter to overcome communication difficulties.

The aim of the current interview-based study was twofold: (1) understanding and cataloguing the communicative challenges encountered by carers from CALD backgrounds (Research Question 1) and (2) evaluating how well Celce-Murcia's (2008) model of communicative competence captures the key components of communication used in care settings (Research Question 2). This study's innovation lies in the gathering of perspectives from PCAs from non-English-speaking backgrounds, their supervisors and older service users and/or their family members.

The data gathered to answer the first research question showed that the communicative challenges facing new PCAs from CALD backgrounds are numerous. Specific

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challenges were identified that related directly to aspects of language or communication, including specific linguistic difficulties such as challenges with general English proficiency, comprehension, speaking, writing and reading, vocabulary and grammar. Some of these linguistic challenges have been previously described in other studies (Bauer et al. 2014; Mackey 2018; Nichols et al. 2015; Shrestha et al. 2023). The current study expanded on this previous research and was able to create a systematic list of these challenges. Apart from linguistic challenges, we also identified instances of PCAs showing a lack of socio-cultural knowledge, lack of medical knowledge/lack of training or experience, and lack of strategic competence. A lack of socio-cultural knowledge and strategic competence was also previously described in the study by Mackey (2018). In terms of socio-cultural competence, our data showed carers at times not understanding humour. This concurs with the findings of Shrestha et al. (2023). While this was mentioned from the viewpoint of older people and their family members, it is important to also acknowledge that what is intended as humour can also come across as rude or insulting to carers, and it is important to acknowledge that this is not a one-way challenge. Similarly, cultural knowledge is often very specific to an area and can therefore also be difficult for those who do not experience any linguistic challenges but are not familiar with the cultural nuances of that area. Similarly, cultural nuances can shift over time and specific cultural knowledge and phrases may be used by older people that are not normally used by the wider community. For this reason, these challenges are likely not isolated to carers from CALD backgrounds.

We also catalogued specific tasks with older people and other interlocutor groups that proved difficult and tasks that were at times avoided by PCAs because they were seen as challenging. These findings add to the limited existing literature in this area. While difficulties communicating with families have previously been documented by Bauer et al. (2014), other findings in our study have not yet been described, to our knowledge, in the literature on carer communication, although some findings mirror previous research on the communication challenges of nurses from CALD backgrounds (*e.g.* Chege and Garon 2010; Cummins 2009; Xu 2008; Xu et al. 2010).

It is of course important to critically evaluate the findings of the current study. Tasks that were mentioned prominently in our data, such as building connections with older people, are difficult for any carers in care settings, and are often created mutually by the carer and the older person. While difficulties were identified in our data, similar difficulties are likely to occur for all carers, regardless of their background. However, building awareness of potential difficulties in training programmes is likely to go some way towards awareness-raising amongst all staff members in care settings. We hope, therefore, that the systematic cataloguing and grouping of the challenges identified in the interviews is helpful not only for inspiring future studies (*e.g.* focussing on particular challenges) but also as a catalyst for the development of training programmes for new PCAs from CALD backgrounds.

Our second research question examined how well Celce-Murcia's model of communicative competence, which was originally developed for language learning/teaching purposes, represents the various aspects of communication identified as challenging in our study. We mapped the findings onto the model of communicative competence proposed by Celce-Murcia (2008). Appendix A shows the various components

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Figure 1. Model of the communicative competence of personal care workers.

and sub-components of the model with a description and examples of the communication difficulties we identified in our study. Our data showed that, although all aspects of Celce-Murcia's model hold in the care communicative setting, additional industry-specific issues emerge. These include knowledge of profession-specific linguistic knowledge (*e.g.* knowledge of specific medical terminology) and competence in specific communicative tasks (such as communicating with residents). We have integrated these aspects into the revised model based on the data in this study and presented them in Figure 1.

In the centre of the model are five competences, arranged from the bottom representing bottom-up competences to those closer to the top, top-down competences. General linguistic and discourse competence is placed at the bottom. This includes the types of aspect we reported under linguistic difficulty, including aspects of pronunciation, lexical and grammatical competencies. We also include the ability to create and comprehend texts in this competence. Profession-specific linguistic and discourse competences are represented next in the figure. These include the knowledge of medical and health terminology, acronyms and abbreviations as well as the ability to create genre-appropriate discourse and texts. Interactional competence was shown to be important in our data, from which we can add further profession-specific speech acts, including flattering, de-escalating and distracting. This aspect also includes important non-verbal and para-linguistic competences which we found prominent in communication in caring for older people, including body language, such as eye-contact, gestures and touch. These competences were found to be particularly crucial with older people and those experiencing cognitive decline.

Socio-cultural competence is depicted as a top-down competence. Difficulties with this competence were prominent in our data, with many instances of problems reported by the participants, including problems understanding humour and understanding Australian idiomatic language. Difficulties were also reported with PCAs not understanding or knowing general cultural practices, not knowing how to do things

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culturally appropriately and coming across as rude or lacking politeness. Finally, at the top of the figure we have placed 'professional knowledge and competence' as this was also mentioned as at times lacking in new PCAs from CALD backgrounds, and having a direct impact on communication. Lack of training and professional and medical knowledge was mentioned by participants as influencing communication negatively.

All five levels described here are mitigated by strategic competence, shown on the right side of the figure. In Celce-Murcia's (2008) model, aspects of strategic competence relate to strategies used in language learning, whilst in the case of our model strategic competence relates to communication strategies that speakers can draw on when experiencing communication difficulties. Asking for clarification, for example, was mentioned prominently in our data, with supervisors and older people (and their family members) expressing concern that PCAs often did not ask for clarification when they failed to understand an utterance.

On the left side of the model, we have added two situational variables that were shown in our data to influence communication: the communication tasks that participants engaged in (*e.g.* communicating using the telephone) and the specific conversation partners they engaged with (*e.g.* colleagues, older people, families or management). These were shown potentially to influence the communication and communicative choices made by PCAs.

We hope that compiling these aspects of communicative competence into a model will help to systematize the communication training offered to new PCAs from CALD backgrounds. Training and teaching materials can potentially be developed based on this model. We also hope that a better understanding of the various competences required can raise awareness amongst all communication partners in care settings.

Our research has a number of strengths. Firstly, our focus on three key interview groups provided a range of perspectives on communication in care settings. Some themes emerged from the interviews of all groups, while others were reported by only some participant groups and would have therefore not been identified if we had not sampled from three groups. Secondly, we hope that the model we created will be useful not only for future research but also for training and support of new PCAs from CALD backgrounds, a group likely to expand in the future.

As with all studies, this research has several shortcomings. We relied exclusively on interview data as we conducted our research at the height of the Covid-19 pandemic, which meant that it was not feasible to visit care settings to gather other types of data, such as observational data. We are very grateful to the participants who agreed to take part in this study under challenging conditions. Secondly, our ethics clearance did not allow us to interview people living with dementia, and therefore we acknowledge that the experiences of this participant group are present in our data only through the voices of their family members.

Our data capture a broad range of challenges facing PCAs from CALD backgrounds. We hope that future research can be designed to include larger and more diverse samples and to collect other types of data for triangulation. Further work is also required to better understand how various aspects of the model interact. For example, the study showed that difficulties with grammar may result in a PCA sounding rude, therefore impacting their politeness. For this reason, we modelled linguistic difficulties lower in

the model, showing that they may underpin other aspects depicted higher up. However, more work is needed to understand the impact of various components on each other.

We adapted Celce-Murcia's (2008) model, drawing on the findings from our data, because we found it the most useful starting point for representing our data. The model set out in Figure 1 and Appendix A is therefore only tentative and further work needs to be done to validate whether the model sufficiently represents the competences needed and the situations encountered by PCAs.

To conclude, we want to reiterate the point we made earlier in our article. The aim of this research was not to portray PCAs from CALD backgrounds in a negative way. In fact, many of our participants noted the amazing capacity of the carers to adapt in their roles, to learn how to communicate with the residents and to gain confidence in their interactions with the older people they were caring for. All PCAs also reported how their communication skills improved over time. We hope that our findings can inspire more systematic support for these carers early on in their careers. Supporting practitioners whose first language is not of the country they are working in to gain a better understanding of communication (*e.g.* in language classes, through support with terminology) and providing training on culturally appropriate care and communication should be an important aspect of training for new staff. At the same time, local carers should be made aware of areas that could be potentially difficult for carers from CALD backgrounds so that they can support their colleagues wherever possible. We feel that it is the care industry's responsibility to support carers from CALD backgrounds and at the same time raise awareness of potential challenges amongst local care staff. After all, staffing shortages will continue to be filled by carers from CALD backgrounds who collectively bring a broad skillset to the industry and provide a high standard of care, and residents may prefer overseas-born carers to those born in Australia (*e.g.* Shrestha et al. 2023), especially if they themselves were born in a different country.

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Appendix A: Components and sub-components of communicative competence model

Component	Sub-component	Description	Examples of difficulties from study
General linguistic and discourse competence	General linguistic competence	Choice of phonological, lexical, morphological and syntactic components	Problems with general English language proficiency, comprehension, speaking difficulties (including accent, speed of speech, use of incorrect grammar), writing difficulties (including vocabulary and spelling, nuances in terminology crucial to documentation, grammar)
	General discourse competence	Selection, sequencing and arrangement of words and structures to achieve a unified message	Appropriately sequencing interactions with older people to get them to do things by: addressing residents, explaining, asking for permission, offering choices etc.
Profession-specific linguistic and discourse competence	Profession-specific linguistic competence	Choice of profession-specific components, in particular lexis	Lack of knowledge of medical and health terminology, acronyms and abbreviations; and specific vocabulary used in aged care
	Profession-specific discourse competence	Selection of structures to create profession-specific discourse	Understanding of genre required for various interactions such as handover meetings, responding to complaints
Interactional competence	Actional competence	Knowledge of how to perform common interactions, including interpersonal exchanges, responding to problems, etc.	Problems with appropriately asking for permission
	Conversational competence	Knowledge of turn-taking (*e.g.* opening and closing conversations, changing topics, collaborating, backchannels)	Problems interacting with colleagues and residents by, for example, using small talk
	Non-verbal/paralinguistic competence	Use of body language, gestures, eye contact, touching, space, non-linguistic utterances (*e.g.* uh-oh)	Problems using appropriate eye contact and body language Noticing body language of residents was also reported as a problem

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(*Continued.*)

Component	Sub-component	Description	Examples of difficulties from study
Socio-cultural competence	Social contextual factors	How the participants' age, gender, status and social distance and their relations to each other affect power and balance	Personality, including being a very quiet person
	Stylistic appropriateness	Politeness strategies, a sense of genres and registers	Coming across as rude/lacking politeness; not knowing how to address older people properly
	Cultural factors	Background knowledge of the target language group, major dialects/regional differences and cross-cultural awareness	Problems understanding humour and slang; not knowing/understanding general cultural practices; not knowing how to do things
Professional knowledge and competence		Medical knowledge/training in aged care; experience working in aged care	Lack of medical knowledge, training and experience; not appropriately explaining care tasks; not offering choices; not efficient when conveying information; problems communicating key information to management; not knowing enough about medication; not knowing enough about how to interact with people with dementia
Strategic competence		Strategies that help meaning-making, such as miming, code-switching, self-monitoring, repair and asking for clarification	Not asking for clarification; frequent asking for clarification was seen as irritating to colleagues; miming and pointing was described as a strategy to deal with communication difficulties

Specific interlocutors	Communicating with colleagues (both during work and in social breaks), families, management, older people, specific groups (*e.g.* people with dementia)
Specific communication tasks	Speaking on the telephone; building connections with residents; gaining residents' trust; knowing how to appropriately address a person

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