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Barriers and enablers to leisure provision in residential aged care: personal care attendant perspectives

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Abstract

This exploratory descriptive study investigated barriers and enablers to the provision of leisure activities for people living in three Australian residential aged care facilities (RACFs) that operated under a household model of care. This research is unique in the international context, as few studies have explored the understandings and experiences of personal care attendants' (PCAs) perceptions of what impacts leisure provision for people living in RACFs. Qualitative data were collected from 17 PCAs via four focus groups. Barriers to leisure provision were identified as PCA–resident ratios, competing demands of the PCA role and a prioritisation of physical care tasks over leisure-related activities. The severity of residents' dementia (cognitive and functional deficits) as well as behavioural and psychological symptoms of dementia were also framed as barriers to participation in and the provision of leisure. Participants identified enablers of leisure provision as related to perceptions of leisure, the experiential knowledge of staff, organisational support and resourcing. The study findings suggest that enhancing leisure provision for people living with dementia will require attention to system issues (*i.e.* staffing levels, ratios, PCA role demands) as well as PCA knowledge and capability to facilitate person-centred leisure.

Keywords: dementia; leisure; residential aged care; barriers; enablers; personal care attendants

Introduction

Dementia is a degenerative neurological syndrome involving the gradual and progressive deterioration of a person's physical and cognitive function, affecting their independence (Park and Cohen, 2019). In Australia, there are approximately 90,000 people living with dementia in residential aged care facilities (RACFs; also known as nursing homes, long-term care settings or care homes) accounting for 52 per cent of the permanent care population (Brown, Hansnata and Hai, 2016).

Similar trends are also observed internationally (Matthews *et al.*, 2013; Hoffmann *et al.*, 2014). With the movement of aged care services to embrace social models of care in the 1960s (Diversional & Recreational Therapy Association of Australia, 2019), aged care providers have, to varying degrees, sought to integrate leisure within their existing care approaches.

'Leisure' is described as uncommitted time during which a person engages in something that they enjoy, by choice, for personal satisfaction (Causey-Upton, 2015). Leisure activities are broad and can include reminiscence, art, listening to music, physical exercise (*i.e.* swimming, walking, dancing, tai chi), board games, social interaction and cultural activities (Fernández-Mayoralas *et al.*, 2015; Tak *et al.*, 2015). Importantly, engagement of older people, including those with dementia, in activities of leisure, has been cited as an indicator of quality of life in long-term care settings (Allen, 2011; Australian Government, 2020). Despite this, leisure for people with dementia who reside in RACFs is under-conceptualised and under-researched worldwide. Furthermore, the provision of leisure can also be understood from a human rights perspective. With a growing focus on the human rights model of dementia care, dementia has been contextualised as a disability as well as an impairment (Cahill, *in press*). Tools such as the UN Convention on the Rights of Persons with Disabilities offers ways of thinking about leisure provision through a human rights lens. For example, access to leisure activities can be understood as a right under Article 30 (Participation in Cultural Life, Recreation, Leisure and Sport) of the UN Convention (United Nations, 2006). Additionally, Cahill (*in press*) also argues that under Article 19 of the Convention, a person in residential care should have a right to have access to 'a broad range of meaningful and culturally appropriate activities'.

There is a growing body of evidence that suggests engagement in leisure activities is associated with numerous physical, cognitive and psychosocial benefits for people living in RACFs with and without dementia. For example, improvements to mental health, the promotion of social interactions, maintenance of social identity (Causey-Upton, 2015; Fernández-Mayoralas *et al.*, 2015; Tak *et al.*, 2015) and improvement in sleep patterns (Bowes *et al.*, 2013) are known benefits of engaging in leisure pursuits. Other related research has shown that engagement in leisure activities can result in a reduction in the use of psychotropic medication for people with dementia displaying changed behaviours (Corbett *et al.*, 2012; Tak *et al.*, 2015; Innes *et al.*, 2016). Indeed, guidelines on addressing changed behaviours (also referred to as behavioural and psychological symptoms of dementia (BPSDs)) recommend leisure activities such as art, music, exercise, social interaction and recreation as preferred non-pharmacological interventions (Antifeau *et al.*, 2013).

Despite the growing body of evidence about the benefits of engaging in leisure activities for people living with dementia, these findings have largely failed to translate into a broader implementation of person-centred leisure provision in RACFs (Causey-Upton, 2015; Tak *et al.*, 2015). Research has reported that older people in long-term care settings have decreased engagement in leisure activities compared to community-dwelling older adults (Vitorino *et al.*, 2013). Furthermore, there is evidence to suggest that people with dementia have poor levels of social engagement and higher levels of non-engaged and non-active behaviour (Morgan-Brown *et al.*, 2011), which in turn has implications for their involvement in leisure-related activities.

Research by Tak *et al.* (2015) found that people living with dementia in RACFs are unlikely to engage in self-directed activity and tend to depend on staff to assist with engagement in leisure activity. Arguably, therefore, frontline care providers such as personal care assistants and other aged staff have an important role in supporting the provision of leisure (Causey-Upton, 2015; Fernández-Mayoralas *et al.*, 2015; Tak *et al.*, 2015).

In Australia, like some other Western nations, the aged care workforce is largely comprised of personal care attendants (PCAs) (Mavromaras *et al.*, 2017; Eagar *et al.*, 2019), a role alternatively titled 'health care assistant' or 'care worker'. The standard qualification for such staff is a Certificate 3 in Aged Care;¹ two-thirds of PCAs had this qualification in 2016 which is similar to the proportion of participants in this study (Mavromaras *et al.*, 2017). According to the most current workforce data, PCAs account for 70 per cent of staff in Australian RACFs, while nursing staff account for 25 per cent and allied health staff account for 5 per cent (Mavromaras *et al.*, 2017). With the emergence of different models of care, the role of PCAs in aged care services has expanded beyond the historical boundaries of personal care to include broader areas of clinical and social care.

The 'household' model of care, also referred to as the 'clustered domestic model', has recently emerged with the intent of removing the historical siloing of job roles amongst aged care staff (Harrison *et al.*, 2019). It is argued that such an approach can provide residents with improved care continuity, enhanced wellbeing, independence and, ultimately, improvements in quality of life (Morgan-Brown *et al.*, 2013). As such, under a household model, PCAs are tasked with the responsibility of a range of duties, from personal care to cooking and laundry (Sharkey *et al.*, 2011; Harrison *et al.*, 2019). Taking on the role of a universal worker, PCAs are reported to have an expanded role in pain assessment, management practices (Andrews *et al.*, 2019) and wound management (Mavromaras *et al.*, 2017). Leisure provision is also included among PCA responsibilities, although this is not known to be the focus of their educational qualification (Australian Government, 2021). Despite this role expansion, little is known about how PCAs engage people with dementia in leisure and operationalise this aspect of their role. This study aimed to explore PCAs' experiences and understandings of their role in leisure provision to identify the barriers and enablers that may exist when working alongside people living with dementia in RACFs.

Methods

Design

This study used an exploratory-descriptive approach to gain knowledge of PCAs' experiences in, and understandings of, their role as leisure providers, and what factors impact on leisure provision. This approach was appropriate because the study sought to uncover previously unexplored perceptions and experiences of this staff cohort.

Data were collected through focus groups with PCAs from three RACFs. Focus groups are well suited when an experience common to all members is to be explored and, in particular, when the issue under exploration is underresearched, as focus groups are known to produce an enriched view of the issues at hand

(Tracy, 2013: 169; Nyumba *et al.*, 2018). Focus groups enable participants to engage in dialogue with others where they can hear their peer's perspectives, compare them to their own and engage in discussion to further understandings amongst the group (Liamputtong, 2011). According to Brinkmann and Kvale (2017), focus groups comprised of participants who have the same organisational standing or positions (as in this research) can create a space where people feel safe to share, less incumbered by impacts of organisational hierarchy. From this sense, dialogic engagement offers participants opportunities for greater self-disclosure; when people share in group discussion, it allows more exploration and information sharing than may have occurred in a one-on-one interview (Tracy, 2013: 169). Moreover, Kamberelis *et al.* (2018) highlight that the use of focus groups acknowledges that knowledge is socially and culturally constructed. This was an important consideration for this project as residential aged care settings are known to be complex environments where cultural, organisational/system and regulatory issues intersect to shape practice and knowledge about practice (Simpson *et al.*, 2013). Through participant discussion, interpretive and descriptive accounts of experiences and understandings about the role of PCAs in leisure provision could be constructed.

Setting

The study was conducted at three sites of a large, not-for-profit, aged care provider. All research sites were operated by a single provider in regional New South Wales, Australia. RACF 1 and 3 were 134- and 100-bed facilities, respectively, and provided care for people with and without dementia. RACF 2 was a 25-bed dementia-specific unit. All RACF sites involved in the study practised a 'household' approach to care for at least three months prior to the study. The intent of this more holistic approach to care is to promote a homelike rather than an institutional focus. Under this model, PCAs are responsible for providing personal care, meals, attending to laundry and the provision of leisure. While PCAs at the participating services were expected to engage residents in leisure activities as part of their everyday role, more formal and organised leisure activities (such as exercise classes/bus trips/art groups) were run by volunteers. In RACF 2, a recreational activity staff member worked alongside other staff in a leisure-focused role. The responsibility for inviting staff to participate in this study was allocated to site managers who posted flyers in staff rooms and relayed information related to the study at general staff meetings. However, this method of recruitment produced low enquiries and in collaboration with site managers a time for the focus groups was arranged. Those available on the day and wanting to participate attended the focus groups. Focus groups were held on site in a private room. The numbers of participants in a focus group depended on the size of the site and staff availability on the day, and ranged from three to seven.

Participants

Staff invited to participate in the study were PCAs who had worked with the organisation for a period of at least three months for a minimum of three shifts per week. Participants were PCAs who had at least three months of experience in the role as

Table 1. Participant demographic data

	N
Participants:	
Focus group 1	3
Focus group 2	7
Focus group 3	4
Focus group 4	3
Gender:	
Male	2
Female	15
Age:	
Range	29–62
Mean	42.5
Unspecified	1
Country of birth:	
Australia	11
Thailand	1
Kiribati	1
Wales	1
Poland	1
Bulgaria	1
Unspecified	1
Years of practice as a personal care worker:	
<1	3
1–5	5
>5	9

per inclusion criteria and were responsible for providing leisure to residents as part of their duties. Staff ranged in age from 29 to 62 years with a mean age of 42. Fifteen of the 17 staff who participated were female. Educational attainment in the group varied from Year Ten to overseas bachelor qualifications. Eight had completed a Certificate 3 in Aged Care. For additional participant characteristics, *see Table 1*. Written consent to participate in the focus groups was obtained from all participants.

Data collection

Seventeen participants engaged in four focus groups conducted across the three RACF sites; two focus groups were held at one site. Focus groups varied in size

Table 2. Focus group guide

<p>(1) How do you understand leisure activities?</p> <p>(a) What does leisure mean to you?</p> <p>(b) Do you understand leisure in the same way for people living with dementia in the service?</p> <p>(c) Do you think leisure is important for people with dementia?</p> <p>(d) When in your shift do you provide resident leisure?</p> <p>(2) Which staff have the responsibility for delivering leisure to people with dementia in your facility?</p> <p>(a) Do you think it is important? What is the most important part of your job?</p> <p>(3) What are the most common problems or barriers you have with providing leisure to people with dementia where you work?</p> <p>(4) What are the enablers or things that help you to provide leisure to people with dementia where you work? What helps you with providing leisure to your residents with dementia?</p>

Table 3. Example of data analysis

Transcript excerpt	Code	Related theme	Key theme
I had a volunteer help me with that painting yesterday, which was so good because I wouldn't have been able, I didn't realise it was going to be as demanding as what it was	Appreciating volunteers' contribution	Support from staff/volunteers	Organisational support/resourcing
We have a very open-minded manager ... who is ... very supportive of our ideas and will always help us to get it done	Appreciates manager's attitude and support	Supportive manager	Organisational support
It depends ... what frame of mind the residents are in. If they're really unsettled then you've got no hope of getting them to do anything	Seeing needs of residents as unpredictable	Resident anxiety affecting leisure engagement	Dementia severity
My main role is taking care of the residents, focus on their personal care, personal hygiene ... after the personal care, after that, we encourage them to join the activities	Personal care comes first	Prioritising of physical care over leisure	Workloads and prioritisation of physical care over leisure

primarily due to participant interest and response rate at the different sites. According to Tracy (2013: 170), valuable data may be captured using three to 12 participants. All group sizes used within this study fell in this range and the use of open-ended questions enabled free-flowing discussion for even the smaller-sized groups. The data were gathered in August 2018. A schedule of questions was

Table 4. Codes, themes and key themes

Codes	Themes	Key themes
<ul style="list-style-type: none"> • Leisure knowledge • Drawing on personal experience • Observation • Educated guess • Knowledge of needs/abilities of people living with dementia • What goes down well • Meeting individual needs • Knowing the person • Leisure as providing purpose • Leisure as pleasurable • Leisure as supporting independence • Seeing some activities as leisure 	<ul style="list-style-type: none"> • Staff knowledge • Experience in the role • Observations-based knowledge • Analysis of experience • Understanding dementia • Understanding of leisure 	<ul style="list-style-type: none"> • Experience-based knowledge
<ul style="list-style-type: none"> • Communicating • Co-operating • Family support • Resource availability • Availability of staff • Valuing volunteers • Pre-planning • Appreciating manager's attitude and support • Seeing leisure workers as valuable • Flexibility in schedule 	<ul style="list-style-type: none"> • Collaboration • Availability of resources • Supportive manager • Support from staff/volunteer 	<ul style="list-style-type: none"> • Organisational support/resourcing
<ul style="list-style-type: none"> • Residents with dementia are disruptive • Reduced ability as a barrier • People with dementia being different • People with dementia having additional needs • Other residents having rights • Increased difficulties in late-stage dementia • Seeing needs of residents as unpredictable • Difficulties with leisure for late-stage dementia 	<ul style="list-style-type: none"> • Seeing dementia as problem • Burden of dementia-related disability • Fairness to others • Resident anxiety affecting leisure engagement 	<ul style="list-style-type: none"> • Dementia severity

(Continued)

Table 4. (Continued.)

Codes	Themes	Key themes
<ul style="list-style-type: none"> • Being time poor • Busy all the time • Multiplicity of roles • Multiplicity of tasks • Multi-tasking • Neediness of residents • Overwork • Personal care comes first • Not enough staff • Leisure in residual time • Residents using wheelchairs miss out • Greater disability leading to fewer leisure opportunities 	<ul style="list-style-type: none"> • Time poor • Heavy workload • Prioritising of personal care • Prioritising of physical care over leisure • Insufficient staff to resident ratio • High disability equals low leisure 	<ul style="list-style-type: none"> • Workloads/prioritising physical care over leisure
<ul style="list-style-type: none"> • Dining together • Knowing what works • Knowing what doesn't work • It's everyone's job • Short bursts on a small scale • One-on-one • Opportunistic leisure 	<ul style="list-style-type: none"> • Social interaction as leisure • Moments of leisure • Informal leisure 	<ul style="list-style-type: none"> • Perceptions of leisure

developed prior to the commencement of the study (Table 2). The questions were framed to allow an exploration of staff perceptions, and experiences about barriers and enablers to the provision of leisure activities for people living with dementia. All focus group discussions were audio-recorded and transcribed verbatim.

Data analysis

Data analysis was guided by Braun and Clarke's (2006) method of thematic analysis, which has an emphasis on an organic approach to organising, describing and interpreting the data. Thematic analysis is a form of content analysis with clearly defined procedures, suitable for identifying patterns of meaning in qualitative data, and involves the generation of codes and themes that provide insights guided by the research question. As a method of analysis it lends itself well to the descriptive methodology because it enables an inductive approach, such that themes emerge from the data (Braun and Clarke, 2012). Given that our research question is underexplored, it would not have been appropriate to use a more deductive method where analysis is conducted from pre-existing theoretical understandings (Merriam and Tisdell, 2016: 17). Braun and Clarke's (2012) six-phase process allowed for working from the 'bottom up' to create a rich and complex

narrative with data extracts to illustrate themes, which they also posit is essential in an area of inquiry where little is known (Clarke and Braun, 2014). Ideas were noted on the transcript and the data were coded line by line. Codes were collated and organised by themes which included sub-sets of codes, subsuming some codes. Table 3 contains an example of the data analysis process. Exemplars from individual narratives are provided in the Results section to illustrate the key themes. This was deemed appropriate as the aim of this research was to uncover perceptions rather than reach a consensus (Silverman and Patterson, 2021: 87). Table 4 contains codes, themes and key themes illustrating the data analysis process.

Results

Here we present the key themes emerging for the focus group discussions. Below, verbatim data are referenced to a particular focus group and individual participant (*e.g.* FG1: P1).

Importance of leisure for people with dementia

Overall, participants considered that the provision of leisure to people living with dementia was an important aspect of care and that a diagnosis of dementia did not preclude residents from having leisure-related needs. Participants reflected on the importance of providing leisure to people with dementia when they stated:

Just because they have dementia doesn't mean they can't enjoy ... the pleasures of life. (FG3: P12)

They definitely have the same interest and the same passion that they always had. (FG2: P3)

The following conversation reflected how staff considered that leisure could provide a sense of relief and distraction from what can be at times a challenging environment of an aged care service and also can assist in moderating behavioural symptoms of dementia:

I think it's [leisure] important because it [the RACF] can be quite a stressful place to be in ... they can get lost in [leisure activity] ... forget their [worries]. [I] think it's important. (FG2: P5)

I think it reduces their frustration. (FG2: P3)

...because they've got something to focus on or put their attention on ... so prevent their behaviour. (FG2: P1)

The immersive nature of leisure was recognised for its effectiveness in reducing anxiety that may be exacerbated by the living environment in RACFs.

Barriers to leisure provision

While staff categorically agreed on the importance of leisure for people living with dementia, as the focus group discussions progressed, a series of barriers to leisure

provision was identified by participants. These barriers were centred around the impacts of dementia severity, staff–resident ratios, competing role demands and workloads.

Dementia severity

Participants across the four focus groups situated the severity of cognitive and functional decline associated with dementia as a barrier to leisure engagement. Staff members explained that changes to residents' cognitive and functional ability could preclude their involvement in leisure pursuits:

They [residents with dementia] still have the same interest; they may not necessarily have the same ability [to participate]. (FG2: 6)

There's some [residents] that would probably really enjoy going out on the bus, but they can't get on the bus physically. (FG3: 16)

Participants also suggested leisure activities offered were unsuitable for residents in more advanced stages of dementia when disability was profound. For example, one staff member in FG4 stated:

There is not a lot [of leisure activities] for them [residents with severe cognitive impairment] to do ... we have residents [with severe dementia] that sit in a water tub chair and do nothing. (FG4: 17)

The presence of BPSDs was another factor which participants identified as a barrier to both (a) resident engagement in leisure and (b) provision of leisure activities by staff. For example, one participant explained how, if a resident was anxious or agitated, this ultimately impacted on their leisure engagement:

It depends ... what frame of mind the residents are in. If they're really unsettled [anxious or agitated], then you've got no hope of getting them to do anything. (FG3: 11)

Moreover, residents who displayed symptoms such as verbal agitation were more likely to be excluded from group activities to avoid upsetting other residents:

You've got someone with dementia who takes off their seatbelt [on the bus] and keeps standing up or constantly when they get agitated [saying:] 'I want to get home to get my kids', next to a person that's got their full faculties ... I know we're all meant to be team together but sometimes you need that separation [between residents with BPSDs and those without]. (FG1: P1)

The presence of BPSDs also permeated decisions about which residents were suitable for volunteer-run activities. Individuals were grouped as one and considered unsuitable as described:

Dementia residents [*sic*] ... are quite challenging for volunteers ... so that I think is another barrier. (FG4: 15)

To ask volunteers to do it, I think is a ... bit of a challenge ... dementia residents [*sic*] are a bit of a challenge that is placed on a volunteer. (FG4: P16)

The effects of dementia on the person's ability, in combination with BPSDs, were viewed as a barrier to participation in the kinds of leisure activities offered by participants.

Workloads and prioritisation of physical care over leisure

Across all four focus groups, workloads and staffing were identified by participants as the main barrier to providing leisure opportunities for residents with dementia. In general, participants reported that staff–resident ratios were inadequate to support the provision of leisure as part of their daily care routines. One participant aptly reflected this concern when they stated: 'It's mostly about not having enough staff' (FG3: P11). Another participant highlighted how, under current staffing arrangements, it was not possible to ensure that all residents in their care were able to attend a morning activity:

If all those 17 residents want to go to exercise, at nine-thirty ... they gotta have breakfast, they gotta be up, ready, they gotta have their medication and everything within two and a half hours. We do not have the time. (FG4: 17)

Participants were asked to describe when in the shift they were able to provide leisure activities to residents, given that this fell under the scope of their responsibility. There were a range of responses reflecting individual PCAs' experience of leisure provision:

By the time you start ... by the time you get everything done, it's almost lunch time, so there is no room [to provide leisure activities]. (FG1: P3)

Probably after lunch. (FG3: P13)

Before lunch, you always find 15–20 minutes when they're all together and you can just drop something ... even the word game] or just reminiscing. (FG2: P10)

Participants explained that their roles under the household approach included the majority of personal care (showering, toileting, dressing) as well as supporting residents with other activities of daily living (preparing and serving meals, cleaning rooms, laundry). Reflecting on the role requirements of PCAs, one participant stated: 'We do everything [for residents] from go to whoa in the day' (FG3: P12). The multiplicity of their role responsibilities was seen to result in heavy workloads and PCAs reported prioritising tasks according to perceived levels of importance and urgency. There was a high degree of consensus amongst participants as to what tasks were given highest priority in the course of everyday care:

Personal hygiene and their care. (FG3: P11)

Prioritising would be making sure that they're ready for the day and medication. (FG4: P15) Personal hygiene first. (FG2: P5)

I think the [personal] care of the residents is probably the foremost. (FG1: P2)

Participants explained that the prioritisation of certain tasks (resident hygiene, personal care and medication management) combined with high levels of resident

dependency ultimately had a flow-on effect for whether residents accessed leisure activities. The following account highlights how residents with higher care needs were more likely to miss out on leisure activities:

Some people can't walk, so for some activities, they can't go easily [*sic*], they need someone to help them to transfer from the bed to the care chair or to the wheelchair. So when the care staff have not enough time, because we need to take care of specific number of residents, we need to prioritise things. So it's a combination of the ability of the residents and also the limitation of time when the care staff have not enough time to transfer the residents, the residents lost their opportunity to join the activity. (FG1: P1)

Transporting residents was reported as hidden additional work involved with leisure activity facilitation:

When you're doing an activity, you also need to be able to have the time to go retrieve those residents and bring them down, when they're in their wheelchairs and what have you ... and then also take them back up as well after the activity. (FG4: 17)

Participants highlighted that another complicating factor to meeting residents' leisure needs was the requirement to take on additional duties when staff shortages occurred. For example, a participant explained that if the facility was short of a Registered Nurse (RN), then one of the PCAs (qualified in aspects of clinical care such as administering medications and wound management) would be required to take on those additional tasks. These circumstances had negative flow-on effects for leisure provision, as described by participants:

If I'm stuck doing the RNs work, I obviously can't be running around doing [leisure] activities. (FG1: P3)

And today I'm doing the RN shift because we didn't have one. My role is the [team leader] which is medications, dressings, liaisoning [*sic*] with the doctors, family, doing activities, setting them up ... a lot of things ... attending to care on the floor when they need it. (FG2: P8)

Perceived staff shortages, a multiplicity of tasks and responsibilities, as well as a prioritising for personal care were collectively seen as logistical barriers to leisure provision.

Enablers to leisure provision

Despite the considerable impact of working with people who have complex care needs and issues of workloads and role complexity, staff were able to identify a number of enabling factors for leisure provision. The use of experiential knowledge to provide leisure activities, how staff conceptualised leisure relative to their role and organisational support, including availability of human resources, were identified as important enablers.

Experience-based knowledge of staff

According to participant accounts, staff knowledge related to the facilitation of leisure was largely drawn from their experience in their job role. The following accounts reflect how staff drew on experience-based knowledge:

Music seems to settle them [people living with dementia] a lot when they're really unsettled. (FG3: P11)

They [people living with dementia] love it you know like if you cook, you will get people with dementia to actually come over and they may not help you or anything, just watch you, the smell, they love it! (FG3: P3)

We play some music and then dance with them. Sometimes we play the music from our phone and then just dance with them. They love Elvis. (FG2: P1)

While experiential knowledge was identified by PCAs as assisting them to make choices about leisure activities, some staff did identify the importance of tailoring activities to the needs of people with dementia; for example:

I think the activity itself should be more focused on people with dementia, like some people with dementia can't play bingo. They can do it with the assistance of somebody, but you couldn't sit down [and] call bingo ... [the activities] need to be specific. (FG1: P2)

Someone with mild dementia can go ... let's say [to] a day centre ... and have a cuppa tea and participate in ball games ... word games and all that stuff [whereas] someone with progressing [more severe] dementia cannot participate, and if we get a person [an] activity that's for mild dementia it obviously will fail. (FG1: P3)

Participants also recognised that solo pursuits including outdoor engagement and provision of therapy dolls could be tailored to resident needs and responses:

We've got one lady that has got two therapy dolls and she loves to put them in the pram and she feeds them. (FG3: P11)

[Name of resident] loves to get out and hose [the garden]. [Other name of resident] likes to feed the birds. (FG3: P11)

Another participant also explained how, based on her experience, one-on-one activities were more suitable for people at later stages of dementia. She stated:

When you ... do activities with people that live [with] dementia, one-on-one is my experience is that it actually benefits them the most [*sic*]. (FG1: P3)

In this way, participants drew from their experiences in the workplace to work out ways to provide the kind of leisure that residents were able to enjoy.

While some staff constructed dementia as a barrier to leisure provision, they were also able to articulate strategies to promote the engagement of residents in individualised activities.

Perceptions of leisure

Staff conceptions of leisure as part of their daily work with residents was found to be an enabler of leisure. In FG2, participants spoke about understanding leisure as part of everyday care:

It can be that one-on-one sitting down flicking through a magazine with them, showing them a photo of their family when you're in their room with them. (FG2: P4)
 I think it's part of what we do. I think it should be part of every day that we come in to work that that's part of your job and not only that, it's you know ... making a difference to them and yeah ... it should be part of everyone's job. (FG2: P5)
 Opportunities can present ... it could just be if you got five minutes of time to flick through the local paper with them, and anything really. (FG2: P6)

Conceptions of leisure as brief informal and person-centred activity was found to stimulate the provision of leisure.

Organisational support and resourcing

Organisational support was identified by participants as important to the provision of leisure from a number of perspectives. Firstly, support for organised leisure activities which were scheduled in advance was considered to be more likely to be successfully undertaken than relying on spontaneous engagement (especially in the context of heavy workloads). Such scheduling allowed staff to be prepared and residents to look forward to the activity:

Every second day, there's a bus trip: Monday, Wednesday, Friday. Some of them [residents] hang out, when they know it's bus trip [*sic*], they'll just be at the door, waiting for the bus to come. (FG3: P13)

In the context of organisational support, having a manager who was supportive of staff member ideas for leisure activities was also reported as a significant facilitator for leisure provision. Participants explained:

We have a very open-minded manager ... who is ... very supportive of our ideas and will always help us to get it done. (FG2: P5)
 She's [manager] very hands on too. If me or [name] or anyone has organised something big, she will go out of her way to be there. (FG2: P8)

Another aspect of organisational support discussed by participants, as an enabler of leisure, was having access to additional support people (either extra staff or volunteers). At one of the facilities, participants reported that the employment of a part-time staff member to facilitate leisure activities at the service was important for ensuring that the residents' leisure needs were being met, amidst competing demands of staff workloads. This was best captured in the following comment:

I think that for our job description, and then trying to do activities too, is a really hard balance some days, and we really need her [part-time leisure staff member] 'cause when we are short of time, like when we're having a really bad day and

you're really pushed for time trying to get activities and that sorted ... you got somebody here to just take that pressure off. (FG3: P11)

The contribution of volunteers was also highly valued by PCAs as an enabler to support the provision of leisure. Participants explained that volunteers either ran or assisted with the running of group activities, such as exercise and art groups. As outlined in the following account, volunteers made a vital contribution to leisure:

I had a volunteer help me with that painting yesterday which was so good because I wouldn't have been able [to do it]. I didn't realise it was going to be as demanding as what it was. It was enjoyable, but next time I know that there's no way I could do it by myself. (FG1: P2)

Right now, there's an art group happening. My mum actually volunteers and does that, and she helps a lot of dementia residents in terms of ... keeping them entertained and focused. (FG4: P17)

Another participant also recounted how group exercise classes, that were well attended by residents, were organised by volunteers:

Just today, [we had] 'boot camp'. It's kind of the exercise that [*sic*] the residents sit on the chair and then [there] will be two or three staff from other organisations, they came voluntarily. (FG2: P4)

The presence of support personnel whose work role had a leisure focus was seen as an enabler to leisure provision.

Discussion

This study provides insights into the perspectives of PCAs, working in residential aged care, about the barriers and enablers to leisure provision for people living with dementia. This study is unique because, to our knowledge, it is one of the first studies to seek directly the perspectives of aged care staff with the responsibility for leisure provision. Participants reported that workloads, competing role demands, shortages of time and a prioritisation of physical care over social aspects of care impacted on the delivery of leisure. Such issues have been documented by others (Zúñiga *et al.*, 2015; Ducak *et al.*, 2018; Australian Nursing and Midwifery Federation, 2019). Of particular importance in this study is that PCAs carried a broad scope of responsibility in their role that included delivery of personal care, support for daily living, some clinical tasks and leisure provision. Our data highlight that the expansion of PCA roles under new models of care (such as the household model referred to in this study) compounds already competing demands.

The impact of staff shortages on leisure provision was discussed at length by participants. When services were short of staff this had a cascade effect on PCAs' responsibilities and their capacity to support residents to engage in leisure pursuits which were identified as low on PCAs' hierarchy of priorities of care. Under these circumstances, residents who required additional physical assistance to join leisure

activities were more likely to miss out. The findings of our study raise concerns about the impact of broadening out the role of PCAs to extend to the provision of support for resident leisure. Staff workloads have been identified as a major theme in the recent Royal Commission into aged care quality and safety in Australia (Royal Commission into Aged Care Quality and Safety, 2019a). Evidence compiled by the Commission has exposed how PCAs who performed multiple roles (involving personal care, cleaning, laundry and kitchen work) were routinely short of time to complete their work (Royal Commission into Aged Care Quality and Safety, 2019b). These circumstances in turn were found to impact adversely the wellbeing of older people in aged care services. Given the backdrop of staff shortages and a prioritisation for the physical care needs of residents, the contribution of staff roles with a leisure focus or of volunteers, when available, was not only valued, but seen as an essential enabler to leisure provision.

In addition to concerns around workloads and staff shortages, the preparedness of aged care staff to provide leisure has also been identified as an issue (Smit *et al.*, 2014). Previous research indicates that a lack of knowledge and understanding about the importance of person-centred leisure provision can impact on the capability of care staff to engage in such initiatives (Ducak *et al.*, 2018). This shortfall was arguably mitigated by the contribution of volunteers and part-time staff whose role had a leisure focus. While some participants identified experience-based knowledge as an enabler to engaging residents in leisure activities, this knowledge was based largely on their experiences of what had worked for other residents rather than tailored to the individual. A review by Travers *et al.* (2016) reports that individualised tailored activities for people with dementia were the most effective in meeting the leisure-related needs of this population. This finding is suggestive that staff require further support to operationalise a leisure role that reflects evidence-based and person-centred approaches.

It is promising, however, that some staff recognised the importance of tailoring activities to the specific needs of a person with dementia. Achieving this relied on the availability of human resources and managerial support, identified as enablers to leisure provision. Additionally, processes or strategies that aim to improve the ability of staff to identify opportunities to implement person-centred leisure are recommended. Some staff in this study already conceptualised leisure as part of their routine work and suggested that this was an enabler to provision. An expanded understanding of what activity may be considered leisure was articulated by some staff who sought opportunities for engaging with residents while in their personal space. Arguably, in the context of competing work demands, the ability to conceive of leisure in a more informal way, as opposed to an organised activity, may open up opportunities for more person-centred approaches, providing that staff have a good understanding of the individual's needs and preferences (Hartmann *et al.*, 2018).

Enhanced knowledge and skills to deliver leisure may also assist PCAs to reconsider barriers to provision and to understand further how they might address barriers. This is of particular relevance to participants in our study who considered resident disability (physical and/or cognitive) as a largely immovable barrier to leisure. Smit *et al.* (2014) have identified that admission into residential care with a diagnosis of dementia carries an assumption of disability and a dependence

on a supportive environment for occupation. In this study, we found that staff perceptions about what people living with dementia can and cannot do, or indeed what types of activities they may be offered, was very much prescribed by their levels of disability. Participants' accounts largely did not explore how they might negotiate resident disability or modify activities to accommodate for disability. This was particularly evident when PCAs were faced with the task of providing leisure experiences for residents at the end stages of dementia or for people who were displaying BPSDs. Based on staff accounts, the inability of these residents to engage in leisure was considered a *fait accompli*.

These findings reflect those widely presented in the literature, that diminished cognitive ability is often considered a predictor of reduced leisure participation (Kolanowski *et al.*, 2006; Beerens *et al.*, 2016; Smit *et al.*, 2017; Ernecoff *et al.*, 2019). It was concerning that participants in our study recommended the segregation of residents with BPSDs from group activities as a solution to reducing disruption of others and offered few alternative leisure options for residents with BPSDs. While these data may be suggestive of a capability deficit of staff (Corbett *et al.*, 2012), it also raises concerns about how staff conceptualise people with dementia and BPSDs within the broader context of care. Indeed, such constructions raise a range of concerns for the provision of rights-based care for people with dementia, which should promote principles of participation, non-discrimination and equality (World Health Organization, 2015).

Conclusions

This study reports on the complexity of enablers and barriers to leisure provision for people living with dementia in three RACFs. System factors, such as a lack of available time to deliver leisure activities and an existing hierarchy of work that prioritised physical and clinical care, impacted the delivery of leisure activities by PCAs. Moreover, residents who had higher levels of dependency, whether this was related to the presence of BPSDs, limited mobility or other functional deficits, were particularly vulnerable to more-limited leisure opportunities. There were, however, a number of enablers to leisure provision which participants highlighted. The approach to leisure as everyday work meant that staff could use experience-based knowledge to provide residents with informal pleasurable experiences through the day. The availability of resources in the form of staff with a leisure focus or volunteers was found to improve leisure provision within a system where this was not highly prioritised. This exploratory study highlights the need to investigate further how the knowledge, skills and confidence of PCAs may be built, in order to challenge understandings of provision of leisure to people living with dementia, in particular that the disability of the person with dementia precludes them from leisure provision.

Recommendations

Research that assists in identifying strategies to support aged care staff to reconsider how person-centred leisure is constructed for people with dementia, especially advanced dementia, is urgently needed. Such strategies should address the increasing complexity and expansion of the PCA role and understanding of how

functional and cognitive deficits can be negotiated to enable person-centred leisure for all people with dementia as routine part of practice. It is recommended that staff educational qualifications for the role of PCA should incorporate leisure education using a human rights lens. The adequate resourcing of staff is critical to improving the provision of leisure in RACFs. Improved funding for aged care that results in lower staff to resident ratios, the presence of recreational staff who prioritise for leisure, in addition to the recruitment of volunteers can be expected to result in improvements in this area. Additionally, leisure education should be provided to managers, shown in this study to be influential in enabling leisure.

Study limitations

Key limitations of this the study relate to its size and setting. All the participants worked at one large residential aged care provider where a household model of care was in practice. This may limit the transferability of the findings to other settings where this model is not in use. Moreover, some of the focus groups contained only three participants. While the themes that emerged from the focus groups were highly consistent across all groups, there is a possibility that the small sizes of some groups could have influenced or limited some of the knowledge construction. Future large-scale work is thus recommended in this area.

Data. Data relating to this study are accessible via the University of Tasmania archives.

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Ethical standards. The study received ethical approval from the University of Tasmania, Human Research Ethics Committee Network (reference number H0017364).

Note

1 The Certificate 3 in Aged Care qualifies staff to conduct activities related to personal care and activities of living, under supervision (Australian Government, 2021).

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