

**Best Practice in Person-centred Health Care for  
Older Victorians**



**Report of Phase 2**

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## **Executive summary**

Phase 2 of the Best Practice in Person-centred Health Care for Older Victorians project was undertaken by the National Ageing Research Institute (NARI) on behalf of the Victorian Department of Human Services (DHS). It involved supporting Health Services in enhancing their person-centred practice, and evaluating the resources and initiatives identified and developed in Phase 1. Thirteen Health Services participated in Phase 2, designing and implementing person-centred care projects over a three-month period. These projects involved clients and carers, direct service providers and service managers.

The following projects were undertaken by the participating Health Services in Phase 2:

- Patient information handbook: A practical guide for patients.
- Key contact and follow-up phone call procedures.
- Meet and greet initiative and case conference restructure.
- Improving health outcomes for older clients with dementia and delirium.
- Motivating health behaviour change: Training session for ambulatory care health professionals.
- Patient information packages.
- Improving goal setting and care planning, and development of person-centred care policy and guidelines.
- A person-centred health care orientation session.
- Care of the older person in the emergency department (ED).
- Discharge planning.
- The experience of relatives and carers of patients aged over 65 years in the Emergency Department: Are person-centred care needs being met?
- Refocusing Culture: Improving care outcomes for older service users of Western Health.
- Goal setting and rehabilitation expectations and communication.

During Phase 2 NARI's principal role was to support the Health Services, and evaluate resources identified in Phase 1. This was done through initial and concluding site visits, and by hosting an introductory seminar and teleconferences. The project team at NARI was also active in identifying further resources and providing support as requested throughout the project.

The evaluation of person-centred health care resources and the website [www.nari.unimelb.edu.au/pchc](http://www.nari.unimelb.edu.au/pchc) revealed many helpful recommendations. Overall, the need for an ongoing commitment to the website's evolution into a comprehensive library of resources was noted.

There were also resources identified that would have been beneficial but were not available:

- A generic statement already translated into many languages that says what to do if you need an interpreter, which could be shared so Health Services do not need to pay individually to have one developed.
- An ongoing electronic forum to share ideas, ask questions, and link groups of people working on, or with experience in specific areas.
- Information and resource guidelines for staff indicating how and where to access quality resources and information.
- Dementia and delirium assessment and management guidelines.
- Person-centred discharge planning requirements and guidelines.
- Information on developing complex needs assessment tools and models
- Information on conducting person-centred family meetings.

In some instances certain attributes of the participating Health Services were considered to influence participation in the project activities:

- The project workers indicating they received the most benefit from the teleconferences were from non-metropolitan Health Services and each had only one representative attend the initial meeting.
- The number of teleconferences each Health Service participated in was not reflected in their comments about the value of the teleconferences.
- Clinical staff with no prior project management experience identified the benefits of using collaborators to upgrade project management skills.

The impact of the person-centred projects on practice was difficult to measure. With many ongoing initiatives and an overall commitment to person-centred health care within the participating Health Services, it was difficult to compartmentalise and evaluate outcomes from specific projects. Furthermore, given the limited timeframe of Phase 2, only one project reached a measurable conclusion after implementation of an initiative. Outcomes from this project included increases in clinicians' perceived importance and confidence in assessing a client's readiness to change a health behaviour, confidence in using some person-centred strategies to improve client motivation, and increases in familiarity with specific person-centred behaviour change strategies.

Additionally, there was one consistent key learning to come out of conducting the projects:

- Engaging support from many key strategic stakeholders is a strong enabler for successful project implementation.

Other common project learnings across a number of projects included:

- Time constraints faced by some clinical staff may make it difficult to take on additional project work.
- Using collaborators can help upgrade skills and fill skill shortages.

There was also a consistent person-centred health care key learning:

- A single person-centred care project can have many beneficial outcomes:
  - Improvements in staff awareness and attitudes.
  - Encouragement of health care consumers to participate in their own health care.
  - New innovations in person-centred care may be developed.

Other common person-centred care key learnings across a number of projects included:

- Time and computer access constraints faced by some clinical staff may make it unlikely they will seek out additional person-centred care resources.
- It may be important to promote what person-centred health care means in practice, and not just use it as a catch phrase.
- A supportive environment can enable person-centred health care.

In summary, many worthwhile learnings from Phase 2 have the potential for broader applications as Health Services continue to work towards best practice in person-centred care.

## **Introduction**

This is a report of Phase 2 of the Best Practice in Person-centred Health Care for Older Victorians project undertaken by the National Ageing Research Institute (NARI) on behalf of the Victorian Department of Human Services (DHS). The study was commissioned to support the implementation of Improving Care for Older People: A policy for Health Services (Improving Care Policy) (Department of Human Services (Victoria), 2003). This policy encourages Health Services to:

- Adopt a strong person-centred approach to the provision of care and services.
- Better understand the complexity of older people's health care needs.
- Improve integration between Health Services' community-based programs and ongoing support services available in the broader community.

The Best Practice in Person-centred Health Care for Older Victorians project has three Phases. Phase 1 was completed in January 2007 (Tinney et al., 2007) and involved undertaking a literature review and a state-wide survey on person-centred health care. The survey was disseminated to allied health, nursing, medical, management and administrative staff working in General Medical wards, Rehabilitation wards, Geriatric Evaluation and Management (GEM) or Aged Care wards, Community Rehabilitation Centres (CRCs) and Continence Clinics in all consenting Health Services. In Phase 3 the survey will be re-administered. Phase 3 is scheduled to begin in August 2007.

Also forming part of Phase 1 was the investigation of good practice initiatives and resources in person-centred health care. Many of the initiatives and resources investigated were reviewed and posted on a website for public and Health Service use. This website can be found at [www.nari.unimelb.edu.au/pchc](http://www.nari.unimelb.edu.au/pchc).

Phase 2 involved supporting Health Services in enhancing their person-centred practice, and in evaluating the resources and initiatives identified in Phase 1. Thirteen Health Services participated in Phase 2, designing and implementing person-centred care projects over a three-month time period. These projects involved clients and carers, direct service providers and service managers.

## **Phase 2**

### **Aims**

The aims of Phase 2 were to:

1. Support Victorian Health Services in the identification, design and implementation of person-centred care projects and initiatives within their Health Services.
2. Trial identified resources to facilitate the implementation of person-centred practice in line with the Victorian Government policy on improving care for older people (2003).
3. Evaluate the impact of these resources on practice.
4. Identify gaps in the resources available on the website [www.nari.unimelb.edu.au/pchc](http://www.nari.unimelb.edu.au/pchc) developed in Phase 1.

### **Objectives**

The objectives of Phase 2 were to:

- Assist Health Services in the identification of person-centred care projects and initiatives to be conducted over a three-month time period.
- Assist Health Services in the design of person-centred care projects and initiatives.
- Assist in the identification and provision of resources to help the Health Services with their person-centred care projects.
- Trial resources that may help the Health Services implement person-centred health care practices.

- Evaluate the person-centred care website [www.nari.unimelb.edu.au/pchc](http://www.nari.unimelb.edu.au/pchc) and processes, outcomes and key learnings associated with the projects being implemented by the Health Services.
- Identify gaps in the resources available on the person-centred care website.

## Activities

The main activities of Phase 2 were:

- Circulation of information and recruitment of Health Services.
- Self-assessment checklists sent to Key Implementation Contacts (KICs) and Executive Sponsors at interested Health Services to help identify potential project goals.
- Initial site visits and background work to plan strategies and timelines for addressing project goals (for information on the individual Health Service projects see Appendix A).
- Introductory seminar for project workers from the participating Health Services, featuring Cathy Balding from Qualityworks and her presentation on change management in Health Services.
- Main activities, providing support and resources as requested (for three months).
- Regularly scheduled teleconferences for feedback and ongoing support.
- Concluding site visits and evaluation.
- Reporting of results to the Health Services and DHS.
- Presentation of results to the participating Health Services.

## Evaluation

The main activities of Phase 2 were conducted over three months, from the end of February to the end of May 2007. In that relatively short period of time staff at the participating Health Services conducted a large amount of quality work towards meeting their goals. The projects put forth by the Health Services did not need to conform to the timelines of Phase 2. Evaluations were based on what had been achieved in that time. A semi-structured interview was conducted and recorded with the key project implementation contacts at each participating Health Service. For the interview outline, see Appendix B. The data was analysed using NVivo 7 qualitative research software.

## Results

The participating Health Services were asked to evaluate the activities and resources facilitated by NARI during Phase 2 through a semi-structured interview. These activities included the initial site visit, introductory seminar, and teleconferences. The Health Services were also asked for a general evaluation of their overall involvement in Phase 2.

In some instances trends in the data varied depending on different features of the Health Services. Certain attributes were considered to influence participation in the project activities.

- Seven of the participating Health Services are physically located in a metropolitan area, six in a non-metropolitan area: the project workers indicating they received the most benefit from the teleconferences were from non-metropolitan Health Services, although not all non-metropolitan Health Services indicated they were beneficial.
- Three Health Services had only one representative at the initial project meeting, eight had two representatives, and two had more than two representatives: the project workers indicating they received the most benefit from regular contact through the teleconferences each had only one representative attend the initial meeting.

- Four Health Services participated in one teleconference, three participated in two teleconferences, and six participated in all three teleconferences: the number of teleconferences each Health Service participated in was not reflected in their comments about the value of the teleconferences.
- Three of the main project implementation contacts also had substantial clinical roles within their Health Service, while ten had mostly project orientated roles: discussions on finding the most effective mix of clinical and project work occurred on multiple occasions, and the benefits of using collaborators to upgrade project management skills was noted by clinical staff with no prior project management experience.

### **Initial site visit**

Project representatives from NARI travelled to eleven of the thirteen participating Health Services during the initial stages of Phase 2. The other two Health Services chose to meet NARI representatives at an alternative location. Each of the participating Health Services indicated that the initial meetings were productive. In some cases they were used to formulate goals and project outlines, while in others they were used to discuss if and how a project already in the pipeline might fit into the Phase 2 project plan. At the initial meetings the projects were at varying stages of readiness for implementation. Some Health Services were looking for project ideas, others already had goals and resources in place, and the remainder fell in between. The general consensus regarding the initial meetings could be summarised as:

*"The initial site visit was useful to formulate the plan of action ...good to get a face to face discussion, to get a sense of what you guys were planning to do and how our project would work within that framework."*

### **Introductory seminar**

The introductory seminar was held on 26 February 2007 at DHS in Melbourne. The seminar was an opportunity for the participating Health Services to introduce, discuss and share resources for their projects. The main feature of the seminar was a presentation by Cathy Balding from Qualityworks on change management in Health Services. Ten Health Services had one or more representatives attend the seminar, two attended a summary session at NARI, and one was unable to attend either.

Feedback on the introductory seminar was mostly positive. The networking opportunity was seen as beneficial:

*"It was useful...to hear what other organisations were doing, how the projects were happening."*

There was much praise for Cathy Balding's participation:

*"The way she presented it. It tended to stimulate your thoughts as to how people take on change..."*

Two attendees indicated they had heard some of the change management information before, and one felt that:

*"In terms of what we're trying to see, information, evidence for this project, I didn't get a lot out of it..."*

### **Teleconferences**

Three sets of teleconferences were held during the main activity period. Due to the numbers involved, the Health Services were grouped according to availability. Teleconferences were held on Wednesdays and Thursdays. The original project plan was to hold the teleconferences fortnightly. However, during preparations for the

second round of teleconferences it became apparent that a fortnightly schedule did not offer sufficient time for meaningful participation. All participating Health Services supported a proposal to extend the time between teleconferences. The teleconferences were held during the weeks of 21 March, 4 April, and 2 May. A proforma was sent to the Health Services the week before each teleconference to be completed and returned to NARI. The proforma requested information from the participating sites on progress, useful resources, and issues to be followed up. Based on the proformas an agenda was drafted and sent to the participants. Each teleconference was recorded and summarised. The Health Services received summaries of all the teleconferences.

Feedback varied. The Health Services that found the teleconferences least useful all had multiple project contacts attend both the initial and concluding meetings, suggesting they were already working closely with others to implement their projects. Some said the diversity of projects undertaken made it hard to find and share common resources.

*"...there wasn't any correlated link that I could see with the other people who were linking in ... there was nothing there that was going to assist us in ... what we were attempting to do."*

*"I also couldn't see that I had anything ... to offer anyone else's project...if we had all been doing the same thing, it would have been quite different, but it was ...comparing apples to oranges."*

*"...I didn't find them useful. That might have been a result of ... time pressure..."*

The Health Services that found the teleconferences most useful were non-metropolitan Health Services, each with only one main project contact attending the initial meeting. They appreciated the accountability, the chance to share ideas and resources, and security in knowing there was support.

*"...running your eye down the goals and objectives, saying well, where are we at? So again it's that accountability."*

*"... the teleconferences were really useful because... you don't feel alone. I think sometimes with project work... you can feel very alone and I think that helps, the teleconferencing. Probably would have liked a couple more ...it is good to have that conversation and know that everything is ok."*

*"It was...good to hear other people stepping through, and how they got around things."*

*"... enjoyed hearing what other people were doing, enjoyed hearing their successes, but also their challenges...I got a lot out of the typed up reports ... I thought they were great, a good way to do it."*

### **Overall involvement in Phase 2**

Feedback from the Health Services regarding their overall involvement in Phase 2 elicited some suggestions for improvement:

- The timeframe was too short, or did not fit with happenings at particular Health Services.
- The projects were too diverse.
- Receiving resources from other Health Services was sometimes difficult as promises to pass along resources were not always followed through.
- A few Health Services stated they did not receive much additional help from their involvement in Phase 2.

Positive comments about the Health Services' involvement in Phase 2 included:

- It provided accountability and focus.
- It provided an impetus to do something practical with the person-centred care principles.
- It was helpful to know there was support from NARI.
- It was helpful to network with other Health Services.

*"It was a good logical next step."*

*"Our involvement has prompted us to reflect."*

*"The energy... sustains itself when you're talking to the other project workers doing the work ... you get ideas... it ... has an accumulative effect."*

*"... the benefit has been the structure and the guidance provided by NARI."*

### **Resources: The website**

The participating Health Services were asked to evaluate the website and its resources developed in Phase 1. The Health Services indicated whether they had used the website and any of its resources, promoted it within their Health Service, and had had feedback on its use by others.

Twelve of the participating Health Services indicated they had reviewed the person-centred health care website, and eleven had promoted it within their Health Service. The Health Service that had not reviewed the website indicated it was because they had access to other resources and they preferred paper-based materials.

Overall, the need for an ongoing commitment to the website's evolution into a comprehensive library of resources was noted.

### **Strengths of the website and its resources**

- It could become a library of resources.
- It is useful to see what other initiatives have been tried.
- It tries to be all embracing.
- The contact people listed in the resources are helpful.
- It has helped to clarify exactly what person-centred care is.
- The PowerPoint presentation is a useful template for education.

*"... the resource section's a strength."*

*"Its good to have the person-centred care definitions available, and the literature and all the different cases that are there around different practice."*

*"... it's easily accessible, and it represents a very wide range of sources of ideas, and it's a sustainable resource..."*

*"I find it really easy to use."*

### **Limitations of the website and its resources**

- It is still immature as a resource library; there are a lot of resources that could be added to it over time.
- Project oriented staff, and staff with time at work to use the internet are more likely to use the website.
- Navigating the website has been a problem for some.
- More needs to be done to promote it.
- More assessment tools would be useful.
- More information about gaining support for initiatives would be useful.

- More information about how to build accountability into projects would be useful.
- It would be more useful to have the primary resources attached and not just the reviews.
- It would be easier to find as a stand-alone link.
- More examples of best practice should be posted.
- It would be beneficial to include the latest literature.
- Assessments in the Emergency Department is lacking.
- Information on person-centred counselling techniques would be useful.
- More information on discipline-centred goal-setting.
- There has been no feedback that staff are using it.
- It would be better if it were truly interactive.
- A message board would be useful.
- A search function just within the person-centred section would be useful.
- Contacting NARI directly is sometimes easier.
- More pictures would make it more attractive, and grab users' attention.
- A link to Carer's Victoria Website would be useful.
- Links to examples of Health Service information / orientation booklets are missing.

*"... people are pretty pushed...clinicians...if they've got time to be looking up anything on the internet, it's going to be about ... drugs... it's not going to be about person-centred care."*

*"... there's lots of good ideas out there that aren't in a form that can actually be collected and posted on a website."*

*"It can be sometimes difficult to chase up [resources]."*

### **Gaps in the Resources**

There were some resources that would have been beneficial to the Health Services in completing their projects, but were not available:

- A generic statement already translated into many languages that says what to do if you need an interpreter, which could be shared so Health Services do not need to pay individually to have one developed.
- An ongoing electronic forum to share ideas, ask questions, and link groups of people working on, or with experience in specific areas.
- Information and resource guidelines for staff indicating how and where to access quality resources and information.
- Dementia and delirium assessment and management guidelines.
- Person-centred discharge planning requirements and guidelines.
- Information on developing complex needs assessment tools and models.
- Information on conducting person-centred family meetings.

### **Impact on Practice**

Evaluating the impact on practice attributed to the resources used during the Phase 2 projects was challenging. With many ongoing initiatives and an overall commitment to person-centred health care within the participating Health Services, it was difficult to compartmentalise and evaluate outcomes from specific projects. Furthermore, the limited timeframe and the scale of projects meant there was insufficient time for most of the projects to produce measurable, quantitative outcomes.

The exception was Broadmeadows Health Service, which ran two four-hour multidisciplinary training sessions for ambulatory health care professionals to enhance skills, knowledge and confidence in using person-centred strategies. Outcomes measured in the clinicians attending the training included:

- Increased perceived importance and confidence in assessing a client’s readiness to change a health behaviour.
- Increased confidence in using some person-centred strategies to improve client motivation.
- Increased familiarity with specific person-centred behaviour change strategies.

## **Key learnings**

The key learnings from the participating Health Services’ projects were derived from reports by the project teams during the initial and concluding site visits, and teleconferences. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. Data was analysed using NVivo 7 qualitative research software.

### **Project key learnings**

A number of key learnings were drawn from the experiences of the Health Services conducting projects. There was, however, one consistent key learning:

#### **1) Engaging support from many key strategic stakeholders is a strong enabler for successful project implementation:**

*“You can have the best science, but in the end the communication and people are what matters.”*

Project officers sought support from consumers, staff, management, and executives. In some instances they also sought financial support for their projects. Pursuing support is one thing but there were also distinct strategies used to win support for the projects:

- **A clearly identified need can help generate support and build momentum for a project:** The ease with which support for some of the projects was generated and maintained within the Health Services was identified as being *“...about identifying a gap that’s been a no-brainer...”*
- **Giving ownership and engaging staff helps generate support for change:**

*“...there’s quite a deal of work that we have to do, and it would perhaps take us longer than a larger organisation, but... there’s a very positive feel about moving forward, engaging the staff in this...”*

- **Support from stakeholders can be won by identifying what they value:**

*“I think St. Vincent’s is pretty person-centred and values this type of thing. So from a management point of view there’s been some interest... because they’re after evidence and will utilise the evidence.”*

- **Ongoing feedback can win support:**

*“... Heather has been very effectively able to gain momentum and to really – not just involve people in a snapshot way, but to involve them in an ongoing way, so that there is a feedback loop.”*

- **Sometimes building support is about timing:** Due to factors beyond the scope of a project, it can be beneficial to wait patiently for an opportunity to move forward.

- **Giving responsibility and praise for an idea to those it will directly impact helps generate support:** Some Health Services positioned their projects to staff as projects generated out of the feedback they had given in Phase 1 during the state-wide survey. By telling staff they had indicated a need for the project, they were able to generate support.
- **Support from managers can enable a project:**

*"And I think that filters down to the clinicians seeing this person [a manager] being very supportive of this and not just being, yes go do the training and whatever, that they are in fact very keen to see this happen. So I think that is very much very important to the success of these sorts of things."*
- **Demonstrations can win support:**

*"... I got some feedback from the people who had been...[at a demonstration] saying...we did not realise what this could mean and we think this needs to have more time devoted to it..."*
- **Meeting challenges wins support:** Meeting the challenge of accreditation by engaging staff and giving them ownership of the care they provide turned out to be a beneficial and constructive process for a project team that gained them further support for the changes involved in their project.

Other common project learnings across a number of projects were:

- 2) **Time constraints faced by some clinical staff may make it difficult to take on additional project work.** Without specifically allocated project time, already busy staff need to take on additional work if projects are to be completed.
- 3) **Using collaborators can help upgrade skills and fill skill shortages.** Some project teams indicated it was valuable to work with NARI, local universities and other Health Services with expertise in research and project work to help enhance some of their clinical staff's research and project management skills.

### **Key person-centred health care learnings**

There were also key learnings relating to person-centred care to come out of the projects conducted by the Health Services:

- 1) **A single person-centred care project can have many beneficial outcomes:**

*"It is part of us moving towards something that provides a more appropriate person-centred approach to the care that we provide."*

Many of the projects brought together staff that would not normally come into contact with each other to work towards common goals. This led to information sharing and was one reason why many of the person-centred care projects and initiatives had wide reaching beneficial outcomes that could not be compartmentalised. Other key beneficial outcomes included:

- **Projects and initiatives may improve staff awareness of, and attitudes towards person-centred health care:** The statistical data from one Health Service's project demonstrated an increase in staff awareness and confidence in using some person-centred strategies. And at another Health Service, "we

*have, of the range of people who sit on the steering committee, a number of those have operational roles in different programs, and I know that the discussions have prompted them to go back to their particular service or programs and better focus on some of the key issues in caring for older people."*

- **Person-centred care projects can encourage health care consumers to participate in their own health care:**

*"If we could give them something that indicates that we're sharing information well with them, and that we want them to do their part as well, and we're keeping them very well informed about their progress, then I think that will help..."*

- **Person-centred care projects may lead to innovations in person-centred health care:** Some projects started the Health Services thinking about new and innovative ways to deliver person-centred health care.

*"I think one of the differences will be if we can put in place an evaluation as to the consumers' view of this sort of documentation..."*

*"...it would be great if we could...develop something that the key contact person ...makes contact with a patient before they actually get here."*

Other common person-centred care key learnings across a number of projects were:

- 2) **Time and computer access constraints faced by some clinical staff may make it unlikely they will seek out additional person-centred care resources:**

The feedback generated on NARI's person-centred care website suggested that staff with time at work may be more likely to look at a person-centred care website and other person-centred care resources. Furthermore, *"...in a lot of Health Services... a lot of allied health staff have access to a computer during the day, but perhaps nursing staff who you might want to be getting this message out to, don't always have that computer screen and access to websites..."*

- 3) **It may be important to promote what person-centred health care means in practice, and not just use it as a catch phrase:** It was identified as important to not just promote the principles of person-centred care to health care staff but also look at *"...how you actually make it real for them in practice."* It was also stressed that *"...at the moment it's very easy to state that something is person-centred, but what does that actually mean...there's more to it."*

- 4) **A supportive environment can enable person-centred health care:** Some of the successes of the Health Services projects were attributed to staff being *"...in an environment where those practices are being supported."*

### **Individual Health Service reports**

Each participating Health Service has been provided with a report of key learnings taken from the outcomes of their person-centred care projects. The individual Health Service key learning reports can be found in Appendix A.

### **Phase 2 summary**

In Phase 2 Victorian Health Services conducted projects and initiatives in person-centred health care. These projects provided an evaluation of the person-centred

health care website [www.nari.unimelb.edu.au/pchc](http://www.nari.unimelb.edu.au/pchc) developed in Phase 1. The projects also further assisted in the identification of additional resources and resource gaps. In addition to the identification and evaluation of resources, key learnings in conducting person-centred health care projects were also drawn from the work conducted by the Health Services.

In Phase 3 of Best Practice in Person-centred Health Care for Older Victorians project, the benchmarking survey conducted in Phase 1 will be re-administered and the outcomes evaluated.

## **References**

Department of Human Services (Victoria). (2003). *Improving care for older people: a policy for health services*. Melbourne: Department of Human Services.

Tinney, J., Fearn, M., Hill, K., Dow, B., Haralambous, B., Bremner, F. (2007). *Best-practice in person-centred health care for older Victorians: Report of Phase 1*. Melbourne: Report for the Department of Human Services.

## **Appendix A: Individual Health Service reports**

### **Ballarat Health Services**

#### **Title of project:**

Patient information handbook: A practical guide for patients.

#### **Aim:**

To improve the hospital experience of older patients through the provision of appropriate information that adequately prepares them for their admission.

#### **Description of the project:**

Develop a comprehensive patient information handbook, in consultation with patients.

#### **Targets identified:**

- Identify and evaluate patient information currently supplied to patients (with particular reference to older patients).
- Identify formats and content of patient information brochures in use by other Health Services.
- Identify the information which ward/hospital staff are regularly asked to provide once patients are admitted.
- Identify the opportunities within the admission/access process for provision of information (i.e. process map of information provision).
- Identify the information older patients think would better prepare them for a hospital stay.
  - Conduct a baseline survey of patients.
- Develop a draft of a printed guide for hospitalised older people and their families.
- Pilot the draft of the information booklet.
- Develop an education program for hospital staff regarding the implications of informing patients with a view to enhancing patient-centred care.
- Implement and evaluate use of the guide.
- Develop a plan to roll out the guide to the general patient population.

#### **Outcomes:**

The team at Ballarat Health Services achieved substantial outcomes within the limited timeframe of Phase 2:

- Identification and evaluation of current patient information, in consultation with patients.
- Identification of patient information brochures in use by other health services.
- Identification of the information which ward/hospital staff are regularly asked to provide once patients are admitted.
- Completion of a prototype booklet, distributed to the advisory committee and other groups within the Health Service for feedback.
- A final draft booklet developed, and scheduled for submission to graphics.
- Development of a hospital map (previously no map available).
- Identification of the need for interpreted materials – main languages to be explored.
- Development of the acute patient information guide has initiated further person-centred consideration of hospital signage and other patient literature.
- Identification of the potential for an online patient information guide – internet and intranet.

#### **Barriers:**

Barriers during Phase 2 were identified by the project team at Ballarat Health Services and reported during teleconferences and at the concluding site visit. Barriers were

issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **The project highlighted additional issues:** The need for interpreted materials and patient information booklets for additional sites, and a more consultative process in addressing signage were identified as additional issues to be addressed.
- 2) **Conflicting stakeholder opinions:** There were conflicting opinions on how much information should go into a patient information booklet. One perspective was that there was too much information in the draft; the other was that patients should receive as much information as possible. There was initial indecision on whether the booklet should be A4 or A5 format or both.
- 3) **Information technology barriers:** The patient consultation process revealed that patients over 80 would generally not look at information on a computer. For those under 80 the biggest barrier to an online information booklet was computer access. A printed version was therefore desirable, and necessary funding needs to be sought.
- 4) **Funding barriers:** The initial prototype was funded out of the money for Centres Promoting Health Independence (CPHI). A business plan will need to be written and approved before roll out.

#### **Key learnings:**

The key learnings from Ballarat Health Services' project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings:

- 1) **A clearly identified need can help generate support and build momentum for a project:** The ease with which support for the project was generated and maintained within the health service has "*... been about identifying a gap that's been a no-brainer...*"
- 2) **Engaging support from many key strategic stakeholders is a strong enabler of successful project implementation:** Support was sought from staff, management and consumers. Development of the initial prototype was fully funded.

The person-centred health care key learnings:

- 1) **A single person-centred care project can have many beneficial outcomes:** If the additional issues highlighted by this project are addressed in a person-centred way, many care improvements may result.
- 2) **Modelling a person-centred, consultative process in conducting projects may raise awareness of person-centred health care within a Health Service:**

*"And if we do this well and communicate effectively about our processes as much as our outcome, then we will have modelled for them [staff] a very consultative person-centred approach..."*

3) **Asking health care consumers for input may encourage them to participate in their own health care:**

*"...that's the thing that we stand the greater chance of influencing actually. That is people being encouraged to ask questions."*

4) **Improvements in person-centred care attributed to specific projects can be difficult to evaluate:** With many initiatives and an ongoing commitment to person-centred health care it is difficult to compartmentalise outcomes.

5) **Time constraints faced by some clinical staff may make it unlikely they will seek out additional person-centred care resources:** The feedback generated on the person-centred care website developed by NARI suggested that project officers and staff with time at work may be more likely to look at a person-centred care website and other person-centred care resources.

**Summary:**

This project by Ballarat Health Services should be a successful initiative in person-centred health care. Outcomes are to include documentation that should make a valuable contribution towards improving hospital stays and in the longer term may provide a model for other person-centred documentation within the Health Service.

## **Barwon Health Service**

### **Title of project:**

Key contact and follow-up phone call procedures.

### **Aim:**

Barwon Health aims to introduce a formalised key contact process in the In-patient Rehabilitation Centre (IRC) and Ambulatory Care Services, and implement a follow-up phone call procedure.

### **Description of the project:**

Implementation of a formalised key contact person and post-discharge follow-up phone call procedure should help improve communication with service users.

### **Targets identified:**

- Scope which area/s will pilot the project changes.
- Develop roles and responsibilities for key contact person.
- Develop a staff information support pack regarding key contact role, and begin training and support.
- Develop name cards and pamphlets with key contact details, responsibilities, and availability to allow service users, carers and families easy access to key contact person.
- Service users of the 'Central' Geriatric Evaluation and Management (GEM) Unit allocated a key contact person to pilot the procedure.
- Develop a protocol for staff completing follow-up phone calls and associated documentation.
- Develop with key staff a directory for staff undertaking follow-up phone calls.
- Identify key staff to carry out follow-up phone calls. With proper training, this may be a clerical role.
- Train staff to carry out follow-up phone calls.
- Commence post-discharge phone calls.

### **Outcomes:**

The team at Barwon Health Service achieved substantial outcomes within the limited timeframe of Phase 2:

- Establishment of a clinical development team, who are happy with the progress.
- Developed a template and roles and responsibilities for key contact staff.
- Created signage and a brochure for patients to make it clear who their key contact is, and when and how to contact them.
- Visual standards group for patient information have approved key contact information.
- Developed a staff information support pack regarding key contact role, including a help directory with Frequently Asked Questions (FAQs), and a fact sheet with process information.
- Key contact to be assigned at Tuesday team meetings – discipline most aligned with patient's need to be assigned as key contact (patients admitted between meetings to be assigned a temporary key contact).
- Developing a support pack for staff making follow-up phone calls – discovered it need not be a clinician (with training, potentially a ward clerk role).
- Started the pilot of the key contact in the 'Central' GEM unit and will roll out from there across other areas in the IRC. By the end of the pilot period, all patients in the 'Central' GEM unit will have a key contact.
- Have had some positive feedback from the pilot site (patients and staff).
- Increasing awareness observed about the role of the key contact.

**Barriers:**

Barriers during Phase 2 were identified by the project team at Barwon Health Service and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Multiple ongoing projects:** There were additional challenges to conducting two projects concurrently as they competed for resources, especially time.
- 2) **Conflicting stakeholder opinions:** Most staff appeared generally happy to embrace the new processes, as long as there was education in place. However, certain staff were concerned that the role of the key contact might infringe on their discipline-specific responsibilities.
- 3) **Time constraints:** There were concerns that the new responsibility might detract from patient contact and increase workloads.
- 4) **Projects were complex:** Bureaucracy and the practicalities of piloting the key contact role on a 'Central' ward where patients have complex needs have proven to be challenging.

**Key learnings:**

The key learnings from Barwon Health Service's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Engaging support from many key strategic stakeholders is a strong enabler of successful project implementation:** Support was sought from staff, management and consumers.
- 2) **Giving responsibility and praise for an idea to those it will directly impact helps generate support:** The formalised key contact role was presented to staff as something they themselves identified as a gap in person-centred care. It was also positioned as work which staff already did, but without a formalised process.

The person-centred health care key learnings were:

- 1) **Projects and initiatives may improve staff awareness of person-centred health care:**

*"I think people are a lot more aware of it than they were six months ago."*

- 2) **There may be practical ways to encourage health care consumers to participate in their health care:**

*"We've spoken lots with health providers, about goals and focusing on patient goals and so on, but this is actually bringing it into a practical realm, of how we can help to do that."*

**3) Consideration of health care consumers' needs may lead to innovations in person-centred health care:**

*"...it would be great if we could actually develop something that the key contact person actually makes contact with a patient before they actually get here."*

**Summary:**

This project by Barwon Health should be a successful initiative in person-centred health care. Outcomes should include a formalised key contact person and post-discharge follow-up call procedure, which have the potential to improve communication, and ultimately improve care.

## **Bendigo Health Care Group**

### **Title of project:**

Improving health outcomes for older clients with dementia and delirium.

### **Aim:**

To ensure consistent diagnosis and management of clients with dementia and delirium.

### **Description of the project:**

Trying to improve health outcomes for clients with dementia and delirium by developing and implementing consistent diagnostic and management tools and procedures. The new tools and procedures are scheduled to be in place by December 2007.

### **Targets identified:**

- Dementia and delirium flow-chart to be developed and implemented into work systems within nominated departments (medical, orthopaedic, and surgical) for ongoing use and evaluation.
- Dementia and delirium diagnosis and management guidelines to be developed and agreed upon.
- Education methods developed, implemented and evaluated in nominated departments, planning competency packages on the Confusion Assessment Method (CAM), and the Abbreviated Mental-State Test.
- Post-audit report to be completed demonstrating increased knowledge and improved detection and management of clients with dementia and delirium in nominated departments.

### **Outcomes:**

The team at Bendigo Health Care Group achieved substantial outcomes within the limited timeframe of Phase 2:

- Timeframe for project completion December 2007, will be tight, but possible.
- Consultation with key stakeholders ongoing, a lot of feedback received.
- A new admission and discharge form, developed as part of a larger person-centred care project (starting on the medical unit), will be linked with the dementia and delirium assessment form, and will also incorporate a new falls tool that has already been launched.
- An audit of the post-discharge needs section of the admission and discharge forms indicated referrals may be given, but not documented on the form – will go back and audit the number of referrals versus what is recorded on the form, and will also audit the number of referrals made on admission versus those made later in the hospital stay. The new admission and discharge form will attempt to link the initial assessment process more closely to referrals.
- Dementia and delirium diagnosis and management guidelines to include medication guidelines.
- Still planning to assess staff knowledge of dementia and delirium, pre- and post-education program.
- Plans to establish a 24-hour response time from geriatricians during business hours for dementia and delirium referrals, and weekend response from registrars, starting in August 2007.
- Post-implementation audit will include the numbers of diagnoses, and of dementia and delirium referrals to the geriatricians.

### **Barriers:**

Barriers during Phase 2 were identified by the project team at Bendigo Health Care Group and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the

future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Staff Changes:** There was a two-month period when the key project implementation position was not officially filled.
- 2) **Conflicting stakeholder opinions:**  
*"On the whole, yes I definitely feel there's support. Um, I'm not sure about the little pockets [of resistance]."*
- 3) **Requirements unclear:** The project team has been awaiting the release of the Department of Human Services' dementia and delirium guidelines. Additionally, the Commonwealth of Australia's guidelines do not specify a recommended age to begin screening.
- 4) **Time constraints:** A screen for depression was also considered, but not included due to time constraints. Some stakeholder resistance was identified as due to time constraints.

#### **Key learnings:**

The key learnings from the Bendigo Health Care Group project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Engaging support from many key strategic stakeholders is a strong enabler of successful project implementation:**  
*"As there have been many different stakeholders at all levels participating in meetings, there is a high degree of awareness across acute, sub-acute, and community sectors. An advantage is having engagement with experts in this area...Also interest from clinical champions in several areas."*
- 2) **Even with some stakeholder resistance, it may be possible to move forward with a worthwhile initiative with support from others:** Despite being unable to gain the support of all stakeholders, this project has been able to move forward by gathering support from others.

The person-centred health care key learnings were:

- 1) **Improvements in person-centred care attributed to specific projects can be difficult to evaluate:** With many initiatives and an ongoing commitment to person-centred health care it is difficult to compartmentalise outcomes.
- 2) **Projects and initiatives may improve staff awareness of person-centred health care:** In pockets of the Health Service there has been a noted improvement in attitudes and awareness of person-centred health care practices.

**3) Projects and initiatives can bring together health service providers across the continuum of care, and may improve care coordination:**

*"Staff who do not normally come into contact with each other have had the opportunity to do so and develop strategies for a common problem."*

**Summary:**

This project by Bendigo Health Care Group should be a successful initiative in person-centred health care. Final outcomes may include more consistent diagnosis and management of older people with dementia and delirium, which have the potential ultimately to improve care within Bendigo Health Care Group.

## Broadmeadows Health Service

### Title of project:

Motivating Health Behaviour Change: Training Session for Ambulatory Care Health Professionals.

### Aim:

To conduct two half-day training sessions for ambulatory health care professionals to enhance skills, knowledge and confidence to use person-centred strategies in their daily work.

To promote an environment that supports staff working in a person-centred way by providing ongoing opportunities for reflection and consolidation of these approaches following initial training.

### Description of the project:

Two interactive half-day training sessions facilitated by a Clinical Health Psychologist were delivered to ambulatory health care professionals. The training included: information on the relevance of adopting person-centred, motivating behaviour change strategies; barriers and enablers to change; the theory behind the strategies; and the introduction and practice of key strategies to facilitate behaviour change. Follow-up reflective practice sessions were scheduled several weeks after the training to enable reflections and problem solving opportunities regarding the strategies as they were applied in daily clinical work.

### Targets identified:

- Promotion of training sessions to raise clinician awareness and interest.
- Confirm attendance numbers for each session and for administration of pre-training questionnaire.
- Administration of pre-training questionnaire to collect baseline data pertaining to existing clinician knowledge, perceived importance, confidence and readiness to employ person-centred behaviour change strategies.
- Conduct two separate workshop training sessions for Ambulatory Care staff.
- Collection of post-training information to evaluate impact of training (i.e. changes in knowledge, perceived importance, confidence and readiness to use strategies).
- Data entry and analysis of pre-post training results.
- Conduct initial follow-up (reflective practice session) and re-administer questionnaire to assess maintenance of any pre-post changes.
- Data entry of follow-up questionnaire.
- Data analysis of, and across, all three time points.

### Outcomes:

The team at Broadmeadows Health Service achieved substantial outcomes within the limited timeframe of Phase 2:

- Implementation of two multidisciplinary, four-hour interactive training sessions.
- 26 health care providers attended the two sessions.

The pre- and post-training data indicated it was beneficial:

<b>Clinician stage of change regarding use of person-centred health behaviour change strategies</b>	<b>Pre-training N=26</b>	<b>Post-training N=26</b>
Pre-contemplation	8%	0%
Contemplation/Preparation	50%	48%
Action	15%	28%
Maintenance	27%	24%

Wilcoxon's matched-pairs tests revealed statistically significant changes (increases) in clinician perceived importance and confidence (efficacy) to assess a client's level of motivation (readiness) to change a health behaviour ( $Z=-2.53, p=0.011; Z=-4.14, p=0.000$  respectively).

Statistically significant changes (i.e. increase) in clinician-perceived importance and confidence to access/use a variety of person-centred strategies to enhance client motivation were also apparent ( $Z=-2.45, p=0.014; Z=-4.18, p=0.000$  respectively).

Statistically significant change (i.e. increase in knowledge/familiarity) with each of the specific person-centred behaviour change strategies post-training were as follows:

- Establishing client rapport (OARS) ( $Z=-3.72, p=0.000$ ).
  - Reducing client resistance to change ( $Z=-3.83, p=0.000$ ).
  - Use of scaling questions to determine readiness ( $Z=-3.73, p=0.000$ ).
  - Recognising and changing less adaptive thoughts ( $Z=-4.13, p=0.000$ ).
  - Goal setting and use of action plans to assist goal setting ( $Z=-2.65, p=0.008$ ).
- 
- Pre-training data from clinicians indicated a strong belief in the importance of person-centred practice but lower levels of confidence to implement in practice.
  - Overwhelming response for ongoing reflective practice sessions to discuss person-centred practice following initial training.
  - New staff are to join the reflective practice sessions.
  - Pre- and post-training results have been fed back to participants.

#### **Barriers:**

Barriers during Phase 2 were identified by the project team at Broadmeadows Health Service and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team was able to overcome the only barrier identified. NVivo 7 qualitative research software was used to analyse the data.

The main barrier identified was:

- 1) **Time constraints:** The training sessions were developed and facilitated by a Clinical Health Psychologist needing to juggle a clinical workload in addition to the training work. Backfill was made available, and reports suggested it was *"nothing too overwhelming."*

#### **Key learnings:**

The key learnings from Broadmeadows Health Service's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. Data was analysed using NVivo 7 qualitative research software.

The project key learnings were:

- 1) **A clearly identified need can help generate support and build momentum for a project:** The success of this project may have been in part due to the efforts made during planning and preparation. This preparation included identifying a need, which was reflected in the baseline data. Identification of needs appears to be an important part of careful project planning *"...if there is a need indicated for ongoing sessions we will certainly try to provide those for clinicians to keep it alive..."*

**2) Support from managers can enable a project:**

*"And I think that filters down to the clinicians seeing this person [a manager] being very supportive of this and not just being, yes go do the training and whatever, that they are in fact very keen to see this happen. So I think that is very much very important to the success of these sorts of things."*

The person-centred health care key learnings were:

**1) A single person-centred care project can have many beneficial outcomes:**

*"...it is interesting to see that staff who were not involved with the workshops are keen to attend the reflective practice sessions."*

**2) Projects and initiatives can improve staff awareness of person-centred health care:** The data indicated that this project has resulted in an increase in staff awareness and confidence in using some person-centred strategies.

**3) A supportive environment can enable person-centred health care:** Some of the success of this project was attributed to staff being *"...in an environment where those practices are being supported."*

**Summary:**

This project by Broadmeadows Health Service has been a successful initiative in person-centred health care. Outcomes include increases in clinicians' perceived importance and confidence in assessing a client's readiness to change a health behaviour, confidence in using some person-centred strategies to improve client motivation, and increases in familiarity with specific person-centred behaviour change strategies. These outcomes have the potential to improve person-centred care at Broadmeadows Health Service.

## **Bundoora Extended Care Centre (BECC)**

### **Title of project:**

Meet and greet initiative and case conference restructure.

### **Aims:**

Trial and evaluate a volunteer meet and greet initiative to help service users navigate the campus.

Trial and evaluate a restructuring of team case conferences, to improve multidisciplinary person-centred health care.

### **Description of the project:**

Two projects were identified as person-centred care initiatives. The first was a meet and greet program, where the volunteer service would be used to help service users navigate the health service campus. The second was a restructure of the multidisciplinary case conferences designed to focus the multidisciplinary teams on person-centred care.

### **Targets identified:**

Meet and Greet Program:

- Initial meetings to discuss meet and greet program.
- Formulate role statement.
- Complete volunteer recruitment.
- Orientation for volunteers.
- Commence the meet and greet program.
- Evaluate the program from the prospective of service users and volunteers.

Restructure of team case conferences:

- Complete background work, identifying the need and required changes.
- Conduct staff education and communication initiatives.
- Develop a team leader role with Allied Health Managers.
- Identify the required education and support for team leaders.
- Call for expressions of interest for team leaders.
- Hold a staff forum to foster communication about the planned changes.
- Provide case conference documentation education for team members.
- Implement the restructure.
- Evaluate.

### **Outcomes:**

The key implementation contact at BECC achieved substantial outcomes within the limited timeframe of Phase 2:

Meet and Greet Program:

- Completed a Courtesy Guide role description, recruited volunteers and developed a roster for the main hours service users visit the campus.
- Service users generally indicated it was a positive experience.
- Meet and greet was particularly useful before and during renovations, when reception was less visible.
- The service ceased when the reception renovations were completed.
- May consider re-implementing with an emphasis on clients from the community – will gather volunteers' and service users' feedback before re-introducing.

Restructure of case conferences:

- Identified the need and the changes required.
- Two new team leaders on board, an occupational therapist and physiotherapist.
- Ongoing education for new team leaders, aiming for a clear articulation of the role in case conferences, and how to manage staff.

- Ongoing feedback for new team leaders, currently holding weekly debriefs.
- Education for staff, clear articulation of the roles in case conferences.
- Most staff welcomed change, recognised poor multidisciplinary team meeting structure and process prior to the changes.
- Formal support from Northern Health Allied Health discipline managers.
- Ongoing target of 4-5 meetings to embed new structure and receive feedback from staff before formal evaluation.

### **Barriers:**

Barriers during Phase 2 were identified by the project implementation contact at BECC and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project implementation contact has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

Meet and Greet Program:

- 1) **Conflicting stakeholder opinions:** Feedback from the volunteers suggested that some volunteers believed the program was not a constructive use of their time, but it still might benefit the service users.
- 2) **Changing conditions:** Over the duration of the project a newly renovated, more obvious reception area was completed. Since reception is staffed from 8am – 8pm, and most after-hours visitors are expected and greeted by nursing staff, the conditions under which the need for the project was identified had changed.
- 3) **Short-term focus:** The focus of the project for some of the volunteers was on the obvious short-term building works, and not on the long-term benefits to community service users.

Restructure of case conferences:

- 1) **The project was complex:** A lot of effort was required to ensure that the new structure would be beneficial to care, well communicated to the staff, and the new team leaders were prepared and supported.

### **Key learnings:**

The key learnings from BECC's projects were derived from reports by the project implementation contact during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learning was:

- 1) **A clearly identified need can help generate support and build momentum for a project:** The meet and greet program had difficulty sustaining momentum as the needs and focus of the program changed over time. The case conference restructure however gained support from staff as there was obvious recognition that the person-centred nature of these meetings could be improved: *"...previously case conference, which is traditionally the only time that the multidisciplinary team comes together to discuss clients, was focussed on dates..."*

The person-centred health care key learnings were:

1) **There may be practical ways to encourage health care consumers to participate in their health care:**

*"So part of this process has been developing some paperwork that supports the client's role in that care environment. So what are the client's goals and how do we actually bring them into what is the care that we provide. Realigning the teams is about getting those client's goals on the table, on the day, in the multidisciplinary environment and that will be the most major shift for us."*

2) **Projects and initiatives may improve staff awareness of person-centred health care:**

*"...the staff is thinking about the client as an individual now."*

3) **Projects and initiatives that consider health care consumers' needs can help drive a larger person-centred culture change:**

*"We have been moving towards an integrated model of care for quite some time, so the realignment of our...case conferences within the community therapy service is part of that...and it is part us moving towards something that provides a more appropriate person-centred approach to the care that we provide."*

**Summary:**

These projects by BECC have been useful initiatives in person-centred health care. Even though the meet and greet program ended when the reception renovations were complete, key learnings from the project may prove beneficial for future projects. Outcomes for the multidisciplinary team case conference restructure have the potential to include a more person-centred focus to the care provided.

## **Eastern Health**

### **Title of project:**

Patient information packages.

### **Aim:**

To finalise and evaluate patient rehabilitation information packages.

### **Description of the project:**

To improve communication with health service users, a comprehensive information package has been drafted. The draft has removable pockets for flexibility and storage, and contains a section with site-specific information, a section about rehabilitation, a place to keep all the information brochures given to patients, a section for goals and health information, and a section for discharge planning. The aim is to have health service users keep the information packages with them throughout their rehabilitation, and to take them home on discharge.

### **Targets identified:**

- Develop prototype by engaging a multi-campus, multidisciplinary advisory committee.
- Interview patients about what information they receive, and what they would like to receive.
- Trial prototype on sub-acute wards across three campuses, and collect feedback from patients and staff.
- Consider literature and advice from other sources on similar projects with assistance of NARI.
- Make recommended modifications to the prototype.
- Print professional end copy.
- Implement across sub-acute wards – every patient to receive a communication package for multidisciplinary use throughout their stay, and which they will take home.
- Survey patients and staff to assess whether the initiative is successful in improving communication.
- Implement further changes as indicated – more staff and patient consultation will be warranted with other changes going on in the Health Service.
- Goal to have communication package complete for opening of a new Wantirna campus in September.

### **Outcomes:**

The key implementation contact at Eastern Health achieved substantial outcomes within the limited timeframe of Phase 2:

- Mock-ups of the patient information packages have been developed and trialled in five sub-acute sites.
- Information collected on the mock-ups has been mostly positive.
- Key recommendations to come out of improving care working groups included improving information sharing and giving of written information to patients – the patient information packages should help with these recommendations and will go before the committee addressing these issues.
- Strong management support within the health service, the whole organisation is moving towards improving care.
- Realised the benefits of more and ongoing patient consultation – many simple things can be fixed to improve patient care if they are known.

### **Barriers:**

Barriers during Phase 2 were identified by the key project implementation contact and reported during teleconferences and at the concluding site visit. Barriers were issues

that slowed or restricted progress of the project, or will do so in the future. The project contact has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **The project was complex:** As this project was conducted along with working groups dedicated to improving care across the Health Service, time was needed to analyse how it would fit in with the recommendations that came out of the working groups, and the improvements to care going forward.
- 2) **Conflicting staff opinions:** A new challenge will be to reintroduce the package to everyone and deal with people wanting to modify it again. Good reasons for why they have done things as they have will be required, as an entire new committee will now look at it.
- 3) **Short-term focus:** Some staff found the mock-up version challenging to evaluate, as they focused on the unprofessional look of the mock-up, and not on its utility or content. They had difficulty seeing past the short-term look of the package to its potential long-term impact on person-centred care.

#### **Key learnings:**

The key learnings from Eastern Health's project were derived from reports by the key project implementation contact during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were as follows:

- 1) **Engaging support from many key strategic stakeholders is a strong enabler of successful project implementation:**  
*"You can have the best science, but in the end the communication and people are what matters."*
- 2) **Sometimes patience may be required:** Due to factors beyond the scope of a project, it can be beneficial to wait patiently for an opportunity to move forward.

The person-centred health care key learnings were:

- 1) **Projects and initiatives may improve staff awareness of person-centred health care:**  
*"I think there's certainly more awareness of person-centred care as a term and as you know, I've had people actually ask me, well what is person centred care...it's developing, and I'm being asked those sorts of things more and more often."*
- 2) **There may be practical ways to encourage health care consumers to participate in their health care:**  
*"If we could give them something that indicates that we're sharing information well with them, and that we want them to do their part as well, and we're keeping them very well informed about their progress, then I think that will help..."*

- 3) **Time constraints faced by some clinical staff may make it unlikely they will seek out additional person-centred care resources:** The feedback generated on the person-centred care website developed by NARI suggested that staff with time at work may be more likely to look at a person-centred care website and other person-centred care resources.
- 4) **It may be important to promote what person-centred health care means in practice, and not just use it as a catch phrase:** There was a risk identified that health care staff may think they are practising person-centred care because they hear the term often, but remain discipline-focused.

**Summary:**

This project by Eastern Health should be a successful initiative in person-centred health care. Outcomes should include a comprehensive information package for service users that will improve communication between service users and service providers. It also has the potential to make a valuable contribution towards improving interdisciplinary teamwork and patient-centred goal setting, further improving care.

## **Latrobe Regional Hospital**

### **Title of project:**

Improving goal setting and care planning, and development of person-centred care policy and guidelines.

### **Aim:**

To improve the involvement of service users in goal setting and care planning.  
To develop person-centred care policy and guidelines for staff.

### **Description of the projects:**

Two projects were identified as person-centred care initiatives. A working group was established with the aim of improving service user goal setting and care planning. The working group is developing recommendations, which include addressing a key contact role. Person-centred care policy and guidelines for staff are also to be developed, incorporating staff input.

### **Targets identified:**

Involving service users in goal setting and care planning:

- Conduct a literature search.
- Start up a working group.
- Decide on trial model to use.
- Decide on initial pilot in one location.
- Commence pilot and evaluate.

Development of person-centred health care policy and guidelines for staff:

- Prepare Monash University to help run focus groups to identify key themes to incorporate into a policy and guidelines.

### **Outcomes:**

The key implementation contact at Latrobe Regional Hospital achieved substantial outcomes within the limited timeframe of Phase 2:

Involving service users in goal setting and care planning:

- A large number of people are turning up to meetings.
- Working group meets fortnightly for 30 minutes, and have decided to address a key contact role to improve service user involvement in goal setting and care planning.
- Project has a lot of ongoing interest and momentum.
- A staff education phase is in discussion with the education group and will begin once the key contact role is formalised.
- The key contact guidelines are with quality.
- Will be piloted in the Rehabilitation Elder Evaluation and Management (REEAM) Unit.
- Copy of goals to be given to service users so they can discuss with family etc.
- Follow-up phone calls to be addressed once key contact in place and effective.

Development of person-centred health care policy and guidelines for staff:

- Gained executive support to develop guidelines and a hospital policy.
- Drafted changes to existing policy documentation.
- Will bring the local university on board, and get further assistance to run staff focus groups.

### **Barriers:**

Barriers during Phase 2 were identified by the project implementation contact at Latrobe Regional Hospital and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will

do so in the future. The project implementation contact has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

Involving service users in goal setting and care planning:

- 1) **The project was complex:** Readdressing the key contact role with staff was always going to be challenging, as it had not worked in the past. The idea was to repackage the role as a facilitator to ensure goal setting was followed-up.
- 2) **Information Technology barriers:** Information technology support has been good, but slow.

Development of person-centred health care guidelines for staff:

- 1) **The project was complex:** The project evolved from developing guidelines into developing hospital policy, which will take more resources but will have a larger impact when complete.

### **Key learnings:**

The key learnings from Latrobe Regional Hospital's projects were derived from reports by the project implementation contact during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Engaging support from many key strategic stakeholders is a strong enabler for successful project implementation:** Support was sought from staff, management, executives and consumers.
- 2) **Using collaborators can help upgrade skills and fill skill shortages:** The local university has been brought on board to assist with the running and analysis of staff focus groups.

The person-centred health care key learnings were:

- 1) **It may be important to promote what person-centred health care means in practice, and not just use it as a catch phrase:**

*"...at the moment it's very easy to state that something is person-centred, but what does that actually mean.... there's more to it."*

- 2) **Projects and initiatives may improve staff awareness of person-centred health care:**

*"I do strongly believe that everybody [staff] wants to do the best for patients ...there is a desire there...it's just a matter of looking at strategies and coaching and supporting them. So in general, I get accepted, invited to lots of groups and meetings..."*

**Summary:**

These projects by Latrobe Regional Hospital should be successful initiatives in person-centred health care. Outcomes should include improved service user involvement in goal setting and care planning, and formal person-centred care guidelines and policy for the hospital. These initiatives have the potential to improve care at Latrobe Regional Hospital.

## **Melbourne Health**

### **Title of project:**

A person-centred health care orientation session.

### **Aim:**

To provide all new allied health staff with an orientation session on Melbourne Health's philosophy on person-centred care with particular emphasis on how it is applied in practice.

### **Description of the project:**

The orientation session for allied health staff will be reworked to include Melbourne Health's philosophy on person-centred care, and how it is applied in practice. Information handouts will be written and supplied to new staff.

### **Targets identified:**

- Identify and explore how best person-centred practice is applied in particular areas (e.g. allied health).
- Identify priorities for educating new staff members in applying best person-centred practice (what does the allied health management team want to emphasise?).
- Identify the most important core indicators of applied person-centred practice relevant to new staff members.
- Develop an allied health orientation session to reinforce Melbourne Health's commitment to person-centred practice with particular focus on how this is applied. The session will be interactive and will include a PowerPoint Presentation.
- Develop information handouts for new staff.
- Trial the presentation and handouts – first to workforce development unit, and allied health managers, then to new staff.
- Make necessary changes and evaluate.

### **Outcomes:**

The project team at Melbourne Health have achieved substantial outcomes within the limited timeframe of Phase 2:

- Support was gained from the allied health managers.
- The presentation was developed and allocated more time during the orientation session.
- Person-centred health care principles will now underpin the entire allied health orientation session.
- Trialled the draft presentation with the workforce development unit and some allied health managers. Received a lot of positive feedback.
- An evaluation form has been developed.
- The presentation was designed so various people can present it.
- The updated allied health orientations will be held monthly from July 2007, and will involve both new senior and new junior staff.
- Have seen a successful localised impact. Moving forward, the aim will be to transfer the learnings to other areas.
- Values to be rolled out to all staff over next few years, a further opportunity to embed person-centred health care principles.
- Are looking at eventually rolling out patient-centred orientation sessions and information handouts across service divisions – looking at adapting a single template presentation (i.e. adapt it for PCWs, nurses et al.) for this purpose.

### **Barriers:**

Barriers during Phase 2 were identified by the project team and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team have been able to overcome the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Time constraints:** The initial challenge was trying to do the topic justice in a short time.
- 2) **Changing staff:** Both the project Key Implementation Contact and the Executive Sponsor were new to the positions at the start of Phase 2.

### **Key learnings:**

The key learnings from Melbourne Health's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learning were:

- 1) **Engaging support from many key strategic stakeholders is a strong enabler of successful project implementation:**

*"There has been great support...assistance from the managers... the education service development unit...and...the care of older people advisory group that crosses the whole health service...."*

- 2) **Demonstrations can win support:**

*"...I got some feedback from the people who had been...[at the trial of the presentation] saying...we did not realise what this could mean and we think this needs to have more time devoted to it in the... orientation."*

The person-centred health care key learnings were:

- 1) **It may be important to promote what person-centred health care means in practice, and not just use it as a catch phrase:** It was identified as important not to just load health care staff with information on person-centred health care but look at "...how you actually make it real for them in practice."
- 2) **The principles of person-centred health care can be used to underpin projects and initiatives:** It was demonstrated that the principles of person-centred care are broadly applicable.

### **Summary:**

This project by Melbourne Health has been a successful initiative in person-centred health care. Outcomes will include person-centred care becoming a key part of the allied health induction, which has the potential to improve care within Melbourne Health.

## **Seymour District Memorial Hospital**

### **Title of project:**

Care of the older person in the Emergency Department (ED).

### **Aim:**

To develop a comprehensive and streamlined assessment and referral model for older patients that present to the ED.

### **Description of the project:**

Staff from other areas of the hospital are regularly required to attend to patients in the ED. To assist staff, and improve care, the need for a comprehensive and streamlined assessment and referral model has been identified. The referral and assessment model will aim to stop fragmentation and focus on the continuity of care.

### **Targets identified:**

- Development of a questionnaire to canvas what staff know/feel about handling patients as they come through the ED door.
- Clearly define the specific needs of all stakeholders.
- Find or develop an evidence-based assessment and referral model that addresses the needs identified.
- Trial the model.

### **Outcomes:**

The team at Seymour District Memorial Hospital achieved substantial outcomes within the limited timeframe of Phase 2:

- Information gathering, and identifying needs ongoing.
- Completed a questionnaire to handout to staff to find out what they know and feel about assessing older persons presenting to the ED.
- Will follow-up with comments from initial survey, then distribute to all staff.
- Completed an audit of initial assessment documentation reviewing one month's data for over 65s presenting to the ED – identified issues with documents from the ED not going into medical records, and histories not completed.
- Met with staff and presented results of the audit. Staff were enthusiastic; they feel they can do this better.
- Staff in the acute area seem to be onboard – they see that existing documentation needs to be improved, and this was further buoyed by the accreditation process.
- New assessment form will comprise two sections - administrative section and medical.
- Will look at information technology packages to put assessment form online.
- Surveyed staff computer capabilities, training for some, but not all will be required.

### **Barriers:**

Barriers during Phase 2 were identified by the project team at Seymour District Memorial Hospital and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Accreditation:** Accreditation was successfully completed during the timeframe of Phase 2. It was identified as both a barrier and an enabler in relation to this

project. Accreditation was time consuming, but it also gave them the opportunity to engage staff, and encourage ownership of the care they provide.

- 2) **Information Technology Barrier:** Some staff prefer not to use computers. Computer competency training will be required for some staff if the assessment forms are to be electronic.
- 3) **Limited onsite staff:** The new assessment and referral model needs to consider the limited onsite staff. Many standard urban hospital roles and services such as a health information manager, records department, onsite pharmacist, and easy access to GPs for medication review referrals do not exist at the hospital.
- 4) **Missing resources:** Finding the evidence for what they are assessing has been a challenge.
- 5) **The project highlighted additional issues:** The project has evolved into more than just an assessment tool. Other existing documentation will be reviewed to address larger issues across the continuum of care, as this project has highlighted that existing systems do not support continuity of care.

### **Key learnings:**

The key learnings from Seymour District Memorial Hospital's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Meeting challenges can build support for a project:** The team met the challenge of accreditation by engaging staff and giving them ownership of the care they provide. This turned out to be a beneficial and constructive process that gained them further support for change.
- 2) **Giving ownership and engaging staff helps to generate support for change:**  
  
*"...there's quite a deal of work that we have to do, and it would perhaps take us longer than a larger organisation, but...there's a very positive feel about moving forward, engaging the staff in this..."*
- 3) **Demonstrations can win support:** Presenting the findings of the documentation audit to staff demonstrated the need for addressing this issue, and won support from staff who believed they could do better.

The person-centred health care key learnings were:

- 1) **A single person-centred care project can have many beneficial outcomes:**  
  
*"It is part of us moving towards something that provides a more appropriate person-centred approach to the care that we provide."*
- 2) **Projects and initiatives may change staff attitudes towards person-centred health care:**

*"It's not measured, just you know, I think staff attitudes...have changed. Oh and certainly...myself as a clinical staff, mine has changed, definitely."*

**Summary:**

This project by Seymour District Memorial Hospital should be a successful initiative in person-centred health care. Final outcomes may include improvements to assessments and referrals in the ED, and information flow across the continuum of care. Such outcomes have the potential to improve care at Seymour District Memorial Hospital.

## **Southern Health**

### **Title of project:**

Discharge planning.

### **Aim:**

To develop a single discharge planning process across all sub-acute in-patient services.

### **Description of the project:**

A single person-centred discharge planning process, including forms, is to be developed and implemented across all sub-acute in-patient services.

### **Targets identified:**

- Examine any similar processes elsewhere that have merit.
- Consult with staff about inadequacies/benefits of current format.
- Draft of new form.
- Trial of new form in two wards.
- Implementation of new form in all wards.

### **Outcomes:**

The team at Southern Health achieved substantial outcomes within the limited timeframe of Phase 2:

- Arranged a trial of the previous form on one ward.
- Review of the existing form and evaluation of use suggested that discharge planning was occurring, though it was not well documented.
- A revised form will go to a social worker and her team for feedback and then will be trialled across two thirty bed wards.
- Completed an interim report regarding staff views on the need for and role of post-discharge follow-up; discovered that it is not necessary to follow up everyone; those referred onto other Southern Health services do not require follow-up (although clinicians may still do so if there is a clinical need).
- Plans going forward include the implementation of a discharge summary procedure, whereby the key liaison person or ward clerk may complete the documentation during team meetings.
- An idea was tabled to invite the ward clerks to team meetings to start completion of forms, and have the key liaison person follow up with forms and relevant clinicians after team meetings - there is a need to ensure that the key liaison role is well defined, and people are not pushing further work onto this role.
- Looking to carbon copy discharge summary documents due to lack of readily available computers and photocopiers.
- Will introduce to team meetings, trial, audit histories, and feedback to team meetings to ensure implemented.
- Will be an ongoing evaluation, including staff and consumer feedback.
- Starting a process of service wide document auditing.

### **Barriers:**

Barriers during Phase 2 were identified by the project team at Southern Health and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Avoiding duplication:** Trying to reduce duplication between required documents (ScoTT, discharge summary, and information to go to the patient) is a challenge.
- 2) **Time constraints:** Completing forms can become an extra burden for clinical staff after team meetings, so trying to make sure the forms are not too onerous (planning to cut half the current form to a single sheet).
- 3) **Conflicting staff opinions:** Designing a form for use across seven units in three sites is challenging, as staff may not see it as a "perfect form" for their specific unit and therefore try to continue use of the familiar process (currently multiple versions in use). Some clinicians are also keeping patient histories in their own clinical notes, and not including them in the proper files.
- 4) **Missing resources:** Southern Health has been identified as a leader in person-centred projects and initiatives. Resources from others in the field are therefore more difficult to find.
- 5) **Information Technology Barriers:** There is limited access to computers and photocopiers.
- 6) **Requirements unclear:** Discharge requirements have not been properly communicated to the Health Service.

#### **Key learnings:**

The key learnings from the Southern Health project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Being a leader presents its own challenges:** As an identified leader in person-centred care projects and initiatives, Southern Health was able to provide a flow of information and assistance to others in the field. However, information and assistance to Southern Health was difficult to find.
- 2) **Giving ownership and responsibility to staff helps generate support for change:**

*"We're looking at what will go to the patient. It then becomes part of their information system, and precipitates more of ...a connection, because you actually have to provide it to somebody, or in the file, or carer or family. They're all given a layer of responsibility which will precipitate."*

The person-centred health care key learnings were:

- 1) **Consideration of health care consumers' needs may lead to innovations in person-centred health care:**

*"I think one of the differences will be if we can put in place an evaluation as to the consumers' view of this sort of documentation..."*
- 2) **Projects and initiatives may improve staff awareness of person-centred health care:**

*"And so that's been [person-centred care] quite a factor in how we've designed forms and what staff actually give to patients. So just that responsibility and recognition that we do need to have that."*

**Summary:**

This project by Southern Health should be a successful initiative in person-centred health care. Outcomes should include a consistent discharge process along with documentation that has the potential to improve care at Southern Health.

## **St. Vincent's Health**

### **Title of project:**

The experience of relatives and carers of patients aged over 65 years in the Emergency Department: Are person-centred care needs being met?

### **Aim:**

To identify the needs and experiences of relatives and carers in the Emergency Departments (ED).

### **Description of the project:**

A convenience sample of relatives and carers who have been in the ED for more than four hours while accompanying patients aged over 65 years will be interviewed face-to-face with a structured questionnaire using Likert scales and some open-ended questions. Carers will be asked to self-identify. Data collected will include: demographic and care responsibilities, perceived level of person-centred care received, and care needs (physical, environmental, communication and other). Carers will also be asked to report their levels of carer strain.

### **Targets identified:**

- Develop research protocol and survey questions.
- Submit ethics amendment.
- Provide project background to ED staff via staff meetings and group e-mail.
- Commence recruitment and survey collection.
- Interview relatives as well as carers, who have been in the ED for more than four hours.
- Data analysis.

### **Outcomes:**

The team at St. Vincent's Health have achieved substantial outcomes within the limited timeframe of Phase 2:

- Have had good feedback from the ED and good buy-in from ED management.
- Getting feedback from carers and family has excited the ED management.
- Expansion to include relatives not just carers recommended by the Medical Director, Andrew Dent.
- Feedback is highly regarded in the accreditation process, and this project on the quality plan for accreditation.
- Keeping person-centred care on the agenda in the ED.
- HARP team in the ED have been recruited to help identify carers.
- Development of a "Things to do in the ED" folder with puzzles etc.
- At last report ten relatives/carers have been interviewed.
- Results so far indicate that carers do a lot, and devote a lot of time to caring.
- Many self-identifying carers are not receiving a carer's allowance.
- Financial support brochure and Centrelink details given to self-identified carers not receiving financial assistance.
- Within ED, management awareness of person-centred care increasing.
- Resources for carers are being distributed post-interview as required (e.g. financial support, community services, respite).

### **Barriers:**

Barriers during Phase 2 were identified by the project team at St. Vincent's Health and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Time issues:** Fitting the project into a busy workload.
- 2) **Differing opinions:** In developing the surveys it took a while to articulate the questions correctly. They did not want to presume what is important to carers. A proper literature review may have proven beneficial.
- 3) **Ethics Approval:** It took seven weeks for the project ethics amendment to be passed.
- 4) **Data Collection Issues:** A review of the recruitment parameters was required once recruitment had begun to ensure numbers. The interview logistics proved to be challenging as the form proved to be cumbersome, and chairs were often unavailable. Discharge destination and patient outcomes were not collected, although those data may be interesting.

### **Key learnings:**

The key learnings from St. Vincent's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Support from stakeholders can be won by identifying what they value:**

*"I think St. Vincent's is pretty person-centred and values this type of thing. So from a management point of view there's been some interest... because they're after evidence and will utilise the evidence."*

- 2) **Building a network of support can help enable a project:**

*"I think for the both of us it's been good to have a professional and academic ... link with NARI. I think that's of benefit to the ED, of benefit to us professionally...not just a professional link, but a personal link that creates collegiality. I think that's of great benefit...it makes people accessible."*

The person-centred care key learnings were:

- 1) **Projects and initiatives may improve staff awareness of person-centred health care:** The presence of the key project implementation contact in the ED conducting interviews may help keep person-centred care on the agenda.
- 2) **Enhancements in person-centred care attributed to specific projects can be difficult to evaluate:** With many initiatives and an ongoing commitment to person-centred health care it is difficult to compartmentalise and evaluate outcomes.
- 3) **A single person-centred care project can have many beneficial outcomes:**

*"St. Vincent's...has signed a memorandum of understanding with Carers Victoria and I've been trying to get in touch...with the state manager...just to let them*

*know that we're doing this as well, and that we've utilised some of their resources, and that type of thing. So that's enriching the acute hospital's links with a community organisation."*

**Summary:**

This project by St. Vincent's Health Service should be a successful initiative in person-centred health care. Outcomes will help the health service better understand the needs of families and carers in the ED, which has the potential to improve care within the health service.

## **Western Health**

### **Title of project:**

Refocusing Culture: Improving care outcomes for older service users of Western Health.

### **Aim:**

To identify baseline staff knowledge and attitudes in dealing with depression, dementia, delirium and functional decline in older service users.  
To develop and evaluate a staff education program based on the baseline results.

### **Description of the project:**

Accurate and detailed baseline data was sought to assess the status of care of older people at Western Health. Audits, surveys and focus groups were conducted to establish baseline staff knowledge and attitudes. This data will aid in the development of an education program and inform a campaign at Western Health to improve care outcomes for older service users.

### **Targets identified:**

- Perform a restraint audit.
- Develop questions to canvas staff attitudes and knowledge of care for older service users.
- Hold 15 to 20 focus groups to establish staff attitudes and knowledge of care for older service users.
- Develop a depression, dementia, delirium and physical restraint knowledge questionnaire for staff.
- Have staff complete the depression, dementia, delirium and physical restraint knowledge questionnaire at the conclusion of the focus groups.
- Analyse questionnaires and focus groups.
- Identify key issues from the analysis.
- Plan a staff education program based on the key issues arising out of the focus groups and questionnaires.
- Implement the education plan.
- Re-issue questionnaires to evaluate the impact of the education plan.

### **Outcomes:**

The team at Western Health achieved substantial outcomes within the limited timeframe of Phase 2:

Built momentum for the project:

- Establishment of a steering committee with a strong commitment to make a difference.
- Established a clear project plan.

Data collection and summaries:

- Completed a restraint audit.
- Focus groups attended by 170 staff across the health service – staff were reported to be happy to participate and have a say.
- Depression, dementia, delirium and physical restraint knowledge questionnaire completed by 163 staff.
- From the focus groups it was established why staff have a lack of confidence with older people: communication is a key issue, and staff do not feel comfortable approaching someone who is confused or agitated, as they do not believe they have the skills to appropriately address the situation.
- Skill deficits need to be addressed with education.
- Developed a table to compare DHS policy across each aspect of functional decline with Western Health's statistical information.

Raising Awareness:

- Data presented to the executives and clinical governance.
- Involving the community with the slogan contest.
- Eight weeks of feature articles appeared in the Western Health newsletter leading up to the Grand Round, featuring different areas of functional decline.
- Presented at the Grand Round a presentation titled: "Refocusing culture: improving care for older service users of Western Health," which was well attended.
- Meeting with the Community Advisory Group to establish consumer and carer involvement.

Going Forward:

- Over the next six months the data will be used to develop clinical indicators for each discipline.
- Key guidelines by which to measure outcomes will be drafted and best practice outcomes will be outlined along with strategies to achieve these.
- Significant progress with the education program to be made in the next six months; long-standing problems and practices will take longer.
- Believe they have now identified ways to improve care for older people.

**Barriers:**

Barriers during Phase 2 were identified by the project team at Western Health and reported during teleconferences and at the concluding site visit. Barriers were issues that slowed or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Time constraints:** Accreditation, the physical size of three acute hospitals, and the large numbers participating in the focus groups and completing questionnaires contributed to the time pressures.
- 2) **Project highlighted other issues:** New needs were identified as the project has been conducted. Patient destinations at discharge were not available for analysis. There had been a 75% increase in referral to the field psychiatry service for people with delirium; and staff shortages in the community aged psychiatry team were identified as causing an influx of patients sent to the Emergency Department.
- 3) **Conflicting stakeholder opinions:** Education is needed. Many key stakeholders did not realise the need in the beginning. This is changing, and support from the stakeholders is being won.
- 4) **Accountability:** There is not yet ownership and accountability for the goals being set. There are many differences between divisions, and there is a need to harmonise approaches across the large organisation.

**Key learnings:**

The key learnings from Western Health's project were derived from reports by the project team during the initial site visit, introductory seminar, teleconferences, and concluding site visit. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Ongoing feedback can win support:**

*"... Heather has been very effectively able to gain momentum and to really – not just involve people in a snapshot way, but to involve them in an ongoing way, so that there is a feedback loop."*

**2) Sometimes building support is about timing:**

*"...it's all about the timing, it's when you raise the issues, and to which groups, and how you get that momentum. But I think that relatively speaking, Heather's done a fantastic job of keeping people in the loop, and just waiting, sitting back and waiting for an opportunity, and waiting for the right time to raise it in a broader forum. So I think a lot of the background work has been done. I wouldn't change that, and I also think the timing of raising the issues in a larger forum has also been really advantageous."*

**3) A clearly identified need can help generate support and build momentum for a project:** This phase of Western Health's project has been about clearly identifying needs. Having done the background work, and having available evidence before moving forward, may be helpful to build support for the changes ahead. *"There is a real commitment to addressing these issues, given that we've highlighted them, there is an overwhelming sense of, ok, we need to work out how we improve this situation."*

The person-centred health care key learnings were:

**1) Projects and initiatives may improve staff awareness of person-centred health care:**

*"We have, of the range of people who sit on the steering committee, a number of those have operational roles in different programs, and I know that the discussions have prompted them to go back to their particular service or programs and better focus on some of the key issues in caring for older people."*

**2) A single person-centred care project can have many beneficial outcomes:**

*"It's had a much bigger impact than just a sort of small project with a beginning and an end..."*

**Summary:**

This project by Western Health has been a successful initiative in person-centred health care. Outcomes include the collection of baseline data on knowledge and attitudes of staff in dealing with older service users. These outcomes are to form the foundation of an education program for staff, with the potential to improve care within Western Health.

## **Wodonga Regional Health Service**

### **Title of project:**

Goal setting and rehabilitation expectations and communication.

### **Aim:**

To improve the communication of patient and family/carer goal setting and rehabilitation expectations.

### **Description of the project:**

A need to improve communication with patients and families/carers in relation to goal setting and expectations of rehabilitation was identified. Input from staff, patients and families/carers to be sought to identify how the current process could be improved to avoid mismatched expectations and conflict as the day of discharge nears.

### **Targets identified:**

- Complete background research into person-centred health care and goal setting.
- Canvas staff for their concerns surrounding goal setting and achieving realistic expectations with patients and families/carers, and possible solutions.
- Discussions during team meetings would be a good place to start staff consultation.
- Develop a set of survey questions for staff, patients and their families/carers to collect opinions on goal setting, their experiences, and suggestions for improvements.
- Analyse the information collected.
- Develop a tool/model for goal setting in the rehabilitation unit that will improve mismatched expectations of families/carers, patients and staff.

### **Outcomes:**

The team at Wodonga Regional Health Service achieved substantial outcomes within the limited timeframe of Phase 2:

- A number of staff members are very interested in the project.
- Collection of information from the NARI person-centred health care website, and the Council on the Ageing (COTA) website.
- Have found a more meaningful way to conduct the project – initially were going to do a small evaluation.
- Have clarified goals, and looked at what they can control and what is beyond their control, and how the goals fit into the bigger picture.
- The project fits in with a number of other initiatives, and accreditation recommended more consultation with families and carers in the community.
- Have presented to the quality committee and have gained their verbal support – quality also has a new project role in place looking at consumer feedback.
- Currently have a post-rehab survey which includes goal setting questions. However, the tool needs to be reviewed for validity as they currently get 100% satisfaction.
- Have been developing a person-centred health care presentation for staff, want to clarify the person-centred approach with staff.
- Learning the process of a research project is an accomplishment in itself - have now clarified the project and how it will fit into the bigger picture and model of care.
- Familiarisation with ethics requirements.

### **Barriers:**

Barriers during Phase 2 were identified by the project team at Wodonga Regional Health Service and reported during teleconferences. Barriers were issues that slowed

or restricted progress of the project, or will do so in the future. The project team has been able to overcome many of the barriers identified. NVivo 7 qualitative research software was used to analyse the data.

The main barriers identified were:

- 1) **Time constraints:** Time is always a challenge for staff, and energies are often spread.
- 2) **Limited onsite staff:** Clinical staff with hours allocated elsewhere are the only staff available to take on extra responsibility for project work. No key staff are allocated only to project work. Clinicians need to be up-skilled at project management.
- 3) **Ethics approval:** There was a new ethics representative on board at the hospital, which made acquiring information about ethics approval more challenging. The national online system for ethics approval that must be used (as they work across the border between Albury and Wodonga (Victoria and NSW)), proved difficult to use and assistance difficult to acquire.
- 4) **Missing resources:** A survey tool existed with some relevant questions, but it is consistently returned scoring 100% satisfaction. A validated tool, or the resources to write a validated tool are needed.
- 5) **Staff changes:** Staff changes within NARI and the health service resulted in a changed project focus.

#### **Key learnings:**

The key learnings from Wodonga Regional Health Service's project were derived from reports by the project team during the initial site visit, and teleconferences. The key learnings have been divided into two categories: project key learnings, and person-centred care key learnings. NVivo 7 qualitative research software was used to analyse the data.

The project key learnings were:

- 1) **Using collaborators can help upgrade skills and fill skill shortages:** The project team indicated it was valuable to work with NARI and other health services that have expertise in research and project work to help enhance some of their clinical staff's research and project management skills.
- 2) **Time constraints faced by some clinical staff may make it difficult to take on additional project work:** Without specifically allocated project time, busy staff may need to take on additional work if projects are to be completed.

The person-centred health care key learnings were as follows:

- 1) **Improvements in person-centred care attributed to specific projects can be difficult to evaluate:**

*"We've got no way of saying attitudes, but certainly...people are starting to use some of the terminology, and starting to be a little bit more aware...so much from our particular project...but because it's part of a bigger drive within the health service."*

- 2) **Time and computer access constraints faced by some clinical staff may make it unlikely they will seek out additional person-centred care resources:** The feedback generated on the person-centred care website developed by NARI suggested that staff with time at work may be more likely to look at a person-centred care website and other person-centred care resources. Furthermore *"...in a lot of Health Services... a lot of allied health staff have access to a computer during the day, but perhaps nursing staff who you might want to be getting this message out to, don't always have that computer screen and access to websites..."*

**Summary:**

This project by Wodonga Regional Health Service should be a successful initiative in person-centred health care. Outcomes should include improved communication of goals and rehabilitation expectations and has the potential to make a valuable contribution towards improving care.

## **Appendix B: Evaluation semi-structured interview outline**

### **Questions for discussion during the site visit:**

Is there anything we have missed that you would like to add to the summary of the information provided to NARI, or is there anything that has changed?

How would you rate your involvement in Phase 2? Were the initial site visit, introductory seminar, teleconferences beneficial to you?

Can you describe any wider impact of the project on your Health Service?

How has person-centred care improved as a result of your project (e.g. staff attitudes, practice)?

What support have you been given from your Health Service (e.g. management support, resources)?

How do you foresee the project extending in the future?

What would you do differently if you were to conduct the project again?

What do you see as the strengths of the NARI PCHC website?

What do you see as limitations of the NARI PCHC website?

Were there any resources that you could not find on the NARI website or elsewhere?