



Best Practice in Person-centred Health Care for Older Victorians

Final Report

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Thank you to members of the project advisory group:

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Executive Summary

This report presents a summary 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).

Aims

The aims of the project were to:

1. assess current practice in relation to involvement of older people and their carers in their health care in Victoria
2. identify current best practice in person-centred care
3. develop and trial resources in Victorian Health Services to facilitate the implementation of person-centred practice in line with the Victorian Government policy on improving care for older people, and
4. evaluate the impact of these resources on practice.

Methodology

The project consisted of three phases.

Phase 1

The activities undertaken in Phase 1 included:

- establishment of a project advisory group
- establishment of a project consumer reference group
- literature review of “What is person-centred health care?”
- a “Benchmarking Person-centred Care” survey within 17 Victorian Health Services
- identification, exploration and evaluation of eight good practice initiatives in person-centred health care within Victorian Health Services
- identification and evaluation of additional resources and initiatives of good practice in person-centred health care, both nationally and internationally
- development of a website containing information about person-centred care.

Phase 2

Phase 2 involved supporting Health Services in enhancing their person-centred care practice. The main activities of Phase 2 included:

- recruitment of and meeting with participating Health Services to plan project strategies and identify manageable goals and timelines
- an introductory workshop, facilitated by a change management expert, for health services to meet together, describe their projects, and discuss goals as well as possible barriers and enablers
- individual projects undertaken by each Health Service
- teleconferences for participating Health Services to discuss goals, challenges and progress
- site visits and interviews at Health Services for evaluation
- individual written feedback summaries to health services.

Phase 3

Phase 3 involved re-administering the “Benchmarking Person-centred Care” survey, with minor changes, to the 17 Health Services that participated in the survey component of Phase 1.

Findings

Phase 1 provided a description of person-centred health care through the literature review. Based on this literature review, and consultation with older service users, a benchmarking survey tool was developed to assess where Victorian Health Services were in relation to person-centred health care attitudes and practices. As well as providing a benchmark of where Victorian Health Services were in relation to person-centred health care, the survey helped identify barriers and facilitators in person-centred health care, areas in person-centred health care in need of improvement, and good practice resources or initiatives in person-centred health care. Following further investigation of these resources and initiatives, help sheets to aid in improving person-centred care, and a website of person-centred health care resources and initiatives were developed.

Phase 2 involved supporting health services in enhancing their person-centred care practice. Furthermore, it aimed to evaluate the usefulness of the overall person-centred health care website and the information included on it, and to identify any gaps in resources. The evaluation revealed many helpful recommendations for improvement of the website, including additional resources and information that could be included, such as assessment tools, discipline-centred goal setting and how to gain support for implementing new person-centred initiatives. In addition, the evaluation identified the need for an ongoing commitment to the website's evolution into a comprehensive library of resources.

The survey undertaken in Phase 3 found that, over a two-year period, there has been an increase in staff awareness of person-centred health care in Victorian Health Services. In the 2007 "Benchmarking Person-centred Care" survey, over 60% of respondents agreed or strongly agreed that their awareness of person-centred health care had increased over the previous two years. However, although re-administration of this survey indicated that there was a change in respondents' awareness of person-centred health care, there was very little change in practice. Similar responses in relation to barriers and enhancers of person-centred health care were generated in 2007 as compared to 2005, with a few notable exceptions. One barrier that was noted in 2005 but not 2007 was communication issues within teams due to territorial issues between staff of different disciplines. In 2007 an additional barrier that was noted was inadequate information technology resources and logistical barriers caused by working in larger Health Services and across multiple sites. In 2007 there was more emphasis on how environmental factors can enhance person-centred health care than there was in 2005, perhaps due to an increase in awareness of how the environment can contribute to person-centred care.

Conclusion

In conclusion, it appears that the "Best Practice in Person-centred Health Care for Older Victorians" project, in conjunction with the "Enhancing Practice Program", the "Improving the environment for older people in Health Services" audit tool, and the "Dementia Care in Hospitals" project, all undertaken as part of the implementation of the *Improving Care Policy*, has had an impact on raising awareness of person-centred health care within Victorian Health Services. It may have been expected that an increase in awareness would translate into improved practice, but this has not necessarily been the case. Person-centred practice relies not only on individual awareness but also on appropriate models of care, resources, education, and supportive organisational cultures. Therefore, it is important that Health Services ensure that appropriate resources are available to staff to enable them to practise health care in a person-centred manner.

Introduction

This report presents a summary 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.

A key element of the *Improving Care Policy* is the refocusing of the culture within Health Services. Health Services each nominated an Executive Sponsor, a Key Implementation Contact (KIC), and a project officer who formed a Community of Practice to facilitate implementation of the policy. The project supported Health Services in identifying person-centred practices and implementing person-centred care, a key principle of the policy.

Aims

The aims of the project were to:

1. assess current practice in relation to involvement of older people and their carers in their health care in Victoria
2. identify current best practice in person-centred care
3. develop and trial resources in Victorian Health Services to facilitate the implementation of person-centred practice in line with the Victorian Government policy on improving care for older people, and
4. evaluate the impact of these resources on practice.

Objectives

The project objectives were to:

- review relevant literature about person-centred health care and its efficacy
- develop a tool for assessment of person-centred health care in Victorian Health Services in consultation with service users
- review existing practice in Victorian Health Services aimed at improving the involvement of older people and their families in their own care
- identify the key lessons that have been learnt from existing person-centred health care initiatives
- develop resources that will help health services to implement person-centred health care practices¹
- trial these resources in selected health services
- evaluate and refine these resources, and
- assess the extent and adequacy of person-centred health care practice from the perspectives of staff working in Victorian Health Services.

Methodology

The project consisted of three phases.

¹ As the project evolved, and the diversity of resources available to support person-centred health care became apparent, the project team, in consultation with the advisory group and consumer reference group, decided that this objective should be modified to “provide easy access to relevant resources through the development of a person-centred health care website”.

Phase 1

Phase 1 ran from February 2005 until December 2006.

The goal of Phase 1 was to assess the extent and adequacy of current person-centred health care practice and identify current good practice initiatives reported in the literature and in Victorian Health Services. The activities undertaken in Phase 1 included:

- establishment of a project advisory group
- establishment of a project consumer reference group
- literature review of "What is person-centred health care?"
- a "Benchmarking Person-centred Care" survey within 17 Victorian Health Services
- identification, exploration and evaluation of eight good practice initiatives in person-centred health care within Victorian Health Services
- identification and evaluation of additional resources and initiatives of good practice in person-centred health care, both nationally and internationally
- development of a website containing information about person-centred care.

Phase 2

Phase 2 ran from October 2006 until July 2007. It involved supporting Health Services in enhancing their person-centred care practice. The main activities in Phase 2 included:

- recruitment of and meeting with participating Health Services to plan project strategies, and identify manageable goals and timelines
- an introductory workshop, facilitated by a change management expert, for health services to meet together, describe their projects, and discuss goals as well as possible barriers and enablers
- individual projects undertaken by each Health Service
- teleconferences for participating Health Services to discuss goals, challenges and progress
- site visits and interviews at Health Services for evaluation
- individual written feedback summaries to health services.

Phase 3

Phase 3 ran from July 2007 to December 2007. It involved re-administering the "Benchmarking Person-centred Care" survey, with minor changes, to the 17 Health Services that participated in the survey component of Phase 1. It was originally envisaged that the original survey would be re-administered. However, minor changes were made to ensure the questions remained relevant, and new data were collected to compare levels of awareness of person-centred practice within each health service and between health services.

Phase 1

Phase 1 was the longest phase of the project, running from February 2005 until December 2006.

Establishment of a project advisory group

An advisory group was established at the beginning of the project to oversee and advise on all aspects of the project. This group included representation from the following bodies:

- Allied Health Consultative Committee
- Australian and New Zealand Society for Geriatric Medicine
- Australian Nursing Federation
- Carers Victoria
- Centre for Culture, Ethnicity and Health
- Consumers Health Forum of Australia
- Council on the Ageing
- Department of Human Services, Victoria
- Health Issues Centre
- Metropolitan Health Services in Victoria
- Rural and Regional Health Services in Victoria

The terms of reference for the advisory group were to:

- advise and contribute to the "Best Practice in Person-centred Health Care for Older Victorians" project
- oversee the methodology for identifying and implementing best practice in person-centred health care
- advise on the findings of the literature and practice review, person-centred health care survey, and the trial and evaluation of resources
- critically review the resources developed by the project team to support the implementation of person-centred health care practice in Victorian Health Services
- communicate progress of the "Best Practice in Person-centred Health Care for Older Victorians" project to respective peak bodies.

The project advisory group met approximately every 2-3 months throughout the project.

Establishment of a project consumer reference group

The advisory group asked that consumers be actively represented throughout the project and recommended that a consumer reference group be formed to guide the project. The consumer reference group met approximately every 2-3 months throughout the project, providing advice from a consumer's point of view on the project methodology and outcomes. This group included volunteers from the National Ageing Research Institute, Council on the Ageing, and Carers Victoria, as well as a representative from Council on the Ageing, who was on both the advisory group and the consumer reference group.



Members of the NARI project team with members of the Consumer Reference Group

Literature Review

Aims

A literature review on person-centred health care was conducted with the aim of investigating the following questions:

- What is person-centred health care?
- What models of person-centred health care are currently being used?
- What evidence is there of the effectiveness of these models?
- What are the documented barriers and enablers for providing a service that is person-centred?
- What tools are currently being used to assess the extent and/or adequacy of person-centred practice in health care?
- What are the concerns of clients and carers in relation to health care?

Parameters of the review

The literature review included Australian and internationally published (peer-reviewed) research relating to person-centred practice. All four levels of evidence determined by Australia's National Health and Medical Research Council (1999), as well as qualitative reports, were included in this review. The key search terms were:

- person-centred practice
- person-centred care
- client-centred practice
- client-centred care
- consumer-focused practice
- consumer-focused care
- patient-centred practice
- patient-centred care
- client goal-setting.

The Cochrane Library and the PubMed and Ovid databases (including Cinahl, Pyschlit and Medline) were searched. The following exclusion criteria were used:

- articles published before 1995
- literature focusing on paediatric clients
- literature considering adults under the age of 70 years, unless they had complex care needs (for example, adults post-traumatic brain injury or stroke).

Recent Victorian reports that included direct feedback from clients or carers (or both) about their experience of health care, such as *Evaluation of home-based rehabilitation in Victoria* (Dow, Black, Bremner, & Fearn, 2004) and *Victorian Patient Satisfaction Monitor* (TQA Research Pty Ltd, 2003) were also included in this review.



Key findings

The literature review identified that there were many definitions of person-centred (patient- or client-centred) health care in the literature. The overriding message was that person-centred health care is about a collaborative and respectful partnership between the service provider and user. The service provider respects the contribution the service user can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs, and the service user respects the contribution the service provider can make, including their professional expertise and knowledge, information about the options available to the service user, and their values and experience. Both the service provider and service user are important as people within the partnership; neither is interchangeable, and the experiences of one cannot be generalised to another.

The literature review also explored the efficacy of person-centred health care. The literature, although limited, was largely supportive of person-centred approaches to care. Things that hinder and things that help in providing person-centred health care were also identified in the literature review.

The full literature review can be obtained from:
<http://www.health.vic.gov.au/older/litreview.pdf>.

Focus groups with consumers

Two focus groups were undertaken with 14 older health service users. The aim of the focus groups was to find out what the service users thought was important in health care, and to use this information to develop the "Benchmarking Person-centred Care" survey.

Older service users identified the following as important in their health care:

- the quality of the treatment they receive, including having excellent surgical, medical, nursing and allied health care provided in hospital and outpatient facilities
- non-patronising attitudes of staff, including:
 - older service users not being called "darling" or "dear" by people they have never met before
 - staff not assuming that older service users are demented or deaf
 - older service users being taken seriously in relation to their own health care, and being given information and/or having their opinions taken seriously
 - older service users having their symptoms taken seriously and not simply diagnosed as "old age"
- continuity of care
- good discharge planning, including consultation with the service user, family and/or carers
- the need for older service users to be assertive in relation to their health care, to find out about their own health condition, and to speak up about their preferences and concerns, and
- adequate parking and public transport access to hospitals.

These issues were incorporated into the "Benchmarking Person-centred Care" survey.

Statewide survey on person-centred care

Aims

The aims of this survey were to:

1. assess current practice in relation to person-centred care from the point of view of staff working within the Victorian Health Service system, and
2. identify a sample of current good practice initiatives for further investigation by the research team.

Development of the survey

As there was no benchmarking tool for person-centred care already in existence, the survey was developed by the research team. It was based on the key elements identified in the literature, and on advice from older people themselves, as important aspects of person-centred care. The advice from older people was drawn from the two focus group discussions with older service users and discussions with the project's consumer reference group.

Description of survey

Respondents were asked to rate, on a 5-point Likert scale, their attitudes, beliefs and current practice in relation to the following six topics:

1. getting to know the older service user (patient or client) (7 items)
2. sharing power and responsibility with older service users (8 items)
3. service flexibility and accessibility (8 items)
4. making sense of services for the older service user (7 items)
5. the working environment facilitates person-centred practice (9 items)
6. concerns expressed by older people (9 items).

Respondents were also given the opportunity to provide free text comments after each question about factors that make it easier or more difficult to work with service users in this way. In section 7 of the survey, respondents were asked to comment on:

- the things that help or detract from working in a person-centred way within their Health Service
- the resources that would support them to work in a person-centred way, and
- any areas in their Health Service where they thought person-centred approaches were already well developed.

For a copy of the survey see Appendix A.

Dissemination

Ethics Approval

Human Research Ethics Committee approval was obtained from each Health Service prior to disseminating the survey.

The survey sample

Seventeen of the health services involved in the Community of Practice chose to participate in the survey (see Appendix B for a list of the participating health services).

The survey was distributed 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) or Community Therapy Services and Continence Clinics in each of the 17 participating Health Services.

How the survey was disseminated

Each health service involved had a Key Implementation Contact (KIC) or project officer who assisted with disseminating the survey within their organisations. Survey respondents could either complete the survey electronically or use a reply paid envelope to complete it in its paper-based form.

Reporting on the survey to individual health services

Each participating health service received a report detailing their individual Health Service results. Each report described:

- a profile of respondents
- quantitative and qualitative responses to Sections 1-6
- a summary of Sections 1-6 detailing the ten items that had the highest practice or agreement rating and the ten items that had the lowest practice or agreement rating
- a summary of the factors that make it easier or more difficult to work with service users in a person-centred way
- the resources that would support staff to work in a more person-centred way
- any areas in their health service where staff thought person-centred approaches were well developed.

Statewide survey report

The statewide survey report followed a similar structure to the individual health service reports. In addition, the statewide survey report detailed differences between metropolitan and rural health services, between acute and sub-acute settings and between nursing and allied health staff.

Survey results

Highest rated practice or agreement survey items

The ten items from Sections 1-6 of the survey with the highest practice or agreement rate, that is the items where the highest number of respondents said they usually/always did something or agreed/strongly agreed with a statement, were:

Attitudes:

- Item 6.2 Health care should be a collaborative partnership between service user and provider (98%)
- Item 4.1 Health services should ensure that the service user has the information they need to understand what is happening to them throughout their whole care experience (97.9%)
- Item 3.1 Services should be accessible to service users of all ages, abilities, from all culturally and linguistically diverse (CALD) backgrounds and indigenous Australians (97.1%)
- Item 1.2 It is important to find out how the service user and carer feel about this episode of care (e.g. worried about surgery, or how they will manage when discharged) (95.7%)
- Item 1.1 It is important to get to know each service user as an individual (e.g. their medical history, social supports, pre-morbid status) (95.1%)
- Item 6.1 The needs and preferences of service users should be central in health services (94%).

Practice:

- Item 1.3 I listen carefully to what service users say (98.9%)
- Item 1.5 I let service users know that I recognise them (e.g. call them by their preferred name, remember and repeat something they have told me) (97.1%)
- Item 1.6 I give service users and their carers adequate time to talk to me (e.g. to discuss their concerns and their expectations) (94.3%)
- Item 1.4 I find out what name the service user prefers to be called (93.1%).

Of the ten items with the highest practice or agreement rate, six were from the section of the survey that asked questions about "getting to know the older service user". All of the items in this section either asked respondents about their attitudes and beliefs or about their own practices, not practices of their program or health service. The other four items in the top ten list were related to the respondents' attitudes and beliefs, over which they also have control.

Lowest rated practice or agreement survey items

The ten items from Sections 1 through to 6 with either the lowest practice or agreement rate, that is the items where the lowest number of respondents said they usually/always did something or agreed/strongly agreed with a statement, were:

Practice:

- Item 6.7 After the service user is discharged, they receive a follow-up phone call or visit (32.5%)
- Item 3.7 We provide services at times that suit service users (including after hours and on weekends) (37.9%)
- Item 3.5 Written materials are provided to service users in their own language by the Health Service (37.9%)
- Item 6.4 This Health Service provides adequate transport and parking to ensure access for older service users and their families/carers (41.7%)
- Item 5.5 The emotional and physical demands of my work are acknowledged and recognised (47.4%)
- Item 3.8 This Health Service is responsive to the needs of indigenous Australians (51.1%)
- Item 4.4 If a service user makes contact with this Health Service, they are directed to the most appropriate service without having to make another call (single point of contact) (56.8%)
- Item 2.4 I ask the carer/s what their goals are for this admission (62.1%)
- Item 6.8 Carers are given time and adequate assistance to prepare for discharge (62.8%)
- Item 2.5 In my service, program or ward, service users have an equal say with the rest of the team in the development of the care plan (64.8%).

All of the items with the lowest practice or agreement rate were about practices; none of them were related to the respondents' attitudes or beliefs. Furthermore, only one of the items with the lowest practice or agreement rate was a staff/personal practice (Item 2.4). The remaining nine items were related to organisational processes. It seems therefore that staff are more inclined to perceive their own practice as person-centred than the practices of the health service.

Most of the ten items listed under the lowest practice or agreement rates were derived from conversations with older service users. This group identified a number of factors which they considered important in person-centred care, including: follow-up after discharge; transport and parking; responsiveness to the needs of indigenous Australians; and inclusion of service users and carers in care and discharge planning. These findings validate the issues identified as problematic by focus group respondents and the consumer reference group in the development of the survey.

Factors that hinder the delivery of good person-centred health care

The factors that were identified as detracting from being able to provide good person-centred health care, such as good communication with and involvement of service users in their own health care, were:

- Service capacity issues, including:
 - lack of time
 - inadequate resources
 - inadequate staffing
 - limited access to interpreters and translated written materials
- Client and family communication issues, such as:
 - language differences
 - cognitive problems
 - differing expectations
 - families wanting or not wanting to participate

- Model of care and organisational issues, including:
 - shortcomings in the model of care
 - lack of flexibility in service hours and location of service delivery
 - lack of management support
- Lack of staff teamwork and communication
- Staff attributes, including:
 - negative staff attitudes
 - inadequate skills regarding person-centred care
- Environmental issues, including:
 - lack of privacy
 - lack of parking and transport
- Inadequate training and education.

Factors that enhance good person-centred health care

The factors identified as enhancing person-centred health care were:

- Model of care issues, including:
 - processes for inclusion of clients and carers in care planning (such as goal setting)
 - processes for enhancing communication with clients and carers (such as key contact persons)
 - flexibility in hours and location of service delivery
- Good teamwork and communication
- Staff attributes, including:
 - high skill levels
 - compassion
 - commitment to person-centred care
- Adequate service capacity, including:
 - adequate time
 - availability of resources (such as interpreters)
 - adequate staffing
 - availability of suitable equipment
- Organisational and management support, including:
 - an organisational culture that supports person-centred care
 - leadership and mentoring
 - recognition and feedback on staff achievements
- Client and family attributes, including:
 - motivation
 - knowledge
- Training and education for staff.

Resources that would help improve person-centred health care

Resources identified by respondents as helping to improve person-centred health care were:

- More service capacity, including:
 - general capacity, such as more time and staff
 - specific resources, such as translated documents and diversional therapists
- More training, education and staff development
- Model of care improvements, including:
 - documentation
 - single point of access
 - client goal setting
- Organisational and management support, including:
 - culture change
 - management support
 - review and feedback

- Enhanced teamwork and communication, including:
 - within the team
 - between services
 - with clients and families
- Environment, including better equipment and facilities
- Staff attributes, including improved staff attitudes.

Good practice in person-centred care

The final question on the survey asked respondents to list any examples of good practice in person-centred health care within their Health Service, that is, where they viewed it to be well developed and effective. The initiatives identified fell into four main categories:

1. Aspects of the model of care that promote client-centred care, such as having a key contact person or a process for goal setting
2. Specific services or resources, such as Post-Acute Care or home-based rehabilitation programs
3. Training and education initiatives provided for staff or clients
4. Organisation-wide initiatives, such as “no lift” policies or the values of the organisation.

Limitations of the survey

This survey was designed to canvass the views of staff and thus to establish a benchmark and a baseline for the Improving Care Policy implementation. Furthermore, it was hoped that it would encourage staff to reflect on their practice and the barriers and enablers to person-centred care in their workplace. However, as there was no triangulation of data collection in Phase 1 (with the exception of the survey design process), the findings do not tell us whether staff perceptions are borne out in practice. In a study by Wellard, Lillibridge, Beanland and Lewis (2003), discrepancies were found between the practices espoused by nurses in a focus group and actual nursing practice (as observed by a researcher). For example, although participants stated that patients should be fully informed and involved in decision-making, those making decisions about patient care were observed as doing so *“away from the bedside and apparently without patient consultation”*. Similarly, in this study, it may be that the practices that survey respondents claim that they are usually or always following already (such as giving service users adequate time to talk) may not be occurring in practice to that extent.

The survey has been developed for use for this study and has not yet been subject to any psychometric evaluation. Whilst the psychometric testing that can be done on a survey such as this is limited, it would be useful to conduct an evaluation of its validity (compared to observational data), reliability and responsiveness to change.

Summary

In summary, this survey provided the project team with:

- a benchmark of person-centred care within Victorian Health Services
- priority areas for further research into person-centred care
- suggestions for resources, such as staff support, staff and service user education and improvements to the model of care, that would assist health services in providing good person-centred care
- areas where person-centred care was presented as already well developed and effective.

The full 2005 “Benchmarking Person-centred Care Statewide Survey” report can be obtained from <http://www.nari.unimelb.edu.au/pchc/outcomes.htm>.

Good practice initiatives

In the “Benchmarking Person-centred Care” survey respondents were asked to provide examples of good practice initiatives in person-centred care that they viewed as being well developed and effective. The project team investigated eight of these initiatives in detail to assist in developing resources for use in improving person-centred health care.

Table 1 shows the eight initiatives that were selected for further investigation, the setting, the location and the particular priority area from the survey that they address. For further details about the selection of these initiatives see the Phase 1 report (<http://www.nari.unimelb.edu.au/pchc/outcomes.htm>).

Table 1. Good practice initiatives selected for further investigation

Initiative	Priority area	Setting	Location
Weekend recreational program (Bendigo Healthcare Group)	Services at times that suit	Sub-acute	Rural/ regional
Communicative Access Care Improvement Group (CACIG) (Barwon Health)	Inclusion of service users in service planning and evaluation	Acute and sub-acute	Rural/ regional
Key contact and client goals in CRC and rehab (Bayside Health)	Allocation and access to key contact person	Sub-acute	Metro
ACCESS Single Point of Contact (Peninsula Health)	Single point of contact	Sub-acute	Metro
Aged Care Consultancy Service (St Vincent’s Health)	Well co-ordinated practice	Acute	Metro
Drivers Unit (Peninsula Health)	Transport and parking	Acute and sub-acute	Metro
Angels @ St V’s (St Vincent’s Health)	Hot food being served hot	Acute and sub-acute	Metro
Staff buddy system (Austin Health)	Well co-ordinated practice	Acute	Metro

Interviews were undertaken with managers, staff and service users (clients and carers) for each initiative, if appropriate. Ethics approval was obtained from all relevant Human Research Ethics Committees prior to undertaking any interviews with service users.

The interviews with managers or staff involved:

- obtaining a description of the initiative
- information about when the initiative was developed
- whether service users were involved in the development of the initiative
- any evaluation that had been done on the initiative
- perceived benefits of the initiative for staff, the organisation and the service user
- any suggested barriers or opportunities to support implementation of the initiative
- lessons learnt through the initiative that would be useful for others.

The interviews undertaken with service users, where appropriate, explored issues such as:

- their experience of the initiative
- the benefits they had received from the initiative
- whether they had had the opportunity to provide feedback about the initiative
- any suggestions for improvement in relation to the initiative.

Key learnings from the investigation of good practice initiatives

Investigation of the good practice initiatives in person-centred health care identified the following as important resources or strategies required for effective implementation of person-centred health care:

- commitment and support from all management and senior staff to person-centred health care
- a dedicated staff member with a person-centred care portfolio
- adequate funding for measures including appropriate staff training and administrative support
- adequate time for staff training and education about person-centred health care in general, and specific activities in person-centred care being implemented within the health service
- commitment to multidisciplinary teamwork
- good communication to keep staff fully informed about person-centred health care resources and initiatives, to maximise the effectiveness of multidisciplinary teams and to improve communication with patients and/or families
- identification of barriers and/or facilitators to effective communication
- inclusion of the patient and/or family in decision making regarding their health care
- provision of a liaison person to represent the patient in team meetings and report decisions back to patients and/or families
- community involvement where appropriate, for example, the use of volunteers as bedside visitors, or to assist with social activities in rehabilitation.

Helpsheets for improving person-centred health care have been developed following the investigation of the good practice initiatives, incorporating the key learnings, and can be downloaded at <http://www.nari.unimelb.edu.au/pchc/outcomes.htm>.

Resource review

The project team reviewed resources and initiatives for use in improving person-centred health care, which were identified through the literature review and the statewide survey. The reviews of the resources/initiatives can be obtained from http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm. Each review included:

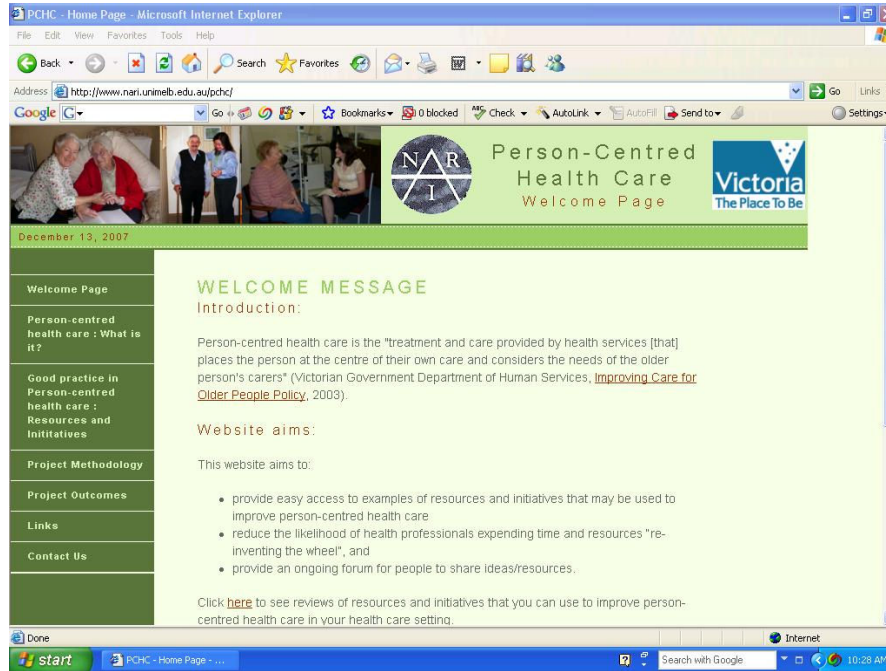
- a description of the resource/initiative and how to obtain further information about it
- information about the resource/initiatives target audience and target setting
- the strengths and limitations of the resource/initiative
- the resource/initiatives availability in languages other than English
- whether any evaluation had been done on the resource/initiatives or whether there were any reported psychometric properties
- the extent to which the resource/initiative addressed the principles of person-centred care identified through the literature review.

Person-centred health care website

A person-centred health care website was developed as a way of sharing the information obtained through Phase 1 of the project, and for use during Phase 2. However, it is anticipated that the audience of the website will go beyond those involved in implementing the Improving Care policy. The aims of the website are to:

- provide health care staff access to resources that may be used to improve person-centred health care
- reduce the likelihood of health professionals having to “re-invent the wheel” regarding resources and initiatives, so that they can spend more time and resources on implementing good person-centred care
- provide a way for people to share their ideas, initiatives and resources in person-centred care.

The website contains general information about the project and person-centred care, provides access to project outcomes, such as the literature review and the statewide survey report, the reviews of the resources and initiatives in person-centred health care, the findings from the investigation of the eight good practice initiatives, help sheets for practising in a person-centre way and a PowerPoint presentation for staff education on person-centred health care.



This website was launched at the Department of Human Services Improving Care Forum in November 2006 and can be viewed at <http://www.nari.unimelb.edu.au/pchc/>.

Phase 1 Summary

Phase 1 provided the project with a benchmark of where Victorian Health Services were in relation to person-centred health care. It identified barriers and facilitators in person-centred health care, areas in person-centred health care in need of improvement, and resources or initiatives that could assist in this improvement. As a result, a website was developed to assist health services in improving person-centred health care in their facilities. This website, and the resources and/or initiatives that have been recommended as ways of improving person-centred care, were evaluated in Phase 2.

Further information about Phase 1, or any of its components, can be obtained from <http://www.nari.unimelb.edu.au/pchc/outcomes.htm>.

Phase 2

The methodology for the second phase of the “Best Practice in Person-centred Health Care for Older Victorians” project was based on the outcomes of Phase 1. Phase 2 ran for 10 months, with the planning component of this phase overlapping with the conclusion of Phase 1.

Phase 2 involved supporting Health Services in enhancing their person-centred care practice. Each participating Health Service selected an area of person-centred health care they wanted to improve, and developed, with the help of the NARI team, achievable goals and timelines. Using resources and initiatives identified and/or developed in Phase 1, the NARI team provided support to the Health Services to achieve these goals. Evaluation of the usefulness of the NARI website, support and resources was undertaken at the end of a three month period.

It was envisaged that Phase 2 would complement the Enhancing Practice Program (EPP) being undertaken by Northern Health and COTA for the Department of Human Services.

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 Improving Care Policy
3. evaluate the impact of these resources on practice, and
4. identify gaps in the resources available on the person-centred health care website (www.nari.unimelb.edu.au/pchc) developed in Phase 1.

Recruitment of sites and initial meeting

Upon expressing an interest in participating in Phase 2, Health Services were provided with an individualised self-assessment checklist of best practice in person-centred health care (see Appendix C). This was provided to Health Services to assist them in identifying areas of priority within their Health Service to address during the project.

Meetings were held between the NARI project team and key staff from each of the 13 participating Health Services prior to beginning the project activities. In some cases the meetings 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 sites had their projects 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.



Initial meeting between NARI team and key staff for Phase 2

Introductory workshop

An introductory workshop, facilitated by Dr Cathy Balding from Qualityworks, was held prior to the sites beginning their project activities. The seminar gave participating Health Services the opportunity to introduce, discuss and share resources for their projects with others. Participants were treated to a presentation by Dr Balding on change management in Health Services, and participated in group work focussing on barriers and enablers to person-centred care identified in the "Benchmarking Person-centred Care" survey from Phase 1.

Individual projects

The implementation stage of Phase 2, where each of the 13 participating Health Services implemented all or part of their proposed person-centred project, ran for three months. The projects undertaken can be categorised into five broad areas:

- Involving the consumer:
 - patient information handbook: a practical guide for patients
 - patient information packages
 - the experience of relatives and carers of patients aged over 65 years in the Emergency Department: are person-centred care needs being met?
- Co-ordinating service delivery:
 - meet and greet initiative and interdisciplinary case conference restructure
 - key contact and follow-up phone call procedures
 - single discharge planning process across all sub-acute in-patient services
- Communication and goal setting:
 - improving goal setting and care planning, and development of person-centred care policy and guidelines
 - improving communication between staff, patients and families/carers (goal setting and rehabilitation expectations)
- Assessment and referral:
 - assessment and referral model for older patients in the Emergency Department (ED)
 - improving health outcomes for older clients with dementia and delirium

- Culture and education:
 - motivating health behaviour change: training session for ambulatory care health professionals
 - person-centred health care orientation session
 - refocusing culture: improving care outcomes for older service users

Teleconferences

Because of the large number of sites involved in Phase 2, two sets of teleconferences were held. Health Services were grouped according to availability. There were three teleconferences for each group during the main activity period. A proforma was sent to the Health Services the week before each teleconference, to be completed and returned to NARI (see Appendix D). 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, even those that they were not involved in.

Evaluation

The participating Health Services were asked to evaluate the activities facilitated by and resources provided by NARI during Phase 2 through a semi-structured interview (see Appendix E).

In general the Health Services found the initial site visits or meetings useful in helping them to formulate a relevant action plan:

"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."

The introductory workshop was viewed as predominantly positive, with many attendees finding the networking opportunity beneficial. Furthermore, participants found Dr Cathy Balding's presentation on change management useful in stimulating thought on the subject:

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

There were mixed responses in relation to whether the teleconferences were useful. Some participants found that the projects were too dissimilar to be of use. However, some non-metropolitan Health Services found them useful as a chance to share ideas and resources with others:

"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."

Twelve of the 13 participating Health Services indicated they had reviewed the person-centred health care website, with 11 stating they 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.

The identified strengths of the website and resources were:

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

The identified limitations of the website and resources included:

- the website is still immature as a resource library; there are a lot of resources that could be added to it over time
- not all staff will have time to use and search the website
- navigating the website can be difficult
- not enough promotion was done of the website
- not enough information on the website about:
 - assessment tools
 - gaining support for initiatives
 - how to build accountability into projects
 - assessments in the Emergency Department
 - person-centred counselling techniques
 - discipline-centred goal-setting
 - Health Service information / orientation booklets
- the actual resources would have been more useful on the website rather than the reviews of the resources
- the website is not interactive enough
- the website requires more pictures to make it more aesthetically pleasing.

In addition to feedback participants provided about the website and the different Phase 2 activities, they also suggested some additional resources that would have been beneficial to them 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.

Feedback to Health Services

Each participating Health Service was 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 obtained from the Phase 2 report (<http://www.nari.unimelb.edu.au/pchc/outcomes.htm>).

Phase 2 Summary

The evaluation of person-centred health care resources and the website (<http://www.nari.unimelb.edu.au/pchc>) through this phase of the project generated many helpful recommendations. Overall, the need for an ongoing commitment to the website's evolution into a comprehensive library of resources was noted, as well as some additional resources that could be included on it.

In addition to the suggestions provided about the website and resources, some key learnings for implementing effective person-centred care into Health Services included:

- engaging support from many key strategic stakeholders is a strong enabler for successful project implementation
- the importance of considering that time and resource constraints faced by some clinical staff may make it difficult to take on additional work or seek out additional person-centred care resources
- 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
 - innovations in person-centred care may be developed
- a supportive working environment can enable person-centred health care.

Phase 3

Phase 3 was undertaken between July and December 2007. It involved re-administering the "Benchmarking Person-centred Care" statewide survey, with minor changes, to the 17 Health Services that participated in the survey component of Phase 1. It was originally envisaged that the original survey would be re-administered. However, minor changes were made to ensure the questions remained relevant, and new data were collected to compare levels of awareness of person-centred practice within each health service and between health services.

Aims

The aims of the modified 2007 survey were to:

1. assess current practice in relation to person-centred care from the point of view of staff working within the Victorian Health Service system
2. assess any differences in current practice (2007) in relation to person-centred care from the point of view of staff working within the Victorian Health Service system as compared to 2005, and
3. capture any changes in staff awareness of person-centred care.

Methodology

The survey was disseminated to all 17 Health Services that participated in the 2005 survey. Once again the survey was mainly distributed 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. However, some Health Services chose to distribute it to other staff outside these criteria.

The 2007 survey was not disseminated to the same respondents who completed it in 2005. However, some respondents did complete both the 2005 and the 2007 surveys.

Description of survey

The 2007 survey was the same as the 2005 survey (see Appendix A). However, some additional questions were added to ensure the questions remained relevant, and new data were collected to compare levels of awareness of person-centred practice within each health service and between health services. The additional questions that participants were asked in 2007 were:

- Did you complete the previous Benchmarking Person-centred Care survey in 2005?
- Have you participated in the Enhancing Practice Program?
- Have you used the NARI PCHC website <http://www.nari.unimelb.edu.au/pchc?>
- My awareness of person-centred care has increased over the past two years (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree, don't know).

Findings

Changes in 2007 as compared to 2005

There were four items on the 2007 survey that had substantial changes (greater than 5%) in responses compared to 2005. There was a reduction in the number of respondents who said:

- hot food is usually or always served hot and service users are usually or always provided with assistance to eat if required
- service users usually or always receive a follow-up phone call or visit after discharge, and
- carers are usually or always given time and adequate assistance to prepare for discharge.

These three items with substantial reductions were related to organisational processes.

Conversely, there was a substantial increase in 2007 in the number of respondents who agreed or strongly agreed that service users are usually able to make a choice that is best for them.

Similar responses in relation to barriers to person-centred health care were generated in 2007 as compared to 2005 with a few notable exceptions. In 2005 some communication issues were recorded within teams due to territorial issues between staff of different disciplines. Similar comments were not recorded in 2007. Also, in 2007 there were comments generated about inadequate information technology resources and logistical barriers caused by working in larger Health Services and across multiple sites, which were not noted in 2005.

Similar responses in relation to things that enhance person-centred health care were generated in 2007 as compared to 2005, with a few notable exceptions. In 2005 education and training was only mentioned as enhancing person-centred practice in metropolitan Health Services. It was suggested rural Health Services might have fewer education and training opportunities. This was not evident in 2007 as all Health Services, metropolitan and rural, commented on education and training initiatives that were seen to enhance person-centred practice. This could be as a result of the Enhancing Practice Program (EPP) conducted by Northern Health and COTA. The EPP focuses on enhancing a culture of person-centred care to improve outcomes for patients, particularly the older patient. Eleven of the 17 Health Services that participated in the survey also participated in the EPP, with the majority of them being from rural areas.

In addition, there was more emphasis on environmental factors in 2007, perhaps due to an increase in awareness of how the environment can contribute to person-centred care. Another project undertaken as part of the *Improving Care Policy* was the development of the "Improving the environment for older people in Health Services" audit tool. This tool was distributed to all Health Services, which may have raised awareness of what impact the environment can have on person-centred health care.

The responses generated in 2007 about good practice initiatives in person-centred health care were very similar to those in 2005. One additional inclusion in 2007 was education and support initiatives for carers.

Awareness and Practice Changes

There was a reported increase in awareness of person-centred care, with over 60% of the respondents agreeing or strongly agreeing that their awareness of person-centred care had increased over the previous two years. One would hope an increase in awareness would translate into improved practice. Comments generated by this question, however, suggest that this is not necessarily the case:

"Awareness has increased. However, practice still needs to be improved."

"My awareness has increased, but the culture of the organisation structure is slow to change."

Person-centred practice relies not only on individual awareness but also on appropriate models of care, resources, education, and supportive organisational cultures. Given the analysis shows the lowest practice and agreement rates are organisational, not individual issues, these organisational factors appear slower to change.

The results of the 2007 survey demonstrate that a transition towards person-centred practice is still occurring within the Health Services. However, it is possible that staff who are more aware of what person-centred care is in practice are more likely to criticise processes and issues which are slower to change and not conducive to person-centred care in practice.

Areas for improvement

Even though there was some improvement in person-centred care practices and awareness, the survey results suggest that there are still areas in person-centred care that require improvement (that is, areas with the lowest agreement or practice rates). These include:

- providing service users with a follow-up phone call after discharge
- providing service users with adequate transport and parking
- providing service users with hot food and assistance to eat their food if required
- providing written material in languages other than English for service users whose first language is not English
- providing services at times that suit service users
- providing service users with a single point of contact at the Health Service
- asking carers about their goals during service users' admission
- being responsive to the needs of indigenous Australians
- having a well co-ordinated practice with minimal duplication, and
- providing staff with support, ensuring that the emotional and physical demands of their work are acknowledged and recognised, and that management expectations are communicated clearly and consistently.

Phase 3 Summary

Re-administration of the "Benchmarking Person-centred Care" survey indicated that there was a change in respondents' awareness of person-centred health care over the previous two years, although there was very little change in practice.

Similar responses in relation to barriers and enhancers of person-centred health care were generated in 2007 as compared to 2005, with a few notable exceptions. One barrier that was noted in 2005 but not 2007 was communication issues within teams due to territorial issues between staff of different disciplines. In 2007 an additional barrier that was noted was inadequate information technology resources and logistical barriers caused by working in larger Health Services and across multiple sites. In 2007, there was more emphasis on how environmental factors can enhance person-centred health care than there was in 2005, perhaps due to an increase in awareness of how the environment can contribute to person-centred care.

A number of areas for improvement were identified.

Overall Summary

The “Best Practice in Person-centred Health Care for Older Victorians” project aimed to work with Health Services to identify person-centred practices and implement person-centred care, a key principle of the *Improving Care Policy*. Phase 1 provided us with a description of person-centred health care through the literature review. Based on this literature review, and consultation with older service users, a benchmarking survey tool was developed to assess where Victorian Health Services were in relation to person-centred health care attitudes and practices. As well as providing a benchmark of where Victorian Health Services were in relation to person-centred health care, the survey also helped identify barriers and facilitators in person-centred health care, areas in person-centred health care in need of improvement, and good practice resources or initiatives in person-centred health care. Following further investigation of these resources and initiatives, helpsheets to aid in improving person-centred care and a website to assist health services in improving person-centred health care in their facilities were developed.

Phase 2 involved supporting health services in enhancing their person-centred care practice, based on the information collected in Phase 1. Furthermore, it aimed to evaluate the usefulness of the overall person-centred health care website and the information included on it, and to identify any gaps in resources. The evaluation generated many helpful recommendations for improvement of the website, including additional resources and information that could be included, such as assessment tools, discipline-centred goal setting and how to gain support for implementing new person-centred initiatives. In addition, the evaluation identified the need for an ongoing commitment to the website’s evolution into a comprehensive library of resources.

Phase 3 involved re-administration of the “Benchmarking Person-centred Care” survey with minor changes to ensure the questions remained relevant. New data were collected to compare levels of awareness of person-centred practice within each health service and between health services. The survey found over the previous two years, there has been an increase in staff awareness of person-centred health care in Victorian Health Services. In the 2007 “Benchmarking Person-centred Care” survey, over 60% of respondents agreed or strongly agreed that their awareness of person-centred health care had increased over the previous two years. However, although re-administration of this survey indicated that there was a change in respondents’ awareness of person-centred health care, there was very little change in practice. Similar responses in relation to barriers and enhancers of person-centred health care were generated in 2007 as compared to 2005, with a few notable exceptions. One barrier noted in 2005 but not 2007 was communication within teams due to territorial issues between staff of different disciplines. In 2007 an additional barrier that was noted was inadequate information technology resources and logistical barriers caused by working in larger Health Services and across multiple sites. In 2007, there was more emphasis on how environmental factors can enhance person-centred health care than there was in 2005, perhaps due to an increase in awareness of how the environment can contribute to person-centred care.

Recommendations

Survey development

Because there was no benchmarking tool for person-centred care in existence when the project began, the research team developed the survey used in this project. However, this survey has not yet been subject to any testing of its psychometric properties. It is recommended that an evaluation of its validity, responsiveness to change and reliability be undertaken.

Website development

The person-centred health care website (<http://www.nari.unimelb.edu.au/pchc>) developed at the conclusion of Phase 1 received positive feedback from participants of Phase 2 of the project. However, there was concern about whether the website would continue to be updated at the conclusion of the "Best Practice in Person-centred Health Care for Older Victorians" project. After developing the website, postcards and posters were developed to disseminate to all Victorian Health Services to advertise the website. Therefore, it is recommended that there be an ongoing commitment to the website's evolution into a comprehensive library of resources and information on person-centred health care.

Resource gaps

In addition, gaps in the information on the website were identified. Further information is required about:

- assessment tools
- gaining support for initiatives
- how to build accountability into projects
- assessments in the Emergency Department
- person-centred counselling techniques
- discipline-centred goal-setting, and
- Health Service information / orientation booklets.

It is recommended that resources be allocated to develop strategies to address these identified gaps.

Additional resources / support

It is recommended that staff be provided with resources and support to practice person-centred health care. Important resources or strategies required for effective implementation of person-centred health care identified through this project include:

- commitment and support from all management and senior staff to person-centred health care
- a dedicated staff member with a person-centred health care portfolio
- adequate funding for appropriate staff training and administrative support
- adequate time for staff training and education about person-centred health care in general, and specific activities in person-centred care being implemented within the health service
- organisational commitment to multidisciplinary teamwork
- good organisational communication to keep staff fully informed about person-centred health care resources and initiatives
- good communication with service users and/or families
- inclusion of the service user and/or family in decision making regarding their health care

- provision of a liaison or key contact person to represent the service user in team meetings and report decisions back to service users and/or families
- community involvement in the care of older service users where appropriate, for example, the use of volunteers as bedside visitors, or to assist with social activities in rehabilitation, and
- a supportive working environment for staff to practice person-centred health care.

Areas for future improvement

Following the 2007 survey it was evident that there were still some areas of person-centred practice that require improvements. These are:

- providing service users with a follow-up phone call after discharge
- providing service users with adequate transport and parking
- providing service users with hot food, and assistance to eat their food if required
- providing written material in languages other than English for service users whose first language is not English
- providing services at times that suit service users
- providing service users with a single point of contact at the Health Service
- asking carers about their goals during service users' admission
- being responsive to the needs of indigenous Australians
- having a well co-ordinated practice with minimal duplication, and
- providing staff with support, ensuring that the emotional and physical demands of their work are acknowledged and recognised, and that management expectations are communicated clearly and consistently.

Further recommendations for discussion and dissemination of findings

It is recommended that the Victorian Department of Human Services generate dialogue, in Australia and with the United Nations, on the description and delivery of the human right to "the highest attainable standard" of health care for older people.

Conclusion

In conclusion, it appears that the "Best Practice in Person-centred Health Care for Older Victorians" project, in conjunction with the "Enhancing Practice Program", the "Improving the environment for older people in Health Services" audit tool, and the "Dementia Care in Hospitals" project, all undertaken as part of the implementation of the *Improving Care Policy*, has had an impact on raising awareness of person-centred health care within Victorian Health Services. It may have been expected that an increase in awareness would translate into improved practice, but this has not necessarily been the case. Person-centred practice relies not only on individual awareness but also on appropriate models of care, resources, education, and supportive organisational cultures. Therefore, it is important that Health Services ensure that appropriate resources are available to staff to enable them to practise health care in a person-centred manner.

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Appendices

Benchmarking Person-Centred Care Survey

Instructions for completing the survey

This survey can be completed on line at http://www.nari.unimelb.edu.au/pchc_survey or completed and returned to Marcia Fearn at the National Ageing Research Institute at PO Box 31, Parkville, 3052. There are reply paid envelopes available from your Key Implementation Contact. Please refer to the definitions (on page 9) for clarification of key terms.

Please complete the survey and either return it to NARI or submit it on line by **Friday 5th August 2005**.

Site you are predominantly located at within Health (please select one)

Site 1 Site 2
Other Please specify _____

Discipline completing form* (please select one)

Administration	<input type="checkbox"/>	Occupational therapy	<input type="checkbox"/>
Allied Health Assistant	<input type="checkbox"/>	Pharmacy	<input type="checkbox"/>
Dietitian	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>
Management	<input type="checkbox"/>	Podiatry	<input type="checkbox"/>
Medicine... Consultant	<input type="checkbox"/>	Prosthetics and Orthotics	<input type="checkbox"/>
Medicine... Other medical	<input type="checkbox"/>	Psychology	<input type="checkbox"/>
Neuropsychology	<input type="checkbox"/>	Social Work	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	Speech Pathology	<input type="checkbox"/>
Other	<input type="checkbox"/>	Please specify _____	

* Please do not complete this question if you are concerned it may identify you (e.g. if you are the only physiotherapist in your program, service or ward).

Employment status

Casual (including bank) Permanent or contract

Program, service or ward (select the area where you spend most time)

General Medical Ward (Acute)	<input type="checkbox"/>	Geriatric Evaluation and Management (Aged care)	<input type="checkbox"/>
Rehabilitation Ward	<input type="checkbox"/>	Community Rehabilitation Centre	<input type="checkbox"/>
Continence Clinic	<input type="checkbox"/>	Other	<input type="checkbox"/>
		Please specify _____	

Sex

Male Female

Throughout the survey, please tick the box that best corresponds with your opinion.

1. Getting to know the older (>70yo) service user (patient or client)

Attitudes and beliefs

1.1 It is important to get to know each service user as an individual (e.g. their medical history, social supports, pre-morbid status)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

1.2 It is important to find out how the service user and carer feels about this episode of care (e.g. worried about surgery, or how they will manage when discharged)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

Practice

1.3 I listen carefully to what service users say

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

1.4 I find out what name the service user prefers to be called

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

1.5 I let service users know that I recognise them (e.g. call them by their preferred name, remember and repeat something they have told me)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

1.6 I give service users and their carers adequate time to talk to me (e.g. to discuss their concerns and their expectations)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

1.7 I seek to find out what is important to service users about their health (e.g. mobility, cognitive function, being part of the family, able to go to the gym)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

2. Sharing power and responsibility with older service users

Attitudes and beliefs

2.1 Health care should be an equal partnership between the service user and provider

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

2.2 If provided with options, service users are usually able to make a choice that is best for them

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

Practice

2.3 I ask service users what their goals are for this admission

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

2.4 I ask the carer/s what their goals are for this admission

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

2.5 In my service, program or ward, service users have an equal say with the rest of the team in the development of the care plan

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

2.6 In my service, program or ward, service users and carers have an equal say with the rest of the team in the development of the discharge plan

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

2.7 My/our care plans are structured around the client's goals

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

2.8 At this Health Service, we provide services in the location that best suits the needs and preferences of the service user (e.g. in a centre, in hospital, in their own home)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

3. Service flexibility and accessibility

Attitudes and beliefs

3.1 Services should be accessible to service users of all ages, abilities, from all culturally and linguistically diverse (CALD) backgrounds and indigenous Australians

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

3.2 Services should be available at times and in places that suit service users and their families/carers

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

Practice

3.3 This Health Service environment is designed to meet the needs of people with physical and cognitive disabilities

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

3.4 I use interpreters when working with service users whose first language is not English (unless I am completely confident that they can converse in English or I can converse in their language)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

3.5 Written materials are provided to service users in their own language by the Health Service

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

3.6 Information is provided in a variety of ways to ensure that all service users have access (e.g. written, verbal, visual)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

3.7 We provide services at times that suit service users (including after hours and on weekends)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

3.8 This Health Service is responsive to the needs of indigenous Australians

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

4. Making sense of services for the older service user

Attitudes and beliefs

4.1 Health Services should ensure that the service user has the information they need to understand what is happening to them throughout their whole care experience

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

Practice

4.2 Service users in my service, program or ward are allocated a key contact person who is known to the service user and their carer/s.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

4.3 The client and carer have ready access to the key contact person (i.e. they are available by phone, messages are returned promptly)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

4.4 If a service user makes contact with this Health Service, they are directed to the most appropriate service without having to make another call (single point of contact)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

4.5 The Health Service in which I work is responsive when service users request information about their health condition and/or care plan

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

4.6 The Health Service in which I work is responsive when carers request information about the service user's health condition and/or care plan (with the client's consent)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

4.7 Service users are given information to enable them to make an informed choice about discharge or transfer from my service.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

5. The working environment facilitates person-centred practice

Beliefs and practice environment

- 5.1 I feel that working with older people is valued within this Health Service
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.2 I feel that I am able to use my skills to the full in my work with older people
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.3 I feel that I work as part of a team with a recognised and valued contribution.
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.4 I like working with older people
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.5 The emotional and physical demands of my work are acknowledged and recognised
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.6 The expectations that my managers have of me in relation to my work with older people are communicated clearly and consistently
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.7 I have been exposed to good role models in care for older people
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.8 I have been exposed to good environments of care for older people
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |
- 5.9 I am supported to develop the skills I need to work with older people
- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| never | rarely | sometimes | usually | always | don't know |

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

6. Concerns expressed by older people

Attitudes and beliefs

6.1 The needs and preferences of service users should be central in Health Services

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

6.2 Health care should be a collaborative partnership between service user and provider

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know

Practice

6.3 I welcome it when older people are informed and question or challenge my advice

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.4 This Health Service provides adequate transport and parking to ensure access for older service users and their families/carers

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.5 This Health Service ensures that service users' personal privacy is respected

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.6 At this Health Service, hot food is served hot and service users are provided with assistance to eat (if required) while the food is still warm

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.7 After the service user is discharged, they receive a follow-up phone call or visit

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.8 Our practice is well co-ordinated and there is minimal duplication when referring clients from one part of the Health Service to another and to community services

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

6.9 Carers are given time and adequate assistance to prepare for discharge

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	rarely	sometimes	usually	always	don't know

Comments: What factors help or detract from working with service users in this way?

Help:

Detract:

7. Barriers, facilitators and best practice

7.1 What do you see as the factors that detract from good communication with and involvement of service users within your Health Service?

7.2 What are the major factors that enhance person-centred practice within your Health Service?

7.3 What resources or support would help you to improve person-centred practice within your Health Service?

7.4 Please list any initiatives that you are aware of within your Health Service where you think that person-centred practice is well developed and effective.

Thank you for taking the time to complete this survey. The Key Implementation Contact at your Health Service will be provided with a copy of the findings for your Health Service for distribution to you.

8. Definitions

Person-centred care has been defined as “*treatment and care provided by health services [that] places the person at the centre of their own care and considers the needs of the older person’s carers*” (Improving care for Older Person’s Policy, 2003, pxiii).

Service user refers to client or patient.

Carer refers to any family member or friend who provides care for an older service user. Care may include personal care, emotional support, care management, help with activities of daily living, such as transport, financial management, shopping and domestic help. It includes both primary (co-resident) and secondary carers (e.g. family members who do not usually reside with the older person).

Appendix B – Health Services participating in survey

Metropolitan Health Services:

Austin Health
Bayside Health
Broadmeadows Health Service
Bundoora Extended Care Centre
Eastern Health
Melbourne Health
Southern Health
St Vincent's Health
Western Health

Rural/regional Health Services:

Ballarat Health Service
Barwon Health
Bendigo Healthcare Group
Goulburn Valley Health*
Latrobe Regional Hospital
North East Health Wangaratta*
Seymour District Memorial Hospital*
Wodonga Regional Health Service*

* These four Health Services form the Hume Health Consortia. However, for the purposes of this survey they were considered separate Health Services.

Appendix C – Person-centred health care – Self-assessment checklist of best practice



Person-centred health care – Self-assessment checklist of best practice

Thank-you for your interest in participating in Phase 2 of the NARI person-centred health care project. This checklist is designed to help you identify elements of person-centred health care that are being done well within your organisation or are part of your organisation, and some that may require improvement. The outcomes may be used in a number of ways to assist your organisation continue to improve person-centred health care, and may also identify priority areas you may like to work on in Phase 2 of the NARI project.

How to complete the checklist:

- This checklist **does not** need to be returned to NARI. It is for your information only, intended to assist you in identifying the priority area/s in person-centred health care that you may wish to focus on during Phase 2.
- It is suggested that the checklist could be completed by the Key Implementation Contact or project officer/manager, in consultation with the Executive Sponsor or other relevant staff.
- You may choose to complete this checklist for your whole Health Service, for selected areas, such as the acute setting, or for selected wards, such as rehabilitation wards or general medical wards.
- When completing this checklist it may be useful to consider:
 - your Health Service results in the "Benchmarking Person-centred Care" survey undertaken by NARI in 2005, and
 - how your organisation has endorsed the person-centred health care philosophy (e.g. documentation, evidence of senior management support).
- The first column in the checklist has been completed for you by the NARI team, based on your Health Service survey responses.
- The 10 items from Sections 1 through to 6 of the survey for which your Health Service had the lowest practice or agreement rate are listed at the end of the checklist.

Should you wish to participate in Phase 2 of the project:

- Please identify up to three priority areas that you may wish to focus on during Phase 2. These priority areas can be as big or as small as you wish.
- Please return your priority areas to: Marcia Fearn, National Ageing Research Institute, PO Box 31, Parkville VIC 3052, Ph: (03) 8387 2512, Fax: (03) 8387 2153, Email: m.fearn@nari.unimelb.edu.au by Monday 29th January 2007.

Person-centred care best practice options	Health Service survey results below statewide average* (Yes, No, N/A)	Practice in this area has improved over the past 12 months (Yes or No)	Identified as potential area for future activity in your organisation (Yes or No)
A. General: Organisational support for person-centred care			
i. Are key staff positions dedicated to person-centred care / facilitating staff behaviour change in this area?	N/A		
ii. Are strategies in place to evaluate progress, facilitators and barriers to person-centred health care in your organisation?	N/A		
iii. Are there opportunities for new staff to be introduced to the organisation's person-centred care philosophy (eg during orientation period, other documentation)?	N/A		
iv. Are resources to provide staff with an understanding of person-centred care easily available (eg guidelines / other resources) and do staff know how to access these?	N/A		
B. Principle 1: Getting to know the older service user (holistic approach as well as individual approach).			
i. Do staff usually have the opportunity, and are they encouraged to get to know each service user as an individual?	Q1.1		
ii. Do staff usually listen carefully to what service users have to say, and incorporate this where appropriate in the management plan?	Q1.2		
iii. Do staff usually find out the name that service users prefer to be called by, and use this name?	Q1.3		
iv. Do staff have opportunities formally (eg part of the assessment; preparation for case conference), or informally to find out what is important to the service user about their health and wellbeing?	Q1.4		
v. Do assessment tools in use elicit information relevant to a holistic perspective of the client?	Q1.7		
	N/A		
C. Principle 2: Sharing of power and responsibility (client as an expert in their own health, sharing of decision making, information).			
i. Are service users (including carers) involved in goal setting in the early stages of their admission, and throughout the admission?	Q2.3		
ii. Is a formal goal setting assessment tool used for clients?	Q2.4		
iii. Are service users actively involved in the development of the care plan and discharge plan?	N/A		
iv. Are formal tools used for coordinating (1) the management plan; (2) communication with the team and service user / carer; and (3) the discharge plan?	Q2.5		
v. Is the location of services able to be responsive (where appropriate) to the needs and preferences of the service user (eg service provided in the home, hospital, or out-patient facility)?	Q2.6		
vi. Are clients and carers given adequate time, information and assistance in preparing for discharge?	N/A		
	Q2.8		
	Q4.7		

Person-centred care best practice options		Health Service survey results below statewide average* (Yes, No, N/A)	Practice in this area has improved over the past 12 months (Yes or No)	Identified as potential area for future activity in your organisation (Yes or No)
D. Principle 3: Accessibility and flexibility (of service provider as a person and of the services provided).				
i. Is information about services available in key relevant languages, and a culturally appropriate and sensitive manner, reflecting the main CALD groups accessing a service / in the service's catchment area?		Q3.1 Q3.5		
ii. Is information about services available for Indigenous Australians, in a culturally appropriate and sensitive manner?		Q3.8		
iii. Has your organisation explored options for flexibility within health services in the time and location of service provision to suit service users where possible (eg scheduling of appointment times; availability of appropriate services after hours or on weekends)?		Q3.7		
iv. Is the service well set up to cater for people with cognitive impairment amongst the range of their presenting symptoms?		Q3.3		
v. Is the service well set up to cater for people with physical impairments amongst the range of their presenting symptoms?				
vi. Are interpreters used routinely for service users whose first language is not English (unless staff are confident the client can communicate effectively in English)?		Q3.4		
vii. Is the internal and external environment of the health care facility responsive to the access needs for people with physical and / or cognitive impairments?		Q3.3		
E. Principle 4: Coordination and integration (consideration of the whole experience from the service user's point of view).				
i. Is a key contact person allocated to each service user?		Q4.2		
ii. Is there good access available by the service user / carer to the key contact person?		Q4.3		
iii. Does the service have a single point of contact for referrers / service users etc?		Q4.4		
iv. Is there a shared documentation process for clients with multi-disciplinary team involvement?		N/A		
v. Are procedures in place to follow-up service users after discharge to ensure appropriate transition from the health service?		Q6.7		
vi. Is there minimal / no duplication of documentation within the health service?				
vii. Is there minimal / no duplication of assessment and documentation in discharge / transfer of client to another part of the service or to an external service provider?		Q6.8		

Person-centred care best practice options	Health Service survey results below statewide average* (Yes, No, N/A)	Practice in this area has improved over the past 12 months (Yes or No)	Identified as potential area for future activity in your organisation (Yes or No)
F. Principle 5: Environment conducive to person-centred care (supportive of staff working in a person-centred way and easy for service users to navigate).			
i. Is a strong team approach to achieving person-centred outcomes incorporated into routine care?	Q5.3		
ii. Are staff supported to enhance skills to work with older people / other clients using a person-centred approach (eg continuing education, conference attendance, etc)?	Q5.9		
iii. Is there easy access to the health care service for the service user and the family / carer (eg physical access, signage etc)?	Q3.3		
iv. Is there adequate transport / parking to ensure easy access for older service users and families / carers?	Q3.6		
v. Does the health service have policies and procedures implemented that ensure clients' personal privacy is protected?	Q6.4		
	Q6.5		
G. Other:			
i. Are procedures in place to ensure that service users are able to eat their meals, (eg is food placed where they can reach it, is assistance provided to ensure they are able to open the packaging), and do staff follow up to ensure that food has been eaten before plates / trays are taken away?	Q6.6		

* This column includes data from your Health Service responses to the NARI Bench-marking Person Centred Care survey completed during Phase 1 of the project. The question numbers noted in this column relate to the relevant question/s in the survey. If there is an N/A in the column it indicates that there were no survey questions specifically related to this item.

Lowest Practice or Agreement Rates (from NARI Survey results)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

From the table above please select your top 3 priority areas for action in improving person-centred health care within your Health Service (these are the areas that you may wish to focus on during Phase 2 of the NARI project):

1. _____

2. _____

3. _____

Please return your priority areas (this page only) to: Marcia Fearn, National Ageing Research Institute, PO Box 31, Parkville VIC 3052, Ph: (03) 8387 2512, Fax: (03) 8387 2153, Email: m.fearn@nari.unimelb.edu.au by Monday 29th January 2007.

Appendix D – Teleconference Proforma

Proforma for NARI Person-centred Care Teleconference

Date and Time of Teleconference: Insert Date and Time

Please return Proforma to Leslie Dowson at NARI no later than: Insert Date

Fax #: 03 8387 2153 or l.dowson@nari.unimelb.edu.au

1. Name of Health Service:	
2. Participant(s) in the teleconference: <input type="checkbox"/> same as previous	
3. Phone number to be rung: <input type="checkbox"/> same as previous	
4. Progress in implementation of project: Steps taken to date:	
Challenges:	
Successes:	
5. Any issues/questions which you would like NARI to follow up:	
6. Have you looked at the NARI website? Yes / No Comments:	
7. Has NARI provided any new resources to help you? Yes/ No	
8. What additional resources would help you?	

Appendix E – 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?