

Best Practice in Person-centred Health Care for Older Victorians



Report of Phase 1

January, 2007

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Acknowledgements

The project team gratefully acknowledges the generous contributions of the following people, without whom this project would not have been possible.

Victorian Health Services:

We thank each of the health services Key Implementation Contacts and/or project workers for their role in disseminating the survey within their Health Service, for assisting us with closer examination of the good practice initiatives selected for evaluation, and for their ongoing support with project activities.

In addition, we acknowledge the medical, nursing, allied health, administrative and managerial staff of the 14 Health Services who completed the Person Centred Health Care survey or participated in the investigation of the good practice initiatives.

Members of the Project Advisory Group:

Thank you to members of the project advisory group:

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Thank you to the members of the project's consumer reference group:

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Ms Margaret Mathers (until 12/05)	National Ageing Research Institute volunteer
Ms Zelma Riddell (from 10/06)	National Ageing Research Institute volunteer
Ms Judy Williams	Carers Victoria
Ms Fay Brassington	Carers Victoria
Ms Hilda Quiroga (until 09/05)	Carers Victoria
Ms Lola McHarg	Council on the Ageing
Ms Maree Jeffs	Council on the Ageing
Ms Sue Hendy	Executive Officer, Council on the Ageing

Consumers:

We gratefully acknowledge the input of the National Ageing Research Institute (NARI) volunteers who participated in focus groups. Thank you for your role in assisting with the design of the survey and in highlighting to us those things that are important to you as users of health care services.

We also acknowledge the contribution of the health service users who agreed to be interviewed as part of our investigation of good practice initiatives in Victorian Health Services.

Victorian Department of Human Services:

We thank the Victorian Department of Human Services, Continuing Care and Clinical Service Development Section for funding this project, and also for their support throughout the project.

Introduction

This report presents a summary of Phase 1 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). This 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 have each nominated an Executive Sponsor, a Key Implementation Contact (KIC) and a project officer who have formed a Community of Practice to facilitate implementation of this policy. This project is supporting Health Services in identifying person-centred practices and implementing person-centred care, a key principle of the policy.

Aims

The aims of this project are 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 (2003)
4. Evaluate the impact of these resources on practice.

Objectives

The project objectives are 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 practices. 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 be modified to provide easy access to relevant resources through the development of a person-centred health care website
- ?? Trial these resources in selected health services
- ?? Evaluate and refine these resources
- ?? Assess the extent and adequacy of person-centred health care practice from the perspectives of staff working in Victorian Health Services.

Methodology

Overall project

The project consists of three phases.

Phase 1

The goal of Phase 1 has been 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 project advisory group
- ?? Establishment of project consumer reference group
- ?? Literature review of "What is person-centred health care?"
- ?? A "benchmarking person-centred care" statewide 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 1 is due to be completed by December 31st 2006.

Phase 2

The outcomes from Phase 1 have been used to develop the methodology for Phase 2. The second phase of the project, scheduled to occur between November 2006 and July 2007, plans to support health services in enhancing their person-centred care practice, using resources and initiatives identified and/or developed in Phase 1, and to evaluate this implementation.

Phase 3

Phase 3 is planned to occur between July and December 2007 and will involve re-administering the "benchmarking person-centred care" statewide survey to the 17 Health Services that participated in the survey component of Phase 1.

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

The project advisory group has 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 has met six times throughout Phase 1, providing advice from a consumer's point of view on the project methodology and outcomes. This group includes volunteers from the National Ageing Research Institute, Council on the Ageing and Carers Victoria, as well as the Executive Officer of Council on the Ageing, who sits on both the advisory group and 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 within the parameters detailed below.

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 in or before 1994
- ?? 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 the "Evaluation of home-based rehabilitation in Victoria" (Dow, Black, Bremner, & Fearn, 2004) report and the "Victorian Patient Satisfaction Monitor" (TQA Research Pty Ltd, 2003) report were also included in this review.

Findings

What is person-centred health care?

There are many definitions of person-centred (patient- or client-centred) health care in the literature. The Victorian Department of Human Services (2003) defines person-centred care in relation to older people 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'.

The main features of person-centred health care derived from the literature can be encompassed within the concept of partnership. The overriding message is that person-centred 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 following principles of person-centred care, are all encompassed within the concept of partnership:

1. Getting to know the patient or client as a person (holistic approach as well as an individual approach)
2. Sharing of power and responsibility (patient or client as an expert in their own health, sharing of decision making, information, the idea of a common ground)

3. Accessibility and flexibility (of the service provider as a person and of the services provided)
4. Coordination and integration (consideration of the whole experience from the point of view of the service user)
5. Having an environment that is conducive to person-centred care (supportive of staff working in a person-centred way and easy for service users to navigate).

Does person-centred health care work?

The evidence presented in the literature, although limited, is largely supportive of person-centred approaches to care. Communication between physician and patient, specifically asking questions about the patient's understanding, expectations and feelings and showing support and empathy, can make a positive difference to patient health outcomes. Clients with mental health problems were more satisfied with case management when they had been randomised to client-focused case management interventions. In the literature on chronic illness, education for practitioners in person-centred care and person-centred education for clients were both found to be beneficial for service users. There was also some evidence in the palliative care literature of improved pain management, when working in partnership with clients. Furthermore improved patient and carer satisfaction, improved adherence to intervention recommendations and an improved sense of professional worth have been reported as outcomes of working in a person-centred way.

What are the things that hinder and the things that help in providing person-centred health care?

The main barriers to person-centred health care identified through this review are:

- ?? Time, with various studies stating that person-centred approaches to care take more time
- ?? Dissolution of professional power, that is, staff experiencing loss of professional status and decision making power
- ?? Staff lacking the autonomy to practise in this way
- ?? The lack of clarity about what constitutes person-centred care, making it more difficult to practise and to explain to clients
- ?? Clients with communication difficulties
- ?? The constraining nature of institutions, including physically or spiritually impoverished environments of care.

The main things that help in person-centred health care are:

- ?? Having skilled, knowledgeable and enthusiastic staff, with good communication skills
- ?? Opportunities for involving the service user, their carers, family and community (for example, volunteers) in health care
- ?? Providing the opportunity for staff to reflect on their own values and beliefs and express their concerns
- ?? Opportunities for staff training and education, and feedback from service users
- ?? Organisational support for this approach to practice
- ?? Working in an environment of mutual respect and trust
- ?? Physically and emotionally enriched care environments
- ?? Providing services in the client's home.

Gaps in the literature

There was little literature that included direct client, carer or family perspectives on person-centred health care. There was also limited empirical evidence about the effectiveness or otherwise of these approaches.

More information about the literature review, and the literature review itself, can be found at <http://www.nari.unimelb.edu.au/pchc>.

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 in developing 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
- ?? Adequate parking and public transport access to hospitals.

In conclusion, the older service users defined the following key elements of person-centred health care:

- ?? Respect from the service provider for the service user as an individual with unique needs, preferences and values
- ?? Recognition by the service provider of the service user’s ability to contribute to their own care
- ?? An equal partnership between the service user and service provider
- ?? Ability of the service user to communicate or assertively request appropriate person-centred care.

Statewide survey on person-centred care

Aims

The aims of this survey were:

1. To assess current practice in relation to person-centred care from the point of view of staff working within the Victorian Health Service system
2. To 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
- ?? 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). Because individual health services provide services to a range of clinical populations, a scoping exercise was undertaken with those services choosing to participate prior to dissemination of the survey. The aim of this scoping exercise was to determine which wards, units or programs in each health service were most appropriate for the survey.

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.

These wards, units or programs were selected according to the following criteria:

- ?? All of the health services participating in the benchmarking survey had each of these wards, units or programs
- ?? Older people, in most cases, represented more than 50% of admissions to these wards, units or programs
- ?? The wards, units or programs selected represented a cross section of the continuum of care, from acute through to sub-acute and community.

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. These reports were only distributed to the relevant health service. They were not disseminated to all health services. 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 results

A report of the statewide survey results was produced and distributed to all health services to use in conjunction with their individual survey reports. 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.

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 usually/always or agree/strongly agree, 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 available at times and in places that suit service users and their families/carers (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 usually/always or agree/strongly agree, 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 practice of the respondent reporting it (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 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:
 - a. Lack of time
 - b. Inadequate resources
 - c. Inadequate staffing
 - d. Inadequate interpreters and translated written materials
- ?? Client and family communication issues, such as:
 - a. Language differences
 - b. Cognitive problems
 - c. Differing expectations
 - d. Families wanting or not wanting to participate
- ?? Model of care and organisational issues, including:
 - a. Shortcomings in the model of care
 - b. Lack of flexibility in service hours and location of service delivery
 - c. Lack of management support
- ?? Lack of staff teamwork and communication
- ?? Staff attributes, including:
 - a. Negative staff attitudes
 - b. Inadequate skills regarding person-centred care
- ?? Environmental issues, including:
 - a. Lack of privacy
 - b. 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:
 - a. Processes for inclusion of clients and carers in care planning (such as goal setting)
 - b. Processes for enhancing communication with clients and carers (such as key contact persons)
 - c. Flexibility in hours and location of service delivery
- ?? Good teamwork and communication
- ?? Staff attributes, including:
 - a. High skill levels
 - b. Compassion
 - c. Commitment to person-centred care
- ?? Adequate service capacity, including:
 - a. Adequate time
 - b. Availability of resources (such as interpreters)
 - c. Adequate staffing
 - d. Availability of suitable equipment
- ?? Organisational and management support, including:
 - a. An organisational culture that supports person-centred care
 - b. Leadership and mentoring
 - c. Recognition and feedback on staff achievements
- ?? Client and family attributes, including:
 - a. Motivation
 - b. 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:
 - a. General capacity, such as more time and staff
 - b. Specific resources, such as translated documents and diversional therapists
- ?? More training, education and staff development
- ?? Model of care improvements, including:
 - a. Documentation
 - b. Single point of access
 - c. Client goal setting
- ?? Organisational and management support, including:
 - a. Culture change
 - b. Management support
 - c. Review and feedback
- ?? Enhanced teamwork and communication, including:
 - a. Within the team
 - b. Between services
 - c. 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 the first phase of the study (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 doing already (such as giving service users adequate time to talk) may not be occurring in practice.

Another limitation of the survey is that it 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
- ?? 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.

Good practice initiatives

As previously stated, 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 then aimed to investigate eight of these initiatives in detail to assist in developing resources for use in improving person-centred health care. In determining the eight initiatives to be investigated further, priority areas were identified from a combination of:

- ?? The “benchmarking person-centred care” survey results (those areas identified in Sections 1 through to 6 as being the least well developed, that is, those areas in which there was the least agreement or practice rate)
- ?? Consultation with Executive Sponsors, KICs and/or project officers, the consumer reference group and the project advisory group
- ?? Review of Health Service complaints data and contact with the Office of the Health Services Commissioner to identify the ten most frequently mentioned complaints by older health service users
- ?? The Victorian Patient Satisfaction Monitor
- ?? Focus groups with older service users.

In total, 13 priority areas were identified:

1. Inclusion of service user and carer in care plan
2. Follow-up after discharge
3. Services at times that suit
4. Inclusion of service users in service planning and evaluation
5. Allocation and access to key contact person
6. Interpreter services
7. Single point of contact
8. Well co-ordinated practice
9. Staff education, including exploring staff attitudes
10. Staff work demands being recognised and acknowledged
11. Responsiveness to the needs of indigenous Australians
12. Transport and parking
13. Hot food being served hot

Following identification of the priority areas, the project team reviewed the good practice initiatives that were identified through the survey, ensuring that each initiative met certain criteria. The criteria included:

- ?? The initiative addressed at least one of the 13 priority areas
- ?? The initiative appeared to adopt the principles of person-centred practice as identified in the literature review
- ?? The initiative was not part of common practice (such as team meetings, family meetings)

- ?? The initiative had not already been widely adopted (such as Post-Acute Care, home-based rehabilitation, Enhancing Practice Program)
- ?? The final group of eight initiatives included a mix of metropolitan and rural/regional initiatives, and acute and sub-acute care initiatives.

The 27 initiatives identified that met these criteria were then provided to the advisory group for review. Each member of the advisory group was asked to rank the top eight initiatives they thought should be investigated further. These votes were counted, and Table 1 shows the initiatives that were selected for further investigation.

Table 1. Good practice initiatives selected for further investigation

Initiative	Priority area	Setting	Location
Patient handover at bedside (Austin Health)	Inclusion of service user and carer in care plan	Acute	Metro
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

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.

Following discussions with staff at Austin Health, the project team determined that the “patient handover at bedside” was not appropriate as an initiative for further investigation as it did not involve the service user at all. As a result, the next highest ranked initiative from the voting undertaken by the advisory group was chosen for further investigation. This initiative was the “staff buddy system” at Austin Health, and this was investigated as another example of a well co-ordinated practice.

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. These helpsheets are available for download at <http://www.nari.unimelb.edu.au/pchc/>.

Resource review

Resources for use in improving person-centred health care were identified through the literature review. These resources, and the additional initiatives and resources identified through the survey but not investigated further, were reviewed by the project team.

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.

The reviews of the resources/initiatives can be obtained from <http://www.nari.unimelb.edu.au/pchc/>.

Person-centred health care website

A person-centred health care website has been developed as a way of sharing the information obtained through Phase 1 of the project, and also 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 and the findings from the investigation of the eight good practice initiatives.

The reviews of the resources and initiatives have been categorised under the following headings:

- ?? Care planning:
 - Coordination of services
 - Discharge planning
 - Measurement tools
 - Goal setting
- ?? Information, education and training
- ?? Conceptual models of care and guidelines
- ?? Use of technology
- ?? Audits / benchmark kits
- ?? Culturally and Linguistically Diverse (CALD) / Indigenous health
- ?? Consumer and Community Involvement.

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

Development of Phase 2 methodology

The methodology for the second phase of the “Best Practice in Person-centred Health Care for Older Victorians” project is based on the outcomes of Phase 1.

The primary aim of Phase 2 is to support health services in enhancing their person-centred care practice, using resources and initiatives identified and/or developed in Phase 1, and to evaluate this implementation. It is envisaged that this phase of the project will complement the Enhancing Practice Program being undertaken by Northern Health and COTA for the Department of Human Services. The Enhancing Practice Program (EPP) aims to help staff re-think and reflect on their attitudes to and perceptions of ageing and older people. The program provides opportunities for participants to reflect on current practice and to consider issues of ageing, ageism, person-centred care and interdisciplinary practice. It challenges current attitudes and behaviours to promote practice change. Table 3 summarises the key components and timelines for Phase 2.

Table 2. Phase 2 components and timelines

Key tasks	Timelines for completion
Finalise Phase 2 methodology, with a focus on priority areas and or/gaps in current capacity to deliver person-centred care.	October – November 2006
Circulate information on Phase 2 and recruit health services to take part. A scoping survey will be conducted with the health services wanting to participate in Phase 2 (this will be circulated to the project officers, Key Implementation Contacts (KICs) and the Executive Sponsors). This will help to identify the individual health service goals or priority areas in person-centred care which they wish to address during Phase 2. The individual health service survey reports and the statewide survey report conducted in Phase 1, which listed areas of person-centred care in need of improvement, may be useful points of reference for the health services at this time.	December 2006 – January 2007
<p>Background activity at NARI, which will involve working with the KICs and/or project officers from each participating health service in determining and planning possible strategies for their health service to address their goals or priority areas. The information and resources developed and collected during Phase 1 will be used as the basis for these strategies.</p> <p>Submit ethics amendments to relevant ethics committees to undertake interviews with consumers as part of the evaluation process.</p>	January - February 2007
<p>Phase 2 activities:</p> <p>?? Introductory seminar for all participating health services (half to full day). The emphasis will be on implementation of outcomes from Phase 1 and change of practice. The seminar will be led by a facilitator experienced in change management.</p> <p>?? Site visits to participating health services by the NARI team to support strategies for implementation and to identify other specific requirements for each site.</p> <p>?? Ongoing support as required from the NARI team throughout Phase 2, including fortnightly teleconferences with all sites (depending on the number of participating sites, it may be necessary to do metropolitan and rural sites separately, with the minutes of each teleconference being shared with all).</p>	February – May 2007
<p>Evaluation at individual sites:</p> <p>?? Interviews with participating KICs and/or project officers.</p> <p>?? Focus groups with staff in participating facilities to determine: <ul style="list-style-type: none"> o which resources/strategies they found useful in achieving their goals or addressing their priority areas in person-centred care o what gaps and/or solutions or other resources were identified o feedback on the process used throughout Phase 2 o feedback on the website as a tool to find person-centred care resources. </p> <p>?? Interviews or focus groups with consumers involved in activities in participating health services.</p>	May – June 2007

Key tasks	Timelines for completion
Project feedback for participating health services. This will be in the form of a seminar which will allow all participating sites to present their achievements throughout Phase 2, and NARI to present the results of the evaluation to all participating sites. This seminar at the conclusion of Phase 2 may provide sites with additional strategies or suggestions that they can use at a later date in their health service to improve person-centred care.	June 2007
Prepare draft Phase 2 report	June 2007
Submit draft Phase 2 report	June 2007
Review of report by Advisory Committee	June – July 2007
Review of report by Consumer Reference Group	June – July 2007
Incorporate feedback and complete Phase 2 report	July 2007

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 has been 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, will be evaluated in the next phase of the project.

Reference List

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

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National Health and Medical Research Council. (1999). *NHMRC standards and procedures for externally developed clinical practice guidelines*. Canberra: NHMRC.

TQA Research Pty Ltd. (2003). *Victorian Patient Satisfaction Monitor: annual survey report year three 2002-2003*. Melbourne: Report for the Department of Human Services, DHS.

Wellard, S., Lillibridge, J., Beanland, C., & Lewis, M. (2003). Consumer participation in acute care settings: An Australian experience. *International Journal of Nursing Practice*, 9(4), 255-260.

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
- 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
- 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.
- never rarely sometimes usually always don't know
- 5.4 I like working with older people
- never rarely sometimes usually always don't know
- 5.5 The emotional and physical demands of my work are acknowledged and recognised
- 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
- never rarely sometimes usually always don't know
- 5.7 I have been exposed to good role models in care for older people
- never rarely sometimes usually always don't know
- 5.8 I have been exposed to good environments of care for older people
- never rarely sometimes usually always don't know
- 5.9 I am supported to develop the skills I need to work with older people
- 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 – Participating Health Services 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 4 Health Services form the Hume Health Consortia, however for the purposes of this survey they were considered separate Health Services.