

Final Report Submission from:

**Brightwater Care Group Inc**

To Health Workforce Australia

**Developing and testing the adaptability and utilisation of care workers as part of an Interdisciplinary Workforce Model of Practice**

*This project was possible due to funding made available by Health Workforce Australia as an Australian Government initiative and does not necessarily reflect the view of Health Workforce Australia.*

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## Executive Summary

Residential Aged Care is challenged with workforce shortages and turnover<sup>1</sup>, rigidity in teamwork models<sup>5, 6</sup> and the absence of client contribution to care<sup>7</sup>. Brightwater Care Group's project ***"Developing and testing the adaptability and utilisation of care workers as part of an Interdisciplinary Workforce Model of Practice"*** set out to determine:

**IF** Brightwater Care Group train and support care workers in collaboration with the client, Allied Health and Nursing staff to carry out 'non traditional' interventions such as 24 Hour Postural Care,

**THEN** Brightwater Care Group will be able to demonstrate the development, implementation and transferability of an Interdisciplinary Workforce Model of Practice.

In order to prove the project hypothesis Brightwater Care Group needed to:

- redesign workforce roles within aged care consistent with emerging evidence about effective care to improve standards and provide for consumer needs and expectations;
- enable staff to work to their full scope of practice, within their range of competencies and with an appropriate and safe span of responsibility (24 hours a day, seven days a week); and
- extend existing workforce roles to provide greater workforce flexibility.

This led to these project objectives:

1. Develop and test the adaptability and utilisation of Care Workers by expanding their existing role to include Postural Care interventions.
2. Develop and test the increasing collaboration of Nursing, Allied Health and Care Workers with the client ('Expert patient'<sup>21</sup>) where they all contribute to an Interdisciplinary Workforce Model of Practice in the area of shared care planning to sustain 24 Hour Postural Care.
3. Improve the consistency and sustainability of service delivery to clients.

Postural Care<sup>36</sup> was selected as the intervention to test the project hypothesis and Orchard's 'Conceptual Model for Patient-Centered Collaborative Interdisciplinary Practice'<sup>14</sup> was chosen as the approach to deliver the required solutions and most closely aligned with the project objectives. The project was a before and after study conducted over a twelve month period involving a single Brightwater Care Group Residential Aged Care Facility (RACF). A mixed research design was utilised with both quantitative and qualitative data collected in relation to the workforce, the client and Postural Care under the auspice of a Program Logic framework to guide project activities.

All Care Workers and Therapy Assistants at the project site were trained in implementation of Postural Care to Certificate IV Level. Nursing, Allied Health & Management staff attended education sessions to learn how to support the staff groups carrying out these new skills as part of a change in scope of practice. A number of clients at the site were assessed for suitability to receive Postural Care and nine Postural Care Plans were developed. Care Workers and Therapy Assistants implemented these Postural Care Plans with support from Nursing and Allied Health staff as well as project staff. Aligned with the project's second component of the hypothesis - site process, duties, roles and responsibilities were analysed and changed to support an Interdisciplinary approach to practice.

In the project's short 12 month timeframe, Brightwater Care Group was able to achieve the project's objectives to develop and test adaptability and utilisation of Care Workers; develop and test increased collaboration between Nursing, Allied Health, Care Worker staff and with the client; and improve the consistency and sustainability of service delivery. Orchard's Model of Practice was adapted to meet the needs of the site. In doing so, Brightwater Care Group was able to verify the project hypothesis. Although this project has many aspects which can be generalised across other areas of residential aged care, further research is required to establish sustainability and transferability across the continuum of care.

Based on the results and lessons learnt through this project, the following are recommended to facilitate a team and/or workforce transition towards an Interdisciplinary model of practice (these recommendations are also consistent with literary evidence on change management<sup>14,47</sup>):

*1: Expand evidence based research on the use of Orchard's adapted Patient-Centered Collaborative Interdisciplinary Practice Model to further explore its transferability to other service or care areas. This needs to include evaluation of cost effectiveness and sustainability. Projects would need to be a minimum of 2 years in duration.*

*2: Ensure change management processes have very clear organisation and management support and commitment which are visible to the staff directly involved to enhance adoption of the change process. This is necessary as implementing an interdisciplinary model is a longer term process and takes more than a 12 month project to achieve.*

*3: Provide support at all levels - organisational, management, RACF Champions and staff - through the change process and within changing roles. (ie key site change champion to support project officer if their time/resources are limited or project officer hours to be increased to effectively provide the change management support).*

*4: Ensure change management strategic workshops or seminars are appropriately pitched to the staffing group attending so all staff are exposed to the process and have a greater understanding of the journey. It also makes it clear what is required from each staff member or discipline. Continue these throughout the project (modifying content as applicable) to facilitate understanding, compliance, opportunity to raise issues and to reinforce change objectives.*

*5: Map out team processes and align processes with the goal of Interdisciplinary Practice from the very beginning so that it does not get lost in the transition if also incorporating a new service/task area at the same time.*

*6. Provide formalized training to Certificate level for Care Workers (to ensure competencies and skills to implement new interventions such as in Postural Care) where possible to increase the attraction to staff and enhance career pathway prospects.*

*7. Provide training to all staff groups when they are required to support a specific discipline's expanded scope of practice so they are engaged and supportive.*

*8: Recognise that it may be difficult to obtain feedback from clients and families in RACF but endeavour to do this and factor the required time/support into the project approach.*

*9. Conduct further research to evaluate the longer terms effects of Postural Care on minimizing client postural deformities and the additional knock on impacts of this to the workforce.*

In addition to verifying the project hypothesis, this project demonstrated that although Postural Care is unique to aged care in Australia, it has significant benefits for clients and the workforce. As the first study known to be conducted in this area, it is hoped that further research be conducted to:

- Examine the implementation of an Interdisciplinary Workforce Model of Practice across all areas in a Residential Aged Care Facilities.
- Examine the introduction and evaluation of Postural Care outcomes to the clients and workforce in a Residential Aged Care Facilities.
- Examine the introduction of client centered care across all areas of care and the subsequent changes to the client and workforce in Residential Aged Care Facilities.

## 1. Brief Organisational Summary

### Profile of submitting organisation

Entity Name	Brightwater Care Group		
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Established in 1901, Brightwater Care Group (BCG) is a large private, not-for-profit provider of quality residential, rehabilitation and community care for people with disabilities and older people with low and high support requirements. Hence it provides services to adults of all ages. BCG employs over 1700 staff.

BCG has twenty two Residential Care Facilities in the Perth metropolitan area located from Joondalup north of Perth to Mandurah south of Perth. Thirteen of these Residential Care Facilities provide a range of accommodation options for older people across the continuum including low, ageing in place, high care and high care with additional needs. BCG also has specialised dementia care and transitional care facilities. The Services for Younger People program provides unique accommodation options with six facilities offering full time residential accommodation for younger people with disabilities, two facilities providing accommodation specifically for people living with Huntington’s Disease and one facility supporting clients transitioning from acute care to alternative accommodation options. Brightwater also operates the Oats Street rehabilitation facility, (unique to Australia), which provides slow stream, outcome based rehabilitation in a residential home setting for younger people with acquired brain injury.

BCG provides a wide range of community care programs, specialist health and transition care services which have provided a platform for care and program innovations. Our community-based services include CACP, EACH and EACH-D packages and, HACC services (with a special focus on community nursing and personal care in the client’s home) to over 650 clients and 79 residential/community transition care places operating within metropolitan Perth. BCG’s Seatec (unique Seating and Equipment Clinic with specialist therapy staff) have an internal and external



customer base and provides specialist clinical consultancy services as well as clinic support to metropolitan and regional clients.

Through this wide range of services BCG spans the care continuum with streamlined referral links at the interface between acute care and residential and community programs as well as integrated care models that involve General Practitioners in the day-to-day care of its clients and residents. Thus it is well-placed to support the dissemination of care, workforce and technological innovations across the health, aged, community services and disability support sectors.

Care innovations have included the implementation of 24-hour Postural Care within BCG's rehabilitation service for young people with complex care needs as a result of neurological disorder or injury. This innovation requires the use of an interdisciplinary team approach for effective implementation. Positive outcomes have included quantifiable improvements in clients' physical functioning and documented improvements in the shared skill base of staff across a range of disciplines who traditionally worked within professional "silos".

BCG has an outstanding record as an employer of choice within the aged and disability sectors in WA. As a Registered Training Organisation, it has an excellent record in education and training and was a finalist in the Australian Institute of Management's WA Large Employer of the Year Award, WA Training Awards in 2007. Through the provision of traineeships we also have the opportunity to provide industry entrants with training that emphasises an integrated model of teamwork. BCG provides Interprofessional Learning with clinical placements for significant numbers of medical, nursing and allied health students each year (over 500 in 2010). These well-established relationships with undergraduate educational institutions are being further strengthened, particularly through the recent award of a clinical training grant received in conjunction with the University of WA and Curtin University.

BCG applied to join the Health Workforce Australia's Caring for Older People Program (CfOP) which intends to support the redesign of the aged care workforce. BCG was accepted as one of the twenty projects within the CfOP. Refer to Appendix 9.1 for Brightwater Care Group's Organisational Chart and the membership/roles of the Project Steering Group.

## 2. Project Planning

### 2.1 Project Rationale

Health Workforce Australia funded BCG to undertake the project:

**‘Developing and Testing the Adaptability and Utilisation of Care Workers as Part of an Interdisciplinary Workforce Model of Practice’** to test “if Brightwater Care Group train and support Care Workers in collaboration with the client, Allied Health and Nursing staff to carry out ‘non traditional’ interventions such as 24 Hour Postural Care, then Brightwater Care Group will be able to demonstrate the development, implementation and transferability of an Interdisciplinary Workforce Model of Practice” and report on what worked and what did not work as significant learning towards the health reform agenda.

Residential Aged Care (RAC) is a challenging area to be working and living in both nationally and within Western Australia. These challenges will increase in magnitude unless we clearly identify the issues and implement systemic workforce innovation and reform to address them. The key challenges identified include:

- Workforce shortages and turnover,
- Rigidity in teamwork models, and
- The absence of client contribution to care.

#### **2.1.1 Workforce Shortages and Turnover**

A major workforce problem in RAC relates to the capacity to attract and retain staff within individual organisations and across the industry as whole – particularly highly skilled health professionals. Workforce supply and turnover has been a known national issue for some time<sup>1</sup>. The impact of this issue will become amplified with the ageing population and demand for RAC to increase significantly over the coming years<sup>2</sup>. Fewer people are entering the area of health care and an ageing workforce means that increasing numbers of health care workers are leaving the workforce or decreasing their hours of work as they approach retirement<sup>2</sup>.

Nursing workforce shortages have been attributed to the physical and emotionally challenging nature of the work<sup>3</sup> with data indicating an annual turnover of one quarter of Care Workers and close to one in five Nurses<sup>4</sup>. The shortage of Nurses in aged care is greater than in other sectors of the health system<sup>3</sup>. A study by Hegley et al 2004<sup>3</sup> found that workforce shortages in Aged Care

reflected the nature of the work in that staff were more likely to report that the work is emotionally challenging and physically demanding and that the workload is heavy. Similar morale and workload concerns have been reported for personal care workers who comprise 58% of all direct care workers in Aged Care. 10% of Aged Care Facilities employ unqualified personal carers indicating a shortage of people with suitable qualifications. This results in a tendency for qualified staff to “shop around” resulting in a high level of ‘workforce turnover’ and related staff turnover costs for the industry as a whole. It has been identified that staff are highly motivated by the intrinsic outcomes of providing good care but are frustrated by insufficient time available to spend with each client<sup>2</sup>.

The workforce shortages in Allied Health professions also mirror those in other health workforce groups<sup>5</sup>. Full time Allied Health positions are generally not available in Residential Aged Care Facilities (RACF) so input is often limited to a small number of sessions per week which may only assist a relatively small proportion of clients within the service. This impacts on the level of continuity and consistency of care innovations or interventions.

### **2.1.2 Rigidity in teamwork models**

An additional challenge is that the roles and responsibilities of the aged care workforce remain traditionally defined in a ‘silo’ model of practice even though client needs have changed and new service models have been developed<sup>5</sup>. The Hogan Review of Pricing Arrangements in Residential Aged Care<sup>6</sup> reported that care is currently fragmented, as opposed to the desired holistic model of care. Increasing care complexity requires a greater degree of “active coordination” than is currently the case. Existing health workforce training is largely based on “siloed” professional groupings. Roles and responsibilities generally remain “traditionally defined” and are not evolving to meet complex client needs to the degree that is necessary to cost-effectively respond to increasing service demands into the future. According to the Productivity Commission Research report<sup>5</sup> there have been mixed responses to proposed role changes and new teamwork models with concerns expressed that there may be a reduction in the quality of care if tasks traditionally undertaken by particular groups (especially Registered Nurses) are undertaken by less qualified personnel. Increasing specialisation within Allied Health has also contributed to a reluctance to embrace new teamwork approaches<sup>8</sup>. The Health Professions Council of Australia (2005) has expressed concern that Allied Health professionals are viewed as “generic” health workers who are able to fill the gaps of workforce shortages therefore devaluing the role Allied Health professionals have in health care. Other common barriers to adoption of a new teamwork model include a lack of understanding of the proposed model, a sense of professional identity being threatened, professional constraints resultant from separate education, socialisation and jargon, fear of losing

power or status, concern that change requires too much time and effort and the impact on client care outcomes is unknown<sup>9,10,11</sup>.

In addition, innovations in Allied Health practice are difficult to introduce into aged care as Allied Health professionals usually work limited hours/shifts with each group (for example Physiotherapists, Occupational Therapists, Speech Pathologists, Psychologists, Dietitians) tending to work as “a wedge in a pie” within rigidly defined roles. Demarcations between the roles of Nursing, Care Workers and Allied Health personnel make it difficult to achieve a holistic person-centred model of care. As the trend in RACFs shows that an increased number of residents have complex health needs<sup>12</sup>, these complex health needs cannot be managed effectively or efficiently using a ‘silo’ model of practice<sup>13, 14</sup>. Integration is limited resulting in duplication and possible conflicting client outcomes<sup>15, 16, 17</sup>. There is a need for the extension of different roles and scope of practice to create greater flexibility and a degree of role substitution. “Inter-professional collaborative teamwork can be enhanced to share work, reduce pressure on particular professions, and improve outcomes”<sup>18 (p18)</sup>. Research shows that employees benefit from work in a collaborative interdisciplinary way<sup>19</sup>. Further research is required to demonstrate benefits for client outcomes<sup>20</sup>. There is a need to develop a clearly documented process for the introduction of workforce innovations into aged care using an Interdisciplinary Model built on a set of competencies and shared understanding by staff involved.

### **2.1.3 The Absence of Client Contribution to Care**

The idea of client contribution to health care is not a new concept and is often referred to as patient-focused care. Other terms used to describe this concept include consumer-centered care, person-centered care, personalised care and family-centered care<sup>7</sup>. The era of the patient as the passive recipient of care is changing and being replaced by a new emphasis on the relationship in which Health Care Professionals (HCP) and patients are genuine partners seeking together the best solutions to each patient’s problem. A relationship in which patients are empowered with information, are encouraged and given the opportunity to contribute ideas to help in their treatment and care. Research shows that people who live with chronic disease often know what they need to do to manage their own condition and, given the necessary skills, can moderate the impact of their disease and improve the quality of their lives<sup>21</sup>.

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) identified patient-centered care as a dimension of high-quality care<sup>7</sup>. When health care professionals, patients/clients work in partnership studies have shown that the safety and quality of the health service increases, costs decrease, patients adherence to recommended interventions increases

and both health care professionals and client satisfaction increases without requiring additional investments in time and resources<sup>22,23,24,25</sup>. Little and colleagues<sup>26</sup> indicated a patient-centered approach is the approach preferred by patients.

The term 'Expert patient' is also another term associated with patient-centered care. 'Expert patients' are when patients manage their condition and treatment in partnership with HCPs<sup>21</sup>. They communicate effectively with professionals and are willing to share responsibility and treatment<sup>11</sup>. Patients are considered experts in relation to their experience of illness, social circumstances, and attitude to risk, values and preferences<sup>27</sup>. Drawing on 'Expert patient' philosophies where possible is an important consideration when looking at improved models of interdisciplinary practice. Capitalising on the expert patient will result in more positive client outcomes and this is of critical importance in the implementation of new services.

Any solution to these three identified challenges needs to be practical, be consistent with the project organisation's strategic interventions and deliver clear benefits. The solution needs to:

- Identify an approach to address these key challenges, and
- Identify an intervention which can test this approach.

#### **2.1.4 Identifying an Approach to Address Key Challenges**

Evidence based theory needs to underpin practice. It also needs to guide the pathway for proposing a way forward to support the project hypothesis. For the project, BCG will need to be able to demonstrate the development, implementation and transferability of an Interdisciplinary Workforce Model of Practice. Throughout the literature there are a number of Models of Practice discussed in relation to health care teams. Boon et al<sup>35</sup> propose that Models of Practice fall along a continuum of integration. Different terms are also used interchangeably to describe the same Model of Practice. Therefore for clarity, this project adopted the following terms and definitions:

*Multidisciplinary*: involves a team of HCP's who work independently and then share information with the rest of the team, usually in a formal setting ie, ward rounds or team meetings<sup>47</sup>. The team is managed by a leader<sup>28</sup>. A Multidisciplinary Model of Practice is primarily focused on organising delivery of services rather than meeting client needs<sup>30</sup>.

*Interdisciplinary/interprofessional*: support shared decision making, shared leadership, accountability and responsibility<sup>31</sup>. HCP's assess and treat clients jointly and pool their knowledge<sup>29</sup>. Leadership changes according to the task at hand and who is best skilled to

lead the team forward to task completion<sup>32</sup>. The focus on Interdisciplinary Models of Practice is on meeting client needs<sup>9</sup>.

Drinka<sup>33</sup> claims “interdisciplinary health care teams are essential for the delivery of health care to frail elderly persons” (p.87). The elderly populations in RACF typically have complex health care needs as a result of multiple co-morbidities. Interdisciplinary practice is considered the best method to address complex client needs, to improve the quality of care and client outcomes within an environment of limited resources<sup>1,13,19</sup>. From a clinical perspective no one profession has the knowledge and skill to effectively address the needs of a client with complex health issues<sup>13,14</sup>. From a workforce perspective interdisciplinary teams have been associated with greater client satisfaction, reduced costs, greater efficiency and better use of the knowledge and skill set of team members<sup>34</sup>. Evidence for the effectiveness of interdisciplinary teams in Australia is limited. It is theoretically supported as the best way forward<sup>1</sup>, but is an area that requires further investigation.

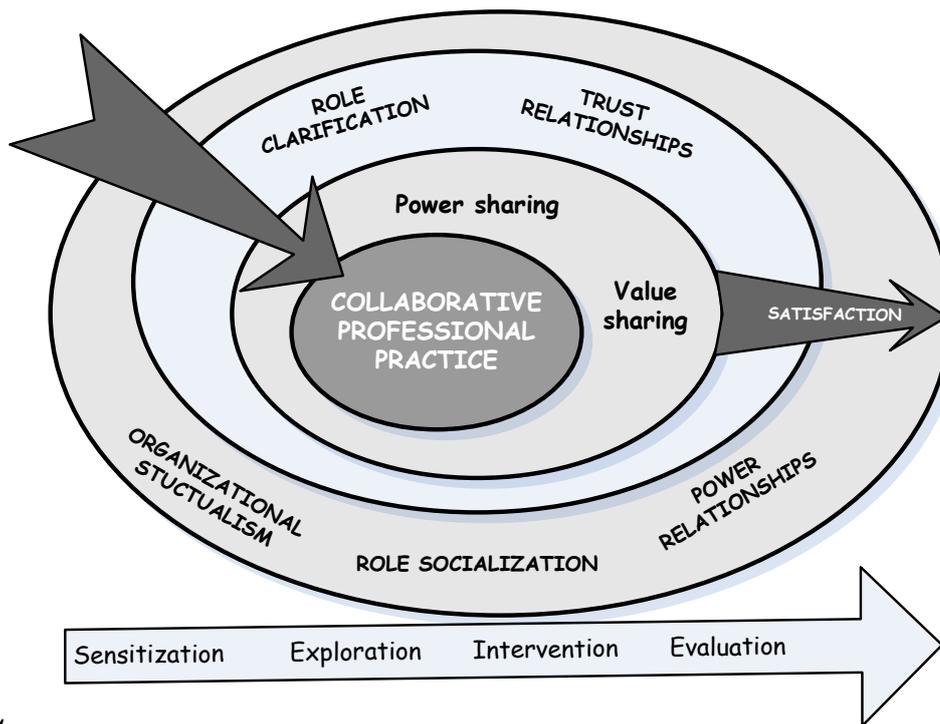
Reviews of the literature showed ‘The Conceptual Model for Patient-Centered Collaborative Interdisciplinary Practice’ developed by C.A. Orchard<sup>14</sup> to have the potential to deliver the required solutions and most closely aligned with the project objectives. Orchard’s Model was selected for the project as a foundation from which the project can base and then develop from (refer to Figure 1 overleaf). The reasons for selection include:

- Central to this model is patient-centered collaborative interdisciplinary practice<sup>19</sup>. Collaborative practice reflects a primary objective of this project as well the organisational service approach adopted by BCG.
- By highlighting the patient, it ensures the focus is on the client across RAC and this is one of BCG’s core values.
- As interdisciplinary practice is defined as a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision making around health issues<sup>14</sup>, this reflected what the project team considered to be an ideal process for testing and demonstrating at a local project level.
- Orchard’s model also depicts the journey which a team must take to achieve patient-centered collaborative interdisciplinary practice. The team’s progress towards this goal is made explicit in Orchard’s model therefore enabling BCG to monitor the team’s progress towards this goal.

Due to the absence of reports on the use of this Orchard’s Conceptual Model for Patient-Centered Collaborative Interdisciplinary Practice in the literature, it appears that BCG’s project is the first to explore the implementation of the model in practice.

## CONCEPTUAL MODEL FOR PATIENT-CENTRED COLLABORATIVE INTERDISCIPLINARY PRACTICE

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*Figure 1*

The outermost circle in the Conceptual Model for Patient-Centred Collaborative Interdisciplinary Practice represents the three barriers to Interdisciplinary Practice<sup>14</sup>. Organisational structuralism is the administrative and decision making process adopted within institutions<sup>14</sup>. Role socialisation is the development of behaviours and attitudes considered necessary to 'fit' into a cultural group<sup>14</sup>. Power relationships looks at the power imbalances between health professionals, within the health system and between the system and the patient<sup>14</sup>. This model recognises the barriers as contributing to lack of shared decision making around patients and to negative outcomes of not involving clients in decisions.

The project's baseline surveys, interviews, mapping and evaluation findings indicate that these barriers are reflected in the project site also. This close alignment prompted the project team to explore this particular model further.

The inner circles of 'The Conceptual Model for Patient-Centered Collaborative Interdisciplinary Practice' represent the enablers. These are role clarification (understanding roles of the team members which leads to role valuing), development of trusting relationships (trusting the knowledge and decision making of each member), power sharing (regardless of educational or professional approach) and value sharing (team members assess the impact on their collaboration which looks at team member satisfaction levels and client outcomes)<sup>14</sup>. The arrow moving through the circles represents the perceived satisfaction of both the patient/resident and staff involved in the delivery of care/intervention. The arrow below the circles represents the change process the RACF team must go through to achieve Interdisciplinary practice<sup>14</sup>.

With this model in mind, strategies recommended by the World Health Organisation in their Framework for Action on Interprofessional Education and Collaborative Practice are currently and/or will be utilised to facilitate Brightwater's change process from multidisciplinary to interdisciplinary practice. Some of these strategies include: compulsory staff training, use of champions, Brightwater organisational support, managerial support, development of conflict resolutions strategies, shared decision making processes, shared resources and structured protocols/policies<sup>1</sup>.

### **2.1.5 Identifying an Intervention Which Can Test This Approach**

A service area or intervention needed to be determined which would allow the approach to be tested in the context of interdisciplinary work. The project team identified Postural Care as an appropriate intervention to implement and test in an interdisciplinary fashion as it is a traditional 'silo' Allied Health intervention known to have positive benefits for clients but a difficult intervention to embed on limited Allied Health hours.

Twenty-four (24) Hour Postural Care involves the use of specific techniques and equipment that protect body shape from the development of physical distortions, and in many cases, correct body shape. Postural Care is an ongoing, dynamic process that considers a person's posture both during the day and at night. It is most effectively administered by direct care staff, with support from Nursing and Allied Health professionals<sup>35,36,37</sup>. Internationally, there is widespread evidence of the effectiveness of Postural Care for children and young adults with movement difficulties, in terms of their sleep, physical health, function and quality of life<sup>38</sup>.

Postural management devices are designed to support an individual in a symmetrical position when sitting, standing or lying<sup>36</sup> (Refer to Appendix 9.2 for pictorial representation of a client in a Postural Care system). People spend approximately one third of their time in bed, so equipment

that supports a symmetrical lying position is an essential component of 24hour postural management programs<sup>35</sup>. Residents in RACF with complex health needs can spend even more time in a lying posture due to the nature of their complex health needs and the intensity of care they require. Pope<sup>39</sup> states management of a person's body shape and posture is a matter of urgency when the risk of body shape distortion is resultant from a later in life onset of disease. Daytime interventions (such as assisting with toileting, pad changes, dressing and so forth) by staff are less likely to be successful if the individual is adopting poor, asymmetrical postures whilst resting in bed. According to Pope<sup>13</sup>, a client's preferred lying posture is compounded in a seated posture. Therefore attempts to address a client's distorted seated 'functional' posture is limiting if lying posture is not also addressed. A study of postural support systems showed there is a need for significant commitment when providing bed- based postural programs including provision of the equipment, training and carer support. However, this was then offset by improved sleep, the need for less repositioning, reduced pain and improved pressure relief<sup>35</sup>.

In Australia, 24 Hour Postural Care has been introduced for younger people with disabilities but is not addressed within the Residential Aged Care sector. Humphreys and Pountney's study<sup>36</sup> on an Integrated Care Pathway (ICP) to improve 24 hour postural management for children and young adults with disabilities investigated developing an ICP and explored staff perception of the difference an ICP made to practice. The results demonstrated significant learning, closer team working, and an increase in clinical reasoning skills and staff confidence. This study<sup>36</sup> showed that to increase the success of interventions, it is worthwhile to involve all staff particularly direct care staff and recipients of Postural Care where possible in the development of an Interdisciplinary Model (IDM) of practice through the provision of Postural Care. An IDM requires a team that communicates well, has respect and understanding of each team member and what the team is working towards<sup>30</sup>. This study highlighted the need for change to be emphasised through the development of an IDM in order to encourage support from managers, leaders and other staff which in turn, confirmed the project team's choice to introduce Postural Care via an interdisciplinary approach was appropriate.

In summary, in response to the key challenges:

- Workforce shortages and turnover
- Rigidity in teamwork models
- The absence of client contribution to care

BCG's project aimed to develop and test the adaptability and utilisation of care workers as part of an Interdisciplinary Workforce Model of Practice in order to contribute toward future service design.

It looked at measuring workforce and client outputs to ensure that benefits accrue to service users and staff in the short term which may be transferrable to the health and aged care industry as a whole in the longer term.

## 2.2 Project Title, Hypothesis, Outline and Target Group

Brightwater Care Group's (BCG's) project ***“Developing and testing the adaptability and utilisation of care workers as part of an Interdisciplinary Workforce Model of Practice”*** hypothesises that:

**IF** BCG trains and supports care workers in collaboration with the client, Allied Health and Nursing staff to carry out 'non traditional' interventions such as 24 Hour Postural Care,

**THEN** BCG will be able to demonstrate the development, implementation and transferability of an Interdisciplinary Workforce Model of Practice.

This project provided the necessary education, skills and resources (including Postural Care training and change facilitation) to direct care staff and their supporting Nursing and Allied Health staff working with a sample of high-care RAC clients who have significant movement problems. In turn these staff groups extended their scope of practice in the provision of 24 Hour Postural Care through the development and implementation of an Interdisciplinary Workforce Model of Practice using an agreed competency framework. All the different professional/work groups involved in this Model were educated to understand the issues related to movement difficulties for aged care clients and to be shown how this can be successfully addressed within normal routines in the 24 hour cycle (i.e. not just during the day when specialised health professionals are available) to benefit themselves and their clients and to support their care worker colleagues in their expanded role. In addition, the recipients of 24 Hour Postural Care interventions were integral to the project with improvements anticipated in their physical, emotional and psychological well being.

BCG's Demonstration Project involved approximately 100 staff working at a BCG RACF which provides care for 61 high care clients including people with complex clinical requirements such that they would benefit from an enhanced Postural Care program. Although the project scope was to work with a sample group of eight high-care RAC clients who have significant movement problems, all 100 staff were involved and trained so that all shift rotations were covered. This workforce practiced within defined professional/role definitions.

## 2.3 Project Aims and Objectives

The aims of this project were to:

- redesign workforce roles within aged care consistent with emerging evidence about effective care to improve standards and provide for consumer needs and expectations;
- enable staff to work to their full scope of practice, within their range of competencies and with an appropriate and safe span of responsibility (24 hours a day, seven days a week); and
- extend existing workforce roles to provide greater workforce flexibility.

The three specific objectives of the project were to:

1. **Develop and test the adaptability** (the ability to readily adjust to different conditions) and utilisation of **Care Workers by expanding their existing roles** in a Postural Care context. The measurements used to determine this were:
  - The number and % of different types of staff attending training sessions who achieved the desired competency outcomes for the training program.
  - An increase in activities shared across staff roles and disciplines. The target was a 50% increase between the commencement and the end of the project
  - An increase by staff of their increased understanding of new Postural Care skills of Care Workers and utilisation of these skills. The target was a 50% increase.
2. **Develop and test the increased collaboration** of Nursing, Allied Health and Care Workers with the client ('Expert patient') where they all contribute to an Interdisciplinary Workforce Model of Practice in the area of shared care planning to sustain 24 Hour Postural Care. The measurements used to determine this were:
  - An increase in the number of staff and variety of professional groups engaged in the interdisciplinary model of care. The target was a 60% increase.
  - An increase in client Postural Care plans populated by the interdisciplinary team. The target was a 60% increase.
3. **Improve the consistency and sustainability of service delivery to clients.** The measurements used to determine this were:
  - An increase in satisfaction with client care. The target was an 80% increase.
  - An improvement in client function and overall wellbeing. The target was a 80% increase.
  - An increase in consumer involvement in client care planning. The target was a 100% increase.

## 2.4 Project Demographics, Service Mix, Organisational Context

The increasing complexity of care needs of older persons has led to increasing specialisation within Allied Health clinicians including an increasing emphasis on proactive management of chronic conditions and health promotion programs. A good example of this specialisation is the development of 24 Hour Postural Care within BCG for younger persons with neurological disabilities. There is a need to facilitate greater input of Allied Health expertise into RACF. The RACF workforce still predominantly functions with staff working in a traditional 'silo', multidisciplinary fashion within their disciplines (Nursing, Allied Health and Care Workers).

The introduction of an Interdisciplinary Workforce Model of Practice provides an opportunity to address this issue of increasing specialisation and the related cost burden it will represent for the Aged Care industry, as it provides Care Workers with the skills to implement specialist interventions such as 24 Hour Postural Care in a more sustainable way. This improves the utilisation of the specialist Nursing and Allied Health staff and embeds the specialist initiatives across the 24 hour spectrum and not for the few hours per day these nursing and allied health staff can be present. Although this project for BCG was tested in just one RACF (with 100 staff of which 51.5% are careworkers), the implications and findings have organisational wide impact with potential workplace reform across all thirteen RACFs. As BCG is strongly represented and connected with groups such as Aged and Community Services Western Australian (ASCWA) and the Western Australian Department of Health, it is in a position to be of influence in the Western Australian RAC sector.

Approx 90% (550) of high-care clients in all of BCG's RACFs, with high care acuity and complex conditions, also have neurological impairment to varying degrees which compromises mobility and postural control. All of these individuals are potential candidates for 24 Hour Postural Care and BCG wished to build on existing expertise in night time positioning for younger people to demonstrate equivalent benefits to older people and the RAC workforce. BCG has 1,426 staff employed across its RACFs. 53% of this population are care workers. Allied Health represents 6.7% of this population of which 56% are Therapy Assistants. There are around 3,000 Aged Care facilities across Australia so there is the potential to roll this initiative out across the high care residential sector through the provision of recommendations for Introducing an Interdisciplinary Workforce Model of Practice.

## 2.5 Project Partners and Stakeholders Involved

Various stakeholders were identified and engaged with throughout the course of the project. They were grouped according to whether they were from within the organisation (internal stakeholders) or external to the organisation (external stakeholders) – refer to Table 1 below. Their roles varied according to the type and level of engagement but generally, the stakeholders were consulted to:

- Ensure appropriate support and promotion of project objectives and deliverables
- Assist with the change management process
- Monitor project impacts

The stakeholders who were involved with the project are identified as being internal or external to the organisation and coded as: **Red**: significant or directly involved

**Orange**: contributing or partially involved or

**Green**: potential contributors or may require project information.

Table 1: Project Stakeholders

INTERNAL STAKEHOLDERS	ENGAGEMENT
Care Manager/Deputy Care Manager of the project site	1:1 initially to develop plan for staff training and backfill Engagement as required throughout project Project team member: meeting fortnightly first half of project and monthly second half of project
Seatec Clinical Specialists (therapists employed by Brightwater's unique specialist Seating and Equipment Clinic)	As a group for consultation throughout the project Attendance at project team meetings as required At least 1 member at each of the 8 Postural Care training sessions (2 days duration each)
Allied Health and Nursing professionals of the project site	As a group for education as per project training plan As a group for specific Postural Care implementation for each client: informal arrangement-varied between weekly to monthly pending on progress of Postural Care implementation Representatives on Project team: meeting fortnightly first half of project and monthly second half of project
Care Workers of the project site especially Postural Care champions	As a group for education as per project training plan As a shift for Postural Care implementation for each client Representatives as Postural Care Champions and Project team members: monthly meetings second half of project

INTERNAL STAKEHOLDERS	ENGAGEMENT
Clients of the project site	1:1 for assessment for Postural Care x 2 Daily implementation of Postural Care for day trials: 10 days Nightly implementation of Postural Care as per plan- ongoing
Manager Residential Aged Care Services (to whom all RACFs managers report to)	As part of the project team to support the Care Manager and to guide the project implementation amongst other workplace changes occurring at the project site Project team member: meeting monthly second half of project
Training and Development department	As a group to develop training plan x 2 Representative on Project steering committee: meeting monthly
Human Resources department	1:1 for support to backfill careworkers as training commences
Care Managers at all Brightwater sites	As a group to keep informed of progress, understand and embrace the change in workforce and model of care for future implementation at their facilities

EXTERNAL STAKEHOLDERS	ENGAGEMENT
Cielle Consultancy	1:1 as per project plan for assessment consultancy, staff training x 4 sessions, client assessment x 4 to support project officer at evaluation stage
HWA Change Manager	1:1 as required for collaboration, regular email and telephone contact, presentations at collaborative workshops, review of interim and final reports
General Practitioners	1:1 for patients that are included in study prior to implementation (letter), communication regarding benefits, post implementation follow up (letter)
The Centre for Cerebral Palsy's 'CP Tech Sleep Clinic'	Peer review as required
Postural Care Tutor	Peer review as required
Aged Care Interest Group (sub group of OT Association Western Australia)	As a group for presentation post project
Sleep Interest Group	As a group for presentation post project

The majority of internal stakeholders formed part of the project team and their details and contributions are listed in Appendix 9.3. An integral part of stakeholder engagement was clear and consistent communication. Refer to Appendix 9.4 for BCG's Communication Plan.

## 3 Project Methodology and Management

### 3.1 Project Type and Methodology

#### **3.1.1 Project Design**

In order to achieve the project objectives:

- Develop and test the adaptability and utilisation of care workers by expanding their existing roles in a Postural Care context,
- Develop and test the increasing collaboration of Nursing, Allied Health and Care Workers with the client where they all contribute to an Interdisciplinary Workforce of Practice in the area of care planning to sustain 24 hour Postural Care, and
- Improve the consistency and sustainability of service delivery to clients

a before and after study over a twelve month period was conducted at one RAC site looking at pre and post quantitative and qualitative measures to identify workforce and service changes as a result of the project activities. The initial intention was to include a second Brightwater RACF as a control comparison site but this was altered to a single subject design. This project scope change was approved by HWA. Refer to section 3.3 for details. This change in project scope did not alter the project's ability to address the research question.

A mixed research design approach was selected to address the project hypotheses and key objectives. Both quantitative and qualitative information was considered essential to address the broad nature of the scope of this project as it involved investigation of staff perceptions and behaviours- the human aspect of the change in practice driven by the project as well as the impact this transition had on workforce and service characteristics. This approach also known as triangulation is viewing from a variety of angles to assist in improving the validity and credibility of the findings<sup>40</sup>. Creswell<sup>41</sup> suggested that a combined research design is advantageous as it enables the researcher to better understand the concept being explored. As this project was exploratory in nature, a mixed design approach was considered the best method design as a purely quantitative or qualitative approach would not completely address the research question.

To illustrate the mixed design approach a number of the data collection methods, data and findings were combined. For example:

- Combined Data Collection - The Care Worker and Therapy Assistant survey was used to produce data to explore the first and second project objectives.

- Combined Data - Job descriptions, duty lists, staff mapping and observations were combined to explore the second project objective.
- Combined Findings – The findings from the competency audit were used to explore objectives one and three.

### **3.1.2 Project Framework**

Program Logic was the framework the project team used to demonstrate design and implementation competence. Using this chain of reasoning to link inputs with results, helped stakeholders achieve shared understanding of the project by providing a common language. Program Logic supports continuous improvement and assists in gap identification as well as providing a basis for robust evaluation and accountability<sup>42</sup>. Utilising the Program Logic framework, the following activities outlines the project approach:

- Establishment of project governance – following BCG’s standard project methodology, a Project Steering Committee was formed, led by the project sponsor who is a senior executive of BCG. This was augmented by the project team. This was supported through tools such as the Project Management Plan and Risk Register.
- Communication channels – engagement of staff, communication, training approach (different levels of training, the development of the course), team meetings; updating the organisation executive, engagement of the clients and their families, GPs and included the use of tools such as flyers, posters, electronic medical records and presentations.
- Training – an essential tool to improve the adaptability of staff and provide the opportunity to utilise their skills. Competencies required were identified and training was developed based on these. (Seatec and Cielle Consultancy developed AQF Certificate IV: Course in Implementation of Postural Care-52295 which is an accredited competency based Postural Care Training Course for Carers registered with the National Training Information Service which will be implemented in this project. This framework from which Postural Care training can be delivered evolved due to the need to implement this internationally acknowledged material in an Australian context). In order to develop this unit, a Postural Care Reference Group (industry wide group) was formed to facilitate the development of the competency based accredited course which had representation from both clinical and training sectors.
- Development and implementation of an Interdisciplinary Workforce Model Practice using 24 Hour Postural Care as an example. Tools included: Orchard’s Interdisciplinary Model of Practice, analysis and review process, development of ‘Postural Care champions’ (to

embed and support the Postural care training conducted), Change Management process (including explaining the benefits of interdisciplinary teams and 24 hour Postural Care, positive experiences elsewhere, support available during the project to staff to facilitate ongoing enthusiasm for the project, opportunities provided to raise concerns and so on), maps of tasks and competencies of staff (pre and post project implementation to demonstrate the embedding of the Interdisciplinary Model).

- Evaluation consisted of data sources Qualitative tools, Quantitative tools and Clinical assessments. These are further explored in section 3.1.3.
- Action learning through Plan Do Study Act (PDSA)<sup>43</sup> cycles was also part of the project methodology to review the workforce changes being developed and tested and adjusted as necessary.

The outputs, strategies and short term outcomes are further explored in Section 4. Medium and long term outcomes were beyond the scope of this 12 month project. Refer to the Program Logic process adapted for this project in Appendix 9.5.

### **3.1.3 Evaluation or Data Collection Tools and Methods**

The project demanded a large and diverse range of data collection tools and methods. Existing tools and resources were utilised where possible and some were developed specifically for the project (for example the Care Worker and Therapy Assistant survey). Tables 2 and 3 lists the data collection tools/methods used and a brief description of how the tool/methods were used. These tools were used to obtain the 42 evaluation measures which are detailed in Appendix 9.6.

*Table 2: QUANTITATIVE MEASURES*

<b>Tool/method</b>	<b>Description</b>
Competency audit	Competent or not competent (nominal scale) based on criteria set by Australian Quality Framework (AQF). Completed by Seatec staff with AQF: Certificate IV Training and Assessment competency following training by Seatec staff. This data item has high inter and intra-rater reliability.
Allied Health and Nursing survey	Developed specifically for project, containing questions presented in a 5-point Likert scale (nominal scale), multiple choice questions (nominal scale) and open-ended questions. Refer to Appendix 9.7 for baseline and final evaluation versions of survey.
Care Worker and Therapy	Developed specifically for project, containing questions presented in a 5-point Likert scale (nominal scale), multiple choice questions (nominal scale) and open-ended

Tool/method	Description
Assistant survey	questions. Refer to Appendix 9.8 for baseline and final evaluation versions of survey.
Team Development Measure	Survey containing 5-point Likert scale (nominal scale) questions producing an interval score representative of team development <sup>44</sup> . This measure was completed by members of the Project team anonymously in order to minimise respondent bias to please the researcher by providing responses they think the researcher wants.
Resident Records	iCare (BCG's electronic client records system) referrals, progress notes, forms and charts. Utilised to identify team processes and client outcomes.
Care Plans	Quantity of BCG Postural Care Plans developed and implemented collected (ratio scale).
HR indicators	Staff classification levels, numbers and salary, cost of training, agency staff costs, staff turnover, new staff numbers, absenteeism obtained from BCG HR department.
OH& S data	Number of critical incidents obtained from BCG OH & S department.
Finance report	Cost of implementing project obtained from BCG finance department.
Staff duty lists	Used in collaboration with job descriptions, staff mapping and observations to explore the role of staff. Obtained from RACF administration.
Staff job descriptions	Used in collaboration with duty lists, staff mapping and observations to explore the role of staff. Obtained from RACF administration.
Modified Barthel Index (MBI)	Interval scale (0-100) of client observed performance in Activities of Daily Living. MBI completed by site staff specific for project.
ACFI funding instrument	Identifies care needs as a basis for funding allocation. Consists of 12 questions (nominal, ratio scales) and 2 diagnosis questions. Completed by site staff.
Australian Therapy Outcome Measures (AusTOMs - Physiotherapy version)	The AusTOMs is an outcome measure (nominal scale) consisting of 9 scales of which 4 were used for the purpose of this project. It is considered a subjective tool as the Physiotherapist (PT) completes the assessment based on their observations. The assessments were completed by the site PT therefore inter-rater reliability was improved. The AusTOMs was considered to be potentially a more sensitive measure of function compared to the MBI and indication of pain compared to the Abbey Pain Scale already used by the site.
Waterlow Scale	Pressure scale obtained from iCare forms (interval scale). Completed by site staff.
Night-Time Positioning Assessment	A measure used to assess the postural outcomes which Postural Care is intended to influence. The reliability of this measure is dependent on the assessors' skill in assessment and the presentation of the client during assessment. All assessors possess expertise in administration of this assessment and each assessment was completed by 2 trained assessors to improve the reliability of the results.
Pulse Oximeter	A valid measure used to collect data on client heart rate and oxygen saturation levels before and during use of Postural Care to assess level of client comfort. Reliability of measure is dependent on accuracy of device and staffs ability to read and record results

Tool/method	Description
	accurately. Observations were taken over 3 nights and the average recorded in attempt to improve reliability and to minimise the impact of any acute events the client may be experiencing at the time.
Thermometer	A valid measure used to collect temperature reading before and during use of Postural Care to assess level of client comfort. Reliability of measure is dependent on accuracy of device and staff's ability to read and record results accurately. Observations were taken over 3 nights and the average recorded in attempt to improve reliability and to minimise the impact of any acute events the client may be experiencing at the time.

Significance level for quantitative data set at 0.05.

*Table 3: QUALITATIVE MEASURES*

Tool/method	Description
Allied Health and Nursing survey	Developed specifically for project, containing questions presented in a 5-point Likert scale (nominal scale), multiple choice questions (nominal scale) and open-ended questions.
Care Worker and Therapy Assistant survey	Developed specifically for project, containing questions presented in a 5-point Likert scale (nominal scale), multiple choice questions (nominal scale) and open-ended questions.
Focus groups	Three separate focus groups included the project team, Postural Care Champions and BCG specialist Allied Health team (Seatec), and support staff. Focus groups held throughout project in response to project activities.
Staff mapping and observations	Team communication, behaviours and processes recorded and interpreted by two researchers throughout project. Process mapping discussed with project team to improve validity.
Night-time Positioning Assessment (Cielle Consultancy Pty Ltd)	All assessors possessed previous training to complete this assessment. Two components of the assessment required subjective observations by the assessor. Reliability of observations were increased by having two trained assessors completing each Night-time Positioning Assessment.

The project team determined the most appropriate assessment tools and methods which could be conducted within the time frame and resource allocation provided by the funding body, Health Workforce Australia (HWA). In addition, HWA set some common measures that all projects needed to report on (e.g. ACFI, MBI, OSH). These common measures were included in the overall evaluation measures (Appendix 9.6) and also detailed separately in Appendix 9.9.

There was concern on the behalf of the project team that the client assessments selected by HWA (the ACFI and MBI) were not considered sensitive enough to detect the changes Postural Care is intended to make. The AusTOMS was selected as a data tool as it has greater content validity than the ACFI and MBI. The chosen scales of the AusTOMS used for analysis specifically assessed balance and postural control, musculoskeletal movement, neurological movement and pain. It was felt that gains through Postural Care would be captured more so in the AusTOMS than the ACFI and MBI which assess functional performance only and does not evaluate impairment, activity limitation, participation restriction and distress/wellbeing. The Night-time Positioning Assessment was selected by the project team as the most appropriate tool to measure the impact of Postural Care on a client's posture and was considered to have content validity.

Validity of qualitative data was addressed through records of observations and focus group discussions, meetings minutes, keeping a project journal and engagement of various samples representative of the target population. The project design is considered to have high external validity in it's applicability of the project results to the wider RAC population. However the strength of the projects external validity will greatly depend on its internal validity<sup>39</sup>, which is further discussed in section 3.1.4. The reliability of data collection was addressed where possible. Assessors for the competency audit and Night-time Positioning Assessment had previous training in the assessments therefore improving inter and intra-rater reliability. Instructions for use of the thermometer and pulse oximeter were provided to address reliability of these results. In relation to the surveys used in the study bias in survey design is acknowledged<sup>39</sup>. In the development of the Care Worker and Therapy Assistant and Allied Health and Nursing surveys questions were designed in both a positive and negative format to address respondent bias to 'please' to researcher. The surveys were reviewed by Brightwaters HR department to further address researcher bias in survey questions. Surveys were complete autonomously to address respondent bias. As stated previously, data items were combined to address credibility of results (Refer to Appendix 9.6 for combination of data items). Survey results were compared with results from process mapping, observations and focus groups and demonstrate concurrent validity.

### **3.1.4 Sample Groups**

Care Workers, Therapy Assistants, Nursing staff and Allied Health staff at the project site represented their discipline populations and participated in baseline, midway (where applicable) and final evaluations. In addition to these discipline samples the site Managers and Seatec therapists were used as sample groups to represent Management and Clinical consultants. A sub-sample of Postural Care Champions consisting of three Care Workers and one Therapy Assistant were utilised to represent the direct care staff group and were involved in ongoing

communication with the Project Officer to address change management issues on site. The project design is able to establish a standard of internal validity as sample groups are reflective of the sample population under study and in turn strengthens external validity.

In order to select the sample of clients most suitable to receive Postural Care, all disciplines were consulted including Care Workers. Each client was reviewed for suitability using a Postural Care checklist (Refer to Appendix 9.10). Eight clients were selected from across the four houses at the project RACF therefore enabling exposure to implementation of Postural Care from all staff via an interdisciplinary model. A client sample size of eight was considered large enough to demonstrate benefits but small enough to be able to incorporate 'Expert patient' philosophies, be closely monitored, comprehensively evaluated and managed on the funding and resources available. Feedback from organisations and staff who have used Postural Care in the care of younger disabled people have confirmed that benefits can be seen and evaluated with the number of clients nominated in this project.

### **3.1.5 Ethics Approval**

Ethics approval was not required for this project as Postural Care was deemed to be an existing clinical application within the organisation's current scope of practice. However all clients and families were involved in the consultation and engagement process (refer to Communication Plan, Appendix 9.4).

## **3.2 Project and Risk Management**

Table 4 overleaf outlines the key project activities and their broad timeframes, key resources involved with these activities and what was actually delivered. Also included are the key risks together with strategies used to manage those risks. For further detail, please refer to Appendix 9.4 for the project's Communication Plan, Appendix 9.11 for the Project Schedule and Appendix 9.12 for the Risk Register.

Table 4: Activities and Risk Management

Project Activity	Key Resources	Deliverables	Key Risks	Risk Management Strategy
Project establishment (approx 2 month duration)	PSG Project manager Project officer	- Project Plan - Communication Plan - Project Risk Register	Activities will consume too much time for the strict 12 month time frame	Commence some activities prior to commencement of the official project e.g. establishment of PSC and project team, meetings scheduled, identification of project officer and the RACF
Stakeholder engagement (throughout the entire project)	PSG Project manager Project officer	- Communication Plan (refer Appendix 9.3)	- Resistance to change  - Lack of ongoing commitment	- Early, clear communication to staff - Various communication methods to keep stakeholders informed and engaged - Ensure senior staff closely involved in the project to provide leadership
Baseline evaluation (approx 1 month duration)	Project team Project officer Staff at RACF RACF clients	- Baseline process and role mapping; staff and client evaluation measures and surveys; - Baseline HR data - Literature review - Hypothetical interdisciplinary model	- Unable to identify appropriate model - Measures not sufficient	- Review of literature on ID models early in project - Peer review of measures and additional components included to ensure as many denominators covered as possible
Staff Training (approx 1 month duration)	Project officer Project team RACF roster clerk	- Training Program - Number of training sessions - Training evaluations - Competency assessments	Not all staff are able to attend training	- Innovative methods employed to ensure all available staff trained - Backfill for all staff training included in project budget - Additional training sessions to capture new/absent staff
Implementation Phase (approx 6 months duration)	Project officer Project team Project manager PSG RACF	- PDSA cycles and associated changes - Interim HWA Project report - Updated literature review	- Lack of ongoing commitment - Allied Health and Nursing staff reluctant to “hand over” responsibilities	- Refer to stakeholder engagement strategies above - Project officer regularly on site at the RACF to support staff and ensure consistent and maintained application of new skills and model of working.

Project Activity	Key Resources	Deliverables	Key Risks	Risk Management Strategy
	Manager		- Inability of chosen RACF residents to be involved along project length	- Promotion of more effective utilisation of expertise. - Identify more residents at the beginning of the project than the 8 residents required for the project sample group i.e. “standby” residents.
Final Evaluation Phase (approx 1 month duration)	Project team Project officer Staff at RACF RACF clients	- Final process and role mapping - Final staff surveys - Final client evaluation measures - Final HR data - Revised interdisciplinary model	- Resident attrition  - Assessors not available	- Additional residents suitable for PC identified earlier in project to be quickly assessed and incorporated as soon as possible (see above) - Several assessors involved so contingencies available (would impact on inter rater reliability though)
Analysis and creation of Final Report (approx 1 month duration)	Project manager Project officer Project team PSG	Final report (including case study)	Sufficient time to create and review and amend	- Time allocated in project plan for this work - Reminders to key resources involved
Dissemination of project results	Project manager	Presentation at appropriate conference such as Better Practice Conferences or Australian Centre for Evidence Based Aged Care.	Unlikely to be able to be achieved in the project’s 12 month timeframe	BCG has committed to dissemination of the project results after the project has closed.

Other factors that positively influenced or promoted achievement of the project objectives, together with strategies used are tabulated below.

Table 5: Project Influencing Factors

Project Objective	Influencing Factor (+)	Strategy
To increase the adaptability of staff by extending the existing roles of Care Workers within an Interdisciplinary Workforce Model of Practice.	<ul style="list-style-type: none"> <li>• Care workers inspired to increase their adaptability within their roles.</li> <li>• Increased numbers of Certificate IV Training and Assessment qualified staff to support training requirements for care workers.</li> <li>• Accredited Postural Care course for carers (acknowledges skill acquisition).</li> <li>• Development of appropriate evaluation documentation.</li> </ul>	<ul style="list-style-type: none"> <li>• Marketing/promotion of project to spark interest in the topic and minimise 'fear of unknown'.</li> <li>• Use of 'success' stories from other applications of Postural Care</li> <li>• Recognised qualification to assist with career development or future study</li> </ul>
To develop an Interdisciplinary Workforce Model (IDM) of Practice with increased collaboration of Nursing, Allied Health and Care Workers	<ul style="list-style-type: none"> <li>• Increased numbers of staff involved in development of Interdisciplinary Model of Practice.</li> <li>• Early engagement with involved staff to explain objectives and benefits, support available, opportunity to raise concerns.</li> <li>• Support for project facility by site senior and middle management.</li> <li>• Development of appropriate evaluation documentation and indicators.</li> </ul>	<ul style="list-style-type: none"> <li>• Active involvement of these staff in the Project Team to assist with Model formulation, evaluation and refinement.</li> <li>• Selected site champions who were well respected and developed their expertise to buddy others.</li> <li>• Adopted a cascade approach so consistent information was provided at all levels.</li> <li>• Supported energy and enthusiasm with immediate response to queries and issues so as to maintain 'flow'.</li> <li>• Capture appropriate data so can determine that an ID Model approach to services ie Postural Care is cost effective in the high-care residential aged care sector - ie "Good care is good for business".</li> </ul>
To improve client outcomes through the increase of client engagement	<ul style="list-style-type: none"> <li>• Development of appropriate evaluation documentation.</li> </ul>	<ul style="list-style-type: none"> <li>• Involve clients as 'Expert patients' where possible, external consultant, residents and/or families as well as facility staff in the development to ensure the appropriate questions are asked and there is 'buy-in' to the process.</li> </ul>

### 3.3 Project Resources and Budget

Table 6 overleaf outlines the approved project budget. The HWA CfOP program funded \$104,215 (ex GST). BCG initially estimated approximately \$75,000 contribution to the project. As the project evolved, BCG's contribution became significantly higher due to the involvement of 2 senior project staff in CfOP collaborative work (including 5 workshops in Melbourne and numerous teleconferences). This, coupled with the greater than anticipated costs of supporting the change management at the project facility, resulted in Brightwater's final contribution to the project to be estimated at \$115,000. If it were not for the goodwill of the organisation to absorb these costs, the project could have ceased at the midway point. It is a key organisational learning not to underestimate the costs of implementing workforce change management.

The project team initially intended to do a comparison study between the implementation facility and a facility with similar demographics. However, when it became apparent that the amount of time and resources required to evaluate a comparison site would be beyond the funding available a scope change was requested to do a before and after study at one RACF. This was approved by HWA. The use of a single subject design was considered sufficient to examine changes in the clients and workforce in order to explore the objectives with the budget and resources available.

There were no variations to the project's funding agreement with HWA. Refer to Appendix 9.13 for the project's final budget report.

Table 6: Project Budget

Resources	HWA Contribution	BCG Contribution
<b>Salary &amp; wage related items</b> <ul style="list-style-type: none"> <li>0.4 FTE Project Officer</li> <li>Expert External Consultancy</li> <li>Backfill and training for/of all 90 project site staff (Nursing, Allied Health and Care Workers).</li> </ul>	<b>Salary &amp; wage costs</b> <ul style="list-style-type: none"> <li>\$42,015</li> <li>\$16,500</li> <li>\$35,100</li> <li><b>Subtotal \$93,615</b></li> </ul>	
<b>Goods and services operating items</b> <ul style="list-style-type: none"> <li>X2 Postural kits for demonstration project</li> <li>Motor vehicle expenses</li> <li>Incidentals</li> <li>Conference travel and accommodation expenses for one person</li> <li>Certificate IV Train the Trainer courses.</li> </ul>	<b>Goods &amp; services cost</b> <ul style="list-style-type: none"> <li>\$5,200</li> <li>\$500</li> <li>\$1,800</li> <li>\$1,500</li> <li>\$1,600</li> <li><b>Subtotal \$10,600</b></li> </ul>	
<ul style="list-style-type: none"> <li>Development of a 2-day Postural Care Training Course for Carers accredited through NTIS</li> <li>Implementation of training (staff time and resources)</li> <li>6 Postural kits</li> <li>Support of implementation of Postural care on site (Seatec staff time)</li> <li>Provision of project sponsor time and effort.</li> <li>Provision of project manager time and effort.</li> <li>Time for Human Resources and Training and Development staff to assist with development of training package and staff survey.</li> <li>Provision of office space, computer, phone and printer for project officer.</li> <li>Provision of office space, computer, phone and printer for external consultant.</li> <li>Provision of training facilities and equipment.</li> <li>Transportation for training including driver</li> </ul>		<ul style="list-style-type: none"> <li>\$28,700</li> <li>\$18,865</li> <li>\$15,491</li> <li>\$6,931</li> <li>\$2,900</li> <li>\$26,100</li> <li>\$2,750</li> <li>\$5,200</li> <li>\$500</li> <li>\$3,600</li> <li>\$3,629</li> </ul>
<b>Total project funding</b>	<b>\$104,215 (ex GST )</b>	<b>\$114,666 (ex GST)</b>

## 4. Project Results

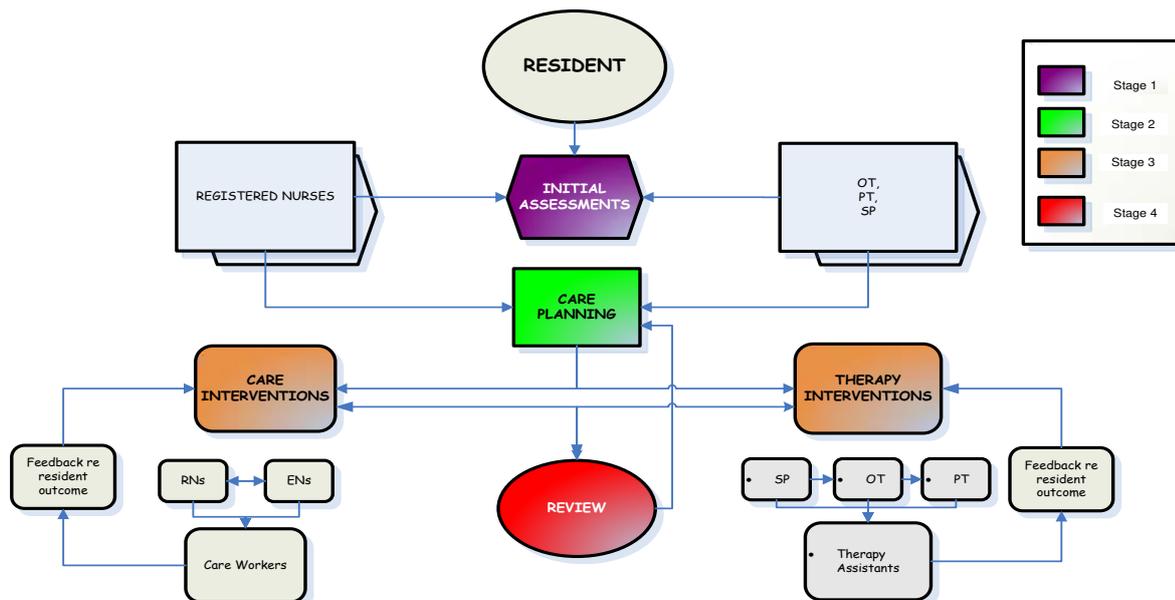
### 4.1 Phase 1 – Project Setup

As highlighted in section 3.1, it was vital to have effective project establishment and engagement with each project activity carefully planned and executed to optimise participant involvement and ownership of the process.

#### 4.1.1 Initial Process

As part of the initial preparation, the baseline workforce (current scope of practice) and client framework needed to be determined. The hierarchy at the project site was documented (refer to Appendix 9.14 for details) as this clearly demonstrated how the traditional ‘silo based’ multidisciplinary team approach has maintained its status quo. This was followed by a workshop whereby the baseline process for client interventions were mapped (Refer to Appendix 9.15 for the map of the client journey detailing different staff functions). As demonstrated in Figure 2, this clearly shows the demarcations of interventions according to ‘care’ or ‘therapy’.

FIGURE 2: CURRENT PROCESS FOR RESIDENT INTERVENTIONS



RN: Registered Nurse EN: Enrolled Nurse OT: Occupational Therapist PT: Physiotherapist SP: Speech Pathologist

The baseline process map was reviewed to determine gaps/problems that had the potential to hinder collaborative and integrative decision making. Problems identified with the current process started with the initial assessment phase. When a client moved into the care facility, Nursing and Allied Health staff completed their individual assessments independently. The individual assessment results were then directly fed into the iCare (BCG's electronic health records system) and Care Plans formulated from this. As the Care Plans are automatically generated from this assessment data, it potentially would contain conflicting information from different disciplines which was of great concern for the direct care staff implementing the Care Plan and the client in receipt of variable care practices<sup>45,46</sup>. There was no process whereby the different disciplines congregated to discuss their findings and in an integrated fashion with the client, develop a client's Care Plan. Although sharing of information may have occurred during informal communication (i.e. hallway conversations or via email) Nursing and Allied Health staff did not get together to pool their findings. In addition, direct care staff were not given the opportunity to report their experiences of caring for the client during this initial care phase. As a result Care Plans did not include input from all disciplines.

Once the Care Plan was developed and put into action, the minimal communication between team members diminished further as Nursing and Care staff, and Allied Health and the Therapy Assistants go along their usual practice. Care Workers tended to provide feedback to Nursing staff and Therapy Assistants provided feedback to Allied Health staff. Sharing of information between these two groups was sparse. Any sharing of information occurred as a direct result of an individual staff member seeking or providing information.

In the Review phase (stage 4 in Figure 2), the same problems and implications were identified as per the initial assessment phase. The process then goes back to the Care Planning phase (stage 2) every 6 months or as clinically indicated.

A major issue identified in this exercise was the lack of structured processes which allowed representatives from all staff groups to congregate to share information and make decisions together. There is a clear two-tiered 'silo' structure. Nursing and Allied Health staff do meet briefly on a daily basis at the "10min at 10.30am" meeting to discuss any significant changes in client care. This meeting did not involve Care Workers or Therapy Assistants. The direct care staff was not given an opportunity to provide feedback of their experiences providing care to clients or contribute to a clients Care Plan unless the result of a HCP seeking feedback form Care Workers for their individual discipline assessment.

Another issue identified in this mapping exercise was reliance on informal methods of communication such as the use of a communication book. It was the responsibility of all staff to

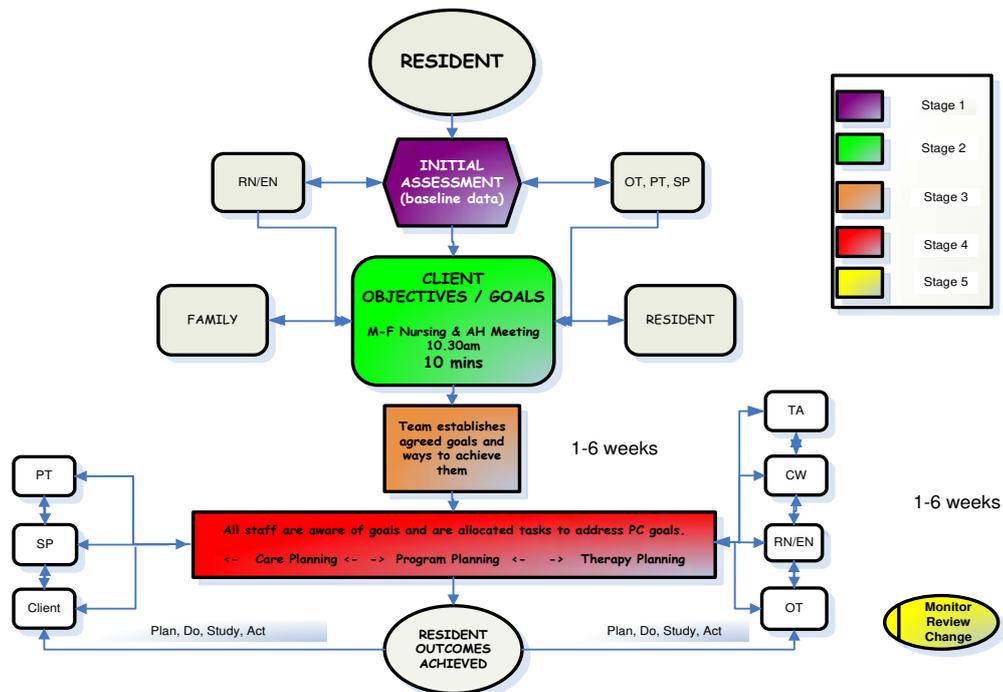
check the communication book at the beginning of every shift for any new and important information regarding clients. All staff were able to provide feedback through this communication book but this generally occurred by Nursing or Allied Health staff who provided updates or highlighted recommendations in client care. Feedback from Care Workers was rarely found in the communication book. 'Conversational communication' on site was a concern as care staff would work in any of the residential houses across the site so care staff were consistently working with different people. As a result care staff experienced difficulty developing trust and understanding of how to communicate with a large number of other care workers (and this was further impounded by variable English speaking and comprehension skills within this sample population). The part-time hours Allied Health staff work also limited the opportunity for Nursing and Care Worker staff to directly communicate with them.

#### **4.1.2 Proposed Process**

By reflecting on this 'silo' based multidisciplinary approach currently happening at the project site, Orchard's Inter-disciplinary Workforce Model of Practice and the World Health Organisation commitment to Interdisciplinary learning and practice, as well as the project objectives, the project team completed another mapping session to develop a vision of what the site process could be (refer to Figure 3 overleaf).

What was proposed was a single stream process by which all disciplines, the client and/or the client's family/significant other were given the opportunity to contribute to the client's Care Plan. At the initial assessment phase all disciplines completed their assessments. This information was then pooled together along with the views/preferences of the client and/or family/significant other to determine what the client wishes were and how best to achieve them. As in interim strategy it was proposed that staff met at the 10min at 10.30am meeting to confirm the client's goals and how to meet them, as the site did not meet formally to discuss Care Plans. Following this, a Care Plan was developed for care staff to implement based on this collaboration. Postural Care was intended to be included in the Therapy program for Therapy Assistants to implement Postural Care as programmed. Care Workers were to be advised when Postural Care was included in the Therapy program as this would impact on their daily duties.

**FIGURE 3: PROPOSED PROCESS FOR RESIDENT INTERVENTIONS**



RN: Registered Nurse EN: Enrolled Nurse OT: Occupational Therapist PT: Physiotherapist SP: Speech Pathologist CW: Care Worker TA: Therapy Assistant

During the implementation phase (stage 4) all staff were to report any concerns/comments in the communication book so that all team members are informed. The 10min at 10.30am meeting was to be used to discuss concerns/comments. A representative Care Worker was to attend these meetings. It was agreed that this should be one of the Postural Care Champions on a rotational basis (3 Care Workers and 1 Therapy Assistant).

Every 6 months or when clinically indicated, client outcomes were to be evaluated with all the disciplines input and the client and family/significant others perspective to determine if the clients goals have changed and how best to meet them. Care Plans and Therapy programmes were to be modified accordingly and the cycle continued through stage 4 and 5 outlined in Figure 3.

Refer to Appendix 9.16 for map of the proposed client journey which identifies required staff functions. This map was re-examined as part of the evaluation process and refined according to the results obtained.

### **4.1.3 Evaluation**

The project evaluation was developed across three main areas:

- Workforce
- Client
- Postural Care

The evaluation measures were tabulated (refer to Appendix 9.6 for the full evaluation table detailing baseline, midway and final data) to ensure there were sufficient components to address the three areas under investigation and sufficient mix of qualitative and quantitative components. Forty two measures were evaluated in total and these included HWA’s CfOP program common data measures (refer to Appendix 9.9).

### **Workforce Baseline**

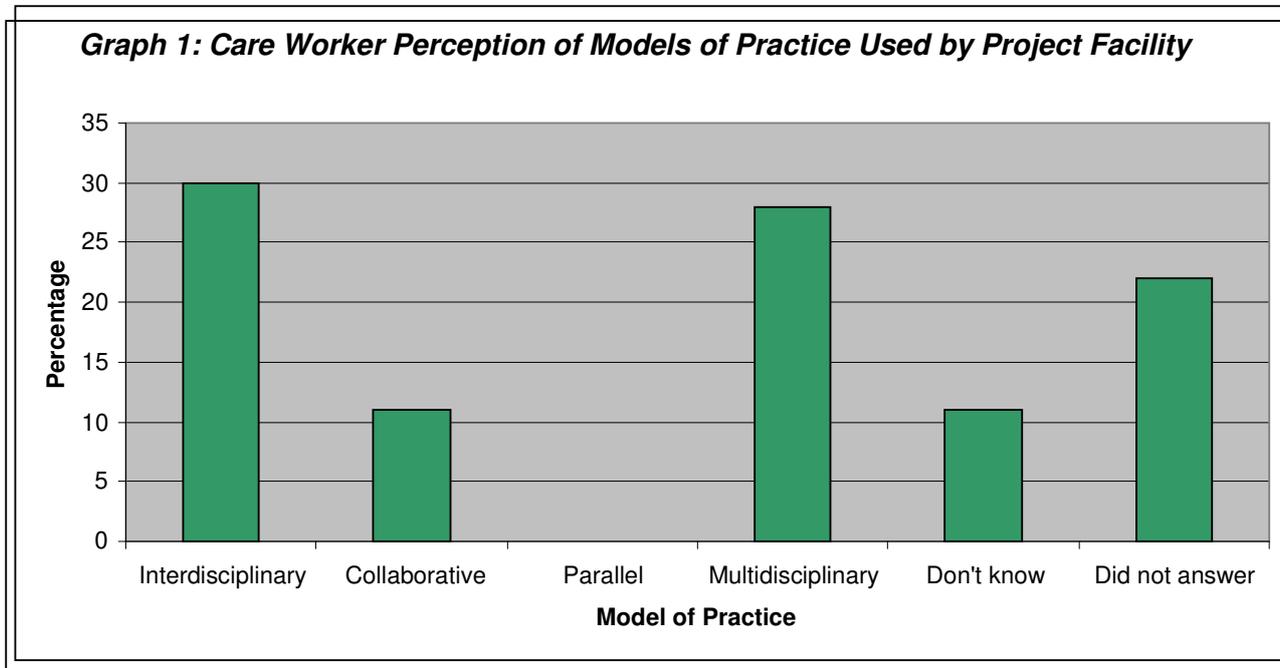
Prior to the commencement of the project the RACF consisted of the following staff groups:

*Table 7: Staff headcount*

Discipline type	Care Worker	Enrolled Nurse	Registered Nurse	Care Manager	Deputy Care Manager	Administration	Allied Health (Including Therapy Assistants)	Total
# of discipline	53	9	12	1	1	15	9	100

In regards to the Care Worker and Therapy Assistant staff population (Sample A: 57 staff, survey return rate 92%) 90.2% indicated ‘*they enjoyed working at the project facility*’ and of these 51.2% indicated ‘*they really enjoyed working there*’.

Care Worker and Therapy Assistants were questioned regarding their understanding of what type of model of practice the project facility used through a survey question (multiple choice). The results are illustrated in Graph 1 overleaf.



It was concluded that this sample of Care Workers and Therapy Assistants (Sample A) did not fully understand the concept of Models of Practice in the context in which the question was presented and this would need to be clarified during the project.

Additional baseline information collected included agency costs, net staff turnover, absenteeism, staff activity related to Postural Care, critical incidences and staff satisfaction. Refer to Appendix 9.6 for details. This information was used for comparison to midway and/or final evaluations.

### **Client Baseline**

The clients were assessed in terms of the average functioning score (ACFI, MBI, AusTOMS-PT), lying posture and joint ranges, presence of pain, Waterlow pressure score, number and severity of pressure areas, interventions received overnight and vital observations. The participating clients could be described as 'low functioning with high care needs' (total ACFI score range: 154.02-189.3; MBI score range: 0-6/100). The participating clients had asymmetrical postures, varying degrees of hypertonicity and limited hip and knee joint ranges. According to the AusTOMS-PT pain impairment scores ranged from 1-4, and activity limitation ranged from 0-1. The participating clients had high to very high Waterlow pressure risk scores but did not have any existing pressure areas. Four out of eight of the clients had mattress overlays in use and all the clients were repositioned every 2-4 hours as part of their pressure management plan. In terms of overnight

interventions not only were clients being repositioned every 2-4 hours, but their continence pads were checked and changed if needed at 10pm, 2am and 5am. Clients were also checked on every hour. Due to the number of overnight interventions it can be concluded that the participating residents were not in receipt of a good nights rest and suffered symptoms of sleep deprivation ie, decreased alertness and reduced immune system functioning and so forth. Finally basic nursing observations (heart rate, oxygen saturation level and temperature) were taken to use as a comparison to determine if the resident was comfortable when set up with Postural Care supports later in the project.

### **Postural Care Baseline**

As illustrated in Table 8 below, it was identified that the site was not equipped to provide Postural Care from a human resources or interdisciplinary perspective. The RACF possessed only one Postural Care kit and the staff did not have any training in Postural Care so the site was not positioned to provide a Postural Care service. Prior to the start of the project Allied Health staff was the only discipline aware of Postural Care concepts. Only one resident had a Postural Care Plan which was not developed in an interdisciplinary manner and was not implemented successfully (ie not implemented to required standard or on a daily basis).

*Table 8: Postural Care Baseline*

Table 8: Postural Care Baseline					
Discipline type		Care worker / Enrolled nurse	Registered nurse	Therapy assistant	Allied health
<b>Prior training in Postural care</b>		0	0	0	1 (PT)
<b>Competency in Postural care</b>		0	0	0	0
<b>Roles and responsibility in Postural Care (in the only prior Postural Care intervention)</b>	<b>Identification</b>	0%	0%	0%	100%
	<b>Assessment</b>	0%	0%	0%	100%
	<b>Trial</b>	0%	0%	0%	100%
	<b>Implementation</b>	0%	0%	0%	100%
	<b>Review</b>	0%	0%	0%	100%

Table 9 illustrates the tasks/duties performed by Care Workers that have a direct relationship to Postural Care prior to project commencement. It reflects the baseline status of the facility with a high work force load and the negative impact on client wellbeing due to disrupted sleep.

*Table 9: Tasks/duties performed by Care workers related to Postural Care*

4am – 9am	9am– 1pm	1pm- 8pm	8pm-4am
<ul style="list-style-type: none"> <li>• Remove soiled linen and place in linen bin</li> <li>• Make bed</li> <li>• Contenance check and pad change if required</li> </ul>	<ul style="list-style-type: none"> <li>• 2-4 hourly repositioning</li> </ul>	<ul style="list-style-type: none"> <li>• 2-4 hourly repositioning</li> <li>• Contenance check and pad change if required</li> </ul>	<ul style="list-style-type: none"> <li>• 2-4 hourly repositioning</li> <li>• Contenance pad check/change 10pm</li> <li>• Contenance pad check/change 2am</li> </ul>

In summary, the baseline data confirmed that a Multidisciplinary Model of Practice was primarily used at the facility. Workforce, client and Postural Care data will be collated and compared to this baseline data during phase two.

## 4.2 Phase Two - Project Testing - Results and Achievements

The most significant achievement of this project was expanding the role of the Care Worker to include implementation of Postural Care at the RACF to a required standard (Project Objective 1). The development of a competency based training course in Implementation of Postural Care and accreditation to Certificate IV level was a critical success factor. The successful implementation of Postural Care at the project facility for eight clients was a subsequent outcome. The most valuable lesson learnt during this project was related to workforce change/development. The project has achieved emerging understanding and acceptance of an Interdisciplinary Model of Practice but complete workforce change is not achievable with a single intervention such as Postural Care or within a twelve month timeframe. Facilitating change in workforce culture/practice will not be transferrable to all other areas of practice without significant support, resources and change management expertise.

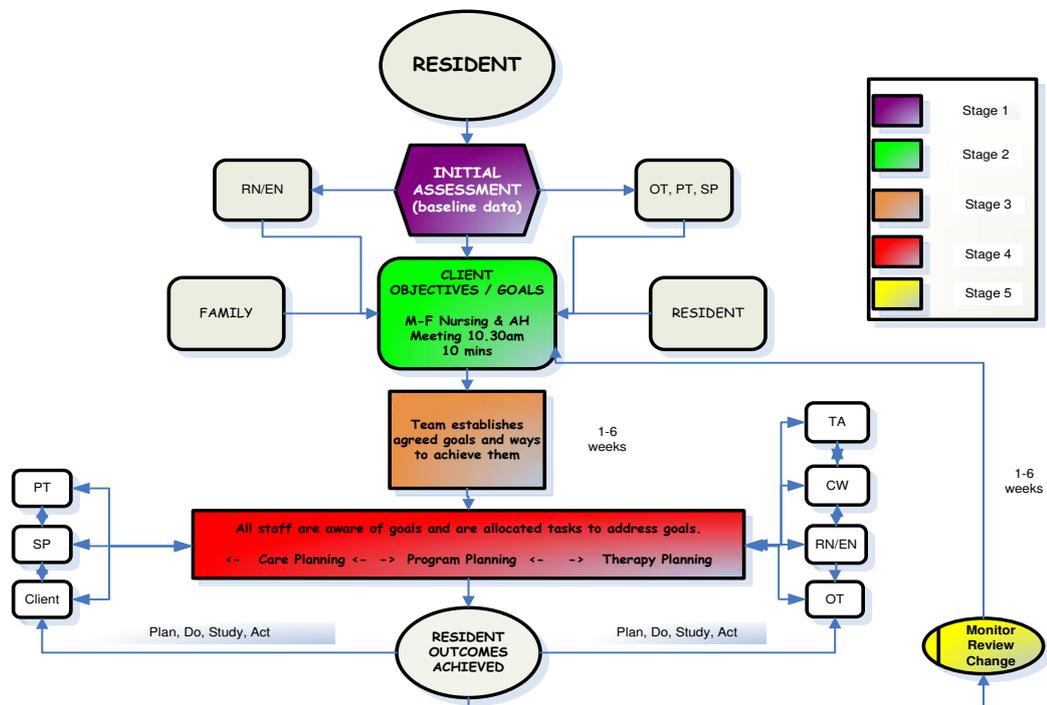
## 4.2.1 Workforce Evaluation

### Facility Level

The project team completed a final mapping session to review the proposed vision of the site process (refer to Figure 3 in section 3). This proposed vision remained largely unchanged with the exception of providing a single stream process by which all team members were accountable to each other therefore the mapping of the client's journey was not repeated. Feedback was to be provided to all team members and the team shared a common goal - the client's goal(s). All disciplines were to be represented at the 10min at 10.30am meeting enabling input from all team members' perspectives. Refer to Figure 4 below for the revised site process map.

REVISED:

FIGURE 4: PROPOSED PROCESS FOR RESIDENT INTERVENTIONS



RN: Registered Nurse EN: Enrolled Nurse OT: Occupational Therapist PT: Physiotherapist SP: Speech Pathologist  
CW: Care Worker TA: Therapy Assistant

Referring to Figure 4, Stages two-five were implemented during the project. The project activities commenced from Stage 2 as no new clients outside the project were assessed for Postural Care. Stage four was implemented with all disciplines engaging in regular communication about Postural Care. An additional arrow was added to the diagram to more clearly illustrate how Stage 5 fitted into the process and to indicate the cyclic nature of the process. At the end of project implementation, a Postural Care Champion was to attend the 10min at 10.30am meeting to discuss issues/concerns with Postural Care. This change activity is yet to be implemented successfully as a Postural Care Champion is not regularly attending the meetings. This is explored further in section 5.

No significant change attributable to this project was evident in net staff turnover, absenteeism, agency cost, staff levels, numbers and hours worked.

Incidentally, the Safety and Health measures indicated the Medical Treatment Injury Frequency Rate (MTIFR) has significantly been reduced (ie injuries requiring medical treatment are occurring less frequently at the conclusion of the project compared with the start). The Lost Time Injury Frequency Rate (LTIFR) has also been reduced (ie injuries requiring recovery time away from work is also occurring less frequently at the conclusion of the project compared with the start). MTIFR was statistically significant but the LTIFR was not (significance set at 5%). Serious Injury Frequency Rate is the summation of MTIFR and LTIFR and showed a significant decrease in the frequency of serious injuries at the conclusion of the project. However, these measures cannot be attributed solely to the introduction of Postural Care due to the likelihood of other confounding factors outside of the scope of the project.

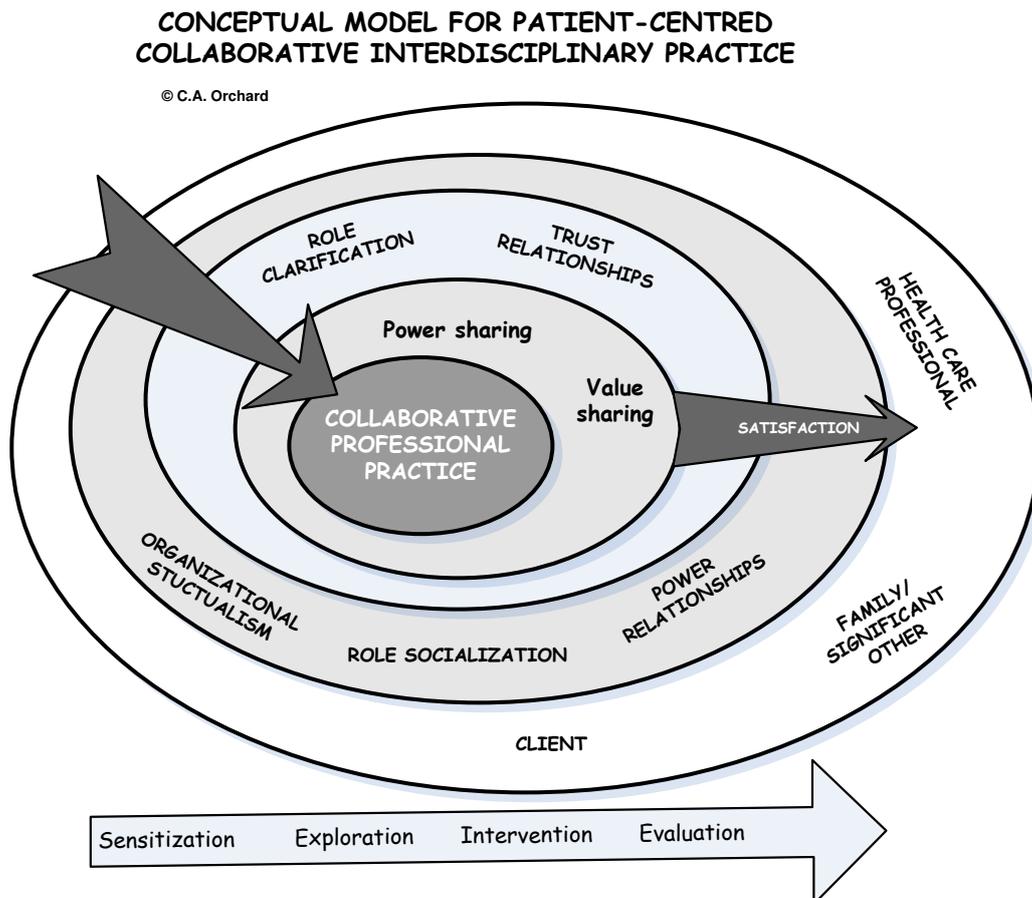
At the start of the project an Allied Health staff member reported they were “hesitant to relinquish their control” over Postural Care but also acknowledged they were unable to provide Postural Care successfully themselves. This same staff member reported at the end of the project having seen the benefits for residents receiving Postural Care and the fact that Postural Care was being implemented successfully made them feel more confident to share the control/responsibility of Postural Care with other staff members.

Based on observations of the project RACF team, Allied Health team members have accepted shared roles and responsibilities regarding Postural Care more so than Nursing staff. Nursing staff were initially, and to a lesser extent, still are reluctant to move away from traditional practices and enable trained Care Workers to take the lead when implementing Postural Care. Based on these observations it was identified that Nursing staff would have benefited from further education on Interdisciplinary practice and their role in supporting Care Workers to take ownership and responsibility to implement Postural Care.

**Interdisciplinary Level**

The project team also completed a session to review the applicability of Orchard’s Conceptual Model for Patient-Centred Collaborative Interdisciplinary Practice. The changes Orchard proposed a team needs to go through in order to develop into an Interdisciplinary collaborative team was experienced by the team at the project facility. Reflecting on the diagrammatic version of Orchard’s model, the project team were concerned that the client was not clearly indicated as the focus of the model. Orchard intended the patient to be apart of the team and not the center of the model<sup>14</sup>. Therefore to represent the team which is inclusive of the client, the only recommended adjustment to Orchard’s Patient-Centered Collaborative Interdisciplinary Practice model was to add another outer circle representing the team. This adaptation to Orchards’ model more effectively illustrated how the site would transition into an interdisciplinary team and is reflected in Figure 5 below.

*Figure 5: Adapted*



The project RACF demonstrated a change in staff functions/work structure (refer Appendix 9.6 measure 23) from the beginning to the end of the project but did not achieve full patient-centered collaborative interdisciplinary practice within the timeframe of this project. In reference to the change process described by Orchard<sup>14</sup>, sensitisation and exploration occurred at the same time as the intervention phase. This was a conscious decision made by the Project Steering Committee in order to phase in implementation of Postural Care so as to not overload the site with a major change in practice. Using this approach also assisted in consolidating the Care Workers and Therapy Assistant skills and knowledge in Postural Care. Through this phased method of introducing change, staff experienced the challenges of the change process, team decisions were made to address the challenges and solutions actioned immediately. However, this approach created an additional challenge in that the staff were working in an interdisciplinary approach only for Postural Care and in a traditional 'silo' approach for all other interventions.

A number of data items were pooled ie observations, process mapping, focus group discussions and survey results in relation to the changes the project facility team has experienced as part of its journey towards patient-centered collaborative interdisciplinary practice. Orchard identified Organisational Structuralism, Role Socialisation and Power Relationships as barriers. The Project team identified that these can sometimes be transformed into enablers.

#### Barrier - Organisational structuralism:

BCG as an organisation did not present any barriers to the change process. BCG organisational values include care, learning, innovation and people which complement a collaborative integrated practice model. The organisation also financially contributed to the project of which the costs were higher than anticipated. Organisational barriers tended to be more at the RACF level. The first site barrier was related to the staffing allocations. At the project facility, Care Workers were allocated shifts in any of the four houses across the site and did not know what house and who they would be working with until the start of their shift. The issue with working across the site in various houses is that it limited the Care Workers' ability to develop trusting relationships with other Care Workers and site staff as well as with residents. It also made it difficult for Care Workers to get to know their colleagues, their skills and knowledge in order to develop mutual respect, synergy and workplace flow. As the project progressed, staffing rosters were altered which meant by the end of the project most Care Workers and Enrolled Nurses worked in the same house for most/all of their shifts. As a result Care Workers were provided an increased opportunity to develop relationships with other staff members allocated to the same house and to know their clients better. This is a critical component of transitioning into an interdisciplinary model of practice.

Another site barrier was the current process for Postural Care as discussed in detail in section 4.1 of this report.

In the initial stages of the project RACF management was able to be engaged in the project as required. However, time constraints and unexpected staffing absences impacted on the actual leadership support able to be provided to direct care staff. In response, the Manager of RAC Services was recruited to the Project team to assist in providing additional leadership and management support and guidance. This was identified as a key driver for change in terms of leadership support. From the midway point of the project, communications directed to the project RACF team were delivered through the site Care Manager rather than through the Project Officer. Through this change in communication the Care Manager was able to demonstrate greater support and leadership for the change in practice required or expected of the team. The Care Manager was also able to use her authority of position to encourage change more so than the Project Officer who was an “outsider” to the project facility team. Thus these changes transformed some of Orchard’s barriers into enablers.

#### Barrier - Role socialisation:

Each discipline brought their own set of values and beliefs to the team. Each discipline group tended to socialise within their group throughout the project. Allied Health were more engaging of the change process and concept of Interdisciplinary practice. This is most likely due to the disciplines’ learning culture of maintaining currency of knowledge and possessing an existing knowledge of Interdisciplinary practice and Postural Care. Within Allied Health each HCP already engaged in some degree of collaboration and joint decision making. Allied Health are required to expand these engagement behaviours and develop trusting relationships with Care Workers. Nursing and Care Workers required the most change in attitude and behaviours. Nursing staff particularly the Enrolled Nurses were very reluctant to change the traditional practices of 2-4 hourly repositioning and regular pad checks and changes throughout the night. Nursing staff were also reluctant to have the mattress overlays removed from the client’s beds. Most Care Workers embraced shared ownership and responsibility for the implementation of Postural Care. This is an area that requires further development as the Care Worker group needed encouragement and support to make contributions to a client’s Postural Care Plan.

#### Barrier - Power relationships:

Power imbalances between disciplines were evident at the start of the project and are still an area that requires further change in order to achieve true collaborative interdisciplinary practice. Power imbalances between the Care Workers and Nursing staff were observed to hinder the confidence

Care Workers had to share ideas and attempt to take the lead in implementing Postural Care as the most educated staff group on site in implementation of Postural Care. It was part of the Postural Care Champions' role to facilitate this change in leadership and create greater balance in power.

In reference to the enablers identified in Orchard's model<sup>14</sup>, BCG's findings did support the following to be enablers but found that significant resources were required to attain this status.

#### Enabler - Role clarification:

As an enabler all staff were provided training at the start of the project. Care Workers and Therapy Assistants were provided the competency based training in Postural Care. Allied Health and Nursing staff were provided awareness training to get an overview of what knowledge and skills Care Workers would possess and this included guidance on what their expected role would be in supporting Care Workers implementing Postural Care. Through these training sessions the expected role changes of Care Workers was articulated. Throughout the course of the project, role clarification statements were further expanded through placement of Duty lists for staff implementing Postural Care in key areas across the site. Role clarification was also further enhanced through the modeling of the Postural Care Champions and managerial communications. Clarification of roles was made more explicit as the project progressed in response to difficulties the team was experiencing as part of the change process. It was also intended to encouraged ownership and responsibility amongst Care Workers.

#### Enabler - Trusting relationships, power and value sharing:

A number of strategies were implemented to facilitate the growth in these areas required to achieve collaborative interdisciplinary practice. Training was provided to equip Care Workers with the skill and knowledge to implement Postural Care. Expected role changes were also communicated thus aiding the development of respect, confidence and trust amongst the team.

Establishing team based communication with the attendance of a Care Worker at the 10min at 10.30am meeting was intended to shift the balance of power and decision making amongst all members of the team. It was also a strategy intended to add value to the Care Worker perspective and assist in developing trust. This particular strategy has not yet been implemented successfully as a representative Care Worker has not been supported to attend meetings regularly. Further managerial leadership will be required to initiate the change in conjunction with the Postural Care

Champions taking ownership and responsibility in attending the meetings. Allied Health staff report they have started to develop trust in their Care Worker colleagues' skills and feedback. The project RACF team needs to go through further change to progress value sharing in order to function as a truly collaborative interdisciplinary team. Allied Health and Nursing staff have started to respect the knowledge and skill Care Workers have in Postural Care.

Members of the Project Team representing each discipline at the Project RACF completed the Team Development Measure (TDM)<sup>44</sup>. According to the results at baseline, the team was in stage 2 in team development meaning that team cohesiveness and communication were present. At the end of the project the team had progressed into stage 3 starting to solidify role clarification<sup>44</sup>. The 'Goals and Means Clarity' component of the TDM are not yet embedded into the team (for a team to be fully functioning and high performing, it needs defined goals and the means to reach them)<sup>44</sup>. A shift towards Interdisciplinary practice is evident through improvement in team characteristics representative of a team that works in a collaborative interdisciplinary manner.

*Table 10: Team Development Measure*

	Commencement of project		Completion of project	
Project team member	Raw Score	Measure (linear scale 0-100)	Raw Score	Measure (linear scale 0-100)
1	94	60	91	57
2	72	44	96	61
3	95	60	118	80
4	75	46	78	48
5	96	61	84	52
6	69	42	93	59
7	111	74	87	54
<b>Mean</b>		<b>55 = Stage 2</b>		<b>59 = Stage 3</b>

The Team Development Measure results identified improvement in these areas and reflect a move towards interdisciplinary practice:

- All team members involved in decision making
- Sharing of ideas and feelings
- Sharing of information
- Improved conflict resolution
- Improved quality of communication
- A sense of team rather than individuals
- Less confusion about how to complete Postural care tasks
- Greater understanding of each disciplines roles and responsibilities
- Greater understanding of the teams goal
- The team goal is more important than personal goals
- Happiness with team progress
- Meaningful experience being apart of the team
- Feel personal contribution is valued by team
- Confidence to suggest how the team can improve
- Open problem solving

The results from the Care Worker/Therapy Assistant and Allied Health/Nursing surveys, direct observations, focus groups and staff interviews also supported these improvements and hence strengthened the concurrent validity of the results. Improvements in these areas indicate the Project RACF team is changing and progressing towards Interdisciplinary practice.

#### **4.2.2 Client Evaluation**

In relation to the patient-centered aspect of the model, two of the participating residents were able to communicate sufficiently to engage in the decision making process. These residents were actively encouraged to communicate their preferences for Postural Care and these were integrated in the residents Postural Care Plan. For the remaining participating residents, family/significant others who were involved in the client's care were approached for their input. Only one client had family member(s) involved in the client's Postural Care. In the absence of family/significant others the residents were closely monitored for any indications of concerns with Postural Care. No such indicators were observed during the project.

The Night-Time Positioning Assessment measured client body symmetry and range of movement to identify postural support required to promote alignment and this measure was the most valid for client outcomes. Refer to Table 11 for an assessment summary for one client's posture.

None of the participating clients experienced any change in function (ACFI, MBI, AusTOM-PT scores). This was anticipated as Postural Care does not directly address functional ability and will not have an impact on function in low to non-functional clients such as the clients participating in this project. Residents did not experience a change in level of pain via the AusTOMs. One resident who experienced pain in his left hip reported improvement in his pain level of his left hip when set up in Postural Care. Resident basic nursing observations were collected in order to assess comfort levels of the non-verbal participating residents and these did not indicate any concern for comfort levels of the residents adjusting to receiving Postural Care.

The two clients able to communicate reported they found using the Postural Care supports comfortable and wished to continue receiving Postural Care. Nine Postural Care Plans were developed and updated as clinically indicated throughout the project and all were implemented successfully (one participating client passed away during the project and another resident was recruited to receive Postural Care). All nine Postural Care Plans were populated by all disciplines with input from the client directly where possible (2/9 clients) or by observing the clients physical response to being supported (7/9 clients).

**Table 11: Night-Time Positioning Assessment (Resident ID: B)**

Before Postural Care	Using Postural care	After Postural Care
		

**Aim:** Maintain symmetry

**Outcome:** Improved chest and pelvic symmetry. Resident has progressed from requiring a Regency flotation chair (a ‘bed’ chair) to a more mobile and manoeuvrable recline/tilt wheelchair with supportive cushions.

**Comments:** Resident was unable to lie flat on her back due to significant difficulty with saliva management. Alpha X-cell pressure care overlay removed. Resident was provided a Cirrus mattress to enable resident to lie in bed with head elevated to 30-40°. Care worker staff report resident is much “straighter” and “looks a lot better”, “is sitting better” and “looks comfortable” in Postural care. Previously resident required turning every 2-3 hours and had a pad change during the night. Now night staff are not required to attend to resident between 10pm-5am unless an incident occurs.

Measure		Baseline	Final	Comments
<b>Chest rotation</b>	Right	25cm	23.75cm	More symmetrical
	Left	27cm	24cm	
<b>Direction of displacement</b>		Right	None	Improved
<b>Pelvic rotation measure</b>	Right	15cm	14cm	More symmetrical
	Left	18.25cm	14.5cm	
<b>Direction of rotation</b>		Right	None	Improved

Pelvic tilt, direction of pelvic obliquity, leg length discrepancy showed no change. Anatomical ranges such as hip flexion, abduction, adduction and knee flexion and extension were difficult to measure due to client's variable movements and tonicity.

### 4.2.3 Postural Care Evaluation

At the end of the project 88% of staff who attended training in Postural Care were deemed competent (Therapy Assistants 4/4 and 41/47 Care Workers). 77% of Care Workers on site are now competent to implement Postural Care safely and to a standard. There was an 80% increase in the number of Postural Care activities shared across roles and responsibilities as illustrated in Table 12 below. All activities are shared and 4/5 activities are shared amongst all clinical disciplines. This sharing of tasks across the team demonstrated increased flexibility and staff collaboration under the auspice of interdisciplinary approach at grassroots level. It also contributes to the sustainability of the intervention.

*Table 12: Percentage of Postural Care activities shared across roles and disciplines*

Postural Care activity	Prior to project				Commencement of project				End of project			
	CW	RN/EN	A/H	TA	CW	RN/EN	A/H	TA	CW	RN/EN	A/H	TA
<b>Identification</b>	0%	0%	100%	0%	0%	50%	50%	0%	10%	40%	40%	10%
<b>Assessment</b>	0%	0%	100%	0%	0%	0%	100%	0%	0%	10%	90%	0%
<b>Trial</b>	0%	0%	100%	0%	60%	10%	20%	10%	60%	10%	20%	10%
<b>Implementation</b>	0%	0%	100%	0%	80%	0%	20%	0%	70%	10%	10%	10%
<b>Review</b>	0%	0%	100%	0%	10%	10%	80%	0%	20%	20%	50%	10%

The tasks/duties performed by Care Workers underwent change and is summarised in Table 13 overleaf.

Table 13:	Tasks/duties performed by Care Workers related to Postural Care			
	4am – 9am	9am– 1pm	1pm- 8pm	8pm-4am
<b>Prior to project</b>	<ul style="list-style-type: none"> <li>Remove soiled linen and place in linen bin</li> <li>Make bed</li> <li>Continence pad check and change</li> </ul>	<ul style="list-style-type: none"> <li>2-4 hourly repositioning</li> </ul>	<ul style="list-style-type: none"> <li>2-4 hourly repositioning</li> <li>Continence pad change</li> </ul>	<ul style="list-style-type: none"> <li>2-4 hourly repositioning</li> <li>Continence pad check/change 10pm</li> <li>Continence pad check/change 2am</li> </ul>
<b>At start of project</b>	<ul style="list-style-type: none"> <li>As above</li> <li>Ensure Postural Care mat is fitted to bed with a flat sheet on top</li> </ul>	<ul style="list-style-type: none"> <li>2-4 hourly repositioning</li> </ul>	<ul style="list-style-type: none"> <li>Postural Care trial observations at set up, 2 hours, 4 hours and 6 hours (over 10 days)</li> <li>As above outside trial times</li> </ul>	<ul style="list-style-type: none"> <li>2-4 hourly repositioning</li> <li>Continence pad check/change 10pm</li> <li>Continence pad check/change 2am</li> </ul>
<b>End of project</b>	<ul style="list-style-type: none"> <li>As above</li> <li>Particular attention to items specific to Postural Care</li> </ul>	<ul style="list-style-type: none"> <li>No repositioning</li> <li>Ensure Postural Care equipment is clean and ready for use</li> </ul>	<ul style="list-style-type: none"> <li>No repositioning</li> <li>Ensure Postural Care equipment is clean and ready for use</li> <li>For residents returning and remaining in bed, set up Postural Care equipment as per Care Plan</li> <li>Complete a continence pad change and complete care after tea</li> </ul>	<ul style="list-style-type: none"> <li>For residents returning to bed, set up Postural Care equipment as per Care Plan</li> <li>Final continence pad change between 9-10pm (no further pad changes or checks until resident wakes in am)</li> <li>No repositioning</li> </ul>

*The key outcomes were:*

- an eventual reduction in the physical component of the afternoon and evening shifts for Care Workers in terms of no repositioning for pressure management or moving clients for continence checks.*
- The knock on impact to the client was the benefits of uninterrupted sleep.*

#### 4.2.4 Evaluation Summary

Some of the project evaluations across the three project areas (Workforce, Client and Postural Care) are summarised against the project objectives in Table 14 below.

Table 14: Evaluation Results Summarised Against Project Objectives

1. Develop and test the adaptability (the ability to readily adjust to different conditions) and utilisation of care workers by expanding their existing roles in a Postural Care context.	
Measure	Output
The number and % of different types of staff attending training sessions who achieved the desired competency outcomes for the training program.	-Number of Seatec staff who achieved Cert IV Training and Assessment competency 4/4 (100%) -Number of Therapy Assistants who attended training: 4/4 (100%) and achieved competency in Implementation of Postural Care: 4/4 (100%) -Number of Care Workers who attended training: 47/53 (89%) and achieved competency in Implementation of Postural Care: 41/47 (87%)
An increase in activities shared across staff roles and disciplines. The target was a 50% increase between the commencement and the end of the project	80% of Postural Care activities are shared across staff roles and responsibilities as compared to 0% at the start of the project.  Target was achieved.
An increase by staff of their increased understanding of new Postural Care skills of Care Workers and utilisation of these skills. The target was a 50% increase.	75% of Nursing and Allied Health staff reported they were confident in the knowledge and skill of Care Workers in Postural Care (27% survey return rate). 25% of Nursing and Allied Health staff reported they were neutral regarding their confidence in Care Workers knowledge and skill. All Nursing and Allied Health staff reported they trust feedback from Care Workers regarding Postural Care. Care Workers identified an additional 11 clients that may benefit from Postural Care. That is a >100% increase in referrals for Postural Care from Care Workers.  Target was achieved.

2. Develop and test the increased collaboration of Nursing, Allied Health and care staff with the client ('Expert patient') where they all contribute to an Interdisciplinary Workforce Model of Practice in the area of shared care planning to sustain 24 Hour Postural Care.	
Measure	Output
An increase in the number of staff and variety of professional groups engaged in the interdisciplinary model of care. The target was a 60% increase.	<p>Baseline – no ID Model</p> <p>Midway – proposed ID Model formulated by Project team across all disciplines</p> <p>Final – revised ID Model formulated by Project team across all disciplines</p> <p>Process Maps (initial, proposed and revised) – engagement of Project team across all disciplines</p> <p>Care Planning - At baseline Postural Care Plans were developed by Allied Health staff only. At the end of the project all staff groups and the client and/or family/significant other were involved in the development of Postural Care Plans (80% increase).</p> <p>Target was achieved.</p>
An increase in client Postural Care plans populated by the interdisciplinary team. The target was a 60% increase.	<p>All 9 Postural Care Plans were populated by the interdisciplinary team (&gt;100% increase).</p> <p>Prior to the project Care Workers did not document on a clients posture in bed. During the project Care Worker documentation on implementation of Postural Care and feedback on Postural Care was present in iCare.</p> <p>Target was achieved.</p>
3. Improve the consistency and sustainability of service delivery to clients.	
Measure	Output
An increase in satisfaction with client care. The target was an 80% increase.	<p>It was difficult to get an accurate measure of satisfaction from the client sample. Using the 'Expert Patient' philosophy, the two clients able to give feedback reported they were comfortable using Postural Care and were happy to continue interventions (100% increase).</p> <p>Target was achieved.</p>

<b>3. Improve the consistency and sustainability of service delivery to clients.</b>	
<b>Measure</b>	<b>Output</b>
<p>An improvement in client function and overall wellbeing. The target was an 80% increase.</p>	<p>Improvements in clients overall levels function were not detected in the functional assessments results. This was expected due to the lack of sensitivity in these assessments to detect the changes Postural Care can provide. However gains were made in posture/seating/transfers for 3 clients which represents 38% increase.</p> <p>The participating clients were inferred to have an increase in wellbeing based on Night-Time Positioning Assessment results as well as observations from care workers (7 clients which is 88% increase) in addition to the client's opportunity for uninterrupted sleep between 10pm and 5am (100% increase).</p> <p>It was found that an improvement in wellbeing was not quantifiable as clients were not able report or comment on their experiences.</p>
<p>An increase in consumer involvement in client care planning. The target was a 100% increase.</p>	<p>Prior to the project, clients were not involved in care planning. All the clients receiving Postural Care were encouraged to participate in the planning of their Postural Care to the best of their ability. 2 clients were actively involved, another client's family was involved and the remaining client participation was passive. &gt;100% increase.</p> <p>Target was achieved.</p>

#### **4.2.5 Project Outcomes**

The outcomes achieved throughout the course of the project are illustrated overleaf (also refer to Project Logic diagram in Appendix 9.5) and marked S (short term), M (medium term) or L (long term). The actual project implementation period was only 6 months so it needs to be noted that only short term outcomes were able to be achieved.

Table 15: Outcomes Summary

Outcome	Comment	Achieved
Framework for decision making (S)	Project governance and outputs clarified project decision making and guided transition towards Interdisciplinary Practice.	√ S
Engagement of staff (S)	Through the communication plan, Project Team, specific communication, focus groups and one on one communication site staff were engaged throughout the project.	√ S
Improved adaptability of staff and utilisation of their skills (S,M,L)	Care Workers were trained to increase their skill level (and thus be more adaptable) to be utilised in the implementation of Postural Care under the auspice of an Interdisciplinary workforce model. Over the medium term (outside the scope of this project), Care Worker and Therapy Assistant duty lists will be amended to formally include Postural Care. Specialist staff (Allied Health) are no longer relied upon as the sole provider of Postural Care.	√ S
Implementation of Postural Care safely and to a standard (S)	Knowledge and skill was assessed in staff to ensure competency in Postural Care with safe implementation of the same skill and knowledge to standard expected and observed.	√ S
Consistent service delivery (S,M,L)	Project facility is able to provide Postural Care to a standard and consistently as 87% of Care Workers are competent in implementation of Postural Care. Postural Care Plans provide a standard for each client's Postural Care requirements for staff to follow.	√ S
Improved client wellbeing (S,M,L)	Clients have experienced some improvement in wellbeing as evident through Night-Time Positioning Assessment results. Continued improvements in wellbeing are expected over the medium/long term but are outside project scope to evaluate.	√ S
Staff able to work to full scope of practice (S,M,L)	Care workers now work to the full scope of their practice in the implementation of Postural Care and are supported by Therapy Assistants.	√ S
Greater workforce flexibility (S,M,L)	The project facility's workforce has the flexibility to provide ongoing Postural Care service for clients which translates to a reduced reactive care workload enabling staff to redirect energies to clients who are not able to receive Postural Care.	√ S
Determine impact of project activities (S,M,L)	The short term impact is evident through the results reported and includes process maps, change in competency levels of staff and change in the quality and logistics of providing Postural Care services.	√ S
Review of workforce changes (S,M,L)	Short term changes are evident through the transition to an Interdisciplinary workforce approach, improved Care Worker shift task demands, and improved injury rates	√ S

## 5. Discussion

### **Scope of the Project**

The project team discussed at length at the beginning of the project whether to evaluate the implementation of an Interdisciplinary Model of Practice at a RACF across all areas of care/service. It was felt that although it may have been easier to implement this in terms of cultural shift and change management, it would not be achievable with the resources provided. Thus the project team determined one intervention would be achievable to be explored and tested using an interdisciplinary approach. It was further deduced that using an intervention that had not been used at any length at the RACF ensured there was no history for staff to compare to or to 'undo' (ie converting from a multidisciplinary approach to a interdisciplinary approach – staff were introduced to the intervention straight away in an interdisciplinary context). It minimised any workforce bias or expectation based on past experience. However, it did result in the project still having very broad parameters in a short time frame to encompass an Interdisciplinary Workforce Model, an intervention (Postural Care) and the client so these three areas were consistently referred to, reported against and measured against to facilitate the project progress.

It is acknowledged by the project team that a significant number of changes occurred at the RACF in a move towards interdisciplinary practice (as reflected in the results) and a new service was introduced. Credit is due to the project team to manage to the multidimensional scope of the project with the resources provided and to achieve the outcomes in a short timeframe (12 months 0 of which 6 months was the actual implementation phase).

It also felt by the project team that all three areas were worthy of further research ie:

- Examine the implementation of an Interdisciplinary Workforce Model of Practice across all areas in a RACF
- Examine the introduction and evaluation of Postural Care outcomes to the clients and workforce in a RACF
- Examine the introduction of client centered care across all areas of care and the changes subsequent changes to the client and workforce in RACF

### **Workforce Perspective**

The BCG experience of implementing Orchard's Patient-centered Collaborative Interdisciplinary Practice Model was covered in detail in section 4.2.1. Orchard's model has proven to be the most

suitable model for application within this project and with the minor change of adding another outer circle to reflect the HCP team and the client and family/significant other position, the model is applicable to other service areas within the Project RACF and within BCG. It is also suggested that the adapted version of Orchard's Model would be applicable to other teams outside of BCG in the Aged Care sector and merits further review.

*Recommendation 1: Expand evidence based research on the use of Orchard's adapted Patient-Centered Collaborative Interdisciplinary Practice Model to further explore its transferability to other service or care areas. This needs to include evaluation of cost effectiveness and sustainability. Projects would need to be a minimum of 2 years in duration.*

Care Workers and Therapy Assistants' awareness level of Models of Practice and how the project facility fits within the definitions of Models of Practice, has started to develop. From the results it is inferred that Models of Practice are a new and unknown concept for the Care Worker population. The results also demonstrate that the facility needs to undergo further change in order to create a sense/culture of Interdisciplinary Practice amongst this staff population as supported by the results of the Team Development Measure (Table 10). This claim is further supported by Care Workers stating *"I don't think people are working together at all. Everyone is more concerned about themselves than the residents. Some staff are great though", "The team members at RACF are working well together to give feedback to each other.*

Care Workers were informed of the changes and benefits the implementation of Postural Care would bring but not in the context of Interdisciplinary Practice in detail as it was perceived by the project team to be information 'overload'. Providing education on Interdisciplinary Practice and the process of change would have enhanced Care Workers perspective on the change process and possibly aided the change management process<sup>47</sup>. However, more project time and resources would have been required to do this. Although Care Workers contributed to Postural Care Plans, their perception of their role in contribution to Postural Care Plans was varied (Refer to Table 14). To improve Care Worker's perception of contribution to Postural Care Plans it is necessary for the RACF meetings to formally include all disciplines so that feedback from Care Workers is recognized as part of Care Plan development/review. This leads to interdisciplinary meetings being held and accepted as standard practice.

*Recommendation 2: Ensure change management processes have very clear organisation and management support and commitment which are visible to the staff directly involved to enhance adoption of the change process. This is necessary as implementing an interdisciplinary model is a longer term process and takes more than a 12 month project to achieve.*

*Recommendation 3: Provide support at all levels - organisational, management, RACF Champions and staff - through the change process and within changing roles. (ie key site change champion to support project officer if their time/resources are limited or project officer hours to be increased to effectively provide the change management support)*

*Recommendation 4: Ensure change management strategic workshops or seminars are appropriately pitched to the staffing group attending so all staff are exposed to the process and have a greater understanding of the journey. It also makes it clear what is required from each staff member or discipline. Continue these throughout the project (modifying content as applicable) to facilitate understanding, compliance, opportunity to raise issues and to reinforce change objectives*

Resulting from the process mapping activities and comparing the current and revised proposed process for resident interventions, a marked shift in unifying the teams process is noted as individual assessment results are combined with the client and/or family/significant other perspective to make joint decisions regarding Postural Care. The feedback communication loops involved all staff members rather than being split into 'therapy' and 'care' sectors. The revised process map facilitated greater collaboration, shared decision making and improved communication, all of which are consistent with high quality healthcare<sup>54</sup>. In the same way the revised process also complemented the adapted version of Orchard's Conceptual Model for Patient-Centered Collaborative Interdisciplinary Practice. The proposed process was implemented to its full extent within the scope of this project.

*Recommendation 5: Map out team processes and align processes with the goal of Interdisciplinary Practice from the very beginning so that it does not get lost in the transition if also incorporating a new service/task area at the same time*

Staffing levels varied slightly as part of the natural movement of a workforce and were not considered a significant change in relation to the project's activities. As reported in section 4.2.3, the roles and responsibility for providing Postural Care has shifted from a service that Allied Health were solely responsible for to a service that the team at the project facility as a collective group are responsible for thus resulting in a more flexible workforce as illustrated in Table 12. The role of the Care Worker has significantly changed taking on 70% of the responsibility in the Implementation phase. This change could not have occurred unless Care Workers were provided training in implementation of Postural Care and supported in this role by other disciplines. Nursing and Allied Health roles have also changed. Therapy Assistants underwent the least amount of change in functions in this context.

*Recommendation 6: Provide formalized training to Certificate level for Care Workers (to ensure competencies and skills to implement new interventions such as in Postural Care) where possible to increase the attraction to staff and enhance career pathway prospects.*

*Recommendation 7: Provide training to all staff groups when they are required to support a specific discipline's expanded scope of practice so they are engaged and supportive.*

### **Client Perspective**

In regards to client evaluation the results were as anticipated. The sample size was proven adequate to demonstrate change resultant from Postural Care as see in Measure 30 in Appendix 9.6). The most significant results were from the Night-time Positioning Assessments where improvements in chest (four out of eight clients) and pelvic (five out of eight clients) symmetry were observed. These results were observed in the clients with greater postural deformity and number of destructive postures. Functional improvements included one client progressing from a Regency flotation chair to a tilt/recline manual wheelchair with foam positional supports, another client with reported improved seated posture and another resident's ability to complete standing hoist transfers had improved. Overall staff reported clients who were receiving Postural Care “*looked comfortable*” and “*straighter*”. This translates to more efficient workforce outputs with less physical demand on staff.

*Recommendation 8: Recognise that it may be difficult to obtain feedback from clients and families in RACF but endeavour to do this and factor the required time/support into the project approach.*

### **Postural Care Perspective**

Initially ‘more’ work was undertaken by Care Workers to undertake training, implement new skills, follow new care plans. Then gradually tasks performed by Care staff on each shift changed as a result of implementing Postural Care. Tasks specific to Postural Care that have been added to day shift care staff duties included the laundering of the equipment and set up of Postural Care equipment when the client returns to bed to rest/sleep. These tasks did not exist prior to the project. Tasks that have been eliminated for both day and night staff when clients are in Postural Care is the need for 2-4 hourly re-positioning as previously indicated in the clients General Care plan (Refer to Table 13 in section 4.2.3 of report and Appendix 9.6: Evaluation data table:

measure 34 for details). In addition to this, for night care staff the 12midnight pad check and change has also be removed from their task/duty list. Overall, the net change to the workforce has been a reduction in the time it takes to complete care tasks and in the physical component of the care work.

*Recommendation 9: Conduct further research to evaluate the longer terms effects of Postural Care on minimizing client postural deformities and the additional knock on impacts of this to the workforce.*

### **Project Knock on Impacts**

Some of the results from the project were not anticipated and have been identified as ‘knock on impacts’. These included:

#### **Workforce knock on impacts**

- Delivering of the competency based Postural Care training to both Care Workers and Therapy Assistants was of particular benefit in resolving existing conflict between these disciplines. Care workers reported they were disgruntled when Therapy Assistants repositioned clients either in their bed or chair after the Care Workers had positioned the client. Therapy Assistants reported they felt a duty of care as well as being part of their duties to position clients in symmetry as per their Therapy plan. Completing the competency based training together greatly improved the confidence, respect, trust and the working relationship between the two staff groups.
- An additional benefit from the training in Postural Care was Care Workers were observed implementing their newly acquired knowledge and skill in Postural Care with other clients on site in collaboration with Allied Health both in lying and seated postures. As a result other clients not participating in the project at the site also benefited from the newly acquired skills of Care Workers and collaboration between staff groups occurred outside the scope of the project.
- Night-time continence management procedures were identified as an area for improvement across the RACF. BCG has commenced a project to explore this issue with the aim of improving client wellbeing through improved opportunity for sleep.
- Night shift Care Workers reported a greater awareness of the need for clients to get a good nights rest. *“When we had to take the clients vital nursing observations for the final evaluation, I felt uncomfortable doing this as I did not want to wake the client up/disturb their sleep”.*

### Client knock on impacts

- Clients are not interrupted by staff completing invasive care such as pad changes during the night. Clients are not disturbed between 10pm and 5am unless there is an incident requiring immediate care. Clients therefore are more likely to benefit from improved wellbeing as they reap the benefits of a continuous sleep period<sup>38</sup>.
- An additional 11 clients at the project RACF were identified by the various disciplines as potentially requiring Postural Care which could translate to a more improved awareness of implementing appropriate interventions to increase client wellbeing and opportunity for working in an interdisciplinary fashion.

### Postural Care knock on impacts

- Four out of five of the participating clients who had mattress overlays prior to the start of the project were able to have the overlays removed as a direct result of receiving Postural Care. This meant that the site experienced savings in purchase (approximately \$3,000 per overlay), running and maintenance costs. Organisational benefits included being able to redirect resources to facilities that do not have the workforce operating in an expanded scope of practice.
- Allied Health reported a reduction in referrals for resident seating and posture reviews across the site since the start of the project. Data for this change was not collected as it was not anticipated as an outcome of the project. An unexpected outcome of the project was that Care Workers were addressing client's posture both in bed and in sitting, implementing the knowledge and skill they learnt through the competency based training to benefit clients who were not participating in the project. These actions of the Care Workers theoretically can be linked to the reduction in referrals (to address resident seating and posture) to Allied Health.

The barriers impacting on implementation are explored in the accompanying Case Study (refer to Appendix 9.17) as are the critical success factors for implementing this project which can be transferrable to other service areas to be delivered under the auspice of an interdisciplinary approach.

## **Project Limitations**

- The time frame was a significant limitation for a project of this broad scope. More time is required if looking at changing an entire RACF's workforce approach, implementing a new intervention to the RACF as well as facilitating a move towards client contribution to care.
- The assessment phase (stage one) of the proposed process for resident intervention was not actioned as part of this project and was therefore not tested. Based on the project results for implementation of stage two to five it is anticipated that there would not be any significant concerns for future implementation of stage one.
- BCG's summation of data collected from the various disciplines and entered into iCare (electronic health record system) was considered to be a project limitation as a large number of various staff were completing assessments (at various intervals) and there were, at times, inconsistencies which caused confusion when the iCare Care Plans were printed. This highlighted a process issue which BCG is currently addressing.
- Number of evaluation measures used. It made it very difficult to implement/collect all measures and analyse the resultant data within the project timeframe due to the volume of data created.
- Survey quality was previously acknowledged as a known limitation of the project in section 3.1.3 of the report. Researcher bias is still likely to be present in the design of the surveys despite attempts to minimise this.
- Survey return rates varied greatly between baseline and final evaluation periods (sample A: 92%, sample B: 27%, sample C: 21%, sample D: 11%). The baseline Care Worker and Therapy Assistant survey is considered to have high internal validity (92%) whereas the other surveys have low internal validity. This in turn limits the external validity of the survey results<sup>39</sup>. At baseline surveys were completed by staff at the training sessions and was therefore seen as compulsory. During the final evaluation period the survey was completed on site in staff's own time. The results of the final surveys may be biased to reflect the views of staff that are positive about Postural Care or enjoy completing surveys. Not all people have the same perspective or personal characteristics influencing their responses<sup>40</sup>.

## 5.1 Organisational Change and Capacity Building

There has been organisational learning, capacity and capability building and experience gained from delivering this project, namely:

- Further understanding of the time, effort and resources required to implement workforce change. BCG understood the challenge required to implement such change through such a project as this but nevertheless still underestimated the time and resources required for the project.
- Reinforced the importance of BCG's use of consistent executive and senior management support and leadership.
- Further understanding of program logic methodology, its usefulness in planning a project and application to other projects.
- Expanded on BCG's experiences in process and role mapping.
- Reinforced awareness of thinking more broadly during the planning phase about possible, seemingly unrelated, issues that may affect a project. For example, night time continence management practices affected the consistent implementation of night time Postural Care and took considerable change management strategies to overcome.
- Consideration to do fewer evaluation measures and put more time into the selection of the measures in the project planning phase.
- Increased awareness of the different communication styles and methods needed for different target groups of staff (particularly from a training perspective).
- There can never be enough communication! Assumptions cannot be made that when people say they understand what is being said that they really do. The same message needs to be said but in different ways to ensure the message is being heard.
- Knowledge and experience of implementing an interdisciplinary model of work practice in a RACF. BCG has a significant program of interdisciplinary student placement and work but not in the general RACF workplace.
- Demonstrated that it is possible, even in a short timeframe, to successfully expand the capacity and capability the role of Care Workers.
- Consolidate the work achieved to date by using this project as a platform and undertake another project at the same RACF next financial year to further embed the interdisciplinary way of working using the intervention of pain management.

## 5.2 Strategies to Promote Sustainability and Generalisability to other Organisations

External characteristics likely to promote the sustainability and generalisability of an interdisciplinary model of practice using Postural Care as an example are:

- Aged Care Accreditation Standards requirement of evidence that an interdisciplinary model of practices are used to enhance resident care and wellbeing.
- The ageing population will continue to drive demand for high quality care residential care facilities and associated staff.
- The ageing and shrinking workforce will be a driver for health care providers to utilise staff more effectively.
- The increasing awareness of the benefits the Interdisciplinary Models of Practice can provide to the RAC industry.
- The increasing awareness of the benefits of this model of practice and subsequent funding by state teaching organisations for student practicums so graduates expect to work in this type of environment.
- AQF Certificate IV: Course in Implementation of Postural Care-52295 which is an accredited competency based Postural Care Training Course for Carers registered with the National Training Information Service. This framework from which Postural Care training can be delivered evolved due to the need to implement this internationally acknowledged material in an Australian context).

Organisational characteristics likely to promote sustainability and generalisability of an interdisciplinary model of practice are:

- Organisation has a strategic workforce planning process and expertise.
- Alignment with organisational strategic direction.
- Organisational commitment of significant funds and resources in a sustained manner to support projects with the view of ensuring its completion and transfer to other initiatives.
- Executive support for projects relating to workforce initiatives with close relationships between internal and external stakeholders.
- The organisation has a track record of successfully completing similar projects.
- Organisational commitment to implementing outcomes and recommendations of projects to ensure they become embedded into everyday practice.
- Ongoing investment in staff training and development with expertise in developing training courses be accredited at appropriate certification level where possible.

Specific project strategies to promote sustainability and generalisability:

- Regular communications to organisational executive to promote the interdisciplinary approach as well as Postural Care and the benefits to workforce and clients.
- Detailed evaluation criteria which included indicators to support increased effectiveness, utilisation and satisfaction of staff, benefits to residents and areas of cost savings in delivering services via the Interdisciplinary Model framework
- Broad stakeholder representation included key organisational staff and industry representatives to ensure validity and contextual application in the WA health and training sector
- Development of a resource to disseminate results that ensure the project works are sustained to implement Postural Care under the auspice of a Interdisciplinary approach This is further explored in the project case study (refer to Appendix 9.17)
- Project staff resourced for national conference presentation and appropriate publications which disseminate project outcomes to other areas in the health and ageing sector.

## 6. Conclusion and Recommendations

It is well known that workforce change takes considerable time and resources and a sustained effort. Although this HWA CfOP project was only a 12 month project, BCG is very proud of what was achieved in a short timeframe.

This project has demonstrated that through training and supporting Care Workers in collaboration with the client, Allied Health and Nursing staff to carry out 'non traditional' interventions such as 24 Hour Postural Care, Brightwater Care Group has demonstrated the development, implementation and transferability (refer to Case Study, Appendix 9.17) of an Interdisciplinary Workforce Model of Practice.

The project successfully achieved its 3 objectives:

*Objective 1: Develop and test the adaptability* (the ability to readily adjust to different conditions) and utilisation **of Care Workers by expanding their existing roles** in a Postural Care context.

This project has demonstrated the readiness of the Care Worker staff to undertake change and transition to an expanded scope of practice by undertaking competency based training to implement Postural Care. Postural Care was shown to be applicable in the aged care sector resulting in benefits for both clients and staff.

*Objective 2: Develop and test the increased collaboration* of Nursing, Allied Health and Care Workers with the client ('Expert patient') where they all contribute to an Interdisciplinary Workforce Model of Practice in the area of shared care planning to sustain 24 Hour Postural Care.

Orchard's Patient-centered Collaborative Interdisciplinary Practice Model has been tested and adapted to meet the needs of BCG. This adapted version of Orchard's Model could be generalisable to any intervention and organisation but requires further consolidation with a different care or service area. Full implementation and acceptance as the general way of working will take considerable future efforts and resources over a sustained period of time. Workforce change does not happen quickly. Orchard's adapted model focuses on the team's transition to patient-centered collaborative interdisciplinary practice. Any intervention that is provided by a HCP or a group of HCPs to a client can utilise this model. The same barriers and enablers will be present in any organisation to a lesser or greater degree than that experienced by the project facility team.

**Objective 3: Improve the consistency and sustainability of service delivery to clients.**

Clients have experienced a more consistent Postural Care service as a minimal safe standard of practice is guaranteed through competency based training for Care Workers, Interdisciplinary Postural Care Plans as a practice guide and support of Nursing and Allied Health staff. Ongoing implementation of these strategies will enable the sustainability of Postural Care over the long term as proven within the timeframe of this project (short term).

In order to build on the outcomes of this project, the following recommendations are put forward:

1: Expand evidence based research on the use of Orchard's adapted Patient-Centered Collaborative Interdisciplinary Practice Model to further explore its transferability to other service or care areas. This needs to include evaluation of cost effectiveness and sustainability. Projects would need to be a minimum of 2 years in duration.

2: Ensure change management processes have very clear organisation and management support and commitment which is visible to the staff directly involved to enhance adoption of the change process. This is necessary as implementing an interdisciplinary model is a longer term process and takes more than a 12 month project to achieve.

3: Provide support at all levels - organisational, management, RACF Champions and staff - through the change process and within changing roles. (ie key site change champion to support project officer if their time/resources are limited or project officer hours to be increased to effectively provide the change management support).

4: Ensure change management strategic workshops or seminars are appropriately pitched to the staffing group attending so all staff are exposed to the process and have a greater understanding of the journey. It also makes it clear what is required from each staff member or discipline. Continue these throughout the project (modifying content as applicable) to facilitate understanding, compliance, opportunity to raise issues and to reinforce change objectives.

5: Map out team processes and align processes with the goal of Interdisciplinary Practice from the very beginning so that it does not get lost in the transition if also incorporating a new service/task area at the same time.

6. Provide formalized training to Certificate level for Care Workers (to ensure competencies and skills to implement new interventions such as in Postural Care) where possible to increase the attraction to staff and enhance career pathway prospects.

7. Provide training to all staff groups when they are required to support a specific discipline's expanded scope of practice so they are engaged and supportive.

8: Recognise that it may be difficult to obtain feedback from clients and families in RACF but endeavour to do this and factor the required time/support into the project approach.

9. Conduct further research to evaluate the longer terms effects of Postural Care on minimizing client postural deformities and the additional knock on impacts of this to the workforce.

## 7. Approvals and sign off

I certify that this project Final Report satisfies the requirements of this organisation.

### **Chief Executive Officer/Executive Director**

Name (printed)			
Position			
Department		Institution	
Signature		Date	

## 8. References and Bibliography

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## 9. Appendices

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