ACI NSW Agency for Clinical Innovation

KEY PRINCIPLES

Living well in Multipurpose Services (MPS)

Principles of Care

Rural Health Network

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

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- *knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- *continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

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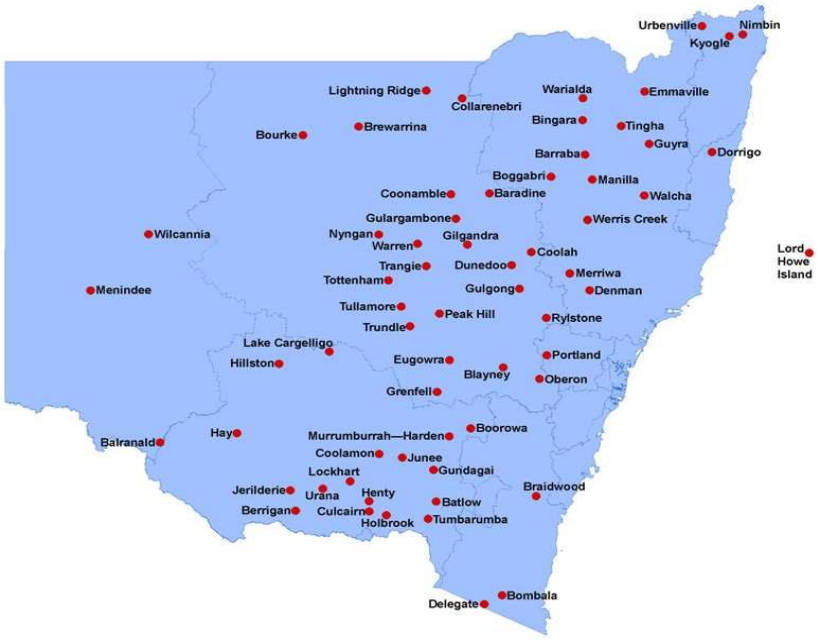
Multipurpose Services in NSW

Multipurpose Services (MPS) are unique health care facilities that provide a combination of health services including acute care, sub-acute care (including respite and palliative care), emergency, allied health, primary health and residential aged care to meet the needs of the local community. There are currently 60 MPS in operation across rural NSW with more MPS in the planning stage.

MPS approved providers are expected to deliver a level of quality residential and home care services in a way that is consistent with the relevant Charter of care recipients' rights and responsibilities. In addition, MPS approved providers are required to meet the National Safety and Quality Health Service Standards prescribed by the Australian Commission on Safety and Quality in Healthcare. The map below illustrates the locations of the MPS in NSW.



While there is not requirement for MPS to meet Aged Care accreditation, the Commonwealth seeks an assurance that MPS provide a level of care consistent with the spirit and intent of the aged care standards where appropriate[1]. MPS are not required to meet Aged Care Standards[2] as is the case with Commonwealth funded Residential Aged Care facilities. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) was funded by the NSW Ministry of Health to undertake a consultation in 2014, and identified the gaps between the NSQHS and the Aged Care Standards in the following areas:

- Homelike Environment
- Role of the person on their own care (resident-centred)
- Cognitive impairment
- Hydration and nutrition
- Leisure activities and lifestyle.

A NSW MPS Reference Group was formed in 2015 to improve the quality of life for residents living in MPS. The ACSQHC consultancy findings were used by the Reference Group as a baseline to develop the MPS Principles of Care.

The ACSQHC is currently developing a revised edition of the NSQHS[3], to address these gaps. An additional project is exploring options to implement NSQHS (V2) across all areas of MPS, including residential aged care.

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Principles of Care for people living well in MPS

The Living Well in MPS Collaborative

The *Living Well in MPS* Collaborative[1] has been designed to support staff to provide care for residents of Multipurpose Services (MPS); not as patients in hospital, but as people living in their home.

Establishing this Collaborative involved a thorough review of the evidence in relation to person-centred practice and wide-ranging consultation with 10 MPS and 2 RACFs across regional and rural NSW.

The *Living Well in MPS* Toolkit has been developed in alignment with the Commonwealth Department of Health Aged Care Standard 2 (Health and Personal Care) and Standard 3 (Care Recipient Lifestyle) in order to enhance lifestyle, independence and wellbeing for people who call MPS home. The Toolkit comprises:

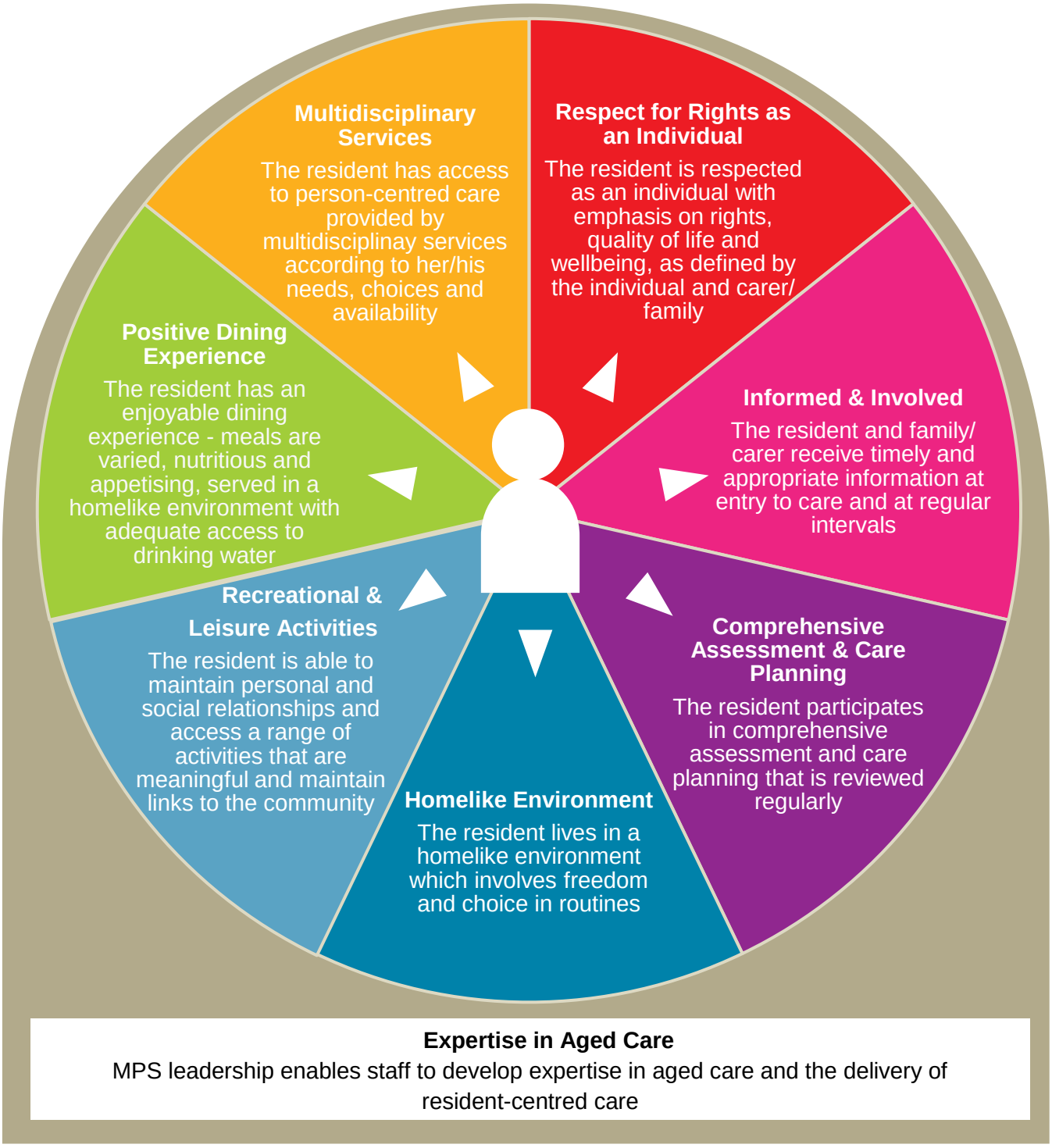
- **Principles of Care** document, identifying eight key principles designed to improve the quality of life and wellbeing of residents living in MPS residential aged care facilities
- **Self-Assessment Checklist**, designed to help MPS identify their current strengths and weaknesses in relation to the eight key principles and prioritise areas they wish to improve
- **Resource Guide** of evidence-based resources and strategies which MPS can implement to foster improvements in relation to the eight key principles
- **Evaluation Package** which will be implemented by participating MPS in order to determine how well the *Living Well in MPS* Collaborative achieves its overall aims.

The *Living Well in MPS* toolkit provides practical strategies which will assist MPS in meeting accreditation requirements. MPS facilities which implement the *Living Well in MPS* Principles of Care through a range of actions will be creating evidence which demonstrates compliance with ACSQHC accreditation.

[1] For further information about the *Living Well in MPS* project, please visit: **http://www.aci.health.nsw.gov.au/resources/rural-health/multipurpose-service-model-of-care-project/mps-model-of-care-project-2015**

Overview

MPS Principles of Care and Services



Respect for rights as an individual

The resident is respected as an individual with an emphasis on rights, quality of life and wellbeing, as defined by the individual and carer/family. This includes privacy, control over life, dignity and lifestyle interests.

Residents receive person-centred care, meeting individual physical, psychological, cultural, spiritual, emotional and social needs, and acknowledging the resident's personal history and preferences. Respect for the individual is demonstrated through focussing on what each resident *can* do, maximising independence and mobility, empowering staff to build relationships and familiarity, and responding to each resident's needs and desires.

Person-centred and respectful care is a right of older people, described in the User Rights Principles 2014 accompanying the Aged Care Act (1997)[4].

What works

Person-centred care is an evidence-based approach to care that uses the recipient's unique personal preferences and needs to guide health care planning. Interventional studies based on person-centred care demonstrate better functional and behavioural outcomes for residents and greater satisfaction with care by residents, carers/families and care giving staff. There is direct correlation between person-centredness and residents' quality of life, pain, depression and ability to perform daily activities.[5, 6]

A person-centred approach to care includes activities that match resident interests, personal histories, and abilities. Interventions tailored to individual residents have been found to be most effective, particularly for residents with dementia; increasing engagement in meaningful activity, improving mood, and reducing agitation, depression and disruptive behaviours.

Ageing well requires autonomy, being able to express oneself, and maintaining control over decision making. Research in the area of ageing has found that older adults make choices and decisions based on their perception of wellness, risk and potential impact on quality of life[7]. Person-centred care is characterised by services' enabling and supporting older people to make choices and **actively participate in decision making**. The resident is supported to exercise choice, decision making and control, with staff prepared for a certain level of risk to allow residents greater freedom.

Person-centred care requires a **shift away from the traditional medical model** of care to provide broad/holistic health and social care. Care is focussed on individualised, supporting relationships, and is less task-focussed. This approach, paired with training staff in person-centred care approaches, enables residents to build relationships, increase socialisation, and participate in mixed group activities[8].

Person-centred care creates a **homelike environment** for residents, where residents are seen as a whole person, and not just a passive care recipient. Consistent rostering allows residents and staff to get to know each other, which builds trust and compliance, and nurtures confidence and a sense of belonging for residents in care.

Applying the principle in practice

This principle requires MPS to identify, respect and respond to individual physical, psychological, cultural, spiritual, emotional and social needs.

Comprehensive initial assessment and social profile identifies resident interests, histories, preferences and abilities ("who I am") and enables staff to offer relevant and appropriate opportunities for residents to engage in life in the MPS.

Regular resident meetings provide opportunity for residents and carers/families to be involved in decision making and planning (eg. recreational activities), to have opinions, share ideas and choices, and raise issues or concerns.

Regular case conferences with a multidisciplinary team, or meetings with carers/families every 6 months have proven to be extremely beneficial in maintaining open communication between the facility and resident, and early identification of issues or concerns which can be addressed before they become problematic.

Respecting resident choice with regards to routines, choice of activity and meals encourages residents' independence and autonomy and works to de-institutionalise staff approaches to care.

Cultural and spiritual care awareness and sensitivities acknowledge that aged care recipients come from a variety of social and cultural backgrounds. Aboriginal Health Worker roles form an important link in maintaining cultural competence in many MPS facilities. Designating a quiet room or place to reflect and worship, and celebrating cultural days will assist in creating cultural sensitivity.

Informed and involved

The resident and family / carer receive timely and appropriate information at entry to care and at regular intervals to maintain choice and control over all aspects of the resident's life.

Residents and carers/family members have the right to actively participate in decision making about the services and care they receive. Information management is a continuous two-way process between the MPS facility and the resident, carer or family to optimise informed decision making.

Across NSW there is considerable variation to pre-admission preparation and Advance Care Planning for residents coming into care in MPS. Development of a standardised documentation set across NSW will support MPS to better communicate and collaborate with the resident and family and enable a higher level of input into decisions, personal choices and service availability options.

What works

The Australian Safety and Quality Framework for Health Care[9] promotes increasing health literacy and partnering with patients, carers and families to make shared decisions. Better informed patients and shared decision making provides a realistic appreciation of risks and benefits, resulting in better quality decisions, adherence to treatment plans and improved sense of empowerment and experience[10].

Older people often have multiple chronic conditions which require access to health services more frequently. Older people are also at high risk of low health literacy, with approximately 80 per cent of older Australians having difficulty reading and understanding health information[11]. Low health literacy is associated with higher hospital presentations and is a strong predictor for mortality[12].

Applying the principle in practice

Initially, MPS should focus improvement efforts across two key points in time: prior to entry and at entry to care. Two information packages will provide consistent and relevant information to prospective or admitting residents and their families/carers. These packages may be made available online to increase accessibility.

A standardised pre-admission Resident and Family Handbook aims to demystify the transition to residential aged care and provide all necessary information for the prospective resident and carer/family to make an informed decision about their care. The box below provides MPS with a checklist of topic areas to be included in a preadmission package.

Resident and Family Handbook

- Requirements for admission: Centrelink information, resident's fees, help available
- Residential Care Service Agreement: rights, responsibilities, legal requirements
- Residents and Family Handbook: Mission, Vision, Values
- General information: meals, laundry, services available, activities, smoking, alcohol, medical services, pharmacy and fees, mail, safety and security, spiritual care
- Equipment and furniture: care for and labelling of belongings, what can the resident bring, storage of motorized wheelchairs / scooters
- Resident Profile: social history and work history, personal profile/history (who is the resident), occupation, children, grandchildren, abilities / interests, pets, sports/games, lifetime achievements, special events, cultural practices
- Managing your affairs: Advance Care Directive (ACD) / Enduring Power of Attorney / Enduring Guardianship
- Admission Form and Medication History
- Local brochure: local area information, map of locality, attractions, information for families, accommodation, restaurants, shopping centres and clubs
- Respite care and palliative care
- My Aged Care Assessment is recommended by NSW Health; How to contact My Aged Care
- Waiting lists
- Pre-admission tours.

A Welcome Pack on admission to residential aged care aims to introduce and orient the resident and carer/family to the facility and clarify expectations. The box below provides MPS with a checklist of topic areas to be included in an admission welcome package.

Welcome Pack

- Welcome letter / pamphlet
- Introduction to Facility: vision, mission and values
  - Introduction and identification staff: uniforms
  - Resident services: what is provided, room allocation, personal belongings, daily routine internet access, room cleaning, nursing care, kitchenette, newspapers
  - Available services: medical care, nursing services, pharmacy and medication management, rehabilitation services and allied health, hairdressing, visiting services e.g. Pets as Therapy, dental services
- New Resident Pharmacy Notification Form
- Personal possessions: valuables, loss, electrical items must be certified
- Daily living activities and independence: personal hygiene, continence, communication, emotional support and therapies, recreational and leisure activities, podiatry, physiotherapy
- Financial Consent (resident activities, hairdresser, continence aids, podiatry)
- Enduring Guardianship and Power of Attorney, Advance Care Directives
- Community Involvement and interaction with MPS: church, schools, volunteers
- Case Conferencing schedule /resident, carer / family meetings
- Privacy and Confidentiality statement
- Residents' meeting schedule
- Meal routine, laundry routine (label clothing)
- Role of carers, families and friends
- Pets
- Alcohol and smoking
- Diverse backgrounds: cultural and spiritual life
- Charter of Residents' Rights and Responsibilities
- Resident leave
- Safety and Security: infection control, food safety, manual handling
- Ageing in place (for episodes of sub-acute care)
- Social: maintaining community involvement e.g., Probus, Rotary, CWA, Bridge Club
- Motorized scooters, wheelchairs
- Volunteers
- Complaints, compliments and expectations
- Resident Agreement
- Helpful telephone numbers (MyAgedCare, The Seniors Rights Service, Aged Care Complaints Commissioner)

J Comprehensive assessment and care planning

The resident participates in comprehensive assessment and care planning that is reviewed regularly.

Assessment and care planning processes with the resident's engagement can focus on activities, schedules, and healthcare consistent with her / his interests and enable the resident to make choices about aspects of her / his life in the facility.

Coordinated and comprehensive care planning improves the quality of life of patients with chronic disease or conditions, reduces depression and is beneficial to the broader health system[13]. Currently there is no consistent standardised documentation set used for Residential Aged Care assessment or care planning across MPS in NSW. MPS are using LHD care plans which are designed for acute care planning and not appropriate for Residential Aged Care planning. Consequently, the process and approach to assessment and care planning for residents across NSW varies and would benefit from further work.

Older people living in MPS often have complex medical and care needs. There is a need to obtain comprehensive clinical information from other practitioners (eg. in General Practice) on admission, and ensure communication processes are in place to start and develop an ongoing relationship for care planning. Residents and carers/families must be central to the ongoing assessment and care planning processes.

What works

Assessment and care planning practices are a means of identifying unique, individual needs and preferences and ensuring these are addressed through a targeted plan of action. Assessment and care planning for residents of MPS require collaborative and interdisciplinary processes, utilising the skills and knowledge of the resident, carer/family and involved professionals. NSW Department of Health have defined eleven broad areas which need to be considered to form the basis of comprehensive assessment and develop appropriate care plans for older people: patient demographics, presenting problems, medical summary, current medication, smoking, alcohol and other drug use, current level of Activities of Daily Living (ADL), continence status, mental and psychological state including cognitive function, sensory summary including vision, hearing, communication issues, social/cultural functioning, carer status, nutritional status and falls risk screening[14].

Dementia screening, assessment and care planning is core business for MPS. About 53% of all permanent residents in Australian Government subsidised aged care facilities in 2009–10 had a diagnosis of dementia with an average length of stay 3 to 5 years. This figure is predicted to rise to 75% within 10 years[15]. A survey of ten MPS across NSW in 2015 indicated that 25% of residents had a dementia. Screening, assessment and care planning should include the resident, carer/family and those responsible for caring and supporting the resident. Where appropriate, care

planning should include individualised strategies to manage people with Behavioural and Psychological Symptoms of Dementia (BPSD), who are at an increased risk of falls.

Evidence now shows that older people's health and function is not linear[16]. Older people can regain function after periods of illness, hospitalisation or disability through comprehensive assessment and care planning. Plans which identify a person's residual functional capabilities, limitations, and possibility for improvement can support options that enable the aged person to live as independently as possible and be supported to live with dignity.

Applying the principle in practice

The following dimensions of care are assessable in the Aged Care Standards 1997[17], and are key care domains of a comprehensive aged care assessment. These dimensions can be used as a check list to develop a consistent template for assessment and care planning relevant to residential aged care sections of MPS.

The aim of assessment and care planning across the domains below are to identify any areas requiring support or management, and to put in place an appropriate care planning which maximises the resident's function, dignity, independence and safety.

Comprehensive assessment and care planning: The Living Care Plan	
Medication management	Medication is managed and reviewed safely and correctly
Communication and cognition	Each Resident (or Representative) is enabled choice and control
Sensory loss	Including sensory aids (eg. glasses, hearing aids, dentures)
Safety	Including mobility/vision/ falls risk assessment and transfers
Nutrition and hydration	Residents receive adequate nourishment and hydration
Personal hygiene and oral health	Hygiene and dental care are maintained
Continence management and	Continence is managed effectively eg regular toileting
Pain management	All residents are as free from pain as possible
Skin integrity	Management consistent with general health
Sleep and resting	Residents achieve natural sleeping patterns
Sexuality	Individual preferences are recognised and respected
Depression and behaviours	Causes which prompt challenging behaviours are managed
Social, Cultural and Spiritual Care	Individual beliefs and customs are valued and fostered
Leisure Interests	Residents are supported to participate in a wide range of activities
Palliative and End of Life Care	The comfort and dignity of the terminally ill resident is maintained
Complex Health Care Needs	Residents are referred to appropriate health specialists
Mobility and Independence	Optimum levels are achieved for all Residents

Homelike environment

A homelike environment involves freedom and choice in routines (eg waking, dressing, engagement in chosen activities) and may also include environmental approaches such as kitchens and laundries accessible to residents, bistro/café style dining room or choice of menu.

The MPS residential aged care section will offer a personalised, safe, clean, comfortable and relaxed environment where residents have a sense of belonging.

A homelike environment in Australia is related to concepts such as pleasant atmosphere, looking and feeling light, airy and homely, having freedom and choices, unrestricted, inviting for relatives and comfortable for children[18].

What works

Queensland Health[19] has adopted a model of care for Residential Aged Care Facilities which incorporates a shift in nursing home care from a medical model to a social model. This model of care maintains continuity of the residents' previous lifestyle, in a homelike environment with provision of aged care specific education for staff.

The Aged Care Branch, Victoria Department of Health has released a suite of documents to inform residential aged care and 'dementia-friendly environments'[20]. They provide evidence, based on research and best practice, which demonstrates that a home-like environment adds continuity and familiarity to everyday life, encourages continued family involvement and strengthens family and friendship ties. In addition, homelike environments for people with dementia enhance social connection and a sense of self which promotes confidence, independence and maximises freedom to maintain continuation of lifestyle as long as possible.

The Eden Alternative is a philosophy for person-directed culture change in aged care that aims to enrich the lives of those who live and work in residential aged care facilities[21]. Children, animals and plants enliven the environment and create an atmosphere reminiscent of home. Benefits include reductions in the total number and type of medications used by residents (e.g. a decline in mind and mood altering drugs), reduced infection rates, improved levels of sociability, reduced levels of boredom and feelings of helplessness among residents, and improved staff retention rates[22].

The Australian Government is currently implementing a significant Consumer Directed Care (CDC) aged care reform program. Working to embed a strong person-centred approach within the residential aged care facility, and at the same time transforming the environment to become more homelike reinforces the rights of residents to exercise choice and control within the MPS[23].

An Australian study conducted in 2008 showed that a homelike environment can enhance the quality of life (QoL) for residents, relatives and the working environment for staff[24]. For residents, improved QoL was demonstrated by decreased agitation, better sleeping patterns, greater freedom and increased appetite / weight gain. Relative's experiences were improved as the lighter, airy homelike atmosphere with garden access increased their comfort when visiting their family member in care. For staff, their work environment was improved by better access to equipment, and feeling more comfortable about the safety of the residents.

Applying the principle in practice

Numerous strategies can be employed to create a physical and social atmosphere beyond the bricks and mortar of MPS facilities to maintain an environment which is family focussed and personal.

- **Promoting flexibility and decision making by the resident**. This can be demonstrated by residents controlling their daily routines, actively engaging in, and leading decision making, selecting activities and their interactions with home (eg. room decorations, creating smaller flexible spaces).
- **Physical layout of the facility.** The layout of the facility can add to the homelike feeling of the environment. There may be small scale living areas, where residents can meet with one another or visitors, kitchenettes with tea making facilities and microwaves, soft music in dining areas with aromas of home cooking, and furnishings that are reminiscent of a home, such as bookshelves, indoor plants, soft furnishings and warm colours.
- **Personal space.** Each resident should have a space that is their own, to be able to use and decorate according to their choice. This may involve the use of their own furniture, chairs for visitors, special personal possessions (photos, memorabilia), telephone, access to internet and email. It is important that this space be a private space, providing some privacy and dignity for the resident.
- **Family participation and language of home.** MPS should be a welcoming and relaxing space for families, encouraging involvement and visits by families. A homelike facility respects and values the cultural and spiritual background of the resident.
- **Ready access to outdoor areas**. Outdoor spaces add to the homelike environment of MPSs and improve physical and mental health. Outdoor spaces can be designed to include meeting spaces, quiet times and activities, encourage gardening and provide space for movement. Well-designed outdoor spaces[25] can improve quality of life and provide residents with the opportunity to engage in meaningful activity.

Recreational and leisure activities

The resident is able to maintain personal and social relationships and access a range of recreational and leisure activities that are meaningful and maintain links to the community.

Providing a diverse range of leisure and recreational activities which reflect the resident's interests and lifestyle, including outings, help the resident maintain meaning and a sense of purpose.

Most older people want to continue to be relevant and connected to their families and communities. Rural communities are a valuable resource and informal carers and community groups play important roles in providing social engagement, spiritual care and support which contribute to the wellbeing of older people.

A survey conducted across six NSW MPS in 2008, indicated that social life and passing the time were key areas for improvement[26].

What works

The concept of meaningful occupation is defined as "any task or activity which is important and meaningful to the individual", and is increasingly important, particularly in relation to managing Behavioural and Psychological Symptoms of Dementia (BPSD)[27]. Consideration of meaningful occupation as resident-led and guided by resident choice instantly widens options for activities where the activities are as varied as the residents themselves. Normal psychosocial and behavioral activities which include animals, music, sensory stimulation, recreation, behavioral and exercise interventions can improve quality of life, sleep, function, engagement and mood[28]. These activities can be conducted within the MPS or in connection with community groups.

Animal-assisted therapy (AAT) is gaining popularity as part of therapy programs in residential aged care facilities. Humans and pet dogs respond to quiet interaction with a lowering of blood pressure and an increase in neurochemicals associated with relaxation and bonding. The presence of dogs in residential aged care may reduce aggression and agitation, and promote social behaviour in people with dementia[29] Pet therapy has been associated with reducing depressive symptoms, loneliness, and agitated behaviours[30]. One study has suggested that an aquarium in the dining room of dementia care unit may stimulate residents to eat more of their meals and gain weight[31]. An original scientific paper published in Croatia in 2013 found that the benefits of pet therapy were particularly demonstrated for depressive symptoms, loneliness, agitated behaviours and dementia.[32]

Horticulture therapy employs plants and gardening activities in therapeutic and rehabilitation activities and is utilized to improve the quality of life of the ageing population, reducing costs for long-term and dementia unit residents. Residents report gardening gives them responsibility, and continuation of their life prior to their time in residential aged care[33].

Preliminary studies have reported the benefits of horticultural therapy and garden settings in reduction of pain, improvement in attention, lessening of stress, reduced agitation, and a reduction in medications and antipsychotics[34]. Emerging evidence suggests gardening may prevent falls (by maintaining older people's balance and gait) and prevent cognitive decline and dementia[35].

The Australian Government Department of Social Services recognise that volunteers form the community's most valuable hidden asset and play an important part in Australia's healthcare system, especially in rural areas.[36] Volunteers can enrich the lives of residents by providing a range of activities that promote social connection and emotional, mental and physical stimulation, whilst keeping residents connected with the local community.

Applying the principle in practice

- **Develop a Resident Profile with each resident**. By getting to know the resident, staff can understand their likes, dislikes and interests, and encourage their participation in activities of their choice.
- **Identify local opportunities for community involvement.** Draw on local community and maintain connections to the community by maximising community involvement. Consider family / community days, intergenerational activities, visiting pets. Encourage community groups to come to the facility (schools, mothers' groups, church, Men's Shed, Adult Day Care).
- **Simplify visiting volunteer requirements.** Engage volunteers – create an activities roster. Create networks with local Private RACFs and share programs.
- **Access local transport options.** Most rural communities have access to a Commonwealth Home Support Program (CHSP) Bus or Community Transport Service, and some MPS have a Service Level Agreement between the LHD and CHSP to utilise the resource on a regular basis (outings, picnics, drives in the country)
- **Network services**. Utilise Diversional Therapy programs developed at a larger regional centre and delivered locally by an Allied Health Assistant / Activities Officer (Certificate IV in Leisure and Health). The Certificate IV in Leisure and Health course is the minimum recognised qualification to work in the field.

Positive dining experience

The resident has an enjoyable dining experience – Meals are varied, nutritious and appetising and served in a calm, homelike environment with adequate access to drinking water.

The dining experience is an opportunity for residents to experience the independence they once knew and still desire. Through appropriate meal consistencies and textures, an optimal dining room setting, and coordination of the total healthcare team, these desires can be reached. The dining experience is an important part of the clinical care of the resident by assuring appropriate nutritional and fluid intake, and helps assure a desirable quality of life even while residing in a long-term care facility.[37]

What works

Of the ten MPS Sites visited in 2015, 30% cooked meals fresh on-site and 70% had transitioned to LHD centralised food services where it was observed that food is pre-packaged and lacks the aroma and texture of fresh meals. In contrast, it was observed that meals cooked on-site in MPS kitchens produce sight, smell and sounds of cooking which also provide excellent orientation of time and place and stimulate the appetite. Residents and staff across all MPS Sites agreed that home cooked is best. *"The highlight of my day is coming out of my room for meals"* (Resident).

In old age, energy requirements are lowered but the nutrient requirements are similar or higher than those of younger adults, necessitating the need for more nutrient rich foods. Those residing in RACFs are thought to be at increased risk of malnutrition because of factors associated with the ageing process; including the need for feeding assistance, poor dentition or swallowing and impaired smell and taste which impact on appetite[38,39]. Due to the normal physiologic effects of healthy ageing or the common medical conditions of this age group, healthy older people are less hungry and become more rapidly satiated after eating a standard meal than younger people. Frequent, small meals therefore become essential to maintaining adequate nutritional intake[40].

A study was undertaken in 2008 to determine the prevalence of malnutrition and investigate nutritional issues in a sample of older people living in eight residential aged care facilities (RACFs) in Australia[41]. Half the residents were well nourished with 43.1% moderately malnourished and 6.4% severely malnourished. Prevalence of malnutrition and decreased Body Mass Index (BMI) were significantly higher for residents older than 90 years of age receiving higher level care. Of the residents considered to be malnourished, very few (17.8%) had been seen by a dietitian in the previous 6 months or were receiving commercial supplements. The study identified that there is a need for systematic, coordinated and multidisciplinary approaches to nutritional care for older people in residential care.

The Dietitian's Association of Australia reported in 2012 that despite the prevalence of malnutrition in Australian Residential Aged Care settings being around 40 – 70%, there are no nutritional and

menu planning standards for use in the aged care setting in Australia.[42] A Working Party is progressing the development of these standards in 2016.

There is some evidence that improvements to the dining environment such as mealtime practices (allowing residents to select their own food and assistance with feeding) can increase daily energy intakes, improve weight gain, and reduce behavioural and psychological symptoms of dementia[43].

Applying the principle in practice

Mealtimes can be the highlight of the residents' day. Ensure as calm and welcoming an environment as possible, encourage resident socialisation, and serve the meals in an appetising way, as they would be at home.

- **Homelike dining environment.** Use tablecloths and serviettes as appropriate with daily laundering processes, not paper place mats. Use crockery and cutlery on the table; not trays. Have condiments on the table; salt and pepper shakers, sauces, jams and spreads, and have appropriate cleaning guidelines for communal use. Use teapots and china mugs (where appropriate). Maintain awareness of infection control, e.g. chipped crockery is discarded. Serve main meal and desserts separately on plates and in dishes, not in pre-packaged containers.

  Within local infrastructure and where possible, have a separate dining room, soft background music, have smaller tables and table settings, newspapers, fresh toast cooking, coffee brewing, smells and aroma for appetite, and appropriately prepared food – adequately heated and not cold.
- **Mealtimes involve more than eating.** Mealtimes at home involve meal preparation, often with family or friends, eating the meal, talking, and then cleaning up. Some residential aged care facilities engage residents in meaningful activities around mealtimes including setting the table, meal preparation or serving meals, and encourage socialisation or activities after the meal[44,45]. Regular barbeques may be engaging for residents and encourage involvement by carers / families and staff.
- **Provide support at mealtimes.** Maximise assistance at meal times by rostering staff meal breaks after residents have finished their meals.
- **Enable choice and control for residents.** Create flexible meal times or meal service choices (e.g. self-catering kitchenettes, facilitate room service if preferred). Distribute snacks or finger foods regularly, for example via a snack cart. Have regular menu review and resident satisfaction surveys to maintain variety of food choices on the menu. Recognize the importance of culturally and/or religiously suitable meals and provide for personal choice e.g. vegetarian.
- **Monitor for malnutrition and dehydration.** Implement a standardised process for the identification, management and monitoring of malnutrition and dehydration. For example, the Malnutrition Screening Tool[46] is available in every LHD and should be linked to an Action Plan to address any gaps identified. Regular dietetic review and provision of nutrient dense foods and supplements where recommended.

Multidisciplinary services

The resident has access to person-centred care provided by multidisciplinary services according to his / her needs, choices and availability, to maximise functional ability and quality of life.

MPS Residential Aged Care facilities can provide rehabilitative and restorative services with referral networks for residents who experience high levels of chronic disease, disability and pain and who are at an increased risk of depression and falls-related injuries[47].

What works

Effective multidisciplinary care is reliant on access to **well-coordinated medical, nursing and allied health care**. Established pathways of care, negotiated with local service providers, facilitate timely access to multidisciplinary care as appropriate.

Primary Health Tasmania (one of the national Primary Health Networks) works with residential aged care facilities in a **service commissioning** capacity to provide allied health services to residents who have low care needs. Services are delivered to individuals or groups and include physiotherapy, podiatry, music therapy, exercise physiology, remedial massage, falls prevention and support moving from home into residential aged care. Primary Health Tasmania suggests this approach has enhanced partnerships between general practice, residential aged care facilities, pharmacists, allied health professionals, hospitals and community health care providers and improved the care pathways and access to health services for older Tasmanians[48].

A study undertaken in 2006/2007 identified that people living in residential aged care accounted for 15 per cent of total health care costs for falls-related injury despite accounting for only six per cent of the population aged 65 years and older[49]. Residents of aged care account for a disproportionate share of falls-related hospital inpatient costs. The proportion of people who fall in an aged care setting increases with age, reflecting the age profile of older people living in such facilities. In 2011/12, 26% of falls-related hospitalisations were for people living in residential aged care (21,284 patients)[50]. Allied health professionals have an important role to play in preventing residents from falling and experiencing harm from falls. The NSW Health *Prevention of Falls and Harm from Falls among Older People: 2011- 2015* sets out actions for **falls prevention** in NSW Health Residential Aged Care services (MPSs and State Government Residential Aged Care Facilities). The Australian Commission on Safety and Quality in Health Care has produced national guidelines to inform clinical practice and assist residential aged care facilities to deliver routine multidisciplinary falls prevention interventions[51].

There is marked variation in the availability (or absence) of **Allied Health services** for MPS residents. Potential workforce remodelling utilising the Allied Health Assistant / Activities Officer roles might be a solution to improve access to lifestyle activities and enable routine allied health interventions in small rural facilities for mobility and preventative risk assessments, exercise groups

and falls prevention interventions. Regular dietetic review, medication review for older people at risk of polypharmacy, speech and swallowing assessment, social welfare and occupational therapy services could potentially be provided with mentor or telehealth support established through a larger regional centre.

Applying the principle in practice

Referral pathways can be sourced within the Local Health District to share staffing and resources; in particular using Telehealth to increase access to multidisciplinary services for residents.

- **Negotiate pathways for referral and service delivery with local providers.** Residents can choose to pay for private services (e.g. dental, physiotherapy, and podiatry) or access private health insurance.
- **Access the Extended Primary Care Program** (EPC). Residents of residential aged care facilities can be eligible for EPC which provides up to 5 Medicare-funded Allied Health visits per year if the GP has contributed to a Multidisciplinary Care Plan. (MBS Item Number 731).
- **Manage residents' risk of polypharmacy.** To ensure medication is appropriate, there is a Medicare-funded second yearly rebate available for Medication Review to be provided by a Community Pharmacist (MBS Item Number 903).
- **Encourage uptake and usage of Telehealth** as a mechanism to provide referral pathways and links with professionals in regional centres (eg. specialist services, psychogeriatric, diabetes). There are numerous MBS Item Numbers for specialist consultations using Telehealth; available via MBS Online **www.mbsonline.gov.au/** .
- **Network services to increase access to multidisciplinary services.** Hub and spoke clinic style services can be maintained within health sectors eg. podiatry, oral health, physiotherapy for mobility assessments on admission, outreach visits from community health services for wound care, social work for end of life support for carers and families (bereavement).
- **Support the uptake of exercise interventions that include balance and strength exercises**. This may be done either by engaging an external provider or by enhancing the role of some staff by providing relevant training eg Assistants in Nursing, Allied Health Assistants, Aboriginal Health Workers.

Expertise in aged care

MPS leadership enables staff to develop expertise in aged care and the delivery of resident-centred care.

To adopt a resident-centred approach to meeting the holistic care needs of residents and to raise the profile of aged care as a speciality, staff must be supported in gaining aged care specific skills and creating networks.

Multipurpose Services (MPS) are unique health care facilities that provide a combination of health services including acute care, sub-acute care (including respite and palliative care), emergency, allied health, primary health and residential aged care to meet the needs of the local community. Conflicting ideologies of acute and aged care service delivery compete within an MPS Model and multiskilling is important to optimise human resources in small rural facilities[52]. In most MPS sites, staff rosters rotate across Inpatient, Emergency Department (ED), Primary Health and Residential Aged Care sections of the MPS. Consultation across 10 MPS facilities in NSW found that nurses find it difficult to work across the emergency, inpatient and residential aged care sections simultaneously; shifting continuously between a clinical, curative model of care for patients, to a wellness, enablement model of care for residents. The complexity of this workforce model and the largely clinical-focused culture of care create a potential barrier to cultivating a homelike environment, where emphasis should be on fostering relationships, supporting leisure and lifestyle activities, providing desirable and diverse nutritional options, and promoting independence.

What works

A study undertaken in Northern Queensland identified that while nurses working in aged care have positive attitudes towards elderly people, they have significant knowledge deficits in areas of age-related sensory loss, age-related lung function changes, age-related learning abilities and the specialist care of the older person.[53] An **aged care workforce** position paper[54] released by Aged and Community Services Australia in 2015, recommended that aged care providers and industry bodies work with registered training organisations to identify career progression opportunities with matching educational pathways for people working in aged care. This proactive approach acknowledges the impact of population ageing, and the need for skilled, flexible workers to provide quality and innovative care and support to the increasing number of older Australians.

Adaptive leadership and management styles which empower staff can shift the focus of decision making and care so that resident's values and preferences come first and they are considered a whole person, (rather than a set of functional limitations). Individuals not in traditional leadership roles (eg nursing assistants) may be key to enabling a resident-centred approach.

Whilst MPS deliver a combination of residential aged care, emergency care, inpatient care and a range of community and primary health care services, the focus of staff education is most often on acute and emergency care. Including aged care specific education in staff education calendars within MPSs would raise the profile of aged care as a specialty and support staff in gaining aged care specific skills and expertise.

Applying the principle in practice

Recognise Aged Care as a 'speciality' and strengthen aged care leadership, partnerships and networking across MPS sites and across LHD boundaries to share ideas, resources, recruitment drives, Key Performance Indicators (KPIs) for accreditation and also provide a benchmark for quality person-centred aged care across MPSs.

Developing and fostering expertise in aged care

- **Review staffing profiles and Position Descriptions** (Outpatient / Inpatient / Aged Care profile) to designate time for Residential Aged Care. Define the skillset required within MPSs and structure interview questions to assess aptitude and attitude to resident-centred care.

  Review Position Descriptions of MPS Nurse Managers to reflect aged care as a specialty, and facilitate resident-centred care approaches and capability training for staff.

- **Link MPS sites** for networking and/or education
  - Telehealth – all NSW Health Videoconference units can be linked at no cost via the NSW Health Bridge: Contact eHealth NSW
  - HealthDirect - Using Google Chrome, a free computer to computer audio-visual link owned by NSW Health (similar to Skype)
  - Webex / Webinar – Link via URL and login for education and tutorials.
- **Establish MPS networking streams** either within or across LHD boundaries to enable sharing of education strategies (eg Grand Rounds, journal club, case studies), ideas and resources; to provide peer support in the face of professional isolation and to enable auditing and benchmarking for best practice performance measures to assist MPS in meeting accreditation requirements.

  MPS Networks can also focus on leadership capability development.

- **Recognise Aged Care as a specialty in MPSs.** Consider minimum certification in aged care for relevant staff. CHC33015 Certificate III in Individual Support is available through Registered Training Organisations (RTOs).
- **Establish Aged Care specific and Palliative Care specific education sessions** and build relationships with local private RACFs to share resources and best practice.

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