DTA Guest Lecture: How do we provide best care for those living in aged care? Let's ask them! - 22 Apr, 2021

Audience Q&A's

QUESTIONS	ANSWERS
Is it possible to access the cards Kristiana spoke of?	While I can't make the cards publicly available, I'd be more than happy to send a copy to people who contact me at kristiana.ludlow@mq.edu.au, and to tell them more about the cards. It was great to see so many people interested in these cards so thank you for your question.
Intent of PCC', but what about actuality? There's just no time, because of low staff levels and commitment level of low paid staff to commit or simply spend time with individuals (and that's what PPC is). Once again, how do we overcome these 'issues' when our organisations are fiscally disinclined to embrace PCC?	Felicity: The intent of the Aged Care Standards and the approach of the Aged Care Quality and Safety Commission continue to drive the embedding of PCC, so organisations who don't move toward this will continue to find that their compliance may be impacted. My experience with staff is that their intent is to engage in an authentic and person centred way, however the organisation needs to ensure that both expectations and permissions are clear for staff to be able to do this. The funding of the industry is an ongoing issue, and one that we may well see addressed within the next budget cycle. In the interim, the utilisation of volunteers coupled with the above expectations of the way that every interaction can be PCC (even if the staff member doesn't have ample time available) is critical. Kristiana: Our research found that person-centred aspects of care could become lower priorities and therefore neglected when workloads were high and staffing levels were low. Staff members tended to be task-focused as they needed to ensure that their assigned duties were completed. This sometimes meant that person-centred aspects of care were missed. However, staff members spoke about trying to incorporate person-centred care into their routines, for example, making sure to have meaningful conversations with residents when doing other tasks such as showering, working around residents' preferences (e.g., shower in morning vs night), and creating opportunities for residents to be independent, even if this took more time. The Royal Commission has recommended minimum contact hours between staff and residents. If this recommendation is taken up, this could give staff members more time to provide person-centred care. While this is a good start, research by Kathy Eagar and colleagues suggests that the minimum of 215 minutes (44 registered nurse minutes) recommended by the Commission means that care homes would operate at a 3 star level ("acceptable"). To achieve 5 stars ("best practice") Eager et al. recommends ≥ 264 minutes (63 registered nurse minutes). For reference, the current Australian average is 180 minutes (36 registered nurse minutes) which is a 1 star level ("unacceptable levels of staffing").
Why do so many facilities lose site of these very important factors when looking after our elderly? Will the Royal Commission address this? Will they factor in time for staff to have time and the training to talk to the elderly, at a level that they understand, like having a real conversation asking open ended questions, listening attentively to their reply, showing a genuine interest in what their life was like, what they enjoy doing, what has bought them pleasure and most importantly show them respect, dignity, compassion, empathy and explore their values and spirituality.	The question captures so many aspects of what care needs to look like, and I believe that the outcomes of the Royal Commission are likely to continue to move the industry to deliver care in this way. Both training and service delivery outcomes for aged care service recipients are a focus.

How can we overcome the problem of passivity for the resident in aged care, sitting for most of the day, not engaged in food preparation or simple domestic tasks with spasmodic acitvities (eg walking/dancing), which are two essential movements for us all on a regular basis?	Meaningful engagement in activities is something to be encouraged. The changing acuity of residents living in residential aged care does mean that for many of them, active participation is more difficult. Ageing residents in the community may also sit for much of the day! Certainly if we strive to find the balance between normal life at home, and the care that is required, it will mean that resident goals can include participation in some of the usual activities of daily living that may be both important to them and assist with their maintenance of wellbeing. This does require a culture of enablement, which can be built through training and role modelling on the floor.
I would be interested to know if people feel supported emotionally if you can spend, say for example, 2 or 3 episodes of psychosocial care a week with them? I can't stop with everyone everyday, but I do try to focus on the people that need that little extra support that day, and spread myself out over the week. It's not ideal but I wonder if the residents interviewed recognised this as acceptable?	Felicity: The 'amount' of psychosocial care that people need to feel supported will differ between individuals. I commend you on individually recognising who may be in need of additional support on a daily basis, and responding where you are able. This is truly PCC. Kristiana: I agree with Felicity - some residents I spoke to didn't want a lot of engagement with staff members, or didn't feel there was a need for emotional support from staff – they had friends and family for that. As long as they were respected by staff members, they were happy. Other residents needed a lot of emotional support and interaction with staff members. Like you have done, staff members became familiar with those that needed more time with staff or greater emotional support. Pastoral carers in particular would prioritise their time with residents who were distressed or who did not have regularly visiting family members. This is one of the reasons I think it's important to try to retain staff members and encourage continuity of care - so that staff members can become familiar with individual residents' needs.
You talked about care and compassion.How do you measure that?	Felicity: Measurement of care and compassion may be through a range of means. Customer experience of care is the ultimate measure where it is possible to do so, and whether this be on an ongoing basis (rating after each interaction which is unlikely to be achievable in this industry setting), listening to feedback that may be provided throughout subsequent care and feeding it back, or through intermittent surveys, we need to continue to find ways to listen. Observation of staff providing care by supervisors and leaders is critical - direct feedback about performance will continue to enhance it. Kristiana: To add to Felicity's comment, the care homes I visited as part of my research, obtained resident and family feedback through a variety of measures. There were more formal measures such as satisfaction surveys, and informal measures such as Town Hall style meetings, feedback boxes, and meetings between residents and catering staff to provide feedback on food.
How can we increase staff ratio?	Deliberate decision making to increase staff at the bedside is the conversation that is happening within the industry. When the budget is handed down, we may see measures to ensure that any funding increase is spent on face to face staff to deliver care. The Royal Commission final report indicated a desire to report on minutes at the bedside for both nursing and care staff.

Goals were introduced to the lifestyle assesment where I work, and we are finding that the residents don't understand the language of what is being asked. Responses have been "to go home", "my family" etc, and I find as a lower level employee that managers are telling us what we should be writing and it is difficult. Some things I dont understand is 54% of aged care homes are struggling financially and posted an operating loss in 2019. Will addressing this issue then flow on and allow us to resolve some of these other issues?	The language around goals is challenging for residents without a skilled staff member guiding thie conversation. Our experience has been that Occupational Therapists are often best placed to have these conversations about what has meaning for the individual in their current circumstances, and that staff will increase their skill level in the conversation when working alongside an OT. The operating loss for many providers is an issue that must be resolved in order to ensure security for residents and longevity for the industry. For many providers, the operating loss is as a result of continuing to try and maximise staff at the bedside whilst concurrently managing the large reform agenda that the industry is facing. We again will look to the government to consider increases in funding for the sector.
How do you document intent sufficiently?	Documentation and measurement of intent can be considered from a corporate and an individual perspective. From a corporate perspective, a review of policies and procedures (starting with the Vision, Mission and Model of Care) will demonstrate intent. How the organisation take this information and support an understanding of it by staff on the floor, culture measurement and outcomes reporting related to customer experience will assist with understanding delivery. From an individual perspective, there is the opportunity to screen employees using high level psychometric profiles prior to employment, to understand their drivers. If people care about people in an authentic way, you have a great platform to build on. It is then about staff engagement in training, demonstrable behaviours and performance development engagement to understand an individual's intent.
What do you do when family members don't want to understand, or come to terms witth the fact that their family member is changing?	Beginning the conversation prior to admission is critical. Understanding the diagnoses may be helped through attendance at information sessions (individual or group) early in the resident's stay. Addressing the emotional impact of resident's decline is critical - the grief, loss and distress may be supported through engagement with support staff at site (may be clinical, chaplains or another person on site who has a good relationship with the family). Care plan reviews or incidents may trigger a meaningful conversation with the resident/family about the likely progression of deterioration.
How do we retain good staff in aged care, when disability seems to have less standards and better pay?	The difference in both standards and pay levels between these industries is a very real issue in terms of recruitment and retention. Until we see some changes to increase alignment (and we are hoping the government will make changes to see this happen), we need to consider how a positive work culture will retain our high performing employees. For many individuals, being in a supportive and engaging workplace will be the choice that they make. Whilst this can be consideration of events and milestones in a workplace, for many people it is more the day to day experience of the way that they are spoken to, the support that they receive and the celebration of the small wins that makes the real difference.