

Aged Care Association Australia (NSW) 21st Annual Congress
May 14-15 2009, Sydney

**PRACTICE-DRIVEN
RESEARCH:
RELEVANT, ROBUST &
REWARDING**



Sydney Melbourne Brisbane Ballarat Canberra

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Practice-driven research (PDR) © McDonald, T. (2006)

Context:

- Two decades of evidence-based practice
- Concurrent development in
 - ▣ technology
 - ▣ accountability
 - ▣ regulatory compliance
- ‘Silver bullet’ mentality about research
- PDR positioning in the very real world of aged care

Project 1:

Adding years to life and life to years

Project goals:

- ❑ Objectively assess health and wellbeing of residents
- ❑ Individually designed therapy program
- ❑ Evaluate benefits of therapy and care interventions
- ❑ Compare measures of physical capacity and quality of life

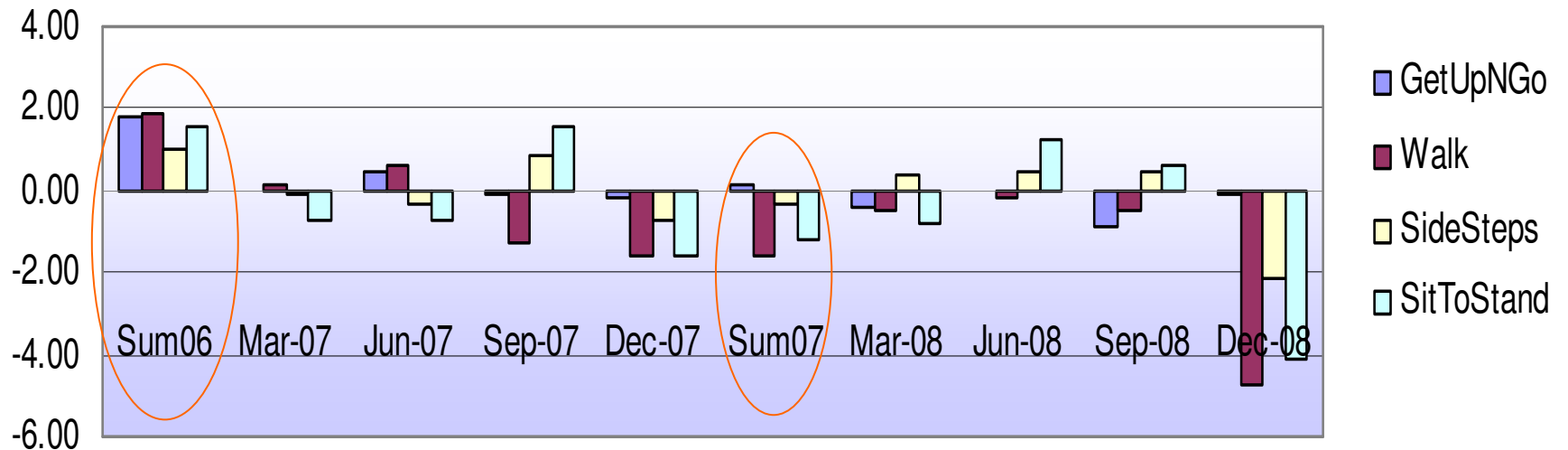
How do we know if we are achieving outcomes in life and quality?

Monitoring and measurement

- Quality of Life and Physical Function measures monitored and evaluated on 10% of low care resident population
- Assessed quarterly
- Outcomes measured are monitored and evaluated by registered nursing and allied health staff
- Strategies implemented to investigate and remedy any factors found to be affecting individual resident outcomes

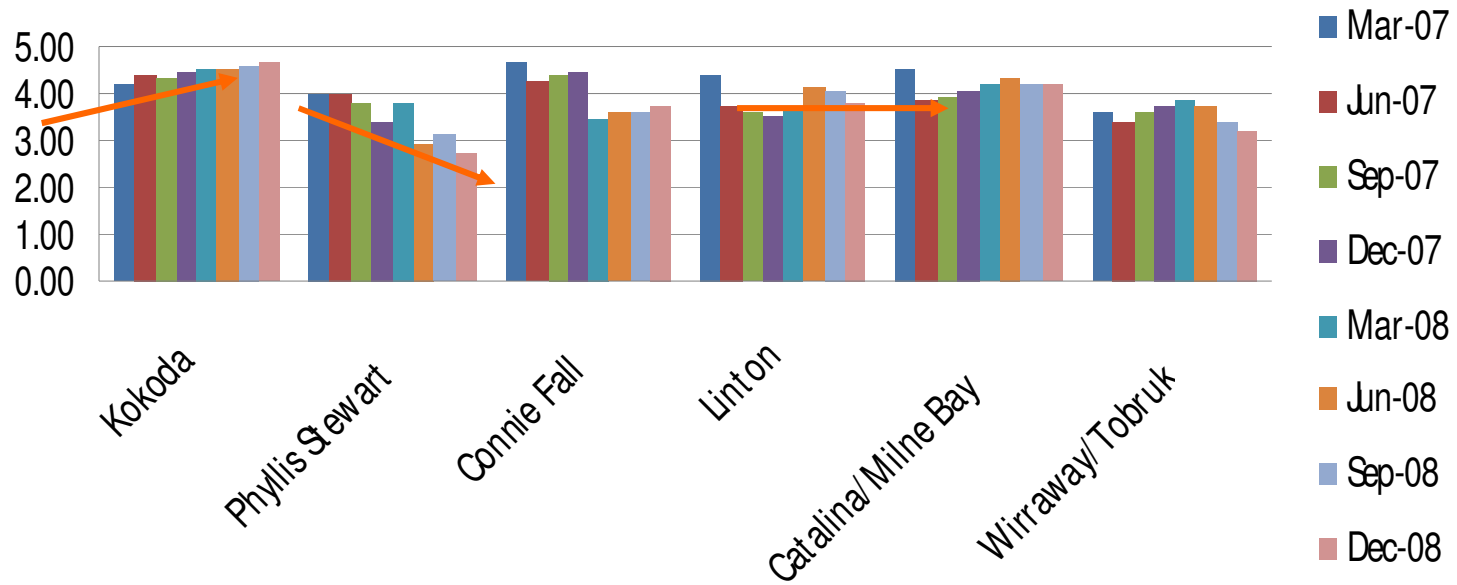
Results

Average Functional Improvement (FI) for all residents 2006-2008 (All functions measured in seconds)



Results

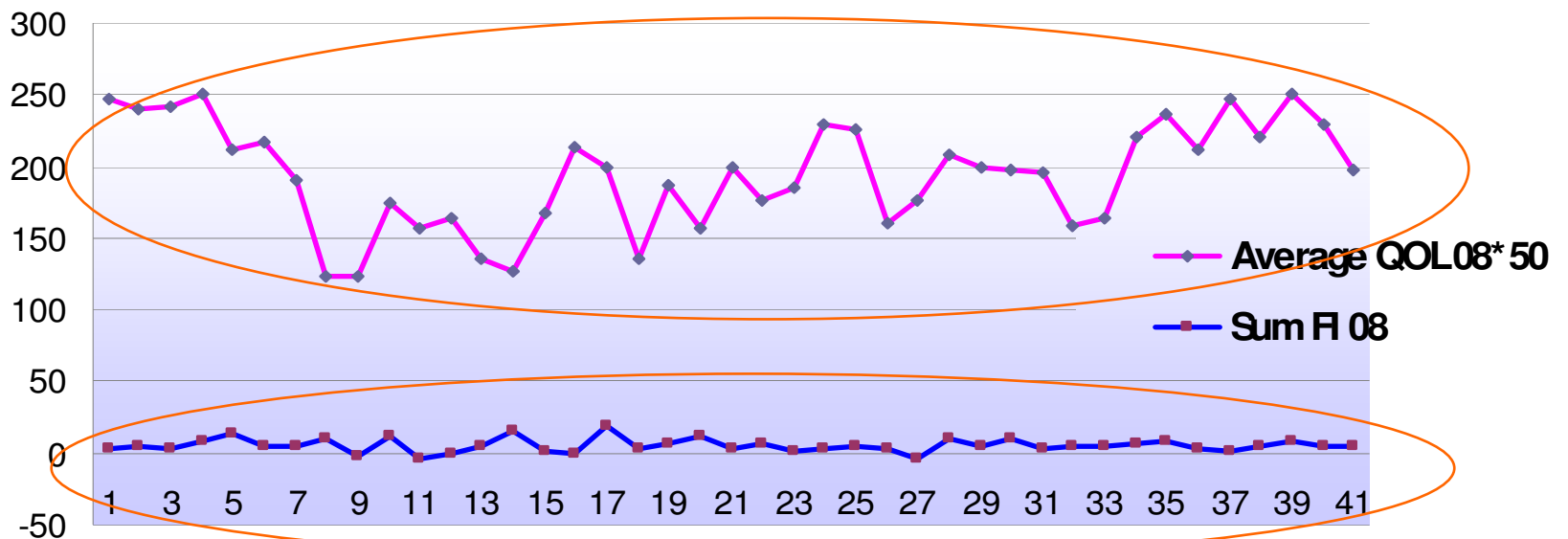
Quality of Life (hostel averages) 2007-2008



Results (average per person scores)



Average Quality of Life for 2008 and Sum Functional Improvement for 2008



Project 2: Mental Health Clinical Pathway

Goals:

- Design and implement best practice model for mental health care
- Introduce psychosocial and non-pharmacological approaches to mental health issues
- Clinical Pathway tailors care, treatment and support to individual psychiatric needs

Assessment and monitoring

Hostel	N° beds	N° assessed (October 2007)	N° flagged	N° on MHP (April 2008)	% of residents on MHP
Peter Cosgrove House	161	130	98	21	13.0
Phyllis Stewart	54	47	31	16	29.6
Connie Fall	65	37	28	26	40.0
North West	73	66	44	19	26.0
Kokoda	63	54	41	28	44.4
Wirraway	40	38	34	12	30.0
Tobruk	43	32	25	15	34.9
Totals	499	404	301	137	27.45%

Implementation and monitoring

Process:

- Each care unit is required to show how the mental health approaches are of benefit to specific residents
- Mental health care is shown in records of case conferencing with families
- All residents were reassessed in December 2008 to determine changes in their condition and effectiveness of the pathway

Project 3:

Enjoyable mealtimes in dementia care units

Goals

- Ensuring mealtimes are socially rewarding for diners
- Staff attitudes and approaches particularly important
- Factors identified that either enhance or impair mealtime experience
- Mealtime protocols and staff training implemented
- Regular re-testing, observational studies

Enjoyable mealtimes in dementia care units

Monitoring

- Observational studies carried out 6 monthly in dining rooms without prior notice
- Nurse unit managers monitor daily and carry out staff coaching when required
- Residents' families informed and involved in mealtime processes

Enjoyable mealtimes in dementia care units

MEALTIME ELEMENT	FACTORS	October 2007 RESULTS		April 2008 RESULTS	
		+ve	-ve	+ve	-ve
Staff Approach and Attitude	Verbal Interaction	67	6	69	2
	Non-verbal Interaction	74	0	117	0
	Assistance/Directives	41	7	66	5
	Cues to intervene	49	19	41	10
Environment	Medication trolley	0	6	8	0
	Staff	6	2	8	0
	Noise levels	10	4	9	0
	Seating arrangements	18	20	37	2
Regulation of Meal	Timing	24	3	19	0
	Meal Plan	19	3	6	0
Totals		308	70	380	19

Results: + ve elements ↑ by 23.8% - ve elements ↓ by 72.8%

Project 4: Positive connections

Goals

- To foster adult-to-adult relationships between residents with mental confusion and general care staff
- Enable staff to interact with the person rather than their dementia

Research-based mechanism

- Easy to read bio of resident kept in care file

Positive connections

Process

- Care staff attitudes and perceptions measured before and after implementation and again in April 2008
- Annual reassessment of staff attitudes and perceptions will inform both policy and education

Positive connections

Evaluation themes	2006 (n=13)		2008 (n=23)	
	Better	No effect	Better	No effect
A. Giving individualised and quality care				
1. Feeling intimidated by the residents' behaviours	2	3	4	1
2. Useful information for care and treatment times	4		6	
3. Understanding the person better	10		5	
4. Knowing their values and what they like	4		3	
	78.2%		94.7%	
B. Knowing personal preferences of residents				
1. Knowing residents' tastes in little things	1	1	5	1
2. Confidence regarding residents' preferences	1		3	1
3. Better interactions on a personal level with residents	3		9	
	83.3%		89.5%	

Positive connections

Evaluation themes	2006 (n=13)		2008 (n=23)	
	Better	No effect	Better	No effect
C. Accessing background information on residents				
1. Feeling rejected by resident when trying to assist	2	1	5	
2. Easy to find information now	11		2	
3. Knowing who they are helps me to form bond with resident	2		8	
	93.75%		100%	
D. Team and family support for staff in units				
1. Confident of meeting family expectations of resident's care	3		4	
2. Understanding family dynamics because of knowing their history	1		3	
	100%		100%	
Total responses:	44	5	57	3
	89.79%		95%	

Project 5:

Specialist wound care service

Goals and processes

- Specialist wound care clinician employed and trained
- Whole-of-organisation approach to wound prevention, treatment and management
- Wound care training for all staff

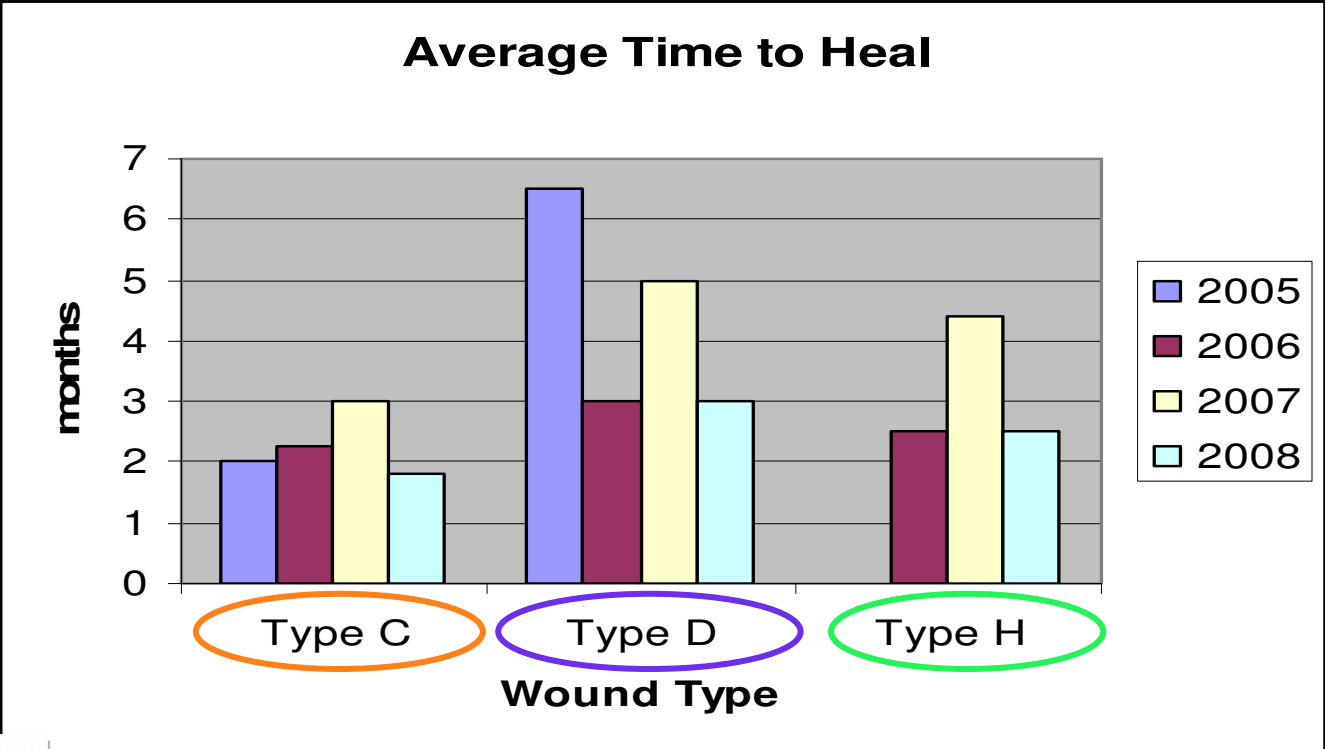
But how do we know if the service is generating good clinical outcomes?

Wound assessment and monitoring

Process

- Detailed medical history to identify skin integrity or personal healing capacity issues
- History of ulcers
- Mobility
- Nutrition and hydration
- Determine risk of sustaining injury or a wound

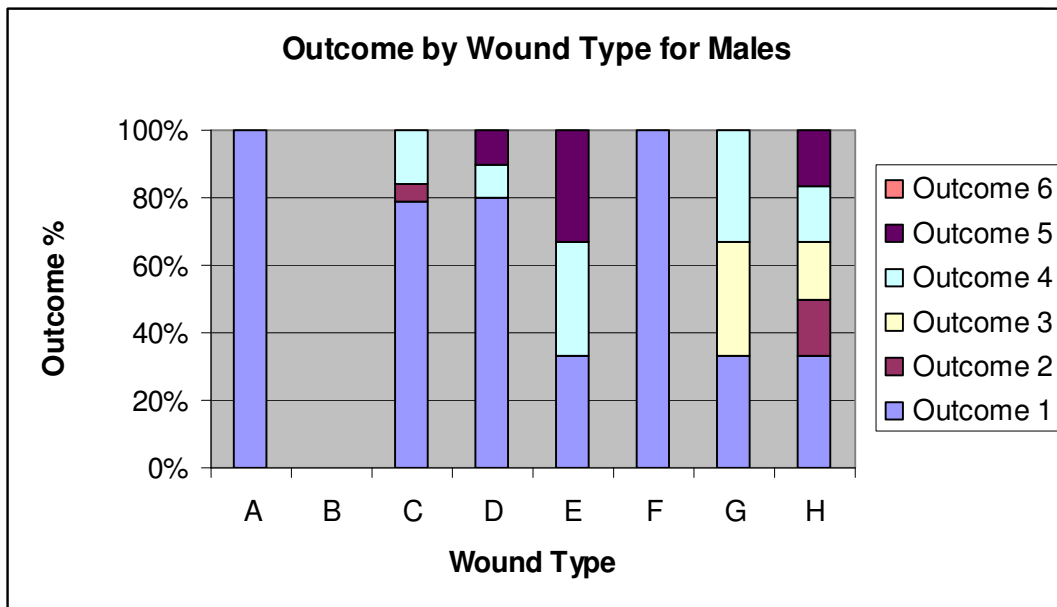
Wound assessment and monitoring



WOUND TYPE

- A = infection
- B = burn/excoriation
- C = injury, skin tear**
- D = vascular ulcer**
- E = malignancy
- F = surgical wound
- G = cavity / sinus
- H = decubiti/necrosis**

Wound assessment and monitoring



OUTCOME OF TREATMENT

7 = deceased (*not graphed*)

6 = unknown /no report (*orange*)

5 = referred to surgeon (*brown*)

4 = GP/specialist referral (*aqua*)

3 = palliative (*cream*)

2 = partially healed (*maroon*)

1 = fully healed (*blue*)

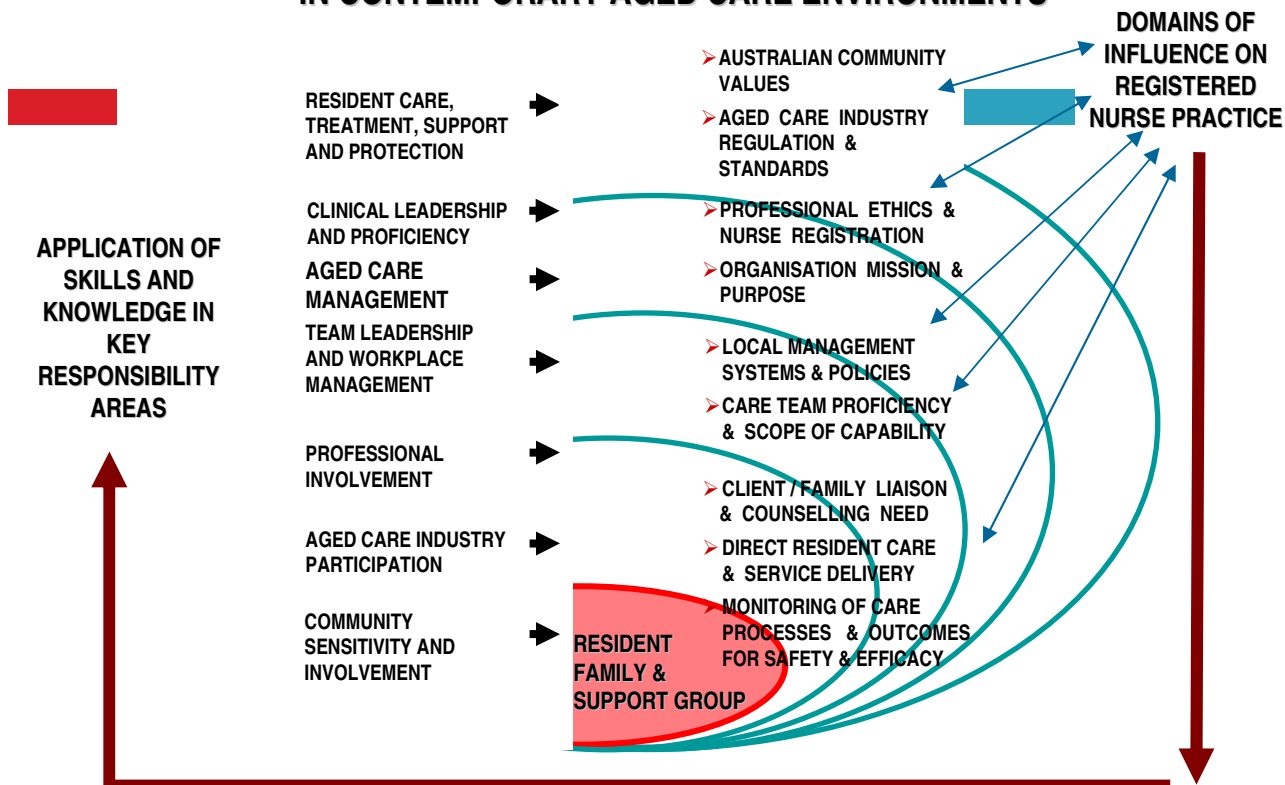
Project 6: of RN practice for contemporary aged care

Model

Rationale and benefits

- Differentiating role of registered nurses working in aged care from nursing practice in acute hospital environments
- Acknowledging full role of aged care registered nurses
- Foundation for recruitment and retention of nursing and care staff

CONCEPTUAL MODEL for REGISTERED NURSE PRACTICE IN CONTEMPORARY AGED CARE ENVIRONMENTS



AGED CARE NURSES:

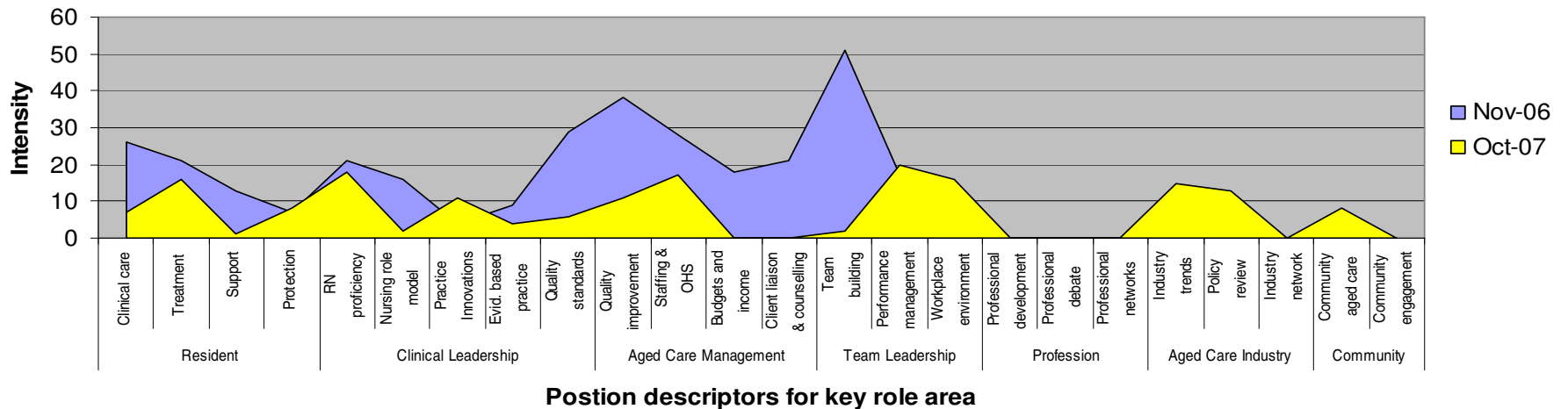
- ... **operate** with multi-disciplinary teams to prevent health breakdown and to maximise ability, self-sufficiency and independence
- ... **focus** on the resident whose need for nursing arises from functional deterioration related to advanced age and morbidity
- ... **aim** to provide appropriate care to the resident & family in ways that enhance quality of life.
- ... **promote** constructive attitudes to ageing and spiritual well-being of residents, families & colleagues
- ... **work** to minimise harm, promote adaptation, & provide appropriate end-of-life care as needed.

Implementation and monitoring

- Model of Practice incorporated into RN Committee meeting agenda
- Uptake monitored by observing participation in RN meetings re topics and enthusiasm during meeting
- Focus of RN moved from problem-oriented discussion to broader one inclusive of the profession, aged care industry and community

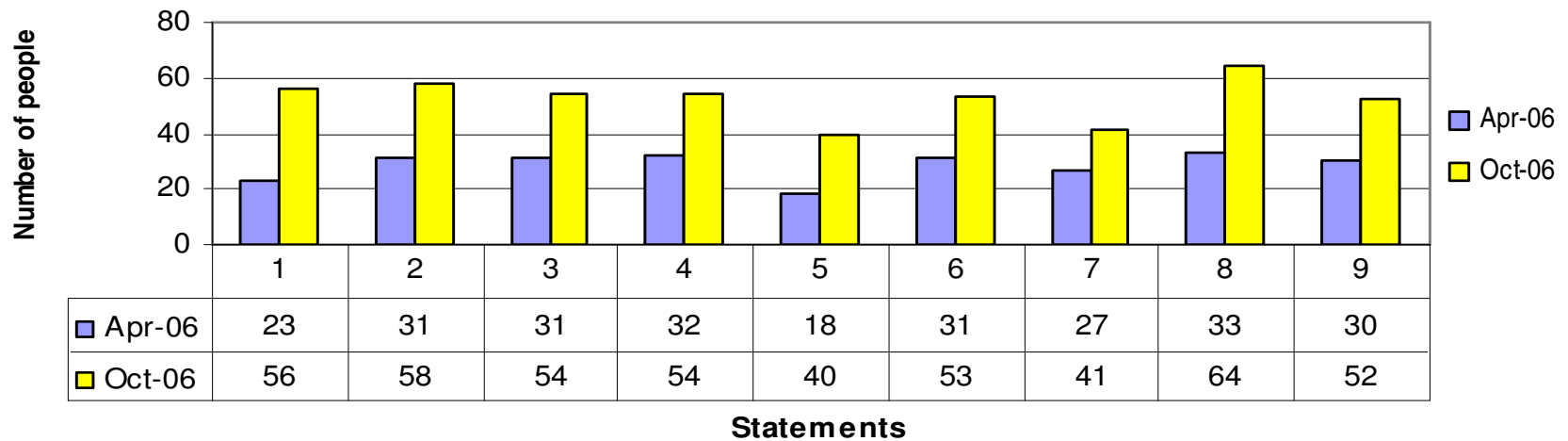
Results: RN role involvement

Intensity of discussions per key performance areas over two RN meetings



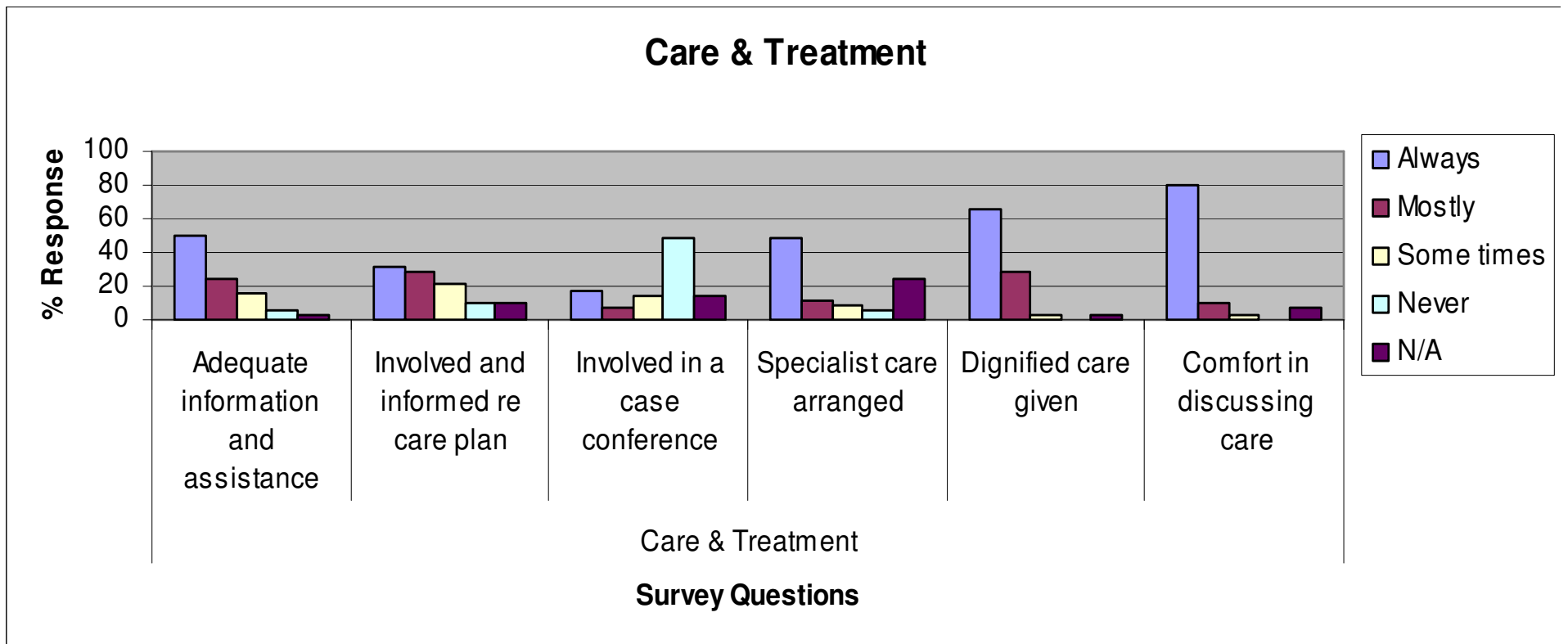
Results: Staff satisfaction

Number of people agreeing with the statements



Results 2008:

Resident/Family views of RN performance



Summary:

- ❑ Practice-driven research centralises the experience and insights of practitioners in aged care
- ❑ These insights can be evidence-based or intuitive
- ❑ Research derived from practice questions add quality and value to the unique aged care context
- ❑ PDR builds confidence in accessing and using research processes and judging findings in terms of relevance, robustness and whether the rewards (outcomes) are feasible and worthwhile.

Thank you

When we guide our lives by "our own pondered thoughts", it then is *our* life that we are living, not someone else's.

[Robert Nozick \(1989\)](#)

