AUSTRALIAN ACADEMY OF CLINICAL LEADERSHIP
making a difference

White paper: How to establish consumer directed care in your residential aged care service

"We want to remain in control over our own life and money ... even in a residential home." (Commission for Social Care Inspection (England), 2006a).

What is it?

Moving to consumer directed care (CDC) in residential aged care is in its essence about shifting from a task-centred orientation to a person-centred orientation. An approach where residents and the staff are empowered to operate at their very highest levels - to be their absolute best selves.

But this requires a shift from delivering basic care to advanced social, emotional and nursing care within a staffing model that is no longer rigidly defined by external factors, such as EBAs and professional turf, but is flexibly shaped by the

people and their strengths. One in which every member of the team is no longer separated by insurmountable divisions and role conflict but are enabled to operate at their highest level of skill, encouraged to extend their knowledge and roles, and work autonomously in collaborations with each other.

Why make the shift?

The key imperative driving the need to adopt a CDC approach to residential aged care is that the consumer is becoming incredibly discerning, and they have many more options than residential aged care services than ever before. So, despite an ageing population, residential aged care services will find it more and more difficult to maintain waiting lists and occupancy.

Over the past 13 years, the proportion of residents aged 90 and over at admission has increased from 16.8 % to over 21% - nearly a quarter of all residents are now over 90 years old! The shape and role of residential aged care must change of necessity. Aged Care Services are becoming the new aged care hospitals - they will increase their focus on advanced clinical specialties such as palliative care, diabetes, cancer care, wound management, dementia care, coronary care and other chronic disease. And of course the roles of nurses and PCAs will need to change to accommodate this increase in acuity. But there is a risk that with this increased level of acute care and specialised health support targeted at the physiological well-being of the person, staff attention might be diverted from the person's other needs - their social and esteem needs, and the need to self-actualise. This lack of attention to the resident's higher order needs is associated with depression. The evidence is that up to 40% of people living in long term care has depression.

In a large study across NSW in 1999-2000 it was found that older people living in the community fear loosing their independence almost as much as they fear loosing their physical health (Quine, 2007).

In 2006, Tucker found that up to 50% of nurses work was not related to direct care at all. Similarly, in a recent study I found that over the course of a 24 hour period, a resident might only get around 2 hours of attention from the nursing staff and this was generally devoted to their physical and safety needs. These people were receiving little emotional and social attention at a time when they were going through one of the most significant phases in their lives - grieving for their lost homes, independence, loved-ones and health.

But what we often don't talk about and which is probably the real problem is dis-empowerment. This is the root cause of depression, deteriorating residents, diminishing functional ability and even work overload for staff. When people enter aged care services or hospitals, they enter into a relationship that is unequal in terms of power - whether we nurses realise this or not the resident is at a disadvantage in this relationship because they become totally reliant on us to meet their every need - even going to the toilet is controlled by us.

But this is the nub of CDC - turning this around and empowering the consumer.

The benefits of CDC in residential aged care

The benefits of empowerment is a heighten sense of self-worth, which prevents and reduces depression. KPMG found that clients who received high care CDC packages actually reported more satisfaction owing to their ability to continue participating in social and community activities, to visit family and friends, their home life and close relationship and their health and well-being improved.

The evidence shows that the residents, staff and organisation benefits in the following ways:

Resident outcomes:

- maintenance of independence & functional ability
- Prevention of nursing sensitive conditions
- reduction in depression
- reduction in aggression
- reduction in neuroleptic drugs
- customer satisfaction
- Improved quality of life

Staff outcomes:

- Reduced workload
- working at highest potential - recognition of strengths
- improved autonomy
- improved interdisciplinary collaboration
- reduced monotony
- improved sense of purpose
- Improved satisfaction

Organisational outcomes

- improved talent attraction & retention
- improved staff engagement
- reduced staffing costs
- reduced customer complaints
- reputation - waiting lists
- improved agility to respond to changes

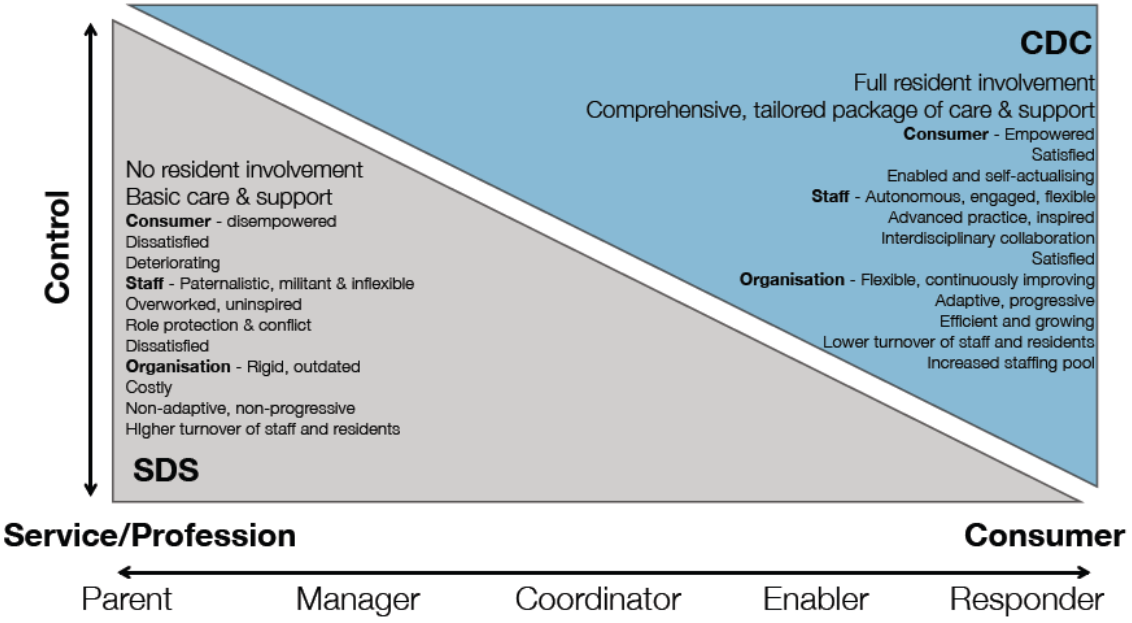
How to embed CDC into residential aged care

It will take a mammoth mental shift for many of us health professionals to take on this new way of caring in residential aged care. Where we "become more like advisers, counselors and brokers, guiding people to make better choices for themselves"(Leadbeater, C., Bartlett, J., & Gallagher, N. (2008). Making it personal. London: DEMOS.)

Nurses are doers. We get things done. Fixing other people's problems and advocating on behalf of those we deem to be helpless - this has been our strength - but could now become the biggest obstacle to overcome as we hand over these responsibilities to our residents and families. To move from doers to enablers, we need to make a quantum mental shift. This re-enablement mindset needs to permeate leadership, management and practice.

In the management development arena we talk about management style and we know how significant this is in setting workplace culture. And how a manager behaves provides the single most powerful message to staff about how they should behave. So an incredibly paternalistic or controlling manager will micro-manage - removing any opportunity for staff to use their own initiative or autonomy - this manager disempowers their staff, making them dependent.

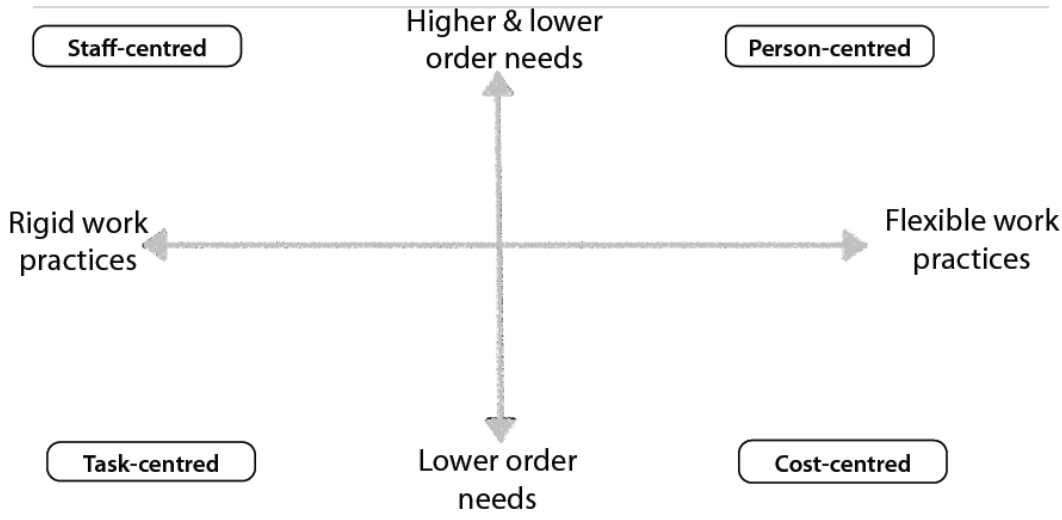
Now take the concept of management style and turn it into "carer style". Carers, whether they are family, nurses or PCAs, can disempower their patients and residents in the exactly the same way that managers can do this. And I argue that carer style can be placed on a continuum from parent to responder (refer to following diagram).



So how do you foster CDC in residential aged care - how do you create a culture that encourages an enabling style of caring where the staff, residents and family work in partnership?

Person-centred aged care (PCAC) is where residents' needs define what work is done, how it is done, by whom and when. People work at their highest levels, collaboratively and freely between roles. Staff spend most of their time focusing on meeting the residents needs - which, according to Maslow range from lower order physical and safety needs, to higher order social, esteem and self-

actualising needs. Residents and staff are encouraged to strive for self-actualisation. In essence, PCAC is meeting the resident's whole needs, using flexible and responsive work practices (refer to the following diagram).



The alternatives are:

Task-centred - this is very controlling; where the work staff do and how they do it is dictated by their routines and traditional roles - not the residents' needs. The resident is shoehorned into these routines. Inefficient work practices (ie. rigid roles) mean that some staff are overwhelmed and others are underwhelmed - and staff don't have time to meet all of the resident's needs. Little time is actually spent with the resident.

Cost- centred - where work practices are flexible but there remains little time or resources to focus on anything but the resident' lower order needs. Being cost-centred at the expense of meeting the residents needs means focusing on what is minimally required to get the job done, with the fewest resources. The focus is on achieving high productivity. This model values output over quality of care. Little time is spent with the actual resident.

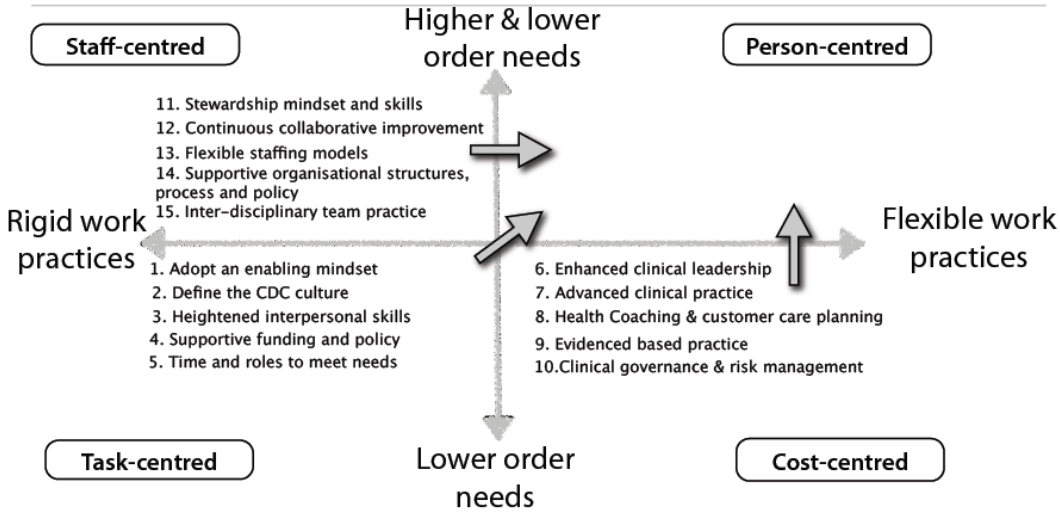
Staff-centred - where staff expand their focus to include the resident's whole needs - but don't change the way they work or their style - they retain control.

I have found that in the main, aged care staff really want to spend more time with the residents but what tends to happen is that staff define person-centred aged care and take tentative steps toward it from the comfort of their routines. They continue to shoe horn the residents needs into the rituals and routines defined by the staff. More time is spent with the resident, but within strict routines and roles. What happens is that people say "of course we can spend more time with the resident, but we will need more time - or more staff to do this." This is

what KPMG found in their evaluation of the CDC Pilot: CDC for some organisations was simply adding more services which is a very expensive proposition and probably not going to make much of difference to the resident's sense of self and wellbeing anyway.

The 15 steps

There are 15 key steps to creating a PCC and embedding CDC into residential aged care:



To move from task-centred to person-centred we need to start with the individual staff, management and organisational mindset - or culture. This is about

1. **Adopting an enabling mindset and**
2. **Defining the CDC culture.**

CDC is a paradigm shift for residential aged care. Community care has been practicing something like CDC for some time - it is a version of the Active Service Model. It comes from the disability sector and is designed to enable people who are loosing their functional ability to retain their self-determination.

But this model works in all facets of life. Douglas McGregor, way back in the 1960s developed the Theory X and Y model of workforce motivation. Managers who ascribed to theory X held the belief that workers were fundamentally useless and lazy and needed to be managed closely. Theory Y managers held the belief that workers were like anyone - they were valuable and able, and self-motivated to do their best, and it was the manager's job to figure out how to get the most out of their people. In my work with leaders and managers, they consistently identify a management style that is enabling as more motivating than one that is controlling. However, I also see plenty of evidence that many managers in aged care seem to hold the Theory X view of their staff. Shifting to a more empowered and enabling approach to managing will take a shift in the

management mindset. And this is a key to fostering a CDC way of working in staff.

Because, in a way, staff also hold a Theory X and Theory Y view of their residents which invariably influences how they treat them. If we believe our residents are useless, then they will be - we will do everything for them, leaving them little choice and little need to maintain their own functional ability. If we believe that they are adults with rights to self-determination, and gain insight into their abilities, values and passions, then we will take on that enabling mindset - and create opportunities and remove barriers to self-actualisation.

So, my theory is that if an aged care manager adopts an enabling mindset - and truly believes in the strengths and value of their staff, then they will create a culture where this style is then exhibited by the staff toward the residents. Rather than seeing their job as 'doing stuff' for the residents, they shift their view that it is about enabling the resident to be their best - to retain their faculties and their self-determination.

Similarly with residents' families and carers. In fact, KPMG found that carers who were more actively engaged in the planning of the CDC packages felt they were being recognised and valued as carers - often for the first time.

> *"But it takes an investment in skills development and also time in designing and promulgating the culture."* (KPMG)

3. Develop sophisticated interpersonal skills.

CDC requires a genuinely collaborative approach to care - one in which the resident is an equal partner and actively contributes to their care planning process. Collaboration values the input of all those involved equally - so there will be plenty of opportunity for disparate views on how best to meet the residents' needs. In the old regime, the nurse or the doctor was right. It took very little interpersonal skill to manage in this environment. However, to negotiate the different world views and come up with a third alternative (as Covey would put it), there needs to be very sophisticated interpersonal communication, where the difficult conversations are not avoided, and differences do not lead to conflict.

4. **Sufficient funding to deliver the care and services required** – Lobby government to deliver policy and funding that encourages and supports CDC - rather than inhibits it. For example, many have found that the current ACFI funding formula favors reactive strategies to behavioural issues rather than pro-active and preventative strategies.

5. **Ensure staff need to have the time and role capacity** to meet the residents' needs. This mean ensuring that there are no gaps between staff roles for residents' needs to be missed. For example, residents are not left alone for long

periods of time because staff are away doing other 'tasks' – or those available do not see it as their job.

To enhance the service's capacity to meet the resident's high order needs as well as their lower order needs, the following 5 strategies are required:

6. **Enhanced clinical leadership** - Shifting staff focus from task to person-centred will take a cultural transformation, which needs strong clinical leadership - leaders who can inspire and motivate their staff to fundamentally change how they practice and work together. Clinical leadership is also about making sure aged care is based on the most current evidence. Nursing managers and RNs in particular have a critical role here because they are the most highly qualified (clinically speaking) to promote best practice and to mentor those around them.

7. Advance their skill levels: To cope with the increasing frailty, acuity and complexity of residents, all staff will have to advance their skill levels. But RNs in particular will need to operate at a much more advanced, autonomous clinical level - being able to perform advanced clinical assessments, diagnose and managing exacerbation of chronic illness (such as diabetes, pain management) episodic acute illness (such as UTIs and URTIs, wounds).

8. Adopt a health coaching approach to care planning: To genuinely engage the resident and their family in CDC, nurses will have to adopt a health coaching approach to care planning. This approach allows the residents to express their view of what their highest potential is - the goals and objectives that they want to achieve - and how these can be met in a way that taps into the strengths and resources of the residents, family and the service.

9. Evidence-based practice means following current evidenced clinical guidelines and continually reviewing practice to makes sure this reflects best practice. This is standard practice in acute settings, but less so in aged care - taking this approach will do away with variable and questionable practices - and also improve your medico-legal standing should anything go wrong - as it invariably does in health and aged care, which leads me finally to

10. Clinical governance and risk management: Ensuring there is a robust clinical governance and risk management infrastructure - this comprise all of the policies, processes and roles that work together to ensure the best possible clinical outcomes for residents.

So what can be done to improve staff flexibility and move toward PCAC?

11. **Manager need to become multipliers of people effort, and adopt a steward mindset** - one that values the survival and growth of the organisation. Their focus broadens from only focusing on resident well-being to focusing on the well-being of the organisation.

12. Fostering a **continuous collaborative improvement culture** - where everyone takes responsibility for identifying and fixing problems, and finding better ways of meeting resident needs.

13. **Creating flexible staffing models** in which every single staff member, be they carer or hotel staff - are working at their absolute highest level - and their roles might be interchangeable depending in the circumstances. With the right approach, staff will become open to changing their roles because they know that they will be allowed to practice in the areas of their strengths. The staff model will be designed to meet the skills and strengths of the staff, and the needs of the residents - not by rigid, state-based policies or EBAs.

14. Supportive organisational structures, process and policy - For truly flexible and responsive work practices, staff should be enabled to make decisions as close to the point of service as possible - rather than wait for managerial approval - the policies, procedures and governing structures should enable this. And this also extends to government policy and funding.

15. Inter-disciplinary team practice - PCAC relies on genuine collaboration between staff. In all of my workshops it has become clear that every member of staff have something of great value to contribute to the care of residents - but can only do this if they are working in collaboration - rather than in silos.

So, there you have it - to achieve CDC in residential aged care, you have to tick off all 15 steps.

The PCAC Program

The PCAC Programs have taken aged care staff and managers through these steps, building their understanding, skills and commitment to delivering PCAC using a CDC approach. The Programs are action based, highly interactive and focus on participants specific work context. The aim is to inspire and skill up staf and managers to genuinely adopt a PCAC approach to their thinking and practice.

The Programs include the following modules, which can be delivered as a complete package or separately:

The PCAC Workshop (One day program): All staff engagement program designed to actively engage staff in defining what PCAC means in practice and the practical steps, practices and strategies they need to take to embed it in their area of work. At the end of this program, a champion group is often convened to lead the charge and ensure all staff come on board.

Continuous Collaborative Improvement (3 day program): Designed to engage the champion group in developing their skills, the tools and process for leading

change and continuous improvement across their organisations. Participants can come from all parts of the organisation.

Leadership for PCAC – This program runs from 1.5 to 5 days depending on the key competencies that are needed. It is particularly designed for the leaders and managers in the organisation, focusing on how they can lead their people and foster a culture that support PCAC and CDC practices. Mentoring sessions are also available to support managers to further develop their thinking, skills and strategies to address real problems, and lead change.

Practicing and leading using a CDC approach (2 day program): Engages the clinical staff in challenging their thinking about resident empowerment, encourages them to adopt an enablement mindset and the skills to recognise the deteriorating resident and undertake powerful health coaching conversations and care planning.

Next steps

I recommend that you take the following 4 steps to get started:

1. Consider which quadrant your organisation currently sits in – how PCAC is it?
2. Identify the factors that could be keeping you there?
3. Engage your staff in discussing what CDC means to them – how could they do this in practice and what do they believe are the benefits and what could get in the way.
4. Contact me to discuss which quadrant your aged care facility is currently occupying and how to move it to the PCAC quadrant. We can consider how a PCAC Program could be tailored to meet your particular needs.

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