Maggie Beer's

BIG MISSION

PERSON-CENTRED CARE

There are many advantages to using a person-centred care approach when caring for older adults, but achieving it in residential care requires a multifaceted approach. Read on to learn more about person-centred care and how the "Partners in Care" model was successfully implemented at Meath Care during the experiment.

In this worksheet we learn;

- ✓ The importance and key elements of person-centred care
- ✓ Potential barriers to person-centred care in residential care
- ✓ How Meath Care's "Partners in Care" model was implemented
- ✓ Initial findings from the experiment

Why is person-centred care important for older adults?

Evidence shows that person-centred care offers several significant benefits for older adults, including:

- ✓ **Improved satisfaction, quality of life and wellbeing**
- ✓ **Better health outcomes**
- ✓ **Increased autonomy and empowerment**
- ✓ **Improved communication and relationships**
- ✓ **Reduced hospital admissions and readmissions**
- ✓ **Holistic care (care addressesing the whole person, including their physical, emotional, social, and spiritual needs)**
- ✓ **Better management of dementia and cognitive impairments**
- ✓ **Enhanced family involvement and support**
- ✓ **Cultural, ethnic and religious sensitivity, and inclusiveness**

Author Elizabeth Oliver

What is person-centred care?

Person-centred care (PCC) is a healthcare approach that focuses on the individual needs, preferences, and values of each person. Person-centred care is applicable across various healthcare settings, including hospitals, GP clinics, mental health services, in-home care and residential care.

What are the key elements of person-centred care in relation to older adults?

The key elements of person-centred care in relation to older adults include:

1. Respect and Dignity – Treating each older person with respect and valuing their preferences, needs, and values.

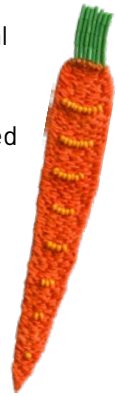
2. Empowerment – Empowering older people to manage their own health and wellbeing, often through education and support.

3. Information and Communication – Providing clear, timely, and relevant information to older people and their families to help them make informed decisions about their care.

4. Participation and Collaboration – Encouraging and enabling older people to take an active role in their own care, including decision-making processes.

5. Holistic Approach – Considering the whole person, including their physical, emotional, social, and spiritual needs.

6. Coordinated Care – Ensuring that care is coordinated across different services and departments to ensure consistency and continuity of care.



Why doesn't person-centred care always happen in residential care?

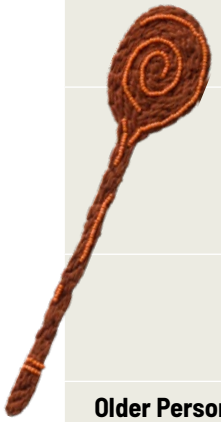
It is important to remember that residential care is a 24-hour day, 7-days a week, 365-days a year business. Whilst it is an honour to be able to care for older people in their last chapter, it requires a coordinated effort to be able to carefully tailor care to each resident.

Implementing person-centred care in residential care can be challenging due to various barriers which can arise from different levels, including organisational structures, staff attitudes and behaviours, and systemic issues.

Listed below are some common barriers to person-centred care:

Area	Barrier	Examples
Organisational	Resource Limitations	Insufficient staffing, time, equipment and resources can limit the ability to provide person centred care.
	Rigid Protocols and Policies	Strict adherence to standardised protocols may hinder the flexibility needed for individualised care.
	Workload and Time Pressures	High caseloads, tight schedules, and restrictive protocols, policies and duty lists can make it difficult for staff to spend adequate time with each person.
	Limited consideration of the built environment	Big, busy, noisy, institutional environments that can cause residents to become agitated and resistive due to overstimulation.
	Breakdowns in communication channels	Staff don't know what is happening, so feel disconnected and disempowered.

	Lack of leadership	Staff may not feel valued or supported, so don't feel inclined to give 100% effort. Or staff are not sufficiently supported / empowered / resourced to deliver the vision.
Workforce	Staff Issues	Staff not knowing the residents or their needs due to high staff turnover or over-reliance on agency staff.
	Lack of Training and Education	Staff may not have the right skills or knowledge to do their job. Staff may not have adequate training in person-centred care principles and communication and relational care techniques.
	Attitudinal Barriers	Staff may have paternalistic attitudes, believing they know what is best for the older adult without considering the person's preferences. They may also underestimate a resident's capacity and potential, resulting in over care and excess disability.
	Resistance to Change	There may be (initial) resistance to adopting new practices and approaches, especially if they require significant changes to established routines.
Older Person-Related Factors	Cognitive Impairments	Older adults may experience conditions such as dementia which can impact their ability to make informed decisions and to manage their own health without tailored support.
	Communication Barriers	Language barriers and sensory deficits can make effective communication difficult.
	Health Literacy	Older adults with low health literacy may have difficulty engaging in decision-making processes.
	Cultural Differences	Differences in cultural beliefs and values can impact the understanding and implementation of person-centred care.
Systemic Issues	Fragmentation of Care	Lack of coordination between different departments / services can lead to fragmented care, making it difficult to implement a cohesive person-centred approach.
	Regulatory and Policy Barriers	Regulations and policies that do not prioritise or support person-centred care can be significant obstacles.
	Inadequate Information Systems	Poorly integrated health information systems can hinder the sharing of resident information necessary for coordinated and individualised care.
Measurement and Evaluation	Lack of Metrics	Difficulty in measuring the effectiveness and outcomes of person-centred care can impede its implementation and improvement.
	Inconsistent Practices	Variability in how person-centred care is understood and applied across different settings can lead to inconsistent practices.
Economic Pressures	Cost Concerns	Implementing person-centred care can be perceived as more costly due to the need for additional resources and time, despite potential long-term savings from improved health outcomes.
	Inadequate staffing	There are not enough staff rostered (or staff are not replaced when they call in sick), resulting in staff not having enough time to do their job well.



Addressing these barriers requires a multifaceted approach, including organisational commitment, staff education and training, system-wide coordination, and policy support. By tackling these challenges, aged care providers can create an environment that supports and sustains person-centred care.

What is task-focused care?

Providing "task-focused care" means that there is a focus on getting the job done, rather than tuning in and personalising care to the individual needs of an older adult. It is care that is delivered "conveyor belt" style, where every resident is treated the same with little consideration of their preferences, resulting in the older adult becoming a passive recipient of the care or even resistant to care. The barriers to person-centred care create a strong pull for staff to become task-focused in order to get through their busy workload.

Here are some examples of task-focused versus person-centred care:

Task-Focused	Person-Centred
Starting morning showers at one end of a corridor, and going room-to-room	Developing an order for completing morning showers based on the preferred wake times of the residents
Referring to residents as their room number	Using residents' preferred name
Pouring out a glass of cordial at each resident's place setting	Asking each resident what they would like to drink when they enter the dining room
A staff member thinking "I've got to do 2 feeds"	A carer thinking "I'm going to help Margaret and John enjoy their meal"
Plating up residents' meals according to a predetermined list	Fostering choice and decision-making by offering self-service or asking residents what they would like to eat, and how much, at the time of the meal
Staff pouring gravy all over a resident's plate of food	Providing residents with a jug of gravy so that they can add their preferred amount on the parts of the meal they want (e.g. perhaps only on their meat and potatoes)
Putting a resident's meal down in front of them without talking (i.e. silent care)	Describing what is on the plate, asking the resident if they would like any condiments
Staff feeding a resident their meal as it is quicker	Allowing a resident to do as much as possible for themselves to maintain their independence
Rushing mealtimes so that the meal finishes within 30 minutes	Extending the mealtime, so that people socialise during their meal and can choose what time they arrive / leave
Staff talking about residents' care needs in front of others, or calling across the dining room	Residents are involved in conversations about their care. Staff conversations about tasks are done discreetly
Wheeling a resident out of the dining room without talking to them	Asking a resident if they would like anything else to eat, asking the resident where they would like to go next

What is the "Partners in Care" care model that was used in the experiment?

A "care model" in residential care refers to a structured framework or approach used to deliver care services and to guide decision-making.

Meath Care had begun implementing its care model, referred to as "Partner's in Care" roughly 12 months before the experiment started. The model focused on increasing staffing and encouraging care staff to slow down and give more time to residents during care routines.

The experiment presented the opportunity for Meath Care to work collaboratively with the Maggie Beer Foundation and a team of experts (comprised of experienced change consultants and allied health professionals) to refine and build on the Partners in Care model and design a more structured, systematic and evidence-informed implementation plan to accelerate the culture change process.

The Partners in Care model evolved to incorporate three core elements:

1. Person-centred – identifying and building upon each resident's strengths, capabilities, interests, lifestyle, and unique biography and cultural background, with the resident at the core as the chief decision-maker

2. Holistic – Taking into consideration more than just residents' physical needs of being showered / dressed / fed / medicated, we consider each aspect of wellbeing, e.g. physical, mental, emotional and spiritual

3. Partnership – reciprocal care between all stakeholders, i.e. there are relationships of trust built between residents, staff, families and the wider community.

What is unique about the "Partners in Care" care model?

The innovative aspects of the model include its interdisciplinary nature, bringing together elements of the Montessori method, person-centred care principles, and the strength-based enablement focus of allied health.

The model is rights-based, with a strong focus on justice and providing a standard of care that residents deserve. The bespoke integration of principles and intervention components was responsive to the local context and informed by a comprehensive audit and assessment process.

A fundamental guiding principle of the model was "doing with" rather than "doing for" residents, shifting the focus of care delivery from tasks to enhancing the lives of all partners in care – residents, staff and families.

The refined model and implementation strategies focused on capacity-building and empowerment, helping all partners in care to reach their potential, within a more enabling, home-like and inclusive environment.

By empowering every member of the team, including residents, it fosters substantive shifts in how care is delivered, especially during mealtimes, to set a new standard for what it means to provide truly person-centred care.

The expanded Partners in Care model that has emerged is a testament to a relentless commitment to not just "do" but to "do differently" — to not just aspire to values, but to live them in daily interactions and care practices. It is the embodiment of collective action and determination to elevate the quality of care to unprecedented levels.

What we did for MAGGIE BEER'S BIG MISSION

A clear vision, delineated roles and accountabilities, and continuous improvement were key to the implementation strategy.

Staff were encouraged to set their own goals, and to identify potential barriers and collaboratively seek solutions, ensuring the model continues to adapt and evolve over time. One of the three floors (Darch) containing 44 residents was selected to be the pilot site for the experiment.

In order to embed the model, the following steps were taken.

Step	Description
Evaluation	Comprehensive baseline assessments were conducted prior to commencement and then at regular intervals, including: • **Project:** audits and observations • **Resident:** interviews, surveys, mood, cognition, clinical indicators (weights, falls, etc), nutritional measures, consumer experience, quality of life • **Staff:** interviews, questionnaires (person-centredness, burnout) • **Care Environment:** environmental assessment tool, relational care, positive person work (mealtime mapping that explored enhancers and detractors of personhood) Data collected by the organisation and change consultants was analysed and reported on by a research team from the University of Tasmania
Forming a Team	• Management, representatives from the Maggie Beer Foundation and, and Maggie's team of experts met weekly • A leadership team was established with representatives from each department • Please refer to video: Mealtime Expertise
Upskilling of Staff	Staff received hands-on, practical workshop style training: • **Leadership** (all staff working in leadership roles) • **Clinical aspects of mealtimes** (clinical and allied health staff) • **Care Model** (all staff) • **Dysphagia** (all staff involved in mealtimes) Care staff also received on-the-floor mentoring by the Care Change Consultants and the catering staff received mentoring by Maggie and the Foundation Chefs
Enhanced Dining	• A comprehensive audit and set of recommendations were developed by the Maggie Beer Foundation • The menu was reinvigorated collaboratively between Meath Care, Maggie and her Foundation Chefs, dietitian and speech pathologist, featuring over 80 enhanced recipes. Please refer to video: Mealtime Expertise • The site transitioned to a full buffet style breakfast. Self-select elements were commenced for lunch and dinner. Please refer to video: Buffet Style Meals

Enabling Environment	• The dining was split into two, with half of the residents continuing to dine in the existing dining room and the other half invited to dine in a new dining area, with each area receiving a make-over • Dementia friendly strategies such as contrast, directional signage and labels were implemented • The external courtyard and balcony were refreshed
Involvement of Residents	• Residents were actively consulted and involved throughout each step of the experiment, for example: - Sharing their meal preferences - Suggesting changes to the outdoor areas - Choosing the colour scheme - Learning about food safety - Trialling new table settings and crockery - Accessing the buffet - Cooking and sampling food - Helping with chores and task boxes - Participating in speech therapy sessions and groups - Planting and tending to the garden - Painting the mural - Providing feedback • Please refer to video: Meaningful Activities

What were the results of the implementation of the "Partners in Care" model during the experiment?

Overall, the experiment was a success. Evidence* shows:

Model / Culture Change	Mealtimes
There is evidence of a cultural shift towards more person-centred care	Mealtime quality has improved during breakfast and lunch, issues relating to the food temperature have been resolved
Both the care staff and the residents have been empowered and engaged through the project	Meal access and choice have been enhanced through the implementation of the buffet, and the upskilling of staff in how to foster choice
Relationships have been strengthened between care staff and residents, as well as between the residents themselves	Mealtime experience and ambience have improved with a calmer, more dignified and social mealtime environment
The model has promoted a sense of community and opportunities for social connection and contribution to the home	

Residents	Staff
There is evidence of enhanced mood and reduced depression e.g. lower levels of boredom and greater engagement in mealtimes and activities	Have a shared vision and understanding of how the model should look in practice
There is improved appetite and mealtime satisfaction	Staff now perceive that they have permission to build relationships and spend time with residents – relationships and knowledge of preferences have deepened
Independence and autonomy are now promoted, residents are keen to serve themselves when there is genuine choice and variety	Are proud of the outcomes and the changes and benefits for residents achieved
Residents have a greater sense purpose	Express strong buy-in and commitment to keep the model going
Residents want the buffet to continue	

Overall, there is wonderful support for the project and for Maggie's contribution – results show that there is an overwhelming sense that the project (while challenging) was worthwhile and that "it's a model that actually works" and that the model "should be everywhere".

"Overall, Maggie Beer is the best in age care for creating this much huge change in all of us, especially for the residents. It's very great"

– Staff member

Final thoughts about person centred care

Through our considered approach in this experiment, true person-centred care has been demonstrated. Are you ready to join Maggie on her Big Mission? Please consider how you can personalise care and access the other resources to learn more about ways to improve the dining experience for older adults.

This Person Centred Learning worksheet has been written by Change Care Consultant and Occupational Therapist Elizabeth Oliver.

Watch MAGGIE BEER'S BIG MISSION on ABC iview.

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Maggie Beer's
BIG MISSION

Working Towards Person-Centred Care

Self Assessment Checklist

Person-centred care can make life better for older adults and improve conditions for those who care for them.

Tom Kitwood (1937-1998) was a pioneer in the field of dementia care. His "flower model" identifies six psychological needs which should to be considered when using a person-centred approach. Use these questions to explore which aspects of person-centred care you are doing well, and where you could improve.

It is important to regularly evaluate practices and models, share findings, and make changes to interactions, programs, and practices as needed. Remember that relatively simple interventions can produce measurable results.

Universal Needs	Example
Love	Is each older adult valued, respected and treasured?
	Are older adults accepted for who they are?
	How is the older person greeted and welcomed?
	Is the older adult provided food they enjoy, at the right temperature?
	Are there opportunities to sit next to a friend/loved one?
	Are there opportunities for affection / intimacy?
	Are older people's accomplishments and special occasions celebrated?
	Do others empathise with the older adult (e.g. take time to consider the world/situation from their perspective)?
	Is the person providing care present and focused on the older person and the interaction rather than the task?
	Are older people invited into the conversation (e.g. not talked about in front of them)?
	Are notices / posters written in language that is inclusive and non-judgemental?

Comfort	Does the older adult have their required aids and is there is adequate light and no glare? Is the older person dressed in clean, well-fitting clothes? How do we ensure the older person is not in pain? Does the space feel homely? Is the table set nicely e.g., table cloths, napkins, flowers? Is there sufficient seating? Is it comfortable, at the right height? Meet their needs? Is the environment at their preferred temperature? Are needed items within the older person's reach? Is there excess clutter? Are older adults able to choose what they want to eat and how much? Is there access to food and drink throughout the day? Can older people access the outdoors to dine? Are there shaded / under cover areas outside?
Identity	Is the older person known and understood by those who provide care (e.g. do they have an awareness of the older person's values, beliefs, interests, abilities, likes and dislikes—both past and present)? Do the older person's individual needs inform every interaction and experience? Are older people addressed by their preferred name (not room number)? Are opportunities for choice and decision-making provided? Are older people treated as a person (e.g. not labelled as though they are a task like "a feed" or by their medical condition such as "the dementias") Are people dressed how they want to be dressed e.g., clothing, hair, makeup, shaven Are older people assisted to do as much as they can for themselves? Has the space been personalised so that it matches the older person's tastes? Do you get a feel for the people using the space (e.g. relevant art work, photos)? Does the space change when new people are admitted?
Occupation	Do older people have opportunities to experience success, joy and meaning in life? Is there a choice of activity resources that are accessible (e.g. books, puzzles, etc)? Do the activities match the needs, interests and preferences of the older people? Are older people given support / permission to participate (e.g. invited, reminded, escorted, use of signage)? Do people providing care offer opportunities for the older person to use their skills and abilities rather than "over caring" for them? Are older people invited to help with daily tasks and do they have the right support and equipment to do so?

Inclusion	Are older adults consulted in decisions that affect them? Are older people able to share their talents (e.g. sharing stories, helping staff)? Are the specific needs of the older adult being accommodated (e.g. different conditions, cultures, hearing / vision, memory)? How do older people know what is happening? Do the people who provide care "do with" the older adult rather than "do for" as part of a supportive and mutually beneficial relationship? Do providers of care describe how they are going to assist so the older person is aware of what will happen (i.e. at a level the older person can understand such as step-by-step)? Are family members included? Does the space help older people feel as though they belong? Is there a sense of community for individuals, families, and staff? Are outdoor spaces easily accessible
Attachment	What can the older person "look after" (e.g. plant, animal, chore)? How are older adults supported so that they can become familiar with what happens? How do those providing care get to know the older adult? What things are done to foster relationships between older adults, staff, families (e.g. spend time together, invited to special events, provided support to remain in contact)? How are people supported to greet each other by name (e.g. easy to read name badges, introductions)? Are those providing care familiar and well trained? How are connections formed with the wider community? How does the space facilitate friendships?