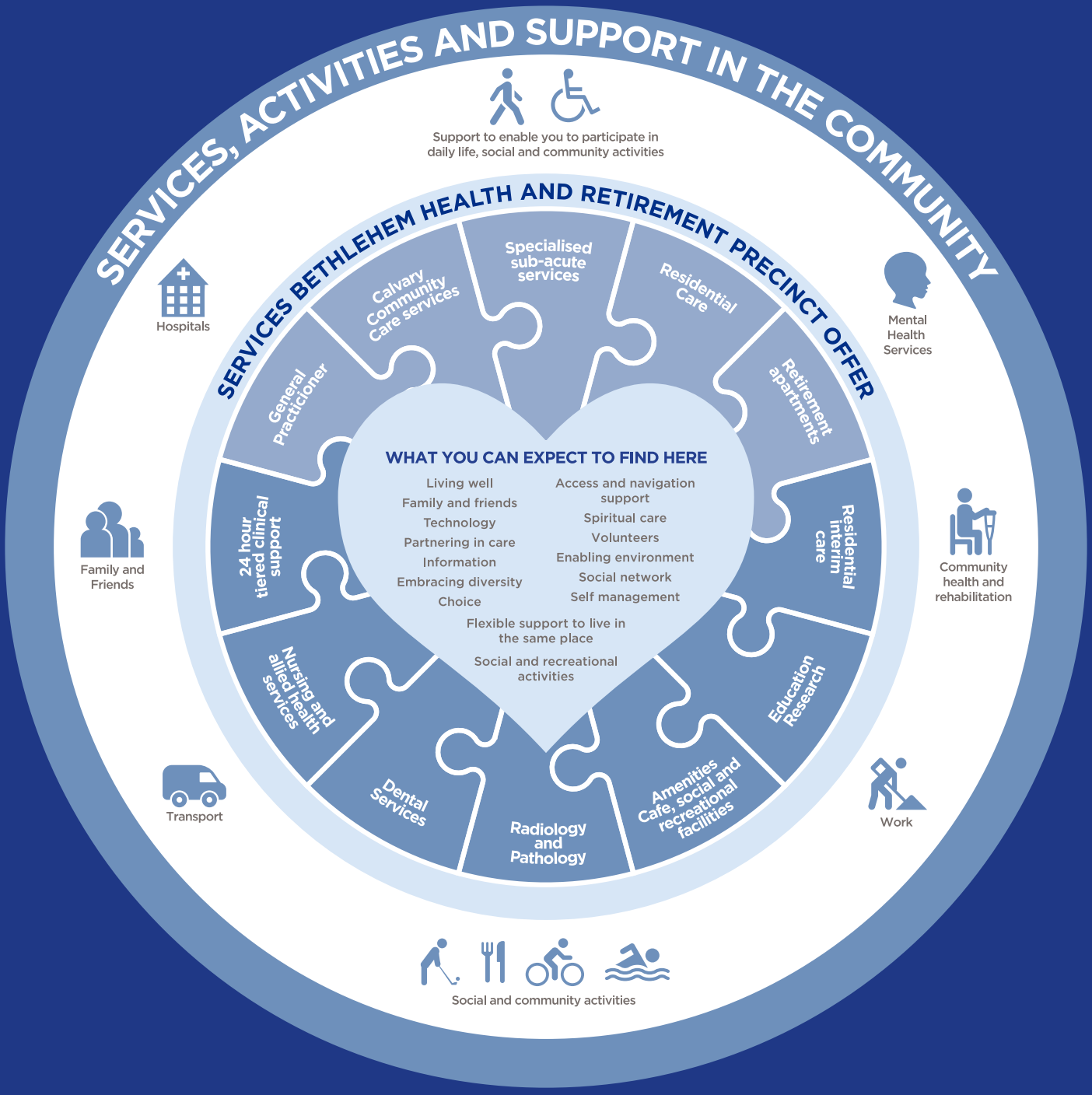


Calvary

CALVARY BETHLEHEM HEALTH AND RETIREMENT PRECINCT **MODEL OF CARE** 2018

Continuing the Mission of the Sisters of the Little Company of Mary

CONTENTS

DEFINITIONS

THIS SECTION DEFINES KEY TERMS THAT ARE USED THROUGHOUT THE DOCUMENT.

CARERS

May include family members and other members of the community such as friends or neighbours who the person agrees to be involved in their care; also known as informal supports.

CONSUMERS

Consumers and carers are members of the public who use, or are potential users of health care services. When consumers or carers are referred to, this means patients, consumers, families (as defined by the patient), carers, significant others and other support people.

COMMUNITY

Is a group of people joined together by a common interest or experience. A number of factors can define a community as they relate to the experience of health, including geographical location, race, age, faith or health need. In the context of this strategy, it is describing a group of people with similar health needs.

COMMUNITY DEVELOPMENT

Focuses on strengthening and mobilising capability within a community and helping communities to improve their health themselves. Community development often focuses on equality and inclusion, by promoting the voice of those communities who are less often heard.

DYING

The terminal phase of life, where death is imminent and likely to occur within hours or days, or occasionally weeks. This is sometimes referred to as 'actively dying'.

END OF LIFE

Death is anticipated within the next 6-12 months. This includes those living with:

1. Advanced progressive, incurable conditions, e.g. neurological or malignant disease.
2. General frailty and co-existing conditions that mean that they are expected to die within 12 months.
3. Life-threatening acute conditions caused by an irreversible sudden catastrophic event.

INFORMAL SUPPORTS

May include family members and other members of the community such as friends or neighbours who the person agrees to be involved in their care.

FAMILY

Includes people identified by the person as family and may include people who are biologically related, joined through marriage or other relationships as well as the family of choice of friends.

FORMAL SUPPORTS

Paid supports such as support workers, personal care assistants, gardeners, maintenance, cleaners, day centres who provide care.

HEALTH

Is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 2018).

INTEGRATED CARE

Initiatives seeking to improve outcomes for those with complex chronic health problems and needs by overcoming issues of fragmentation through linkage of services of different providers along the care continuum (WHO, 2014).

LIFE LIMITING ILLNESS

Term used to describe where death will be a direct consequence of the illness.

NETWORK OF SUPPORT

Informal supports, formal supports and clinical care providers.

PALLIATIVE CARE

An approach that improves the quality of life of people and their families facing the problems associated with life limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Palliative care is undertaken by all clinicians involved in care (WHO W. H., 2018).

PROGRESSIVE NEUROLOGICAL DISEASE

Are conditions where there is a progressive deterioration in functioning of the central or peripheral nervous system. Common progressive neurological diseases include dementia, Parkinson's disease and multiple sclerosis. Less common diseases include motor neurone disease and Huntington's disease.

SERVICE

Any individual or multi-disciplinary service providing health or care services.

SETTING

Is a location where services are provided and includes residential care, retirement apartments, specialist health inpatients ward, clinics and the community.

SPECIALIST HEALTH SERVICE

Sub-acute specialist palliative care and state-wide progressive neurological disease service provided through inpatient, centre-based and home based care.

SPECIALIST PALLIATIVE CARE

Multi-disciplinary teams with specialised skills, competencies, experience, training in specialist palliative care. People with more complex needs may require access to these services.

WELL-BEING

A subjective state that can be evaluated across three domains: (i) perceived life satisfaction; (ii) emotions experienced; and (iii) self-realization and a sense of purpose or meaning (Kuruvilla, 2018). It is a conscious, self-directed and evolving process of achieving full potential.

1

EXECUTIVE SUMMARY

1.1 Background and Development

CALVARY HEALTH CARE BETHLEHEM IS A SPECIALIST HEALTH SERVICE, PROVIDING PALLIATIVE CARE SERVICES AND A STATE-WIDE PROGRESSIVE NEUROLOGICAL DISEASE SERVICE THROUGH INPATIENT, CENTRED-BASED AND HOME BASED CARE. WITH A FOCUS ON WELLNESS AND ACTIVE ENGAGEMENT IN LIFE, THE MULTIDISCIPLINARY TEAMS WORK COLLABORATIVELY WITH PATIENTS AND OTHER PROVIDERS AS PARTNERS IN INTEGRATED CARE.

Further opportunities to develop the model of care and particularly the integration of health and care services that enable people to live well as their care needs change across the continuum of care was brought about by a combination of factors including:

- Bethlehem's ageing infrastructure, impacting on the delivery of contemporary, best practice health
- The opportunity to enhance the sustainability of the specialist health services by increasing the volume and breadth of activity on the site
- Service gaps identified in Calvary Health Care Bethlehem's service plan for its current population, causing extended periods of care in inappropriate settings
- Social and health needs of the growing ageing population of the southern metropolitan region of Melbourne, where Calvary Health Care Bethlehem resides
- Calvary's experience elsewhere in residential care, retirement living and community care services

As a result of these opportunities, it was proposed to redevelop the current Calvary Health Care Bethlehem site to create the 'Calvary Bethlehem Health and Retirement Precinct'; a purpose built facility for specialist health services integrated with the first Calvary Retirement Community in Victoria, Calvary Community Care, primary care, retail services, social and recreational spaces.

Key enablers identified for the model of care for the Bethlehem Health and Retirement Precinct include:

- A clear project story or vision, leveraging from Bethlehem's current service profile
- A purpose built facility
- Technology
- Workforce models
- Integrated clinical governance, policies and procedures
- Financial models

Key barriers were identified and mitigated with:

- A well-articulated vision and objectives of the model of care
- Review of the current literature, best practice and benchmarking
- Project structure and governance
- Consultation and communication strategy
- Consumer engagement from conception

The model of care was proposed to be developed in 3 parts as described in figure 1. Steps 1 and 2 are encompassed in this document.

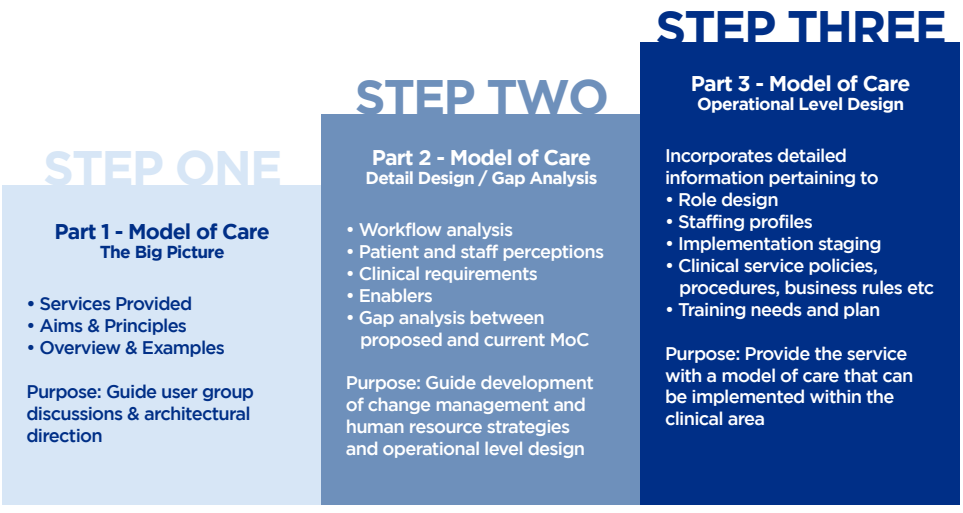


Figure 1: Model of Care Components

1.2

Overview of the Bethlehem Health and Retirement Precinct services

The Bethlehem Health and Retirement Precinct will provide an integrated model of care with:

- Residential care
- Retirement apartments
- Community care services
- Specialist health services - palliative care and State-wide progressive neurological health services
- General practitioners, radiology and pathology services
- Retail/café tenancies
- Social and recreational facilities including public green spaces

The Bethlehem Health and Retirement Precinct integrated model of care will include 'initiatives seeking to improve outcomes for those with complex chronic health problems and needs by overcoming issues of fragmentation through linkage of services of different providers along the care continuum' (WHO, 2014). Integrated care will be provided in all settings, in partnership with the person, their family and carers and a range of external providers and utilising available funding sources.

There are different views and challenges of integrated care for recipients of care, providers and managers as shown in figure 2.

PATIENTS

Easy access and navigation; seamless care

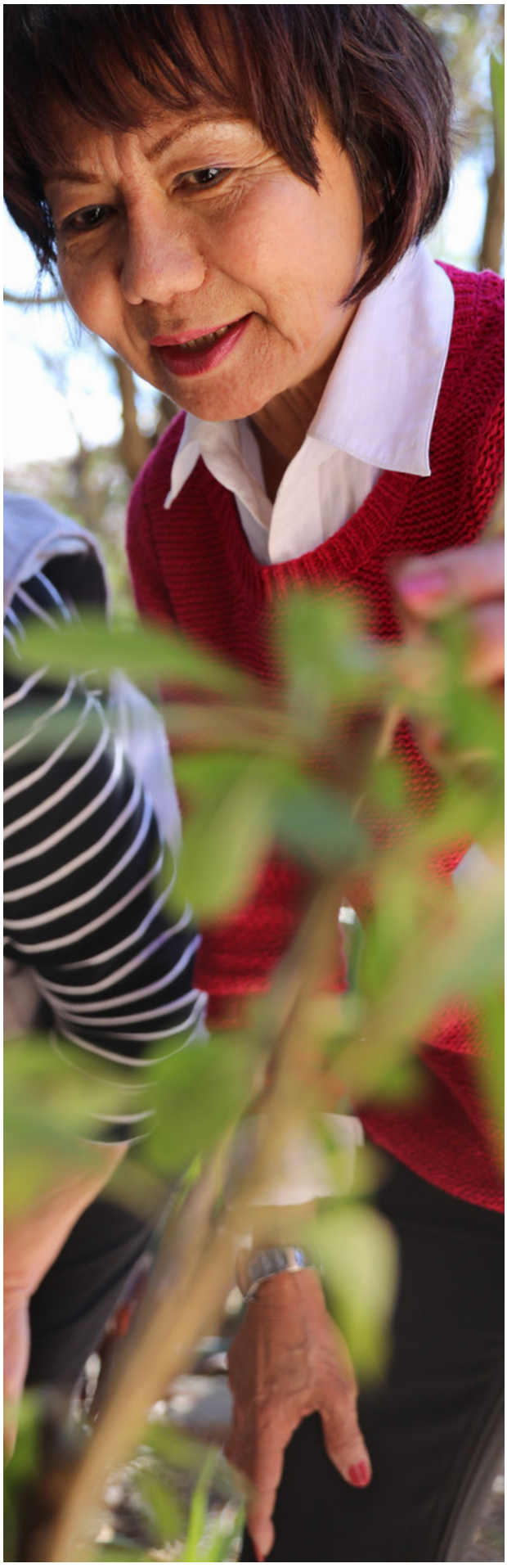
PROVIDERS

Interdisciplinary teamwork, coordination of tasks, services and care across professional and organisational boundaries

MANAGERS

Oversight of combined funding streams; coordination of joint performance targets; supervision of enlarged professionally diverse staff; management of complex organisational structures and inter-agency relationships; building and maintenance of shared culture

Figure 2:
Different Views of Integrated Care
(adapted from Lloyd and Wait 2006)



Integrated care in the Bethlehem Health and Retirement Precinct will be achieved by:

- Provision of care underpinned by the Spirit of Calvary, Calvary's Mission and Values and the Bethlehem Health and Retirement Precinct model of care principles
- Ensuring people have access to appropriate care and support to prolong independence - through access to information they are able to understand to make informed decisions, assessment and triage of individual needs, clinical escalation pathways, navigational support and proactive care planning
- Facilitation of communication with people and their network of support
- Ensuring care is aligned with individual goals of care within and as people transition between settings of care
- Ensuring care is coordinated and across professions and organisations and based on the needs of individuals and their goals, through clearly articulated roles and responsibilities
- Consumer engagement in clinical governance and service development

From consumers' perspectives gathered through consultation, key components of the integrated model of care are depicted in the word cloud in figure 3.

1.3

Key innovations and changes associated with the model

The innovation and change meter in figure 4 provides a quick reference to the innovation and the expected change associated with the integrated model of care.

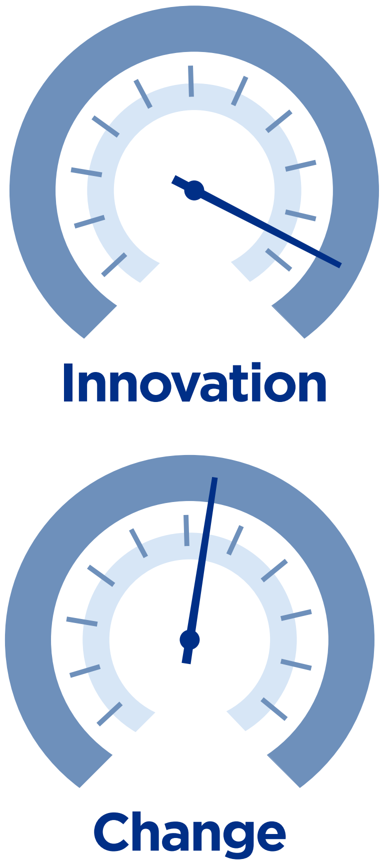


Figure 4:
Innovation and change impact estimates

Figure 3:
Key components of the model from consumers' perspectives

The key innovation in the Bethlehem Health and Retirement Precinct is the integration of residential care, retirement living supported with community care, specialist health and primary care services, education and research and social and recreational facilities: a combination unique to Calvary and within Australia.

Whilst Calvary Health Care Bethlehem strives to provide integrated care through partnership with other providers, this innovation is an opportunity to address both social and health needs of people across the continuum of care through integrated care on one site, providing opportunity to:

- Further understand, develop, demonstrate and advocate for solutions to the barriers for integrated care, particularly for people with high and complex needs
- Enhance options for this populations' care pathway with access to appropriate respite and permanent care for people with high and complex needs or utilise interim care services in residential care where specialist health inpatient discharge planning is delayed
- Minimize unnecessary transfers to acute settings through 24 hour tiered clinical escalation pathways across the site, supported by a mobile audio-visual communications platform to facilitate monitoring and communication functions throughout the facility
- Access to specialist health services across the continuum of care in various settings to build and support the capacity of primary care teams to manage people with high and complex needs
- Age in place in an enriched environment and be supported to live in the same place as care needs change
- Options to support terminal care in people's preferred location

The potential impact on the model of care and role design of current and emerging technology to facilitate remote monitoring, access to information, facilitation of communication between the persons' network of supports and support manual handing tasks is still speculative at this point, but expected to transform future service delivery and the integrated care model.

A summary of the future state, key changes and key benefits are documented in table 1 and figure 5.

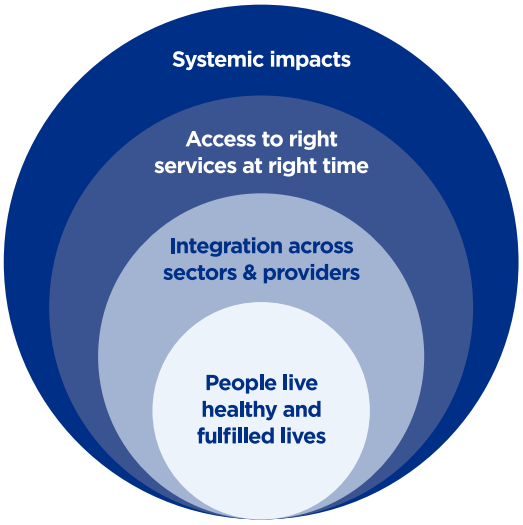


Figure 5:
Key benefits of the innovation

	FUTURE STATE	BENEFITS
SERVICES PROVIDED	• Specialist health services - palliative care and Statewide progressive neurological services • **Residential care** • **Interim care** • **Retirement apartments with services available from Calvary Community Care** • **Primary care services** • **NDIS and Aged Care opportunities** • Education and Research • Community Capacity Building	• Integrated coordinated care for individuals contributing to the sustainability of aged care, disability and health services + Information and access to navigational support • The opportunity for people to live a healthy and fulfilled life in an enriched environment and to age in place in the local community • Opportunity to understand and address residential care gaps for people with PND and others with high and complex needs • Interim care options for people who no longer require health services • Options for terminal care in people's preferred location • Additional respite options to support carers, enabling people to remain in the community • Opportunity to build and support capacity of primary care teams in palliative care and managing people with progressive neurological diseases
SERVICE RECIPIENT POPULATION	A diverse range of people including: • **Healthy people over the age of 55** • Adults with **dementia**, other progressive neurological diseases and other life limiting malignant and non-malignant diseases	• Development of a vibrant, interconnected community • Opportunities to expand the care provided for people with progressive neurological diseases and palliative services to people with dementia • Demonstrate gaps and build capacity of residential care to support people with progressive neurological diseases • Opportunity to support people to live well, over their later life
ACTIVITY AND VOLUME CHANGE	• **New activity and volume in residential care and retirement apartments** • Increased demand expected for palliative home based care and centre based programs	• Sustainability of the site with increased scale of services and shared service opportunities • Building and supporting capacity of residential care and community care to support people with a range of conditions to end of life
CLINICAL GOVERNANCE	• **Integrated aged care, community care, health and disability clinical governance within the precinct** • **Bed licensing** • Accreditation in aged care, health and disability	• Facilitation of integrated care • Transfer of learnings across sectors
OPERATIONAL STRUCTURE	• **Integrated operational and management structure for the site**	• Sustainable structure • Ability to meet requirements for multiple reporting streams
SERVICE RELATIONSHIP (INTERNAL)	• Integrated relationship between specialist health services and residential care • **Allied health are an integrated part of residential care** • **Integrated relationship between retirement apartments, community care and allied health where chosen** • Strengthening of relationships between inpatient, clinic and community services • **Integrated GP services** • **Diagnostic services**	• Opportunities to ensure an educated workforce in palliative care and managing people with high and complex needs • Facilitate coordinated care across the continuum • Provision of a one stop shop for primary investigation, reducing transfers off-site

Note: key changes are documented **bold**.

	FUTURE STATE	BENEFITS
SERVICE RELATIONSHIP (EXTERNAL)	• Strengthening of relationships with GP's • Strengthening relationships with local residential care facilities • **Community partnerships to enhance living well**	• Reduced duplication or inappropriate use of other health services • Earlier access to specialist palliative care services
CULTURAL CHANGES	• The Spirit of Calvary will continue to underpin the culture of the services provided • **The scale and range of services will grow the workforce profile**	• Flexible, resilient and skilled workforce that will continue to meet the needs of the community into the future • Breadth of opportunity to develop skills for the work
TECHNOLOGY	• Opportunities for emerging technologies will be developed, trialled and made available to care recipients and staff	Technology will play an important role in: • Enabling independence of people • Urgent and less time critical clinical escalation and referral • Supporting monitoring of clinical and other indicators • Facilitating workflows and communication between staff within and between teams • Facilitating communication between providers, people and their families in all environments • Reducing risks for all
FACILITIES	• **Purpose built facilities**	• Health promoting, safe and enabling environments for all people, including those with cognitive challenges • Shared facilities to enhance interactions and efficient use of spaces • Enabling patient and family centred care
POLICIES AND PROCEDURES	• **Standardised policies** • **Aligned procedures/processes implemented across service settings where possible** + Processes may differ based on workforce models and interactions of ICT systems	• More efficient workflows • Highly reliable culture of care • Reduced variation and improved clinical outcomes • Improved experience for those receiving care
WORKFORCE REQUIREMENTS	• **Deputy Director Clinical Services** • **Residential Care Coordinator** • **Retirement Coordinator** • **Support workers (CCC)** • **Accountant** • **Chef** • **Food services assistants** • Nursing • Allied health • Leisure and lifestyle • Care companions • Education • Support roles	• Breadth of service range provides new workforce opportunities
ROLES AND RESPONSIBILITIES	• Clear accountabilities and responsibilities	• Supporting integrated care • High reliability • Reduced variation in practice • Streamlining of services

Note: key changes are documented **bold**.

1.4
Next steps

The next steps following endorsement of the model of care are:

- Use of key enablers in development of operational design, facility detailed design and ICT requirements
- Development of Implementation plan (high level milestones)
- Development of a Communication and change management plan
- Development of a Workforce plan
- Development of Education and training plan
- Review and development of policies and procedures and business rules

2

BACKGROUND AND DEVELOPMENT

CALVARY HEALTH CARE BETHLEHEM (CHCB) IS REDEVELOPING ITS CURRENT SITE TO DEVELOP A PURPOSE BUILT FACILITY FOR ITS CURRENT SPECIALIST HEALTH SERVICES, WITH THE ADDITION OF THE FIRST CALVARY RETIREMENT COMMUNITY IN VICTORIA: INCLUDING RESIDENTIAL CARE AND RETIREMENT APARTMENTS, CALVARY COMMUNITY CARE, PRIMARY CARE AND SOCIAL AND RECREATIONAL FACILITIES.

Many of the current Calvary Health Care Bethlehem facilities were built in the 1960s and are no longer conducive to enabling the delivery of contemporary, best practice health care, nor are they designed to enable its changing model of care to increasingly ambulatory care services.

Service gaps identified in Calvary Health Care Bethlehem's Service Plan 2016 include:

- Residential care options for people with progressive neurological conditions, currently causing extended hospital stays
- Changing levels of support and clinical care requirements for people with chronic conditions and the frail elderly as their function declines
- People with malignancies who have complex care needs, who may not be able to be managed at home for the remainder of their life
- Suitable interim care for people with complex care and/or complex psychosocial issues including the above examples, who require extended sub-acute inpatient stays, as discharge to home is no longer an option or is delayed due to the need for home modifications and other support structures

The southern metropolitan region of Melbourne, where Calvary Health Care Bethlehem is located, also has an ageing population. Older people are living longer and with less disability, however there are demonstrated increasing pressures on informal supports, health and aged care systems to support greater numbers of people as they age. This provides an opportunity to address some of the local issues in alignment with Glen Eira Council's Positive Ageing Strategy, by leveraging Calvary's capabilities.

Founded in 1885 by the Sisters of the Little Company of Mary, Calvary is a charitable, not-for-profit, Catholic health care organisation. Calvary's Mission is to provide health care to the most vulnerable, including those reaching the end of their life. At a national level, Calvary has expertise in retirement and aged care services operating 15 facilities in NSW and the ACT and providing community care services across Australia. Calvary also operates 15 public and private hospitals nationally; Calvary Health Care Bethlehem is a Calvary public hospital located in Melbourne, Victoria.

By developing residential care facilities and retirement apartments on the same site as Calvary Health Care Bethlehem's specialist health services there is an opportunity to:

- Address health, care and social needs of people as they age to enable them to live well
- Ensure people can age in the same place of residence and where partners can live in the same facility, one with high care needs
- Provide ease of access to allied health, specialist palliative, statewide progressive neurological services, community care and general practice to enable and prolong independence
- Provide coordinated, integrated care and levels of support that are flexible to enable participation over the course of a person's life
- Collaboratively monitor people to anticipate and proactively respond to changes
- Provide a place that enables people to die in their chosen location with the level of support they require
- Develop a translatable model

The redevelopment of the Calvary Health Care Bethlehem site will also increase the scale of services provided and provide opportunities for shared services and the introduction of primary care and retail services to ensure sustainability of the site.

A workshop with Calvary's Executive and leaderships teams for Public Hospitals, Retirement Communities and Community Care established the vision, aims and objectives based on a literature review and industry knowledge. The agreed intent was to develop a model of care that was a 'different game with new rules', challenging thoughts on what facilitates successful integration of care.

A Consumer Reference Group was established to provide feedback on various aspects of the model of care as it progressed and provide advice on further consumer engagement.

A discussion paper was developed which included related evidence for consultation and feedback from consumer advocacy groups, the Glen Eira Council, the Consumer Reference Group, Calvary Health Care Bethlehem's Community Advisory Council and key internal stakeholders.

There was overwhelming support for the vision, objectives and model of care principles. Additional service gaps and a range of additional services were identified for further analysis. It was also noted that a state-wide solution was required for the service gap for residential care for people with progressive neurological diseases to ensure people can live close to their home and community. The Calvary Bethlehem Health and Retirement Precinct provides an opportunity to further understand, develop and advocate for solutions to the barriers associated with their care needs. Feedback is detailed in appendix section 10.

The main concerns raised were:

- Accessibility to retirement apartments and residential care for Calvary Health Care Bethlehem's current population, including the flow of the interim beds to maintain access to these
- Meeting the needs of people of a range of ages and with complex, high care needs within the one residential care facility
- Specialist health inpatient ward management of multiple patient types

Information was gathered on current services to identify gaps between the current services and the model of care objectives and principles. This included service activity data, patient flows, staff workflows and consumer and staff perceptions. Further literature review, benchmarking and information from conference attendance and networking with industry experts including Calvary staff informed the requirements for the future model of care for each component of the services. Consumers and staff were also invited to discuss components presented in the literature that would enable the model of care objectives and principles during interviews and focus groups.

3

OVERVIEW OF THE SERVICE

3.1 Vision

THE BETHLEHEM HEALTH AND RETIREMENT PRECINCT WILL ENABLE ITS COMMUNITY TO LIVE WELL WITH AUTONOMY, ASSISTED BY INTEGRATED, FLEXIBLE SERVICES.

3.2 Aims and Objectives

3.2.1 Aims

The Bethlehem Health and Retirement Precinct aims to be:

1. A place that enables people to live a healthy and fulfilled life.
2. A place to build friendships and stay connected to the local community.
3. A place to feel safe and enabled in an accessible environment for all
4. A place that embraces diversity and empowers people to make their own decisions and lifestyle choices.
5. An option for people to age in their local community, and to live in the same place and their care needs change with access to appropriate and timely interventions and supports to maintain independence.
6. A place that enables people to die in their chose location with the level of support they require.

3.2.2 Objectives

The overarching objectives of the Bethlehem Health and Retirement Precinct model of care are:

1. To provide an experience for all people engaging with the Bethlehem Health and Retirement Precinct that meets or exceeds their expectation
2. Enablement of all people to remain independent, actively engaged and integrated into their community, safe and living in their place of choice, including people with high and complex needs.
3. To contribute to the sustainability of aged care, disability and health services - by ensuring people have access to coordinated services in the right setting at the right time by the right person.
4. To enable people to make informed decisions for anticipatory care planning.
5. To ensure peoples' dying experience is in their chosen location with the level of support they require.
6. To develop a model that can be translated to other locations.

3.3

Model of Care Principles

THE MODEL OF CARE PRINCIPLES FOR THE BETHLEHEM HEALTH AND RETIREMENT PRECINCT ARE UNDERPINNED BY THE SPIRIT OF CALVARY, CALVARY'S MISSION AND CALVARY'S VALUES OF HOSPITALITY, HEALING, RESPECT AND STEWARDSHIP.

PERSON AND FAMILY CENTRED

- Human rights based approach with recognition that all people have rights and responsibilities
- Needs and preferences of individuals are incorporated into care that is responsive to an individual's identity, uniqueness, culture, ethnicity, language, gender, age, sexuality, religion and spirituality
- Partnership in care that is family sensitive and supportive of a network of relationships
- The delivery of care is prioritised around the people receiving care rather than the service providers
- Open disclosure ensuring appropriate and professional communication

LIVING WELL

- Facilitation of meaning, purpose and connectedness
- Health promoting and enabling environment
- People are enabled to maintain and develop family and community connections and interests
- People have the opportunity to learn and contribute
- The wellbeing of a person's network is supported

CONSUMER DRIVEN

- People have autonomy and choice including the opportunity to take risks, and can be supported or assisted in decision making as required
- The needs and preferences of the people served will drive the activities and care
- Structures will ensure consumers are engaged in the development of services where possible

SEAMLESS INTEGRATED CARE

- Single point of access to services
- Care is well coordinated and support is provided to assist in navigating health, aged care, disability and community systems
- Clear communication framework between care providers, recipients of care and informal supports
- Collaborative monitoring of wellbeing to proactively respond to and anticipate changing needs

EXCELLENCE, QUALITY AND SAFETY

- Evidence based, best practice care is provided by appropriately trained and credentialed staff
- Unacceptable variation in practice is reduced
- Creation of a high reliability culture of care which enables people to have the same experience at any point of entry, supported by organisational protocols and pathways
- The safety of all people is enhanced by the environment and policies and procedures aimed to minimise risk

RESEARCH GENERATING, EVOLVING, LEARNING

- Research generated by the model informs future best practice
- Service delivery is agile and responsive to changing needs of the population
- New technologies that enable people to achieve their goals are trialled and implemented
- A learning culture focused on continuous improvement, supporting broader workforce development

SUSTAINABLE

- Operational efficiency and transparent use of resources
- Translatable model

3.4

Overview of services

THE SERVICES THAT WILL BE PROVIDED IN THE BETHLEHEM HEALTH AND RETIREMENT PRECINCT ARE DETAILED IN TABLE 2.

Table 2. Services offered in the Bethlehem Health and Retirement Precinct

SERVICES	COMPONENTS
SPECIALIST HEALTH SERVICES	Inpatient, clinics, day centre, in-reach, home based clinical service: - Specialist Palliative Care service - Statewide Progressive Neurological Service
RESIDENTIAL CARE	A residential care facility with private bedrooms and ensuites, communal home and community spaces
RETIREMENT APARTMENTS	1, 2 and 3 bedroom contemporary independent living units for people 55 years of age and over
CALVARY COMMUNITY CARE	On-site support to enable people to participate in daily life, social and community activities
GENERAL PRACTITIONERS	On-site general medical services
RESPITE CARE	To support the well-being of carers, short term overnight accommodation in residential care, day centre and in-home respite is available
INTERIM CARE	Short term care alternative, where people are awaiting placement in residential care or discharge is delayed
RADIOLOGY AND PATHOLOGY	Diagnostic services
DENTAL SERVICES	General and specialist dental services
GENERAL NURSING AND ALLIED HEALTH SERVICES	Integrated care across care pathways - Clinical psychology - Dietetics and nutrition - Music therapy - Neuropsychology - Nursing - Occupational therapy - Physiotherapy - Speech pathology - Social work - Spiritual care - Bereavement services
CAFE AND RETAIL SERVICES	On-site café and shops
SOCIAL AND RECREATIONAL FACILITIES	• Gymnasium • Hydrotherapy • Gardens • Public green space • Community spaces to host larger or smaller social, recreational and lifelong learning activities
EDUCATION, INNOVATION AND RESEARCH	Integrated education, innovation and research within the clinical and care environments. Opportunities for broader workforce development in palliative care, progressive neurological diseases and aged care.

3.5
Population served

3.5.1
Expected catchment and demographics

The specialist health service provides community palliative care services to the local government areas (LGA's) of Glen Eira, Port Phillip, Kingston, Stonington and Monash. The Statewide Progressive Neurological Disease service provides services, access to clinical trials and/or education and secondary consultation for clinicians throughout the state of Victoria. Patients also attend this service from interstate, particularly NSW and Tasmania.

Based on Calvary's experience, the retirement apartments are expected to attract a range people from various backgrounds and abilities from 55 years to 95 years old. Most people accessing permanent or respite services in the residential care facilities are expected to be from or have family located in the surrounding suburbs of the LGA of Glen Eira, nearby LGA's in the southern metropolitan region of Melbourne or not able to access appropriate care closer to their homes.

The associated primary care facilities and retail facilities are expected to attract the immediate local community and potential family and carers of people residing in the Bethlehem Health and Retirement Precinct.

3.5.2
Catchment demographics

Catchment demographics are detailed in the Appendix, section 11.2.

A summary of findings include:

- The southern metropolitan region of Melbourne has a greater ageing population than the rest of Melbourne (Aspex Consulting, 2015)
- 4.4% of the Glen Eira population report a severe or profound disability, 69% of these people are older than 65 (ABS, 2015)
- 36% of Glen Eira residents are born overseas from over 60 countries; 28% are from countries where English is not their primary language
- The largest older immigrant populations include the United Kingdom, Southern Europe (Greece and Italy), Eastern Europe (Poland and Russia), Germany and South Africa and the largest growing new immigrant populations include India, China and Sri Lanka
- There is a very small population (<0.2%) of people of Aboriginal or Torres Strait Islander origin residing in the Glen Eira council and the southern metropolitan region compared with the rest of Australia (3%)
- It is estimated that approximately 11 percent of the population and 10% of people over 65 years of age identify as lesbian, bisexual, gay, transsexual or intersex (LGBTI) in Australia.

3.5.3
The Australian Ageing Population and Care Requirements

Australians over the age of 65 are a growing population that:

- Are more physically active and are more active members of their communities with stronger social connections than in previous years (AIWH, 2016)
- Are living longer and with less disability (ABS, 2015)
- Make a considerable economic and social contribution to the community through paid and unpaid work (AIWH, 2016)

There are however increasing pressures on informal supports, health and aged care systems to support greater numbers of people as they age.

Table 3: Ageing population and support requirements

POPULATION GROUP (WASSUM, 2013)	BIRTH AND AGED (WASSUM, 2013)	PERCENTAGE OF GLEN EIRA POPULATION	REQUIRE SUPPORT ONE ACTIVITY (MIN) (ABS, 2015)	LIVE IN RESIDENTIAL CARE (ABS, 2015)	OTHER COMMENTS (WASSUM, 2013)
GREATEST (GI) GENERATION	Born <1925 >92 years	1.5%	88.5%	36%	
SILENT GENERATION	Born 1925-1945 72-92 years	8.5%	56%	9.3%	Greatest growing group.
BABY BOOMERS	Born 1946-1964 54-72 years	21%	22%	0.7%	Diverse group of which choice will be an important factor.

People generally prefer to remain living at home for as long as possible (Crisp DA, 2013), and they may use aged care in different combinations to achieve this. A small but increasing number of people are moving into retirement villages (Nathan A, 2015) due to both 'push and pull factors' described in the literature. 'Push factors' are associated with a change in health or disability status or death of a spouse. 'Pull factors' include the opportunity to maintain a healthy lifestyle and preparation for future health concerns (Crisp DA, 2013).

In general, health conditions that require ongoing nursing care and assistance may affect the level of care an individual needs. This is particularly the case with chronic or progressive conditions; a diagnosis of dementia is a strong predictor for entry to permanent residential aged care. Impaired mobility and general frailty are also associated with the need for permanent residential aged care. In particular, falls are a serious health risk that has an impact on care needs, affecting approximately 30% of older people (Gillespie et al. 2012). These and other common conditions, such as cardiovascular disease, musculoskeletal problems and incontinence - influence the level of support required, and are common in people in permanent residential aged care (AIHW 2010; AIHW 2017; McLeod et al. 2011) (AIHW, 2017).

Further information demographic details on how people access aged care be found in the Appendix, section 11.5.1.

3.6

Evaluation Framework

Committed to achieving the objectives set out in section 3.3.2, Calvary has established an evaluation framework. The aim of the evaluation is to measure and describe over time the impact and effectiveness of the model of care against the outlined objectives.

The following model (figure 6) visually outlines the linear sequence of steps required to meet the model of care objectives and provides a roadmap from which a detailed evaluation project plan will be established; included are high-level assumptions linking each step.

Figure 6: Evaluation Framework

INPUTS	OUTPUTS		OUTCOMES - IMPACT		
	ACTIVITIES	PARTICIPATION	SHORT	MEDIUM	LONG
Retirement apartments Residential care beds Sub-acute specialist palliative and progressive neurological health services Community care services GPs, radiology and pathology services Retail/café tenancies Social and recreational Workforce Policies and procedures Vision for the BHRP Governance model Facilities design Funding streams: - Subacute health inpatient and ambulatory - NDIS - CHSP - Medicare - Private health insurance - DVA - Commonwealth Dept. of Ageing - Self-funded Funding models Technology	Integration of clinical services Provision of services and activities that support enablement, social inclusion, autonomy and choice Provision of advice, secondary consultation, education and training to local service providers Provision of residential care for people with high and complex needs Provision of interim care for people with complex care needs Provision of end of life care Provision of respite care Development of systems to enable patients/residents to be active participants as co-creators and managers in their health care Community development and capacity building Redesigned funding models to support model of care Development of sustainable workforce model and a well workforce Research, leadership and advocacy in relation to end of life issues and progressive neurological diseases Evaluation of the model	Retirement apartment residents Residential care residents Palliative care patients Progressive neurological patients Staff and volunteers Family caregivers and support network Local community External service providers Department of Health and Human Services Commonwealth Department of Ageing NDIA Private Health insurance providers DVA Medicare South Eastern Metropolitan Primary Health Network Southern Metropolitan Palliative Care Consortium Architects, builders and interior designers Deakin University	Improved access to appropriate and timely clinical care Increased access to interventions that support patients/residents to maintain independence Earlier recognition of functional decline Increased provision of appropriate clinical care to people living in the community Increased care for people closer to home Increased access to he broader community for residents Increased opportunities for patients/residents to learn from and contribute to their community Unwarranted variation in practice is reduced Appropriately trained and credentialed staff Patients/residents/carer goals and expectations are known and supported by the BHRP teams Initial evaluation of short term outcomes and model of care delivery	Improved person centred support Improved coordination and continuity of care Improved communication across internal and external support/care providers Improved patient/resident safety Improved patient/resident clinical outcomes Increased uptake of self-management initiatives Reduced carer stress/burden Improved patient/resident experience Increased staff satisfaction Improved staff safety and wellbeing Increased use of anticipatory care plans Increased capacity of local service providers Improved patient/resident quality of life Ongoing monitoring of short term outcomes Evaluation of medium term outcomes and model of care delivery to date	Increased number of residents living independently (& living independently for longer) Increased social inclusion Increased number of people ageing in place Increased number of people dying in their chosen location Translatable model of care Sustainable model of care Systems for ongoing monitoring of outcomes established Write up of final evaluation

ASSUMPTIONS				
- Availability of a skilled workforce - Appropriate facility design - Funding stream availability - All planned spaces delivered	- Retained specialist health services in patient and ambulatory - Appropriately funded beds - Suitably skilled workforce in place	- Availability and engagement of all participant groups	- Short term outcomes achieved - Systems established for ongoing monitoring of outcomes	- Medium term outcomes achieved - Ongoing availability and engagement of participant groups

4 SERVICE MODEL

4.1 Patient flows

PEOPLE'S INDIVIDUAL JOURNEY IS IMPACTED BY THE RATE OF THEIR DECLINE, ACUTE EXACERBATIONS OF THEIR ILLNESS, PSYCH-SOCIAL AND PERSONAL FACTORS.

They and their family all require at various times and intensity:

- Disease management
- Informed and timely decision making
- Support to access available resources and to navigate the system
- Psychological and spiritual support
- Increasing support and assistive devices to maintain quality of life
- Management of physical symptoms
- Management of acute physical and mental health episodes
- Rehabilitation
- Terminal care

People will be able to live independently on-site or in the local community and be supported to remain in their place as their care needs change with support as required from Calvary Bethlehem Health and Retirement Precinct specialist health services, primary care and Calvary Community Care services, integrated with other community and health services of their choice.

People can access services from the Bethlehem Health and Retirement Precinct or choose to use other providers for aspects of their care. Access to support and care will be via a single point with triage to respite or permanent care, home care or specialist health inpatient or centre based care. Some may need to access residential care, either directly from the community or via specialist inpatient assessment and interim care.

Figure 7 below demonstrates new pathways in the Bethlehem Health and Retirement Precinct due to integration of services on the same site including:

- Access to interim care whilst planning discharge home or to a new home
- Access to residential care suitable for people with progressive neurological diseases including dementia, chronic conditions and frail elderly people
- In-home and overnight respite options and potential to develop day centre options for young people and people with dementia
- Suitable overnight respite options for people with progressive neurological diseases, which may also be appropriate to support people accessing multiple clinic appointments with the statewide progressive neurological service
- On-site access to allied health, the state-wide neurological service and palliative care for people living in residential care and retirement apartments
- On-site access to diagnostics, reducing the need to off-site transfer

Other new care pathways include:

- Access to retirement apartment living for people who are healthy or have health concerns and would like to maintain a healthy lifestyle, with access to supports as their care needs change
- Option for partners with different care needs to live on the same site
- Access to general practice onsite

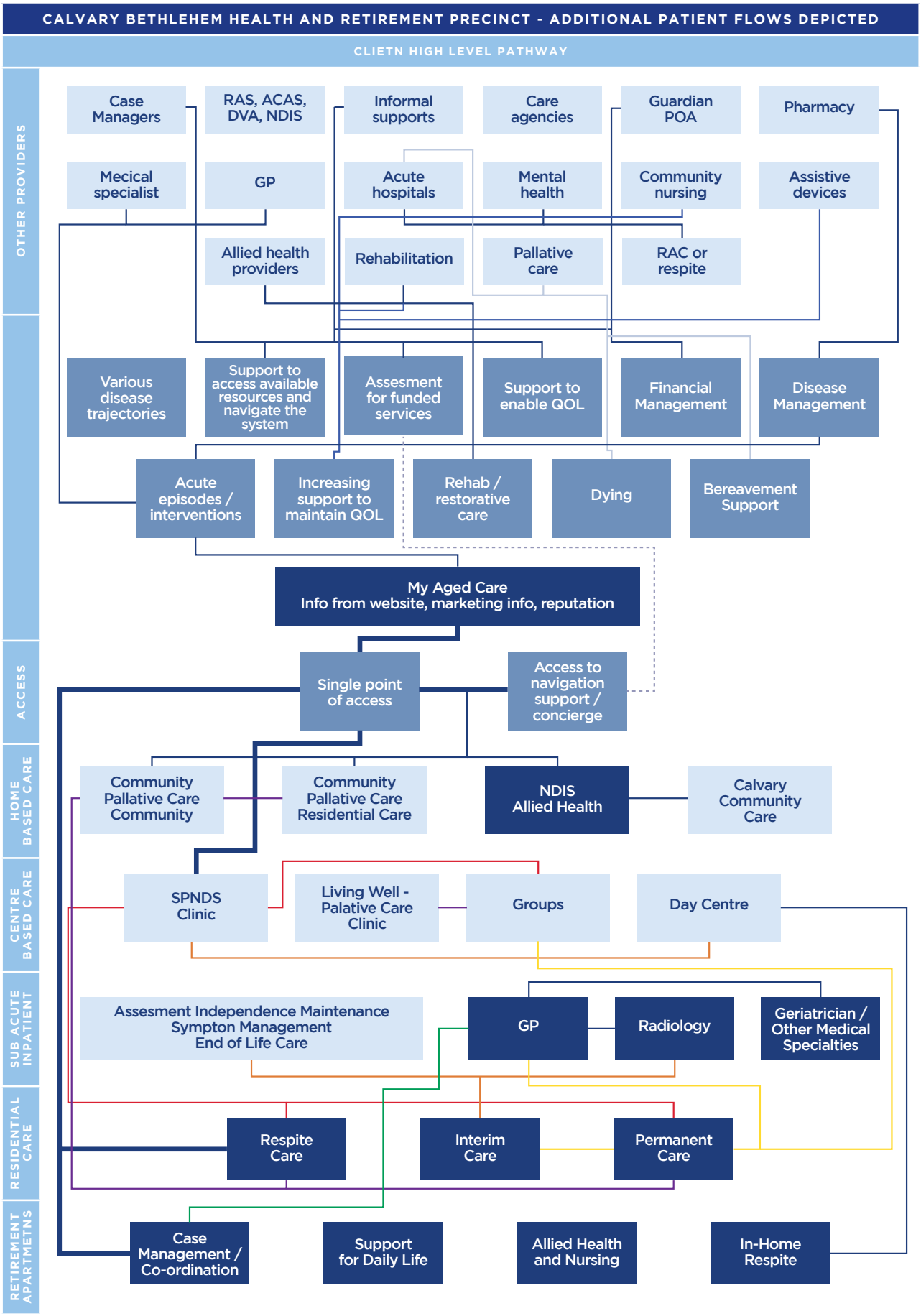


Figure 7. Calvary Bethlehem Health and Retirement Precinct - new pathways

4.2

Service relationships

Service relationships providing multi-disciplinary integrated care for both internal and external services are depicted in figure 8.

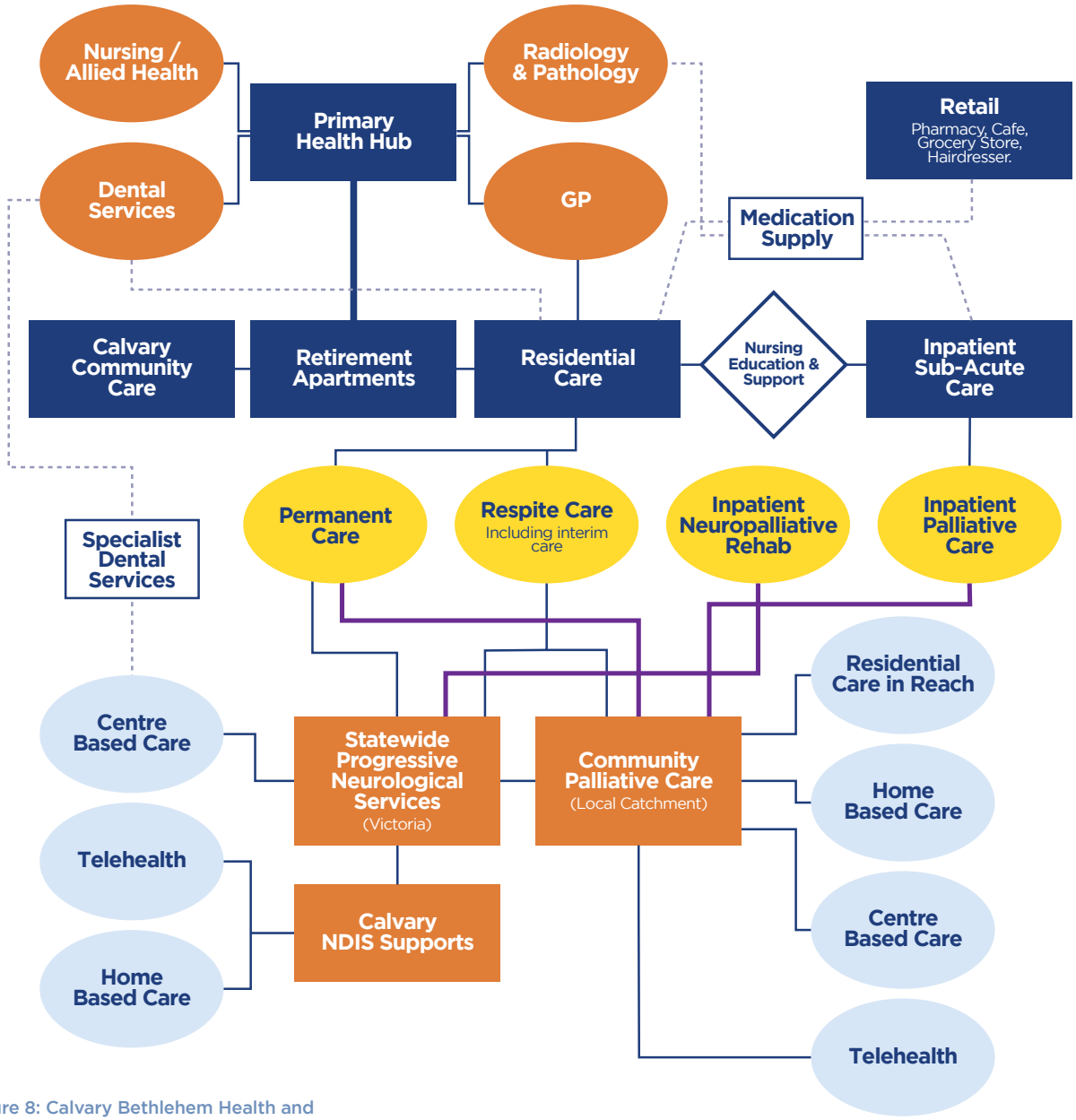


Figure 8: Calvary Bethlehem Health and Retirement Precinct Service Relationships

SERVICES PROVIDED ACROSS THE VARIOUS COMPONENTS OF THE PROJECT

Access and triage
After hours coordination
Allied health
Medical Specialists
Nursing and care services
Music and art therapy
Diversional therapy
Exercise physiology/ personal trainers/AHA's
Spiritual care
Education and research
Volunteers
Food services
Hospital services (reception/concierge, cleaning, supplies, maintenance)
Corporate services

Community Providers - GP, medical specialists, acute and sub-acute hospitals, mental health providers, NDIS providers, community care providers, community health provides (nursing and allied health), community advocacy groups, community groups, PAGs, transport (public and private providers), universities and other research institutes and education training providers

4.3
Clinical and operational governance

4.3.1
Clinical Governance

Aligned with the Calvary Health Care governance system, Calvary Bethlehem Health and Retirement Precinct governance and reporting structure enables streamlined decision-making for optimal operation of the site. The Calvary Bethlehem Health and Retirement Precinct executive is responsible for ensuring the governance and reporting structure is operationalised and regularly reviewed to ensure the structure meets the performance, quality, safety, risk and compliance monitoring and reporting requirements for the site.

As a site providing a breadth of services and care programs supported by varying funding sources, Calvary Bethlehem Health and Retirement Precinct has a number of entities to which it is accountable and required to provide compliance and monitoring reports to:

- Victorian Department of Health and Human Services
- Australian Department of Health and Ageing
- Calvary Executive through the National Director Public Hospitals, National Director Retirement Communities, National Director Community Care, National Director of Mission, National Director of Clinical Services, National Manager Clinical Safety and Quality
- Calvary Board of Directors through the Calvary Executive
- National Disability Insurance Agency
- Medicare
- Private Health Insurance providers
- Accreditation bodies
- Calvary Bethlehem Health and Retirement Precinct Retirement 'body corporate/committee'

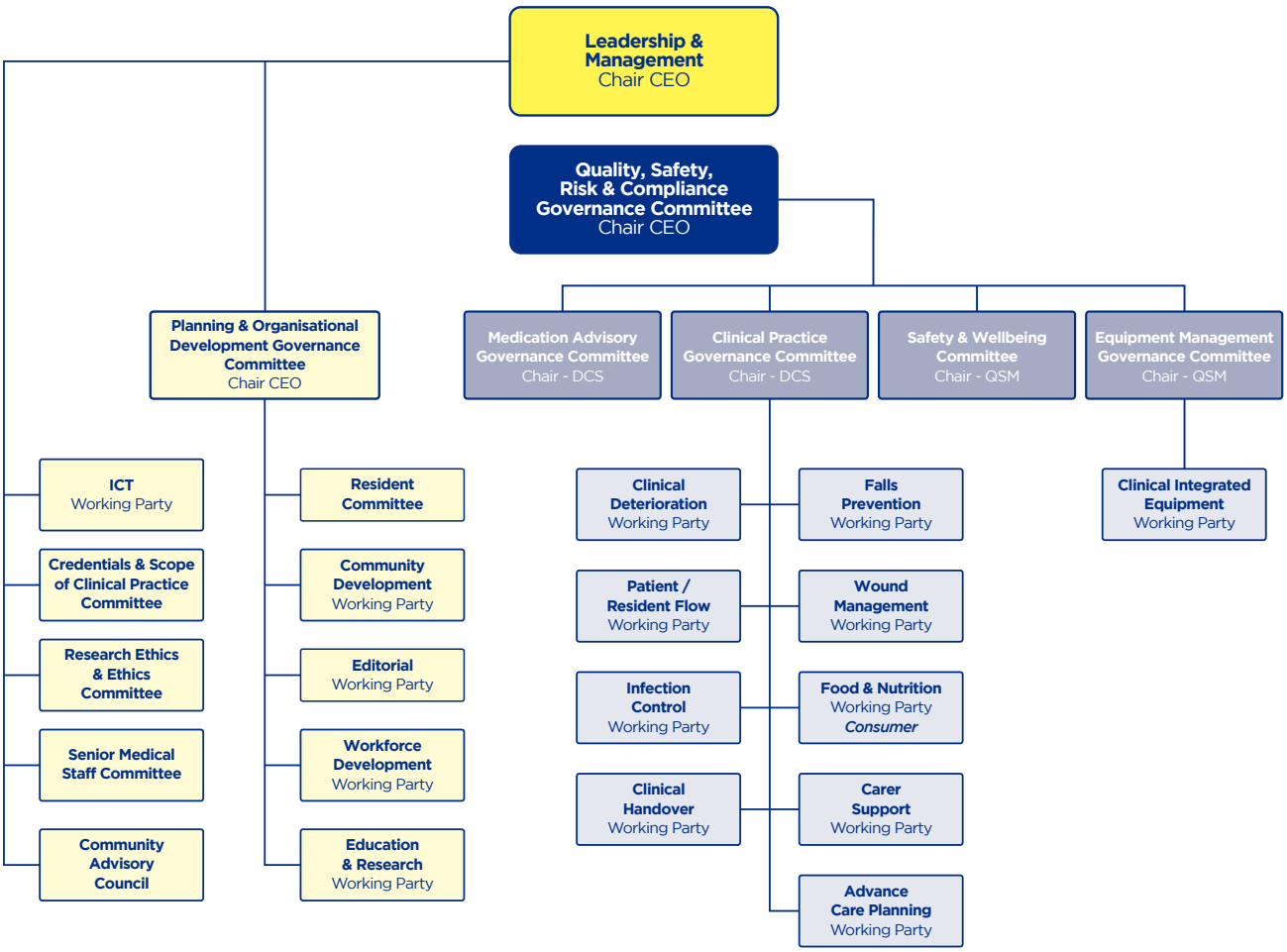


Figure 9. Bethlehem Health and Retirement Precinct committee structure and reporting lines

4.3.2

Operational Governance

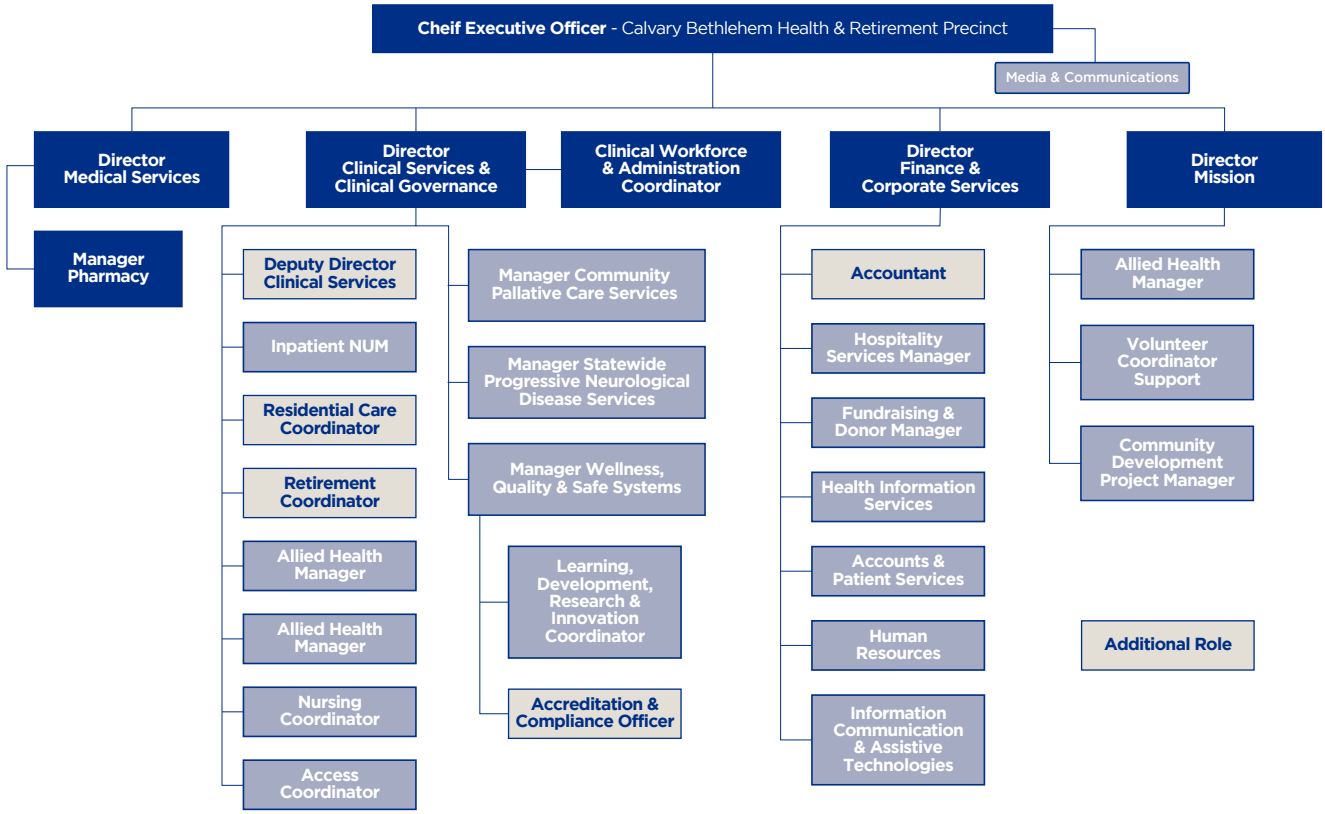


Figure 10. The proposed operational structure provides clear lines of accountability in the Bethlehem Health and Retirement Precinct.

5

INTEGRATED CARE

DEVELOPING INTEGRATED CARE REQUIRES OVERCOMING BARRIERS BETWEEN PRIMARY AND SECONDARY CARE, PHYSICAL AND MENTAL HEALTH, AND HEALTH AND SOCIAL CARE TO PROVIDE THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE (HAM, 2013). TO BE ACHIEVED, INTEGRATED CARE REQUIRES GOOD COMMUNICATION, INFORMATION SHARING AND A SHARED UNDERSTANDING OF THE ROLES OF ALL THOSE IN THE NETWORK OF SUPPORT.

The implementation of the model of care principles, underpinned by the spirit of Calvary and Calvary's mission and values will facilitate integrated care across services and care settings in the Bethlehem Health and Retirement Precinct. A detailed description of enablers can be found in the appendix section 11.

5.1 Living Well

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and a fundamental right of all people (WHO 2018). Well-being is a subjective state that can be evaluated across three domains: (i) perceived life satisfaction; (ii) emotions experienced; and (iii) self-realization and a sense of purpose or meaning (Kuruvilla, 2018). It is a conscious, self-directed and evolving process of achieving full potential.

Living well or achieving one's optimal well-being, requires individuals to achieve their potential in the domains of:

- Physical health - the ability to maintain a healthy quality of life that allows us to get through our daily activities. This includes health prevention, reducing modifiable risks and interventions recommended for diagnosing and managing health conditions
- Social Health - the ability to relate to and connect with other people in our world. This requires opportunities for inclusion, and opportunities for people with different interests, ages and cultural backgrounds.
- Intellectual health - the desire to learn new concepts, improve skills and seek challenges in pursuit of lifelong learning
- Emotional health - the ability to understand ourselves and cope with the challenges life can bring. It includes opportunities for enjoyment and laughter and is linked to purpose in life
- Spiritual health - purpose and meaning in our lives, hope and fulfilment
- Occupational health - the ability to get personal fulfilment from our jobs or our chosen career fields while still maintaining balance in our lives. It also includes the maintenance of life roles including family roles, social roles and participation in volunteer roles

Healthy lifestyles and actively participating in one's own care are important at all stages of a person's life with or without disability. The domains of health are interdependent on one another, and focus on one aspect, can contribute to wellbeing in another (e.g. improved physical communication skills can improve social wellbeing). An individual's beliefs and values, their health literacy, their current health status and social determinants of health such as gender, life stage, cultural background and access to resources (education, employment, social connections and safety and support) are barriers and may impact on an individual's choices related to their maintaining aspects of their health.

Evidence to support various ways of living well can be found in section 10.5.2.

Examples of services on-site that people will be able to access to live well, based on their individual needs are listed in table 2 in the Appendix section 11.3.

Figure 11. Dimensions of Wellness Rees, 2018

Table 4: Enablers of Living Well

ENVIRONMENT	- Evidence based design principles are incorporated into the design to enhance people's well-being including access to natural light, views of nature and access to outdoor garden spaces for all people - An environment that promotes safe physical activity and social connections have been shown to have positive impacts on people's health. (NARI, National Ageing Research Institute, 2016) - Principles of dementia enabling environments are incorporated into the design which consider auditory, visual, sensory and aromatic aspects of the environment (Environments, 2018) - An enriched and stimulating environment that utilizes the arts (music, art, sculpture, dance) meaningfully - People have access to a range of spaces and opportunities to support engagement in meaningful activities and self- management - Ease of access to therapy and activity spaces for people in the sub-acute inpatient ward, interim care and residential care - Staff facilities to promote their health and well-being
TECHNOLOGY	- Access to Wi-Fi throughout the facility to connect to family, friends and the broader community - Assistive technology - Home modifications to suit individual needs - Incorporation of smart home technology for remote monitoring in retirement apartments - New technologies, such as telecare and robotics, sensors and wearable technology, and virtual and augmented reality (Medical Device Research Institute, 2017)
PARTNERSHIPS	- Links and partnerships with a variety of community organisations to ensure a diverse range of opportunities to meet individuals needs either on-site or that can be accessed in the community - Partnerships with the Arts to facilitate exhibitions, music recitals and artists in residence - Pilot of new programs and groups on-site that can transfer into community programs - Funding opportunities through Trusts and funds and other philanthropic sources
CULTURE	- Leadership and organisational culture that supports wellness for staff and recipients of care - The culture supports a network of support for individuals, the functionality of the family and wellbeing of carers - Foster a culture of community supporting each other
WORKFORCE	- Implicit in all roles - Role modelling living well and facilitating people to live well is a function of all clinical and care roles

TECHNOLOGY AS AN ENABLER

The digital revolution is expected to transform health, aged care and disability sectors, both through the uptake of technology by recipients of care and providers. Bethlehem has a rich history of working with assistive technologies to facilitate quality of life and health care. Building on this rich history the Calvary Bethlehem Health and Retirement Precinct will continue to have this focus, expanding into new technologies. There is evidence to support that older people are increasingly utilizing technology in their lives (refer to appendix 5.3)

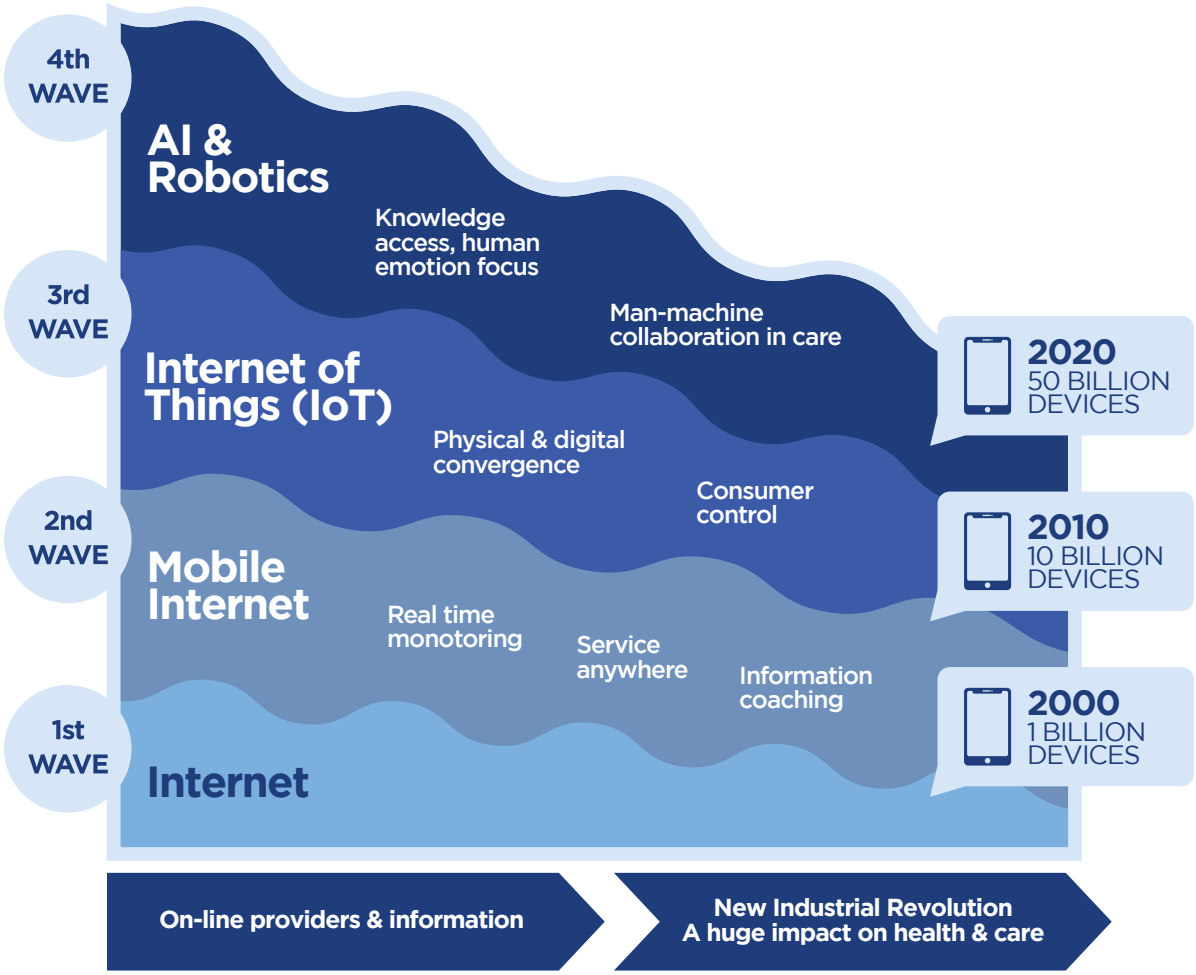


Figure 12: Technology impacts on aged care (McCallum, 2017)

5.2 Person and Family Centred Care

5.2.1 Person Centred and Family Centred Care

Person and family centred care is a key model of care principle and important to the delivery of integrated care. The following principles of person-centred care, are all encompassed within the concept of partnership in care (NARI, 2006):

1. Getting to know the patient or client as a person
2. Sharing of power and responsibility
3. Accessibility and flexibility (of service provider as a person and of the services provided)
4. Coordination and connection of services
5. Having an environment that is conducive to person centred care (supportive of staff working in a person centred way and easy for service users to navigate).

Evidence is limited in the literature regarding the outcomes of patient centred care, however what is available is supportive of the approach. There is evidence of improved patient and carer satisfaction, improved adherence to intervention recommendations and an improved sense of professional worth as outcomes of working in a person-centred way (NARI, 2006).

Person-centred interventions in residential aged care facilities have been associated with psychosocial benefits to residents and staff. Two studies have found that a higher rate of falls occurred in residents receiving person-centred care interventions compared with residents receiving usual or traditional aged care (Brownie S, 2013). People's choices may involve an element of risk that they choose to take, despite known potential consequences. Person centred care involves ensuring the network of support is supportive of those choices and works with the person to understand and mitigate these risks.

The main barriers to person centred care identified in the literature are:

- Staff time
- Staff lacking autonomy and professional power to practice in this way
- Clients with communication difficulties
- Lack of understanding of person centred care (Brownie S, 2013)

Theae barriers are recognised and will be monitored through audit and evaluation processes.

5.2.2

Inclusion

Central to person-centred care is that the needs and preferences of individuals are incorporated into care that is responsive to all individuals. Calvary values respect, which recognizes the value and dignity of every person.

The Bethlehem Health and Retirement Precinct model will promote respect for individuals, inclusion and raise awareness of issues of discrimination through the delivery of care that is responsive to an individual's culture, ethnicity, language, gender, age, sexuality, religion and spirituality.

Care and services provided will be appropriate to the needs of people with diverse characteristics and life experiences though enablers of patient and family centred care and inclusion.

Table 5: Enablers of Patient Centred care and Inclusion

ENVIRONMENT	- An enriched environment - warm and home-like, supportive of the physical and psychosocial needs of people and their families; provides a sense of purpose and place - Incorporation of universal design principles - An environment that enables care for all people including those with behaviours of concern/bariatric/ frail/mobility/visual impairment and/or cognitive impairment and inclusive of people of people from different cultures, languages and religions - Provision of visual and auditory privacy for personal care, clinical consultations and interventions, family/ carer discussions with clinical and care staff, the dying process and for grieving
WORKFORCE	- Provision of an engaging employee experience to attract and retain people oriented to person-centred care and to drive a strong customer experience (Jegatheeswaran, 2018) - Staffing models focused on staff empowerment - Strategies to attract and retain a diverse workforce, reflective of the local community - Use of volunteers to facilitate the patient experience
QUALITY	- Identification of barriers to accessing care at the right time for individuals or population groups and development of strategies to facilitate care - Shared care plans to facilitate person centred care for the network of support
EDUCATION	- Staff training and support to practice person-centred care - Education and training in culturally responsive practice for all staff - Staff understanding the life experiences and needs of LGBTI people and being equipped with the necessary tools to provide LGBTI-inclusive practice
TECHNOLOGY	- Recipient of care portals to facilitate sharing of information between network of care - Technological solutions are tailored to the physical and cognitive abilities of population served and include multi-modal activation - Assistive technology - Use of applications that translate common care requirements
CULTURE	- Leadership and organisational culture that supports person-centred care and diversity - Opportunities to get to know people, and share aspects of their story - Flexible and responsive services to support individual needs
EXTERNAL RELATIONSHIPS	- Access to community advocacy groups to facilitate understanding and needs of people of different cultural and ethnic backgrounds, different sexualities, religions and health conditions
SERVICES	- Access to interpreters and information available in people's preferred language where possible - Development of age, gender and culturally appropriate activities to meet people's needs on-site and/ or development of connections in the community - Food available that responds to the cultural and religious requirements of individuals - Worship and liturgy; both within the Catholic tradition and in a more ecumenical and interfaith manner - Transport options to access services

5.3
Consumer Driven

5.3.1
Autonomy

The Bethlehem Health and Retirement Precinct will support personal autonomy - a person's right to make their own decisions about their lifestyle, their health, care and services, their future planning and how they spend their funds.

Choice is important to all people and a fundamental human right and includes dignity of risk. 'Dignity of risk' means respecting each individual's autonomy and self-determination to make choices for himself or herself, despite the known risks. Health and care providers have a responsibility to ensure people can exercise their rights and are provided with information and education that they can understand to make decisions. This includes both the risks of options being considered and the likelihood and the consequence of each risk occurring.

Active decision making relies on a person's capacity to participate (Human Rights Commission, 2012). Where people are unable to make their own decisions, people can be supported with decision making by trusted people in their network and nomination of a substitute decision maker. Early consideration or nomination of a substitute decision maker/s in people with progressive neurological diseases including dementia provides opportunities to share values and beliefs that can guide future decision making.

Service provision will be flexible and responsive to allow choice or options to individuals to suit their individual needs and preferences, and support access.

5.3.2
Health Literacy

Health Literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health (WHO, 2018). Health literacy is central to empowerment and a person being able to take control of their own health care through making informed health decisions, seeking appropriate and timely care and managing the processes of health and wellness (Health, 2018). The Australian Bureau of Statistics Adult Literacy and Life Skills Survey (2006) showed that 60 per cent of Australians have less than adequate levels of literacy and health literacy, and only 6 per cent of the Australian population has 'high' health literacy levels.

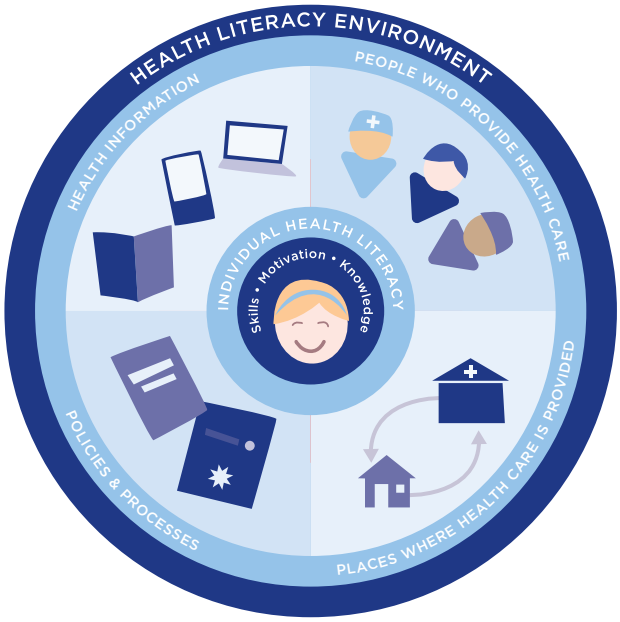


Figure 13. Health Literate Environment (Healthcare, 2018)

The Bethlehem Health and Retirement Precinct will assist peoples' decision making related to health and care needs by providing a *health literate environment* which considers ease of access to information, education of the workforce, policies and procedures that support health literacy and navigational support.

5.3.3

Quality Drivers

The Aged Care Quality Standards (ACQS) and the National Safety and Quality Healthcare Standards (NSQHS) ensure consumer participation in aged care and health settings. Health literacy is also implicit in the new NSQSH standards. The NDIS Quality and Safeguarding Framework will be implemented from 2018. The NDIS principles highlight choice and control and include strategies to ensure dignity of risk for participants.

Consumer participation can happen at a number of levels:

- Individual - involvement in individual care and care decisions
- Program - involvement in co-design, implementation and evaluation of programs
- Organisation - involvement in higher level decision making and governance

Consumers will be involved at all levels in the Bethlehem Health and Retirement Precinct.

5.34

Funding models

Funding models have been redesigned in very recent years to ensure consumers have more choice and control, with the aim of providing a market driven and sustainable approach to care. Consumers will drive quality and innovation by exercising choice as to which providers they use, and how they choose to spend their funds.

The National Disability Insurance Scheme allocates funding to participants related to reasonable and necessary supports deemed to be required to achieve their goals. Consumer Directed Care has been implemented into Community Aged Care Services and home care packages are assigned to consumers. Consumer choice is expected to influence residential aged care funding in the near future

Table 6: Enablers of a Consumer Driven Precinct

ACCESS TO INFORMATION	- Provision of easy access to health and care related information and services and navigation assistance - Design print, audio-visual, and social media content that is easy to understand and act on - Meet the needs of populations with a range of health literacy skills, including those where English is not their first language - Communicate clearly services people will have to pay for and associated costs
QUALITY AND INNOVATION	- A strategy and framework to embed consumer participation throughout the organization - Include consumers in the design, implementation and evaluation of health and care related information and services improvement (Healthcare, 2018) - Monitoring and evaluation of consumer participation - Integration of health literacy into planning, evaluation measures, service users safety and quality - Community development and engagement in relation to death and dying - Improve access to care for individual needs
WORKFORCE	Navigational support will be inherent in all health and care related roles. Key roles include: - General medical practitioner and other medical specialists - Triage roles - Retirement apartment coordinator - Care coordinators /NDIS Support Coordinators - Social workers Resources allocated to support consumer participation and provision of health literate information (Centre, 2018)
EDUCATION	Education framework includes assisting consumer choice and control - Use health literacy strategies in interpersonal communications and confirm understanding at all points of contact especially high-risk situations, including care transitions and communications about medicines - Importance of provision of timely information to support proactive decisions Education and support of consumers participating at organisational level

5.4
Integrated, coordinated care

The model of care principles for the Bethlehem Health and Retirement Precinct model include seamless integrated care, a key concept of the model of care. This aims to ensure people are able to receive care aligned with their goals as they transition between settings of care (health services, home, residential care).

Encompassed within integrated, coordinated care is:

- Single point of access to services
- Care is well coordinated and connected between providers and support is provided to patients, carers and families to assist in navigating health, aged care, disability and community systems
- Clear communication framework between care providers, recipients of care and informal supports
- Collaborative monitoring of wellbeing to proactively respond to and anticipate changing needs

5.4.1
Access and transfer of information between care settings

5.4.1.1
Access to information

Information on Calvary Bethlehem Health and Retirement Precinct will be available on:

- Calvary's website
- My Aged Care
- NDIS - PRODA
- A variety of Aged care, health and disability websites
- Brochures and other publications
- Social media

The most important avenues that information about the model of care and services will be shared will be direct marketing, networking, educational forums and relationships with referrers and recommendations of family and friends. Roles that will be important to target include general medical practitioners, medical specialists, other health services and care and health providers, patient advocacy organisations (NGO's) and central roles supporting initial provision of information of options for NDIS and Aged Care Services.

A survey by National Senior Services Australia found that while 90 per cent of their survey respondents indicated using their computer daily for email, internet or other tasks, they prefer human sources of information and advice, including health (general medical practitioners and medical specialists as first preference) and financial experts, family and friends, and government offices, to digital sources (Rees, 2018)

Initial and ongoing experiences will be important to people continuing to choose Calvary along their care pathway as their needs change. Initial connection with Calvary may begin with Calvary Community Care services, the onsite general practice, the Bethlehem Health and Retirement Precinct specialist health services, the day centre programs or overnight respite. People may also access residential care or the retirement apartments without prior experience of other services and begin their connection there.

5.4.1.2
Access

Referrals and referrals enquiries for the specialist health services, residential care and retirement communities will be directed to one central point - Access and Intake.

Access and intake functions will include:

- Provision of further information about services
- Navigational support
- Site tour bookings
- Receipt of referrals through online portals (My Aged care, NDIS), fax, letter and email
- Confirmation of demographic details and sufficient referral information for clinical triage
- Clinical triage to ensure patient referrals meet the eligibility criteria, identify goals of care and determine the best setting for initial assessment
- Pre-admission assessment where required
- Monitoring of access key performance indicators to minimise time to care

Figure 14 demonstrates expected information flow.

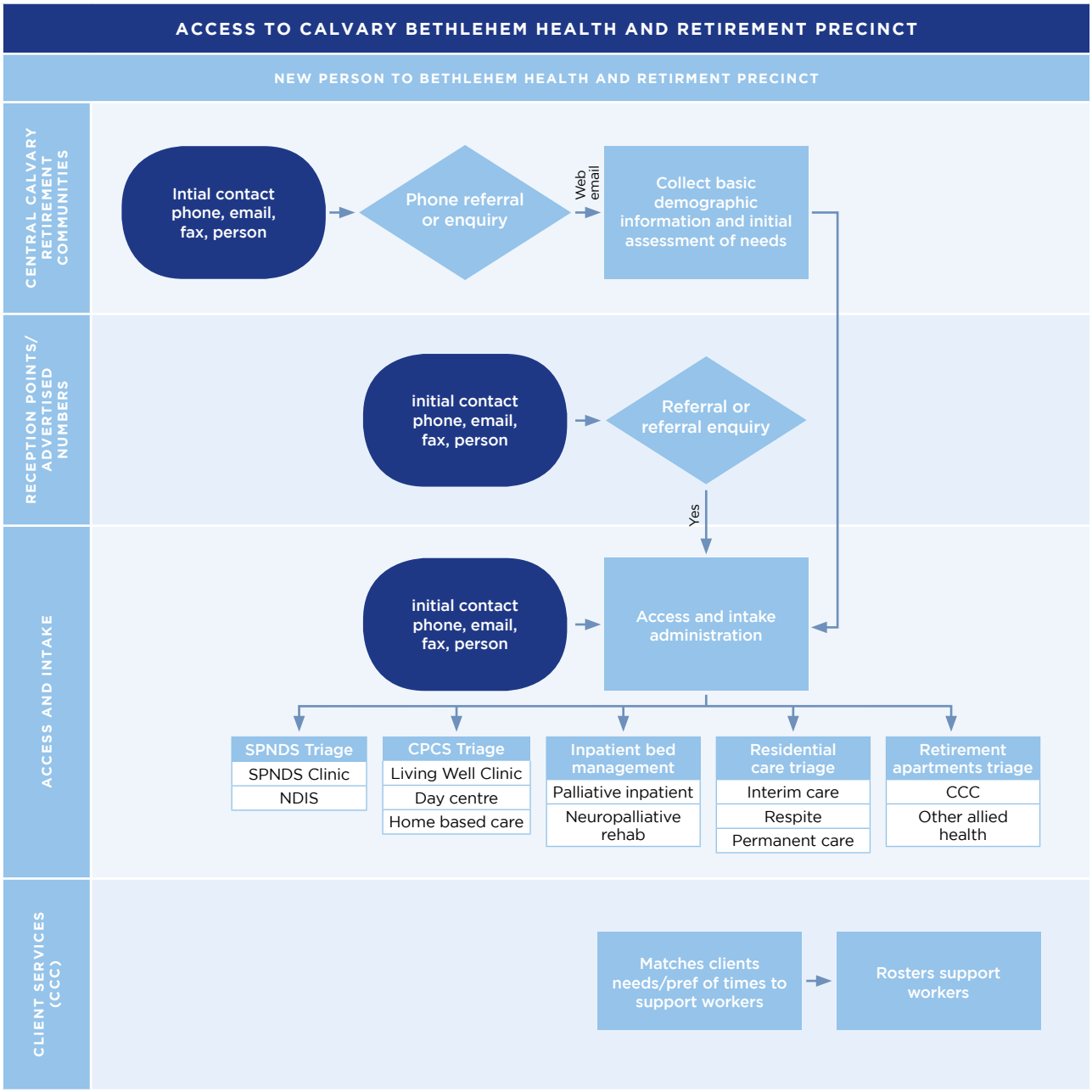


Figure 14: Access to Calvary Bethlehem Health and Retirement Precinct

Referrals and enquiries that originate from the Calvary Retirement Communities 1800 number will be connected automatically or through an initial contact with a central operator to Access and Intake administration. Calvary Community Care's central 1300 number may also direct appropriate referrals to the Bethlehem Health and Retirement Precinct.

People purchasing the retirement apartments will be offered options of packages suited to their needs, including initial base services. Some people may have home care services arrangements in place either with Calvary Community Care or an alternate provider. Initial needs assessment will be undertaken by the retirement apartments triage to develop options suited to the individual. Service agreements and rostering of services from Calvary Community Care will be developed following agreed service requirements.

5.4.1.3
Transfer between settings

New referrals to disciplines or services within a setting will be managed by the setting through systems and processes.

Where a referral is required to a new setting, access and intake will be notified. Information will be provided by the internal referrer for triage to confirm goals of care, prioritise care needs and ensure related funding requirements are completed.

5.4.1.4

24/7 tiered access to care

Assessment of individual needs and goals of care drive the care plan in all settings in the Bethlehem Health and Retirement Precinct.

New clinical issues and care requirements are communicated by people and their families to their clinical and care teams either by:

- Face to face consultations or family meetings
- Telephone/telehealth
- Email
- Communication boards and books (inpatient and residential care settings)

Assessment of need determines the response required and may include intervention, escalation or referral to other services (internal or external). Clearly defined and documented escalation and communication pathways will support access to the right clinical support at the right time.

Immediate unplanned care requirements in inpatient and residential care settings will be communicated by patients and families through a technology solution, that notifies the right person(s) for the task requested, escalating until the person has been attended to.

Access to care and request for review of care requirements is facilitated through communication between team members in person or via telephone and email. Formal communication channels in the various settings include team handovers, ward rounds, family meetings and multi-disciplinary team meetings and tools to support these such as journey boards. Communication is also documented in the relevant case notes to meet regulatory requirements and to facilitate broader team communication.

Urgent assistance in the case of urgent need or an emergency will be raised by technological solution to notify the immediate team members in the specialist health services and residential care. An emergency response will be raised through an emergency code blue (444) which will notify the emergency response team.

For people living in the retirement apartments, individualised escalation plans will be developed. Available technology will be utilised for monitoring, alerts and communication in cases of urgent or emergency need. Response to alerts and communication will be triaged in and out of hours and escalated to the appropriate teams for a response.

Table 7: Enablers Integrated, coordinated care

ENVIRONMENT	- Facilities that support private consultations with clinical staff for people and their families - Sub-acute inpatient ward interface with residential care and access to interim care - Therapy spaces will be arranged according to functional activity, rather than discipline to facilitate interdisciplinary assessment and treatment. - Staff work spaces facilitate collaborative interdisciplinary care - Single point of access to the site - Services are organised to support common journeys of people accessing the facility - Intuitive wayfinding, supporting the needs of the population served (people with cognitive issues, English as a second language, reduced eyesight, visual conflict)
TECHNOLOGY	- Use of technologies to support information provided to people - Use of technologies to support registration and admission processes - Use of an unique identification of people accessing services across the site and across systems to avoid duplication of people in the one system (TBC) - Transferable and/or shareable information from one setting to another: o Demographic details o Handover information o Discharge summaries (specialist health inpatient services) o Shared care plans (specialist health services, GP, other health and care providers, including residential care) o Advance Care plans - Options for sharing information between the Bethlehem Health and Retirement Precinct and external providers include My Health Record or a platform with functions of MyNetCare. - Options for sharing information between Calvary systems of iPM, Vitro, iCare and Goldcare are required to be explored. - Telehealth to support access to specialist health services in residential care facilities and homes where people are unable to access the clinic environment - Technology solutions to alert need are required to be able to be: o Multi-modal to be activated by people with a range of physical and communication abilities o Integrated with peoples own technology solutions that support their communication e.g. eye gaze systems o Both elicited by monitoring information and deliberate alerts to elicit a response - Clinical communication devices have the ability to access multiple telephony, alert systems, pagers: o Patient journey board o The same referral mechanism for all settings for the same service where possible

Table 7 continues next page.

WORKFORCE	- Clearly defined roles and responsibilities of care and health providers - Opportunities for roles or individuals to be appointed to roles that work across settings to facilitate relationships and information flow - Navigational roles that transcend settings. Roles that facilitate access to the right care: o General medical practitioner and other medical specialists o Clinical care liaison coordinators (specialist health services) o Specialist palliative care nurses (specialist health services) o Care coordination nurse (specialist health and residential care) o Huntington's disease clinician o Retirement apartment coordinator and supporting care coordinators o Residential care coordinator o NDIS Support Coordinators o Nurses and allied health professionals - Roles that monitor and respond to alerts: o After hours coordinator o Reception o Emergency management team o Primary care teams o Access and triage roles o Partnerships and collaborations to facilitate access to care at the right time in an individual journey
QUALITY	Processes to ensure access for CALD groups, address language barriers and other barriers to accessing care for populations

5.4.2

Excellence, Quality and Safety

Excellence, quality and safety underpin the model of care. The model of care principles ensure excellence, quality and safety for all people.

- Evidence based, best practice care is provided by appropriately trained and credentialed staff
- Unacceptable variation in practice is reduced
- Creation of a high reliability culture of care which enable people to have the same experience at any point of entry, supported by organisational protocols and pathways
- The safety of all people is enhanced by the environment and policies and procedures aimed to minimise risk

A risk management approach is key to ensuring quality of care and safety of patients and staff. Risks are assessed and strategies are implemented to reduce risk or reduce the likelihood of occurrence or consequence of the risks.

The main risks to recipients of care in the Bethlehem Health and Retirement Precinct identified are:

- Falls (higher rate than other facilities due to population)
- Medication errors
- Infections
- Pressure wounds
- Behaviours of concern to others
- Deteriorating condition
- Malnutrition and choking
- Mental health
- Barriers to access to care

The main risks to staff are:

- Manual handling of patients and equipment
- Patient's behaviours of concern (occupational violence)
- Medication preparation (crushing medications)
- Repetitive strain (workstations and other repetitive tasks)

Risks and incidents are monitored and reported. Quality measures are implemented, reviewed and reported through the Clinical Governance Framework. Incidents are investigated and utilised to facilitate continuous improvement.

Table 8: Enablers of Excellent, Quality and Safety

ENVIRONMENT	- Specialist health services meet minimum design standards Victorian Health Facility Design Guidelines Victoria or Australasian Health Facility Guidelines as appropriate - Facility design eliminates or reduces key risks - Facility design ensures efficient common workflows - Swipe card to all secure rooms and medication cupboards provide record of access
TECHNOLOGY	- Implementation of new technologies to reduce or eliminate risks to people and staff o Falls risks - utilise sensor lights, automated doors, dimmable lighting, o Medication management risks - electronic medication management system o Equipment solution for crushing medications near bedrooms - Use of technology to reduce manual handling risk of staff - e.g. ceiling hoists in bedrooms - Solution to display 'How we are going information' electronically in Specialist Health Services to be viewed by staff, patients and carers/families
WORKFORCE	- Attraction and retention of talent in roles across aged care, palliative care and neuropalliative rehabilitation - Competency framework - Implementation of performance management processes - Roles responsibilities include continuous improvement - Opportunities for quality projects, innovation, research and career progression to facilitate attainment of excellence
EDUCATION	**Educational framework that incorporates:** - Opportunities for reflective practice for staff to identify gaps in service, knowledge or practice against the evidence or best practice (audits, benchmarking, data review, literature review/journal club, projects) - Occupational health and safety - Education of key competencies - Mandatory training for emergency procedures, infection control, medication management and risk assessment.
QUALITY	- Integrated clinical governance structure - Integrated policies and procedures that reflect the highest standard across Aged Care Quality Standards (ACQS), the National Safety and Quality Healthcare Standards (NSQHS) and NDIS quality standards. - Outcome measurement – Evaluation Framework
CULTURE	- Clinical leadership in striving for excellence, quality improvements, innovation and research - Expectation of high reliability culture - Recognition of excellence - Culture of risk and incident reporting

5.4.3
Dementia support

Calvary Community Care Dementia Framework encompasses the WEEL model of care which represents Wellness, Engagement, Environment and Learning for people with dementia. It is consistent with the broader model of care principles with the Bethlehem Health and Retirement Precinct and will be utilised in this setting. WEEL promotes the premise that although a person has been diagnosed with dementia, enjoyment of life and the opportunity to live well in an enriched environment is a basic human right.

Wellness will be enabled through a multi-disciplinary approach to care as well as particular strategies to reduce modifiable risks associated for people with dementia including but not limited to:

- Food strategies that promote food and fluid intake and reduce the risk of choking, graze all day
- Maintenance of physical function - strengthening exercises focusing on balance and falls mitigation
- Use of technologies to aid independence and facilitate engagement in meaningful activities
- Music therapy - therapeutic singing, dance/movement, receptive music therapy, instrumental improvisation, musical reminiscence, Millieu orientation and attention to the aural environment
- Medication management options to maintain independence where possible
- Risk mitigation for delirium
- Management of mental health
- Social engagement, including links to the on-site and broader community
- Spiritual needs identification and support
- Identification of unmet needs
- Management of behavioural and psychological symptoms of dementia
- Carer support and respite
- Palliative care
- Engagement in meaningful activities

Engagement in meaningful activities will be enabled by the implementation of the Montessori-Based Dementia Programming method.

The Montessori method was developed initially to support child development by Maria Montessori in the early 1900's. The mission is to enable individuals:

- To be as independent as possible
- To have a meaningful place and make meaningful contributions in and to their community
- To possess high self esteem

Psychologist Cameron Camp, PHD, has taken this approach and applied it to people with dementia. His research has shown this approach to learning, one based on rehabilitation principles can benefit people with cognitive impairment, called the Montessori-Based Dementia Programming method.

Integrating this approach into practise requires activities, roles and routines to be created based on the needs, strengths, skills, abilities and interest of a person with dementia and delivered in an environment that supports cognitive loss. Programs are individualised and can be provided individually or in groups. Information regarding each individual's story, their strengths and interests needs to be readily available and could be facilitated through technology.

This approach is person centred care, core to the model of care principles in the Bethlehem Health and Retirement Precinct. Barriers to providing this approach are consistent with barriers to providing person centred care.

"How can we connect with the person that is still here? Our focus is to work with the strengths that remain and engaging with the individual. What you do for me you take from me."

Table 9: Enablers of dementia support

ENVIRONMENT	The environment has been shown to be an important component to facilitate independence and engagement for people with cognitive issues. The environment should reflect the Dementia Enabling Environment Principles (Environments, 2018) and an enriched environment, stimulating engagement in meaningful activities
TECHNOLOGY	- Technology has the potential to increase people's independence by providing monitoring of usual behaviours, prompts for regular tasks and alerting support. - Technology can also be used for enjoyment to connect to previous times and place e.g. Music, virtual reality.
LEARNING	- Calvary Community Care Dementia Framework includes learning and development of staff to support the embedding of knowledge, skills and of the Montessori method to provide excellence in care and support people living with dementia. - Understanding individual triggers, what are the unmet needs
WORKFORCE	- Use of volunteers to facilitate engagement - Support workers and care companions are key to dementia care - Leisure and lifestyle, pastoral care, music therapy - Access to neuropsychologists and speech pathologists

5.4.4
Palliative Care

Palliative care is part of standard care and the role of all health and care providers, supported by family and community members and a core component of care provided by all services and settings in the Bethlehem Health and Retirement Precinct. It is an approach that improves the quality of life of people and their families facing the problem associated with life limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Effective palliative care is proactive, anticipatory and individual (WHO W. H., 2018).

Essential components of palliative care include:

1. Early access to palliative care
2. Discussions about future treatment decisions, care, lifestyle preferences and dying
3. Determining goals of care and care planning
4. Quality of life
5. Terminal care
6. Bereavement care

The Bethlehem Health and Retirement Precinct will play a role in community awareness of death and dying. Raising awareness about death and dying reduces the stigma of death, and provides a platform for the community to develop its own capacity to support people through the process and assists people to be informed about formal supports available to improve access to care, including specialist palliative care. In 2016, approximately 75% of people accessing specialist palliative care in Australia had a primary diagnosis of cancer. Deaths in Australia due to Alzheimer's disease and other chronic conditions received proportionally less access to specialist palliative care with opportunities to benefit from specialist palliative care interventions or other appropriate support.

Discussions about death and dying will be the responsibility of all health and care providers in the Bethlehem Health and Retirement Precinct. Education and support of primary care staff has shown to be important in implementation of early discussions regarding dying (Johnston N, 2016). Advance care planning (ACP), preferred place of death discussions and documentation ensures people are well-informed about their disease and treatment options to make decisions. Research on end of life decision-making has identified six major types of patient goals: to be cured; to live longer; to improve or maintain function / quality of life; to be comfortable; to achieve life goals; and to provide support for family / caregiver (Kaldjian et al, 2008).

There is good evidence that integrating specialist palliative care with disease modifying therapies improves symptom control, quality of life and family satisfaction. Moreover, early access to specialist palliative care can reduce the provision of clinically non-beneficial therapies, prolong life in some populations, improve the quality of life of people with life-limiting illness and significantly reduce hospital costs. Triggers can be utilised to facilitate recognition in different disease trajectories (DHHS D. o., 2018) as well as the use of needs assessment tools. Specialist palliative care services can provide education to facilitate needs identification. For people diagnosed with progressive neurological diseases including dementia early discussions about prognosis, goals of care and ACP are critical as they can provide guidance for treatment decisions, care and lifestyle preferences and allow patients to retain a sense of autonomy despite progressive cognitive or functional decline. Appointment of a substitute decision maker is also an important part of developing an ACP in this population to ensure the substitute decision maker understands the person's values and beliefs (Centre C. D., 2016). The neurologist or general practitioner are best placed to have these discussions (Robinson M, 2017).

Palliative care will be based on the assessed needs of people, their carers and families, rather than on diagnosis, age or prognosis. Agreed goals of care will inform care planning and guide medical decision making. Acute deterioration can be identified and responded to accordingly to prevent unnecessary transfer to another setting.

Care plans will ensure people's pain and or other physical symptoms are effectively controlled and they have access to psycho-social, spiritual and bereavement support as required. People's quality of life will be facilitated through active promotion of self-management and self-sufficiency by providing interventions that support people to make the most of their own capacity as well as facilitating opportunities to enjoy life and live well, based on their individual values and goals.

THE THREE-PHASE MODEL OF GOALS OF CARE		
CURATIVE OR RESTORATIVE PHASE 'Beating it' - not considering death	SUPPORTIVE AND PALLIATIVE CARE PHASE 'Living with disease, anticipating death'	TERMINAL PHASE 'Dying very soon
Default position for most patients	**Disease deemed to be incurable and progressive**	**Death seems to be imminent**
Goals of care guide medical decision-making: • All appropriate life-prolonging treatment deployed • Resuscitation: escalation unless otherwise specified	**Goals of care guide medical decision-making:** • Measured life-prolonging and stabilising treatments • Quality of life • Resuscitation: varied response depending on situation and advance care plan • Limitations of medical treatment (resuscitation plan)[6] are in place	**Goals of care guide decision-making:** • Comfort, quality of life and dignity • Advance care plan reactivated • Site of care and death revisited • Limitations of medical treatment (resuscitation plan) in place and reviewed.

(Thomas R, 2014)

5.4.4.1

Death and dying

People will be supported to die in the locations of their and their family's preference where possible. Timely recognition that a person may be imminently dying enables goals of care to be reviewed and a care plan to develop that is responsive to the changing needs and preferences of the patient, their family and carer. It also aims to ensure that transfer of patients who are imminently dying to alternate facilities is avoided.

Care in the last few days of life will include:

- Diagnosis of dying (multi-disciplinary team discussion and communication with family/carers)
- Exclusion of reversible causes
- Use of terminal care tool (where required)
- Care plans that support comfort, dignity and quality of life
- Appropriate support for carers (NHS, 2011)

The person and their family will be encouraged to create an environment that is meaningful for them. Death will be acknowledged with dignity in line with Calvary's value of respect. Death care and ritualising of the bereavement process will also be dependent on the person and families preferences, which may include their culture and religion. Bereavement support will be available to the person, their family and carers at all phases of their end of life journey.

Table 10: Enablers of Palliative Care

WORKFORCE	- Clearly defined roles and responsibilities across the continuum of care - Access to PCA's able to provide 24 hour support in terminal care phase in the community and retirement apartments - Clinical champions in palliative care in all settings
EDUCATION	- Bethlehem Health and Retirement Precinct palliative care education framework - Death audits and education programs for residential care facilities - Community engagement in death and dying conversations
ENVIRONMENT	**Recipients of care** - An emphasis on serenity for all environments incorporating palliative care - Retirement apartments have the capacity to support changing needs of people including hospital beds - Privacy for the dying process and to spend time with carers, family and friends - Pathways to and from places of care to morgue and to hearse pick-up show respect and dignity **Carers and family** - Ability to stay overnight in the same room with a loved one when dying (choice of same room, same bed) - Privacy to grieve with family outside of the patient's bedroom

5.4.5

Informal Supports/Carers

A carer in this context is defined as a person who provides any informal assistance, in terms of help or supervision, to older people (aged 65 years and over) and those with disability.

In 2015:

- 11.5% of the population were carers
- 55 years was the average age of a primary carer
- Over one-third of primary carers (37.8%) were living with disability themselves
- Females made up the majority of carers, representing 68.1% of primary carers and 55.5% of all carers
- Most carers are a spouse or adult child

Impacts of caring for an older person or person with a disability include:

- Increased rates of depression, stress and anxiety compared to non-carers
- Negative impact on physical health
- Social isolation if not able to maintain time for friends, interests, hobbies and work
- Financial implications if unable to work (ABS, 2015)

Interventions to support carers available will include:

- Access to information, education and training
- Psychosocial therapies
- Case management approaches
- Peer support programs
- Respite care

"Respite at a place that doesn't understand my husband's care needs or enable his independence does not help. I need to go every day to reduce his anxiety and tell the carers what his needs are. I'd like to be able to do some things for myself or even go away for a few days."

5.4.6

Education, Innovation and Research

Quality of care is dependent on the implementation of evidence based, best practice care and reliant on innovation in response to the changing needs of the population. Research conducted within the Bethlehem Health and Retirement Precinct and elsewhere develops the evidence base and education is the tool to translate this into clinical practice.

As such, one of the key principles of the model of care is research generating, evolving, learning. Encompassed within this is that:

- Research generated by the model will inform future best practice
- Service delivery is agile and responsive to changing needs of the population
- New technologies that enable people to achieve their goals are trialled and implemented
- A learning and research culture focused on continuous improvement, supporting broader workforce development

5.4.6.1

Education

Education supports competency for individual roles, provides inspiration and drive to staff to improve the quality of the services and supports the sustainability of the workforce. It's a requirement to meet National Accreditation Standards in health and aged care. It is the tool that translates research into practice.

The Bethlehem Health and Retirement Precinct has the clinical expertise to provide information and knowledge to students and the broader workforce in the areas of palliative care, progressive neurological diseases and aged care. There are many opportunities to provide experiential learning through clinical experience and mentorship with people with a range of conditions at different stages of their disease progression, demonstrating the benefits of the co-location of services and its integrated model of care. Holistic education can be provided that includes person centred care and opportunities to understand the various roles of team members and how they work together to achieve people's goals. There is potential to further develop educational business opportunities to generate revenue.

5.4.6.2

Innovation

Innovation may be seen as the application of better solutions that meet new requirements. The need for new requirements for the people accessing services in the Bethlehem Health and Retirement precinct population will be driven by consumer feedback, quality indicators, emerging new evidence and external drivers such as funding bodies, creating an ever-evolving model of care. New interventions, ways of providing services and technology will be piloted and monitored for their effectiveness and implemented as standard care. Consumers will be engaged in all parts of the continuous improvement cycle.

5.4.6.3

Research

STATEWIDE PROGRESSIVE NEUROLOGICAL DISEASES

As most people with Motor Neurone disease (MND) or Huntington's disease in Victoria attend the Statewide Progressive Neurological Disease Service (SPNDS), there is a critical mass of patients to support clinical trials and other clinical research. Access to clinical trials is reported by consumers to be important aspect of their care, supporting their hopes of a cure and in maintaining their quality of life. Maintaining a critical mass of patients on-site is also important for research sustainability.

The clinical trials and research conducted often in collaboration with other health services and/or universities includes:

- Drug trials - outcomes are measured through questionnaires, outcome measures of functional status and biomarkers through blood samples, for example
- Clinical research related to allied health interventions e.g. assistive technologies and music therapy
- Contribution to national and international patient registries and biobanks, creating platforms for scientific and translational research
- Supervision of research honours and PhD students

CALVARY PALLIATIVE AND END OF LIFE CARE RESEARCH INSTITUTE

A virtual institute provides a platform, connecting research groups undertaking palliative care research at Calvary Health Care Kogarah, Calvary Health Care Bethlehem, Calvary Mater Newcastle and Calvary Health Care Bruce.

The main areas of research in palliative patients includes rehabilitation in palliative patients and community palliative care (use of medications, non-malignant disease, presentations to emergency department). The Palliative Care Clinical Studies Collaborative RAPID pharmaco- vigilance studies utilise patients from Bethlehem.

FUTURE RESEARCH OPPORTUNITIES

Future opportunities for research in the Bethlehem Health and Retirement Precinct include:

- The development of strong linkages or partnerships with acute tertiary health services such as the Alfred Health and Monash Health, both affiliated with Monash University is the strategic approach to facilitate access and involvement in phase 1 and complex drug trials for new therapies for PND's which require acute tertiary services
- Opportunities to undertake palliative care research within residential care facilities will be enhanced with the integration of residential care on-site
- Evaluation of the model of care
- Wellness, mental health, maintenance of physical health, quality of life and carer's wellbeing
- Dementia related research

Table 11: Enablers of education, innovation and research

RESEARCH CULTURE	- Organisational recognition in the importance of research to provide clinical leadership and service development in area of expertise, to facilitate the translation of research into practice and the ability to attract talent to facilitate workforce sustainability - Office of research to develop research framework, support ethics processes, monitor research guidelines, facilitate communication and collaboration, support administration processes
LEARNING CULTURE	- Time for learning is prioritized and protected, supported by the leadership, policies and procedures - Opportunities for experiential learning and reflection are supported for internal and external learners - Flexible model - offering study days for roles where there is limited opportunity during work hours - Educational responsibilities are incorporated into role descriptions
WORKFORCE	- Service agreements, joint appointments and credentialing to facilitate phase 1 clinical trials - Joint appointments with universities to facilitate research and education - Opportunities for joint research fellow with other health services - Research administration role - Multi-disciplinary educational roles or portfolios to support internal education - graduate, students, clinical support and clinical education - External education roles to provide training to the broader community (onsite and offsite)
ENVIRONMENTS	- Office of education and research - Low fidelity simulation facilities - e.g. a simulated room of the current clinical and care environment - Multi-purpose space suitable for educational forums (lectures, workshops) - Research clinical spaces - waiting space, interview room and treatment room (up to 4 people simultaneously ideally for future proofing of less complex infusion based drug trials) - Laboratory space and storage to support clinical trials - freezers, fridges, clinical trial procedure folders, associated consumables and computers. - Computer laboratory (hotdesks) for research and education students - Space incorporated into the clinical and care environment to integrate education and research

6

SERVICES PROVIDED ACROSS THE PRECINCT

THE FOLLOWING SERVICES WILL BE PROVIDED ACROSS ALL SETTINGS IN THE BETHLEHEM HEALTH AND RETIREMENT PRECINCT.

6.1 Reception and concierge

Reception will provide Calvary's value of hospitality, providing a welcoming initial contact for visitors for the Bethlehem Health and Retirement facilities.

Hours of operation: 7:00am-8:00pm.

Table 12: Reception and concierge functions:

FUNCTIONS	TASKS
CUSTOMER SERVICE	- Welcome - General enquiries - Wayfinding - Information on accessing general services in the precinct and local neighbourhood - Visitor sign-in/Security pass register - Assist with trip sign-up and reservations - Mail service and stamp sales - Photocopying, fax and laminating services - Voting forms/ballots - Room bookings (including retirement apartments)
MAIN SWITCHBOARD FUNCTIONS	- Answering and directing calls - Responsible for maintenance of "on call" rosters and diary, ensuring that Patient List is kept up-to-date - Update and manage the telephone data base as required - Logging of telephone faults through BEIMS system & supplier (Nexon) support contacts - Provide residents phone listings - Emergency management role - PA system announcements
AFTER HOURS INPATIENT FUNCTIONS	- Admissions - After hours manual receipting of fees, appliance hire, etc;
ADMINISTRATION	- Maintain hospital vehicle booking system, including drivers' license register - Maintain and be accountable for register of keys - Responsible for newspaper and magazine delivery, including handling and recording of monies received; - Accountable for courier and taxi voucher booking and control - Franking of outgoing mail, including enveloping as required - Sort and distribute incoming mail and faxes

Further review of administrative functions will occur in the next phase, with other hospitality functions.

Table 20: Enablers to support reception and concierge function

	- Wayfinding support (mobile applications and/or screens) - Resident and patient portals - to access information, book trips and facilities - Electronic communication boards - to access information about what is happening on-site - Swipe card security system to minimise need for shared keys - Electronic room booking system - Electronic car booking - Communications to facilitate wayfinding and direct contact with high volume contact locations - Telecommunications - Taxi-phone
WORKFORCE	- Reception workforce - Volunteer concierge (peak times)
EDUCATION	- Customer service training - Brochures and resources of the local area
ENVIRONMENT	- Environment and key landmarks supports intuitive wayfinding - Simple signage information supports intuitive wayfinding

6.2 After hours coordination

After Hours Coordination functions:

- Assume role of Director of Nursing and Chief Warden role after hours
  - Escalation of clinical issues in residential care and specialist health inpatient ward
  - Emergency management
  - Ensure a safe environment for all recipients of and staff within designated units with particular reference to security, fire prevention, hazards and infection control
- Triage of community specialist health service after hours calls
- Monitor and triage retirement apartment alerts and calls
- Manage nursing and PCA resources after hours
- Support and monitor the safety of staff undertaking out of hours visits

Table 13: Enablers of after-hours coordination functions

TECHNOLOGY	A mobile audio-visual communications platform to facilitate monitoring and communication functions throughout the facility will be key to support this function
WORKFORCE	Grade 5 nurse (1600-2330 and 2300-0730)

6.3 Medical services

Medical services provided in the Specialist Health Services include:

- Palliative care physicians
- Neurologists
- Geriatrician
- Psychiatrists

A general medical practice (GP) has been proposed to provide services on-site with the model to be determined. If chosen by individuals, the GP is in a good position to coordinate the care of those in the residential aged care facility and retirement apartments. GP's are also recognised as being in a good position to promote active ageing and to provide information on physical activity and healthy eating. They can also monitor mental health and develop advance care plans with their patients (National Ageing Research Institute, 2016) (RACCP Curriculum for Australian General Practice, n.d.).

Table 14: Enablers of medical services

ENVIRONMENT	Consulting rooms
TECHNOLOGY	Ability to share information

6.4
Dental Services

General and specialist dental services are required on-site in the Bethlehem Health and Retirement Precinct. General services are required for people living in residential care and potentially the retirement apartments.

Specialist dental services are required for people with progressive neurological diseases as they have a higher than average incidence of oral disease because of physical and psychological deteriorations that result out of neglect and a general decline in oral care. Early access to care reduces risks related to oral health. For patients in the later stages of their disease, a major goal is to maintain oral hygiene, to improve comfort and reduce the risk of secondary issues like gum disease and aspiration pneumonia which negatively impact health and quality of life.

A collaborative project by Calvary Health Care Bethlehem, Link Health and Community and The University of Melbourne will facilitate access to dental care for people with PND.

Table 15: Dental services enablers

ENVIRONMENT	Refer to patient centred care Dental consultation room
TECHNOLOGY	Ability to share appointment information and case notes with link health and community.

6.5
Pharmacy Services

A hospital pharmacy will provide for the specialist health services:

- Clinical pharmacy services - review of drug charts, provision of advice to medical staff, patient education and discharge medication focusing on the inpatient ward
- Clinical trials - clinical pharmacy services and dispensing
- Drug supply and dispensing of drugs - specialist health inpatient ward, emergency CPCS drugs, low volume outpatient supply (Outpatient compassionate supply, Outpatient botox)
- Education of other health professionals
- Policy and drug formula responsibilities

A community pharmacy will be engaged to provide:

- Individual residential care packs based on medication charts prescribed by the general practitioner of those people living in residential care
- Medication packs for people living in the retirement apartments if they choose

Table 16: Pharmacy service enablers

ENVIRONMENT	**Hospital Pharmacy** - Pharmacy that meets the Pharmacy Authority regulations - Receipt and dispatch area - Dispensing benches and workstations for clinical pharmacists - Medicine storage solutions including stock flow smart solutions, secure store, refrigerator, freezer - Clinical trials medicines and protocol storage
WORKFORCE	- Pharmacists
SERVICE PROVIDERS	- Community pharmacy to provide residential care, support access to emergency drugs and non-imprest items after hours - Medicine supplier to provide imprest drugs in ward and pharmacy

6.6

Nursing and Allied Health

Nursing and allied health services will be accessible in all settings based on needs identified and referral criteria. Disciplines expected to be available in each setting are detailed in table 17.

Table 17: Nursing allied health disciplines accessible in each setting

	SPECIALIST HEALTH SERVICES (ALL SETTINGS)	RESIDENTIAL CARE	RETIREMENT APARTMENTS	COMMUNITY
NURSING	x	x	x	
OCCUPATIONAL THERAPY	x	x	x	x
MUSIC THERAPY	x	x		x
PHYSIOTHERAPY	x	x	x	x
EXERCISE PHYSIOLOGY		x	x	x
SPEECH PATHOLOGY	x	x	x	x
DIETETICS	x	x	x	x
SOCIAL WORK	x	x (interim care)		x
PASTORAL CARE	x	x	x	
NEUROPSYCHOLOGY	x	x		x
CLINICAL PSYCHOLOGY	x	x	x	x
PODIATRY		x		

Specialist expertise will be available across aged care, palliative care and neuro-rehabilitation. In some cases, skills are transferable across settings and patients groups. Escalation pathways will support access to expertise in an area when required.

Clinical governance mechanisms will support supervision of staff, quality and safety of service provision. Various funding sources will support access to the care, based on eligibility criteria including specialist health funding, Medicare, residential care based on ACFI, homecare packages level 3 and 4, NDIS and private health and private funding.

6.6.1
Lifestyle coordination

Lifestyle coordination will be incorporated into:

- Residential care
- Centre based care - day centres
- Specialist health inpatient ward - behavioural management

Lifestyle coordination will ensure the development of responsive and fresh individual and group lifestyle programs, targeted across all domains of health, provided in partnership with residents, pastoral care, volunteers, allied health therapies and external agencies to facilitate all the domains of wellness. It will include:

- Identification of unique needs of the people through consultation and assessment
- Management of relationships of external agencies providing individual and group programs
- Identification for opportunities for shared activities across the precinct to meet people's individual needs. Examples include:
    - Age appropriate social and recreational activities, for the needs of younger people are integrated across specialist health inpatient ward, interim care and residential care (with the potential to incorporate community members through a day centre program if appropriate)
    - Montessori programs
    - Integrated exercise groups across specialist health inpatient, interim care and residential care where appropriate for people with similar goals and functional levels
    - Shared art and craft facilities and activities
    - Shared recreational, spiritual, communal and community spaces and activities where appropriate.

Table 18: Lifestyle coordination enablers

ENVIRONMENT	The placement of shared facilities at the fringe or outside of wards and homes for ease of access or otherwise within the community hub
WORKFORCE	Allied health assistants and activity coordinator roles support the implementation of lifestyle programs. Collaboration and integration of allied health therapies into the lifestyle program to facilitate wellbeing such as music and art therapy, pastoral care, exercise physiology and physiotherapy.

6.7
Specialist Palliative Care Services

Specialist palliative care services can support people with a life-limiting illness through:

- Direct care for people requiring specialist palliative care interventions
- Shared care arrangements with other healthcare providers
- Consultation and advice to other services and healthcare teams providing palliative care
- Education and training
- Undertaking and disseminating research about caring for the dying and their families/carers (DHHS, 2017)

The Bethlehem Health and Retirement Precinct is a level 3 Specialist Palliative Care service providing:

- Inpatient admitted episodes
- Community Palliative Care Services
    - Home based care: community and residential care, telehealth
    - Centre based care:
- Living Well clinics and group interventions
- Day Centre program
- 24 hour phone support for patients, families and other care and health providers
- Education of primary care providers
- Palliative care research

Access to specialist palliative care services is provided through inpatient care for assessment, symptom management, independence maintenance and terminal care, where this is the most appropriate setting to achieve people's goals. Most patients (63% in 2016/17) are referred from the Community Palliative Care Service or have accessed services prior.

Tables 19, 20 and 21 detail Community Palliative Care Services provided in the Bethlehem Health and Retirement Precinct.

Table 19: Home based community care (people's homes)

REFERRAL CRITERIA	SERVICES OFFERED	FOCUS OF SERVICE	DE-ESCALATION CRITERIA	ESCALATION CRITERIA
- High dependency needs - Complex symptoms and problems which may be impacting the patient and/ or their support network - Previous or risk of acute hospital presentations - Have fewer health professionals involved in their care (e.g. GP, Sub-Acute, CPCS) - Patient is unable to attend clinic sessions	- In-home and telehealth services - Complex and persistent symptom management - Active implementation of advance care planning - Psycho-social and emotional support for patients and carers - Grief and bereavement support - 24 hour phone and in-home nurse support - Allied health support - Equipment needs - Volunteer companioning - Education of patient, carers and network of providers - Advocacy	- Specialist support to remain in their preferred place of care - Facilitation of development and implementation of advance care plans Education and support of primary care team - Care coordination in collaboration with the network of providers	- Have become stable in 6-8 consecutive visits	- Change in symptoms

Table 20: Home Based Community (Residential Care)

REFERRAL CRITERIA	SERVICES OFFERED	FOCUS OF SERVICE	DE-ESCALATION CRITERIA	ESCALATION CRITERIA
- Complex symptoms and problems which may be impacting the patient - Acute presentations or hospitalizations, or is at risk of preventable presentations	- Case review to facilitate identification of deteriorating people - On-site specialist palliative care assessment and complex and persistent symptom management24 hour phone support - Education of patient, carers, nurses and network of providers - Advocacy	- Identification of deteriorating people - Needs identification - Facilitation of development and implementation of advance care plans - Education of staff - Complex symptom management	- Primary team managing care plan - Not in terminal phase	- Change in symptoms

Table 21: Living Well Clinics

REFERRAL CRITERIA	SERVICES OFFERED	FOCUS OF SERVICE	ESCALATION CRITERIA
- Prognosis 18-24 months - Goals of care related to quality of life - Have a number of other health professionals involved in their care (e.g. GP, Acute/Sub-acute, Disease-specific specialists - Multi-disciplinary referrals	**Range of services offered depending on prognosis:** - 24 hour phone support - 'Check-in' phone call 2 weeks before clinic appointment - Clinic appointments every 1 to 6 months (medical and nursing) - Advance Care Planning - Allied Health individual therapy - Group therapies (exercise, breathlessness, fatigue management) - Patient Liaison - Education programs	- Manage symptoms - Maximise patient independence, wellness and quality of life - Planning for future needs - Psycho-Social support for patients and family members - Prevent hospital admissions	- Change in symptoms

Early access to specialist palliative care services is facilitated through:

- Relationships with others in the health sector
  - Through peak body membership and leadership roles
  - Joint or part-time appointments across a range of referring health services
  - Attendance at multi-disciplinary meetings at acute and sub-acute health services
  - Relationship with pulmonary rehabilitation and HARP programs to identify appropriate referrals
  - Secondary consultation and support to general practitioners
- Services offered early in the palliative care pathway
  - Living Well Clinics
  - Day centre
  - Access to palliative care physicians in the Statewide PND Service
  - In-reach services at residential care facilities including death audits, review of patients to support referral and provide education

A research study of integrated specialist palliative care in residential care facilities to assist in identifying deteriorating patients, and supporting communication of death and dying conversations found that length of stay in acute hospitals was reduced by 3.77 days and that 76% of people had a documented preferred place of death and 96% of those died in their preferred place (M, 2016). A model where specialist palliative care are attending case conferences at a transitional care facility and nursing home to facilitate identification of deteriorating people or those who would benefit from specialist palliative care services is being trialled currently by Bethlehem and will inform the model of care for the Bethlehem Health and Retirement Precinct.

Education and support of informal and formal carers is a key focus in all settings. For people living onsite in the Bethlehem Health and Retirement Precinct, direct education and support will be able to be provided to carers through the education programs and the Specialist Palliative Care service for individual needs.

People may access a combination of specialist palliative care services at one time for example day centre and home based care or day centre and living well clinics. People may also access specialist palliative care services in different settings and at different intensities along their care pathway, dependent on their and their family's needs and the needs of their primary care team. Enablers of integrated coordinated care between providers and settings ensures integrated care.

Potential future opportunities

- Symptom management for people with chronic conditions to optimize quality of life

Table 22: Enablers of Specialist Palliative Care

WORKFORCE	Specialist multidisciplinary team, most of whom will have specialist qualifications, extensive experience and skills in palliative care including: - Medical practitioners - Nurses - Allied health - Volunteers (PCA, 2018) Primary nursing model to facilitate continuity of care in the community palliative care services Recognising and supporting the contribution of families and carers to the palliative care service system
EDUCATION AND RESEARCH	- Integrated approach to education and research - Refer to education and research enablers
ENVIRONMENT	**Patient and carer needs** - See centre based care (Day Centre, Clinics, Group programs) **Clinical Environment** - See specialist health centre based care (Day Centre, Clinics, Group programs) **Staff - see Appendix section 11**
TECHNOLOGY	- Electronic boards to facilitate patient allocation and team communication - Mobile devices for telecommunication and access to clinical information - Telehealth platform - Patient monitoring and communication applications (speculative)

6.8

State-wide Progressive Neurological Service

The State-wide PND Service has been providing a range of interdisciplinary assessment and neuro-palliative rehabilitation for people with a diagnosed PND or a working diagnosis of a PND for nearly thirty years and was designated a Statewide service provider in 2011.

As a Level 5 specialist service provider, the Statewide PND Service provides:

- On-site admitted rehabilitation
- Assessment and neuropalliative rehabilitation for local patients and the more complex cases that require the face-to-face expertise of the Calvary team through clinics and telehealth
- Secondary consultation and liaison services to generalist rehabilitation services across the state to assist with the management of people with PND (DHHS D. o., Specialist Rehabilitation, 2018)
- Leadership and education of the broader workforce and demonstrated research capability to facilitate service development across the state

The Statewide PND Project (2012/16) lead by Calvary Health Care Bethlehem, Barwon Health and the Department of Health developed a framework for delivering health services to people with Progressive Neurological diseases in Victoria with level 4 PND services operating now independently at Northern Health and Barwon Health. The development of a Statewide PND network aims to provide access to specialist care closer to people's homes.

The future recommendations of this project include:

1. Developing a statewide PND network - further metropolitan and regional level 4 PND services
2. Ensuring well-coordinated services across sectors
3. Addressing the physical, social and emotional needs of people at any given time
4. Linked care with research to ensure access to therapeutic trials for patients and evidence based care

The progressive neurological diseases managed include: Huntington's disease, Motor Neurone Disease, Multiple Sclerosis, Muscular Dystrophy, Multiple System Atrophy, Parkinsonian Syndromes, Spinocerebellar Ataxias and others.

Patients with complex needs or rapidly changing disease may be managed from diagnosis through the duration of their disease (e.g. MND, HD). Others may be referred in the later stages of disability. The relationship between neurology, rehabilitation and palliative care in people with long term neurological conditions has been described by Turner et al (Turner-Stokes L, 2008).

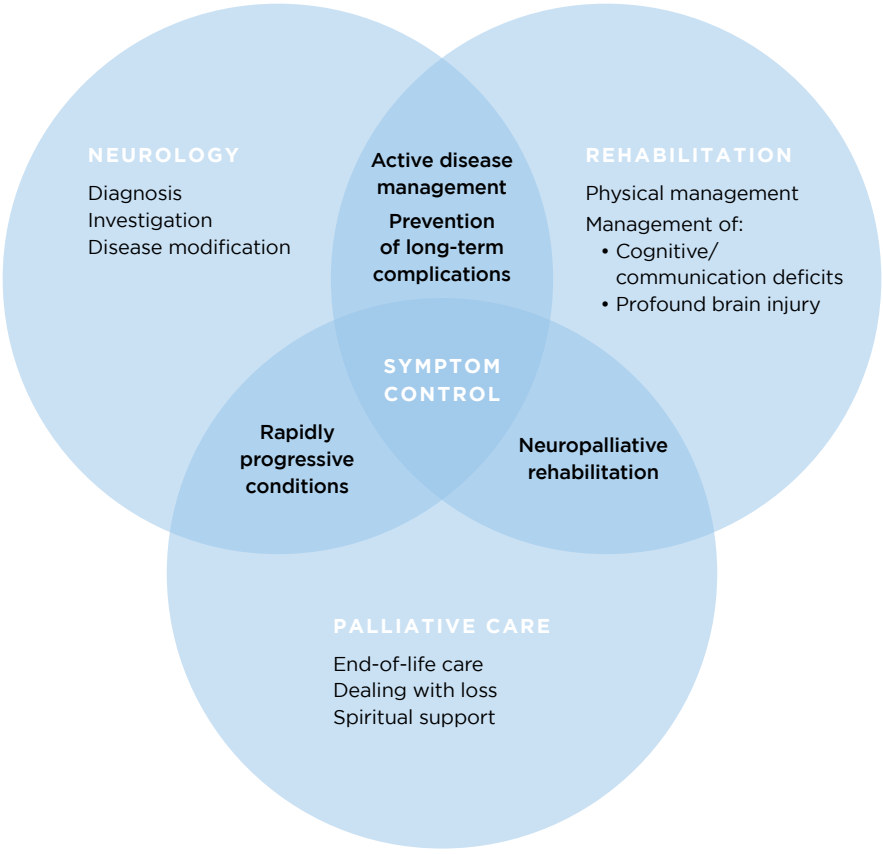


Figure 12 The interaction between neurology, palliative care and rehabilitation in people with long term neurological diseases (Turner-Stokes L, 2008)

This model provides the basis of the model of care for this population in the Bethlehem Health and Retirement Precinct, where rehabilitation principles drive active promotion of self-management and self-sufficiency by providing interventions that support people's independence. Information is provided to patients and their families about their disease and prognosis to inform decision making across the continuum of care. Advance care planning is facilitated as early as possible in care planning.

Table 23: Statewide PND Service

REFERRAL CRITERIA	SERVICES OFFERED	FOCUS OF SERVICE	WORK IN PARTNERSHIP WITH	INTEGRATED CARE FACILITATED BY
- Diagnosis or working diagnosis of progressive neurological diseases	- Diagnosis - Second opinion - Disease management - Clinical trials - Centre based -interdisciplinary assessment and management - Individual and joint medical, nursing and allied health interventions - Telehealth - Group programs - Education of patient, carers, and network of providers - Day centre programs	Neuropalliative rehabilitation - Wellness and quality of life - Prevention of complications - Assistive technologies - Cognitive and behavioural management - Communication, secretion and swallowing management - Diet and home enteral nutrition - Psycho-social needs - Carer support - Partnerships in care - End of life conversations and ACP - Secondary consultation and liaison - Education and research	- Patients, families and carers - GP's and local community providers - Community based organisations such as MND Vic, HD Vic, MS Australia, MD Association and Parkinson's Victoria - Other health services (Austin, Monash, Alfred) - Community palliative care services	- Pre-admission triage - Setting goals of care - Advance care planning - Shared care plan follows patient journey (internal/ external) - Multidisciplinary team meetings - Handover between services - Family meetings - Direct contact with external providers, including Telehealth, attendance at acute site team meeting - Key navigational roles such as clinical care liaison and HD clinicians

Wellness and quality of life is supported by the provision of information about peoples' condition and prognosis, recommended interventions, access to formal supports and assistive technologies and other environmental modifications. The adjustments to a person's life as a result of these diagnoses, can be overwhelming. Navigation and psycho-social support for people, their carers and families are important aspects of care along the care pathway. The team work closely with other health professionals and service providers. The roles and responsibilities of providers are negotiated based on the needs of the patients.

Early access to specialist palliative care may be initially accessed through clinic appointments. Referral to community palliative care services is triggered when resources are required more regularly in the home environment.

Care may be provided as an inpatient for assessment symptom management, independence maintenance and terminal care, where this is the most appropriate setting to achieve people's goals. Respite care will be able to be accessed in the residential care facilities for people who require clinic appointments over a number of days due to fatigue or who need to access to specialist expertise available on limited days.

Education of informal and formal carers regarding the diseases and individual implications is a key focus in all settings. Trials of care can be supported in the inpatient setting where new skills need to be acquired for carers.

Nearly 20% of the Statewide PND patients live in residential care or supported accommodation and continue to access the service. Telehealth and secondary consultation via telephone support the care of these individuals through education and support to carers and health providers in these environments. Contracted services are also provided to individual residential settings.

For people with progressive neurological diseases living onsite in the Bethlehem Health and Retirement Precinct, direct education and support will be able to be provided to carers through the State-wide PND service. Allied health services will be able to be provided by people skilled in the management of PND where required.

6.8.1

Registered NDIS Provider

The Bethlehem Health and Retirement Precinct a registered provider of NDIS supports, focusing on people with progressive neurological diseases. 60% of the State-wide PND Service patients are expected to be eligible for the NDIS. Approximately 60% of those live in the nearby NDIS regions of inner and outer Eastern Melbourne, Bayside Peninsula and Southern Melbourne and will be seeking NDIS providers to provide NDIS supports for allied health, in addition to their health needs.

The benefits of becoming a NDIS provider are expected to include:

- Continuation of current services that will change funding streams
- Access to allied health expertise in PND is available for people, particularly whilst the model is evolving
- The opportunity to pilot integrated care models across health and disability services for this population
- The opportunity to provide an integrated service model for participants with Calvary Community Care and within residential care for participants
- To maintain an identity with the progressive neurological group
- Workforce sustainability by providing opportunities for therapists to maintain experience at a primary care level
- To provide an opportunity to provide new services that can't currently be provided due to resource constraints either through SACs or NDIS funding

NDIS participants living on-site (in residential care and retirement apartments) and those in the community will be able to access NDIS supports for support coordination and allied health therapies, including assessment of assistive devices and carer training.

Future directions of the Statewide Progressive Neurological Service

- The statewide model of care framework has the potential to reduce activity for Calvary Health Care Bethlehem as other metropolitan and regional integrated PND sites develop.
- This in turn creates the opportunity to look at other patient groups that may benefit from this model of care, including people with brain tumours and dementia
- NDIS funding for support coordination and assistive technology in particular may have an impact on the role of the health service in supporting people with progressive neurological diseases
- Potential NDIS funds provide an opportunity to consider recreational and further group programs that could be accessed by people in the community and living on-site with the opportunity to validate these models of care to disseminate results to the wider community of service providers
- Development of integrated services model with Calvary Community Care
- Growth in clinical research trials is expected with new treatments being developed, however a collaborative approach with universities and other health services is required to maintain involvement, particularly with more complex trials requiring access to tertiary hospital infrastructure and diagnostics.

Table 24: Enablers of the Statewide Progressive Neurological Service

WORKFORCE	Multidisciplinary team including: Medical Specialists - Neurologists - Neuro Psychiatrists - Respiratory Physicians - Austin Victorian Respiratory Support Service (session per week) - Palliative Care Physicians - Rehabilitation Physician Allied Health Neurological Nurses Other Services - Volunteers - Dental services - Research clinicians - Austin Lung Function Technician (day per week)
EDUCATION	Integrated approach to education and research Refer to education and research enablers
ENVIRONMENT	Refer to Centred Based Care and Education, Innovation and Research Specific requirements for functional assessment and demonstration facility for occupational therapy and physiotherapy for people with progressive neurological diseases, in addition to a physiotherapy gym space is outlined in the appendix under building requirements
TECHNOLOGY	Refer to Centre Based Care

6.9
Food services

Food is a part of every culture and is connected to people's identity. Food experiences can connect individuals to the past, places, and other people. Food is also an important part of religious observance and spiritual ritual for many faiths. People's quality of life and wellbeing is impacted by their food experience.

The quality, taste, smell and visual appeal of food and options available in the Bethlehem Health and Retirement Precinct must meet or exceed people's expectations. This will be achieved by providing:

- Healthy, contemporary and multi-cultural foods that will be available at all times of the day
- Food options that cater to people's nutritional, swallowing, cultural and religious requirements as well as individual choice
- A food service model that is flexible, responsive, and adaptive to meets people's needs
- Implementing strategies to minimize risks in this population of food safety, choking and malnutrition
- Trialling and implementing new technologies and methods of food preparation and delivery
- Opportunities for meaningful activities related to food where desired by people
- Dining provides an opportunity to create an environment of social inclusion and mutual support

6.9.1
Access to food

Fresh fruit, supplies to make fresh and toasted sandwiches, biscuits, cheese, cereal, toast, finger foods and pre-packaged frozen meals will be available in residential care and sub-acute inpatient ward kitchenettes for preparation by people supported by family or care staff at any time of the day.

Main and mid meals will be provided to people in residential care and sub-acute inpatient ward at set times. People living in the retirement apartments will be able to access take-away meals at set times.

Retail facilities including cafés and a general store for common food supplies will be available to all in the Bethlehem Health and Retirement Precinct.

6.9.2
Nutritional, swallowing and feeding requirements

The nutritional, swallowing and feeding requirements of people expected to access food services in the Bethlehem Health and Retirement Precinct are listed in table 25.

6.9.3
Food Service model

A central kitchen provides hostess model/plated model to residential care and plated service to the specialist health service inpatient ward and retirement apartments (where requested).

The food service model will provide choice by providing:

- A continental breakfast daily
- A seasonal menu of soft vegetarian and two soft meat options for lunch and dinner, derived from a range of cultural influences and provided in all texture modified options
- A short order menu alternate - to be requested two hours prior to meal time
- Halal and Kosher meals sourced from an external provider

Smells of cooking may be achieved through a hostess model in residential care and heating of foods to enhance people's appetite. Basic food preparation can be undertaken in the domestic kitchens in residential care by the care companions and with the resident where chosen. Opportunities for preparation of food for people also could be achieved through cooking programs or function preparation. Other opportunities for meaningful activities in residential care will be provided with a decentralised serving model and local kitchen including dishwashing facilities for all meals.

The ward or residential care area will be responsible for:

- Serving of food and/or distribution
- Returning plates from inpatient ward
- Morning and afternoon tea distribution
- Local dishwashing in residential care
- Monitoring and ordering of local refrigerator/pantry
- Monitoring food safety

Efficiencies will be achieved through:

- Sourcing fresh ingredients and pre-prepared meals from a variety of providers
- Combination of cooking technologies including cook fresh and cook chill
- Providing soft main meals that can be easily texture modified as the main meal options, based on the needs of more than 60% of people in residential care and specialist health inpatients

Revenue from potential commercial opportunities and/or co-payments could support the range of options in the food model. People can invite family and friend for meals catered by the service. Providing food packs to people who live in the retirement apartments on regular and texture modified diets has the potential to grow as people age to remain in their place. This service could be extended to the local community based on market testing. There are particularly limited options in texture modified foods accessible in the community. Food services facilities could be utilised 24 hours a day to support additional volume. Feasibility of these commercial options requires further testing.

Table 25: Nutritional, swallowing and feeding requirements of common populations

	DEMENTIA	GENERAL AGEING	PND'S	TERMINAL CARE
NUTRITIONAL REQUIREMENTS				
Meals need to meet macro and micronutrient needs for all	X	X	X	X
Meals to visually appealing, colourful and tasty to encourage eating	X	X	X	X
Cater for therapeutic diets that impact on health , e.g. low FoDMAP, gluten free, high energy, high protein, renal diets, heart health, diabetes	X	X	X	X
Provision of good quality finger food to meet nutrition needs	X			X
Access to appropriate range of oral nutritional supplements (in addition to food options)	X		X	X
Choice of serving size	X	X	X	X
Variety of meals	X	X	X	X
TEXTURAL REQUIREMENTS				
Regular, soft, minced, puréed diet Regular, naturally, mildly, moderately & extremely thick fluids	X	As required	X	X
Meet Australian Standards for texture modified foods & fluids	X	X	X	X
FEEDING AND SWALLOWING				
Safe and appropriate provision of meals.	X	X	X	X
Assistance with feeding	X		X	X
Set-up with meals (cutting up foods, placement of meals)	X		X	X

Table 26: Enablers of the food model

ENVIRONMENT	**Recipients of Care** - Places to prepare and eat food for people in all settings, separate to the clinical environment - Opportunities through food preparation and dining for people and their families to maintain their relationships and their roles in one another's' lives - A range of dining environments available including: o Private and social dining settings within each setting o Bookable private dining spaces for smaller groups to host family and friends o Larger group spaces for indoor and outdoor celebrations o Café style dining o Bar style recreational environment for people living in the retirement apartments **Food services requirements** - Central hybrid style kitchen - Domestic kitchens in residential care and inpatient ward with minor cooking equipment for supplementary foods: Smart pack oven, microwave, fridge and freezer, toaster. - Food trolleys **Staff** - Toilet and change facilities - Access to staff room and parent room
TECHNOLOGY	- Electronic ordering system with the ability to integrate with a range of communication technologies to support people of various physical and cognitive issues to make food choices (includes visual prompts) - Information related to dietary requirements including the need for modified diets is transferred between settings
WORKFORCE	- Assumes bulk delivery to the ward and distribution managed by ward/residential care facility o Chef - 8 hours, 7 days o Kitchen hand - 15 hours, 7 days (assumes plating in kitchen for specialist health ward and hostess model) o Food services assistant - 10.5 hours per day in each residential care setting which could alternately be integrated into care companions roles and responsibilities (with FTE) o Food monitor for inpatient ward - 4 hours per day
POLICIES AND PROCEDURES	Development of policies and procedures that ensure food safety, whilst not limiting independence and choice.
FOOD COSTS	- An industry benchmark for food in an Aged Care Environment is around $8.50-$9.50 per day, however this figure is based on limited texture modifications. - To accommodate our patient needs where approximately 60% of people are anticipated to be on a texture modified diet, it is recommended another $2 per day added for the additional food required to meet nutritional requirements.

6.10 Volunteers

Volunteers dedicate their time to enhance the care offered to people, their families, friends and the community.

A growing body of research suggests formal volunteering is associated with better mental, physical and functional health and that activities lead by older adults are better positioned to foster others engagement (Greenfield E, 2012). Participation will be enabled through the provision of volunteering opportunities to deliver volunteer programs and roles on site and into the community, providing support, including but not limited to:

- Specialist health services
- Programs in residential care
- Leading social, physical, educational and community activities
- Broader community engagement
- Participation on committees

"The palliative day centre gives opportunity for purpose and meaning - even for volunteers who support it."

7

CARE SETTINGS

7.1 Specialist health services inpatient ward

A 32 bed sub-acute inpatient ward in the Bethlehem Health and Retirement Precinct will provide:

- Specialist palliative care for people with complex physical or psychosocial care needs
- Neuropalliative rehabilitation for people with progressive neurological diseases

Nominally there are 16 beds for each function.

The inpatient admission is viewed in the broader context of the continuum of care to address goals that can only be achieved in that setting.

Reasons for admission to the specialist health inpatient ward include:

1. Assessment - planned admissions to undertake holistic review of the patient's current and future care needs, to plan for and implement an ongoing care plan including allied health, medical or nursing intervention
2. Symptom management - unplanned admission due to change in function or circumstance and/ or exacerbation in symptoms including behavioural management
3. Independence maintenance - planned admission with a focus on optimising the patient's level of function requiring an interdisciplinary approach with a defined management and/or discharge plan, including reconditioning and training in the use of equipment
4. Terminal care - patient is in the terminal phase of their illness with complex symptom issues or significant family distress

Inpatient care requirements include:

1. Personal care
2. Hoist and assisted transfers and either assisted or wheelchair mobility
3. Feeding/enteral feeding management - 60% texture modified diet and many require assistance feeding
4. Communication methods to enable social engagement and care needs and preferences met
5. Medication management
6. Medical management including investigations and symptom management
7. Therapy - optimising physical, behavioural and cognitive function to maintain quality of life and wellbeing
8. Emotional and spiritual support for patient, carers and family
9. Behavioural management
10. Continence management
11. Non-invasive ventilation (NIV) and oxygen management
12. Terminal care
13. Discharge planning

The potential impacts on future activity include:

- Reduced overall length of stay with alternate options for people with less complex needs or awaiting residential care, increasing workload associated with admissions and discharge planning
- Increased acuity and demand for inpatient specialist palliative care - particularly chronic diseases and dementia
- Potential for weekend admissions and discharges to maintain workflow

Table 27: Enablers of Specialist Health Inpatient Ward

WORKFORCE	- Key roles that work across settings; specialist health inpatient and ambulatory care, residential care and interim care where operationally appropriate (e.g. clinical care coordinator, allied health roles, clinical nurse specialists, medical staff) - Timely multi-disciplinary palliative and/or neurology expertise is available to patients either directly or via consultation as appropriate - Access to high medical specialties and interventions is facilitated where possible onsite and through transfer to the most appropriate setting where it is required for the inpatient episode of care - Multi-disciplinary team o NUM, Nurses o Clinical Care Coordinator (facilitates access and discharge) o Palliative Care Physicians and junior medical staff o Neurologists and junior medical staff o Pharmacists o Allied health clinicians o Personal care assistants o Ward support o Volunteers
OTHER SERVICES	Access to high volume diagnostics onsite - Xray, CT, pathology
ENVIRONMENT	**Patients, carer and family requirements** - Refer to Appendix Section 11 - Communal living environment separate from bedrooms to encourage social connection, dining and for people to spend time with family and visitors - Kitchen/pantry to prepare and store foods and drinks - Calm and quiet access to indoor and outdoor spaces to de-escalate behaviours of concern and other recommendations to reduce risks (see appendix environmental enablers) Section 11.5 - Access to therapy and activities of interest on or close to the ward - Washing machine and dryer facilities for patient's family to wash clothes - Bedrooms and ensuites are required to: o be of size and layout to maximise independent mobility in electric wheelchairs and minimise risks to patients, family and staff o Include wardrobe and drawers for people's clothes and personal items and a locked drawer for valuable items o Locked drawer for medications (bottles and packs) o Bedrooms require 2 comfortable visitors chairs **Clinical and staff requirements are detailed in Appendix Section 11**
ICT	Technology will play an important role in enabling independence in patients, communication between staff, staff and patients and reducing risks for both staff and patients. - Refer to the appendix section 11.4
QUALITY AND SAFETY	- Review of The Assessment and Discharge to Residential Aged Facility Care procedure - Development of procedures to support discharge to interim care

"The social aspect of the ward is one of the highlights."

7.2
Centre Based Care

7.2.1
Clinics

Multi-disciplinary clinics support access to:

- State-wide Progressive Neurological Disease Service
- Specialist Palliative Care - Living Well Clinics

Patients arrive at the Welcome Desk to confirm their:

- Identity
- Confirm their GP
- Confirm their Medicare number, NDIS status and any other funding or reporting requirements
- Complete consent

A clinic nurse monitors people in the waiting room, supports clinical assessments and flow between clinical appointments, negotiating with clinicians to minimise wait times.

Appointments with most clinicians occur in the clinic setting. Occupational therapy and physiotherapy appointments require functional assessment in either the 'assessment and demonstration facility' or the physiotherapy gym. Music therapy and recording occurs in a soundproof room or group rooms.

People can see up to six clinicians in a day, which can be tiring. New people to the service report the experience can be overwhelming and waiting can be a sad experience, particularly for the PND service. People can utilise their time as preferred between appointments in the waiting options or wellbeing spaces. Models to facilitate the patient experience include joint appointments and patients remaining in the room whilst clinicians move to facilitate privacy where needed.

Clinician's interaction is supported by a multi-disciplinary hotdesk space and multi-disciplinary meetings.

Primary care general practice, nursing and allied health clinics are likely to occur in separate facilities to the multi-disciplinary specialist health service clinics.

7.2.2
Group Programs

Group programs provide therapeutic interventions that support people to live well for people that meet referral criteria for the specialist health services.

Examples include:

- Huntington's disease men's carers group
- Huntington's disease choir
- Palliative care exercise group, fatigue management, breathlessness
- Meditation groups
- Music therapy
- Art therapy

7.2.3
Day Centre

Day Centre programs provide respite for carers and provide opportunities for people to improve their quality of life and wellbeing through engagement in meaningful activities. A palliative care day centre is well established.

The program length varies dependent on the group. Lunch is provided to facilitate social interaction. The programs activities are driven by the group members and include access to group and individual therapeutic interventions. There are opportunities to develop programs through different funding streams for:

- Aged care
- NDIS participants

Table 28: Specialist Palliative Care Day Centre

REFERRAL	INTERVENTIONS	FOCUS OF SERVICE
- Independent or supervision required - Continent - Nil behaviours of concern - Goals of care related to quality of life	- Group needs based approach - Art Therapy - Music therapy - Skills maintenance or development - Cognitive gymnastics - Excursions	Wellness and quality of life - Socialisation - Peer support - Intellectual health - Emotional and spiritual health - Respite for carers

Table 29: Enablers of Centre-Based Care

ENVIRONMENT	**Patients and carers** - Ease of access between centre-based care facilities, clinical research facilities, reception and waiting to facilitate patient flow - Patient flow to incorporate discrete arrival, waiting and departure for new patients who are often overwhelmed - Access to waiting spaces options - quiet, private and more interactive options that facilitate peer support and opportunities to engage while waiting - Visitors chair in consulting rooms and space for carers and family to attend appointments - Access to food and beverage options to purchase in the broader precinct - Access to non-clinical spaces to make food and drinks, rest and recuperate, engage with others and be alone - Space for family to meet with clinical team **Clinical and staff requirements see the appendix section 11**
TECHNOLOGY	- Access to free Wi-Fi (patients and family) - Scheduling system that supports multi-disciplinary appointments - Telehealth platform - Monitoring and communication applications between health provider and patient (speculative) - Patient flow technology that facilitates multi-disciplinary care - Technology to capture consumer feedback - Electronically facilitate information sharing between internal settings of care (specialist health and residential care) and community providers
WORKFORCE	- Customer focused service team to facilitate welcoming of patients on their arrival, departure and flow between appointments regardless of service

7.3 Residential care

Residential care provides:

- Short term respite care
- Interim care
- Palliative care
- Permanent care

The primary focus of residential care is as a home for people with high care needs. Most people (83% in 2014/15) in residential care in Australia had high care needs across one of the domains of complex health care, activities of daily living or behaviour as measures on the Aged Care Funding Instrument.

Person centred care will be led by residents and their care plan, developed individually based on their needs and preferences and inclusive of opportunities for their life goals. Engagement of their skills in purposeful and meaningful activities, will be incorporated into their day through access to individual and/or group programs that also aim to target all domains of health. Care companions will encourage residents to be self-sufficient where possible and allow residents to take the lead on timing of activities and lifestyle choices. The relationship between the person, others in their homes, their family, friends and the staff will be nurtured.

CARE COMPANIONS WILL BE RESPONSIBLE FOR:

- Facilitation of supporting an enriched and stimulating environment
- Personal care
- Medication administration (within scope of practice)
- Domestic assistance including light household tasks including basic food preparation, personal laundry, ironing, dusting and wiping of surfaces
- Facilitation of care plan goals in collaboration with families including but not limited to:
  - Social engagement
  - Incidental and purposeful exercise
  - Use of skills for light household tasks for example basic food preparation, personal laundry, ironing, dusting and wiping of surfaces, garden maintenance
  - Learning of new skills
  - Social support and community access

AN ENRICHED ENVIRONMENT

People will be able to access a range of activities developed from consumer feedback that is meaningful to them either in a group or as an individual. This may include regular personal, domestic or recreational, spiritual, or educational pursuits or activities or one off bucket list activities.

Pastoral care, leisure and lifestyle roles, allied health assistants under the supervision of relevant allied health therapists, volunteers, music and art therapists will be key to activation of an enriched environment in collaboration with the care companions, people, families and friends.

The role of allied health including music and art therapists will be to:

- Individualise interventions based on needs for individuals and families
- Educational role - with care companions, other staff and family and friends to utilize interventions effectively
- Environment - ensuring the environment facilitates living well

CLINICAL CARE

People will be encouraged to attend clinical consultations with clinicians in their clinic where possible to maximise independence. Clinician's documentation in iCare, handover with residential care nursing staff and building the capacity of PCA's will facilitate care needs and goals being met.

General Practitioners will be responsible for:

- Primary medical care, including medication prescription
- Advance care planning and palliative care planning
- Care coordination and referral to other services

All other specialist expertise will be provided through consultancy in the appropriate environment such as geriatricians and psycho-geriatricians. Key relationships will be developed with the Dementia Centre and primary mental health teams to support people with mental health issues.

Registered nurse/s will be responsible for:

- Clinical coordination role
- Care planning oversight in consultation with resident, family and other providers of care
- Management of residents with a changing condition or function including escalation and referral processes
- Pain management interventions (hot packs, wax baths, TENS machines)
- Oversight of medication administration and monitoring
- Family meetings

An ACFI registered nurse will provide support and education to ensure best practice assessment in the appropriate language required to support access to appropriate funds for individuals.

Enrolled nurses will be responsible within their scope of practice for clinical assessment and interventions including but not limited to:

- Medication administration and monitoring
- Wound management
- Respiratory support management
- Continence management
- Palliative care

The after-hours coordinator or the clinical coordinator in specialist health inpatient ward will provide clinical support as per escalation processes.

Referral to allied health disciplines will be completed by registered nurses or people's GP related to needs to assess and improve/maintain their physical, cognitive or behavioural functioning and quality of life. Therapy recommendations to be implemented by the resident with assistance from the care companions or family (or nursing staff where required). Training of specific individual requirements will be undertaken with the primary carers including family and personal care assistants. Capacity building and collaboration with the primary carers will be a key focus. Short term goal orientated intervention will be provided where negotiated (may require additional funding depending on needs - NDIS, Medicare, Private health insurance, extra fee).

Specialist Palliative Care Services will provide support, advice and develop capacity of the primary care team to provide palliative care for individuals and provide specialist interventions where required. Proactive involvement in care planning processes will facilitate early access to specialist palliative care where required. People with Progressive Neurological Diseases will continue to be managed by their neurologist and/or the State-wide Progressive Neurological Team with access to specialist palliative care when required.

Behavioural management plans will be developed based on assessment and consultation of key team members including the GP, nursing, PCA's, pastoral care, and lifestyle coordinators. Environmental factors such as the need for a lower stimulation environment will be considered where appropriate. Escalation of behaviours can be referred to an internal behavioural management consultancy team consisting of psycho-geriatricians, neuropsychologists, speech pathologists and occupational therapists as required.

Escalation to external consultancy where required - Dementia Centre

- Dementia Behaviour Management Advisory Service
- Severe Behavioural Response Team
- Severe Behavioural Response Unit (under development by Australian Government)

Table 30: Enablers of Residential Care

ENVIRONMENT	**Recipients of care**- Refer to person and family centred care enablers - A home-like environment - Dementia enabling environment - Communal living environment separate from bedrooms to encourage social connection and for people to spend time with family and visitors - opportunities for intimate, private conversations and larger family gathering - A dining area to facilitate individual plating and shared eating experiences - Kitchen facilities to prepare basic meals (continental breakfast, sandwiches, heat foods) - Access to group spaces - music therapy, exercise groups, cognitive challenges - Activity stations based on resident interests - Activity room to leave out projects - jigsaws, art therapy projects - Access to indoor and outdoor spaces - to entertain, to gather with family and friends (BBQ and dining spaces) for celebrations, sensory gardens, raised gardening beds - Secure, purposeful wandering spaces with enough sunlight to create a stimulating environment - Individual bedrooms with ensuite.
TECHNOLOGY	Technology will play an important role in enabling independence in residents, communication between staff, staff and patients and reducing risks for both staff and patients. Refer to the appendix section 11.
WORKFORCE	Key roles across specialist health inpatient, residential care and interim care that are provided across settings where operationally appropriate (e.g. clinical care coordinator, allied health roles) **New roles:** - Residential care coordinator - Registered and enrolled nurses - Personal care assistants - Lifestyle coordination Development of care companion champions in patient centred care and Montessori method, palliative care, the management of people with progressive neurological diseases

7.4 Interim Care

Interim care is focused on optimising people's independence and well-being, whilst working towards an appropriate discharge location with the level of supports required. Four beds within residential care are planned to provide interim care to minimise inappropriate extended hospital lengths of stay and premature admission to residential aged care. The interim care model is benchmarked on other transitional care programs, tailored to the specific needs of people with progressive neurological diseases and others requiring palliative care.

Services will be delivered within residential care which will provide access to carer, nurses, pastoral care, lifestyle programs and bereavement services based on development of an individual care plan. Primary medical management is provided by people's own general practitioner or the on-site General Practitioner. Additional clinical services will be available to provide low level therapy and case management to achieve peoples' goals of interim care.

Respite funding, individual co-payment and DHHS top up funding (to be confirmed) will be required to facilitate discharge. People will be able to access up to 63 days plus 21 days extension for respite services.

Information is provided to patients and their families about their condition and prognosis to inform decision making across the continuum of care. This aims to enable people to make considered decisions, not necessarily when they are under pressure to do so. Whilst most people are aware of their options the decision to take up a particular aged care program, or to change to a higher level of care does not always follow recommendations. 25% of those who are recommended for residential care do not take this up for more than two years. The decision is triggered by a range of factors, including changes in care needs (AIHW, 2017). In 2013/14 in Australia most people entered residential aged care, having previously used respite services (39%) and HAAC services (36%). 5% used transitional care programs prior to entry.

Data reviewed at Calvary Health Care Bethlehem in 2016/17 supported length of stay not requiring longer than 12 weeks in total. Most of these patients with a length of stay greater than four weeks were waiting transfer to residential care, a portion died in the interim. People who were discharged home included those awaiting carers in place and care during a non-weightbearing status (NWB) period.

To maintain flow within the interim care facility admission criteria is recommended to include:

- Specialist health inpatients or ambulatory patients that would benefit from goal-orientated, time limited care to:
  - optimise their physical and cognitive functional capacity
  - assist in making long term care arrangements for their care
- People who are eligible for long term and respite residential care with a completed ACAT assessment

Examples of suitable candidates include:

- People who are unable to be cared for at home and who plan to transfer to permanent residential care
- People who are medically stable, but whose care may extend longer than a few weeks and whose palliative care needs are not complex (e.g. people with glioblastoma or metastatic prostate cancer).
- People who are planned for discharge home but are awaiting
  - Funded home modifications to be completed for discharge
  - Funded equipment required for discharge
  - Funded care or informal care arrangements to be in place
  - Carer education
  - Carer needs temporarily limit home discharge NWB status for a defined period, broken arm

The current Assessment and Discharge to Residential Aged Facility Care procedure is utilised by specialist health services and requires all patients who have a stable PCOC rating of 1 for 7-10 days to undergo a defined process of referral to residential care. The processes to access interim care will be defined in the next phase.

Patients will be referred from the specialist health services to Access and Intake for Interim Care. Acceptance to the program will be based on admission criteria and bed availability.

Table 31: Enablers of Interim Care

WORKFORCE	Key roles that provide care across specialist health inpatient, residential care and interim care where operationally appropriate (e.g. clinical care coordinator, allied health roles) Additional EFT for interim care in addition to residential care staffing: • Case manger 0.1 EFT • Other allied health as per goals 0.2 EFT

7.5 Retirement apartments

Retirement apartment living will enable people to live independently with access to high levels of support if required. It will be a place to build friendships and stay connected with the local community. Living well will be enabled by access to facilities to support self-management of health and social interactions as well as coordinated social, educational and participation opportunities. There is an opportunity to facilitate people with chronic conditions or those at risk of becoming or having become frail to live well, through coordinated integrated services and by enabling preventive strategies and access to appropriate support and restoration after acute episodes.

People living onsite will be able to access home care services through Commonwealth Home Support Packages (CHSP), Home Care Packages, NDIS funding, private funding or a mixture of funding options.

The retirement triage role will:

- Support the re-sale of retirement units and manage incoming and outgoing resident requirements
- Support sales and marketing of retirement apartments
- Assess home support and clinical needs prior to purchase and provide navigational support to facilitate access to services required

The retirement coordinator role will:

- Monitor well-being of residents
- Recommend referrals to other services including, liaison with others including the GP where relevant
- Further assess for home support to maintain independence with changing need
- Support development of social and recreational programs and committees for people living in the retirement apartments
- Clinical care (where appropriate)
- Facilitate communication with people living in the retirement apartments
- Ensure compliance with Retirement Villages Act and regulatory bodies

Additional roles where negotiated with individual clients:

- Support management of CHSP and home support packages where agreed by the resident
- Nursing support

The number and level of clients requiring support for CHSP and home care packages will determine workforce requirements. Additional case managers and administrative support will be provided where required.

Client services officer/s (CSO) role includes rostering unless functions are automated. Clients from the Bethlehem Health and Retirement Precinct will be allocated to the same team of CSO's at Calvary Community Care to facilitate working relationships.

Support worker services are likely to be located onsite to enable people to choose this flexible model as their care needs change. A pilot project reviewing supported care packages for people living in retirement villages showed that onsite staff or a dedicated team of care workers enabled some projects to deliver a personalised level of service that had high preventive care and social support value for care recipients at relatively low cost. This was demonstrated in frequent, short visits to care recipients (for example, up to three times daily) to check on condition, assist with medications and, where necessary, provide guidance or physical assistance to promote mobility. The cost of providing this level of assistance is likely to be prohibitive unless care recipients are co-located and using the same provider. The evaluation found evidence that the care packages helped delay entry to residential aged care among retirement village residents (AIHW: Hales C, Ross L & Ryan C, 2006).

Support workers provide:

- Personal care
- Social support and community access
- Transport
- 24 Hour and overnight care
- In-home respite care
- Disability and specialist adult services
- Return from hospital support
- Domestic assistance
- Facilitate transition to residential care where required

Providing flexibility and choice, as well as maintaining the same support workers onsite could be facilitated by:

- Self-rostering - Plan when care is wanted and who with
- Cheaper days and time peak/off peak times offered to spread the workload and options to choose anyone, including a preferred person (within the fit of a support person)
- People can roster guaranteed hours and bank 'extra hours' to choose to use flexibly as needed
- Escalation of issues noted by the support worker are raised to the retirement apartment coordinator

People will be able to access clinical care through:

- On-site GP
- Specialist health services based on referral criteria
- Allied health services as arranged through care packages or other funding mechanisms

Education and support for support workers to facilitate the model of care principles will be provided for core competencies, supported by education of individual needs.

Individual packages of clinical and care needs to support and enable people to remain independent as their needs change will be able to be developed, funded from the range of funding options available (see appendix Section 11).

Opportunities for the development of Living Well programs to maintain independence either on-site or in partnership with other providers include:

- Chronic disease management programs
- Memory support programs
- Pain management programs
- Continence management
- Falls and Balance programs

Table 32: Enablers of the Retirement Apartment

ENVIRONMENT	**People** - Contemporary 1, 2 and 3 bedroom apartments - Separate entrance to the facility through car park and ground floor - Security supports access between floors to facilitate interaction - Design supports changing needs for existing and new occupants - Summer Foundation Design Guidelines: https://www.summerfoundation.org.au/designing-for-inclusion-and-independence/ - SF Hunter Housing designs https://www.summerfoundation.org.au/resources/hunter-housing-demonstration-project-apartment-features/ - Smart storage solutions within unit and additional storage solutions - Car parking **Staff** - Retirement apartment design that minimises risks to support workers - Access to tea/coffee and staff lounge facilities
TECHNOLOGY	- Platform to share health and care information with a range of providers if agreed by the person - Smart home technology automation and monitoring - Access to telehealth in people's homes - Technology to reduce risk of falls - Use of normalised technology - mobile phones, iPads, pay wave to pay resident fees
WORKFORCE	- Navigational support role integrated with care coordination where possible - Provision of facilities, links with the community and information to support self-management of wellbeing (physical, social, intellectual, emotional, spiritual, occupational) - Support workers credentialed to meet the needs of the residents on-site - Critical mass on support workers to support flexibility of the model
EDUCATION	- Refer to educational enablers in the appendix section 12.

8

MODEL OF CARE IMPLICATIONS

8.1 Workforce implications

A Workforce Working Group will be established in phase 3. The scope of work will include:

- Workforce Strategy
- Confirmation of workforce roles and functions
- Competencies and accreditation
- Training and education requirements
- Recruitment and retention strategies
- Communication with industrial organisations
- Development of a communication and change management plan

The appendix, section 11.1 details the operational structure and related responsibilities as well a summary of enablers identified to facilitate the model of care.

8.2 Clinical Governance implications

A Clinical Governance Working Group will be established for phase 3 of the model of care project. The scope of work will include:

- Development of new policies and procedures, aligned with agreed processes
- Review of current policies and procedures to ensure they reflect the highest standard across Aged Care Quality Standards (ACQS), the National Safety and Quality Healthcare Standards (NSQHS) and NDIS quality standards.

The appendix, section 11.2 includes a summary of clinical governance enablers identified which will require further review in the next phase.

8.3 Technology implications

An ICT Requirements Working Group will be established for phase 3 of the model of care. The scope of work will include:

- Feasibility of ICT requirements including the sharing and transferring of information between Calvary systems such as iCare, Goldcare, Vitro and iPM
- Infrastructure requirements
- Information management strategies

The appendix, section 11.4 includes a summary of technology enablers identified which will require further review in the next phase.

8.4 Building implications

The building implications will inform the detailed design of the Bethlehem Health and Retirement Precinct. Working Groups will be established to review and inform detailed requirements. Appendix 11.

8.5 Communication and Engagement Strategy

A Clinical Governance Working Group will be established for phase 3 of the model of care project. The scope of work will include:

- Community Engagement Strategy
- Marketing Strategy

9

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10

APPENDIX

10.1 Summary of feedback from the discussion paper

There was overwhelming support for the vision and objectives for the Bethlehem Health and Retirement Precinct discussion paper from key stakeholders at Calvary Health Care Bethlehem, Calvary Community Care (Melbourne), Calvary Retirement leadership team and relevant peak bodies and other key stakeholders.

10.1.1 What people liked

- The unique offering of integrated services on the one site
- The contemporary approach to integrated service delivery that offers consumers choice as well as the ability to 'age in place'
- The ability for people to remain connected within the precinct as well as to the broader community outside the precinct
- The active addressing of palliative care options for clients across the spectrum of service delivery
- A focus on enablement, wellness and engagement to maintain quality of life
- The idea of the interim beds
- After hours clinical support
- Residential care for people with progressive neurological disease, including young people and the opportunity to provide a demonstration site or opportunity to enrich and encourage other residential care facilities to manage people with PND

10.1.2 What resonated with people?

- Integrated coordinated care - 70% of survey respondents
- Person centred care - 62% of survey respondents
- Integration of education and research - 59% of survey respondents
- Living well - 56% of survey respondents
- Autonomy and Ageing in Place - 46% of survey respondents

10.1.3 Service gaps

- Confirmed appropriate accommodation for people with PND, including young people. Model suggested to explore barriers and the development of a model that could be translated to other residential facilities to support people's choice of location
- People who can't be cared for at home who require a longer period of care
- Transitional care (whilst awaiting home)
- Family accommodation - ward for end of life and education and apartment for relatives/patient for clinic/research over more than one day.
- Streamlined pathways to Calvary Community Care for inpatients and outpatients from Calvary Health Care Bethlehem

10.1.4 Concerns raised in relation to the model of care

- Accessibility to retirement apartments and residential care for CHCB's current population, including cost and the occupancy flow of the transitional beds to maintain access to these
- Meeting the needs of people from a range of ages and with complex, high care needs within the one residential care facility
- Sub-acute inpatient ward management of multiple patient types

The Model of Care Principles have been updated to reflect feedback from the consultation process.

Additional ideas raised to ensure people live well, age in place, with integrated coordinated services will be further explored in the next phase of the detailed model of care design.

Other topics commonly raised in consultation related to:

- Building requirements
- Funding models to support the model of care

Please note there is a separate Redevelopment Project Control Group that oversees the building development.

Frequently asked questions have been developed to answer some common questions relating to the model of care.

10.1.5 Next Steps

The next phase will utilise the feedback for further exploration and analysis to inform the development of the detailed model of care in consultation with staff, consumers and other key stakeholders. This will include:

- Patient flows and workflows within and between services
- Potential future impacts on the model of care
- Enablers to achieve model of care principles and objectives
- Clinical and operational governance
- Building design implications
- ICT requirements
- Workforce implications and plan
- Financial implications

10.2

Catchment Demographics

AGE

The southern metropolitan region of Melbourne which includes the LGA's of Glen Eira, Port Phillip, Kingston, Stonington and Monash, has a greater ageing population than the rest of Melbourne with the greatest growth in the 70-79 year old group (62%) and the 80-85 year old group (55%) (Aspex Consulting, 2015).

Calvary Health Care Bethlehem's (2016/17) population represents an older population than the local community.

Table 1. Reported age of catchment, Calvary Health Care Bethlehem patients and people living in residential care.

AGE	AUSTRALIA (ABS 2016)	GLEN EIRA (.ID, 2018)	CALVARY HEALTH CARE BETHLEHEM (2016/17) IPM			RESIDENTIAL CARE (ABS, 2015)
			INPATIENTS	CPCS	SPNDS	
0-18	24%	21%	0	1%	0	0
18-34	26%	26%	2%	<1%	7%	<1%
35-49	21%	21%	6%	4%	18%	<1%
50-59	11%	12%	12%	8%	12%	<1%
60-69	9%	9.5%	21%	15%	25%	<1%
70-84	6%	7%	36%	35%	27%	5%
85+	1%	3%	24%	37%	<1%	25%

DISABILITY

- 6% of the Australian population have a severe or profound disability (ABS, 2015)
- 4.4% of the Glen Eira population report a severe or profound disability, 69% of these people are older than 65 (ABS, 2015)
- 86 (7%) of SPNDS patients are reported to live in residential aged care and another 85(7%) in other supported accommodation due to chronic progressive diseases. 12 of these people live in residential care facilities in Glen Eira or the surrounding LGA's

CULTURAL BACKGROUND

- 28% of Victorian are born overseas compared with 36% of Glen Eira residents born oversea
- English is not 28% of Glen Eira's residents primary language
- Calvary Health Care Bethlehem population (2016/17)
  - Inpatients[1] - 36% are born overseas and 27% where English is not their primary language
  - CPCS[2] - 28% born overseas and 24% where English is not their primary language
  - SPNDS[3] - 17% born overseas, 14% where English is not their primary language
  - Representative of age of immigrant populations
- In 2016/17, 74 people (3%) required an interpreter to access services at Calvary Health Care Bethlehem. The most common languages used in order of frequency were Greek, Russian, Cantonese, Mandarin, Vietnamese, Thai and Dari.

1 Note: Data integrity for country of origin limited as IPM reverts to Australian when other input is not provided
2 Note: Data integrity for country of origin limited as IPM reverts to Australian when other input is not provided
3 Note: Data integrity for country of origin limited as IPM reverts to Australian when other input is not provided

Table 2. Reported country of origin of catchment location and Calvary Health Care Bethlehem 2016/17

	VICTORIA 2016 (.ID, 2018)	GLEN EIRA 2016 (.ID, 2018)	CALVARY HEALTH CARE BETHLEHEM 2016/17 (IPM)		
			INPATIENTS	CPCS	SPNDS
1	England	England	England	England	England
2	India	India	Greece	Greece	Italy
3	China	China	Italy	Italy	Greece
4	New Zealand	South Africa	Germany	Poland	India
5	Vietnam	Israel	Poland	Russia	China
6	Italy	Greece	India	China	Germany
7	Sri Lanka	New Zealand	China	Germany	Sri Lanka
8	Philippines	Poland	Ireland	India	New Zealand
9	Malaysia	Ukraine	Russia	Scotland	South Africa
10	Greece	Russia	South Africa	Bulgaria	Poland

ABORIGINAL AND TORRES STRAIT ISLANDER

- 3% of the Australian population compared with <0.2% of the Glen Eira council and the southern metropolitan region of the population are of Aboriginal or Torres Strait Islander origin
- Calvary Health Care Bethlehem in 2016/17 provided treatment to one person who reported they were of Aboriginal or Torres Strait Islander origin

SEXUALITY

It is estimated that approximately 11 percent of the population identify as LGBTI in Australia. One in 10 people over the age of 65 identify as LGBTI in Australia.

PARTNERSHIP STATUS

	CALVARY HEALTH CARE BETHLEHEM 2016/17		
	INPATIENTS	CPCS	SACS
Married/defacto	56%	46%	49%
Single/divorced/ separated widowed	41%	35%	23%
Not reported	3%	19%	28%

RELIGION

Table 3. Reported religions of catchment and Calvary Health Care Bethlehem[4]

	VICTORIA 2016	GLEN EIRA 2016 (.ID, 2018)	CALVARY HEALTH CARE BETHLEHEM 2016/17 (IPM)		
			INPATIENTS	CPCS	SACS
Roman catholic	23%	17%	22%	7%	19%
Judaism	0.7%	16.3%	3%	4%	3%
Other Christian	19%	10%	21%	6%	44%
Greek orthodox	2.7%	5%	8%	3%	7%
Hindu	2.3%	4%	<1%	<1%	<1%
Buddhist	3.1%	2%	<1%	<1%	3%
Islam	3.3%	<1%	0	0	2%
No religion	31.7%	31.3%	8%	1%	3%
No information	9.4%	8.2%	37%	77%	64%

4 Data captured in IPM, noting that data capture at Calvary Health Care Bethlehem for religion is not captured routinely.

10.3

Current Services Gap Analysis Summary

A review of services activity data, patient flows, workflows and consumers and staff perceptions provide the basis for the gaps identified in table 3 and 4. Retirement Community's gaps are based on Haydon Retirement Community in the ACT and the specialist health services gaps are based on Calvary Health Care Bethlehem. Gaps from Calvary Community Care as based on previous work of the Calvary Silver Circle Model of Care Project 2013 and current services Southern Melbourne region. The gaps highlighted, provide opportunities to improve delivery of the model of care in the future.

Table 4. Review of current services against Calvary Bethlehem's Health and Retirement Precinct model of care objectives.

OBJECTIVE	EVIDENCE OF GAPS
1. Experience that meets or exceeds expectations	**Specialist health services** • Pre-admission notes are not specific in relation to goals of admission • Goals in the shared care plan are not always documented • Some patient and families are not sure how long they are here and when/why they would go home • Food taste, visual, smell and visual appeal does not meet many people's expectations. • Inequity of choice for people not on regular unmodified food and fluids. **Retirement Communities** • No gaps identified **Community Care** • Communication between customer, CSO and support worker – IT solution under development
2. Enablement of all people to remain independent, actively engaged and living in their place of choice	**Sub-acute health services** • Higher functioning people report they could be more actively engaged and meaningfully occupied during their inpatient stay • Education of paid carers and carers in residential care is not routinely provided prior or on discharge (system limitations) • Options for social engagement during dining could be enhanced **Retirement Communities** • Mobility limitations are a factor for people needing to move into residential care due to the villa style apartments • Limitations where people live alone, to be supported as their needs increase • Current food models have limited or no opportunity for food preparation **Community Care** • Acknowledgment that people pay for support workers mostly to do rather than support or facilitate people to do themselves
3. Ensure people have access to the right setting at the right time, by the right person seamlessly	**Specialist health services** • People are transferred off-site for investigations of symptoms, which can be tiring and uncomfortable • People stay in inpatient specialist care beyond their care needs whilst waiting for discharge home or to residential care • Staff report lack of clarity about who is responsible from discharge until the next appointment (accountability gap not resourced in inpatient ward) • Staff report timeliness of access to the right person with the expertise to provide advice can at times lead to poorer outcomes • Assessment of dietary requirements can be delayed – the person receives puréed diet until confirmed **Retirement Communities** • Clinical services are limited to GP and nursing • Escalation to acute services requested by family at times **Community Care** • Matching the client needs with a support worker – skills/competence/common sense (training - base level and complex skills program addressing this) • Change in need may be identified but not able to be actioned - may need to go through funding assessment process for additional resources unless privately funded- funder may determine services (where brokered) • Difficult to get allied health assessment quickly unless privately funded • Hard to resource workforce for overnight and 24 hour care that is sustainable at short notice

Table 4 continues next page.

4. Enable people to make informed decisions for anticipatory care planning and ensure people's dying experience is in their chosen location	**Specialist health services** • Patients report not being informed of all of the services available or not understanding what the services provide • Patients are referred to inpatient palliative care near their death, with a proportion having no previous palliative care • Anticipatory care planning for some individuals on case review could have minimised long inpatients stays awaiting residential care • Patients acknowledge their denial in the planning process that contributes to limitations in anticipatory planning • Advance care plans are in place for 17% of SPNDS patients **Retirement Communities** • Palliative care toolkit compliance with process is inconsistent. Staff reporting time to complete paperwork is a barrier **Community Care** • Palliative care competencies – training addressing
5. Integration of and into the broader community	**Specialist health services** • There is limited opportunity and options to connect to the broader precinct in the current environment **Retirement Communities** • Current model has limitations in providing support for residents to access the broader community
6 Develop a model that can be translated to other locations	• Evaluation framework • High care needs, in particular support of NIV ventilation can't be supported due to resource constraints and perceived issues of safety

10.3.1

Table 4. Review of current services against Calvary Bethlehem's Health and Retirement Precinct 'Model of Care Principles'.

MODEL OF CARE PRINCIPLES	EVIDENCE OF GAPS/ISSUES
PERSON AND FAMILY CENTRED CARE:	**Specialist health services** • Issues with patient privacy with transport to bathrooms, clinical consultation in shared rooms • Communication between clinicians and clinicians and carers/family • Privacy for families grieving • Access to clothes in wardrobes **Retirement Communities** • Residents need to move to a secure memory support house when their absconding-type behaviours escalate and their care needs increase • Task oriented model versus patient centred model • AIN Tafe training focuses on competency of tasks. Previous experience in aged care in other organisation may be tasks orientated. Both of these factors impacts on staff ability to provide resident centred care and not have to worry if a shower is not completed • Resident centred care is limited to activities on-site and could be extended to external appointments and bucket list activities that have meaning to the resident **Calvary Community Care** • Relationship – main relationship with support worker – 30% turnover of staff impacts continuity of care and matching. • Information not necessarily provided to CCC when cease service (death/change in provider/ change accommodation) impacting support worker relationships
LIVING WELL/ ENABLEMENT:	**Specialist health services** • Higher functioning patients report active engagement in meaningful activities could be enhanced • Consistent active promotion of self-management and self-sufficiency by providing interventions that support people to make the most of their own capacity • Assessment of carers needs **Retirement Communities** • No access to gym facilities or exercise physiology on-site • Lifestyle coordinator role difficult to recruit to appropriately • Carers provide a more hotel like service in the non-secure houses - responding to need, but perhaps not enabling people • ACFI funding supports not encouraging independence to tasks for financial sustainability • Limitations in support model for laundry and meals to be enabled to be independent and for carers to engage these activities when desired • Incidental exercise to reduce sedentary nature of lifestyle incorporated into care • Medication administration model is task orientated • Handover is clinically focused, less about resident goals/activities for the day **Calvary Community Care**
SEAMLESS INTEGRATED CARE:	**Specialist health services** • Roles and responsibilities of team members are not clearly understood which at times can lead to a lack of respect of each other's roles • Integrated team medical model and integrated multi-disciplinary team model on the inpatient ward is unanimously identified as an issue • Timely multi-disciplinary care is limited by expertise available each day (varies for each day of the week) • Discharge dates are not routinely forecast for unplanned patients prior to admission and are not routinely documented on the handover sheet, white board or in patient rooms. • Handover sheet is medically focused – not functional and discharge planning • Communication channels • Continuity of care between specialist services requires improvement – current service improvement focus

Table 4 continues next page.

SEAMLESS INTEGRATED CARE:	**Retirement Communities** • Mental health aspects of care – how else can these be addressed • Psycho-geriatric support - needs to be processes in place to get physically aggressive residents managed or out of facility if can't be managed • After hours medical management **Community Care** • Privately funded – often don't have case manager and can fall through cracks of mainstream supports • Information received about the client may be insufficient to determine if you can provide services and the right match (may need more information including visit to the client)
CONSUMER DRIVEN:	**Specialist health services** • Consumers report that their ability to understand who does what and how the system works can impact their ability to direct their own care (health literacy) • The patient bedside boards are not well utilised to communicate with patients **Retirement Communities** • Perceived limitations of people's abilities to make their own decisions **Calvary Community Care** • Consumers report that knowing who to ask for what to solve issues and problems is not easy. This happens by accident at times (health literacy)
EXCELLENCE, QUALITY SAFETY:	**Specialist health services** • Safety issues for patients and staff with equipment in corridors, bathrooms and limited circulation space in rooms • People losing weight during admissions that previously had maintained weight • People requiring supplements during admission that have previously been maintaining weight at home • Higher incidence of falls than benchmarked Calvary facilities **Retirement Communities** • Medication administration with drug trolley is an OH&S issue • Model of care doesn't translate to a highly reliable culture across sites **Calvary Community Care** • Client/support worker matching
RESEARCH GENERATING, EVOLVING, LEARNING	**Specialist health services** • Post graduate palliative care students have reported the experience doesn't meet their expectations in relation to the patient mix • Limited palliative care research • Phase 1 and complex medical trials expected to grow - require access to advance life support and advance medical imaging facilities not supported in a sub-acute site **Retirement Communities** • OT not routinely utilised - opportunities to explore both cognitive and technical strategies **Community Care** • Progressing with mobile communication solutions for support workers
SUSTAINABILITY:	**Specialist health services** • Transferring physically dependent patients to the bathroom for personal care and toileting could be more efficient with the use of technology and reduced distances between locations • Consumable monitoring and ordering **Retirement Communities** • Medication management model • Consumable monitoring and ordering **Community Care** • Funding models

10.4
Consumer perspectives

Consumers were interviewed in focus groups and individually, to assess gaps in current services related to the model of care principles and what they thought would be important to delivering the aims of the model of care. A summary is detailed in table 5.

Table 5: Summary of Consumer Perspectives

INPATIENT FEEDBACK - CURRENT SERVICES	
PATIENT AND FAMILY CENTRED CARE	Staff are very caring, patient and kind Staff listen to my needs and respond Staff are very supportive Patients report being happy to negotiate with staff in relation to other patients and staff demands A number of patients report having to wait for a long time for call bells to be answered. At times are calling out to get attention – most understand, others are anxious/angry Nurse/patient ratios are an issue Unable to access clothes in my wardrobe as bed is in the way
LIVING WELL	The social aspect of the ward is one of the highlights Patients and families are very friendly and supportive of one another Music therapy is wonderful The food is improving but was much better when there was a kitchen onsite Low functioning patients report there are plenty of activities – socialisation with other patients is a key motivator and meaningful activity. Patients who are mobile find there is not much for them to do. They don't feel mentally or physically challenged OT are a great help with equipment for independence Respite is preferred at CHCB than residential care due to the enablement and active engagement focus and the understanding of people's care needs.
CONSUMER DRIVEN	There is a bit of a shock if you haven't been here before - no one explains the type of patients You don't see people bringing children for this reason Care is led by the staff - happy with this Not knowing what services are available while you are here means it is difficult to drive your own care You don't know how to contact the people you want to see There is limited opportunity for choice with personal care is undertaken or when meals arrive
SEAMLESS INTEGRATED CARE	Most patients and carers feel like the team communicate with them and with each other Some patients report not being aware of any plans to go home or any idea what is going to happen next Don't mind telling my story to different people to help them help me
EXCELLENCE, QUALITY AND SAFETY	The quality of care is exceptional. Very happy with quality of the care Staff do a good job in a difficult environment Staff know how to manage their care needs – not the same in residential care respite Compassion fatigue at times There is nowhere to put wheelchairs and walkers which makes it unsafe. Equipment in the bathrooms is unsafe. To get to the basin you need to move at least one item. Care is much better than other hospitals
RESEARCH, LEARNING AND EVOLVING	Haven't seen any students here
SUSTAINABLE	There is a notable number of agency staff that aren't as knowledgeable as the regular staff – are more inefficient (forget to give medications at the right time, need to tell them your routine)

Table 5 continues next page.

INPATIENT FEEDBACK - IMPORTANT IN THE NEW MODEL OF CARE	
PATIENT AND FAMILY CENTRED CARE	More privacy is required - going to the bathroom Single rooms to sleep Space to talk privately to clinicians Room needs to have space for walker/wheelchair patient chair and 2 comfortable visitor chairs Drawer to lock up valuables and other drawers to keep toiletries Wardrobe to keep our things
LIVING WELL	Natural light that is filtered in bedrooms Food quality -wholesome nutritious food Warm and comfortable environment - not clinical; homely with curtains and TV on the wall Place to do a jigsaw/art - where you can leave things and come back to them A beautiful garden with trees and filtered light Sensory garden and interactive garden - good for families and kids Peace and quiet overnight is important
CONSUMER DRIVEN	Brochure of the services available when you are an inpatient Lunch should be later Dinner definitely needs to be later Be good to be able cook food yourself here (or family)
SEAMLESS INTEGRATED CARE	
EXCELLENCE, QUALITY AND SAFETY	Needs to be space to store equipment in rooms or other locations Outdoor pathways that are safe for wheelchairs
RESEARCH, LEARNING AND EVOLVING	Patients could support staff in training new carers of their specific needs
SUSTAINABLE	

Table 5 continues next page.

SPNDS CLINICS - CURRENT SERVICES	
PATIENT AND FAMILY CENTRED CARE	First appointment was very overwhelming emotionally (repeated by a number of people) Team is very supportive Focus on my individual needs Staff listen to me and my family's needs Often see 5 people so long day - has improved with joint appointments. Would not want to stay overnight Prefer one long day Others prefer 2 or 3 appointments only Some people have appointments on different days – one person suggested they'd like to stay overnight Very flexible model that works with you Going back and forth between waiting room and various clinic rooms is tiring.
LIVING WELL	Living well is what this service is about - this is the mission Service monitors me but can't help me improve although does help me to manage things that have become difficult Great advice to help manage things ourselves Free Wi-Fi is helpful to keep busy while waiting Tea and coffee facilities are handy The physical environment. The building is depressing and reminds them of the "old medical model" Seeing other people in the waiting area is depressing , not that seeing other people with the same disease was sad, but more that being in a room full of other sad people was challenging
CONSUMER DRIVEN	As a newcomer you can't drive the show - you don't know who can help you with what Once you plug into individual people they are good at suggesting who to talk to about what You don't want to believe what they tell you to plan for...but it turns out to be true – you learn the hard way
SEAMLESS INTEGRATED CARE	Good communication between team members and GP and local palliative care Teamwork is expected behind the scenes Work well as a team Clinic nurse does a wonderful job in coordinating appointments on the day, trying to reduce gaps between appointments Gaps between appointments is an issue when you are here for such a long time Another OT who comes to my house. The OT here and the other talk to each other Seems like the care is continuous from when I was on the ward Had to go elsewhere for xray which was very distressing
EXCELLENCE, QUALITY AND SAFETY	Excellent service Very professional and kind staff All services you need in the one location is one of the best things Staff are very supportive You don't want to need to come here – but it's the best place to come if you need to
RESEARCH, LEARNING AND EVOLVING	Research is very important Interested in being involved in any research undertaken Staff are very knowledgeable about technology and equipment
SUSTAINABLE	Staff appear very efficient

Table 5 continues next page.

SPNDS CLINIC - IMPORTANT IN THE NEW MODEL OF CARE	
PATIENT AND FAMILY CENTRED CARE	Perhaps one or two appointments initially may be best to help people take in information Would love if staff were based in a hub and patients based in a room, (comfortable, with tea and coffee making facilities) with relevant staff coming into room as needed. Alternatively different waiting area's or "pods"
LIVING WELL	Café would be great on site to break up the day
CONSUMER DRIVEN	It might be good to have a video about the service, how it works and who does what Could ask what do you need help with - talking? Getting in and out of bed, bed comfort - and who you see for what - not the other way around
SEAMLESS INTEGRATED CARE	Having someone to lead or show you the way is the most important. There are always stumbling blocks along the way that are hard to work out how to get around. Navigation.
EXCELLENCE, QUALITY AND SAFETY	
RESEARCH, LEARNING AND EVOLVING	More research funding needs to be directed to MND Evidence in MS that exercise can improve the nerve function – research into the motor neurone is also required
SUSTAINABLE	

Table 5 continues next page.

COMMUNITY PALLIATIVE CARE AND PALLIATIVE CLINICS	
PATIENT AND FAMILY CENTRED CARE	Staff are flexible
LIVING WELL	The staff help improve quality of life and comfort
CONSUMER DRIVEN	Staff listen to what I want The service helps me to stay at home which is what I want
SEAMLESS INTEGRATED CARE	Good communication between team members –doesn't matter if a different person comes, they still know all the details and who I am as a person Nathan is lovely and I hope he visits again but not sure (IP)
EXCELLENCE, QUALITY AND SAFETY	Staff are wonderful Very caring and supportive staff Amazing service - lovely staff Emotional support is very important Nurses that visit at home are very knowledgeable and put me at ease. If I'm unwell the staff are very responsive and help to manage my symptoms
RESEARCH, LEARNING AND EVOLVING	
SUSTAINABLE	

Table 5 continues next page.

PALLIATIVE DAY CENTRE – IMPORTANT IN THE MODEL OF CARE	
PATIENT AND FAMILY CENTRED CARE	Options of where people can be - active group space and quiet space for 1:1 interaction or to be alone
LIVING WELL	Music and art therapy is important to be included Also think meditation is helpful 'How to breath better' – like the rehab program Gym or physical maintenance program
CONSUMER DRIVEN	
SEAMLESS INTEGRATED CARE	Would be ideal if people could continue to attend day centre when they are an inpatient or moved into residential care
EXCELLENCE, QUALITY AND SAFETY	Chairs need to easily moved around for different activities
RESEARCH, LEARNING AND EVOLVING	Research is important for hope Like having students – helps to develop more people that can support people like us in the future
SUSTAINABLE	Volunteer transport is very important in the model - otherwise it would be hard to get here

Table 5 continues next page.

CALVARY COMMUNITY CARE	
PATIENT AND FAMILY CENTRED CARE	The cleaning and house maintenance are the first things people find it difficult to do on their own. Family are very busy. Good to be in a place that relieves the burden on them. People often see their room as the only place left that is theirs once they move to a nursing home. There is a sense of loss to adjust to.
LIVING WELL	Exercise is very important Friends who live in a retirement community can go to the café and get their main meal for $12. They only need to manage light breakfast and lunch on their own Transport is the main limiting factor to being engaged in community events - the train is too busy, even half price taxi's can be expensive. Family should be encouraged to visit. Connection with someone outside their family and the normal environment - show they care about them. Ensure people are not forgotten. Important to have a mix of ages – no one wants to live segregated from society
CONSUMER DRIVEN	People should not be just left alone - need to be supported and encouraged
SEAMLESS INTEGRATED CARE	
EXCELLENCE, QUALITY AND SAFETY	The care is the most important. People need to be considered – left where they can access a call bell if they need, or that they can reach their meal or get support if they can't. The drinks need to be able to be opened - it's the little things that make the caring of high quality.
RESEARCH, LEARNING AND EVOLVING	
SUSTAINABLE	

10.5

Literature Review

10.5.1

Ageing and Care pathways

The 10 most common conditions that had an impact on people's need for assistance with their lives as they aged were heart disease (46%), arthritis (38%), dementia (31%), abnormal gait or mobility (28%), falls (28%), mental health conditions (26%), incontinence (23%), cerebrovascular disease (22%), diabetes (21%) and chronic lower respiratory diseases (17%) (AIHW, 2017). As people age, they are more likely to have multiple conditions (National Ageing Research Institute, 2016).

The number of people with dementia is projected to triple to around 900,000 by 2050 with the main risk factor being advancing age. Most people with dementia live with others in private dwellings (AIHW, 2012).

Age is a strong predictor of residential care. As at 30 June 2016, 59% of people in permanent residential aged care in Australia were aged 85 and over, compared with 43% of people using the Home Care Packages Program (HCP) (AIHW 2017). Gender is also closely associated with use of permanent residential aged care: approximately two-thirds of people in permanent residential aged care at 30 June 2016 were women. Compared to men, women enter permanent residential aged care later in life, generally having received formal assistance through other aged care programs at younger ages (AIHW 2014a). (AIHW, 2017)

People with a co-resident carer were less likely to enter permanent residential aged care than those with a non-resident carer, while those with a non-resident carer were less likely to have used respite residential aged care (AIHW 2014a). The appropriate formal support at home can also delay people's entry to permanent residential aged care: people who used community-based aged care services took longer to enter permanent residential aged care, whereas people with no previous aged care use (or use of respite residential aged care only) were more likely to enter permanent residential aged care after an assessment (AIHW 2011). (AIHW, 2017)

There are also other demographic differences in how people use aged care. People from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people may face additional barriers in accessing aged care services. For example, service use among people from CALD backgrounds may be influenced by cultural practices and expectations around aged care; and by communication barriers, socio-economic disadvantage and lack of awareness of Australian services (FECCA 2015). (AIHW, 2017)

Aboriginal and Torres Strait Islander people may face similar issues, as well as experiencing higher prevalence and earlier onset of many chronic health conditions that affect care needs. Compared with non-Indigenous people, Indigenous people generally use mainstream aged care services less, particularly permanent residential aged care (AIHW 2017), although this may partly be affected by under-reporting of Indigenous status among people who use services (AIHW 2012). (AIHW, 2017)

REGION OF BIRTH	
Australia	70%
United Kingdom/Ireland	11%
Southern and Eastern Europe	10%
Western and Northern Europe	3%
Other	6%

PREFERRED LANGUAGE	
English	91%
European Languages	7%
Other	2%
High degree of English proficiency[b]	82%

USUAL ACCOMMODATION[a]	
Private residence (owned/mortgaged)	69%
Private resisdence (rented)	13%
Retirement village (self-care unit)	13%
Other/unknown	6%

RECOMMENDED LONG-TERM ACCOMMODATION[a]	
Residential aged care	74%
Private residence	22%
Retirement village	2%
Other/unknown	2%

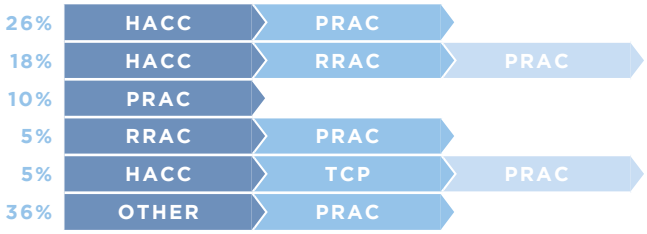
CARER STATUS[a]	
Had a carer	85%
Co-resident carer	42%
Non-resident carer	44%
No carer	13%
Unknown/not applicable	2%

CURRENT LIVING ARRANGEMENTS[a]	
Lived alone	49%
Lived with others	49%
Unknown/not applicable	2%

a At the time of their most recent ACAT assessment which provided approval for PRAC.
b Includes people born in Australia and those who are rated 1 for English-language proficiency.

Figure 1: People who entered residential care in 2013/14 by selected characteristics

A review of pathways into residential care (AIHW, 2017) found the five most common pathways in Australia to Aged Care Services for nearly two thirds of people in 2013/14 were as shown in figure XX:



LEGEND

HACC - Home and Community Services

PRAC - Permanent Residential Care

RRAC - Respite Residential Care

TCP - Transition care Programs

Figure 2: The five most common pathways into residential care.

Respite (39%) and HACC (36%) were the most common programs used last before entering permanent residential care. This was followed by transition care programs (8.2%) and aged care packages (7.0%). One in 10 (10%) people had not used other aged care programs before.

On average people had used Aged Care Services for 2 years before access to permanent residential care. For HACC services the average length of services was 4 years and for home care packages 2 years and transition care 2 months.

10.5.2

Evidence to Support Living Well

A summary of evidence to support living well includes:

- Engaging in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely can prevent disease and functional decline, extend longevity and enhance one's quality of life (WHO, 2012).
- Participation in regular, moderate physical activity can reduce the onset of chronic diseases in both healthy and chronically unwell people and can improve or sustain function. It can also increase independence and reduce the risk of falls (National Ageing Research Institute, 2016).
- A physically, intellectually and socially engaged lifestyle may slow cognitive decline, and improve function in healthy older adults, delay onset of dementia, reduce atrophy in memory-related brain regions (notably the hippocampus) and delay mortality (Bennett D, 2014)
- Inadequate social support is associated with an increase in mortality, morbidity and psychological distress as well as a decrease in overall general health and well-being (Leedalh, 2014).
- Close relationships and social integration across your life are the strongest predictor of length of mortality (Holt- Lundsted J, 2010)
- The importance of close relationships between people living onsite, family, staff and community members has been demonstrated to have an influence on health and well-being of people living in residential care facilities in the UK, with trust being of particular importance (Leedalh, 2014).
- A growing body of research suggests formal volunteering is associated with better mental and physical and functional health and that activities lead by older adults are better positioned to foster others engagement (Greenfield E, 2012).
- Intergenerational programs have been shown to be beneficial for both the older and younger generation for example, programs where older people teach younger people, shared site programs with older and younger people - cited in (National Ageing Research Institute, 2016)
- In 2014-15, 51 per cent of Australians over 65 were internet users (ABS, 2016), up from 46 per cent in 2012-13 (ABS, 2014).

10.5.3

Evidence to support technology use in older Australians

- A Deloitte mobile consumer survey found 78 per cent of people aged 63 to 75 years owned a smart phone in May-July 2017, up from 69 per cent between June-July 2016, while 82 per cent of 55 to 64-year-old's owned one (Mitchelson,2017)
- An online survey of National Seniors in Australia in 2017 found digital access is becoming a normal aspect of social engagement for 11% of older people who responded, noting the respondents were, consequently, a digitally literate cohort. Of these:
    - 90 per cent use a computer on a daily basis for email, internet or other tasks;
    - 36 per cent have contact with their children by text message or on social media 3 or more times per week, with another 33 per cent having contact once or twice each week;
    - 34 per cent have contact with family members, such as siblings, by text or social media at least once or twice a week;
    - Almost half have text or social media contact with friends at least once or twice a week;
    - 30 per cent indicated they accessed government websites for financial information about retirement; 23 per cent seek health and lifestyle information online.

11

SUMMARY OF ENABLERS OF THE MODEL OF CARE

The enablers of the model of care have been developed through review of the evidence, benchmarking, consultation with internal and external stakeholders and consumers. They are not exhaustive, but targeted at current gaps. They will be reviewed in the next phase of work developed to confirm implementation requirements.

Workforce enablers include an operational structure that articulates lines of accountability and responsibility documented in figure 3. The indicative workforce requirements to enable the model of care will be finalised following detailed design works.

An important workforce enabler is attracting talent across aged care, palliative care and neurological services as well as support functions. Providing an engaging experience for employees not only helps attract and retain skilled employees, but it also helps drive a strong recipient of service experience. Factors that contribute to positive employee experience funded through Deloitte research (Jegatheeswaran, 2018) are detailed in figure 2 below.

Figure 2: Factors that contribute to positive employee experience (Jegatheeswaran, 2018)

SIMPLY IRRESISTIBLE ORGANISATION™ MODEL				
MEANINGFUL WORK	SUPPORTIVE MANAGEMENT	POSITIVE WORK ENVIRONMENT	GROWTH OPPORTUNITY	TRUST IN LEADERSHIP
Autonomy	Clear and transparent goals	Flexible work environment	Training and support on the job	Mission and purpose
Select to fit	Coaching	Humanistic	Facilitated talent mobility	Continuous investment in people
Small, empowered teams	Investment in development of managers	Culture of recognition	Self-directed, dynamic learning	Transparency and honesty
Time for slack	Agile performance management	Fair, inclusive, diverse work environment	HIgh-impact learning culture	Inspiration
CROSS-ORGANISATIONAL COLLABORATION AND COMMUNICATION				

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Workforce and culture enablers identified through consultation and literature review are documented in table 8 and table 9.

Partnering with others and working collaboratively with other organisations is another way to enable the model of care outcomes to broaden capacity with expertise or resources available elsewhere. Opportunities are detailed in table 10.

Education and learning enablers are detailed in table 11.

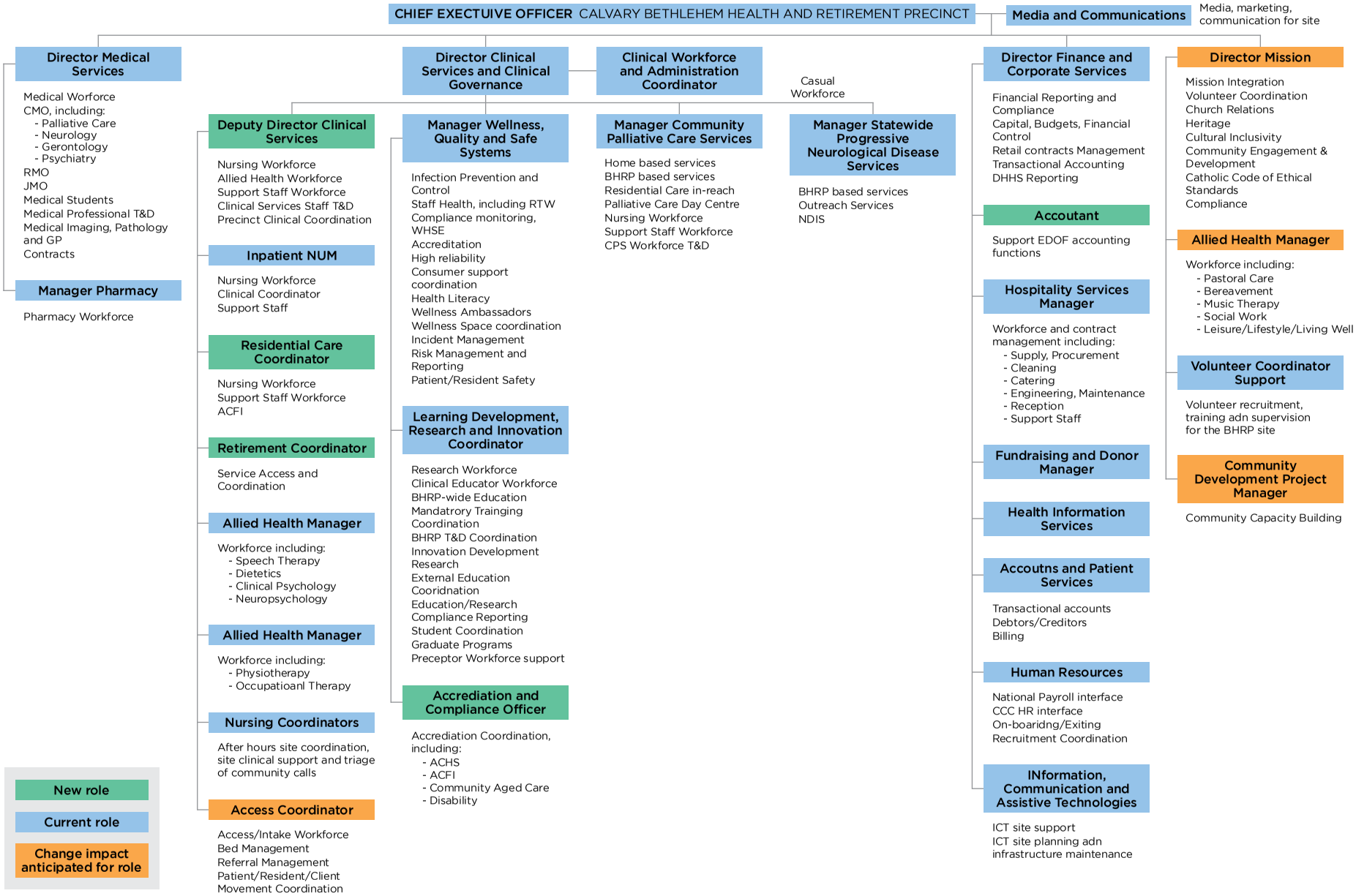

Figure 3: Bethlehem Health and Retirement Precinct operational structure with operational responsibilities articulated

Table 8: Summary of workforce enablers identified through consultation

INTEGRATED CARE	
LIVING WELL	- Facilitating people to live well is a function of all clinical and care roles, driven by service managers - Supporting and encouraging staff to live well is important for their wellbeing and as a role model to people accessing services - Pastoral care, lifestyle coordinators, allied health assistants and volunteers will provide support for individual and groups that facilitate well-being
PATIENT CENTRED CARE	- Recruitment strategies to attract people oriented to patient-centred care - Strategies to attract and retain a diverse workforce, reflective of the local community - Staffing models focused on staff empowerment - Use of volunteers to facilitate the patient experience - Skilled, knowledgeable and enthusiastic workforce with good communication skills - Continuity of care facilitated by models that assign people to the same care and health staff where possible
CONSUMER DRIVEN CARE	Navigational support will be inherent in all health and care related roles to facilitate informed decision making. Key roles include: - General medical practitioner and other medical specialists - Retirement apartment coordinator - Care coordinator - Care choices advisor - NDIS Support Coordinators - Social workers Resources allocated to support consumer participation and provision of health literate information (Centre, 2018)
INTEGRATED CARE	- Roles that work across and between settings to facilitate relationships and information flow - Joint appointments or dual appointments at other health facilities to facilitate access to care - Clearly defined roles and responsibilities of care and health providers - Navigational roles that transcend settings and have knowledge of all systems
EXCELLENCE, QUALITY AND SAFETY	- Attraction and retention of talent in roles across to aged care, palliative care and neuropalliative rehabilitation - Competency framework - Implementation of performance management process - Roles responsibilities standardly include continuous improvement - Equipment solution for crushing medications at the bedside
PALLIATIVE CARE	- Aligned to patient centred care workforce enablers - Clearly defined roles and responsibilities across the continuum of care - Access to PCA's able to provide 24 hour support in terminal care phase in the community and retirement apartments - Clinical champions in palliative care in all settings
EDUCATION, INNOVATION AND RESEARCH	- Service agreement, joint appointment and credentialing to facilitate phase 1 clinical trials - Joint appointments with universities to facilitate research and education - Development of joint accreditation processes for SPNDS research staff with health services to undertake research - Opportunities for joint research fellow with other health services - Research administration EFT (level and time TBC) - Multi-disciplinary educational roles or portfolios to support internal education - graduate, students, clinical support and clinical education - External education roles to provide training to the broader community (onsite and offsite)

Table 8 continues next page.

CARE SETTINGS	
SPECIALIST HEALTH INPATIENT WARD	- Joint appointments in key roles across specialist health inpatient and ambulatory care residential care and interim care where operationally appropriate (e.g. clinical care coordinator, allied health roles, clinical nurse specialists, medical staff) - Timely multi-disciplinary palliative and/or neurology expertise is available to patients either directly or via consultation as appropriate - Access to high medical specialties and interventions is facilitated where possible onsite and through transfer to the most appropriate setting where it is required for the inpatient episode of care - Access to disciplines outlined in the workforce requirements for specialist palliative care and statewide neurological with the addition of: o Clinical Care Coordinator (facilitates access and discharge) o Junior medical staff o Pharmacists o Nurses o Personal care assistants o Ward support - Volunteers
RESIDENTIAL CARE	Appointments across and between specialist health inpatient, residential care and interim care where operationally appropriate New roles: - Residential care coordinator - Registered and enrolled nurses - Care companions - Lifestyle coordination and AHA's - Volunteers
INTERIM CARE	Additional EFT for interim care in addition to residential care staffing: - Case manager 0.1 EFT - Other allied health as per goals 0.2 EFT
RETIREMENT APARTMENTS	- Navigational support role integrated with care coordination where possible - Provision of facilities, links with the community and information to support self-management of wellbeing (physical, social, intellectual, emotional, spiritual, occupational) - Support workers credentialed to meet the needs of the residents on-site, including palliative care to support end of life in the retirement apartments - Critical mass of support workers to support flexibility of the model - Access to nursing and allied health workforce

Table 8 continues next page.

SERVICES	
RECEPTION	- Reception workforce (assumed 1 person for opening hours) - Volunteer concierge (peak times)
SPECIALIST PALLIATIVE CARE	Multidisciplinary team including: - Palliative care physicians - Geriatrician - Specialist palliative care nurses - Physiotherapy - Occupational therapy - Pastoral care - Bereavement councillors - Clinical psychologists - Access to speech pathology and dietetics on a needs basis - Volunteers - Primary nursing model to facilitate continuity of care in the community palliative care services
STATEWIDE PROGRESSIVE NEUROLOGICAL DISEASE SERVICE	Multidisciplinary team including: Medical Specialists - Neurologists - Neuro Psychiatrists - Respiratory Physicians - Austin Victorian Respiratory Support Service (session per week) - Palliative Care Physicians - Rehabilitation Physician Allied Health - Physiotherapists - Occupational Therapists - Speech Pathologists - Dieticians - Clinical Psychologists - Neuropsychologists - Social Workers - Music Therapists Neurological Nurses - Clinical Liaison Nurse - Clinical Nurse Consultant - Clinic nurse Other Services - Pastoral care workers - Volunteers - Dental services - Research clinicians - Austin Lung Function Technician (day per week) Administration - Manager - Administration assistants
LIFESTYLE COORDINATION	Allied health assistants and activity coordinator roles support the implementation of lifestyle programs. Collaboration and integration of allied health therapies into the lifestyle program to facilitate wellbeing such as music and art therapy, pastoral care, exercise physiology and physiotherapy.
AFTER HOURS COORDINATION	Grade 5 nurse (1600-2330 and 2300-0730)

Table 9: Summary of culture enablers identified through consultation

LIVING WELL	- Leadership and organisational culture that supports wellness for staff and recipients of care
PATIENT AND FAMILY CENTRED CARE	- Leadership and organisational culture that supports patient centred care and inclusion - Opportunities for all people in the network of care to get to know people, and share aspects of their story - Respectfully acknowledging and supporting diversity and 'diversity within diversity', to allow people to embrace their diverse characteristics and life experiences - Flexible and responsive services to support individual needs
CONSUMER DRIVEN CARE	- Leadership that promotes empowerment of people - Patient centred and consumer driven care pervades through the culture of care
INTEGRATED CARE	- Leadership and cultural barriers to integration of services to facilitate the patient pathway are identified and strategies are implemented to mitigate these
EXCELLENCE, QUALITY AND SAFETY	- Clinical leadership in striving for excellence, quality improvements, innovation and research - Expectation of highly reliable culture - Culture of risk and incident reporting
RESEARCH CULTURE	- Organisational recognition of the importance of undertaking and collaborating in research to provide clinical leadership and service development in area of expertise, the translation of research into practice and workforce sustainability including the ability to attract talent. - Office of research to develop research framework, support ethics processes, monitor research guidelines, facilitate communication and collaboration, support administration processes.
EDUCATION CULTURE	- Learning culture on continuous improvement - Time for learning is prioritized and protected, supported by the leadership teams and policies and procedures - Opportunities for experiential learning and reflection are supported for internal and external learners - Flexible model - offering study days for night staff/role where limited opportunity during work hours - Accessible role models - Educational responsibilities are incorporated into role descriptions - Implementation of performance management

Table 10: Partnering with others

LIVING WELL	- Links and partnerships with a variety of community organizations to ensure a diverse range of opportunities to meet individuals needs either on-site or that can be accessed in the community - Partnerships with the Arts to facilitate exhibitions, music recitals and artists in residence - Pilot of new programs and groups on-site that can transfer into community programs - Funding opportunities through Trusts and funds and other philanthropic sources
PATIENT AND FAMILY CENTRED CARE	- Access to community advocacy groups to facilitate understanding and needs of people of different cultural and ethnic backgrounds, different sexualities, religions and health conditions
INTEGRATED CARE	- Role purposes include expectation of collaboration with other service providers and accountabilities - Relationship development with community partners is incorporated into key executive and management roles and a role of the Community Advisory Council
EXCELLENT, QUALITY AND SAFETY	- Outcome measurement and evaluation of the model of care is proposed to be undertaken in partnership with universities
RESEARCH, INNOVATION AND EDUCATION	- Partnerships are actively sought and developed to conduct education programs for the broader workforce capacity building - Research partnerships and collaborations are the strategic direction to further engage and drive the research agenda

Table 11: Summary of education enablers identified through consultation based on target group

PROFESSIONAL DEVELOPMENT OF STAFF	- **Mandatory training undertaken on an annual basis** - **Assessment and opportunities to maintain core competencies required for individual roles** - **Learning culture focused on continuous improvement**	- Opportunities to identify gaps in service, knowledge or practice against the evidence or best practice to implement reflective practice (audits, benchmarking, data review, literature review/ journal club, projects) - Opportunities to learn new skills, challenge knowledge and implement changes in practice (MDT meetings, ward round, case reviews, self-learning opportunities, short and sharp sessions, BWEP sessions, tutorials, external courses and conferences in person or via technology (online or webinar), opportunities for further study (Masters, PHD), quality projects - Supervision, mentoring and performance review - Development opportunities to progress career goals (opportunities for broader responsibilities - e.g. portfolios, participation committees and projects, acting in roles)
STUDENTS	**Undergraduate students**	- Clinical placements to a range of Melbourne and interstate universities and accredited learning institutions - Clinical experience opportunities for registered and enrolled nurses, allied health and medical students in inpatients, residential care and ambulatory settings on-site, in the community and via technology
	Post graduate students	- Graduate nursing preceptors - Post graduate palliative care nursing - Medical post graduate interns, residents, registrars - Allied health post graduate clinical placements - Post graduate dental - special needs - Post graduate medical students - fellowship exam preparation

BROADER WORKFORCE		- Education through clinical support provided to joint patients, secondary consultation and information.
		- Leadership in development of education forums and workshops (MND and Huntington's Disease)
		- Participation at conferences, education days
		- Palliative care education to other residential care facilities includes:
		  o Death audits
		  o Targeted educational program based on findings
		- Staff participate or provide advocacy and clinical leadership within their professional bodies' and special interest groups and other peak bodies.

	Further opportunities for the broader workforce education	- Allied health and nursing - other progressive neurological diseases - Personal care assistants - progressive neurological diseases, particularly MND and Huntington's disease - Personal care assistants - palliative care, aged care - Nursing - palliative care

Table 12: Summary of education enablers identified through consultation to enable model of care principles

INTEGRATED CARE	
PATIENT CENTRED CARE	- Staff training and support to practice patient-centred care and consumer driven care - Education and training in culturally responsive practice for all staff - Staff understanding the life experiences and needs of LGBTI people and being equipped with the necessary tools to provide LGBTI-inclusive practice
LIVING WELL	Education framework incorporates: - Staff training and reflection on domains of living well and how their practice promotes this through either direct intervention, providing opportunities for self-management and opportunities to enhance their overall wellbeing. - Building capacity of primary care teams to support people to live well in their daily lives
CONSUMER DRIVEN CARE	Education framework includes assisting consumer choice and control: - Use health literacy strategies in interpersonal communications and confirm understanding at all points of contact - Importance of provision of timely information to support proactive decisions - Address health literacy in high-risk situations, including care transitions and communications about medicines Education and support of consumers participating at organisational level
INTEGRATED CARE	- Services provided across the continuum of care provide opportunity for staff and students to understand and reflect about key issues and issues for individuals over time and their role and function in the network of care. Education framework that incorporates: - Proactive strategies to plan care - Understanding of barriers to integrated care - Roles and responsibilities
EXCELLENT, QUALITY AND SAFETY	Educational framework that incorporates: - Opportunities for reflective practice for staff to identify gaps in service, knowledge or practice against the evidence or best practice (audits, benchmarking, data review, literature review/ journal club, projects) - Occupational health and safety Mandatory training for emergency procedures, infection control, medication management and risk assessment.
DEMENTIA CARE	- Calvary Community Care Dementia Framework includes learning and development of staff to support the embedding of knowledge, skills and the Montessori method to provide excellence in care and support people living with dementia. - Staff are trained to identify triggers of unmet need in individuals
PALLIATIVE CARE	- Development of Bethlehem Health and Retirement Precinct palliative care education framework - Awareness for neurologists about early discussions about ACP for people with progressive neurological diseases. - Death audits and education programs for residential care facilities including competency in managing syringe drivers in residential care - Community engagement regarding death and dying
EDUCATION	- Customer service training - Brochures and resources of the local area

11.2

Clinical Governance Enablers

An integrated clinical governance structure for the site provides governance and reporting mechanism to ensure compliance with regulatory and funding bodies requirements.

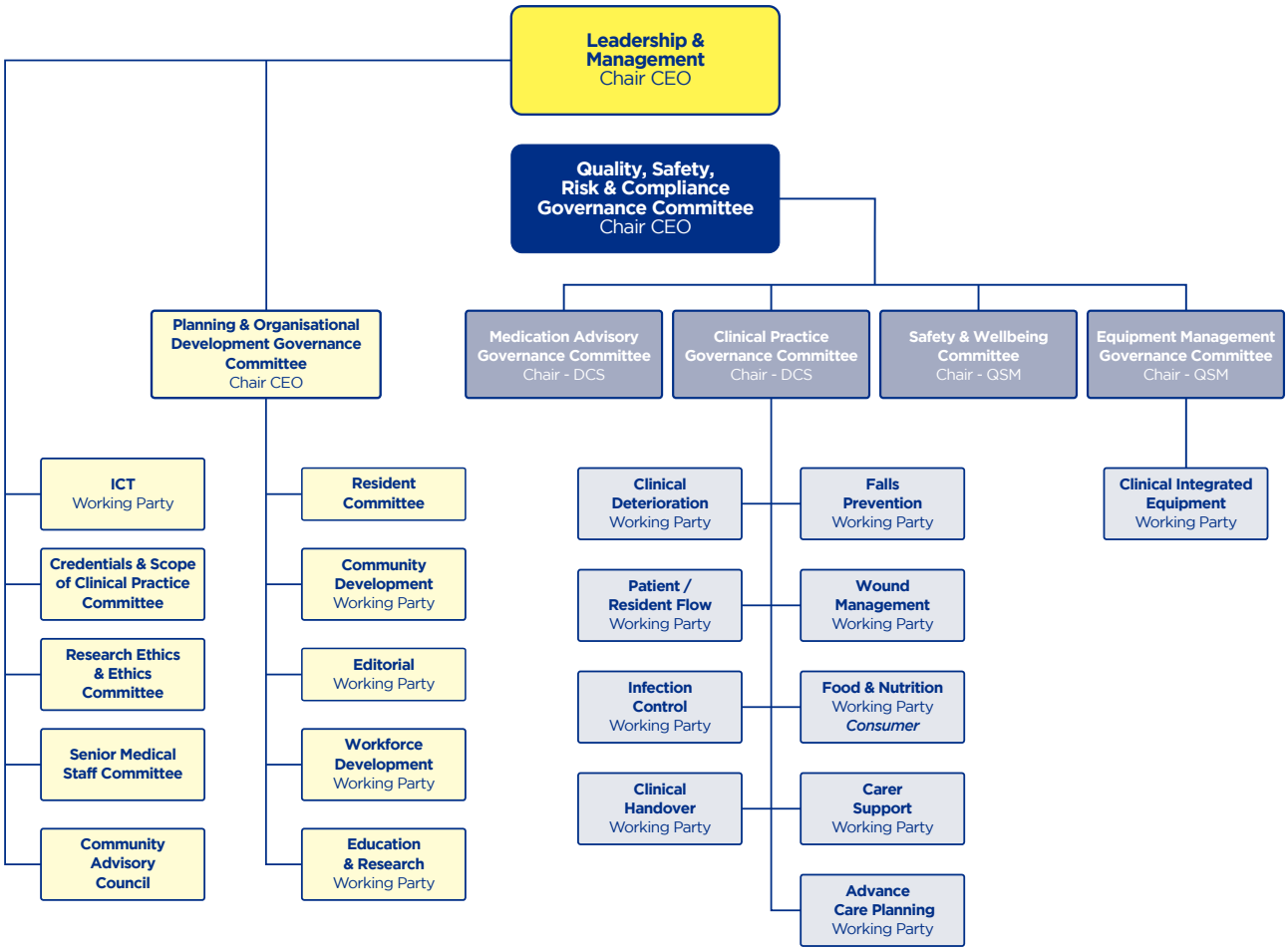

Figure 4: Governance and reporting structure in the Bethlehem Health and Retirement Precinct

Current policies and procedures will be reviewed to ensure they reflect the highest standard across Aged Care Quality Standards (ACQS), the National Safety and Quality Healthcare Standards (NSQHS) and NDIS quality standards. Policies and procedures will be integrated to facilitate quality and safe care.

Table 13 details frameworks and policies and procedures for review and development identified during consultation to enable the model of care.

Table 13: Frameworks, Policies and Procedures, Business Rules

PATIENT AND FAMILY CENTRED CARE	- Procedures to ensure recipients of care understand their rights and responsibilities - Policies and procedures that support individualized care: o Holistic assessment o Triage of needs to ensure right people at the right time o Involving the person, their family in their care • Goal setting • Care planning • Provision of information and education to assist decision making - Embedded in policies and procedures is a culture of inclusion - Procedures support a diverse range of consumer engagement in the design, implementation and evaluation of services
CONSUMER DRIVEN CARE	- A framework to embed participation throughout the organization - Include consumers in the design, implementation and evaluation of health and care related information and services improvement (Healthcare, 2018) - Monitoring and evaluation of consumer participation - Integration of health literacy into planning, evaluation measures, service users safety and quality - Policies and procedures are aligned to support the rights of recipients of care - A policy stating the organisational commitment to consumer participation - Policies and procedures to guide consumer participation - Assessment procedures include identification of appointed substitute decision makers
INTEGRATED CARE	- Pre-admission procedures to ensure information from referrers and other care providers is recognised and incorporated in care planning o Establishing goals of care o Verbal and written handover procedures o Pre-admission meetings
EXCELLENCE QUALITY AND SAFETY	- Integrated clinical governance structure - Integrated policies and procedures that reflect the highest standard across Aged Care Quality Standards (ACQS), the National Safety and Quality Healthcare Standards (NSQHS) and NDIS quality standards. - Continuous evaluation processes to support accreditation - Review of ventilation policy for residential care
EDUCATION, INNOVATION, RESEARCH	Standardised policies and processes for research undertaken within the Bethlehem Health and Retirement Precinct
SPECIALIST HEALTH INPATIENT	- Review of The Assessment and Discharge to Residential Aged Facility Care procedure - Development of procedures to support discharge to interim care

11.3

Services identified to enable people to 'Live Well' in the Bethlehem Health and Retirement Precinct

There will be many opportunities to live well in the Bethlehem Health and Retirement Precinct. Examples of services that enable people to live well across the domains of wellness are listed in table 14. Further testing with consumers will occur in the next phase.

Table 14: Service identified to live well in the Bethlehem Health and Retirement Precinct

PHYSICAL	- Onsite access to general medical services - Onsite access to diagnostic services - Access to general and specialist dental services - Access to allied health services including podiatry - Access to specialist health services - specialist palliative care or statewide neurological services - Assessment of health issues and referral to appropriate services in all settings - Access to trained carers and health professionals with expertise in aged care, palliative care and progressive neurological diseases - Use of technologies to aid independence and facilitate engagement in meaningful activities - Exercise groups for various disease groups and functional levels - Variety of healthy, aromatic, appetizing meals available 24/7 - Sexual health initiatives (emotional health) - Montessori dementia program - Facilities that support self-management - hydrotherapy, gym
SOCIAL	- Day centre programs for palliative care, younger people with disabilities and for people with dementia which will also offer opportunities for intellectual, emotional, spiritual and physical health - Access to Wi-Fi to access social media and other technologies that enhance social connection - Diversional programs for inpatients and residential care with behaviours of concern - Transport options for people living on-site - Research group activities or interventions - Groups programs for different interest/needs with therapeutic and peer support outcomes (Photo voice, Huntington's disease choir, Art Therapy, Music therapy) - Dancing groups (also supports physical, emotional and spiritual health) - Facilities that support social interaction such as cafés, BBQ areas, indoor and outdoor meeting places
INTELLECTUAL	- Links with community education providers e.g. UA3 and others - Skills development groups and opportunities (including education and support regarding technology) - Mindfulness groups - Quizzes and other cognitive challenges in day centre, residential care and inpatient groups - Montessori dementia program

Table 14 continues next page.

EMOTIONAL	- Access to clinical psychology and psychiatry for mental health issues - Access to pastoral care, social work and bereavement support - Trusted network of support (contact with family and friends, health and care providers, other people working and living on-site) - Intergenerational programs (also supports social health) - Music therapy (also can support intellectual, spiritual and social health) - Art therapy and art and craft groups (also can support intellectual, spiritual and social health) - Pet therapy - Virtual reality - Carer support programs
SPIRITUAL	- Access to pastoral care and faith leaders - Diversional therapy - Chapel services and multi-faith spaces for prayer and rituals - Mindfulness groups - Montessori dementia program - Research
OCCUPATIONAL	Volunteer roles: - Supporting programs in residential care - Opportunities to lead social, physical, life-long learning and community activities - Opportunities for roles and responsibilities within committee and care settings (can be small)

Table 15: Other services identified to enable the model of care

PATIENT AND FAMILY CENTRED CARE	- Access to interpreters - Access to information available in people's preferred language where possible - Development of age, gender and culturally appropriate activities to meet people needs on-site and/ or and development of connections in the community - Food available that responds to the cultural and religious requirements of individuals - Worship and liturgy; both within the Catholic tradition and in a more ecumenical and interfaith manner - Transport options to access services
CONSUMER DRIVEN	Access to Information - Provide easy access to health and care related information and services and navigation assistance - Design and distribute print, audio-visual, and social media content that is easy to understand and act on - Meet the needs of populations with a range of health literacy skills, including those where English is not their first language - Communicate clearly services people will have to pay for and associated costs

11.4

Technology enablers

Technology is expected to revolutionise health and care services in the next 10 years. Technology identified during consultation to enable the model of care is documented in table 16. Table 17 is a summary of the technology roadmap developed by ACITP in collaboration with Flinders University and ASIC.

Table 16: Technology identified to enable the model of care

LIVING WELL	- Access to Wifi throughout the facility
	  o for email and social platforms
	  o access to information
	  o self-monitoring technology
	  o remote monitoring technology
	  o other applications as they evolve
	- Assistive technology
	- Use of technology such as virtual reality for physical, emotional and intellectual

PATIENT AND FAMILY CENTRED CARE	- Recipient of care portal to facilitate sharing of information between care network (service providers, family and recipient of care as determined by person) - Access to information online - Contributing to the development of online health translation - Use of applications that translate common care requirements Inpatient ward, residential care and other care settings - Communication solutions (e.g. nurse call) between recipients of care and care providers are tailored to the physical and cognitive abilities of population served and include multi-modal activation - Environmental control systems that people use can be integrated into the environment to activate functions - e.g. entertainment systems, light switches and other software systems available in rooms - Entertainment system in inpatient ward and residential care inclusive of movies, television, music and opportunities to access in-house educational programs and access to internet/intranet/portal. - Ability to play own music through a range of technical solutions (own device, USB)

INTEGRATED CARE	- Use of a unique identification of people accessing services across the site and across systems to avoid duplication of people in the one system (TBC)
	- Use of technologies to support registration and admission processes
	- Transferable and/or shareable information from one setting to another
	  o Demographic details
	  o Handover information
	  o Discharge summaries (specialist health inpatient services)
	  o Shared care plans (specialist health services, GP, other health and care providers, including residential care)
	  o Advance Care plans
	- Options for sharing information between the Bethlehem Health and Retirement Precinct and external providers include My Health Record or a platform with functions of MyNetCare.
	- Options for sharing information between Calvary systems of iPM, Vitro, iCare and Goldcare are required to be explored.
	- Telehealth to support access to specialist health services in residential care facilities and homes where people are unable to access the clinic environment

EXCELLENCE, QUALITY AND SAFETY	- Implementation of technologies to reduce or eliminate risks to people and staff
	  o Movement sensor technology is used to enable independence reduce the risk of falls - e.g. sensor lights, automated doors
	  o Dimmable lighting to assist with re-orientation, minimise falls risks
	  o Use of technology to reduce manual handling risk to staff – e.g. ceiling hoists in bedroom
	  o Communication system alerts able to distinguish need - e.g. need to go to toilet, falls mat alert, etc.
	- Solution to display 'How we are going information' electronically in Specialist Health Services to be viewed by staff, patients and carers/families

Table 16 continues next page.

DEMENTIA CARE	- Technology has the potential to increase people's independence by providing monitoring of usual behaviours, prompts for regular tasks and alerting support. - Technology can also be used for enjoyment to connect to previous times and place e.g.. music, virtual reality.
CLINICS	- Access to free wifi (patients and family) - Scheduling system that supports multi-disciplinary appointments - Telehealth platform - Monitoring and communication applications between health provider and patient (speculative) - Patient flow technology to support multi-disciplinary clinics - Technology to capture consumer feedback - Electronic facilitation of information sharing between internal settings of care (specialist health and residential care) and community providers
RESIDENTIAL CARE	- Interactive games including virtual reality to engage and challenge people - Applications that facilitate communication between the resident and their family and staff
RETIREMENT APARTMENTS	- Platform to share health and care information with a range of providers if agreed by the person - Smart home technology automation and monitoring - Access to telehealth in people's homes - Technology to reduce risk of falls - Use of normalised technology - mobile phones, iPads, paywave to pay resident fees
RECEPTION AND CONCIERGE FUNCTIONS	- Wayfinding support (mobile applications and/or screens) - Resident and patient portals - to access information, book trips and facilities - Electronic communication boards - to access information about what is happening on-site - Swipe card security system to minimise need for shared keys - Electronic room booking system - Electronic car booking - Communications to facilitate wayfinding and direct contact with high volume contact locations - Telecommunications - Taxi-phone
AFTER HOURS COORDINATOR	- Mobile audio-visual communications platform to facilitate monitoring and communication functions throughout the facility
COMMUNITY PALLIATIVE CARE	- Electronic boards to facilitate patient allocation and team communication - Mobile devices for telecommunication and access to clinical information - Telehealth platform - Patient monitoring and communication applications (speculative)

Table 17: Aged care roadmap at a glance www.ACIITC.com.au.roadmap

DESTINATION	ISSUES TO BE ADDRESSED	ACTION	SHORT TERM <2 YEARS	MEDIUM TERM 3-5 YEARS	LONG TERM 5-7 YEARS
1. TECHNOLOGY-ENABLED SYSTEMS	1. Need for interoperability, open standards and common platforms 2. Under-developed sector technology readiness 3. Fragmented capacity building and a failure to embed technology in aged care 4. Need for a national data exchange and readiness for electronic data usage 5. Need for aged care B2B and B2G interfaces in order to create an open ecosystem of secure data exchange	Adapt for aged care Open Standards and protocols that facilitate interoperability and sharing of information	→		
		Undertake a *Technology Maturity Assessment* of the aged care system's technological readiness, reviewing use of technology across the spectrum of care services, and structural arrangements, underpinning systems and capacity for interoperability. Repeat every three years.	→	→	→
		Develop an implementation plan to accompany the standardisation of interoperability across the aged care sector		→	
		Collaborate with the Department of Health to embed technology capability as an essential requirement of aged care delivery	→	→	→
		Establish a national data exchange and reporting hub to support providers with advanced business intelligence, analytics and reporting capabilities	→		
		Develop a holistic government strategy for the aged care sector, that provides B2B and B2G interfaces in order to create an open ecosystem of secure data exchange.	→	→	
2. TECHNOLOGY-ENABLED SERVICES	1. Service sector silos 2. Failure to integrate technology as a core feature of ages care 3. Informed choice and improved system navigation 4. Insufficient co-design	Establish a national network linking end users (consumers, their supporters and service providers) with developers of technology to support co-design and co-evaluation	→		
		Develop a specific cluster within this network to support co-design in the development of Smart Homes for older Australians	→		
		Develop a series of Demonstration Pilots to demonstrate how to extend existing telehealth and telemedicine programs into aged care (residential and community), and how to support the electronic sharing of consumer and service data between aged care and health system providers	→	→	→
		Explore with the disability sector scope to provide a specific component focused on older people in its NED database	→		
		Develop an App to assist in navigating assistive technologies designed to meet the needs of older people	→		
		Establish a Technology Initiative Fund, combining government support with providers pooling funds and resources, to support aged care providers to purchase and/or develop technologies to integrate into their care services	→	→	

Table 17 continues next page.

DESTINATION	ISSUES TO BE ADDRESSED	ACTION	SHORT TERM <2 YEARS	MEDIUM TERM 3-5 YEARS	LONG TERM 5-7 YEARS
3. TECHNOLOGY-ENABLED INFORMATION AND ACCESS	1. **Under-developed and inequitable consumer readiness** 2. **Addressing factors that determine adoption of technology**	Develop a national *Digital Literacy Strategy* for consumers, supporters and providers to ensure they have the skills to use technology-based products and services designed for older people.	→	→	
		Develop a national *Technology Awareness Raising Strategy* to ensure consumers and their supporters are informed about technology based products and services for older people.	→	→	
		Develop a national Technology Equity Strategy for aged care consumers, their supporters and aged care providers to address inequitable access arising from disadvantage (e.g. because of location, affordability, information, skills).	→	→	
		Develop a tool for aged care providers to profile their consumers' technological readiness/digital literacy. Repeat this over time to measure the impact of digital literacy interventions and to monitor the effectiveness of the first three Actions.	→	→	
4. TECHNOLOGY-ENABLED ASSESSMENT	1. **Need for a technology lens in assessment and care planning.** 2. **Under-utilisation of technology-enabled assessment.**	Develop a pilot to trial the embedding of technology expertise in assessment and care planning, and analyse outcomes achieved for providers and consumers.	→		
		Based on Pilot findings, establish a dedicated pool of Technology Specialists to advise on potential technology solutions or enhancements.	→	→	
		Review existing validated assessment tools, identifying those that have been automated. Update every three years and share with the sector.	→	→	→
		Ensure that assessors and clinical care managers receive training in the application of automated assessment tools.	→	→	→
5. TECHNOLOGY-LITERATE AND ENABLED WORKFORCE	1. **Under-developed workforce technological readiness.** 2. **Under-developed informal carer technological readiness** 3. **Limited video-conferencing infrastructure** 4. **Under-developed potential to improve workforce productivity**	Include questions designed to identify technological readiness in the ongoing National Census of the Aged Care Workforce.	→		
		Design, implement and evaluate (via a series of Pilots) a national *Workforce Technology Development Strategy* to build capacity to use technologies effectively and integrate them into service processes and systems.	→	→	→
		Provide increased opportunities for online learning and video-conferencing (possibly via a dedicated incentive fund) and explore capacity for sharing operational costs across aged care providers.		→	→
		Include informal carers in paid workforce training and learning opportunities designed to enhance digital literacy and confidence.		→	→

11.5

Environmental and building enablers

Environmental and building enablers identified are documented in table 18.

Table 18: Environmental and building enablers of the model of care

	INTEGRATED CARE
LIVING WELL	- Evidence based design principles are incorporated into the design to enhance people's well-being including access to natural light, views of nature and access to outdoor garden spaces for all people - An environment that promotes safe physical activity and social connections has been shown to have positive impacts on people's health. (NARI, National Ageing Research Institute, 2016) - Principles of dementia enabling environments are incorporated into the design including human scale of environments, reduced stimulation, wayfinding incorporating architectural design to assist orientation, sense of place and points of interest - Provide opportunities for incidental exercise and rest (various functional levels incorporated) - Ease of access to therapy and activity spaces for people in the sub-acute inpatient ward, interim care and residential care - People have access to a range of spaces to support engagement in meaningful activities and self-management including but not limited to: o A chapel or multi-faith space o Movie room, library, internet access stations, group spaces for music therapy, exercise groups, cognitive challenges, gymnasium, hydro therapy o Activity room to leave out projects - jigsaws, art therapy projects o Outdoor spaces with various functions: • A green open place - for vistas and visits with active outdoor spaces for children • A meeting place for festivity and pleasure • An area facilitating fascination of nature sensory gardens, rich in species • Raised gardening beds, kitchen gardens, • Quiet reflection and serene areas and small labyrinth • Enclosed, safe and secluded places that have sunlight most of the day, (Spring, 2016) o Facilities to make a meal for yourself or family member o Retail, café and social gathering places for all o Choice of dining options - private dining in apartment, residential care room or sub-acute inpatient bedroom; private dining space to host family or friends; indoor and outdoor function areas for celebrations - Staff facilities to promote their health and well-being include staff rooms, access to a gym, variety of food options, lockers, bike shed, access to toilets and breast-feeding facilities
PATIENT AND FAMILY CENTRED CARE	- An enriched environment - warm and home-like supportive of the physical and psychosocial needs of people and their families and opportunities to engage in meaningful and stimulating activities - An inclusive environment for all people - age, gender, sexuality, culture, religion and spirituality whilst maintaining the LCMHC and Catholic identity - Universal design principles - An environment that enables care for all people including those with behaviours of concern/bariatric/frail/mobility/visual impairment and/or cognitive impairment - Design ensures future flexibility to meet individual people's needs in the retirement apartments - Priority for recipients of care areas to have access to natural light and views of nature - Appropriate balance of privacy and safety - Opportunities for social stimulation and fulfilling relationships o Places to prepare and eat food for people in all settings, separate to the clinical environment o Opportunities through food preparation and dining for people and their families to maintain their relationships and their roles in one another's lives o A range of dining environments available including dining settings within each setting, bookable private dining spaces for smaller groups, larger group spaces for indoor and outdoor celebrations, café style dining and a bar style recreational environment for people living in the retirement apartments o A hostess food model has been shown to improve social interaction in residential care o Places to meet as a family or couple in private or semi-private (indoors and outdoors) o Social environments that facilitate sense of community including play area for children

Table 18 continues next page.

PATIENT AND FAMILY CENTRED CARE	- Acknowledgement of people of Aboriginal and Torres Strait Islander origin - Visual and auditory privacy is provided in all settings for personal care, clinical consultations and interventions, family and carer discussions with clinical and care staff, the dying process and for grieving - Quiet, intimate, social and active opportunities are incorporated in the design to spend time with others including carers, volunteers, family and friends - Separation of staff and clinical or home areas to enhance privacy in the multidisciplinary clinical environment of sub-acute inpatients, residential care and interim care - Non-clinical staff write-ups to facilitate access to clinical and care staff - Access to communal lounge that is accessible for people in wheelchairs - Access to laundry for personal items - Sub-acute inpatient ward, interim care and residential care bedrooms and ensuites are required to: o be of size and layout to maximise independent mobility in electric wheelchairs o facilitate people sitting out of bed o facilitate safe movement between rooms o accommodate up to one family member overnight o accommodate two visitors comfortably at other times o space for charging of equipment, storing NIV o include wardrobe and drawers for people's clothes and personal items and a locked drawer for valuable items o include locked drawer for medication and solution for bottled medication - Residential care bedrooms in addition require the ability to be personalised and require smart storage solutions - Access to facilities that support the wellbeing of carers and family across the facility o toilet/disabled toilet o baby change room/parent room o access to retail and café o private spaces to gather as a family, grieve, communicate with carers and clinicians o access to facilities to make drinks and snacks and to rest and recharge away from clinical and care environments (separate to retail)
CONSUMER DRIVEN	- Services are organised to support common journeys of people accessing the facility - Intuitive wayfinding, supporting the needs of the population served (people with cognitive issues, English as a second language, reduced eyesight, visual conflict) - Environment and key landmarks support intuitive wayfinding - Simple signage information supports intuitive wayfinding
INTEGRATED CARE	- Single point of access to the site - Sub-acute inpatient ward interface with residential care and access to transitional beds to provide support - Therapy spaces will be arranged according to functional activity, rather than discipline. This will facilitate interdisciplinary assessment and treatment. - Staff work spaces facilitate collaborative multidisciplinary care - Facilities support integrated care and include private spaces for family meetings/team meetings/handover/ telehealth/telephone conversations/education
EXCELLENCE, QUALITY AND SAFETY	- Facility design eliminates or reduces key risks: o Behaviours of concern • Provide access to calm and quiet areas for people with cognitive and behavioural issues and ease of access to outside areas • Minimal furniture and streamlined rooms - no breakable furniture and fixtures in all patient areas • Ensure safety from self-harm o Falls and manual handling • Specialist Health services and residential care bedrooms and ensuites are required to: • Be of size and layout to maximise independent mobility in electric wheelchairs, minimise the risks of falls, minimise risks to staff when feeding and moving patients • Flooring to reduce the impact of falls o Medication Management • Medication room design incorporates quiet zones to reduce distraction for drugs of dependence (DD) reconciliation and preparation of syringe drivers and IV preparations • Swipe card to all access rooms and medication cupboards provide record of access • Solution for crushed medications at bedside - Specialist health services meet as a minimum design standards Victorian Health Facility Design Guidelines Victoria - Facility design ensures efficient common workflows

Table 18 continues next page.

DEMENTIA CARE	The environment has been shown to be an important component to facilitate independence and engagement for people with cognitive issues. The environment should reflect the Dementia Enabling Environment Principles (Environments, 2018). 1. Unobtrusively reduce risks 2 Provide a human scale 3. Allow people to see and be seen 4. Reduce unhelpful stimulation and over stimulation 5. Optimise helpful stimulation such as meaningful visual cues 6. Support movement and engagement 7. Create a familiar space 8. Provide opportunities to be alone or with others 9. Provide links to the community 10. Respond to a vision for way of life
PALLIATIVE CARE	Refer to patient centred care enablers **Recipients of care** - An emphasis on serenity for environments incorporating palliative care (sub-acute inpatient ward, residential care, residential care) - Retirement apartments have the capacity to support changing needs of people including hospital beds - Privacy for the dying process to enable patients to spend time with carers, family and friends - Pathways to and from places of care to morgue and to hearse pick-up show respect and dignity **Carers and family** - Ability to stay overnight in the same room with a loved one when dying (choice of same room, same bed) - Privacy to grieve with family outside of the patient's bedroom
EDUCATION, INNOVATION AND RESEARCH	- Interview rooms for supervision of staff and students within clinical environments - Access to education spaces for groups within clinical environments (particularly for nursing) - Low fidelity simulation facilities - e.g. a simulated room of the current clinical and care environment (space for simultaneous simulation – up to 4 beds) - Multi-purpose space suitable for educational forums (lectures, workshops) - Clinical spaces (office and clinical areas) have capacity to include students - Research clinical spaces - waiting space, interview room and treatment room (up to 4 people simultaneously ideally for future proofing of less complex infusion based drug trials) - Laboratory space and storage to support clinical trials - freezers, fridges, clinical trial procedure folders, associated consumables and computers. - Office of education and research - Computer laboratory (hotdesks) for research and education students
SUSTAINABILITY	- Maximum flexibility and therefore generic requirements need to be applied across all bedrooms of each unit (sub-acute inpatient, interim care and residential care) - Flexible design of spaces enable sharing of activity and therapy spaces - Ease of access across the site to support sharing of recreational, social, physical activity spaces across the site - Design provides opportunities for shared meeting, educational and function spaces. - Adequate storage with varied stores for consumables, equipment across site - Environmentally sustainable design that provides operational benefits - Design supports efficient staff workflows

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CARE SETTING	
INPATIENT WARD	**Patients, carer and family requirements** - Communal living environment separate from bedrooms to encourage social connection, dining and for people to spend time with family and visitors - Kitchen/pantry to prepare and store foods and drinks - Calm and quiet access to indoor and outdoor spaces to de-escalate behaviours of concern - Access to therapy and activities of interest on or close to the ward - Washing machine and dryer facilities for patient's family to wash clothes **Clinical requirements** - Maximum flexibility and therefore generic requirements need to be applied across all bedrooms to minimise bed moves - Design promotes patient centred care, where efficient staff workflows support staff to be near the bedside - People are able to be observed from outside the room - Staff are able to see patient before entering the room to minimise risks in relation to behaviours of concern - Staff zone in bedroom with access to the patient, medication drawer, electronic medical record and utilities - Medication room to incorporate the main functions o pick from imprest or refrigerator o access and reconcile DD's for (2 people) – minimal distractions o preparation of sub-cutaneous injections, syringe drivers and other medications (2 people) – minimal distractions - Clean utility with mobile solution for sub utilities for clean consumables - Access to dirty utility from bed rooms within 10-15m - One centrally located resuscitation trolley - Common infectious diseases include VRE, CRE, gastro, C- diff which require normal pressure isolation and contact precautions - a solution is required to keep the protective equipment outside the room - Waste - paper waste, confidential, plastics, recycle, clinical waste (yellow infection) bins, sharps, purple chemo bins - Linen - access to linen trolleys - Facilities to support multi-disciplinary model of care – staff stations, multidisciplinary hotdesks that provide privacy, access to forms, systems, communication and patient journey board **Storage** - Equipment bays for commonly used medical devices - Equipment storage (commodes, chairs), non-sterile goods **Staff requirements** - Place to lock up bag (code to open) - Individual and team communication solutions - Staff room (on ward) - Toilets - Handover/meeting/education space/ debrief space - NUM office - Ward clerk station - Access to staff parent room (breast feeding room)
CENTRE BASED CARE	**Patients and carers** - Ease of access between centre-based care facilities, reception and waiting to facilitate patient flow - Patient flow to incorporate discrete arrival, waiting and departure for new patients who are often overwhelmed - Access to waiting spaces options - quiet, private and more interactive options that facilitate peer support and opportunities to engage while waiting - Visitors chair in consulting rooms and space for carers and family to attend appointments - Access to relevant information - Access to food and beverage options to purchase in the broader precinct - Access to non-clinical spaces to make food and drinks, rest and recuperate, engage with others (well-being space) - Access to disabled toilets - Baby change and parent feeding room - Space for family to meet with clinical team

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CENTRE BASED CARE	**Clinical requirements** Patient flow in clinics required to support separate arrival and departure functions at reception for both people standing and in wheelchairs - Medical consulting rooms that meet staff and patient needs - 1 treatment room for minor procedures - Soundproof interview rooms for nursing, speech pathology, neuropsychology, clinical psychology and social work - Group therapy rooms - Sound proof music therapy room, with the ability to record music - Space for performances and celebration - Physiotherapy exercise gym incorporating space for group programs - SPNDS OT/PT assessment and demonstration facility – see SPNDS - Food storage and preparation for speech pathology and dietician - adjacent to consulting rooms **Clinical research space** The clinical research space is required to be integrated but in addition to clinic space. Requirements are listed in Education and research enablers **Back of house workstations and administrative storage** - Workstations for administrative functions - arrival, departure, bookings, billing. - Multi-disciplinary hotdesks for clinical staff - Photocopier/fax/scan **Storage** - Medical record storage - Stationary storage - Secure paper and paper bins - Consumable store **Staff Requirements** - Place to lock up bag (code to open) - Team communication solutions - Staff room - Toilets - Handover/meeting/education space/ debrief space - Manager office - Access to staff parent room (breast feeding room)
RESIDENTIAL CARE	**Recipients of care** - A home-like environment - refer to dementia care enablers - Communal living environment separate from bedrooms to encourage social connection and for people to spend time with family and visitors - opportunities for intimate, private conversations and larger family gatherings - A dining area to facilitate individual plating and shared eating experiences - Kitchen facilities to prepare basic meals (continental breakfast, sandwiches, heat foods) - Privacy for personal care, the dying process and to spend time alone or with others including with carers, family and friends - Access to group spaces - music therapy, exercise groups, cognitive challenges - Activity stations based on resident interests - Activity room to leave out projects - jigsaws, art therapy projects - Access to indoor and outdoor spaces - to entertain, to gather with family and friends (BBQ and dining spaces) for celebrations, sensory gardens, raised gardening beds - Secure, purposeful wandering spaces with enough sunlight to create a stimulating environment **Carer and family requirements** Refer to person and family centred care enablers **Clinical requirements** Maximum flexibility and therefore generic requirements need to be applied across all bedrooms

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RESIDENTIAL CARE	Clinical rooms access to be designed discretely to avoid confusion to people with cognitive issues - Medication room – storage of DD's and refrigerated items. Preparation of medication - Clean utility with mobile solutions for access to common clean consumables - Access to dirty utility from bed rooms within 10-15m? - Waste - paper waste, confidential, plastics, recycle, clinical waste (yellow infection) bins, sharps, purple chemo bins - Linen - discrete access to linen trolleys - Washing machine and dyer for patient's clothes **Equipment Storage** Most equipment will be stored in people's rooms, however discrete storage of medical equipment (BP monitors, oxygen saturation and standing hoists) is required **Staff requirements** - Lock up bag (code to open) - Individual and team communication solutions - Workstation's for administrative staff - Access to staff lounge - Toilets - Access to staff parent room (breast feeding room)
RETIREMENT COMMUNITY	**People** - Contemporary 1, 2 and 3 bedroom apartments - Separate entrance to the facility through carpark and ground floor - Security supports access between floors to facilitate interaction - Design supports changing needs for the same and new occupants (future flexibility of services and design, home modifications) - Summer Foundation Design Guidelines: https://www.summerfoundation.org.au/designing-for-inclusion-and-independence/ - SF Hunter Housing designs https://www.summerfoundation.org.au/resources/hunter-housing-demonstration-project-apartment-features/ - Smart storage solutions within unit and additional storage solutions - Car parking **Staff** - Retirement apartment design that minimises risks to support workers - Access to tea/coffee and staff lounge facilities - Access to multi-disciplinary consultation room

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	SERVICES
COMMUNITY PALLIATIVE CARE	**Patient and carer needs** - See centred based care (Day Centre, Clinics, Group programs) **Clinical Environment** - See specialist health centred based care (Day Centre, Clinics, Group programs) - Office environment that supports collaborative team work - Quiet and private spaces to facilitate telehealth, clinical supervision of staff and students, private conversations and management functions. - Meeting/handover/education space - Office support facilitates - Food and beverage facilities and staff lounge **Storage** - Consumable store **Equipment store** - Basic kits - Syringe driver kits - Other equipment (blood gas machine, stethoscope, bladder scanner) Access to central storage of patient loan equipment
STATEWIDE	**See centred based care**
PROGRESSIVE NEUROLOGICAL SERVICE (SPNDS)	**Assessment and demonstration facility(PT/OT/SPNDS)** - Space for four concurrent sessions - x2 PT and x2 OT concurrently - Accommodate 3-4 people per session - Provide visual and auditory privacy (larger clinic rooms and shared open space) - Shared Open space - Demonstration equipment for trial - Power wheelchairs (standard, tilt in space) - Manual wheelchairs (standard, tilt in space and transit) - Walking frames (standard, bariatric) - Hoists (standing, floor and sara steady) - Slings (toileting and general purpose) - Electric Lift recliner chair - Electric bed - Commode (standard, tilt in space) - Over toilet frame and bidet - Plinths x 2 - Cupboards - Trolley space for smaller items - Walking rails - Steps - Space for practising driving power wheelchairs (especially for introduction of scanner controls) - Splinting area for making hand splints (table, materials and heating unit) - Technology area with secure storage - Clinic rooms x 2 with ceiling hoist and 2 x plinths **Equipment store** - Access to central storage of patient equipment - OT equipment storage to provide options **Clinical research space** The clinical research space is required to be integrated but in addition to clinic space. Requirements are listed in Education and research

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PROGRESSIVE NEUROLOGICAL SERVICE (SPNDS)	**Staff** - Office environment that supports collaborative team work - Quiet and private spaces to facilitate telehealth, clinical supervision of staff and students, private conversations and management functions - MDT Meeting/handover/education space - Office administration support facilitates (stationary store photocopier, printers, secure and paper bins) - Food and beverage facilities and staff lounge - Access to parent's room for breastfeeding mothers - Toilets - Lockers
PHARMACY	- Pharmacy that meets the Pharmacy Board regulations - Receipt and dispatch area - Dispensing benches and workstations for clinical pharmacists - Medicine storage solutions including stock flow smart solutions, secure store, refrigerator - Clinical trials medicines and protocol storage
DENTIST AND MEDICAL SERVICES	Consultation rooms specific to needs
ALLIED HEALTH	Music therapy storage - accessible to ward, music therapy room and residential care

11.6
Funding Environment

A key enabler is the funding environment. The following outlines key funding streams that will be utilised to provide care, across the care settings. A mix of funding streams will be utilised across the care settings.

11.7
Aged Care

The Aged Care System has the following components:

- Help in your own home - Commonwealth Home Support Program (previously HACC) or Aged Care Packages (Level 1 - Level 4)
- Transition Care (TCP) - Transition care can be provided for a period of up to 12 weeks. This may be extended to 18 weeks if you are assessed as needing more help while in transition care.
- Respite Care
  - Community - in-home, day centre, community outings (previously HACC)
  - Residential care (RRAC)
  - Emergency respite
  - Permanent Residential Aged Care (PRAC) - After entry to permanent residential aged care, people's care needs and health conditions are assessed using the Aged Care Funding Instrument (ACFI).
- Short term restorative care - 8 weeks care provided in the home, community or residential care
- Permanent care – funding is based on the Aged Care Funding Instrument. Changes to how this is applied is expected over the next two years.

Assessment - Assessment for Commonwealth Home Support packages and community respite are completed by Regional Assessment Services (RAS). Aged Care Assessment Team (ACAT) provides assessment for all other services. Waitlisting is common for Aged Care Packages and for vacancies in some Residential Aged Care homes.

All packages approved are transportable with the client to any service provider of their choice.

All services require a minimum payment for care provided, with additional amounts determined by an income assessment.

11.8
NDIS

The National Disability Insurance Scheme (NDIS) has replaced the current disability system to provide individualised support for people with disability, their families and carers.

To be eligible for NDIS a person has to be:

- Under 65 years of age
- A permanent resident or Australian citizen
- Have a permanent disability that impacts their function significantly

Each participant will have an NDIS plan developed based on their needs, goals and aspirations which will be reviewed every 12 months. The plan is developed by the client in conjunction with NDIS health planners to confirm the reasonable and necessary supports that will be funded by the NDIS.

THE NATIONAL DISABILITY AGENCY (NDIA) HAS DEVELOPED 15 SUPPORT CATEGORIES THAT ARE ASSESSED BY THE OUTCOMES FRAMEWORK DOMAIN.

SUPPORT PURPOSE	OUTCOMES FRAMEWORK DOMAIN	SUPPORT CATEGORY (PLAN BUDGETS)
CORE	**Daily Living** **Daily Living** **Daily Living** **Social & Community Participation**	1. Assistance with Daily Life 2. Transport 3. Consumables 4. Assistance with Social & Community Participation
CAPITAL	**Daily Living** **Home**	5. Assistive Technology 6. Home
CAPACITY BUILDING	**Choice & Control** **Home** **Social and Community Participation** **Work** **Relationships** **Health & Wellbeing** **Lifelong Learning** **Choice & Control** **Daily Living**	7. Coordination of Supports 8. Improved Living Arrangements 9. Increased Social and Community Participation 10. Finding and Keeping a Job 11. Improved Relationships 12. Improved Health and Wellbeing 13. Improved Learning 14. Improved Life Choices 15. Improved Daily Living Skills

People under 65 years of age living in residential aged care will be eligible to receive assistance from the Scheme including:

- A planning and assessment conversation and support to explore alternative age-appropriate living arrangements and to make progress towards goals;
- Assistance with care-related costs charged by an aged care provider (excluding daily living expenses or accommodation charges);
- Supports to access age-appropriate social, civic and community activities and sustain informal support networks with family, friends and carers.
- Therapy including allied health supports (e.g. occupational therapy, speech pathology and physiotherapy) which have been shown to improve independence, social and economic participation in the community or to instruct delegated support workers to manage highly complex needs.
- Specialised equipment supports related to a person's on-going functional impairment which are not part of the residential aged care package or which may be provided in the treatment of a medical condition.

11.9 Medicare

Medicare provides funding for a range of supports including:

- General practitioners
- Medical specialists
- Optometrists
- Dental
- Care in public hospitals and some components of treatment in a private hospital
- Lower cost prescriptions
- Telehealth services

Additional funding relevant to the Bethlehem Health and Retirement Precinct people include:

CHRONIC CONDITION PLAN

- GP management plan
- Team Care plan - includes funds for referral to relevant allied health services for a maximum of 5 sessions per calendar year.

HEALTH ASSESSMENT

A medical practitioner can utilise an MBS health assessment item to undertake a more comprehensive assessment of a patient with complex care needs. Health assessments also permit the needs of specific groups (Aboriginal and Torres Strait Islander people, refugees and aged care residents) to be addressed in a targeted and culturally appropriate manner.

DIABETES

People with type 2 diabetes can receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dieticians, on referral from a GP.

CASE CONFERENCING

Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service.

A 'chronic medical condition' is one that has been, or is likely to be, present for at least six months. There is no list of eligible conditions. However, the CDM items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team. Case conferences can be undertaken for patients in the community, for patients being discharged into the community from hospital and for people living in residential aged care facilities.

RESIDENTIAL MEDICATION MANAGEMENT REVIEW

The Residential Medication Management Review (RMMR) is an MBS item for permanent residents of a residential aged care facility (RACF). It involves collaboration between a GP and a pharmacist to review the medication management needs of a resident.

A RMMR is for residents who are likely to benefit from such a service. In particular, it is for residents for whom quality use of medicines may be an issue, or who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

The need for an RMMR can be identified by the resident, the resident's carer or a member of the resident's health care team. However, the resident's doctor must assess the resident and decide whether an RMMR is clinically necessary. As with DMMRs, payment for the review under the MBS will not occur until after the second patient consultation.

GP MENTAL HEALTH TREATMENT PLAN

Assessment and referral to psychology services with funds for up to 10 sessions per calendar year.

MEDICARE SAFETY NET

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

11.10
Private Health Insurance

People can elect to use their private health insurance for specialist health inpatient services without a gap (TBC)

11.11
Specialist Health Services

COMMUNITY PALLIATIVE CARE SERVICES

The Department of Health and Human Services for the provision of community palliative care services based on targets.

STATEWIDE PROGRESSIVE NEUROLOGICAL AMBULATORY SERVICES

The Department of Health and Human Services provides SACS funding based on targets of allied health and nursing contacts.

INPATIENT WARD

The Department of Health provides funding for 16 inpatient specialist palliative care beds and 16 rehabilitation beds.

11.12
Private Funds

People can choose to utilise their own funds to pay for services or to pay for 'gap' fees where appropriate.

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