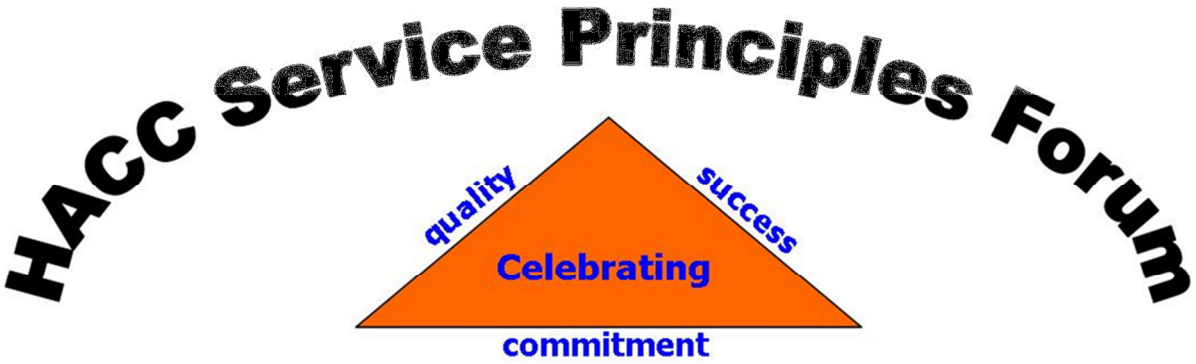


Eastern Collaborative Project (ECP) and Southern Services Reform Group (SSRG) HACC Service Principles Forum

14 December 2011

Introduction

The ECP and SSRG began the planning process of the cross regional HACC Service Principles Forum in March 2011. Both felt that it was imperative to focus on positive outcomes that demonstrated success and saw it as a vehicle to celebrate commitment and quality services in each region.

The principles in themselves are not new and are something that all service providers should be achieving in some form or another. The launch of the HACC Service Principles gives providers a policy document to support the achievement of positive outcomes for users of services

As the service principle forum was to be a celebration of success the planning group mirrored the service principle document and focused on the telling of stories to highlight each principle. Each principle was to have two stories, one from each region (East and South) and the session would also have some workshop type component as well as the opportunity to end the year on a celebratory note as we entered the festive season.

Summary of the Day

The Forum outline was kept simple, again to focus on success/strengths rather than barriers/weaknesses. Some 50 people attended the forum with an equal mix of South and East. In the first part of the forum each principle was presented with a mixture of south/east presenters followed by a 'speed consultation' on the question 'What is the most common theme that has emerged from what you have heard from the presenters so far?' After a short break the principles were again presented with a mixture of south/east presenters and again followed with a `speed consultation' on the question 'What has to change to achieve the principles?'

The concept of `speed consultations' was used because most presentations ran overtime despite being given clear guidelines about time limits but it was important to allow each to tell their story. We triggered the speed consultation to focus the workshop components of the forum to be time limited and outcome driven with a hint of competition and humour to lighten the load.

Raw data from the workshop components are included in the appendix documents of this report. An analysis of the questions suggested the following:

What is the most common theme that has emerged from what you have heard from the presenters so far?

Listening and really getting to know a client is very much the basis on which you can build the achievement of positive outcomes for clients. It is difficult to accurately reflect in words what is meant by listening and getting to know a client. The stories reflected active listening by engaging clients in conversation. Getting to know a client isn't just about data such as their name, address and date of birth and of course chatting about their needs… it's much more and it's important to remember as well.

Quality of life also emerged as a common theme. This could be described as a person's chosen lifestyle and they should be supported to achieve whatever that chosen lifestyle might be. Innovation and creativity support this with a large smattering of flexibility and collaboration. We heard 6 stories describing each principle but overlapping with others, and each story captured these common themes.

What has to change to achieve the principles?

Although the focus on the day was to celebrate success and showcase stories for each of the principles it was clear from feedback that there were some things that needed to change. Attitudinal change seemed a common response and this could be interpreted in a number of ways. Is it the attitude of the Provider? The worker? The client? Or the Funder? Could it be that all need to be supported to change in some way? This is worth further investigation and analysis.

Red tape and bureaucracy points to changes needed from a funding perspective. Menu driven services and time restrictions are changes that can be made by the provider upon negotiating with the funder. Language and listening are changes that a worker can make and the client needs to actively participate as well. Passive participation is disempowering and we need to get clients to actively partner in the process. Maintaining the status quo should no longer be an option.

Instant Consultation using Wordle

Another component of the forum was to ask people to scribe words that came to mind during the presentations that captured the essence of what they heard. These single words were then collated into the one document and a wordle created:

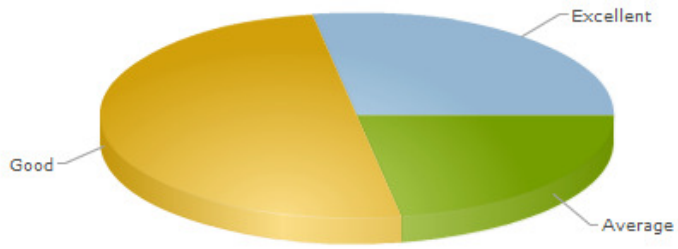
The wordle creatively demonstrates by size of font the most significant and commonly used words to describe the essence of the HACC service principles – choice, individualised, collaboration, respect and flexibility. It is a powerful tool that creates a simple format to capture the essence of what stands out within the principles

Evaluation

The ECP uses an efficient online survey tool that is part of its communication package to evaluate and gather information. This tool is available to any organisation that contributes to regional collaborative activities.

The evaluation of the forum highlighted the success of the day and the questions and data from the evaluation is included in the appendices of this report.

The presenters were rated well with over 77% being rated good to excellent and all being rated above average. Given that many of the presentations ran overtime (some of the comments reflected this) this rating is a good result.



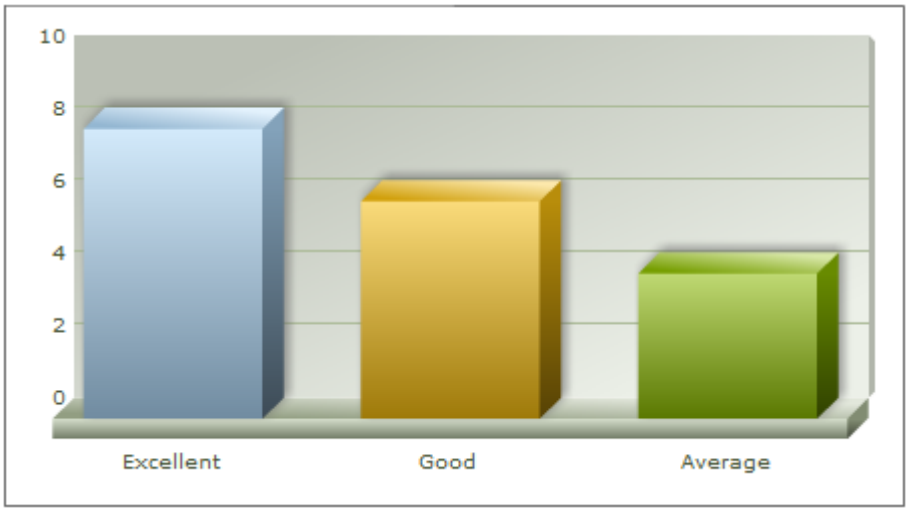
Comments included:

Seeing the passion that so many had to assist people in our communities

Some heart warming stories and job satisfaction presenters felt

The stories were great

The organisation of the day was also rated highly, with excellent feedback to both collaborative projects.



Comments included:

Fantastic effort by both collaborative projects. A real reform activity, and hopefully some change will come out of it.

It was a great afternoon which was well organised.

Well done to Sally and Lui for getting this good-sized group together in an informative and well-paced event.

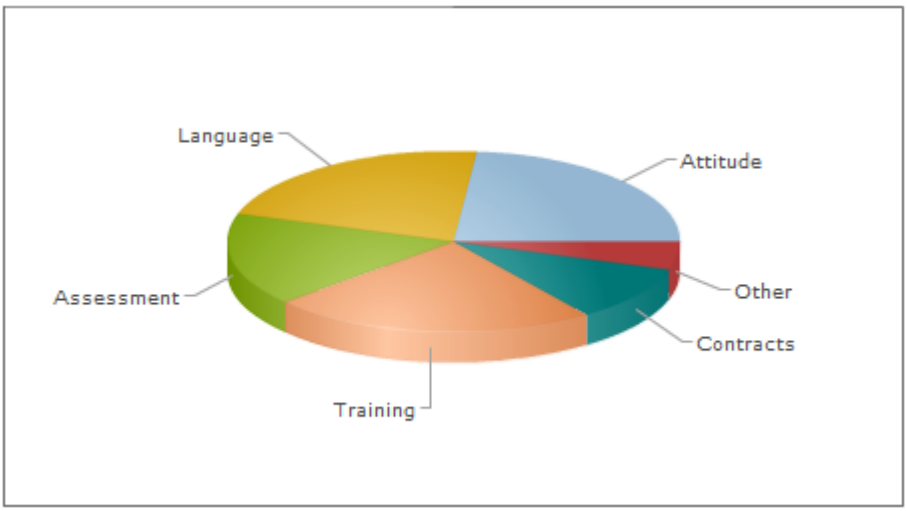
The evaluation also asked the question what would you like to hear more about in relation to the HACC Service Principles?

The following are examples of potential future workshops

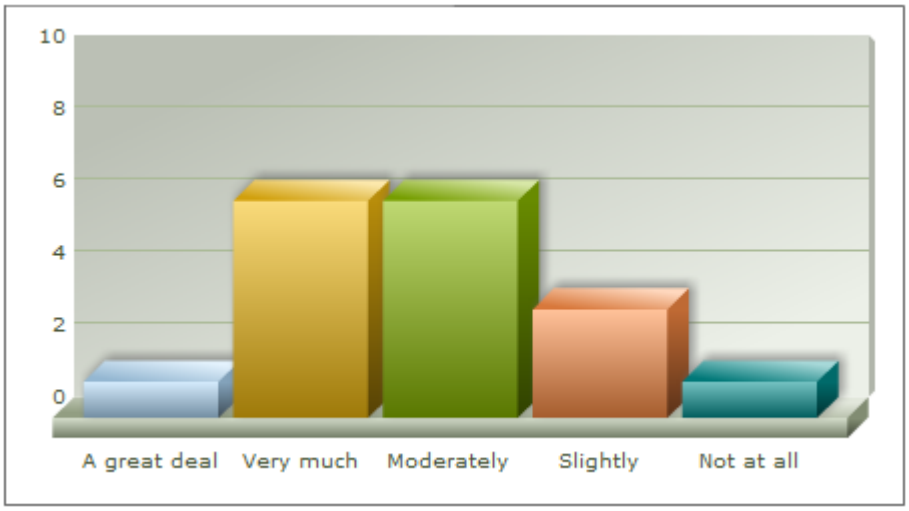
1. How A2HC will be part of the broader HACC service responses and their role in supporting the principles. How can they support cross referral through agencies particularly with enablement assessment and interventions/services?
2. How the service principles have been applied in relation to working with people with dementia.
3. Raising awareness of the service principles across all levels of an organisation. Management can be openly supportive of principles but policies & procedures aren't.
4. The obstructions experienced when putting the principles into practice, and how to overcome these difficulties.
5. How the principles are viewed and experienced from the consumer perspective.

Within the evaluation we also asked the question 'For the HACC Service Principles to be successful, what do we need to CHANGE?'

Checkboxes based on the collected information from the forum were used to establish what people rated as most important to change. Attitude, training and language all scored highly with assessment and contracts also significant.



75% of respondents had a significant increase in their understanding of the HACC service principles following the forum, again highlighting the success of the format and outcomes of the day.



Conclusion

From verbal and written feedback the event was clearly successful with a full capacity of registrations totalling over 50 attendees.

The forum clearly achieved one of the Key Result Areas of the collaborative projects which is to: facilitate stakeholder engagement through a range of regional workshops, forums, events and regional meetings (to facilitate communication between regions and funders/policy makers and support translation of policy ie. HACC Service Principles into practice)

The ECP and SSRG held the joint forum to promote the principles in each region and to identify areas of change. The forum achieved both these outcomes and provided direction for the future.

Clearly 'attitude and language' are two areas that each region can focus on in the future to further promote service reform and should be reflected in plans for 2012/2013

We look forward to bringing further cross regional forums in 2012 and watch out for the innovative sequel titled `How to fit a square peg in a round hole'.

HACC Service Principles : Stories that Demonstrate Success

Principle 1 – Promote each person's opportunity to maximise his or her capacity and quality of life.

a. Ashling O'Boyle (ECH Inc): The story about Mr Pavarotti. Elderly gentleman, paranoid schizophrenia, socially isolated, has memories of delusions and experiences financial difficulties. He makes poor financial decisions and impulsively buys items he doesn't necessarily need. His passion is music, he plays the clavinova and loves opera.

Initially Mr Pavarotti began attending a social program in the city to have a meal. He would sit close to the door but started saying 'hello' to a couple of people. It was suggested that he could attend the University of the Third Age who were delivering sessions on opera. The sessions went for 3 hours and incorporated watching and discussing a particular opera. For success there was some coaching to practice catching the 3 buses that took Mr Pavarotti to the venue. He sat at the back of the room where he felt safest.

The impact of these social engagements was significant to Mr Pavarotti's wellbeing and quality of life, including health factors demonstrated by an improvement in blood sugar levels. This person centred approach ensured that his independence had been optimised.

b. Marie Noble (Anglicare): Presents 3 stories of success – Mrs D (75yrs), Mrs Jackson and Mr M (80yrs).

Thirty years ago Mrs D escaped domestic violence and since then she has been on the move – living in many different places which were never really 'homes', just somewhere she could afford, often small, with no backyard and no privacy.

More than anything Mrs D wanted a home with a backyard and a garden. She wanted to be linked with other people but did not want to join a group. She was presented with options which in itself were a 'big deal'. She had lost the skills to make choices and for the first time she was asked to choose where she wanted to live based on her needs. Her home now has a backyard and with increased confidence she was even able to contact the council to ask for assistance trimming a tree. This was viewed as a huge achievement. In her new home the rent is affordable which has meant she can now afford to buy new clothes and enjoy social visits from a volunteer. The impact of the intervention was considerable – Mrs D was able to rediscover her 'self' worth through relearning to make choices.

Mrs Jackson was a country person who had been living in a large home in an environment where she was well known and could participate in numerous community committees. Due to an age related injury she needed to move to Adelaide to receive appropriate medical treatment. The house she bought did not accommodate all of her furniture and became cluttered, it also needed some renovations. Some of her belongings were left unpacked – it became a situation which left her feeling depressed and with a sense of helplessness. She was also losing contact with her friends.

Mrs Jackson learnt how to ask for help. Some man-power was provided to assist with re-organising things. It was evident that interdependence can lead to independence. She was rediscovering her decision making skills and succeeded in re-establishing herself.

Mr M is 80years old. He wasn't able to open his favourite brand of milk after the manufacturer changed the top. A care worker spent half hour with Mr M devising a new way for him to open the milk bottle. This small intervention had a significant impact to Mr M's overall wellbeing.

Principle 2 – Provide services tailored to the unique circumstances and cultural preferences of each person, their family and carers.

c. Anna Howard (Uniting*Care* Wesley Adelaide): A presentation exploring principle two incorporating a personal, professional and CALD perspective.

Anna's parents are Italian and migrated to Australia 55 years ago, her mother is now 80 years old. She required some in-home assistance and requested someone from an English speaking background which surprised Anna who was expecting her to request a worker who could speak Italian. Her mother's reasoning was she wanted to keep practicing her English - none of her grandchildren or son in-laws can speak Italian and she wants to continue to be able to communicate with them. Her mother is enjoying the regular visits and the relationship between worker and consumer has become reciprocal. The care worker is interested and eager to learn about Italy and her mother is learning more about 'Aussie' culture and was recently delighted to discover that garlic is used by Australians as well as by Italians and Greeks!

d. James Girvan (Carer Support): The story about Super Mum who is 22 years old and has 2 young children, both with complex physical and intellectual disabilities.

In 2010 Super Mum was doing year 12 in a class with other mothers, all wanting to complete school. Carer Support was able to provide a range of assistance including respite, assistance during the birth of her 3rd child and fortnightly volunteer counselling. Through their Carelink Service she was able to be connected to disability advocacy and housing assistance. Carer support staff were also able to assist with providing advocacy in regards to an issue that was happening at school which led to a positive outcome. They were also able to provide a printer so school work could be completed at home, massages to promote wellbeing, car maintenance to ensure easy access to transport and an overnight respite break.

In December 2011 – 14 months on, Super Mum is engaged to be married, finished year 12 and received an award for outstanding achievement. She is now focusing on her own health and wellbeing and has joined a gym. She has become an active member of the Carer Support 'Carer Advisory Group' – a position which she feels is empowering.

Principle 3 – Ensure choice and control are optimised for each person, their carers and families.

e. Pauline Button (ACH): Mrs P is a 68 year old woman who has a background in nursing. She has previously had a hip replacement and suffers from anxiety and asthma. She has difficulty doing her housework and volunteered to manage her own consumer directed care package.

Mrs P wanted to choose who provided her services – she liked having the responsibility of organising services herself and this inspired and motivated her to update her computer skills. She became committed to doing the job well and developed an excel spread sheet to monitor her services. She was so impressed with the consumer directed care program that she wrote a letter to ACH managers explaining how delighted she was to participate in the program and how confident and comfortable she felt managing the care workers who were providing a combination of gardening, housework and home maintenance services. Mrs P became passionate about consumer directed care and developed an optimistic outlook for the future.

f. Carole Matthews (Resthaven): Giving back choice and control to the carer.

The carer support group had its beginnings as an action research project where carer education was offered over a 6 week period. The ideology of the group encompassed self-management principles and persuasion, encouraging carers to make small changes promoting better health and wellbeing through goal setting and action plans. Carers were encouraged to share strategies and to set achievable action plans that created a sense of satisfaction and increased wellbeing. When the carer education course finished the group continued to meet as a support group and another carer education group commenced. Both groups met for relaxation exercises followed by lunch, creating an environment to chat and socialise. The program has led to social connections and friendships outside of the group. The group is still continuing in this successful format.

The Carer Advisory group meets regularly. One carer made the statement 'If only my family and friends knew how to support me.' From this statement the group brainstormed all the information they felt friends and relatives needed to know. The end result was a booklet titled 'With a Little Help…, How family and friends can support a Carer.

Principle 4 – Emphasise responsive service provision for an agreed time period to be reviewed as agreed.

g. Janet Sniedze (Family Home Support Services): A number of scenarios are presented to demonstrate flexible care which is adjusted as required with the client's changing needs.

Mr 89 was discharged for rehabilitation after sustaining a fractured neck of femur. He lives with a carer. He received personal care three times a week but with support and encouragement towards independence the service was no longer required after 3 weeks.

Mr 85 required services for social inclusion and shopping support. His wife had been admitted to a residential care home. He was encouraged to start doing his own cooking which he enjoyed and began enquiring about different ingredients to make different meals. Through this process he now cooks regularly and has increased confidence.

Mr 78 was initially discharged from hospital with services for long term personal care assistance and was experiencing reoccurring urinary tract infections and a high risk of falls. He required standby assistance with showering and domestic help including change of bed linen. As services progressed Mr 78 started going for short walks and was encouraged to attend an exercise class – taxi transport was organised. Nine months later he had improved significantly and could even manage his own Christmas shopping. Exercise has ultimately increased his quality of life, he now enjoys greater independence.

Mrs 93 suffers from arthritis, hand injury, glaucoma and cataracts. She was receiving domestic services. She was admitted to hospital for four months and upon discharge her domestic help continued. To best meet Mrs 93's needs the service remained very flexible. If she felt unwell and was experiencing a lot of pain, workers would assist with personal care and when she was feeling better domestic chores could be done instead. She has just given up driving, she cooks all of her meals and still meets regularly with a close friend.

Mrs Mid 70's weighed only 37kg after being discharged from hospital. She requested shopping assistance but wanted to continue shopping at a favourite specialised shop 10km away. This was organised and continued for 4 years. It allowed greater independence and companionship from the care worker. She eventually moved into a residential care facility.

h. Alison Bowden (City of Onkaparinga): Two stories, one about Mary who is 76 years old and had a fall at home, the second about Beryl who is 82 years and was resisting any assistance from services.

Mary lost her confidence after having a fall and being on the floor for 14 hours before she was found. She was unable to use the community bus because of her injuries and was not eligible for services from other providers. Mary became depressed. She felt old, useless and alone. The Transport and Social Support Program worked with Mary to provide support while she was recovering. This included transport for shopping, bill paying and taking her to exercise and rehabilitation programs with an experienced care worker. Ultimately this intervention helped Mary to regain her confidence and self-esteem. She no longer requires the intensive assistance she initially received and has progressed to a volunteer program which offers social outings with a companion.

Beryl was referred by SA Ambulance. They had been to her home on more than one occasion because Beryl had fallen from her bed. The concern was around occupational health and safety as Beryl's home was cluttered and the bedroom ceiling was in a state of dis-repair. She lived in a semi-rural location and was quite resistant to accepting assistance. The first home visit was essentially about 'getting to know each other'. It was observed that one of the glass panels on the veranda was almost falling out. Beryl was asked if she would like to have it removed which she agreed to but wanted the glass back! They got inside and could see only one clear space – a chair by the front door where the weekly groceries were put when they were delivered. A small pathway led through the house to her bed but was not wide enough to accommodate Beryl's walking frame which she required for mobility. This was a concern but an even more significant issue was the collapsing ceiling – it needed to be fixed. Beryl's family were suggesting that she move to a residential care facility which she didn't want but to stay in her own home the ceiling had to be repaired. The procedure would involve clearing out her bedroom. This was achieved with the help of a care worker and during the process they discovered forgotten treasures, particularly old photographs. Beryl was

ex-army and hadn't been to a reunion for years – with encouragement from the care worker transport was organised and she got to a reunion to meet with old friends.

Work with Beryl continued. The bedroom was cleared, there was some clear bench space created in the kitchen, a clean fridge and a cleared area on the dining room table to work on collating old photographs. The bedroom ceiling was finally repaired and it was 'pigeon poo' that was causing the damage! For some time Beryl was able to stay quite safely in her own home but after some hospital admissions she ultimately made the decision to move to residential care. She made the choice because of constant falls and the realisation that she could no longer stay safely at home. It was her decision. She has now been in care for 2 years. The initial concerns that she would not flourish in these surroundings have been quashed as Beryl is thriving in her new environment.

Principle 5 – Support community and civic participation that provide valued roles, a sense of purpose and personal confidence.

i. Devon Mellows (City of Holdfast Bay): Kevin who likes to sing became a participant in the Life Links Program.

Kevin joined Life Links singing group 7 years ago. Singing has become an important part of his life and in many ways it has changed his life. The group is called the Singing Magpies and Kevin takes on the role as 'main singer'. Being part of this group has improved his health. He has reduced his smoking and has experienced a significant positive impact on his mental health – 'If it wasn't for singing I would have jumped off a bridge.' The singing group meet weekly at the Glenelg Community Centre.

j. Matt Moody (City of Burnside): A story about a 50 year old male with an acquired brain injury who has an interest in art and art based activities.

Information technology assisted with the process of finding a community based art program for this artistic gentleman. On the YMCA website the word ART was typed in and all art programs available were identified. There were 40 programs across the Adelaide metropolitan area. One was identified as being the most appropriate and for the first session a care worker went with the gentleman. The program focus was painting landscapes and out of the 10 people enrolled in the class he already knew 2 of them. He loved the experience and continued to attend regularly each week. The final outcome has been very positive – his work has been exhibited and he is selling some of his paintings.

Principle 6 – Provide appropriate workforce training and development.

k. Di Savvas (Domiciliary Care): How to build a sustainable training model that inspires people and changes how they think.

A meeting with a consumer diagnosed with younger onset dementia prompted the development of this project when it became clear that the consumer was committed to sharing her story. She agreed to work with Staff at Domiciliary Care to make a film about her experiences, to answer questions – the tough questions, and getting to the heart of the matter. The film is being professionally

produced and will be available for workers in the sector to view. It will be used as an educational tool and will be beneficial for in-house training.

l. Bronwyn Harding (ACH): Mrs Smith is 85 years old and suffers from chronic illness and depression. She has lost her husband and has down-sized, having moved to a smaller property. She was referred for domestic services.

Mrs Smith was receiving weekly house cleaning and gardening. During a regular review it was revealed that she was not happy with services and she knew that she had been labelled a difficult client. She was a lady who was used to being in control but that control had slipped away. Things had gone missing – a necklace, a table cloth, and there was an excess water bill – the gardener must have left the tap on! She was grieving. The new house was in a new area, in a new community. She hadn't unpacked much so a care worker was engaged to help with unpacking. Together they began rediscovering things. They found the computer which with the help of the care worker was set up and internet connected. She was now able to email family who lived interstate and was given support to visit friends that she had lost contact with. Life changed for Mrs Smith. She is now connected with her new community, she is enjoying bread making, has become a member of an advisory group and is planning to visit her relatives in Melbourne.

What was different in this service provision? Recruitment is very important. A shared vision is vital across the organisation, including management. All staff and volunteers need to understand creative community practice. Training plays a pivotal role for this to work – for example, 'Living as an Older Person' (Better Practice Project) and being informed about what's in the community for older people to access.