TEACHING AGED CARE FACILITIES:
IMPLEMENTING INTERPROFESSIONAL PREVOCATIONAL
EDUCATION AND PRACTICE IN RESIDENTIAL AGED CARE

Andrew Robinson, Emma Lea, Laura Tierney, Catherine See, Annette Marlow
Claire Morley, Jan Radford, Amanda Lo, Fran McInerney
Michael McCall & Claire Eccleston

December 2013

ISBN 978-1-86295-933-0 (e-version)
ISBN 978-1-86295-932-3 (paper)

Correspondence: Professor Andrew Robinson, Wicking Dementia Research and Education Centre, Private Bag 143, Hobart, Tasmania, Australia 7001
Contents

1  Preamble—The Burning Issue ................................................................. 1

1.1  Background Research ........................................................................... 2
1.1.1  Study 1—Pilot Data: Feasibility of a quality clinical placement program in aged care .......... 2
1.1.2  Study 2—Defining essential components of a quality clinical placement program ............ 3
1.1.3  Study 3—Refinement of the quality clinical placement program ........................................ 3
1.1.4  Study 4—Assessment of the sustainability of gains .............................................................. 3
1.1.5  Study 5—Developing the Evidence Based Best Practice Model (EBBPM) Program ............ 3
1.1.6  Findings from subsequent studies ......................................................................................... 5

1.2  Wicking Prototype Teaching Aged Care Facilities (TACF) Program ............... 5
1.2.1  Whole of organisation approach ......................................................................................... 6
1.2.2  Six stages of the Wicking Prototype TACF Program .......................................................... 7

1.3  Key Foci of the Clinical Placement Curriculum ............................................ 10
1.3.1  Inter-professional learning—IPL ......................................................................................... 10
1.3.2  Dementia palliation .............................................................................................................. 11

2  Implementing Placements around the Evidence Based Best Practice Model (EBBPM) ............................................................................. 13

2.1  Establishment ......................................................................................... 13
2.1.1  Partnerships need momentum ......................................................................................... 13
2.1.2  Program governance ................................................................................................. 13
2.1.3  Curriculum ............................................................................................................... 13

2.2  Preparation ............................................................................................ 14
2.2.1  Building links and creating a collaborative infrastructure ................................................. 14
2.2.2  Operationalising placement preparation ............................................................................. 16
2.2.3  Facility preparation—Placement organisation and resource development ......................... 19
2.2.4  University based preparation of students and resources .................................................... 21

2.3  Support on Site ....................................................................................... 26
2.3.1  Student orientation ................................................................................................. 26
2.3.2  Developing a structured placement schedule/program ....................................................... 27

2.4  Ongoing Evaluation ............................................................................... 34
2.4.1  Clinical stream evaluation ............................................................................................ 34
2.4.2  Organisational stream evaluation ...................................................................................... 35

2.5  Conclusion .............................................................................................. 36

3  References ............................................................................................... 40

4  Appendices ............................................................................................... 45

4.1  Appendix 1—Sample Mentor Leader Position Description: University School and RACF .... 45
4.2  Appendix 2—Sample Pre-site Visit Agenda .................................................... 47
4.3  Appendix 3—Sample Memorandum of Understanding ............................................... 50
4.4  Appendix 4—Example of Nursing Student Learning Objectives ................................. 58
4.5 Appendix 5—Example of Medical Student Learning Outcomes ........................................ 59
4.6 Appendix 6—Example of Paramedic Student Learning Outcomes .................................. 61
4.7 Appendix 7—Example of Tool Developed by RACF Staff to Facilitate their Involvement in the Assessment of Nursing Students’ Competency During the Clinical Placement .... 62
4.8 Appendix 8—Dementia/Palliation Presentation .................................................................. 64
4.9 Appendix 9—Orientation Checklist Used for Wicking TACF Program ............................ 90
4.10 Appendix 10—Sample Nursing Student Placement Program ........................................ 92
4.11 Appendix 11—Sample Paramedic Student Placement Program ..................................... 93
4.12 Appendix 12—Sample Medical Student Placement Program ....................................... 95
4.13 Appendix 13—Example IPL Activity- Multiple Student Groups ..................................... 96
4.14 Appendix 14—Example IPL Activity- Medical Students ................................................ 98

List of Figures and Tables

Figure 1: Diagrammatic Representation of the Draft Evidence Based Best Practice Model .......... 4
Figure 2: Six Stages of the Wicking Prototype TACF Program .............................................. 7
Figure 3: Placement Preparatory Model .................................................................................. 17
Table 1: Mentor Preparation Meetings ................................................................................... 20
Table 2: Student Preparation .................................................................................................. 23
Table 3: Description of Components of the Wicking TACFP Surveys ..................................... 37
Figure 4: Quantitative Evaluation Schedule for Wicking TACFP ........................................... 39
Glossary

AIHW - Australian Institute of Health and Welfare
DoHA – Department of Health and Ageing
EBBPM – Evidence Based Best Practice Model
EN – Enrolled Nurse
IPL – Inter-professional Learning
PEP – Professional Experience Placement
RACF – Residential Aged Care Facility
RN – Registered Nurse
TACF – Teaching Aged Care Facility
UTAS – University of Tasmania
WDREC – Wicking Dementia Research and Education Centre

Acknowledgements

The authors would like to acknowledge the contribution of the funding body, which supported this project, namely the Victoria and Tasmania Dementia Training Study Centre (previously known as TIME for dementia).

We also wish to acknowledge the many people involved in the Teaching Aged Care Facilities Program.

Investigators: Professor Andrew Robinson, Dr Catherine See, Dr Emma Lea, Dr Marguerite Bramble, Annette Marlow, Dr Sharon Andrews, Professor Fran Mclnerney, Professor Denise Fassett, Jo-Ann Jones, Michael McCall, Associate Professor Jan Radford, Associate Professor Erica Bell, Dr Claire Eccleston, Dr Brigit Stratton, Claire Morley, Professor Barbara Horner, Professor Isabelle Ellis, Dr Elaine Crisp, Fulton Smith, Dr Kate-Ellen Elliott, Dr Michael Annear, Dr Peter Lucas and Dr Megan Stronach.

Wicking project team: Olive Schmid, Imogen Jones, Ron Mason, Dr Chona Hannah, Zoe Hingston

Collaborators at Curtin University: Rebecca Osseiran-Moisson and Denise Griffiths

Collaborators at the Australian Catholic University (Vic): Cathy Donohue

GP tutors: Dr Amanda Lo, Dr Jane Fuller, Dr Paul Hanson, Dr Stuart Guest, Dr Rosemary Ramsey, Dr John Fisher

Mentors and mentor leaders at the participating facilities.
1. Preamble—The Burning Issue

Australia currently faces multiple challenges in providing high quality care in residential aged care facilities (RACFs). The resident population is rapidly moving to higher levels of dependency with an associated increase in care needs (Andrews-Hall, Howe et al. 2007). This trend is set to escalate as the ageing of the population intensifies and reliance on community care for all but the most dependent elderly people becomes the norm. Given estimates that 80% of residents now in high care facilities have some form of cognitive impairment/dementia (Andrews-Hall, Howe et al. 2007), it is arguable that into the future, high care RACFs will have a growing role in providing sub-acute end of life dementia care. Hence the focus of this project on developing curriculum content to facilitate student knowledge and understanding around the care of people with dementia living in RACFs.

The increasing demand for skilled care in RACFs has been accompanied by a growing shortage in the nursing aged care workforce. The 2012 Aged Care Workforce Report (King, Mavromaras et al. 2012) notes that the proportion of Registered Nurses (RNs) in the sector has declined from 21% of the direct care workforce in 2003 to 16.8% in 2007 and 14.9% in 2012. The report also makes it clear that residential facilities are increasing their reliance on unregulated workers providing care to our frail elders with their proportion of the workforce increasing from 58.5% to 68.2% in the same period. This is compounded by the fact that the aged care environment does not appear to offer strong career pathways for qualified staff so recruitment and retention are significant problems.

The trend of increasing dependency combined with a decreasing skill set raises questions as to how we will ensure that increasingly dependent residents, many of whom have dementia, receive appropriately skilled care.

This scenario dictates a rethink of the future for aged care. We need to build the capacity of RACFs to respond to a complex and changing future and, in the process, recruit and retain a new generation of highly skilled practitioners. The ongoing viability of RACFs depends on a high quality sustainable workforce and talent pipeline. Creating positive learning experiences for students across all disciplines is a central concern because the evidence clearly indicates that the clinical placement itself is “seminal” in determining students’ future employment choices (Andrews, Brodies et al. 2005). Yet residential aged care facilities remain unpopular as sites for clinical training (Happell 2002).

A key issue is a lack of capacity within RACFs to provide students with a positive placement experience, which stems from a complex mix of individual, team and organisational capability issues (Robinson, Cubit et al. 2004; Robinson, Cubit et al. 2004; Abbey, Abbey et al. 2006; Robinson, Andrews-Hall et al. 2007; Robinson and Cubit 2007; Robinson, Abbey et al. 2009; Robinson, Andrews-Hall et al. 2008). Some issues include poor training of, and recognition for, aged care mentors, inadequate orientation to facilities, limited support and supervision and poorly developed partnerships between universities and aged care organisations (Robinson 2009). To support the transition of RACFs into the 21st century we must create an environment to attract leaders who will facilitate high performance cultures at a whole of organisation
level. Part of this process will involve breaking down organisational isolation of RACFs (Andrews, Lea et al. 2012) to forge new relationships and networks that will support the delivery of evidence based care. A key strategy to break down the isolation of the aged care sector is the development of formalised partnerships between universities and aged care organisations. This will become the magnet that attracts committed doctors, nurses and allied health professionals and business leaders to choose aged care environments as preferred workplaces. This is critical to ensure our future workforce has the knowledge and skills necessary to provide evidence based care to people with dementia resident in RACFs.

1.1 Background Research

Members of the Wicking Dementia Research and Education Centre (WDREC) have been working on developing strategies to support capacity building in aged care environments for over ten years. This work has focussed on developing a model of evidence based aged care nursing placements (see below) (Robinson and Cubit 2005; Robinson, Venter et al. 2005; Abbey, Abbey et al. 2006; Robinson, Abbey et al. 2006; Andrews-Hall, Howe et al. 2007; Robinson, Abbey et al. 2007; Robinson, Andrews-Hall et al. 2007; Robinson and Cubit 2007; Robinson, Andrews-Hall et al. 2008; Robinson 2009; Robinson, Abbey et al. 2009; Robinson 2011); falls practice (Haralambous, Haines et al. 2010; Moore, Hill et al. 2011; Andrews, Lea et al. 2012; Haines, Nitz et al. 2012; Lea, Andrews et al. 2012; Nitz, Cyarto et al. 2012); and, dementia palliative care (Andrews, McInerney et al. 2009; Toye, Robinson et al. 2012; Toye, Lester et al. 2014).

The Wicking Teaching Aged Care Facilities (TACF) program, which underpins this document, has been developed as a result of comprehensive preliminary studies, which are outlined below.

1.1.1 Study 1—Pilot Data: Feasibility of a quality clinical placement program in aged care

Between 2001 and 2002 two cohorts of nursing students (n=26) participated in three-week clinical placements in two RACFs with the involvement of 15 nurse mentors. Using an action research methodology (Street and Robinson 1995), students on placement and their mentors participated in weekly parallel meetings, where they explored their experiences of learning and teaching. A feedback loop between the two groups enabled participants to give non-threatening feedback on key issues (Guba and Lincoln 1989). Participation in these weekly meetings helped both students and mentors to interrogate their practice and in the process develop, implement and evaluate strategies to foster evidence based teaching and learning (Robinson, Cubit et al. 2003). The project evaluation demonstrated a positive change in students’ attitudes to working in aged care and confidence in caring for residents with dementia. Simultaneously nurse mentors reported greatly increased confidence and capacity to effectively support students on clinical placement (Robinson and Cubit 2005; Robinson and Cubit 2007). These findings provided the basis for development of the Evidence Based Best Practice Model (EBBPM) program.
1. **Preamble- The Burning Issue**

1.1.2 **Study 2—Defining essential components of a quality clinical placement program**

An action research approach was again used to scope the issues that impact on student learning. This project, Building Connections in Aged Care, was funded by the Department of Health and Ageing (DoHA) and implemented in six Tasmanian RACFs, who also contributed funding. It involved four second year nursing students undertaking a three week placement in each facility. The findings illustrated the limited capacity of RACF staff to effectively support students on placement despite their attempts to implement the program. They also highlighted students’ lack of preparation for practice in aged care (Robinson and Cubit 2007), inadequate orientation to the RACFs (Robinson, Andrews-Hall et al. 2008), poor learning experiences during the placement (Robinson, Andrews-Hall et al. 2007), ill-informed support from mentors around the care of people with dementia, and lack of opportunity to engage with residents, all of which had a negative impact on their placement experience (Robinson, Cubit et al. 2004).

1.1.3 **Study 3—Refinement of the quality clinical placement program**

Study 3 implemented a reconfigured program with a second cohort of students in the same six RACFs, using the same methodology. Refinement included a comprehensive placement planning exercise, revision of information provided to RACFs by the university, development of a standardised orientation program, reconfiguring the placement to promote student continuity with both residents and mentors, and the development of resources and arrangements to support student learning. These changes resulted in a marked improvement in student possible/definite interest in working in aged care as well as improvements in orientation (Robinson, Andrews-Hall et al. 2008), students’ sense of feeling supported (Robinson and Cubit 2007), and the effectiveness of teaching and learning (Robinson, Andrews-Hall et al. 2007). Staff also reported increased confidence as mentors, greater capacity to support students and facilitate teaching and learning and that participation had improved the development of professional practice (Robinson, Cubit et al. 2004).

1.1.4 **Study 4—Assessment of the sustainability of gains**

Study 4 assessed the sustainability of gains achieved in the previous stage, where the program was implemented with a third cohort of students, with greatly reduced input from the research team (Robinson, Venter et al. 2005). A subsequent follow-up evaluation involving both intervention RACFs and a control group was then undertaken (Robinson, Andrews-Hall et al. 2006). The findings highlighted high-level sustainability in the context of limited research support and the vulnerability of RACFs to changing circumstances (Robinson, Andrews-Hall et al. 2007).

1.1.5 **Study 5—Developing the Evidence Based Best Practice Model (EBBPM) Program**

Subsequently, the Department of Health and Ageing funded a national four state study, Modelling Connections in Aged Care (Robinson, Abbey et al. 2006). The purpose of this study was to determine the national applicability of findings from Studies 1-4 (referred to above) and collate the evidence to develop a comprehensive Evidence Based Best Practice Model
1. Preamble- The Burning Issue

(EBBPM). The project was conducted during 2005–2006 and involved undertaking the first systematic review of aged care clinical placements (Abbey, Abbey et al. 2006) and a program of surveys and focus group discussions with nursing students and aged care staff in 12 RACFs across the four states was undertaken (Robinson, Abbey et al. 2006). The systematic review revealed that there are no high level evidence-based models for undergraduate clinical placements in RACFs and that clinical education in nursing generally is informed by what is at best a low level evidence base. Consistent with the findings of study 2, and despite differences in terms of size, location, available support and staffing level, the findings revealed a comparable lack of capacity within the RACFs to support students on placement. They also confirmed that students’ placement experiences were characterised by fear and anxiety and a subsequent negative disposition towards working in RACFs. The model developed as part of study 5 covers all the steps necessary to the introduction, maintenance and ongoing evaluation of quality clinical placements for undergraduate students in aged care settings. Figure 1 provides a diagrammatic representation of the model.

![Figure 1: Diagrammatic Representation of the Draft Evidence Based Best Practice Model (Robinson, Abbey et al. 2006)](image-url)
1. Preamble - The Burning Issue

1.1.6 Findings from subsequent studies

As outlined above, the Wicking Centre has also conducted a range of studies, which aimed to develop evidence based practice in RACFs using an action learning/action research approach.

The first of these projects employed this approach to develop evidence based falls practice in RACFs (Haralambous, Haines et al. 2010; Moore, Hill et al. 2011; Andrews, Lea et al. 2012; Haines, Nitz et al. 2012; Lea, Andrews et al. 2012; Nitz, Cyarto et al. 2012). This project was funded through DoHA Encouraging Best Practice in Aged Care: Funding Round 1 program.

A second stream of research involved two projects funded through the DoHA Local Palliative Care Grants: Round 5. Both these projects aimed to develop capacity within the aged care sector to provide a palliative approach to the care of people with dementia in RACFs (Andrews, McInerney et al. 2009; Toye, Robinson et al. 2012; Toye, Lester et al. 2014).

These projects all had a dominant clinical focus. That is, the focus of the action research effort to develop evidence based practice primarily centred on working with clinical staff. Organisational managers were very supportive of the projects and were involved in negotiating staff involvement, facilitating activities and receiving reports on progress and outcomes.

Together with our work in developing clinical placements (projects 1–5 cited above), these projects all achieved commendable outcomes, reported in the papers and presentations cited previously. Once projects had concluded, however, the sustainability of impacts diminished over time. As we have noted elsewhere (Robinson 2009), despite the best intentions, a history of entrenched hierarchy, operational division and the stress of operating in an environment where impending crises often loom large; limiting the capacity of RACFs to respond effectively, and thereby ensure sustainability of achievement. This analysis directly informed the development of the Wicking TACF Program.

1.2 Wicking Prototype Teaching Aged Care Facilities (TACF) Program

As outlined above, the Wicking Prototype TACF program developed out of our previous research work, recognises that to achieve sustainability in evidence based practice within aged care contexts requires the implementation of a whole of organisation approach to change.

With this in mind the Wicking Prototype TACF program involves the concurrent implementation of: (i) an organisational stream designed to drive the development of a high performance organisational culture; and (ii) a concurrent clinical stream designed to facilitate evidence-based inter-professional aged care clinical placements.

Through implementing whole of organisation change the Wicking Prototype TACF program aims to:

1. Provide groups of inter-professional students with a positive placement experience to develop a more positive attitude to working in/engaging with aged care.
1. Preamble- The Burning Issue

2. Build organisational and leadership capability within aged care facilities to both support students’ professional education and drive a high performance culture across the organisation.

3. Create an organisational environment conducive to establishing a teaching aged care facility.

The WDREC utilised the Evidence Based Best Practice Model (EBBPM) of quality aged care clinical placements, developed in the Modelling Connections project (study 5), in the design of the Wicking Prototype TACF program. This program was conducted in two Tasmanian mid-sized, stand-alone, RACFs between March 2011 and June 2013. In the Wicking Prototype TACF program medical, nursing and paramedic students’ placements overlapped to facilitate inter-professional engagement and shared experiences of learning and teaching. There was also a significant increase in the numbers of students on placement—from six nursing students annually to over 80 medical, nursing and paramedic students per year in each of the two Prototype TACFs, a more than 1200% increase.

Hence the focus of this document is the development of curricula for nursing, medical and paramedic students who participate in large-scale clinical placements in RACFs. However, the principles can also be applied to other groups of students.

1.2.1 Whole of organisation approach

As outlined above, the Wicking Prototype TACF program drives a whole of organisation change process that involves the concurrent implementation of two distinct, though inter-related, intervention streams:

1. The Clinical Stream involves the implementation of an innovative, mentor-based inter-professional clinical placement program adaptable to the needs of students from a range of health care disciplines. The program is informed by the EBBPM of quality clinical placements in aged care, developed through a range of preliminary studies (Robinson and Cubit 2005).

2. The Organisational Stream involves the implementation of a program of organisational design and leadership capacity building to enable the development of a high performance culture within the RACFs and the successful implementation and embedding of the EBBPM. The organisational stream of the program is predicated on evidence that:
   • developing student placements is an effective strategy to engage RACF staff and managers in capacity building and clinical leadership processes; and
   • positive placement experiences are generally associated with a positive organisational culture and strong leadership and business processes.

Enhancing organisational capability, and ultimately organisational performance, as a mechanism for improving outcomes within the sector supports the work undertaken in relation to student placements and mentoring through an integrated program approach. During the early stages of the program, an organisational review was undertaken, which focused on identifying organisational imperatives that would support or counter the successful implementation of the mentor-based RACF clinical placement program. Data collection and analysis of the organisational context of the facility in the context of the Wicking prototype
1. Preamble- The Burning Issue

TACF program took approximately six days of consulting using the adapted Burke-Litwin Organisational Design and Development Model (Burke and Litwin 1992). Subsequent to this organisational review there was a focus on engaging RACF staff and leadership to build capacity within the RACF, positively influence attitudes to working in aged care and build a consistent high performance culture across the organisation. It was envisaged that developments in these areas would better equip facilities to effectively support students during clinical placements.

It would be unrealistic not to expect some sensitivity when an organisation is asked to lay bare its challenges in driving high performance within such a challenging sector; yet the desire for a positive future of partnership is clearly strong in the environments studied to date. Engaging in honest dialogue in relation to the targets set, the benefits to be gained and the investment of time, energy and resources required to achieve success for all involved is an ongoing responsibility of all those guiding the program. Considering all elements of organisational culture and performance is the only way to ensure a united approach to achieving the desired outcomes.

1.2.2 Six stages of the Wicking Prototype TACF Program

Implementation of the Wicking Prototype TACF Program involved six stages. These are described below and illustrated in Figure 2.

Figure 2: Six Stages of the Wicking Prototype TACF Program

Stage 1: Discovery—Preparation

The Discovery/Preparation stage is the time the aged care stakeholders engage with the program and develop their capacity and capability to support large-scale inter-professional student placements. Stage 1 of the organisational stream involves an organisational review led by an organisational consultant, which focuses on identifying organisational imperatives.
that would support or counter the successful implementation of the mentor-based RACF clinical placement program. The Discovery process set out a plan of action to address issues such as: (i) strategic alignment; (ii) leadership development; (iii) implementation of new work processes and practices; (iv) developing change and communication strategies; and (v) a clarification of role accountabilities and workforce architecture. As the program rolls out across subsequent stages (see below) the organisational consultant engages with the organisational leaders and members of the mentor group approximately every two months, alongside monthly phone or Skype contact with key leaders in each facility. In these sessions the agreed action plan is reviewed and updated, and strategies to address barriers to achievement are discussed and developed.

We highly recommend that Organisational Stream activities take place but recognise that this may not be feasible in all environments in the context of resource constraints. It must be recognised that our evidence, referred to above, highlights that an inability to undertake an organisational intervention will most probably compromise the sustainability of improvement achieved in the clinical stream, which is outlined below.

Stage 1 in the clinical stream involves establishing a mentor group with 10–12 members in each RACF. Within this group a Mentor Leadership Group is identified, comprising at least three members and a leader appointed according to the position description (see Appendix 1). Members of the mentor group participate in ten preparatory sessions (see section 2.2.3), facilitated by an academic familiar with action research/action learning methods. During these meetings mentors are supported to scope the issues that might impact on their capacity to implement the EBBPM program, participate in activities designed to stimulate their engagement with the research and develop action plans to address identified issues and concerns that might impact on their role as mentors.

The clinical hook underpinning the clinical stream is ‘dementia palliation’, which reflects the fact that up to 80% of residents can have dementia (Andrews-Hall, Howe et al. 2007), and that it is not uncommon for over 30% of residents to die in any one year (Australian Institute of Health and Welfare 2012). Hence the care of people with dementia, and configuring care within a palliative approach, provides an ideal focus for the students practice while on placement.

Stage 2: Run In- First Student Placements

The Stage 2 ‘Run In’ begins when the first group(s) of students commence clinical placements in the RACFs. This is a highly preliminary and evaluative stage, hence the title ‘run in’, intended to inform the subsequent delivery of the program to the second cohort of students (in Stage 4). It provides an opportunity for the RACF mentor group members to: (i) engage further with the action learning process and the often unfamiliar process of developing an evidence-based approach to their practice as mentors to students; and (ii) identify the key barriers to successful implementation of the program both at an organisational and a practice level. As far as practical, placements are configured to overlap in order to facilitate inter-professional learning (IPL), although this will require close liaison between the respective schools, which place the students in the RACFs (see section 2.2.2). Consistent with the EBBPM,
implementation of on-site student support includes a pre-placement site visit (see Appendix 2), students’ participation in a dementia palliation workshop, and a range of other preparatory activities. These activities are implemented through site-specific action plans, which are developed as part of mentor engagement in the action research process during the ten preparatory meetings in Stage 1.

**Stage 3: Review and Strategy Design**

The Review and Strategy Design of Stage 3 is critical to realising the intent of the action research/action learning method that underpins the Wicking TACF model. The evaluation approach is documented in section 2.4. The evaluation operationalises the collaborative intent of the approach that underpins the Wicking Prototype TACF program model, by providing the respective RACF and university stakeholders with access to evaluation findings prior to the arrival of the second cohort of students, in Stage 4. This involves collection of data in Stages 1–2, analysis of the data in Stage 3, and subsequent presentation of the findings to RACF and respective School staff at scheduled meetings. The presentations are followed by a series of activities, which involve both RACF and School staff developing action plans to embed gains and address issues and concerns prior to the arrival of the second cohort of students in Stage 4.

**Stage 4: Trial/Prototype Phase of Second Student Placements**

In the Clinical Stream the members of the mentor group in each RACF implement local-specific action plans, designed to address issues and concerns identified in the Stage 3 evaluation, with a second cohort of students. At the same time, in the Organisational Stream the leadership consultant works with the RACF executive team to reconfirm strategic organisational priorities for change during this next phase of the program. A particular focus is increasing the involvement of non-clinical senior leaders in the strategic change that would be required to ready the organisation for TACF status—including requisite governance and structural considerations, communication and change management considerations and any particular resourcing issues to be addressed. It is also important to note that changes to curricula initiated within the respective Schools in response to the Stage 3 evaluation findings are also implemented.

**Stage 5: Second Review and Strategy Design**

In this stage, Stage 4 evaluation data are analysed, with a confidential report produced that includes a comparison of Stage 2 and 4 cohorts and recommendations for the future. Similar to Stage 3, the findings are presented to RACF and respective School staff at scheduled meetings and the respective groups then take action to address issues and concerns identified and to consolidate gains made in Stage 4.

**Stage 6: Consolidation**

The Consolidation Stage provides the opportunity for the university and RACF partners to consider the gains made and effort needed to develop to a point where establishing a TACF
might be possible. This involves replication of Stages 2–5 with additional cohorts of students involved in clinical placements.

1.3 Key Foci of the Clinical Placement Curriculum

Two key foci were identified for the clinical placements. These foci were informed by the existing literature on student education, clinical placements and the context of the aged care sector. These foci are inter-professional learning and, as referred to above, dementia palliative care.

1.3.1 Inter-professional learning—IPL

Contemporary health care is characterised by increasing complexity; in particular, the care and management of frail elders with their associated co-morbidities demands a co-ordinated multidisciplinary health team response (Hammick, Freeth et al. 2007). Inter-professional education and learning has been promoted as a mechanism to enhance such a coordinated response and is suggested to result in improved health care delivery (Hammick, Freeth et al. 2007). RACFs provide students with an ideal environment to develop their knowledge and skills related to inter-professional practice in the context of providing care to frail elders.

IPL can be understood as “learning that arises from interaction between members (or students) of two professions” (Nisbet, Lee et al. 2011:5). This may take place spontaneously in the workplace or educational setting or through organised and structured inter-professional education (ibid). Successful implementation of IPL requires collaboration between the health and education sectors, particularly amongst the leadership of the university, health service and local clinicians (ibid).

Although there is growing recognition of the need for IPL, the education of health professionals is still typically conducted in silos (Thistlethwaite and Nisbet 2007). Existing structures and practices including different models of learning, teaching and supervision facilitate this specialisation and act as a barrier to teamwork (Braithwaite, Westbrook et al. 2007; Nisbet, Lee et al. 2011). An increasing interest in IPL in Australian universities has resulted in an increase in IPL activities particularly in terms of clinical placement programs, the rural setting, establishment of clinical educator positions and campus based opportunities (Dunston, Lee et al. 2009; Nisbet, Lee et al. 2011). However, in general, IPL activities and initiatives in Australian universities are not embedded in the curricula, formally evaluated or coordinated with other IPL efforts (Dunston, Lee et al. 2009; Nisbet, Lee et al. 2011). Further, our work shows (Robinson, Abbey et al. 2006) little evidence of multi-disciplinary practice in RACFs, which—taken with the above mentioned isolation experienced by aged care staff (Andrews, Lea et al. 2012; Lea, Andrews et al. 2012)—means IPL or inter-professional practice is unfamiliar to many aged care staff. Given the siloed nature of much undergraduate health professional education it is probable that many academic staff also have a limited understanding or experience of IPL (McNair 2005). Our current program, conducted across universities in three states, certainly indicates that this is the case.
1. Preamble- The Burning Issue

The limited engagement among the stakeholders with inter-professional learning means that initiating IPL activities is often unfamiliar to all parties, so considerable planning, time and resources need to be applied to this activity (see section 2.3.2 for details).

1.3.2 Dementia palliation

Dementia is assuming increasing prominence in the delivery of health care services. Consistent with increasing population longevity, the incidence of dementia in Australia is rising sharply. Dementia is the third leading cause of death in Australia and the second leading disease burden for people aged 65 or over (Australian Institute of Health and Welfare 2012). The proportion of people with dementia is expected to treble by 2050 (World Health Organization and Alzheimer's Disease International 2012).

In RACFs the impact of dementia and an ageing population is huge, particularly over recent years. In 1999, 49% of permanent residents were aged 85 years and over and by 2009, this proportion increased to 55% (Australian Institute of Health and Welfare 2010). Over time an ageing population is also associated with increasing dependency (Andrews-Hall et al, 2007), with more of those admitted to RACFs remaining until the end of their life. The Australian Institute of Health and Welfare (AIHW) reports that death is the major reason for separation from permanent care, with the proportion of separations due to death increasing from 76% in 1998/99 to close to 88% in 2008/09 (AIHW, 2010). This means that residential aged care increasingly involves the provision of end-of-life care (Andrews-Hall et al, 2007), which in turn highlights a need to focus attention to providing a palliative approach to care provision.

In RACFs a central factor escalating the impact of this change has been the increasing numbers of residents with dementia. Surprisingly, the AIHW did not report the incidence of dementia in the annual aged care statistical overview reports until the 2007/08 report, published in 2009. At this time they noted that around half of all residents had a diagnosis of dementia (AIHW, 2009), although the most recent estimate suggests by 2008/09 this percentage had risen to 60% (AIHW, 2010).

As a life-limiting condition, dementia requires a long-term, palliative approach to care (Department of Health and Ageing 2006; Department of Health and Human Services 2008). Despite publication of best practice guidelines (Mitchell, Teno et al. 2009) and models of care (Tasmanian Palliative Care Service delivery model (Di Guilio, Toscani et al. 2008)), many poor palliative care outcomes remain for people with dementia. For example, evidence indicates that 40% of people with advanced dementia resident in aged care facilities experience burdensome and inappropriate interventions and inadequate pain and symptom management (Mitchell, Teno et al. 2009). In addition, the overuse of treatments (Di Guilio, Toscani et al. 2008), invasive and futile tests (Sampson, Ritchie et al. 2005) and unplanned transfers to hospital have been reported for people with dementia.

In this context dementia palliative care was identified by the project team as the ‘clinical hook’ to underpin the students’ placement. Residential aged care placements offer students of all disciplines a context to consider dementia as a terminal condition that is best managed by care configured through a palliative approach framework. The placement provides students with a unique opportunity to engage with people with dementia over time: to develop students’ skills
1. Preamble- The Burning Issue

in assessment, communication, and understanding of the person with dementia, and the issues that impact on residents as they progress across the trajectory. It also provides students with the opportunity to spend time with family carers during visits and to learn about the impact of dementia on families and the lives of sufferers. In all these activities the rubric of dementia palliation, the ‘clinical hook’, provides students with a lens through which to consider their practice and care options.
2 Implementing Placements around the Evidence Based Best Practice Model (EBBPM)

Placements in the Wicking Prototype TACF program are configured in line with the EBBPM (Robinson et al. 2006). This model provides an evidence based framework for structuring placements in ways that will support learning and teaching in RACFs. As outlined previously, the EBBPM was developed out of a systematic review as part of the Modelling Connections in Aged Care project (see section 1.1.5). It covers all aspects necessary to the introduction, maintenance and ongoing evaluation of a standardised model for the conduct of quality clinical placements for undergraduate students in aged care settings. The Wicking Prototype TACF program, which informed the development of this document, is based on the four distinct and sequenced steps outlined in the EBBPM: establishment; preparation; on-site support; and ongoing evaluation.

2.1 Establishment

Establishment refers to preliminary steps that are recommended as necessary to forge a new partnership between the RACF and the schools at the university (Robinson, Abbey et al. 2006). These first steps should focus on gaining and publicising commitment at the CEO and board level to the concept of the partnership and ensuring that the necessary structures and processes to implement and maintain the partnership are understood and accepted by all parties. The next step is to ensure that the intended curriculum to be delivered by the partnership meets research-based best practice standards.

2.1.1 Partnerships need momentum

The building of close and mutually supportive relationships, which are foundational to forming a partnership, needs to be formalised and extended into the management chains of both the university and the RACF. Therefore, the memorandum of understanding (MOU) between the university and the RACF needs to be at the level of Faculty Dean/Head of School and RACF Board Chairman/CEO. The MOU needs to cover the mechanism for collaboration between the RACF and the university and the number of clinical placements that will be provided for each student group. This is the first step in bridging the gap between the aged care sector and universities. A template can be found in Appendix 3.

2.1.2 Program governance

The development, implementation, and evaluation of aged care undergraduate clinical placements involves a large number of people. In Australia, links between the aged care sector and the tertiary education sector are at best limited and often non-existent. Therefore, the governance of setting up placements must enable the building of strong and meaningful networks between the two sectors.

2.1.3 Curriculum

Developing learning outcomes and unit outlines prior to students commencing the placement is important to ensure that the intended curriculum meets best practice standards. Aged care
2. Implementing Placements around the Evidence Based Best Practice Model

content in undergraduate degrees should be of equal status with other clinical areas, as a curriculum focusing on acute care suggests to students that aged care is not a desirable option for future work (Pearson, Nay et al. 2001; Happell 2002; Nurses Board of Victoria 2002; Moyles 2003; Queensland University of Technology 2004). Specific learning outcomes need to be developed for each student group.

Examples of nursing, medical and paramedic learning objectives, developed in the Wicking Prototype TACF program, can be found in Appendices 4, 5, and 6. In reality the limited engagement of undergraduate health professional courses with the residential aged care sector means that in many cases curricula need to be developed from scratch. For example, in the Wicking TACF program we found no evidence in the literature of curricula developed for medical or paramedic students undertaking aged care placements in the sector. In cases where the students on an aged care placement are only a small proportion of all students in that specialty, it may be useful to use the generic learning outcomes alongside bespoke resources designed to support the students’ engagement in the placement.

One such resource is the ‘Clinical Assessment Tool’ (see Appendix 7), which was developed for nursing students to record the activities they engaged in and provide a record of their competency achievement in different areas. The tool was developed collaboratively by mentors at one of the aged care facilities involved with the Wicking Prototype TACF program. It was a local response to concerns that mentors often struggled to assess students’ progress in the context of working with them intermittently; a problem associated with the part time and casual status of much of the aged care workforce (King, Mavromaras et al. 2012), which in turn compromises efforts to facilitate continuity between mentors and students (see section 2.2.4). In effect the tool functioned as a learning aid for nursing students and mentors to link learning opportunities on placement and achievement of the relevant Nursing Competency Domains.

2.2 Preparation

Preparation deals first with the work that must be done with students in the university before they begin their clinical experience; it then focuses on the work that must be done within the RACFs with management, staff, residents and their families. Preparation should focus on the university and RACF collaborating on preparing for the placements, lessening students’ initial shock at confronting old and frail bodies (Robinson and Cubit 2005) and residents with dementia (Robinson and Cubit 2007), as well as deepening staff and mentors’ understanding of the students’ needs (Robinson, Abbey et al. 2006).

2.2.1 Building links and creating a collaborative infrastructure

Developing student placements in residential aged care facilities comprises two phases. Phase one includes setting up the placement, and developing the placement curriculum and associated IPL activities. The focus then shifts to operationalising the program; operationalisation involves collaboration between key university and RACF staff and the work of a number of subgroups. Some of these key roles are outlined below.
2. Implementing Placements around the Evidence Based Best Practice Model

*Mentor Leader*

To support student placements a senior clinical nurse, employed within the RACF, is recruited and appointed to the role of Mentor Leader. The Mentor Leader is involved in the selection/recruitment of mentor group members and takes responsibility for the co-ordination and facilitation of the mentor group. They also take overall responsibility for liaison with students and university staff (see section on Academic Liaison below).

The placement structure utilised in the Wicking Prototype TACF program does not involve the employment of a clinical teacher. Rather, students are embedded in the facility, being supported by the mentors and other facility staff. For this reason it is vital to direct available funding to building the capacity of the Mentor Leader and mentor group to support student learning and teaching. Building Mentor Leader capacity and capability is a key factor in the sustainability of this approach.

In the Wicking Prototype TACF program, funding was used to second the Mentor Leader from their usual clinical role (i.e. 0.2 EFT across the year) to work with the respective School staff in setting up the placement, to lead the mentor group in organising the placement and the facilitation of student learning and teaching during the placement. However, the extent to which the Mentor Leader should be seconded depends on their role in supporting the student placements. In the Wicking Prototype TACF program we estimated that supporting 10–12 nursing students on five days per week placements in one facility required the Mentor Leader to be seconded at least two days per week during placements. This would be in addition to a series of days they would be seconded to participate in preparatory activities, and evaluation following the completion of the placement.

*Mentor Group*

A mentor group is established in each RACF and, under the guidance of the Mentor Leader, takes a primary role in both planning placements and facilitating student learning and teaching. In the Wicking Prototype TACF program the mentor groups comprised Registered Nurses, Enrolled Nurses, care staff, and a range of activity/allied health staff. Mentors are selected on the basis of demonstrating an interest/enthusiasm/commitment to support student learning and teaching. Evidence indicates that many aged care staff lack the confidence to support student learning in practice (Robinson, Abbey et al. 2006). To support capacity building, mentors in the Wicking Prototype TACF program participated in a series of ten preparatory sessions, which are outlined in section 2.2.3. During student placements RN mentors take responsibility for assessing the nursing students’ competence, assisting them to meet their learning objectives and supervising their work with other mentors. They will also liaise with Academic Liaison staff from other Schools to provide feedback on student performance in practice.

Additionally, up to three members of the mentor group should be identified to join a Mentor Leadership group, with the Mentor Leader outlined above. Having a leadership group mitigates problems that might arise if the Mentor Leader is unavailable, and helps spread the load associated with developing and supporting large-scale student placements.
2. Implementing Placements around the Evidence Based Best Practice Model

**Academic Liaison**

The Academic Liaison is a university employee who is an integral member of the unit teaching team and is responsible for overseeing the placements. They are the university contact person who liaises with the Mentor Leader and represents the particular School in directly supporting students on placement. The Academic Liaison coordinates and facilitates: pre-placement information/education sessions for students; the development of Information Toolkits (see section 2.2.4); contributes to mentor education; and, works closely with the Mentor Leader to facilitate students’ learning and teaching. It is important that the person employed in this role is not merely a general university staff member but has expertise in aged care.

In the Wicking Prototype TACF program the role of the nursing Academic Liaison evolved to include far greater direct engagement with students and mentors during the placements.

**Network Officers**

The Network Officer is a university employee who supports engagement between the RACFs and the relevant School staff. This is an administrative role supporting the development of partnerships between the RACF and relevant School, but the incumbent is not involved in the development of the actual placement as that is the province of the respective disciplinary groups.

In the Wicking Prototype TACF program both medical Network Officers and paramedic Network Officers were appointed to facilitate engagement between the respective Schools, as they had no prior history of working with each other. That is, this was the first time that students from these schools had participated in clinical placements in RACFs. In these circumstances the key role of the Network Officers in the Wicking program was to support the respective school and RACF staff in organising the roll-out and co-ordination of the medical and paramedic clinical placement programs, in conjunction with the nursing placement program. Co-ordination by the Network Officers was critical to developing inter-professional learning activities.

### 2.2.2 Operationalising placement preparation

The figure below (Figure 3) illustrates how the preparatory process was operationalised in the Wicking Prototype TACF program. Operationalising this structure is important for a number of reasons.

1. There is good evidence of poor levels of integration and engagement between the residential aged care sector and the broader health and community care sectors (Fine 2000; Productivity Commission 2008). Consequently, residential aged care facilities are relatively isolated from the broader health care environment.

2. Evidence indicates that there is a problem in health professional education as students from different disciplines rarely have the opportunity to learn together because students are typically educated in professional silos (McNair 2005; Braithwaite, Westbrook et al. 2007; Stone 2007). This situation was evident in the context of the Wicking Prototype TACF program, which highlighted limited engagement between health profession schools
within the university. Addressing this situation is particularly important given the focus of the clinical placement program on IPL.

Figure 3: Placement Preparatory Model

3. Operationalising inter-professional aged care placements not only involves facilitating the engagement of schools/professional disciplines with each other, but also supporting their engagement with the aged care sector. This is a complex task as in general many health profession schools have no or limited prior engagement with the sector. For example, while the discipline of nursing has been found to have the most contact with aged care, evidence suggests that this engagement lacks depth (FitzGerald, Pincombe et al. 2001; Wotton and Gonda 2004; Chang and Corgan 2006), a finding confirmed in the multi-state Wicking TACF program. It is apparent that most other disciplines have little or no ongoing contact with the sector. For example, evidence indicates that it is unusual for schools such as medicine (Health Workforce Australia 2011), paramedic practice (Dixon, Mason et al. 2009; Jolly, Sutton et al. 2012), pharmacy, exercise physiology, physiotherapy, speech pathology, podiatry and occupational therapy to have a substantive engagement with aged care (Robinson et al. 2006). Additionally, while there are claims of engagement, the evidence suggests they usually involve one way liaison and are quite precarious (Gassner, Wotton et al. 1999).
2. Implementing Placements around the Evidence Based Best Practice Model

These issues mean that operationalisation of the program must be driven as a strategic priority at a faculty/cross faculty level within universities. There must be high level recognition that engagement with the aged care sector and the concurrent facilitation of inter-professional learning among undergraduate health professional students are strategic priorities.

In this way inter-professional aged care placements developed as part of the Wicking Prototype TACF program challenge the silos operating within health professional education, and silos which separate the tertiary education and aged care sectors.

The Placement Preparatory Model (Figure 3, above) provides the organisational arrangements adopted in the Wicking Prototype TACF program to support inter-professional and inter-sectoral engagement. An explanation of each group is outlined below.

**Reference Group**

Where the placement program is set up as a project, the Reference Group oversees the project at an organisational level. They are responsible for: monitoring and providing advice on project activities; providing feedback regarding evaluation; promoting access to information networks, key respondents and key decision making committees; reviewing resourcing issues; and discussing strategies for maximising sustainability after project completion. The group meets bi-annually, commencing one month prior to placements. The Reference Group is made up of relevant stakeholders which may include, but not be limited to, representatives from the Department of Health and Ageing, consumer group and industry body representatives, the CEO (or nominee) of each RACF and heads of the involved university Schools, etc.

**Clinical Placement Facilitation Team**

The Clinical Placement Facilitation Team is the group that takes responsibility for coordinating placement activities. Team meetings provide an opportunity for representatives from the involved schools to meet and work on the strategic development of the program. They also discuss the ongoing improvement of the students’ experiences of placement, discuss concerns, resolve any issues, and develop resources aimed at further improving placements. In the Wicking Program this group met on a weekly/fortnightly basis, commencing at least two months prior to students starting placement. The Wicking Prototype TACF program Clinical Placement Facilitation Team comprised nursing, medical and paramedic Academic Liaisons, other relevant representatives from the Schools, the medical and paramedic Network Officers, and Project Officers.

**Curriculum Groups**

Students on clinical placements typically engage in opportunistic learning rather than following a well-developed, structured schedule (Lambert and Glacken 2005; Barnett, Cross et al. 2008). The Wicking Prototype TACF program model of student placements aims to make learning more strategic. The development of curriculum for students whilst on placement needs to be driven out of the discipline specific schools and in partnership with the aged care...
2. Implementing Placements around the Evidence Based Best Practice Model

facility. The Curriculum Groups are made up of the relevant university discipline curriculum experts, Academic Liaison (e.g., GP tutor), Mentor Leader, a representative of the team putting the unit together for the students, and a representative of the relevant School. When developing the curriculum, consideration needs to be given to the strategy for operationalising IPL.

Dementia Palliation/Complex Care of Aged Care Residents/IPL Working Group

The Dementia Palliation/IPL Working Group focuses on the broader curriculum and how to pursue the two main objectives of the student clinical placements: for students to develop the knowledge and capacity to provide evidence based care to people with dementia and the embedding of IPL activities into the placement. This group needs to bring together an Academic Liaison for each school involved in the placement (nursing, medical, paramedic, etc.), Mentor Leaders, the medical and paramedic Network Officers as well as the Project Officers. The Academic Liaisons advise on how to engage the different student groups in IPL activities while the Mentor Leaders advise on how to operationalise IPL in their facility. A separate Working Group needs to be formed for each facility where student placements are taking place as the education and activities need to be tailored to ensure specific suitability and effectiveness.

Bi-Annual Workshop

As part of the Wicking TACF program, IPL workshops are held bi-annually to discuss and evaluate the IPL activities, consider any new relevant research and plan future IPL activities. These meetings are attended by the RACF Mentor Leaders, Academic Liaison staff from each School, university staff involved in setting up the placements, available experts in the field and most importantly the clinical staff supervising students and delivering care to residents.

2.2.3 Facility preparation—Placement organisation and resource development

Action Learning

An action learning approach is employed in relation to the organisational design and leadership capability development components of the project. Action learning involves key participants resolving and taking action on real problems in real time, learning through critical questioning and personal reflection on their own practice while doing so (Marquardt 2000). Theory is then offered to supplement experiential findings and learning. One attraction of action learning in this context is its power to engage participants within a particular system or setting to solve difficult challenges through application of learning to practice, thus supporting real behaviour change and the strengthening of individual and organisational capability (Marquardt 2003).

Action learning provides a framework for developing the placement programs, facilitating the activities of the mentor groups and the iterative development of the curriculum over successive cycles of student placements.
2. Implementing Placements around the Evidence Based Best Practice Model

*Mentor Preparation*

Members of the RACF mentorship group need to be appropriately prepared in order to promote quality placements. Preparation meetings held fortnightly should begin four to five months prior to the commencement of placements. The table below (Table 1) outlines the topics to be covered in each session.

**Table 1: Mentor Preparation Meetings**

<table>
<thead>
<tr>
<th>Setting up the Project</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. <em>Introduction to the Project and Initial Survey Completion</em></td>
</tr>
<tr>
<td></td>
<td>• Completion of initial (baseline) mentor survey, if applicable</td>
</tr>
<tr>
<td></td>
<td>• Introduction to the project, background, aims, outcomes</td>
</tr>
<tr>
<td></td>
<td>• Review mentor meeting schedule</td>
</tr>
<tr>
<td></td>
<td>• Role of the mentor group &amp; mentor leaders, communication strategies &amp; group rules</td>
</tr>
<tr>
<td></td>
<td>2. <em>Action Learning and Mentor Briefing</em></td>
</tr>
<tr>
<td></td>
<td>• Introduction to the evidence based best practice model to facilitate quality clinical placements in aged care (EBBPM)</td>
</tr>
<tr>
<td></td>
<td>• Introduction to action learning</td>
</tr>
<tr>
<td></td>
<td>• Role of the mentor leader</td>
</tr>
<tr>
<td>Dementia Palliation and Mentoring Content</td>
<td>3. <em>Dementia as a Terminal Condition</em></td>
</tr>
<tr>
<td></td>
<td>• Presentation &amp; discussion around dementia as a terminal condition</td>
</tr>
<tr>
<td></td>
<td>• Discussion around strategies to facilitate student learning about dementia &amp; identification of barriers</td>
</tr>
<tr>
<td></td>
<td>4. <em>Palliative Approach to Care</em></td>
</tr>
<tr>
<td></td>
<td>• Presentation &amp; discussion around dementia &amp; a palliative approach to care</td>
</tr>
<tr>
<td></td>
<td>• Discussion around strategies to facilitate student learning about a palliative approach to care and identification of barriers</td>
</tr>
<tr>
<td></td>
<td>5. <em>Clinical Education in an Aged Care Setting</em></td>
</tr>
<tr>
<td></td>
<td>• Presentation &amp; discussion around clinical education in an aged care setting</td>
</tr>
<tr>
<td></td>
<td>6. <em>Mentoring</em></td>
</tr>
<tr>
<td></td>
<td>• Presentation &amp; discussion on mentoring strategies</td>
</tr>
<tr>
<td></td>
<td>• Discussion around how mentors can facilitate the EBBPM with a dementia palliative care focus</td>
</tr>
<tr>
<td></td>
<td>• Presentation &amp; discussion on cultural and communication development</td>
</tr>
<tr>
<td></td>
<td>• Discussion around strategies to facilitate student learning &amp; identification of barriers, such as dealing with negative students</td>
</tr>
<tr>
<td>Preparing for Placement—Planning and Taking Action</td>
<td>7. <em>Organisation of Students</em></td>
</tr>
<tr>
<td></td>
<td>• Strategies to support engagement &amp; address perceived barriers to teaching &amp; learning</td>
</tr>
<tr>
<td></td>
<td>• Action planning around structure of student placement, student timetable/program</td>
</tr>
<tr>
<td></td>
<td>• Tabling of the Student Information Toolkit for Mentors</td>
</tr>
<tr>
<td></td>
<td>• Discussion around development of a Student Orientation Manual (facility information pack)</td>
</tr>
<tr>
<td></td>
<td>8. <em>Organisation of Mentors</em></td>
</tr>
<tr>
<td></td>
<td>• Strategies to support engagement &amp; address perceived barriers to teaching &amp; learning</td>
</tr>
<tr>
<td></td>
<td>• Discussion of roles &amp; responsibilities in facilitating student placement</td>
</tr>
<tr>
<td></td>
<td>• Issues that may undermine the mentor role</td>
</tr>
<tr>
<td></td>
<td>• Action planning around strategies to facilitate continuity between students &amp; residents &amp; between mentors &amp; students</td>
</tr>
<tr>
<td></td>
<td>• Action planning around strategies to communicate with facility staff outside the</td>
</tr>
</tbody>
</table>
2. Implementing Placements around the Evidence Based Best Practice Model

<table>
<thead>
<tr>
<th>Preparing for Placement—Planning and Taking Action (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mentor group &amp; residents about the placements and student needs</td>
</tr>
<tr>
<td>• Action planning around engaging staff from outside the mentor group to assist with mentoring</td>
</tr>
<tr>
<td>9. Student Engagement</td>
</tr>
<tr>
<td>• Strategies to prepare students &amp; enhance their engagement in a RACF clinical placement</td>
</tr>
<tr>
<td>• Action planning around pre-site visit &amp; student expectations meeting</td>
</tr>
<tr>
<td>• Tabling of, &amp; feedback on, Student Orientation Manual</td>
</tr>
<tr>
<td>• Discussion on professional development activities while students are on placement</td>
</tr>
<tr>
<td>• Discussion about the role of the Academic Liaison</td>
</tr>
<tr>
<td>• Action planning around strategies to facilitate inter-professional learning</td>
</tr>
<tr>
<td>10. Final Preparation and Pre-Placement Survey Completion</td>
</tr>
<tr>
<td>• Distribution of final Student Information Toolkit for Mentors</td>
</tr>
<tr>
<td>• Discussion around mentor experiences of meeting together</td>
</tr>
<tr>
<td>• Discussion around feelings &amp; perception of level of preparation now placements are imminent</td>
</tr>
<tr>
<td>• Completion of pre-placement mentor survey, if applicable</td>
</tr>
</tbody>
</table>

Examples of resources given to mentors during the Wicking Prototype TACF preparation meetings include:

- Code of Ethics for Nurses in Australia (Nursing and Midwifery Board of Australia)
- Code of Professional Conduct for Nurses in Australia (Nursing and Midwifery Board of Australia)
- A National Framework for the Development of Decision-Making Tools for Nursing and Midwifery Practice (Nursing and Midwifery Board of Australia)
- National Competency Standards for the Registered Nurse (Nursing and Midwifery Board of Australia)

2.2.4 University based preparation of students and resources

Preparation work for the clinical placements needs to be undertaken both in the RACFs and with students. Prior to students commencing their clinical placement, university school and RACF staff should collaborate to build capacity and capability to facilitate student learning. Preparatory work should also be undertaken with students to discuss the placement, develop appropriate expectations, and challenge any underlying prejudices they might have with respect to aged care (Happell 1999; Heslop, McIntyre et al. 2001; Happell 2002; Abbey, Abbey et al. 2006; Lovell 2006; Wray and McCall 2007; Stevens 2011).

Student Information Toolkit for Mentors

Preparing RACF staff involves developing an information toolkit, which is developed by the respective schools. The toolkit contains information about: Academic Liaison contact details; a guide for clinical facilitators and mentors; unit outlines; student responsibilities; Dementia-Palliation Education Program; student workbooks; and timetable of student activities and formal teaching sessions. It is developed by the respective disciplinary members of the curriculum group (See Figure 3 in section 2.2.2). In the Wicking Prototype TACF program a new

[21]
version of the toolkit was provided to RACF staff each semester students were on placement to account for the changes associated with each cohort of students.

Listed below are the kinds of documents that might be included in a toolkit:

- A “Guide for Clinical Facilitators and Preceptors” (University of Tasmania 2010).
- A copy of the Dementia-Palliation Education Program.
- Clinical Reasoning: Instructors Resource (University of Newcastle 2009).
- Information sheet outlining the skills of students at each year level.
- Overview of Professional Experience Placement (PEP) units and copy of student PEP workbook (relevant for nursing students at UTAS).
- A copy of the Student Feedback Record (relevant for nursing students at UTAS).
- Facilitator and Preceptor Decision Tree to Identify and Support Students at Risk on PEP (relevant for nursing students at UTAS).
- Academic Liaison name and contact details.
- Unit code, outline, learning outcomes, any assessments the students are expected to undertake whilst on placement.
- Paramedic student specific documents include: names of students; paramedic students’ prior learning and clinical experience in aged care; paramedic students’ scope of practice; guidelines for student practice, including activities they may do unsupervised and/or supervised; and a list of knowledge and skills students should acquire during their placement.
- Medical student specific documents include: student timetable/program; workbook; and log of activities.

A placement curriculum and structure needs to be developed for each group of students. Each needs to fit with the requirements of their course, but in line with the ‘clinical hook’ underpinning the placement program, maintain a strong dementia palliation focus.

The programs for nursing and paramedic students participating in the Wicking Prototype TACF program are semi-structured and involve attendance at activities for the residents (i.e. diversional therapies, etc.) as well as education sessions that are organised by either the facility or project team. In contrast, the medical student placement is a much more structured program focusing on students’ participation in audits, utilisation of dementia screening tools, completion of comprehensive medical assessments, resident engagement and resident safety (Robinson, See et al. 2012).

Student preparation for aged care placements begins four to six weeks before the commencement of the university semester. The different aspects of preparation for each student group can be seen in the table below (Table 2).
2. Implementing Placements around the Evidence Based Best Practice Model

Table 2: Student Preparation

<table>
<thead>
<tr>
<th>Nursing</th>
<th>Medical</th>
<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Information Session</td>
<td>Project Information Session</td>
<td>Project Information Session</td>
</tr>
<tr>
<td>Project Consent and Pre-</td>
<td>Project Consent and Pre-</td>
<td>Project Consent and Pre-</td>
</tr>
<tr>
<td>Placement Evaluation Session, if applicable</td>
<td>Placement Evaluation Session, if applicable</td>
<td>Placement Evaluation Session, if applicable</td>
</tr>
<tr>
<td>Pre-site Visit</td>
<td>Cognitive Testing Workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meeting with Associate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professor of General Practice</td>
<td></td>
</tr>
</tbody>
</table>

Project Information Session

Project information sessions are held four to six weeks prior to the student placements. These sessions are facilitated by relevant school staff that preferably have experience in, and a commitment to, aged care. The intent is to provide students with detailed information about the placement and the commitment required of them. A forum for questions and answers is also provided in this session.

Pre-Site Visit

Consistent with the EBBPM approach (Abbey, Abbey et al. 2006) in the Wicking Prototype TACF program nursing students participated in a pre-site visit to the RACF around one week prior to their placement (the logistics of organising such a visit for medical and paramedic students proved impossible in the context of the Wicking program).

The pre-site visit is intended to enable students to familiarise themselves with the RACFs and discuss issues such as the focus of the placement, the plan for the first day of placement and the need to work with different staff. A student expectations meeting is also held at this time to discuss issues such as student and facility expectations of the placement and the need for students to work with carers and Enrolled Nurses (ENs) as well as RNs. The pre-site visit also provides an opportunity for students to meet the mentor group and participate in a geographical orientation to the facility. At this meeting the nursing students are provided with a number of resources including:

- Individual student rosters.
- A student placement program which details what activities students will be involved in within the facility.
- A student orientation manual developed by the facility containing information such as an overview of the facility, a map of the facility, facility mission statement, student orientation checklist, and an evaluation sheet.

A detailed agenda for the Wicking project pre-site visit including the expectations meeting has been included in Appendix 2.

Evaluation of the Wicking Prototype TACF program has indicated that the pre-site visit is a valuable experience for the students and mentors alike. The students have reported that the visit and expectations meeting helped them to feel more prepared, increased their confidence
and settled their nerves. Students were provided with “a lot of student and nursing home information, patient information and what the residents were generally like” which worked to “settle nerves and get an understanding of the upcoming placements”. The mentors also appreciated the expectations meeting and asked if the Project Officer could “please do it again”.

Cognitive Assessment Workshop

Prior to placement some medical students involved in the Wicking Prototype TACF program attended a three-hour cognitive assessment workshop conducted by a neuropsychologist with experience in the assessment and care of dementia patients. During the workshop students learn how to differentiate dementia from normal ageing, delirium and depression, how to assess mental status and cognitive function in the elderly, how to assess for common psychological and mental health issues in the elderly, non-pharmacological management options for the elderly and end-of-life issues and palliative care in dementia.

Meeting with Discipline Champion

Prior to commencement of the placement, medical and paramedic students meet with a high profile influential staff member, who can act as champion for the placement. In the case of these students this is important because there are no precedents for their involvement in a dedicated aged care placement. Further, the findings of our research indicate that, in general, medical and paramedic students come into a placement with less than a positive attitude and low expectations. For example, one medical student participating in the Wicking Prototype TACF program “Felt like I could be doing things other than aged care that would be more beneficial—a better use of my time. That was my initial reaction”. Meeting with a champion provides students with an opportunity to talk about the placement, express their concerns, and discuss the learning opportunities associated with having ongoing access to frail elderly residents, most of whom have some form of dementia. It is also a time that relevant resources can be distributed to students.

Dementia/Palliation Package

The residential aged care landscape in Australia is changing. With increasing ages at admission and increasing levels of dependency amongst the resident population, duration of stay for residents in aged care facilities is relatively short and commonly ends in death (Andrews-Hall, Howe et al. 2007). This means that residential aged care facilities and staff are increasingly providing end-of-life care to residents. As discussed above, to reflect this care orientation dementia palliative care was identified as the clinical focus underpinning the students’ placements in the RACFs.

Many of the students involved in aged care placements may not have previously encountered people with dementia or someone who requires palliative care. In order to develop the students’ understanding, knowledge and skills in the area of dementia palliative care a two to three-hour education session has been developed. The Dementia/Palliation Package was first developed as part of the Opening a Dialogue: Improving Communication and Practice in Advanced Care and End of Life Care Planning project. This project was the collaborative work
2. Implementing Placements around the Evidence Based Best Practice Model

of the University of Tasmania and Australian Catholic University, and funded by the Department of Health and Ageing, Australia. These education sessions are held at the start of the placement and in the Wicking Prototype TACF project are attended by nursing and paramedic students. The package consists of three sessions on the topics of:

- Dementia as a Terminal Condition
- Dementia and a Palliative Approach to Care
- Care for Residents with Dementia in RACFs—Communicating with Residents, Family and Staff

The PowerPoint slides used in these sessions can be found in Appendix 8.

Allocation of Students to Mentors

For many student groups, facilitating continuity between mentors and students needs to be considered in the placement preparation phase. This is especially important for those students who will work directly with staff, such as nurses. For example, existing literature suggests that the allocation of a designated mentor to a nursing student is important for a good quality placement experience (Myall, Levett-Jones et al. 2008; Barnett, Cross et al. 2010). However, The Aged Care Workforce Final Report 2012 (King, Mavromaras et al. 2012) indicates that 90.5% of the residential aged care workforce involved in the direct care of residents is employed on a part time, casual or contract basis; a trend also confirmed by other literature (Heale, Mossey et al. 2009). These work arrangements make achieving significant continuity between an individual mentor and individual student unrealistic. Yet, if expectations are set up amongst students that they will have a mentor who works with them consistently on placement, the mentor is unlikely to be able to deliver on this expectation. This issue needs to be considered when establishing undergraduate clinical placements, especially for groups of students that will work closely with RACF staff on an ongoing basis (in the case of the Wicking project this included nursing and paramedic students).

An approach adopted in the Wicking Prototype TACF program facilitated continuity between students and mentors. This involved allocating students to one area of the facility for the entire time they are on placement. Allocating students to an area is supported by Bourgeois, Drayton and Brown (2011) who note that the students feel welcomed and supported by the staff and develop a sense of closeness and support for the other students allocated to the area. Our evaluation also highlighted the benefits of this approach, consistent with the findings of Bourgeois, Drayton and Brown (2011).

Facilitating this arrangement means that the membership of the mentor group needs to include staff who work in the different areas of the RACF where students will be rostered. For example, in the Wicking project between two and four mentors regularly worked in each area where students were rostered. For students, working in one area over the course of the placement not only supports their developing knowledge and understanding of the residents in that area, but also provides the opportunity for the mentors assigned to that area to collectively take responsibility for the learning and development of all of the students allocated to them.
2. Implementing Placements around the Evidence Based Best Practice Model

Mentors who are able to provide feedback/constructive criticism to students, and encourage discussion of progress, are seen to contribute to a positive placement experience and promote confidence (Myall, Levett-Jones et al. 2008). The allocation of students to a geographical area of the facility, supported by consistent membership of the Mentor Group, fosters these types of relationships and supportive practices. In the Wicking Prototype TACF program this approach has been adopted for nursing and paramedic students. The benefits are evident in the Wicking Prototype TACF program evaluations. These data illustrate the importance of students perceiving mentors as helpful, supportive and friendly. A statistically significant relationship was found between these characteristics in mentors and a positive experience of teaching and learning among students. In turn a positive experience of teaching and learning was found to have a statistically significant relationship with the likelihood of students considering working in aged care in the future.

However, it may not be appropriate for all students to be allocated to nursing and care staff mentors during aged care placements. For example, the fifth year medical students participating in the Wicking Prototype TACF program have a more independently structured placement than the other student groups. These students are not allocated to a specific area of the facility. Rather, they are allocated a number of residents to engage within the context of their assessment activities, and these residents are generally spread geographically across the facility. This approach allows the medical students to have continuity of residents.

2.3 Support on Site

Support on site covers the measures that must be implemented and the climate that must be cultivated if student and staff collaboration in practice and learning about practice is to be as fruitful and stimulating as it could be. As well as facilitating continuity between students and their mentors, other important elements of support include: ensuring students feel welcome; orientation to sources of information and support; familiarising students with the working environment, including the roles of different grades of staff, information on layout and responses to problems; and, explaining the needs and morbidities of the elderly in residential care (Robinson, Abbey et al. 2006). Support on site can also be provided through debriefing, a stage that has a vital part to play in assisting students and staff to find meaning in their experiences and to reflect on how that meaning may relate to any preconceptions they may have had.

2.3.1 Student orientation

Orientation needs to be considered a critical and important element of the clinical placement experience (Robinson, Andrews-Hall et al. 2008). It has been shown that one of the most important aspects of making students feel welcomed, and in influencing positive opinions of their placement, is a formalised, structured orientation and welcoming, friendly staff (Storey and Adams 2002; Clare, Brown et al. 2003; Clare and van Loon 2003; Robinson, Venter et al. 2005). In contrast, when students do not feel welcomed and supported on their arrival to the facilities they quickly become disenchanted (Robinson, Andrews-Hall et al. 2008). This negatively influences their perceptions of aged care nursing, and affects the likelihood that they will consider a career in aged care (Abbey, Abbey et al. 2006). By contrast, setting up placements with an effective and thorough orientation was found to have a positive impact on
students’ perceptions of aged care and their stated likelihood of future work in the field (Robinson, Andrews-Hall et al. 2008; Chenoweth, Jeon et al. 2010).

Research into orientation processes at twelve representative Australian RACFs indicates that the perception of students and mentors regarding the quality of student orientations can be very different (Robinson, Abbey et al. 2009). The staff in these facilities and the students undertaking clinical placements completed a survey describing the frequency with which 30 key orientation activities took place. These activities included orientation to staff, orientation to facility, emergency procedures, common tasks and resources, job organisation and whether facility staff were aware of student arrival. The consistent differences between the recollections and understandings of these orientation activities between staff and student groups were alarming (Robinson, Abbey et al. 2009). For 29 of the 30 questions asked in the survey, the staff confidence in the orientation’s coverage and effectiveness was higher than the students’ confidence. The extent of the differences is surprising as for 70% of the activities, the discrepancy was greater than 10% and for 43% of the activities it was greater than 20% (Robinson, Abbey et al. 2009). These misperceptions and discrepancies are supported by findings from the current Wicking Prototype TACF program. This lack of awareness among RACF staff regarding the thoroughness and quality of orientation, as perceived by students, hampers the ability of facilities and their staff to improve their orientation procedures and provide an effective and positive placement experience.

The development and use of an orientation checklist can ensure that all important components are discussed. The orientation process and checklist should cover orientation to the building, key staff members, facility processes, important policies and documentation, infection control practices and manual handling. The checklist is developed to be specific to each RACF including information relevant to their local context. A copy of the orientation checklist utilised in the Wicking Prototype TACF program is attached (see Appendix 9).

To assist the orientation process students are also provided with a Student Orientation Manual. This manual primarily includes information about the RACF, so a site-specific manual needs to be developed by each RACF. Some of the information provided in the manual includes: an overview of the facility; mission statement; relevant RACF policies; organisational structure; roles and contact details of key staff; a floor plan/map of the RACF; student code of conduct; and the student orientation checklist.

2.3.2 Developing a structured placement schedule/program

A placement timetable or schedule is developed in collaboration between the Academic Liaison staff from the university and the Mentor Leader. A structured timetable also allows the students to see in advance what they will be working on and who they will be working with over the course of the placement. Wherever possible, the timetables are developed collaboratively with involvement from all stakeholder university schools. The schedule for each of the student groups should enable them to meet at key points during the placement. Importantly, the scheduling of common activities provides opportunities for structured inter-professional engagement.
2. Implementing Placements around the Evidence Based Best Practice Model

In order to ensure that learning during placement is strategic, placement structure is developed prior to commencement. This development is co-ordinated by the Mentor Leader in each facility. Some activities will be common to all groups of students, while some will be specific to the needs of one student group. An outline of the activities included in the Wicking Prototype TACF program are presented below.

Generic Activities

Day 1:

- Introduction to the program.
- Meet key staff, e.g., Academic Liaison, Director of Care, mentors, Mentor Leader, other RACF staff.
- Meeting of all students on placement in the facility whenever a new group of students start their placement.
- Orientation to and tour of the facility.
- Orientation to and preparation for activities that students will engage in while on placement e.g. IPL activities.
- Meeting of IPL student groups, which includes allocation of a resident to each group by RACF staff (see Inter-Professional Learning section below for a discussion of IPL opportunities).

Whilst on placement:

- Student learning and teaching facilitated by members of the mentor group in each of the areas where students are allocated—students will not always work with the mentors so mentors also have a role in supporting other staff in the area and developing their capacity to work with students (see section 2.2.4 for a discussion of allocating students to mentors).
- Dementia/palliation education session usually held on day 2 or 3 (see section 2.2.4).
- Manual Handling session (see Manual Handling section below).
- Review the principles of Geriatric Assessment—learn strategies for interacting with residents with dementia.
- Education sessions organised by university staff and RACF staff (see Education Sessions section below for examples).
- Weekly parallel feedback meetings for both students and mentors facilitated by a university staff member who is familiar with action learning/research methods (see Student Feedback and Debriefing and Mentor Feedback and Debriefing sections below).
- Wound care.
- Once during the placement students will make a presentation to the other students and RACF staff—for example, a case study of a resident they have been looking after; if there have been opportunities to undertake inter-professional learning activities, a group presentation may be delivered on an assessed issue related to a resident, and using the perspectives of the various disciplinary groups.
2. Implementing Placements around the Evidence Based Best Practice Model

- Other activities that may present themselves include experience of: hygiene procedures; medication rounds; wound assessment; physiotherapy; leisure and lifestyle; and other activities being attended by the residents.

*Nursing Student Specific Activities*

A sample program for nursing student placements can be found at Appendix 10. Some of the nursing student specific activities that may be included are outlined below:

- Handover.
- Hygiene.
- Assist with resident meals.
- Wound care and assessments.
- Medications.
- Resident care documentation.

*Paramedic Student Specific Activities*

The key focus of the paramedic placement in RACFs is to develop students’ understanding of dementia and the concept of dementia palliation. Staff from the UTAS paramedic course, in collaboration with members of the Wicking Prototype TACF program and mentors at the two facilities, developed the placement schedule for the paramedic students. The placement program includes a range of clinical, non-clinical and inter-professional learning activities, structured with dementia palliation as the ‘clinical hook’. Concerned that paramedic students’ training was not adequately preparing them for the demographic and epidemiological transition forecast for the 21\textsuperscript{st} century—i.e. an ageing population and increase in the number of people with dementia—the Wicking Prototype TACF program introduced clinical placements in RACFs as a compulsory component of the undergraduate course.

On placement, students develop a range of “soft skills” that help them work more effectively with people, including older people with dementia, and their families/carers. These “soft skills” include communication, empathy and human understanding, skills that are often overlooked in contemporary paramedic curriculum (Marshall 2009; Willis, Pointon et al. 2009). As a consequence of their placement students have reported improved understanding of the aged care sector and recognition of the role of paramedics in responding to the challenges of an ageing population with increased levels of dementia. Students also report an improvement in the clinical skills required to work with older people and their understanding of ageing and infirm bodies.

A sample program for paramedic student placements can be found at Appendix 11. Some of the paramedic student specific activities that may be included are outlined below.

Whilst on placement:

- Simulated ambulance transfer and follow-up discussion (Day 2).
2. Implementing Placements around the Evidence Based Best Practice Model

- Brief teaching sessions of topics specific to paramedic students’ education—e.g., preparation for ambulance arrival, falls assessment, initial management of a patient with chest pain.
- Assessments of allocated residents in the RACF.

**Medical Student Specific Activities**

General practitioners (GPs) play an important role in the provision of primary, palliative and end of life care to residents of aged care facilities, including those with dementia (RACGP 2006; Andrews-Hall, Howe et al. 2007; AIHW 2010). At a time when there are escalating needs of residents and an increasing reliance on unregulated workers within the aged care sector, access to GPs in RACFs is also decreasing (Lewis and Pegram 2002; Martin and King 2008). Whilst on clinical placement in general practice many medical students may not be exposed to providing medical care to RACF residents, nor do they have extended teaching on this aspect of general practice. The focus of the medical student placements is to improve students’ knowledge of caring for people with dementia and to facilitate their engagement with the aged care sector with the intention of influencing their future career choices. For medical students at UTAS involved in the Wicking Prototype TACF program, this is the first time they have been in a clinical setting without constant, on-site supervision by a medical practitioner. To compensate for this the students’ placement schedule is highly structured with students having a range of activities to engage in which are clearly specified. In this sense structure acts as a proxy for medical supervision. However, in the Wicking Prototype TACF program students are also supported by GP tutors, who meet with them for 1.5 hours early in the morning for a structured program and an hour at the end of the day back at the general practice. These meetings/tutorials provide the students with the support and guidance to undertake their clinical placement within the RACF.

A sample program for medical student placements can be found in Appendix 12. Some of the medical student specific activities that may be included are outlined below.

**Whilst on placement:**

- In pairs (or solo) undertake a Comprehensive Medical Assessment each day on an allocated resident. Each day students may be asked to focus on a different issue, for example, falls prevention, polypharmacy, assessment of confusion, nutrition, skin care or continence or use a different tool—e.g., the Geriatric Depression Scale or Barthel’s Index. The Comprehensive Medical Assessment of residents with escalating levels of dementia is a key focus of the clinical placement for medical students.
- In pairs (or trios) undertake medication reviews.
- Access to a GP tutor on a daily basis to guide learning and provide feedback.
- Multiple times whilst on placement students participate in case-based learning tutorials with the GP tutor.
- Students may be asked to give presentations on topics relevant to their placement experience including: the assessment and management of confusion in the RACF context; risk factors and prevention of falls in the RACF context; nutritional optimisation in the
2. Implementing Placements around the Evidence Based Best Practice Model

RACF resident; investigation and management of continence issues in the RACF context; and behaviour management of dementing patients, especially of aggression.

- Topics of the GP tutorial may include: advance care planning; palliative care physical symptom assessment and management; terminal care; and the perspectives of the RACF staff and the GP in caring for patients (including those with dementia) as a team.

- Other activities that may present themselves (must be approved by the GP tutor and nursing Mentor Leader) include: processing new admissions; conducting initial assessments on acute problems e.g. new onset confusion; engaging with the Hospital Aged Care Liaison Team if the Team visits the RACF; undertaking clinical audit activities; interviewing family members; writing up reports; reading around issues encountered; attending educational sessions; and engaging with other undergraduate students to carry out activities and present findings to RACF staff towards the end of the placement (IPL presentation).

- Undertaking clinical audits on a topic nominated by the RACF under the guidance of a pharmacist who also has input into formal teaching programs related to prescribing.

**Manual Handling**

Early in the placement the RACFs provide students with a session on manual handling. The session may be what the RACF would normally provide for staff and new trainees and may vary depending on the local context and resources available in each facility. In the past, students have found these sessions to be particularly useful, even if they had attended manual handling sessions before. Students need to be reminded of techniques for moving residents in their beds, patient positioning, using a lifting hoist and transferring residents who have fallen.

**Education Sessions**

During student placement, in the Wicking Prototype TACF program RACF Mentor Leaders develop an education program to support students’ learning and teaching. The planned sessions are available to both student groups and facility staff. The topics covered in these education sessions depend on specific staff expertise and the availability of external experts to present. Topics addressed in the Wicking program include:

- Aged Care Assessment Team.
- Older people’s mental health.
- Dysphagia and swallowing difficulties.
- Dementia related to continence, hydration and urinary tract infections and application of aids.
- Dementia falls and injury prevention.
- Legal status of advance care directives and guardianship.
- Dementia diagnosis in primary care.
- Elder abuse.

The types of speaker and organisation who could be accessed to provide education to the students in the RACF include:

- Aged Care Assessment Team.
2. Implementing Placements around the Evidence Based Best Practice Model

- Dementia Behaviour Management Advisory Service.
- Dementia Care Support.
- Pharmacist.
- General Practitioner specialising in palliative care.
- General Practitioner with patients living at the facility.
- Wound care specialist from hospital.

**Inter-professional Learning (IPL)**

Having a number of student groups undertaking clinical placements in the same RACF provides an opportunity for inter-professional learning. Firstly, the timing of student placements needs to intentionally maximise opportunities for student overlap whilst on placement. Once on placement, opportunities to enhance student inter-professional engagement need to be acted upon. The key opportunity for IPL in the RACF environment is the conduct of resident assessments.

However, operationalising an IPL activity—in the context of the previously mentioned siloed schools, and limited inter-sectoral engagement—requires careful planning. This should include the following steps:

- On the first day of the placement, or when a new group of students commences, it is important to hold an IPL meeting with all students, the Mentor Leader and the Academic Liaison. At this meeting the IPL task is explained and students are allocated to an IPL group consisting of students from the different disciplines undertaking placements at that RACF (normally this group would include no more than 3 students). The Mentor Leader then allocates to each group a resident with whom they conduct assessments. This is generally a resident with dementia.

- Following this IPL preparatory session, students meet three times to complete the IPL assessment activity. At the first meeting students conduct the assessment of the resident in front of their inter-professional peers so they gain insights into the respective disciplinary foci.

- Students subsequently meet as a group to develop a presentation focusing on either (i) the different disciplinary insights that came out of their assessments of the resident or (ii) a specific issue or concern related to the resident they have assessed.

- At the end of the week each group gives a presentation to the staff at the RACF and their peers on an aspect of resident assessment derived from the different lenses of each of their disciplines. The students should also articulate what they have learnt as a result of their inter-professional collaboration. Student handouts for the IPL task can be found in Appendices 13 and 14.

**Student Feedback and Debriefing**

Whilst on placement, students attend a weekly feedback meeting, which in the Wicking Prototype TACF program was facilitated by the Project Officer. During these meetings they discuss their expectations, experiences in the facility and are encouraged to critically reflect on the issues raised. A range of different issues may arise from these meetings. In the Wicking
program, issues raised by students in these feedback meetings include the patient load being too high, a desire for increased autonomy, an understanding of the students’ role amongst other staff in the facility, requests for more interaction with residents (both clinical and social), increased time in the presence of a registered nurse, and increased explanation from facility staff when confronted with a sudden change in a resident’s care plan or condition.

A facilitated feedback loop is instituted between the student group and the mentor group, who also meet weekly (see Mentor Feedback and Debriefing section below), in each RACF as this method of communication has been shown to facilitate teaching and learning in practice (Robinson, McInerney et al. 1999; Robinson and Cubit 2005). The exchange of information between the two groups is on an agreed-to basis. This means that members of each group decide what information they want the members of the other group to access. It is important for the university staff member facilitating these meetings to ensure that permission has been granted by the speaker/s to any feedback being disseminated to the parallel student or mentor group. Where possible, the mentor group meets directly after the student group, so that the feedback can be presented in a timely manner.

As part of the action learning approach used in this project, the feedback from these meetings can be used to make changes for the remainder of the placement as well as subsequent placements. Evidence for this has emerged from the Wicking program. For example, second year nursing students described how their feedback on limited opportunities for autonomy had resulted in greater opportunities for autonomy being available ("obviously something’s been said about that issue"). One student reported how “this week they said we could go off and do dressings”, which had not occurred previously. Another explained how “the ENs and RNs [had been] more positive, more ‘come and do this, do that’...better than it was”.

Students find the feedback meetings to be a positive experience. For example, 56% of second year nursing students in the Wicking Prototype TACF program found the feedback meetings to be ‘extremely helpful’ for their clinical experience. Students who found participation in weekly feedback meetings very helpful had a higher mean teaching and learning score compared with those students who found it not at all helpful. The perceived usefulness of receiving weekly feedback from nurse mentors also correlated with students’ likelihood of working in aged care following graduation. Of the students who found the weekly feedback to be very helpful, 84% reported that they were likely to work in aged care in the future compared to only 25% of students who found the feedback to be not at all helpful.

**Mentor Feedback and Debriefing**

Following the commencement of student placements, the mentor groups meet on a weekly basis at each RACF. Similar to the parallel student meetings, during these meetings the mentors discuss their experiences of acting as a mentor to students. These meetings provide mentors with the opportunity to change their practice and aspects of how the placement is run in response to their own discussions and the feedback provided from the student meetings. Mentors involved in the Wicking Prototype TACF program found these meetings to be valuable, with 82% reporting that they were extremely or very helpful in facilitating their
work as a mentor. Ninety-six per cent of the mentors found being able to give and receive feedback from the students whilst on placement extremely or very helpful.

2.4 Ongoing Evaluation

The importance of including evaluation as an integral part of the clinical placement program is to ensure that the effect of implementation is continually monitored. However, very few students, faculty or facility staff involved in the Wicking Prototype TACF program had previously experienced a placement that was subject to an evaluation. Ongoing evaluation is integral to the EBBPM and two of the six stages of implementation of the Wicking Prototype TACF program were dedicated to Review and Strategy Design. Assessment of how successful implementation of the placements has been must be ongoing as variables will change across facilities and over time. For example, staff changes may mean that parts of the model may need to be re-implmented (Robinson, Andrews-Hall et al. 2006). This model of developing clinical placements is collaborative and to align with that it is important to feedback the outcomes of the placements to all participants. There is literature to suggest that not involving the clinical staff in the feedback and evaluation process leaves them feeling unsure of the effectiveness of the placement that they provide (Tremayne 2007). This can contribute to negative attitudes regarding clinical placements (ibid). Providing them with meaningful feedback allows for collaboration on the review and redesign of the placement program and structure.

2.4.1 Clinical stream evaluation

A number of evaluation tools were used for evaluating the Wicking Prototype TACF program. The qualitative and quantitative evaluation is described below. The use of evaluation tools varies depending on what aspects of the placements are being evaluated.

**Qualitative Data Collection and Analysis**

Qualitative data were collected from meetings and interviews held with mentors, students, and key stakeholders, as follows:

- Students—the weekly feedback meetings that students participated in throughout the placements.
- Mentors—pre-placement preparation meetings, weekly feedback meetings held throughout placements, as well as one or two focus group discussions held post-placement to share their perceptions of the issues that impact on student placements.
- Mentor Leaders—pre and post-placement interviews.
- University staff—single interviews were held with university staff members who were involved with the pre-site visits at the facilities or who were involved with student assessments related to the placement.

In the Wicking Prototype TACF program, these meetings and interviews were digitally audio-recorded and transcribed. The transcripts were subjected to thematic analysis undertaken by two members of the research team, who met regularly to discuss the findings. These meetings provided the researchers with an opportunity to interrogate their interpretations of the data.
and clarify inconsistencies and explore alternate explanations. As such, they were crucial to maintaining rigour in the analytic process and ensuring that the researchers remained cognisant of their own position within the research. From this first level analysis of the data in the Wicking program, meeting minutes (case notes) were developed. These contained an account of issues discussed at the meeting under thematic headings. A broad range of themes related to placement preparation and experiences was identified, such as continuity between students and staff, consistency of supervision, opportunities for inter-professional learning, and knowledge of dementia. Participant narrative excerpts (coded with a unique identifier) were included to support this first level analysis. These minutes were returned to the respective mentor groups before the next meeting, but not to the students due to their short-term involvement in the project. The minutes were provided to mentors to give them an opportunity to continue critical reflection on the issues raised and consider the analysis presented. The return of meeting minutes to mentors also provided a checking mechanism to establish both the credibility of the analysis (Erlandson, Harris et al. 1993) and face validity (Lather 1991).

Quantitative Data Collection and Analysis

A description of the questionnaires included in the quantitative component of the evaluation of the Wicking Prototype TACF program can be found in the table below (Table 3). An evaluation schedule is followed where quantitative surveys are administered to all groups involved before the commencement of placements, at the end of the first week of placement and at the completion of the placement for each group of students. This is illustrated in the figure below (Figure 4).

2.4.2 Organisational stream evaluation

In addition to the meetings and interviews, organisational evaluation was conducted. Examples of insights sought during the organisational evaluation include: employee engagement; organisational climate; impact of staff/resident ratios on staff capacity to act as mentors; effective strategies to foster teaching and learning; and the impact of experience in a high/low care environment. During the discovery stage of the Wicking Prototype TACF program, organisational evaluation included reviews of organisational documents, a cost of turnover activity, and interviews and focus groups with RACF senior leaders and clinical staff. In addition, regular meetings were held to review achievements against recommendations and identify a defined program of work. Some aspects included in the organisational action plan include: external environment; leadership; business model; culture and values; people engagement; work unit climate; management practices; systems, processes and procedures; and task requirements and individual capability. During the subsequent stages of the Wicking Prototype TACF program, the organisational consultant engaged with the organisational leaders and members of the mentor group monthly to review and update the agreed action plan. Strategies to address barriers to achievement of the action plan and communication challenges were also discussed. Where the group identified leadership development priorities, these needs were also addressed.
2. Implementing Placements around the Evidence Based Best Practice Model

2.5 Conclusion

This document provides an account of how to institute an evidence-based inter-professional aged care placement. It provides a guide for organisations to consider when operationalising such placements. We hope you find it informative and useful in configuring placements to suit your local context.
2. Implementing Placements around the Evidence Based Best Practice Model

Table 3: Description of Components of the Wicking TACFP Surveys

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESCRIPTION</th>
<th>RATIONALE</th>
<th>SURVEYED GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics and Attitudes</td>
<td>A range of demographic and attitude items, including experience in aged care and, for students, feeling welcome in the facility and intention to work in residential aged care following graduation</td>
<td>Assess attitudes, collect background information and compare and contrast attitudes of different groups.</td>
<td>Students</td>
</tr>
<tr>
<td>Dementia Knowledge Assessment Tool Version 2 (D-KAT) (Toye, Popsecus et al. 2007)</td>
<td>Contains 21 items on dementia knowledge (responses: “yes”, “no”, “don’t know”)</td>
<td>Ascertain knowledge of dementia prior to and after placements.</td>
<td>Students</td>
</tr>
<tr>
<td>Clinical Learning Organisational Culture Survey (CLOCS) (Henderson, Creedy et al. 2010)</td>
<td>Contains 28 items about the culture in the work environment (5 point scale ranging from “strongly agree” to “strongly disagree”). Comprises five subscales: recognition, dissatisfaction, affiliation, accomplishment, and influence.</td>
<td>Assess mentors perceptions of their organisational culture and their capacity to contribute to, or influence the organisational culture of the RACF as it relates to teamwork, professional development and support.</td>
<td>Mentors</td>
</tr>
<tr>
<td>Clinical Mentor Self-Efficacy Questionnaire (CMSEQ) (Heale R, Mossey, S et al. 2009)</td>
<td>27 items about experiences facilitating student learning. Assesses the mentors’ perceptions of their organisational culture as it relates to their clinical learning (5 point scale ranging from “not at all confident” to “always confident”). Comprises four subscales: providing an insider perspective; being a role model; facilitating student learning; and assisting students to integrate.</td>
<td>Measure mentors perceived confidence in performing various roles associated with student learning and their mentoring role.</td>
<td>Mentors</td>
</tr>
<tr>
<td>UWE Interprofessional Education Questionnaire (IPE) (Pollard, K. C., Miers, M. E., &amp; Gilchrist, M. 2005)</td>
<td>Measures attitudes towards working and learning in multi-disciplinary team environments (5 point scale from “strongly agree” to “strongly disagree”). Comprises 4 subscales: communication and teamwork; interprofessional learning; interprofessional interaction; and roles and relationships.</td>
<td>Gauge attitudes towards working and learning in multi-disciplinary team environments prior to and after placements.</td>
<td>Students</td>
</tr>
<tr>
<td>Death Anxiety Questionnaire (DA) (Carmel, S &amp; Mutran E 1997)</td>
<td>Measures a person’s fear of death and dying (5 point scale ranging from “strongly agree” to “strongly disagree”).</td>
<td>Assess students’ level of anxiety as it relates to death and dying.</td>
<td>Students</td>
</tr>
<tr>
<td>Clinical Learning Environment Inventory (CLEI) (Chan 2002)</td>
<td>41 items about student perceptions regarding learning experience in RACF (4 point scale from “strongly agree” to “strongly disagree”). Comprises six subscales:</td>
<td>Ascertaining the level of student satisfaction with the learning environment and experience, and how learning was facilitated or impeded by mentors.</td>
<td>Students</td>
</tr>
</tbody>
</table>
### 2. Implementing Placements around the Evidence Based Best Practice Model

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Description</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching and Learning Assessment (T&amp;L) (Robinson, A.L., Andrews-Hall, S. &amp; Fassett, M. 2007)</td>
<td>15 items about student/mentor experiences of their placement and teaching within an RACF (5 point scale from &quot;strongly agree&quot; to &quot;strongly disagree&quot;).</td>
<td>Students, Mentors, Clinical Academic Tutors, Tutors</td>
</tr>
<tr>
<td>Orientation Checklist</td>
<td>32 items about whether various orientation items were covered (&quot;yes&quot;, &quot;no&quot;, &quot;not sure&quot;)</td>
<td>Assess perceptions regarding whether students were welcomed, and oriented to OHS and RACF policies and procedures.</td>
</tr>
</tbody>
</table>
2. Implementing Placements around the Evidence Based Best Practice Model

**Figure 4: Quantitative Evaluation Schedule for Wicking TACFP**

<table>
<thead>
<tr>
<th>Students</th>
<th>Mentors</th>
<th>DOC</th>
<th>Clinical Academic Tutors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool details in table above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-placement</td>
<td>When join the program</td>
<td>Week after all placements finish</td>
<td></td>
</tr>
<tr>
<td>Facility Information Form</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentor Initial Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentor Pre-placement Survey</td>
<td>Towards end each week new students start (at weekly meeting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentor Final Survey</td>
<td>End of placement for the relevant clinical group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Pre-placement Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students End of Week 1 Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Final Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Academic Tutor Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOC Orientation Checklist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentor Leader Orientation Checklist</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* To be collected at the end of the block of 10 week pre-placement meetings for Stage 2. To be collected immediately before first student placement for Stage 4.
3 References


Australian Institute of Health and Welfare (2010). Dementia and the take-up of residential respite care. Canberra. AIHW.


3. References


Happell, B. (1999). "When I grow up I want to be a ...? Where undergraduate student nurses want to work after graduation." *Journal of Advanced Nursing* 29(2).


3. References


Robinson, A., S. Andrews-Hall, et al. (2006). Building connections in aged care follow-up evaluation, School of Nursing and Midwifery, University of Tasmania.


3. References


University of Newcastle (2009). Clinical reasoning: Instructor resources. School of Nursing and Midwifery, Faculty of Health, University of Newcastle.

University of Tasmania (2010). Learning and teaching in clinical settings: A guide for clinical facilitators and preceptors. Launceston, School of Nursing and Midwifery, Faculty of Health Science, University of Tasmania.


4. Appendices

4.1 Appendix 1—Sample Mentor Leader Position Description: University School and RACF

University Name

POSITION DESCRIPTION

<table>
<thead>
<tr>
<th>School/Section:</th>
<th>University School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position Title:</td>
<td>Mentor Leader</td>
</tr>
<tr>
<td>Location:</td>
<td>RACF</td>
</tr>
<tr>
<td>Classification:</td>
<td>0.2 EFT RN 14 month appointment</td>
</tr>
<tr>
<td>Date:</td>
<td>July 2012</td>
</tr>
</tbody>
</table>

1. POSITION SUMMARY
This position will act as a Mentor Leader in the development of undergraduate aged care clinical placements.

2. SUPERVISION
2.1 Immediate Supervisor:
RACF CEO/DON & Head of School or nominee
2.2 Subordinates:
(If applicable)

3. PRIMARY TASKS
- Provide leadership to support the effective operation of the mentor group established at (name of RACF).
- Provide a primary liaison between the mentor group and their associated activities supporting students and the University (name) team
- Schedule regular meetings of the mentor group in liaison with the University (name) team and facilitate regular attendance at mentor meetings by the members of the mentor group
- Develop resources, including educational programs/schedules and rosters, to support medical, nursing and paramedic (and any other relevant disciplines) students experience quality clinical placements in aged care
- In liaison with University (name) team provide overall coordination and management of student placements, including pre-site visits, orientation of students to the facility and students engagement in clinical and education activities
- Liaise as required with relevant University (name) School of (relevant discipline) academic staff, with responsibility to oversee the respective student placements.
- Support the roll out of evaluations involving students and mentor group members in liaison with the University (name) team.
4. **Level of Responsibility**
- Perform tasks under the general direction of RACF CEO/DON and Head of School or nominee.
- While decisions are generally made within the scope of established procedures and guidelines, a high level of initiative and personal discretion is expected.

5. **Position Relationships**
The incumbent is expected to relate effectively with:
- CEO & DON of (RACF name)
- Head of School or nominee
- University (name) academic staff who support students on placement
- Students on placement
- Staff within (RACF name)

6. **Selection Criteria**
**Essential**
- Registered Nurse
- Good oral, written and interpersonal skills.
- High level organisation skills
- Minimum of 12 months experience in residential aged care, and a keen interest in dementia and palliative care and the implementation of evidence based practice
- Commitment and strong motivation to lead the development of quality clinical placements for undergraduate students in aged care in the development of (RACF name) as a learning organisation.
- Ability to communicate and collaborate effectively with a range of aged care staff, other professionals and University staff.
- Enthusiasm and a passion to mentor undergraduate students and support other staff in taking on mentoring roles.
- Ability to support and debrief staff who will be part of a mentor group.
- High level communication and collaboration skills to facilitate the planning for, and conduct of, student placements at the facility
- Commitment to ensure the effective evaluation of the project as outlined in the project protocol.

**Desirable**
- Post Graduate nursing qualification
- Significant experience in the care of people with dementia

**Position Description Approved**

Head of School & (RACF name) CEO:

______________________________________________________________
4. Appendices

4.2 Appendix 2—Sample Pre-site Visit Agenda

Student Pre-Site Visit—RACFs

Where possible, pre-site visits are held at each RACF for 1st and 2nd year nursing students to better prepare students for the aged care placement. They are held close to the placement date, usually in the week prior to placement. The length of the visit is two hours, with the first hour being a discussion of student, School and facility expectations of the placement and the second hour being orientation, including information about rosters, mentors and other details and a facility tour. Catering is sometimes provided.

Pre-site visit agenda:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Staff in attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st hour</td>
<td>Discussion around student expectations of placement</td>
<td>TACF Project Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Academic Liaison</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mentor Leader</td>
</tr>
<tr>
<td>2nd hour</td>
<td>Orientation</td>
<td>Mentor Leader or delegate</td>
</tr>
<tr>
<td></td>
<td>• Introduction to the facility including how staff are arranged on the Units and supervisory arrangements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Administration including rosters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provision of relevant documents such as the Student Orientation Manual</td>
<td></td>
</tr>
</tbody>
</table>

1st hour—Discussion around student expectations of placement:

*Note: This is based on previous student expectations meetings. This guide will need to be adapted according to the different circumstances of individual residential aged care facilities, students and Schools.*

INTRODUCTION

- Introduction of key staff and brief outline of their roles:
  - Academic Liaison (including visiting times)
  - Mentor Leader
  - University School Team
  - Various RACF roles—carer, EN and RN

- Who to approach for guidance
- Introduction to the facility and how staff are arranged on the Units
- Role, availability and access to mentors, including any primary and secondary mentors

BACKGROUND

- Purpose of clinical placement
- The importance of students spending significant time with carers
- Student roles in identifying their own learning outcomes and objectives
DISCUSSION

- Initiate discussion with students where they can share their expectations of the placement

During this discussion it is important to address the following issues:

- That students will have a timetable and schedule to guide their placement activities
  - important to note difference from usual approach which centres on opportunistic learning
  - involves strategic learning
- Key focus on developing skills in the assessment of older people with multiple co-morbidities, including dementia
- The importance of students working with carers and providing hygiene care as a key assessment activity
- Mention other key educational activities students will participate in
  - Dementia Palliation workshop—and why we present that
  - Cognitive assessment of residents with dementia
  - IPL engagement—structures associated with participation in this activity, students informed of their IPL partners and allocated residents
  - Working with ENs and medication administration—how to maximise learning opportunities
  - Opportunities for nursing and paramedic students to participate in medical student tutorials

2nd hour—Orientation:

INTRODUCTION

- Introduction to the facility and how staff are arranged on the Units
  - walk around the facility to orientate students to the environment
- Discuss who to approach for guidance
- Discuss how students will engage with mentors
  - i.e. supervisory arrangements

ADMINISTRATION

- Process for informing about sick leave and the need to make up the time
- Confidentiality agreement explained and signed
- Discuss prescribed PEP (Professional Experience Placement) hours
  - mentors won’t sign off on self-directed learning (i.e. if students go home)
- Students informed that they have been rostered in pairs
  - students directed to do their allocated residents together after first couple of days, once they have settled in
- All students are welcome to attend the medical student presentations
4. Appendices

**PROVIDE**

- Student orientation manual with information about the facility. These may include:
  - Overview of the facility
  - Facility mission statement
  - Facility policies
  - Staff hierarchy and structure
  - Contact details and roles of key staff
  - Floor plan/map of the facility
  - Student Code of Conduct
  - Student Orientation Checklist
- Student timetable/program
- Resident's diagnosis list
- Clinical Assessment Tool
  - explain that role of the tool is to let other staff know what students can do
- Student In Service sheet with details of education/training sessions available
- Mentor group list with pictures
- Any extra handouts—e.g. dementia, palliative care, etc.
4.3 Appendix 3—Sample Memorandum of Understanding

STUDENT PLACEMENT AGREEMENT

This Agreement is made on the day of , 2013

BETWEEN

THE UNIVERSITY (name) a body corporate continued under the (relevant Act), of (address) ABN (number) (the University)

AND

(ORGANISATION NAME) trading as (RACF name) and its registered office situated at (address) ABN (number)

RECITALS

A. The Parties have each expressed an interest to further advance the mutually beneficial programmes in tertiary education in the area of aged care. It is intended this agreement will assist in building and developing the relationship.

B. The TACF project aims to provide (names of student disciplines) students with a positive placement experience so they develop a more positive attitude to working in residential aged care facilities (RACFs).

C. (RACF name) have agreed to accept placements of undergraduate students of the University from the Faculty of Health Science at their facility located at (address).

D. The parties have agreed the placements will be managed in accordance with the terms and conditions of this agreement.
OPERATIVE PART

The parties agree as follows:

1. Interpretation and Definitions

1.1 Definitions

**Academic Liaison** means a University employee who has expertise in aged care and a commitment to excellence in clinical education.

**Commencement Date** means the day this agreement is signed.

**Completion Date** means 18 months after the Commencement Date.

**Discipline** means the disciplines taught at the University (name) in the Faculty of Health Science which includes Nursing, Medicine, and Paramedic Practice.

**Evidence Based Best Practice Model** means a model to facilitate quality clinical placements in aged care that was developed by Robinson *et al.* (2008)¹ and forms the basis for the organisation of the placements detailed in this agreement.

**Information Toolkit** means an information booklet that includes details about the students’ course, learning objectives and guidelines for placement facilitation, and is used by Mentors to facilitate quality clinical placements in aged care.

**Mentor** means an employee of (RACF name) appointed to supervise, evaluate and oversee students whilst on their placement at the Facility.

**State Reference Committee** means a committee to provide guidance and advice and facilitate linking into relevant networks. State reference committee members will include representatives from key bodies such as the Department of Health and Ageing, Council On The Ageing, Aged and Community Services Australia, and the Department of Health and Human Services (Tas.), as well as participating RACF CEOs, Heads (or nominees) of the UTAS School of Medicine and School of Nursing and Midwifery, a GP representative, and project team members (project leader, organisational consultant, project coordinator). The committee will meet twice annually.

2. Term

This agreement commences on the Commencement Date and ends on the Completion Date unless agreed between the parties otherwise.

---

4. Appendices

3. **Payment**
(RACF name) agrees to pay to the University on the Commencement Date the sum of $\text{(amount)}$.

4. **Clinical Placements for students undertaking the Bachelor of Nursing (BN)**

4.1 (RACF name) agrees to provide not less than 30 clinical placements for University (name) BN students during the term of this agreement as follows:

(a) 10 clinical placements for second year University (name) BN students during semester (number) in (year),

(b) 10 clinical placements for second year during semester (number) in (year); and

(c) 10 clinical placements for first year University (name) BN students in semester (number) (year).

4.2 (RACF name) will notify and negotiate with University (name) on the student distribution and dates acceptable for the clinical placements referred to in:

(a) Clause 4.1 (a) not less than 4 weeks; and

(b) Clause 4.1(b) and (c) not less than 12 weeks

prior to the student placements.

5. **Clinical Placements for students undertaking the Bachelor of Medicine and Bachelor of Surgery (MBBS)**

5.1 (RACF name) agrees to provide not less than 18 clinical placements for University (name) MBBS students during the term of this agreement as follows:

(a) 6 clinical placements for fifth year University MBBS students during semester (number) in (year),

(b) 12 clinical placements for fifth year University MBBS students during semester (number) in (year)

5.2 (RACF name) will notify and negotiate with University (name) on the student distribution and dates acceptable for the clinical placements referred to in:

(a) Clause 5.1 (a) not less than 4 weeks; and

(b) Clause 5.1(b) not less than 12 weeks

prior to the student placements.
6. Clinical Placements for students undertaking the Bachelor of Paramedic Practice (BParamedPrac)

6.1 (RACF name) agrees to provide not less than 10 clinical placements for University (name) BParamedPrac students during the term of this agreement in semester (number) in (year).

6.2 (RACF name) will notify and negotiate with University (name) on the student distribution and dates acceptable for the clinical placements referred to in clause 6.1 not less than 12 weeks prior to the student placements.

7. The University Obligations

7.1 The University shall prepare an Information Toolkit to assist staff at (RACF name) to support the students.

7.2 Appoint an Academic Liaison for each Discipline to co-ordinate and oversee the placements in their respective Discipline and liaise with the Mentor and students.

7.3 Prepare and hold meetings for Mentors prior to placements to discuss the student’s course, placement expectations, Information Toolkit, the Evidence Based Best Practice Model and dementia palliation, including discussions on how to apply this new knowledge to mentoring students.

7.4 Provide all students with access to the dementia palliation workshop materials in paper copy or electronically.

7.5 Ensure that nursing students are adequately prepared for aged care placements by participation in:

(a) a seminar to prepare students for the aged care placement including but not limited to discussing student expectations and (RACF name) expectations; and
(b) visit to a residential aged care facility.

7.6 Complete evaluations on the implementation of the Evidence Based Best Practice Model including student, Mentor and organisational evaluations.

7.7 Analyse the data and project outcomes including reporting to (RACF name) the recommendations for future student placements.
8. **(RACF name) Obligations**

8.1 Appoint Mentors for the students.

8.2 Provide access to a Mentor for each student.

8.3 Ensure Mentors attend preparatory meetings and workshops both prior to and during the placements, including attendance at a weekly training session on dementia, palliative care and related subjects during the term of the placements, and participate in evaluation.

8.4 Identify and appoint a Mentor Leader to be responsible for preparation, co-ordination of placements and liaise with the Academic Liaison for the respective Discipline.

8.5 Arrange a weekly training session for students and (RACF name) staff on dementia, palliative care and related subjects during the time of the student placements.

8.6 Ensure there is on site a room available to accommodate meetings to develop placement arrangements, student and Mentor workshops, weekly student and Mentor meetings and weekly forums on dementia and palliative care.

8.7 Co-ordinate and ensure attendance of not less than 85% of Mentors to meetings and workshops during both the development stage of project and the student placements.

8.8 Facilitate and encourage participation of (RACF name) employees and key stakeholders, as required and appropriate, in interviews, focus groups, surveys related to management organisational dynamics and learning systems.

9. **Exchange of Information**

Each party agrees that during the project they will use all reasonable endeavours to exchange information relating to plans and proposed initiatives related to the project. It is intended this will occur by attendance at regular meetings held between both University and (RACF name) employees involved in the project.

10. **State Reference Committee**

The parties agree to liaise and accommodate as necessary the State Reference Committee who are appointed by the University to provide guidance and advice and link the parties into relevant networks, through bi-annual meetings.
11. **Oversight Committee**

The parties will appoint an oversight committee consisting of the Head of School or nominee for each Discipline and the CEO or nominee of (RACF name). The oversight committee must meet at least once during the term of the project and is required to endeavour to progress initiatives and overcome any barriers to the collaborative projects.

12. **Review of the Agreement**

The Oversight Committee meeting must meet to discuss the progress of the agreement and review any priorities for the collaboration for the following year.

13. **Dispute Resolution**

13.1 Should any dispute arise in relation to this Agreement, the Parties must use all reasonable endeavours to settle the matter within fourteen (14) business days of all Parties becoming aware of the dispute.

13.2 If the Parties fail to satisfactorily resolve the dispute under clause 13.1, a third person appointed by the President of the Law Society of Tasmania will be asked to act as mediator to try and resolve the dispute.

13.3 The Parties must co-operate to the extent necessary to enable the mediator to mediate the dispute within 20 Business Days of his or her appointment and the fees of the mediator will be paid by the Parties in the proportion determined by the mediator.

13.4 If the dispute is not settled in accordance with clause 13.3, then the dispute must be referred to arbitration in accordance with the provisions of the Commercial Arbitration Act 2011.

14. **Miscellaneous**

(a) This Agreement is the entire agreement of the parties concerning its subject matter and supersedes all other representations, negotiations, arrangements, understandings or agreements between the parties.

(b) If any part of this Agreement is or becomes invalid, void, voidable, illegal or unenforceable for any reason, that part is severed and the remaining parts continue to be enforceable and are to be construed with any additions, deletions and modifications that are necessary to give effect to the remaining parts of the Agreement.

(c) While each party will use reasonable endeavours to ensure that the persons responsible for delivering the Project have the expertise necessary to perform
the duties described in the Schedules, to the extent the law allows, it makes no warranties, representations or undertakings as to the fitness for a particular purpose of any service provided or the results of the Project, as described in the reports and explained in any requested meetings.

(d) Each party to this agreement shall be solely responsible for any and all actions, suits, damages, liability and other proceedings brought against it as a result of the alleged negligence misconduct error or omission of any of its officers, agents or employees. Neither part is obligated to indemnify the other party or to hold the other party harmless from costs or expenses incurred as a result of such claims; and each shall continue to enjoy all rights, claims and defences available to it under law.

(e) The covenants contained in this Agreement are made for the benefit of the parties and bind the parties, their heirs, executors, administrators, successors and assigns.

(f) This Agreement may be signed in counterparts and all counterparts taken together constitute one document.

(g) This Agreement may only be varied by agreement in writing by the parties.

(h) This Agreement is governed and construed in accordance with the laws of the State of Tasmania and the parties irrevocably submit to the jurisdiction of the courts of that State.
4. Appendices

Executed as an Agreement

SIGNED for and on behalf of the UNIVERSITY (name)
by its authorised representative:

__________________________
Print name:
Title:

Witness (please sign)

__________________________
Full name

__________________________
Address

__________________________
Occupation

SIGNED under seal for and on behalf of RACF name by its authorised representatives:

_____________________________
Signature
_____________________________
Print Name

_____________________________
Signature
_____________________________
Print Name
4.4 Appendix 4—Example of Nursing Student Learning Objectives

All Students Learning Objectives Regarding Dementia

1. Understand the connection between dementia and death.
2. Describe the nature of the dementia trajectory (often progressive; prolonged deterioration; no clearly defined terminal phase).
3. Identify how the dementia trajectory can interact with other disease trajectories.
4. Identify the stages of dementia (descriptive understanding) and key changes that occur as the dementia progresses.
5. Identify the importance and benefits of initiating discussion with family members of people with dementia (PWD).

Nursing Professional Experience Placement Objectives

The student will:
• Assist the RN/EN/AIN with personal care needs (activity, safety, hygiene, comfort, nutrition, elimination);
• Actively participate in core nursing skills (e.g., vital signs, health assessment, physical examination, infection control, administering medications) while under supervision;
• Become more familiar with nursing, medical and other relevant documentation (policies, procedures, protocols, incident reports).
• Utilise critical thinking/problem-solving skills and accurately document any assessment undertaken in the presence of an RN (e.g., assessing a wound);
• Understand how assessment, planning, implementation and evaluation strategies are used by an RN in conjunction with the Australian Nursing and Midwifery Council (ANMC) competencies;
• Develop pharmacological knowledge and participate in medication administration (e.g., oral medications, injections, eye drops, creams, ointments, suppositories, inhaled medications) under the direct supervision of a registered nurse;
• Will cultivate an understanding of the importance of developing positive working relationships with all members of the healthcare team and will function in a team environment;
• Demonstrate a developing sense of professional responsibility.
4. Appendices

4.5 Appendix 5—Example of Medical Student Learning Outcomes

Learning Outcomes

These learning outcomes may be met by immersion in the facility but also by the specific activities or formal teaching programs organised for your week of placement. They will also have been touched on in previous placements and formal programs. This placement offers a chance to achieve these learning outcomes in a very practical sense and in the unique context of a residential aged care facility and related independent living units. The learning outcomes are based upon:

- the RACGP’s curriculum statement for aged care
- “Medical Care of Older Persons in Residential Aged Care Facilities” 4th edition (the silver book)
- “Guidelines for Palliative Care Approach in Residential Aged Care”

**Theme 1 (Human Health and Disease)**

1. Demonstrate the use of health promotion in the elderly including nutrition and exercise.
2. Demonstrate awareness of how physical and psychological changes of aging affect lifestyle, including how people cope and situations in which they no longer cope.
3. Demonstrate an ability to assess for common psychological and mental health issues in the elderly.
4. Describe how to, and demonstrate an ability to, perform assessments on patients regarding their mental status and cognitive function.
5. Formulate management plans that require an understanding of the impact of multiple health conditions and chronic disease in the elderly.
6. Formulate management plans and design audits that require an understanding of pharmacology in older people including altered drug metabolism and special risks of drug therapy especially from polypharmacy.
7. Design and undertake some aspect of audit as a clinical care quality improvement activity in an Aged Care Facility in relation to e.g. falls, advance care directives, behaviour management.
8. Show how to take a history and examination in order to elicit common diseases that affect the aged, involving carers where appropriate.
9. Describe and undertake functional assessments on elderly people, including of their social behaviour, continence, mobility (including falls risk), and activities of daily living.
10. Describe how to investigate and refer appropriately for diseases affecting the elderly.
11. Understand the importance of clinician continuity of care for the elderly.
12. Understand the palliative approach to care of patients in an aged care facility including those with dementia.
13. Understand environmental and behavioural management options for dementia patients with challenging or socially unacceptable behaviours.
4. Appendices

**Theme 2 (Communication and Collaboration)**

1. Demonstrate awareness of the impact of sensory impairment on effective clinician-patient communication and measures to address these barriers.
2. Demonstrate awareness of how cultural and social barriers to clinician-patient communication with older people and the strategies to overcome these.
3. Demonstrate awareness of how consultation environmental factors such as privacy, background noise and location can affect communication in the elderly.
4. Describe how families and carers may affect patient communication.
5. Demonstrate awareness of the roles of the clinical team caring for people in a Residential Aged Care Facility.
6. Demonstrate awareness of the methods used by the clinical team to enhance health outcomes for Residential Aged Care Facility residents.

**Theme 3 (Community Health and Disease)**

1. Describe the epidemiological patterns of common medical and psychological conditions that affect older people.
2. Discuss the social and behavioural impact of aging.
3. Discuss how ethnicity, socioeconomic status, gender, family and community supports and geographical location may affect aged care service needs, including acceptance and availability of services and activities.
4. Summarise the social structure of aged care health services including structures in community, hospital and residential aged care settings.
5. Discuss the role of family and carers in providing aged care including carer stress.

**Theme 4 (Personal and Professional Development)**

1. Demonstrate awareness of issues of patient autonomy in older people.
2. Describe the principles behind power of attorney, and advance medical care plans and identify legislative processes that implement them.
4. Appendices

4.6 Appendix 6—Example of Paramedic Student Learning Outcomes

2nd Year Paramedic Student Learning Outcomes

Theme 1: Clinical Assessment/Patient Management

1. Describe the principles of a palliative approach to care
2. Discuss the social and behavioural impact of aging
3. Describe the nature of the dementia trajectory and how it can interact with other disease trajectories

Theme 2: Clinical Skills and Procedures

1. Describe how to and demonstrate an ability to approach, take a history and perform an examination in order to elicit common diseases that affect the aged, involving carers where appropriate, including the patient’s mental status and cognitive function

Theme 3: Critical Thinking/Decision Making

1. Describe the principles behind power of attorney, and advance medical care plans and identify legislative processes that implement them

Theme 4: Communication and Collaboration

1. Understand the importance of and describe strategies for communicating including non-verbal behaviours as a way of communicating needs for people with dementia and their family members

Theme 5: Professionalism

1. Identify synergies that exist between the various health disciplines and strategies for effective communication to provide aged care
2. Identify measures which enhance the effective delivery of patient care when a paramedic is called to a nursing home
4. Appendices

4.7 Appendix 7—Example of Tool Developed by RACF Staff to Facilitate their Involvement in the Assessment of Nursing Students’ Competency During the Clinical Placement

Clinical Assessment Tool

Student Name:__________________________  
Primary Mentor:__________________________  
Secondary Mentor:________________________

<table>
<thead>
<tr>
<th>Learning Opportunity</th>
<th>Activity</th>
<th>Relevant Competency Domain</th>
<th>Observe ECA/EN/RN</th>
<th>Supervise EN/RN</th>
<th>Competent RN</th>
</tr>
</thead>
</table>
| Hygiene care         | Hand & nail care  
|                      | Skin care  
|                      | Full bed sponge  
|                      | Showering, drying, dressing  
|                      | Skin integrity  
|                      | Assisting to toilet  
|                      | Incontinence skin care  
|                      | Application of incontinence aid  
|                      | Oral hygiene | | | |
| Wound management     | Aseptic technique  
|                      | Care of diabetic wounds  
|                      | Care of skin tears  
|                      | Simple wound dressing  
|                      | Complex wound dressing | | | |
| Oxygen therapy       | Oxygen via mask  
|                      | Oxygen via nasal cannula  
|                      | Oxygen concentrator  
|                      | Changing oxygen cylinder | | | |
| Physiotherapy        | Manual handling  
|                      | Positioning in bed/chair  
|                      | Chest physiotherapy  
|                      | Walking & exercise program | | | |
| Nutrition            | Assisted feeding with swallowing difficulties  
|                      | Assisted feeding of PWD | | | |
| Therapeutic Communication | Dementia  
|                      | - Validation  
|                      | - Reminiscence  
|                      | - Distraction  
|                      | - Withdrawal | | | |
Nursing Competency Domains

Professional Practice—PP
Provision & Coordination of Care—P&CP
Collaborative & Therapeutic Communication—C&TC
Critical Thinking & Analysis—CT&A

<table>
<thead>
<tr>
<th>Learning Opportunity</th>
<th>Activity</th>
<th>Relevant Competency Domain</th>
<th>Observe ECA/EN/RN</th>
<th>Supervise EN/RN</th>
<th>Competent RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment &amp; management of the older person</td>
<td>Wound swab</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Throat swab</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urine specimen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Faeces specimen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood sugar levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vital signs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management</td>
<td>SC injections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IM injections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transdermal medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Syringe drivers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inhalers and spacers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nebulisers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye drops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heat pack/cold pack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crushed oral medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topical medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pessaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suppositories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enemas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>S8 medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sublingual medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Transfer to hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Progress notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliation</td>
<td>Dementia palliation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preparation of deceased person’s body</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Appendices

4.8 Appendix 8—Dementia/Palliation Presentation

Aged Care Clinical Placement
Dementia-Palliative Care Lecture

For
Medical, Nursing and Paramedic students

Dementia as a Terminal Condition

Associate Professor Fran McInerney,
Australian Catholic University

Professor Andrew Robinson,
Wicking Dementia Research and Education Centre

School of Nursing and Midwifery UTAS

Dr Sharon Andrews,
Wicking Dementia Research and Education Centre
4. Appendices

Session Objectives

1. Acknowledge dementia as a terminal condition.
2. Understand the connection between dementia and death.
3. Describe the nature of the dementia trajectory [often progressive; prolonged deterioration; no clearly defined terminal phase].
4. Identify how the dementia trajectory can interact with other disease trajectories.
5. Identify the stages of dementia (descriptive understanding) and key changes that occur as the dementia progresses.
6. Identify the importance and benefits of initiating discussion with family members of people with dementia (PWD).

Dementia: What is it?

• A group of features.
• Begins slowly.
• Many types, the main two are:
  - Alzheimer’s (most common)
  - Vascular dementia
• Others including Lewy-body's, fronto-temporal, AIDS-related, alcohol related, Pick's and Parkinsonian dementias (AIHW 2006).
4. Appendices

Alzheimer’s Disease

- Most common dementia (two thirds of cases)
- Onset is gradual & progression is slow
- May be early language disturbances (word substitutions, impaired comprehension)
- Delusions & hallucinations in 50%

Vascular Dementia

- Abrupt onset & step-wise decline

More general features of the dementias

- Impaired memory, planning, insight & initiative
- Shuffling and difficulty walking
- Fluctuating emotions (Leys, Enlundand & Erikjnuttj, 2002; Alzheimer’s Australia 2005)

Dementia is caused by degenerative diseases

The symptoms get progressively worse as the brain degenerates

People die because of dementia due to loss of brain function, which impacts on body functions necessary to sustain life.
4. Appendices

Dying of dementia: implications brain cell death

Cessation of eating and drinking:
• problems with chewing and swallowing – muscles and nerves required no longer work
  in a coordinated fashion (Gillick & Mitchell 2002).

Infections:
Reductions in mobility, people become bed/chair bound, may not be able to report
symptoms of an infection (Volicer and Hurley 1998).
• Pneumonia - reduction in the ability to cough, reduced ability to clear lungs
  and airways of bacteria.
  - Unable to hold self upright, difficult to clear airways.
  - Aspiration on saliva or inhaling food, fluid into lungs (problems
    with swallowing)
• Urinary infections

Strokes: for those with a history of dementia of vascular causes.

How do dementia and other diseases interact?

• Many diseases/health problems become more common as people age (e.g., heart disease, kidney disease, muscle and bone
  problems, cancer).
• Likewise the risk of developing dementia increases with age and with risk factors such as high blood pressure, smoking, diabetes,
  high blood fat levels.
• Dementia can make assessing other health problems more difficult
  (e.g., poorer memory and insight may stop the person from giving
  an accurate history of how they are managing).
• Need to differentiate dementia from delirium.

Decision-making about health issues becomes more complicated.
Consequences of Dementia:

Brain damage which results in impairment of many aspects of life:

1. Cognitive problems
2. Behavioural responses
3. Functional deficits
4. Movement problems
5. Psychiatric conditions

1. Cognitive problems

Problems with:

- Memory.
- Planning activities – e.g., how to shower self or dress.
- Impulse control – e.g., pinching someone on the bottom, shouting when frustrated, hitting out when frightened or frustrated.
- Expressive speech – e.g., difficulty with naming objects, or finding the right word and sometimes swearing instead.
- Usual learned behaviours – knitting, cooking, sewing, driving, gardening.

(Caro et al. 2002)
2. Behavioural responses

- Disappearance of old behaviours, e.g., less irritable and stubborn or perhaps more irritable and stubborn; loss of humour or become more placid.
- Emergence of dysfunctional behaviours such as apathy, disinhibition, wandering, aggression (in response to fear/frustration), perseveration (going on and on about something).
- More difficult for care-givers than cognitive problems.
- Common cause of carer burn-out.
- May be the main reason for placement.

(Caro et al. 2002)

3. Functional deficits

Activities of daily living:
- eating, dressing, bathing, grooming

Instrumental activities of daily living:
- phoning, banking, shopping, shaving

4. Movement problems

More likely as the dementia progresses
- Disturbed gait (walking / balance)
- Rigidity
- Jerks
- Falls (Qizilbash & Lopez-Arietta 2002)
5. Psychiatric conditions

- Depression is frequently present in people with dementia. Their function and cognition worsens if they have depression as well.
- Depressed persons may complain of physical symptoms/problems – ‘sadness’ may be lacking.
- Anxiety is common and difficult to treat.
- Psychosis: hallucinations (seeing or hearing things that aren’t there), delusions (false ideas), illusions (based on reality).
- If these symptoms are not upsetting to the person with dementia they may not need treatment, due to side effects of medications. (Brodarty et al. 2001)
4. Appendices

Dementia trajectory to death

- characterized by slow progressive decline;
- slight increase in functional loss as death approaches (Covinsky et al. 2000).

“No abrupt changes that signal the onset of a terminal phase...”
Different to the path of someone with untreated cancer
(Covinsky et al. 2000).

Difficult to recognise the dying phase.

The importance of understanding dementia as a terminal illness

- ‘At nursing home admission, only 1.1% of residents with advanced dementia were perceived to have a life expectancy of less than 6 months; however, 71.0% died within that period’ (Mitchell, Kiely, Hamel 2005).

People with dementia:

- Less to have advance care directives.
- More likely to experience burdensome interventions at the end of life e.g. hospitalisation and invasive procedures.
- Often receive sub-optimal palliative care.
4. Appendices

Clinical course of advanced dementia

- US study (Mitchell et al. 2009) followed 323 nursing home residents with advanced dementia for 18 months in 22 nursing homes.
- Distressing symptoms during last 18 months were common: dyspnoea (46%), pain (39.1%), pressure ulcers (38.7%), agitation (38.7%), aspiration (40.6%).
- Symptoms not confined to the terminal stage in this study – but evident throughout the end of life course.
- Highlights proactive deployment of palliative care – well before the terminal stage.

Clinical course of advanced dementia cont...

Common complications in the last 18 months of life

<table>
<thead>
<tr>
<th>Frequent complications</th>
<th>Probability of at least one episode during study period</th>
<th>6 month mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>41.1%</td>
<td>46.7%</td>
</tr>
<tr>
<td>Febrile episode</td>
<td>52.6%</td>
<td>44.5%</td>
</tr>
<tr>
<td>Eating problems</td>
<td>85.8%</td>
<td>38.6%</td>
</tr>
</tbody>
</table>
4. Appendices

In summary

- Dementia, causes death - is a terminal disease,
- Difficult to recognise the terminal phase,
- People with dementia are fragile in their health (especially in advanced dementia), and
- An approach that emphasises comfort, quality of and proactive care planning to avoid burdensome interventions is necessary

Wicking Dementia Research and Education Centre

Dementia and a Palliative Approach to Care

Associate Professor Fran McInerney,
Australian Catholic University
Professor Andrew Robinson,
Wicking Dementia Research and Education Centre
School of Nursing and Midwifery Utas.
Dr Sharon Andrews,
Wicking Dementia Research and Education Centre
Session Objectives

- Describe the principles of a palliative approach to care.
- Identify when, where and by whom a palliative approach can be implemented.
- Describe the applicability of a palliative approach to the care of people with dementia (PWD).
- Recognise the benefits of implementing a palliative approach to care for PWD at residential aged care facilities as early as practicable.

Overview

- Introduction to a palliative approach,
- Contemporary developments in palliative care,
- Specialist palliative care,
- Terminal care,
- Who can benefit from a palliative approach, where and by whom can it be provided.
- Palliative approach and aged care
How do dementia and palliative care go together?

Because dementia is a terminal condition, then it makes sense that a palliative approach to care provision is appropriate.

So, what is a palliative approach?

A Palliative Approach aims to

... improve the quality of life (QoL) of people with life limiting conditions such as dementia,

... provide support for family throughout the illness journey and in bereavement.

... reduce suffering through early identification, assessment and treatment of pain and other physical, cultural, psychological and spiritual needs;

... proactive approach applicable at any point in the illness journey

(ADoHA 2006)
4. Appendices

A Palliative Approach also involves

... a multi-disciplinary approach;

... collaboration and information sharing with the person and their family;

... Focused on the quality of living and dying;

... tailored to meet the needs of the individual.

(ADoHA 2006)

A palliative approach - Who can benefit from?

Any person with a life limiting illness at any stage of that illness.

• Includes people with malignant (e.g., cancer) and non-malignant conditions such as demential
• HIV/AIDS, MND, Parkinson's disease, COPD, advanced heart, renal, liver disease, cancer AND advanced frailty due to old age.

Who can provide a palliative approach to care?

• All health care professionals
4. Appendices

Where would a palliative approach be implemented and who might do this?

- The palliative approach can be implemented wherever the person with the life-limiting illness is – e.g., home, RACF, hospital.
- Best implemented by a multi-disciplinary team.
- Providers are generally the ‘aged care team’ which includes aged care staff (carers, nursing staff, allied health, GP).
- The team may also access specialist palliative care resources as needed and available.

Specialist Palliative Care

- Those services with palliative care as their core specialty.
- Usually needed by a specific minority of people – complex care.
- Input from specialist service usually provided in partnership with primary care provider (nursing staff, GPs).

Terminal Care

- Refers to the management of an individual in the last days or week of life.
- The person is in a progressive state of decline.
- Care process is sharply focused on comfort and support. (ADoHA 2006)
4. Appendices

What a palliative approach is NOT...

- It is NOT the same as terminal care,
- It is NOT only provided by specialist palliative care trained staff,
- It is NOT offered when “nothing else can be done”,

Why is a palliative approach important in residential care?

- Shorter length of stay of increasingly dependent residents (approx 50% of residents die every 12 months in high care) (Andrews-Hall et al. 2007).
- Over half (53%) of residents have some form of dementia (AIHW 2010).
- More complex care needs (including for those with other illnesses i.e. multiple co-morbidities).
- Approx 88% of people in RACFs will exit via death (AIHW 2010).
Why is a palliative approach important in residential care? cont.....

Profile of residents is rapidly changing:

- Older ages when admitted,
- Higher dependency for longer periods of time,
- More complex care needs from the time of entry to RAC.

- Difficulty in recognising trajectory of progressive decline to death – especially for people with non-malignant conditions (e.g. dementia).

Dying with dementia

- Living-dying trajectory is ambiguous.

- May not be a clearly defined end of life phase.

- Need for care and support over the course of their illness journey, not just in the final days of life:

This is what a palliative approach to care offers.
4. Appendices

Benefits of a palliative approach to the care of people with dementia in RACFs

- Promotion of a positive and open attitude towards death and dying – a different lens through which to view care.
- Fosters active and open discussions with family caregivers of PWD about deterioration, dying and the importance of planning for care.
- Focuses on quality of life rather than a “treatment as usual approach”.
- Values collaboration with multidisciplinary team members to improve quality of care.

Focuses on quality of living and quality of dying!

A Palliative Approach to care – best practice in RACFs

- Best practice guidelines (ADoHA 2006)
Two key considerations in implementing a palliative approach for people with dementia in RACFs

Guidelines for a Palliative Approach in Residential Aged Care (ADoHA 2006)

Section 5 – Advanced Dementia

Guideline 11:
Remaining in familiar surroundings is beneficial for residents with dementia as this helps promote feelings of orientation and security.

Guideline 13:
The use of aggressive medical treatment of infections / other illnesses is not recommended for residents with advanced dementia. Instead, a palliative approach is recommended, which might include short-term antibiotic therapy to improve symptoms and quality of life.

Care for Residents with Dementia in RACFs

Communicating with Residents, Family and Staff
This session...

Has a focus on:

- What are some of the things we need to think about to improve our communication with residents, family caregivers and other staff caring for people with dementia to better enable a palliative approach for affected individuals?

The needs of people living with and dying of dementia have to be addressed and families/loved ones are key players in this process

- One strategy that is consistent with a palliative approach is relationship-centred care (Nolan et al 2004).
- Relationship-centred care involves a collaboration between patients, their families, health professionals and the wider community and values all of these players.
- Collaboration can assist residents, families, and staff, as partners in care, address their needs, fears and concerns through the sensitive sharing of knowledge of the resident, dementia and palliative care

“Fear is always a bad counsellor...”
4. Appendices

Communication – what is spoken and what is said...

We all communicate in verbal and non-verbal ways – while verbal content is of minor importance to all of us, people with dementia are even more sensitive to tone and body language – so, pay close attention to the ‘music’ rather than the ‘lyrics’ in communicating.

Elements of Personal Communication
- 7% spoken words
- 38% voice, tone
- 55% body language

For people with dementia, their behaviour is often a form of communication

Non-verbal behaviours
eg: agitation, restlessness, aggression, combativeness

May reflect unmet need,
eg: pain, hunger, thirst, toileting

Repetitive vocalizations and changes in tone, urgency, or rapidity of speech can signify unmet needs, even if the specific verbalizations are meaningless

Nurses should try to interpret the meaning of these behaviors rather than dismissing them as symptoms of the dementia
4. Appendices

Sources of assessment data – making meaning out of mystery in dementia behaviours

- Resident history/nursing/care notes
- Holistic resident assessment – physical, psychological, social, emotional and spiritual aspects of the person
- Information gained from family/significant others
- Information gained from facility care staff eg nursing, personal/extended care staff
- Information gained from the aged care team eg. diversional therapists/lifestyle staff, pastoral carers

Communication with family caregivers of people with dementia

Communication, primary mechanism to manage uncertainty:

Content: What is said
- Clear, reliable, and informed information, consistent amongst health care team.

Relationship: How it is said
- Building trusting relationship by demonstrating empathic (feeling with) behaviours – acknowledging family caregivers’ emotions; listening; providing emotional support; encouraging questions.
Help families to understand what it means for their relative to have dementia and the implications of this

Why is this important?
• Most people are unaware that dementia is a terminal condition
• Families are often unsure about what will happen to their relative as the dementia progresses
• Families tend to think that their relative will die of a sudden/acute event, rather than a progressive process of decline

Some cues for nursing staff
• Can you tell me, what is your understanding of your relative’s dementia?
• Has anyone talked to you about what dementia means for you relative’s future health?
• Even though there is no cure for dementia would you like to know about the type of care we provide to ensure that your relative has the best possible QOL?

“NURSE” the Emotions

• Name – “I see how upset you are”
• Understand – You wanted to care for your husband at home. I see how difficult this must be for you”
• Respect – “I am really impressed by your caring and involvement”
• Support – “We will get through this together”
• Explore – “Tell me”
4. Appendices

How can we show family members that you want them to be involved?

Active Listening: turn full attention to the person rather than focusing on your own concerns or what to say in response. Focus not so much on what you say, but demonstrating that you are willing to listen, and prepared to try and understand. Provide feedback showing that you have understood.

This is a difficult time. How are you going?

It sounds like you are really concerned about his pain?

How might care staff use opportunities in daily practice to raise dementia with families?

Initiating and enabling/continuing a dialogue requires: listening, acknowledging and acting

Fx: “..mum doesn’t seem as well as she used to be…”
PCA response: “can you tell me what changes you have noticed?”
PCA response .... “I realise that it must be difficult for you to see your mum like this, some of those changes may be part of your mum’s dementia”.

“Would you like to speak with the nurse who could provide you with some more information and answer some more of your questions”.

[86]
Communicating with other members of the health care team

- Providing care is a team effort – we all contribute knowledge and understanding in a variety of ways...
- To ensure efficiency and effectiveness, effective communication is necessary – respect for each other’s contributions is central
- This communication may be oral or written – both forms take skill and practice
- It is critical to remember and respect the knowledge and contribution of all members of the aged care team

Communicating as a team member

Sharing information
(what have you observed?)

Listening attentively
(what do your colleagues have to offer based on both their expertise and knowledge of the resident?)

Using understandable communications
(eg professional language; reframing content if not understood; asking for rephrasing if you don’t understand; “choosing your moments”)
Communicating as a team member

Reflecting on own contribution/performance
(what have you to offer the care encounter?)

Providing feedback
(what have your learned?)

Responding to feedback from others
(appreciating others’ engagement)

Finally...

• Think about how you communicate....
• Are there strategies which you can use to improve your communication and interactions with
  • People with dementia,
  • Family caregivers
  • Other members of the health care team.
• Think about how your methods of communication can promote a palliative approach to care.
Acknowledgments

Royal Hobart Hospital Aged Services
• Dr Jane Tolman, Director
• Jane Davis, Nurse Practitioner
• Ruth Haynes, Clinical Nurse Consultant

Specialist Palliative Care Services, Hobart.
• Angela Bresnehan, Clinical Nurse Consultant,
• Sandra Brown, Clinical Nurse Consultant,
• Fiona Jones, Specialist Palliative Care Social Worker

For further information on the types of dementia and risk factors there are a range of internet based resources

Western Australia Dementia Training Study Centre:
http://cra.curtin.edu.au/wadtsc/wadtsc_usefulResources.html

Or the Victorian and Tasmanian Dementia Study Centre:

Department of Health and Ageing – Dementia Resource guide:
### Appendix 9—Orientation Checklist Used for Wicking TACF Program

#### Teaching Aged Care Facilities Program

**Orientation Checklist—Students**

**Instructions:**

Here are some statements about your orientation

- Please cross **only one** box (yes, no, or not sure) for every statement.

<table>
<thead>
<tr>
<th>During orientation to the facility:</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was there a formal orientation program?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did one person coordinate your orientation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Were you introduced to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The Director of Care/Nursing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Other Registered Nurses (RNs)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Enrolled Nurses (ENs)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Carers/ECAs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Domestic &amp; catering staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Reception staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Were you shown where to put your bag?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Were you shown where the toilets are?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Were you shown the tea room?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Were you told how your day would be organised?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Were you told when and where to have meal breaks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Were you told what to do in the event of fire or emergency?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Were you told what to do in an emergency situation with a resident?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Were you shown where the fire exits are?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Were you told what to do when the phone rings?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Were you told what the smoking policy is?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Were you told where to access computing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Were you told what books/resources are available &amp; where?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Were you told what time your day started?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Were you told what time your day finished?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Appendices

(continued) During orientation to the facility:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Were you told what to do if you are running late or can’t attend a day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Were you told what to do if you feel sick &amp; need to go home?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Were you told what to do if you need to go home early?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Were you told what to do if you are feeling anxious or upset?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Were you told who to contact if you hurt yourself?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Were you told where to access a telephone to make a call?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Were you given an orientation to the unit/area (walk around)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Were you given an overview of manual handling and lifting policy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Did you get the feeling that the staff were expecting you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Was the role of RNs in the aged care facility what you expected?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this questionnaire.
### 4.10 Appendix 10—Sample Nursing Student Placement Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday 29 April 2013</th>
<th>Tuesday 30 April 2013</th>
<th>Wednesday 1 May 2013</th>
<th>Thursday 2 May 2013</th>
<th>Friday 3 May 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800-1600</td>
<td>0800-1600</td>
<td>0800-1600</td>
<td>0800-1600</td>
<td>0800-1600</td>
<td>0800-1600</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>0800-1030</td>
<td>0800-0900</td>
<td>0700-1030</td>
<td>0800-1030</td>
<td>0800-0900</td>
</tr>
<tr>
<td></td>
<td>Study notes of resident, for IPL activity</td>
<td>Observe/assist resident hygiene, breakfasts, etc.</td>
<td>Resident Care Medications with RN/EN Resident Breakfasts</td>
<td>Medications—assist RN/EN</td>
<td></td>
</tr>
<tr>
<td>1030-1100</td>
<td>1030-1100</td>
<td>1030-1100</td>
<td>1030-1100</td>
<td>1030-1100</td>
<td>0900-1200</td>
</tr>
<tr>
<td>Morning Tea</td>
<td>0900-1200 Dementia / Palliation Workshop</td>
<td>Morning Tea</td>
<td>Morning Tea</td>
<td>Presentation preparations</td>
<td></td>
</tr>
<tr>
<td>1100-1200</td>
<td>1200-1245</td>
<td>1100-1300</td>
<td>1100-1200</td>
<td>1100-1200</td>
<td>1200-1300</td>
</tr>
<tr>
<td>Discussion of IPL tasks</td>
<td>Observe Medication Round</td>
<td>Assist RN/EN with assessments, wounds, observations / urinalysis</td>
<td>Assist RN/EN as yesterday</td>
<td>Presentation, with IPL student, to RACF staff</td>
<td></td>
</tr>
<tr>
<td>1200-1300</td>
<td>1245-1330</td>
<td>1300-1330</td>
<td>1200-1300</td>
<td>1300-1400</td>
<td></td>
</tr>
<tr>
<td>Lunch provided</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Feedback meeting Lunch provided</td>
<td></td>
</tr>
<tr>
<td>1300-1500</td>
<td>1330-1600</td>
<td>1330-1500</td>
<td>1300-1430</td>
<td>1400-1600</td>
<td></td>
</tr>
<tr>
<td>Meet Staff</td>
<td>Meet with IPL students</td>
<td>Revisit orientation checklist with Mentor Team member.</td>
<td>Meet with IPL student</td>
<td>Assist residents with afternoon tea, and care needs</td>
<td></td>
</tr>
<tr>
<td>1500-1600</td>
<td>1430-1530</td>
<td>1430-1530</td>
<td>1430-1530</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timetable and roster discussion</td>
<td>In-service — Wound Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 4.11 Appendix 11—Sample Paramedic Student Placement Program

#### Paramedic Student Curriculum 2012 (1-week placement)

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Why</th>
<th>Resources given to students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st day of placement</strong></td>
<td><strong>Meet the UTAS Clinical Liaison</strong>—Introduction to aged care clinical placement program</td>
<td>OPportunity for students to become familiar with both the geographical layout and organisational structure of the facility</td>
<td>A student placement program/timetable, which detailed when students would attend different activities within the facility</td>
</tr>
<tr>
<td></td>
<td>Meet DON and mentors</td>
<td></td>
<td>Student information kit developed by each facility, including information such as an overview of the facility, a map of the facility, facility mission statement, student orientation checklist and an evaluation sheet.</td>
</tr>
<tr>
<td></td>
<td><strong>Orientation</strong> to and tour of the facility</td>
<td></td>
<td>Handout of summary points</td>
</tr>
<tr>
<td></td>
<td>‘R/V of Geriatric Assessment’ including engaging with person with dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd day of placement</strong></td>
<td><strong>3 hour education session</strong> on dementia/palliation</td>
<td>Dementia/palliation is the focus of the placement so this initial session gives necessary information to students who may not have encountered a PWD</td>
<td>Handouts of dementia/palliation presentation</td>
</tr>
<tr>
<td></td>
<td><strong>Simulated ambulance transfer</strong> and follow-up discussion</td>
<td>Reinforces principles of person-centred care (including key informants) when transferring a person with dementia from the RACF</td>
<td>Handout of summary points</td>
</tr>
<tr>
<td><strong>Weekly whilst in placement</strong></td>
<td><strong>1-hour weekly meeting</strong> facilitated by project team member</td>
<td>Opportunity to discuss any issues or concerns arising</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joint meeting with medical and nursing students where applicable</td>
<td>Feedback loop to weekly mentor meetings providing opportunity for quick resolution of issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Manual Handling session</strong></td>
<td>Opportunity for interprofessional learning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule</td>
<td>Activity Description</td>
<td>Benefits</td>
<td>Resources</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>At least weekly whilst in placement</strong></td>
<td>Deliver short teaching sessions on topics specific to paramedic students’ education: preparation for ambulance arrival, falls assessment, and the initial management of a patient with chest pain</td>
<td>Opportunity to discuss the information RACF staff can make available to paramedics on a call out to ensure a successful case</td>
<td>Handout of summary points</td>
</tr>
<tr>
<td></td>
<td>Education sessions organised by RACF staff, provided by both internal and external agencies focusing primarily on dementia/palliation</td>
<td>Increases the students exposure to education on dementia/palliation</td>
<td>Copies of power point presentations Other literature relevant to presentation</td>
</tr>
<tr>
<td></td>
<td>Assessments of allocated residents in the teaching aged care facility</td>
<td>Opportunity for students to practice assessment skills and interpret findings</td>
<td></td>
</tr>
<tr>
<td><strong>Last day of placement (weekly)</strong></td>
<td>Students will present an IPL case study arising from resident assessments in collaboration with medical and/or nursing students. Attendance open to all. Feedback/ debriefing session with paramedic tutor</td>
<td>Learning opportunity for paramedic students to put case study together and practice presentation skills</td>
<td>Opportunity for nursing students and RACF staff to learn more about common conditions</td>
</tr>
</tbody>
</table>
### Appendix 12—Sample Medical Student Placement Program

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-10:30am Facility tour – Allocation and meeting of residents 10:30 - 11am Manual Handling Education Session</td>
<td>9-10am Review Allocated Residents on Wards 9:30-11:00am Medication Reviews – the importance of and how to perform. With Pharmacist (all day)</td>
<td>9:00am-12pm Bedside Teaching with GP Tutor 9am-12pm Patient interviews/Inter-Professional Learning Task</td>
<td>9am-12pm Patient interviews/Inter-Professional Learning Task</td>
<td></td>
</tr>
<tr>
<td>11am-12pm Inter-Professional Learning Introduction 12-1pm Intro to Placement with GP Tutor</td>
<td>10am-1pm Palliative Care Education Session (GP Tutor) 11:00am-12:00pm Perform medication review Resident 1 Work in pairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch 12-1pm</td>
<td>Lunch 1-2pm</td>
<td>Lunch 12-1pm</td>
<td>Lunch 12-1pm</td>
<td>Lunch 12-1pm</td>
</tr>
</tbody>
</table>

**Case Based Learning (CBL) at University Campus**

<table>
<thead>
<tr>
<th>2-4pm Interprofessional Learning Task – with Nursing students</th>
<th>1:00-2:00pm Perform medication review Resident 2 Work in pairs</th>
<th>1-3pm Review Allocated Residents on Wards 1-2pm Inter-Professional Learning Presentation 2-4pm Patient interviews/summary of patient assessment on Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:00-5:30pm CBL with GP Tutor (at Facility)</td>
<td>4:00-5:30pm CBL with GP Tutor (at Facility)</td>
<td>4:00-5:30pm CBL with GP Tutor (at Facility)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2:00-4:00pm Medication review case presentation and discussion</th>
<th>3-4pm Wound Care Education session with Nursing Students</th>
<th>2-4pm Patient interviews/summary of patient assessment on Wards</th>
<th>4:00-5:30pm CBL with GP Tutor (at Facility)</th>
</tr>
</thead>
</table>
4. Appendices

4.13 Appendix 13—Example IPL Activity- Multiple Student Groups

Wicking Teaching Aged Care Facility (TACF) Program
Inter-Professional Learning (IPL) Activity
Semester 2, 2013

Background—Inter-Professional Education

As part of your placement in the TACF program you will engage in an interprofessional assessment of a resident in the aged care facility. Inter-professional education/learning (IPL) and collaborative practice can play a significant role in mitigating many of the challenges faced by health systems around the world (World Health Organisation 2010). IPL assumes that health care professionals work with each other in a collaborative manner as well as with colleagues from other disciplines to provide quality care. According to the World Health Organisation, if professionals who work together are familiar with each other's roles and respective scopes of practice, the efficiency and effectiveness of care is improved for patients/clients and their family members. Therefore, it is important for students who are studying to become health professionals to have adequate knowledge of one another's professions. For the purposes of this task we have defined IPE as "... when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (Centre for the Advancement of Inter-professional Education, 2002).

Intended Learning Outcomes of the IPL Task

- Students from nursing, paramedic practice, and medicine will demonstrate learning with, from and about each other.
- Students will demonstrate the ability to collaborate with their inter-professional team members.

The IPL Activity

- Each student will be allocated to an IPL group by the Mentor Leader. Each group will consist of a mix of students from nursing and medicine and/or paramedic practice (2nd semester)
- The Mentor Leader allocates IPL group members a resident with whom to undertake an assessment—generally it will be a resident with dementia. Academic Liaison staff may determine a specific focus for the assessment (i.e., falls risk)
- Students undertake the assessment with their particular disciplinary focus (i.e., medical students may conduct a Comprehensive Medical Assessment (CMA), nursing students a nursing assessment etc.)
When & What?

Students will meet four times to complete the IPL assessment activity. These meetings will be scheduled into the respective student timetables, and include:

1. **Introduction**—on the first day of the placement (or when a new group of students begins on placement), all students participate in an introductory session, also attended by relevant academic and facility staff. At this session, an overview of Inter-professional Learning is presented and the IPL activity discussed. Students are then allocated to their IPL group (configured according to the disciplinary mix of students and numbers on placement during that week) and assigned a resident with whom they will conduct an assessment. The student members of the individual IPL groups then meet together briefly to discuss how they will operationalise the IPL activity. Scheduled times for students to meet as part of the IPL activity (see points 2 to 4 below) will have already been scheduled into their weekly roster.

2. **Initial Assessment**—students conduct the assessment in front of their inter-professional peers so they gain insights into the respective disciplinary areas. The assessment process should take no longer than 1.5 hours (i.e., if three students each student will have up to 30 minutes). If necessary, students may have to return individually at another time to meet with the resident to complete their assessment. **Note that students must not video, audio record, or photograph residents as part of presentation preparations.**

3. **Student Group Meetings**—subsequently, students will meet as a group to,
   a. Identify a specific issue or concern related to the resident they have assessed (i.e., pain etc.), and develop a presentation that addresses this issue from their particular disciplinary perspective.
   b. Develop a presentation which addresses the specific disciplinary insights that come out of their respective focussed assessments (as determined by Academic Liaison staff).

4. **Student Presentations**—students present their focussed assessment of the resident to peers and staff members at a grand round meeting on Friday afternoon. The session will last for 1 hour. Individual presentations should last for no more than 10 minutes.
   a. This joint presentation should clearly articulate the key issue arising from the resident assessment as well as what students have learnt as a result of their inter-professional collaboration. You will need to describe if the presenting problem is long standing or a recent development. Presentations should preferably focus on a surprising or unusual issue that facility staff may not have previously considered.
   b. Student presentations should also include recommendations for ongoing care and management.
   c. All presentations must be made using Power Point.
   d. Provide an electronic and hardcopy of your presentation to the Mentor Leader. Remove your name from the presentation as mentors are primarily interested in your recommendations for improvements to resident care.
4.14 Appendix 14—Example IPL Activity- Medical Students

Wicking Teaching Aged Care Facility (TACF)  
Program Southern Medical Student Inter-Professional Experience (IPE)—Semester 2, 2013

**Background**

As part of your placement in the TACF program you will engage in an inter-professional assessment of a resident in the aged care facility. Inter-professional experience (IPE) and collaborative practice can play a significant role in mitigating many of the challenges faced by health systems around the world (World Health Organisation 2010). IPE assumes that health care professionals work with each other in a collaborative manner as well as with colleagues from other disciplines to provide quality care. According to the World Health Organisation, if professionals who work together are familiar with each other’s roles and respective scopes of practice, the efficiency and effectiveness of care is improved for patients/clients and their family members. Therefore, it is important for students who are studying to become health professionals to have adequate knowledge of one another’s professions. For the purposes of this task we have defined IPE as "... when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (Centre for the Advancement of Inter-professional Education, 2002).

**Intended Learning Outcomes**

Medical students will demonstrate the ability to collaborate with and learn from their inter-professional nurse mentors.

**When & What?**

1. **Introduction**  
On the first day of the placement, medical students participate in an introductory session, also attended by relevant academic and facility staff. At this session, an overview of the IPE activity and intended learning outcomes are discussed. Following the presentation, medical student will meet briefly with the nurse mentor to get a general overview of the resident assessment.

2. **Initial Assessment**  
Medical students will perform a biopsychosocial assessment of their resident with a view to developing a key issues list for the patient and, subsequently, a presentation on one salient medical issue. **Note that students must not video, audio record or photograph residents as part of their presentation preparations.**
4. Appendices

3. **Mentor Meetings**
Following the assessment, medical students will present their findings and recommendations to the nurse mentor (a highly qualified nurse practitioner within the facility who has an intimate knowledge of the resident). The mentor will then discuss the student assessment in the context of their knowledge and experience with the resident. The nurse mentor may consult the resident notes or take the student back to the resident to help them to better understand and reflect upon the relevant issues. This process should take up to one hour.

4. **Student Presentations**
Medical students present their focussed assessment of the resident to peers and staff members at a grand round meeting on **Friday afternoon. The session will last for approximately one hour. Individual presentations should last for no longer than 10 minutes.**

   a. This presentation should clearly articulate a list of key issues arising from the resident assessment with focus on the management of one of these issues as well as what students have learnt as a result of their inter-professional collaboration with a nurse mentor. You will need to describe if the presenting problem is long standing or a recent development. Presentations should preferably focus on a surprising or unusual issue that facility staff may not have previously considered. Your Mentor Leader may assist you in identifying useful topics to explore.

   b. Your presentation should also include recommendations for ongoing care and management in relation to the chosen medical issue.

   c. All presentations must be made using Power Point.

   d. Provide an electronic and hardcopy of your presentation to the Mentor Leader. Remove your name from the presentation as mentors are primarily interested in your recommendations for improvements to resident care.
TEACHING AGED CARE FACILITIES: IMPLEMENTING INTERPROFESSIONAL PREVOCATIONAL EDUCATION AND PRACTICE IN RESIDENTIAL AGED CARE

© Wicking Dementia Research and Education Centre, University of Tasmania, 2013.

Andrew Robinson, Emma Lea, Laura Tierney, Catherine See, Annette Marlow
Claire Morley, Jan Radford, Amanda Lo, Fran McInerney
Michael McCall & Claire Eccleston

December 2013
Correspondence: Andrew Robinson, Wicking Dementia Research and Education Centre,
Private Bag 143, Hobart, Tasmania, Australia 7001