

RELATIONSHIP-CENTRED CARE

Describing the development of a new clinical model of care in response to aged care changes in Australia

INTRODUCTION

Many clinicians are familiar with the rapid and substantial aged care reforms over recent years (Royal Commission into Aged Care Quality and Safety 2019), driven largely by the Royal Commission into Aged Care Quality and Safety. The subsequent Aged Care Act (2024), and strengthened Aged Care Standards (2025) (<https://www.agedcarequality.gov.au/providers/quality-standards>), importantly established a 'rights-based' framework; emphasises the older person's control over their care; and mandates service performance measurement and benchmarking (Smith, Travers, Roberts et al 2024).

STARTING CHANGE

Over an 18-month period, a large aged care provider (responsible for 41 residential care homes, among other activities), supported by a university research partnership, has been changing its traditional Model of Care (MoC) to align with the Standards. Current dominant MoCs have not kept pace with ageing populations or the growing complexity of residents' needs (Hullick, Conway, Higgins et al 2016). And the need for advanced clinical skills in residential care (RC), particularly end-of-life (EoL) care is increasingly recognised as a global concern (Eagar, Westera, Snoek et al, 2019).

Using co-design processes, the aim is to improve residents' quality of life (QoL), support them to live with meaning and purpose; de-institutionalise services and care delivery; and shift from task-based to relationship-based care. The principle of co-design is that people affected by an issue have the right to participate in designing responses, through genuine partnerships.

Relationship-centred care has been utilised in policy and research over many years, emphasising an holistic MoC as well as valuing individual personhood – their life story; their needs, wishes and preferences; their family and other relationships; and their social environment (Casey, Carroll, Coghlan et al 2024).

University ethics approval was received for this work.

PROCESS

With the external legislative impetus to support extensive change, the process commenced with an overarching awareness of the need to change clinical work practices to assist older people to live 'normally', despite living in institutional care. The explicit goal was to work *with* people, not doing to or for them, symbolizing organisational respect and the individual's right for control over their own life. Alongside the MoC development, a deep dive into existing EoL care and pain management was completed.

To develop a new MoC, five "pioneer" homes were identified based on differing sizes, settings, and resident profiles. Across these homes, fifteen facilitated workshops were conducted, involving many participants – residents, relatives, clinical employees, managers, and organisational representatives. The overall MoC emerged as the most pressing issue to improve residents' everyday outcomes and overall QoL.

WHAT HAS CHANGED?

To underpin changes, a complete review of the systems was undertaken: IT infrastructure, human resourcing, clinical management, accounts, and included reporting obligations and measures to demonstrate improvements.

Each home identified core areas of focus for the MoC – relaxed awakening; dining; consistent assignment; 'what matters' to individuals; and medication management – which were then tailored to reflect the characteristics of each home's residents.

Both residents and care employees questioned why residents needed to be woken at a common time (historically in place to provide hygiene care in a short timeframe). It was agreed to trial 'relaxed awakening', where individuals choose when to wake and when to have breakfast, provided in buffet style.

Other mealtimes were also reviewed, especially the evening meal, which now has extended times, enabling residents to choose their own mealtimes, and includes a menu for choice.

A focus on rostering provides consistent assignment, so clinical employees may develop a deeper understanding of each individual's needs and preferences. A proposal to replace 'personal carer' with 'care companion' aims to reflect a more equal, relationship-focused approach.

In line with consistent staffing, the organisation is exploring a household MoC, where smaller resident groups live together in a home-like environment, with dedicated clinical employees, and residents may participate in familiar daily activities.

As residents increasingly articulate what matters to them, new initiatives have been introduced to support wellbeing, alleviate loneliness and promote physical activity. Walking groups, aqua aerobics (where appropriate), and other exercise programs have been established to help residents stay active and connected.

Early work has begun on a revised medication model where residents' medications are stored in their rooms. Supported by new software, this approach aims to enhance privacy and dignity, shift practice from rushed 'medication rounds', and reduce the risk of medication errors.

The deep dive into palliative care and EoL care revealed significant gaps, prompting the appointment of a Nurse Practitioner with a specialisation in palliative care, to facilitate, educate, and support clinical employees across all homes. A major priority is the implementation of a consistent, evidence-based palliative and EoL care model grounded in national standards and integrated into both the MoC and the organisation's strategic goals, particularly its commitment to promoting mental and spiritual wellbeing at the end of their life.



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The deep dive into pain management identified important areas for improvement. Although the annual mandatory pain management education exceeded benchmark levels, a third of residents lacked a formal diagnosis for chronic or acute pain. Anticipatory EoL medications were not consistently charted and the use of other ‘as required’ medications were often inappropriate or inconsistent.

DISCUSSION

Documenting organisational changes highlights that a new MoC represents a profound organisational shift, with every aspect of service delivery affected, especially for clinicians. Meaningful organisational commitment from the Board to the bedside has therefore been essential to the project’s success.

Feedback through the legislatively required Consumer Advisory Body, the organisation’s consumer-engagement mechanism, has been especially influential. Participation continues to increase, with reflections on and suggestions about care quality, consistently highlighting employees’ respectful, holistic approach to care. Of note is a reduction in behaviours of concern among residents and increased satisfaction with food across all homes. The shift toward encouraging activity has been positively received, and participation in social activities has increased.

Qualitative feedback from clinical employees indicates a more detailed approach to individualised care; improvements in resident behaviour, social connection, and health outcomes, including weight gain and fewer unwitnessed falls. The work,

especially hygiene care, is spread across the day, reducing pressure on employees, and fewer complaints have been noted.

Strengthening clinical employees’ understanding of pain assessment tools, EoL care, dementia-related pain behaviours, and care planning is critical to supporting holistic care (Aasmul, Sandgathe Husebo et al 2016). Employees report reduced distress and burnout when residents’ pain is more effectively assessed and managed (Aasmul, Sandgathe Husebo et al 2016).

Education is a central enabler of change (Spacey, Scammell, Board et al 2019). Education of care-focused employees requires careful planning, to ensure learning is meaningful not burdensome; but, the optimal amount and format remain contested (Spacey, Scammell, Board et al 2019). Nevertheless, equipping clinical employees to feel confident in increasingly complex roles is essential to the success of the MoC.

CONCLUSION

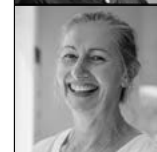
Implementing a project of this magnitude has required strong leadership, Board commitment and substantial engagement from all employees. The MoC pilot initiatives will be progressively implemented and formally evaluated over the next few years, supporting the transition from task-based to relationship-centred care. Co-design has fostered honest dialogue, and equal partnerships enabling a notable cultural shift. Residents, often assumed to have limited expectations of their care, are now routinely asked what matters to them, a core element of the emerging MoC.

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