AUSTRALIAN WORKPLACE
INNOVATION AND SOCIAL
RESEARCH CENTRE

THE UNIVERSITY of ADELAIDE

TRACS NATIONAL EVALUATION

REPORT OF 2ND WORKSHOP

Kate Barnett and Cecilia Moretti
May 2014

Report prepared for the Department of Social Services, Canberra

CONTENTS

1 TRACS WORKSHOP MAY 2014

The first half of the day was dedicated to Project presentations focusing on key outputs and outcomes achieved to date.

The workshop was opened by Dr Sue Hunt, Senior Nurse Adviser for the Department of Social Services. Dr Hunt announced that Projects can apply for a six month extension, to the end of 2014.

Gina Rocks, Director of the Professional Support and Better Practice Section of the Ageing and Service Improvement Branch provided further information about this, asking Projects to focus on the activities they wish to pursue in the additional six months and the relationship of these to their Project, the benefits the additional activities will bring to key stakeholders, the resources needed to accomplish them and the sustainability implications of those activities. Projects have since been sent a template to structure their proposals.

Donna Moody Group Manager Ageing and Aged Care Services Group, Dr Sue Hunt, DSS Senior Nurse Adviser, Shirley Browne Branch Manager Ageing and Service Improvement Branch, Gina Rocks, Director Professional Support & Better Practice Section, Anandhi Raj Assistant Section Manager Professional Support & Better Practice Section

1.1 PARTNERSHIPS

The discussion was framed around these four questions:

- *What are the incentives and disincentives for aged care providers and education and training providers to collaborate in a TRACS partnership?*
- *What has been learned about the ingredients for an effective partnership?*
- *How do we enable continuity and consistency of commitment in the face of turnover and loss of champions?*
- *Can TRACS projects be built from scratch or is TRACS more suited to working with established foundations and partnerships?*

Listening to Prof Elizabeth Beattie

What are the incentives and disincentives for aged care providers and education and training providers to collaborate in a TRACS partnership?

- A key disincentive for many aged care providers relates to resourcing, being time poor unless compensated for their time, even when drivers such as workforce development and enhanced quality of care are involved. An ongoing problem for aged care leaders is that they have to deal with a complex range of problems and issues, much of which has to do with the practicalities of delivering services – leaving little or no time or energy for innovation.
- For both partners, negative prior experience in a TRACS type affiliation can be a deterrent.
- Accreditation standards constitute a major obstacle; they consume an aged care organisation but lack any reference to what many TRACS projects want to achieve, including high quality care. Accreditation is often the major source driving aged care organisations and the TRACS model therefore lacks immediate relevance for some providers.
- However, other aged care providers are driven by the desire to be learning organisations, where students and staff have opportunities to learn and ultimately to deliver better care, and aged care is promoted as viable and attractive work. Partnering to undertake research which is designed to inform the provision of care is a key incentive for many and associated with this, developing a reputation as a leader in care is an important driver.
- For education and training organisations, the major incentives are usually related to providing good quality clinical education for students, and having

the opportunity to undertake research focused on older people and their care - and related to this, the opportunity to publish from that research.

- However, aged care organisations also benefit from student placements in two key ways – they can be an important recruitment tool -'try before you buy' especially for VET trained students who have clearly chosen aged care as their field of work – and Projects provided multiple examples of students contributing positively to the care of residents, and residents regarding student placements as a value-add for their care.

One Project made this comment:

> ***'What's in it for me' needs to be part of the equation. People need to know/have a vision up front that a collaborative will 'give them something'. TRACS is competing with many other 'voices' for collaboration. So it really needs to be clear it is offering something of value.***

What has been learned about the ingredients for an effective partnership?

- The partnership needs to be of benefit to all partners (not just one).
- Good communication is essential.
- Enduring commitment is also critical. As one Project commented –

> ***Partners need to really commit for the duration of the project and each partner must take control of making sure their commitment is tangible. People come and go – but the project must be delivered.***

Simon Pavelic from the Resthaven Project, Dr Helen Rawson from the Deakin University Project and Dr Jeanine Teo from the University of Adelaide led G-TRAC Project

- A critical ingredient is early investment in the project establishment process, pursuing a dialogue to create a shared vision, to build thinking about what actions need to be taken, and about how/what to measure, as well as support and commitment from senior management. This provides a framework for holding partnerships together.
- In the early stages there is a huge focus on defining and planning project activities, but what is also needed is a long-term vision that is shared by

partners (including organisational executive) and preferably built into the organisation's strategic goals.

- It has been found that a joint project management structure works well. Examples given were:
  - ✓ the University of Wollongong and IRT partnership, which appointed 2 joint project managers - one for each partner. These are exceptionally well connected with their respective sectors and also work well with each other;
  - ✓ the Project lead from the Griffith University project held a joint position at RSL Care in Brisbane and has been able to work effectively across both organisations.
- Apart from designing roles that work across partner organisations, providing a bridge between them, it is also critical to have the 'right' people in those roles – with knowledge of both and the ability to be flexible and attuned to the needs, cultures, key drivers and so on, of both.
- It helps to engage aged care staff and build trust when the university team has experience of direct relevance to the provision of care – for example, clinical nursing experience or direct experience in the VET sector.
- One participant argued that working from a base of trust and respect is more important than having a formal MOU in place, although it was noted that generally that formal agreements are important because they can protect arrangements in the event of staff/leadership changes and other turnover of key stakeholders.
- The term 'partnership' is seen as being used loosely. Participants agree that partnerships have to operate on an equal footing, ensuring that all parties' voices are heard, that there is a transparent negotiation of requirements, and acknowledging that requirements/ conditions/ experiences can differ significantly between partners.
- It was observed that the aged care industry rarely provides significant input – the TRACS/TNH model is mostly driven by educational institutions. Nevertheless, it was also seen that aged care organisations need to take more responsibility for leading/determining the process. They can have more input rather than having placements or research 'done to' them, and need to be proactive and take on a leadership role.
- TRACS relationships were compared to marriages – where the 'rules of engagement' need to be worked out and the incentives and disincentives to be involved for each partner are understood by all. For example, publications are important to universities but unlikely to be a driver for aged care organisations. Working within this analogy, it was considered important to establish rules about how to communicate, structures and processes to ensure partners are on an equal footing. It was noted that in the early stages partners often 'speak different languages', and that these are difficult to grasp in the early stages of the relationship.

How do we enable continuity and consistency of commitment in the face of turnover and loss of champions?

- It is critical to have champions at multiple levels in the organisation, from senior management level to middle management and direct care providers, otherwise senior management turnover can be fatal to the delivery of the project. If there is commitment at the floor level and just above, the withdrawal of management endorsement may at least be survived in the short term. Support from management ensures consistency of commitment and ideally this should be present for the duration of a Project. One Project commented –

  I think we need to spell this out better at the outset when we are asking people to consider being partners in a project in the future. They need to know what the commitment really means.

- Specific strategies are needed to ensure engagement from the direct care level. For example, the Deakin led Project engaged in a dedicated process of baseline data collection that involved providers, consumers and their families, and this became as much about creating the connections/rapport, building trust and credibility, as about collecting data. Where this worked well, the project survived in spite of management turnover. Several Projects have identified and supported Mentors for students and Mentor Leaders. Others have provided training in research collection and translation that has acted to engage those at middle management and direct care levels.

- Those managing the Project also need to be Champions and there is a need for at least one in each partnering organisation. There is an accompanying need for a contingency plan to manage turnover of Champions.

WISeR Evaluators Kate Barnett and Cecilia Moretti

Can TRACS projects be built from scratch or is TRACS more suited to working with established foundations and partnerships?

It was generally agreed that the TRACS model has worked best where partnerships were already established rather than developed from scratch,

especially in the timeframe of some 18 months. It was noted that partnerships take time to build, and for trust to be established.

1.2 Building capacity in the aged care sector

This session was structured by the question -*What have we achieved so far, as a program, in building capacity in the aged care sector, particularly in relation to:*

- *Providing high quality student clinical education*
- *Workforce education and development*
- *Enabling a research evidence base in aged care*
- *Structuring and supporting organisational change*

There was some discussion about broader challenges facing the sector as a whole, and about changing directions, but the bulk of the discussion centred on achievements in relation to developing high quality student clinical education.

Kirsty Marles, Project Coordinator, ACH Group Project

1.2.1 Providing high quality student clinical education

Projects are very positive about the achievements made in relation to providing high quality student education, having been able to use the resources provided with Program funding to support key roles, such as, IPL Facilitators and Mentors drawn from the aged care workforce. There was considerable discussion about the many challenges for aged care organisations in providing clinical placements, and about the way forward for the sector as a whole.

- Placements are complicated when aged care organisations have multiple affiliations with different universities and involving multiple professions. This can be confusing for staff on the floor who need to be flexible to manage these complexities, especially in an IPL based model of student placement. One suggestion is to use a student placement coordinator, based in the aged care organisation, who can negotiate across the relationship with education providers, but this requires specific resourcing and may not be feasible for smaller organisations.

- Helping Hand noted that it has taken them many years to develop sufficiently to be able to do student placements properly; it took numerous meetings with the educational institutions involved, sometimes to find that HH wasn't able to meet what they wanted. Developing a centralised student placement system not only provides greater control, but enables HH to plan placements and coordinate them in order to support an IPL clinical placement model. In turn, this supports a conversation occurring between the aged care provider and education and training providers, which is often absent. HH noted that aged care providers can, and should, take more responsibility in defining and driving the process. They now charge universities for taking students on placement and providing them with a high quality learning experience.
- It is also important for workplaces to be student-ready with appropriate infrastructure to support learning and education, in particular IT systems and dedicated learning spaces.
- It is possible for aged care providers to support clinical education by leveraging from other sources, with several TRACS projects having drawn on funding from Health Workforce Australia.
- The need was identified for a conversation across gerontology leaders about what constitutes 'readiness' in graduates to go out and work in the aged care sector, noting that many are being sent in without adequate preparation. The question was raised about why this appears to be acceptable for aged care but not in other fields.

Prof Renuka Visvanathan and Dr Jeanine Teo from the G-TRAC Project (University of Adelaide)

The importance of Mentor roles

Across Projects with a student education component, the designation of aged care staff to mentor students has emerged as a positive feature of good quality clinical placements. Projects made these observations about Mentors:

- Mentoring needs to happen at different levels, across different roles-and applied with flexibility according to need. However, mentor choice is critical – the mentor must be committed and have experience in caring for

older people, be committed to fostering education within a learning environment, and be open to using evidence to foster 'smarter' working.

- Mentoring takes different formats – from clinical supervision to reflective mentoring, to providing structured opportunities to raise and test aspects of learning and work.
- It was argued that funding for student education is better directed to seconding a mentor leader from the aged care service and building their capability than paying for a university-based facilitator. A conjoint position was also seen as achieving better results for students.
- Several Projects have found that it is more effective to develop a group of mentors, with two or three designated Leaders. This addresses issues associated with turnover and shares responsibility for mentor leadership.

Among the qualities identified for a good Mentor were the following:

- ✓ detailed knowledge of the role for which they are mentoring
- ✓ the skills to create a meaningful experience that reflects the role for which they are preparing.
- ✓ leadership and planning skills
- ✓ allocates to students responsibilities which are within their capacity
- ✓ provides students with the opportunity to 'try things out'
- ✓ enables students to think for themselves
- ✓ provides opportunities for students to present ideas
- ✓ models behaviour, including a productive attitude towards work.

HAS THERE BEEN ANY IMPACT ON INCREASING THE AGEING/AGED CARE FOCUS OF HEALTH SERVICES CURRICULUM?

It was agreed that this impact is minor, mainly because of the difficulties involved in making major changes to curriculum (particularly unwieldy university systems and processes, and the influence of accreditation bodies), and the time taken to achieve this impact.

The existing health workforce curriculum was described by participants as being highly influenced by acute care sector accreditation standards. There is seen to be a need to ensure that accreditation bodies understand the need to train the health workforce to work effectively with growing numbers of older people. Nevertheless, it was agreed that valuable change can be achieved by 'tweaking' and developing existing curricula, and that this is happening within TRACS projects with a student education component.

However, it is possible for TRACS Projects to demonstrate what is possible. Representatives from the Deakin led Project note that the School of Nursing and Midwifery at Deakin recently completed successful accreditation. The fact that the Tri-focal Model of Care was being integrated into the undergraduate curriculum was of great appeal to the accreditors. The link between the practice setting through the TRACS project, the School's research and education activities, with a common focus on the model, resonated with them.

1.2.2 Workforce education and development

A number of positive outcomes were identified in relation to workforce education and development, and a number of lessons were emerging:

- A key pressure is the ongoing need to prioritise resident needs and this often means that workforce training and development needs will be delayed to address urgent resident needs. Educators will arrive for sessions and find that the staff who should be participating in those sessions have been taken off to address resident issues. Educators from one Project have tried a number of solutions, including delivering training on the ward, but find that is less than ideal (too many disruptions). Achieving genuine organisational commitment to training and development was described by several Projects as an ongoing challenge for which no solution has been found.
- One aged care provider has tried to use handover periods to do training, supported by appropriate back-filling (noting that this needs dedicated resourcing). This organisation finds that care workers are willing to do training on their own time (describing them as 'incredibly hungry for knowledge and improvement') but RNs less so. A number of participants described aged care workers in their Project as keen to learn but time-poor.
- Participants noted that organisational culture is key to the success of workforce training and development. Staff are more likely to engage if management is actively behind the program, reinforcing that it is important and where a culture of learning has been embedded at all levels and across the clinical, service and organisational areas where there is evidence of upskilling and knowledge sharing. One project observed that it faces the challenge of learning being individually driven by motivated staff members, but not supported organisationally (when they return to their sites).

Catherine Heffernan (Griffith Univ Project), Prof Andrew Robinson (Univ of Tasmania Project) and Anne Loupis (Hammondcare Project)

Some of the discussion focused on the important role of technology in supporting workforce education.

- There was strong agreement among participants about the need for aged care training to maximise the benefits of new technologies – particularly in enhancing access to learning and enabling flexible delivery.
- One approach, being used by the U of Tasmania project involves online moodle training, with the dementia education program having been completed by thousands of aged care workers. This initiative has found that people with lower educational outcomes are the most consistent completers because they are very interested in their care roles (supporting the observations of other participants about the carer workforce interest in learning).
- Moodle-style learning is also seen as effective for baseline staff training and development – using it to identify talent/ potential leaders, who can then receive more intensive training (e.g. as occurs with the Joanna Briggs Institute approach to learning, adopted by the University of Southern Queensland project, and by the CHART project with its use of the Monash university intensive training program).
- Flexible delivery was seen as extending beyond online and videoconferencing delivery to mobile 'on the go learning' which reflects wider social trends to 24/7 access to information. One participant noted –

The days of 2-4 hour workshops are in the past.

Incentives to participate in workforce education, other than the identified motivation of the carer workforce to simply learn more, included linking learning opportunities to valuing the workforce, and providing accreditation points of some kind.

Anandhi Raj, Kate Barnett, Donna Moody and Gina Rocks

- Some participants also argued that if people feel valued, invested in, they will engage with training offered to them, observing that because workers know their organisation has put money into developing them, they feel valued and are motivated to participate.
- In some Projects participants gained a Certificate or points towards professional accreditation which has been found to provide an incentive for participation.

1.2.3 Enabling a research evidence base in aged care

- The USQ project has been structured to provide intensive development of research skills and the skills needed to translate research findings into practice to six people from Anglicare Southern Queensland. Partnering with the Joanna Briggs Institute (JBI) the 6 Research Fellows have received two one week intensive training sessions at JBI in Adelaide, with ongoing support from the Project and JBI staff. The research projects have emanated from a clinical audit at AnglicareSQ to ensure their relevance to care practice. The model is also designed to encourage those Fellows to support their peers in research translation. Project leaders have observed a growing confidence among the Fellows and an accompanying realisation of the potential benefits of their research findings to residents.

Dr Clint Moloney (ACCERT Project University of Southern Queensland) with Prof Alison Hutchinson and Dr Joan Ostaszkiewicz (Deakin University Project)

- One participant with a long standing involvement in research partnerships noted that the most successful research is grown from an aged care service idea, and crosses diverse disciplines.
- Another Project noted that aged care services lack a traditional role in undertaking research and tend to draw the connection between practice and outcomes without the intervening factor of research. Consequently, there is a need to address this gap in thinking.
- Organisations can benefit from an 'organisational health check' to determine whether there is capacity to facilitate research evidence

acknowledgement and implementation in health care. Enabling research evidence can be seen within the *PARIHS* Framework which sees the interplay between the organisational context, facilitation to implement change, and evidence.

- Other Projects also observed the need to change thinking about aged care capacity in research, including building the confidence of aged care workers to undertake research and to translate this into their practice. They noted a growth in this confidence as their Projects progressed, and the importance of mentoring by university partners in building that confidence and supporting them in undertaking research projects.
- There was also some discussion about the need for aged care workers to have the skills to use evidence to inform their practice, but not necessarily to have the skills to conduct research.

Kate Barnett with Jen Smith and Prof Catherine Hungerford from the CHART Project (University of Canberra)

1.2.4 Structuring and supporting organisational change, and building learning cultures

There was agreement across the Projects that leadership is critical to achieving organisational change and the evolution of a learning culture in aged care organisations. Leadership includes empowering staff and giving them the confidence to implement changes, and then sharing examples of success across the organisation. However, leaders themselves often need support to undertake this role and this highlights the importance of having enduring support at a high level within the organisation and an underpinning philosophy of continuous improvement.

One participant commented that leadership can be supported with programs designed for this purpose, using the example of the Hartford Foundation in the US which picked up the teaching nursing home model after funding via two key programs ceased in the late 1980s[1]. The Foundation has produced around 4500

[1] **John A Hartford Foundation** (JAHF), in partnership with the **American Academy of Nursing**, launched the multi million dollar *Building Academic Geriatric Nursing Capacity* (BAGNC) Program to produce expert researchers, teachers and

leaders, who then work across the aged care sector, multiplying the impact of their education. It was observed that it would be positive if a similar initiative could be implemented in Australia.

Are there some aged care organisations and some education providers who can never be a TRACS? ie should we be focusing on those for whom a TRACS 'readiness' exists? If so, what are the attributes of that readiness?

This question was discussed and there was strong agreement that not all aged care and education providers have the capacity to pursue the TRACS model, and some may have capacity but not necessarily be ready to do so and require support to achieve readiness. Some participants believe that readiness should be assessed prior to committing to a TRACS partnership, and where these exist but are not working well because of a lack of readiness, continuing with them should be reviewed.

Prof Andrew Robinson and Dr Cathy See from the University of Tasmania led Project with Helen Loffler from the UniSA-Helping Hand Aged Care Project

1.3 Can we live with failure: challenges and impediments

There is much that can be learned from the failures and challenges of TRACS projects, as well as from their successful outcomes. The discussion focused on key challenges and impediments to meeting Project and Program goals.

Churn and loss of champions

A common challenge across Projects has been the loss of champions in the aged care organisations involved, and this brings with it the need to build relationships from scratch, unless multiple champions exist in that organisation. *(See feedback in Partnerships section on overcoming churn and loss of champions.)*

It was noted that churn can work to a Project's advantage when it removes people who have been unsupportive or blocking of a Project, and that the loss of a Champion can mean gain elsewhere in the aged care sector as the Champion

practitioners to lead the gerontology field and ultimately improve the care of older people. The Program includes 9 *Hartford Centers of Geriatric Nursing Excellence* and a distinguished Scholar and Fellow Awards Program. In 2004 the **Atlantic Philanthropies** provided additional support as did the **Mayday Fund.**

takes their commitment to the TRACS model with them, and may even continue to implement it.

Is critical mass important?

It was agreed that small size can present difficulties and that usually larger aged care organisations have the critical mass needed to participate in a TRACS initiative. Where problems were being experienced, these tend to involve smaller size organisations.

Nevertheless, there are examples that defy this trend, such as, Mt St Vincent in Ulverston (UTas led project) and Banksia Village at Broulee (U of Canberra led project) – noting that both are in rural settings and with strong connections to their local community.

It was agreed that the critical success factors involve the combined impact of the (learning and innovation focused) culture of an organisation, its leadership and its workforce.

Is physical infrastructure important?

Most participants agree that absence of appropriate physical infrastructure to support learning and education in an aged care setting can be a significant impediment. Of particular importance are dedicated learning spaces and appropriate technology (computers, wifi and internet access). These facilities are critical for both student and workforce education.

1.4 Sustaining Program impact

There was insufficient time left to discuss this issue, but the Projects' applications for an extension of funding will need to address these questions:

- *What can Projects continue to do with, and without, resourcing?*
- *What are the bare minimum resources needed to support continued effort by the Projects?*
- *What is the best value for money if additional funding could be found?*

However, there was some discussion about the strategies already in place to sustain Projects' impact. It is seen as critical for those with TRACS-style expertise to grow a body of influence/voice in this area. It is expected that students, staff, managers and senior executives involved in TRACS projects will take this influence with them, spreading the capacity brought in the process.

Most projects have developed resources, such as, student orientation and induction kits or videos, tools to assist mentors and supervisors supporting student education, programs and courses that build workforce knowledge and skills and some projects are developing videos. All of these resources need to be disseminated widely across the aged care, higher education and VET sectors and TRACS projects have a role to play in this. There are also Research related resources, such as the ITRACS (U of Wollongong and IRT Project) Research Tool Kit, which supports evaluation and is designed for the aged care setting.

Projects have begun the process of dissemination by collaborating with the Australian Association of Gerontology (AAG). In 2013 a dedicated TRACS Symposium provided information about the Program and some of its Projects,

and conference organisers report that the feedback has been extremely positive. In 2014, Projects are negotiating with the AAG to run a pre-conference workshop and several Projects have submitted papers for this and other conferences, such as, the national ACSA conference. There is significant scope for Projects to work with State level AAGs to run seminars and present at State conferences.

Many Projects have a publications plan in place, with papers being written and submitted for acceptance to aged care and health journals. In addition, Clint Moloney from the U of Southern Queensland (ACCERT) Project advises that an opportunity exists for TRACS funded projects to publish together in the *International Journal of Evidence Based Healthcare* as a special issue focusing on building research utilisation in aged care. Using the Journal's author guidelines[2] potential submissions would need to address one of the following topics: **Evidence Synthesis; Evidence Transfer** or **Evidence Utilisation.** Projects should liaise with Clint if they would like to pursue this opportunity. *Clint is also a JBI Fellow and will negotiate the possibility of a TRACS Symposium at its 2015 Annual Conference.*

It was agreed that existing resources should be made available to other aged care organisations across the sector. In the short term, the national evaluation website can host these, but in the longer term, Projects identified the need for a centralised information collection point or clearinghouse that can share on a national and global scale, supporting the evolving TRACS Community of Practice.

L-R Dr Jeanine Teo (GTRAC Project), Wendy Morey (Resthaven Project), Megan Corlis (Helping Hand Aged Care), Kirsty Marles (ACH Group Project), Rosie Bonnin (GTRAC Project), Simon Pavelic (Resthaven Project), Helen Loffler (Helping Hand Aged Care), Sue Gilbert-Hunt (UniSA Project) and Charlotte Rees (UniSA Project)

[2] http://edmgr.ovid.com/ijebh/accounts/ifauth.htm

2 Appendix: Workshop Participants

Project	Participant Name and Role
University of Canberra (CHART)	Prof Catherine Hungerford, Project Lead
	Jen Smith, Project Coordinator (UoC)
Southern NSW Local Health District	Sarah McPherson, Project Officer (apology)
University of Tasmania (Wicking TACF)	Prof Andrew Robinson, Project Lead
	Catherine See, Gravitas (Organisational Change Lead)
Hammondcare	Anne Loupis, Project Manager
RSL LifeCare	Carrie Spinks, Project Coordinator (RSL LifeCare)
	Frances Russell, Project Evaluator (ACU)
University of Wollongong (ITRACS)	Prof Richard Fleming, Project Lead and Research Program Coordinator (UoW)
	Dr Gillian Stillfried, Project Manager (UoW)
	Barbara Squires, Project Research Program Co-Director (IRT Research Foundation)
University of Sthn Queensland (ACCERT)	Dr Clint Moloney, Project Lead
	Dr Melissa Taylor, Project Officer (USQ)
Queensland University of Technology	Prof Elizabeth Beattie, Project Lead
Griffith University (Triple C)	Catherine Heffernan, Project Manager
Brotherhood of St Laurence	Dr Helen Kimberley, Project Lead
	Alan Gruner, Senior Manager, Residential Aged Care, Brotherhood of St Laurence
	Ashley Carr, Project Evaluator (BSL)
Deakin University	Prof Alison Hutchinson, Project Lead
	Dr Helen Walker, Project Manager
	Dr Helen Rawson, Project Team member
	Dr Joan Ostaszkiewicz, Project Team member
St John's Village	Karen Marsh, Project Manager
University of Adelaide (GTRAC)	Prof Renuka Visvanathan, G-TRAC Centre Director (UoA)
	Rosie Bonnin, Project Coordinator (UoA)
	Dr Jeanine Teo, Medical Educator & Project Evaluator (UoA)
University of SA & Helping Hand Aged Care (ReSeE)	Dr Susan Gilbert-Hunt, Project Lead (Overall Project)
	Megan Corlis, Project Lead (Helping Hand)
	Charlotte Rees, Project Coordinator (UniSA)
	Helen Loffler, IPL Clinical Facilitator (Helping Hand)

PROJECT	PARTICIPANT NAME AND ROLE
ACH Group	Kirsty Marles, Project Coordinator
Resthaven Inc	Simon Pavelic, Project Manager
	Wendy Morey, Project Lead
DEPARTMENT OF SOCIAL SERVICES	**PARTICIPANT NAME AND ROLE**
Donna Moody	Group Manager, Ageing and Aged Care Services Group
Dr Susan Hunt	Senior Nurse Adviser, Aged Care Quality & Compliance Group
Shirley Browne	Branch Manager, Ageing & Service Improvement Branch, Ageing and Aged Care Services Group
Gina Rocks	Director, Professional Support & Better Practice Section, Ageing & Service Improvement Branch
Anandhi Raj	Assistant Section Manager, Professional Support & Better Practice Section, Ageing & Service Improvement Branch