Co-designing and Implementing Decision Support Tools

A practical playbook for home, community and residential care teams.

HEART OF POSITIVE AGEING

Bolton Clarke



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Acknowledgement of Country

Bolton Clarke sites are located across Australia and New Zealand. We recognise the Traditional Owners and their connection to land, sea, culture and community. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples.

About this Playbook

A playbook is a practical guide that provides a structured approach to addressing a problem and implementing change in practice.

This Playbook provides guidance for developing and implementing Decision Support Tools (DSTs) for aged care services. It is designed for anyone involved in improving practice (e.g. clinical teams, quality and safety team members, project leads, etc). Use this playbook when addressing a practice issue that requires change.

This playbook covers:

- **When is a DST is appropriate?**
- **A step-by-step guide for developing a DST**
- **Approaches for co-design and implementation**

This playbook combines co-design and evidence review with a focus on implementation and evaluation. A DST development case-study in this playbook draws on:

- A review of the literature
- Co-design workshops with interest-holders
- Implementation planning
- Evaluation through surveys and interviews.



What is a Decision Support Tool (DST) and when is it appropriate?

What is a DST?

A DST helps team members make evidence-informed decisions by guiding them through key information and decisions. A DST can be used when a problem is complex and its solution requires end-user input and real-world fit.

When is a DST appropriate

When data or reports indicate complex decision-related issues that contribute to:

- Incidents
- Safety or quality concerns
- Complaints
- Practice that varies from best practice
- Team member or client dissatisfaction

Decision Support Tools can:

- Help team members make safe, evidence-based decisions by presenting easy-to-use information.
- Improve safety, consistency, team member performance, and care outcomes.
- Support aged care providers to manage risk and meet requirements under the strengthened Aged Care Quality Standards.



Getting started: steps for co-designing a DST

Begin with understanding the real-world experiences of its users.

- Listen to team members and clients to understand what is happening in practice.
- Combine key insights into a practical DST that reflects how the work process is done.
- Validate DST against evidence, policies, and expert advice to ensure the tool is accurate and ready for implementation.

The following steps offer a guide to getting started, with each step explained further in this playbook:



Case study: Designing a DST for urethral catheter procedure

This case study applies the DST design steps and is referenced throughout the Playbook.

Urethral catheterisation CASE STUDY

Catheter-related incidents highlighted the need for a DST to support team members alongside relevant policies.

1. The organisation's quality improvement team identified key interest-holders and invited nine Registered Nurses (RNs), including continence specialists, to co-design workshops.
2. Information was gathered through three one-hour World Café sessions, exploring factors contributing to incidents, as well as evidence-based prevention strategies, before, during and after catheter insertion.
3. The key insights were captured through whiteboards and transcripts from the workshops.
4. Insights were organised into a draft DST.
5. The draft DST was refined and aligned to existing organisational procedural guidelines.
6. The team then sought input from regional nurses and a continence expert to confirm the tool's validity and relevance across different settings.
7. To prepare for implementation, two additional workshops focused on how to implement the DST within existing workflows and systems.

Following a trial implementation, team member feedback and outcome data were used to evaluate and refine the tool before broader use.

Co-design in action: Developing a DST

Co-design means designing solutions with the people who will use the DST.

The double diamond[1] (Figure 1) is a useful framework for co-design and involves four simple steps:
Discover, Define, Develop and Deliver. People are at the centre of the process, so that solutions are grounded in real needs and lived experiences.

Discover is to understand the problem by speaking to all the people affected.

Define is to gather insights and understand key issues to define an initial DST.

Develop is to test and refine the tool into a more final state.

Deliver involves implementation planning of the tool into practice.

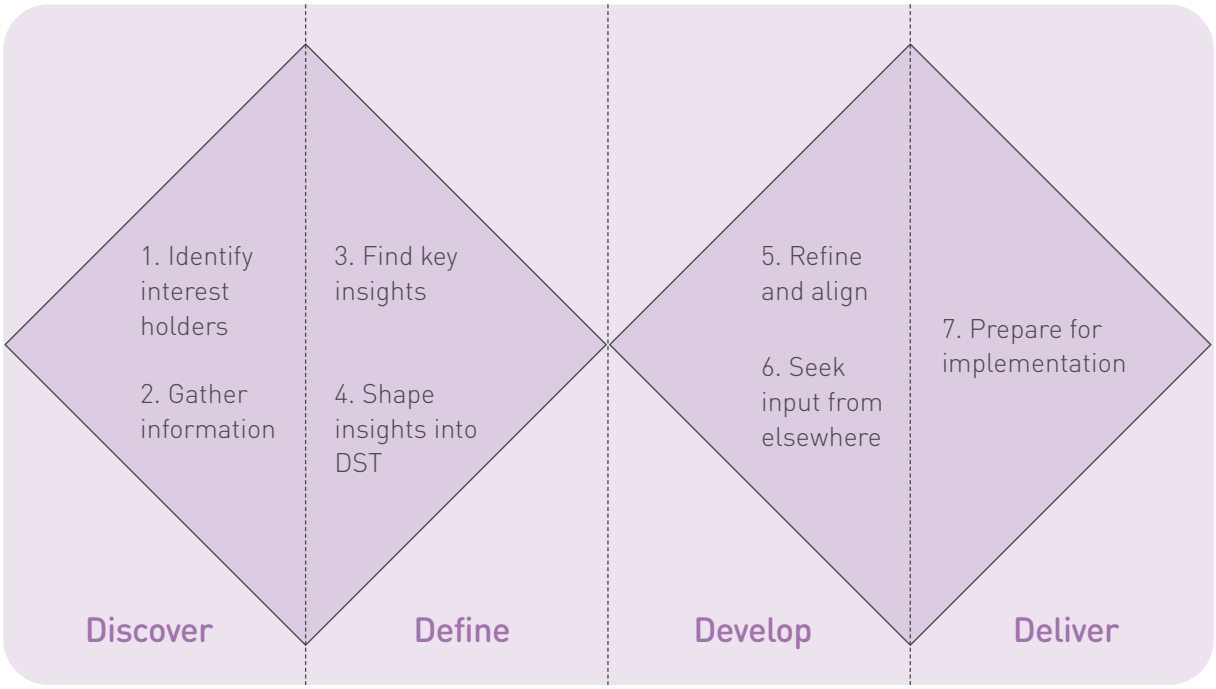


Figure 1: Double diamond framework

[1]Double diamond framework – Design Council, https://www.designcouncil.org.uk/our-resources/the-double-diamond

Co-design in action: Discover

1. Identify the right interest-holders

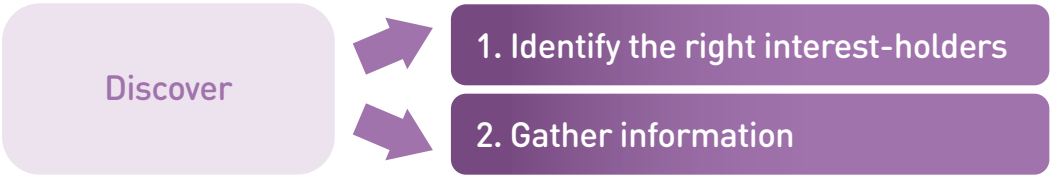
- Those who are affected by the problem and solution
- Those who influence decisions
- Those who will use the DST.

This may include frontline team members, experts, clients and implementation partners.

2. Gather information

Gather information through surveys, workshops or observations to explore:

- What team members know and feel confident doing?
- Whether team members have the time, resources and support they need?
- What encourages or discourages team members from following best practice?
- What is working and what is not?
- What policies and procedures say, and how they are applied in practice?



Urethral catheterisation CASE STUDY

1. Identify the right interest-holders

   RNs were recruited from Residential Aged Care (RAC) and Home and Community Services (HCS) through manager nominations, with selection based on clinical experience and metropolitan and regional representation. Nine RNs participated in the co-design workshops.

2. Gather information

   Five one-hour workshops were held over three months with three focused on DST content development and two on implementation strategies. A World Café[2] method was used to support collaborative discussion through small-group rotations.

[2]The World Cafe – https://theworldcafe.com/key-concepts-resources/world-cafe-method

Co-design in action: Define

3. Find key insights

The information gathered is analysed to identify critical decision points, including:

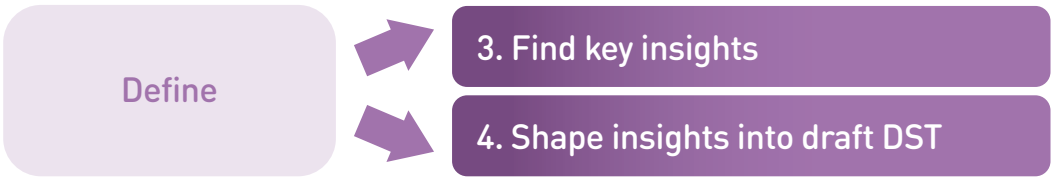
- Areas of uncertainty or variation in decision-making
- Frequently misunderstood or missed steps
- Gaps between policy and everyday practice.

These key insights help clearly define the problem the DST needs to address and prevent the tool from becoming too broad.

4. Shape insights into draft DST

Once key insights are agreed, they are translated into a draft DST by organising information into clear steps, prompts, practice points, or decision pathways that align with workflows.

The focus is on clarity, simplicity, and usability to support decision-making without adding unnecessary complexity.



Urethral catheterisation CASE STUDY

3. Find key insights

   In World Café sessions, key insights were generated and refined through the discussion process itself. These were captured on a digital whiteboard and organised by the project team. Workshops were also recorded and transcribed to support analysis and ensure no insights were missed.

4. Shape insights into draft DST

   The project team worked together to integrate themes and discussion points from the workshops into a flowchart format to form the initial draft DST.

Co-design in action: Develop

5. Refine and align

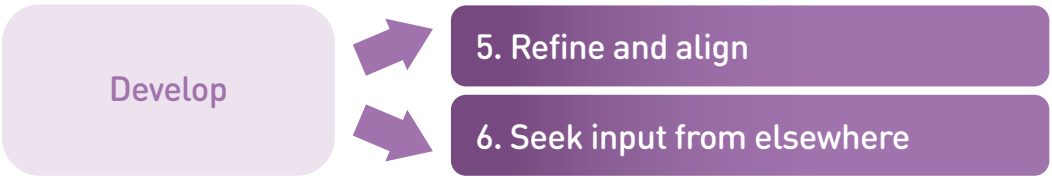
The DST is further developed by aligning key insights with existing policies and procedures to reflect real-world practice and organisational requirements.

Refinement also improves DST clarity and decision points for ease of use.

6. Seek input from elsewhere

Input is then sought from broader groups, for example, clinical experts, governance teams, and implementation partners.

This wider review helps test assumptions, identify gaps, and assess whether the DST is suitable across different settings.



Urethral catheterisation CASE STUDY

5. Refine and align

   The draft DST was aligned to the organisation's Insert Indwelling Urethral Catheter Procedure. Relevant sections of the procedure were referenced throughout the DST to support consistency and avoid duplication. Additional clinical guidelines were incorporated where appropriate to further strengthen alignment with best practice.

6. Seek input from elsewhere

   Five RNs in a regional RAC home and four regional community nurses provided feedback on contextual applicability of the DST. A continence clinical nurse specialist then reviewed the revised DST to confirm clinical accuracy, leading to final adjustments before implementation. Refer to Appendix A for the final DST.

Co-design in action: Deliver

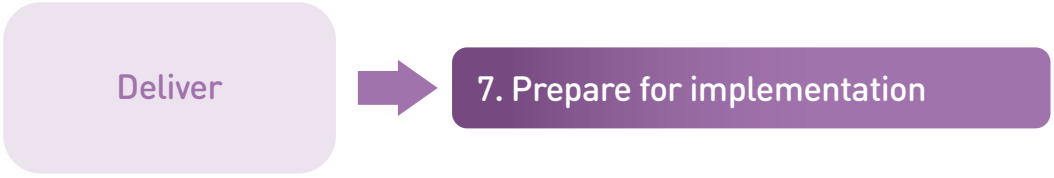
7. Prepare for implementation

Co-design underpins successful implementation.

Involving DST users in implementation planning helps strengthen uptake.

It enables DST users to identify potential barriers and enablers to uptake, and the necessary strategies needed to help mitigate these (e.g., training resources, quick reference guides, supportive team culture or leadership behaviours).

Conversations with DST users should inform appropriate communication channels and frequency, integration of the DST into existing workflows, and who should be involved in implementation.



Urethral catheterisation CASE STUDY

7. Prepare for implementation

   The last two workshops examined barriers and enablers to using the DST in practice and implementation strategies were developed around:

   - Education and training
   - Communication and awareness
   - Integration into systems and workflows
   - Leadership and culture
   - Continuous improvement

   Supporting materials were developed, including a training video, training presentation, poster, and an information sheet on the DST, along with work to fit the tool into existing systems and support from leaders to encourage team members to use it in everyday practice.

Tool implementation: From co-design to practice

Implementation is strongest when co-design shapes both the tool and its rollout.

Bolton Clarke uses the Implementation Framework for Aged Care (IFAC)[3] (Figure 2) providing a practical guide for translating evidence into practice while placing co-design at the centre of the process.

The framework covers:

- Why do we need change?
- What do we know from evidence and the information we gather?
- Who will benefit from the tool?
- Who will be the implementation partners and what strategies will be used?
- What difference are we making using the tool in practice?

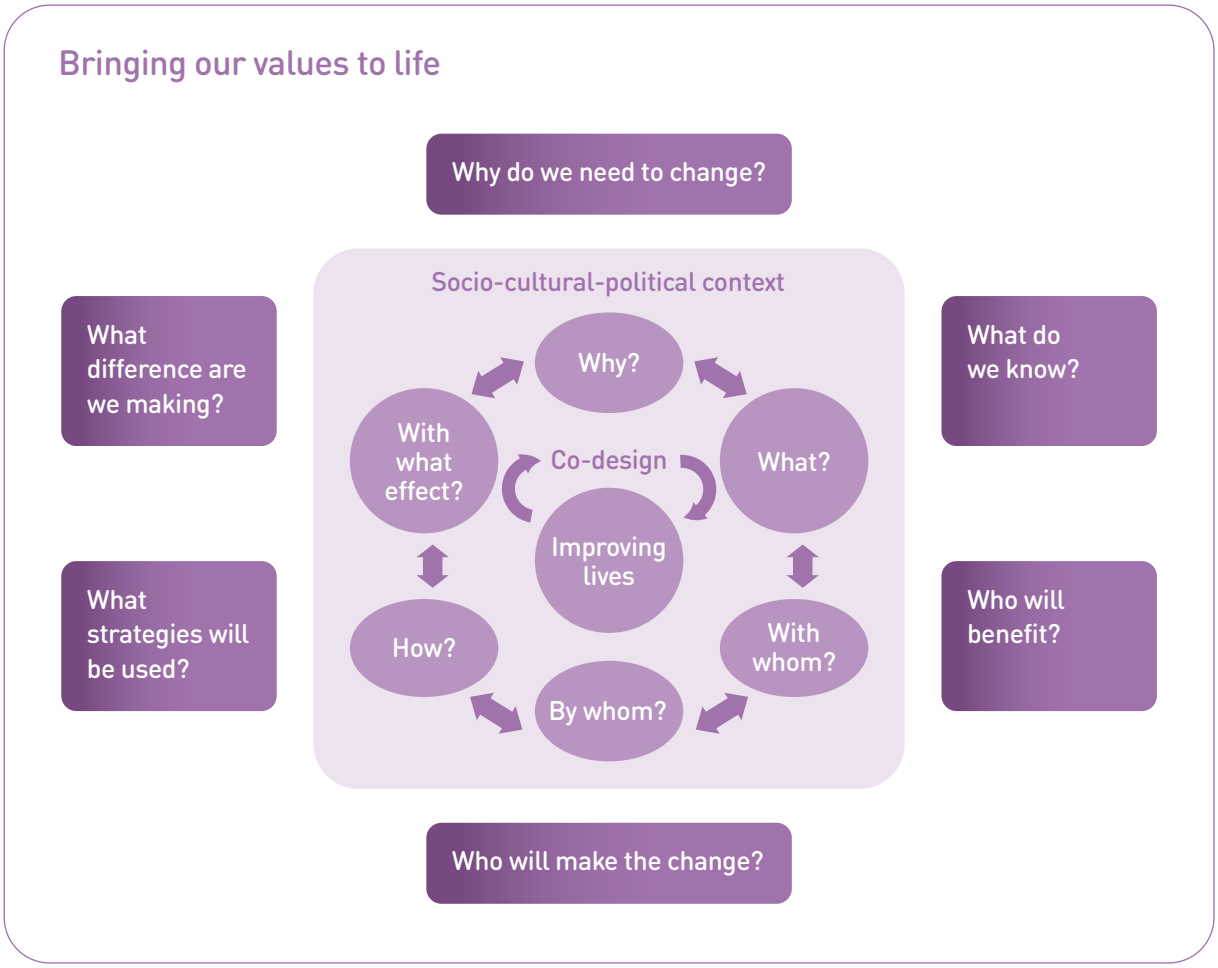


Figure 2: Implementation Framework for Aged Care (IFAC)

[3]Meyer, C., R. Ogrin, X. Golenko, E. Cyarto, K. Paine, W. Walsh, A. Hutchinson and J. Lowthian (2022). A codesigned fit-for-purpose implementation framework for aged care. Journal of Evaluation in Clinical Practice 28(3): 421-435

Evaluation of the DST

To see whether the co-designed DST is working and making a difference, information is collected and compared before and after to answer a simple question: Are we seeing an improvement? Information may include:

Clinical/health outcomes

Clinical outcomes describe changes in a person's health status, safety, or wellbeing resulting from care provided using the DST (e.g. falls, pressure injuries, hospitalisation).

Service outcomes

Service outcomes describe changes in the quality, safety, efficiency, or functioning of a service because of using the DST (e.g., number of incidents, adverse events, complaints, compliance with guidelines, confidence or competence, variation in practice).

Implementation outcomes

Implementation outcomes describe how the DST is put into practice and used by team members (e.g., uptake, consistency of use, acceptability, feasibility, fidelity, and sustainability).


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Appendix A - HCS decision support - Insert indwelling urethral catheter

Start preparations...

PRACTICE POINT - Competency is required per catheter type (female/male).
You are NOT considered competent if you:

- Are working outside your scope of practice
- Are not signed off for this catheter type
- Have not performed this procedure in the past 12 months
- Are not confident or not re-assessed after catheter incident involvement.

Do you have current competency, know the content of the latest IDC Procedure, have enough time, are confident AND know the escalation process?

NO → **DO NOT PROCEED** - and ensure that appropriate actions are taken so the procedure can be carried out safely.

YES

Is this a planned or unscheduled change?

UNSCHEDULED → Use clinical judgement to determine if the catheter requires replacement or if conservative measures can fix the issue. Consult a Subject Matter Expert (SME) if needed.

REQUIRES CHANGE

NO

PLANNED

Before proceeding **CONFIRM**:

- Valid authorisation form
- Catheter-related care plan
- Correct equipment available

YES

Partner with the client and obtain verbal consent

Are there client **RISKS** for this procedure today?

YES → CONSIDER

Before proceeding, review these potential **RISKS**:

- Unclear indication of catheter use
- Urological/genital issues or surgery (e.g., abnormal anatomy, enlarged prostate, urethral trauma, urethral stricture, invasive tumour/metastases, history of false passage)
- History of traumatic/complex insertion
- Autonomic dysreflexia
- Anticoagulant medication
- Urinary retention / blocked catheter (where catheterisation and rapid urine drainage may pose risk of shock)
- Acutely unwell not related to Catheter-Associated Urinary Tract Infection (CAUTI)
- Behavioural concerns
- Dehydration/inadequate urine in bladder (consider hydration, clamping, or timely removal of previous catheter)
- Constipation
- Catheter size and type requested not in line with best practice
- Known allergy (e.g., latex, anaesthetic gel, antiseptic)

Mitigate risk(s) in line with the care plan and IDC Procedure OR consult a Subject Matter Expert.

NO

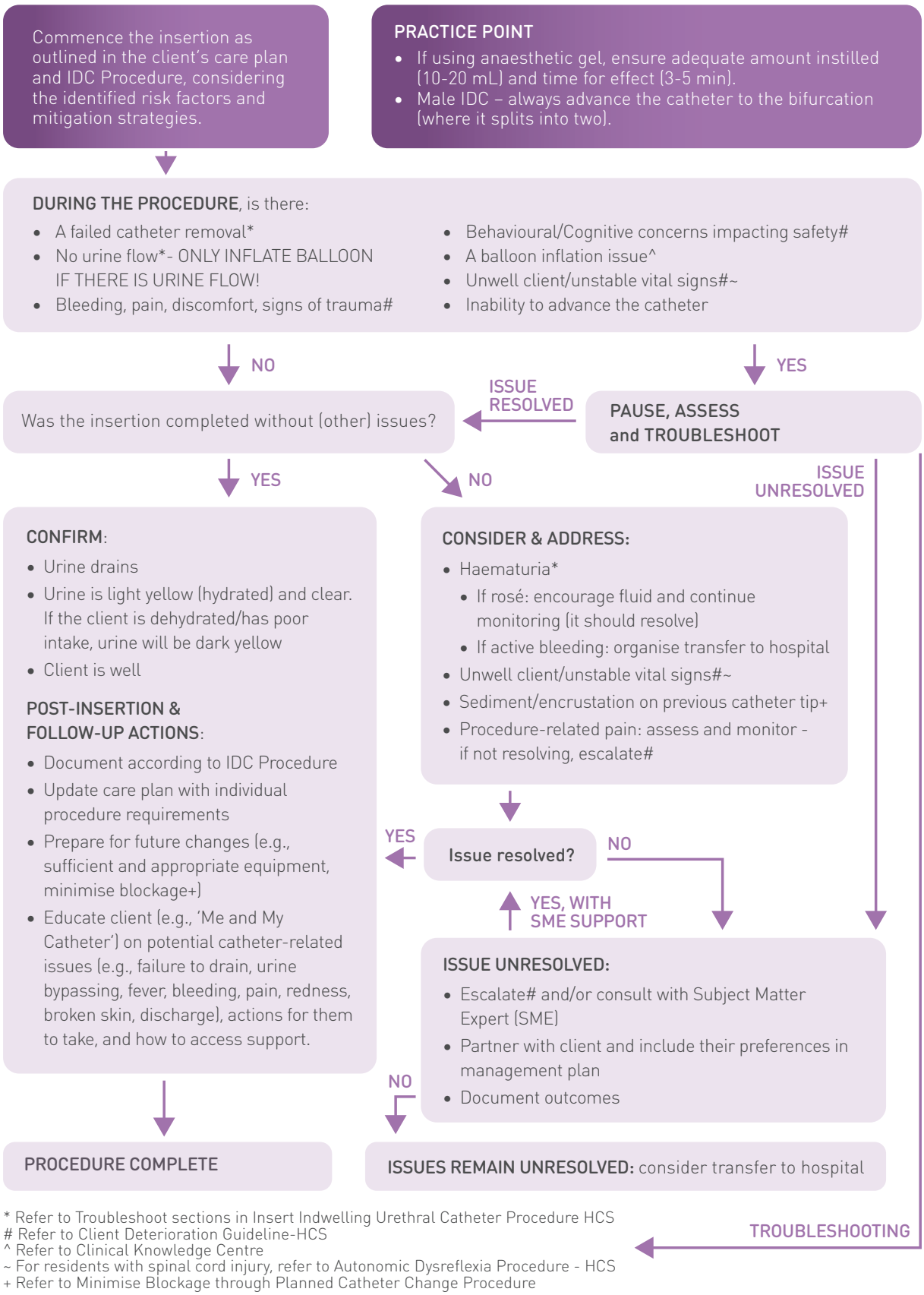
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This decision support tool is designed to assist and enhance clinical decision-making. It does not replace your professional clinical judgement, which remains essential in all circumstances. Ensure you use the latest tool version.

Note: This DST was developed for a specific organisational context. Organisations wishing to use this tool should review and adapt it to ensure alignment with their local policies, procedures, systems, and workforce needs.

Appendix A - HCS decision support - Insert indwelling urethral catheter



* Refer to Troubleshoot sections in Insert Indwelling Urethral Catheter Procedure HCS
\# Refer to Client Deterioration Guideline-HCS
^ Refer to Clinical Knowledge Centre
~ For residents with spinal cord injury, refer to Autonomic Dysreflexia Procedure - HCS
\+ Refer to Minimise Blockage through Planned Catheter Change Procedure

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Project team

- **Arti Appannah (playbook author)** - Research Fellow
- **Linda Schnitker (playbook author)** - Research Fellow
- **Katherine Platt** - Head of Clinical & Service Governance
- **Janeen Cato** - Manager Clinical Innovation
- **Stuart Donohoe** - Senior Manager Clinical Quality Governance
- **Sarah Halkyard** - Manager Clinical, Safety & Quality
- **Kathy Pope** – Clinical Team Leader (in-home aged care services)
- **Sristi Pyakurel** – Clinical Nurse Leader (residential aged care)
- **Kate McLeod** - Senior Clinical Nurse Adviser
- **Carly Meyer** – Senior Research Fellow
- **Claudia Meyer** – Senior Research Fellow
- **Elizabeth Robinson** – Research Officer

Would you like to know more?

For questions about the co-design process, implementation preparation, or adaptation of the urethral catheterisation Decision Support Tool to your local context, please contact:

Linda Schnitker
Research Fellow, Bolton Clarke Research Institute

Lschnitker@boltonclarke.com.au


Olivia



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Bolton Clarke is the brand name for a group of companies being RSL Care RDNS Limited ABN 90 010 488 454,
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