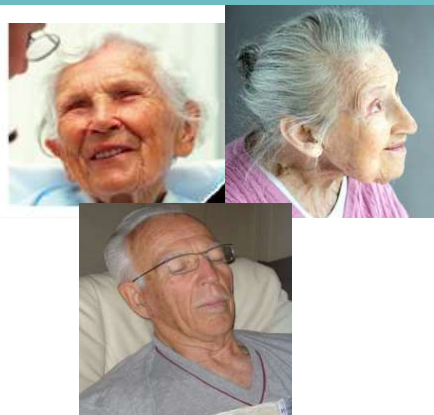


*Time for Evidence based Action around prn Medicines
in Aged Care*

TEAM Aged Care

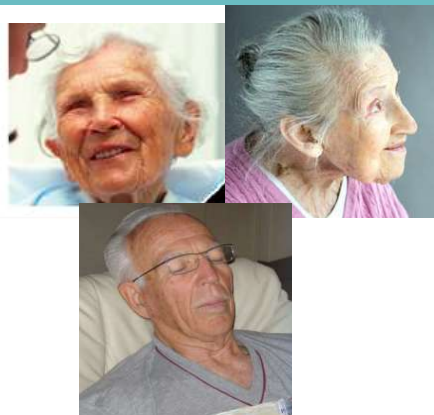
***Sue Edwards, Aine Heaney, Ruth Greene, Simone Rossi, Simon Pavelic, Debra
Rowett,
on behalf of the TEAM Aged Care Consortium***





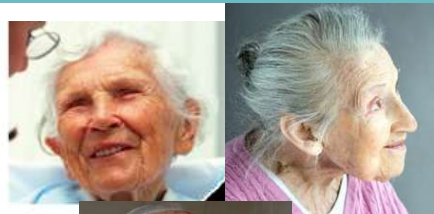
PRN medicines are of value

- In addition to regular medications, the availability of when required (PRN) medicines for aged care residents ensures that changes in health care needs can be met in a timely and individualised manner.
- PRN medicines are integral to implementation of end of life care pathways.
- **Person centred care**



PRN medicines risks of harm

- Excess sedation, increased confusion and falls risk in the case of antipsychotic and benzodiazepine medicines,
- Under treatment of pain if PRN analgesia is used instead of regular analgesia for chronic pain or under use of PRN analgesia for breakthrough or incident pain,
- Interactions/duplication with regular medicines



PRN medicines

- prescribed by a GP for an individual resident
- may be nurse initiated for some medications

Complex clinical decisions made in the face of uncertainty

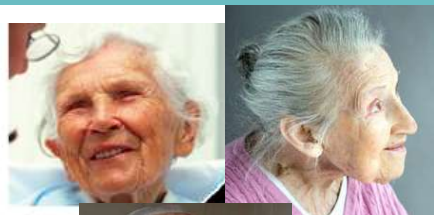
Balance between efficacy and harms



Agitation

Which PRN medicine could be appropriate?

Medication	Dose	Frequency	Indication
Paracetamol 500mg	1-2 qid	Prn	<i>Pain</i>
Coloxyl with senna	1-2 night	Prn	<i>constipation</i>
Risperidone 0.5mg	1 bd	Prn	<i>agitation</i>
Oxazepam 15mg	½ - 1 tablet	Prn	<i>Sedative or agitation</i>
Panadeine forte 500/30mg	2 qid	Prn	<i>Severe pain (max 8 incl paracetamol above)</i>



Aim

Improve knowledge, skills, and confidence of aged care staff with respect to PRN medicines for

- pain
- constipation
- behaviours of concern
- sleep

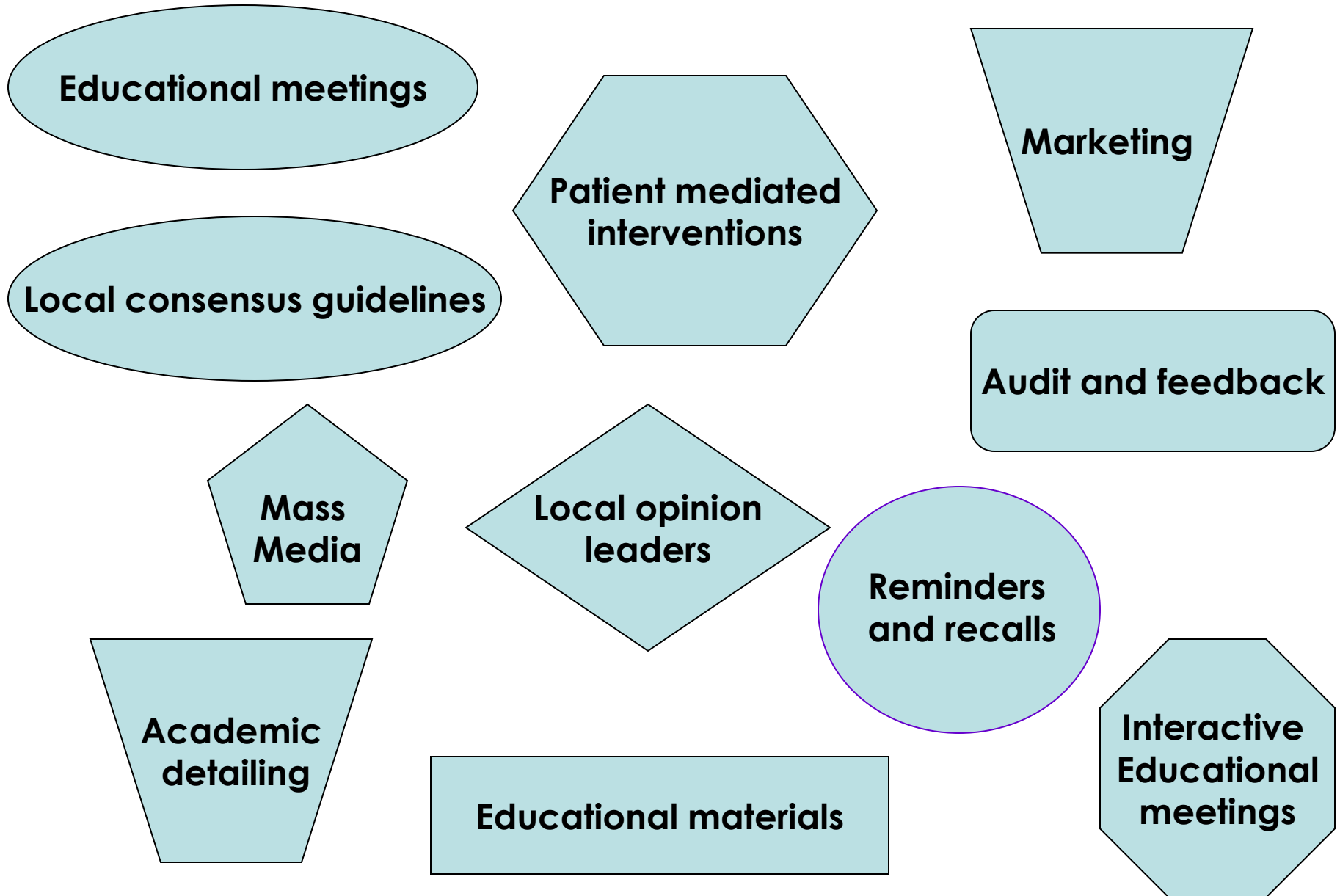
Assess our methodology

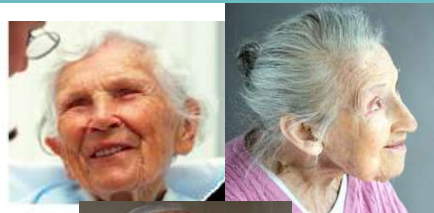


What did we aim to do cont.

- All care staff
 - To provide a training model that acknowledges medication administration involves not only the staff administering medicines but also other aged care staff through perceiving care needs that may warrant administration of PRN medicines as well as follow up and assessment of outcomes if a PRN medicine is administered

A Taxonomy of Professional Behaviour Change





Methods

Evidence based change management processes used in this project were:

- Audit and feedback to the facilities regarding the target medicines.
- Educational visiting (academic detailing) to Aged Care staff (mostly 1:1)
- Small group resident meetings



Audit and feedback

NPS Drug Utilisation Evaluation kits (DUE Kits)

DUE of antipsychotic use in the management of dementia

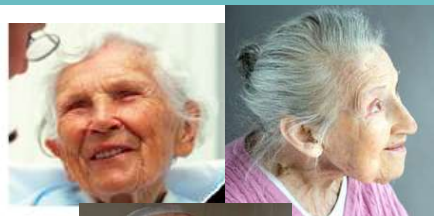
DUE of hypnotic medicines for the management of insomnia in aged care facilities

DUE of analgesic use for persistent pain

DUE of laxative use for chronic constipation

– http://www.nps.org.au/health_professionals/drug_use_evaluation_due_programs/due_kit_for_care_homes





Academic Detailing/Educational Visiting

Academic detailing – American
Educational visiting – Australian

It is a methodology that involves face to face education of individuals where possible or very small groups of 2 or 3 people with the aim of changing professional behaviour to be consistent with the evidence.

Face-to-face discussions and answering of questions arising. The technique recognizes individual attitudes and beliefs and personal barriers to behaviour change and is delivered within a service philosophy.

Person centred education



Academic Detailing Visits bring the best available evidence to where the care is delivered and can be tailored to meet the needs and varying scopes of practice of aged care staff



Academic detailing/ Educational Visiting Service Delivery in Australia

General Practitioners

- 1991 commenced in SA for 200 GPs
- 1999 National Prescribing Service programme
- greater than 70% of GPs in Australia have participated
- over 70,000 visits conducted Australia wide

Hospitals

- involves hospital doctors, nursing and pharmacy staff
- over 80 hospitals (public and private),
- greater than 3000 educational visits

Residential Aged Care

Innovative model in the Aged Care industry and is the first time this method of education has been utilized in a formal way for aged care staff in Australia. It has required both educators and learners to think outside of traditional teaching and learning models to facilitate and be part of this education.



Questions

- Is '*educational visiting or academic detailing*' achievable as a training delivery option in aged care homes and can it have extended reach?
- Does '*educational visiting or academic detailing*' influence aged care staff knowledge and behaviour in accord with the evidence informed project key messages?
- Does this method of training influence the use of medicines for pain, constipation, behaviours of concern and sleep in accord with the project key messages?



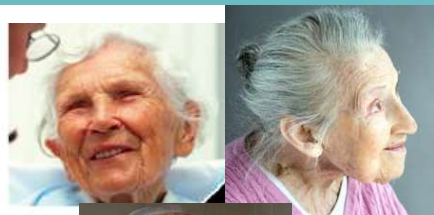
Implementation

4 educational visitors

- 10 Residential aged care homes
- South Australia and Victoria
- Metropolitan, rural, remote and culturally specific

1. Identification of systems in current usage at facility
2. Visit dates set in consultation with facility
3. Appointment sheets provided to “link” staff person
4. Individual appointments of 20 - 30 minutes with aged care staff

- 3 successive modules provided



PRN – Pro Re Nata

P = Perceive the need

R = Report and relieve

N = Note the effects

Pain Module

PRN medicines

Perceive the need : Report and relieve : Note the effects

TEAM Aged Care
Unit for Enhanced Senior Adults around RNs Medication in Aged Care
Funded by the Department of Health and Ageing



PAIN

Perceive that pain might be an issue
Assess the pain
Individualise management
Note effects/benefits and side effects

When required (PRN) medicines

PRN medicines are an integral part of resident care.

- They assist in the management of conditions or symptoms that are not easily managed by the resident on an ongoing basis.
- PRN medicines are provided for the individual resident and recorded on the medication chart.
- PRN medicines for pain can be used to prevent pain recurring and to treat pain when it occurs.
- PRN medicines for constipation can be used to prevent constipation and to treat constipation when it occurs.

You can help...
What you can do



TELL care staff when you are uncomfortable, hurting or in pain. Don't wait for us to ask about your pain.

Tell us where your pain is and what it's like

Pain from different parts of the body comes from a variety of causes. Knowing where your pain is coming from and how it feels (aching, burning, stabbing) helps us to work with you to choose the best treatment. Tell staff if it is a new pain.

What else can you do?

Ask for pain relief before you get too uncomfortable. It is harder to ease pain once it has taken hold.

Remember to tell care staff about any pain that doesn't get better, even after having pain medicine.

Please tell care staff if you think you might have a side effect from the medicine, eg stomach pain, dizziness, rash or other symptoms.

For information about pain medicines call the Consumers medicine information line on 1300 888 763.

It's important to discuss pain issues with your doctor.

TEAM Aged Care

The TEAM Aged Care program is funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPAC) program.

We Care About Your Pain

You may not have pain now but what would you do if you experienced pain.

TEAM Aged Care

Perceive

Is this resident in pain now?

Might she be in pain when she walks?

Many factors can affect pain in an individual resident, such as:

- Chronic pain: a common condition that involves long-term or constant pain, often described as a dull, aching, burning or throbbing pain that does not go away.
- Acute pain: a common condition that is described as a sharp, intense pain that is usually short-lived.

Recognising these signs and symptoms in pain is the first step.

How can residents continue to live independently and still experience health and quality of life?

Consider pain management being part of your care plan. Consider how it affects the quality of life.



Assess

Regularly assess residents for pain using valid instruments and record the resident's level of pain.

ASK THE RESIDENT:

Do you have any pain? Where is the pain? How long has the pain been there? How does the pain feel? How does the pain affect your daily life? How does the pain affect your sleep? How does the pain affect your mood?

Assessing pain for residents with dementia who are unable to describe their pain is a challenge. Consider using a validated instrument to assess their pain.

Observe the resident

50% of pain is

- Unrelieved
- Unrelieved by analgesics
- Unrelieved by non-pharmacological measures
- Unrelieved by a combination of both
- Unrelieved by a combination of both and non-pharmacological measures

Individualise management

There are different theories as to the experience of pain, and several different administration techniques are available. Multiple and/or alternative treatments can alleviate discomfort, improve mood, and reduce the need for analgesics.

Always take into account the resident's pain, the individual's condition, and the resident's care plan.

The goal of pain management is that all residents can live as free as possible from pain at all times.¹

Management is not about the length of time a resident will suffer but about the quality of their life.

Individualise management

Chronic pain?

Chronic pain is pain lasting long periods of time. Chronic pain is not always caused by the tissue damage of an injury and frequently does not have any clearly identifiable cause.

Resident's current drug use and health care services may be making it more difficult to manage their pain. Consider a regular review of the resident's care plan.

Regularly review drug use and health care services to ensure they are appropriate for the resident's needs.

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Note the effects – benefits and side effects

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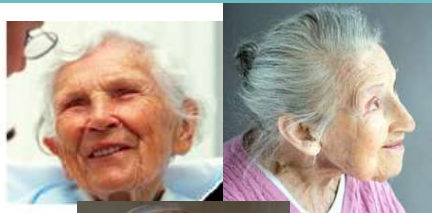
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Signs of Pain in Older People

Facial expressions

- Frowning
- Grimacing
- Rapid blinking
- Sad expression

Movements

- Tense or rigid posture
- Guarding/protecting body part
- Fidgeting, pacing, rocking
- Difficulty moving, decreased movement
- Changed gait – walking strangely

Activity levels

- Appetite – not eating
- Rest patterns, sleeping a lot or very little
- Wandering
- Changes in normal routine or activity

Mental state

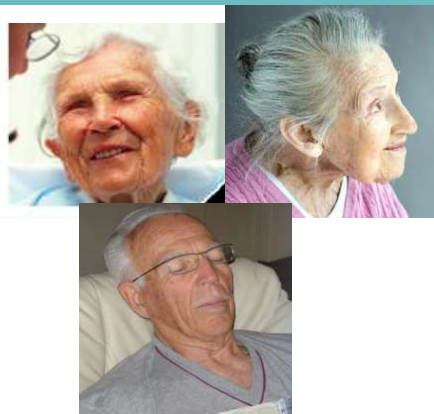
- Confusion
- Crying
- Irritability
- Distress

Noises

- Sighing, moaning or groaning
- Grunting
- Chanting
- Calling out
- Noisy breathing
- Asking for help
- Verbal abuse, swearing

Personality

- Aggressiveness
- Fighting or resisting care
- Avoiding socialising, becoming withdrawn
- Inappropriate or disruptive behaviour



Key messages

- Pain identification: use both staff observation and residents self reports
- Report / document symptoms of pain
- Regular administration of analgesia is the most effective medication measure for persistent pain
- **PRN medicines can be useful prior to an activity to reduce predictable (incident) pain** or for breakthrough pain
- Analgesia induced side effects can often be anticipated and avoided – **think about laxative use preemptively**
- Assess for effectiveness and side effects of analgesics



Perceive and assess

Report and relieve

Note the effects (including side effects)

Behaviours of Concern Module

PRN medicines
Perceive the need - Report and relieve - Note the effects

BEHAVIOURS OF CONCERN

Behaviours which cause distress to the person or others.

When required (PRN) medicines

- are not the primary management strategy for behaviour of concern
- may be used to relieve acute symptoms or distress
- are used to manage symptoms or distress that are not usually managed by the resident or caregiver
- are used to manage symptoms or distress that are not usually managed by the resident or caregiver

Using medicines to manage behaviours of concern

Perceive and assess

Behaviours of concern have been reported in up to 60% of people with dementia. The types of behaviour often change over time as dementia progresses.

Report and Relieve

Report and describe the behaviours of concern to the individual and the care and nursing staff. Best outcomes are achieved if care is tailored to the needs of the individual and the care and nursing staff.

Perceive and Assess

Behaviours of concern

Behaviours of concern have been reported in up to 60% of people with dementia. The types of behaviour often change over time as dementia progresses.

Report and Relieve

Report and describe the behaviours of concern to the individual and the care and nursing staff. Best outcomes are achieved if care is tailored to the needs of the individual and the care and nursing staff.

Note the effects

Perceive the effects of the medicine and the person of the person with effects. Be able to report them, and their consequences.

Report and Relieve

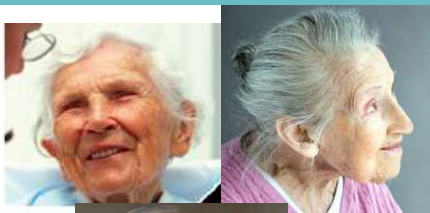
Report and describe the behaviours of concern to the individual and the care and nursing staff. Best outcomes are achieved if care is tailored to the needs of the individual and the care and nursing staff.



Key Messages

- Perceive and assess triggers for the behaviour of concern
- Use care/nursing based strategies as the first option
- Only consider PRN antipsychotic or benzodiazepine medicine where there is risk to the resident or others
- Put in place strategies to maintain the resident safety after administration of an antipsychotic or benzodiazepine
- Review and document effectiveness and side effects

Some Resources



NPS NEWS National Prescribing Service Newsletter

59 2008

Inside ▶

Prescribing drug used in Alzheimer's disease

Discontinuing treatment

Treatment for behavioural and psychological symptoms of dementia

Anticholinergic drug can worsen dementia

Case Study 54
Caring for patients with Alzheimer's disease

Drugs used in dementia in the elderly

Around 200 000 Australians have dementia, the most common cause is Alzheimer's disease (50% to 70% of cases).¹ Other causes include vascular dementia (10% to 20% of cases), dementia with Lewy bodies (up to 10%), fronto-temporal dementia and dementias due to Parkinson's disease, drug and alcohol abuse or head injury.^{1,2} Dementia often has a combination of causes.¹

Behavioural and mood problems become more common as dementia progresses. The umbrella term for these symptoms is behavioural and psychological symptoms of dementia. This NPS News looks at both the pharmacological and non-pharmacological management of these symptoms and, more broadly, dementia.

Non-pharmacological management of dementia

Non-drug strategies promote independence and can maintain cognitive and physical function in people with dementia. Individualised management and involve the patient, their family and carers whenever possible.³

The evidence for many non-pharmacological interventions is limited. However, good clinical practice suggests that regular physical and recreational activity, memory aides (e.g. calendars, schedules or memory books) and environmental modifications (e.g. visual prompts, motion-sensor lights) can be useful.⁴

Cognitive stimulation programs where patients participate in activities that involve some degree of cognitive processing, such as reminiscence, or word or card games, can improve cognition and quality of life.⁵

Pharmacological management of Alzheimer's disease

The cholinesterase inhibitors (donepezil, galantamine and rivastigmine) and the N-methyl-D-aspartate (NMDA) antagonist, memantine, are approved for use in Alzheimer's disease. These drugs are not approved for any other type of dementia.

The cholinesterase inhibitors and memantine do not alter the pathology of Alzheimer's disease.⁶ At best, they may temporarily delay progression and improve symptoms according to subjective measurements or cognitive assessment tools (Table 1). There are two main assessment tools used to establish whether a patient is eligible for a cholinesterase inhibitor or memantine under the Pharmaceutical Benefits Scheme (PBS), the MMSE and the 5MIST.

NPS is an independent, non-profit organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

National Prescribing Service Limited
ABN 61 062 054 393 | Level 2/418A Elizabeth Street Surry Hills NSW 2010 | PO Box 1147 Strawberry Hills NSW 2012
Phone: 02 8217 8700 | Fax: 02 9211 7378 | email: info@nps.org.au | web: www.nps.org.au



Sundowning

CHANGED BEHAVIOURS AND DEMENTIA

This Help Sheet explains why some people with dementia are particularly restless in the afternoon and evening, a condition sometimes known as sundowning. It gives some practical advice to families and carers for managing sundowning.

What is sundowning?

People with dementia may become more confused, restless or irritable late in the afternoon or early evening. It can be worse after a move or a change in their routine. They may become more demanding, restless, upset, suspicious, disoriented and even see, hear or believe things that aren't real, especially at night. Attention span and concentration can become even more limited. Some people may become more impulsive, responding to their own ideas of reality that may place them at risk.

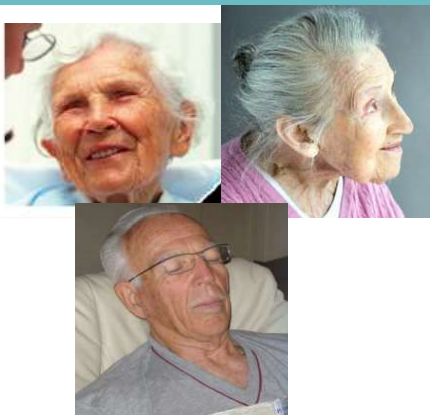
What causes sundowning?

No one is sure what causes sundowning, although it seems to result from changes that are occurring in the brain. People with dementia tire more easily and can become more restless and difficult to manage when tired.

Sundowning may relate to lack of sensory stimulation after dark. At night, there are fewer cues in the environment, with the dim lights and absence of activity from outside daytime activity. A person experiencing sundowning may be hungry, uncomfortable, in pain or needing to use the toilet, all of which they can only express through restlessness. As the dementia progresses and they understand less about what is happening around them, they may become more frantic in trying to restore their sense of familiarity or security. Many families and carers say that the person becomes more anxious about "losing home" or "losing mother" late in the day which may indicate a need for security and protection. They may be trying to find an environment that is familiar to them, particularly a place that was familiar to them at an earlier time in their life.



Contact the National Dementia Helpline on 1800 100 500



Perceive the need Report and relieve Note the effects *Sleep Module*

Getting a Good Night's Sleep

TEAM Aged Care
The TEAM Aged Care project is funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) program.

Sleep facts
Sleep patterns change as we age so that sleep is usually lighter and more broken.
As we get older we generally require less sleep.
There is no ideal amount of sleep. Some people need very little sleep and still function well during the day, while others need a lot more sleep.
It is usually better to manage sleep difficulties by trying non-drug methods first.

TEAM Aged Care
If you need more information about sleep medicines you can call the Consumer Medicine Information Line on 1300 888 763.

TEAM Aged Care

PRN medicines
Perceive the need · Report and relieve · Note the effects

SLEEP

Principles & The team responsible when completed

When required (PRN) medicines

- Sleep medicines are not other medicines and not alcohol
- If you are unable to sleep it is not necessary to take medicines that is provided to you just to help you sleep
- You should be encouraged to try to sleep naturally by using relaxation techniques
- You should be encouraged to try to sleep naturally by using relaxation techniques
- You should be encouraged to try to sleep naturally by using relaxation techniques

Perceive and Assess

Sleep facts
Normal sleep patterns change throughout life. As we age sleep patterns change to become more fragmented. It is normal to wake up more often at night and to need less sleep than you did when you were younger.

Medicines and other substances
Medicines and other substances can affect sleep. Some medicines, such as antidepressants, can make it harder to fall asleep. Some medicines, such as sedatives, can make it easier to fall asleep. Some medicines, such as painkillers, can make it harder to stay asleep.

Report and Relieve

Report and describe
The sleep team will ask you to describe your sleep problems. They will ask you how often you wake up at night, how long it takes you to fall asleep, and how long it takes you to get back to sleep.

What you can do
There are many things you can do to help you sleep better. Some of these include:

- Going to bed at the same time every night
- Making your bedroom a comfortable place to sleep
- Avoiding caffeine and alcohol before bed
- Avoiding heavy meals and drinks before bed
- Exercising regularly during the day
- Relaxing before bed
- Using relaxation techniques
- Using a white noise machine
- Using a weighted blanket
- Using a sleep mask
- Using earplugs
- Using a fan
- Using a humidifier
- Using a white noise machine
- Using a weighted blanket
- Using a sleep mask
- Using earplugs
- Using a fan
- Using a humidifier

Note the effects

When you take a sleep medicine, you should notice some effects. These effects can be good or bad. Some effects are common to all sleep medicines, while others are specific to certain medicines.

Effects on sleep
Sleep medicines can help you fall asleep faster and stay asleep longer. They can also help you wake up in the morning.

Side effects and their consequences
Sleep medicines can have some side effects. Some of these include:

- Drowsiness
- Headache
- Stomach pain
- Constipation
- Dry mouth
- Blurred vision
- Dizziness
- Feeling tired the next day
- Feeling confused
- Feeling dizzy
- Feeling lightheaded
- Feeling dizzy
- Feeling lightheaded
- Feeling dizzy
- Feeling lightheaded

Other things to know
You should tell your doctor if you are taking any other medicines, including over-the-counter medicines, herbal supplements, and alcohol. You should also tell your doctor if you have any medical conditions, such as liver or kidney disease, or if you are pregnant or breastfeeding.



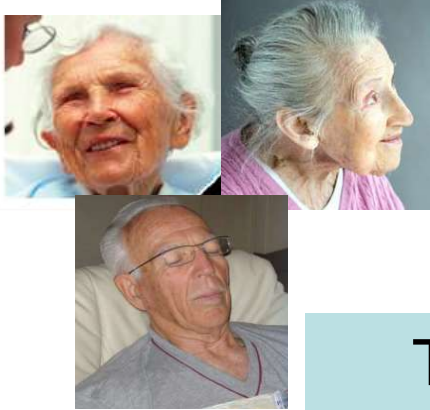
Key Messages

- **For all staff**
- KM 1: For all residents - sleep problems, changes in daytime functioning, day time naps should be assessed and reported.
- KM2: Look for contributing factors for all reports from a resident or others of insomnia.
- KM3: Use care plans to inform carer/nursing strategies when possible. If the decision to treat insomnia with medicines is made, **PRN is preferred to regular use**
- KM4: If sedatives are required monitor the resident for change and report/record effectiveness and any side effects.



Outcomes

- Is '*educational visiting or academic detailing*' **achievable** as a training delivery option in aged care homes and can it have extended reach?
- Does '*educational visiting or academic detailing*' **influence aged care staff knowledge and behaviour** in accord with the evidence informed project key messages?
- Does this method of training **influence the use of medicines** for pain, constipation, behaviours of concern and sleep in accord with the project key messages?



Achievable

Through delivery of three modules to ten aged care homes situated in South Australia and Victoria (including metropolitan, rural and remote, ethnic specific and not for profit organisations) this project demonstrated that the model is ***flexible and transferable to a range of aged care settings.***

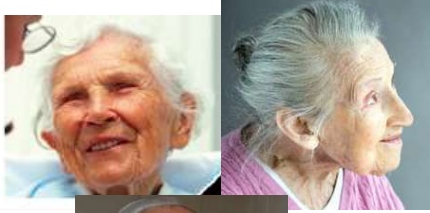
This model ***addresses the individual learning needs*** of aged care staff, it is tailored to their knowledge and expertise, their scope of practice and level of health and clinical literacy.



Extended reach

A large number of staff (675 individuals) were trained, involving a total of 1395 educational encounters with approximately 450 staff trained in each of three modules (reaching 100% of staff in some aged care homes).

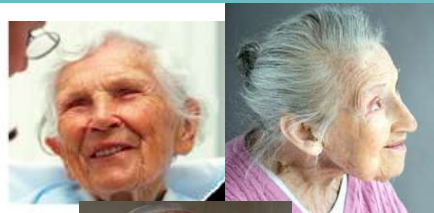
The training in the project was delivered by 1.3 FTE educational visitors (4 part time staff) over the 15 month intervention period using materials developed by the Project team.



Efficient

Potential workforce efficiency gains

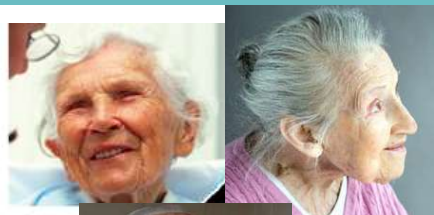
The model respects and values individual staff by providing training ***at a time convenient to staff in the workplace***, minimizing the need for staff travel or the need to attend training out of work hours. It reduces the risks for errors in communication at clinical handover by offering structured educational encounters throughout the shifts, including night shifts, and minimises staff time 'off the floor' for training substantially.



Valued

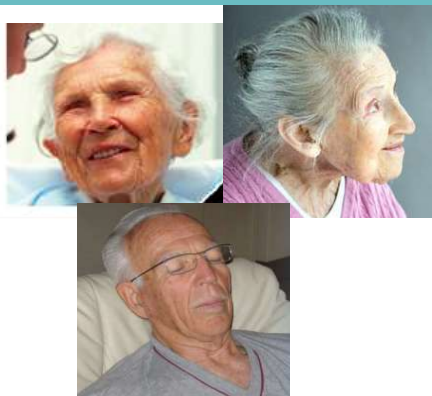
Valued and sustainable

The training was ***valued by all aged care staff***, including Aged Care Home managers, registered nurses, personal care workers, and maintenance and food services staff. For each module staff evaluations showed greater than 99% of all staff agreed or strongly agreed that the training provided useful information and 96% agreed or strongly agreed it was of relevance to their practice.



Impact – measurable changes demonstrated

Change was evident with each module, demonstrating that this model is effective across a range of common clinical areas of practice in aged care (pain, constipation, behaviours of concern, sleep) (and offers the potential for delivery of training, for example, high risk medicines e.g. warfarin, incontinence, common infections).



Perceive and Assess

Behaviours of concern

Behaviours of concern have been reported in up to 90% of people with dementia.^{1,2}

The types of behaviour often change over time as dementia progresses.⁴

It is the impact of the behaviour and not its nature which determines whether it is a problem.

Any person's perception of behaviour can be subjective.⁴

A behaviour which may be of concern in one setting might not be of concern in another.⁴

Look for triggers

Agitation, aggression, inappropriate behaviour, disinhibition, wandering or being noisy and calling out have many possible causes.

Some of the underlying causes of an observed behaviour you may need to consider include pain, constipation, an empty hunger, thirst, loneliness, boredom, infection, depression, delirium, or medication.

Different residents can have different causes or combinations of causes for an observed behaviour of concern. For example, management of patients who are vocally disruptive because of pain will be different from those where over-stimulation is the trigger.⁴

Report and Relieve

Report and describe

Report and describe the circumstances of the specific behaviours. Collecting this information will help with developing care plans to manage the behaviour.

Report the behaviour that is being displayed/observed.

- What are identifiable trigger/contributing factors?
- When does it occur? (The impact of a behaviour of concern may be greater at times than during the day)
- How long does the behaviour occur for?
- How often does the behaviour occur?
- What is the level of distress or risk to the resident, staff or others?
- What interventions/strategies help reduce the behaviour?

Individualise management

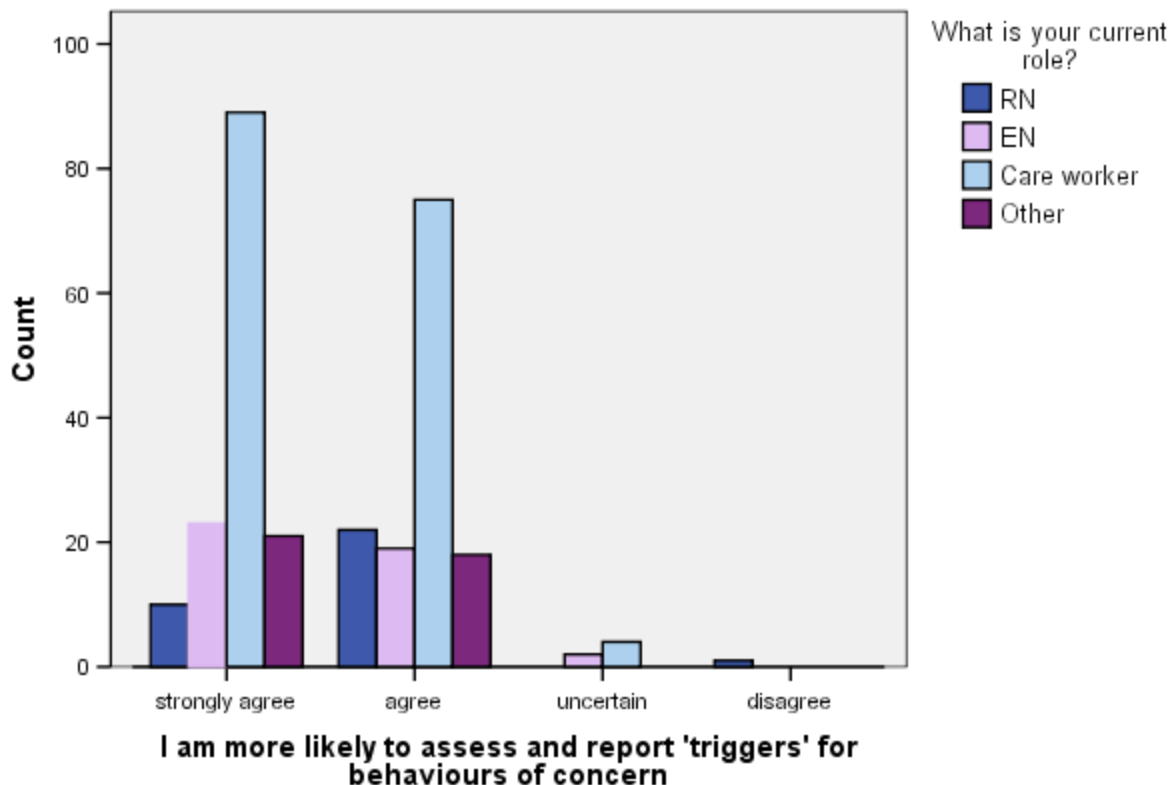
Aged Care Standards 2.13 (Behavioural Management) requires that 'the needs of residents with challenging behaviours are managed effectively'.³

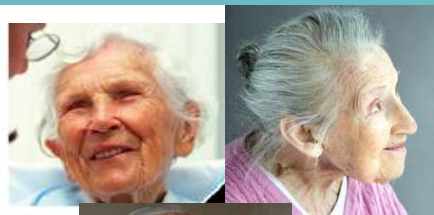
Best outcomes are achieved if care is tailored to the needs of the individual and the care and realistic goals are set. Try care or nursing based approaches first for behaviours of concern.

Where possible identify triggers and use this information to prevent the behaviour or reduce the escalation or impact of the behaviour. A response may be something that:

- you do or say for need doing or saying
- changes in the environment
- changes in the way people think and act

Use a team effort to ensure discovery of the best response possible.⁴





Impact – measurable changes demonstrated

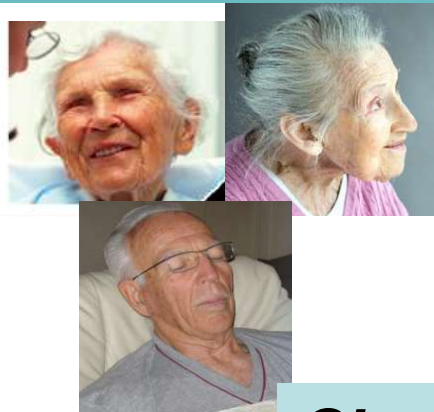
Change of knowledge — 96% of care staff indicated that they were more aware of the adverse effects of antipsychotics after the Behaviours of Concern module.



Impact

– measurable changes demonstrated

Change of behaviour — 97.4% of staff indicated they were more likely to assess for factors contributing to sleep difficulty after the Sleep module.



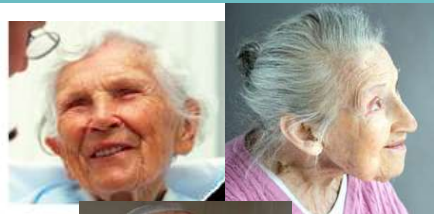
Impact

– measurable changes demonstrated

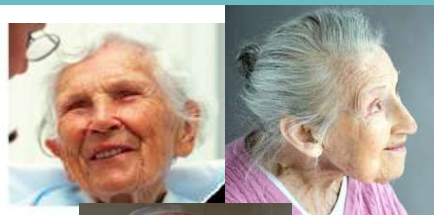
Change to medicine use and resident care —
30% increase in the prescribed use of paracetamol in accord with the residents' documented needs.

PRN doses of antipsychotic administered reduced by 37.5%.

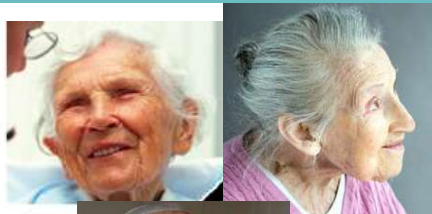
Significant increase in trial withdrawal of benzodiazepines from 19.2% pre intervention to 31.9% following the visiting programme.



Academic detailing as a training program can be delivered efficiently while also delivering on the other dimensions of performance, quality, effectiveness and equity



The TEAM Aged Care project was funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) Program



The Team

DATIS Repatriation General Hospital
Australian Medicines Handbook
National Prescribing Service
General Practice Network South
Pathways Health and Education Consultants
Casa Elda Vaccari
Kangaroo Island Health Service
Kirribilli At Encounter Bay
Havilah Hostel
McCracken View
Ross Robertson Memorial Care Centre
Sandpiper Southern Cross
St Johns
West Park Nursing Home Aged Care & Housing
Yankalilla Centre Aged Care & Housing