Caring for Cognitive Impairment Campaign

Webinar No 2 Getting started: Lessons from the field
30 August 2016

Anne Cumming
Principal advisor, Cognitive Impairment

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Overview

- Background
- Aim of today's webinar
- Three presentations:
  - **Fred Graham**, CNC Dementia & Delirium, Princess Alexandra Hospital, Brisbane
  - **Sharon Strahand**, CNC Aged Care, Hornsby Ku-ring-gai Hospital, Sydney
  - **Mark Yates,** Geriatrician and researcher, Dementia Care in Hospitals Program
- Summary
- Time for questions at the end. Type them as we go into the Questions pane of the control panel. You can also put your hand up. If you have joined by telephone, enter your pin number so we can unmute you.

CARING FOR COGNITIVE IMPAIRMENT

Cognitive Impairment

is an important safety and quality issue for all Australian hospitals

Patients with cognitive impairment such as dementia and/or delirium have more falls, pressure injuries and functional decline

Dementia and delirium are poorly recognised

30-40% of delirium cases can be prevented

Learn how to recognise cognitive impairment

Prevent delirium

Act to keep people with cognitive impairment safe

We can all make a difference

Cognitive Impairment Program

Main areas:

1. *A better way to care*
2. Delirium clinical care standard
3. National Safety and Quality Health Service Standards
4. Caring for Cognitive Impairment campaign

System for caring for cognitive impairment

- ✓ Identify patients at risk of delirium
- ✓ Implement multicomponent delirium prevention strategies
- ✓ Screen for cognitive impairment
- ✓ Assess for delirium and re-assess with any changes
- ✓ Investigate and treat the causes of delirium
- ✓ Establish goals of care based a person's preferences

System for caring for cognitive impairment

- ✓ Address medication issues
- ✓ Communicate effectively and seek information to provide individualised care
- ✓ Respond to additional care needs
- ✓ Respond appropriately to behavioural issues
- ✓ Partner with patient, carers and family
- ✓ Provide a supportive environment
- ✓ Manage transitions effectively

Aim of webinar

- Assist those who are embarking on system improvement to improve care of people with cognitive impairment
- Provide three examples and lessons learnt so far
- Emphasise that there is no “right way”
- Think about what you have in place in your hospital
- Understand that it is an ongoing, continuous process of improvement

Fred Graham

CNC Dementia & Delirium

Princess Alexandra Hospital
Brisbane

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Leading hospital wide change to improve care for patients with dementia and delirium

Frederick Graham

CNC Dementia & Delirium,
PAH

Webinar Presentation for Caring for Cognitive Impairment Campaign
For the Australian Commission For Quality and Safety in Health Care (ACSQHC)
2016, Brisbane Queensland

Metro South Health

QUT Queensland University of Technology

DCRC Dementia Collaborative Research Centres

Princess Alexandra Hospital

Princess Alexandra Hospital

- Brisbane, Australia
- Large metropolitan hospital
- Approx. 800 beds
- 3rd Magnet ® designation

Our story started in 2007

- 3 Internal Medicine Wards
- High rates of falls and aggressive events associated with care for people with cognitive impairment
- 70% of falls were occurring in patients with a cognitive impairment
- Falls and aggressive events occurring despite traditional strategies to reduce risk such as 1:1 specials (high usage of specials)
- Negative reputation of wards affecting recruitment and retention due to high rates of clinical incidences (falls and aggression) leading to carer stress

Close Observation Unit (2008)

- 8 beds servicing 3 medical wards (76 beds)
- Environmental design - Glazed Glass doors (reduce noise) + contrasting toilet seats
- Increased staff ratio (4 x AM; 4 x PM, 2 x ND)
- Development of recreational resources and specialised clinical tools
- Adoption of theoretical approaches (PLST, NDB) and a person-centred philosophy
- Specialist training of staff
- Access to existing allied health services plus geriatric and psychiatric consultation

Minor environmental modifications - Contrasting toilet seatscan promote functional continence

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Outcomes

- Reduced falls by 30%
- Increased staff retention
- Increased staff morale, improved BPA workplace culture
- Reduced workforce costs due to reduced external & internal casual staff use
  - 62.7% reduction in 1:1 special use
  - Less staff leave & vacancy due to improved workplace
- Continues to this date

Further outcomes

Enabled the development and testing of:

1. Specialised behavioural observation tool designed for acute care
2. Sunflower chart to promote person-centred communication
3. Recreational activity resources

Behavioural observation chart

- Hourly assessment of ***frequency, duration and intensity*** of behaviour
- Assessment of pain
- Evaluate response to a variety of intervention – analgesic and other medication, exercise, recreation and toileting

Queensland Government

PITTSBURGH AGITATION SCALE

SCORE Only mark the highest intensity score observed over the hour.	Aberrant Vocalisation Repetitive requests or complaint, non-verbal vocalisations, eg, moaning, screaming.	Motor Agitation Pacing, wandering, moving in chair/bed, seeking comfort, picking at objects, taking others possessions. Rate "intrusiveness" by normal social standards, not by effect on other patients If verbally "intrusive" or "disruptive" rate under "vocalisation".	Aggressiveness Score "0" if aggressive only when resisting care.	Resisting Cares Record associated activity in the 6th hrly scoring space provided on the graph eg. WASHING, EATING, DRESSING, MEDS, TOILETING.
0	Not present	Not present	Not present	Not present
1	Low volume ☐ Not disruptive in milieu ☐ Includes crying	Pacing or moving about in chair at normal rate ☐ Appears to be looking for spouse ☐ Purposeless movements	Verbal threats	Procrastination or avoidance
2	Louder than converstions ☐ Mildly disruptive ☐ Redirectable	Increased rate of movements: ☐ Mildly intrusive ☐ Easily redirectable	Threatening gestures ☐ No attempt to strike	Verbal or gesture of refusal
3	Loud ☐ Disruptive ☐ Difficult to redirect	Rapid movements: ☐ Moderately intrusive or disruptive ☐ Difficult to redirect in milieu	Physical towards property	Pushing away to avoid task
4	Extremely loud ☐ Screaming or yelling ☐ Highly disruptive ☐ Unble to redirect	Intense movements: ☐ Extremely intrusive or disruptive ☐ Not redirectable	Physical towards self or others	Striking out at caregiver

© Pittsburgh Agitation Scale developed by Rosen, J., Burgio, L., Kollar, M., et al., (1994)

VERBAL PAIN SCALE

Verbal Descriptor Scale – Mild to moderate dementia may reliably self-report pain. Always try for self report.

PAINAD SCALE

Pain Assessment in Advanced Dementia. Observational Pain Assessment Tool – scores from 0-10. Use when patient cannot self report pain.

ITEMS	0	1	2	SCORE
Breathing independent of vocalisation	Normal	Occasional laboured breathing. Short period of hyperventalion.	Noisy laboured breathing Long period of hyperventilation. Cheyne-stokes respirations	(0-2)
Negative vocalisation	None	Occasional moan or groan. Low level speech with negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	(0-2)
Facial experession	Smiling or inexpressive	Sad, frightened, frowning	Facial grimacing.	(0-2)
Body language	Relaxed	Tense, distressed pacing, fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	(0-2)
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	(0-2)
				TOTAL (0-10) Record on obs. chart

RECORD SCORES ON REVERSE PAGE

© PAINAD developed by Warden, V., Hurley, A. C., & Volicer, L., (2003)

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Behavioural Observation Chart

(Affix patient identification label here)

URN:

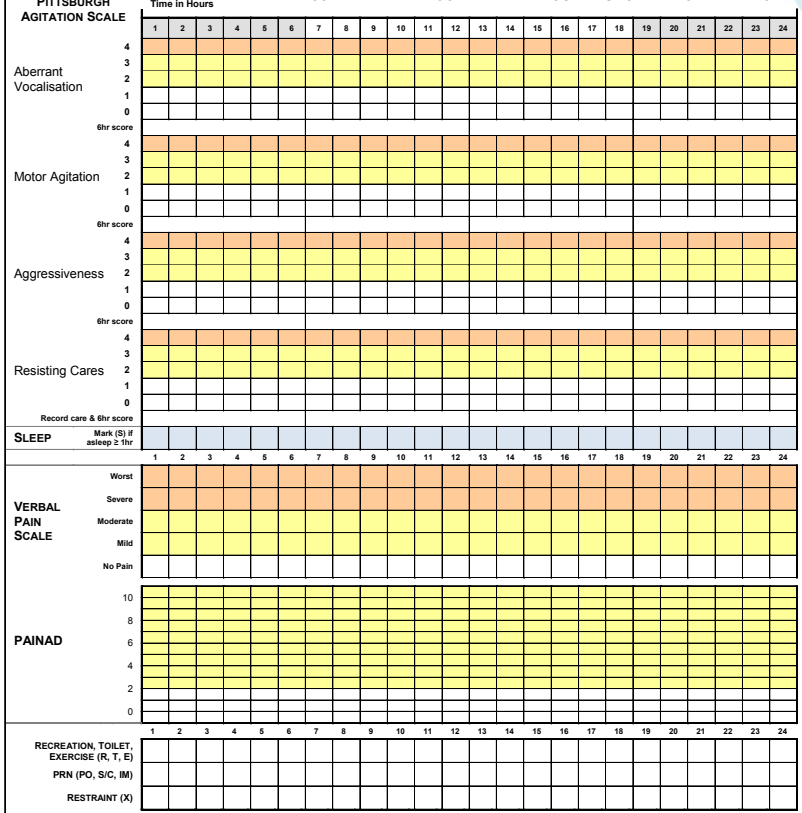
Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

PRINCESS ALEXANDRA HOSPITAL BEHAVIOURAL OBSERVATION CHART ©



Baseline Continue to observe. Explore patient's life story. Consider delirium reduction strategies & activities for persons with dementia.

Escalation 1st line: Address needs – consider pain, toileting, position, emotion. Problem solve within person's reality. Try distraction & diversion.
2nd line: (Use if 1st line ineffective). Consider PRN medications. Reduce stimuli. Remove potential missiles & dangers.

Crisis Keep calm. Take action to ensure others safety. Remove dangers. Continue to search for causes. Consider – calling for assistance from security, IM sedation, and restraint.

Date: **Day:**

Chart incorporates the Pittsburgh Agitation Scale, Verbal Descriptor Scale & PAINAD. Developed at the Internal Medicine Unit, PAH by Frederick Graham (CNC) in 07-12-2009, revised 05-04-2013.

Behavioural Observation Chart

PRINCESS ALEXANDRA HOSPITAL BEHAVIOURAL OBSERVATION CHART ©

PITTSBURGH AGITATION SCALE

Time in Hours: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Aberrant Vocalisation — 4 3 2 1 0 — 6hr score

Motor Agitation — 4 3 2 1 0 — 6hr score

Aggressiveness — 4 3 2 1 0 — 6hr score

Resisting Cares — 4 3 2 1 0 — Record care & 6hr score

SLEEP — Mark (S) if asleep ≥ 1hr: S S S S S

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

VERBAL PAIN SCALE: Worst / Severe / Moderate / Mild / No Pain

PAINAD: 10 8 6 4 2 0

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

RECREATION, TOILET, EXERCISE (R, T, E)

PRN (PO, S/C, IM): IM IM S/C IM IM IM

RESTRAINT (X): X X X X X X X

PRINCESS ALEXANDRA HOSPITAL BEHAVIOURAL OBSERVATION CHART ©

PITTSBURGH AGITATION SCALE

Time in Hours

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Aberrant Vocalisation
4 3 2 1 0
6hr score

Motor Agitation
4 3 2 1 0
6hr score

Aggressiveness
4 3 2 1 0
6hr score

Resisting Cares
4 3 2 1 0
Record care & 6hr score

SLEEP Mark (S) if asleep ≥ 1hr

S S S S S S S S S

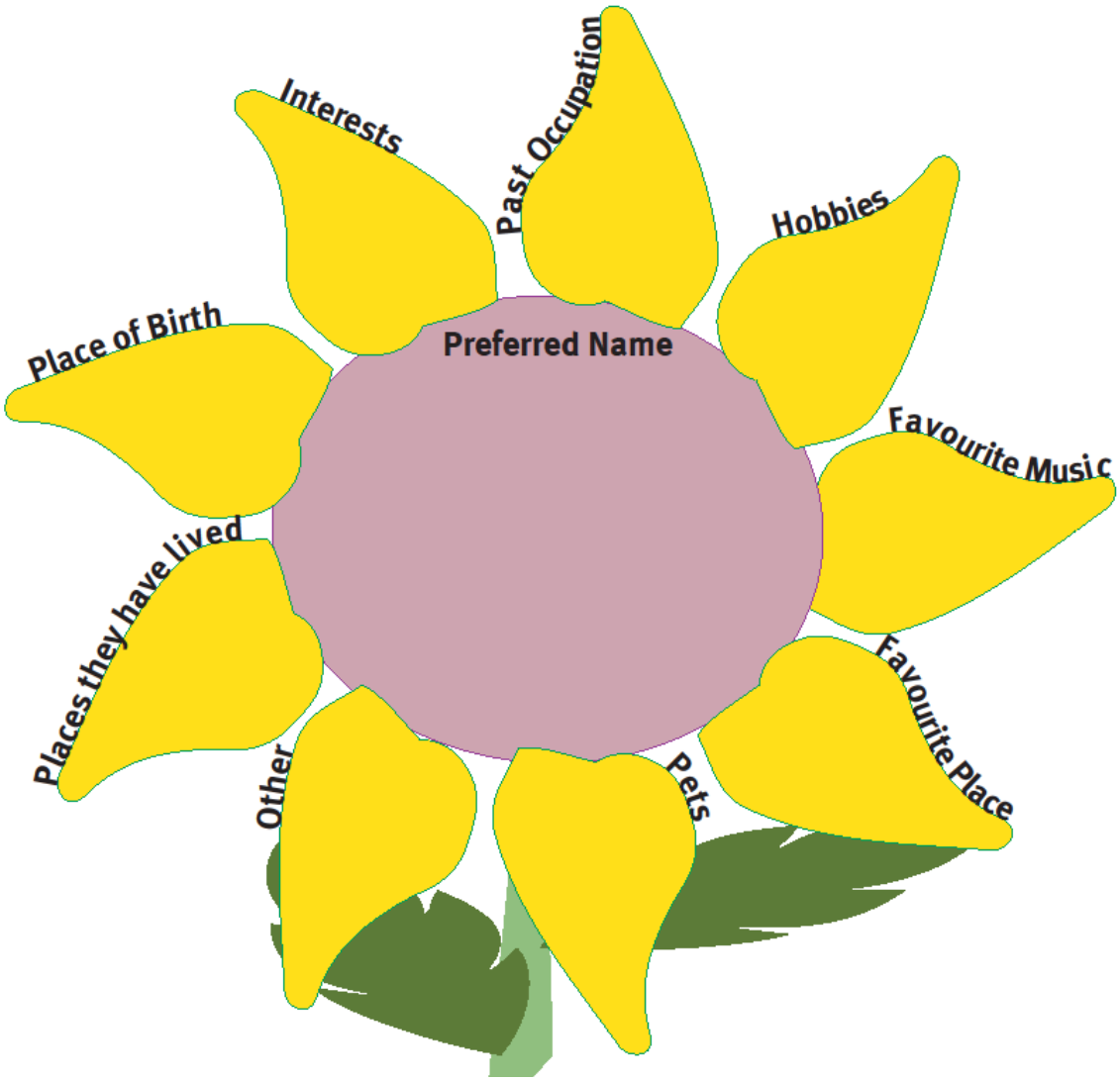
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

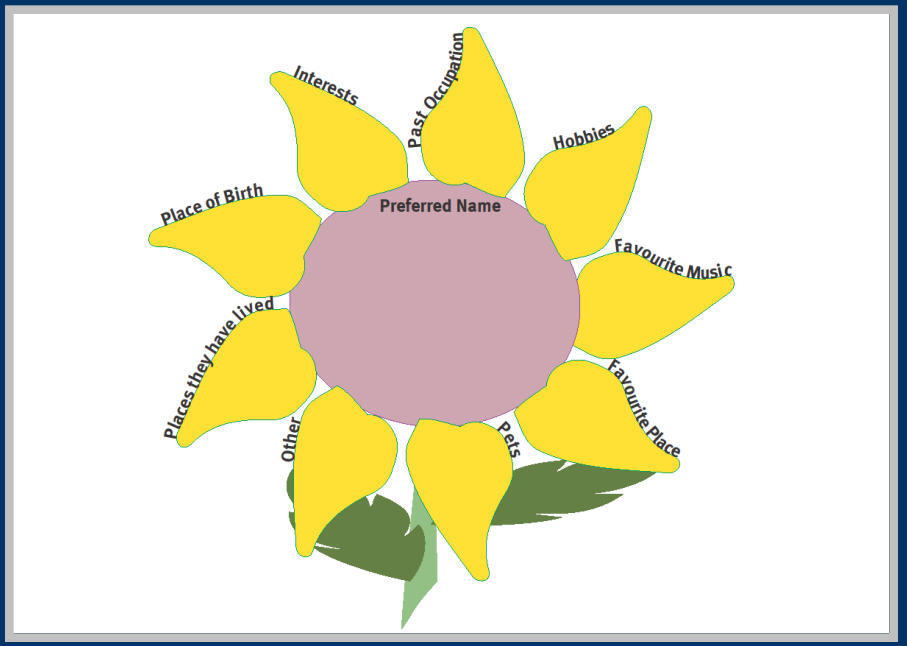
VERBAL PAIN SCALE
Worst
Severe
Moderate
Mild
No Pain

PAINAD
10 8 6 4 2 0

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

RECREATION, TOILET, EXERCISE (R, T, E)
T
PRN (PO, S/C, IM)
RESTRAINT (X)


Preferred Name
Interests
Past Occupation
Hobbies
Favourite Music
Favourite Place
Pets
Other
Places they have lived
Place of Birth



MODEL OF CARE

- Increased staffing
- Constant Supervision for high falls risk
- Person Centred Care (Kitwood, 1997)

  biography, creativity, flexibility, choice
- Communication
- Emotional support

PATIENT LIFE STORY CHART
Obtain collateral information from family & carers
KEEP UP TO DATE

URN:
Family Name:
Given Name:
Date of Birth:

LIFE STORY	
BORN:	**INTERESTS:**
(Place, year)	(Hobbies, talking points)
CHILDHOOD:	
(Where, hobbies, schooling)	
FAMILY:	
(Partners, children)	**FAVOURITE THINGS:**
	(Pets, objects, favourite activities)
OCCUPATIONS:	
(Jobs, volunteers, armed service)	
	GAMES:
	(Board games, puzzles)
SIGNIFICANT LIFE EVENTS:	
(Achievements, accidents, marriages, births)	**MUSIC:**
	(Favourite songs & styles)
	SPORTS:
	(Sports played and favourites now)

Activities relevant to past occupations or personality

Themed Fiddle Boxes

Aims:

Reminiscence

Explore stories with familiar items

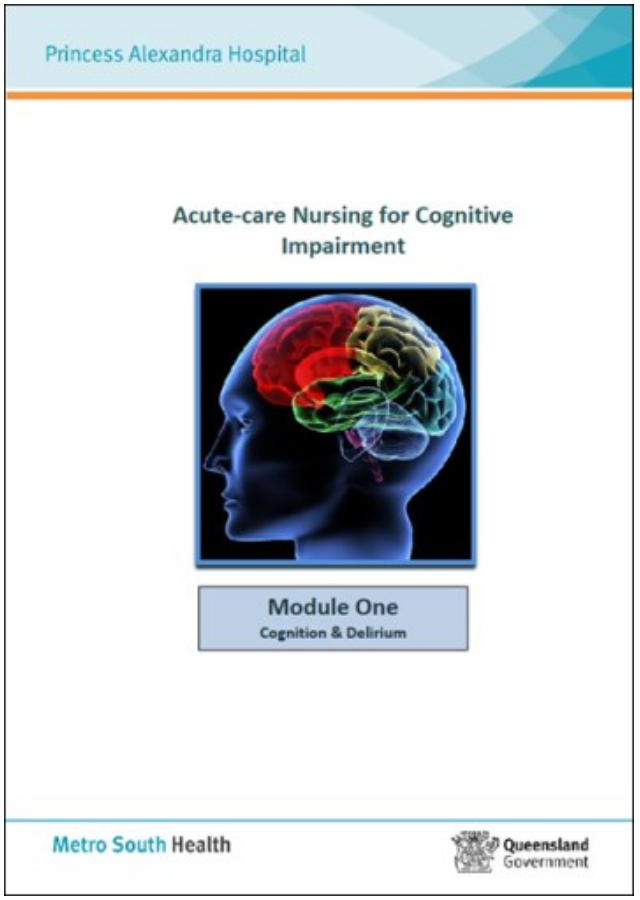
Textural exploration

CNC Dementia and delirium
(2009 - 2016)

- **Opportunistic** – donation to geriatric department from patient family
- Trial of CNC in acute block leading to adoption of role after 1 year
- Specialised patient assessment and care, role model best practice
- Promote organisational awareness and change
- Provide appropriate education and training to prepare workforce
- Introduce evidence-based clinical tools and models of care

Education (3 modules & 2hr workshop)

- Module One
  - Physiology & Cognition
  - Delirium
- Module Two
  - Dementia
  - Models of Dementia Care
- Module Three
  - Behavioural Observation
  - Pain in Dementia
  - Pharmacological Management of BPSD
  - Patients with High-risk Behaviours



Education

- Over 800 nurses attended workshops
- Overwhelmingly positive feedback
- All graduate nurses expected to complete
- Mandated 80% completion in all medical units

Cognition Champions

Recruited through education rollout:

- 200 passionate nurses
- Meet monthly
- Develop resources for wards
- Educate staff locally
- Roll model best-practice

Cognition Champions

Cognition Corners

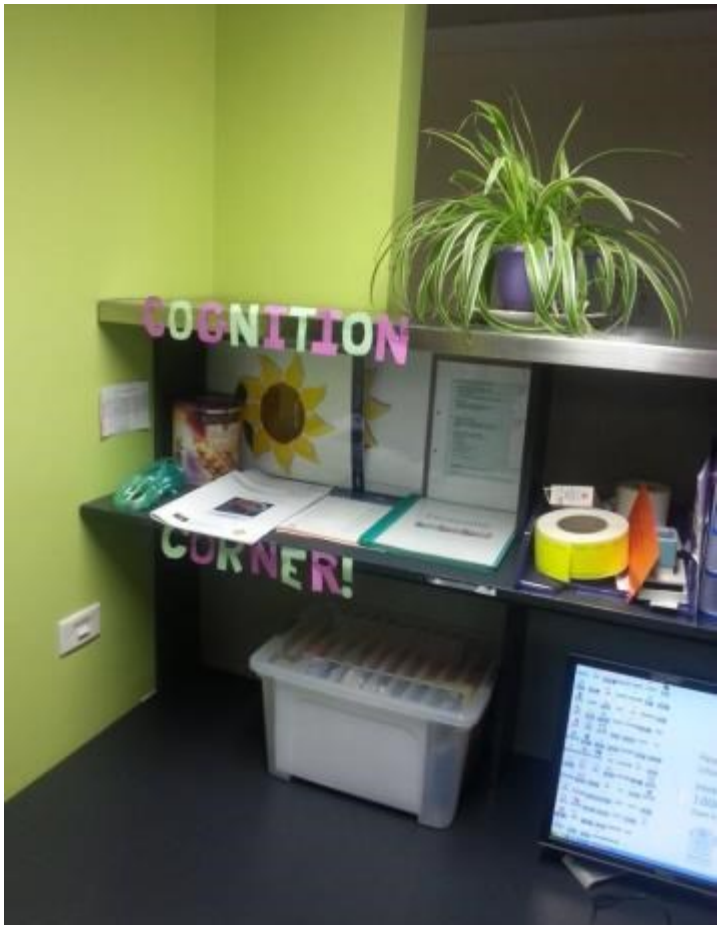


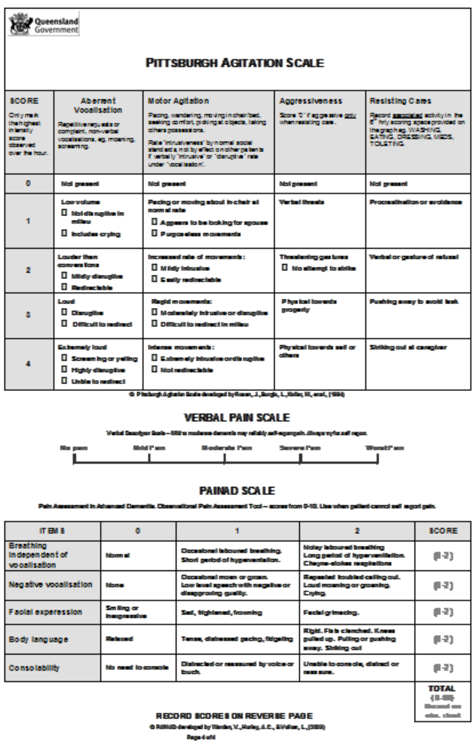
Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Box of Activities

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Rollout of resources developed in Close Observation Unit



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VERBAL PAIN SCALE

No pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain

PAINAD SCALE

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Facial expression	Smiling or inexpressive	Sad, frightened, frowning	Facial grimacing.	(0-2)
Body language	Relaxed	Tense, distressed pacing, fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	(0-2)
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	(0-2)
				TOTAL

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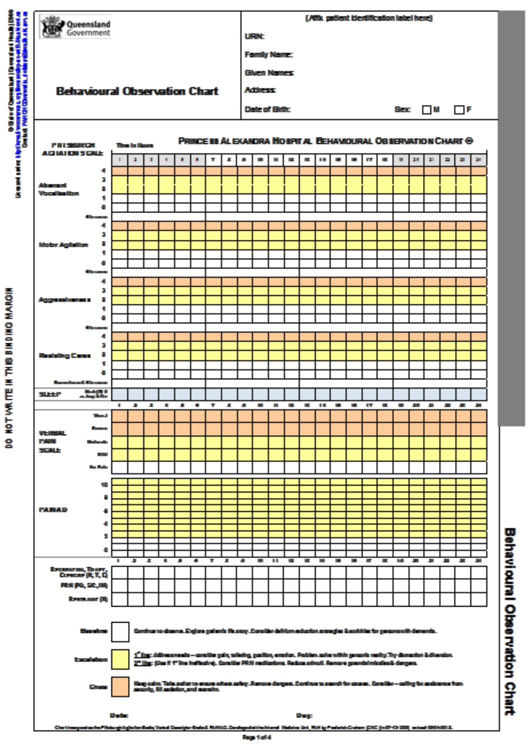

Queensland Government

Behavioural Observation Chart

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URN:
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Address:
Date of Birth: Sex: ☐ M ☐ F

PRINCESS ALEXANDRA HOSPITAL BEHAVIOURAL OBSERVATION CHART ©

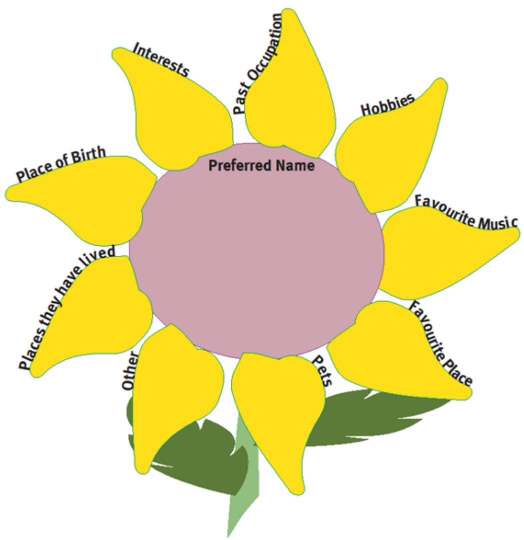
Time in Hours

Aberrant Vocalisation
Motor Agitation
Aggressiveness
Resisting Cares
VERBAL PAIN SCALE
PAINAD

DO NOT WRITE IN THIS BINDING MARGIN

Behavioural Observation Chart

Page 1 of 4



Volunteers engagement

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

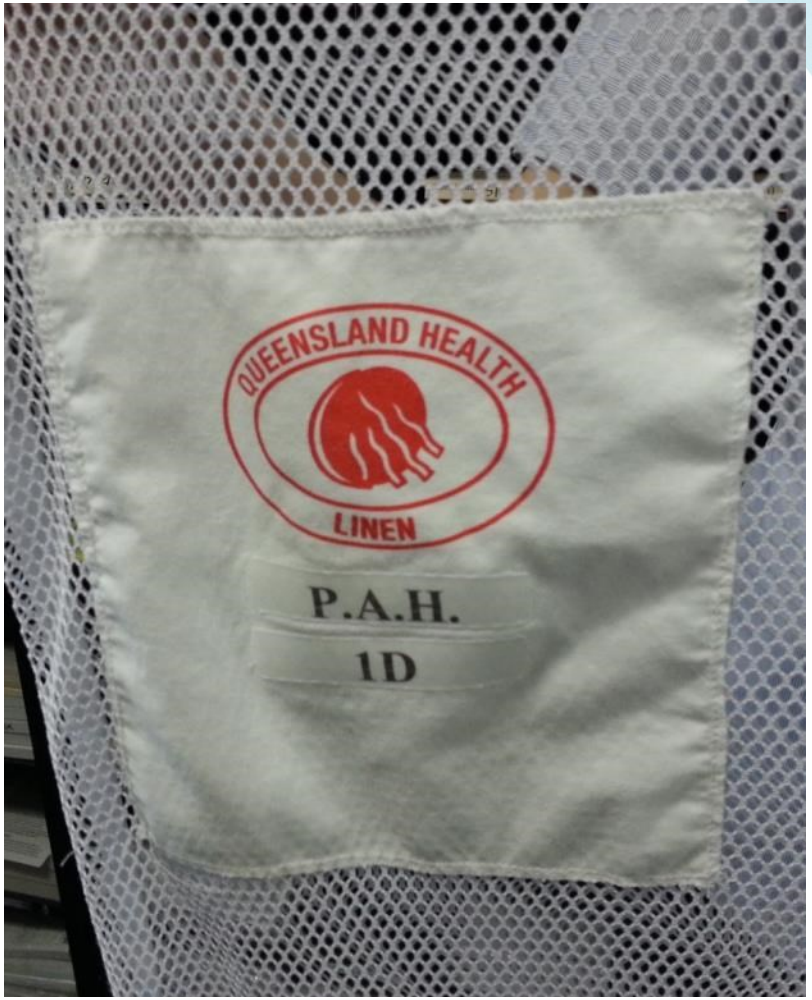


Image courtesy PAH Cognition Champions Group, photographer Fred Graham

IDC dec

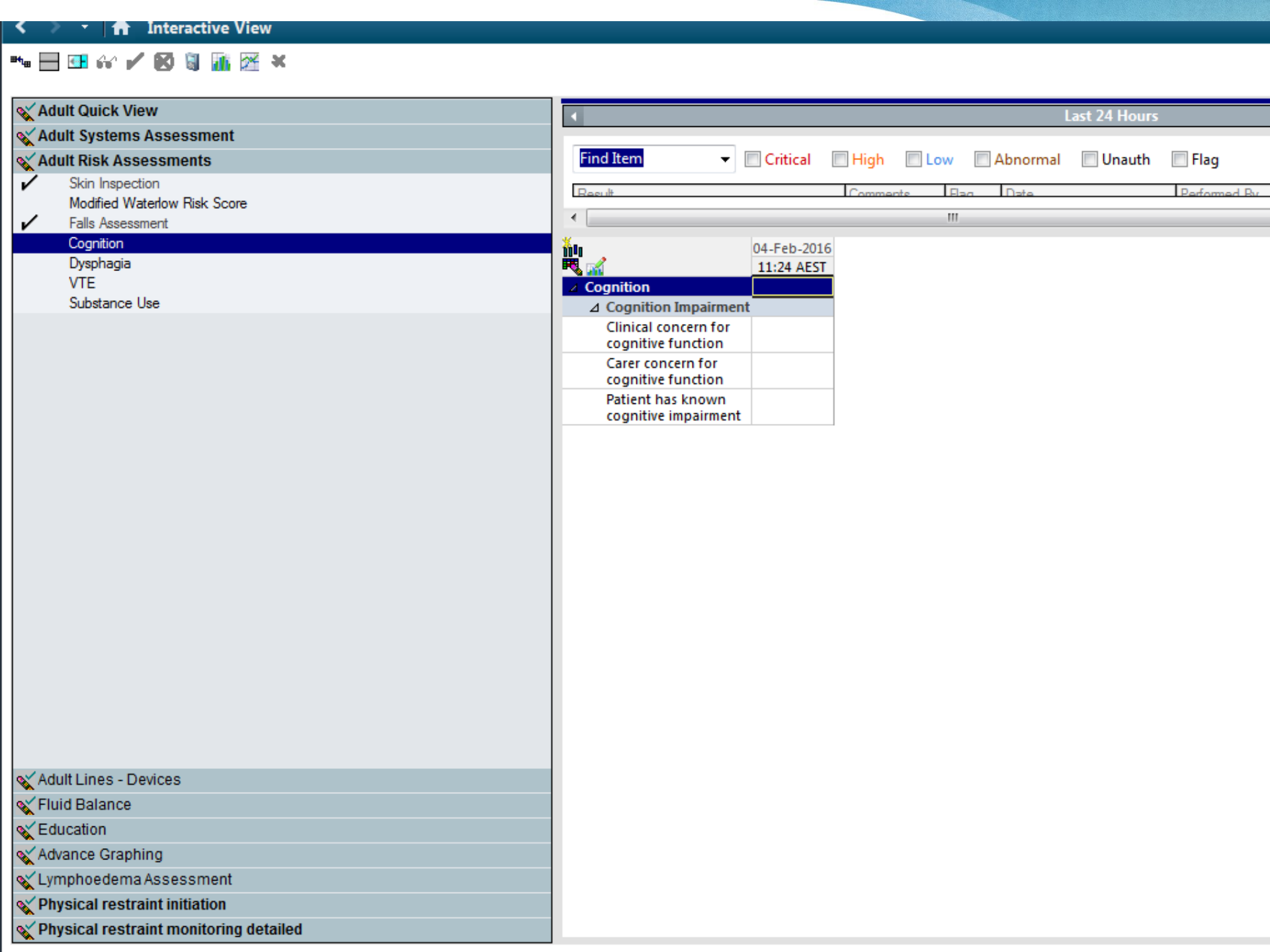
Image courtesy PAH Cognition Champions Group, photographer Fred Graham

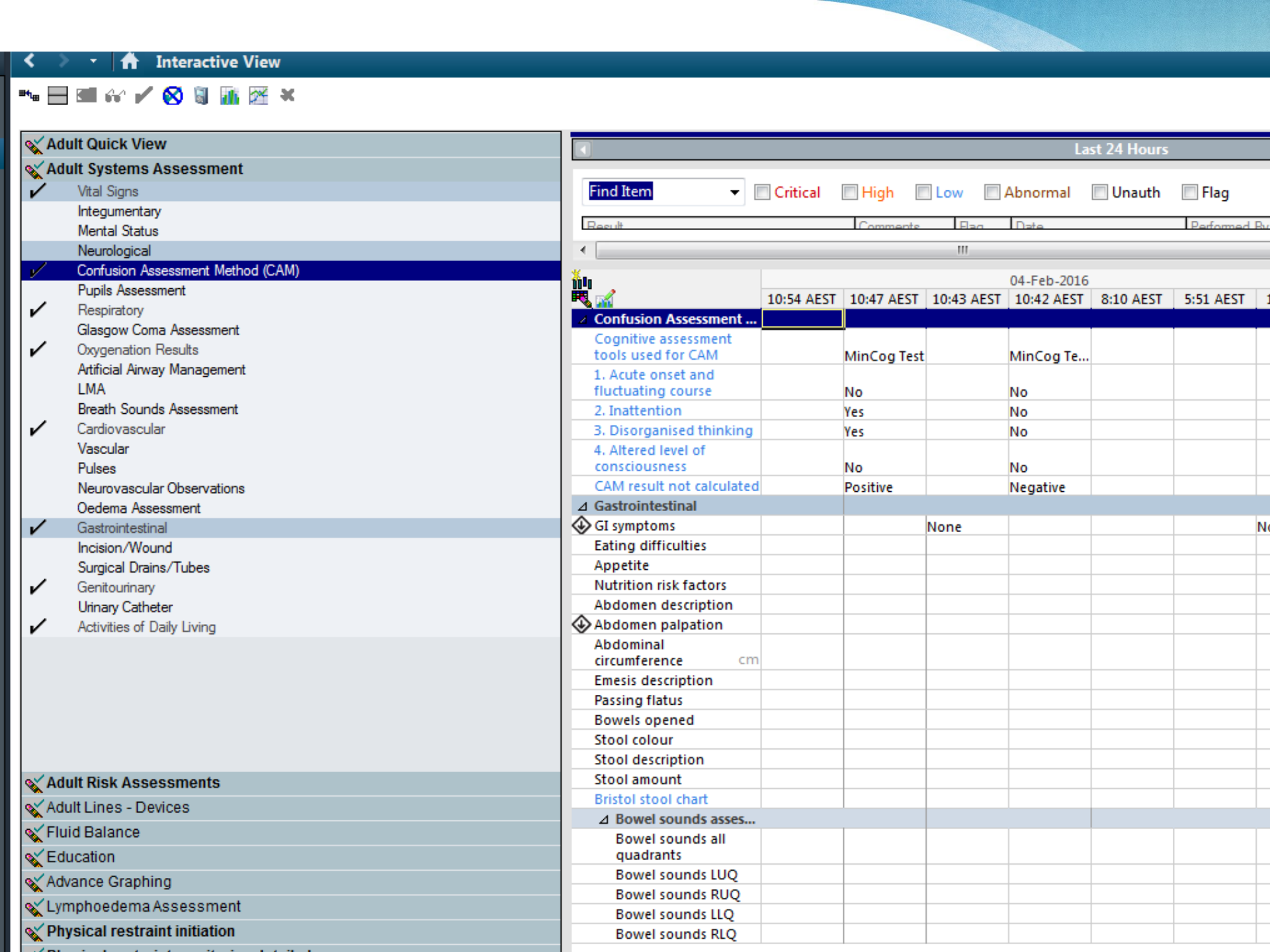
Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Bedside Table Fiddle Blankets

Image courtesy PAH Cognition Champions Group, photographer Fred Graham

Fiddle Blanket


Interactive View
Adult Quick View
Adult Systems Assessment
Adult Risk Assessments
Skin Inspection
Modified Waterlow Risk Score
Falls Assessment
Cognition
Dysphagia
VTE
Substance Use
Adult Lines - Devices
Fluid Balance
Education
Advance Graphing
Lymphoedema Assessment
Physical restraint initiation
Physical restraint monitoring detailed
Last 24 Hours
Find Item
Critical
High
Low
Abnormal
Unauth
Flag
Result
Comments
Flag
Date
Performed By
04-Feb-2016
11:24 AEST
Cognition
Cognition Impairment
Clinical concern for cognitive function
Carer concern for cognitive function
Patient has known cognitive impairment


Interactive View
Adult Quick View
Adult Systems Assessment
Vital Signs
Integumentary
Mental Status
Neurological
Confusion Assessment Method (CAM)
Pupils Assessment
Respiratory
Glasgow Coma Assessment
Oxygenation Results
Artificial Airway Management
LMA
Breath Sounds Assessment
Cardiovascular
Vascular
Pulses
Neurovascular Observations
Oedema Assessment
Gastrointestinal
Incision/Wound
Surgical Drains/Tubes
Genitourinary
Urinary Catheter
Activities of Daily Living
Adult Risk Assessments
Adult Lines - Devices
Fluid Balance
Education
Advance Graphing
Lymphoedema Assessment
Physical restraint initiation
Last 24 Hours
Find Item
Critical
High
Low
Abnormal
Unauth
Flag
Result
Comments
Flag
Date
Performed By
04-Feb-2016
10:54 AEST
10:47 AEST
10:43 AEST
10:42 AEST
8:10 AEST
5:51 AEST
Confusion Assessment ...
Cognitive assessment tools used for CAM
MinCog Test
MinCog Te...
1. Acute onset and fluctuating course
No
No
2. Inattention
Yes
No
3. Disorganised thinking
Yes
No
4. Altered level of consciousness
No
No
CAM result not calculated
Positive
Negative
Gastrointestinal
GI symptoms
None
Eating difficulties
Appetite
Nutrition risk factors
Abdomen description
Abdomen palpation
Abdominal circumference
cm
Emesis description
Passing flatus
Bowels opened
Stool colour
Stool description
Stool amount
Bristol stool chart
Bowel sounds asses...
Bowel sounds all quadrants
Bowel sounds LUQ
Bowel sounds RUQ
Bowel sounds LLQ
Bowel sounds RLQ

CogChamps Research Project

Can a knowledge translation intervention involving cognition champions improve care practices toward people with cognitive impairment?

- 2 year study (2015 – 2017) (Funded by Department of Social Services, Australian Government)
- Quasi Experimental design
- 6 intervention wards - 4 medical & 2 surgical
- 2 Control wards - 1 medical & 1 surgical
- Data collection – 3 month pre; immediately post, 3 month post, 6 month post

Principle Investigators: Dr C. Travers (QUT), Mr F. Graham (PAH), Prof. A. Henderson (PAH), Prof. E Beattie (QUT), Dr J McCrow

Intervention

- Knowledge translation intervention
- Training of Cognition Champions on identification of delirium and best practice care
- Ward cultural levers
  - Recognition and reward
  - Strong ward leadership support
  - Teachable moments
- Use of existing clinical and recreational resources

Principle Investigators: Dr C. Travers (QUT), Mr F. Graham (PAH), Prof. A. Henderson (PAH), Prof. E Beattie (QUT), Dr J McCrow

Local changes expanding to hospital wide ...

2008 Local strategy – close observation unit

- Response to adverse events and staff burnout
- Developed innovative care resources and educational materials

2009 CNC dementia & delirium – clinical, educational and strategic role

- Clinical presence, role modelling, teachable moments
- Strategic input to systems and policy
- Identified obvious knowledge and practice gap
- Hospital adoption of assessment tools, resources and education

2011 Cognition Champions Recruitment (awareness raising)

- Recruited through education program
- Local champions leading change, embedding resources and tools
- Digital hospital tools (2015)

2015 Researching Knowledge Translation

- Can CogChamps improve care practices?

Sharon Strahand

CNC Aged Care

Hornsby Ku-ring-gai Hospital
Sydney

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Establishment of a Dementia and Delirium unit

Sharon Strahand

Act. Div. Mgr Rehab and Aged Care
Hornsby Hospital

July 2016

CHOPs
CARE OF CONFUSED HOSPITALISED OLDER PERSONS

NSW GOVERNMENT Health
Northern Sydney Local Health District

Ward 1A in 2012: "We're so busy!"

- 'No-one else is as busy as we are'
- 'We get all the hard patients'
- 'We're always under the pump here'
- 'No-one understands how heavy this ward is'

NSW GOVERNMENT Health
Northern Sydney Local Health District

DRG complexity in Lumby

Values	DRg Acui						Av Epis LOS				
Count of mrn											
Years	disch ward	Outlier F	A	B	C	D	Z	A	B	C	D	Z
2012	L1A	No	467	380	34	3	101	8.8	4.6	4.4	1.0	5.8
		Yes	37	8			10	31.2	14.5			14.9
	L1A	Total	504	388	34	3	111	10.5	4.8	4.4	1.0	6.6
	L1B	No	386	402	30	1	122	9.1	3.9	3.1	2.0	4.0
		Yes	26	11			13	32.5	13.6			11.2
	L1B	Total	412	413	30	1	135	10.6	4.1	3.1	2.0	4.7
	L2A	No	231	584	37	2	236	7.3	3.0	3.2	1.0	2.1
		Yes	9	16			13	29.8	12.8			7.3
	L2A	Total	240	600	37	2	249	8.2	3.2	3.2	1.0	2.4
	L2B	No	347	515	39	1	207	8.8	3.4	3.5	1.0	2.2
		Yes	17	14	1		10	29.8	8.4	14.0		17.1
	L2B	Total	364	529	40	1	217	9.8	3.6	3.8	1.0	2.9
2012 Total			1520	1930	141	7	712	10.0	3.8	3.6	1.1	3.6
2013	L1A	No	422	409	71	10	128	8.6	4.3	3.9	2.6	3.4
		Yes	34	27	1		13	33.7	18.4	11.0		17.5
	L1A	Total	456	436	72	10	141	10.5	5.2	4.0	2.6	4.7
	L1B	No	358	495	37	3	173	8.6	3.8	3.4	1.0	3.5
		Yes	29	17	2		23	38.4	13.6	6.5		21.0
	L1B	Total	387	512	39	3	196	10.8	4.1	3.5	1.0	5.5
	L2A	No	260	741	47	2	335	6.8	3.0	2.9	2.0	1.8
		Yes	13	25	1		19	25.9	12.3	17.0		7.7
	L2A	Total	273	766	48	2	354	7.7	3.3	3.2	2.0	2.1
	L2B	No	314	689	66	1	250	7.8	3.3	4.4	1.0	2.0
		Yes	19	39			14	31.4	11.3			6.7
	L2B	Total	333	728	66	1	264	9.2	3.8	4.4	1.0	2.2
2013 Total			1449	2442	225	16	955	9.8	3.9	3.9	2.1	3.2
Grand Total			2969	4372	366	23	1667	9.9	3.9	3.8	1.8	3.4

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Dementia (all types) and Delirium numbers across HKH 2010-2012

- 1B = 230
- 2A = 136
- 2B = 166
- MGW = 98
- Ger = 103
- EMU = 110
- **1A = 315**

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Multi Resistant Organisms

- This ward designated for isolation beds
- Anything up to 10 at any one time
- Barrier nursing – more time consuming
- Frail elderly often in isolation beds

STROKE UNIT

- 6 bedded stroke unit in the ward

  - Delirium implicated in Stroke
  - High acuity nursing
  - Beds used for non-Stroke patients (not quarantined)

FALLS

Ward recording Fall					
Sum of Line Count	Column Labels				
Row Labels	**Ward 1A HK**	Ward 1B HK	Ward 2A HK	Ward 2B HK	Grand Total
2012					
Jan	3			3	6
Feb	4	3	1	2	10
Mar	5			1	6
Apr	5	3	3	2	13
May	13	2	2		17
Jun	6	7	4	1	18
Jul	3	7	2	1	13
Aug	6	3	3	2	14
Sep	5	4	1	1	11
Oct	10	1	2	2	15
Nov	2	2	1	1	6
Grand Total	**62**	32	19	16	129

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Aggression Response Team Incidents (Code Black)

2012	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
1A	**2**	**2**	**2**	**2**	**2**	**6**	**1**	**3**	**0**	**5**	**16**	**4**	**45**
1B	3	5	2	1	6	2	1	3	4	6	11	5	49
2A	0	3	0	3	2	0	1	0	0	0	1	0	10
2B	0	1	2	4	2	0	3	15	1	1	0	0	29

2013	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
1A	**4**	**0**	**4**	**11**	**12**	**4**	**10**	**2**	**9**	**21**	**14**	**3**	**94**
1B	10	5	3	7	3	2	2	6	3	4	16	7	68
2A	2	0	1	1	2	0	0	3	1	5	3	0	18
2B	0	1	3	4	6	2	5	2	0	0	1	1	25

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Clinical Practise Improvement project to look at the issues

- Exec sponsor – DON
- Multi-disciplinary group
- Two prongs to project:
  - Environment and care delivery on the ward – take it back to the staff for their input
  - Write a proposal for a specialised Dementia and Delirium unit and present it to the GM

Problems…..

- Very large scope (potential for numerous smaller projects identified)
- Entrenched ward culture
  - Too busy doing to see alternative approaches ("Just need more staff!") and slow to try anything new
  - Some instability in NUM position
  - Essentials Of Care sidelined previously
  - New projects such as Individual Patient & Staff Experience* and Hourly rounding for the 5 Ps** went to other wards (?where they were more likely to succeed)

It was tough going and we needed help

*(Studer group)

** (Pain, Position, Pan (toileting), Personal belongings (close by), Proximity (call bells, walking aids etc)

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- Addressed the plight of the confused older in-patient
- Provided principles against which to measure performance and progress
- Highlighted the need for enhanced environment
- Fitted in well with the existing Clinical Practise Improvement project

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Pursuing the dream

- Proposal developed for a stand-alone dementia and delirium unit and presented to the GM – accepted the need but fiscal constraints with the proposed stand-alone model
- 2014: Advent of CHOPs
- 2015: Surgical wards moved into the new surgical building
- **Finally the stars aligned and establishment of a new Dementia and Delirium Unit was endorsed**.

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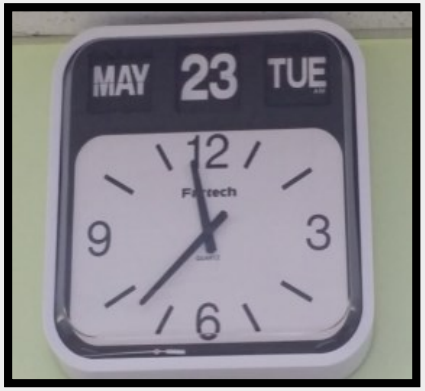
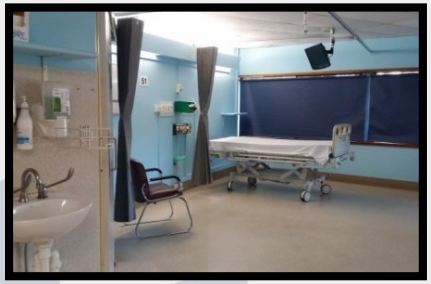
Why??

- **Winter surge had been problematic**
- **Clinicians were able to demonstrate a win-win scenario**
- Taking up the 2 vacated wards and turning them into one ward allowed for:
  - Increase of bed base
  - Space for transit lounge and ambulatory care in the ward they vacated
  - Safe surging with
    - Improved patient flow – medical patients all in one place
    - Improved clinical care – as above
  - And….it provided a designated quiet area for the D&D unit without the expense of opening a stand-alone unit

The Unit

- Exists within the medical ward previously called 1A
- 10 dedicated beds – different configuration
- Rooms painted in different colours
- Activity room
- Carers/Family room
- Murals
- Clear signage for bathrooms
- Time and date clocks – more to come
- Swipe card access only for fire stairs
- Staffing adjusted for busy times





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The Impact

- Reduced noise and activity has resulted in a calm and pleasant environment in the new unit: patients are visibly more settled.
- Unexpectedly the other side of the ward is also much quieter and calmer; nurses comment that they can concentrate so much better on caring for the very unwell patients now.
- Nurses are gaining in confidence and developing their skills in delivering care to this cohort: they more easily recognise it as a specialty now.
- The old environment actively worked against the nurses delivering optimal care to this patient cohort.
- Many nurses have expressed a very genuine enjoyment at working in the unit and are embracing person-centred care.
- Families have space to be at the bedside and provide reassurance to their loved ones.

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Positive outcomes are already emerging

- Falls rates are trending down – concentrating on unwitnessed falls stats
- CHOPS audit showed Carer involvement has increased in all aspects
- ART calls trending down but more significantly, fewer i/m meds being given when an ART is needed
- Patient complaints trending down only 2 in past 6 months since the unit was opened

What makes it work?

- The people:
  - New dynamic and enthusiastic NUM
  - Excellent support from the Acute Care of the Elderly (ACE) team including Geriatrician, Advanced Trainee, CNC and other aged care staff
  - The nursing staff stepping up to the challenge and embracing the model
  - Good support from the multi-disciplinary team

The wider support network

- Engaged Executive
- Proactive Fund raising manager
- Rehab and Aged Care support
- Dementia and Delirium Committee
- Community: Dementia and Delirium Volunteers
- NSLHD Carer support service
- ACI through CHOPs

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Establishment of the unit was the achievement of a goal – but we have only just got started!! So much more to do…

- Continue with supportive education for the nursing staff
- Engagement of Designated Carers
- Expand the Dementia and Delirium volunteer visitor programme
- Music and Memory (Arts Health Institute and ACI) programme
- Delta Dogs
- Investigate opportunities for employing a Diversional Therapist
- Transition this model of care successfully into stage 2 of hospital rebuild

CHALLENGES

- Nothing happens quickly in health – be prepared for change to take at least 1-2 years if not longer
- Engaging Executive – learn what matters to them and use it to get their attention (i.e. patient flow, cost-savings)
- Funding – even small things cost money, investigate ways to get some money on the table as a sign of good faith
- Competing priorities – of the organisation and for yourself, sometimes things have to go on the back burner for a while but don't get discouraged

Advice for others

- Make sure you have executive support (inc. an engaged sponsor)
- Get help from wherever you can: ACI, Essentials of Care, Clinical Governance Department etc
- Tie it in with other initiatives where possible (like our CPI project)
- Surround yourself with a very good multi-disciplinary team
- Have evidence to support the change you want to make, both locally through stats and at a governance level through Operational/Service/Clinical plans for the hospital and the LHD
- Celebrate any wins – it keeps the momentum going
- Never give up on a good idea – it doesn't stop being a good idea just because it doesn't fly the first, second or third time!

ANGEL, THE LABRADOODLE VISITING THE UNIT

QUESTIONS?

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Mark Yates

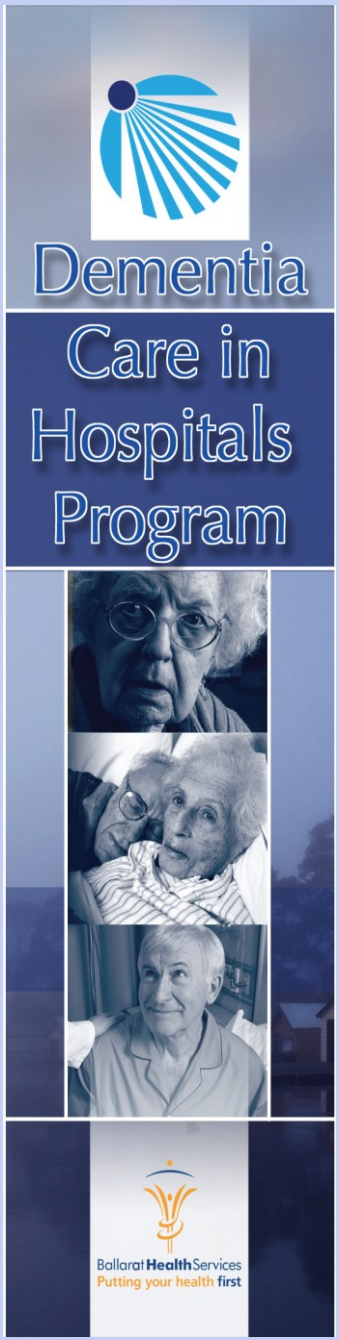
Geriatrician and researcher

Dementia Care in Hospitals Program

Ballarat Health Services

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

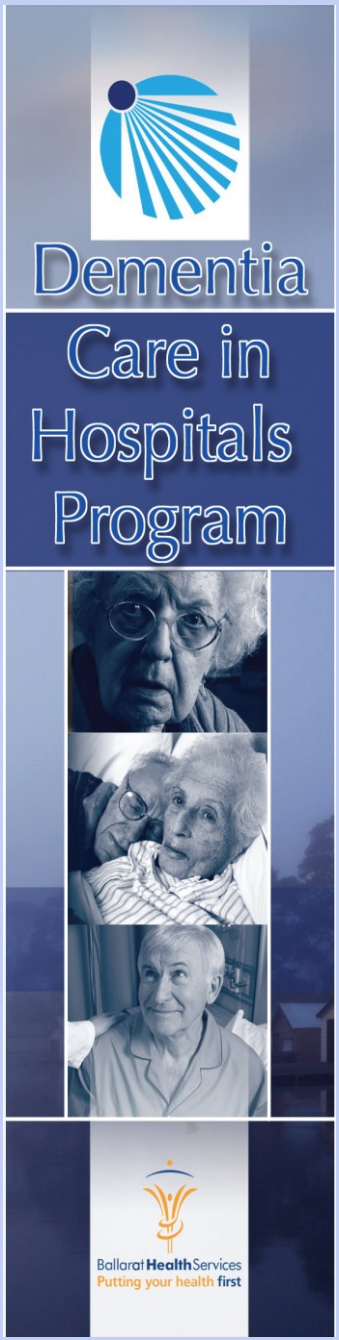
NSQHS STANDARDS



August 2016

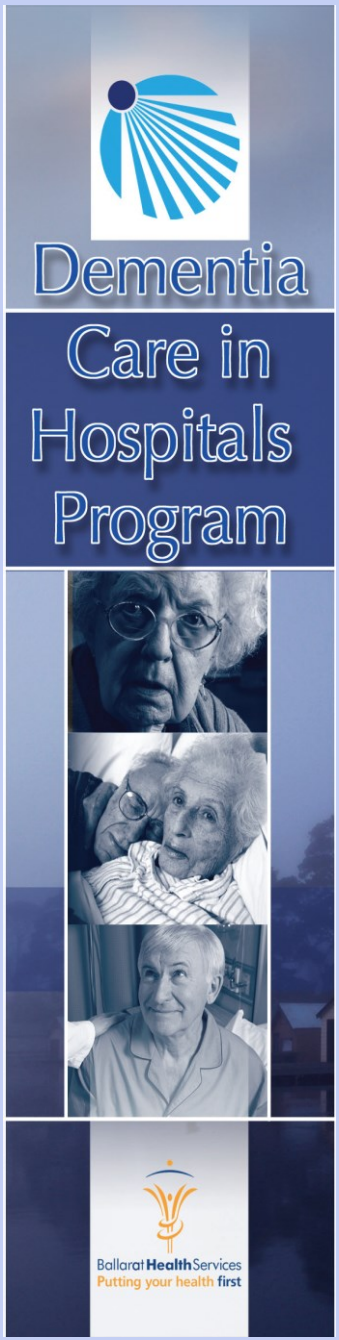
Getting Started – Insights from 12 years of the Dementia Care in Hospitals Program

A/Professor Mark Yates
Consultant Geriatrician
Meredith Theobald
Director of Nursing Subacute Services
Michelle Morvell
CNC Cognition
Ballarat Health Services



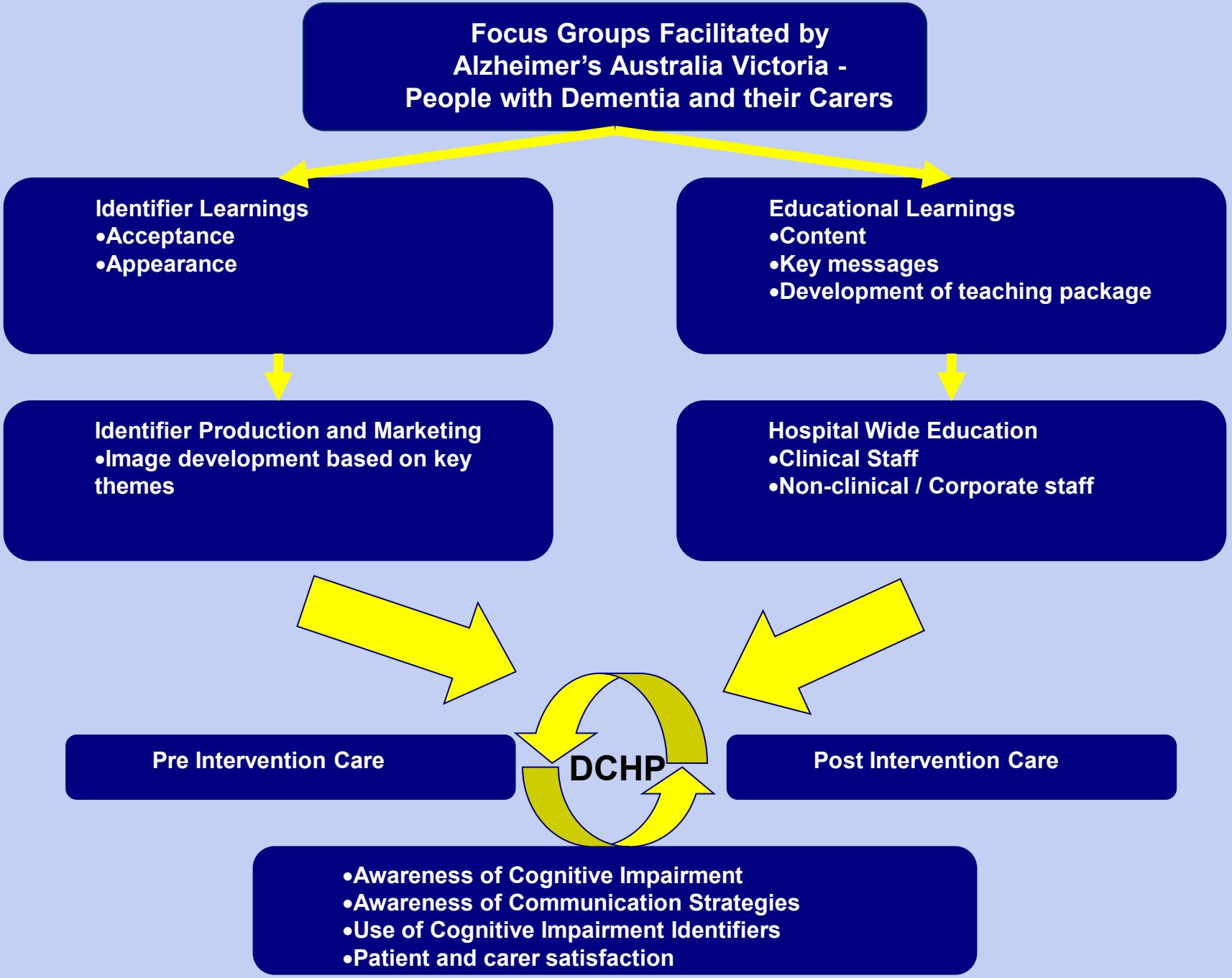
Risk Identified

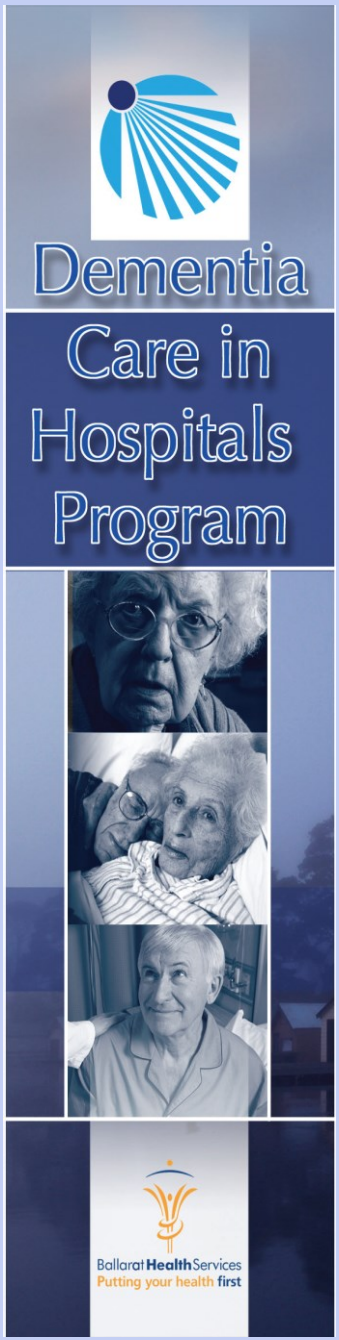
- 2001 – CNC Cognition
- 2002-4 – Development and first evaluation of the Dementia care in Hospitals Program
- 2005-2007 – Rollout and re-evaluation in the public sector
- 2011-2013 – Rollout and re-evaluation in the private sector
- 2015 – National rollout and re-evaluation



Trademark BHS

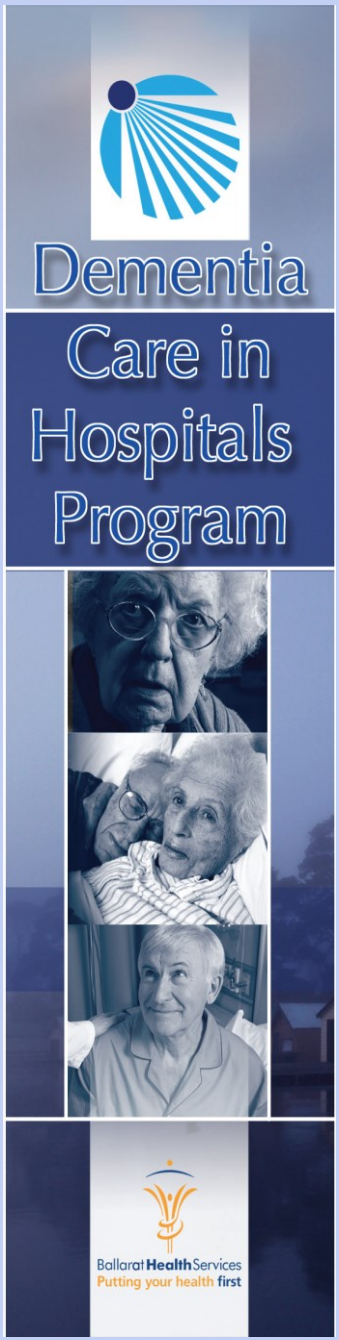
- Introduce yourself
- Make sure you have eye contact at all times
- Remain calm and talk in a matter of fact way
- Keep sentences short and simple
- Focus on one instruction at a time
- Involve carers
- Give time for responses
- Repeat yourself… don't assume you have been understood
- Do not give too many choices


Focus Groups Facilitated by
Alzheimer's Australia Victoria -
People with Dementia and their Carers
Identifier Learnings
•Acceptance
•Appearance
Educational Learnings
•Content
•Key messages
•Development of teaching package
Identifier Production and Marketing
•Image development based on key themes
Hospital Wide Education
•Clinical Staff
•Non-clinical / Corporate staff
Pre Intervention Care
DCHP
Post Intervention Care
•Awareness of Cognitive Impairment
•Awareness of Communication Strategies
•Use of Cognitive Impairment Identifiers
•Patient and carer satisfaction



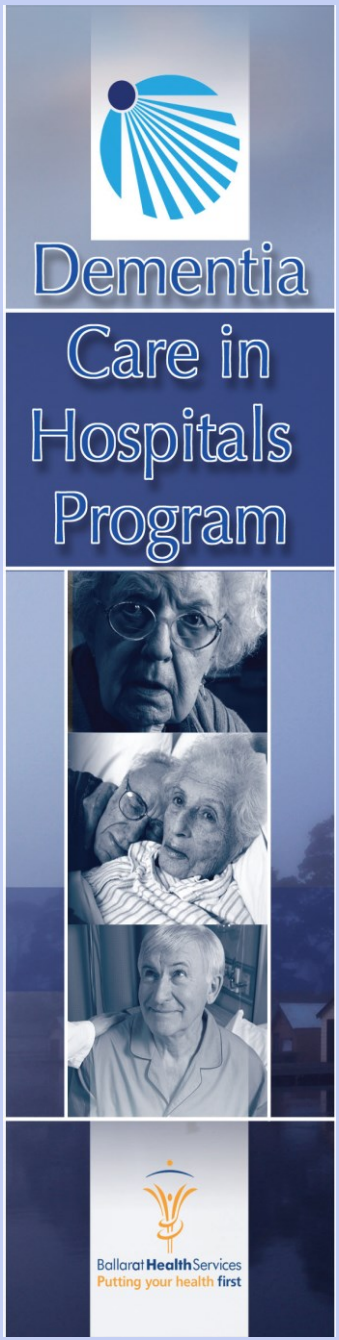
Lesson from the Field – Screening, Awareness and Organisational Change

- Cognitive impairment is not easily identified
- Organisations do not appreciate the prevalence of CI, delirium and dementia in patients
- The care paradigm has to change



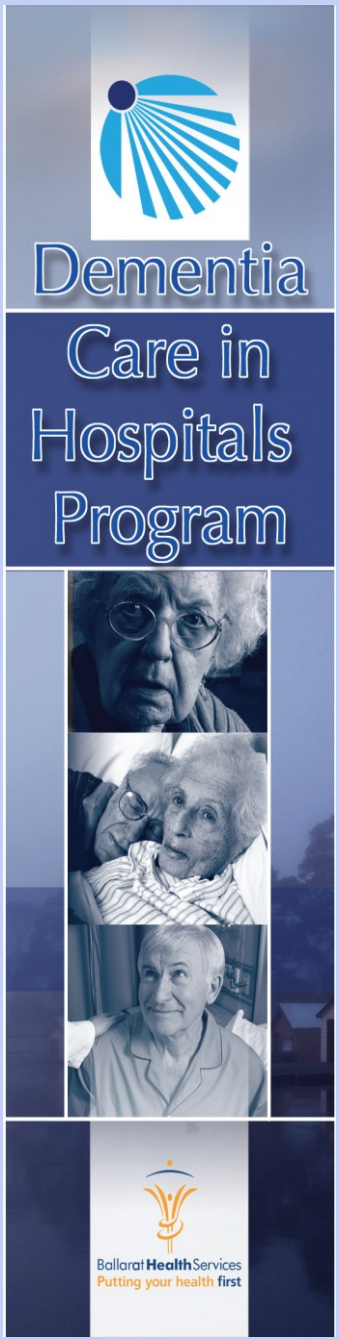
Identifying the levers

- External
  - Dementia as a National Health Priority Area
  - ACSQHC – new standards
  - Consumers
- Internal
  - Costs
    - Patient related
      - Cost
      - Risk
    - Staff related



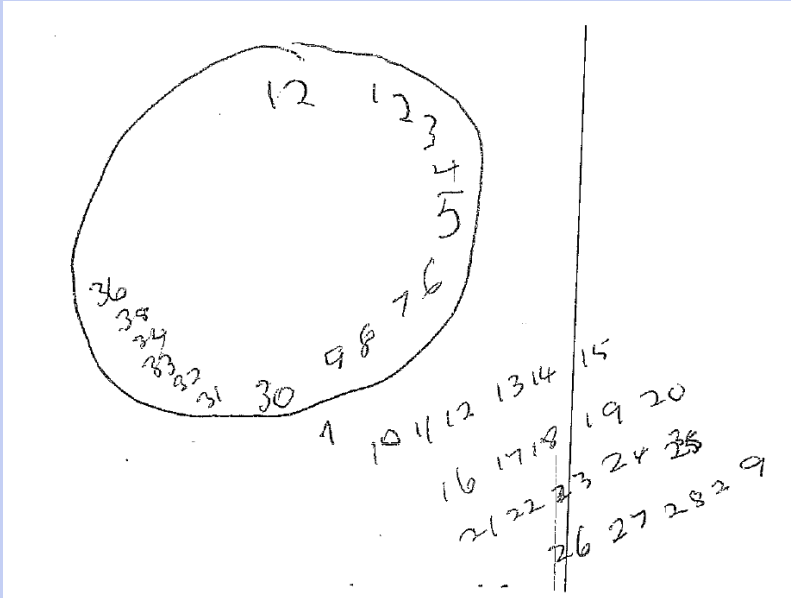
Defining and demonstrating the size of problem

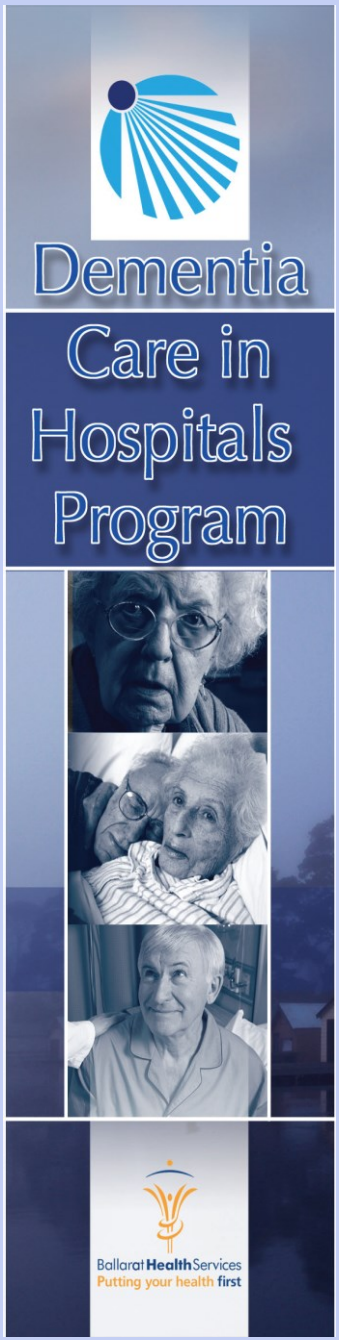
- All patients 65 and older
- Make it real – ward audit



Choosing the appropriate cognitive screening tool

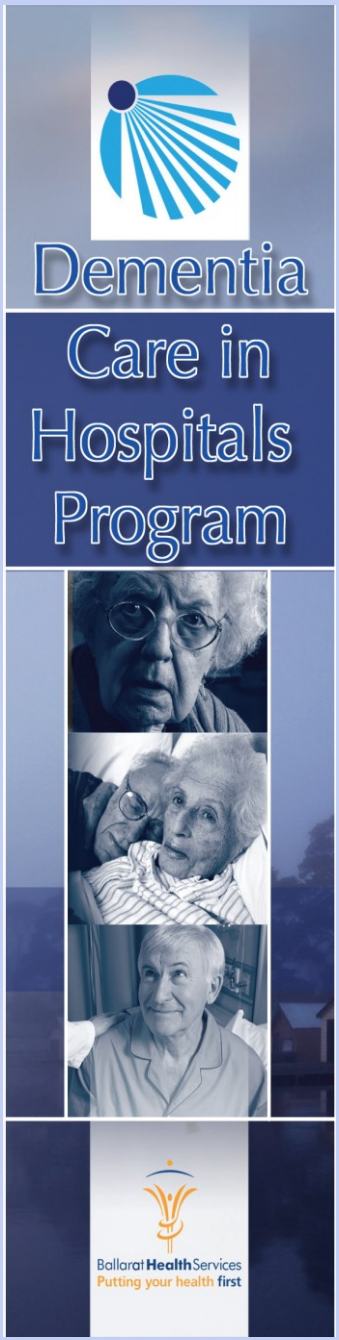
- Validity
- Familiarity
- Efficiency
- Effectiveness –Clock Drawing Test





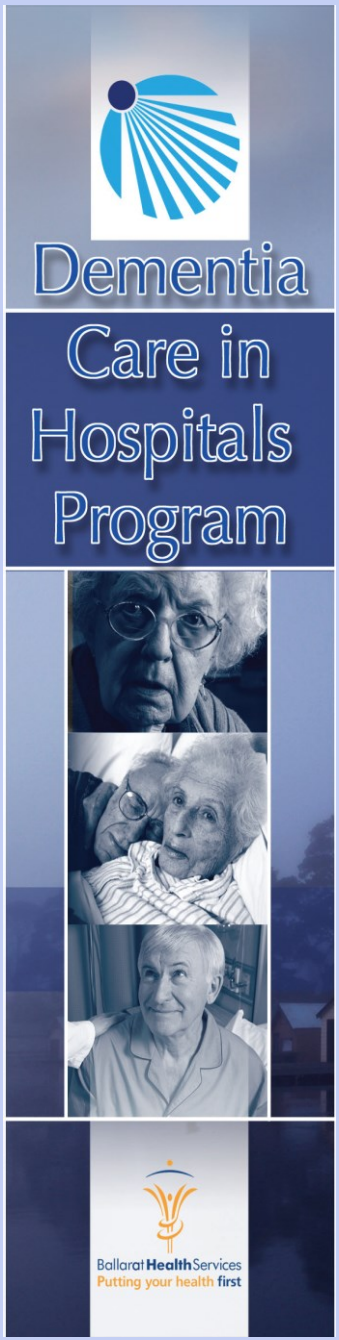
Building the team

- Ward-based champions
- Nurse educators
- Clinical nurse consultants
- Key medical leaders
- Executive support



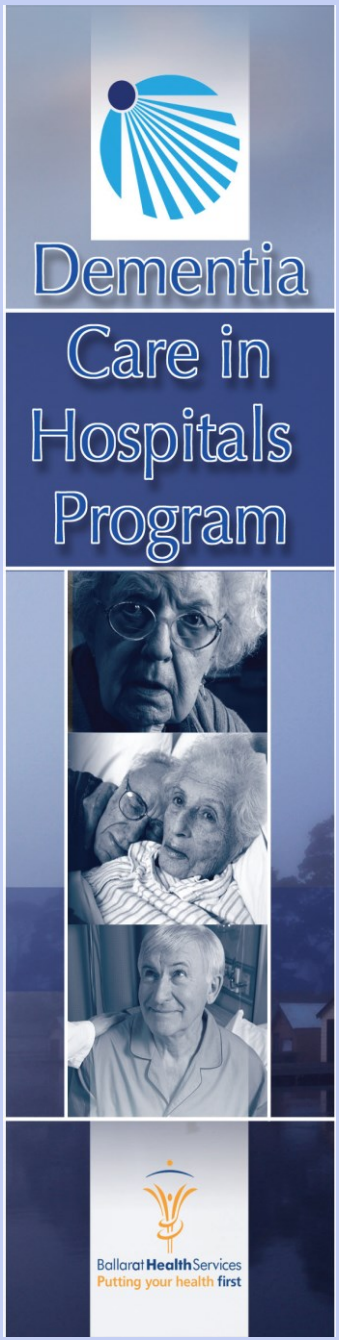
Define screening and the cognitive pathway

- Not selective screening or when a bother
- Support the practice change
  - Direct visual feedback of the percentage screened
  - Chocolate
  - Champions



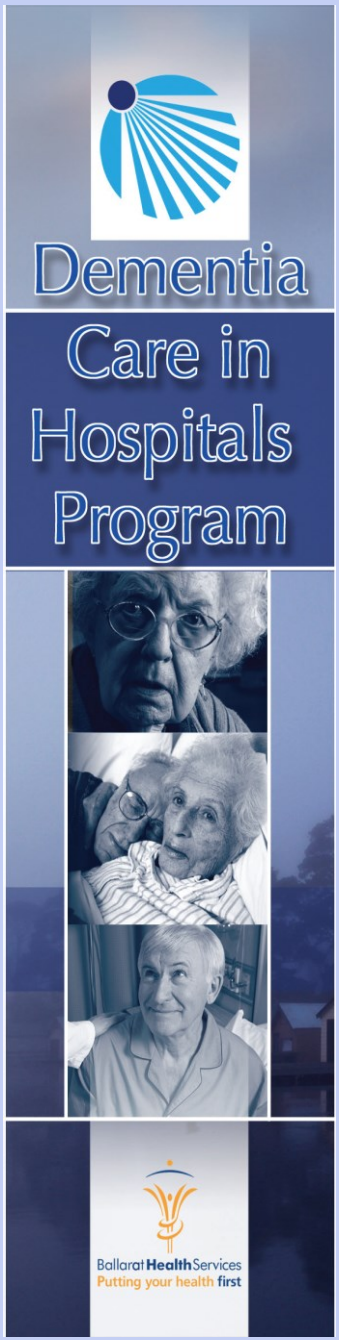
Bring all the staff in – they all have a role

- The CII allows an all of hospital approach
- Non-Clinical staff are working in hospitals for a reason



Be patient

- Culture and practice change takes time – allow twelve months
- Need to get the penny to drop - a critical mass of wards


Dementia
Care in
Hospitals
Program
Ballarat Health Services
Putting your health first

Thank you . . . . . .

Dementia Care in Hospitals Program

Ballarat Health Services
Putting your health first

ANY QUESTIONS?

Summary

- Promote cognitive impairment items in Version 2 and campaign
- Understand your context and your organisation's priorities
- Take time to work out your local issues, barriers and possible solutions – consult
- Local data for baseline and for tracking progress
- Get others on board, encourage leadership across disciplines
- Connect with others who are making improvements
- Recognise progress, share success

Thank you

cognitive.impairment@safetyandquality.gov.au