

Clinical Excellence Division



CQHHS Cognitive Care Project

Project Close Report

CQHHS Cognitive Care Project

Published by the State of Queensland (Queensland Health), August 2018



This document is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit creativecommons.org/licenses/by/3.0/au

© State of Queensland (Queensland Health) **2018**

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

For more information contact:

Clinical Excellence Division, Department of Health, GPO Box 48, Brisbane QLD 4001, email generic email address if available.

This project was funded by the Health Improvement Unit and sponsored by the Statewide Older Persons Health Clinical Network.

Disclaimer:

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

TABLE OF CONTENTS

1.	Overview.....	4
	Project Summary.....	4
2.	Lessons learnt	7
2.1	Methods	7
2.2	Key Findings	7
	Challenge #1	7
	Action #1: Communicate	8
	Challenge #2	9
	Action #2: Collaborate	10
	Challenge #3:	11
	Action #3: Create Understanding.....	11
2.3	What Worked Well.....	12
	Communicate and Collaborate	12
	Create Understanding	13
2.4	What Could be Improved.....	14
2.5	Key Outcomes.....	145
3.	Closure Activities	16
3.1	Recommendations and Ongoing Actions for CQHHS	16
3.2	Application of Lessons Learnt for Queensland Health	16
3.3	Initiative Transitioning to Business as Usual (BAU)	17
4.	Approval and Endorsement	17
5.	Contact Officer.....	18
	References.....	19
	Appendix A.....	20
	Appendix B.....	21

1. Overview

Project Summary

Background and Aim

Dementia care is a national health priority in Australia. High quality care for people with cognitive impairment is every hospital's concern, as is reflected in the new National Safety and Quality Health Service standards incorporating cognitive care principles.

The Cognitive Care Project was funded by the Healthcare Improvement Unit (Clinical Excellence Division). It originally set out to identify appropriate environments within Central Queensland Hospital and Health Service (CQHHS) in which people experiencing extreme behavioural and psychological symptoms of dementia (BPSD) could best be supported. However, early stakeholder engagement and literature and internal process reviews identified that the existing inconsistent and inefficient delivery of services for persons with dementia (PWD) experiencing BPSD could not be adequately addressed through environmental design principles alone. Rather, the organisation's underlying resources and processes needed structure and development to support best practice care. Stakeholder engagement helped to identify three key areas in which CQHHS required development to meet current best practice cognitive care recommendations: Communication, Collaboration, and Creating Understanding. These themes became the focus of project objectives and outcomes, with the overall aim of improving collaborative pathways of care for people experiencing BPSD.

Key Objectives and Approaches

Stage 1 of the Cognitive Care Project (March 2016 – February 2017) focused on engaging key stakeholders to identify existing cognitive care practices and associated service gaps and/or knowledge and skill requirements. The project team developed two clinical pathways of BPSD management (a hospital inpatient pathway and a community/RACF pathway) designed to improve the quality and safety of care provision for this client group through collaborative practice and improved communication. Application of Brodaty, Draper & Low's (2003) 7-tiered model of service delivery guided outcomes development and determination of referral pathways to local specialist teams. Tools were selected to facilitate pathway use, with the goal of improving communication and collaboration across services regarding cognitive impairment and BPSD through development of a shared/common language. A brief pilot trial of the pathways and associated tools established face validity and afforded opportunity to gather feedback, via an implementation science approach.

Stage 2 (March 2017 – 30 June 2018) extended the work completed in Stage 1 by consolidating local service provider relationships and simplifying the collaborative decision pathway for supporting people experiencing BPSD and/or delirium within Rockhampton and surrounding areas. The updated decision pathway, 'BPSD 123', stepped staff through the basic model of service delivery. In addition to broader implementation of the pathway & tools, Stage 2 largely focused on education development and delivery. Stakeholder engagement identified the primary staff knowledge gaps. Education delivery ultimately aimed to improve understanding of dementia and BPSD, delirium and the experiences of hospitalised individuals with these presentations. Figure 1 illustrates an adaptation of Brodaty et al.'s 7-tiered model, which summarises project objectives and outputs (in blue), the key stakeholder groups involved at each level (in orange) and the final project recommendations and ongoing initiatives to foster ongoing knowledge translation (in red – also see Section 3).

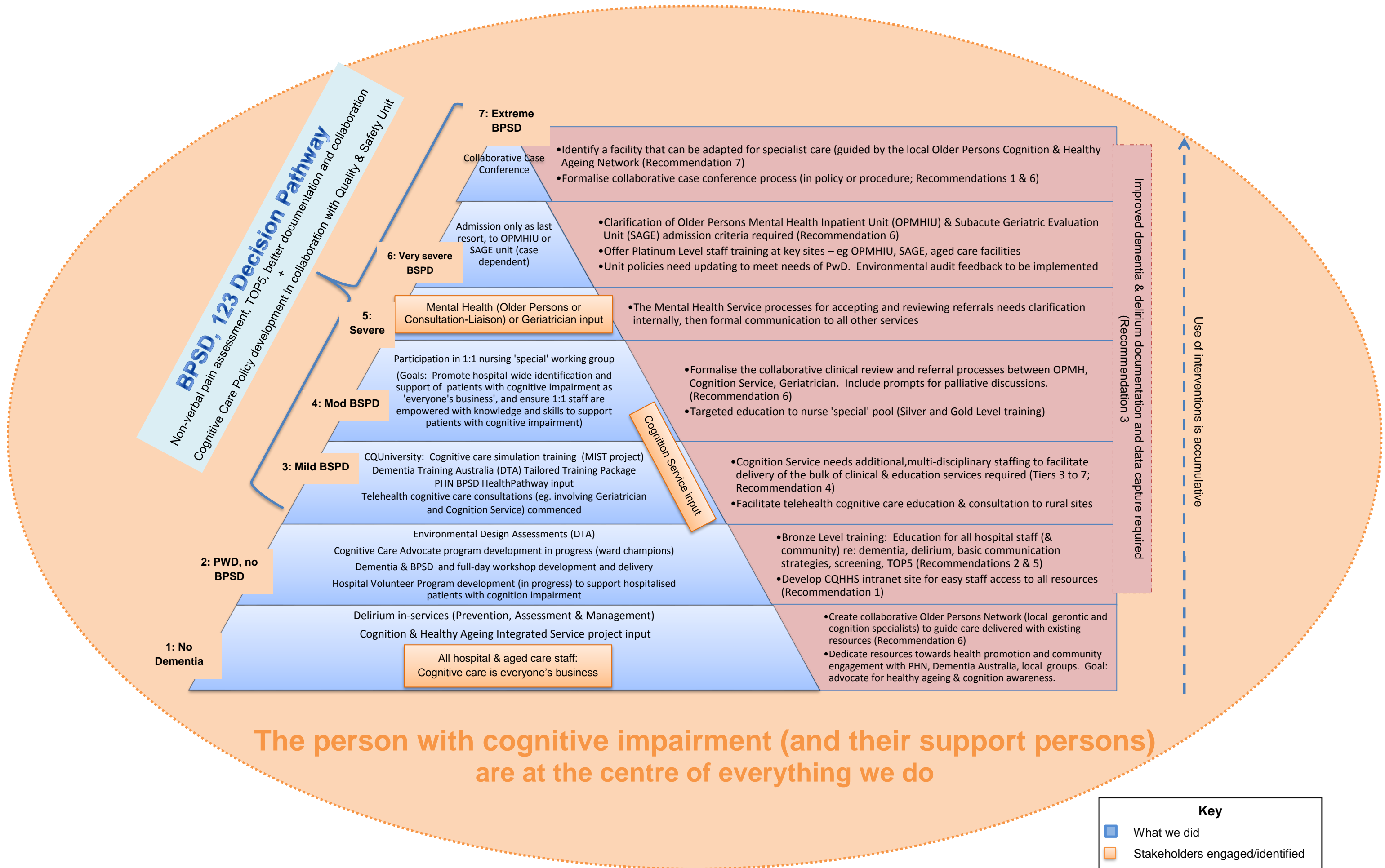


Figure 1. CQHHS Cognitive Care Project Summary
(adapted 7-tiered model of service delivery; Brodaty et al., 2003)

Page deliberately left blank

2. Lessons learnt

2.1 Methods

A Knowledge to Action framework was applied throughout the project implementation. Under this model, the key aspects of the 'knowledge creation' phases were:

- An ongoing literature review to ensure best-practice concepts were presented to stakeholders at every stage of the project
- Review of existing processes via:
 - Site visits (which highlighted the variability across wards and facilities and the different approaches to cognitive care based on prevailing understanding and identification of the issues at hand and the resources available)
 - Preliminary data collation and review (eg. Delirium or dementia presentations to ED, delirium or dementia diagnoses per ward, clinical incident data related to dementia or 'behaviour')
- Liaison with key stakeholders (eg. face-to-face, surveys, workshops, planning days) throughout the project planning and implementation to facilitate an appreciative enquiry approach to identifying the challenges and solutions to creating system improvement
- Development of a collaborative decision pathway of BPSD support, based on stakeholder input and literature

Following the key themes of, "Communicate, Collaborate and Create Understanding", the 'action' phase involved:

- Implementation of a small pilot trial of the initially developed BPSD clinical pathway and associated tools
- Subsequent revision and redevelopment of the BPSD decision pathway based on feedback from the pilot phase
- Identification and/or development and delivery of suitable education opportunities to meet staff needs
- Broader implementation of 'BPSD 123' and associated tools across Rockhampton hospital and surrounding areas (Capricorn Coast Hospital and Health Service, Eventide Nursing Home, North Rockhampton Nursing Home)

2.2 Key Findings

The following offers a summary of the key challenges to collaborative support for people with BPSD identified through stakeholder engagement and process review, and the chosen approaches to addressing them to meet project objectives.

Challenge #1: There was no consistent means of assessing, managing or communicating the presentation of BPSD within or across services

Preliminary review of Diagnostic Related Group (DRG) data suggested that there are very few Rockhampton hospital patients who experience delirium or have a diagnosis of dementia. In addition, there was not any data indicating whether patients experienced BPSD. This is likely compounded by the lack of objective criteria to determine the severity of BPSD (NSW Department of Health, 2006). Likewise, a snapshot of clinical incident data (PRIME records) highlighted that BPSD is not captured in meaningful way. Use of arbitrary data categories like 'behavioural' creates a system in which very little meaning or interpretation can be made regarding cognitive impairment-specific incidents. Therefore, it is highly probable that the available data is not accurate due to under- or misdiagnosing of delirium and failure to consistently document confirmed dementia diagnoses in patient records (Australian Commission on Safety and Quality in Health Care, 2018). This has implications for allocation of resources, service development and patient care.

Similarly, existing processes for initiating one-on-one nursing 'specials' to support patients with cognitive impairment were arbitrary and inconsistent. It was not clear upon retrospective data review whether patients receiving 'specialling' were experiencing delirium or BPSD (or both), or other symptoms or conditions. Staff providing one-on-one support were not offered any additional training and often received no specific communication regarding the individual patient's communication preferences or other needs.

Stakeholder Comments

- "More informative communication is a requisition. Knowledgeable carers have more confidence in delivering safe cares."
- "Time and information (are) very important. Time to complete all tasks – observation and documentation – supporting co-workers to achieve these new goals. Information from our work – to help other clients in the future."

Action #1: Communicate

To begin to address these issues, the project team reviewed and collated the clinical tools currently in use around the HHS. To facilitate BPSD decision pathway completion, clinical tools were selected in consultation with stakeholders, to develop a consistent means of communication for this patient cohort within and across services. Chosen tools included:

- Confusion Assessment Method (CAM; Inouye, 2003) for delirium screening
- Abbey Pain Scale (Abbey, et al., 2004) for non-verbal pain assessment
- TOP 5 tool (Clinical Excellence Commission, 2014) for supporting care and communication for the patient with cognitive impairment

The overarching principles guiding development and application of the pathway were:

- Person-centred; dignity in care (NSW Health, 2013)
- First-line interventions: non-pharmacological (Guideline adaptation committee, 2016)
- Promoting carer support and education
- Palliative/supportive philosophy (Clinical Practice Guidelines for Dementia in Australia, 2015)
- Collaborative, multidisciplinary – shared frame of reference

Challenge #2: There was lack of clarity regarding roles and responsibilities amongst services involved in providing care to people experiencing BPSD

Stakeholder Comments

- From a consumer: “Listen to carers more and employ staff who are able to relate to people with dementia”
- Duplication of service delivery
- Lack of awareness regarding service boundaries (eg. Which teams service community versus hospital) – impacts discharge planning and continuity of care
- Limited capacity for after-hours assessment and management of BPSD &/or delirium
- Time/resource constraints impede delivery of best-practice non-pharmacological strategies
- Difficulty in identifying and following an individual’s personal journey with dementia (eg. When was the diagnosis made (and what was it)? Who made it? What is the individual’s baseline presentation? What teams have already had input?)

BPSD management has historically been subject to debate and boundary contention between mental health and aged care services (NSW Department of Health, 2011). The National Framework for Action on Dementia 2015-2019 (Department of Health, 2015) recommends that collaboration occurs on three fronts to facilitate optimal, biopsychosocial and person-centred BPSD management practices, with a focus on avoiding unnecessary hospitalisations for people living with dementia. Firstly, formal collaborative partnerships between such hospital services and RACFs, local community networks, primary health care networks and private practitioners must be formed to assist in minimising emergence of BPSD or in reducing its impacts. Secondly, the Framework identifies outreach services from psychogeriatricians, geriatricians and other health professionals as a desirable arrangement in community and RACF dementia care. Finally, collaborative dementia care is incomplete without creation of partnerships with the individual living with dementia and their families or caregivers. These recommendations guided the Cognitive Care Project’s goals for collaboration.

A review of existing services within the local area highlighted that there were multiple services and clinicians providing care to individuals with dementia and BPSD in Rockhampton. At the time of service review (2016), CQHHS provided the following services in Rockhampton:

- 1.5 FTE geriatricians in the public sector
- A 27-bed subacute geriatric evaluation (SAGE) unit
- A 1.5 FTE nurse-led Cognition Service
- A nurse practitioner-led Residential Acute Care Service (RACS)
- 1 FTE psychogeriatrician
- A community-based Older Persons Mental Health Service (OPMHS)
- An 8-bed Older Persons Mental Health Inpatient Unit (OPMIU)
- A Mental Health Consultation Liaison Service for hospitalised patients

Several of these services (including the SAGE and Older Persons Mental Health Inpatient units) had only been established within the past approximately 12 to 18 months. Likewise, several specialist clinician positions (including geriatricians and psychogeriatrician) had only been filled within a similar timeframe. The recent development of these teams and services contributed to the situation, wherein no specific tools or guidelines were identified to directly clarify or address service boundaries in the assessment and management of BPSD across the hospital services. A single patient could therefore be referred to multiple specialist teams (often only once the patient’s BPSD had escalated in severity). Each team could potentially complete their episode of care without being aware the patient was simultaneously being seen by other specialists. This has repercussions for consistency and continuity of patient care and reduces health service efficiency.

Action #2: Collaborate

Key members from each of the services were consulted (and included in the project Steering Committee) to find agreement on collaborative approaches to supporting people with BPSD, according to the 7-tiered model of service delivery for BPSD (Brodaty, et al., 2003). This model provides a basis for an evidence-based clinical pathway of care that considers the complexity involved in collaborative BPSD management. It categorises BPSD symptoms according to severity from Tier 1 (*No dementia*) to Tier 7 (*Dementia with extreme BPSD*) and makes recommendations for appropriate management strategies at each level, with Tier 7 requiring the highest level of intervention and support. The National Framework for Action on Dementia endorses the 7-tiered model as a guide in developing clinical management strategies, organisational policies, resources and support for BPSD management (Department of Social Services, 2015). The final, local adaptation of the decision pathway, 'BPSD 123', is illustrated in Appendix A.

'BPSD 123' prompts staff through 3 basic steps to support a person presenting with changes to memory, thinking or behaviour.

Step 1: Does the person have a delirium?

- Delirium screening (CAM)
- Prompts for identifying and treating the cause of delirium

Step 2: Personalising care

- Does the person have pain? Use a non-verbal screen if they may not be able to communicate pain experience articulately.
- Consider engaging with people who know the person best (eg family) to write a TOP 5.
- Prompts (accompanied by education) for staff to observe and document the person's neuropsychiatric changes objectively, undertaking 'detective work' to gain understanding of the person's experience.

Step 3: Does the person need specialist review? To whom do we refer?

- Recommendations for initial point of specialist referral, guided by Brodaty, et al. (2003) and best-practice guidelines

To consolidate a new collaborative process, specialist services began holding collaborative case review meetings during periods of shared patient care. For instance, the Cognition Service began attending SAGE unit multidisciplinary team meetings and OPMHS case review meetings when providing input for clients. Specialist team members reported noticing improved communication and collaboration on these occasions. On three occasions during the project, when a person presented with Tier 7 (extreme) BPSD, emergent complex case review meetings were held to assist in identifying the best approaches for the patient's ongoing care needs. Incorporation of the TOP5 tool in the pathway encourages improved collaboration and communication with the person with cognitive impairment and their support persons. Furthermore, the project team collaborated with representatives from the local Primary Health Network, to assist in developing the BPSD HealthPathways for general practitioners. This helped to ensure the specialist referral processes identified through stakeholder consultation were communicated to patients' primary health providers.

Preliminary endeavours at using the decision pathway in rural sites (Capricorn Coast Hospital and Health Service) indicate that the pathway is still applicable and can be easily adapted. Steps 1 and 2 on the decision pathway remain unchanged, while Step 3 (specialist referral) can be adapted to reflect locally available specialist services. Telehealth consultations have been used when specialists were unable to attend referrals in person.

Challenge #3: There was limited opportunity and prompting for staff to attend locally-orientated, dementia-specific training

“The first step to making a person’s stay safer is to understand the different forms of cognitive impairment, the people who are at risk, and what we need to be alert to,” (Australian Commission on Safety & Quality in Health Care, 2018). However, the lack of easy access to dementia and BPSD-specific training for staff was identified as a major barrier to translation of evidence-based practice recommendations within the local health services. Staff described challenges in attending training offered at larger centres out of town, including difficulties in arranging time off work. This potentially limits staff’s ability to recognise and respond to cognitive changes or BPSD, which has implications for patient outcomes.

Stakeholder Comments

- “Every staff member working with (older) patients should have some form of dementia training.”
- “More training for everyone. Can never know too much when caring for dementia people.”
- “More training needed for ALL staff including allied health, OSOs and cleaners and kitchen staff.”
- “For wards who deal with a high level of patients with BPSD and/or delirium, in-service or workshop education should be mandatory. Staff are educated online as to how to handle these patients, but have no real handling experience, and have not been educated as to what actually happens biologically for those with BPSD and/or delirium. I think that having background knowledge is beneficial. I have noticed that many staff members may not even recognise a patient’s behaviours as being linked to BPSD and/or delirium. I believe this comes from lack of experience and lack of education.”
- “Staff are not recognising the need to refer, not recognising BPSD or looking at what is happening behind the behaviour. Referrals then only get done when there is an incident (ie when the behaviour has escalated).”

Action #3: Create Understanding

In response to this identified need, the Cognitive Care Project team developed and coordinated multi-modal cognitive care training opportunities for staff, including:

1. Ongoing in-services, ‘lunchbox’ education sessions, videoconferences and mini-conferences to educate teams about ‘BPSD 123’ and the associated tools
2. A full-day, ‘Caring for the Patient with Impaired Cognition’ workshop, delivered by the Cognition Service staff and the Nurse Practitioner Gerontics
3. Development of a 10-minute, ‘TOP5 Introductory Video’, in collaboration with CQUniversity’s MASK-ED team (see <https://www.cqu.edu.au/about-us/structure/schools/nm/simulation/mask-ed/what-is>)
4. Coordination with Dementia Training Australia (<https://www.dementiatrainingaustralia.com.au/>) to develop a Tailored Training Package for CQHHS (in progress)

In addition, staff expressed a desire to undertake simulation training in which they could practice identifying early signs of patient distress and assess and respond to escalating BPSD for the patient. A subsequent project, “Multifaceted Innovative Simulation Training,” was initiated in collaboration with CQUniversity, incorporating some of the university’s existing education methods, MASK-ED and TagTeam. To facilitate ongoing knowledge translation, the MIST project includes scope for five staff to be trained in MASK-ED and MIST education techniques. The MIST project is still underway. Initial trials of the simulation training during the full-day workshop have received positive feedback (see Section 2.3).

2.3 What Worked Well

Communicate and Collaborate

Staff feedback indicated that 'BPSD 123' was generally well-received. Anecdotal reports from specialist team members of observing trends towards increased delirium and BPSD identification in hospitalised patients seemed to support this. Similarly, staff survey responses reflected that some improvements to patient care were noted (see below).

BSPD,123: Staff Feedback

What do you like about it?

- "It's easy to navigate and understand with clear management/contact plan"
- "Easy to follow, colour coding, simple language"

What don't you like about it?

- "Another form to complete and file, downloading and printing when colour is not an option"
- "It's not utilized by all staff members"

What changes did you see to patient care?

- "Improvements all round when you focus on personalized approach and care"
- "Use of the TOP5 seems beneficial"
- "I like the Top 5 tool for cognitively impaired clients, I think it is valuable for staff to have personalized techniques for managing clients' care so as to reduce occurrences of agitation or distress, improve client care, and allow care provision to be more efficient and less stressful for staff. The online training video for this tool is great."
- "I think staff have another resource to use and a better understanding of BPSD"
- "When we sent referrals according to the pathway, it seemed as though staff identified the changes in (the person) earlier than in the past. The 2 recent pathway referrals had positive CAMs and ended up being treated for UTIs – their behavior subsequently settled. The process was initiated earlier than in the past."

How can we improve BSPD, 123 use?

- "I will now mention TOP5 and CAM in my patient handover."
- "TOP5 should be introduced to ED at time of arrival."
- "Suggested that 'TOP5 activated' gets put on Patient Flow Manager when completed. Discussed with NUM: approved and currently happening in our ward"
- "Staff need ongoing education and support about BPSD, the pathway and tools; otherwise it just gets forgotten about"

However, upon chart review it was difficult to ascertain in which instances 'BPSD 123' had been followed, as the physical form was not included in hospital documentation. This was the case even when there was physical evidence that specific tools or processes outlined in the pathway had been followed (eg. completion of CAM, initiation of TOP5, referral to Cognition Service). It is not clear why this occurred, although it is possible that it reflects 'change fatigue' or reluctance to print out another form.

There seems to be increasing uptake of the clinical tools, particularly the TOP5 tool as a method for engaging with family and support persons of people with cognitive impairment (see below).

TOP5 completions: A snapshot from one hospital ward

2016: 3
2017: 34
2018 (January to June): 21
Total: 58

More collaborative referrals occurred between Older Persons Mental Health Service and Cognition Service following project implementation. In January – June 2015 (prior to project commencement), there were no referrals made between Older Persons Mental Health and the Cognition Service. In January – June 2018, a total of six mutual referrals occurred between these services. Cognition Service now periodically attends the Older Persons Mental Health Service's case review meetings when sharing care of mutual clients.

Create Understanding

In-services, mini-conferences and full-day workshop attendance reached over 500 staff members across the following sites:

Capricorn Coast Hospital and Health Service

- Medical ward
- Community Health Team
- Volunteer Services

Rockhampton Hospital

- SAGE unit
- Medical ward
- Surgical ward
- Volunteer Services
- Hospital-wide Physiotherapy team
- Hospital-wide Allied Health Assistant team
- Speech Pathology team
- Older Persons Mental Health Inpatient Unit
- Older Persons Community Mental Health Service
- Rehabilitation Services
- Community Acute and Non-Acute Services

- Hospital in the home
- Complex Care Coordinators
- Residential Acute Care Service
- Nurse Navigators

Residential Aged Care Facilities

- Eventide Nursing Home
- North Rockhampton Nursing Centre
- (plus two private aged care facilities)

Stakeholder Comments

- “The 3-session training was excellent – we received very good feedback from staff”
- “All staff should be mandated to undergo THIS training (Caring for the Patient with Impaired Cognition Workshop)”
- “Doctors should attend too”
- “More education!! Compulsory dementia education that involves all members of the health care team”
- “Need ongoing education and training, especially on appropriate communication strategies”
- “Need program of education to safety specials to support their interaction with clients with cognitive impairment...”
- “Workshops need to be catered to different knowledge/qualification levels - RNs need to understand assessment and referral processes, medications, diagnosis (eg dementia vs delirium) as well as de-escalation skills, whether provided by video, online training or workshop. Top 5 video is already helpful here. AINs don't need some of this higher level stuff but need practical skills-based training in how to communicate with people with cognitive impairment as well as how to de-escalate agitated clients - workshops with practicing of skills/demonstrations/scenarios etc would be good (ie MaskEd method of teaching could be effective here)”

Beyond project completion, bookings for education continue to be made from across the HHS. This highlights the interest and need for locally available cognitive care training for staff. There was considerable feedback indicating that staff believe that some degree of cognitive care training should be mandated across the HHS. This prompted some early conceptualising of a tiered approach to cognitive care training (see Appendix B). The Cognition Service is continuing this discussion with Dementia Training Australia; no plans have been finalised yet.

2.4 What Could be Improved

There were several major limitations in project implementation and outcome measurement, including:

- Due to project scope and available resources, the decision pathway was not implemented the entire CQHHS, or even across an entire facility.

- There was limited buy-in and active project endorsement from senior clinical and executive staff with many contributing factors. This created impediments to in-service delivery and culture and practice change.
- Even within wards where 'BPSD 123' was introduced, the decision pathway and tools were not always routinely activated. Activation often only occurred due to involvement of key staff members, rather than being part of usual business.
- Specialist services did not always respond to referrals according to the decision pathway (eg. BPSD was not always accepted as appropriate referral criteria for some teams).
- The Neuropsychiatric Inventory Questionnaire was perceived as being unnecessary and too time-consuming for staff and it was not completed (it will likely be removed from the pathway).
- The Cognition Service is responsible for responding to most pathway referrals and currently is responsible for all cognitive care training. While DTA's Tailored Training Package will eventually assist with foundational knowledge requirements, ongoing pathway uptake and implementation is not sustainable with current staffing and resource levels.
- Barriers to identifying reliable quantitative outcomes data impeded measurement of project success.
- Education delivery has not reached all staff. Staff at different clinical and non-clinical levels will have different education needs.

2.5 Key Outcomes

Communicate & Collaborate:

- Selection of tools to facilitate assessment and support of patients presenting with changes to memory, thinking and/or behaviour. Common tools facilitate communication across services.
- Development of a collaborative decision pathway, 'BPSD, 123', which prompts staff through 3 basic steps in supporting the patient, in alignment with NSQHS Standards and other best practice recommendations.
- Specialist services commenced collaborative case review during periods of shared care, in addition, to increased referrals between services.
- Agreement regarding specialist service boundaries and collaborative processes; subsequent referral recommendations included in 'BPSD, 123' (based on Brodaty, et al.).

Create Understanding:

- Contribution to the development of the CQHHS Older Person strategy.
- Development and coordination of multi-modal cognitive care training for staff, to improve understanding of dementia and BPSD, delirium, the perspective of patients experiencing cognitive impairment and the HHS' chosen approaches to supporting them:
 - Ongoing in-services, 'lunchbox' education sessions, videoconferences and mini-conferences to educate teams about 'BPSD 123' and the associated tools
 - A full-day, 'Caring for the Patient with Impaired Cognition' workshop, delivered by local cognitive care specialist teams
 - Development of a training video in collaboration with CQUniversity's MASK-ED team
 - Coordination with Dementia Training Australia to develop a Tailored Training Package for CQHHS.
- A "Multifaceted Innovative Simulation Training" (MIST) collaboration with CQUniversity and CQHHS. Incorporating some of the university's existing education methods, MASK-ED and TagTeam training combined methodologies, incorporating simulation training specific to caring for patients with impaired cognition.

3. Closure Activities

3.1 Recommendations and Ongoing Actions for CQHHS

Multiple local services and agencies must play a role in a multifaceted approach to supporting and accommodating people experiencing BPSD, particularly those experiencing more severe symptoms.

Based on the project's findings, the limitations outlined in 2.4 and stakeholder feedback, the project recommendations are summarised below.

1. The decision pathway 'BPSD 123' and its associated tools and service model to be implemented across CQHHS, as per the drafted policy 'Supporting Patients with Impaired Cognition'. The specialist referral recommendations outlined in Step 3 on the pathway will need to be adapted to meet rural and remote facility needs.
2. To facilitate achieving Recommendation 1, CQHHS' senior managers and clinicians to actively support cognitive care pathway and policy implementation by attending available training, facilitating staff to attend training, and promoting the Cognitive Care Advocate program and decision pathway implementation.
3. Review and revise clinical documentation and coding processes to facilitate capture of meaningful quantitative data regarding patients with cognitive impairment. This could involve a quality improvement project in which clinical coding staff work with medical staff to develop a mutually effective system.
4. Business case to be submitted to increase Cognition Service staffing and resources, to meet referral response demands and the remaining education development and delivery requirements. As the Cognition Service delivers specialist cognitive support and education across multiple areas of the HHS, it is recommended the Service budget be shared across business units.
5. Cognition Service to engage with Clinical Research and Education teams regarding standardising and expanding cognitive care training – consider concept outlined in Appendix B. Continue engaging with Dementia Training Australia and CQUniversity on tailored, collaborative training approaches outlined in this report.
6. Further planning and clarification to occur between Mental Health Services and Geriatric, Subacute and Hospital Avoidance Services, to address remaining ambiguities surrounding support for patients at various levels of the 7-tiered service model. This will include revising ward-specific model of service documents and policies, to be communicated across the HHS. This will also contribute to expansion of the CQHHS Older Person Health Strategy.
7. Develop an Older Persons Healthy Ageing and Cognition Network, with membership to include key senior clinical and non-clinical representatives (including consumers).
8. The Older Persons Healthy Ageing and Cognition Network to progress discussions regarding 'most appropriate' local environments for patients experiencing extreme BPSD, with considerations to include provision of specialist level training to staff in the selected sites.

3.2 Application of Lessons Learnt for Queensland Health

To facilitate new uptake of project outputs (particularly in regional and rural areas), we recommend:

- Further work be undertaken to create a common language in clinical documentation and coding for patients with cognitive impairment and older-person specific diagnostic groups. This must include consultation with consumers, and education for clinicians to facilitate practice change.
- Local Older Persons Healthy Ageing and Cognition advocacy groups be established to offer leadership in development of older persons' health services and care environments (including people with cognitive impairment)
- The collaborative processes, decision pathway ('BPSD, 123') and tools are adapted according to

local resources and identified needs, before being formalised in cognitive care policy

- Innovative, multi-modal cognitive care education programs are developed or adopted for all staff (clinical and non-clinical), including experiential components to foster better understanding of the patient’s perspective.

3.3 Initiative Transitioning to Business as Usual (BAU)

- The collaborative processes, decision pathway and associated tools developed in the Cognitive Care Project have been written into the CQHHS ‘Supporting Patients with Cognitive Impairment (Delirium and/or BPSD)’ policy. The document has been drafted and is currently undergoing standard review and feedback processes.
- Education development and delivery, including Dementia Training Australia’s Tailored Training Package development, CQUniversity’s MIST project and Cognition Service’s in-services are ongoing.
- A CQHHS intranet site is being developed so that staff can easily access all cognitive care resources and the cognitive care training portal.
- A Cognitive Care Advocate program (‘ward champions’) is being developed as part of the Nursing “Special” Working Group. This will facilitate ongoing knowledge translation.
- A Hospital Volunteer program to support patients with cognitive impairment is being developed collaboratively between the Cognition Service and the Volunteer Coordinator.

4. Approval and Endorsement

<input checked="" type="checkbox"/> Close the Project
<input type="checkbox"/> Revise and resubmit
Comments:

Project Manager

Name	Dr Jane McLean		
Position	CNC Cognitive Care Project		
Signature	<i>Signed copy received on 06/08/18</i>	Date	

Project Sponsor

Name	Kieran Kinsella		
Position	Executive Director – Rural & District-wide Services		
Signature	<i>Signed copy received on 06/08/18</i>	Date	

5. Contact Officer

If you have any questions regarding this document or if you have a suggestion for improvements, please contact:

Contact officer: Dr Jane McLean
Cognition Service

Phone: 4920 7500

References

- Access Economics. (2009). *Keeping dementia front of mind: Incidence and prevalence 2009-2050; report for Alzheimer's Australia*. Retrieved from https://fightdementia.org.au/sites/default/files/20090800_Nat__AE_FullKeepDemFrontMind.pdf
- Abbey, J., Piller, N., De Bellis, A., Esterman, A., Parker, D., Giles, L., & Lowcay, B. (2004). The Abbey pain scale: A 1-minute numerical indicator for people with end stage dementia. *International Journal of Palliative Care Nursing*, 10(1), 6-13. doi: 10.12968/ijpn.2004.10.1.12013
- Australian Commission on Safety and Quality in Health Care. (2018). *Why is cognitive impairment important?* Retrieved from <http://cognitivecare.gov.au/>
- Australian Institute of Health and Welfare. (2012). *Residential aged care in Australia 2010-11: A statistical overview*. Retrieved from <http://www.aihw.gov.au/publication-detail/?id=10737422821>
- Brodaty, H., Draper, B., & Low, L.F. (2003). Behavioural and psychological symptoms of dementia: A seven tiered model of service delivery. *Medical Journal of Australia*, 178(5), 231-34. Retrieved from https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service?0=ip_login_no_cache%3D1c45247b6b02f0ce5f1c276e60fcde23
- Clinical Excellence Commission. (2014). *TOP 5: Improving the care of patient with dementia 2012-2013*. Sydney: Clinical Excellence Commission. Retrieved from http://www.cec.health.nsw.gov.au/___data/assets/pdf_file/0006/268215/TOP5-Final-Report.pdf
- Department of Health. (2015). *National framework for action on dementia 2015-2019*. Retrieved from <https://www.dss.gov.au/ageing-and-aged-care-older-people-their-families-and-carers-dementia/national-framework-for-action-on-dementia-2015-2019>
- Guideline adaptation committee. (2016). *Clinical practice guidelines and principles of care for people with dementia*. Sydney: NHMRC Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People.
- Inouye, S. K., VanDyck, C. H., Alessi, C. A., et al. (1990). Clarifying confusion: The Confusion Assessment Method. A new method for detecting delirium. *Annals of Internal Medicine*, 113, 941-8.
- Laver, K., Clemson, L., Bennett, S., Lannin, N. A., & Brodaty, H. (2014). Unpacking the evidence: Interventions for reducing behavioural and psychological symptoms in people with dementia. *Physical & Occupational Therapy in Geriatrics*, 32(4), 294-309. doi: 10.3109/02703181.2014.934944
- NSW Department of Health. (2006). *Summary report: The management and accommodation of older people with severely and persistently challenging behaviours*. Retrieved from <http://www.health.nsw.gov.au/mhdao/publications/Publications/SumReport-Mgmt-Accom-Oldrpeop-Severly-Pers.pdf>
- NSW Department of Health. (2011). *Dementia services framework 2010-2015*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2011_004.pdf

Appendix A

BPSD, 123: Decision Pathway for Patients Experiencing Behavioural & Psychological Symptoms of Dementia

Has your patient experienced a change in thinking, communicating or behaviour?

NB: This form does not replace clinical judgement. If there is imminent risk of harm to the patient or to others, follow your unit's specific procedures (eg. Code Black or call 000).

1.

Does the patient have a delirium?
 Assess using the CAM
 Identify & treat causes (where possible)
 Follow delirium management protocol*
 *Contact Cognition Service if you require more information

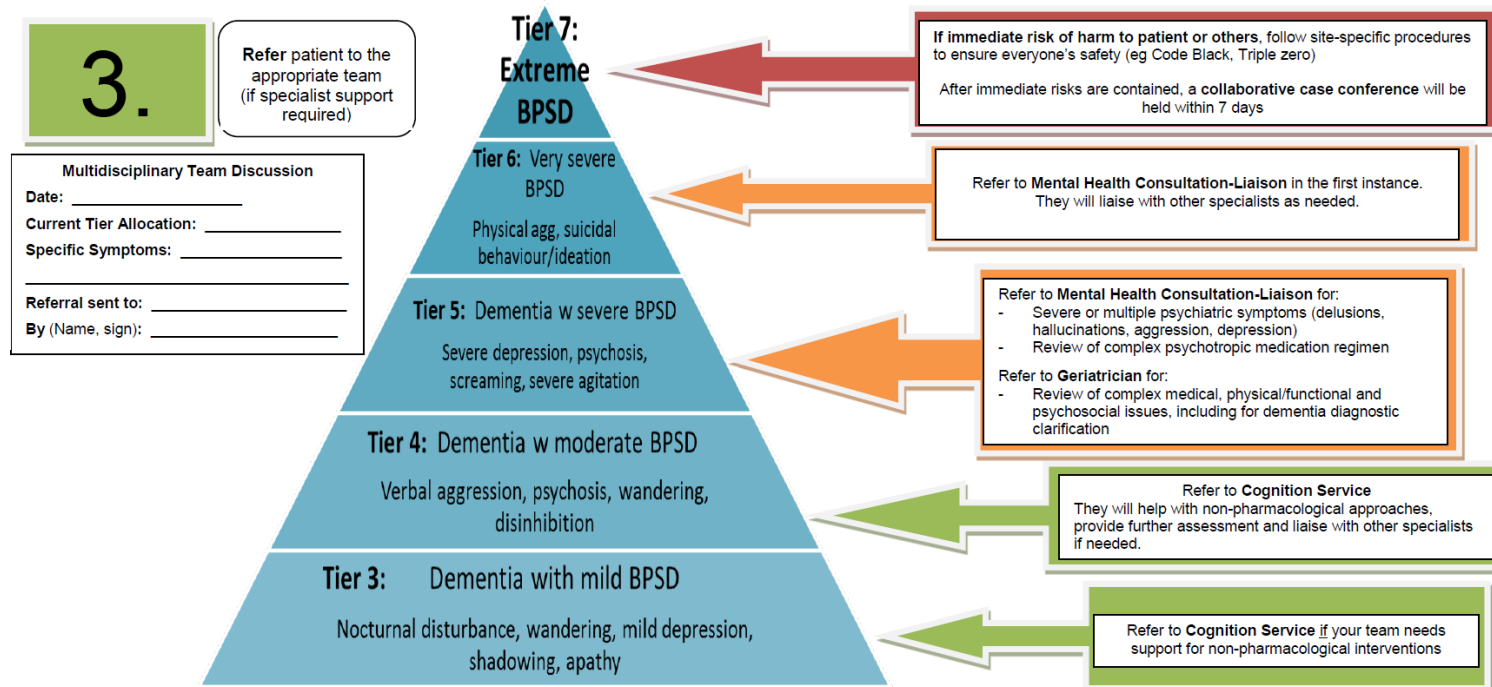
Does the person have a diagnosed dementia? Could there also be BPSD present?

2.

Introduce personalised interventions, based on:
 TOP5
 Abbey Pain Scale
 Documented observations – use **behaviour chart**, review social history
 Assess symptom severity (mild, moderate, severe): Use **NPI-Q** or see over page for a guide

Key
 BPSD: Behavioural and psychological symptoms of dementia
 CAM: Confusion Assessment Method (QHEPS, clinical forms)
 NPI-Q: Neuropsychiatric Inventory Questionnaire (QHEPS, clinical forms)

Step 3 illustrates recommended referral model for Rockhampton. Sites external to Rockhampton may not have access to all specialist services.



Appendix B

Example Concept for Targeting Cognitive Care Training to Different Roles, Based on Local Feedback

Bronze (All clinical & non-clinical staff; ideally mandatory)

- Dementia, delirium & depression: The essentials (including overview of BPSD, 123)
- Basics of communicating with and supporting the person with cognitive impairment
- Introduction to TOP5

Silver (AINs, junior clinical staff)

- Dementia, depression, delirium: Initial screening
- Administering a CAM (& basic non-pharma preventive/supportive strategies)
- Contributing to a TOP5
- BPSD, 123
 - Noticing change in your patient (and what to do about it)
 - Describing neuropsychiatric symptoms

Gold (RNs, senior clinical staff)

- 3Ds: Capacity, Cognitive Screens, and Clinical Investigation
- TOP5: Collaborating with family & caregivers
- BPSD, 123
- Person-centred conceptualisation (eg PIECES model) & writing management plan
- Capabilities based care planning to PwD
- Considerations in pharmacological management of BPSD
- Advance care planning, applying palliative philosophies to care

Platinum (Cognitive Care Advocates/'Champions')

- 'Train the trainer'
- Spend a day in the Cognition Service (peer skill sharing program)

The '3Ds' in ED

- Dementia, depression, delirium
- Delirium screen (CAM)
- TOP5
- Early signs of escalation in neuropsychiatric symptoms (& what to do about it)
- Advance care planning
- Consent and decision-making capacity fundamentals