

Evaluation of Education and Training of Staff in Dementia Care and Management in Acute Settings

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Executive summary

The projects

The Education and Training in Dementia Care and Management in Acute Settings Project had the overall goals of (i) promoting an acute care service environment that would be responsive to the needs of people with dementia, their families and carers, and, (ii) facilitating continuity of care between service providers of people with dementia, especially at the time of discharge from an acute care setting. To achieve these goals, four health service organisations were funded to undertake the development and implementation of multi-strategy education and training programs for staff in the care and management of people with dementia in a hospital or acute ward.

Projects were initiated in the second half of 2003 by Bairnsdale Regional Health Service, Ballarat Health Services, Southern Health and a Gippsland Health Services Consortium.

The evaluation

A team from the Lincoln Centre for Ageing and Community Care Research at La Trobe University was commissioned to evaluate the four projects. The evaluation aimed to provide qualitative and quantitative information about the achievements of the projects, including changes in the target groups' awareness and knowledge of care and management of people with dementia, and changes in the policies and practices of organisations involved in care and management of people with dementia. The evaluators were also required to identify key elements associated with positive changes and program components that could contribute to sustaining the education and training strategies after the project funding ceased, and to provide recommendations regarding future education and training in care and management of people with dementia in hospitals or acute ward settings. A pre and post survey design was employed for the evaluation.

Key findings from the evaluation

Prevalence of dementia in hospital settings

The Southern Health project team collected data on all patients who were admitted to either of the two medical wards which formed the study sites over two data collection periods. In addition to basic demographic and medication information, a measure of cognitive impairment was collected for all patients and behavioural observations recorded for a sub sample, providing a valuable profile of the extent of cognitive impairment and associated behavioural manifestations in a large sample of unselected admissions to a general medical ward.

Over 18% of the sample was considered to be cognitively impaired on the basis of a standard test. Approximately two-thirds of patients who were assessed as cognitively impaired showed agitated behaviours in the seven days after admission.

Responsiveness of hospitals to the needs of patients with cognitive impairment

Each project undertook a pre-intervention audit of their organisation's current policies and practices with respect to people with dementia or other cognitive difficulties. The results from this benchmarking exercise suggested that there was significant room for improvement in the adoption of policies and practices which would make the facilities more responsive to the needs of patients with cognitive impairment. On average the facilities involved in these projects fully or partially complied with approximately 16 of the 27 aspects of practice addressed in the audit.

Staff perceptions of patients with dementia

The evidence suggests that most acute care staff do not find caring for people with dementia unrewarding or difficult but a significant minority do. Of the responses to the pre-education surveys, 35% of Bairnsdale staff, and 34% of Ballarat staff rated their level of satisfaction in dealing with patients with dementia as low or very low. In the Southern Health sample, 17% agreed or tended to agree with the statement that patients with dementia gave no job satisfaction. When asked to rate how well they currently cared for patients with dementia, 48% of Gippsland Health Services

Consortium respondents to the pre-education survey gave a score of four or less on a 10-point scale from not very well to very well.

Carer perceptions of the hospital experience

Information from carer surveys from two of the projects provides insights into the experience of carers when a person with cognitive impairment is hospitalised. While the majority of carers surveyed during the pre-training phase were satisfied with their experience, a number of issues were raised in both projects. A significant minority of carers said they were not satisfied with the information about the condition of the patient and about treatment. Also, carers wanted better communication with staff, and felt that staff did not listen to their opinion enough or utilise their input for care planning.

Impact of the education programs

A consideration of both the qualitative data gleaned through interviews and pre and post questionnaire data suggests that, by and large, all four projects were successful in improving staff knowledge and perceptions about dementia, and about effective care of patients with dementia. Three projects provided quantitative pre-post data on the impact of the training. While the number of questions asked varied from project to project, these data indicated: post-training increases in knowledge about dementia and delirium (three projects); increased comfort in dealing with patients with cognitive impairment (three projects); increased confidence in dealing with patients with cognitive impairment (one project); and greater appreciation of family involvement in the care of patients with cognitive impairment (one project). In addition, the level of reported job satisfaction in working with patients with dementia showed a clear increase after the education programs had been implemented in the three projects where this was measured.

Impact on organisational practices

A comparison between the pre and post-training Organisational Audits completed by the four services indicated that the projects positively influenced aspects of organisational practice with respect to dementia care. All four projects reported overall improvement in the organizational response to dementia on those aspects of practice measured by the organizational audit tool.

Conclusions and recommendations

Dementia education in acute care settings

The experiences of the projects analysed in this report have important implications for the future development and implementation of dementia education in acute settings. These can be summarised as follows:

- Executive level support, and the support of key staff including senior nursing and medical staff, are critical to the success of dementia education.
- Key internal stakeholders need to be involved in program planning, for example through membership of a Dementia Education Reference Group.
- Training programs should:
 - be based on assessed local needs and priorities;
 - draw on existing expertise in dementia education
 - be developed in consultation with staff and carers
 - Content should address both factual knowledge about dementia and other causes of cognitive impairment, and the development of skills in communicating and working effectively with patients who have dementia or other cognitive impairments. Training should also explicitly address the role of carers and families in the care of dementia patients.
 - Face-to-face training should be conducted by individuals who have expertise in working with patients with dementia, and who are qualified and experienced in training.
 - The curriculum must be flexibly organised, packaged to facilitate delivery in varied length sessions, and for different staff groupings, and readily repeatable.
 - Face-to-face training needs to be supported by subsequent access to related resources in the form of brochures, manuals or on-line material, and appropriately skilled resource persons who can support staff in the ward.
 - A whole-of-facility approach to training should be encouraged.

Recommendation 1

That health service providers use the findings and conclusions of this evaluation to inform the content and delivery of dementia education programs to all staff in acute settings.

That DHS facilitate the development of guidelines, and an associated resources guide, for the content and delivery of dementia education programs to all staff in acute settings across the State.

Dementia management practices in acute settings

Although the projects focused on educational/training activities they all had an impact on organisational practices related to dementia management and care, either as a consequence of the education or as a result of a direct project intervention. One of the key learnings from the evaluation is that staff education in dementia care needs to be complemented by hospital procedures and policies which support better care management of patients with dementia. Based on the experience of the participants in the projects, we would suggest the following organisational practices be considered for universal adoption:

- All patients are screened for cognitive impairment.
- Where the patient has been identified as having dementia or cognitive impairment from other causes, this should be clearly identifiable to staff working with that patient, for example in the nursing care plan.
- Staff should have access to a person(s) with expertise in understanding and managing patients with dementia who: can support nursing staff in managing patients with agitated behaviours; contribute to ongoing skill development of staff; and advocate for process and protocol development.
- The hospital should establish formal links with external sources of expertise such as the Cognitive Dementia and Memory Service (CDAMS) and Alzheimer's Australia Vic (AAV).
- The whole of the acute experience, including discharge planning, should take account of the patient's dementia status by involving the family/carer and facilitating referral to appropriate community services.

- Good dementia care and management practices should be addressed in the hospital's ongoing quality assurance activities.
- All staff, direct and non-direct care, need to be incorporated into culture change strategies and activities to enhance dementia care and management practices.

Recommendation 2

- That health service providers use the findings and conclusions of this evaluation to inform local practice principles for management of patients with dementia in acute settings.
- That DHS facilitate the development of a standard guide that specifies best practice principles for management of patients with dementia, to be used in all acute settings.

Background

In 2001 12.9% of Victorians (625,951 people) were aged 65 and over. It is expected that this percentage of the population will increase as the population ages. Increases in the numbers of older people will lead to increased demands on health and support services, including aged care residential services and acute health services even if current rates of admission remain the same. The *Victorian Burden of Disease Study* indicates that there will be an increase in the burden from degenerative diseases due to an ageing population, including neurological, sense and musculoskeletal disorders.

The *Victorian Burden of Disease Study: Morbidity* indicates that dementia is by far the most important single contributor, accounting for three-fifths of the overall female neurological and sense disorder burden. Dementia is ranked fourth in the top twenty leading causes of overall female burden. In men dementia and hearing loss together account for three-fifths of the overall male burden due to neurological and sense disorders. Projections indicate that in women, dementia may take over from ischaemic heart disease as the largest cause of ill health in Victoria in 2016. In men, there will be a significant move in the ranking order of dementia from eleventh to fifth. In 2001, it was estimated that there were 41,000 people aged over 60 years living with dementia, and that this proportion will increase by 61% over the next two decades.¹

In response to the impact of dementia on older Victorians, the Rural & Regional Health & Aged Care Services Division of the Department of Human Services developed a framework *Dementia Care and Support in Victoria - 2000 and Beyond*. This framework recommended objectives and actions to:

- Strengthen and expand direct client service delivery to people with dementia, and their families and carers.
- Ensure high quality of service.
- Build community awareness and understanding of dementia.

The framework identified where improved services would have practical benefits for people with dementia, and their families and carers, and provided a guide for decisions about service funding and delivery. The framework aimed to encourage

¹ Alzheimer's Association (2001) Information sheet.

practical actions for improving understanding of the need for support and services for people with dementia, based on the knowledge acquired through dementia service developments and research.

The care and management in acute settings of people with cognitive impairment including dementia is an issue of increasing importance. In Australian hospitals, 15-50% of all patients admitted have a level of cognitive impairment.² The management of a person in an acute hospital is complicated when they have dementia. Issues such as capacity for communication can affect an otherwise straightforward management of a clinical condition. In addition, impaired mental status is the most commonly identified factor in patients who fall while in hospital. Nay et al suggest that "Acute hospitals are not generally equipped to cope with people with dementia".³

While there is little research on the education and training of staff in acute settings on the care and management of people with dementia, there is some information on aspects of the care and management of people with dementia in acute settings, including:

- Staff responses.
- Specific policies and practices, for example understanding, preventing and managing agitated behaviours.
- Experiences of families and carers of people with dementia.
- Appropriate admission and discharge practices.
- Desirable personal qualities of staff.

A research report by Professor Bev Taylor⁴ contains recommendations on a range of relevant factors in the care and management of people with dementia in acute settings, including:

- Effective communication.
- Sensitive handling of people with dementia, and their families and carers.
- Meeting hygiene needs.
- Continence.

² Source: Marriott, J. (2003). The Use of Psycho-tropic Medicines in the Elderly – presentation to Nursing the Confused Elderly Person, Melbourne 3rd-4th Feb 2003 AUSMED Publications.

³ Nay et al. (2000), p. 14. Improving the admission and discharge practices of acute and sub-acute facilities in relation to people with dementia. Report to Victorian Department of Human Services p. 14.

⁴ Taylor, B. (1996).

- Medications.
- Providing for mental and emotional needs.
- Monitoring.
- Time spent with the patient, and their families and carers.
- Nutrition.
- Personal property.
- Restraint.
- Staff training, skills and knowledge.

In addition, Nay et al (2000) identify seven indicators of evidence-based practice in acute and extended care settings in admission and discharge of people with dementia, namely:

- Mission statement.
- Facility infrastructure including research and education.
- Staffing.
- Environmental requirements.
- Assessment.
- Communication.
- Care practices/ interventions.

This work on the care and management of people with dementia in acute hospitals indicates that the following principles need to be considered:

- Involvement of families and carers in all stages of the care of the person.
- Hospital admission procedures that involve families and carers to assess cognitive capabilities and determine individual needs and preferences.
- Education, awareness and support of: all staff, including medical and nursing staff, porters, maintenance staff, cleaners and other staff; patients; families and carers.
- Modification of the physical environment.
- Modification of hospital routines.
- Appropriate responses to issues such as confusion, continence, pain management, and depression.
- Appropriate responses to agitated behaviours including aggression and sexually inappropriate behaviour.

- Development of appropriate discharge practices for people with cognitive impairment.

Further, hospitals need to develop, and regularly review, their restraint policy.⁵

Against this background, the Aged Care Branch of the Victorian Department of Human Services developed the Education and Training of Staff in Dementia Care and Management in Acute Settings Project.

⁵ See the Restraint Guidelines released by the former Health Department Victoria in 1991.

The projects

The Education and Training in Dementia Care and Management in Acute Settings Project had the overall goals of (i) promoting an acute care service environment that would be responsive to the needs of people with dementia, their families and carers, and (ii) facilitating continuity of care between service providers of people with dementia, especially at the time of discharge from an acute care setting.

To achieve these goals project teams were required to:

- Implement a multi-strategy education and training program of staff in the care and management of people with dementia in a hospital or acute ward, from the time of admission to discharge planning and discharge, and incorporating acute, accident and emergency departments.
- Develop a program that can be transferred to other patient areas or hospitals.
- Implement systemic changes that ensure continuous improvement and sustainability of the program without requiring continued external funding.
- Develop a multi-disciplinary and 'whole of facility' team approach.
- Address opportunities and challenges to education and training of staff in dementia care and management in the project proposal.
- Document the processes in planning and implementing the multi-strategy program for education and training in dementia care and management.
- Establish data collection systems and measures, and be prepared to provide data for project evaluation on request to an independent evaluation team.

Within this broad set of requirements the four projects were free to vary their approach consistent with their particular contexts, priorities and resources available. The specific objectives of the four projects are summarised below. Further details of the projects are provided under the individual project evaluations in 1.3.

Bairnsdale Regional Health Service

Initial objectives:

- To identify and implement evidence-based best practice guidelines in dementia diagnosis, assessment and management during an acute health episode.
- To deliver education for nurses and environmental service staff, to establish a resource person to provide individual consultation to ward staff regarding management of agitated behaviour, and to develop and implement dementia care pathways.

Ballarat Health Services

Initial objectives:

- To develop a hospital wide education program to improve both the awareness of and communication with people with dementia.
- To develop a bed-based identifier for cognitive impairment and determine if people with dementia and their carers find it acceptable when used at Ballarat Health Services.
- To determine if a hospital wide education program with a cognitive impairment identifier will improve the hospital care experienced by patients with dementia and their carers.

Southern Health

Initial objectives:

- To pilot an education and training program designed to change attitude, values and behaviour of staff towards patients with dementia in an acute medical unit.
- To deliver a full day training program for all staff, train mentors and champions to provide on-going support, and use a comparison ward to monitor program effectiveness.

Gippsland Health Services Consortium

Initial objectives:

- To educate staff in the targeted facilities regarding knowledge of dementia assessment and management by education sessions and development of learning resources.
- To introduce a range of organisational practices to support more effective responses to dementia including standard cognitive assessments, a cognitive impairment management pathway, support for staff working with patients with agitated behaviours, follow-up of hospital discharge, and more involvement of carers in planning of patient care and discharge.

The evaluation

Aims of the evaluation

The evaluation of the projects aimed to provide qualitative and quantitative information about the achievements of the projects, including changes in the target groups' awareness and knowledge of care and management of people with dementia, and changes in the policies and practices of organisations involved in care and management of people with dementia.

In addition to reviewing the project impacts and outcomes, the evaluators were also required to identify key elements associated with positive changes, and those components that could contribute to sustaining the education and training strategies after the project funding ceased.

Finally the evaluators were to make recommendations based on the above regarding education and training in care and management of people with dementia in hospitals or acute ward settings.

Evaluation model

The basic logic of the evaluation was as follows:

Effective education and training strategies should result in changes in knowledge, attitude and behaviour of staff, and in changes to organisational processes to the extent that these could be influenced by recipients of the training over the project lifespan. These changes in turn should be related to improved outcomes for patients and their families and carers.

Consistent with this logic, the evaluation was designed to address project processes, impacts and outcomes. The process evaluation had the aim of examining the extent to which the project activities were consistent with the objectives of the project and the extent to which the relevant target groups and organisational processes were engaged. The process evaluation also aimed to identify barriers to, and facilitators of, project achievements. The impact evaluation would focus on immediate changes that occurred as a result of the project activities, including changes in knowledge or awareness among groups and changes

in organisational policies and practices related to care of the patient with dementia. Outcomes were to be assessed in terms of patient behaviours and family experiences from admission to discharge.

A pre and post survey design was employed for the evaluation.

Collaboration between evaluators and project teams

The evaluation proceeded as a collaboration between the evaluators and each project team. The role of evaluator as it emerged out of discussion with the teams was encompassed by the following agreed objectives:

- To work collaboratively with project teams to add value to their projects.
- To provide advice and assistance with planning the evaluation, that is developing the evaluation framework.
- To provide advice and assistance with development of evaluation tools.
- To undertake or assist with evaluation data collection and analysis.
- To facilitate sharing of ideas, evaluation tools and methodologies among the four projects.

Evaluation activities

1 Initial interviews with project staff and other key hospital personnel

These involved site visits and had the aims of:

- Clarifying project aims, objectives and activities.
- Developing a local evaluation plan consistent with the above model and acceptable to each team.
- Setting up protocols for the collection of process information, for example any evaluation tools to be used to monitor staff response to educational sessions.
- Identifying current patient data collection procedures.
- Assisting with the identification of appropriate impact and outcome indicators.

2 Development of data collection tools

- Following the initial meeting a process evaluation template for use by the project teams was developed and made available to each team. The process evaluation

aimed to document each of the four projects in terms of the project objectives, project activities and schedule, the personnel involved, communication strategies used in planning or implementing the project, the education or training activities, and the barriers and facilitators in implementing the project (see Appendix 1).

- Sample questions, and standard questionnaires, for the pre and post staff and carer surveys were provided to each team. A number of these were tested and published questionnaires from the literature on dementia and ageing.⁶ Teams were assisted to develop their own final instruments.
- An organizational audit tool was developed and each team was requested to complete this pre and post training. The audit asked the management to rate the organisation on 27 statements with respect to various aspects of practice—mission statement, environment, assessment process, communication, care practices/interventions and discharge planning (see Appendix 2).⁷
- A range of patient outcome indicators were identified and suggested for consideration by the teams.

3 Data collection and analysis

- Completed questionnaires, audit tools and process evaluations were collected by the evaluators, data were coded where necessary, entered on a master data base and analysed.
- Members of the project team and a sample of project participants were interviewed toward the end of the project period. The aims of these interviews were to (i) complete data collection, and (ii) identify factors which were significant in facilitating or enabling achievement of project objectives. Comments on the particular experiences from the project were also solicited.

⁶ For example, University of Alabama at Birmingham Alzheimer's Disease Knowledge Test (Barrett et al., 1997), Alzheimer's Disease Knowledge Quiz (Deickmann, Zarit, Zarit and Gatz, 1988), Kogan's Old People Scale (Armstrong-Esther et al., 1989), Consumer and Carer Satisfaction Survey (Victorian Mental Health Service).

⁷ The Organisational Audit used in the evaluation was adapted from the Short EBIT (Evidence-based Identification Tool) developed by Nay et al., (2003) and the UK Department of Health (2003).

Evaluation outcomes

Bairnsdale Regional Health Service Summary of project activities

Planning and implementation

The project commenced with the establishment of a multi-disciplinary Steering Committee comprising key stakeholders within the Bairnsdale Regional Health Service (BRHS), and consumer and carer representatives. This committee developed the terms of reference for the project, appointed the project manager, and oversaw the implementation of the project.

The Steering Committee was established in June 2003 but the Project Manager was not engaged in a permanent capacity until November 2003. The project continued until July 2004 and the Project Manager worked 0.84 EFT from November 2003 until July 2004.

Education

Education sessions were developed using information from the Pathways to Dementia Care Program (produced by Maria Rodda from the LaTrobe Regional Health Service, Aged Persons Mental Health Service), literature searches and feedback from the initial survey of nursing staff. Sessions were conducted at the change of shift in the afternoon and kept to approximately 30 minutes. All training was delivered by the project manager—a qualified trainer. The primary target group was nursing staff, but the presentation was modified to also suit other groups, namely Environmental Services, Allied Health and Engineering staff.

In addition, an education session for the visiting medical officers was conducted. This was done in collaboration with the East Gippsland Division of General Practice and attracted Continuing Medical Education points.

The dementia education session was also presented to undergraduate nurses on rotation at BRHS during the life of the project and to members of staff at the Sutherland Lodge (a BRHS dementia specific hostel).

As well as the structured education sessions in the wards, the project manager provided impromptu education sessions to ward staff. Usually these focused on the management of particular patients who were manifesting agitated behaviours.

Organisational development

In addition to the staff education program, a number of changes were made to the organisational structure of the health services, and to strengthen links with community service providers. These included:

- Updating the Admission and Discharge form. A section on cognition is now included on the Admission and Discharge form that is completed for all admissions into all areas of BRHS. If there are any concerns or a positive response to any of the key questions, staff are directed to complete the "Complex Planned Care Chart" tool.
- The Complex Planned Care Chart tool was developed with input from family members who had had a relative with dementia in hospital. The tool aims to develop a holistic picture of the patient with dementia and their usual behaviours and particular routines. It suggests basic strategies for caring for these patients.
- The preadmission assessment form has been redeveloped to screen for possible dementia.
- Dementia resource folders designed to meet needs of both staff and families are now available in all acute patient areas, the Allied Health Department and the Community Health Department.
- A brochure on delirium, 'Information for Families and their Friends about Delirium', has been produced as part of the resources available for families of patients with dementia.
- Establishing links with community service providers and carers. The project manager has become a member of the Bairnsdale and District Aged Care Network and facilitates the Bairnsdale and District Carers Support Group.

Sustainability

Several strategies were implemented to help maintain the program impacts, including placing the education sessions on the hospital intranet, and reviewing resource material as part of the hospital's quality processes. The practices

implemented by the project will also be sustained through participation of a number of committees within BRHS in the quality cycle.

Evaluation data

Program reach

A total of 118 staff [excluding Visiting Medical Officers (VMOs)] attended the training sessions, including 46 nursing staff, 15 allied health, 11 Environmental Services, 7 Engineering staff, 8 District Nurses, and 31 undergraduate nurses. All Allied Health and Engineering staff attended the dementia training session. Attendance rates for nursing staff averaged 75% of staff working that particular day.

Changes in surveyed staff attitudes, knowledge and behaviour

BRHS staff were surveyed prior to the training in November 2003, and post-training in June 2004. A total of 55 survey forms were distributed to nursing staff prior to the training and 52 (95%) were returned for analysis. Post-training, 69 surveys were distributed to nursing and allied health staff and 47 (68%) were returned. Of the returned surveys, nearly half the staff (47%) had attended the training. Although Environmental Services staff were included in the training, they were not surveyed.

The following analysis presents most of the results of the pre and post surveys separately as different questionnaires were used at the two stages. The pre-training survey was based on the University of Alabama at Birmingham Alzheimer's Disease Knowledge Test. Four of the ten items in the Knowledge Test were used, together with other items on staff experience, comfort, communication with patients/carers and job satisfaction. The post survey was developed by the Project Steering Committee.

Of the nurses surveyed prior to training, 29% rated their experience in preparing them to care for patients with dementia as high/very high, and 67% rated it as adequate—a small minority 4% rated their experience as very low. Table 1 below shows that about half the nursing staff surveyed prior to training gave the correct answer to the four questions on Alzheimer's disease.

Table 1: Staff knowledge—pre-education

Alzheimer's Disease Knowledge Test	Per cent correct answer
When a patient develops a sudden onset of confusion, disorientation, and inability to sustain attention, this presentation is most consistent with the diagnosis of? (Alzheimer's; <u>Delirium</u> ; Major depression; Pick's)	51.0
Which of the following cognitive deficits is most likely to occur first during the progression of Alzheimer's disease? (Inability to recognise a family member; <u>Disorientation to date</u> ; Inability to name common objects, such as watch or a pen; Disorientation to place)	51.0
Which of the following is the most common cause of severe memory loss in people older than age 65 years? (<u>Alzheimer's disease</u> ; Senility; Normal ageing; Hardening of the arteries)	52.9
Which of the following statements is true concerning the use of physical restraint with patients with dementia? (<u>Restraints can contribute to the development of physical health problems</u> ; Restraints are usually necessary for patient safety; Restraints reassure patients by establishing limits; Restraints tend to calm agitated patients)	58.8

Pre-training, the majority of staff respondents indicated acceptable or better levels of comfort, job satisfaction and communication (Table 2). While it was difficult to measure the impact following training because different questionnaires were used, the brief post-training survey indicated a high degree of satisfaction among the respondents who had attended a training session. All reported that the sessions were relevant to their ward setting and almost all (96%) reported that the training contributed to better care of patients with agitated behaviours. In addition, all attendant respondents said that the training improved their level of comfort in dealing with patients, almost all (91%) said it helped with their job satisfaction, and all reported it helped their appreciation of family involvement.

Table 2: Staff self-rated comfort, job satisfaction and communication—pre-education

Self-rated measures of:		Pre-training %
How would you rate your level of comfort in dealing with patients with dementia?	Very high/high	27
	Acceptable	65
	Low/very low	8
How would you rate your level of job satisfaction in dealing with patients with dementia?	Very high/high	10
	Acceptable	55
	Low/very low	35
Please indicate your satisfaction with the present level of communication between hospital staff and patients' families or caregivers.	Very high/high	47
	Acceptable	37
	Low/very low	16

In summary, measuring the impact of the training was difficult because different questionnaires were used, but the indications were that there was a high degree of satisfaction among the respondents who had attended a training session, and an increase in the level of comfort in dealing with patients, job satisfaction, and appreciation of family involvement following training.

Organisational changes

A comparison between the pre and post-training Organisational Audits completed as part of the project evaluation indicated that the project also influenced aspects of the organisation's practices (see Appendix 3 for the full results). The pre-audit was conducted in November 2003 and the post-audit in June 2004. The audit asked the management to rate the organisation on 27 statements with respect to various aspects of practice taken from the Short EBIT (mission statement, environment, assessment process, communication, care practices/interventions and discharge planning).

The post-audit showed that the BRHS fully complied on eight and partially complied with 16 of the 27 aspects of practice documented in the Short EBIT. Compared with the pre-audit, this was an improvement on 12 aspects of practice. The areas of practice where most improvement was reported were care practices/interventions (4 of 4 aspects improved), assessment processes (3 of 4 aspects improved), and communication (2 of 5 improved).

Table 3: Organisational practice—pre and post training

Area of practice	Pre-training		Post-training	
	Partially complied	Fully complied	Partially complied	Fully complied
Mission statement (2 aspects)	1	0	0	1
Environment (6 aspects)	4	0	5	0
Assessment processes (4 aspects)	1	0	4	0
Communication (5 aspects)	4	1	2	3
Care practice/ interventions (4 aspects)	1	0	3	1
Discharge planning (6 aspects)	3	2	2	3
Total	14	3	16	8

Note: See Appendix 2 for the adapted Short EBIT used in the evaluation.

Barriers and facilitators

The main reported barriers were the delayed appointment of the Project Manager and other staffing constraints, and delays in implementing new information technology across the hospital.

The project was facilitated by support at the executive level, and by key staff and community members. Other factors were the experience of the project manager, involvement in the multidisciplinary round of acute care wards, and the links established across the organisation.

Ballarat Health Services

Summary of project activities

Planning and implementation

A Steering Committee was responsible for the planning and implementation of the Ballarat Health Services project. The committee involved a range of Ballarat Health Services staff and the Alzheimer's Australia Vic (AAV), and comprised the Clinical Nurse Consultant Cognition (Project Manager), Clinical Director of Sub-acute Services, Executive Director Nursing, Manager Nursing Education and Clinical Practice, Privacy Officer, and AAV Grampians region Counsellor/Resource Worker. Other representatives from the AAV were also involved in the planning stages of the project. A range of hospital committees, including the Nursing Practice Committee, Nurse Leadership, Division of Internal Medicine, Division of Surgery, Clinical Operational Group and Quality Committee were also involved to engage key hospital staff.

The project was conducted from May 2003 to July 2004 by the Clinical Nurse Consultant Cognition (Project Manager) who worked 0.5 EFT for the duration of the project, and the Clinical Director Sub-acute Medicine who worked an average of 2.5 hours per week over the project. In addition, a number of staff from the above committees, the hospital, and the AAV were involved in particular parts of the project.

Education and support

The education program delivered to Ballarat Health Services staff was based on themes obtained through a series of focus groups. The focus groups were conducted by the AAV Counsellor in the Grampians region and comprised 22 semi-structured interviews with 39 participants from the local AAV support group (people with dementia and their carers). Participants were asked to reflect on their experiences of acute care and similar experiences, for example medical specialist, community health organisations and other health service providers. From the groups, 22 key themes emerged from the difficulties experienced by patients and carers. The nine most frequently reported themes became the key communication targets and provided the foundation for the education package. The education

package, based on the themes identified by the focus groups, was developed using the expertise of key Ballarat Health Services staff (Clinical Director Sub-acute Medicine, Clinical Nurse Consultant, Cognition) and a representative from the AAV.

The duration of the training sessions was 30–40 minutes and comprised a Power Point presentation, including quotes derived from the focus group work. The training sessions were conducted by the Clinical Director Sub-acute Medicine, and the Clinical Nurse Consultant, Cognition. Each education session commenced with a seven minute video of "Carers' Experience of the Acute Hospital System". The education sessions were developed to be easily understood by all disciplines, both clinical and non-clinical, across the acute hospital site. The image of the Cognitive Impairment Identifier, and the nine key communication points learnt throughout the sessions, were reinforced by the distribution of printed bookmarks to all participants of the training sessions.

In addition to the education program, Clinical Nurse Specialists (or "Champions") from each ward were selected to oversee the uptake of the project, and to act as the ward's liaison with the project team. Each project champion was asked to monitor admission of new patients, identify appropriate patients for the project, and liaise with the new ward if a patient was transferred.

Other strategies implemented to raise awareness about the care of patients with dementia, delirium or cognitive impairment and the use of the Cognitive Impairment Identifier (CII) (see below) included:

1. Internal newsletter "Health Matters"—used for project promotion via hospital Intranet and paper copies to all areas.
2. Community awareness—media launch through Ballarat's local newspaper "The Courier".
3. Hospital Medical Officers handbook.
4. Posters throughout the hospital, in particular hospital foyer and lifts.
5. The use of the CII at the bedside and on all project correspondence and literature.
6. Advertising on the bottom of white boards throughout medical and surgical wards.
7. Project Resource Folders located on each participating ward.
8. CII stickers.
9. CII bookmarks to support education message.

10. Flyers throughout hospital cafeteria and outpatient areas, displaying the CII image and key communication points. Distributed after staff had responded to CII awareness audit.
11. Annual Report.

Organisational development

Cognitive Impairment Identifier

A feature of the Ballarat Health Services project was the implementation of a Cognitive Impairment Identifier (CII), with the aim of improving hospital care for people with dementia, delirium, or memory and thinking difficulties through the presence of a visual cognition impairment identifier. The CII paralleled current hospital use of hearing and vision impairment identifiers. The team monitored three wards and found that 21% of patients had a sensory identifier displayed on their bed.

Using the themes identified from the focus groups with the AAV support group, a graphic designer was engaged to develop identifier prototypes. The final design was chosen by people who participated in the focus groups.

Cognitive Impairment Identifier Project Resource Folders were developed for each participating ward to provide project information. The folders contained the project pathway "Working with the Cognitive Impairment Identifier", giving staff stepwise guidance for identifying patients for the project, and information to support patients through to discharge.

Sustainability

Both physical and cultural factors contribute to the sustainability of the impact of the project. The physical presence of the CII throughout the hospital is a reminder of the issue of cognitive impairment, and the resource folder provides a framework for procedural changes for patients with cognitive impairment. The display of the CII, together with the key communication principles, have been embedded in hospital practice. Feedback from the project suggests a cultural change among nursing staff, and the "all-of-hospital" approach reinforces the importance of the issue across the service.

Evaluation data

Program reach

Ballarat Health Services has a total EFT of 1900. A total 200 staff attended one of the 16 education sessions (including two lunchtime multidisciplinary team open forums). A relatively higher proportion of engineering staff, environmental services, ward clerks and security staff received education compared to nursing and allied health staff. Medical staff were relatively least represented at the education sessions.

Changes in surveyed staff attitudes, knowledge and behaviour

Ballarat Health Services staff were surveyed just prior to receiving the Education Program in September 2003, and were followed up after the training in April and June of 2004.

A total of 200 staff were surveyed pre training and 170 (85%) returned questionnaires. Of these, 62% were direct care staff (nurses–49%, allied health–10%, medical–3%), and 38% non-direct care staff (cleaners and other environmental services–17%, engineering–15%, security–6%). Overall, a majority of respondents were female (62%) but this depended on staff type. The great majority of direct care staff (83%) were female, and the great majority of non-direct care staff (74%) were male.

Post-education, questionnaires were distributed to staff six weeks after they attended the education sessions. Questionnaires were sent to all of the 200 staff who attended a session and 82 (41%) were returned—56% direct care staff (nurses–42%, allied health–14%), and 44% non-direct care staff (cleaners and other environmental services–18%, engineering–18%, security–8%). As with the pre-education survey, most respondents were female (64%) and this was strongly related to the type of staff—85% of direct care respondents were female compared with 26% of non-direct care respondents. The questionnaire contained a number of questions on staff confidence, comfort, job satisfaction, and organizational support, and the same questionnaire was used for both pre and post surveys.

Changes in self-perceived confidence, comfort and job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties are presented in Table 4 below. On average, staff reported a satisfactory level of confidence, comfort and job satisfaction prior to training, with direct care staff reporting higher measures than non-direct care staff. To some extent, this may reflect previous experience, as 53% of direct care staff and only 7% of non-direct care staff reported that they had any previous dementia education. Table 4 indicates that the education program had a positive impact on both groups of surveyed staff, as they reported an improvement on all three measures.

Table 4: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

Self-rated measures:		Means (1)		
		Direct care staff	Non-direct care staff	All staff
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Pre	3.06	2.90	3.00
	Post	3.24*	3.03*	3.15*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Pre	3.12	3.00	3.07
	Post	3.32*	3.10*	3.22*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Pre	2.71	2.82	2.75
	Post	2.97*	2.93*	2.95*

Notes:

(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.

(2) * Change in "desired" direction.

Two-way analysis of the staff type and sex of the respondents to the pre-education survey produced a significant difference between men and women in their self-rated job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties. The mean score for men (2.9) was higher than that for women (2.7), with the mean scores for male (3.1) and female nurses (2.5) reflecting this difference. The male/female scores for medical staff and security

staff were also different but these were not reliable because of small sample sizes (4 and 9 respectively).⁸

Both groups of respondents also felt that the level of organizational support had improved following the Education Program, but their perception of the hospital environment in terms of meeting patients’ needs had decreased (Table 5). This appears to be a negative impact of the Education Program, but could be a result of heightened awareness of the environment needed to support patients with dementia, delirium, or memory and thinking difficulties.

Table 5: Staff rating of organizational support and environment—pre and post-education

Self-rated measures:		Means (1)		
		Direct care staff	Non-direct care staff	All staff
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Pre	2.79	2.56	2.71
	Post	3.00*	2.68*	2.86*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Pre	2.21	3.24	2.57
	Post	2.17	2.96	2.52

Notes:

(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.

(2) * Change in “desired” direction.

The questionnaire contained two questions that measured aspects of staff knowledge of people with dementia, delirium, or memory and thinking problems. A comparison of the measures pre and post training indicates an improvement in both aspects. Table 6 shows that relatively more direct care and non-direct care staff were able to list strategies in effective communication with patients with dementia, delirium, or memory and thinking problems post-education compared with pre-education. In addition, both staff groups reported a more realistic estimate of the proportion of patients with dementia, delirium, or memory and thinking problems in hospital.

⁸ Two-way analysis of the groups post-education was not reliable because of small samples in a number of the groups.

Table 6: Staff knowledge—pre and post-education

Staff knowledge		Percent who gave one or more strategies		
		Direct care staff	Non-direct care staff	All staff
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Pre	82.5	37.1	65.5
	Post	97.4*	79.3*	89.6*

Table 7 shows that relatively more respondents gave the “correct” estimate of the proportion of patients post-education than pre-education, and relatively fewer were more than 10% out in their estimate.

Table 7: Staff knowledge—pre and post-education

Staff knowledge		Direct care staff	Non-direct care staff	All staff
Pre-education				
%				
What proportion of patients do you think you come across in the hospital with dementia, delirium, or memory and thinking difficulties?	Correct	22	23	22
	Within 10%	32	25	27
	Over 10%	46	52	49
Post-education				
%				
	Correct	34	26	31
	Within 10%	26	23	24
	Over 10%	40	51	45

Note: An audit of patient records established that 31% of patients had dementia, delirium, or memory and thinking difficulties. The table shows the percentage of respondents who gave 30% (correct), 20% or 40% (within 10%), and 10% or 50% and above (over 10%).

The follow up survey on staff attitudes, knowledge and behaviour did not assess the overall usefulness of the Education Project, but this was asked in a separate survey on the impact of the CII (see below). Almost all respondents to the survey (93% of direct care and 92% of non-direct care staff) said that the education received through the project was useful.

In summary, comparison of pre and post measures indicated an increase for both clinical and non-clinical staff in their knowledge, and confidence, comfort and job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties. Both staff groups also rated the level of organizational support higher post than pre-education.

Changes in carer satisfaction

The Ballarat Health Services project also aimed to improve the satisfaction of carers with carer/hospital relationships and communication. In July and August 2003, prior to the Education Program, 25 carers of people with a cognitive impairment were followed up by phone by the Clinical Nurse Consultant Cognition after the person they cared for had been discharged, and interviewed about their hospital experience. Of the carer respondents to the pre-training survey, 84% were female. After the Education Program, carers were given a questionnaire at discharge, and asked to complete it anonymously and return it to the Cognition Nurse. A further 31 carers returned surveys.

Most carer respondents were satisfied with the aspects of their experience which the hospital measured in the pre-training survey. However, on a number of aspects a significant minority (20–25%) of carers were not satisfied. These aspects were: information about the condition and treatment; staff not knowing if the patient had cognitive difficulties and hence expecting the patient to do more than they were capable of; communication between staff and patients with cognitive difficulties (staff introducing themselves on a regular basis); and taking notice of the information offered by carers.

Table 8 below shows that on a wide range of aspects of hospital experience, carer satisfaction increased, and/or dissatisfaction decreased when the pre and post scores were compared. Post-education, the proportion of carers who reported positive experiences increased, and the proportion who reported negative experiences decreased, compared with the pre-education measure. In addition, the satisfaction of carers increased and the dissatisfaction decreased on eight of the 11 measures of the hospital/carer relationship. While satisfaction decreased on the other two measures, the level of dissatisfaction decreased to a greater extent when compared pre and post.

Table 8: Carer satisfaction—pre and post-education

Measure of carer satisfaction		Percent (1)	
		Satisfied	Not satisfied
How satisfied are you that the hospital staff knew the person you care for has problems with memory and thinking?	Pre	80	20
	Post	87*	6*
How satisfied are you that staff introduced themselves to the person you care for on a regular basis?	Pre	70	25
	Post	81*	0*
Are you satisfied the person you care for was not expected to do more than they were capable of?	Pre	75	20
	Post	84	6*
Are you satisfied the staff explained things to the person you care for in a simple way and checked if they were understood?	Pre	65	15
	Post	90*	6*
How satisfied are you the staff made you welcome to provide information about the person you care for?	Pre	80	15
	Post	78	9*
When you voluntarily offered information regarding the person you care for, how satisfied are you the staff listened to or took notice of you?	Pre	80	20
	Post	84*	6*
Are you satisfied the hospital staff was understanding of any challenging behaviours that may have been exhibited by the person you care for?	Pre	55	10
	Post	87*	3*
How satisfied are you with the information you were given about the condition and treatment of the person you care for?	Pre	70	25
	Post	78*	19*
How satisfied are you hospital staff gave you the option of receiving discharge information for the person you care for?	Pre	70	15
	Post	81*	3*
How satisfied are you this hospital is friendly for people with memory and thinking difficulties and their carers?	Pre	85	15
	Post	92*	6*
Have you and/or the person you care for had positive experiences within a hospital setting? (2)	Pre	90	10
	Post	100*	0*

Notes:

(1) Satisfied/ very satisfied; dissatisfied/very dissatisfied. 'Unsure' not included.

(2) Yes/no responses.

(3) * Change in "desired" direction.

In summary, the proportion of carers who reported positive experiences increased and the proportion who reported negative experiences decreased post-education, compared with the pre-education measure. Carer satisfaction increased and/or dissatisfaction decreased, on a wide range of aspects of hospital experience after the education sessions compared with pre-education.

Cognitive Impairment Identifier

To measure the impact of the introduction of the Cognitive Impairment Identifier (CII), staff were asked to complete a brief questionnaire. In April 2004, questionnaires were sent to all staff who participated in the education sessions, and to nursing staff on the participating wards. Of the estimated 250 questionnaires distributed, 122 (49%) were returned for analysis. Of these, 76% were direct care staff (nurses–65%, allied health–11%), and 24% non-direct care staff (cleaners and other environmental services–6%, ward clerks/assistants–5%, engineering–13%).

Table 9 shows that the CII had considerable penetration five months after implementation. The great majority of direct care staff (83%), and the majority (62%) of non-direct care staff, had some contact with the CII. A majority of direct care staff (63%) reported they were in contact with the CII daily or weekly.

Table 9: Contact with the Cognitive Impairment Identifier

Contact with the CII		Direct care staff %	Non-direct care staff %	All staff %
How frequently would you come in contact with the Identifier?	Daily	38	27	36
	Weekly	25	7	21
	Monthly	3	0	2
	Less frequently	17	28	19
	No contact	17	38	22
	Total	100	100	100

The introduction of the CII appears to have had a considerable impact on the way staff, particularly direct care staff, interact with patients but less of an impact on the interaction with carers. Table 10 shows that the great majority of direct care

staff (79%) and the majority of non-direct care staff (61%) said that the CII had changed the way they interacted with patients. However, less than half of both groups who responded to the survey said it had changed the way they interacted with carers.

Table 10: Impact of the Cognitive Impairment Identifier

Change in practice	Direct care staff (% yes)	Non-direct care staff (% yes)	All staff (% yes)
Did seeing the Cognitive Identifier change the way you interact with the patient?	79	61	76
Did seeing the Cognitive Identifier change the way you interact with carers?	43	29	40

A number of respondents to the questionnaire included comments on how their interaction with patients with cognitive impairment and/or their carers had changed. Of the 68 (56% of the 122 responses) who commented on staff/patient interaction, the great majority (85%) said the presence of the CII impacted on their communication with patients (for example by paying more attention to communication and using better principles of communication). A fifth (22%) said they were more tolerant and understanding of patients with a cognitive impairment, for example they took account of the patient’s cognitive capabilities, took more time with the patient, or lowered their expectations compared with other patients. A small proportion (3%) said they had a greater awareness of the importance of the environment, for example in the placing of food, or the general importance of the patient’s surroundings.

A smaller proportion (23%) of the 122 respondents also commented on their changed interaction with carers. Of these, the great majority (79%) said they now involved carers to a greater extent, for example by paying more attention to their views or using them as the primary informant, using their experience in managing the patient’s behaviour, or involving them in care planning and/or discharge planning for the patient. Over a third (36%) also said they now were more likely to utilize carers in communicating with patients, and/or to provide carers with more information on the patient’s progress than previously. About 7% said they were generally more understanding of the carer’s role.

Changes in organisational practices

The project also influenced some aspects of the organisation's practices, as reflected in the changes reported in the pre and post-training Organisational Audits (see Appendix 3 for the full results). The pre-audit was conducted in October 2003 and the post-audit in June 2004.

The post-audit completed by the Project Manager, the Director of Aged Care and Rehabilitation Medicine, and the Clinical Nurse Consultant Cognition, showed that the Ballarat Health Services fully complied on 14 of the 27 aspects of practice documented in the Short EBIT and partially complied with nine. Compared with the pre-audit, this was an improvement on four of the statements of practice, with a reported decrease in one aspect. The area of practice where most improvement was reported was the physical environment, where two (adequate signage and personalized cueing) of the six aspects improved.

Table 11: Organisational practice—pre and post training

Area of practice	Pre-training		Post-training	
	Partially complied	Fully complied	Partially complied	Fully complied
Mission statement (2 aspects)	2	0	2	0
Environment (6 aspects)	3	2	1	4
Assessment processes (4 aspects)	1	3	1	3
Communication (5 aspects)	2	3	1	4
Care practice/ interventions (4 aspects)	1	1	2	1
Discharge planning (6 aspects)	2	2	2	2
Total	11	11	9	14

Note: See Appendix 2 for the adapted Short EBIT used in the evaluation.

Barriers and facilitators

Significant barriers to the delivery of an education program were the clinical demands on staff, the inflexibility of rosters, and the nature of shift work. It is also important to recognise that other projects may be competing for hospital resources and staff time.

An important facilitator was the previous developments implemented by the Ballarat Health Services, for example the employment of a Cognitive Nurse Consultant, and the recognition of the importance for management practices of cognitive impairment among patients. The project was also facilitated by: support for the project at executive level; the active clinical roles of key project staff; the appointment of Project Champions; the engagement of nursing staff; and the marketing of the Cognitive Impairment Identifier throughout the hospital.

Southern Health—Monash Medical Centre

Summary of project activities

Planning and implementation

A Steering Committee with a wide representation of staff and other stakeholders was responsible for monitoring and guiding the project at Southern Health. The Steering Committee comprised the Director of Nursing, Medicine Program; the Director of Nursing, Rehabilitation and Aged Services Program (RASP) Project Manager; representatives from medical, nursing, allied health, and non-clinical staff; a representative from DHS Southern Metropolitan Region; and a consumer advocate from Alzheimer's Australia Vic (AAV). In addition, there were regular meetings between the Project Manager and the Director of Nursing, Medicine, and consultations with AAV and an occupational therapist in the Emergency Department of Monash Medical Centre.

Planning and implementation of the project were supported through the publication of a staff newsletter, information sessions to promote awareness of the project, and an interest group.

The project was conducted from September 2003 to July 2004 by the Project Manager, who is an experienced clinical psychologist specialising in staff development for aged care staff, particularly those working in dementia care. The Project Manager worked 0.5 EFT for the duration of the project.

Education and support

The training was delivered by the Project Manager. Training was provided to staff of Monash Medical Centre (MMC) Ward 44 South in November 2003 and Lions Ward, Dandenong Hospital in June 2004. The training content was based on a person-centred approach to the understanding and management of dementia and included factual knowledge about dementia, experiential aspects of dementia, and effective care practices including communication skills for working with patients who have dementia.

The training was attended by nurses, allied health staff, ward clerks and porters. Training was conducted in the Monash Institute for Health Services Research and consisted of a full-day for nurses and a half-day for others. Medical staff on rotation were included on an individual basis. New staff and students were given training during sessions in February and March 2004.

Follow-up visits to the ward were made frequently by the Project Manager, to sustain the efforts of staff to implement the training and maintain focus on dementia as an issue for their attention, and to assist them to shift attitudes and integrate person-centred dementia care into their everyday care procedures.

In addition to these visits two further strategies were employed: Mentors and Champions. Two Mentors were engaged to assist staff of MMC Ward 44 South to maintain and practically implement the skills developed from the training. The mentors were experts in dementia care from a specialist aged care facility (Kingston Centre). They attended MMC Ward 44 South regularly at least weekly and discussed individual patients with staff, conducted an orientation for new staff, and kept a journal of their interventions.

Six Champions were selected from among the staff nursing group, to maintain the skills of the staff group by acting as a source of encouragement and information for their colleagues, and to orient new staff and medical staff on rotation.

Criteria for selection as a champion were:

- Senior staff identified by the Nurse Unit Manager (NUM) and Project Manager as leaders.
- Personality skills to communicate well and respectfully with their colleagues.
- Respected by their colleagues.

Champions training

- A training session of one hour was developed and held in early 2004. The content of the training was:
 - Review of full-day training content.
 - Outline of duties of a champion.
 - Communication skills.
- This training was delivered by the Project Manager.

Organisational development

The physical environment was reviewed pre (19 November 2003) and post-education (7 June 2004) using the Therapeutic Environment Screening Survey for Nursing Homes (TESS-NH).⁹

Sustainability

The champions trained as part of the project are likely to remain a feature of the staffing at MMC Ward 44 South. An interest group formed during the project has become increasingly involved in lobbying for improved services for patients with dementia and their carers.

Evaluation data

Program reach

A total of 39 Monash Medical Centre (MMC) hospital staff and 22 Dandenong Hospital staff were trained in person-centred dementia care. Proportions of target groups that attended the education were: nursing 79%, allied health 100% (of those associated with the target units), percentage of porters (not known, as many porters visit the unit), and ward clerks 100%.

Staff attitudes

All nurses and allied health staff in the treatment ward (MMC Ward 44 South) of the Southern Health project were surveyed prior to training in November 2003. Porters were surveyed prior to training in March 2004. A total of 30 staff (22 nurses, 2 social workers and 6 porters) completed the Dementia/Confusion Care Scale. The results are presented in Table 12 below. Post-training data was not collected. On about half the items (11 of 23), clinical (nurses and social workers) and non-clinical (porters) staff surveyed at Southern Health expressed similar attitudes to patients with dementia. On the remaining items, clinical staff were more positive in their attitudes than non-clinical staff. An assessment of the impact of staff training on attitudes was not possible because the staff were not surveyed post-training.

⁹ Sloane et al., 2000. The Therapeutic Environment Screening Survey for Nursing Homes (TESS-NH): An observational instrument for assessing the physical environment of institutional settings for persons with dementia. *Journal of Gerontology: Social Sciences*, 57B, 2, S69-S78.

Table 12: Staff attitudes to patients with dementia—pre-education

I find that patients with dementia/confusion generally	Means (1)		
	Nurses/ SW	Porters	All staff
Seem to behave in a completely aimless way or do things for no reason	2.6	2.7	2.6
Are anxious	2.5	1.3	2.2
Are unpredictable	2.5	2.0	2.4
Are apathetic or seem to have limited emotions	3.0	2.5	2.9
Are selfish	3.3	3.3	3.3
Are paranoid	2.6	2.7	2.6
Are submissive or give in to everything done to them	3.3	3.2	3.3
Are attention seeking or demanding	3.0	2.5	2.9
Are manipulative	3.1	3.0	3.1
Are ungrateful	3.8	3.0	3.6
Are frightened or vulnerable	1.8	1.7	1.8
Are deliberately difficult	3.5	3.0	3.4
Know what they want and stand up for themselves	3.2	3.0	3.2
Experience a normal range of emotions	2.5	2.3	2.5
Need someone close by all the time	2.3	2.2	2.2
Have a meaningless life	3.3	3.0	3.2
Are stubborn or resistive	3.0	2.7	2.9
Are aggressive or hostile	3.1	2.5	3.0
Object or react negatively to care they receive	2.9	2.3	2.8
Give no job satisfaction	3.3	3.3	3.3
Are unhappy or depressed	3.4	2.3	3.2
Are anguished or full of emotional pain	3.0	2.3	2.9
Feel lonely or abandoned	2.7	2.2	2.6

Note: 1=Agree. 2=Tend to agree. 3=Tend to disagree. 4=Disagree.

Patient characteristics

The Southern Health Project compiled profiles on patients admitted to both the 'treatment' ward (Monash Medical Centre Ward 44 South) and the control ward (Dandenong Hospital Lions Ward), before the education program and again at follow up.

During two months of the pre-education phase (September to November 2003 at Dandenong and September and October 2003 at the Monash Medical Centre), and the post-education phase (April and May 2004 at Dandenong and April 2004 at the Monash Medical Centre), staff administered the Abbreviated Mental Test (AMT)¹⁰ to all admitted patients. If there was a score of seven or lower, the patient's behaviour was observed for seven days and recorded on the Cohen-Mansfield Agitation Inventory (CMAI)¹¹. If a patient showed any agitated behaviour (a score of 2 or more on the CMAI), the observation and recording continued until discharge. Basic demographic and medication information was also recorded.

During the five months of data collection a total of 683 patients were profiled. About two thirds of the patients were aged 60 years and over (67.7% at Dandenong and 64.9% at MMC) (Table 13), and a majority were female (55.9% at Dandenong and 56.7% at MMC).

Table 13: Age profile of patients

Age	Dandenong %	Monash %	Total %
1-19 years	0.5	0.0	0.3
20-39 years	15.2	16.4	15.6
40-49 years	6.4	6.2	6.4
50-59 years	10.2	12.4	10.9
60-69 years	12.9	16.9	14.1
70-79 years	26.9	20.3	25.0
80+ years	27.9	27.7	27.8
Total	100.0	100.0	100.0
N=	420	177	597

Note: Age was not recorded for 86 patients.

¹⁰ See Jitapunkul, Pillay and Ebrahim (1991). The Abbreviated Mental Test: Its use and validity. *Age and Aging*, 20: 332-336.

¹¹ See Cohen-Mansfield, Mark, and Rosenthal (1989). A description of agitation in a nursing home. *Journal of Gerontology, Medical Sciences*, 44, 3, M77-M84.

On average, 18.3% of patients scored seven or lower on the AMT and were considered to be cognitively impaired. The proportion of cognitively impaired patients varied across the two locations and between the different time periods, with the range from 11.9% to 25.7% (Table 14).

Table 14: AMT scores of patients

Location	Period	Not cognitively impaired (AMT 8+) %	Cognitively impaired (AMT 0-7) %	Total %
Dandenong Hospital	Sept–Nov 2003	82.6	17.4	100.0
	April–May 2004	84.0	16.0	100.0
	Total	83.1	16.9	100.0
	N=	399	81	480
Monash Medical Centre	Sept–Nov 2003	74.3	25.7	100.0
	April–May 2004	88.1	11.9	100.0
	Total	78.3	21.7	100.0
	N=	159	44	203
TOTAL		81.7	18.3	100.0
N=		558	125	683

The majority of patients (65.6%) who scored seven or lower on the AMT exhibited agitated behaviours in the seven days after admission. However, the proportion varied considerably between the two locations, with a range from 44.4% at the MMC to 85.7% at Dandenong (Table 15). There was also some variation between the time periods, particularly at the MMC, and in the proportion of females with an AMT score of seven or lower who exhibited agitated behaviour (69.7%) compared to males (60.9%). Further statistical analysis using logistic regression confirmed a significant relationship between locations and agitated behaviour. The reason/s for this is unknown, and the finding provides an opportunity for exploration further to this study. The analysis also showed a significant relationship between the presence of agitated behaviour and the recorded AMT, that is patients with a low AMT score were more likely to exhibit agitated behaviour. There was no significant relationship between age or gender and agitated behaviour during the hospital stay.

Table 15: Behaviour profile of patients with an AMT score of 7 or lower

Location	Period	No agitated behaviour (CMAI=1) %	Agitated behaviour (CMAI ≥2) %	Total %
Dandenong Hospital	Sept–Nov 2003	38.9	61.1	100.0
	April–May 2004	55.6	44.4	100.0
	Total	44.4	55.6	100.0
	N=	36	45	81
Monash Medical Centre	Sept–Nov 2003	16.2	83.8	100.0
	April–May 2004	14.3	85.7	100.0
	Total	15.9	84.1	100.0
	N=	7	37	44
TOTAL		34.4	65.6	100.0
		43	82	125

Carer satisfaction

The Carers Survey was developed from a previous carer satisfaction questionnaire.¹² Pre-intervention, 14 carers (9 men and 5 women) were surveyed by telephone by a Southern Health social worker experienced in telephone interviewing. Initially, the aim was to complete the survey with each carer as they were attending the unit to visit their relative, but few patients with dementia and agitated behaviour had visitors, and for those who did have visitors it was often difficult for staff to “catch” the visitor. This necessitated telephone interviews both pre and post intervention.

Overall, the great majority (89%) of carer respondents said they were satisfied or very satisfied with the help the person they care for received in hospital. However, there was a relatively high level of dissatisfaction with a number of aspects of the relationship between the hospital and the carer. Table 16 below shows that half the carers felt that staff did not listen to their opinion enough, or utilise their input for care planning. Also, a relatively high proportion were dissatisfied with the information they received about the illness, treatment, and admission procedures

¹² AC Neilson in a Department of Human Services Victoria review of Victorian Public Aged Persons Mental Health Services.

for the person they care for, and with the help they received in caring for the patient post-discharge. Qualitative analysis of the small number of post-training interviews suggested no improvement.

Table 16: Carer satisfaction—pre-education

How satisfied are you ...	Per cent of respondents		
	Dissatisfied/ very dissatisfied	Neither dissatisfied nor satisfied	Satisfied/ very satisfied
With how quickly you have received help from this unit when you have needed it?	10	20	70
With the information you have been given about the illness or condition of the person you care for?	30	0	70
With the information you have been given about the medication the person you care for is taking?	22	0	78
That the staff have the skills to help the person you care for?	10	20	70
That staff listen to your opinion about the needs of the person you care for?	50	0	50
With the input you have had into the plan to help the person you care for?	33	11	56
With the way staff relate to you?	10	10	80
With the amount of time staff spend with the person you care for?	22	0	78
That staff respect your views?	13	12	75
With the level of involvement you can have in this unit?	20	20	60
With the admission procedure for the person you care for to get into hospital?	25	0	75
With the information you were given about practical matters on the ward (e.g. visiting times)?	0	0	100
With the information you were given about the condition and treatment of the person you care for?	25	0	75
With the help you were given to plan for the time when the person you care for left the ward?	25	0	75
Overall with the help the person you care for received at the ward?	0	11	89

Organisational changes

A comparison between the pre and post-training Organisational Audits completed by the project indicated that the project also influenced aspects of the organisation's practices (see Appendix 3 for the full results). The pre-audit was completed in December 2003 and the post-audit in June 2004, by the nurse unit manager of MMC Ward 44 South and the project manager.

The post-audit showed that the Monash Medical Centre fully complied on nine and partially complied with seven of the 27 aspects of practice documented in the Short EBIT. Compared with the pre-audit, the centre reported an improvement on nine of the statements of practice and a decline on two statements. The areas of practice where improvement was reported were discharge planning (4 of 6 aspects improved), the mission statement (2 of 2 aspects improved), assessment processes (1 aspect improved), and communication (1 aspect improved). There was a reported improvement in one aspect and a decline in two aspects of the environment between the two audits.

Table 17: Organisational practice—pre and post training

Area of practice	Pre-training		Post-training	
	Partially complied	Fully complied	Partially complied	Fully complied
Mission statement (2 aspects)	1	0	1	1
Environment (6 aspects)	3	1	3	1
Assessment processes (4 aspects)	0	0	0	1
Communication (5 aspects)	3	2	2	3
Care practice/ interventions (4 aspects)	0	0	0	0
Discharge planning (6 aspects)	3	0	1	4
Total	10	3	7	10

Note: See Appendix 2 for the adapted Short EBIT used in the evaluation.

A comparison of the pre and post Therapeutic Environment Screening Survey for Nursing, however, indicated that there had been no significant change to the physical environment over the project, and that the facility still has some way to go

to become more “dementia-friendly” in this regard. The project manager noted structural problems with the unit for persons with dementia/ confusion, characteristic of most hospital wards, that is long, wide corridors that lead to other units or stairwell exits; little or no visual cueing; between-unit doors that remain open most of the time; high level of noise both human and mechanical; artificial light; uneven light in corridors; low levels of light in personal spaces; no recreational spaces; no kitchen; no television room; no outside walking space; institutional style and scale of architecture rather than home-like; objects to negotiate in corridors; multi-bed rooms; absence of recreational/ occupational space; and lack of privacy.

Barriers and facilitators

The demands of working in a larger metropolitan hospital place considerable barriers on an increased responsiveness to the issue of dementia and cognitive impairment among patients. The workload of staff can hamper them having time to adopt new practices. Emergency department staff in particular can be overwhelmed by the immediate medical issues, at the expense of putting into practice appropriate strategies for managing the dementia dimensions of their patients.

Nurses require:

- On-hand support to assist in implementing in busy wards the skills addressed in training.
- Identified support to help implement, in ward structure and practices, the changes required to better meet the needs of patients with dementia.

The implementation of the project was facilitated by supportive leadership of the hospital nursing management, supportive leadership within the unit, in particular the Nurse Unit Manager, and individual nurses who felt that dementia care was interesting and valuable.

Gippsland Health Services Consortium

Summary of project activities

Planning and implementation

The Gippsland Health Services Consortium for the project comprised the following healthcare organisations:

- West Gippsland Healthcare Group – Medical Ward and Emergency Department.
- Latrobe Regional Hospital – Orthopaedic Ward & Aged Persons Mental Health Service.
- South Gippsland Hospital.
- Gippsland Southern Health Service – Leongatha campus.
- Kooweerup Regional Health Service.
- Cognitive, Dementia and Memory Service (CDAMS) - West Gippsland Healthcare Group.

The project commenced with the establishment of a Project Committee with representation from all the consortium members and partners, and a DHS Gippsland Region representative. The Committee agreed to the project objectives and timelines. Staff with expertise to develop the training program were identified and an expert working group established. This group consisted of a dementia specialist, a psychogeriatrician, a geriatrician, and a Cognitive Dementia and Memory Service (CDAMS) consultant.

Education

This team adopted a train the trainer approach to the provision of dementia education at each of the five sites involved in the consortium. The Project Committee believed that by developing local capacity the sustainability of the project outcomes would be maximised.

The expert working group developed the training program and volunteers were sought from each organization to take on the trainer role. Nine staff members attended a 2-day workshop on dementia education and adult learning. These trainers then had the responsibility of developing a training program for their own

organisation that would meet the staff needs. The aim was to provide education to both nursing and non-nursing staff. Two service education programs were provided: a brief education package where staff were required to attend two separate half hour sessions conducted during the overlap time between morning and afternoon shifts; and a two hour in-service education program where staff needed to be released from their work areas to attend the education session.

Organisational development

- Patient documentation was reviewed to identify the current capacity to document the management and discharge needs of dementia patients.
- A cognitive assessment tool was trialled in the emergency department to identify confused patients on presentation.
- An initial cognitive screen was trialled to identify patients that needed further assessment.
- Dementia management strategy cards were developed and printed for each of the organisations.
- Information packages for loan to family members and carers of the patient with dementia were made available.

Sustainability

Linkage with Alzheimer's Australia Vic was established to assist in ongoing education of both staff and carers, and information kits purchased to assist with the education of home carers, and the ongoing education of staff. A data projector and laptop computer were purchased for each of the consortium members to assist in the delivery of ongoing education to staff and community groups. Local staff at each site received training in the provision of dementia education.

Evaluation data

This team measured changes in staff knowledge, behaviour and attitudes to dementia, and changes in organisational practices. A description and summary of the project activities was also documented. No information was collected from carers.

Program reach

A total of 378 staff employed in nursing, allied health, environmental services, food services, porters and clerical areas across the five sites of the Gippsland Health Services Consortium were invited to complete an initial survey regarding dementia. Of this group 117 (31%) attended a training session.

Changes in surveyed staff attitudes, knowledge and behaviour

Staff were surveyed prior to attending a training session in September and October of 2003. Post-training, staff were surveyed in May 2004. From a total of 117 attendees across the five sites, 22 completed the pre-training survey, 15 completed the post-training survey, and a further 39 completed both. Of these 76 respondents, 84% were direct care staff (registered nurses, personal carers and allied health), and 16% non-direct care staff. A majority (57%) of direct care respondents who attended training reported that they had previous training in caring for a person with dementia, but only 9% of non-direct care staff had previous training.

A comparison of the means in Table 18 shows that the self-reported knowledge of direct care staff was similar before and after the training, but non-direct care staff reported a considerable increase in knowledge. Both direct care and non-direct care staff reported increased ratings for their management of patients with dementia, with non-direct care staff reporting a greater improvement.

Table 18: Staff knowledge and management—pre and post-training

Knowledge and management		Means (1)		
		Direct care staff	Non-direct care staff	All staff
Rate your current knowledge of dementia	Pre (n=59)	5.08	2.00	4.61
	Post (n=53)	5.04	5.13*	5.06*
Rate how well you currently manage patients with dementia	Pre (n=57)	4.94	3.43	4.75
	Post (n=52)	5.25*	5.63*	5.31*

Notes:

(1) Ratings on a 10 point scale where 1=Not very well and 10=Very well.

(2) * Change in "desired" direction.

Table 19 shows that compared to before the training sessions, relatively more staff post-training were able to list types of dementia, risks associated with

hospitalization of patients with dementia, and strategies for managing patients with dementia. The improvement was marked for non-direct care staff who attended a training session.

Table 19: Staff knowledge—pre and post-training

Types of dementia, risks and strategies		Percent who listed 1 or more		
		Direct care staff	Non-direct care staff	All staff
List 3 types of dementia	Pre (n=60)	92.2	33.3	83.3
	Post (n=55)	97.9*	87.5*	96.4*
List 5 risks associated with hospitalisation of patients with dementia	Pre (n=60)	92.2	55.6	86.7
	Post (n=40)	97.1*	100.0*	87.5*
List 5 strategies that can be implemented to manage a patient with dementia	Pre (n=60)	92.2	55.6	86.7
	Post (n=55)	97.9*	100.0*	98.2*

Note: * Change in “desired” direction.

The specific knowledge questions reported in Table 20 below show that the post-training knowledge (as measured by the mean scores of these six statements) improved for both direct care and non-direct care staff.

Table 20: Staff knowledge and attitudes—pre and post-training

Knowledge/attitude statement		Means (1)		
		Direct care staff	Non-direct care staff	All staff
Most older people have dementia	Pre (n=58)	4.14	3.33	4.02
	Post (n=54)	4.22*	3.63*	4.13*
Only older people suffer from dementia	Pre (n=59)	4.22	3.67	4.14
	Post (n=54)	4.04	4.25*	4.07
More can be done in the workplace to manage people with dementia	Pre (n=58)	1.80	2.33	1.88
	Post (n=54)	1.59*	2.38	1.70*
Dementia is a natural part of growing older	Pre (n=59)	4.04	3.44	3.95
	Post (n=54)	4.15*	3.75*	4.09*
Managing patients with dementia is part of my job	Pre (n=58)	1.67	3.44	1.95
	Post (n=54)	1.59*	3.00*	1.80*
In most cases there is not much that can be done to manage patients with dementia	Pre (n=59)	4.12	3.89	4.08
	Post (n=54)	4.43*	4.38*	4.43*

Notes:

(1) 1=Strongly Agree. 2=Agree. 3=Undecided. 4=Disagree. 5=Strongly Disagree.

(2) * Change in "desired" direction.

In summary, a pre/post comparison indicated that self-reported knowledge improved for non-direct care staff, while self-rated management of patients and specific knowledge of dementia improved for direct care and non-direct care staff.

Changes in organisational practices

The project also influenced aspects of the organisation's practices as reflected in the changes reported in the pre and post-training Organisational Audits (see Appendix 3 for the full results). The pre-audit was conducted in October 2003 and the post-audit in June 2004.

The post-audit completed by the management showed that the West Gippsland Healthcare Group¹³ fully complied on ten and partially complied with 16 of the 27 aspects of practice documented in the audit. Compared with the pre-audit, this was an improvement on 14 of the statements of practice. The areas of practice where most improvement was reported were: discharge planning (four of six aspects improved); assessment processes (three of four improved); communication (three of four improved); and the physical environment (two of six aspects improved).

Table 21: Organisational practice—pre and post training

Area of practice	Pre-training		Post-training	
	Partially complied	Fully complied	Partially complied	Fully complied
Mission statement (2 aspects)	2	0	1	1
Environment (6 aspects)	2	2	3	3
Assessment processes (4 aspects)	0	1	3	1
Communication (5 aspects)	3	0	4	1
Care practice/ interventions (4 aspects)	3	0	4	0
Discharge planning (6 aspects)	2	1	1	4
Total	12	4	16	10

Note: See Appendix 2 for the adapted Short EBIT used in the evaluation.

Barriers and facilitators

The involvement of separate organisations meant that distance between sites was a significant communication barrier for this project. Strategies to mitigate the disadvantages caused by distance included scheduling monthly project meetings throughout the duration of the project, the production of a dementia project newsletter, and extensive use of email as the major communication tool between meetings.

¹³Only pre post audit results for the major member of the consortium, the West Gippsland Health Care Group, are reported here.

An important initiative in establishing the project and engaging staff was the use of staff focus groups. Prior to the pre education survey and staff education sessions, focus groups were held in each of the participating organisations. Staff were invited to attend and inform the facilitators (members of the project team) in their own words of their experiences, understanding and feelings about dementia. Staff were also encouraged to make suggestions on what could be done to make it easier for them to care for patients with dementia and their families.

The focus groups were valuable in raising awareness of the project, and providing information on what the project was trying to achieve and how it could proceed. Most importantly the groups provided an opportunity for staff to have a say in the project at the developmental stage. Conducting the focus groups also gave the facilitators the opportunity to meet with staff in their work environments, and to introduce themselves to staff from other organisations involved in the project.

Overview of outcomes

Prevalence of dementia in hospital settings

The Southern Health Project collected data on all patients who were admitted to either of the two medical wards which formed the study sites over the two data collection periods. In addition to basic demographic and medication information, scores on the Abbreviated Mental Test (AMT)¹⁴ were routinely collected for all these patients. Where a score of seven or lower was obtained, (scores of seven or below on this test are widely accepted as indicative of cognitive impairment), the patient's behaviour was observed for at least seven days and recorded on the Cohen-Mansfield Agitation Inventory (CMAI).¹⁵ In total, data on 683 patients were collected, providing a valuable profile of the extent of cognitive impairment and associated behavioural manifestations in a large sample of unselected admissions to general medical wards. Most of the patients admitted to these wards were elderly and female. Two-thirds of the sample were aged 60 years and over, and 56% were women.

Over 18% of the sample scored seven or lower on the AMT and, on this criterion, were considered to be cognitively impaired. These figures suggest a much higher incidence of cognitive problems among hospital patients than previous national data have indicated. For example in 2004 the Australian Institute of Health and Welfare reported¹⁶ that 1.2% of all hospital separations (or 79,000 separations) involved people with either a principal or additional diagnosis of dementia (additional diagnoses are recorded if they contribute to the consumption of hospital resources). If same-day separations are excluded, people with any diagnosis of dementia accounted for 2.3% of hospital separations. The differences are no doubt due to the different criteria used to determine presence of cognitive impairment, that is score on the AMT in the Southern Health samples, which does not distinguish between dementia and other causes of cognitive impairment compared to a diagnosis of dementia for the AIHW figures.

¹⁴ See Jitapunkul, Pillay and Ebrahim (1991).

¹⁵ See Cohen-Mansfield, Mark, and Rosenthal (1989).

¹⁶ See AIHW (2004) The impact of dementia on the health and aged care systems.

In the Southern Health sample, two-thirds of the patients who scored seven or lower on the AMT exhibited agitated behaviours in the seven days after admission, suggesting that the AMT score was a useful screening tool. In terms of management and care issues for hospital staff and systems, the Monash Medical Centre figures provide a more useful estimate and give added emphasis to the need to be responsive to people with cognitive impairment, compared with figures based on a diagnosis of dementia.

Further analysis of variables that were associated with agitated behaviour within the cognitive impaired group confirmed that low AMT scores were predictive of agitated behaviour, and that after taking account of AMT scores, neither gender nor age predicted agitated behaviour. However, location or environmental factors did play a role. There was a higher incidence of agitated behaviour in one of the study wards compared to the other ward, even after controlling for AMT scores, age and gender.

Overall these findings suggest that:

- The incidence of cognitive impairment within an unselected hospital population is likely to be significantly higher than would be indicated by a recorded diagnosis of dementia.
- A cognitive screening test such as the AMT provides meaningful information in terms of agitated behaviours, observed subsequently in the ward.
- The extent to which cognitively impaired patients manifest agitated behaviours is influenced by the ward environment, management and care practices, and the level of cognitive impairment.

How responsive are hospitals to the needs of patients with cognitive impairment?

Each project undertook a pre-intervention audit of their organisation's current policies and practices with respect to people with dementia or other cognitive difficulties. The audit tool was adapted from the Short EBIT (Evidence-based Identification Tool) and a good practice checklist (UK Department of Health)¹⁷, and covered six broad areas:

¹⁷ See Nay et al (2003) and UK Department of Health (2003). Discharge from hospital: Getting it right for people with dementia. www.doh.gov.uk/jointunit/changeagentteam

- The organisation's mission statement.
- The environment.
- Assessment.
- Communication.
- Care practices/interventions.
- Discharge planning.

Each of the six areas has a number of aspects of policy and/or practice and project teams were required to rate their sites on each of the aspects using a three-point scale (1 = does not comply; 2 = partially complies; 3 = complies). In this way 27 aspects of the organisation could be rated (see Appendix 2 for complete tool and guide).

The results from this benchmarking exercise suggested that there was significant room for improvement in the adoption of policies and practices, which would make the facilities more responsive to the needs of patients with cognitive impairment:

- In the Bairnsdale Regional Health Services study, the initial audit showed that full compliance was evident with three of the 27 rated aspects and partial compliance with 14. Best area was discharge planning.
- In the Ballarat Health Services study, the initial audit showed that partial compliance was evident on eleven of the 27 rated aspects and full compliance with a further seven. Rated well in all areas, reflecting prior focus on dementia management in this hospital.
- In the Southern Health study, the initial audit showed full compliance on three of the 27 rated aspects and partial compliance with another ten. Low rating in most areas was evident.
- In the Gippsland Health Services Consortium study, the initial audit showed full compliance on four of the 27 rated aspects and partial compliance on eleven. Best performing area was assessment.

There was no consistent pattern of strengths or weaknesses across the facilities, rather the audit ratings reflected the particular history of the different organizations.

Staff perceptions of patients with dementia

While it is difficult to combine findings from the four projects, some generalizations about staff perceptions of patients with dementia can be made from a consideration of the pre-training surveys. There is evidence to suggest that significant proportions of staff in acute care settings find caring for people with dementia unrewarding and difficult. Of the responses to the pre-education surveys, 35% of Bairnsdale staff and 34% of Ballarat staff rated their level of satisfaction in dealing with patients with dementia as low or very low. In the Southern Health sample, 17% agreed or tended to agree with the statement that patients with dementia gave no job satisfaction. When asked to rate how well they currently cared for patients with dementia, 48% of West Gippsland respondents to the pre-education survey gave a score of four or less on a 10-point scale from not very well (1) to very well (10).

Carer perceptions of the hospital experience

Information from carer surveys from two of the projects provides insights into the experience of carers when a person with cognitive impairment is hospitalised. While the majority of carers surveyed during the pre-training phase were satisfied with their experience, a number of issues were raised in both projects. A significant minority of carers said they were not satisfied with the information about the condition of the patient and about treatment. Also, carers wanted better communication with staff, and felt that staff did not listen to their opinion enough, or utilise their input for care planning. There was evidence from one project that there is unrecognised cognitive impairment among some patients.

Did the projects meet their objectives?

Staff education

Training packages were developed by project staff together with local experts in dementia, with some projects also utilizing the expertise of external organisations such as Alzheimer's Australia Vic (AAV) and feedback from staff and carer/consumer surveys. As a consequence the training curriculum varied in both depth and breadth across sites. All programs addressed basic information about dementia, and strategies for effective management or interaction with patients

exhibiting symptoms of dementia, but the emphasis and range of content covered within these two broad areas varied considerably from project to project. In most projects, the education was delivered by expert and experienced staff through sessions scheduled where possible to fit with staff rosters and work demands. The Gippsland Health Services Consortium, with five sites in different localities, utilized a train-the-trainer approach.

Reach

The four projects reported that a total of 496 staff, including both clinical staff (medical, nurses and allied health) and non-clinical staff (engineering staff, environmental services, ward clerks and security staff), received training. Only two projects reported total staff numbers to enable a calculation of the proportion who received education—these ranged from 10% for Ballarat to 31% for the Gippsland Health Services Consortium. There were some indications that relatively fewer medical staff received training than other clinical staff.

Impact

A consideration of both the qualitative data gleaned through interviews and pre and post questionnaire data suggests that, by and large, all four projects were successful in improving staff knowledge and perceptions about dementia, and about working effectively with patients with dementia. Three projects provided quantitative pre post data on the impact of the training. While the number of questions asked varied from project to project, these data indicated: post-training increases in knowledge about dementia and delirium (three projects); comfort in dealing with patients with cognitive impairment (three projects); confidence in dealing with patients with cognitive impairment (one project); and appreciation of family involvement in the care of patients with cognitive impairment (one project). In addition, the level of reported job satisfaction in working with patients with dementia in the three projects, where this was measured pre-post, increased over the pre-education levels.

Organisational change

A comparison between the pre and post-training Organisational Audits completed by the various services indicated that the projects also positively influenced aspects of organisational practice with respect to dementia care. All four projects reported overall improvement in the organizational response to dementia on those aspects of practice addressed in the adapted Short EBIT. The adapted Short EBIT addresses 27 aspects of organizational practices related to effective dementia care; the increases between the pre and post audits for the participating services ranged from three to 14 aspects of practice, with the services complying with between 17 and 26 of the aspects of practice when measured post intervention. There was no common pattern in the reported improvements with respect to the areas of practice.

Factors that facilitated project achievements

This review of the four projects suggests that successful implementation of dementia education will be facilitated by:

- Obtaining support at executive level and from key staff, including senior nursing and medical staff, for the aims of the program.
- Involving key internal stakeholders (for example through membership of a reference group and a project management group) in program planning and delivery.
- Establishing links with external agencies/organisations with expertise in dementia and dementia care.
- Consultations with both staff and carers pre program delivery.
- Employment of an experienced project manager with expertise in dementia care.
- Recruiting program champions in each of the staffing groups targeted by the program.
- Providing high quality 'professional' education presentations that address the reality of the participants' work situation, in addition to general content.

And for sustainability:

- Ensuring both the education offerings and associated resources, and any care management procedures or protocols introduced as a consequence of the training, are incorporated into mainstream hospital operational and quality mechanisms.

Gender issues

Wherever possible project data were analysed by gender. Overall the findings confirm previous reports that most staff, particularly nursing and allied health staff, and most patients with dementia, are female. Of particular interest were data that suggested that female staff found working with patients with some cognitive impairment less rewarding than did their male counterparts. Illustrative data that bear on these points is provided below.

Patients

In the Southern Health project—where data were collected from a total of 683 patients admitted to general medical wards—the majority of patients who were assessed as having some degree of cognitive impairment were female (68.1% average over both sites).

Staff

The majority of the 170 respondents who completed pre-training questionnaires in the Ballarat project were female (62%) but this depended on staff type. The great majority of direct care staff (83%) were female, and the great majority of non-direct care staff (74%) were male.

Of more interest was evidence that suggested that female staff found working with patients who had some cognitive impairment less rewarding than did their male counterparts. Two-way analysis of the staff type and gender of the Ballarat pre-intervention sample produced a significant difference between men and women in their self-rated job satisfaction, in dealing with patients with dementia, delirium, or memory and thinking difficulties. The mean score for men (2.9) was higher than that for women (2.7), that is the males reported higher job satisfaction. Although this finding is hard to interpret because of the difference in gender distribution across staff groups, analysis of gender differences in job satisfaction within the group of nurses was consistent with the overall trend, with the mean scores for male nurses (3.1) and female nurses (2.5) significantly different. The male/female scores for medical staff and security staff were also different, but these were not reliable because of small sample sizes (4 and 9 respectively).¹⁸

¹⁸ Two-way analysis of the groups post-education was not reliable because of small samples in a number of the groups.

Carers

In the Ballarat project, 25 carers were followed up by telephone after the person they cared for had been discharged and interviewed about their hospital experience. Twenty of the 25 were female. However, in the small sample of carers surveyed in the Southern Health study, the majority were male (nine out of 14).

Conclusions and recommendations

Older people are significant users of health services, and in the coming years, population growth combined with ageing will mean that a greater number of older Australians will need access to health and community care services¹⁹. There is a strong correlation between older age and demand for medical and hospital services. Currently people over the age of 70 years use more than 46% of all multi-day patient stays. As the percentage of older people in our society increases, patients will be older in every hospital department, except maternity and paediatrics. It therefore becomes part of every staff member's responsibility to consider older people as their main patient group.

The prevalence of moderate to severe dementia among people aged 70–74 years is 11%, rising to 18% for people aged 75–79 years, and 40% for people aged 85 years and over. Given that dementia in older people is often under-diagnosed, it is important that people with cognitive impairment are identified early in their care in the acute setting, that is on admission, and that the condition is actively managed.

The projects have confirmed the importance of addressing dementia in acute care settings. The information gained through this evaluation indicates there is a significant prevalence of cognitive impairment and related behavioural manifestations within the general hospital patient population. The data also suggests that many staff lack knowledge and or experience, and confidence, with patients with these characteristics, and that this can have an adverse impact on staff satisfaction with their work. There is some suggestion that the job satisfaction of female staff is particularly adversely affected.

Improving Care for Older People, A summary of policy for Health Services (DHS 2003) suggests that all staff in the acute setting should be trained to have a strong awareness of the needs of older people, so they can plan work practices and interactions. This evaluation has confirmed that a relatively minor investment in education can have noticeable effects on both staff attitudes and hospital practices regarding the care and management of people with dementia.

¹⁹ *Improving Care for Older People, A summary of policy for Health Services*, Victorian Department of Human Services, 2003.

Dementia education in acute settings

The experiences of the projects analysed in this report have some important implications for the future development and implementation of dementia education in acute settings. These can be summarised as follows:

Administration

- ***Executive level support, and the support of key staff including senior nursing and medical staff, need to be engaged and demonstrated.***

Acute care settings tend to be busy workplaces where immediate and urgent patient health issues are inevitably—and properly—at the forefront of staff concerns, and as a consequence, the dementia dimension of the patient's condition can be relegated to 'non-core business'. As one informant commented in the post-project interviews in response to the question "How have you applied what you learnt in the training?", "When you get back to the ward it can be very busy and there are other priorities—it's easy to forget about dementia issues".

In this context strong and ongoing commitment and support from management and senior clinical staff to maintain a focus on dementia are required.

- ***Key internal stakeholders need to be involved in program planning, for example through membership of a Dementia Education Reference Group.***

Involving key internal stakeholders at the planning stage is an important strategy to assist in the development of the required organizational commitment for program delivery. Effective dementia education needs to be facility wide, so all groups should be represented at the outset.

Program development

- ***Training programs should be based on assessed local needs and priorities***

It is apparent from this evaluation that hospitals vary in the extent to which dementia management issues are being, and have been, addressed. If the sample of hospitals in this evaluation is indicative of those in Victoria, it is to be expected that some facilities will have implemented a range of educational and policy initiatives regarding dementia care and management and others will be less advanced in this area. Systematic gathering of information on training needs will not only be important for the development of a relevant program that builds on previous work, but can be an important first step in promoting greater awareness of the needs of the patient with dementia and their families, and current care and management shortcomings.

- ***Training programs should draw on existing expertise in dementia education***

There exists a great deal of expertise in dementia education both within some acute settings and within organisations such as Alzheimer's Australia Vic (AAV) and the Cognitive Dementia and Memory Services (CDAMS). These resources should be utilised in developing educational /training programs for acute settings. The experience of the project teams has been that this material is very relevant and readily adaptable to acute care settings.

- ***Training programs should be developed in consultation with staff and carers***

These projects suggest that involvement of staff in planning dementia education is valuable, not only to ensure that specific concerns or issues are addressed in the training, but also as an important strategy to increase staff participation in the subsequent training.

Similarly carers and families of the person with dementia bring a distinctive perspective and set of insights into the behaviour and needs of the patients, and are a valuable resource.

Content

- ***Content should address both factual knowledge about dementia and other causes of cognitive impairment, and the development of skills in communicating and working effectively with patients who have dementia or other cognitive impairments. Training should also explicitly address the role of carers and families in the care of dementia patients.***

Delivery

- ***Face-to-face training should be conducted only by individuals who have expertise in working with patients with dementia, and who are qualified and experienced in training.***

A common theme from the qualitative data gathered in this project was that the impact of the training was related to the perceived expertise and credibility of the trainer. For nurses in particular, practical advice for responding effectively to patients manifesting symptoms of dementia, that took account of the realities of their workplace, was highly valued.

- ***The curriculum must be flexibly organised, packaged to facilitate delivery in varied length sessions, and for different staff groupings, and readily repeatable.***

The reality of hospital work practices means that many staff are only available for training for short periods of time, and these times vary according to shifts and other work contingencies. Training also needs to be repeated to meet needs of a changing workforce.

- ***Face-to-face training needs to be supported by subsequent access to related resources in the form of brochures, manuals or on-line material, and appropriately skilled resource persons who can support staff in the ward.***

Again feedback from the projects stressed the importance of ongoing support following training. The availability of an individual who is readily accessible and who can reinforce the skills acquired in training and advise on management of specific issues as they arise, is likely to be the most valuable resource in ensuring

maintenance of training effects. Staff with particular expertise/knowledge in dementia should be identified as resources/champions in each setting, and for each staffing group.

- ***A whole-of-facility approach to training should be encouraged.***

Dementia education should not be restricted to clinical or direct care staff. The experience gleaned through these projects confirms that all staff who are likely to come into contact with patients need to have at least a basic understanding of dementia, its impact on patient behaviour, and the implications for effective interaction and communication with patients. These projects have demonstrated that dementia education for non-clinical staff is both needed and effective.

Recommendation 1

That health service providers use the findings and conclusions of this evaluation to inform the content and delivery of dementia education programs to all staff in acute settings.

That DHS facilitate the development of guidelines, and an associated resources guide, for the content and delivery of dementia education programs to all staff in acute settings across the State.

Dementia management practices in acute settings

Although the projects focused on educational/training activities they all had an impact on organisational practices related to dementia management and care, either as a consequence of the education or as a result of a direct project intervention. One of the key learnings from the evaluation is that staff education in dementia care needs to be complemented by hospital procedures and policies which support better care management of patients with dementia. Based on the experience of the participants in the projects we would suggest the following organisational practices be considered for universal adoption:

- ***All patients are screened for cognitive impairment.***
- ***Where the patient has been identified as having dementia or cognitive impairment from other causes, this should be clearly identifiable to staff working with that patient, for example in the nursing care plan.***
- ***Staff should have access to a person(s) with expertise in understanding and managing patients with dementia who can support nursing staff in caring for patients with agitated behaviours, contribute to ongoing skill development of staff, and advocate for process and protocol development.***
- ***The hospital should establish formal links with external sources of expertise such as Cognitive Dementia and Memory Services (CDAMS) and Alzheimer's Australia Vic (AAV).***
- ***The whole of the acute care experience, including discharge planning, should take account of the patient's dementia status by involving the family/carer and facilitating referral to appropriate community services.***
- ***Good dementia care and management practices should be addressed in the hospital's ongoing quality assurance activities.***
- ***All staff, direct and non-direct care, need to be incorporated into culture change strategies and activities to enhance dementia care and management practices.***

Recommendation 2

That health service providers use the findings and conclusions of this evaluation to inform local practice principles for management of patients with dementia in acute settings.

That DHS facilitate the development of a standard guide that specifies best practice principles for management of patients with dementia, to be used in all acute settings.

Appendix 1

Process Evaluation Template

Process evaluation: Documenting the project activities

What is required for this part of the evaluation is comprehensive documentation of what was involved in implementing your project, including a description of all activities undertaken in planning and delivering the project activities, the participants involved and the resources utilised.

Typically a process evaluation also includes commentary on factors that assisted achievement of project outcomes and the barriers or difficulties that had to be overcome.

Although the aims and proposed project activities are described in the original project proposals, the process evaluation addresses what actually happened in implementing the project and is essential to adequately interpret project outcomes and to assess the extent to which program outcomes could be achieved in other settings.

Towards the end of the project we will be seeking information from each team in the areas outlined on the guide below.

How to use the guide

Please use as much space as necessary; all we require is information under the headings provided and roughly in the format suggested here.

You can use this guide for maintaining ongoing project details. You may also find this guide useful for organising your own project report to DHS.

A Process Evaluation Guide for the Dementia Training Project

1 Project objectives

Include a brief statement of the objectives of your project.

2 Project activities and project schedule

List the main project activities undertaken over the period of the project.

Project activity	Timeline (months)
Etc	

3 Personnel involved in project planning and implementation

Project staff

List those staff responsible for implementing the project.

Staff member	Position	Time involved (EFT)
Staff member 1		
Etc		

Committees, reference groups and/or working groups established to help plan and/or implement the project.

For each such group complete:

- Name of group
- Role
- Membership (individual and position)
- Number of meetings over life of project

Other individuals and organisations consulted in planning and or implementing the project.

4 Other communication strategies used in planning or implementing the project

Please describe any communication strategies, in addition to the consultations and committees described above, that were employed in the project (eg use of newsletter, website etc).

5 Training or education activities

Please describe:

- The process by which the training content was developed.
- A summary of the content of the training (provide full details as an attachment).
- The training format (length of training, any support material produced, any follow up to training).
- The groups for whom the training was developed (i.e. the target groups).
- The number of sessions conducted for each group.
- Number of attendees.
- Proportion of target groups who attended the training sessions and follow up if relevant.
- Who delivered the training, including qualifications of the trainer(s).
- Any feedback on the quality of the sessions and material used.

6 Other activities undertaken as part of the project

For each activity briefly describe the developmental process, what was entailed and the deliverables.

7 Other resources expended

List any other costs involved in implementing the project in addition to staff time above.

8 Barriers

What were the main barriers to achievement of project objectives?

9 Facilitators

What factors were important in helping achieve project objectives?

10 Project outcomes

What specifically did you achieve in your enhancement project?

11 Follow-up

What is likely to follow from this project?

12 Any other comments

Appendix 2

Organisational Audit Template

DEMENTIA TRAINING PROJECT: ORGANISATIONAL AUDIT

Content

This audit²⁰ aims to provide a benchmark of your facility's current policies and practices with respect to people with dementia or other cognitive difficulties. The audit covers six broad areas:

- The organisation's mission statement.
- The environment.
- Assessment.
- Communication.
- Care practices/interventions.
- Discharge planning.

Each of the six areas has a number of aspects of policy and/or practice. Please rate your facility on each of the aspects using a three-point scale (generally, 1 = does not comply; 2 = partially complies; 3 = complies). There is also space for you to add comments about each of the areas. At the end of the audit are some explanatory notes (adapted from the Nay and Koch, 2003, publication) on each of the areas that may assist in the ratings. Please read these before completing the audit.

As this is a benchmarking exercise, for future reference please feel free to report on - by qualitative comment or rating - any other any aspect of organizational practice regarding dementia care that you feel could change as a consequence of your project.

Scope

If your project involves more than one organization it would be useful to complete the audit for each organization; if the project involves a single organization you will need to decide which section or units are being described.

Who should complete this?

It is up to each project team to decide on who should be involved in completing this audit. One model, for example, would be for the Project Manager to complete it in consultation with relevant staff. Alternatively, a subgroup of the project committee could be given the task.

Queries

If you have any questions, points requiring clarification or just feedback please contact myself, Peter Foreman (03 9479 1721), or Dr Ian Gardner (03 9479 5983).

²⁰ The audit has been adapted from the Short EBIT in Nay, R & Koch, S. (2003) Improving the admission and discharge practices of acute and sub-acute care facilities in relation to people with dementia, and the UK Department of Health (2003) Discharge from hospital: Getting it right for people with dementia.

Return

Please return the completed audit by 1st November 2003, via mail or email to:

Associate Professor Peter Foreman
 Lincoln Centre for Ageing and Community Care Research
 La Trobe University Bundoora VIC 3083
 Email: P.Foreman@Latrobe.edu.au

Name of facility:

Date of audit:

Completed by:

1. The mission statement

	<i>1 Yes</i>	<i>2 In part</i>	<i>3 No</i>
Reflecting on the Mission Statement:			
Does the Mission Statement indicate that the facility values caring for people with dementia by recognizing their particular needs?			
Is its philosophy reflected in infrastructure, practices and interventions?			

Comments:

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Rating

2. The environment

	<i>1 Does not comply</i>	<i>2 Partially complies</i>	<i>3 Complies</i>
The facility environment supports the person with dementia or other cognitive impairment with:			
Adequate signage			
Personalized cueing			
Safety			
Reduced stimuli			
Minimal moves within the facility			
Availability of a day room during hospitalization for occupational or sensory therapies			

Comments:

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Rating

3. Assessment processes

	<i>1 Does not comply</i>	<i>2 Partially complies</i>	<i>3 Complies</i>
Protocols are in place to ensure that a cognitive assessment using recognized tools is carried out on anyone presenting with confusion			
Protocols are in place to ensure that a comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment			
Protocols are in place to ensure comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment and an evaluation of medications			
All standard assessments are done by one person only e.g. RN or doctor, and the comprehensive assessment determined by a multidisciplinary team			

Comments:

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4. Communication

	Rating		
	<i>1 Does not comply</i>	<i>2 Partially complies</i>	<i>3 Complies</i>
Communication reflects best practice in communicating with people who are dementing			
Evidence that there is a comprehensive history and nursing care plan available for all staff caring for the person			
Provision for gathering of information from the family/carers, according to the level at which they wish to be involved			
People from diverse cultural backgrounds are provided with appropriate interpreters			
Evidence of comprehensive information exchange with the family			

Comments:

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5. Care practices/interventions

	Rating		
	<i>1 Does not comply</i>	<i>2 Partially complies</i>	<i>3 Complies</i>
There is an agreed care pathway for dementia in place			
Protocols are in place from preadmission to discharge, for involvement of the informal carer in the treatment of the patient - depending on the willingness of the carer and the patient's consent			
Protocols are in place from preadmission to discharge, for staff to monitor trigger factors for adverse behaviours and plan treatment accordingly			
Protocols are in place from preadmission to discharge, for discharge planning undertaken in consultation with the patient and family			

Comments:

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6. Discharge planning

	Rating		
	<i>1 Does not comply</i>	<i>2 Partially complies</i>	<i>3 Complies</i>
The facility's policy ensures that:			
There is a named person responsible for discharge co-ordination			
Discharge is an actively managed process which begins at the point of admission			
Roles and responsibilities are clearly defined, including identifying people/services with dementia expertise			
All discharge decisions are made by an inter-disciplinary team, managed by someone who is trained and skilled in the needs of people with dementia			
A copy of the discharge policy is made available to patients and their relatives on admission			
There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia			

Comments:

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Please feel free to add any further comments on any aspect of the facility's response to dementia.

Thank you,
Peter Foreman on behalf of the Evaluation Team 17.10.03

Explanatory notes

These explanatory notes are intended to assist the completion by providing further information on how to interpret the items in the audit.

1. The mission statement

The facility should have a Mission Statement, which reflects an understanding of, and support for, people with dementia and their families. Ideally, you will find clear evidence of this. However, there should at least be a general acknowledgment of individuality, diverse care needs and delivery of quality care to all patients.

2. The environment

The facility environment should support the person with a cognitive impairment. People with dementia are extremely vulnerable to getting lost and being 'abused' because they interfere with other people's belongings. They generally suffer anxiety related to environments that are not dementia friendly. This increases the demands on carers and the level of support required. Increased security, providing a therapeutic environment, which ensures the person's safety, and preventing frequent moves within the facility, requires certain protocols so that the patient can be monitored, assessed, and treated without exacerbating the problem.

Personalised cueing

Admission to hospital can cause distress, disorientation or deterioration in the person with dementia. Large clear cueing--including for example familiar picture cues--permits the confused person to negotiate the ward/unit layout thus enabling him/her to find such places, for example as the toilet, the bedroom, own cupboards etc.

Having a special unit for the older confused patient in an acute care facility is one way of providing an appropriate environment. These units draw upon the combined expertise of acute medicine and geriatric medicine and/or psychiatry in treating and managing acute illness and behavioural difficulties associated with dementia in an appropriately designed environment.

A proportion of people with dementia develop behaviours that challenge the skills of staff. These behaviours may include wandering and/or noisy aggressive behaviours. There are many ways in which an organisation can anticipate and reduce such behaviours. Examples to look for include: secure areas; camouflaged doors/cupboards; poisons/medications locked away; and safe places for clients to smoke.

Reduced stimuli

Along with security, having the facility reduce stimuli, for example in regard to noise, lighting, smells, etc. in the environment is essential for the provision of optimum care to the older person with dementia. This is quite a challenge in hospitals that are not designed to cater for this particular population. Using space creatively can allow certain areas to be designed to suit people who prefer low stimulation. Indicators would be consideration being given to light, noise, smells, temperature, 'traffic' through the area and so on.

Minimal moves

People with dementia are more likely to become agitated if they experience numerous moves within a facility. Recognition of this would be reflected in processes that reduced the number of moves a client has to make.

3. Assessment

The family and staff recognise the essential phase of assessment.

Ideally the initial assessment will be sufficiently comprehensive to identify any indicators of possible dementia and allow appropriate interventions to follow. At the least there would be protocols in place that would allow early recognition of potential problems and steps to put in place to ensure maximum support for the person and attending family.

Assessment would include at least cognitive assessment, an evaluation of medication, blood profile and identification of any reversible causes. Co-ordination of information from a preadmission clinic contributes to the avoidance of unnecessary and invasive procedures and tests on older people. Unnecessary and invasive procedures and tests are a source of distress especially to older confused patients.

Standard assessments

Ideally the initial standard assessment should be determined by a multidisciplinary team and be completed by one health professional, probably a case manager. Thereafter referral for assessments should build upon knowledge obtained and not require assessment duplication. It is important that an assessment of ADLs is performed at admission, and there is continuous assessment of ADLs throughout hospital stay, and an assessment of ADLs on discharge.

4. Communication

Consideration is given to all aspects of communication relevant to the patient.

Each person has a unique relationship with the environment that can manifest itself by their behaviour. As dementia is characterised by memory deficit, disorientation and decreased cognitive functioning, best practice in communicating with people with dementia is an essential component of care.

Communication reflects best practice

Every communication with someone who is confused is a first meeting regardless of how many times an interaction has taken place. In communicating it is essential for staff to try and minimise the number of staff interacting with the person, provide a quiet environment, use simple statements, become familiar with the person's communication techniques, use prompts when recommended, be alert to non verbal cues indicating distress, validate the person's reality and be prepared to adapt their communication technique.

Developing a comprehensive history and nursing care plan

A comprehensive history is required if the developed care plan is truly reflective of the person's needs. Information regarding the person should be provided by the patient, family/carers and GPs. Information required includes: the patient's likes and dislikes; preferences regarding sleeping patterns, what they actually enjoy doing, the food they like, and any other support which helps the patient cope with

the dementia. Continuous communication with the family facilitates the family's involvement, where desired, in preparing a comprehensive care plan.

As most people with dementia live in their own homes, community support services are vital to maintain the independence and individuality of the person. General practitioners (GPs) and community support services play a significant role in minimising the disruption, disorientation and potential deterioration caused by admission to acute and extended care facilities. They also play a significant role in ensuring a smooth transition to and from the hospital. Therefore, ongoing communication is desirable.

Provision for appropriate interpreters

Access to interpreting services is essential. People from diverse cultural backgrounds should be provided with appropriate interpreters. Interpreters should be utilised for serious communication, such as gaining informed consent.

5. Care practices/interventions

There is a consistent application of the core values of the mission statement reflected in protocols and practice.

When an older person who has dementia requires admission to hospital consideration should be given to the person as a whole, taking into account his/her environment, lifestyle, and level of functional dependency with care planned accordingly.

Consideration for the person as a whole

Providing for the individuality of each patient is the role of the nurse. Where possible, an environment should be created that reflects their home environment - for example; their routine in hospital should reflect their routine when at home, the time they rise, go to bed, shower, dress, the types of clothes worn, the time they eat, the food they eat and the social activities normally undertaken.

Validation of the informal carer's role

Protocols for involvement and validation of the informal carer's role in the treatment of the patient, depending on the willingness of the carer, and the consent of the patient are another aspect of appropriate response to dementia. This should be dealt with sensitively as some carers find too much involvement traumatic for them.

6. Discharge planning

Discharge planning is essential in ensuring the effective management of an acute hospital admission. For people with dementia early discharge planning is of particular importance as their needs are complex. Discharge planning extends beyond the hospital walls making optimal use of GPs, other health care providers, and social services, and involves arrangements for the medical follow-up of acute illness and for other care and support services. Discharge planning is always undertaken in consultation with the patient and family.

Appendix 3

Organisational Audits—project summary scores

Pre and post organisational audits from:

Bairnsdale Regional Health Service.

Ballarat Health Services.

Southern Health—Monash Medical Centre.

Gippsland Health Services Consortium.

Scoring for Organisational Audits:

1= Does not comply.

2= Partially complies.

3= Fully complies.

Note that the scoring for the Mission Statement has been reversed for consistency with the other items.

Bairnsdale Regional Health Service

The mission statement	Pre-rating	Post-rating
Reflecting on the Mission Statement:		
Does the Mission Statement indicate that the facility values caring for people with dementia by recognizing their particular needs?	1	1
Is its philosophy reflected in infrastructure, practices and interventions?	2	3
The environment		
The facility environment supports the person with dementia or other cognitive impairment with:		
Adequate signage	2	2
Personalized cueing	1	2
Safety	2	2
Reduced stimuli	1	1
Minimal moves within the facility	2	2
Availability of a day room during hospitalization for occupational or sensory therapies	2	2
Assessment processes		
Protocols are in place to ensure that a cognitive assessment using recognized tools is carried out on anyone presenting with confusion	1	2
Protocols are in place to ensure that a comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment	1	2
Protocols are in place to ensure comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment and an evaluation of medications	1	2
All standard assessments are done by one person only e.g. RN or doctor, and the comprehensive assessment determined by a multidisciplinary team	2	2
Communication		
Communication reflects best practice in communicating with people who have dementia	2	2
Evidence that there is a comprehensive history and nursing care plan available for all staff caring for the person	3	3
Provision for gathering of information from the family/carers, according to the level at which they wish to be involved	2	3
People from diverse cultural backgrounds are provided with appropriate interpreters	2	3
Evidence of comprehensive information exchange with the family	2	2
Care practices/interventions		
There is an agreed care pathway for dementia in place	1	2
Protocols are in place from preadmission to discharge, for involvement of the informal carer in the treatment of the patient - depending on the willingness of the carer and the patient's consent	1	2
Protocols are in place from preadmission to discharge, for staff to monitor trigger factors for adverse behaviours and plan treatment accordingly	1	2
Protocols are in place from preadmission to discharge, for discharge planning undertaken in consultation with the patient and family	2	3

Discharge planning		
The facility's policy ensures that:		
There is a named person responsible for discharge co-ordination	2	2
Discharge is an actively managed process which begins at the point of admission	3	3
Roles and responsibilities are clearly defined, including identifying people/services with dementia expertise	2	2
All discharge decisions are made by an inter-disciplinary team, managed by someone who is trained and skilled in the needs of people with dementia	2	3
A copy of the discharge policy is made available to patients and their relatives on admission	1	1
There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia	3	3

Pre-audit conducted 21 November 2003; post-audit conducted 28 June 2004

Ballarat Health Services

The mission statement	Pre-rating	Post-rating
Reflecting on the Mission Statement:		
Does the Mission Statement indicate that the facility values caring for people with dementia by recognizing their particular needs?	2	2
Is its philosophy reflected in infrastructure, practices and interventions?	2	2
The environment		
The facility environment supports the person with dementia or other cognitive impairment with:		
Adequate signage	2	3
Personalized cueing	2	3
Safety	3	3
Reduced stimuli	3	3
Minimal moves within the facility	2	2
Availability of a day room during hospitalization for occupational or sensory therapies	1	1
Assessment processes		
Protocols are in place to ensure that a cognitive assessment using recognized tools is carried out on anyone presenting with confusion	3	3
Protocols are in place to ensure that a comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment	3	3
Protocols are in place to ensure comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment and an evaluation of medications	3	3
All standard assessments are done by one person only e.g. RN or doctor, and the comprehensive assessment determined by a multidisciplinary team	2	2
Communication		
Communication reflects best practice in communicating with people who have dementia	2	3
Evidence that there is a comprehensive history and nursing care plan available for all staff caring for the person	3	3
Provision for gathering of information from the family/carers, according to the level at which they wish to be involved	3	3
People from diverse cultural backgrounds are provided with appropriate interpreters	3	3
Evidence of comprehensive information exchange with the family	2	2
Care practices/interventions		
There is an agreed care pathway for dementia in place	1	2
Protocols are in place from preadmission to discharge, for involvement of the informal carer in the treatment of the patient – depending on the willingness of the carer and the patient’s consent	1	1
Protocols are in place from preadmission to discharge, for staff to monitor trigger factors for adverse behaviours and plan treatment accordingly	2	2
Protocols are in place from preadmission to discharge, for discharge planning undertaken in consultation with the patient and family	3	3

Discharge planning		
The facility's policy ensures that:		
There is a named person responsible for discharge co-ordination	2	2
Discharge is an actively managed process which begins at the point of admission	3	3
Roles and responsibilities are clearly defined, including identifying people/services with dementia expertise	3	3
All discharge decisions are made by an inter-disciplinary team, managed by someone who is trained and skilled in the needs of people with dementia	1	1
A copy of the discharge policy is made available to patients and their relatives on admission	1	1
There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia	2	2

Pre-audit completed 27 October 2003; post-audit completed June 2004

Southern Health—Monash Medical Centre

The mission statement	Pre-rating	Post-rating
Reflecting on the Mission Statement:		
Does the Mission Statement indicate that the facility values caring for people with dementia by recognizing their particular needs?	1	2
Is its philosophy reflected in infrastructure, practices and interventions?	2	1
The environment		
The facility environment supports the person with dementia or other cognitive impairment with:		
Adequate signage	2	2
Personalized cueing	2	1
Safety	1	3
Reduced stimuli	2	2
Minimal moves within the facility	3	2
Availability of a day room during hospitalization for occupational or sensory therapies	1	1
Assessment processes		
Protocols are in place to ensure that a cognitive assessment using recognized tools is carried out on anyone presenting with confusion	1	1
Protocols are in place to ensure that a comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment	1	1
Protocols are in place to ensure comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment and an evaluation of medications	1	1
All standard assessments are done by one person only e.g. RN or doctor, and the comprehensive assessment determined by a multidisciplinary team	1	3
Communication		
Communication reflects best practice in communicating with people who have dementia	2	2
Evidence that there is a comprehensive history and nursing care plan available for all staff caring for the person	3	3
Provision for gathering of information from the family/carers, according to the level at which they wish to be involved	2	3
People from diverse cultural backgrounds are provided with appropriate interpreters	3	3
Evidence of comprehensive information exchange with the family	2	2
Care practices/interventions		
There is an agreed care pathway for dementia in place	1	1
Protocols are in place from preadmission to discharge, for involvement of the informal carer in the treatment of the patient - depending on the willingness of the carer and the patient's consent	1	1
Protocols are in place from preadmission to discharge, for staff to monitor trigger factors for adverse behaviours and plan treatment accordingly	1	1
Protocols are in place from preadmission to discharge, for discharge planning undertaken in consultation with the patient and family	1	1

Discharge planning		
The facility's policy ensures that:		
There is a named person responsible for discharge co-ordination	2	3
Discharge is an actively managed process which begins at the point of admission	2	3
Roles and responsibilities are clearly defined, including identifying people/services with dementia expertise	1	3
All discharge decisions are made by an inter-disciplinary team, managed by someone who is trained and skilled in the needs of people with dementia	2	2
A copy of the discharge policy is made available to patients and their relatives on admission	1	3
There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia	1	1

Pre-audit conducted 19 December 2003; post-audit conducted 10 June 2004

Gippsland Health Services Consortium

The mission statement	Pre-rating	Post-rating
Reflecting on the Mission Statement:		
Does the Mission Statement indicate that the facility values caring for people with dementia by recognizing their particular needs?	2	2
Is its philosophy reflected in infrastructure, practices and interventions?	2	3
The environment		
The facility environment supports the person with dementia or other cognitive impairment with:		
Adequate signage	2	2
Personalized cueing	1	2
Safety	3	3
Reduced stimuli	1	2
Minimal moves within the facility	2	3
Availability of a day room during hospitalization for occupational or sensory therapies	3	3
Assessment processes		
Protocols are in place to ensure that a cognitive assessment using recognized tools is carried out on anyone presenting with confusion	1	2
Protocols are in place to ensure that a comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment	1	2
Protocols are in place to ensure comprehensive assessment is carried out on anyone presenting with confusion, which includes a cognitive assessment and an evaluation of medications	1	2
All standard assessments are done by one person only e.g. RN or doctor, and the comprehensive assessment determined by a multidisciplinary team	3	3
Communication		
Communication reflects best practice in communicating with people who have dementia	1	2
Evidence that there is a comprehensive history and nursing care plan available for all staff caring for the person	2	3
Provision for gathering of information from the family/carers, according to the level at which they wish to be involved	2	2
People from diverse cultural backgrounds are provided with appropriate interpreters	2	2
Evidence of comprehensive information exchange with the family	1	2
Care practices/interventions		
There is an agreed care pathway for dementia in place	1	2
Protocols are in place from preadmission to discharge, for involvement of the informal carer in the treatment of the patient - depending on the willingness of the carer and the patient's consent	2	2
Protocols are in place from preadmission to discharge, for staff to monitor trigger factors for adverse behaviours and plan treatment accordingly	2	2
Protocols are in place from preadmission to discharge, for discharge planning undertaken in consultation with the patient and family	2	2

Discharge planning		
The facility's policy ensures that:		
There is a named person responsible for discharge co-ordination	1	3
Discharge is an actively managed process which begins at the point of admission	3	3
Roles and responsibilities are clearly defined, including identifying people/services with dementia expertise	2	3
All discharge decisions are made by an inter-disciplinary team, managed by someone who is trained and skilled in the needs of people with dementia	2	3
A copy of the discharge policy is made available to patients and their relatives on admission	1	1
There is a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia	1	2

Pre-audit conducted 22 October 2003; post-audit conducted June 2004.