Centre for Research on Ageing
[influencing policy – improving practice – enhancing quality of life]

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Centre for Research on Ageing

**Sub Units**

T G Smith Dementia Research & Development Unit
Alzheimer’s Australia WA Research & Development Unit
ARC/NHMRC Research Network in Ageing Well – State Hub
**WA Dementia Training Study Centre – Lead Partner**
QUT Dementia Collaborative Research Centre – Curtin University Node

**Health in Ageing** (ageing well/ageing productively, health and well-being of older people, supportive environments, accommodation, workforce, retirement, wellness & independence)

- **Aged Care Services** (services and support systems, alternative and innovative models of service delivery, health workforce)
- **Dementia** (models of service delivery, carers, workforce capacity)
Research Programs

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Responding to the challenge of dementia - an action research perspective

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Aged Care Assessment Team
Seniors’ Mental Health Unit
Alzheimer’s Australia WA
Centre for Research on Ageing
Staff Development Albany Regional Hospital

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NB. We did not seek to criticise systems or practice; we acknowledge the complexity & challenges of acute care. Our focus was on improving practice and outcomes for staff and people with dementia.
Background

- Currently the over 60 age group accounts for a third of hospital separations and half of bed-days (McCallum & Mundy, 2002). By 2021 this will reach 18% and 26% by 2051.
- The average length of stay for people with dementia was 5.3 days, compared to 3.7 days for all patients (Australian Hospital Statistics, 2001-03).
- State demographic data reports that the LGSHS has one of the highest percentages of people aged 65 years and over compared to other areas within the state.
- In 2000 the percentage of people aged 65 years and over in the LGSHS was 14.1%. This compares to 10.7% for the state.
- In 2016 it is projected that these figures will increase to 18.2% for the LGSHS and 13.9% for the State.
Background contd

- Research suggests that older people do not do well in the acute areas of hospitals as it is least like a homelike environment and the care provided does not necessarily assist with the older patient’s transition from hospital back to their place of residence (Victor, et al., 2000)

- Dramatic increase in the number of people diagnosed with dementia will produce a further burden on the acute care environment

- Dementia is overloading an already stretched acute health system
Issue

Locally based ‘Dementia Action Group’ had identified concern that:

- People with dementia often have unmet needs when in hospital.
- Staff in the acute setting find caring for people with dementia challenging.
The study

- A pilot project to improve the management of people with dementia in the rural acute setting through the development of a care pathway
- Planned for the Lower Great Southern Region – initial focus at Albany Regional Hospital
- Engaged the support of Centre for Research on Ageing to facilitate research process and learning of the participants

Aims:
- Develop a multidisciplinary care pathway
- Support staff with practice & educational initiatives to improve assessment of symptoms & behaviours
- Increase knowledge & skills of staff
Methodology

Action Research

Action research adopts a participative approach to enable the participants to learn and be involved in a research process and outcomes that could have a long-term benefit.

- Within the learning process, emphasis is placed upon collaboration between individuals, development of skills, reflective practice and open inquiry.
- Developing commitment to reflection and learning is viewed as an essential component of good organisational management and integral to the development of what is now often referred to as a ‘learning organisation’ (Reason, 2001).
Approach

The project adopted a range of strategies to ensure that:

- Nurses and multi-disciplinary staff in the acute care setting were kept informed and involved in development and trialing the tool

- Staff, carers and people with dementia were engaged through focus groups, and provided with opportunities to inform the process

- Participants were able to determine issues, concerns and effectiveness of tool

- Study adhered to principles of ethics and confidentiality
Care Pathway

- Integrated care *pathways* also known as *coordinated care pathways*, *care maps*, or *anticipated recovery pathways*
- Task orientated care plans which detail essential (predicted) steps in the care of patients with a specific clinical problem and describe the patient's *expected clinical course*
- They offer a structured means of developing and implementing local protocols of care based on evidence based clinical guidelines

It was acknowledged that a diagnosis of dementia is not a condition that has an “expected clinical course”
- Dementia is often the co-morbid diagnosis
- The traditional format of a clinical pathway, identifying clinical outcomes (predicted) would not be useful
- A care pathway that could be simply defined as a *pre-determined plan* designed for patients who have a specific diagnosis was needed
- Focus on nursing practice in first stage
Method - Stages

Stage One:
- **Audit current situation**
  Audit of documentation and summarise common practice and issues in diagnosis, documentation and care as reported by staff
- **Identify issues for people with dementia and their carers**
  Conduct focus groups/carer interviews with a sample of families
- **Identify issues for staff**
  Conduct focus groups to identify awareness of dementia, assessment, skills and experience in caring

Stage Two:
- **Draft care pathway**
  Design a *draft* pathway; discuss project pathway and dementia plan progress with hospital executive and staff
- **Identify challenges** associated with the use of a care pathway
- **Conduct awareness information sessions** on use of dementia care pathway, inviting staff feedback. Display copies of the pathway how it is to be implemented on a display board accessible to all staff
Method contd.

Stage Three:
- Pilot use of the dementia pathway within pilot site
- Develop dementia ‘resource manual’ for staff
- Provide support to staff to maximise the pathway’s potential use when caring for the PWD
- Provide informal education to staff when working with PWD
- Monitor the use of the pathway through staff feedback sessions, ward consultation

Stage Four:
- Audit documentation associated with people with dementia who have been in hospital and summarise common practice and issues in diagnosis, documentation and care as reported by staff
- Staff focus group & consultation with staff on wards
- Engage Health Service Executive
- Identify strategies for ongoing implementation of care pathway
- Provide Dementia Training work-shop on acute care and include training in use of the pathway and feedback
1 Audit of records pre pilot

- 40 records (01/02/05 – 28/02/06) 219 admissions of people with dementia
- limited information about the PWD’s presenting symptoms or individual needs
- many PWD were not accepting of their admission
- responses to their admission were categorised in three areas - aggression, verbal agitation and physical non-aggression
- responses were often seen as a difficulty rather than a form of communication
- use of chemical and physical restraint was evident to manage some of these responses (often no reason or consent)
- response to the admission was often recorded as “wandering”
2 Issues for people with dementia & their carers

ON ADMISSION
- Limited knowledge of type of dementia
- Limited knowledge of a known diagnosis
- Individual needs of person with dementia not always asked
- Time spent in A & E varied

DURING THE STAY
- Both advantages and disadvantages for a single room or a shared room
- Limiting number of bed moves
- Medications given not always supervised
- Access to toilet and shower
- Available use of a recliner chair for the carer who stays with person for extended time periods

ON DISCHARGE
- Carer not informed of PWD’s needs at discharge
3 Issues from staff within focus groups

DOCUMENTATION
- Limited information found on admission forms, nursing notes and GP notes; no appropriate form; no space

DIAGNOSIS
- GP assumes staff know all about the person and focus on reason for admission

ENVIRONMENT
- Patient safety; appropriateness; limited possibility to modify; workload for domiciliary staff
- Increase knowledge and understanding
- Insufficient training; problem solving; advice

RESOURCES
- Activity person; dementia specialist;
- Policy, procedures, guidelines
- Restraint; discharge planning
4  Care Pathway Trial

- Occurred over a 3 month period
- Decided to trial on the wards more likely to receive patients with dementia - a surgical ward, medical ward, rehabilitation ward and Accident and Emergency
- Staff informed via emails to all clinical managers, flyers on all wards, display board accessible to all nursing staff explaining the use of the pathway, meetings with individual ward
- Weekly visits to wards encouraging the pathway’s use, supporting staff to use it and understand it
- Meeting with ward staff to promote and educate the use of the pathway and to receive any feedback on its use
- Consultation meetings with staff assisting them to support the PWD using the “care strategies” form and giving advice on some strategies
- A video was shown to all wards on caring for the PWD in the acute care environment
5 Post trial - evaluation

1. Audit sample of records (13)

The audit of patients’ records aimed to reveal if there had been a change to documentation, reporting on a change to care, as a result of the implementation of the Dementia Care Pathway.

The data was inconclusive, but did reveal valuable information about staff confidence and competence in the care of people with dementia in the acute setting.
2. Staff provided positive feedback and informed modifications to care pathway documentation

- ‘pathway easy to understand’
- ‘helped manage behaviours of concern’
- ‘use patient photos’
- ‘wordy and confusing at first’
- ‘useful for understanding person’
- ‘complete assessment for all patients – essential’
- ‘education very useful’
- ‘issues of more documentation’
3. Broader environmental factors

- Any hospital development to consider environmental needs of PWD
- All staff need training
- Need to continue to develop and refine
- Need expertise – resource person
- A good tool needs to allow for holistic continuity of care
- Combine documentation
- AND roll out across the region as soon as possible (staff from another hospital)
General recommendations from project

Environment
- Safety of patients
- Dementia-friendly environment
- Adaptation of hospital – implications for redevelopment
- Engage family carer - resource

Documentation
- Review of policy on restraint
- Assessment (alert) of all patients over 65 years
- Nursing care plans include individual needs
- Clear diagnosis in admission notes (GP)
- Pain assessment charts
- Admission forms need to prompt needs
- Documentation & information sharing between agencies
Staff resources
- Regional dementia specialist role
- Key resources within hospital
- Activity/diversional therapist role
- Importance of role of ancillary staff (contact)

Education
- Core staff development topic all staff
- Ongoing education initiatives - videos, websites, materials
- Utilise existing education programs (AAWA)
Outcomes of project

- Dementia Care Package including Care Pathway, for nurses, has been implemented in Albany Regional Hospital
- Workshop on person-centred care by Alzheimer’s Australia WA with particular focus on acute care & care pathway have been held (more planned)
- Report commissioned from Alzheimer's WA identifying ways to modify the hospital environment & recommendations on care practice (garden, interior design, future hospital redevelopment)
- Dementia Resource Manual developed with strategies for care practices, problem solving, referral information
- Dementia Prompt (alert)
Summary

- Recognise the limitations of the study, short time period & limited numbers
- Have addressed a number of issues associated with the care of people with dementia in an acute setting
- Learning process for members of the team – potential of action research
- Excellent example of inter-agency
- Successful pilot
Further directions

- Submitted report to WACHS & established process of monitoring further implementation
- Discuss continuing the process with ARH
  - Continue to work on Care Pathway with staff - incorporate allied health
  - Further review policies and procedures
- Broaden pilot to other Regional Hospitals
- Engage GPs and referring doctors
- Explore regional dementia consultant role (progress)
- Collaborate with the WA DTSC and AAWA in development of hospital education initiative (in progress)
Thank you