DCRC
Dementia Centre for Research Collaboration

ONLINE SYMPOSIA: DAY 1
Wednesday 4th November
10.00am – 12.30pm AEDT

Changed behaviours and psychological symptoms associated with dementia

ABSTRACTS: 10.15am – 10.45am

Dr Christine While
Dementia Training Australia

Dr Minah Gaviola
University of Newcastle

Prof Steve Macfarlane
Dementia Support Australia

EXPERT PANEL: 10.50am – 12.20pm

MODERATOR

Glenn Rees
Alzheimer's Disease International

Dr Leanne Jack
Queensland University of Technology

Prof Kathy Eagar
Australian Health Services Research Institute (AHSRI)

Dr Jacki Wesson
Residential Care by Montefiore

Prof Simon Bell
Centre for Medicine Use and Safety

Pat Sparrow
Aged & Community Services Australia

Mr Robert Day
Dementia & Supported Ageing
Commonwealth Department of Health

Register FREE
https://tinyurl.com/y5r35lvk

For more information on DCRC visit www.dementiaresearch.org.au

Australian Government
National Health and Medical Research Council

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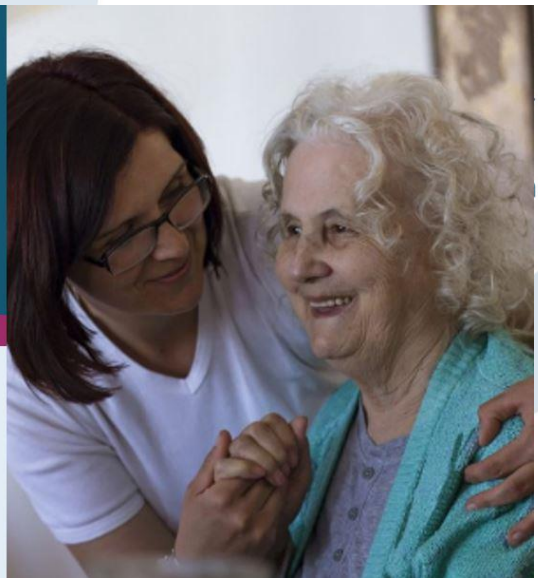

Changed behaviours and psychological symptoms associated with dementia

TWO ONLINE SYMPOSIA

Wednesday 4th and 11th November 2020

PROGRAM DAY 1: Wednesday 4th November, 10am – 12.30pm AEDT

Event Name:	DCRC Online Symposia | Australia		
Date:	Wednesday, 4th Nov 2020	**Time:**	10:00am – 12:30pm
Contact Details:	Host / Technical Contact: Claire Burley Ph: +61 403 804 907; E: c.burley@unsw.edu.au		

The symposia will be recorded for broad circulation. Data or information that is not ready for wide circulation will be censored from the recording before distribution.

Time	Action
10:00am – 10:05am	**Dr Claire Burley & Dr Nadeeka Dissanayaka** - General housekeeping - Introduce special interest group and ADDResearch
10:05am – 10:10am (5mins)	**Prof Henry Brodaty, Director DCRC** - Welcome
10:10am – 10:45am	**Session 1: Abstract presentations** SESSION CHAIR: Dr Nadeeka Dissanayaka
10:10am – 10:20am (7-min talk)	Presenter 1 - **Dr Christine While** Affiliation: Dementia Training Australia Talk Title: *At the end of the KT 'pipeline': Facilitating implementation of evidence-based interventions for dementia-related changes in behaviour*
10:20am – 10:30am (7-min talk)	Presenter 2 – **Dr Minah Gaviola** Affiliation: The University of Newcastle Talk Title: *Implementation of an individualised music intervention for people with dementia in residential aged care*
10:30am – 10:40am (7-min talk)	Presenter 3 –**Prof Steve Macfarlane** Affiliation: Dementia Support Australia

	Talk Title: *A national database for assessing holistic, individualised, multimodal behavioural and psychological interventions*
10:40am – 10:45am (5 minutes)	**5-min Q&A for presenters 1-3** Moderated by Dr Nadeeka Dissanayaka
10:45am – 10:50am	*Break for 5 minutes*
10:50am – 12:20pm	**Session 2: Expert panel presenters and discussion** SESSION CHAIR: Dr Claire Burley
10:50am - 11:00am (10-min talk)	Expert 1: **Dr Leanne Jack**, Intensive Care, Emergency and Acute Care Nursing Study Area Coordinator Affiliation: Queensland University of Technology Talk Title: *Personal experience with caring for someone living with dementia*
11:00am - 11:10am (10-min talk)	Expert 2: **Prof Kathy Eagar**, Director Affiliation: Australian Health Services Research Institute (AHSRI) Talk Title: *Challenges in aged care services and how we address these: Insights from other services*
11:10am – 11:20am (10-min talk)	Expert 3: **Dr Jacki Wesson**, Dementia Specialist & Research Coordinator Affiliation: Residential Care by Montefiore Talk Title: *Challenges and successes with dementia care in residential settings*
11:20am – 11:25am	**5-min Q&A for experts 1 and 2 and 3**
11:25am – 11:35am (10-min talk)	Expert 4: **Prof Simon Bell**, Pharmacist & Director Affiliation: Centre for Medicine Use and Safety, Monash University Talk Title: *Developing guidelines for the appropriate use psychotropic medicines in people living with dementia*
11:35am – 11:45am (10-min talk)	Expert 5: **Patricia Sparrow**, Chief Executive Officer Affiliation: Aged & Community Services Australia Talk Title: *Ageing policy and challenges in aged care services*
11:45am – 11:55am (10-min talk)	Expert 6: **Mr Robert Day**, Assistant Secretary, Dementia & Supported Ageing Affiliation: Commonwealth, Department of Health Talk Title: G*overnment perspective on dementia and aged care services*
11:55pm – 12:00pm	**5-min Q&A for experts 4, 5 and 6**
12:00pm – 12:20pm (20 minutes)	**EXPERT PANEL (all 6 speakers) DISCUSSION & AUDIENCE Q&A** ***'Where do we go next with dementia care and research?'*** Moderated by **Glenn Rees, Alzheimer's Disease International**
12:20pm – 12:30pm (10 mins)	Prof Henry Brodaty – Summary and future directions Dr Claire Burley – Close symposium

Email: c.burley@unsw.edu.au
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DCRC
Dementia Centre for Research Collaboration

Online Symposia 2020

Changed Behaviours and Psychological Symptoms Associated with Dementia
Wed 4th Nov, 10am – 12.30pm AEDT

Anxiety and Depression in Dementia Research Network (ADDResearch)
Wed 11th Nov, 10am – 12.30pm AEDT

Australian Government
National Health and Medical Research Council

www.dementiaresearch.org.au

1

Acknowledgement of the Country

I would like to acknowledge the traditional owners and their custodianship of the land on which this symposium is held, and pay respects to Elders past, present and emerging.

2

Housekeeping

- Q&A function for typing questions – please address them to a particular speaker or a general question to the panel
- Session chair/ moderator will refer to Q&A for questions and direct them to the speaker or panel
- Feel free to introduce yourself when you type your question
- Three ~7-minute abstract talks, 5-minutes for questions
- 5-minute break
- Six 10-minute expert panel presentations (5-minutes for questions after 3 speakers)
- Twenty-minute expert panel discussion with Q&A
- Symposia resources will be available on the DCRC website (including webinar recording, speaker bios, contact details, and abstracts) www.dementiaresearch.org.au

Dementia Training Australia

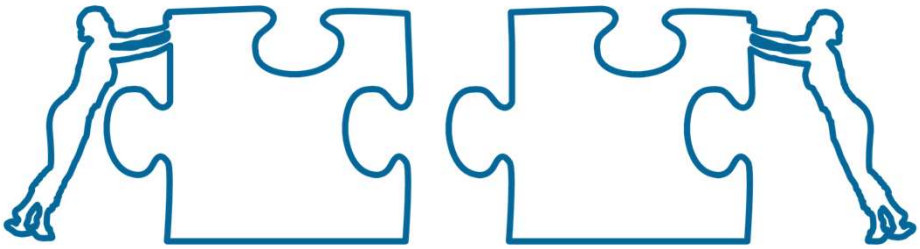
At the end of the KT 'pipeline': Facilitating implementation of evidence-based interventions for dementia-related changes in behaviour.

Chris While PhD
Margaret Winbolt PhD
Belinda Goodenough PhD
Jacqui Watts

Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

1

Knowledge Translation



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Fellowship program

2

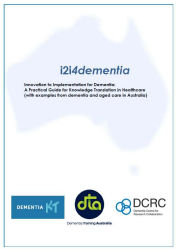
Fellowship Program

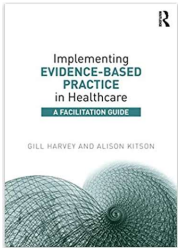
The aim is to improve the ability of Australian aged care service providers and clinical leaders (Fellows) to implement evidence-based dementia care.

Encourage organisational KT capacity → Build clinical leader KT skills → Promote adoption of knowledge into practice → **Systems to support adherence**

3

What guides delivery?





Thinking

Doing

4

TOOLS
- i2i4dementia
- Toolkits in project management and evaluation
- Project templates

TRAINING/EDUCATION
- Half day introductory workshop
- Monthly 1-hour virtual meetings
- Micro training: resistance, readiness and empathy

IMPLEMENTATION SUPPORT

TECHNICAL ASSISTANCE
- Mentor (facilitation approach)
- Monthly meetings
- Access to evidence resources
- Access to dementia expertise

QUALITY ASSURANCE
Monitoring:
- progress
- barriers
- fidelity with the evidence

Pre-post program evaluation

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Fellowship program

5

The KT projects

Intergenerational programs	Kinder group – onsite/off site	↓ antipsychotic medication ↑ engagement & enjoyment
	Mother-baby group-onsite	↔ BPSD post attendance ↑ engagement & enjoyment
Mealtime enhancement	Change staff behaviours Increase meal serving time Quieter dining environment	↓ BPSD ↓ Staff & resident stress
	Baine Marie Increase meal serving time Quieter dining environment	↓ Unplanned weight loss Focussed 20-minute meal
Multisensory therapy	Sensory room: group & 1:1	↑ Engagement ↓ Agitation & wandering (Ob)
Activity programs	Montessori	↓ PRN psychotropic medication ↓ BPSD ↑ Engagement ↑ PCC
	Culturally appropriate	↓ Physical aggression ↓ Resistiveness to care ↑ Engagement
Lifestory work	Story board	↑ Staff knowledge of resident Distraction tool
	One-page profile	↑ Staff knowledge of resident ↓ Resident to staff aggression ↑ Staff understanding of behaviour

6

Case study

AIM: To introduce Montessori activities and environment as a best practice approach to dementia care

OBJECTIVES

To increase resident engagement in meaningful activities

To decrease responsive behaviours and the use of prn medications

To increase person-centred care

7

Key implementation steps

- Residents were assessed using the Montessori assessment tool
- Life story review
- Identify meaningful roles and activities
- Establish Montessori activity stations, interactive wall art and signage
- Environmental modifications
- All staff in the unit to engage residents in the Montessori activities and roles

8

Integration strategies	
Montessori Champions	Volunteer x 1 and lifestyle x 1
Training	Inhouse Montessori training for 20 staff Supporting Montessori Environments workshop for 2 staff
Support	'Workplace' Montessori group Role modelling and weekly meetings provided by Fellow
Procedural changes	Night shift checklist to maintain the activity stations Montessori activity/roles cheat sheet at nurses' station
Communication	Montessori information given to all staff Open letter displayed inside the RACF explaining the project to residents and visitors
Sustainability planning	Establishment of a 'Montessori Committee' Recruitment and training of volunteers Montessori included in the staff orientation program

9

Process and outcome evaluation

Process evaluation

Interviews with 10 staff

➔ Adaptations to the program

- ➔ Activities suitable for male residents
- ➔ Music based activities
- ➔ Removal of less popular activities

Outcome evaluation measures (pre-post)

- P-CAT
- Staff observation/charting (behaviour and engagement)
- Audit of PRN antipsychotic medication use
- Incident reports: resident aggression

10

Outcomes

Following the implementation of Montessori program there was:

- a 30% reduction in PRN psychotropic medication use
- higher levels of engagement and lower levels of responsive behaviours
- an increase in person-centred care
- observations of: increased staff confidence in identifying early signs of agitation and intervening to prevent escalation.

11

Dementia Training Australia

A national approach to accredited education, upskilling and professional development for the dementia care workforce

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Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

UNIVERSITY OF WOLLONGONG AUSTRALIA

dementia australia

LA TROBE UNIVERSITY

QUT

THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

12

References

Goodenough, B., & Young, M. (2017). *Innovation to Implementation for Dementia (i2i4dementia): A Practical Guide to Knowledge Translation in Health Care* (with examples from aged care and dementia). Dementia Centre for Research Collaboration. Australia.

Harvey, G., & Kitson, A. (2016). PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, 11(1).

Wandersman, A., Chien, V., & Katz, J. (2012). Toward an Evidence-Based System for Innovation Support for Implementing Innovations with Quality: Tools, Training, Technical Assistance, and Quality Assurance/Quality Improvement. *American Journal of Community Psychology*, 50(3-4), 445-459

DTA knowledge translation framework is informed by the Awareness-to-Adherence Model published in: Pathman, DE., Konrad, TR., Freed, GL., Freeman, VA., Koch, GG. (2006). The awareness-to-adherence model of the steps to clinical guideline compliance. The case of pediatric vaccine recommendations. *Medical Care*, 34(9). 873-89

Edvardsson, D., Fetherstonhaugh, D., Gibson, S. and Nay, R. (2010). Development and initial testing of the Person-centred Care Assessment Tool (P-CAT). *International Psychogeriatrics*, 22, 101-108.

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1

Implementing individualised music for people with dementia in residential aged care: perceptions and experiences of staff, family and guardian

Dr Minah Amor Gaviola
Professor Isabel Higgins
Dr Sophie Dilworth
Associate Professor Liz Holliday
Associate Professor Kerry Inder

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2

Individualized music listening intervention

Evidence on the promising impact of individualised music for people with dementia

Paucity of research focusing on implementation

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3

Research Objectives, Design, Setting and Population

Objective	• Explore the perceptions and experiences of staff and family or guardian regarding the implementation of an indivdualised music intervention for people with dementia
Design	• Qualitative description (data: focus group, qualitative interviews, care notes documentation)
Setting and sample	• Two residential aged care facilities in NSW • Total participants: 32 people with dementia, 14 staff, 7 family/guardian • FG (n=6 staff); Interviews (n=4 staff, 1 guardian)

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4

Implementation strategies

Training and education

Program champions

Feedback

Reminders

Images from http://clipart-library.com/fee-cliparts.html

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5

Themes

1. Transcendental reminisces, the calm, the joy and the elation

"One resident was looking for her husband and she's like, oh, can John hear this, and [it] took her back to… just the love on her face, it was beautiful. I've never seen it before". Courtney (AIN, Focus Group)

2. Optimism, excitement, and the snowball effect

"Once you see the joy on their faces…and the calming you're more inclined to do it [put the music on]". Courtney (AIN, Focus Group)

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6

Themes

3. Pitching in for the older person, it's not rocket science and the hurdles

"In my email I said to her [another friend who visited Mary]*, the little device* [iPod shuffle®] *is sort of self-explanatory with the volume and whatever but I said there is a button at the bottom to turn it on and it will show green".* Deborah (Guardian, Individual Interview)

4. Music beyond the intervention

"I think if we had [meaning we need] *either a TV with the music playing through it or a DVD or something with music".* Therese (Team Leader, Interview)

7

Highlights

Facilitators

- Positive responses of the older people
- Simplicity of the music intervention

Challenges

- Older person: discomfort from the headphones
- Staff: equipment use and care (e.g. not charging, not putting back in storage)

8

Conclusion

Implementation of an individualised music listening intervention for people with dementia in a residential aged care setting by trained staff and family/guardian:

- ❖ Feasible
- ❖ Positive experience for the people with dementia, their family/guardian, and staff.

9

Acknowledgements

- PhD supervisors
- Facility managers, participating people with dementia, family members, guardians and staff
- Australian Government Research Training Program (RTP) Scholarship

Thank you…

10

A national database for assessing holistic, individualised, multimodal behavioural and psychological interventions

A/Prof Steve Macfarlane

Dementia Support Australia

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1

Dementia Support Australia

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=

DBMAS + SBRT + Needs Based Assessment
Eligibility for SDCP

2

DSA Model of Care

Behavioural disturbances such as 'agitation' are seen as *symptoms*, **not** diagnoses **in themselves.**

Most DSA clients will have symptoms across 5-7 of the 12 NPI domains

We explore the *causes* **of these symptoms and institute multimodal behavioural/psychological/social/environmental interventions** *simultaneously*

<u>This approach does not lend itself to evaluation using a RCT methodology</u>

Enter, the role of Big Data….

3

"Quantity has a quality all its own" - Joseph Stalin

4

Evaluating DSA outcomes

DSA routinely administers the Neuropsychiatric Inventory (NPI) at intake into, and discharge from, DSA services.

This study reports on impacts of the DSA program as measured by the NPI.

- 5,803* people living with dementia
- Residing in RACHs
- Linear mixed-effects model controlling for the effects of: length of service provision, sex, age, baseline score.

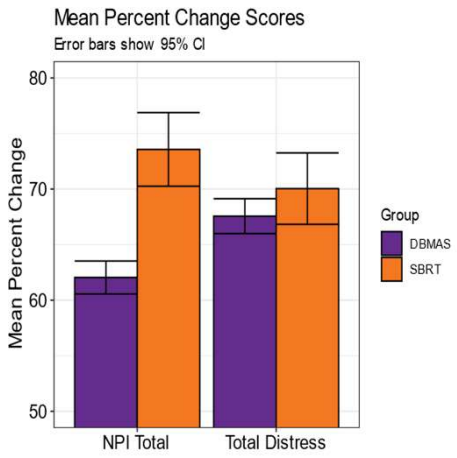
*DSA cases meeting the eligibility criteria in the period from 01/01/2018 to 31/12/2019

Table 1. Demographic Characteristics

Measure	Combined	DBMAS	SBRT
Sample Size	5803	5106	697
Continuous: Mean (SD)			
Age	82.32 (8.55)	82.62 (8.47)	80.09 (8.81)
Case Length	57.14 (26.06)	56.77 (25.7)	59.87 (28.44)
Sex: N (%)			
Male	2552 (44)	2137 (41.9)	415 (59.5)
Female	3245 (55.9)	2964 (58)	281 (40.3)
Other	6 (0.1)	5 (0.1)	1 (0.1)
Dementia Type: N (%)			
Alzheimer's Disease	2144 (36.9)	1848 (36.2)	296 (42.5)
Dementia In Alcohol Abuse	81 (1.4)	69 (1.4)	12 (1.7)
Other Dementia	131 (2.3)	114 (2.2)	17 (2.4)
Dementia In Parkinson's Disease	76 (1.3)	67 (1.3)	9 (1.3)
Dementia Unspecified	1639 (28.2)	1497 (29.3)	142 (20.4)
Frontal Lobe Dementia	189 (3.3)	159 (3.1)	30 (4.3)
Lewy Body Dementia	170 (2.9)	147 (2.9)	23 (3.3)
Mixed Dementia	441 (7.6)	384 (7.5)	57 (8.2)
Vascular Dementia	675 (11.6)	583 (11.4)	92 (13.2)
Missing	257 (4.4)	238 (4.7)	19 (2.7)

5

Results



DBMAS

- 62% reduction in total NPI scores from intake to discharge
- 68% reduction in total distress scores

SBRT

- 74% reduction in total NPI scores
- 70% reduction in total distress scores

All effect sizes >1.3 (Cohen's *d*).

Table 2. (Covariates not represented in table)

Dependent Variable	*B*	95% CI	SE	df	*t*	*p*	*d*
DBMAS Total Score	-6.13	[-6.28,-5.98]	0.07	5688	-82.07	$p < 001$	1.29
DBMAS Total Distress	-9.08	[-9.29,-8.87]	0.11	5688	-84.56	$p < 001$	1.35
SBRT Total Score	-30.00	[-31.35,-28.65]	0.69	894	-43.60	$p < 001$	1.71
SBRT Total Distress	-12.60	[-13.18,-12.02]	0.29	894	-42.76	$p < 001$	1.76

Dementia Support Australia

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6


Questions
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DS
Dementia Support Australia

Personal experience caring for someone living with dementia

Ray's dementia journey - August 2015 to May 2019

Presented by Dr Leanne Jack
04/11/2020

1

Life is beautiful-
actually, it is perfect.

2

The subtle loss of problem-solving skills are noticed

Having trouble finding words

Then there is 'THE DIAGNOSIS'

3

Who do we turn to for help?

4

How do I take to care for hubby? I'm an experienced nurse and I am lost!

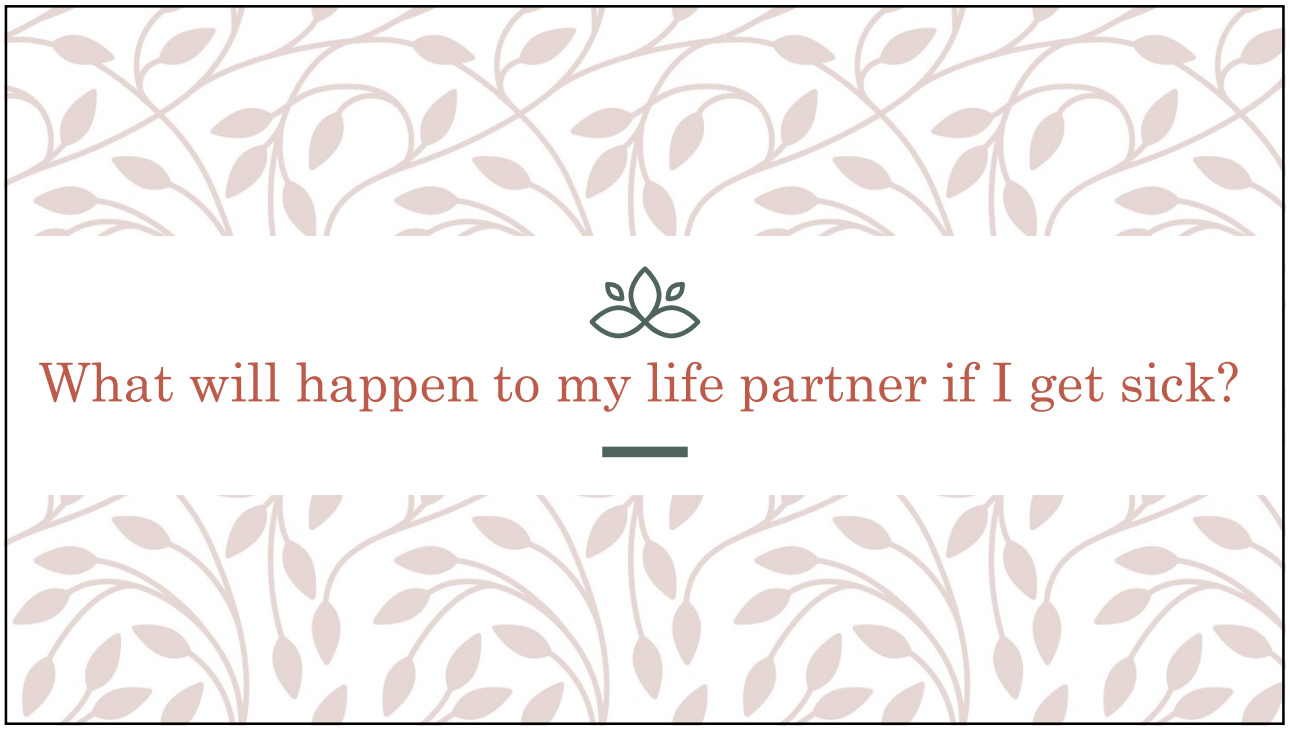
5

What healthcare systems and governmental bureaucracy do we need to navigate?

6


What legal issues do we need to be set-up?

7


What will happen to my life partner if I get sick?

8

I'm still young. How do I hold dual roles – care partner, wife, employee?

9

How long do we have before this thief steals you away? We've only been married for 5 years.

10

Why is there no central system, healthcare team to guide us through this journey?

11

Following the dementia diagnosis, there is loss, sadness, grief, fear, anxiety, irrational guilt.

How do I care for the man I love and not let this thief of a disease define us.



12

I haven't met your new friend? It's nice to meet you (visual and auditory person)

Get these rabbits off my feet; they're eating me!

13

14

Look at me - I haven't changed, I'm still me.

Step into my reality, help me navigate this disease.

Walk with me, don't leave me behind.

15

Ever changing behaviours, moods, comprehension and object recognition.

- Background – osteoarthritis, rheumatoid arthritis, hearing impairment, significant dyslexia, reflux, grade 3 melanoma (contained), life-long smoker, sedentary job, previous builder and line-haul truck driver, minimal hobbies except building things & painting houses
- Hallucinations, delusions
  - Auditory, visual, tactile
- Distrust, decreasing vocabulary, agitation, fear……just kill me, just kill me!
- GP, geriatrician (I'm only 59 years), ACAT, My Aged Care, solicitor, Aged Care Financial Advisor, NDIS, superannuation, pension, Centre Link, banks, community support services, social support, physiotherapy, GPS tracking devices, emergency respite care, RACFs that decline admitting YOA (it's worse for the care partner and family than the RACF), permanent care (I'm a nurse, how can I fail you and have to admit you into permanent RAC)

16

17

Our fears are realised: hubby needs permanent care.

The best and worst of care:

- Poor staff-resident ratios, profit first, care second, failure of duty of care, disengagement with hubby – it's too scary to develop an individualised person-centred care plan based on the 20-page document you needed, poor hygiene, inadequate wound care, poor medication compliance, lack of meaningful activities for an agile younger man
- Discussions with management about poor care – problems continue, hubby is 'at risk'
- Difficult decision – move Ray into a new RACF – caring staff, person-focused, as meaningful activities as possible, enabled to walk, staff take him on walks, welcome pets & music, friendly environment, staff appeared contented, we curled up for Wednesday afternoon powernap, end-of-life care focused
- YOA continues to challenge RAC – this is not the place for a younger person!

18

Where is the evidence-based practice and healthcare education?

- The person with dementia is not a business transaction – they are a whole person with feelings, emotions, understanding (in their capacity) – embrace this
- Clear lack of evidence-based care in some facilities
- Care partners would like to be involved with research. I was only approached 6 months after Ray's passing to participate in grief research
- Grief is dementia's friend – grief counselling must be incorporated into holistic care of the person with dementia and their care partner, family and friends
- Why is there a clear lack of access to psychological supports or partner/family supports following RACF admission
- Preparation of care partners for impending end-of-life discussions need to be held
- Dementia care and care of the ageing and frail must become an educational specialty in healthcare

19

Risk – ask us what level of risk we are prepared to accept.

I want to live, enjoy meaningful activities, be a young man.



20


This thief is winning
Remember me - I still love you

21


The lived journey is tough, difficult, sad, rewarding, fulfilling.
Ask questions, don't be afraid to ask for help, we all need help at some point.
Although the physiological outcome of dementia is death, you don't need to allow this disease to define you and your relationships.
Thank you

22

Challenges in aged care services and how we address these: insights from other services

Professor Kathy Eagar

Australian Health Services Research Institute

November 2020

1

Context: AHSRI Research Centres

- Centre for Health Service Development (CHSD)
- National Casemix and Classification Centre (NCCC)
- Centre for Health Research Illawarra Shoalhaven Population (CHRISP)
- Australasian Rehabilitation Outcomes Centre (AROC)
- electronic Persistent Pain Outcomes Collaboration (ePPOC)
- Palliative Care Outcomes Collaboration (PCOC)
- Ngarruwan Ngadju First Peoples' Health and Wellbeing Research Centre

2

National Health Reform Agreement 2020-2025

This is the overarching Commonwealth-State health agreement to drive changes 2020-2025

'Value-based care' is the language to remember

3

Shared action on long-term health system reform

- a. Improving efficiency and ensuring financial sustainability
- b. Delivering safe, high-quality care in the right place at the right time; through
  - i. Nationally cohesive health technology assessment
  - ii. Paying for value and outcomes
  - iii. Joint planning and funding at a local level
- c. Prioritising prevention and helping people manage their health across their lifetime;
- d. Driving best practice and performance using data and research

4

"Value and outcomes" in dementia care

Dominant paradigm for the next decade

5

Health outcome

A change in an individual or group of individuals that can be attributed (at least in part) to an intervention or series of interventions

3 key ideas:

- change
- attribution
- intervention

Health outcome
≠
Health status

6

Before and after

- Health outcome = difference in health status 'before and after' intervention.
  - grounded in an acute care paradigm in which sick patients receive treatment and, as a result, get better.
  - the way that clinicians (and consumers) typically judge the success of most health care interventions.

7

With and without

- Health outcome = the difference between the person's quality of life and health status with the intervention compared to what would have happened if they had received either (1) no intervention or (2) ***another type of intervention***
- Includes outcomes for both consumers and carers
- Our three national outcome centres are all based on this
- Works for dementia

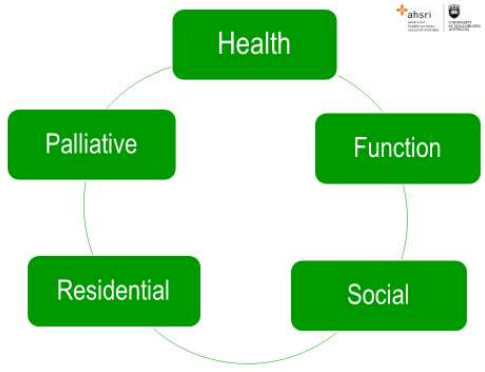
8

Most of the Aged Care Royal Commission proposals assume aged care is a silo

Older people, YOD and carers have holistic needs that cannot be met if aged care is a silo

9

The five domains of aged care: all equally important



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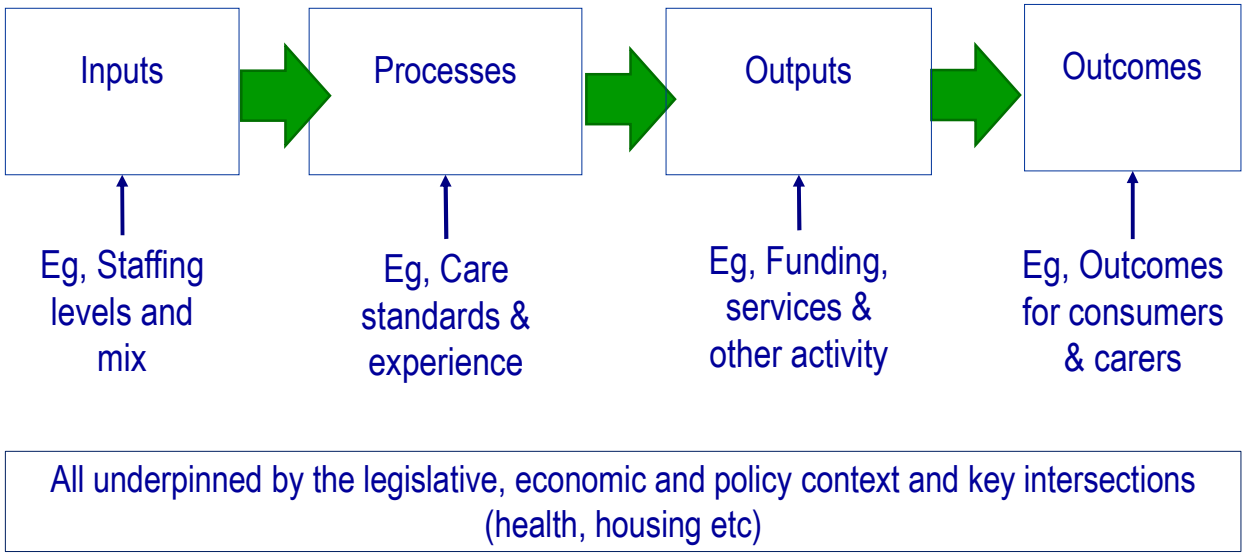
Intervention points in the aged care system



11

The evidence / policy nexus in aged care

- Evidence-free policy
- Policy-based evidence
- Evidence-based policy
  - Driving evidence-based practice

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Challenges and successes with QUALITY dementia care in the residential setting

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'Lie of the land' in the industry
A range of expectations and experiences

Where we are now

- Residential care is changing
- We know **what** it should look like –
  - Human rights
  - Dementia as a disability
  - Rehabilitation & enablement

The path ahead

- We are still working out **how** to get there
- The day-to-day implications for implementing the strategic directions are significant

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Montefiore today – estimated data

631
CONSUMERS

52.5%
with a diagnosis of dementia

64.4%
do not live in a dementia specific unit

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Current touchpoints at the coalface

Supported decision-making, restraint & informed consent

- What is supported decision-making and when is it used, by whom?
- What is the role of a secure dementia unit (physical restraint)?
- When is a psychotropic medication a chemical restraint?

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And a couple more…

Behaviour support for people experiencing aggressive behaviour

- How do we balance in individual rights vs safety and rights of others?
- Approaches to calming escalation vs managing aggressive behaviours – does language matter?
- Training, training and then some education?

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Moving forward, as we can – real time, real life

- **Supported decision-making** –
  - to avoid adding more trauma to an already traumatised person
  - to help guide selection and trial of non-pharmacological interventions

Decision Making Ability Worksheet

Firstly – what is the decision to be made?

Steps to assess whether the person has decision making capacity:

1. Can the person understand the nature and consequences of the decision?
2. Can they weigh up the relevant information in order to express a preference?
3. Can they retain the relevant information long enough to make a decision?
4. Can they communicate their decision in some way?

Comments

Supported Decision Making Preparation Guide

Steps	Planning ideas	Discussion notes
What is the decision to be made?	State the question:	Confirm that this is what the discussion is about – [resident] agrees/ what is his understanding of the situation? What do we mean? Discuss behaviours (e.g. list opposite)

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Moving forward, as we can – real time, real life

- **Informed consent for chemical restraint –**
  - upholding legislation while supporting rights

Montefiore RESTRAINT CONSUMER INFORMATION

Montefiore: supporting a restraint free environment

A guide for consumers, and their representatives

Changes were made to the Aged Care Quality Standards and the Quality of Care Principles by the Australian Government, effective 1 July 2019. This brochure will clarify what this means for you.

Residential care provides you with individualised and high-quality support for your needs. At the same time, your human rights are respected and protected, promoting your right to the enjoyment of the highest attainable standard of physical and mental health, and to protection from exploitation, violence and abuse. This includes care and support that is 'person-centred' and restraint-free.

Under the amendment to the Quality of Care Act (Minimising the Use of Restraints) 2019, restraint has been defined as:

Any practice, device or action that interferes with a consumer's ability to make a decision or which restricts their free movement.

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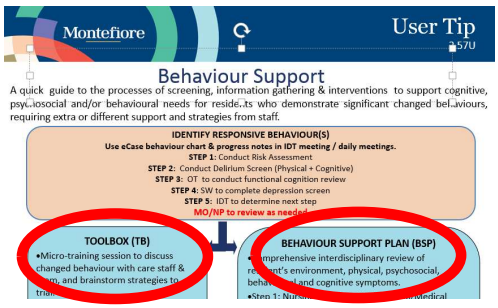
Moving forward, as we can – real time, real life

- **Re-framing service delivery and making sense of prevention -**
  - model of support and internal processes for enabling participation
  - education for staff



Montefiore User Tip

Behaviour Support

A quick guide to the processes of screening, information gathering & interventions to support cognitive, psychosocial and/or behavioural needs for residents who demonstrate significant changed behaviours, requiring extra or different support and strategies from staff.

IDENTIFY RESPONSIVE BEHAVIOUR(S)

Use eCase behaviour chart & progress notes in IDT meeting / daily meetings.

STEP 1: Conduct Risk Assessment

STEP 2: Conduct Delirium Screen (Physical + Cognitive)

STEP 3: OT to conduct functional cognition review

STEP 4: SW to complete depression screen

STEP 5: IDT to determine next step

MO/NP to review as needed

TOOLBOX (TB)

•Micro-training session to discuss changed behaviour with care staff & ... and brainstorm strategies to ...

BEHAVIOUR SUPPORT PLAN (BSP)

•Comprehensive interdisciplinary review of ...nt's environment, physical, psychosocial, ... and cognitive symptoms.

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Our goal: *best practice behaviour support = quality dementia care*

QUESTIONS?

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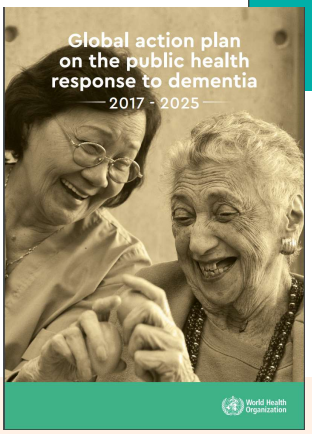

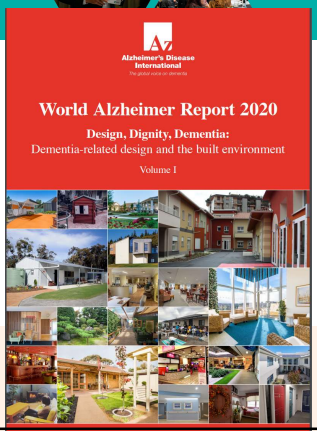

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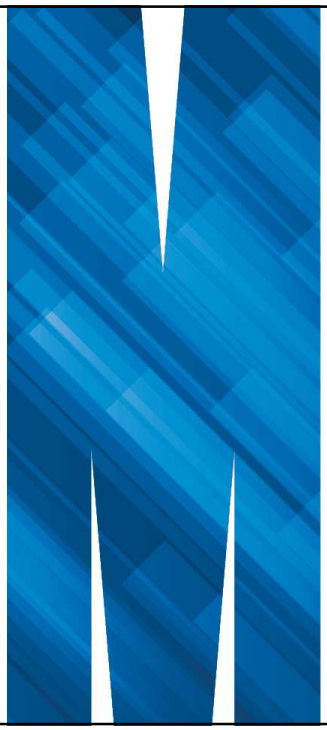
DEVELOPING GUIDELINES FOR THE APPROPRIATE USE OF PSYCHOTROPIC MEDICINES IN PEOPLE LIVING WITH DEMENTIA AND IN RESIDENTIAL AGED CARE

Wednesday November 4

Professor Simon Bell
Supported by the Dementia Centre for Research Collaboration



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Acknowledgement of Country

'I wish to acknowledge the people of the Kulin Nations, on whose land Monash University operates. I pay my respects to their Elders, past, present and emerging. Attendees may based elsewhere, so we pay our respects to Traditional Owners of the land from wherever you may be joining us.'

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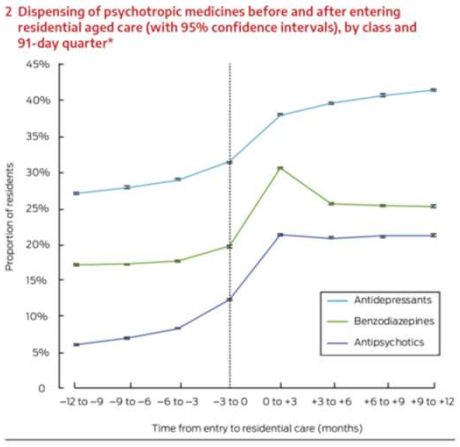
Background



Harrison S et al Med J Aust 2019

- Medication safety is Australia's newest National Health Priority Area
- Up to 95% of residents have one or more medication-related problems (average 3-4 medication-related problems per resident)[1]
- Medication administration and management is the leading source of complaints to the Aged Care Complaints Commissioner[2]

1. Chen EY et al. Australas J Ageing 2019. 2. Aged Care Commissioner Complaints Annual Report 2017-2018

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Background

https://agedcare.royalcommission.gov.au/news-and-media/royal-commission-aged-care-quality-and-safety-interim-report-released

Commissioners identified three areas where immediate action can be taken:

- to provide more Home Care Packages to reduce the waiting list for higher level care at home
- **to respond to the significant over-reliance on chemical restraint in aged care**, including through the seventh Community Pharmacy Agreement
- to stop the flow of younger people with a disability going into aged care, and speed up the process of getting out those young people who are already in aged care.

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Background

- This project will adopt, adapt, update and develop guidelines on the appropriate use of psychotropic medications to incorporate current best available evidence
- Outputs from the project will include:
  - Clinical Practice Guidelines targeted at medical practitioners and senior clinical staff
  - resources for other healthcare staff (e.g. clinical case scenarios, fact sheets, decision aids)
  - a Consumer Companion Guide in a concise and easily accessible format
  - a co-designed implementation and dissemination plan

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Guideline Development Group

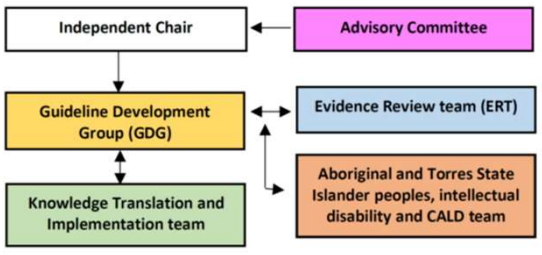

Figure. Organisational chart

18-member team comprising an independent chair from Cochrane Australia, geriatricians, clinical pharmacologists, pharmacists, nurses, experts in knowledge translation, experts in Indigenous and migrant health, aged care provider representatives, a general practitioner, a legal practitioner, a physiotherapist and a consumer/carer.

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Plan

Guideline document format

- adopt recommendations from existing guidelines and incorporate new evidence and recommendations as required
- guidelines take a medication-focussed format (antipsychotics, benzodiazepines, antidepressants)
- cross reference existing guidelines and resources for non-pharmacological therapy

Development process

- staged approach using elements of Living Guideline approach
- Guideline Development Group meets every 6 weeks to review the evidence from 2-4 clinical questions and develop corresponding recommendations
- Evidence Summary Tables and GRADE Evidence Profiles

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Plan

Population

- people living in residential care
- transitions to and from residential aged care
- people living with dementia who receive high level home care packages
- inclusive of Aboriginal and Torres Strait Islander Peoples, people from CALD backgrounds, people with intellectual disability, and people in rural and remote Australia
- recognise specific medication use issues associated with end-of-life care and palliative care settings and cross reference to other guidelines and resources as required

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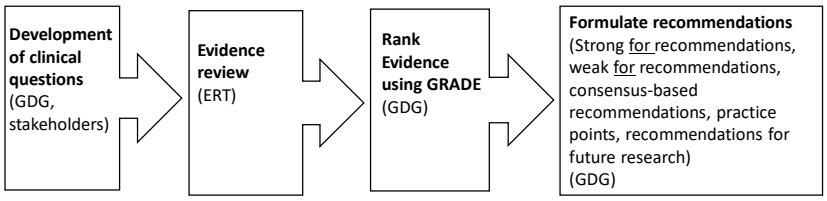
Develop

- Clinical questions prioritised and mapped against existing guidelines
- Perform systematic reviews to update evidence > NHMRC-ARC Dementia Development Fellows
- Use the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) process to formulate recommendations
- Developed through MAGICapp



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Review

- As per the NHMRC process, the draft guideline will undergo an independent review and public consultation process
- The draft guideline will also undergo open public consultation for 30 days and will be accessible on the NHMRC public consultation website
- Independent review process will involve targeted content experts, consumers, end-users and methodological experts

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Implementation

- Integrated knowledge translation approach with concurrent implementation planning
  - inform and prioritise the clinical questions and guideline topics
  - develop understanding of current practise and decision making
  - gauge the feasibility and usability of guidelines
  - identify barriers and enablers for implementation of recommendations
  - help tailor strategies and accompanying resources to overcome identified barriers
- Implementation and dissemination plan co-designed with stakeholders, recognising that dissemination and communication strategies will be different for different audiences

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Contacts

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