

Improving the Management of Severe Behavioural and Psychological Symptoms of Dementia (BPSD) in Hospitals

Benchmarking of Current Models of
Care for Patients with Dementia and
BPSD in Victorian Health Services

Final Online Report

Prepared by:

National Ageing Research Institute (NARI)

May 2023

Report prepared for the **Victorian Department of Health (DH)** and the **Victorian Sub-acute Executive Peak Body** by the **National Ageing Research Institute (NARI)** – May 2023

Contributing Authors: Amy Parker, Sue Williams, Stephanie Garratt, Frances Batchelor

Acknowledgements: Austin Health, Barwon Health, Bendigo Health, Grampians Health Ballarat, Monash Health, Northern Health, Peninsula Health, St Vincent's Hospital Melbourne, Western Health

Suggested Citation: Parker, A., Williams, S., Garratt, S., & Batchelor, F. (2023). *Improving the Management of Severe Behavioural and Psychological Symptoms of Dementia (BPSD) in Hospitals: Benchmarking of Current Models of Care for Patients with Dementia and BPSD in Victorian Health Services (Final Online Report)*. National Ageing Research Institute (NARI): Parkville, Victoria, Australia.

Contents

LIST OF FIGURES	5
LIST OF TABLES	6
ABBREVIATIONS	8
EXECUTIVE SUMMARY	10
1. BACKGROUND	11
1.1 Dementia and Severe BPSD in Hospitals	11
1.2 'Improving the Management of Patients with Severe BPSD in Victorian Hospitals' Project	11
1.3 Project Components	12
2. OVERVIEW	13
2.1. Study Aim	13
2.2 Study Objectives	13
3. PROJECT DESIGN	14
3.1 Procedure	14
3.2 Recruitment	14
3.3 Consent	17
3.4 Data Collection	17
3.5 Data Analysis	17
4. KEY FINDINGS	18
4.1 Patient Demographics	18
4.2 Assessment	18
4.3 Care Provision	23
4.4 Workforce	39
4.5 Education & Training	41
4.6 Physical Environment	47
4.7 Organisational Approach to Care	50
4.8 Additional Comments about the Management of Patients with BPSD	60
5. DISCUSSION	62
5.1 Dementia and BPSD	62
5.2 Aggression, Agitation and Violence	62
5.3 Identifying and Addressing Individual Needs	63
5.3 Management Approaches	64
5.4 Access to Appropriate Resources	66
5.5 Supporting and Empowering the Workforce	67
5.6 Universal Dementia-Friendly Hospital Design	68
5.7 Limitations	69

6. CONCLUSION.....	71
7. REFERENCES	72
8. APPENDICES.....	74
Appendix 1: Examples of Disciplines Involved in the Care of Patients with Dementia and BPSD According to Care Setting.....	74
Appendix 2: Responses regarding Care Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD.....	75
Appendix 3: Responses regarding Rostering Models Designed to Manage BPSD	77
Appendix 4: Responses regarding the Influence of Funding on Models on Care	78
Appendix 5: Responses regarding Organisational Perspectives about Care of Patients with Dementia and BPSD	80
Appendix 6: Responses regarding Strategies used for Aberrant Vocalisation, Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD	83
Appendix 7: Responses regarding Strategies used for Motor Agitation Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD	85
Appendix 8: Responses regarding Strategies used for Aggressiveness Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD	88
Appendix 9: Responses regarding Strategies used for Resisting Care Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD	91
Appendix 10: Responses regarding Challenges to Care Provision for Patients with Dementia in Hospital	94
Appendix 11: Responses regarding Challenges to Care Provision for Patients with Dementia and Behaviours of Agitation, Aggression and Violence in Hospital.....	98

LIST OF FIGURES

Figure 1: Survey Responses	14
Figure 2. Tools Used to Screen or Assess Dementia/Cognition, Combined (N=95)	20
Figure 3. Tools Used to Screen or Assess AAVB, Combined (N=92).....	22
Figure 4. Tools Used to Screen or Assess Delirium, Combined (N=86)	22
Figure 5. Transfer Processes to Support Care for Patients with Dementia and BPSD, Combined (N=85)	23
Figure 6. Processes Used to Record Triggers of BPSD, Combined (N=85).....	24
Figure 7. Processes Used to Monitor Challenging Behaviours, Combined (N=85)	25
Figure 8. Care Planning Tools, Combined (N=85)	26
Figure 9. Pharmacological Interventions, Combined (N=85)	27
Figure 10. Non-pharmacological Interventions, Combined (N=85)	29
Figure 11. Code Greys (planned or unplanned) in the past 12 months related to patients with Dementia (N=85)	29
Figure 12. Code Blacks in the past 12 months related to patients with Dementia (N=85)	29
Figure 13. Code Black Responses in the Past 12 Months related to Patients with Dementia, By Care Setting (N=85).....	30
Figure 14. Specific OVA Management Approaches used in Relation to Care of Patients with Dementia, By Care Setting (N=85).....	30
Figure 15. Approaches to Involve Families in Care and Management of Patients with Dementia, Combined (N=81).....	34
Figure 16. Barriers to Discharging Patients with Dementia Experienced, Combined (N=81)	37
Figure 17. Specific Barriers to Discharge Identified, Combined (N=81).....	38
Figure 18. Provision of Education and Training for Staff about Dementia (including BPSD) and managing AAVB, By Care Setting (N=76)	42
Figure 19. Discipline/s Responsible for Staff Training and Education, Combined (N=44)	44
Figure 20. Topics Covered in Staff Education and Training, Combined (N=44)	45
Figure 21. Discipline/s Responsible for Providing Family/Carer Education, Combined (N=21)	46
Figure 22. Movement of Patients with Dementia to Different Beds within the Ward, Combined (N=76)	48
Figure 23. Approaches used to Ensure Person-centred Care for Patients with Dementia, Combined (N=75)	51
Figure 25. Processes to Monitor Challenging Behaviours in Patients with Dementia, Combined (N=75)	53
Figure 26. Recording Triggers vs. Monitoring Challenging Behaviours in Patients with Dementia, Combined (N=75).....	54
Figure 27. Policies and Procedures to Record/Respond to AAVB in Patients with Dementia, Combined (N=75)	55

LIST OF TABLES

Table 1. Survey Respondent Demographics – Clinical Units and Roles Represented (N=104)	15
Table 2. Care Settings & Clinical Units of Participants (N=104)	17
Table 3. Patient Demographics According to Health Service (N=104)	18
Table 4. Assessment for Dementia across Hospital Care Settings (N=95)	19
Table 5. Tools Used to Screen or Assess Dementia/Cognition, By Care Setting (N=95).....	20
Table 6. Screening and/or assessment of AAVB, By Care Setting (N=92).....	21
Table 7. Tools Used to Screen or Assess AAVB in Hospital, by Care Setting (N=92)	21
Table 8. Tools Used to Screen or Assess Delirium of those who reported using a tool, By Care Setting (N=86)	22
Table 9. Transfer Processes to Support Care for Patients with Dementia and BPSD, By Care Setting (N=85)	23
Table 10. Processes Used to Record Triggers of BPSD, By Care Setting (N=85)	24
Table 11. Processes Used to Monitor Challenging Behaviours, By Care Setting (N=85).....	25
Table 12. Care Planning Tools, By Care Setting (N=85)	26
Table 13. Pharmacological Interventions, By Care Setting (N=85)	27
Table 14. Non-pharmacological Interventions, By Care Setting (N=85)	28
Table 15. Examples Provided by Survey Respondents of Strategies used to Manage Challenging Behaviours	31
Table 16. Approaches to Involve Families in Care and Management of Patients with Dementia, By Care Setting (N=81).....	34
Table 17. Specific Barriers to Discharge for Patients with Dementia, By Care Setting (N=81)	37
Table 18. Staff Types/Disciplines, By Care Setting (N=74).....	39
Table 19. Presence of Dementia Specific Nurses (N=74).....	40
Table 20. Use of Additional Staffing or "Specialling" Practices (N=74).....	41
Table 21. Changes to Rosters of Staffing Levels because of Behaviours of Patients with Dementia (N=74)	41
Table 22. Education and Training about Dementia, BPSD, and managing AAVB for Specific Staff Groups .	42
Table 23. Timing of Staff Training and Education, By Care Setting (N=44).....	43
Table 24. Discipline/s Responsible for Staff Training and Education, By Care Setting (N=44)	43
Table 25. Topics Covered in Staff Education and Training, By Care Setting (N=44)	45
Table 26. Education and Training Provided for Families/Carers, By Care Setting (N=76)	46
Table 27. Discipline/s Responsible for Providing Family/Carer Education, By Care Setting (N=21)	46
Table 28. Ward Environment Modifications - Dementia-Friendly, By Care Setting (N=76)	47
Table 29. Ward Environment Modifications – Management of Aggression, By Care Setting (N=76)	48
Table 30. Movement of Patients with Dementia to Different Beds within the Ward, By Care Setting (N=76)	48
Table 31. Movement of Patients with Dementia to Different Beds within the Ward to Manage Behaviour, By Care Setting (N=76).....	49

Table 32. Use of Seclusion in Patients with Dementia to Manage Behaviour, By Care Setting (N=76)	49
Table 33. Approaches used to Ensure Person-centred Care for Patients with Dementia, By Care Setting (N=75)	50
Table 34. Processes to Record the Triggers of Challenging Behaviours in Patients with Dementia, By Care Setting (N=75).....	52
Table 35. Processes to Monitor Challenging Behaviours in Patients with Dementia, By Care Setting (N=75)	53
Table 36. Policies and Procedures to Record/Respond to AAVB in Patients with Dementia, By Care Setting (N=75).....	55
Table 37. Regular Reporting Regarding AAVB in Patients with Dementia at Senior Management Level, By Care Setting (N=75).....	56
Table 38. Responsibility for Preparing Reports for Senior Management around AAVB in Patients with Dementia, By Care Setting (N=48)	56
Table 39. Reporting Line of Information about AAVB and patients with Dementia, By Care Setting (N=48) .	57
Table 40. Monitoring and Addressing Staff Wellbeing in Organisations (N=74)	57
Table 41. Approaches Taken to Involve Families in Care and Management Patients with Dementia, By Care Setting (N=74).....	58
Table 42. Potential for Funding models to Influence the Care Provided to Patients with Dementia, By Care Setting (N=74).....	59
Table 43. Weaknesses and Opportunities Regarding Organisational Approaches to the Care of Patients with Dementia	60

ABBREVIATIONS

AAVB	Aggression, Agitation and Violent Behaviour
ACE	Addenbrooke's Cognitive Examination III
ACER	Addenbrooke's Cognitive Examination – Revised
BEHAVE-AD	Behavioural Pathology in Alzheimer's Disease
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CFA	Criteria for Admission
CGA	Comprehensive Geriatric Assessment
CPO	Constant Patient Observer
DA	Dementia Australia
DBMAS	Dementia Behaviour Management Advisory Service
DH	Department of Health
DOS	Delirium Observation Scale
DSA	Dementia Support Australia
ED	Emergency Department
FAB	Frontal Assessment Battery
GEM	Geriatric Evaluation and Management
HREC	Human Research Ethics Committee
KICA	Kimberley Indigenous Cognitive Assessment Tool
KT	Kettle Test
LOS	Length of Stay
MMSE	Mini-Mental State Examination
MOCA	Montreal Cognitive Assessment
MOOC	Massive Open Online Courses
NARI	National Ageing Research Institute
NUCOG	Neuropsychiatry Unit Cognitive Assessment Tool
OPA	Office of the Public Advocate
PAS	Pittsburgh Agitation Scale

RAGE	Rating Scale for Aggressive Behaviour in the Elderly
RUDAS	Rowland Universal Dementia Assessment Scale
SDA	Specialist Disability Accommodation
SDCP	Specialist Dementia Care Program
VCAT	Victorian Civil Administrative Tribunal

EXECUTIVE SUMMARY

Hospitals are known to be challenging places for people with dementia. Numerous physiological and psychosocial factors associated with being acutely unwell, combined with an unfamiliar and often unsuitable physical and social environment, can exacerbate symptoms of dementia. These new or changing symptoms can be difficult to manage, cause significant distress to patients, family members, staff and other patients, may result in harm to people with a dementia diagnosis or to others, and result in increased morbidity and mortality.

This benchmarking study forms part of a larger project titled '*Improving the Management of Patients with Severe Behavioural and Psychological Symptoms of Dementia (BPSD) in Victorian Hospitals*' conducted by the National Ageing Research Institute (NARI) on behalf of the Victorian Department of Health (DH). The results from all components of the project will help to inform service delivery and the development of a best practice model of care for patients with BPSD in Victorian public hospitals.

The primary objective of this project component was to report the current models of care in place for the management of patients with dementia and BPSD in Victorian hospitals. An online benchmarking survey was conducted involving staff from health services across Victoria to identify the guiding principles and service delivery processes in place and to establish gaps between current and published best practice. It was part of a larger project centred on the management of dementia and severe BPSD in hospital settings. The results from all components of the project will help to inform service delivery and the development of a best practice model of care for patients with BPSD in Victorian public hospitals.

Ethical approval for this study was obtained from Austin Health Human Research Ethics Committee (HREC) on July 6th, 2021 (HREC/75588/Austin-2021). In addition to routinely collected demographic, administrative and clinical data, qualitative information in the medical record that was related to the admission was used by data collectors to provide estimates of agitation and BPSD using the Pittsburgh Agitation Scale (PAS),¹ and the Brodaty Seven-Tiered Model of Management of BPSD,² respectively.

Key Findings

The management of patients with dementia and BPSD in hospital is complex, requiring an interdisciplinary approach that involves different healthcare professionals working together in often stressful circumstances. The impact of this can be significant, affecting various aspects of healthcare delivery. These patients often have longer LOS because of their need for specialised care and the challenges in managing BPSD that contribute to delays in diagnosis, treatment, and discharge planning. This can lead to increased adverse events, higher healthcare costs and greater utilisation of hospital resources.

Across the sample of 104 hospital clinicians representing emergency and urgent care, acute and sub-acute care settings within 13 health services across metropolitan, regional, and sub-regional Victoria, all survey respondents reported working with patients who had dementia. Almost all (99%) indicated they had observed aggressive behaviour in this population. Despite this, there was an identified lack of consistency regarding models of care that have been developed to support the assessment and management of patients with dementia and BPSD in Victorian hospitals. This was evident both between and within health services, particularly across different care settings, and was largely driven by the absence of overarching policies and formal guiding principles.

Numerous gaps were also observed between current and evidence-based best practice for this patient cohort. This included compliance with screening and assessment for both dementia and aggression, agitation and violent behaviour (AAVB), patterns of pharmacological intervention use, ability to identify and address individual patient needs, availability of appropriately trained human resources, access to dementia-friendly environments and the presence of governance systems and processes that support the delivery of safe and high-quality health care. A lack of acknowledgement regarding the presence and specific requirements of patients with dementia in all adult wards/units (including emergency and urgent care, acute and sub-acute care), as well as the critical role of families/carers in supporting care provision, was also apparent.

1. BACKGROUND

1.1 Dementia and Severe BPSD in Hospitals

Dementia is recognised as a significant and growing issue for health and aged care services in Australia. While dementia is not an inevitable or normal part of the ageing process, dementia was the leading cause of death of women and the second leading cause for men in 2020.³

The term “dementia” describes a group of conditions characterised by gradual impairment of brain function, which impacts daily function. Dementia symptoms include difficulties with memory and thinking, communication and speech, and/or mobility, and changes in personality and behaviour. For people formally diagnosed with dementia, difficulties in communicating and expressing needs may manifest in many ways. The Behavioural and Psychological Symptoms of Dementia (BPSD) refer to symptoms of dementia such as mood disturbances, hyperactivity-type symptoms, psychotic symptoms, changes in appetite, hoarding, night-time behaviour disturbances and “wandering” and can affect between 60 and 90% of people with dementia to varying extents.⁴ These symptoms often have a significant impact on people with dementia, carers and family, and have been associated with reduced functional ability, premature admission to residential care, increased hospitalisation rates, and increased stress for carers and for the person with dementia.⁵

The use of the term ‘BPSD’ is controversial as such symptoms may manifest because of the circumstances and situations perpetuated by other people and by external environments, and also from physical causes (such as medication side effects, undetected or untreated pain or discomfort, infections).⁵ However, the term is frequently used in clinical contexts and in the literature alongside other terminology such as changed behaviours, responsive behaviours, unmet needs, behaviours of concern, challenging behaviours and non-cognitive or neuropsychiatric symptoms of dementia.

Hospitals are known to be challenging places for people with dementia, particularly those presenting with BPSD. Numerous physiological and psychosocial factors associated with being acutely unwell, combined with an unfamiliar and often unsuitable physical and social environment, can exacerbate symptoms. These new or changing symptoms can be difficult to manage, cause significant distress to family members, staff and other patients, pose a significant risk of harm to patients themselves or to others, and result in increased morbidity and mortality.

1.2 ‘Improving the Management of Patients with Severe BPSD in Victorian Hospitals’ Project

A key issue identified by the Victorian Sub-acute Executive Peak Body in 2019 was whether Victorian health services have the capacity to meet the needs of a growing number, and increased severity, of people presenting and being admitted to hospitals with BPSD. A preliminary benchmarking survey of nine metropolitan and three regional health services in Victoria revealed that all health services provide care for patients with dementia and BPSD in sub-acute settings, but individual models of care (including management approaches and patient pathways relating to relevant ED and acute care settings) varied significantly between health services.⁶ In addition, several challenges to achieving a responsive Geriatric Evaluation and Management (GEM) service, the most common specialist model of care used in Victoria for patients with dementia and BPSD, were identified. Challenges included workforce recruitment, retention, level of skill, and access to specialist mental health services, and issues relating to the built environment.

Since the commencement of this project in 2019 there have been a myriad of issues for hospitals relating to care of older people due to the COVID-19 pandemic. Across Australia the COVID-19 pandemic placed and continues to impact service provision in hospitals and RACF. In Victoria, at least 191 RACF experienced at least one COVID-19 outbreak in the early years of the pandemic. Transfer to hospital was a common response for residents who tested positive for COVID-19 and required medical care. Many of those transferred from RACF to hospital had a diagnosis of dementia and the challenges in managing BPSD were exacerbated.

As a result, the National Ageing Research Institute (NARI) was commissioned by the Victorian Department of Health (DH) to undertake a comprehensive review of the management of patients with severe BPSD in Victorian Hospitals (*Improving the Management of Patients with Severe BPSD in Victorian Hospitals* project).

This benchmarking study forms part of that larger project.

1.3 Project Components

The *Improving the Management of Patients with Severe Behavioural and Psychological Symptoms of Dementia (BPSD) in Victorian Hospitals* project consists of multiple components. These include:

1. Establishment of an agreed definition of 'severe BPSD';
2. Exploration of national and international best practice principles and models of care regarding the hospital management of patients with severe BPSD through a rapid literature review;
3. Exploration of the extent and impact of severe BPSD on incidents, adverse events and outcomes in hospital settings within Victorian health services (through a population prevalence study, a point prevalence study, and a retrospective manual file audit);
4. Exploration of the local actions currently in place within Victorian health services to manage patients with severe BPSD in the hospital setting and compare these against best practice (using an online benchmarking survey); and
5. Exploration of the experience of family members* and staff relating to the current hospital management of severe BPSD within Victorian health services.

**Due to the COVID-19 pandemic, family member experience was not explored*

The results from all components of the project will help to inform service delivery and the development of a best practice model of care for patients with BPSD in Victorian public hospitals.

2. OVERVIEW

2.1. Study Aim

This study aims to identify current principles and models of care in place for the management of patients with dementia and BPSD in Victorian hospitals; gaps between current and published best practice for the management of patients with severe BPSD; and where and when gaps exist in the patient journey, and for what reasons.

It is part of a larger project centred on the management of dementia and severe BPSD in hospital settings. The results from all components of the project will help to inform service delivery and the development of a best practice model of care for patients with BPSD in Victorian public hospitals.

Specifically, this report presents the findings from the benchmarking survey of the project. This component uses data collected from metropolitan, regional and sub-regional health services across Victoria.

2.2 Study Objectives

2.2.1 Main Objectives

The primary objective of the study is to gain knowledge about the prevalence, impact and management of dementia and BPSD in participating Victorian hospitals and identify gaps in evidence-based care provision.

3. PROJECT DESIGN

3.1 Procedure

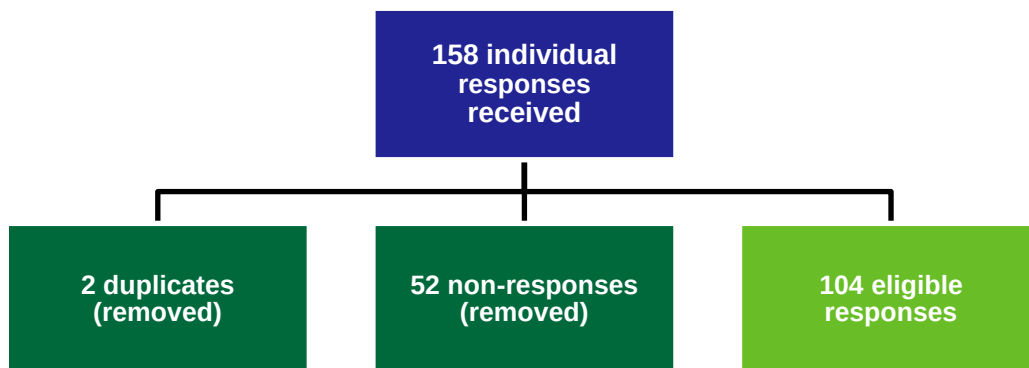
Ethical approval for this study was obtained from Austin Health Human Research Ethics Committee (HREC) on July 6th, 2021 (HREC/75588/Austin-2021). De-identified participant data was obtained from an online benchmarking survey of hospital clinicians from across all Victorian public health services.

3.2 Recruitment

All 28 health services across metropolitan, regional and sub-regional Victoria were approached to invite clinicians to share their experience regarding the current principles and models of care related to the management of patients with dementia in hospital. Of these, clinicians from 13 health services responded (representing a 46% response rate).

A total of 158 individual clinician responses were received (Figure 1). Of these, there were 52 entries where the survey was opened but no responses were recorded (beyond the respondent's health service and role). An additional 2 entries were duplicates. Once duplicates and non-responses were excluded, this left a sample of 104 eligible responses to the benchmarking survey.

Figure 1: Survey Responses



It is worth noting that not all questions were answered within eligible survey responses. Throughout this report, therefore, the number of responses received for each individual question will vary – this is indicated within each sub-heading.

The respective health services, clinical units and roles represented by survey respondents are outlined in Table 1.

Table 1. Survey Respondent Demographics – Clinical Units and Roles Represented (N=104)

Health Service	Responses (n=104)	Clinical Units of Survey Respondents	Roles of Survey Respondents
Alfred Health	1	Intensive Care Unit (1)	Clinical Nurse Manager (1)
Austin Health	10	Acute Geriatric (5) General Medicine (3) Aged Care and Neurological Rehabilitation (1) Subacute (1)	ANUM (3) NUM (4) RN (2) Geriatrician (1)
Barwon Health	4	General Medical (1) Rapid Assessment and Planning Unit (1) Geriatric Evaluation and Management (1) Acute care (1)	Clinical Liaison Nurse (1) NUM (3)
Bendigo Health	5	Rehabilitation (2) Aged Mental Health (1) Whole Hospital (Unspecified) (1) Respiratory (1)	NUM (4) RN (1)
Eastern Health	1	Acute Geriatric (1)	Geriatrician (1)
Grampians Health Ballarat	2	General Medical (1) Geriatric Evaluation and Management (1)	Geriatrician (1) NUM (1)
Mildura Base Public Hospital	3	General Medicine (3)	Behavioural Management Nurse (1) NUM (2)
Monash Health	12	Emergency Department (1) General Medical (1) Geriatric Evaluation and Management (3) Orthopaedics (1) Rehabilitation (3) Subacute (2) Transitional care Program (1)	ANUM (1) CNS (1) Physician (1) Geriatrician (2) Head of Music, Art, & Child Life Therapies (1) Music Therapist (1) NUM (2) Physiotherapist (2) Speech Pathologist (1)

Health Service	Responses (n=104)	Clinical Units of Survey Respondents	Roles of Survey Respondents
Northern Health	14	Acute Geriatrics (1) Aged Mental Health (2) General Medical (3) Geriatric Evaluation and Management (6) Orthopaedics (1) Stroke/Neurology (1)	ANUM (1) Neuropsychologist (1) NUM (4) Operational Director (1) Social Work (7)
Peninsula Health	7	Acute Geriatrics (1) Geriatric Evaluation and Management (1) Geriatric Evaluation and Management – Dementia (4) Whole Hospital (Unspecified areas) (1)	ANUM (2) Clinical Nurse Consultant (1) Diversional Therapist (1) NUM (2) Patient Services Manager (1)
Royal Melbourne Hospital	1	Geriatric Evaluation and Management – Dementia (1)	Geriatrician (1)
St Vincent's Hospital Melbourne	13	Aged Mental Health (6) General Medical (2) Geriatric Evaluation and Management (3) Subacute (1) Whole Hospital (Unspecified areas) (1)	ANUM (1) Clinical Nurse Consultant (1) Clinical Nurse Consultant - Behaviour Management (1) Clinical Nurse Educator (1) Geriatrician (3) NUM (2) OT (2) Registrar (2)
Western Health	31	Acute Geriatric (4) Aged, Cancer and Continuing Care (1) Emergency Department (7) General Medicine (4) Geriatric Evaluation and Management (7) Geriatric Evaluation and Management – Dementia (1) Oncology (1) Subacute (4) Transitional Care Program (1) Whole Hospital (Unspecified areas) (1)	Allied Health Assistant (1) Deputy ED Director (1) Diversional Therapist (1) EEN (1) Geriatrician (7) NUM (2) Oncologist (1) Operations Manager (1) OT (2) Physician (4) Registrar (5) RN (5)
Total	104		

The proportion of respondents from each hospital care setting, and the range of clinical units represented within these, is outlined in Table 2.

Table 2. Care Settings & Clinical Units of Participants (N=104)

Care Setting	Clinical Unit	n	%
Emergency and Urgent Care	Emergency Department (8)	8	7.7%
Acute	- Acute Care (1) - Acute Geriatric (12) - General Medicine (18) - Intensive Care Unit (ICU) (1) - Oncology (1) - Orthopaedics (2) - Rapid Assessment and Planning Unit (1) - Respiratory (1) - Stroke/Neurology (1)	38	36.5%
Sub-acute	- Aged, Cancer, and Continuing Care (1) - Aged Care & Neurological Rehabilitation (1) - Aged Mental Health (9) - GEM (22) - GEM-Dementia (6) - Rehabilitation (5) - Sub-acute Aged Care (1) - Sub-acute (not specified) (7) - Transitional Care Program (TCP) (2)	54	51.9%
Multiple Areas	Consult to whole hospital/all areas (unspecified) (4)	4	3.8%

3.3 Consent

Information about the voluntary nature of participation was provided in writing at the start of the online survey. Clinicians were advised about the details of the project and what was expected of them from this component. If potential participants decided to proceed, consent was implied by completion and submission of the survey. If a potential participant did not wish to complete the survey, no further involvement in the study was indicated.

3.4 Data Collection

Survey development was informed by the literature review previously conducted to identify national and international best practice principles and models of care regarding the hospital management of patients with dementia and BPSD. Data items consisted of open, closed and multiple-choice items, which were developed by experts in hospital dementia care representing all participating health services as well as NARI project team members. Feedback was incorporated into a final version of the online benchmarking survey.

3.5 Data Analysis

Raw data was downloaded into Excel and cleaned. RStudio (an open-source IDE integrated development environment software program for statistical analysis) and Excel were used to generate and analyse the responses for each section of the survey. Descriptive data (numbers and percentages) were used to describe key findings within each of these categories. Given the purpose of the survey, statistics were generated for the sample as a whole although some questions were evaluated and reported according to care setting.

4. KEY FINDINGS

4.1 Patient Demographics

All survey respondents reported that patients with dementia were present in the ward/unit they worked on, with 99% also indicating that aggression had been observed in this population.

Information regarding the patient demographics represented on behalf of the survey respondents are summarised in Table 3 and Figure 1. The reported length of stay (LOS) of patients on these wards/units ranged from 0.5 – 182 days however this varied significantly across health services depending on the care settings and clinical units that were represented by survey respondents. The average LOS was 22 days.

The average patient age (over a 12-month period as estimated by survey respondents) across the sample was between 30 and 90 years however this changes to between 50 and 90 years if the minimum average age is excluded (assuming that this significantly younger age represents the ED population). Despite this, even with all responses included, the average age of the patient population considered in this sample was 74 years.

Table 3. Patient Demographics According to Health Service (N=104)

Health Service	n	Average LOS (days on ward)		Average Patient Age (estimate past 12 months)	
		Range	Average	Range	Average
Alfred Health	1	5 days	5 days	60 years	60 years
Austin Health	10	7 – 28 days	16.7 days	68 – 80 years	76.3 years
Barwon Health	4	6 – 21 days	13.75 days	30 – 84 years	67.3 years
Bendigo Health	5	5 – 32 days	21.7 days	70 – 80 years	75 years
Eastern Health	1	6.5 days	6.5 days	71 years	71 years
Grampians Health Ballarat	2	5 – 18 days	11.5 days	60 – 78 years	69 years
Mildura Base Public Hospital	3	7 days	7 days	66 – 90 years	75.3 years
Monash Health	12	1 – 182 days	46.9 days	60 – 75 years	69.4 years
Northern Health	14	5 – 90 days	24 days	70 – 85 years	76.2 years
Peninsula Health	7	6 – 63 days	29.5 days	60 – 85 years	73 years
Royal Melbourne Hospital	1	28 days	28 days	85 years	85 years
St Vincent's Hospital	13	9 – 42 days	23.1 days	50 – 85 years	75 years
Western Health	31	0.5 – 91 days	18.9 days	30 – 88 years	73.3 years
TOTAL	104	0.5 – 182 days	22 days	30 – 90 years	74 years

4.2 Assessment

4.2.1 Dementia (N=95 responses)

Overall, 62% of respondents (n=59) indicated that patients were assessed for dementia during admission on their ward, with 46% (n=) indicating that this assessment happened at admission or early in the patient's presentation.

One-third of respondents (33%, $n=2$) working in emergency and urgent care indicated that screening and assessment of dementia and cognition was not performed in this setting. This finding was also reported by 14% ($n=5$) of respondents from acute and 2% ($n=1$) from sub-acute settings.

Of the 11 respondents who selected “other”, suggested reasons for this included issues surrounding compliance with assessment practices and the patient dependant nature of these (i.e. may not occur if the patient is known to the ward before they are admitted)

Table 4. Assessment for Dementia across Hospital Care Settings (N=95)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=36		N=49		N=4	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
No	2	33%	5	14%	1	2%	1	25%
Yes – conducted in ED, handed over on admission to this ward	1	17%	14	39%	10	20%	0	0%
Yes – at admission or early in presentation to this ward	1	17%	12	33%	30	61%	1	25%
Yes – during admission to this ward	1	17%	24	67%	32	65%	2	50%
Other	2	33%	5	14%	2	4%	0	0%
Unsure	0	0%	2	6%	0	0%	0	0%

The Mini-Mental State Examination (MMSE) was the most common tool used to screen for or assess dementia across all hospital settings (81%, $n=77$), followed by the clock drawing test (59%, $n=56$). Most survey respondents (80%, $n=76$) did not use the Brodaty Tiers.

When considering specific care settings, Comprehensive Geriatric Assessment (CGA) and the Rowland Universal Dementia Assessment Scale (RUDAS) were also used in a number of emergency and urgent care settings (17% of responses, respectively), while the RUDAS was again popular in acute care (64%, $n=23$). Respondents from sub-acute strongly favoured the MMSE (90%, $n=44$) however also reported using the clock drawing test (73%, $n=36$) and CGA (45%, $n=22$).

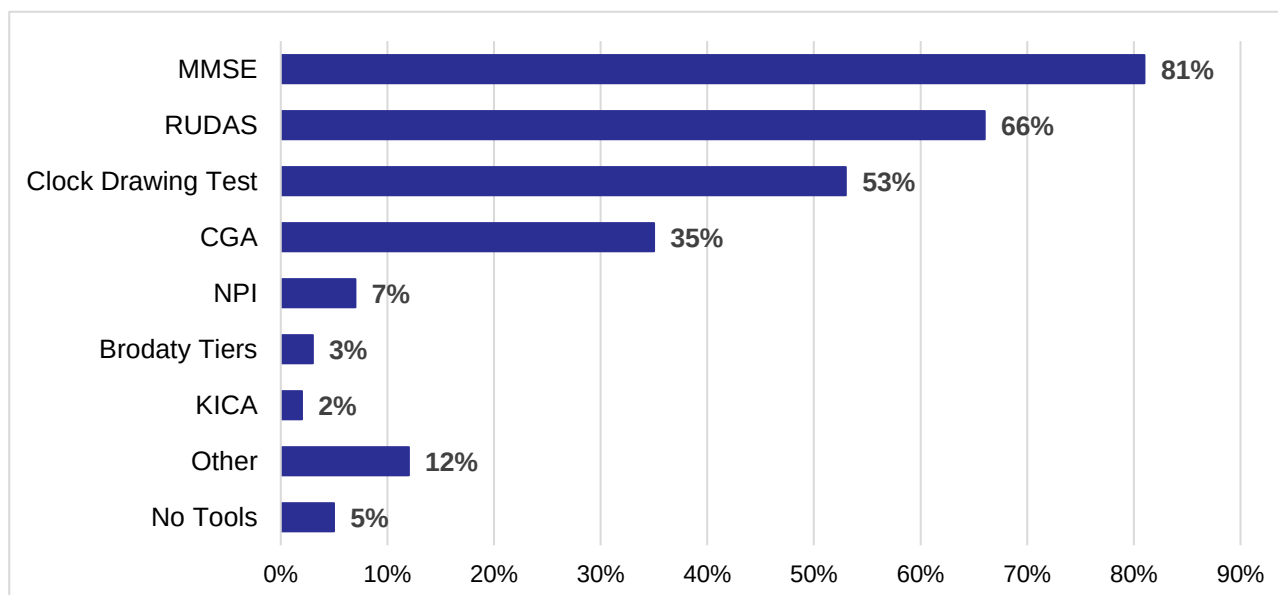
Of the respondents who selected ‘other’ types of screening/assessment tools, these included:

- 4AT
- Addenbrooke’s Cognitive Examination – Revised (ACER)
- Frontal Assessment Battery (FAB)
- Addenbrooke’s Cognitive Examination (ACE) III
- Neuropsychiatry Unit Cognitive Assessment Tool (NUCOG)
- Cognistat
- Kettle Test (KT)
- “Cognition-delirium assessment under risk assessment on EMR”
- “Functional cognitive assessment with OT”
- “Imaging”

Table 5. Tools Used to Screen or Assess Dementia/Cognition, By Care Setting (N=95)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=36		N=49		N=4	
	n	%	n	%	n	%	n	%
None	2	33%	2	6%	0	0%	1	25%
CGA	1	17%	9	25%	22	45%	1	25%
MMSE	2	33%	28	78%	44	90%	3	75%
Clock Drawing Test	1	17%	17	47%	36	73%	2	50%
RUDAS	1	17%	23	64%	0	0%	3	75%
Kimberley Indigenous Cognitive Assessment Tool (KICA)	0	0%	0	0%	6	12%	2	50%
Neuropsychiatry Inventory (NPI)	0	0%	2	6%	0	0%	0	0%
Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD)	0	0%	0	0%	0	0%	0	0%
Brodaty 7-Tier Model	0	0%	0	0%	2	0%	1	25%
Montreal Cognitive Assessment (MOCA) Test for Dementia	0	0%	3	8%	3	6%	0	0%
Other	0	0%	5	14%	6	12%	0	0%
Unsure	2	33%	3	8%	5	10%	0	0%

Figure 2. Tools Used to Screen or Assess Dementia/Cognition, Combined (N=95)



4.2.2 Aggression, Agitation, and Violent Behaviours (N=92)

When asked to tick all that apply for the location and timing of screening and/or assessment for agitation, aggression and violent behaviours (AAVB), 92 responses were received. Almost two-thirds of respondents (61%, $n=56$) indicated that patients were screened and/or assessed in emergency or urgent care and the findings of the screening were handed over on admission to the unit. A similar number (60%, $n=55$) responded that screening and/or assessment for AAVB also occurred on admission (i.e. early) to the unit.

Table 6 provides the location and timing of screening and/or assessment of AAVB based on the particular care setting for which the respondent was reporting. Multiple responses were possible.

Table 6. Screening and/or assessment of AAVB, By Care Setting (N=92)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=34		N=48		N=4	
	n	%	n	%	n	%	n	%
No assessment	0	0%	3	9%	2	4%	1	25%
Yes – conducted in ED, handed over on admission to this ward	3	50%	26	76%	25	52%	2	50%
Yes – at admission or early in presentation to this ward	1	17%	22	65%	31	65%	1	25%
Yes – during admission to this ward	1	17%	22	65%	26	54%	0	0%
Other	1	17%	1	3%	1	2%	1	25%
Unsure	0	0%	3	6%	5	10%	0	0%

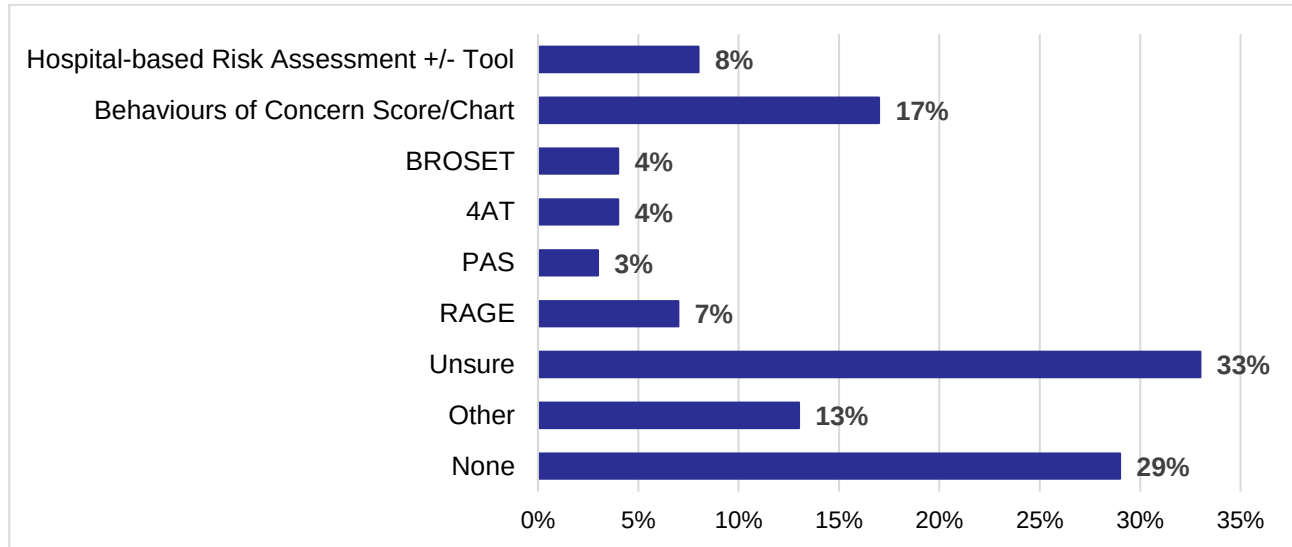
The tools used to identify and/or assess AAVB in hospitals varied greatly within and between care settings (Table 7). Behaviours of concern scores/chart were the most common tool used in both emergency and urgent care (83%, $n=5$) and sub-acute (16%, $n=8$) while acute settings were more likely to use a hospital-based risk assessment tool (17%, $n=6$).

Regarding these tools, most were reactive – frequently occurring after an incident has taken place. In addition, it is important to note that, of those who selected ‘unsure’, 20% of respondents stated that the assessment or screening of AAVB was either outside of their scope of practice, had never used a tool for this, or were unsure in general.

Table 7. Tools Used to Screen or Assess AAVB in Hospital, by Care Setting (N=92)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=36		N=49		N=4	
	n	%	n	%	n	%	n	%
None used	0	0%	11	31%	13	27%	3	75%
Rating Scale for Aggressive Behaviour in the Elderly (RAGE)	0	0%	2	6%	4	8%	0	0%
Pittsburgh Agitation Scale (PAS)	0	0%	1	3%	1	2%	1	25%
4AT	0	0%	1	3%	3	6%	0	0%
BROSET Violence Checklist	0	0%	3	8%	1	2%	0	0%
Behaviours of Concern Scores/Chart	5	83%	3	8%	8	16%	0	0%
Hospital-based Risk Assessment or Risk Assessment Tool	0	0%	6	17%	1	2%	0	0%
Other	1	17%	5	14%	6	12%	0	0%
Unsure	0	0%	9	25%	21	43%	0	0%

Figure 3. Tools Used to Screen or Assess AAVB, Combined (N=92)



4.2.3 Delirium (N=91)

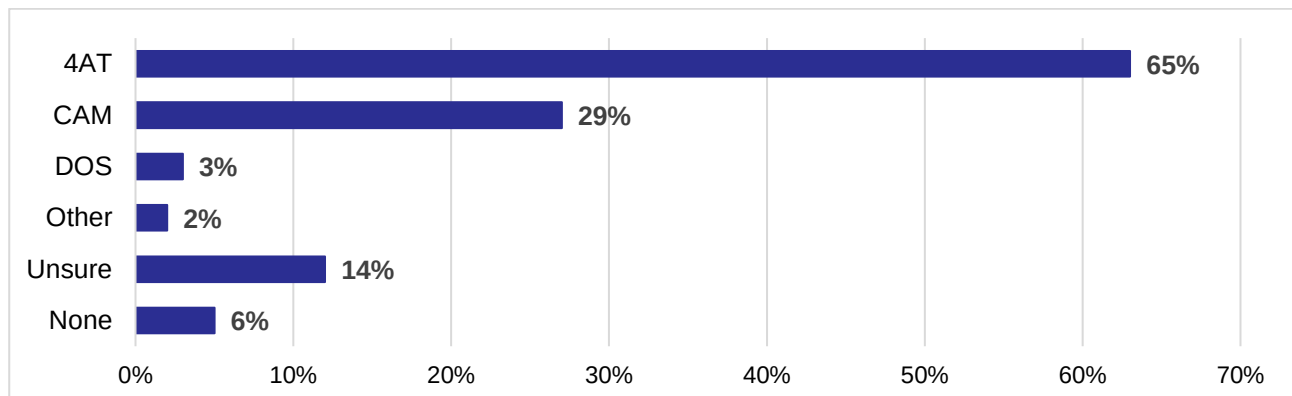
Almost all (95%, $n=86$) of respondents indicated that they screened or assessed patients for delirium on their unit; 5 respondents were unsure if patients were screened for delirium. The most common tool used for delirium screening was the 4AT (65%, 56 out of 86 responses).

'Other' tools mentioned by respondents included the Orientation-log (O-Log) and geriatrician assessment (other questions assessing alertness and distractibility).

Table 8. Tools Used to Screen or Assess Delirium of those who reported using a tool, By Care Setting (N=86)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=7		N=35		N=42		N=2	
	n	%	n	%	n	%	n	%
4AT	6	86%	20	57%	28	67%	2	100%
Confusion Assessment Method (CAM)	1	14%	17	49%	5	12%	2	100%
Delirium Observation Scale (DOS)	0	0%	1	3%	2	5%	0	0%
Other	0	0%	1	3%	1	2%	0	0%
Unsure	0	0%	3	9%	9	21%	0	0%
None	0	0%	1	3%	4	10%	0	0%

Figure 4. Tools Used to Screen or Assess Delirium, Combined (N=86)



4.3 Care Provision

4.3.1 Transfer Processes (N=85 responses)

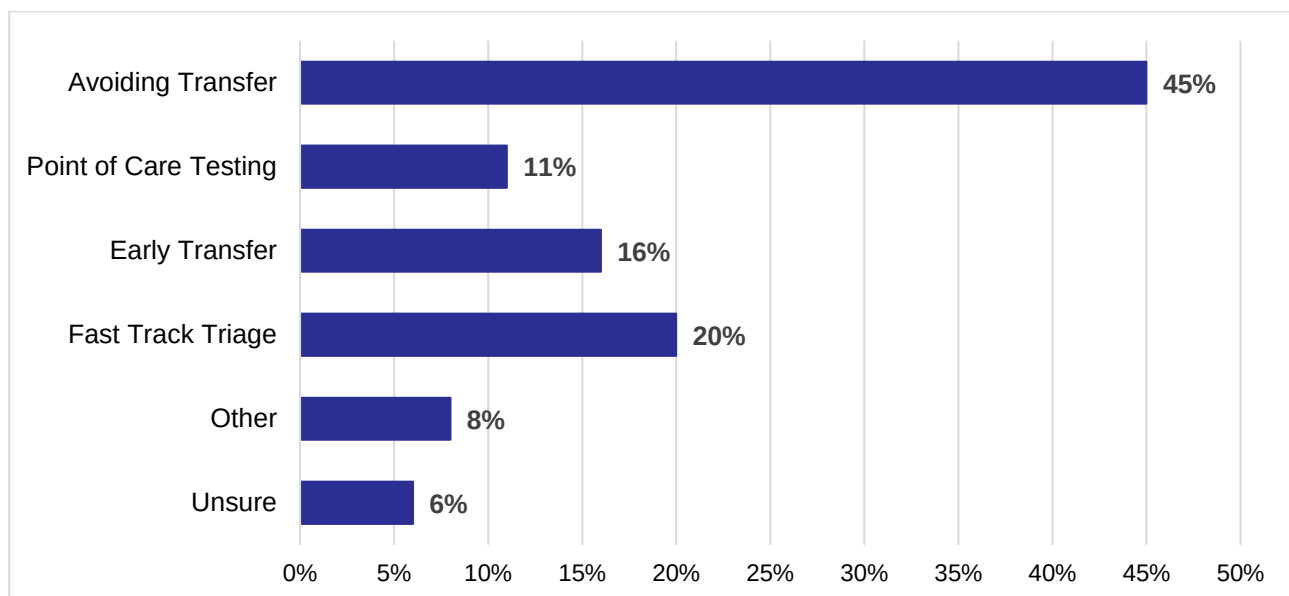
Two-thirds of respondents (66%, $n=56$) indicated that their ward had a transfer process in place to support staff in providing care for patients with dementia and BPSD. In emergency and urgent care, one-third (33%, $n=2$) of respondents suggested that early transfers to other units were employed while avoiding transfer between wards/sites was the dominant strategy used by acute and sub-acute settings (40%, $n=12$ and 53%, $n=24$ respectively).

Despite this, when examining the findings for different care settings, half (50%, $n=3$) of respondents from emergency and urgent care settings suggested that there were no identified transfer processes for this patient population. This was also the case in one-third (33%, $n=10$) of acute settings. Only 22 respondents (26%) reported more than one transfer process being in place.

Table 9. Transfer Processes to Support Care for Patients with Dementia and BPSD, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	n	%	n	%	n	%	n	%
None	3	50%	10	33%	13	29%	3	75%
Avoiding transfer between wards/sites	1	17%	12	40%	24	53%	1	25%
Point of care testing to minimise transfer	1	17%	2	7%	6	13%	0	0%
Early transfer to another unit	2	33%	4	13%	8	18%	0	0%
Fast track triage	0	0%	5	17%	12	27%	0	0%
Other	0	0%	4	13%	3	7%	0	0%
Unsure	0	0%	1	3%	4	9%	0	0%

Figure 5. Transfer Processes to Support Care for Patients with Dementia and BPSD, Combined (N=85)



4.3.2 Recording Triggers for BPSD (N=85)

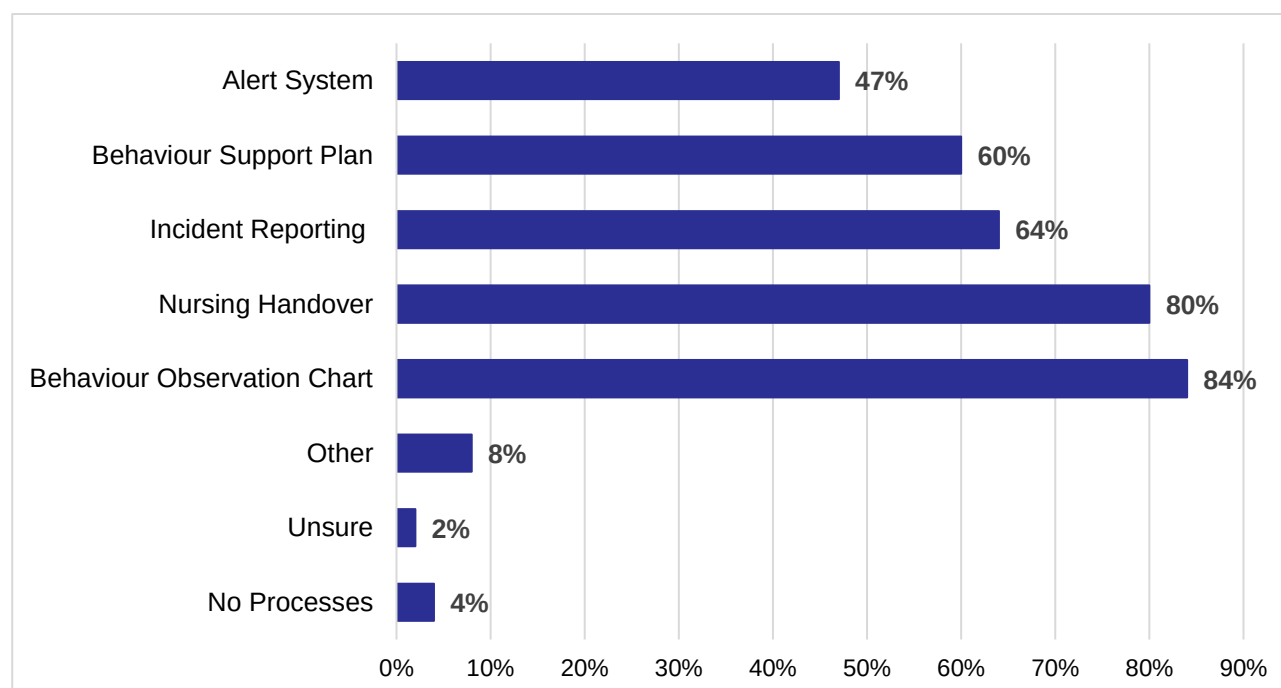
The most common process for recording triggers for BPSD was the use of behaviour observation charts (84%, $n=72$), followed by nursing handover (80%, $n=68$). This was consistent across all care settings.

Sub-acute wards were the most likely care settings to record triggers of BPSD, frequently using a wide range of strategies including nursing handover (91%, $n=41$), behaviour observation charts (87%, $n=39$), incident reporting (78%, $n=35$), behaviour support plans (64%, $n=29$) and alert systems (51%, $n=23$). Similar patterns were observed in acute settings at slight lower rates. In emergency and urgent care settings, however, the use of processes to record triggers of BPSD were mostly limited to behaviour observation charts (83%, $n=4$) and nursing handover (50%, $n=3$).

Table 10. Processes Used to Record Triggers of BPSD, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	n	%	n	%	n	%	n	%
No processes	0	0%	1	3%	2	4%	0	0%
Alert System	1	17%	13	43%	23	51%	1	25%
Behaviour Support Plan	0	0%	18	60%	29	64%	4	100%
Incident Reporting	1	17%	17	57%	35	78%	1	25%
Nursing Handover	3	50%	23	77%	41	91%	3	75%
Behaviour Observation Chart	4	83%	23	77%	39	87%	4	100%
Other	1	17%	2	7%	4	9%	0	0%
Unsure	0	0%	0	0%	1	2%	1	25%

Figure 6. Processes Used to Record Triggers of BPSD, Combined (N=85)



4.3.3 Monitoring Challenging Behaviours (N=85)

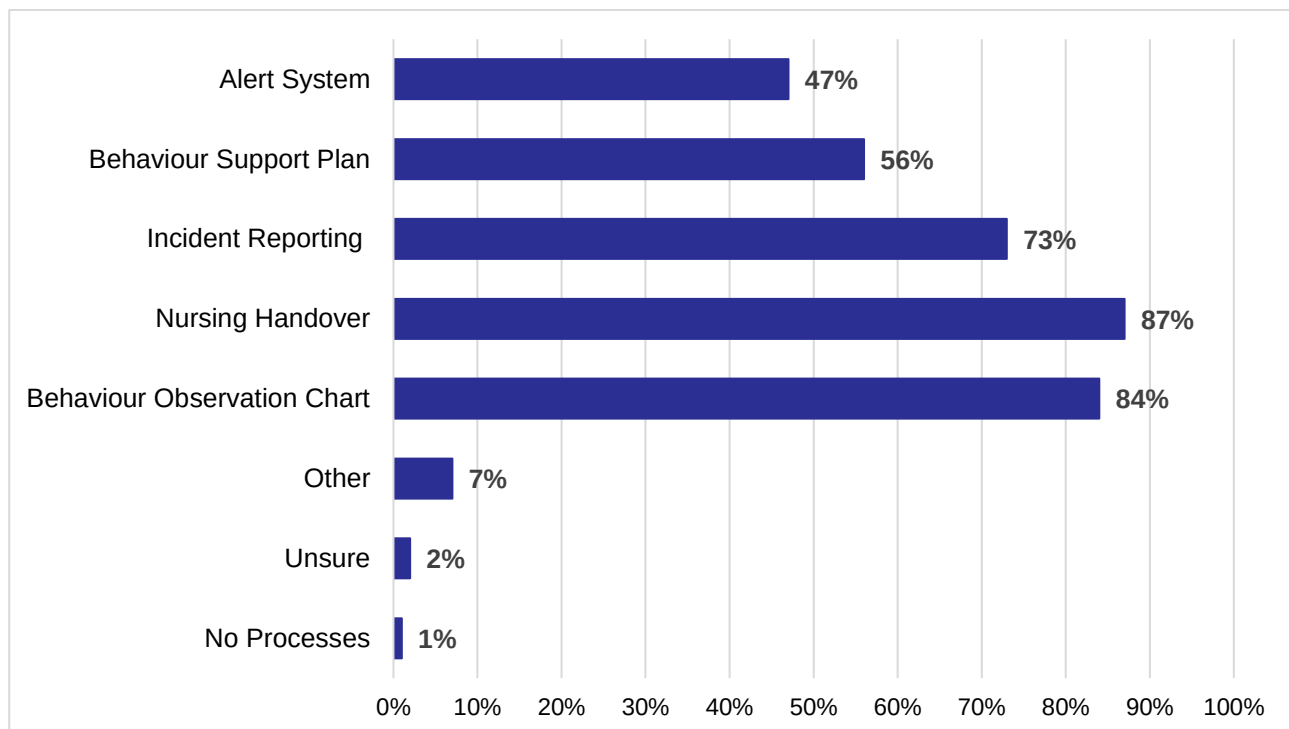
Across most care settings, the processes used to monitor challenging behaviours for patients with BPSD were similar to those employed to record triggers. Nursing handover was the most common process used, reported by 87% ($n=74$) of respondents, followed by the use of behaviour observation charts (84%, $n=71$). Acute and sub-acute care were more likely to use specific processes to monitor challenging behaviours than emergency and urgent care settings.

Over half of respondents 59% ($n=50$) indicated that four or more processes were employed.

Table 11. Processes Used to Monitor Challenging Behaviours, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	n	%	n	%	n	%	n	%
No processes	0	0%	0	0%	1	2%	0	0%
Alert system	3	50%	13	43%	23	51%	1	25%
Behaviour support plan	0	0%	16	53%	28	62%	4	100%
Incident reporting	2	33%	21	70%	36	80%	3	75%
Nursing handover	2	33%	27	90%	41	91%	4	100%
Behaviour observation chart	4	67%	25	83%	38	84%	4	100%
Other	1	17%	1	3%	4	9%	0	0%
Unsure	0	0%	0	0%	1	2%	1	25%

Figure 7. Processes Used to Monitor Challenging Behaviours, Combined (N=85)



4.3.4 Care Planning Tools (N=85)

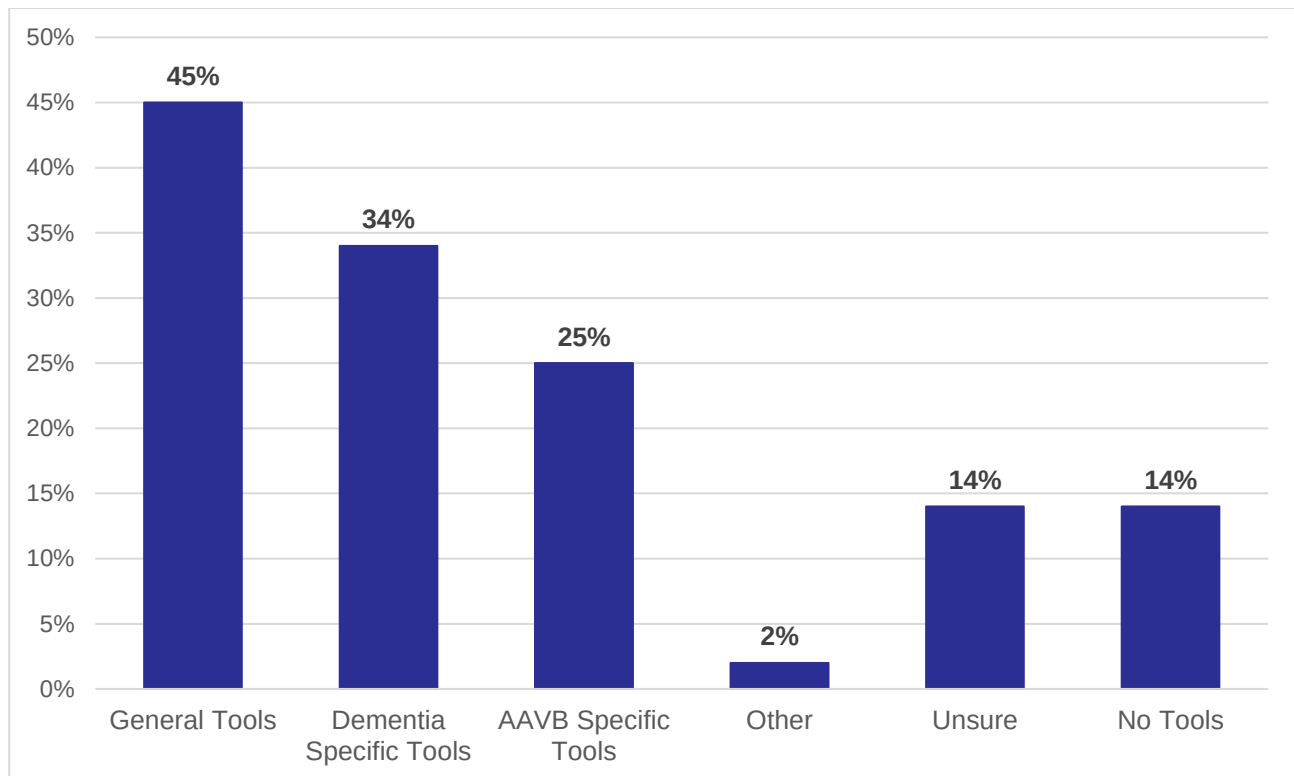
Around one-third of survey respondents (34%, $n=29$) used dementia specific care planning tools to support the care of people with dementia in hospital. The most common care planning tools reported were general tools (45%, $n=38$).

While only half of respondents from emergency and urgent care settings (50%, $n=3$) indicated that care planning tools were used to support the care of people with dementia, an additional one-third (33%, $n=2$) reported being unsure. The degree to which individual care planning tools were used was similar across acute and sub-acute care settings, however, specific tools for AAVB to support the care of people with dementia were more likely to be used on acute wards (30%, $n=9$ on acute wards vs. 22%, $n=10$ on sub-acute wards).

Table 12. Care Planning Tools, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
No processes	3	50%	4	13%	2	4%	3	75%
General Tools	0	0%	13	43%	25	56%	0	0%
Dementia Specific Tools	0	0%	11	37%	17	38%	1	25%
Tools Specific for AAVB	1	17%	9	30%	10	22%	1	25%
Other	0	0%	0	0%	2	4%	0	0%
Unsure	2	33%	5	17%	5	11%	0	0%

Figure 8. Care Planning Tools, Combined (N=85)



4.3.5 Pharmacological Interventions (N=85)

The majority of respondents (80%, $n=68$) reported that antipsychotics were used to support the management of patients with dementia and BPSD on their ward/unit. This was relatively consistent across all care settings.

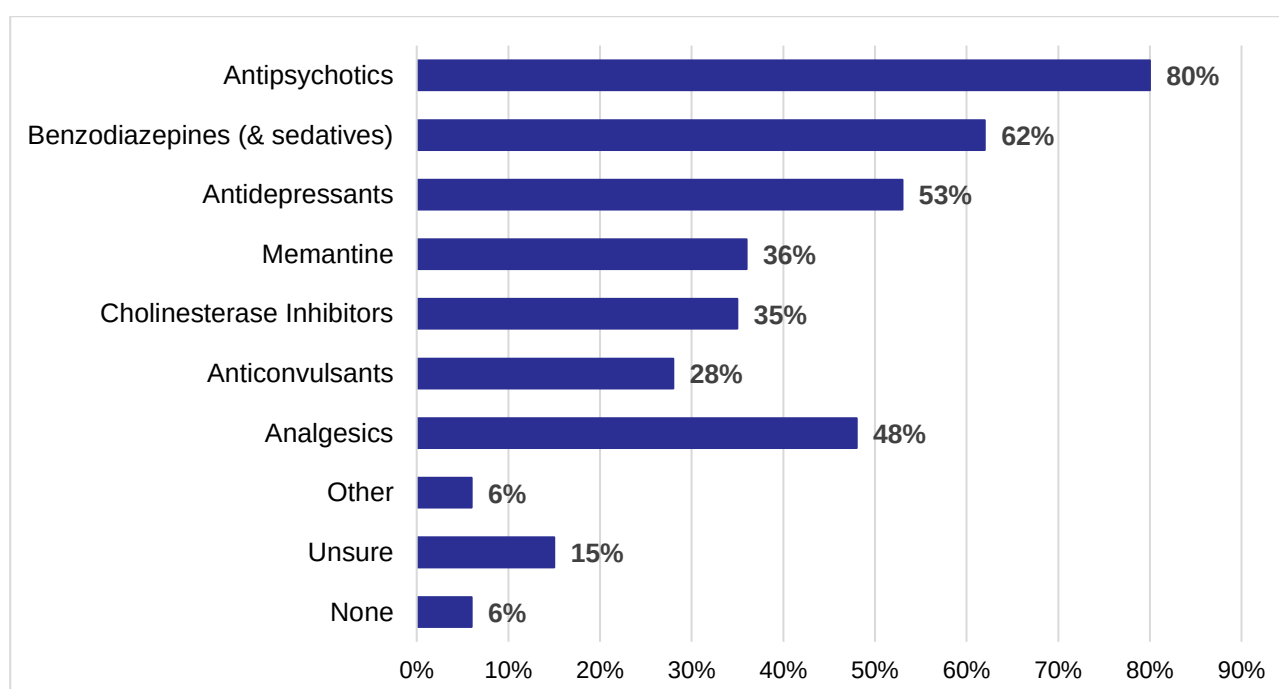
Use of benzodiazepines (and sedatives), however, was considerably higher in emergency and urgent care settings (83%, $n=5$) compared with acute (67%, $n=20$) and sub-acute settings (58%, $n=26$). The opposite phenomenon was observed regarding anti-depressants, with these medications being prescribed most frequently in sub-acute settings (62%, $n=28$) followed by acute (43%, $n=13$) and emergency and urgent care (17%, $n=1$).

One respondent stated that they used medications sparingly and preferred non-pharmaceutical strategies.

Table 13. Pharmacological Interventions, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	n	%	n	%	n	%	n	%
None	1	17%	1	3%	3	7%	0	0%
Antipsychotics	5	83%	25	83%	34	76%	4	100%
Benzodiazepines (& sedatives)	5	83%	20	67%	26	58%	2	50%
Antidepressants	1	17%	13	43%	28	62%	3	75%
Memantine	1	17%	9	30%	19	20%	2	50%
Cholinesterase Inhibitors	2	33%	8	27%	18	40%	2	50%
Anticonvulsants	0	0%	5	17%	18	40%	1	25%
Analgesics	3	50%	12	40%	24	53%	2	50%
Other	0	0%	0	0%	5	11%	0	0%
Unsure	0	0%	5	17%	7	16%	1	25%

Figure 9. Pharmacological Interventions, Combined (N=85)



4.3.6 Non-pharmacological Interventions (N=85)

The most common non-pharmacological intervention reported to support the management of patients with dementia and BPSD in hospital was additional staffing (80%, $n=68$), followed by allocation to a single room (76%, $n=65$). The least common non-pharmacological intervention used across all care types was seclusion (2%, $n=2$).

Of the 12 “other” responses provided, these included:

- Modified visiting hours;
- Pet therapy;
- Family involvement;
- Specialist nursing support/education; and
- The ‘forget me not flower’ approach.

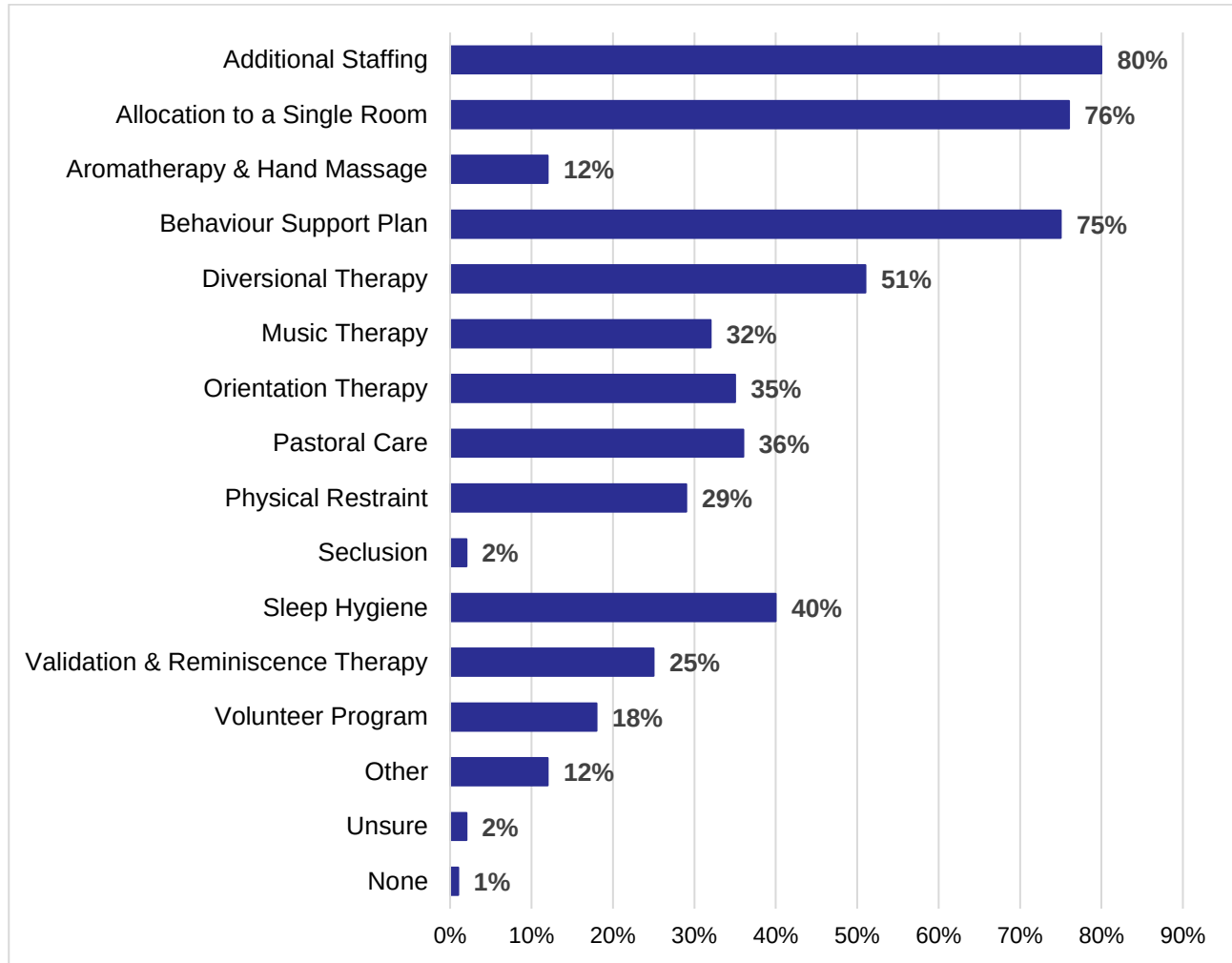
In emergency and urgent care, additional staffing (67%, $n=4$) was the predominant non-pharmacological strategy used. Despite this, additional staffing was utilised most in acute care (93%, $n=28$). Allocation to a single room (83%, $n=25$), behavioural support plans (80%, $n=24$) and physical restraint (50%, $n=15$) were other interventions commonly used in acute settings.

Sub-acute care settings used a wide range of non-pharmacological strategies, including behavioural support plans (80%, $n=36$), allocation to a single room (78%, $n=35$), additional staffing (71%, $n=32$), diversional therapy (58%, $n=26$), pastoral care (51%, $n=23$), music therapy (47%, $n=21$), and sleep hygiene (47%, $n=21$). Sub-acute settings were also the most likely care setting to include a volunteer program (22%, $n=10$).

Table 14. Non-pharmacological Interventions, By Care Setting (N=85)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=30		N=45		N=4	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
None	1	17%	0	0%	0	0%	0	0%
Additional Staffing	4	67%	28	93%	32	71%	4	100%
Allocation to a Single Room	2	33%	25	83%	35	78%	3	75%
Aromatherapy & Hand Massage	0	0%	1	3%	9	20%	0	0%
Behavioural Support Plan	0	0%	24	80%	36	80%	4	100%
Diversional Therapy	1	17%	13	43%	26	58%	3	75%
Music Therapy	0	0%	6	20%	21	47%	0	0%
Orientation Therapy	0	0%	12	40%	18	40%	0	0%
Pastoral Care	0	0%	8	27%	23	51%	0	0%
Physical Restraint	1	17%	15	50%	8	18%	1	25%
Seclusion	0	0%	1	3%	1	2%	0	0%
Sleep Hygiene	0	0%	12	40%	21	47%	1	25%
Validation/Reminiscence Therapy	0	0%	2	7%	17	38%	2	50%
Volunteer Program	0	0%	3	10%	10	22%	2	50%
Other	1	17%	3	10%	6	13%	0	0%
Unsure	1	17%	0	0%	0	0%	1	25%

Figure 10. Non-pharmacological Interventions, Combined (N=85)

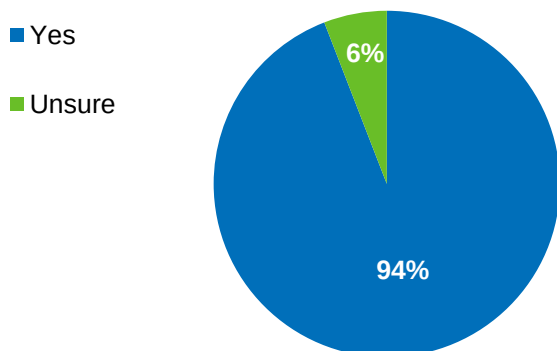


4.3.7 Emergency Responses (N=85)

Code Grey

Almost all respondents, 94% ($n=80$), reported that there had been a code grey related to patients with dementia on their ward within the last 12-months (Figure 11). Of the 6% ($n=5$) respondents that were unsure, four respondents were from sub-acute wards/units, and one was from an acute care setting.

Figure 12. Code Greys (planned or unplanned) in the past 12-months related to patients with Dementia (N=85)



Code Black

Nearly one-fifth (19%, $n=16$) of respondents reported that a code black had been called on their ward in the past 12-months related to a patient with dementia (Figure 12). Of those, the highest proportion of respondents indicated that they worked in acute care settings (30%, $n=9$).

Figure 11. Code Blacks in the past 12-months related to patients with Dementia (N=85)

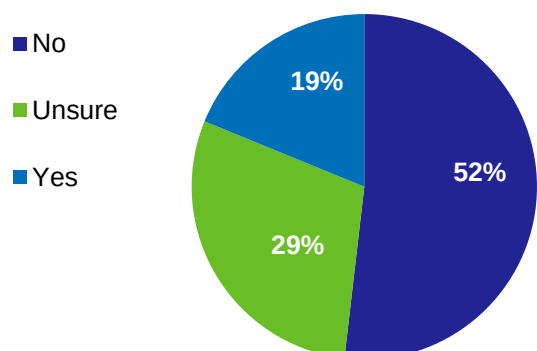
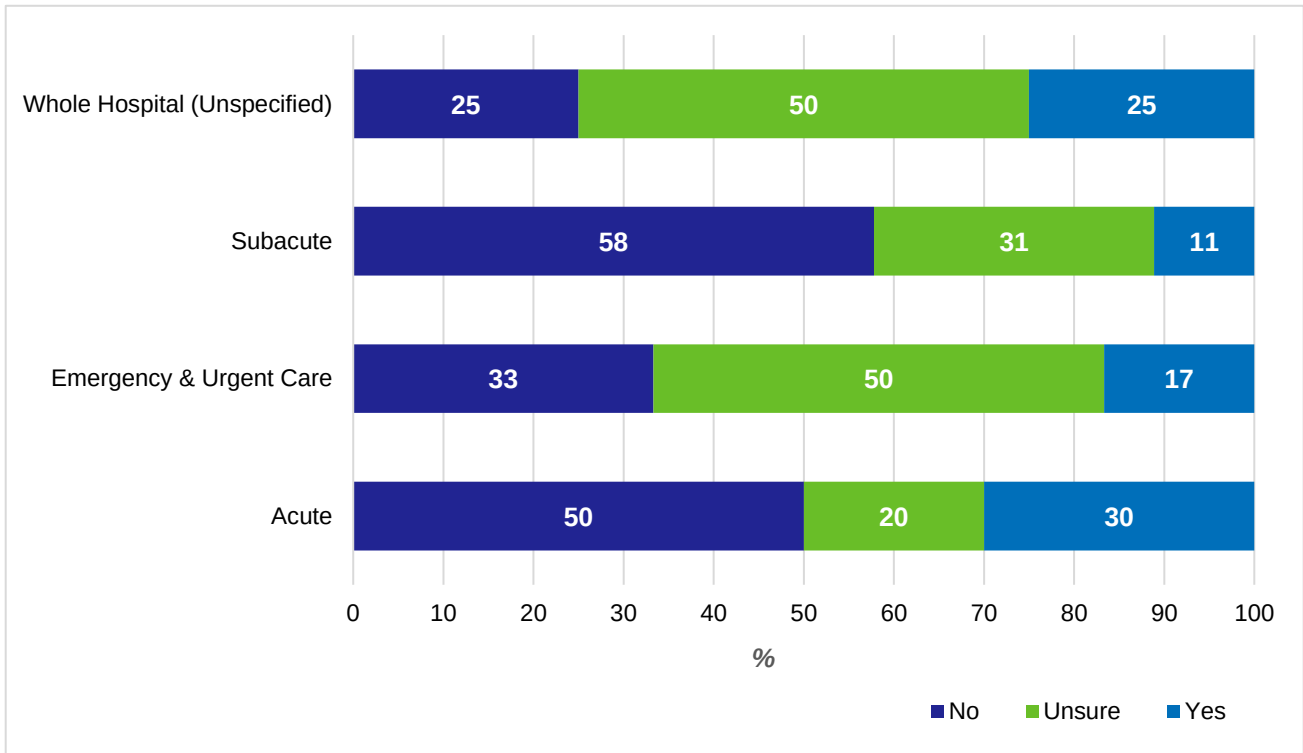
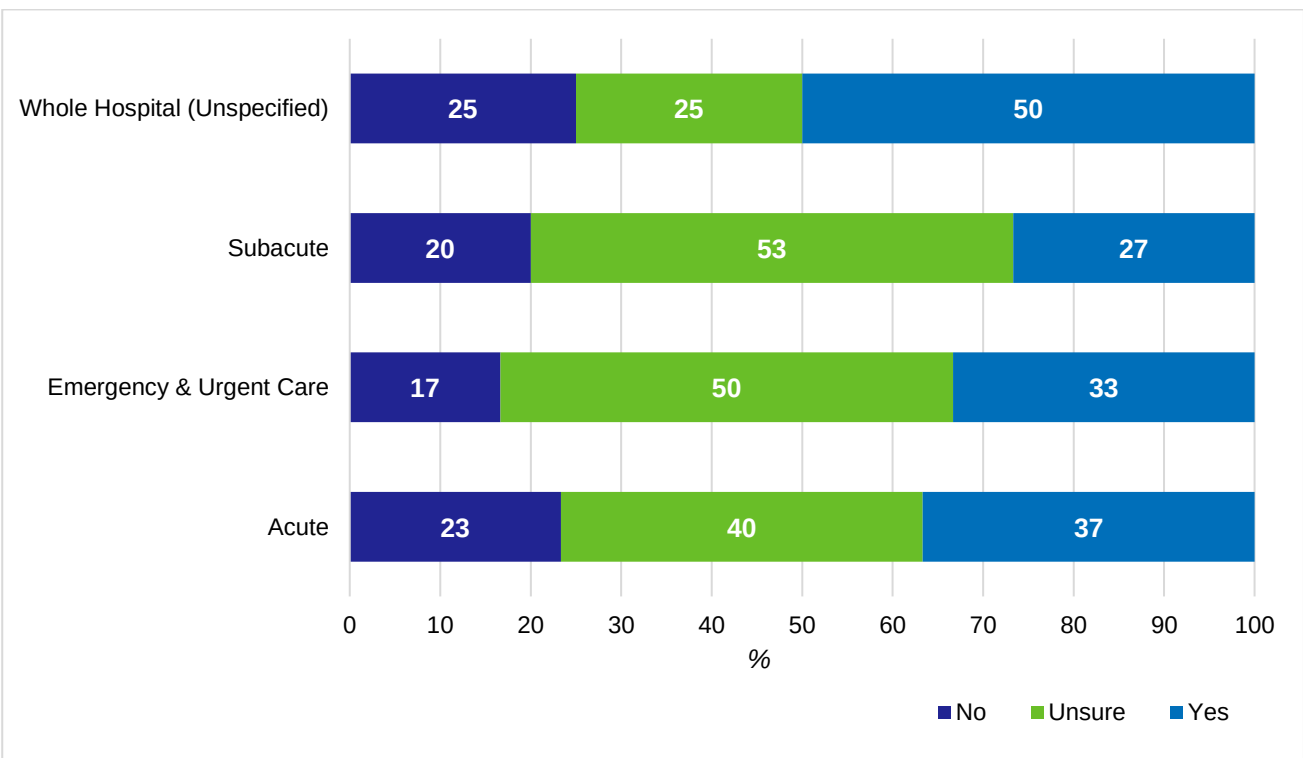


Figure 13. Code Black Responses in the Past 12 Months related to Patients with Dementia, By Care Setting (N=85)



Across all care settings combined, 32% of respondents ($n=27$) suggested that specific OVA management approaches were used on their ward in relation to the care of patients with dementia and BPSD. Despite this, almost half (47%, $n=40$) were unsure if their ward had any specific approaches while 21% ($n=18$) reported a lack of approaches altogether.

Figure 14. Specific OVA Management Approaches used in Relation to Care of Patients with Dementia, By Care Setting (N=85)



4.3.8 Strategies to Manage Challenging Behaviours (N=85)

Overall, survey respondents provided a vast range of strategies used to manage challenging behaviours exhibited by patients with dementia in hospital. In line with the PAS, the severity of these behaviours were categorised into four specific behavioural dimensions:

1. Aberrant Vocalisation
2. Motor Agitation
3. Aggressiveness
4. Resisting Care

A small number of respondents indicated that there are limited to no strategies used, however it was acknowledged that this tends to result in overuse of pharmacotherapy. The full range of free text comments made by survey respondents according to care setting and behaviour type can be found in Appendices 6-9.

Table 15. Examples Provided by Survey Respondents of Strategies used to Manage Challenging Behaviours

Strategies used to Manage Challenging Behaviours	Emergency & Urgent Care	Acute Care	Sub-acute Care
Pharmacological	✓	✓	✓
• Prn medications		✓	✓
• Anti-psychotics		✓	✓
• Analgesics		✓	✓
• Antidepressants		✓	
• Mood stabilisers		✓	
Non-Pharmacological	✓	✓	✓
• Involve family members/carers/friends	✓	✓	✓
• Allow patient to walk around	✓	✓	✓
• Provide a change of environment	✓	✓	✓
• Diversional therapy	✓	✓	✓
• Identify unmet needs		✓	✓
• Provide 1:1 supervision / specialising	✓	✓	✓
• Re-direct		✓	✓
• Access additional staff to provide assistance	✓	✓	✓
• Music therapy	✓	✓	✓
• Assess/manage pain	✓	✓	✓
• Assess/manage hunger/thirst	✓	✓	✓
• Assess/manage continence	✓	✓	✓
• Assess/manage skin integrity	✓	✓	
• Leave patient alone (if safe) and re-approach later	✓	✓	✓
• Alter communication method		✓	✓
• Offer patient choices / negotiate	✓	✓	✓

• Manage delirium	✓	✓	
• Provide re-assurance		✓	✓
• Provide explanations	✓	✓	✓
• Ignore / increase tolerance of behaviours		✓	✓
• Move patients to a single room / close to reassurance / high visibility location		✓	✓
• Offer social interaction / company	✓	✓	
• Engage in recreational activities		✓	
• Isolate from other patients		✓	
• Regular / timed attendance to patient		✓	
• Optimise sensory stimulation		✓	
• Reduce visual / auditory triggers	✓	✓	
• Massage		✓	
• Get to know the patient and develop relationships		✓	
• Reinforce boundaries and expectations		✓	
• Document / handover de-escalation approaches	✓	✓	
• Re-orient patient to time / place		✓	
• "Patient watch"		✓	
• Use distractions / diversions		✓	✓
• Formal group activities		✓	
• Use a wanderers alarm		✓	✓
• Mechanical/physical restraint/restrictive practices		✓	✓
• Ensure a safe physical environment		✓	✓
• Encourage physical activity		✓	✓
• Reminiscence activities		✓	✓
• Prioritise rest		✓	
• Use a onesie for patients who disrobe			✓
• Ask families to provide personal items to make the environment familiar / recognisable / comforting		✓	
• Access to outside areas		✓	✓
• Develop care plans / behavioural support plans, including stepped plan of care		✓	✓
• Pre-warning regarding upcoming interventions		✓	✓
• Team nursing approach	✓	✓	✓

• Consistant care staff			✓
• Try different staff members if required		✓	
• Consider time of day		✓	
• Carefully select staff for employment		✓	
• Observe from a distance		✓	
• Allow patients to refuse care (if safe)		✓	
• Group care requirements		✓	
• Medical and/or allied health review		✓	✓
• Keep requested items in reach			✓
• Provide 1:1 time and allow patient to self-soothe			✓
• Transfer to Dementia Management Unit			✓
• Talk about the patients subject/s of interest		✓	✓
• Use mittens			✓
• Nurse in intensive care area of ward			✓
• Provide meaning places for patients to visit			✓
• Diversional environmental design			✓
• Ensure good lighting by day and dim lighting by night to minimise disorientation in unfamiliar environment			✓
• Involve behaviour support nurse			✓
• Talk to patient regarding behaviours			✓
• Minimise interventions – only provide absolutely necessary care			✓
• Use interpreters		✓	
Emergency Responses			
• Organise planned code-greys	✓	✓	✓
• Call unplanned code grey	✓	✓	✓
• Call code black			✓
• Request assistance from security staff	✓	✓	✓

One particular theme that emerged were staff attitudes to the care of patients with dementia and the choice of wording used to describe the challenging behaviours observed. For example, a number of respondents indicated disliking the word “wandering”, instead suggesting that patients with dementia generally move around in an attempt to seek particular items, locations and/or stimulation within their environment. Considering “wandering” in this way was suggested to facilitate consideration of why this behaviour may be occurring, identify potential unmet needs and develop specific non-pharmacological management strategies that address these. It was also suggested that giving patients "permission to wander" by providing secure environments that incorporate alternative and meaningful spaces to use/visit.

Effective communication with the patient, using appropriate tone and volume of voice, was another common approach that underpinned management strategies. This included pre-warning patients prior to upcoming interventions to avoid 'fright' or impulse reactions; reassurance to minimise the perceived need to protect themselves; listening to and addressing patient concerns; providing explanations and engaging in negotiation.

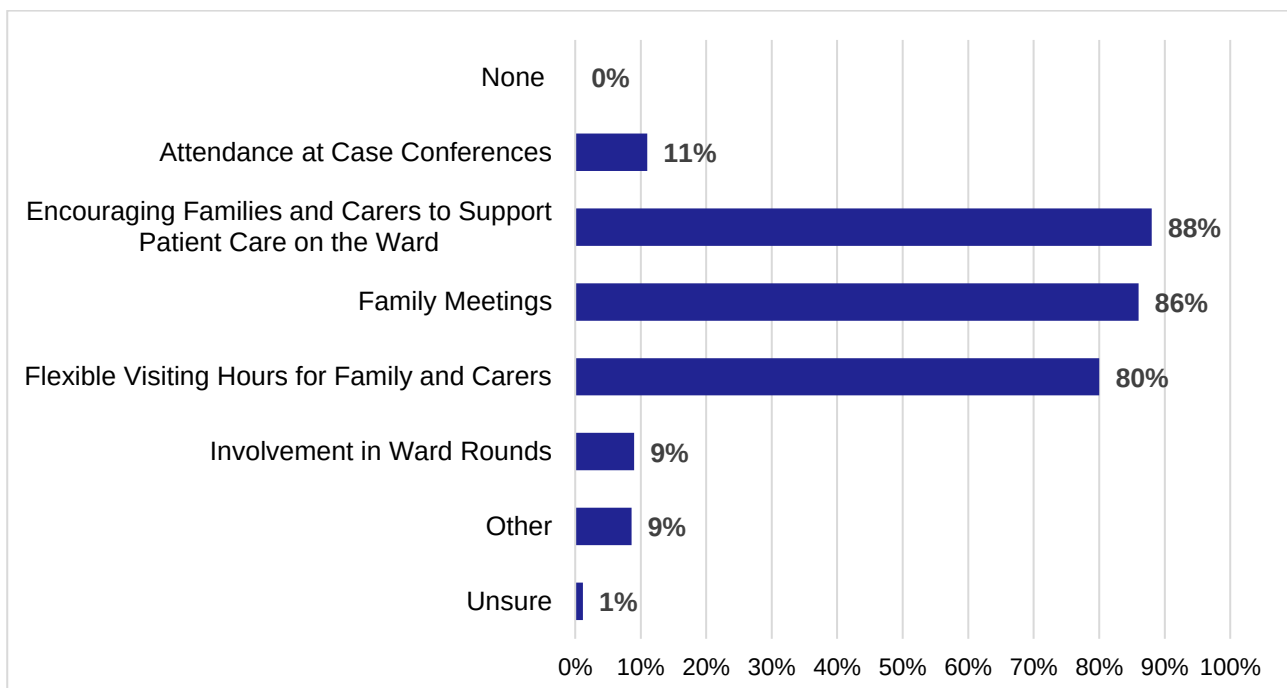
4.3.9 Involving Families in Care (N=81)

The most common approach used to involve families in care provision was encouraging families and carers to support patients care on the ward (88%, $n=71$). This was closely followed by family meetings (86% $n=70$). All respondents indicated that there was at least one approach taken, with 89% ($n=72$) indicating that at least two approaches were used.

Table 16. Approaches to Involve Families in Care and Management of Patients with Dementia, By Care Setting (N=81)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=6		N=28		N=43		N=4	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
None	0	0%	0	0%	0	0%	0	0%
Attendance at Case Conferences	0	0%	3	11%	6	14%	0	0%
Encouraging Families and Carers to Support Patient Care on the Ward	3	50%	26	93%	38	88%	4	100%
Family Meetings	1	17%	25	89%	41	95%	3	75%
Flexible Visiting Hours for Family and Carers	5	83%	25	89%	32	74%	3	75%
Involvement in Ward Rounds	0	0%	4	14%	3	7%	0	0%
Other	1	17%	2	7%	4	9%	0	0%
Unsure	0	0%	0	0%	1	2%	0	0%

Figure 15. Approaches to Involve Families in Care and Management of Patients with Dementia, Combined (N=81)



4.3.10 Challenges to Care Provision

Almost 100 individual free text comments were recorded from survey respondents regarding the challenges associated with managing older people with dementia in hospital. Common themes that emerged include:

1. Patient Presentation

- Challenging behaviours e.g. sundowning; wandering; resistance to care; aggression; intrusive behaviour; assaults on staff
- Communication difficulties (including with patients who do not speak English)
- Complex psychosocial issues
- High risk of adverse events e.g. delirium, falls, incontinence, pressure injuries
- Increased medical, nursing and personal care needs
- Family understanding/expectations of the patient's condition
- Constant stream of patients with dementia through the hospital system who are admitted from nursing homes however cannot be discharged back to the same location
- Ability to facilitate person-centred discharge planning due to cognitive impairment
- Combination of physical and cognitive frailty

2. Management Approaches

- Identifying and managing unmet needs
- Excessive use of pharmacotherapy after hours
- Decision making regarding the use of pharmacological vs non-pharmacological strategies
- Reactive rather than proactive approach to management of triggers
- Culture around restrictive practices
- Not enough resources/activities to provide distraction
- Getting to know the patients and their behaviours
- Competing challenges of looking after other medically unwell patients, patients with mental illness and the general feeling of the amount of time spent caring for patients with BPSD

3. Workforce

- Lack of time to provide individualised care due to the high volume of patients
- Insufficient staffing ratios
- Unable to access specialty staff e.g. psychiatry; diversional therapy; allied health
- Staff knowledge gaps (pathophysiology of dementia; de-escalation)
- Availability/variation in quality of staff providing 1:1 supervision

4. Environment

- Inappropriate physical environment e.g. high visual/auditory stimulus; clutter; not enough room
- Lack of safe and secure indoor/outdoor areas for patients to walk around
- Unfamiliar environment/routine/people

5. Organisational Factors

- Patients with dementia being admitted as outliers on other specialty wards
- COVID (including infection control restrictions and reduced capacity for family to visit)
- Difficulty accessing families and interpreters
- Lack of clear and consistent management protocols
- Ineffective use of behaviour support plans
- No volunteer program
- Mixture of patients with and without dementia in the one ward

Specific challenges relating to the management of older people with dementia *and* behaviours of agitation, aggression, and violence challenging in hospital were also recorded. While many of these were similar to those outlined above, overall they were more emotive and extreme in nature. Additional comments included:

1. Level of Complexity

- Increased amount of paperwork in managing patients with dementia
- Time required to complete VHIMS reporting, tracker charts etc.
- High medical acuity of patients
- Takes time to determine optimal medication doses

2. Clinical Decision-Making

- Managing excess use of psychotropic meds vs. risk of injury to staff other patients
- Knowing when to resort to medication rather than non-pharmacological techniques, particularly when staffing is low and nursing staff are anxious and worried
- Balance between environmental restraint vs. locked ward
- Culture of relying on pharmacological management
- Limited number/availability of non-pharmacological management strategies
- Respecting the rights of the patient as well as those around them

3. Bed/Ward/Unit Configuration

- Putting similar patients all together in same environment can increase risk of violence
- Mixed ward population can result in other patients without dementia becoming frightened
- Presence of environmental elements that can trigger aggression: noisy, high traffic, shared rooms, limited visitation of carers, no safe access to outdoor spaces, unsuitable ED environment
- Lack of a cognitive impairment intensive care/high dependency unit
- Not enough single rooms
- General wards cannot do much to manage these patients

4. Staff Allocation

- Inexperienced staff with poor understanding regarding the cause of challenging behaviours and handling OVA incidents
- Poor staff confidence in managing patients with dementia, especially those who are aggressive
- Frequently changing staff
- Staff who work on different wards don't always get to observe the patient across the whole day
- Lack of specialty/geriatric consultation services
- Medical responsiveness if prn medication not working

5. Education and Training

- Lack of staff training
- Poor medical staff knowledge of medication dosage and titration
- No process for upskilling new staff (exacerbated by high staff turnover)

6. OH&S

- Staff safety e.g. verbal/physical violence towards staff
- Fear of being assaulted and/or injured, fatigue, burnout, emotional distress, feelings of helplessness, having to constantly apologise to families for sub-optimal care
- Concern regarding the wellbeing of other patients

4.3.11 Barriers to Discharge (N=81)

85% of respondents (n=69) indicated there were barriers to discharging patients with dementia from their ward (Figure 16).

Of these, the most common barriers reported were:

1. Waiting list for appropriate residential aged care (86%, n=59)
2. Limited capacity of destination ward (84%, n=58)
3. Awaiting = appointment for guardian (71%, n=49)
4. Awaiting Victorian Civil Administrative Tribunal (VCAT) decision or hearing (71%, n=49)
5. Unclear discharged destination (67%, n=46)

Figure 16. Barriers to Discharging Patients with Dementia Experienced, Combined (N=81)

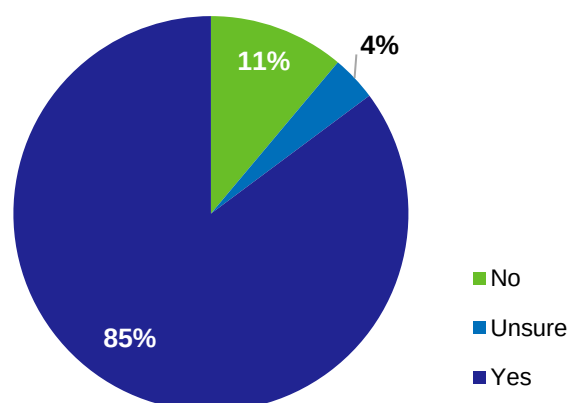
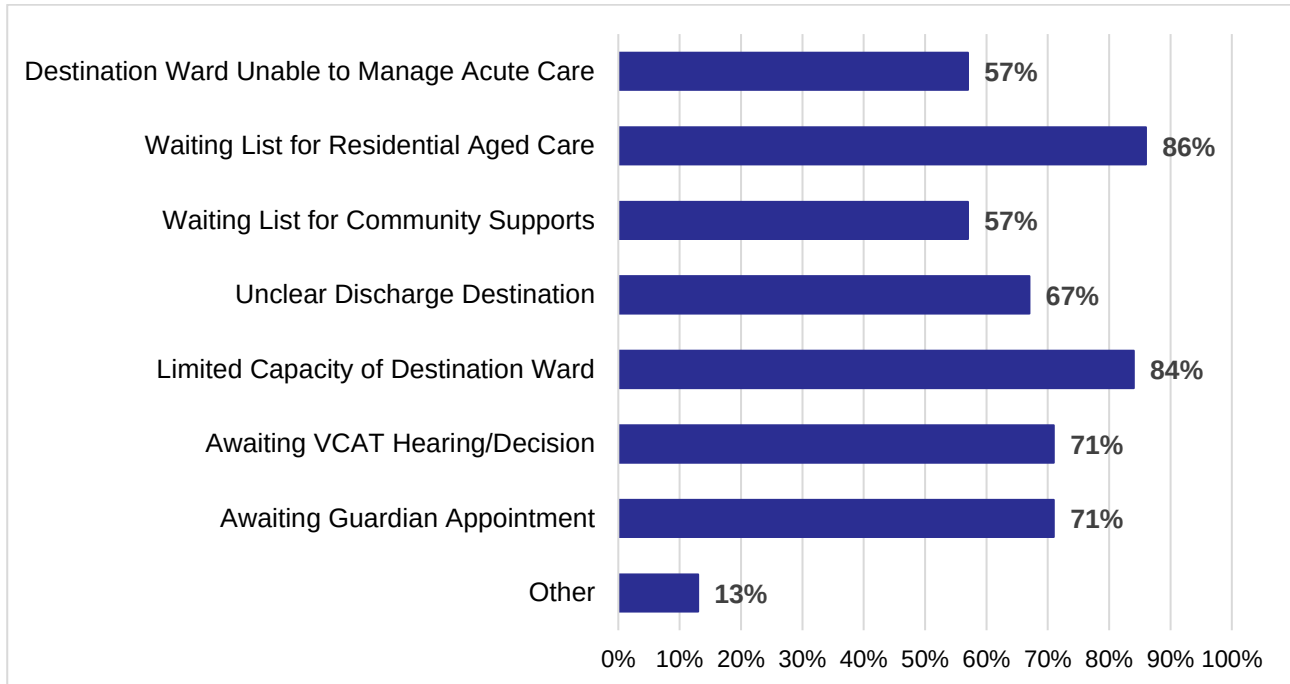


Table 17. Specific Barriers to Discharge for Patients with Dementia, By Care Setting (N=81)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=7		N=33		N=39		N=2	
	n	%	n	%	n	%	n	%
Responded there were no barriers or unsure if barriers	2	29%	2	6%	8	21%	0	0%
Awaiting Appointment of a Guardian	0	0%	13	39%	32	82%	2	100%
Awaiting VCAT Hearing/Decision	0	0%	16	48%	30	77%	2	100%
Limited Capacity of Destination Ward (secure ward, dementia specific ward, older persons psychiatric ward)	3	43%	20	60%	31	79%	2	100%
Unclear Discharge Destination	3	43%	15	45%	24	62%	2	100%
Waiting List for Appropriate Community Supports	2	29%	16	48%	20	51%	1	50%
Waiting List for Appropriate Residential Aged Care	1	14%	22	67%	32	82%	2	100%
Ward Destination Unable to Manage Acute Care Needs	1	14%	15	45%	20	51%	2	100%
Other	0	0%	1	3%	7	18%	1	50%

Figure 17. Specific Barriers to Discharge Identified, Combined (N=81)



Of the 13% ($n=9$) of respondents who indicated there were “other” barriers, a range of additional challenges and barriers to discharge were noted, alongside further detail around residential aged care, community support, NDIS, and VCAT. These included:

- 🗨️ ***“Reluctance to complete discharging plan from acute care, so patients are transferred to sub-acute for discharge planning processes”***
- 🗨️ ***“Family concerns or obstruction”***
- 🗨️ ***“New restrictive practice legislation has changed the ability to transfer patients who are managed with both pharmacological and non-pharmacological means into permanent care. There is hesitancy from Residential Aged Care facilities to take anyone complex or needing time as they do not having the staffing resource to support non pharmacological management. There is also minimal community supports available currently let alone funding enough to support someone living with dementia in the home.”***
- 🗨️ ***“These days waiting lists have not been the concern. There is limited access to Specialist Dementia Care Program (SDCP) and at present we have four patients who have a psychiatric condition and underlying dementia and suitability for mainstream Residential Aged Care or even SDGP is not appropriate so then access into mental health is extremely challenging. The waste of our bed days for patients awaiting Victorian Civil Administrative Tribunal (VCAT) is a mess - and then Office of the Public Advocate (OPA) on top of that. Average 6 weeks for VCAT then 3 weeks for OPA, which is wrong. The NDIS process is appalling - patients awaiting a process and no quality of life in this unit with average 7 months. One 14 months and died 2 weeks after new Specialist Disability Accommodation (SDA) built.”***
- 🗨️ ***“Slow NDIS processes for patients under 65, and with early onset dementia. Limited support for patients from overseas/not Medicare eligible. There are limited supports for patients requiring/preferring carers of their similar culture and language – Our health service receives patients from a large catchment area however our community programs only service council areas close-by. Some gaps in service available based on council area.***

4.4 Workforce

4.4.1 Multi-disciplinary Team Members (N=74 responses)

Almost two-thirds of respondents 65% ($n=48$) reported that geriatricians were core team members, while 31% ($n=23$) suggested that they were able to access these staff members for individual patients on referral. Nursing specialists, however, were largely unavailable across all care settings (39%, $n=29$). This was particularly evident in emergency and urgent care settings (60%, $n=3$). Involving Old Aged Psychiatrists and Mental Health Specialists in assessment and care provision was also challenging, with 27% ($n=20$) respondents reporting that each of these services were not accessible.

Survey respondents listed a number of specific disciplines involved in the care of patients with dementia on their respective wards/units. In some cases, the examples provided varied according to the care setting. These are outlined in Appendix 1.

Table 18. Staff Types/Disciplines, By Care Setting (N=74)

Discipline	Care Setting	Yes – No Referral, part of Team		Yes – By Referral Only		No	
		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Geriatrician	ED & Urgent ($n=5$)	1	20%	4	80%	0	0%
	Acute ($n=27$)	14	52%	12	44%	1	4%
	Sub-acute ($n=42$)	33	79%	7	17%	2	5%
	TOTAL ($n=74$)	48	65%	23	31%	3	4%
Old Age Psychiatrist	ED & Urgent ($n=5$)	0	0%	0	0%	5	100%
	Acute ($n=27$)	0	0%	20	74%	7	26%
	Sub-acute ($n=42$)	9	21%	25	60%	8	19%
	TOTAL ($n=74$)	9	12%	45	61%	20	27%
Other Medical Specialists	ED & Urgent ($n=5$)	0	0%	3	60%	2	40%
	Acute ($n=27$)	3	11%	16	59%	8	30%
	Sub-acute ($n=42$)	2	5%	27	64%	13	31%
	TOTAL ($n=74$)	5	7%	46	62%	23	31%
Medical (General)	ED & Urgent ($n=5$)	0	0%	2	40%	3	60%
	Acute ($n=27$)	17	63%	6	22%	4	15%
	Sub-acute ($n=42$)	25	60%	10	24%	7	17%
	TOTAL ($n=74$)	42	57%	18	24%	14	19%
Nursing	ED & Urgent ($n=5$)	5	100%	0	0%	0	0%
	Acute ($n=27$)	27	100%	0	0%	0	0%
	Sub-acute ($n=42$)	42	100%	0	0%	0	0%
	TOTAL ($n=74$)	74	100%	0	0%	0	0%
Nurse Specialists	ED & Urgent ($n=5$)	1	20%	1	20%	3	60%
	Acute ($n=27$)	4	15%	14	52%	9	33%
	Sub-acute ($n=42$)	8	19%	17	40%	17	40%
	TOTAL ($n=74$)	13	18%	32	43%	29	39%

Pharmacists	ED & Urgent (n=5)	2	40%	3	60%	0	0%
	Acute (n=27)	27	100%	0	0%	0	0%
	Sub-acute (n=42)	39	93%	3	7%	0	0%
	TOTAL (n=74)	68	92%	6	8%	0	0%
Allied Health	ED & Urgent (n=5)	3	60%	2	40%	0	0%
	Acute (n=27)	15	56%	12	44%	0	0%
	Sub-acute (n=42)	35	83%	7	17%	0	0%
	TOTAL (n=74)	53	72%	21	28%	0	0%
Mental Health Specialists	ED & Urgent (n=5)	0	0%	5	100%	0	0%
	Acute (n=27)	0	0%	23	85%	4	15%
	Sub-acute (n=42)	4	10%	24	57%	14	33%
	TOTAL (n=74)	4	5%	50	68%	20	27%
Security Staff	ED & Urgent (n=5)	2	40%	3	60%	0	0%
	Acute (n=27)	4	15%	22	81%	1	4%
	Sub-acute (n=42)	7	17%	32	76%	3	7%
	TOTAL (n=74)	13	18%	57	77%	4	5%
Other Staff	ED & Urgent (n=5)	1	20%	1	20%	3	60%
	Acute (n=27)	2	7%	6	22%	19	70%
	Sub-acute (n=42)	7	17%	10	24%	25	60%
	TOTAL (n=74)	10	14%	17	23%	47	64%

4.4.2 Dementia Specific Nurses (N=74)

The 12% (n=9) of respondents who indicated having dementia specific nurses on their ward outlined their roles and responsibilities as including the following:

- Reviewing patients with dementia
- Assisting with delirium management
- Educating and supporting other nurses
- Behaviour support plan development
- Reviewing behaviours of concern

One sub-acute respondent highlighted that their hospital had a large number of nursing staff currently working towards bachelors of dementia care/gerontology and similar postgraduate qualifications.

Table 19. Presence of Dementia Specific Nurses (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		TOTAL	
	N=5		N=27		N=42		N=74	
	n	%	n	%	n	%	n	%
No	4	80%	20	74%	30	71%	54	73%
Unsure	1	20%	3	11%	7	17%	11	15%
Yes – by referral only	0	0%	4	15%	2	5%	6	8%
Yes – part of rostered staff	0	0%	0	0%	3	7%	3	4%

4.4.3 Additional Staffing/Specialling (N=74)

The majority of respondents indicated that their wards either used additional staffing/specialling 'occasionally' (46%, $n=34$), or 'regularly' (47%, $n=35$). These practices were most likely to be used in emergency and urgent care settings (100% using additional staffing either 'occasionally' or 'regularly'). See Appendix 2 for free text comments provided regarding additional staffing/specialling.

Table 20. Use of Additional Staffing or "Specialling" Practices (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		TOTAL	
	N=5		N=27		N=42		N=74	
	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%	<i>n</i>	%
No	0	0%	1	4%	3	7%	4	5%
Unsure	0	0%	0	0%	1	2%	1	1%
Yes – occasionally	1	20%	11	41%	22	52%	34	46%
Yes – regularly	4	80%	15	56%	16	38%	35	47%

4.4.4 Rostering or Staffing Changes (N=74)

Overall, 42% ($n=31$) of respondents reported that changes to rosters and staffing levels were changed to assist in managing the behaviours of patients with dementia and BPSD. The majority of comments related to additional staffing (e.g. specials, nurses, health service assistants) for increased monitoring/observation or review of nursing staff skill set/mix per shift. See Appendix 2 for the full list of free text comments.

Table 21. Changes to Rosters of Staffing Levels because of Behaviours of Patients with Dementia (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		TOTAL	
	N=5		N=27		N=42		N=74	
	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%	<i>n</i>	%
No	1	20%	12	44%	12	29%	25	34%
Unsure	3	60%	5	19%	10	24%	18	24%
Yes	1	20%	10	37%	20	48%	31	42%

4.5 Education & Training

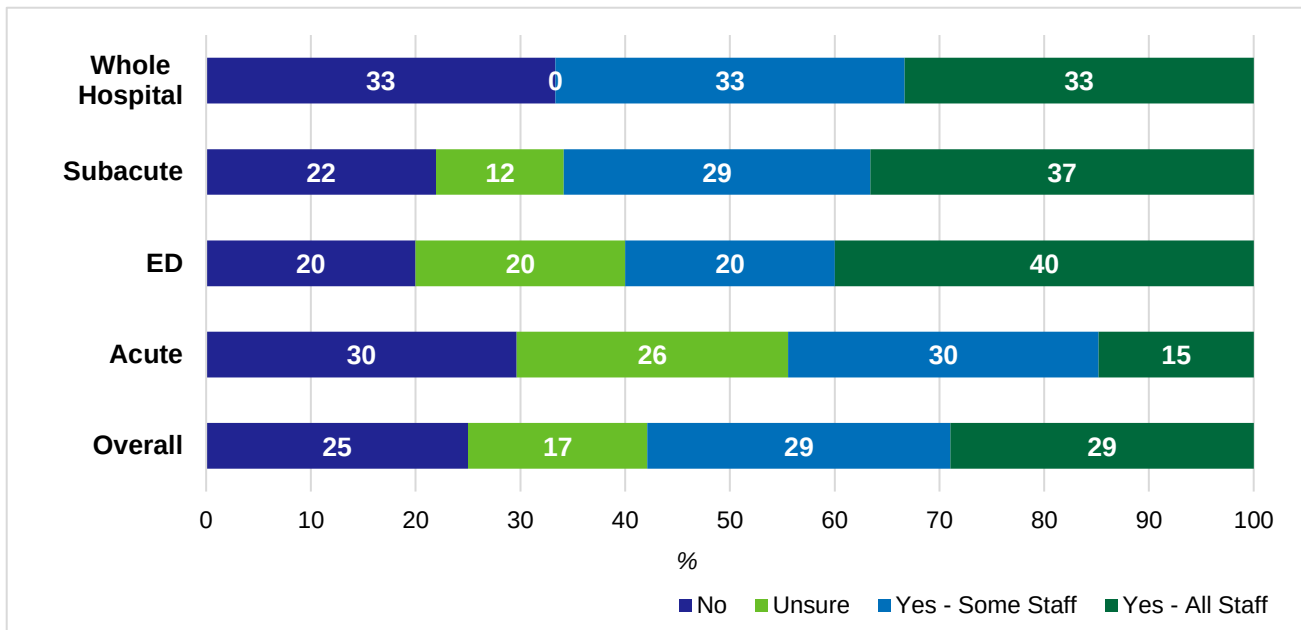
4.5.1 Target Staff Groups (N=76 responses)

Overall, only 29% ($n=22$) of respondents indicated that all staff receive education and training regarding dementia, BPSD and managing AAVB, with the same proportion also reporting that this is available for some staff. One-quarter (25%, $n=19$) of respondents suggested that no education and training is provided.

Education and training regarding dementia and AAVB was most common in sub-acute wards, with 66% ($n=50$) of respondents indicating that at least some, if not all, staff were provided with education and training. Staff working in acute care were least likely to receive education and training dementia and managing AAVB. Almost one-third (30%, $n=23$) of respondents suggested that it was not provided within this setting, with an additional 26% ($n=20$) of respondents stating they were unsure. Comments regarding this included:

- No formal training provided (but online learning was available);
- Education came from nursing staff on the ward;
- Delirium training was mandatory (but unsure about dementia training); and
- Nursing staff already appear to have the knowledge.

Figure 18. Provision of Education and Training for Staff about Dementia (including BPSD) and managing AAVB, By Care Setting (N=76)



When asked about which the staff groups who have access to education and training about dementia, BPSD, and AAVB, a range of responses were reported based on the care setting. In acute care, education and training was suggested to be available for nursing and medical staff. In sub-acute care, however, different responses suggested that education and training was open to all.

Again, specific comments regarding the type and access to education and training for staff regarding dementia, BPSD and AAVB varied both within and between care settings.

Table 22. Education and Training about Dementia, BPSD, and managing AAVB for Specific Staff Groups

Acute Responses	Sub-acute Responses
- Recently added the Understanding Dementia MOOC by the Wicking Centre to the schedule of training highly recommended for staff - Other non-dementia specific aggression management training is attended face to face for 8 hours every two years - Online learning package on aggression management - Generally training is inadequate - Often only senior staff or those who attend dementia-related meetings - Very limited to certain days	- Online education module for staff - available as an opt in for all staff - with COVID the completion rates have decreased along with an increase in the turnover of staff - Residents and registrar education on orientation and at teaching sessions - Ward KPI due to the high incidence of aggression that staff under take 'RiSCE' training within our organisation - Gerontology Course offered to staff - Dementia - Ad hoc education on ward (depends who is working on the day) - Limited education due to COVID restrictions in past few years

Of the 44 respondents who indicated that education and training about dementia (including BPSD) and managing AAVB was provided to staff (either some or all), 36% (n=16) reported that this was considered mandatory, 50% (n=22) indicated that it was not mandatory while 14% (n=6) were unsure.

In particular, a respondent from acute care noted that:

“Technically [training and education around dementia, BPSD, and AAVB] it should be [mandatory], however when there is training staff are usually on duty in the ward.”

4.5.2 Delivery Methods (N=44)

Respondents who indicated that education and training about dementia (including BPSD) and managing AAVB was available for staff were also asked about when this was delivered. The most common time reported for training and education to be provided was as part of the staff orientation process (45%, $n=20$). Annual training was also popular (32%, $n=14$), particularly in ED and urgent care settings (67%, $n=2$).

Table 23. Timing of Staff Training and Education, By Care Setting (N=44)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total	
	N=3		N=12		N=27		N=2		N=44	
	n	%	n	%	n	%	N	%	n	%
As Part of Staff Orientation Process	1	33%	4	33%	14	52%	1	50%	20	45%
Annually	2	67%	4	33%	8	30%	0	0%	14	32%
6-Monthly	0	0%	1	8%	0	0%	0	0%	1	2%
Other	0	0%	4	33%	12	44%	0	0%	16	36%
Unsure	1	33%	2	17%	2	7%	1	50%	6	14%

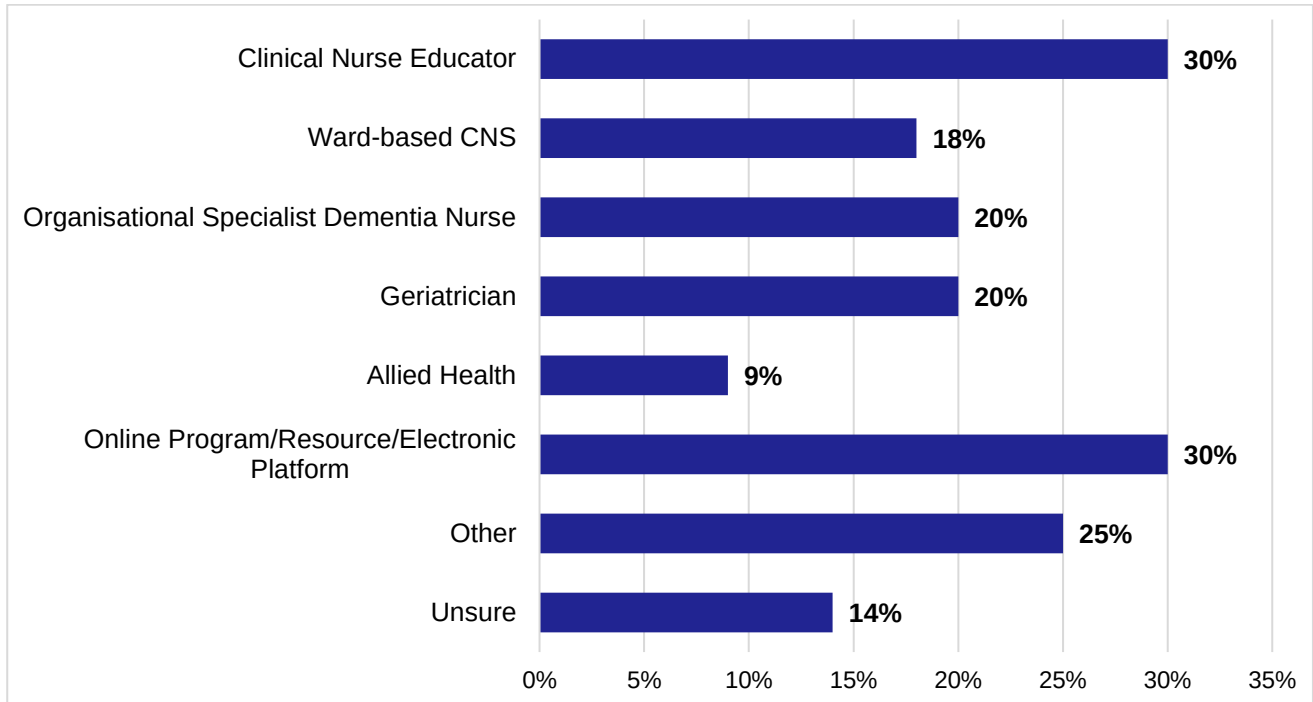
Those respondents who selected 'other' delivery schedules gave a range of alternative options for education and training. For acute care, there was typically an online option available to staff at any time (self-directed learning) and ward in-services more than twice a year. Sub-acute respondents reported monthly education sessions, ad hoc or as needed services, case reviews, online self-directed learning, and one respondent highlighted that they have an entire professional dementia care program that all new staff complete with a variety of levels (work on this is ongoing).

In regards to who delivers education and training to staff, the most common overall responses were clinical nurse educators (30%, $n=13$); and online programs/resources/electronic platforms (30%, $n=13$). On acute wards, majority of education and training is delivered by nursing (58%, $n=7$) and medical staff (17%, $n=2$). On sub-acute wards, however, allied health are also involved (15%, $n=4$).

Table 24. Discipline/s Responsible for Staff Training and Education, By Care Setting (N=44)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=3		N=12		N=27		N=2	
	n	%	n	%	n	%	n	%
Clinical Nurse Educator	1	33%	3	25%	9	33%	0	0%
Ward-based Clinical Nurse Specialist (CNS)	0	0%	2	17%	6	22%	0	0%
Organisational Specialist Dementia Nurse	1	33%	2	17%	6	22%	0	0%
Geriatrician	1	33%	2	17%	6	22%	0	0%
Allied Health	0	0%	0	0%	4	15%	0	0%
Online Program/Resource/ Electronic Platform	1	33%	3	25%	8	30%	1	50%
Other	2	67%	4	33%	5	19%	0	0%
Unsure	1	33%	1	8%	2	7%	1	50%

Figure 19. Discipline/s Responsible for Staff Training and Education, Combined (N=44)



Examples of online programs, resources, and platforms mentioned by survey respondents included Dementia Australia (DA) Training, and the University of Tasmania dementia-specific massive open online courses (MOOCs). 'Other' responses indicated that staff received training from geriatric advanced trainees, other physicians (e.g., emergency physician, junior doctors), behavioural nurses, and code grey trainers.

4.5.3 Content (N=44)

The most common education and training topics covered across all care settings included identifying risk factors, responding to, and managing AAVB (77%, $n=34$, respectively). Education related specifically to dementia and BPSD was less frequent, with dementia knowledge (59%) and communication for patients with dementia (57%) only included in just over half of training sessions.

Education for staff working in emergency and urgent care mostly included identifying risk factors for AAVB and responding to/managing AAVB (100%, $n=3$, respectively). These topics, in addition to education about BPSD, were the most likely to be included in education for sub-acute staff (81%, $n=22$ for each topic). Within acute settings, provision of person-centred care (75%, $n=9$) was the most common topic included in education and training sessions for staff.

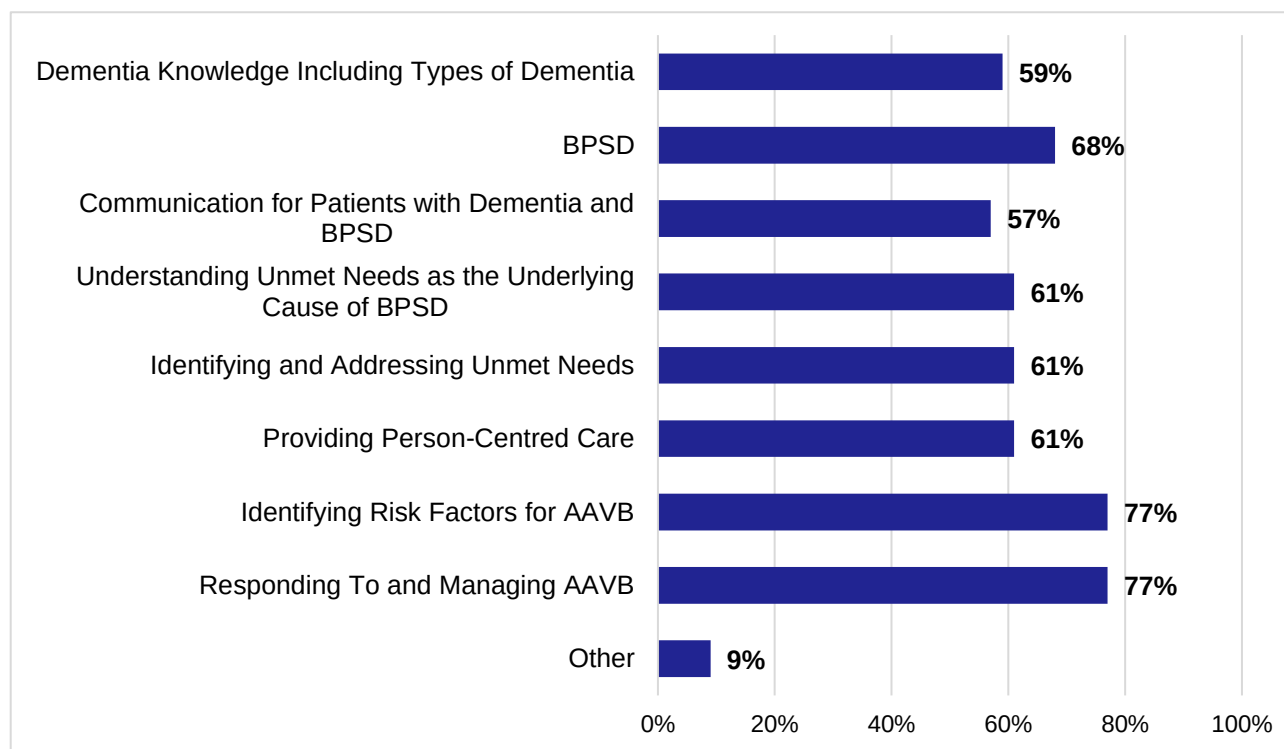
In regards to 'other' topics covered as part of education and training programs, one acute care respondent reinforced the usefulness of the University of Tasmania's Understanding Dementia MOOC (this was the basis for their education). Another respondent from sub-acute care highlighted that emotional support was covered as a topic (unclear if this related to staff or patients) while another outlined a suite of topics including:

- Mentoring
- Care needs
- Communication
- Understanding the person
- Case reviews looking at individuals
- Removing the words 'behaviour' and 'BPSD' from staff vocabulary
- Looking at the individual person

Table 25. Topics Covered in Staff Education and Training, By Care Setting (N=44)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=3		N=12		N=27		N=2	
	n	%	n	%	n	%	n	%
Dementia Knowledge including Types of Dementia	0	0%	7	58%	19	70%	0	0%
BPSD	1	33%	7	58%	22	81%	0	0%
Communication for Patients with Dementia and BPSD	1	33%	7	58%	17	63%	0	0%
Understanding Unmet Needs as the Underlying Cause of BPSD	1	33%	7	58%	19	70%	0	0%
Identifying & Addressing Unmet Needs	1	33%	8	67%	18	67%	0	0%
Providing Person-centred Care	1	33%	9	75%	17	63%	0	0%
Identifying Risk Factors for AAVB	3	100%	8	67%	22	81%	1	50%
Responding To & Managing AAVB	3	100%	8	67%	22	81%	1	50%
Other	0	0%	1	8%	2	7%	1	50%

Figure 20. Topics Covered in Staff Education and Training, Combined (N=44)



4.5.4 Families and Carers (N=76)

In total, 28% (n=21) respondents reported that there was education and training provided to families/carers about dementia, BPSD and managing AAVB. Almost half (45%, n=34) suggested that their ward setting did not provide education and training for families/carers, while 28% (n=21) were unsure. For those who were unsure, the overarching reason was because education and training for family/carers was suggested to be ad hoc, provided incidentally and/or clinician-dependent rather than formal and structured.

Table 26. Education and Training Provided for Families/Carers, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=5		N=27		N=41		N=3		N=76	
	n	%	n	%	n	%	n	%	n	%
No	2	40%	11	41%	18	44%	3	100%	34	45%
Unsure	3	60%	9	33%	9	22%	0	0%	21	28%
Yes	0	0%	7	26%	14	34%	0	0%	21	28%

Of the respondents who indicated that their ward provided education and training to families/carers, the roles most commonly associated with this activity were geriatricians (50% of respondents, $n=11$), followed by Allied Health (45%, $n=10$). "Other" responses typically discussed the following:

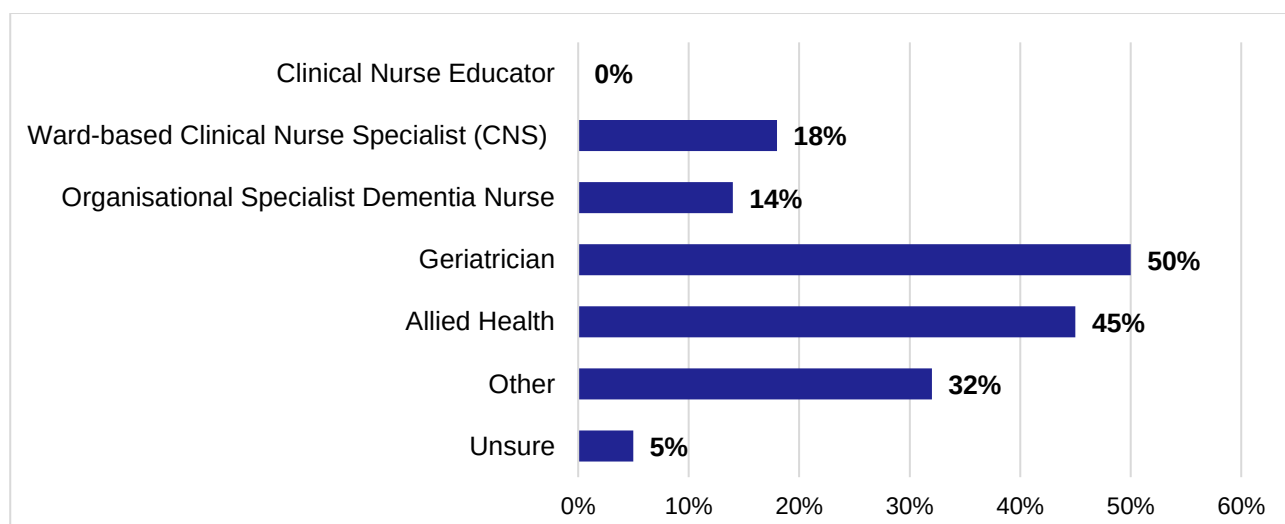
- Education/training was a team activity
- NUMs/ANUMs filled this role
- There was no standardised education approach (role was related to an individual need/concern)

In acute settings, family/carer education was most likely to be provided by geriatricians (71%, $n=5$) while allied health (50%, $n=7$) was the discipline most likely to be responsible for this in sub-acute settings.

Table 27. Discipline/s Responsible for Providing Family/Carer Education, By Care Setting (N=21)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital
	N=0		N=7		N=14		N=0
			n	%	n	%	
Clinical Nurse Educator	-		0	0%	0	0%	-
Ward-based CNS	-		1	14%	3	21%	-
Organisational Specialist Dementia Nurse	-		2	29%	1	7%	-
Geriatrician	-		5	71%	6	43%	-
Allied Health	-		3	43%	7	50%	-
Other	-		2	29%	5	36%	-
Unsure	-		0	0%	1	7%	-

Figure 21. Discipline/s Responsible for Providing Family/Carer Education, Combined (N=21)



4.6 Physical Environment

4.6.1 Dementia-Friendly Environments (N=76 responses)

Only 30% ($n=23$) respondents, all from acute and sub-acute care settings, indicated that their ward environment had been modified to make it dementia-friendly. There were three key types of change that met this definition:

1. Visual Changes - included coloured toilet seats, art on the walls, day/time orientation boards, colour contrasts, good lighting, and directions
2. Security Changes - primarily related to measures designed to stop wandering and having locked sections
3. Spatial Changes - tended to be larger-scale and included having more single rooms, open environments, wider spaces, “safe spaces” where patients could wander or investigate, outdoor garden space, a lounge and dining space, windows with views, and space for families/carers to stay if needed.

For respondents who were unsure if modifications had been made (16%, $n=12$), this uncertainty came from the following:

- Not understanding what “dementia-friendly” meant;
- Having only some rooms that catered for dementia patients (these were reported as being centrally located near the nurses’ station); and
- Modifications were ongoing and not yet complete.

Table 28. Ward Environment Modifications - Dementia-Friendly, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=5		N=27		N=41		N=3		N=76	
	n	%	N	%	n	%	n	%	n	%
No	5	100%	13	54%	20	49%	3	100%	41	54%
Unsure	0	0%	5	16%	7	17%	0	0%	12	16%
Yes	0	0%	9	30%	14	34%	0	0%	23	30%

4.6.2 Aggression Minimisation (N=76)

Compared to “dementia-friendly” modifications, it was less likely that environmental changes had been made to minimise/manage aggressive behaviours in wards/units, with only 22% of respondents ($n=17$) indicating that this had occurred.

Modifications to manage aggressive behaviours included:

- Locked areas on the ward
- Reinforced walls
- Hidden exit for staff
- Removal of objects that could be used as weapons
- Rooms with barn doors (single bathrooms, sliding doors rather than doors on hinges)
- Having a quiet zone
- Making the environment more ‘homely’

One sub-acute respondent identified that, while single rooms were important, they were lacking.

Table 29. Ward Environment Modifications – Management of Aggression, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=5		N=27		N=41		N=3		N=76	
	n	%	n	%	n	%	n	%	n	%
No	3	60%	21	78%	25	61%	3	100%	52	68%
Unsure	1	20%	3	11%	3	7%	0	0%	7	9%
Yes	1	20%	3	11%	13	32%	0	0%	17	22%

4.6.3 Bed/Room Allocation (N=76)

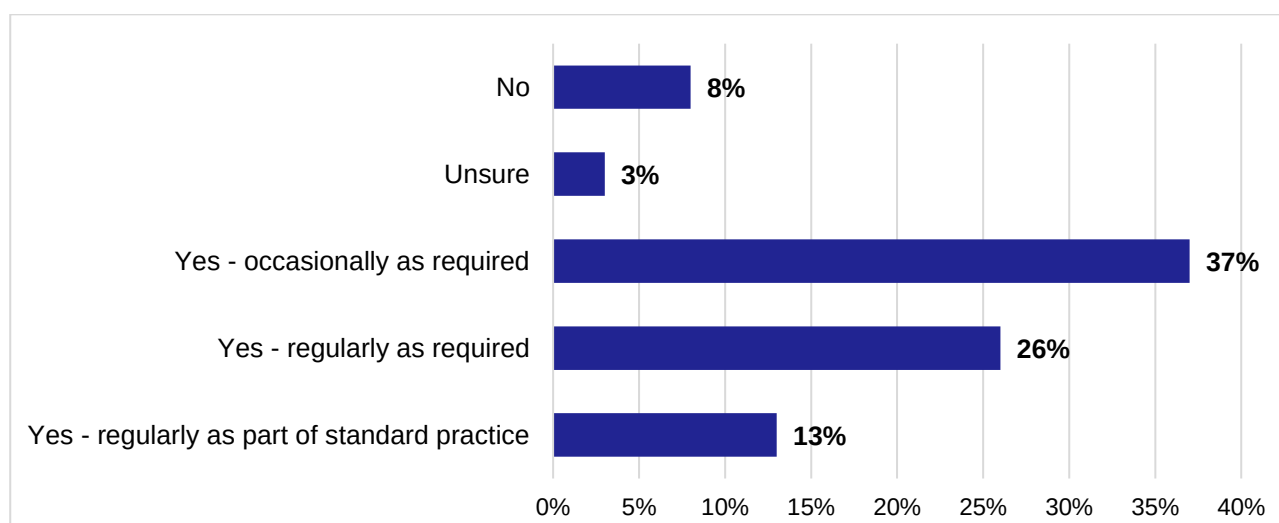
Overall, the majority of respondents suggested that patients with dementia were moved to different beds within their wards (90%, $n=68$) with 17% ($n=13$) indicating that they move patients with dementia regularly as part of standard practice.

For those who indicated they did not move patients with dementia to different beds (8%, $n=6$), this was either because they were a sub-acute or acute ward and patients with dementia and BPSD were directly admitted to a particular bed (and did not move to avoid confusion); or there was no capacity/a lack of beds to move these patients to.

Table 30. Movement of Patients with Dementia to Different Beds within the Ward, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=5		N=27		N=41		N=3	
	n	%	n	%	n	%	n	%
No	0	0%	2	7%	4	10%	0	0%
Unsure	0	0%	1	4%	1	2%	0	0%
Yes - occasionally as required	0	0%	10	37%	16	39%	2	67%
Yes - regularly as required	1	20%	11	41%	14	34%	1	33%
Yes - regularly as part of standard practice	4	80%	3	11%	6	15%	0	0%

Figure 22. Movement of Patients with Dementia to Different Beds within the Ward, Combined (N=76)



Further to this, respondents were asked if they moved patients with dementia to different beds within the ward because of behaviour. For the 7% ($n=5$) of respondents who indicated that their respective wards/units did not move this patient population, the reasons were similar to those provided previously – there was either not enough space to move patients with dementia who are demonstrating challenging behaviour or these patients were not moved to avoid triggering BPSD.

Table 31. Movement of Patients with Dementia to Different Beds within the Ward to Manage Behaviour, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=5		N=27		N=41		N=3		N=76	
	n	%	n	%	n	%	n	%	n	%
No	0	0%	1	4%	4	10%	0	0%	5	7%
Unsure	0	0%	1	4%	0	0%	0	0%	1	1%
Yes - occasionally as required	1	20%	6	22%	15	37%	2	67%	24	32%
Yes - regularly as required	2	40%	14	52%	16	39%	1	33%	33	43%
Yes - regularly as part of standard practice	2	40%	5	19%	6	15%	0	0%	13	17%

4.6.4 Seclusion (N=76)

Regarding the physical environment, a number of respondents from emergency and urgent care (20%, $n=1$), acute (22%, $n=6$) and sub-acute (15%, $n=6$) settings reported using seclusion on their wards. Despite this, overall, almost two-thirds (61%, $n=46$) indicated that seclusion was not used.

Additionally, 18% ($n=14$) of respondents indicated being unsure about the use of seclusion on their ward to manage challenging behaviour demonstrated by patients with dementia. Reasons provided for their uncertainty included:

- They did not understand what “seclusion” meant;
- The use of seclusion was dependent on the level of violence a patient displayed (in general they did not isolate patients); and
- They had a seclusion room but hadn’t used it in a very long time.

Table 32. Use of Seclusion in Patients with Dementia to Manage Behaviour, By Care Setting (N=76)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=5		N=27		N=41		N=3		N=76	
	n	%	n	%	n	%	n	%	n	%
No	4	80%	17	63%	25	61%	0	0%	46	61%
Unsure	0	0%	4	15%	10	24%	0	0%	14	18%
Yes	1	20%	6	22%	6	15%	0	0%	13	17%

4.7 Organisational Approach to Care

4.7.1 Person-Centred Care (N=75 responses)

Across all care settings, the most common approaches used to support person-centred care were actively engaging patients, families and carers as partners in their own care (72%, $n=54$), followed by ensuring that patients, families and carers are aware of the organisations complaints process (63%, $n=47$). Two respondents (3%) reported that no strategies were implemented, while an additional six (8%) were unsure.

One respondent from a sub-acute setting commented that, in their experience:

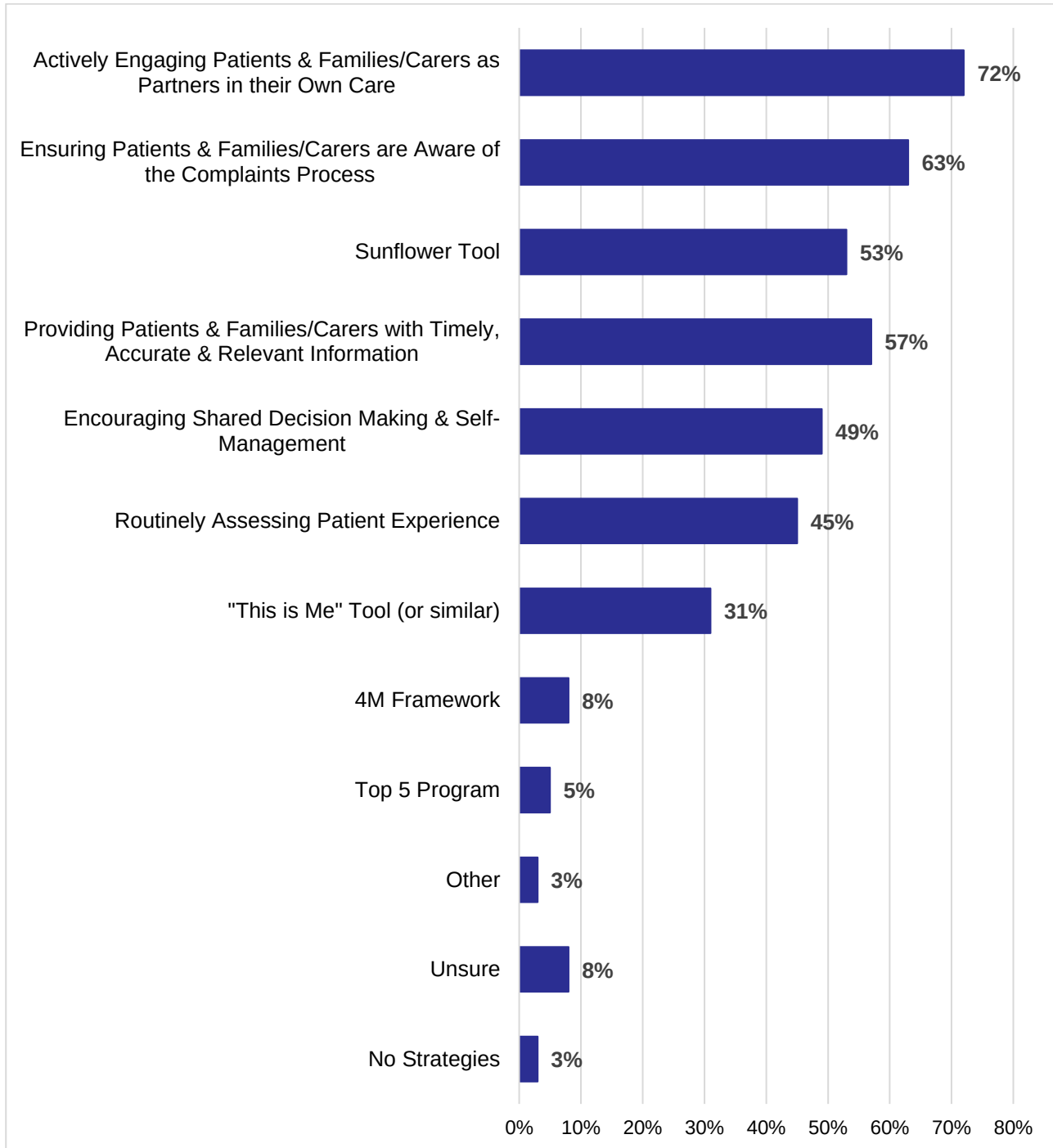
“Shared decision making/actively engaging patients and families is often advocated for by Social Work and Allied Health and not necessarily built into any structured processes /tools”.

They thought that their ward worked very collaboratively and had less trouble with this, but had also experienced this as an issue in other wards across their organisation.

Table 33. Approaches used to Ensure Person-centred Care for Patients with Dementia, By Care Setting (N=75)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=4		N=27		N=41		N=3	
	n	%	n	%	n	%	n	%
No Strategies Implemented	0	0%	0	0%	2	5%	0	0%
Unsure	2	50%	2	7%	2	5%	0	0%
Other	0	0%	1	4%	1	2%	0	0%
Use of the 4M Framework	1	25%	3	11%	2	5%	0	0%
Use of the Sunflower Tool	1	25%	16	59%	21	51%	2	67%
Use of the Top 5 Program	0	0%	1	4%	3	7%	0	0%
Use of the "This is Me" Tool (or similar)	0	0%	8	30%	14	34%	1	33%
Actively Engaging Patients, Families, & Carers as Partners in their Own Care	1	25%	20	74%	32	78%	1	33%
Encouraging Shared Decision Making & Self-management	1	25%	15	56%	21	51%	0	0%
Providing Patients, Families, & Carers with Timely, Accurate, & Relevant Information & Education that Minimises Literacy-related Barriers	1	25%	15	56%	26	63%	1	33%
Ensuring that Patients, Families & Carers are Aware of the Organisation's Complaints Process	2	50%	17	63%	27	66%	1	33%
Routinely Assessing Patient Care Experience	1	25%	11	41%	22	54%	0	0%

Figure 23. Approaches used to Ensure Person-centred Care for Patients with Dementia, Combined (N=75)



4.7.2 Recording Triggers of (and Monitoring) Challenging Behaviours (N=75)

The most common processes used to record the triggers of challenging behaviours for patients with dementia were nursing handover (79%, $n=59$) and behaviour observation charts (79%, $n=59$). For those who indicated they used "other" processes, these ranged from a care support plan to an "about me" form or they had a patient board in the handover room.

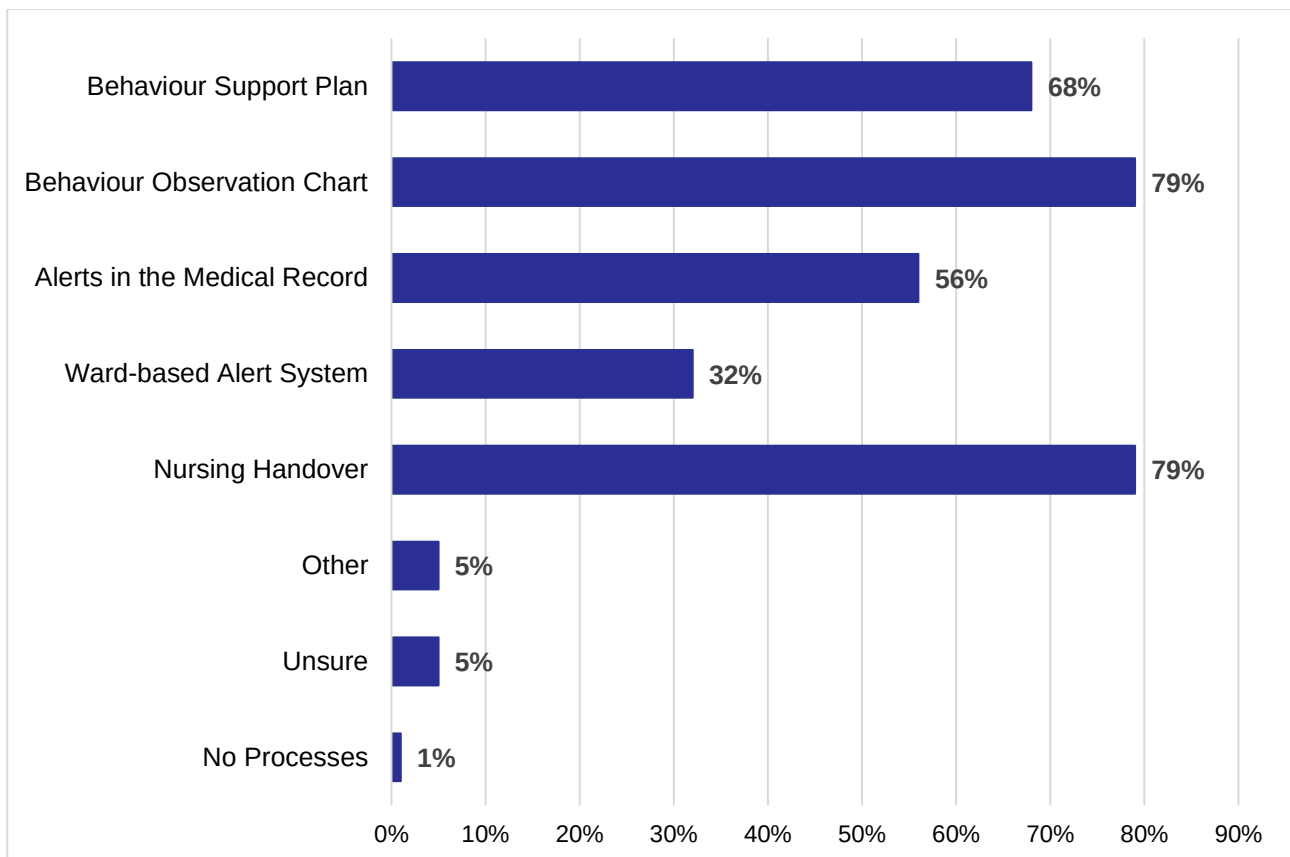
Processes to record the triggers of challenging behaviours in patients with dementia to were more likely to be used in sub-acute than acute settings, while respondents from emergency and urgent care were largely unsure of whether there were any processes in place at all. Behaviour support plans, in particular, were employed by 67% ($n=18$) of acute care and 73% ($n=30$) of sub-acute care settings.

The use of alerts in the medical record was most likely to be used in acute care (63%, $n=17$).

Table 34. Processes to Record the Triggers of Challenging Behaviours in Patients with Dementia, By Care Setting (N=75)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=4		N=27		N=41		N=3	
	n	%	n	%	n	%	n	%
No Processes in Place	0	0%	0	0%	1	2%	0	0%
Unsure	2	50%	1	4%	0	0%	1	33%
Other	0	0%	2	7%	1	2%	0	0%
Nursing Handover	1	25%	21	78%	35	85%	2	67%
Ward-based Alert System	0	0%	8	30%	16	39%	0	0%
Alerts in the Medical Record	1	25%	17	63%	23	56%	1	33%
Behaviour Observation Chart	2	50%	20	74%	34	83%	3	100%
Behaviour Support Plan	1	25%	18	67%	30	73%	2	67%

Figure 24. Processes to Record the Triggers of Challenging Behaviours in Patients with Dementia, Combined (N=75)



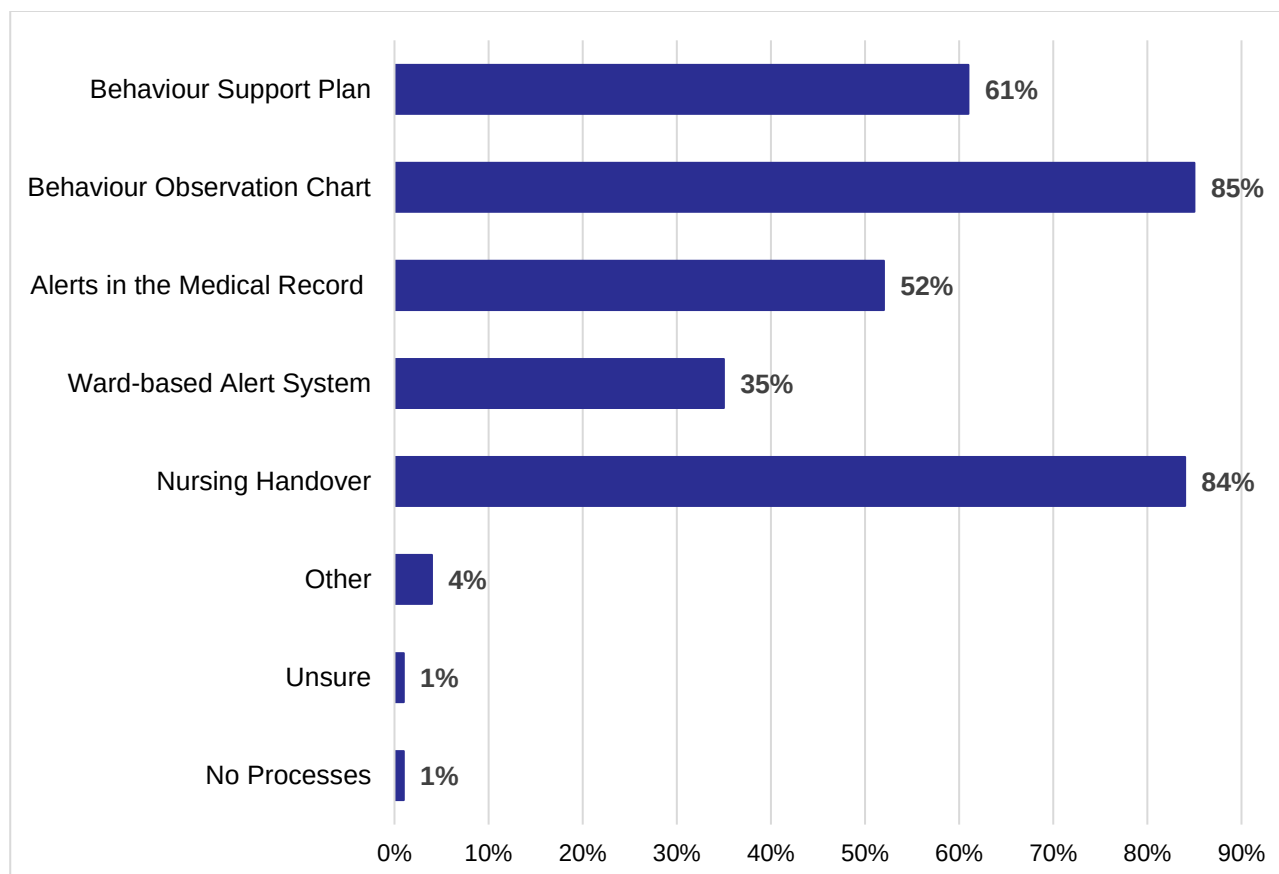
Monitoring challenging behaviours of patients with dementia across all care settings was most commonly supported by behaviour observation charts (85%, $n=64$) and nursing handover (84%, $n=63$). Of those who indicated 'other' processes were used, these included care support plans, constant patient observer (CPO) notes, and regular medication reviews.

Similar to recording the triggers of challenging behaviours in patients with dementia, processes used to monitor these behaviours were more likely to be utilised in sub-acute than acute settings. Despite this, behaviour observations charts were reported to be used equally across acute (85%, $n=23$) and sub-acute (85%, $n=35$).

Table 355. Processes to Monitor Challenging Behaviours in Patients with Dementia, By Care Setting (N=75)

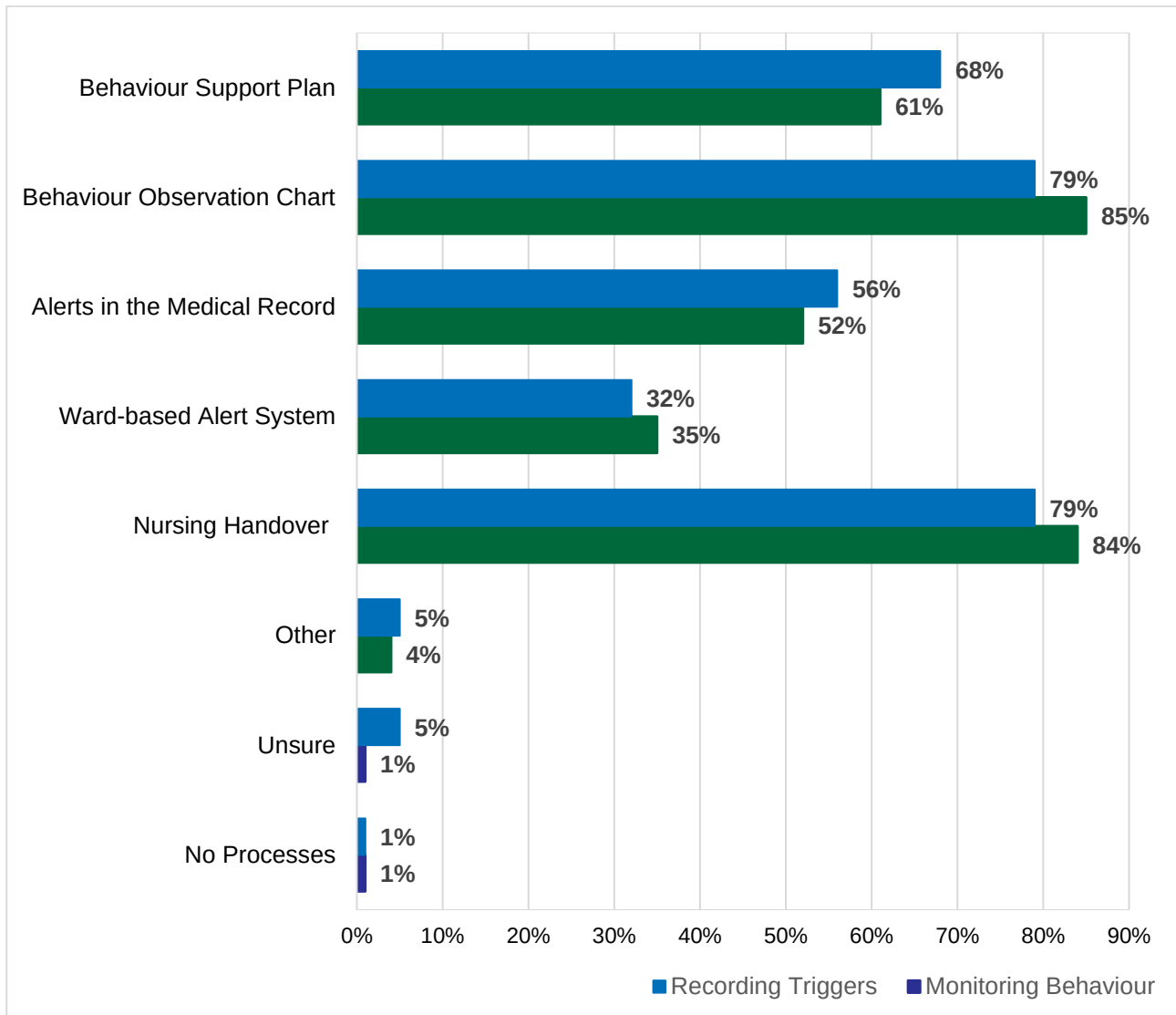
	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=4		N=27		N=41		N=3	
	n	%	n	%	n	%	n	%
No Processes in Place	0	0%	0	0%	1	2%	0	0%
Unsure	1	25%	0	0%	0	0%	0	0%
Other	0	0%	1	4%	2	5%	0	0%
Nursing Handover	1	25%	23	85%	37	90%	2	67%
Ward-based Alert System	0	0%	6	22%	20	49%	0	0%
Alerts in the Medical Record	1	25%	13	48%	24	59%	1	33%
Behaviour Observation Chart	3	75%	23	85%	35	85%	3	100%
Behaviour Support Plan	1	25%	15	56%	29	71%	1	33%

Figure 24. Processes to Monitor Challenging Behaviours in Patients with Dementia, Combined (N=75)



When comparing the use of processes to record triggers of challenging behaviours (a proactive strategy) vs. monitoring challenging behaviours (a reactive strategy), overall there was a fairly even balance between the two approaches.

Figure 256. Recording Triggers vs. Monitoring Challenging Behaviours in Patients with Dementia, Combined (N=75)



4.7.3 Policies and Procedures to Record/Respond to AAVB in Patients with Dementia (N=75)

The most commonly procedure to record and/or respond to AAVB of patients with dementia was formalised incident reporting (e.g. Riskman) (92%, $n=69$), followed by documentation in the medical record (85%, $n=64$). For those who indicated they also had “other” policies and procedures, these ranged from security +/- specialising, to code greys. One respondent also highlighted that there was no place for them to send patients if their behaviour escalates, as they often receive patients with dementia and AAVB from other units—they tended to arrange for external security and would only refer to Dementia Support Australia (DSA) for attempt at Specialist Dementia Care Program (SDCP) or DSA to follow up in care. They also suggested rarely referring to the Dementia Behaviour Management Advisory Service (DBMAS) as they have previously been advised that they are already using the same strategies DBMAS would put in place. This was reflected in the low proportion of respondents who indicated that referrals to DBMAS were made within their care setting in response to AAVB (9%, $n=7$). Referrals to Victoria Police were also made by 4% ($n=1$) of acute settings and 7% ($n=3$) of sub-acute settings.

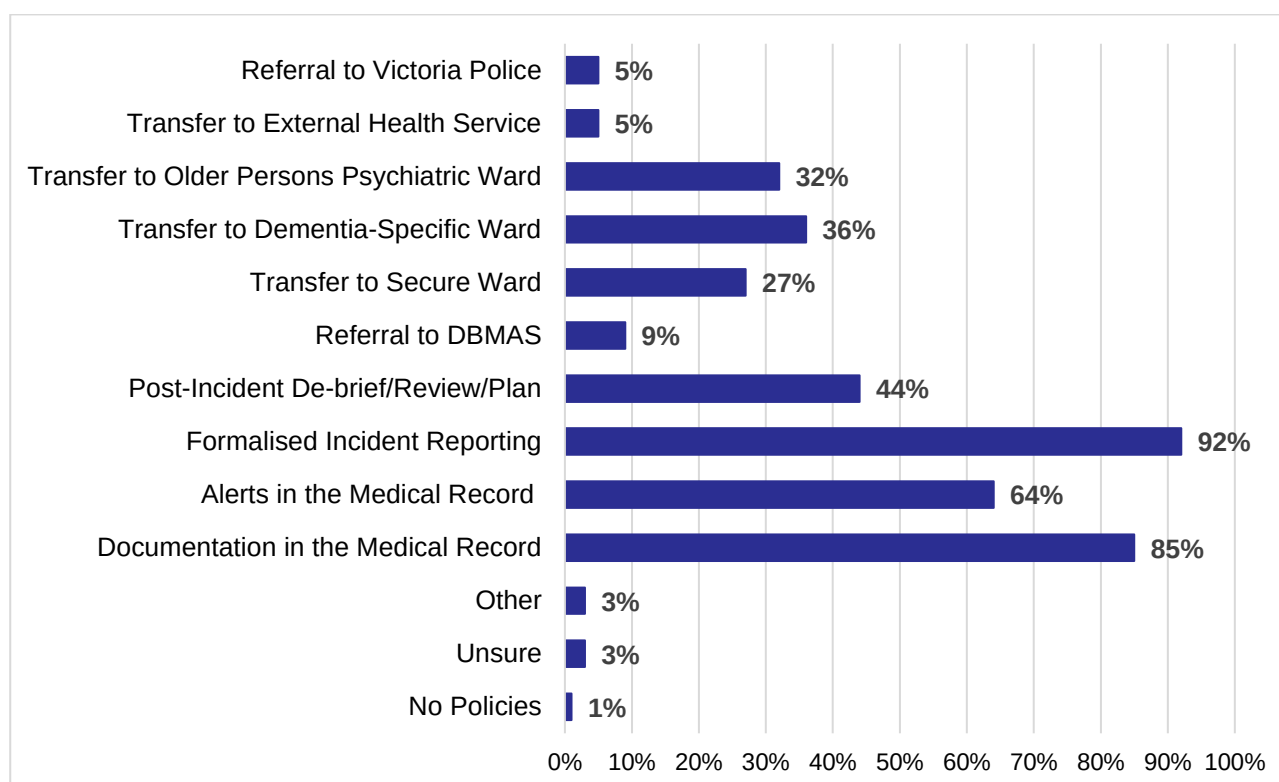
Just over half of respondents from sub-acute wards (54%, $n=22$) reported that post-incident debrief/review/planning occurred following AAVB in patients with dementia, with similar findings from emergency and urgent care settings (50%, $n=2$). This proportion was lower in acute settings (33%, $n=9$).

Additionally, one respondent (4%) from an acute care setting suggested there were no policies and procedures in place to record/respond to AAVV in patients with dementia.

Table 366. Policies and Procedures to Record/Respond to AAVB in Patients with Dementia, By Care Setting (N=75)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital	
	N=4		N=27		N=41		N=3	
	n	%	n	%	n	%	n	%
No Policies and Procedures	0	0%	1	4%	0	0%	0	0%
Unsure	1	25%	0	0%	1	2%	0	0%
Other	0	0%	0	0%	2	5%	0	0%
Documentation in Medical Record	3	75%	24	89%	35	85%	2	67%
Alerts in Medical Record	3	75%	19	70%	25	61%	1	33%
Formalised Incident Reporting (e.g. Riskman)	3	75%	26	96%	37	90%	3	100%
Post-Incident De-brief/Review/Planning	2	50%	9	33%	22	54%	0	0%
Referral to DBMAS	0	0%	1	4%	6	15%	0	0%
Transfer to Secure Ward	1	25%	7	26%	11	27%	1	33%
Transfer to Dementia-Specific Ward	1	25%	10	37%	15	37%	1	33%
Transfer to Older Persons Psychiatric Ward	2	50%	10	37%	12	29%	0	0%
Transfer to External Health Service	0	0%	0	0%	4	10%	0	0%
Refer to Victoria Police	0	0%	1	4%	3	7%	0	0%

Figure 267. Policies and Procedures to Record/Respond to AAVB in Patients with Dementia, Combined (N=75)



4.7.4 Reporting (N=75)

While the majority of respondents suggested that regular reporting occurred at senior management levels regarding AAVB in patients with dementia (64%, $n=48$), 13% ($n=10$) indicated that this was not the case on their ward. In addition, 23% ($n=17$) were unsure, typically because they were not part of the senior management team and were therefore unaware of what was reported.

Table 377. Regular Reporting Regarding AAVB in Patients with Dementia at Senior Management Level, By Care Setting (N=75)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=4		N=27		N=41		N=3		N=75	
	n	%	n	%	n	%	n	%	n	%
No	0	0%	2	7%	8	20%	0	0%	10	13%
Unsure	1	25%	9	33%	7	17%	0	0%	17	23%
Yes	3	75%	16	59%	26	63%	3	100%	48	64%

The most common role identified as being responsible for preparing reports regarding AAVB incidents in patients with dementia was ANUMs/NUMs (56%, $n=27$). “Other” reported roles who have involvement in this process included the “RiSCE team”, Multi-disciplinary Team, and Clinical Nurse Coordinators.

Divisional quality and safety representatives were used by two-thirds (67%, $n=2$) of emergency and urgent care settings to prepare reports for senior management regarding AAVB in patients with dementia, however only by 35% ($n=9$) of sub-acute and 6% ($n=1$) of acute care settings.

Table 388. Responsibility for Preparing Reports for Senior Management around AAVB in Patients with Dementia, By Care Setting (N=48)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=3		N=16		N=26		N=3		N=48	
	n	%	n	%	n	%	n	%	n	%
ANUM/NUM	1	33%	12	75%	13	50%	1	33%	27	56%
Ward Quality & Safety Representative	1	33%	6	38%	2	8%	0	0%	9	19%
Division Quality & Safety Representative	2	67%	1	6%	9	35%	0	0%	12	25%
Other	0	0%	1	6%	5	19%	2	67%	8	17%
Unsure	0	0%	0	0%	2	1%	0	0%	1	2%

Those who were aware of regular reporting at senior management levels around AAVB and patients with dementia ($n=48$) were also asked where this information was presented. Overall the most common response was at divisional quality and safety meetings (46%, $n=22$) however this was more likely to occur in emergency and urgent care settings (67%, $n=2$) and sub-acute (58%, $n=15$) as opposed to acute care settings (25%, $n=4$). Just over one-third (38%, $n=18$) indicated that this information was presented in at least two forums. “Other” responses included:

- ☛ “Restrictive intervention meetings”;
- ☛ “Huddles” and;
- ☛ “Morbidity and mortality meeting within the department”.

Table 39. Reporting Line of Information about AAVB and patients with Dementia, By Care Setting (N=48)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=3		N=16		N=26		N=3		N=48	
	n	%	n	%	n	%	n	%	n	%
Not Presented	0	0%	0	0%	3	12%	0	0%	3	6%
Unsure	0	0%	2	13%	1	4%	1	33%	4	8%
Other	0	0%	3	19%	3	12%	0	0%	6	13%
Ward Meetings	1	33%	8	50%	9	35%	1	33%	19	40%
Division Quality & Safety meetings	2	67%	4	25%	15	58%	1	33%	22	46%
Organisation Quality & Safety Meetings	0	0%	4	25%	7	27%	1	33%	12	25%

4.7.5 Staff Wellbeing (N=74)

Respondents were asked about how their organisation monitors and addresses the wellbeing of staff who care for patients with dementia. The majority of respondents (82%, $n=61$) identified that their organisation used more than one method to monitor and address staff wellbeing. The most common method for monitoring and addressing wellbeing of staff across all care settings was offering an employee assistance program (or similar) (76%, $n=56$), while informal post-incident de-briefs (62%, $n=46$) also occurred regularly. Formal post-incident de-briefs, however, were less common (24%, $n=18$). A substantial proportion of sub-acute settings (70%, $n=28$) used planned code greys for patients with dementia and BPSD to assist in addressing staff wellbeing, however this was far less likely in emergency and urgent care (50%, $n=2$) and acute care settings (20%, $n=15$).

Of those who indicated that 'other' methods to monitor and address staff wellbeing were in use, one stated there were no formal structures, while another highlighted that they held manager meetings daily but that after-hours and escalation of care needs had led to staff feeling isolated.

Table 400. Monitoring and Addressing Staff Wellbeing in Organisations (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=4		N=27		N=40		N=3		N=74	
	n	%	n	%	n	%	n	%	n	%
No monitoring	0	0%	2	7%	2	5%	0	0%	4	5%
Education & training regarding managing dementia & BPSD	0	0%	12	44%	17	43%	0	0%	29	39%
Employee Assistance Program (or similar)	2	50%	20	74%	32	80%	2	67%	56	76%
Regular opportunities to meet with ANUM/NUM	1	25%	16	59%	15	38%	0	0%	32	43%
Formal post-incident de-briefs	1	25%	4	15%	12	30%	1	33%	18	24%
Informal post-incident de-briefs	1	25%	18	67%	24	60%	3	100%	46	62%

Rotating staff allocation for people with dementia & BPSD	0	0%	14	52%	16	40%	1	33%	31	42%
Planned code greys for people with dementia & BPSD (as required)	2	50%	15	20%	28	70%	3	100%	48	65%
Other	0	0%	0	0%	2	5%	0	0%	2	3%
Unsure	1	25%	3	11%	4	10%	0	0%	8	11%

4.7.6 Approaches to Involving Families in Care (N=74)

The most common approach to involving families in care was encouraging families and carers to support patient care on the ward (85%, $n=63$), followed by holding family meetings (81%, $n=60$). Flexible visiting hours (77%, $n=57$) were also widely available. These three approaches were utilised more in acute and sub-acute rather than emergency and urgent care settings.

The majority of respondents (84%, $n=62$) indicated that their organisation used at least two approaches to involve families and carers in care. For those that indicated they used “other” approaches, these fell into two categories: completing the ‘about me form’ with families; and phone contact with family. One respondent from an emergency and urgent care setting suggested that, because of the nature of the ED environment, contact with patients and families was too brief to engage in these options.

Table 41. Approaches Taken to Involve Families in Care and Management Patients with Dementia, By Care Setting (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=4		N=27		N=40		N=3		N=74	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
None	0	0%	0	0%	0	0%	1	33%	1	1%
Unsure	2	50%	1	4%	1	3%	0	0%	4	5%
Other	0	0%	1	4%	2	5%	0	0%	3	4%
Involvement in Ward Rounds	1	25%	2	7%	5	13%	0	0%	8	11%
Attendance at Case Conferences	1	25%	3	11%	4	10%	0	0%	8	11%
Family Meetings	1	25%	22	81%	35	88%	2	67%	60	81%
Encouraging Families & Carers to Support Patient Care on the Ward	1	25%	25	93%	35	88%	2	67%	63	85%
Flexible Visiting Hours for Families & Carers	2	50%	22	81%	31	78%	2	67%	57	77%

4.7.7 Funding Models (N=74)

Almost three-quarters of respondents 74% ($n=55$) indicated they thought that funding models had the potential to influence the care provided to patients with dementia in hospitals. This appeared to be a significant issue within emergency and urgent care settings, with 100% ($n=4$) agreement from survey respondents.

Table 422. Potential for Funding models to Influence the Care Provided to Patients with Dementia, By Care Setting (N=74)

	Emergency & Urgent Care		Acute		Sub-acute		Whole Hospital		Total (%)	
	N=4		N=27		N=40		N=3		N=74	
	n	%	n	%	n	%	n	%	n	%
No	0	0%	1	4%	4	10%	1	33%	6	8%
Unsure	0	0%	3	11%	10	25%	0	0%	13	18%
Yes	4	100%	23	85%	26	65%	2	67%	5	74%

A significant number of responses were provided regarding how and why funding models influence the care of patients with dementia (see Appendix 4 for full comments). These can be summarised as follows:

- Staffing
 - Nursing ratios
 - Specialising
 - Access to specialist services (e.g. diversional therapy)
- Equipment/Resources
- Environmental Modifications
- Education and Training
- Developing new models of care (especially on acute wards)
- Dementia-specific RACF beds

For those who were unsure (18%, n=13), comments tended to focus on needing more money to upgrade care environments and to recruit more nursing staff. One sub-acute respondent highlighted that patients with BPSD require significant amounts of time and cause a great deal of stress in both staff and other patients. They felt that some of these behaviours could be avoided if the ward environment was modified in such a way as to create a less challenging space for those who are cognitively impaired.

4.7.8 Other Responses Regarding Organisational Perspectives about Care of Patients with Dementia

Survey respondents were also given the opportunity to provide free text responses regarding their organisational perspectives about the care of patients with dementia in hospitals (see Appendix 5 for full comments). The following comments summarise the numerous themes identified in the overall responses:

- 🗨️ ***“The care of patients living with dementia in an acute health service is dreadful overall. Although in saying that the care for those patients with symptoms up to Brodaty Tier 5 can be handled in the acute with more training of undergraduate and environmental considerations about how to respond / communicate and care for this vulnerable and increasing population.*”**
- 🗨️ ***We urgently require separate units to care for those Tier 5-7 patients who are coming directly from RAC, and some from home, into acute which are not the appropriate environments, these patients if they do not have an acute delirium require ?direct entry to a SDGP / or psychiatric care unit.***
- 🗨️ ***We need to improve the quality of the care provided for these patients living with dementia, as well as other patients who are being cared for within the health service who are scared, vulnerable and distressed and reduce the OVA staff by caring for them by appropriately trained staff and within the appropriate well-designed environment.”***

Another respondent suggested trialling an innovative model of care to address the widely-acknowledged weaknesses in current care provision:

- 🗨️ ***“I am keen to implement a shared care Aged Psych, Geriatric unit called a Cognitive Assessment and Management Unit (rather than secure GEM as I don't think that's what it is). It will need close***

to acute nursing from a mix of psych and GEM type nurses, routine Psych and Geri management of patients, lots of SW, OT and diversional therapy, a secure exit and an outdoor space.”

From the comments provided by respondents, a number of current weaknesses and future opportunities regarding the care of patients with dementia in hospitals were identified (see Table 38).

Table 43. Weaknesses and Opportunities Regarding Organisational Approaches to the Care of Patients with Dementia

Current Weaknesses	Future Opportunities
- Set-up of physical environments - Poor staff education and training - Hospital focus on bed flow; surgical waiting lists - Inadequate nurse: patient ratios for this population - Waiting time for VCAT, guardianship and psych-geriatric nursing home bed availability - Lack of Secure GEM wards - Use of mechanical and chemical restraints - Inaccurate handover from ED - Cost of specially trained staff - Current funding models inappropriate for patients with dementia who have an acute illness	- Dementia-friendly area within the ED - Organisation-wide models of care and dementia-friendly environments (considering that patients with dementia are present on all hospital wards) - Geriatricians attached to all adult wards - Improve structure and consistency of assessment and management approach - More resources and equipment that encourage the use of non-pharmacological strategies - Increased OT and Diversional Therapy - Review of funding models - Greater availability of 1:1 supervision/specialling - Access to safe and secure outdoor environments

4.8 Additional Comments about the Management of Patients with BPSD

4.8.1 Emergency and Urgent Care

“The ED is a unique and challenging environment for all patients but particularly difficult for those with cognitive impairment. The structure, physically and clinically, is not designed to meet the needs of patients with dementia/BPSD. In addition, it is often where patients with the most extreme symptoms are sent when they are no longer able to be managed in their own environments. These are issues that need to be addressed at an organisational and regulatory level and are unlikely to be resolved solely with policy or procedure. Whilst we should always be striving to improve the care of our patients through implementing improved training, informed policy and robust procedure, we would be remiss to not also consider the broader context in which we work.”

4.8.2 Acute Care

“We don’t do [management and care of patients with dementia/BPSD] well as the environment is terrible for these people. It is noisy and over-crowded. The staff are run off their feet and don’t have the time to spend with these patients.”

“Generally I have concerns about the number of staff who have sustained injury as a result of violence on ward. There has been no practical response to address this.”

“I feel we are generally understaffed and lack resources. We have training to manage general aggression, but this includes boundary setting and reasoning and behaviour contracts. It assumes patients are GCS15 which the majority of our patients are not. This education is generally not appropriate, so I feel as a ward we are not prepared.”

“Acute ward environment is not set up to manage cognitively impaired persons. There is no access to outdoors, lack of single rooms. Corridors are busy/cluttered with equipment.”

- “We regularly use HSAs to manage patients with complex behaviours, they are the least experienced staff looking after the most complex behavioural patients with no or little training.”

4.8.3 Sub-acute Care

- “Limited resources available to provide adequate non-pharmacological interventions to help with BPSD, inconsistent education provided to staff and families.”
- “I think we have lots of rotation of staff and regular education and refreshers would be ideal. I personally have been in this role for just over 12 months now and don’t feel I have had much time to attend formal education and have mostly learned about dementia and BPSD on the job and through observation/listening to more experienced staff provide education to families. I would love to build my expertise and introduce a regular running group for education/support to families on the ward one day.”
- “There is a need to improve care for this group but this needs investment of resources to assist in driving cultural change and support the nursing staff in particular. The OTs on the ward are very experienced in supporting people experiencing BPSD but time limitations mean supporting this group and the staff to use more non-pharmacological strategies is limited. I am concerned at the use of PRN medication for this group in addition to restricting their movement by placing them in a chair pushed up to a table. They are at particularly high risk of functional decline during their admission to the ward.”
- “Wards are understaffed to manage the increasingly complex presentations and so patient are not getting best care they are just getting basic care.”

4.8.4 Whole Hospital (unspecified)

- “Broadly there is the collective will to do this better, often the physical environment + resource limitations get in our way.”

5. DISCUSSION

As per the population prevalence, point prevalence and manual file audit studies recently conducted by NARI as part of a wider project into the hospital management of this patients with dementia and BPSD, this benchmarking study is the first time that information has been documented regarding service delivery and models of care for this patient population in Victoria. Eligible responses to the survey were received from over 100 hospital staff across multiple disciplines, care settings and clinical units within 13 metropolitan, regional and sub-regional health services. All survey respondents reported having experience in management of patients with dementia within emergency and urgent care, acute care and/or sub-acute care settings which suggests that the results are strongly reflective of the current experience of staff in Victorian hospitals.

5.1 Dementia and BPSD

Patients with dementia and BPSD who require hospitalisation often have complex care needs, with those affected requiring support from a number of health teams and professionals.⁷ Within the current benchmarking survey, the complexity of patients with dementia and BPSD was evident across many of the different model of care elements explored. Both individually, and collectively, this patient population is anecdotally considered particularly challenging to manage in hospital. This is due to a number of inter-related factors including: underlying neurological changes often leading to BPSD, heterogeneity of presentations meaning that individualised care is required, cognitive deficits that can result in difficulties in communication and decision-making, presence of co-morbidities that can influence the progression/ management of dementia and environmental factors that have the potential to trigger or exacerbate BPSD. Examples of complexity identified by respondents in the current survey relating to the management of patients with dementia and BPSD in Victorian hospitals included: extreme rates of observed aggression (reported by 99% of survey respondents), high requirements for 'occasional' or 'regular' additional staffing/specialist (93% of respondents) and recognised barriers to discharge (85% of respondents) which included long waiting lists for appropriate residential aged care and the limited capacity of destination wards to manage challenging behaviours.

The impact of complexity in patients with dementia can be significant, affecting various aspects of healthcare delivery. These patients often have longer LOS as a result of their need for specialised care and the challenges in managing BPSD that contribute to delays in diagnosis, treatment, and discharge planning. This can lead to increased adverse events, higher healthcare costs and greater utilisation of hospital resources. This was supported by findings from the benchmarking survey in which particular challenges to care provision identified by survey respondents included the large volume of patients with dementia in hospitals, inadequate staffing levels/experience, issues implementing non-pharmacological strategies and working within environments that do not support the care of this patient population.

Finally, patients with dementia may present ethical dilemmas in hospitals. For example decision-making capacity, advance care planning, consent for medical procedures, and balancing patient autonomy with safety considerations require ethical deliberation and intensive discussion between all members of the interdisciplinary team. This requires further exploration in future research activities.

5.2 Aggression, Agitation and Violence

With dementia impacting both receptive and expressive communication abilities, AAVB are mechanisms by which many patients in hospital with this condition communicate pain, fear, boredom, overstimulation by the physical environment and/or an unmet need such as hunger, thirst, or the need for toileting.⁸ As outlined previously, the presence of aggression, agitation and violence in patients with dementia and BPSD was identified in the benchmarking survey as a significant challenge within Victorian health services. Almost all of respondents (94%) reported that there had been code grey emergency responses related to AAVB in patients with dementia and BPSD on their ward in the last 12 months, with approximately one-fifth (19%) indicating that a code black response had been required due to actual or potential aggression involving a weapon or serious threat to personal safety.

These findings highlight the multiple challenges faced by hospital staff in managing complex patients with dementia and BPSD who demonstrate AAVB. Limited knowledge and training in dementia care, inadequate staffing ratios, time constraints, and the demanding nature of BPSD can not only create difficulties in providing appropriate care but can also increase the risk of OVA.

5.3 Identifying and Addressing Individual Needs

5.3.1 Person-Centred Care

Unmet needs in patients with dementia are one of the main causes of BPSD, leading to psychological or emotional distress which manifests in aggressive or agitated behaviours. While acute medical requirements during hospitalisation are overwhelmingly met through diagnostic assessments and the subsequent development of treatment plans by emergency and/or admitting medical staff, the individual patient's physical, social, emotional and psychological needs are often overlooked. Identifying and addressing these needs, maintaining a consistent routine and establishing a familiar environment is critical in reducing confusion, minimising anxiety and avoiding the potential development/exacerbation of BPSD.

Person-centred care acknowledges that every patient is a unique and complex individual, respects their preferences and recognises the knowledge they bring about their personal health and healthcare needs.⁹ While this approach has been shown to improve health outcomes, it can also reduce anxiety, enhance trust and ensure a better care experience for patients, their families/carers and hospital staff. The current benchmarking survey revealed that strategies to support person-centred care for patients with dementia were most likely to be used in acute and sub-acute wards (as opposed to emergency and urgent care), with a wide variety of approaches employed in these settings. Tools that provided staff with information about the individual patient's personal profile and preferences, such as the Sunflower Tool and the "This is Me" Form (or similar), were reported to be frequently used in acute and sub-acute care settings. However overarching frameworks that promote person-centred care, including the Top 5 program and 4M approach, were less likely to be utilised.

Regardless of strategies used within individual hospital settings, person-centred care must be embedded on a day-to-day basis at an organisational level in order to be successful. Within the current survey, this was most apparent through the active involvement of patients, families and carers as partners in their own care (predominantly achieved through encouraging families/carers to support patient care on the wards, participation in family meetings and flexible visiting hours) as well as staff education/training related to the provision of person-centred care. However, less than half of survey respondents suggested that routine assessment of patient/family/carer experience was conducted within Victorian health services and there was minimal evidence to suggest the development of policies and procedures for involving patients and families/carers in their own care.

5.3.2 Screening and Assessing for Dementia and AAVB

Acknowledging that patients with dementia and BPSD have greater and different care needs compared to other older patients in hospital is important in ensuring the provision of safe and quality care. Particular considerations for these patients include communication difficulties that impact both verbal comprehension and expression as well as the potential need for specific types of cognitive stimulation, emotional support/reassurance, adequate supervision and an environment that is free from hazards and appropriately monitored and/or secured. Screening for dementia as early as possible into an admission (including assessment of the potential risk for AAVB) is therefore critical in supporting the development of tailored care plans and proactive interventions that align with patient need.

Despite this, compliance with screening and assessment for both dementia and AAVB was raised as an issue in the benchmarking survey, with significant variation in both the point of time and care setting/s in which this occurs, as well as the nature (proactive vs. reactive) and type of tools used. There were also a number of survey respondents who reported that screening and assessment does not occur at all.

5.3 Management Approaches

Within the literature, general consensus is that models of care for managing patients with dementia and BPSD in hospitals needs to be multi-component, multi-disciplinary and multi-level within organisations. This was supported by the findings from the current benchmarking survey which revealed that the interventions used to assist in the management of challenging behaviours demonstrated by patients with dementia and BPSD are highly variable both within hospital care settings and between health services across Victoria. While this may be partially explained by the provision of person-centred care, and staff responding appropriately to the different care needs of individual patients, a number of survey respondents reflected that their organisation's management approach needed to be more consistent across all wards, clinical units and care settings.

5.3.1 Non-pharmacological vs. Pharmacological Interventions

Multiple clinical trials and systematic reviews have found that non-pharmacological interventions can be effective in managing patients with dementia and BPSD in hospitals¹⁰ and should therefore be used as the first line approach. The benchmarking survey revealed that there are a substantial number of non-pharmacological strategies being employed in Victorian health services to assist in managing this patient population, with 75% of respondents indicating that behavioural support plans are utilised in their respective organisations. Diversional therapy, orientation therapy, music therapy, pastoral care and sleep hygiene were other common non-pharmacological interventions that were reported in the survey.

The main exception to this was emergency and urgent care where only four non-pharmacological interventions (additional staffing, allocation to a single room, diversional therapy and physical restraint) were used by a small number of health services. Instead, this setting reported the highest rate of antipsychotic and sedative use across all hospital care types (83% of respondents, respectively). Best practice regarding the use of antipsychotic medications states that these should be considered a last resort to manage agitation, aggression and psychotic symptoms in patients with dementia and BPSD due to the risk of side effects and the potential to cause adverse events including death. Sedative medications are generally also only recommended in patients with dementia for the short-term treatment of agitation. While the rate of antipsychotic and sedative use in emergency and urgent care was particularly high, it remained significant across all care settings. Future studies should therefore focus on exploring the indications for prescription and associated dosage regimens for individual patients in order to justify their use. Additional findings from the survey regarding pharmacological interventions suggested that the rate of antidepressant use was found to increase across the care continuum, beginning at 17% in emergency and urgent care settings, then rising to 43% in acute and 62% in sub-acute care. While antidepressants are frequently used in the later stages of dementia to control irritability and rapid mood swings,¹¹ again, the specific reasons for their usage in different care settings requires further investigation in order to make firm conclusions regarding this apparent trend.

Of particular concern regarding the management of patients with dementia in Victorian hospitals, however, was the reported levels of restrictive interventions used including physical (i.e. bodily) restraint. The use of physical restraint has ethical, legal and clinical consequences, violating a patient's right to freedom and dignity. There is also evidence that its use is associated with adverse physical, psychological and social outcomes and increases the risk of death.^{12,13} As a result, the Victorian government recommends that physical restraint should only be used as a last resort and only for short periods in extreme emergencies. An in-depth study reviewing the decision-making processes and supporting governance structures relating to the use of physical restraint in managing patients with dementia in Victorian hospitals is therefore warranted.

5.3.2 Proactive vs. Reactive Strategies

When screening and assessment for dementia and potential risk of AAVB is conducted early into a patient's hospital admission, management strategies can be developed and implemented to avoid or minimise BPSD. Whilst not specifically identified as a non-pharmacological management strategy, almost two-thirds (65%) of survey respondents reported using planned code greys for patients with dementia and BPSD in hospital. Interestingly, use of this proactive approach was highest in sub-acute care (70% of respondents) which was the hospital setting that reported the lowest rate of code black emergency responses for this patient population.

These findings suggest that planned code greys, where staff conduct risk-based assessments to determine whether an incident is anticipated to occur and subsequently request assistance prior to a scheduled event, could be an important non-pharmacological strategy for preventing escalation of aggression, agitation and violence in patients with dementia and BPSD in hospitals. Despite this, a substantial proportion of survey respondents (21%) across all hospital settings suggested that there were no preventative OVA approaches employed on their ward/unit in relation to the care of patients with dementia and BPSD, while almost half (47%) indicated they were unsure.

Additionally, while a number of interventions that were reported to be frequently used in managing patients with dementia in hospital are assumed to be responsive to the presence of challenging behaviours associated with BPSD (e.g. additional staffing, allocation to a single room and use of sedation), the rationale for these was not specifically explored within the benchmarking survey. It is therefore possible that some of these management strategies may have, in fact, been proactive as part of a care behavioural support plan in attempting to provide quality care and minimise the risk of harm for the patient as well as for their family/carers and hospital staff.

5.3.3 Promoting Continuity of Care

With many patients with dementia finding comfort in familiarity and routine, changes in their environment, care providers, and/or management strategies can lead to increased confusion, agitation, and distress. Consistency in management approaches and individual interventions across all staff and care settings can therefore help create a stable and predictable environment which prevents confusion, reduces anxiety, aids transitions, minimises risk of fragmented/disjointed care and enhances patient function. Findings from the benchmarking survey suggest that, while models of care vary within and between Victorian health services, there are a number of processes that have been established to recognise the need for continuity in patient care. These include the use of nursing handover and behaviour observation charts to identify triggers and record/monitor challenging behaviours as well as behaviour support plans and other care planning tools to document/communicate management strategies (mostly in acute and sub-acute settings). Avoiding the movement of patients with dementia between wards/units and utilising point of care testing were also reported by varying numbers of survey respondents.

From an organisational perspective, standardised models of care promote efficient resource utilisation within hospitals. By establishing consistent processes, protocols, and care pathways, clinicians can streamline workflows, minimise duplication of efforts, and avoid unnecessary tests, treatments and/or transfers. This can lead to improved resource allocation, reduced healthcare costs, and optimised utilisation of staff, equipment, and other hospital resources. Additionally, when there are clear and standardised care models in place, it becomes easier to train new staff members and ensure they adhere to established guidelines that support evidence-based practice in maximising patient outcomes.

5.3.4 Supporting Families and Carers

Consistency in management approaches not only benefits patients with dementia, but also assists their families/carers to co-ordinate care effectively with clinicians and access available resources that can support them in their role. By establishing clear communication channels and a consistent routine, families/carers can develop a better understanding of the patient's current needs and future treatment goals, anticipate potential challenges, and provide appropriate support/guidance to prevent and/or minimise these.

While majority of survey respondents indicated that families/carers are encouraged to support patient care on the ward during flexible visiting hours, almost half (48%) reported that there was no education or training provided regarding dementia and managing AAVB with no mention of whether strategies were implemented to monitor and address wellbeing. Furthermore, in most instances, it was suggested that families/carers do not participate in regular, 'real-time' communication forums (such as ward rounds and case conferences) with the interdisciplinary team. This impacts the accuracy and timeliness of information exchange, capacity for shared-decision making and ability to build trusting relationships.

Interestingly, perceived obstruction/concerns from families/carers was raised in the survey as a barrier for discharge. Valuing and empowering families/carers as partners in care improves experiences and outcomes for patients with dementia, enhances satisfaction and morale of hospital staff and maximises organisational efficiency. Hospitals should therefore provide families/carers with resources that offer support, education, and training, helping them understand the condition, develop coping strategies, and navigate the challenges of caring for someone with dementia.

5.4 Access to Appropriate Resources

Many of the evidence-based interventions used to support the care of patients with dementia and BPSD in hospitals require specialised and dedicated resources. For example, the non-pharmacological management of this complex patient population is known to require substantial time allocation for assessing individual symptoms, identifying behavioural triggers, developing care plans, making referrals, managing symptoms, communicating outcomes and providing ongoing support for families/carers. However, within the current benchmarking survey, workforce resources were identified as one of the most significant challenges to care provision for patients with dementia and BPSD.

5.4.1 Interdisciplinary Care Team

The management of patients with dementia and BPSD in hospitals requires an interdisciplinary team approach in which team members collaborate to provide comprehensive care, manage symptoms, and maximise functional ability. Given that this patient population is present in almost every hospital care setting, as evidenced by the span of survey respondents, all adult wards/units should have access to full variety of clinicians with expertise in assessing and managing BPSD including geriatricians, specialist cognition nurses, social workers, occupational therapists, physiotherapists, speech pathologists, neuropsychologists, dietitians, music therapists and diversional therapists to support non-pharmacological interventions.

Findings from the benchmarking survey indicate significant variation in the available range of team members within each care setting. This limits the ability to implement evidence-based practice, person-centred care and proactive management strategies that meet the individual needs of patients, increasing the risk of BPSD.

5.4.2 Skilled Clinicians

In addition to the type of team members required, hospitals also need clinicians who have comprehensive understanding, awareness, skills and competence in assessing, treating and managing patients with dementia. For example, patients with dementia often require significant medication management to address symptoms such as cognitive decline, behavioural disturbances, and co-morbid conditions. Hospitals therefore need pharmacists who are knowledgeable about dementia medications and potential interactions to ensure proper prescribing, administration and monitoring. This requires organisational commitment to staff education and training that is delivered in a timely manner using face-to-face formats delivered by experts in the field.

In spite of this, staff education and training programs are often lacking, particularly when there are chronic workforce shortages and overwhelming hospital demand pressures. This was verified by survey respondents in the current study, with one-quarter (25%) reporting that staff education and training for staff regarding dementia and AAVB was not provided in their care setting. Sub-acute was the most likely setting to provide staff education and training however, despite having a strong multidisciplinary presence, it was only available for the full range of disciplines in just over one-third (37%) of wards/units.

5.4.3 Cognitive Stimulation and Engagement

Resources that offer cognitive stimulation and engagement opportunities for patients with dementia and BPSD can assist in maintaining cognitive ability, improving mood, and enhancing wellbeing. This includes activities that utilise memory aids, sensory stimulation tools, and promote social interaction and engagement. Although many of these can be facilitated by hospital volunteers, only 10% of survey from acute and 22% from sub-acute settings suggested that volunteer programs were available to support the delivery of non-pharmacological interventions (these programs were not available in emergency and urgent care settings).

This may be the result of concerns regarding the severity of AAVB in this patient population and the potential risks to volunteers or, alternatively, a lack of available human and/or material resources to support the delivery of these programs. Where volunteers are involved in the care of this patient population, however, they should be provided with the same supports as clinical staff. This includes appropriate education and training regarding the management of dementia, access to employee assistance programs, regular supervision and de-briefing.

Planning, designing, co-ordinating and implementing recreation and leisure-based activity programs to support, challenge and enhance the psychological, spiritual, social, emotional and physical wellbeing of patients is the dedicated role of Diversional (or Recreational) Therapists.¹⁴ Within the benchmarking survey, just over half of respondents (58%) from sub-acute reported that diversional therapy was available. Access to this service was less likely in acute (43% of respondents) and emergency and urgent care (17%).

5.4.4 Dementia-specific Supports

Given the presence of patients with dementia across all adult hospital settings, health services have been required to develop local policies, procedures and processes for responding to the potential challenges associated with managing this patient population. Across Victoria, a number of larger metropolitan hospitals have dedicated dementia-specific units or wards that are designed to provide a safe and supportive environment for patients with advanced dementia. These units often have enhanced security measures, adapted physical spaces, and trained staff who are knowledgeable about dementia care and BPSD.

With the current study, only a small proportion of respondents (6%) reported they were completing the survey as a clinician who worked on a dementia-specific ward. However over one-third (36%) indicated that their care setting referred patients with dementia to dementia-specific wards as a strategy for responding to AAVB, with transfer to an older persons psychiatric ward or a secure ward also reported as a management option by 32% and 27% of respondents, respectively. Considering that the overall survey responses were analysed by care setting, as opposed individual clinical unit, specific models of care for these dementia-specific environments requires further investigation. Interestingly, only 12% of survey respondents indicated having access to speciality clinical nursing roles relating to dementia. The minimal reported use of this resource to assist in managing challenging behaviours or providing education, training and support for staff and/or families/carers of patients with dementia can therefore be largely assumed to be the result of a lack of dedicated roles within health services. As has been shown by the recent Safer Care Victoria Delirium Collaborative,¹⁵ the introduction of organisation-wide improvement teams (including a mix of senior and junior nurses, doctors, allied health staff, consumers and a dedicated clinical nurse educator/specialising role) could drive significant improvements in the care of patients with dementia in Victorian hospitals. Particular deliverables should focus on sustainable approaches for embedding screening/assessment tools, developing policies and procedures for implementation of management strategies/escalation processes, prioritising education and training (both on the ward and in new staff orientation) and creating supportive physical and cultural environments.

Additionally, a small number of respondents (9%) reported accessing external dementia-specific supports from DSA, in particular, the DBMAS. DBMAS is funded by the Australian Government and is designed to provide proactive behavioural support, regardless of where the person is, their dementia diagnosis or age.¹⁶ However the low referral rate to DBMAS, in addition to reports from some survey respondents that referral to these services was discouraged by their organisation, requires further analysis.

5.5 Supporting and Empowering the Workforce

The management of older people with dementia and BPSD in hospital is complex and challenging, requiring an interdisciplinary approach that involves different healthcare professionals working together in often stressful circumstances. As the current benchmarking survey indicates, many people with dementia who experience BPSD, also frequently demonstrate aggression, agitation and physical violence. Managing these behaviours can be difficult, particularly in a hospital setting where time-pressed staff may not be familiar with the individual's history or preferences and therefore may not be able to meet their needs. In addition, patients with dementia often have difficulty communicating which can increase BPSD and make it challenging for healthcare providers to provide appropriate care.

As a result, caring for these patients can be physically, mentally and emotionally demanding, which can lead to fatigue, burnout and high staff turnover. This can make it increasingly difficult to provide consistent and high-quality care. Furthermore, while managing patients with dementia and BPSD requires specialised training and ongoing professional development, staff members may not have enough time to attend education sessions and/or the level of instruction they receive may not be adequate or appropriate.

5.5.1 Appropriate Staffing Levels

High clinical workloads make it difficult to devote enough attention to identify and address each patient's individual needs, with widely-acknowledged chronic staff shortages across all disciplines leaving fewer staff members to provide care. Numerous survey respondents suggested that analysis of current funding models, with a view to increase staffing levels, is essential to preventing/managing AAVB, providing highly adaptable and responsive care and supporting high-quality service delivery for these patients.

Almost half of respondents in the current survey, suggested there were reactive changes to rostering and staffing levels to assist in managing challenging behaviours in patients with dementia. In particular, the use of additional staffing to assist in managing dementia and BPSD was highest in acute care settings (93%). This could be due to an increased prevalence/intensity/frequency of challenging behaviours associated with medical acuity and/or a lack of alternative non-pharmacological interventions and accompanying resources available to manage these. Respondents from acute wards also reported the lowest rate of education and training for staff regarding dementia, BPSD and managing AAVB (15%) across all care settings.

5.5.2 Culture of Care

Supporting hospital staff in managing patients with dementia and BPSD requires a multi-faceted approach that includes training and education, effective communication strategies, environmental modifications, adequate staffing levels and collaboration among clinicians who are experienced in the care of this population. It is also crucial to promote a culture of empathy, patience, and person-centred care within hospitals to ensure the health and wellbeing of both staff and patients.

The culture in acute care reported by respondents within the current survey was of particular concern, with numerous suggestions that there needs to be greater acknowledgement and improved management of the overall geriatric population in this setting, including those living with dementia. Proposed strategies to support this included better understanding/awareness of person-centred approaches, increased staffing resources and improved access to specialist clinicians such as geriatricians, occupational therapists and diversional therapists. Accessible and targeted education was also highlighted as a key strategy for improving care. While responses from sub-acute settings were similar, the main focus was on resourcing and the need for more dementia-specific units with mental health clinician involvement for patients with severe BPSD. Respondents from multiple care settings suggested that the main change required to culture in emergency and urgent care environments was the need for geriatric-friendly EDs.

Organisational approaches to monitoring and addressing staff wellbeing were reported by almost all survey respondents however whether these were appropriate and accessible in meeting their needs was not explored. This was reflected in comments from clinicians suggest that they felt stressed, isolated and vulnerable by the possibility of being exposed to OVA. Providing a hospital environment that promotes quality and safety through a culture of care for patients, families/carers and staff is paramount.

5.6 Universal Dementia-Friendly Hospital Design

Patients with dementia often experience cognitive impairments that can affect their perception, orientation, memory, and ability to navigate and understand their environment. Hospitals can be overwhelming places for these patients due to a range of factors including bright lights, noise, unfamiliar surroundings, confusing layouts and a high level of 24-hour activity. Concerns regarding the suitability of hospital environments for patients with dementia, and the impact this has on care provision and health outcomes, were raised by numerous respondents across all care settings throughout the current benchmarking survey.

5.6.1 Visual, Spatial and Security Set-up

Dementia-friendly hospital design aims to create a calm, soothing and reassuring atmosphere, reducing agitation and aggression that may arise from sensory overload and heightened anxiety. Despite this, less than one-third of survey respondents (30%) indicated that their ward environment had been modified to make it dementia-friendly, with even fewer respondents (22%) reporting that modifications had been made to minimise/manage aggression.

Minimising noise and distractions, ensuring adequate lighting and using familiar objects to create a sense of familiarity can help alleviate confusion and distress for patients with dementia in hospital. In addition, physical features such as secure doors, non-slip flooring and minimised hazards helps mitigate risks and reduces the chances of falls, accidents, and wandering-related incidents. As a result, environmental modifications are crucial for wellbeing, safety and quality of care. By creating dementia-friendly environments, hospitals can help mitigate the challenges faced by these patients, support their dignity and improve their overall care experience.

5.6.2 Orientation and Wayfinding

Hospitals are large and complex environments, making it challenging for patients with dementia to navigate and find their way around general areas (such as entrance foyers), ward spaces and bedside zones. Clear signage, accessible facilities, uncluttered spaces and intuitive layouts can help patients feel less disoriented, reduce their reliance on others, maximise their function and enable them to maintain a sense of independence and autonomy. The use of pictorial symbols and other visual cues can also facilitate understanding and aid in effective communication between patients and staff, promoting better care delivery and improving outcomes.¹⁷

5.7 Limitations

The methodology used for the benchmarking study involved data collection from health professionals working in metropolitan, regional and sub-regional health services across Victoria. All 28 Victorian health services were approached by NARI to invite clinicians to complete the online survey regarding the current principles and models of care related to the management of patients with dementia in hospital. Participation was therefore voluntary and self-directed.

Limitations associated with the study methodology that may potentially impact the accuracy and interpretation of the information obtained include:

1. **Self-completion Bias:** The findings presented in this report were obtained via self-completion. This type of methodology introduces a number of biases which may affect the accuracy of the data, including social desirability bias where the data collectors involved in data collection provide certain responses in order to make a good impression rather than reporting accurate information.
2. **Self-selection Bias:** The methodology with which health professionals volunteered to participate in the study was not controlled for in the study protocol. It is therefore possible that those clinicians who chose to participate had a particular bias regarding the management of patients with dementia in hospitals. This may have resulted in responses that were not necessarily reflective of current practice. In addition, the self-selected nature of recruitment meant that there were differences in the number of respondents from each health service, care setting, clinical unit and professional role.
3. **Non-response Bias:** Given that respondents had autonomy over survey completion, situations may have occurred in which they chose not to include certain responses. In addition, responses may not have been provided due to difficulty in finding required information, lack of knowledge/understanding of questions and/or the overall length of the survey.
4. **Question Bias:** Despite careful and considered survey design, involving collaboration with expert clinicians, some questions may have unintentionally been leading, ambiguous and/or open to (mis)interpretation by survey respondents.

Other possible limitations of the study that should be considered include:

- Background/experience of survey respondents and the impact of their knowledge/understanding regarding different elements of models of care.
- Difficulty attributing aggressive, abusive or threatening behaviours to dementia alone i.e. what was the impact of other co-morbidities including delirium etc.
- No specific survey questions regarding gender or diversity e.g. culturally, religious and/or linguistic diversity.

6. CONCLUSION

Dementia is recognised as a significant and growing health and aged care issue in Australia. Although hospitals are known to be challenging places for people with dementia, in particular those with BPSD, there is limited information available about the prevalence of this patient population in inpatient hospital settings. The current benchmarking survey aimed to identify current principles and models of care in place for the management of patients with dementia and severe BPSD in Victorian hospitals. It is part of a wider project focusing on the management of dementia and severe BPSD in hospital settings that will help inform service delivery and the development of a best practice model of care for these patients in Victorian public hospitals.

The current benchmarking survey was completed by 104 hospital clinicians representing emergency and urgent care, acute and sub-acute care settings within 13 health services across metropolitan, regional and sub-regional Victoria. All survey respondents reported working with patients who had dementia, with 99% indicating they had observed aggressive behaviour in this population. Unsurprisingly, there is significant variation in the local models of care that have been developed to support the assessment and management of patients with dementia and BPSD in Victorian hospitals. This was evident both between and within health services, particularly across different care settings, and was largely driven by the absence of overarching policies and formal guiding principles.

In addition, numerous gaps were between current and evidence-based best practice for this patient cohort. This included compliance with screening and assessment for both dementia and AAVB, patterns of pharmacological intervention use, ability to identify and address individual patient needs, availability of appropriately-trained human resources, access to dementia-friendly environments and the presence of governance systems and processes that support the delivery of safe and high-quality health care. A lack of acknowledgement regarding the presence and specific requirements of patients with dementia in all adult wards/units (including emergency and urgent care, acute and sub-acute care), as well as the valuable role of families/carers in supporting care provision, was also apparent.

Overall, the study reinforces that the management of patients with dementia and BPSD in hospital requires a multi-faceted, comprehensive and person-centred approach that takes into account the individual's medical history, functional level, personal preferences, and social/emotional/psychological needs. In order to achieve this, all members of the interdisciplinary care team must be provided with sufficient education and training as well as appropriate resources and workplace supports to ensure they can provide high-quality care that also maintains their own health and wellbeing. This should be underpinned by a physical, cultural, political and financial environment that supports best practice, encourages the active involvement of patients and families/carers in their care and recognises the significant existence and complexity of this vulnerable patient population. The development of government policies and consistent models of care that are adequately resourced to support the management of patients with dementia in Victorian hospitals models is critical to organisational efficiency and effectiveness in improving care outcomes.

7. REFERENCES

1. Rosen, J. *et al.* The Pittsburgh Agitation Scale: A User-Friendly Instrument for Rating Agitation in Dementia Patients. *The American Journal of Geriatric Psychiatry* **1**, 52–9 (1994).
2. Brodaty, H., Draper, B. M. & Low, L.-F. Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia* **178**, 231–4 (2003).
3. Australian Institute of Health and Welfare (AIHW). *Dementia in Australia (Online)*. <https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/about> (2022a).
4. NSW Ministry of Health & The Royal Australian and New Zealand College of Psychiatrists (RANZCP). *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW Health Clinicians*. (2013).
5. Cunningham, C., Macfarlane, S. & Brodaty, H. Language paradigms when behaviour changes with dementia: #BanBPSD. *International Journal of Geriatric Psychiatry* **34**, 1109–1113 (2019).
6. Munro, D. *Caring for People With Dementia in Victorian Hospital Benchmarking Data Report*. (2020).
7. Australian Institute of Health and Welfare (AIHW). *Dementia in Australia: Understanding BPSD in Australia*. at <https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/behaviours-and-psychological-symptoms-of-dementia/understanding-bpsd-in-australia> (2023).
8. Weitzel, T. *et al.* The special needs of the hospitalized patient with dementia. *Medsurg Nursing* **20**, 13–18 (2011).
9. Victorian Department of Health. *Person centred practice*. at <https://www.health.vic.gov.au/patient-care/person-centred-practice> (2023).
10. Li, Y. Q. *et al.* Non-pharmacological interventions for behavioural and psychological symptoms of dementia: A systematic review and network meta-analysis protocol. *Frontiers in Psychiatry* **13**, 1039752 (2022).

11. Dementia Australia. Drugs used to relieve behavioural & psychological symptoms of dementia. at <https://www.dementia.org.au/information/about-dementia/what-is-dementia/how-is-dementia-treated/drugs-used-to-relieve-behavioural-psychological-symptoms-of-dementia> (2022).
12. Department of Health and Human Services. Physical restraint: Standardised care process. at <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/factsheets/s/scp-physical-restraint-pdf.pdf> (2018).
13. Department of Health. National Aged Care Quality Indicator Programme, Resource manual for residential aged care facilities, Part A: Handbook. at <https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual-30-part-a?language=en> (2015).
14. State Government of Victoria & Victorian Skills Authority. Victorian Skills Gateway: Diversional Therapist (Also known as Recreational Therapist). at <https://www.skills.vic.gov.au/s/occupation/a0k4a0000009dV0AAI/diversional-therapist> (2023).
15. Safer Care Victoria (SCV). Delirium collaborative. at <https://www.safercare.vic.gov.au/improvement/projects/oppc/delirium> (2020).
16. Dementia Support Australia. Dementia Behaviour Management Advisory Services (DBMAS). at <https://www.dementia.com.au/dbmas> (2022).
17. Dementia Australia. Dementia Language Guidelines. at <https://www.dementia.org.au/sites/default/files/resources/dementia-language-guidelines.pdf> (2021).

8. APPENDICES

Appendix 1: Examples of Disciplines Involved in the Care of Patients with Dementia and BPSD According to Care Setting

Discipline	Emergency and Urgent Care	Acute Care	Sub-acute Care
Medical Specialists	Not stated	Palliative Care, Pain Specialists, All specialties within health service (e.g. stroke/neuro, cardio, neurosurg, ortho, rheum, ID, pain team).	
Nurse Specialists	Not stated	Cognition CNC, Wound specialist, Behavioural nurse, Delirium CNC, Stoma care/continence care, Clinical nurse educators, Behaviours of concern nurse, CNS stroke/neuro	Skin integrity, Palliative care, Falls, Diabetes, Wound care, Delirium, Dementia consultant, Pain CNC, Mental health, Behavioural nurse consultant, Heart failure CNC
Allied Health	Occupational therapy, Physiotherapy, Speech pathology, "Various"	Physiotherapy, Occupational therapy, Speech pathology, Social work, Dietitian, Speech language therapist, Podiatry, Allied health assistant	Physiotherapy, Occupational therapy, Speech pathology, Social work, Dietitian, Speech language therapist, Podiatry, Allied health assistant, Pastoral care, Exercise physiologist, Spiritual care, Music therapist
Mental Health Specialists	Not stated	Psychiatry, Old age psychiatry, Neuropsychology, Clinical psych, Mental health CNC, Consultation liaison nurse (tertiary mental health assessment)	Psych liaison nurse, Old age psychiatrist, Psychiatric nurse, Clinical psych, Neuropsychologist, Aged persons mental health team, Enhanced crisis assessment team, Health psychology, Aged mental health registrar
Other Staff	Not stated	Patient service assistant, Health care worker /security special 1:1, Advanced trainee in geriatric medicine, Basic physician training, Hospital medical officer	Spiritual care, Diversional therapy, specials, Delirium CNC, Cleaners, Patient service assistant, Ward clerks, Allied Health Assistant, Registered undergraduate student of nursing - RUSON, Pastoral care, Volunteers, Aboriginal liaison officer

Appendix 2: Responses regarding Care Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD

Care Setting	Free Text Responses
Emergency & Urgent Care	Security or non-health special most frequently to sit with Psych patients
Acute	- Patient watch by PCA's. - In the Increased observation room we have 4 patients to 1 RN and 1 Health assistant in nursing 1:1 nursing to provide extra supervision 1:1 nursing used to keep patient safe if risk to themselves Also used when patient is a threat to other patients - One on One observation Engaging in diversional Therapy Observation for triggers for behaviours of concern - usually health assistants who aid in re-direction for wandering patients and assist with ADL's 1:1 care, within arm's reach. To prevent escalation, wandering or intrusiveness 1:1 nursing care to patients who have been identified by senior nursing staff or mental health staff as requiring additional observation or support. Often limited by available resourcing. - usually supervision or assistance, fall prevention - Sitting with patient, taking to patients, attending care needs, escalating behaviours of concern, ambulating them where possible - Reassurance and company 24 hr 1on 1 care - Additional supervision and engagement with patient. - Dependant on individual nurse. Unsure if there is a policy of expected roles. - Additional support - ADLs Distraction/diversional activities assist to mitigate falls risk - Supervision to reduce falls risk. Alert nursing staff when assistance needed. Distraction techniques. - Health Care workers- sit in the room with patients - Occasionally for patients who pose risk to themselves or others from aggressive/agitated behaviours. Support diversion therapy tasks. - attending to basic needs (e.g. assistance with meals, toileting, wash/shower) 1:1 nursing if approved by executives. Diversional therapy- Non-Clinical ward assistant - Watching and supervising the patient.
Sub-acute	- Assistance with providing personal care, monitoring for falls harm minimisation. redirection and engagement in activities. Supervision whilst receiving treatment, i.e. IV infusion. - High falls risk or high risk of restraint - Any - To provide 1:1 support for disturbed and agitated patient.

- ☞ Usually a nurse and it always depends on whether there is an additional nursing staff who is available. Usually they sit with the person or walk with them, provide the aforementioned approaches.
- ☞ very occ and security - haven't used any since March - in last 12 months for three patients
- ☞ Increased supervision
- ☞ security specials + health care workers
- ☞ they follow them around and watch them
- ☞ 1:1 care for patient - redirection, falls prevention, oral intake etc.
- ☞ monitoring of behaviours and seeking assistance when behaviours escalate, diversional therapy, although sometimes skillset/knowledge of special nurses about dementia care is limited
- ☞ HCW or security specials.
- ☞ Falls reduction, Pressure injury reduction
- ☞ 1:1 special supervision
- ☞ either security or ruson - no nursing or clinical care - just presence to minimise injury or absconding
- ☞ depending on acuity and associated behaviour we would consider the following;
 1. use of ICA
 2. specialling
 3. extra staff just to manage the increase in behaviours, especially the intrusive, grabbing of others.
- ☞ watching patient
- ☞ extra staff
- ☞ HSA & RUSON or Nurse
- ☞ Changing all the time may be for Falls risk Absconding risk Violence risk Behaviour management
- ☞ observation, redirection, falls prevention de escalation
- ☞ Security;
- ☞ some patients are identified by screening or handover to require a "special"
- ☞ Varies: to prevent falls risk is major risk to prevent absconding to prevent self-harm and ensure patient safety
- ☞ 1:1 observation nurse - RUSON providing SIMON (I don't know what these acronyms stand for)
- ☞ Observation and redirection and distraction
- ☞ CPO - often requested by not available

Appendix 3: Responses regarding Rostering Models Designed to Manage BPSD

Free Text Responses

- When we have 15 or more patients displaying BPSD we may request an additional staff member to assist in mitigating risk. I.e. incidents of aggression and falls. We also may get an additional staff member for a patient with known aggression being transferred from the acute service for the first 24/48hrs.
- Specials if able
- Additional Nurse/RUSON as 1:1
- In the last 12 months when identified patients that are requiring extra resource then we do this, managing it shift by shift - Although to accommodate for the increased acuity of our patients we have we have increased our ratio of staff each shift from the inadequate ratios for this speciality is paid to health services.
- Ideally allocate 1:1 but COVID/understaffing limits additional staffing
- skill set of staff on each shift
- Nursing changes - I am unaware of specifics
- not sure NUM usually manages this
- By requesting additional staffing.
- NUM makes 1:1 special nursing decisions
- extra staff for constant observation for Pt with behaviour of concerns
- Only nursing staff - does not affect doctors.
- skill mix review
- Extra staff as required (if we can get them)
- Increased level of staffing to supervise or special patients.
- RUSON, Health Service Assistants or nursing staff rostered to provide 1:1 care
- Site-wide coordination on occasion regarding load-levelling at a nursing level if high BOC demands occurring
- Not Known
- We can request additional HSA staff support - we be strategic about who is allocated to these patients
- 1:1 observation nurse

Appendix 4: Responses regarding the Influence of Funding on Models on Care

Care Setting	Free Text Responses
Emergency & Urgent Care	- Geriatric-friendly ED will need funds to set up and also provide education - Staffing Suitability of the model of care Reducing bed block
Acute	- These patients require a huge amount of resources but often are just incorporated into everyday care which is insufficient for their needs - Able to modify areas of the ward to provide safer environment for the patient. Increased funding around nursing to provide 1:1 when patient is very vulnerable - Support for education and training support for environmental alterations or additions support more Dementia Specific RACF beds / Fast track VCAT - More funding equals the ability to have more staff/equipment/training to effectively look after patients with dementia - Increased funding to ensure adequate staffing to prevent agitation/aggression and support patients to get the best care they can - Funding models that considered the specialist experience and knowledge required by staff caring for patients with dementia, in addition to the additional resourcing that is required to provide a highly adaptable and responsive level of care. - Making dementia friendly wards activities provided appropriate staffing - Because it influences staffing and ability to provide adequate care. It also influences resources like activity coordination (which we no longer have) and access to diversional therapies. - The wards could be designed in a much better way and have increased numbers of trained staff to provide for the specialised needs of these patients. - More resources, better staffing. More education. - Opportunity for more OT and diversional therapy however inadequate staffing and therefore discharge planning is given priority - In my opinion for the acute hospital setting - focus is on bed flow and surgical wait lists - Training and education for staff. To provide environment that promotes safety - More consistent approach- very guided and useful to isolated areas. Very difficult to implement changes by self - ward very passionate - Acute funding models do not accurately reflect the increased resourcing required to manage a patient with an acute illness who also has co-existing dementia/BPSD. - Physical structure of the ward to deliver best care to these patients; nurse specialist, diversional therapist - If we have access to funding to provide diversional therapy for example: Virtual Forest from Dementia Australia. - More staffing and resources to ensure a patient-centred approach.
Sub-acute	- If funding was available to provide better staffing and resource for occupational activities then we may see a reduction in aggression/agitation. - Cost of specially trained staff is prohibitive - No additional funding despite increased nursing needs

	🗨 Funding models limit the staffing that would enable use of a more person centred non-pharmacological approach 🗨 The staffing of this unit hasn't been revised accordingly and the increased acuity and numbers of patients living with dementia requires a different model of care that needs urgent addressing 🗨 Increased staffing numbers/ hours within Diversional Therapy, this provides patients with 1:1 and appropriate person-centred care for their individual needs. Not taking away nursing staff from their roles in care 🗨 Increased nursing ratios to allow the time required to care for patients with BPSD 🗨 The wards that care for these patients are typically GEM wards, ratios are lower on these wards which increased stress on the ward in very complex situations. Frequent budget over runs are a feature 🗨 It may affect staffing level and experience, facilitates may not accept consumers with BPSD due to higher of level support they require. 🗨 Limited with nursing ratios and AH, medical EFT - given the increased complexity of these patients, staff cannot no longer meet the demands and are burning out. Patients are getting basic care only. More staff, more practical training is required 🗨 Sub-acute nursing ratios don't reflect the care needs of patients with dementia. 🗨 Access to more resources will encourage the use of non-pharmacological strategies that although can be effective require time and commitment from trained staff to implement on the wards, better access to appropriate dementia care RACFs to minimise length of stays in hospital, better support for families caring for patients with dementia at home 🗨 Not enough money or resources equals poor care for BPSD patients 🗨 Need funding to optimise environment, staffing (trained and relevant) e.g. diversional therapy. Access of safe and secure place e.g. garden 🗨 Just if there is a model that recognises the higher needs of such patients monetarily, then this should in theory translate to better care 🗨 Provision of resources to adequately provide the appropriate care for these patients. An appropriate and separate area for these patients, potentially a Secure GEM with mental health input. 🗨 Pt.-Nurse ratios have an influence on the care provided to pts. 🗨 Increase staffing and specialist staffing to look after dementia patients. especially at GEM it is impossible to get a 1:1 special for a violent patient- Nurse with 5 patients is expected to look after the dementia patient too 🗨 Opportunity for increased staffing, improved 1:1 interaction to reduce behaviours of concern, training opportunities to upskill staff, funding for diversional therapy/activities 🗨 Staffing and training
Whole Hospital	🗨 Need specialist team of nurse consultants/Geriatrician to help with management of these patients. 🗨 Physical environment and staffing resources (lack there-of) are significant limitations to providing high quality care - particularly the lack of a diversional therapist not on DMU

Appendix 5: Responses regarding Organisational Perspectives about Care of Patients with Dementia and BPSD

Care Setting	Free Text Responses
Emergency & Urgent Care	Emergency Departments are poorly set up to manage the care needs of patients with dementia
Acute	There needs to be huge work in the area of education to nurses and doctors who have these patients on non-geriatric wards. Strategies used on non-geriatric wards are poor and often the patient will be transferred to our ward (acute geriatric medical) and have strategies in place that have a better outcome for patients. Our hospital population is aging and there are dementia patients in all wards. We need better standardized approach to the care of dementia patients that needs to be implemented across the whole organisation not just the geriatric or aged care wards. I believe there should be a geriatrician/AT attached to all wards to help manage patients with BPSD These wards do a great job, but would do even better if provided a better environment and resourcing. There is a great deal to do to elevate understanding and awareness of person-centred approaches to care of people with dementia in my organisation as a whole In my opinion for the acute hospital setting - focus is on bed flow and surgical wait lists Increased funding to ensure adequate staffing to prevent agitation/aggression and support patients to get the best care they can More resources, better staffing. More education. Opportunity for more OT and diversional therapy however inadequate staffing and therefore discharge planning is given priority Funding models limit the staffing that would enable use of a more person centred non-pharmacological approach just if there is a model that recognises the higher needs of such patients monetarily, then this should in theory translate to better care Pt.-Nurse ratios have an influence on the care provided to pts. Not enough money or resources equals poor care for BPSD patients More funding equals the ability to have more staff/equipment/training to effectively look after patients with dementia More consistent approach- very guided and useful to isolated areas Very difficult to implement changes by self - ward very passionate More staffing and resources to ensure a patient-centred approach.
Sub-acute	The hospital system is to set up to manage anyone with behaviours associated with cognitive changes. We make modifications to staffing and the environment for children we need to value our older population the same. I am very keen to implement a shared care Aged Psych, Geriatric unit called a Cognitive Assessment and Management Unit (rather than secure GEM as I don't think that's what it is). It will need close to acute nursing from a mix of psych and GEM type nurses, routine Psych and Geri management of patients, lots of SW, OT and diversional therapy, a secure exit and an outdoor space

- ☛ *Require more high care bed PGNH, reduce the time waiting for VCAT hearing and guardian appointment.*
- ☛ *The care of patients living with dementia in an acute health service is dreadful overall. Although in saying that the care for those patients with symptoms up to Brodaty Tier 5 can be handled in the acute with more training of undergraduate and environmental considerations about how to respond / communicate and care for this vulnerable and increasing population. We urgently require separate units to care for those Tier 5 - 7 patients who are coming directly from RAC and some from home into the acute which are not the appropriate environments, these patients if they do not have an acute delirium require? direct entry to a SDCP / or psychiatric care unit. We need to improve the quality of the care provided for these patients living with dementia, as well as other patients who are being cared for within the health service who are scared, vulnerable and distressed and reduce the OVA staff by caring for them by appropriately trained staff and within the appropriate well designed environment.*
- ☛ *I feel like BPSD management in ED could be optimised further such as a dementia-friendly ward section*
- ☛ *Staffing resources and specialist roles are a priority*
- ☛ *Identification and support of patients with dementia needs to be improved and all staff should have training and knowledge in how to care for patients with dementia whilst in hospital*
- ☛ *Very long survey, with some degree of repetition. Might get more responses if get it shorter.*
- ☛ *These patients are often needing a bed in my unit because of their behaviour. Failure to have a secure GEM unit in this hospital has been a contributing factor.*
- ☛ *Education, Education*
- ☛ *There is a dementia friendly ward at another site in our organisation but the waitlist for this can be really long. There need to be more funded wards like this*
- ☛ *Completing this survey has highlighted to me that we need to be more structured in our approach.*
- ☛ *More acute settings tend to rely on increased levels of mechanical and chemical restraints to manage patients on the ward with dementia.*
- ☛ *There just needs to be more accessible education options.*
- ☛ *It is not uncommon for patients with dementia to be transferred from the ED in the middle of the night. The information handed over regarding behaviours is often inaccurate*
- ☛ *Able to modify areas of the ward to provide safer environment for the patient. Increased funding around nursing to provide 1:1 when patient is very vulnerable*
- ☛ *Support for education and training support for environmental alterations or additions support more Dementia Specific RACF beds Fast track VCAT*
- ☛ *Cost of specially trained staff is prohibitive*
- ☛ *Provision of resources to adequately provide the appropriate care for these patients. An appropriate and separate area for these patients, potentially a Secure GEM with mental health input.*
- ☛ *The wards that care for these patients are typically GEM wards, ratios are lower on these wards which increased stress on the ward in very complex situations. Frequent budget over runs are a feature*
- ☛ *No additional funding despite increased nursing needs*
- ☛ *Access to more resources will encourage the use of non-pharmacological strategies that although can be effective require time and commitment from trained staff to implement on*

	<i>the wards, better access to appropriate dementia care RACFs to minimise length of stays in hospital, better support for families caring for patients with dementia at home</i> 🗨 <i>Staffing and training</i> 🗨 <i>The wards could be designed in a much better way and have increased numbers of trained staff to provide for the specialised needs of these patients.</i> 🗨 <i>If we have access to funding to provide diversional therapy for example: Virtual Forest from Dementia Australia.</i> 🗨 <i>Training and education for staff. To provide environment that promotes safety</i> 🗨 <i>Sub-acute nursing ratios don't reflect the care needs of patients with dementia.</i> 🗨 <i>Need funding to optimise environment, staffing (trained and relevant) e.g. diversional therapy. Access of safe and secure place e.g. garden</i> 🗨 <i>If funding was available to provide better staffing and resource for occupational activities then we may see a reduction in aggression/agitation.</i> 🗨 <i>Increased staffing numbers/ hours within Diversional Therapy, this provides patients with 1.1 and appropriate person-centred care for their individual needs. Not taking away nursing staff from their roles in care</i> 🗨 <i>Funding models that considered the specialist experience and knowledge required by staff caring for patients with dementia, in addition to the additional resourcing that is required to provide a highly adaptable and responsive level of care.</i> 🗨 <i>Because it influences staffing and ability to provide adequate care. It also influences resources like activity coordination (which we no longer have) and access to diversional therapies.</i>
Whole Hospital	🗨 <i>A dementia specific unit with staff that are interested and want to work in this field employed. Ward environment modified to suit needs and activities and resources to be provided</i> 🗨 <i>These patients require a huge amount of resources but often are just incorporated into everyday care which is insufficient for their needs</i> 🗨 <i>Making dementia friendly wards activities provided appropriate staffing</i> 🗨 <i>Acute funding models do not accurately reflect the increased resourcing required to manage a patient with an acute illness who also has co-existing dementia/BPSD.</i> 🗨 <i>Physical structure of the ward to deliver best care to these patients; nurse specialist, diversional therapist</i> 🗨 <i>It may affect staffing level and experience, facilitates may not accept consumers with BPSD due to higher of level support they require.</i> 🗨 <i>Geriatric-friendly ED will need funds to set up and also provide education</i> 🗨 <i>Staffing Suitability of the model of care Reducing bed block</i>

Appendix 6: Responses regarding Strategies used for Aberrant Vocalisation, Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD

Care Setting	Free Text Responses – Aberrant Vocalisation
Emergency & Urgent Care	
Acute	- No set strategies. Manage each individually - Behaviour Care Plan & behaviour huddle would be undertaken. Often the strategy is to understand triggers to these behaviours, provide reassurance etc. - Analgesia, repositioning, toileting, company and engagement in activities, music therapy. - Manage pain, delirium and sensory deficits Sensory therapies - Low threshold for pain relief, location close to reassurance, encouraging tolerance rather than pharmacological action - Single rooms, utilizing family members - Reassurance - Single room to allow patients to be vocal; Calm approach; Involvement of family - Individualised - These questions would take quite a long time to answer, I'm afraid. - Diversion therapy, 1:1 support, keep away from others, PRN medication - Pain relief, family phone calls, family visits. - Reassurance. High visibility location. Regular and timed attendance to the patient so they don't feel forgotten. Likely anti-psychotic meds if non-pharmacological interventions were unsuccessful. - Medications e.g. analgesia, antidepressants, antipsychotics, mood stabilisers Optimising sensory stimulation Changing position in environment to minimise visual triggers Music - e.g. listening or singing, noise cancelling headphones with preferred music Food and fluid Preferred activities that match interests Time outside Reducing other identified triggers 1:1 time, reassurance Massage Sensory therapies/modulation - Non-pharmacological - Pain number one, address and try if any signs, ? bowels , is there a delirium, alongside non pharmacological strategies - Music therapy, find out why - getting to know the person , why is this occurring - maybe loneliness, boredom, ask families - Reinforcing boundaries and expectations Handing over above - De-escalation approach-access other appropriate areas Ask if they are physically ok quietly ask what they would like music therapy - Addressing requests, reassurance, 1:1 supervision, attending to pain - Extra nursing care resources and diversional therapy - Medication, diversional activities, move the consumer to another section of the ward - Attention to unmet needs, single rooms, use of families/carers. - Reassurance, address needs - Reassurance, regular assessment for any unmet needs, involve family/carers, 1:1 special, medications (unfortunately), documentation and handover of behaviours, fill in About Me form - Writing out information, orientating them to time and place, utilising relatives/friends.

Sub-acute	🗨 <i>Unable</i> 🗨 <i>Attempt to meet unmet needs Assess for pain Family presence Reassurance</i> 🗨 <i>Medication</i> 🗨 <i>Trying to work out underlying needs</i> 🗨 <i>Calming voice, speaking to patient, offering food/drink/analgesia/toileting</i> 🗨 <i>Limited to no strategies - tends to result in overuse of pharmacotherapy</i> 🗨 <i>Referral to music therapy</i> 🗨 <i>Unsure</i> 🗨 <i>Nursing special; determining triggers; addressing complaints; keeping requested items in reach</i> 🗨 <i>Nursed in Intensive Care Unit of our ward use of sensory resources engage in activity pain assessment and management of same distraction medical reviews - rule out the 4 P's (poo, pus, pain, pee)</i> 🗨 <i>1:1 time, allowed to self-soothe, participation in activities</i> 🗨 <i>Acknowledgement, meetings with Snr mx, pain assessment, non-pharmacological interventions.</i> 🗨 <i>Ensure care attended to</i> 🗨 <i>Calm environment</i> 🗨 <i>Listening and reassuring patient. Distraction techniques. Contacting family for support in caring for patient.</i> 🗨 <i>Reassurance; Diversional therapy; Stimulation</i> 🗨 <i>Try to re-direct or assist to the requests; Move patient from general areas to ensure they do not agitate co patients; Engage to try and work out what the patient needs (if anything) i.e. analgesia</i> 🗨 <i>None</i> 🗨 <i>Diagnostics for organic cause; attend to basic needs</i> 🗨 <i>Assess for pain constipation, retention and depression</i> 🗨 <i>Contact family to assist either by phone or attending</i> 🗨 <i>MO consider medication if indicated; One on one support; Additional visiting hours for family; Weighted toy animals</i> 🗨 <i>See if we can provide these requests; Use strategies known to calm patient; Check for pain/vital signs/incontinence; Diversional therapy.</i> 🗨 <i>Re-direction; diversional activities i.e. folding sheets, colouring in, sitting in the nurses station.</i>
Whole Hospital	

Appendix 7: Responses regarding Strategies used for Motor Agitation Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD

Care Setting	Free Text Responses – Motor Agitation
Emergency & Urgent Care	- Trying to sit in wheelchair and wheeling around ward - Walk with patient engage in conversation; involve family; medication; music therapy - Redirection; offering walks; diversionary therapy; assessing for unmet needs particularly toileting 1:1 special nursing; family visitation - Pain assessment ; CPO/ special 1:1; pharmacological - Allowing to wander with supervision - Redirection
Acute	- We try and employ a "patient watch" but staff experience varies widely with some not being able to manage these patients and staff resources often not available - Allow patients to wander or walk around; Often utilise an extra resource to re-direct a person away from others rooms. - Directed walking; group activities; AHA exercise programs; Timed toileting; pain relief; fidget activities. - Rule out or treat delirium; Address unmet needs; Reduce environmental stimulation; Individualised activities - Distraction; Using activities, dolls etc.; Allowing walking where safe; Assessing for drivers - Wanderers alarm; Proximate alarms - Diversional activities - Removing all objects in proximity of patient; Not always able due to being an acute medical ward; Ideally 1:1 nursing when staffing available - Individualised and single room - These questions would take quite a long time to answer, I'm afraid. - Safe environment for patient to move around; Diversion activities; PRN medication; Mechanical restraint. 1:1 nursing specials; Providing stimulating tasks (e.g. folding towels) - Fiddle blankest are given to those who pick at lines or other objects; Provided with objects of their own for diversion, plus others are trialled i.e. fiddle box and toys, colouring pages, music..... - Medications e.g. analgesia, antidepressants, antipsychotics, mood stabilisers Physical activity; Sensory therapies/modulation; Providing items to collect; Encouraging rest - seated activities; If falls risk is an issue, often placed in a chair and pushed up to a table with an activity in front of them; Reassurance and redirection; Reminiscence Sensory apron; All in one suit; referred activities that match interests; Gardening; Time outside; Other Occupational Therapy and Recreational Therapy Guided Approaches - Dislike the word wandering - people move to seek and find within their environment ? toilet identify and ask, redirect, why is this occurring - provide activities, what interests them, highlight their space and their items - use of doonas for their bed and items that show that this is their space, why are they disrobing - ? toilet - Walk with patient; Redirection; Entertain patient with hobbies if possible; Encourage visitors (COVID restricted) - Distraction with activity of choice; Walk outside; Music therapy; Physical game; Reminiscence activity - Distraction and diversional therapy

	- Access to outside areas; Diversional therapist; Single rooms, Individual assessment of best ways to divert patients e.g. using food to persuade, or visual cues that they respond to - Diversional activities (repetitive activities, physical activities), 1:1, Re-direction, Observe/leave and approach, Medication, Allow safe area to wander, Accompanied walks outside. - Additional staffing sought to ensure patient and staff safety; Use of pharmacological agents and code greys if there is a danger to patient or others. - Attention to unmet needs; Single rooms; Use of families/carers; Ensure safe spaces; Additional staffing. - Additional staff; Checking unmet needs; Orientation; Re-direction 1:1 nursing; Involve family/carers; Regular assessment for unmet needs; Frequent supervised walks; Medications; Documentation and handover of behaviours; Fill in About Me form - We have not been very successful with strategies with this behaviour as our ward is shaped like an L with narrow hallways.
Sub-acute	- Unable to comment - Mostly allow these behaviours where safe or consider transfer in to DMU where such behaviours are much more acceptable, and where both inside and outside environments are more conducive - Medication - Allowing wandering with CPO supervising if safe to do so. Other times, may need physical restraints if unsafe or disruptive to others - Calming voice, speaking to patient, offering food/drink/analgesia/toileting - Ensure comfortable, check continence, pain; Refer to 'Sunflower' Chart and see if can engage in talking about any subject of interest; Try and manage in single room - quieter and supports other patients; If able/ appropriate take patient for a walk; Refer to music therapist; Contact NOK - Allowing to wander on a secure ward with a special - Referral to music therapy - Unsure - Nursing special; Wandering/chair/bed alarms; Mittens; Removing negative stimuli or risky objects; Determining individualised diversion tactics; Engaging in a task (folding towels; Walking; Reminiscence therapy; Fiddle apron if available and COVID safe) - Nursed in Intensive Care Unit of our ward as appropriate or available; Use of sensory resources, including music; Engage in activity; Pain assessment and management of same; Distraction; Medical reviews - rule out the 4 P's (poo, pus, pain, pee); Use of onesies for disrobing with consent - Sensory items; Allowed to walk with supervision - Placed in locked part of the ward and allowed to walk around; Re-direction - Engagement in diversional activities (where available) - Diversion; Distraction; Extra nursing - Remove objects/items not required; Increased supervision; Specialling - Place close to nursing station; Distraction techniques; Close supervision; 1:1 special by nurse or nurse assistant. - Health care workers to monitor and allow patients to wander "Permission to wander"; Alternative space for people to use/visit e.g. dining room, nursing station area; Meaningful wandering; Diversional motor tasks e.g. stimulus

	<i>blanket; In our other units - we have a bus stop installed, 'bookcase' design on doorways</i> ☛ <i>Diversional therapy; Engage patient into activities they enjoy; Music therapy; Give the patient some space if it is safe to do so</i> ☛ <i>1:1 special; Diversional therapy</i> ☛ <i>As above</i> ☛ <i>Providing one-on-one nursing</i> ☛ <i>Mostly only environmental controls; We have a semi-secure area; Behaviour support plan; Onesies (all in one suits that can't be easily removed) for those disrobing; One on one support; Family support; Weighted toy animals; Distraction - music, TV etc.</i> ☛ <i>Use diversional therapy such as music, videos, colouring in, take them for walks. ; Remove dangerous objects; Utilise 1:1 nursing if allowed.</i> ☛ <i>Regular walks around the ward with a volunteer or RUSON; Sitting in the nurse's station; Having other objects to collect from around like pens/gloves/paper etc.</i>
Whole Hospital	

Appendix 8: Responses regarding Strategies used for Aggressiveness Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD

Care Setting	Free Text Responses – Aggressiveness
Emergency & Urgent Care	- Medication; Code greys 1:1 planned code greys; Family - Move to less stimulating room; Offering drink/food; Asking family to deescalate over the phone or in person; Music therapy; Leave patient and approach at a later time 1:1 special nursing; Family visitation; Pharmacological management; Code grey - Pain assessment; Skin assessment; Continence care; CPO/ special; 1:1 unplanned code grey; Pharmacological 1-1 special; Pharmacological therapy
Acute	- De-escalation techniques and "patient watch" if available - Understand underlying causes to aggression; develop a care plan of strategies to understand triggers. - Remove self or others if safe to do so and reapproach at another time; Psychotropics/ benzo's; Allow to exit into contained garden spaces; Ignore behaviour; Firm boundary setting. - Remove co-consumers to another area of the ward; Reduce environmental stimulation and remove potential weapons; Staff approach, talk down and soft word strategies (safewards) - Code Greys if severe; Boundary setting; Other non-pharmacological strategies; Assessing for drivers, Antipsychotic if severe/risky/driven by psychotic phenomena - Behaviour management plans; Planned code greys - Identify unmet needs - Code Grey; Security 1;1 if severe behaviours - Individualised and single room - These questions would take quite a long time to answer, I'm afraid. - Keep patient away from other people; Provide a safe environment to move around; 1:1 talk down, Assess; Diversion strategies; PRN medication; Last resort to mechanical restraint. - Code greys - Diversional techniques as above; Reassurance to minimise their need to protect themselves; Utility of good lighting by day and dim lighting by night to minimise disorientation in unfamiliar environment; Staff to warn patient pre every intervention to avoid 'fright' or impulse reaction; Single room placement. - More than one staff on approach Medications: Usually antipsychotics, including IM delivery, antidepressants, analgesia if pain is identified as a possible issue, mood stabiliser Physical activities Sensory therapies/modulation Activities matched to interests Leaving and reapproaching Removing other consumers from the environment Restrictive practices if required Simplify communication, non-threatening non-verbal communication, one person talking at a time, leaving and reapproaching, removing other consumers who might be at risk - Brainstorm together, get to know the patient, through their family, share this knowledge, our speech and friendly face (or eyes in a mask) develop relationships, care support plan is constantly updated with suggestions from staff, work in pairs, carefully select staff for employment, let a person walk around, decals for the doors so a person isn't distressed and wanting to go home because they identify a door, homely environment

	with things to do, extreme is security available, identify the staff a person is comfortable with and she this staff members strategies - lots of mentoring, stand back and move away and come back later if someone upset, slow down, distraction, give a person space because more than likely they are feeling scared and their space invaded 🔊 Code Greys Reinforce behaviours not acceptable 🔊 be aware of own safety first and of others contact appropriate support security if requires call appropriate code 🔊 Distraction and diversional therapy 🔊 as above 🔊 Leave and reapproach, observe from distance, code grey, move other consumers to another section of the ward, medication 🔊 Additional staffing sought to ensure patient and staff safety. Use of pharmacological agents and code greys if there is a danger to patient or others. 🔊 Attention to unmet needs, single rooms, use of families/carers. Ensure safe spaces. Additional staffing. Code grey where required. Pharmacological strategies where others fail. 🔊 reassure, contact family, check unmet needs ensure safety of staff and other patient If at risk-code grey 🔊 1:1 security special, regular assessment for unmet needs, involve family/carers, medications, documentation and handover of behaviours, About Me form, behaviours support plan 🔊 Single room, additional care resources plus or minus a security special, utilising the about me form and behaviour support plan.
Sub-acute	🔊 Unable 🔊 Code grey Special - security or rusion Identify triggers and minimise Single room Diversion Medication 🔊 Medication 🔊 code grey, assessing if underlying cause, calling family, antipsychotics, temporary physical restraints in extreme situations 🔊 Calming voice, speaking to patient, offering food/drink/analgesia/toileting 🔊 * Let patient know this behaviour is unacceptable. If safe approach patient otherwise let them know that leaving the room and will return * If behaviour continues can proceed to a code grey * start working towards, with MDT a behavioural management plan 🔊 Consideration of pharmacotherapy if danger to self or others, asking family to help settle, consideration of moving wards to DMU 🔊 Referral to music therapy 🔊 unsure 🔊 Nursing/security special; low stimuli room; single room 🔊 nursed in Intensive Care Unit of our ward as appropriate or available use of sensory resources including music engage in activity pain assessment and management of same distraction medical reviews - rule out the 4 P's (poo, pus, pain, pee) medication reviews use of PRN 🔊 encouraged to stay in room, 1:1 time, diversional tools, redirection 🔊 code greys or walking away 🔊 As above, as well as pharmacotherapy as appropriate 🔊 Remove objects/items not required. Increased supervision. Specialling 🔊 1:1 special. Pharmacological. Distraction. Provide calm environment. 🔊 Behavioural Nurse support

	- Behaviour support plan with individualised strategies - drawn up by BOC specialist nurse +/- medical and neuropsych input - try to de-escalate the situation using non-confrontational body language and language diversional therapy If patient has good rapport with certain staff utilise them - Distancing Remove objects that could be used as weapons Re-attend when calm - redirect cod grey assess for pain and as above - Code Grey - security attends - Individualised patient behaviour support plan by Behaviour support nurse Additional staff not attending patient on their own environment controls e.g. removing threatening objects from the environment security guards, code grey, code black as needed Consideration of medications - Call code grey. Ensure staff and patient safety. Remove dangerous objects. Talk to patient regarding concerns. PRN medication. Restraints if unable to control physical aggression. - Identifying triggers and avoiding escalation through redirection/validation etc. Code greys when required
Whole Hospital	

Appendix 9: Responses regarding Strategies used for Resisting Care Provided by Additional Staffing/Specialling to Manage Patients with Dementia and BPSD

Care Setting	Free Text Responses – Resisting Care
Emergency & Urgent Care	- Having 3-4 staff to assist with hygiene; Documenting refusal - Retreat and reorganise; Planned code greys; Security; Medication - Step back and attempt at later date; Slow calm communication; Sign post and explain each step/interaction; Offer choices for patient to choose 1:1 special nursing; Family visitation; Pharmacological management; Code grey - Pain assessment; Skin assessment; Continence care; Pharmacological; Leave Pt alone and attend again later when calms down. - Family to aid; Ensure delirium managed effectively
Acute	- De-escalation and try again later - Re-approach at a later time; Ask family to come in and assist. - Clustered care activities; Stepped plan of care; Planned code grey for interventions if required; Analgesia: Benzo's pre tasks; Objects either towel face washer/rail to hold while attending hygiene - If safe, leave return in 10 minutes; Another member of staff approach; Reassurance - Trying again later; Understanding drivers; Trying with different staff, time of day etc. - Planned code greys; Develop rapport, - Get assistance from family members - Strategies set up with family/familiar faces; Allowing patients to refuse as long as safe for the patient if refusing will lead to further harm planned code greys used 2 staff and swap nurses in and out - These questions would take quite a long time to answer, I'm afraid. - To build up rapport and trust; Assess mental state and reason for resistive to care; Use different staff to approach; Provide incentive if appropriate; Encourage freedom of choice to work with staff; Give time to process and response; Positive words; Gender sensitive. - Liaising with family or carers to ascertain what methods they have used in past; Using team nursing approach (more than x1 nurse) to attend care; Attempting at different times of day; Documenting and handing over strategies that are successful; Grouping care requirements together to minimise interruption to patient - Involve family if possible to encourage compliance; If required code greys - Re-try after period of 15-30 minutes; Observe best windows of time during course of the day to maximise interventions during those periods - behaviour charts assist with this pattern identification; Ask friends/family to assist where appropriate as a reassuring presence/voice. - Reassurance; More than one staff if needed; Leaving and reapproaching; Medication if needed prior to care; Shower cape; Towels placed over the person; Simplify communication; Non-threatening non-verbal communication; One person talking at a time; Matching communication to need. - As above; Ask family, request their guidance, find out why this maybe so - ? sexual abuse; Come back later, maybe it is cultural or they a male rather than a female?? - Give patient a break and come back alter; Try family to convince; Back off if becoming agitated - Be aware of own safety first and of others; Contact appropriate support; Security if required; Call appropriate code

	- Disengage and re-approach at a later time; Making eye contact + simple explanation of task; Consistent carer/staff where possible - Multiple staff assisting in care; Medical and allied health review for strategy and pain management 2 staff to assist during ADL; Leave and reapproach; Have another staff to approach; Allow staff distance; Diversional activities; Identify the person's life history - Move away; Try again later; Use of families/carers. - Come back later; Check concerns; Use interpreters / family 1:1 special; Regular assessment for unmet needs; Involve family/carers; Offer intervention when more amenable; Medications; Documentation and Handover of behaviours; About Me form: Behaviour support plan - Leaving them alone and calling a planned code grey; Review medications; Get family involved.
Sub-acute	- Unable - Leave and come back; Family assistance; More staff to assist; Medication; Ensure no unmet needs - consider pain/depression/fear; Planned code greys; Minimise intervention - Discussion with mPOA about the level of intervention to consider - Leave them be if possible, and return at another time; Trying male or female staff; Planned code grey if needed for their physical wellbeing - Speaking calmly to patient and giving them a break and trying again later; Let patient know that we need to perform whatever care it was and say we will return in 15min, return and try again; Trial another staff attending instead; Notify medical and engage MDT - Harm minimisation approach of only providing absolutely necessary care - Referral to music therapy - Unsure - Involve family in care; Complete care at time suitable to patient (i.e. preference for shower morning or afternoon) - Nursed in Intensive Care Unit of our ward as appropriate or available; Use of sensory resources including music; Engage in activity; Pain assessment and management of same distraction medical reviews - rule out the 4 P's (poo, pus, pain, pee); Medication reviews; Use of PRN - Explanation of all tasks; Returning if safe to do so and offer assistance again - Reproach - Bringing in family members - Reassurance; Alternate staff to approach; Specialling; "Familiar" staff - Listening and reassuring patient; Distraction techniques; Contacting family for support in caring for patient. - Negotiation; Choice offering; Reassurance; Familiar staff/carers/family support - Engage with families - Planned code grey; Timetable for ADLs - As above - Various strategies - combination of techniques described above - Trying again later; Distraction; Additional staff; Planned code grey if needed; Behaviour management plan; Utilizing regular staff who know patient - or alternately rotating staff if this is too stressful for them - Talk to patient; Address any concerns; Diversional therapy; Reassure patient; Speak with family to help.

	Not sure how the nursing staff manage this exactly, I am not usually in a situation where a patient will need to push me away. I might try to encourage engagement or leave patient alone and try another time.
Whole Hospital	

Appendix 10: Responses regarding Challenges to Care Provision for Patients with Dementia in Hospital

Free Text Responses

- No time to provide diversion, not great physical environment to reduce dementia related behaviours/delirium, until recently limited capacity for family to visit, risk of harm to self or others looking after aggressive and violent patients
- Escalated behaviour
- When there is no constant patient observer, it's difficult for nurse to closely supervise Pt who's agitated/ anxious and to look after other delegated Pt's for the shift
- Environmental triggers of delirium development: noisy, high traffic, shared rooms, limited visitation of carers
- The environment and insufficient staffing
- Individualized care needs
- Lack of skills, environment, lack of activities and lack of staff
- The ward is primarily a cardiothoracic and respiratory ward therefore the staff are trained to manage this population. Most of the dementia patients are under a gen med bed card and therefore outliers. Staff are not trained/supported to manage these behaviours
- Volume of other inpatients
- The environment no dedicated patient space, no access to outside areas as we are on the second floor. No activities for them to do, no walking areas for them to wander around in.
- The environment, staffing numbers and skill-set, relative reluctance of Psychiatry to share/take over care (more consultative and very bound by catchment and diagnosis compared with physical health specialties)
- The environment as this is a temporary ward when moved from WTN for a minimum of 12 months. We do not have a patient space.
- Behaviours can pose risks to staff and the patients themselves.
- Built environment (e.g. communal wards, visual clutter, etc.). Adequate staffing levels. Infection control restrictions with COVIC. Mixed staff skill and knowledge re dementia care. Institutional culture around restrictive practices.
- Appropriate space
- Multiple patients presenting with sun downing behaviours at the same time
- Environment not suited to patient. It affects other patients. Noise can affect them
- Difficult to communicate with non-English speakers
- Staff shortage, patient's aggression, wandering and intrusive behaviour. Lack of suitable seating, need bigger and safe garden so that patient can walk around. Need more group activities and physiotherapist input for functional gain.
- Environment, lack of resources and activities
- Dementia patients are unable to follow direction
- Workload, noisy environment, not secure
- The environment of the ward, and lack of resources to aid in reassuring and distracting these patients
- Ward very busy and not ideally set up for patients with dementia i.e.: minimal area to walk around, bright, noisy
- High stimulus environment. High foot traffic.

- 🗨️ *Impact on staff and patients*
- 🗨️ *Wandering/ falls/ aggression/ calling out*
- 🗨️ *There are complex psychosocial issues (housing, safety in community, carer burden) which is difficult to address in hospital setting. The person is in unfamiliar setting which may exacerbate symptoms of dementia.*
- 🗨️ *Not enough staff, junior staff with? not enough training.*
- 🗨️ *ward environment- noise, activity, unfamiliar routine, away from family or familiar carers*
- 🗨️ *As distraction techniques and de-escalation strategies don't always work, it's hard to manage aggression associated with Dementia.*
- 🗨️ *Needing more time in a time-poor environment*
- 🗨️ *Staffing levels - not sufficient to work with the numbers of patients who have dementia and also the mix of mental health patients. The time spent with dementia patients does not allow for the appropriate time for mental health patients and having this type of patient is not conducive to recovery.*
- 🗨️ *Knowing when to resort to medication rather than non-pharmacological techniques, particularly when staffing is low and nursing staff are anxious and worried*
- 🗨️ *Staffing resources, lack of de-escalation skills, high staff turnover, non-optimal environmental spaces for dementia management.*
- 🗨️ *No clear management protocols. Behaviour management plans are lacking and not taught well to junior doctors*
- 🗨️ *Noisy environment, nil activities for engagement/lifestyle activities, lack of space to roam/wander including outdoor space*
- 🗨️ *The environment - design of areas, layout, lack of space or secure outdoor areas and appropriately designed space. Staff not adequately trained to managing these patients. The ratio of these patients - 4 patients to 1 nurse is challenging when sun downing or simultaneous agitation episodes. Lack of diversional therapy resources available or the staffing to run the activities.*
- 🗨️ *Assaults on staff. The environment is terrible for managing these patients*
- 🗨️ *Emergency is busy department, minimal access to distraction techniques*
- 🗨️ *Low allied health staffing, increased complexities of our patients*
- 🗨️ *Complex behaviours, verbal and physically aggressive. Non-compliant with management. Wandering patients, High falls risk. Stimulating patients mentally.*
- 🗨️ *Manage their ADLs, meds*
- 🗨️ *The older person with challenging behaviours requires increased medical and nursing input.*
- 🗨️ *Varying levels of staff experience/knowledge about dementia. Complex family dynamics. DC planning in a way that is person centred when a person with dementia has poor insight into their needs.*
- 🗨️ *Multiple factors*
- 🗨️ *Time*
- 🗨️ *Not enough staff to manage*
- 🗨️ *Aggressive/wandering behaviour//unfamiliar daily routine*
- 🗨️ *Not having enough time*
- 🗨️ *Not enough staff and high work loads*
- 🗨️ *Providing activities to keep them busy and active. Aggression management. Having good behaviour plans for what to do side from medications restraints and "delirium prevention"*
- 🗨️ *Intrusive, noisy, demanding, do not follow instructions*

- 🗨️ Open ward environment- not dementia specific
- 🗨️ Time intensive care, multitude of risks when they come into hospital - falls, delirium, incontinence, PI's etc. Communication challenges.
- 🗨️ Patient safety, staffing levels, disruptions to work, environment
- 🗨️ GEM side of the ward- If patients with dementia are in a mixed cohort with other patients it becomes difficult to manage if you have a wandering confused dementia patient and then a patient that potentially has a complex wound which may take up to an hour to complete. In the dementia management area there are a high number of behavioural patients many presenting with BPSD, in a small area with up to 6 patients that may be aggressive agitated or violent it can become challenging at times to maintain safety of staff and patients
- 🗨️ Staffing in Div therapy to provide 1:1 appropriate support
- 🗨️ Adequate staffing. Access to family and translators.
- 🗨️ Sometimes lack of education/experience with junior staff (nursing, allied health)
- 🗨️ Process for up-skilling new staff (high staff turnover), physical environment and limited resources to engage in occupation to reduce disruption to routine and risk of escalating behaviour, lack of OT or diversional therapist EFT to implement preventative programs (OT priority in acute is discharge planning due to EFT)
- 🗨️ Environmental factors, not appropriate room/ward set up. Limited staffing to provide 1:1
- 🗨️ Lack of space, noise, lighting
- 🗨️ Reduced staffing, reduced skill, in appropriate environment, limited family visitors, no volunteers
- 🗨️ De-escalation and reassurance
- 🗨️ Nursing resourcing
- 🗨️ Their behaviours and risks imposed to others and themselves
- 🗨️ Noisy environment, not contained, busy, many distractors
- 🗨️ Ward layout difficulty implementing non-pharmacological strategies for managing BPSD
- 🗨️ Ward layout, staff shortages, staff knowledge gaps, getting staff to all work towards a consistent management plan
- 🗨️ The physical ward environment (decor, layout, environmental noise, shared bays - not enough single rooms), not enough staffing to support non-pharmacological strategies)
- 🗨️ Staffing mix - skillset and levels, physical environment, need for isolation, challenges around getting unmet needs managed, excessive use of pharmacotherapy after hours
- 🗨️ Environment - hospitals are not designed to suit needs of cognitively impaired
- 🗨️ Skillset of nursing staff may not match the needs, ward is staffed for patients for lower subacute care needs (both medical and nursing)
- 🗨️ The ability to provide 1:1 to redirect behaviour at times is limited due to multiple patients with competing needs including those without dementia i.e. bariatric and palliative patients
- 🗨️ Multifaceted difficulties largely around resources to provide one on one care which is individually tailored and responsive to their needs. Education level and skill level among staff dealing with such patients is variable- some manage better than others. Tools that assist with tailoring care to the individual are not well utilised and therefore triggers for aberrant behaviours are 'reacted' to rather than proactively engaged with and prevented. Often, staff crowd patients that need space and time- resulting in escalated aggression. Ward environments and the ED are often too loud, too busy and too stimulating for patients with dementia and delirium- our environment contributes to what become escalating management concerns resulting in use and dependence on anti-psychotic and non-pharmacological treatments. which add insult to injury

- 🗨️ *Staff potentially not understanding the pathophysiology of dementia, environmental restraints in regards to providing a stimulating environment (e.g. day/night routine, activities to promote physical and mental stimulation, objects or environments that remind the patient of home or is comforting, less noise and distractions), lack of dementia specific educational opportunities*
- 🗨️ *Ward environment, large cohort of patients from NESB/CALD backgrounds and language barrier, staff training and knowledge, COVID visitor restrictions*
- 🗨️ *Resistance to care and aggression*
- 🗨️ *This is part and parcel of our routine work. This unit preferentially looks after frailer older adults presenting with acute medical illness. We have a higher density of both physical and cognitive frailty as a consequence. The challenges faced are no different to those in other units (e.g. staff availability and time, lack of meaningful diversional therapy), but the staff are more experienced in managing and supporting these people*
- 🗨️ *Getting to know the patients and their behaviours, family understanding/expectations of patient condition*
- 🗨️ *Availability of staff resources and time, space limitations*
- 🗨️ *Understanding how to deescalate behaviours*
- 🗨️ *The ED environment, limited resources etc.*
- 🗨️ *The ED is a busy, noisy, and at times chaotic environment.*
- 🗨️ *The mixture of those who do not have a cognitive impairment and those who are living with dementia in the one space. The education for staff about caring for a person with dementia.*
- 🗨️ *The competing challenges of looking after other medically unwell patients, patients with mental illness and the general feeling of the amount of time spent caring for the BPSD*
- 🗨️ *The constant stream of them through the hospital system, coming in from Nursing homes with behaviours of concern, because the NH changed meds and now we have to manage them and then the NH won't accept back on DC.*
- 🗨️ *Time poor*
- 🗨️ *Having enough time to spend with the person*
- 🗨️ *Noisy unfamiliar environment for patients. Variation in quality of CPOs.*
- 🗨️ *Unpredictable ward environment, busy workload, shared rooms, staffing issues, concerns about patient and staff safety*
- 🗨️ *Ward environment, noise, people*
- 🗨️ *Aggression and violence*
- 🗨️ *High traffic in the area being an in between ward among 4 wards hence noise*
- 🗨️ *Sometimes difficult to deliver care*
- 🗨️ *The ward is always very busy with a heavy workload. Dementia patients often require 1 to 1 nursing, often even more assistance. It can therefore be difficult to attend other patients in a timely manner. They can be very intrusive to other patients, their space and belongings due to their dementia and thinking everyone is in their place. At times due to unfamiliar faces, masks and environment can be difficult to get some to engage with staff*

Appendix 11: Responses regarding Challenges to Care Provision for Patients with Dementia and Behaviours of Agitation, Aggression and Violence in Hospital

Free Text Comments

- Managing excess use of psychotropic meds vs risk of injury to staff other patients, putting similar patients all together in same environment can increase risk of violence, balance between environmental restraint vs locked ward
- Support and proper management plan
- ?not enough training
- A number of environmental elements that can trigger aggression: noisy, high traffic, shared rooms, limited visitation of carers, not safe access to outdoor spaces
- Lack of an intensive care unit, the environment and insufficient staffing levels
- As above
- as above
- As above
- As above
- As above.
- As above. Staff safety also a concern.
- As per above.
- Behaviours can pose risks to staff and the patients themselves.
- Built environment (e.g. communal wards, visual clutter, etc.). Adequate staffing levels. Infection control restrictions with COVID. Mixed staff skill and knowledge re dementia care. Institutional culture and procedure around restrictive practices and response to episodes of agitation/aggression.
- Clear plans
- Complex presentations requiring implementation of consistent behaviour strategies
- Constant violence towards staff. Time required to de-escalate behaviour takes time away from other patients
- Could not communicate with them, family sometimes does not help with management, non-compliance of patient with medication
- Difficult to reassure due to poor cognition or delirium. No high dependency unit. Physical complications from medication.
- Environment, awareness of triggers/stressors, education , ability to deescalate
- Fear of being hit, bitten, spat on
- Fear of injury to staff, concern around other patient's wellbeing
- Generally a lack of understanding of these behaviours and their causes. The ward has a mixed population of patients who don't necessarily have dementia and they become frightened when observing the behaviours of concern around them. The ward environment is noisy and busy with lots of different people in the area at any given time and this often adds to the irritability of someone who is already agitated
- Hard to deal with, staff vary in confidence to deal with aggression.
- High stimulus environment. High foot traffic.
- How to manage patient sensitively
- How to safely restrain/ manage without drugs or restraints

- Identifying triggers for behaviour, unpredictable behaviours, environmental challenges in the ward, lack of opportunities for engagement, management approach by clinicians can vary
- Inadequate pharmacological management, language barriers,
- Inadequate staff in management of physical aggression. As well as all factors listed in Q.6.
- Inadequate staffing and staff who does not have training in mental health nursing does not manage behaviours of concern safely.
- Increased need for 1:1 supervision, risk of injury while working
- Keeping patients and staff safe. Sometimes these patients require high numbers of staff.
- Knowing when to resort to medication rather than non-pharmacological techniques, particularly when staffing is low and nursing staff are anxious and worried
- Lack of appropriate
- Lack of clear guidelines and plans. Inexperience with patient cohort
- Lack of information about patient likes, dislikes and inability of carers and families to visit due to restrictions on visitation
- Lack of quiet space, lack of resources to diversional therapy, training for staff to handle de-escalation and how to deal with OAV incidents, ratio of patient to staff and the amount of paperwork in managing these patients i.e. restraints, VHIMS reporting, tracker charts etc. Knowledge level for medical staff with medication dosing and titration. Overlap of specialty with psych/geri psych.
- Lack of resources. High acuity of patients. Environment
- Limited non pharm options, staff not comfortable with these patients, frequently changing staff
- Low allied health staffing, increased complexities of our patients, staff not appropriately skilled to manage increase demand and behaviours
- Maintaining a safe work environment for staff and patients
- Manage them
- Managing the medical and nursing needs of the patients with dementia, while making sure the staff is also safe and not exposed to verbal and physical violence
- Mixed cohort of pts, BPSD can be disruptive for other pts. Nursing staffing levels not sufficient to manage number of wandering or aggressive pts at times.
- Multiple factors
- Multiple pts. with varying needs
- Not able to look after other patients
- Not able to provide 1:1 care
- Not enough assistance
- Not enough staff and high work loads
- Not knowing how to manage aggression or having staff or resources to do so.
- Often need one on one assistance 24/7
- Open ward environment- not dementia specific
- Patient safety, Staff safety, time intensive care, respecting the rights of the patient as well as those around them.
- Patient safety, staffing levels, disruptions to work, environment other patients safety
- Patients can be violent and aggressive knowing how to read escalating behaviours and how to respond to them
- Personal safety. Providing 1:1 individual support

- 🗨️ *Physical aggression. Restiveness and inability to provide care.*
- 🗨️ *Poor understanding of what BPSD is and what measures can assist with this. Lack of resources/time.*
- 🗨️ *Process for up-skilling new staff (high staff turnover), physical environment and limited resources to engage in occupation to manage BPSD, lack of OT or diversional therapist EFT to implement or contribute to behaviour management strategies (OT priority in acute is discharge planning due to EFT)*
- 🗨️ *Proximity to other patients, potential for other patients to be exposed. Overall hospital staffing unable to provide extra nurses to provide 1:1 for safety*
- 🗨️ *Proximity to other patients*
- 🗨️ *Reduced staff, reduced skills, inappropriate environment, limited family support and not volunteers*
- 🗨️ *Repetitive behaviour*
- 🗨️ *Safety fears*
- 🗨️ *Safety of staff and of themselves.*
- 🗨️ *Same as 6*
- 🗨️ *Same as above*
- 🗨️ *Same as above however difficult when you still need to provide personal ADL care for this cohort of patients, so can't always just walk away and give the patient time.*
- 🗨️ *Same as Q 6, also not all staff are based on a ward - visit to action a referral so don't always get to observe the Pt across the whole day*
- 🗨️ *Similar to above answer*
- 🗨️ *Skill level of staff who look after these patients is variable. Lack of speciality/Geri consult services to provide input.*
- 🗨️ *Skillset of nursing staff may not match the needs, ward is staffed for patients for lower subacute care needs (both medical and nursing), design of ward no specific for BPSD patients, no dedicated staff for BPSD management e.g. no diversional therapists*
- 🗨️ *Space to safely deescalate without posing risk to others*
- 🗨️ *Staff are at risk of injury. Staff feel time poor and don't have capacity to 'get to know the person'. The ward environment is not suited to those who benefit from walking around and engaging in activities. We don't have a safe outdoor area to break the monotony of the ward/bedroom environment. We don't have enough engagement activities or staff to support these available.*
- 🗨️ *Staff potentially not understanding the pathophysiology of dementia, especially in regards to behaviours of concern (physical and verbal) that likely are secondary to changes in the brain and not how the person would behave prior to these changes, verbal and physical sexual inappropriateness (especially around personal hygiene), physical aggression or the risk of physical aggression, staffing limitations/shortages at times impacting ability to provide effective and safe care to those with dementia*
- 🗨️ *Staff skill and knowledge, ward environment, COVID visitor restrictions, lack of specific dementia nurse or diversional therapist, access to nurse/security specials, culture of relying on pharmacological management, particularly after hours*
- 🗨️ *Staff working knowledge and support*
- 🗨️ *Staffing - gaps in rosters, nursing cover unfamiliar with BPSD and management. Hospital flow - movement of patients from ED to wards, within ED, within wards, often at unsettling times of the day (i.e. night!). Difficulty for family/carers to visit and support during the COVID era. Lack of knowledge about the person given the acute nature of their arrival on the wards (need to get background details when they arrive - their personal history is as important as the past medical history)*
- 🗨️ *Staffing (if patient needs 1:1), medication regimes (right med, takes time to get to dose), doctors responsiveness if PRNs not working and patient still aggressive*

- 🗨 *Staffing levels, training, space to allow the person to move, falls risk and use of restrictive interventions, availability of resources for engagement, use/overuse of medications, and lack of behaviour plans to minimise risk of responsive behaviours.*
- 🗨 *The ability to provide empathy*
- 🗨 *The ED environment, limited resources to observe and support, inter-current illness*
- 🗨 *The imperative to keep patients and staff safe and to provide care for all in a busy often understaffed environment*
- 🗨 *The lack of single rooms, the noise of our environment, inadequate outdoor space, frightening for inexperienced staff*
- 🗨 *The time that is required, staffing numbers and experience, support from medical and allied health in developing strategies in managing symptoms of dementia.*
- 🗨 *There is very little we can do for them on a general ward. It isn't the right place for them and is unfair to them, the staff and the other patients. Their families are upset about the aggression.*
- 🗨 *Time poor Increase pressure on staff caring for others*
- 🗨 *Time, skill mix*
- 🗨 *Tiring for nursing staff - risk of burnout. For doctors, the emotional distress, feeling helpless, having to constantly apologise to families for less than ideal care.*
- 🗨 *Unpredictable ward environment, busy workload, shared rooms, staffing issues, concerns about patient and staff safety*
- 🗨 *Ward environment, noise, people, other patients, shared rooms, limited time for nurses to engage meaningfully*
- 🗨 *workload of other patients , trying to manage aggressive, confused patient as well*
- 🗨 *Lack of space, noise, lighting*
- 🗨 *Reduced staffing, reduced skill, in appropriate environment, limited family visitors, no volunteers*
- 🗨 *De-escalation and reassurance*
- 🗨 *Nursing resourcing*
- 🗨 *Their behaviours and risks imposed to others and themselves*
- 🗨 *Noisy environment, not contained, busy, many distractors*
- 🗨 *Ward layout difficulty implementing non-pharmacological strategies for managing BPSD*
- 🗨 *Ward layout, staff shortages, staff knowledge gaps, getting staff to all work towards a consistent management plan*
- 🗨 *The physical ward environment (decor, layout, environmental noise, shared bays - not enough single rooms), not enough staffing to support non-pharmacological strategies)*
- 🗨 *Staffing mix - skillset and levels, physical environment, need for isolation, challenges around getting unmet needs managed, excessive use of pharmacotherapy after hours*
- 🗨 *Environment - hospitals are not designed to suit needs of cognitively impaired*
- 🗨 *Skillset of nursing staff may not match the needs, ward is staffed for patients for lower subacute care needs (both medical and nursing)*
- 🗨 *The ability to provide 1:1 to redirect behaviour at times is limited due to multiple patients with competing needs including those without dementia i.e. bariatric and palliative patients*
- 🗨 *Multifaceted difficulties largely around resources to provide one on one care which is individually tailored and responsive to their needs. Education level and skill level among staff dealing with such patients is variable- some manage better than others. Tools that assist with tailoring care to the individual are not well utilised and therefore triggers for aberrant behaviours are 'reacted' to rather than proactively*

engaged with and prevented. Often, staff crowd patients that need space and time- resulting in escalated aggression. Ward environments and the ED are often too loud, too busy and too stimulating for patients with dementia and delirium- our environment contributes to what become escalating management concerns resulting in use and dependence on anti-psychotic and non-pharmacological treatments. which add insult to injury

- 🗨 Staff potentially not understanding the pathophysiology of dementia, environmental restraints in regards to providing a stimulating environment (e.g. day/night routine, activities to promote physical and mental stimulation, objects or environments that remind the patient of home or is comforting, less noise and distractions), lack of dementia specific educational opportunities
- 🗨 ward environment, large cohort of patients from NESB/CALD backgrounds and language barrier, staff training and knowledge, COVID visitor restrictions
- 🗨 Resistance to care and aggression
- 🗨 This is part and parcel of our routine work. This unit preferentially looks after frailer older adults presenting with acute medical illness. We have a higher density of both physical and cognitive frailty as a consequence. The challenges faced are no different to those in other units (e.g. staff availability and time, lack of meaningful diversional therapy), but the staff are more experienced in managing and supporting these people
- 🗨 Getting to know the patients and their behaviours, family understanding/expectations of patient condition
- 🗨 Availability of staff resources and time, space limitations
- 🗨 Understanding how to deescalate behaviours
- 🗨 The ED environment, limited resources etc.
- 🗨 The ED is a busy, noisy, and at times chaotic environment.
- 🗨 The mixture of those who do not have a cognitive impairment and those who are living with dementia in the one space. The education for staff about caring for a person with dementia.
- 🗨 the competing challenges of looking after other medically unwell patients, patients with mental illness and the general feeling of the amount of time spent caring for the BPSD
- 🗨 The constant stream of them through the hospital system, coming in from Nursing homes with behaviours of concern, because the NH changed meds and now we have to manage them and then the NH won't accept back on DC.
- 🗨 Time poor
- 🗨 Having enough time to spend with the person
- 🗨 Noisy unfamiliar environment for patients. Variation in quality of CPOs.
- 🗨 Unpredictable ward environment, busy workload, shared rooms, staffing issues, concerns about patient and staff safety
- 🗨 Ward environment, noise, people
- 🗨 Aggression and violence
- 🗨 High traffic in the area being an in between ward among 4 wards hence noise
- 🗨 Sometimes difficult to deliver care
- 🗨 The ward is always very busy with a heavy workload. Dementia patients often require 1 to 1 nursing, often even more assistance. It can therefore be difficult to attend other patients in a timely manner. They can be very intrusive to other patients, their space and belongings due to their dementia and thinking everyone is in their place. At times due to unfamiliar faces, masks and environment can be difficult to get some to engage with staff