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

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Lincoln Centre for Research on Ageing

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Project Background

In June 2004 the Ballarat Health Service was funded by the Department of Human Services to design and implement a project to improve the hospital care experience for people with dementia and their carers. The project included the introduction of a bedside identifier for cognitive impairment in the context of a hospital approach to education that focussed on improving staff awareness and communication with respect to patients with cognitive impairment. Independent evaluation of the initiative at Ballarat suggested that the education and associated cognitive impairment identifier (CII) had improved the responsiveness of staff to this patient group and to their carers. Moreover, carers had reported improved satisfaction with the care provided.

On the basis of the success of the original project, a team from Ballarat Health Services in collaboration with the Department of Human Services Aged Care Branch and Continuing Care and Clinical Services Unit sought expressions of interest from other acute care organisations across Victoria to implement a similar dementia care program in their setting. Eight acute care facilities were successful in gaining funding support to implement the program in 2006. The participation organisations are listed below.

Project objectives and philosophy

The dementia care program which is the focus of this evaluation is linked to the use of the CII and was designed to:

- Improve the awareness of, communication with , and care for, people with dementia
- Seek to engage their carers in the hospital care experience.

Organisations participating in the program undertook to work collaboratively with the Ballarat Health Service Project Team to implement the program and adopt the program's philosophy as reflected in commitment to the following key implementation principles and actions:

- Executive sponsorship and commitment to long term change
- Nomination of key organisations contacts and or project officer backed by a steering committee comprising key stakeholders and consumer representatives
- Support for the evaluation of the program
- An all-of-hospital education program
- A commitment to using the CII as in the original program i.e., when cognitive impairment is identified the organisation will respond to the patient with appropriate communication and involvement
- The organisation will use an established process for identifying cognitive impairment when present in patients or readily introduce such a process
- A commitment to engage and involve carers of patients with cognitive impairment as partners in care throughout the hospital experience
- A commitment to sustainable change in dementia care in the hospital.

Implementing the Project

Participating organisations

The project was taken up the following organisations:

Austin Health

Barwon Health

Broadmeadows Health

Latrobe Regional Hospital

Northeast Health Wangaratta

Peninsula Health

Royal Melbourne Hospital

St. Vincent's Health

Latrobe Regional Hospital withdrew from the project prior to implementation of the CII and associated education.

Establishing the projects in each setting

The participating organisations visited Ballarat Health Services (BHS) for a planning day in late 2005 prior to commencement of the project. This day was designed to facilitate networking, establish working relationships with other participating organisations, and gain understanding of project timelines, targets etc. The evaluation team was present and the broad evaluation plan was discussed. Planning and data collection tools for the baseline survey were made available. Organisations were encouraged to start collecting carer satisfaction data using the survey tool provided as soon as feasible.

During February and March 2006 the BHS team visited each of the participating organisations to train local staff in the use of the CII and to provide a curriculum, teaching approach and resources for use by the organisation in implementing the program locally.

A general plan for project implementation following the training was provided which outlined the following sequential activities with suggested timelines:

- Carry out initial staff perception survey (pre intervention survey) and commence all of hospital education program (April 2006)
- Commence use of CII (May to November 2006)
- Complete second staff perception survey (post) and follow up carer satisfaction survey (August – November 2006).

Role of Ballarat Health Services Project Team

In addition to training organisational facilitators and key stakeholders and provision of an educational package for use of the facility, the BHS provided:

- Ongoing support and mentoring through regular phone and email contact, with additional visits on a needs analysis
- Cognitive Impairment Identifiers
- Project pathway and resource manuals for key clinical areas
- Data gathering and evaluation tools, e.g., Carer Satisfaction Survey and Staff Perceptions Survey.

Following initial training session and provision of project material each setting then proceeded to implement the project consistent with local demands, resources and priorities. A summary of how the project was implemented in the different settings is provided in the next section.

The Projects

Austin Health

Project setting

The Dementia Care in Hospitals Education Program was piloted in three acute (two general medical and one orthopaedic) and two sub-acute wards in the Austin Hospital and the Heidelberg Repatriation Hospital. These wards were chosen because they have the highest proportions of older people.

Key project activities

- **Establishment of project steering committee:** Following acceptance of the program by Austin Health, a multidisciplinary working group was formed to support the project. The group included key hospital stakeholders.
- **Education sessions:** The education package utilising material provided by Ballarat Health Services was delivered to most staff on the pilot wards—80% of nursing staff on 4 out of the 5 target wards were trained. Follow up sessions were conducted to educate new staff, rotating staff and staff who missed the initial training.
- Other education strategies:
  - The weekly Austin Health Newsletter was used to publicise the launch of the project and the introduction of the Cognitive Impairment Identifier (CII) into the hospital.
  - Two Grand Round Presentations (60–90 minute education sessions open to all staff) entitled Managing Delirium in the Hospitalised Elderly, and The Practicalities of Dementia and Delirium in a Hospital Setting, were delivered to staff. The presentations included information on the rationale and purpose of the CII.
  - Brochures describing the project and the use of the CII were distributed to staff. Brochures informing carers of the CII were also distributed.
- Other activities:
  - Development of a form for staff to record patients with a CII to create accountability in the use of the CII.
  - Development of a ward resource folder that includes information for staff and patients, copies of the MMSE and CAM, flow chart for the use of the CII, and other information (Alzheimer's Australia brochures and articles on behaviour management of patients in hospitals).
  - Self-directed learning packages for staff on delirium and dementia.
- **Evaluation:** staff questionnaires distributed at educations sessions and sent to staff 3–6 months post-education. Carer satisfaction surveys were distributed by the pilot wards.

Barwon Health

Project setting

Initially, the Dementia Training Project was piloted in five acute (ACE unit, HW5, HW7, Emergency Department and the pre-admission joint clinic) and two sub-acute wards (North, Central and South) at the McKeller Centre, before rolling out to other wards/departments in Barwon Health.

Key project activities

- **Establishment of a working group:** Following acceptance of the program, a multidisciplinary working group was formed to support the project. The group included key hospital stakeholders and met monthly over the life of the project.

- **Establishment of an implementation group:** This group met weekly and was responsible for delivering the education, providing support selected areas, and implementing the CII and toolkit.

- **Other communication strategies:** A wide variety of strategies were implemented to inform staff of the program. These included printed material such as newsletters, posters and flyers, emails and memos, meetings with interested and influential staff, meetings with ward and department contacts, orientation program for new volunteers and contractors, implementation flow chart, alerts in the hospital patient management system, toolkits, and use of the website.

- **Education sessions:** The material provided by Ballarat Health Services was adapted to suit Barwon Health. To date, one-hour education sessions have been delivered to 1,216 staff and sessions are ongoing.

- **Other education strategies:**
  - Orientation program for all new employees, volunteers and contractors
  - Ward-based training on a needs basis.
  - One-hour open forums in February and March 2007

- **Other activities:**
  - Inclusion of the identifier on the hospital management system
  - Inclusion on the data warehouse reports
  - Identifier on nursing ward handover sheets
  - Development of identifier tags for the use on walking aids
  - Development of door signs that display the identifier
  - Development and implementation of a flow chart protocol for wards
  - Development of alert stickers for patient histories and referrals

- **Evaluation:** Staff questionnaires distributed at educations sessions and sent to staff 3–6 months post-education. Carer satisfaction distributed by the wards involved in the project.

Broadmeadows Health Service

Project setting

The Education and Training of Staff in Dementia Care and Management Project was piloted in at the Broadmeadows Health Service—a sub-acute facility. A further roll out to the Bundoora Extended Care Centre and the Northern Hospital are still to occur.

Key project activities

- **Establishment of groups/committees:** The Northern Health Steering Committee for Improving Care for People with Cognitive Impairment and the Broadmeadows Health Steering Committee were established to coordinate and drive the project.
- **Other communication strategies:** These included:
  - Internal nursing newsletter (two editions)
  - Posters throughout the hospital
  - Use of CII at the bedside and on project correspondence and literature
  - CII bookmarks
  - Hospital intranet launch and reminder of the nine key communication strategies
  - Launch with lunch provided and dissemination of literature about dementia.
- **Education sessions:** Training was delivered to 160 staff by the education manager, clinical support nurse and ward champions.
- **Other activities:**
  - Inclusion of the identifier on the hospital management system
  - Cognitive screening for all patients admitted to the GEM and Rehabilitation Units necessitated further training of nursing staff
  - Integration of the cognitive screening into the interdisciplinary admission form
  - Delirium guidelines developed
  - Discharge follow up guidelines developed
  - Introduction of a patient profile form, completed by carers, that gives personal background relevant to the care of the patient and involves the carer from the point of admission and also starts the process for informed discharge planning
  - Ward resource folders
  - Review of physical layout of outdoor area, with proposal for modification.
- **Evaluation:** Staff questionnaires distributed at educations sessions and sent to staff 3–6 months post-education. Carer satisfaction distributed by the wards involved in the project.

Northeast Health Wangaratta

Project setting

The Dementia Care Program at North East Health Wangaratta began in January 2006 with the aim of improving the care of inpatients with a cognitive impairment and engaging carers in their care while in hospital.

Key project activities

- **Establishment of project working party:** A multidisciplinary working group of key hospital stakeholders was formed to support the project.
- **Communication strategies:** Articles publicising the project in the North East Health newsletter and web site, the Improving Care for Older Care newsletter, and the North East Division of General Practice. Also, an article for the North East Health Wangaratta Quality Report, and presentations at the physician's weekly meetings and the leadership group meeting.
- **Staff education:** One-hour education sessions on prevalence and nature of dementia, use of the CII, information to improve staff awareness of patients with a cognitive impairment, strategies for communicating with people with a cognitive impairment, and the importance of engaging the carers of patients with a cognitive impairment. Education sessions were given to nursing, medical, allied health, environmental, catering, pharmacy, administration and executive staff.
- **Use of the CII** above the beds of patients assessed as having a memory or thinking difficulty.
- **Use of charts, and stickers** on care plans and other paperwork to identify people with a memory or thinking difficulty.
- **Evaluation:** hospital staff completed questionnaires prior to the education sessions and a follow up six-months later. Carer satisfaction surveys were distributed prior to the education and four months later.
- **Other activities:**
  o Development of a Confusion Assessment form
  o Development of an Abbreviated Mini Mental form, again on trial and modified over the year as reviewed by staff. These forms are ready to put onto the electronic forms for risk assessment for clients in the medical and surgical wards
  o Development of a brochure for carer's patients and staff in language more related to clients and carers
  o Development of a flow chart specific for nursing staff to manage the paperwork and to enable nursing staff to put interventions and referrals into place in a consistent and timely manner
  o Engaging the community by having articles in the local paper, posters around the organisation, publication in the General Division of GPs' newsletter, featuring on North East Health web site, and submitting a article for the North East Health Wangaratta Annual Report.

Peninsula Health

Project setting

The project was implemented at three sites, Mt Eliza Rehabilitation and Aged Care Services (three Geriatric Evaluation and Management wards), Mornington Peninsula Hospital-Rosebud (two acute wards) and Frankston Aged and Extended Care (two sub-acute wards).

Key project activities

- **Project establishment:** The project was linked into an ongoing program of activity—and related infrastructure—addressing aged health issues (e.g., falls, cognitive impairment) already established in the Mount Eliza Centre which provided a platform for program implementation. For example, ward champions for the existing falls and cognitive programs provided support for the CII project.

- **Screening:** As part of the ongoing cognition program, screening (using MMSE or AMTS) had already been introduced in the target wards.

- **Staff education:** Training was conducted for both clinical and non-clinical staff (e.g., kitchen staff) over a six-week period. One hundred and fifty staff undertook the training which was provided in multiple, seventy-five minute training sessions— including some night sessions—at each of the locations. Training was conducted by the Manager/Clinical Nurse Consultant of the Cognition Service at Mount Eliza with the assistance of a visiting occupational therapist.

- **Evaluation:** All staff were surveyed prior to the commencement of the training program. Staff who attended the training received a follow-up questionnaire six weeks later. Difficulty was experienced in obtaining carer surveys. Staff found it difficult to identify carers (a diagnosis of dementia was required in order to identify relevant carers for the baseline survey), and to get carers involved in the questionnaire.

Royal Melbourne Hospital

Project setting

The Cognitive Awareness Project was piloted on 2 wards at the Royal Melbourne Hospital. One acute general medical ward (5 South East), and one sub-acute Rehabilitation Aged Care Ward (9 West).

Key project activities

- **Establishment of project steering committee:** Following acceptance of the initial expression of interest, a multidisciplinary working group was formed to support the project. The group included key hospital stakeholders. A Consumer Reference Committee was also recruited.

- **Introduction of cognitive screening:** As cognitive screening was not routine practice in the target wards the initial step was to establish formal cognitive

impairment screening process. Nursing staff in both wards were trained in use of the Abbreviated Mental Test Score (AMTS).

- **CII education** was provided for more than 100 clinical and non-clinical staff from the two wards.

- **Evaluation:** carer satisfaction surveys collected for 6 weeks prior to any education or usage of the CII; staff completed the staff perception surveys immediately before commencement of the education session; staff perception surveys and carer satisfaction surveys repeated after education and introduction of CII.

- In addition to the formal evaluation activities staff on both participations were questioned on all aspects of the project and this feedback was to revise procedures as project implementation proceeded.

- **Focus groups with CALD populations:** The project manager contacted Alzheimer's Association Victoria to assist with inviting CALD carers to participate in semi-structured group interviews discussing the acceptability of the use of a CII. Focus groups of carers of different ethnic background were conducted. This aspect of the project was conducted in collaboration with St Vincent's Health (SVH).

St Vincent's Health

Project setting

The Cognitive Awareness Project (part of the Enhancing Care for Older People Project) was introduced to four areas in the hospital—the Medical Assessment and Planning Unit, the Orthopaedic Ward and two general medical wards (9 East and 9 West). These areas were chosen because they are the entry and admission points for a large proportion of older people presenting to the health service.

Key project activities

- **Establishment of project steering committee:** Following acceptance of the initial expression of interest, a multidisciplinary working group of key hospital stakeholders was formed to support the project.

- **Introduction of cognitive screening:** As cognitive screening was not routine practice in the target wards the steering committee selected the MMSE as a screening tool for all patients over 65 years of age. A comprehensive education programme to provide education on cognitive screening using the MMSE was initiated. An initial group of 33 nursing and allied health staff was provided with a 3-hour training session on cognitive screening using the MMSE with a view to becoming trainers for other staff. A further six education sessions were provided to 50 nursing staff in the target wards and the pre-admission clinics, and 20 staff in the emergency department were trained to administer the AMTS.

- **CII education** was provided for more than 100 clinical and non-clinical staff from the target wards.

- **Staff education:** The education on cognitive screening was augmented by sessions supporting the publication of the newly revised Delirium Clinical Practice Guidelines. Four sessions were provided to 60 nursing staff on the target wards. Junior Medical

Staff received education of the delirium guidelines and the CII project from the Director of Geriatric Services.

- **Evaluation:** Staff completed a questionnaire prior to the education sessions and surveyed again six weeks after education and introduction of CII. Carer satisfaction surveys were distributed for six weeks prior to any education or usage of the CII and until four months after the completion of the education sessions.

- **Focus groups with CALD populations:** The project manager contacted Alzheimer's Association Victoria to assist with inviting CALD carers to participate in semi-structured group interviews discussing the acceptability of the use of a CII. Focus groups of carers of different ethnic background were conducted. This aspect of the project was conducted in collaboration with Royal Melbourne Hospital.

- **Other activities:**
  o Posters and signs placed in common rooms and toilets
  o Relevant documentation centrally located in document trays
  o Project manager attending handover to catch up with issues
  o Use of the hospital email to raise awareness among the broader hospital community
  o Nurses on each ward identified as local "champions" and provided with extra support and education
  o The project manager met with each participating ward to provide and receive feedback on progress of the project
  o An educational display set up outside the hospital cafeteria (in both the acute and sub-acute hospitals) during Alzheimer's Awareness Month
  o Details of cognition screening have been included as part of the revised falls and pressure area risk screening tools completed on admission for all patients aged over 65
  o Addition of the AMTS to the nursing admission documentation
  o Other activities included Delirium Guidelines launch and education, MMSE education, cognitive screening in the ED, cognitive screening in the Preadmission Investigation Education and Research (PIER) Centre and cognitive screening in the Elective Surgery Access Service (ESAS).

The Evaluation

Aims

In collaboration with the participating organisation and the Ballarat Health Service Project Team, a team from the Lincoln Centre for Research on Ageing at La Trobe University was commissioned to assist with the evaluation of the projects in each in setting.

The aim of the evaluation was to assess the implementation and impact of the training model in each setting employing, as far possible, evaluation tools designed by the Ballarat team to evaluate the original project.

The evaluation included both an assessment of project processes, and an outcome evaluation including a pre and post measures of staff knowledge and attitude, and pre and post carer measures.

In addition, the evaluation team consulted with each participating organisation to advise on additional patient and organisational evaluation data that could considered in order to provide a more informative evaluation report.

Evaluation activities

Changes in staff knowledge and attitudes were measured by surveying staff by written questionnaire just prior to the education sessions and post-education. The time between the pre and post survey varied among the projects from 6 weeks to 3 months. The questionnaire was part of the Ballarat Health project package provided to each facility. The content of the questionnaire was similar to that used by Ballarat Health in their pilot project (see Lincoln Centre for Ageing and Community Care Research and Victorian Department of Human Services, (2005), *Evaluation of Education and Training of Staff in Dementia Care and Management in Acute Settings*) (the questionnaire is reproduced in Appendix 1).

The projects also attempted to measure the impact on the carers of people with a cognitive problem or difficulty through pre and post questionnaires (see Appendix 2). A carers questionnaire, again based on the original project, was also provided as part of the package and the project team in each setting was asked to survey carers of patients with cognitive impairment at baseline (i.e., prior to the introduction of the CII and at least six week after the introduction of the identifiers). However, all projects had difficulty obtaining feedback from carers. The results of the carer surveys are presented in summary form in the Overview of outcomes section of the report.

In addition, the independent evaluator provided the teams with a pro-forma for recording process evaluation information, and encouraged the teams to identify, and monitor over the project duration, other data routinely collected by the facility (for example falls data, frequency special intervention/security requests), that could be considered as an indicator of how well patients with cognitive impairment were being managed in the facility. Although some projects did attempt to monitor such data only common evaluation data is reported below. (More detailed individual project information can be found in the project accountability reports provided by each team to the Department).

Evaluation outcomes

For all projects the pre-education return was higher than the post-education, and the number of returns from clinical staff outnumbered those from non-clinical staff. Of the total of 1,611 questionnaires returned from the seven projects, three-quarters were pre-education (74.4%) and a quarter (25.6%) post-education. Of the total, most were received from clinical staff (59.5% pre-education and 19.7% post-education) while non-clinical staff returned 15.0% pre-education and 5.9% post-education. The numbers returned from the seven projects varied considerably (Table 1 below).

Table 1: Numbers of questionnaires returned—all projects

Survey time		Clinical staff	Non-clinical staff	Total
Pre-education	Austin Health	134	7	141
	Barwon Health	177	66	243
	Broadmeadows Health Service	85	24	109
	North East Health Wangaratta	141	48	189
	Peninsula Health	208	71	279
	Royal Melbourne Hospital	65	15	80
	St Vincent's Health	148	10	158
	Total	**958**	**241**	**1,199**
Post-education	Austin Health	48	1	49
	Barwon Health	48	21	69
	Broadmeadows Health Service	48	8	56
	North East Health Wangaratta	86	21	107
	Peninsula Health	37	26	63
	Royal Melbourne Hospital	11	4	15
	St Vincent's Health	39	14	53
	Total	**317**	**95**	**412**
TOTAL		**1,275**	**336**	**1,611**

Austin Health

Austin Health started the staff training in March 2006. In total, more than 200 staff attended a training session, and a further 35 food service staff were given a modified presentation. Survey forms were distributed prior to the training and 141 (approximately 71%) were returned for analysis (food service staff were not surveyed). Post-training, 49 surveys were returned for analysis (35% of the number returned pre-training).

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Of the Austin Health staff surveyed prior to the Dementia Care in Hospitals Program, the great majority (79.3%) reported a problem or difficulty in working with patients with dementia, delirium or cognitive difficulties, and over half (54.3%) reported a problem or difficulty in working with their carers and/or family (Table 2). The proportions for clinical staff were higher than the average of all projects but lower for non-clinical staff. Consistent with a higher level of contact with patients and their families, clinical staff were more likely to report a problem or difficulty than non-clinical staff.

Table 2: Staff rating of difficulty of working with patients and carers—pre-education

		Percent with a problem/difficulty	
Self-rated problem/difficulty:		**Austin Health**	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	80.5	*84.5*
	Non-clinical staff	57.1	*40.6*
	All staff	79.3	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	55.4	*56.3*
	Non-clinical staff	33.3	*20.2*
	All staff	54.3	*49.6*

Disruptive behaviour and communication difficulties are the most commonly reported problems/difficulties, with staff skills, hospital resource issues, patient safety and wandering also relatively common (Table 3). Austin staff more frequently reported disruptive behaviours and less frequently reported hospital resources as a problem compared to the average of staff of all projects. The other problems/difficulties were similar to the other projects.

Table 3: Problems with working with patients with cognitive difficulties—pre-education

Problem/difficulty:	Percent of respondents			*All projects*
	Clinical	**Non-clinical**	**All staff**	
Disruptive behaviours	61.8	100.0	63.2	*40.9*
Communication	43.1	50.0	43.4	*47.7*
Staff skills	27.5	0.0	26.4	*28.7*
Hospital resources	24.5	0.0	23.6	*37.4*
Safety of the patient	18.6	0.0	17.9	*17.7*
Wandering	17.6	0.0	17.0	*15.0*
Treatment/diagnosis/assessment issues	13.7	0.0	13.2	*16.0*
Family/relatives	7.8	25.0	8.5	*6.3*
Safety of staff and other patients	5.9	0.0	5.7	*5.2*
Hospital protocols/procedures	5.9	0.0	5.7	*9.5*
Total respondents	102	4	106	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

The reported level of knowledge (as measured by the proportion reporting one or more correct strategies for working/communicating effectively with patients with cognitive difficulties) among the surveyed clinical staff was lower than the project average prior to the education program and showed a small (non-statistically significant) decline in the follow-up survey (Table 4). Although included for interest, the number of returned surveys from non-clinical staff was too small for meaningful analysis.

Table 4: Staff knowledge—pre and post-education

| | | Percent who gave one or more strategies | | |
| | | Austin Health | | *All projects* |
Staff knowledge:		Pre	Post	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	82.7	80.9	*89.7*
	Non-clinical staff	85.7(1)	100.0(1)	*77.8*
	All staff	82.9	81.2	*87.2*

Notes:
(1) Sample size too small for meaningful pre-post tests on the non-clinical group.

Changes in staff attitudes

The level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the surveyed Austin Health clinical staff was lower than the all project average prior to the education program. All three measures increased (confidence significantly) among those staff who returned a survey after the education program (Table 5). The results from non-clinical staff are included but they are too small for meaningful analysis.

Table 5: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

| | | Means (1) | | |
| | | Austin Health | | *All projects* |
Self-rated measures:		Pre	Post	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.16*	3.44*	*3.24*
	Non-clinical staff	2.57(2)	3.00(2)	*3.05*
	All staff	3.14*	3.43*	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.22	3.35	*3.28*
	Non-clinical staff	2.57(2)	3.00(2)	*3.06*
	All staff	3.18	3.35	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.85	3.02	*2.88*
	Non-clinical staff	2.57(2)	3.00(2)	*2.93*
	All staff	2.84	3.02	*2.89*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
(2) Sample size too small for meaningful pre-post tests on the non-clinical group.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

The staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was higher in Austin Health than the project average, and showed an increase post-education. There

was a similar pattern in the staff experience of how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and cognitive difficulties (Table 6).

Table 6: Staff rating of organizational support and environment—pre and post-education

Self-rated measures:		Means (1)		
		Austin Health		*All projects*
		Pre	Post	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.83	2.98	*2.74*
	Non-clinical staff	2.57(2)	4.00(2)	*2.79*
	All staff	2.82	3.00	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.52	2.75	*2.38*
	Non-clinical staff	2.50(2)	4.00(2)	*2.85*
	All staff	2.52	2.78	*2.47*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
(2) Sample size too small for meaningful pre-post tests on the non-clinical group.

Impact of the Cognitive Impairment Identifier

Austin Health also surveyed staff post-education on their awareness of the CII, and its effect on their interaction with patients and carers. While the number of responses was limited (n=15), the survey indicated that there was some impact on practice. Over half (53%) of respondents reported daily contact with the identifier and a further third reported weekly contact. Almost all respondents reported that seeing the identifier changed the way they interacted with patients (7% significantly, 40% moderately and 40% a little). To a lesser extent the CII also impacted on staff interaction with carers (7% significantly, 20% moderately and 40% a little).

Barriers

- Staff on ward areas not having the capacity to test patient's cognition, or staff outlining workload issues as barriers to testing.
- The education level and confidence of individual staff members regarding using any tool to test cognition.
- Conflicting ideas of who should conduct any cognitive testing, especially as most nursing staff had never had the opportunity to learn.
- Aged Care issues not seen as "important" in the acute wards, with a lot of promotion needed to gain interest in the program.
- Length of time needed to recruit nursing staff to hold the CII portfolio.

- The time (4 months) to get the patient brochure approved by the patient information committee.
- Human resource issues on wards.
- Competing priorities for ward staff.
- Competing priorities for project staff.
- Difficulty of facilitating carer contact.

Facilitators

- Good coordination of education sessions by the nursing educators in the Clinical Nursing Education Department.
- Perceived need for a program like this within the organisation.
- Good Nurse Unit Manager support (mostly).
- Project coordinator to focus on and drive the program.
- Capacity building around cognitive test has begun.
- Existence of a MMSE medical record within the organisation meant we did not need to create one.
- A number of behavioural management strategies that had already been developed by one unit that were made available to other areas.

Barwon Health

Education sessions for the Dementia Care in Hospitals Program began in June 2006 with staff in the Sub-acute Inpatient Rehabilitation Unit. Sessions to other groups/units in Barwon Health were delivered through to October. In this period a total of 1216 staff attended an education session. Questionnaires were distributed prior to the training and 177 were returned for analysis by clinical staff and 66 by non-clinical staff—a total return rate of 20.0%. Post-education, 69 questionnaires (48 from clinical staff and 21 from non-clinical staff) were returned for analysis (28.4% of the number returned pre-education).

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties

Over two-thirds of Barwon Health staff reported a problem or difficulty in working with patients with cognitive problems, and just over 40% reported a problem or difficulty in working with their carers and/or family before the Dementia Care in Hospitals Program (Table 7). Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff.

Table 7: Staff rating of difficulty of working with patients and carers—pre-education

		Percent with a problem/difficulty	
Self-rated problem/difficulty:		**Barwon Health**	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	81.5	*84.5*
	Non-clinical staff	37.1	*40.6*
	All staff	69.8	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	51.0	*56.3*
	Non-clinical staff	13.2	*20.2*
	All staff	41.2	*49.6*

Communication difficulties were the most commonly reported problems/difficulties, with disruptive behaviours, hospital resources, staff skills and patient safety also relatively common (Table 8). The problems/difficulties presented in Table 8 were broadly similar to the averages reported across all projects.

Table 8: Problems with working with patients with cognitive difficulties—pre-education

Problem/difficulty:	Percent of respondents			
	Clinical	Non-clinical	All staff	*All projects*
Communication	49.3	56.5	50.3	*47.7*
Disruptive behaviours	37.1	34.8	36.8	*40.9*
Hospital resources	34.3	26.1	33.1	*37.4*
Staff skills	23.6	26.1	23.9	*28.7*
Safety of the patient	20.0	8.7	18.4	*17.7*
Treatment/diagnosis/assessment issues	17.9	17.4	17.8	*16.0*
Wandering	15.0	0.0	12.9	*15.0*
Hospital protocols/procedures	15.0	0.0	12.9	*9.5*
Safety of staff and other patients	7.1	4.3	6.7	*5.2*
Family/relatives	6.4	4.3	6.1	*6.3*
Total respondents	140	23	163	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

Staff knowledge (as measured by the proportion reporting one or more correct strategies for working/communicating effectively with patients with cognitive difficulties) among the surveyed staff was similar to the project average prior to the education program but both clinical and non-clinical staff showed a statistically significant increase in the follow-up survey (Table 9).

Table 9: Staff knowledge—pre and post-education

| Staff knowledge: | | Percent who gave one or more strategies | | |
| | | Barwon Health | | *All projects* |
		Pre	Post	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	87.6*	97.9*	*89.7*
	Non-clinical staff	65.2**	95.2**	*77.8*
	All staff	81.5**	97.1**	*87.2*

Notes:
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in staff attitudes

In general, the level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the Barwon Health staff was higher than the all project averages prior to the education program. Self-rated confidence, comfort and job satisfaction increased among clinical and non-clinical staff who returned a survey after the education program, with non-clinical staff reporting statistically significant increases on all three measures (Table 10).

Table 10: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

| Self-rated measures: | | Means (1) | | |
| | | Barwon Health | | *All projects* |
		Pre	Post	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.27*	3.52*	*3.24*
	Non-clinical staff	2.96**	3.45**	*3.05*
	All staff	3.18**	3.50**	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.40	3.50	*3.28*
	Non-clinical staff	3.05*	3.48*	*3.06*
	All staff	3.31	3.49	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.96	3.08	*2.88*
	Non-clinical staff	2.95**	3.31**	*2.93*
	All staff	2.96*	3.15*	*2.89*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

The staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was higher in Barwon Health than the average over all projects, and showed an increase post-education. The reported staff experience of how well equipped is the hospital environment

to meet the needs of patients with dementia, delirium, or memory and cognitive difficulties also showed an increase (statistically significant for clinical staff) post-education (Table 11).

Table 11: Staff rating of organizational support and environment—pre and post-education

Self-rated measures:		Means (1)		
		Barwon Health		*All projects*
		Pre	Post	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.75	2.94	*2.74*
	Non-clinical staff	2.86	3.14	*2.79*
	All staff	2.78*	3.00*	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.33*	2.61*	*2.38*
	Non-clinical staff	3.00	3.10	*2.85*
	All staff	2.50**	2.76**	*2.47*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Barriers

- Facilitators unable to provide daily/weekly prompting/encouragement that seemed to be required for full implementation.
- Poor staff engagement at times from the Acute site.
- Shortage of clinical champions.
- Difficulty in obtaining carer engagement and feedback.
- Poor medical staff engagement and attendance for education.

Facilitators

- Dedicated enthusiastic staff, who believe in the project and have good working relationships with frontline staff across a variety of disciplines. An example of good practice of cross discipline working to implement this program.

Broadmeadows Health Service

The Education and Training of Staff in Dementia Care and Management at Broadmeadows Health Service began in late July 2006. A total of 160 staff attended an education session. Questionnaires were distributed prior to the training and 109 were returned for analysis (85 from clinical staff and 27 from non-clinical staff), a total return rate of 68.1%. Post-education, 56 questionnaires (48 from clinical staff and 8 from non-clinical staff) were returned for analysis (51.4% of the number returned pre-education.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties

Pre-education, three-quarters of Broadmeadows Health staff reported a problem or difficulty in working with patients with cognitive problems, and over 60% reported a problem or difficulty in working with their carers and/or family (Table 12). Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff.

Table 12: Staff rating of difficulty of working with patients and carers—pre-education

Self-rated problem/difficulty:		Percent with a problem/difficulty	
		Broadmeadows Health	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	81.2	*84.5*
	Non-clinical staff	54.5	*40.6*
	All staff	75.7	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	69.2	*56.3*
	Non-clinical staff	31.6	*20.2*
	All staff	61.9	*49.6*

Communication difficulties, disruptive behaviours, hospital resources, and staff skills were the most commonly reported problems/difficulties at Broadmeadows Health, with patient safety and wandering also relatively common (Table 13). The proportion of communication difficulties and disruptive behaviours was higher than the averages reported across all projects, with other categories broadly similar (Table 13).

Table 13: Problems with working with patients with cognitive difficulties—pre-education

Problem/difficulty:	Percent of respondents			
	Clinical	Non-clinical	All staff	*All projects*
Communication	53.6	100.0	61.7	*47.7*
Disruptive behaviours	53.6	25.0	49.4	*40.9*
Hospital resources	37.7	8.3	33.3	*37.4*
Staff skills	29.0	25.0	28.4	*28.7*
Safety of the patient	20.3	0.0	17.3	*17.7*
Wandering	15.9	8.3	14.8	*15.0*
Family/relatives	13.0	0.0	11.1	*6.3*
Hospital protocols/procedures	5.8	25.0	8.6	*9.5*
Treatment/diagnosis/assessment issues	8.7	0.0	7.4	*16.0*
Safety of staff and other patients	5.8	0.0	4.9	*5.2*
Total respondents	69	12	81	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

Staff knowledge among the surveyed staff was lower than the project average prior to the education program among clinical staff and higher among non-clinical staff. Both clinical and non-clinical staff showed an increase in the follow-up survey (Table 14).

Table 14: Staff knowledge—pre and post-education

| | | Percent who gave one or more strategies | | |
| | | Broadmeadows Health | | *All projects* |
Staff knowledge:		Pre	Post	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	84.7	89.6	*89.7*
	Non-clinical staff	81.8	87.5	*77.8*
	All staff	84.1	89.3	*87.2*

Changes in staff attitudes

In general, the level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the Barwon Health staff was higher than the all project averages prior to the education program. With the exception of job satisfaction among clinical staff, both clinical and non-clinical staff reported increases in all measures at the post-education survey (Table 15).

Table 15: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

| | | Means (1) | | |
| | | Broadmeadows Health | | *All projects* |
Self-rated measures:		Pre	Post	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.37	3.48	*3.24*
	Non-clinical staff	3.38	3.50	*3.05*
	All staff	3.37	3.48	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.32	3.33	*3.28*
	Non-clinical staff	3.25	3.63	*3.06*
	All staff	3.30	3.38	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.87	2.83	*2.88*
	Non-clinical staff	3.17	3.38	*2.93*
	All staff	2.94	2.91	*2.89*

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

Changes in organisational practice

The staff-perceived level of organisational support and suitability of the hospital environment for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was higher at Broadmeadows Health than the project averages, but only non-clinical staff reported a post-education increase (Table 16).

Table 16: Staff rating of organisational support and environment—pre and post-education

Self-rated measures:		Means (1) Broadmeadows Health		All projects
		Pre	Post	Pre
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.76	2.65	2.74
	Non-clinical staff	3.17	3.38	2.79
	All staff	2.85	2.75	2.75
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.50	2.38	2.38
	Non-clinical staff	3.09	3.17	2.85
	All staff	2.62	2.46	2.47

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

Barriers

- Staffing changes resulted in changing constitution within the NH steering committee, and this group failed to gain momentum and which resulted in reduced support for the roll out of the program across the Northern Hospital.

- Different studies being conducted simultaneously across the campuses with each campus seeing their own research projects/activities as the priority. Work is underway to promote the concept of working together and sharing learnings and expertise across campuses. Concern that the CII program would jeopardise results of research currently underway.

- Time as a resource not quarantined for the program was an issue. However, it did encourage delegation of many aspects of the program which may assist in the sustainability of the program.

Facilitators

- Support from staff involved in the education roll out was critical, i.e., Education Manager, Clinical Support Nurse, and ward champions.
- Support from the Ballarat team and in particular from Meredith Theobold.
- An easily transferable educational package and evaluation tools.

Northeast Health Wangaratta

Staff educations sessions for the Dementia Care in Hospitals Program began in February 2006. A total of 189 staff questionnaires were distributed prior to the training and all were returned for analysis (141 from clinical staff and 48 from non-clinical staff). Post-education, 107 questionnaires (86 from clinical staff and 21 from non-clinical staff) were returned for analysis (56.6% of the number returned pre-education.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Before the education sessions, three-quarters of staff surveyed at North East Health Wangaratta reported a problem or difficulty in working with patients with cognitive problems, and 40% reported a problem or difficulty in working with their carers and/or family (Table 17). Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff. The proportion of clinical staff who reported a difficulty in working with patients with cognitive difficulties was higher than the average of the projects but other comparable proportions were lower than the overall average.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Table 17: Staff rating of difficulty of working with patients and carers—pre-education

| | | Percent with a problem/difficulty | |
Self-rated problem/difficulty:		Northeast Health	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	87.1	*84.5*
	Non-clinical staff	35.6	*40.6*
	All staff	74.6	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	46.7	*56.3*
	Non-clinical staff	17.9	*20.2*
	All staff	40.2	*49.6*

Inadequate hospital resources was the most commonly reported problems/difficulties in working with patients with cognitive difficulties, with wandering, communication difficulties, disruptive behaviours, and staff skills also relatively common (Table 18). In general, non-patient issues (particularly hospital resources) were more frequently reported by Wangaratta staff than other project staff, and with the exception of wandering, patient issues less frequently reported.

Table 18: Problems with working with patients with cognitive difficulties—pre-education

	Percent of respondents			
Problem/difficulty:	Clinical	Non-clinical	All staff	*All projects*
Hospital resources	54.2	14.3	50.0	*37.4*
Wandering	32.5	28.6	32.1	*15.0*
Communication	25.8	78.6	31.3	*47.7*
Disruptive behaviours	31.7	21.4	30.6	*40.9*
Staff skills	30.8	28.6	30.6	*28.7*
Safety of the patient	26.7	0.0	23.9	*17.7*
Treatment/diagnosis/assessment issues	16.7	0.0	14.9	*16.0*
Hospital protocols/procedures	11.7	0.0	10.4	*9.5*
Safety of staff and other patients	7.5	0.0	6.7	*5.2*
Family/relatives	4.2	0.0	3.7	*6.3*
Total respondents	120	14	134	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

The level of staff knowledge among the surveyed clinical staff was higher than the overall project averages, and lower among non-clinical staff prior to the education program. Both clinical and non-clinical staff showed a increase (statistically significant for non-clinical staff) in the follow-up survey (Table 19).

Table 19: Staff knowledge—pre and post-education

		Percent who gave one or more strategies		
		Northeast Health		*All projects*
Staff knowledge:		Pre	Post	*Pre*
What do you think is important in	Clinical staff	91.4	94.1	*89.7*

working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Non-clinical staff	56.2*	81.0*	*77.8*
	All staff	82.4*	91.5*	*87.2*

Notes:
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in staff attitudes

The level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the Barwon Health staff was lower than the all project averages prior to the education program. However, all measures increased (most significantly) among clinical and non-clinical staff who returned a survey after the education program (Table 20).

Table 20: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

		Means (1)		*All projects*
		Northeast Health		
Self-rated measures:		**Pre**	**Post**	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.06*	3.26*	*3.24*
	Non-clinical staff	3.02	3.24	*3.05*
	All staff	3.05*	3.25*	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.12*	3.35*	*3.28*
	Non-clinical staff	2.96	3.29	*3.06*
	All staff	3.08**	3.34**	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.60*	2.82*	*2.88*
	Non-clinical staff	2.70*	3.24*	*2.93*
	All staff	2.63**	2.91**	*2.89*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

The staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was lower in North East Health Wangaratta than the project averages, but both measures showed an increase post-education (Table 21). In particular, clinical staff reported statistically significant increases on the level of organisational support and the suitability of the hospital environment.

Table 21: Staff rating of organizational support and environment—pre and post-education

Self-rated measures:		Means (1)		
		Northeast Health		*All projects*
		Pre	Post	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.40**	3.02**	*2.74*
	Non-clinical staff	2.59*	3.14*	*2.79*
	All staff	2.45**	3.05**	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	1.96**	2.51**	*2.38*
	Non-clinical staff	2.63	3.05	*2.85*
	All staff	2.13**	2.62**	*2.47*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Barriers

- Not been able to achieve all the time lines activities due to not having the most appropriate documentation available for staff to use. Documentation has been on trial base and has required modification over the year.

- Introduction of a new project, new ideas, staff resistance to change, generating more paperwork, staff concerns of labelling of clients and confidentially of clients medical history.

Facilitators

- Key person to drive the project.
- Executive support.
- Co-operation within the departments.
- Key working party members in the units.
- Exposure of the project within the organisation e.g., notice boards displayed around the organisation for Alzheimer's Awareness month. Central to the display was the Cognitive Impairment poster.
- Articles of the project in the Base bulletin.
- Inclusion in the Quality report for the organisation.
- Articles in the local chronicle re implementation and progress.
- Regular articles in the newsletter for the regional program for Improving Care for Older people.
- Regular contact with the Meredith Theobald Ballarat Health Service over the year.
- Trip back to Ballarat in September to speak and listen to other organisation and to share experiences.

Peninsula Health

The Dementia Care in Hospitals Program began in April. Questionnaires were distributed to all staff prior to the training and 208 were returned for analysis by clinical staff and 71 by non-clinical staff. Post-education, 63 questionnaires (37 from clinical staff and 26 from non-clinical staff) were returned for analysis (30.3% of the number returned pre-education.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Prior to the education program, nearly three-quarters of Peninsula Health staff reported a problem or difficulty in working with patients with cognitive problems, and almost half reported a problem or difficulty in working with their carers and/or family (Table 22). Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff. The proportions of staff of Peninsula Health reporting a problem were similar to those from the other projects.

Table 22: Staff rating of difficulty of working with patients and carers—pre-education

Self-rated problem/difficulty:		Percent with a problem/difficulty	
		Peninsula Health	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	82.5	*84.5*
	Non-clinical staff	40.0	*40.6*
	All staff	72.1	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	57.8	*56.3*
	Non-clinical staff	23.3	*20.2*
	All staff	49.6	*49.6*

Communication difficulties, inadequate hospital resources, and disruptive behaviours were the most commonly reported problems/difficulties, with a lack of staff skills also relatively common (Table 23). With the exception of relatively higher reporting of inadequate hospital resources, the problems/difficulties presented in Table 23 were broadly similar to the averages reported across all projects.

Table 23: Problems with working with patients with cognitive difficulties—pre-education

Problem/difficulty:	Percent of respondents			All projects
	Clinical	Non-clinical	All staff	
Communication	43.5	83.3	48.6	47.7
Hospital resources	54.7	8.3	48.6	37.4
Disruptive behaviours	41.0	41.7	41.1	40.9
Staff skills	27.3	25.0	27.0	28.7
Safety of the patient	14.3	12.5	14.1	17.7
Treatment/diagnosis/assessment issues	14.9	0.0	13.0	16.0
Wandering	9.3	16.7	10.3	15.0
Hospital protocols/procedures	5.6	8.3	5.9	9.5
Safety of staff and other patients	5.0	4.2	4.9	5.2
Family/relatives	3.7	4.2	3.8	6.3
Total respondents	161	24	185	864

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

Staff knowledge (as measured by the proportion reporting one or more correct strategies for working/communicating effectively with patients with cognitive difficulties) among the surveyed clinical staff was similar to the project average prior to the education program and higher among non-clinical staff. Clinical staff showed an increase, and non-clinical staff a decrease in knowledge, in the follow-up survey (Table 24).

Table 24: Staff knowledge—pre and post-education

		Percent who gave one or more strategies		
		Peninsula Health		*All projects*
Staff knowledge:		Pre	Pre	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	90.7	97.1	*89.7*
	Non-clinical staff	88.4	84.0	*77.8*
	All staff	90.1	91.7	*87.2*

In general, the level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the Peninsula Health staff was higher than the all project averages prior to the education program. Post-education, all three measures increased among clinical and non-clinical staff— self-rated confidence and comfort showed statistically significant increases (Table 25).

Table 25: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

		Means (1)		
		Peninsula Health		*All projects*
Self-rated measures:		Pre	Pre	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.35*	3.62*	*3.24*
	Non-clinical staff	3.07**	3.48**	*3.05*
	All staff	3.28**	3.57**	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.32**	3.65**	*3.28*
	Non-clinical staff	3.10**	3.48**	*3.06*
	All staff	3.26**	3.58**	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.97	3.16	*2.88*
	Non-clinical staff	3.09	3.36	*2.93*
	All staff	3.00*	3.24*	*2.89*

Note:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

The staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was higher in Peninsula Health than the project average, and showed a statistically significant increase post-education. Post-education, the reported staff experience of how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and

cognitive difficulties decreased among clinical staff, and increased among non-clinical staff (Table 11).

Table 26: Staff rating of organisational support and hospital environment—pre and post-education

		Means (1)		
		Peninsula Health		*All projects*
Self-rated measures:		**Pre**	**Pre**	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.93**	3.35**	*2.74*
	Non-clinical staff	2.84**	3.48**	*2.79*
	All staff	2.91**	3.40**	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.51	2.40	*2.38*
	Non-clinical staff	2.88	3.19	*2.85*
	All staff	2.59	2.70	*2.47*

Note:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Facilitators

- This service was able to build the CII project as an ongoing program of activity for age care services. Ward champions and portfolio representation for cognition issues were already in place and were an important factor in the project's successful implementation.

- The project was overseen by a senior manager and clinical nurse consultant, and staff time was dedicated to the project

- Cognitive impairment screening had just been introduced in the wards prior to the project and was accepted by staff.

Barriers

- The cost of the identifier: the project at Peninsula Health quickly used their 50 identifiers and lacked funds to pay for additional kits

- Lack of resources for follow-up and ongoing support: the education sessions generated requests from some areas (e.g., the acute wards as Rosebud Hospital) for further advice and support provision of care to patients with cognitive impairment which could not be met.

Royal Melbourne Hospital

Eduction sessions in the Cognitive Awareness Project began in June 2006. Approximately 190 staff attended a CII education session and/or an education session on cognitive screening. Questionnaires were distributed prior to the training and 65 were returned for analysis by clinical staff and 15 by non-clinical staff—a total return rate of 42.1%. Post-education, 15 questionnaires (11 from clinical staff and 4 from non-clinical staff) were returned for analysis (23.1% of the number returned pre-education.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Over 80% of Royal Melbourne staff reported a problem or difficulty in working with patients with cognitive problems, and nearly half reported a problem or difficulty in working with their carers and/or family (Table 27). Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff.

Table 27: Staff rating of difficulty of working with patients and carers—pre-education

Self-rated problem/difficulty:		Percent with a problem/difficulty	
		Royal Melbourne	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	91.9	*84.5*
	Non-clinical staff	35.7	*40.6*
	All staff	81.6	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	55.2	*56.3*
	Non-clinical staff	16.7	*20.2*
	All staff	48.6	*49.6*

Communication difficulties, disruptive behaviours and staff skills were the most commonly reported problems/difficulties, with hospital resources, patient safety and treatment/diagnosis/assessment issues also relatively common (Table 28). The proportion of staff who reported that hospital resources were an issue was lower than the averages reported across all projects, with the other problems/difficulties presented in Table 28 broadly similar.

Table 28: Problems with working with patients with cognitive difficulties—pre-education

	Percent of respondents			
Problem/difficulty:	Clinical	Non-clinical	All staff	*All projects*
Communication	47.4	100.0	50.8	*47.7*
Disruptive behaviours	36.8	75.0	39.3	*40.9*
Staff skills	31.6	0.0	29.5	*28.7*
Hospital resources	22.8	0.0	21.3	*37.4*
Safety of the patient	22.8	0.0	21.3	*17.7*
Treatment/diagnosis/assessment issues	19.3	0.0	18.0	*16.0*
Wandering	15.8	25.0	16.4	*15.0*
Hospital protocols/procedures	17.5	0.0	16.4	*9.5*
Safety of staff and other patients	5.3	0.0	4.9	*5.2*
Family/relatives	1.8	0.0	1.6	*6.3*
Total respondents	57	4	61	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

Clinical staff knowledge (as measured by the proportion reporting one or more correct strategies for working/communicating effectively with patients with cognitive difficulties) among the surveyed staff was higher, and non-clinical staff lower than the project average prior to the education program. Both clinical and non-clinical staff showed increases in the follow-up survey (Table 29).

Table 29: Staff knowledge—pre and post-education

| | | Percent who gave one or more strategies | | |
| | | Royal Melbourne | | *All projects* |
Staff knowledge:		Pre	Post	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	93.5	100.0	*89.7*
	Non-clinical staff	64.3(1)	100.0(1)	*77.8*
	All staff	88.2	100.0	*87.2*

Notes:
(1) Sample size too small for meaningful pre-post tests on the non-clinical group.

Changes in staff attitudes

In general, the level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among the Royal Melbourne Hospital clinical staff was lower than the all project averages prior to the education program. Clinical staff reported an increase in comfort at follow up, and statistically significant increases in self-rated confidence and job satisfaction (Table 30). Non-clinical staff also reported increased confidence and comfort but small sample sizes make comparisons problematic.

Table 30: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

| | | Means (1) | | |
| | | Royal Melbourne | | *All projects* |
Self-rated measures:		Pre	Post	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.11*	3.70*	*3.24*
	Non-clinical staff	3.27(2)	3.75(2)	*3.05*
	All staff	3.14*	3.71*	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.23	3.70	*3.28*
	Non-clinical staff	3.36(2)	4.00(2)	*3.06*
	All staff	3.25*	3.79*	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.79*	3.10*	*2.88*
	Non-clinical staff	2.87(2)	2.75(2)	*2.93*
	All staff	2.80	3.00	*2.89*

Note:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
(2) Sample size too small for meaningful pre-post tests on the non-clinical group.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

In general, the staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program

was lower in the Royal Melbourne Hospital than the project average, but showed an increase post-education. The reported staff experience of how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and cognitive difficulties also showed an increase (statistically significant for clinical staff) post-education (Table 31).

Table 31: Staff rating of organisational support and hospital environment—pre and post-education

Self-rated measures:		Means (1)		
		Royal Melbourne		*All projects*
		Pre	Post	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.66	2.70	*2.74*
	Non-clinical staff	2.64(2)	3.00(2)	*2.79*
	All staff	2.66	2.79	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.51	2.80	*2.38*
	Non-clinical staff	2.60(2)	3.25(2)	*2.85*
	All staff	2.53	2.93	*2.47*

Note:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
(2) Significant change pre-education to post-education, * 5%; ** 1%.

Barriers

- Specific staff were not allocated to this project (as was mentioned in the initial expression of interest document). This impacted significantly on the time available to work on this project. The most significant barrier was the lack of 'drivers' / 'champions' assigned to the project. There needed to be an allocated person with time, resources and passion to spend with patients, carers and in educating staff when required.

- High rates of staff turnover in allied health and nursing made it difficult to keep the project on track, particularly as specific staff were not allocated to the roll out of this project.

- Routine screening for cognitive impairment is not entrenched practice in the acute wards of the health service. Introduction of routine screening is seen as time consuming and an added responsibility to an already comprehensive admission process.

- Nursing staff reported that they do not have time to do screening.

- Finding time for education sessions is competitive. The time available for nursing education session if 30 minutes at a maximum, in which time it is challenging to cover the content of the sessions. There were other competing demands on education times, i.e., the roll out of medication chart.

- Need to focus more on team engagement/ not just N/S – if you as an OT notice someone has CI and they don't have a CII, what is the process?

- We have had some recent staff changes, which has impacted on this project's success.

Facilitators

- It has now become the role of HMO's to complete cognitive screening for all admissions to medical units.
- The programme has been included on the quality plan of the participating wards.
- Strong support from Allied Health continues.
- Other clinical areas have expressed an interest in roll out of the project in the future.
- Steering committee and management is committed to the project.
- Changing the screening tool to the AMTS has encouraged more "buy in" from nursing staff.
- Changing screening criteria guidelines – try to screen everyone over 70 years (rather than 65 years) but prioritise those admitted with acute confusion / live alone / "older old" / multiple co-morbidities

St Vincent's Health

Education sessions for the Dementia Care in Hospitals Program began in June 2006. A total of 263 staff attended an education session, or training on cognitive screening or the CII. Questionnaires were distributed prior to the training and 148 were returned for analysis by clinical staff and 10 by non-clinical staff—a total return rate of 56.3%. Post-education, 53 questionnaires (39 from clinical staff and 14 from non-clinical staff) were returned for analysis (33.5% of the number returned pre-education.

Staff difficulty in working with patients with dementia, delirium or cognitive difficulties and/or their carers

Of the St Vincent's Health staff surveyed prior to the education program, nearly 90% reported a problem or difficulty in working with patients with cognitive problems, and over 60% reported a problem or difficulty in working with their carers and/or family (Table 32). The proportions of staff reporting a difficulty/problem were higher than the overall project averages. Clinical staff were more likely to report a problem or difficulty in working with patients and/or their carers than non-clinical staff.

Table 32: Staff rating of difficulty of working with patients and carers—pre-education

		Percent with a problem/difficulty	
Self-rated problem/difficulty:		St Vincent's	*All projects*
Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	91.0	*84.5*
	Non-clinical staff	55.6	*40.6*
	All staff	88.9	*76.1*
Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?	Clinical staff	63.3	*56.3*
	Non-clinical staff	22.2	*20.2*
	All staff	60.8	*49.6*

Communication difficulties were the most commonly reported problems/difficulties by StVincent's Health staff, with staff skills, disruptive behaviours, hospital resources, and treatment/diagnosis/assessment issues also relatively common (Table 33).

Table 33: Problems with working with patients with cognitive difficulties—pre-education

	Percent of respondents			
Problem/difficulty:	Clinical	Non-clinical	All staff	*All projects*
Communication	51.2	100.0	53.0	*47.7*
Staff skills	35.7	60.0	36.6	*28.7*
Disruptive behaviours	32.6	60.0	33.6	*40.9*
Hospital resources	36.4	0.0	35.1	*37.4*
Treatment/diagnosis/assessment issues	26.4	0.0	25.4	*16.0*
Safety of the patient	14.0	20.0	14.2	*17.7*
Hospital protocols/procedures	10.1	0.0	9.7	*9.5*
Family/relatives	9.3	20.0	9.7	*6.3*
Wandering	5.4	0.0	5.2	*15.0*
Safety of staff and other patients	2.3	0.0	2.2	*5.2*
Total respondents	129	5	134	*864*

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Communication includes difficulties in communicating with the person, difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation.
Disruptive behaviours such as verbal and physical aggression, and refusal to comply with instruction.
Wandering including climbing cot sides.
Hospital resource issues such as inappropriate ward environments (e.g., busy, noisy, no quiet areas, shared rooms, no locked ward to prevent patients from wandering), lack of activities to keep dementia patients occupied. Also, workload issues and staff-patient ratios (e.g., inadequate time to provide appropriate monitoring and supervision)
Hospital procedures/protocols not appropriate or lacking (e.g., inadequate information recorded on patients, unreliable information between the patient/family and the hospital, inadequate information at handover, team approach to care), poor follow up post-discharge.
Staff skills includes lack of knowledge and skills (e.g., involving patients in decisions, understanding the needs of patients with dementia), empathy for families of patients with dementia, inflexibility of staff, and lack of support from other staff.
Safety of the patient when they are confused, the risk of falls and continually getting out of bed.
Safety of staff and other patients e.g., because of violent behaviour, interfering with/disturbing other patients
Treatment/diagnosis/assessment issues including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories.
Family/relatives includes issues such as lack of understanding and acceptance of the person's condition, or lack of cooperation, and difficulties in getting accurate information from families.

Changes in staff knowledge

Staff knowledge (as measured by the proportion reporting one or more correct strategies for working/communicating effectively with patients with cognitive difficulties) among the clinical staff was similar to the project average, and higher among non-clinical staff prior to the education program. Both clinical and non-clinical staff showed an increase in the follow-up survey (Table 34).

Table 34: Staff knowledge—pre and post-education

| Staff knowledge: | | Percent who gave one or more strategies | | |
| | | St Vincent's Health | | *All projects* |
		Pre	Pre	*Pre*
What do you think is important in working or communicating effectively with patients with dementia, delirium, or memory and thinking difficulties (list 3)?	Clinical staff	90.3	94.9	*89.7*
	Non-clinical staff	88.9	100.0	*77.8*
	All staff	90.3	96.2	*87.2*

Changes in staff attitudes

In general, the level of confidence, comfort and job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties among St Vincent's Health staff was similar to the all project averages prior to the education program. Self-rated confidence, comfort and job satisfaction increased among clinical and non-clinical staff who returned a survey after the education program (Table 35). In particular, there were significant increases in self-rated comfort in dealing with patients with dementia, delirium or memory and thinking difficulties.

Table 35: Staff self-rated confidence, comfort and job satisfaction—pre and post-education

| Self-rated measures: | | Means (1) | | |
| | | St Vincent's Health | | *All projects* |
		Pre	Pre	*Pre*
How would you rate your confidence in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.29	3.49	*3.24*
	Non-clinical staff	2.80*	3.36*	*3.05*
	All staff	3.26	3.45	*3.20*
How would you rate your level of comfort in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.30**	3.64**	*3.28*
	Non-clinical staff	2.90**	3.57**	*3.06*
	All staff	3.28**	3.62**	*3.24*
How would you rate your level of job satisfaction in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	3.01	3.26	*2.88*
	Non-clinical staff	2.60	2.92	*2.93*
	All staff	2.98	3.17	*2.89*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Changes in organisational practice

The staff-perceived level of organisational support for dealing with patients with dementia, delirium, or memory and cognitive difficulties prior to the education program was similar in St Vincent's Health to the project average, and there was a significant increase post-education (Table 36). The reported staff experience of how well equipped is the hospital

environment to meet the needs of patients with dementia, delirium, or memory and cognitive difficulties was also similar to the overall project average. At follow up, this measure showed an increase among clinical staff, but among non-clinical staff there was a significant decrease. One possible explanation for this decrease is heightened awareness of desirable features of the hospital environment, but this was not evident in the other projects.

Table 36: Staff rating of organisational support and hospital environment—pre and post-education

| | | Means (1) | | |
| | | St Vincent's Health | | *All projects* |
Self-rated measures:		Pre	Pre	*Pre*
How would you rate the level of organisational support you receive in dealing with patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.76**	3.10**	*2.74*
	Non-clinical staff	2.50	2.69	*2.79*
	All staff	2.74*	3.00*	*2.75*
In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium, or memory and thinking difficulties?	Clinical staff	2.42	2.61	*2.38*
	Non-clinical staff	3.00*	2.31*	*2.85*
	All staff	2.46	2.53	*2.47*

Notes:
(1) 1=Very low. 2=Low. 3=Satisfactory. 4=High. 5=Very high.
Significant change pre-education to post-education, * 5%; ** 1%.

Barriers

- An organisational decision was taken to reconfigure the unit allocation to two of the wards involved in the CII project (9th floor) initiated several issues concerning education requirements and staff transfers and change in patient profile and led to the withdrawal of the 9th floor staff.

- Two of the resource nurses have moved positions. As the resource nurses are also responsible for many other projects, such as mentoring graduate nurses and supervising students, this impacted significantly on the time available to work on this project.

- Routine screening for cognitive impairment is not entrenched practice in the acute wards of the health service. Introduction of routine screening is seen as time consuming and an added responsibility to an already comprehensive admission process.

- Copyright issues relating to the use of the MMSE have required extensive follow up from the project manager. A typographical error on the approved medical record form is in the process of being resolved, however the print run is delayed until the copyright issue is resolved. This is seen as a state-wide / national issue rather than simply related to this health service.

- Finding time for education sessions is competitive. The time available for nursing education session if 45 minutes at a maximum, in which time it is challenging to cover the content of the sessions.

- It has been extremely difficult to obtain carer surveys. Many of the carers requests assistance completing the form which is time consuming for ward staff, and project manager is often not available when carer is present. Several carers have taken the form home but fail to return it, either in person or by post

Facilitators

- The programme has been included on the quality plan of the participating wards, ensuring that outcomes will be reviewed and followed up.
- Older person's resource nurses are acting as local champions.
- Steering committee and management is committed to the project.
- Acting on feedback and changing the screening tool from the MMSE to the AMTS has encouraged more "buy in" from nursing staff.
- Changing screening criteria guidelines – try to screen everyone over 70 years (rather than 65 years) but prioritise those admitted with acute confusion / live alone / "older old" / multiple co-morbidities.
- Inclusion of the AMTS on the nursing admission documentation.
- Inclusion of a screening score on falls and pressure areas risk screening tools.
- Members of the Aged Care Consult Service (ACCS) team have promoted the project.
- Increased presence of project manager on participating wards.
- Publicity and project updates via "Broadcasts" on the hospital intranet and Alzheimer's awareness month.

Overview of Outcomes

This section presents an overall view of the evaluation activities and draws out findings that point to the recommendations.

Role of Ballarat Health Services Project Team

Staff who attended the training days conducted by the Ballarat Health Services team were asked to evaluate the presentation. The evaluation questionnaire contained items on the objectives of the presentation, time allocated for the presentation, the content of the Teaching Package, and preparedness to educate others. Responses from the 83 staff who returned a questionnaire were positive across all settings. The mean rating for all items was between positive and strongly positive.[*] Comments from the small minority who answered negatively were concerned about the presentation needing more time or needing more education before they felt confidant to educate others about the program. In addition, a number of projects commented positively in their process reports on the ongoing support received from the Ballarat team.

Staff perceptions

Difficulty in working with patients with dementia, delirium or cognitive difficulties

Working with patients with a cognitive impairment, and to a lesser extent their carers, is a significant issue for hospital staff. Consistent with a higher level of contact with patients and their families, clinical staff were more likely to report a problem or difficulty than non-clinical staff. Over 80% of clinical staff and 40% of non-clinical staff surveyed prior to the education sessions reported that they had experienced a problem or difficulty in working with patients with dementia, delirium or memory and thinking difficulties. Moreover, over half the clinical staff and a fifth of non-clinical staff reported a difficulty or problem working with the carer or family of patients with a cognitive difficulty.

Communication issues, a focus of the education sessions in the projects, were the most common concern of staff in dealing with patients with a cognitive difficulty. Nearly half (48%) of all pre-education respondents reported difficulties in communicating with the person (including difficulties in comprehending instructions or discussion, problems with memory and concentration, as well as lack of insight and disorientation), 41% reported disruptive behaviours (such as verbal and physical aggression, and refusal to comply with instruction; wandering was coded separately and reported as a problem by 15% of staff) and 37% reported inadequate hospital resources (such as a lack of activities to keep dementia patients occupied; inappropriate ward environments e.g., busy, noisy, no quiet areas, shared rooms, no secure ward to prevent patients from wandering; workload issues and staff-patient ratios e.g., inadequate time to provide appropriate monitoring and supervision). Lack of staff skills (including lack of knowledge and skills e.g., involving patients in decisions, or understanding the needs of patients with dementia; empathy for

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[*] For example, Question 1: The key objectives of the day were presented clearly—1=strongly disagree; 2=disagree; 3=agree; 4=strongly agree.

families of patients with dementia; inflexibility of staff; and lack of support from other staff), patient safety and treatment/diagnosis/assessment issues (including variable assessment and diagnosis, inconsistent treatment plans, and difficulty of obtaining accurate patient histories) were also relatively commonly reported.

Staff knowledge

Staff knowledge (as measured pre and post-education as the proportion of respondents reporting one or more strategies important in working or communicating effectively with people with cognitive difficulties) improved in almost all projects for both clinical and non-clinical staff.

Staff attitude

Self-reported staff confidence and level of comfort in dealing with patients with cognitive difficulties improved (most statistically significant) over the pre and post measures across all projects. Both clinical and non-clinical staff reported increased levels of confidence and comfort. Self-reported job satisfaction also increased with six of the seven projects reporting higher levels post-education than pre-education.

Organisational support and hospital environment

The staff (clinical and non-clinical) rating of the level of organisational support received in dealing with patients with cognitive difficulties increased (over half statistically significant) with six of the seven projects reporting higher levels post-education than pre-education. In the other project, only non-clinical staff reported an increase. The perceived improvement in the level of job satisfaction in dealing with patients with cognitive difficulties also increased with clinical and non-clinical staff of four of the seven projects reporting higher levels, and some staff of the other three reporting an increase.

Carer perceptions

All projects attempted to assess any impact of the program on carer satisfaction. However, the response rate of carers both pre and post the education program was low. Table 37 below presents the numbers of questionnaires returned by carers across the projects.

Table 37: Number of carer questionnaires returned—all projects

	Pre-education	Post-education	Total
Austin Health	7	1	8
Barwon Health	0	9	9
Broadmeadows Health Service	20	6	26
North East Health Wangaratta	7	26	33
Peninsula Health	16	9	25
Royal Melbourne Hospital	21	0	21
St Vincent's Health	25	7	32
TOTAL	**96**	**58**	**154**

While the varying responses across the projects means that it is not meaningful to test for pre and post-education differences, responses to the surveys indicate some of the issues important to carers in their hospital experience. Of the total responses from carers, 79.1% reported that they had positive experiences in a hospital setting, and 16.5% reported they had not had a positive experience (4.3% reported both). Table 38 below presents the comments from carers who had positive experiences in hospital. The most important was the experience with quality hospital staff. Understanding and respecting the needs of patients with a cognitive difficulty and their carers was also reported, as was the hospital environment and the quality of the medical treatment received.

Table 38: Positive experiences of carers in a hospital setting—all projects

Positive experience:	Percent of respondents
Quality of the staff	71.0
Felt understood and the needs of the patient respected	15.0
Staff listened to the carer and respected the needs of the carer/family	13.0
Hospital environment	11.0
Informative staff	9.0
Quality of the medical treatment	6.0
The use of the Cognitive Impairment Indicator	1.0
General	4.0
Total respondents	100

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Quality of staff includes caring and kind staff, teamwork and general standard of care.
Hospital environment includes hospital services such as food, conditions such as provision for privacy and flexible visiting arrangements and suitable hospital equipment

Table 39 below presents the comments from carers who had negative experiences in hospital. They almost mirror the positive experiences above with the quality of hospital staff (including understanding and respecting the needs of patients with a cognitive difficulty and their carers), poor information and hospital conditions most commonly reported.

Table 39: Negative experiences of carers in a hospital setting—all projects

Negative experience:	Percent of respondents
Staff not responsive to the needs of the patient	29.6
Poor information	29.6
Poor hospital conditions	25.9
Lack of staff	11.1
Poor medical treatment	7.4
Need for interpreters	3.7
Staff not responsive to the needs of the carer/family	3.7
General	14.8
Total respondents	100

Notes:
Multiple responses—columns add to more than 100% because respondents gave up to three responses.
Poor information includes poor discharge plan or information.
Hospital conditions includes poor food (and particular food needs), and disturbance from other patients.

Factors that influenced the success of the project

An overview of the barriers to successful implementation would suggest that staff capacity was an important factor. Where ward staff implementing the Cognitive Impairment Identifier had inadequate time due to ward priorities or the demands of concurrent projects, lacked confidence or expertise in the screening or use of the indicator, had insufficient training, or perceived that they were receiving inadequate support for implementing the project from senior staff or from the project team then not surprisingly implementation was more patchy.

Similarly a lack of perceived organizational support from senior staff and the executive, inadequate communication about the project and its rationale, and existing work routines or ward practices that were difficult to reconcile with the project requirement were also significant barriers.

On the other hand those factors associated with successful project roll out tended to be the converse of the above. Adequate staff resources dedicated to the project, support from senior staff, appointment of local champions and ongoing support from the Ballarat team were all nominated as important project enablers. The extent to which the CII requirements could build on or be built into existing organizational procedure and developments was also an important factor in project uptake (and no doubt in the ongoing use of the CII). For example if the project could utilize existing infrastructure (e.g., staff member on site with responsibility for, or expertise in, cognitive impairment issues) and complement ongoing organizational developments it was more likely to be successful. Similarly incorporation of the project activities into the ongoing operational protocols or procedures of the facility facilitated project implementation, for example including the use the CII into the quality plan for the organization, writing the use of a cognitive screening tool into the nursing admission documentation.

Conclusion

There is a significant prevalence of cognitive impairment and related behavioural manifestations within the general hospital patient population.[*] The great majority of staff in all projects report a difficulty in working with patients with a cognitive impairment. A significant minority of carers of people with a cognitive impairment also reported a negative experience in a hospital. The surveys of carers also showed that the quality of staff is the most important factor contributing to a positive experience in a hospital. The focus of the Dementia Care in Hospitals Program on training staff to understand and work more effectively with patients with a cognitive impairment is consistent with these findings.

Although limited in scope, and subject to differences in project administration (e.g., response rates and the time period between the pre and post-education surveys), this evaluation has documented improvements in staff knowledge, attitudes and perceived organisational support. Levels of all, or most of these measures showed an increase between pre and post education across all projects. To determine whether these improvements continue will require further evaluation. Reports from the projects indicate the following as important in sustaining gains made through the Dementia Care in Hospitals Program:

- Staff capacity, including adequate time in the face of the demands of other duties and projects, training and expertise in screening for cognitive impairment and the use of the CII, and the appointment of local champions.

- Organisational support at the ward level, and at the management and executive levels of the hospital.

- Building the program (including use of the CII) into organisational structures such as operational protocols and procedures, and documentation.

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[*] Lincoln Centre for Ageing and Community Care Research and Victorian Department of Human Services, (2005), *Evaluation of Education and Training of Staff in Dementia Care and Management in Acute Settings.*

Appendices

Appendix 1:

Dementia Care in Hospitals Program—Survey of Staff

Prior to the education program on dementia care and management, we are interested in your views and experience of dealing with patients with cognitive impairment and their carer/family. The information will assist the hospital in training staff, improving the quality of care for these patients, and improving communication with carers/families.

Please put your completed questionnaire in the envelope provided.

All replies will be strictly confidential and you will not be identified in any way.

Please tick the box which best describes your position.

☐ **clinical staff**, e.g. nursing, medical, allied health etc   ☐ **non-clinical staff** e.g. engineers, ward clerks, etc

Non-clinical Staff: Have you ever been offered Inservice or education on dementia or delirium?

Yes ☐   No   ☐

1. What proportion of patients do you think you come across in the hospital with dementia, delirium or memory and thinking difficulties?

10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐

2. How would you rate your confidence in dealing with patients with dementia, delirium or memory and thinking difficulties?

very low ☐   low ☐   satisfactory ☐   high ☐   very high ☐

3. How would you rate your level of comfort in dealing with patients with dementia, delirium or memory and thinking difficulties?

very low ☐   low ☐   satisfactory ☐   high ☐   very high ☐

4.   How would you rate the level of organisational support you receive when dealing with patients   with dementia, delirium or memory and thinking difficulties?

very low ☐   low ☐   satisfactory ☐   high ☐   very high ☐

5   How would you rate your level of job satisfaction in dealing with patients with dementia, delirium or memory and thinking difficulties?

very low ☐   low ☐   satisfactory ☐   high ☐   very high ☐

6   In your experience how well equipped is the hospital environment to meet the needs of patients with dementia, delirium or memory and thinking difficulties?

very low ☐   low ☐   satisfactory ☐   high ☐   very high ☐

7   Have you experienced any problem or difficulty working with patients with dementia, delirium or memory and thinking difficulties?

Yes ☐   No ☐

If you answered yes, please list the 3 most significant difficulties:

1. ....

....

2. ....

....

3. ....

....

8   What do you think is important in working or communicating effectively with patients with dementia, delirium or memory and thinking difficulties? Please list the 3 most important:

1. ....

....

2. ....

....

3. ....

....

9. Have you experienced any problem or difficulty working with the carer or family of patients with dementia, delirium or memory and thinking difficulties?

Yes ☐   No ☐

If you answered yes, please list the 3 most significant difficulties:

1. ....
....

2. ....
....

3. ....
....

Appendix 2:

Dementia Care in Hospitals Program—Carer Satisfaction Survey

Please circle the number which best represents your opinion:

1. How satisfied are you the hospital staff knew the person you care for has problems with memory and thinking?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

2. How satisfied are you staff introduced themselves to the person you care for on a regular basis?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

3. Are you satisfied the person you care for was not expected to do more than they were capable of? e.g. remembering to keep to a fluid restriction, attending to toileting needs etc.

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

4. Are you satisfied the staff explained things to the person you care for in a simple way and checked if they were understood?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

5. How satisfied are you the staff made you welcome to provide information about the person you care for? e.g. were you asked about their likes and dislikes, or difficulties they have with communication?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

6. When you voluntarily offered information regarding the person you care for, how satisfied are you the staff listened to or took notice of you?

1	**2**	**3**	**4**	**5**	**?**
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

7. Are you satisfied the hospital staff was understanding of any challenging behaviours that may have been exhibited by the person you care for?

1	**2**	**3**	**4**	**5**	**?**
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

8. Have you and /or the person you care for had positive experiences within a hospital setting?

Yes/No?

If yes, what made it positive?

If no, what made it negative?

9. How satisfied are you with the information you were given about the condition and treatment of the person you care for?

1	**2**	**3**	**4**	**5**	**?**
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

10. How satisfied are you hospital staff gave you the option of receiving discharge information for the person you care for? e.g. information about follow-up appointments, medication changes

1	**2**	**3**	**4**	**5**	**?**
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

If satisfied was it adequate?

Yes/No?

11. How satisfied are you this hospital is friendly for people with memory and thinking difficulties and their carers?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

12. In your opinion was the bed based identifier of memory and thinking difficulties useful in helping the hospital staff respond effectively to the needs of the person you care for?

1	2	3	4	5	?
Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied	Unsure

All feedback is very useful for us in better meeting the needs of people with memory and thinking difficulties.

Please feel free to make any additional comments regarding the bed base identifier of memory and thinking difficulties.

Should you have any questions regarding this questionnaire contact?

Fill in contact here……….

Thank you for your time and effort in completing this survey.

Appendix 3:

Process Evaluation Template

Documenting the project activities

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

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

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

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

How to use the guide

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

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

Dementia Care in Hospitals Project
Process Evaluation Guide

1   Project objectives

Include a brief statement of the objectives of your project.

2   Project activities and project schedule

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

Project activity	Timeline (months)
Etc	

3   Personnel involved in project planning and implementation

Project staff

List those staff responsible for implementing the project.

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

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

For each such group complete:

      Name of group

      Role

      Membership (individual and position)

      Number of meetings over life of project

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

4   Other communication strategies used in planning or implementing the project

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

5   Training or education activities

Please describe

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

6   Other activities undertaken as part of the project

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

7   Other resources expended

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

8   Barriers

What were the main barriers to achievement of project objectives?

9   Facilitators

What factors were important in helping achieve project objectives?

10   Project outcomes

What specifically did you achieve in your enhancement project?

11   Follow-up

What is likely to follow from this project?

12   Any other comments