Midland Regional Dementia Behavioural Support and Advisory Service.

Ruth Thomas, Coordinator. January 2011

The regional dementia advisory and support service coordinator roles (four to cover NZ) were introduced late 2010. The service is specifically with regard to people diagnosed (or likely to be diagnosed) with dementia and who require psychological and behavioural (BPSD) intervention as part of their care i.e. those people with a complicated presentation.

The main role tasks are highlighted in the service's brochure.

Background to the role:

What does this service offer?

Advice and education sessions to care facilities, DHBs and support services such as Alzheimer's branches, Age Concern and Home Services regarding... Living with Dementia, Care giver Stress, Nutrition and Dementia, Behaviours That Challenge, Different types of Dementia.

Forwarding referrals to Mental Health Services for Older People teams in the Midlands region. Advise about the physical layout and colour schemes for rest homes and hospitals for people living with dementia. A quarterly Newsletter to share ideas, research and best practice.

Who can access this service?

Anyone who is caring for someone living with dementia and that is displaying behaviours that challenge e.g. family, whanau, informal/unpaid care givers, paid care givers, DHB staff, volunteer organizations, rest home staff, home care staff.

Am I charged for this service?

No, there is no charge for any of these services.

Since being in post I have...

- Visited virtually every residential care facility (RCF) in the Midland region that offers Secure Dementia and/or Psycho-geriatric level care.
- Met with each of the DHB's MHSOP/HOP teams, Health of Older People Planning and Funding Managers, Mental Health Planning and Funding Managers and a number of Alzheimer's society branches.
- Undertaken a stocktake/review of various aspects such as RCF provision, education, support/advice for RCF and the desired aspects of this role.
- Introduced a quarterly newsletter specifically aimed at RCF.
- Started to roll out the Dementia Care Education series for RCF.
Stock Take Report

The stock take was undertaken with the strong and underpinning guiding principles to:

- Improve the quality of life of those living and dying with a dementia and displaying behaviours that challenge,
- Help inform funding and planning decisions of DHBs,
- Advocate for those not able to do so for themselves due to a dementia.

The stocktake covered tiers 4-7 inclusive of the seven-tiered model of care that is recommended that all DHBs use to guide funding and service planning decisions.

The main limitations on the findings are:

- With regard to the ability to create a gap analysis of residential secure dementia and psycho-geriatric level care with regard to the range and level of care provided at these levels and therefore the validity of this.
- Many of the recommendations strongly align with the draft "Dementia Services and Mental Health and Addiction Services for Older People" Guidelines. The field has moved on since this draft was undertaken and the draft needs to be updated.
- My recommendations were aligned with the "Dementia Services and Mental Health and Addiction Services for Older People" Guidelines. Many of these have been included in the draft for the 2012 guidelines with the inclusion of all levels of care.

Findings

Suggestions

DHBs

Support and Advisory Service

Inpatient and RCF bed provision

Current and planned provision is reasonably consistent but the range varies greatly with some DHBs having no provision. This may in some instances result in the assessed care being in response to bed availability as opposed to actual need.

Yearly reassessment of resident needs to ensure correct placement and best use of bed provision. Introduce "swing" beds to give more flexibility in bed use. Agree a standard assessment tool to provide consistency in outcome.

Staffing Ratios

Consistent as an average but the range varied greatly – usually as a result of other staff working within the RCF being available to help out. It is understood some RCFs were understaffed or struggled to recruit adequate levels of staff.

Introduce acuity based staffing levels. Make available time limited (24, 48 hours) funding for 1:1 safety watch staff for RCF during acute behavioural difficulties and/or major medication reviews.

Perceived Support

From MHSOP/POP teams:

Predominantly perceived as good or excellent and timely. Particularly if there was a named contact in the team.

From GPs:

Very variable, ranging from excellent to very poor. Anecdotally support is "interest led" as opposed to "process led".

Out Of Hours including psychiatric crisis teams:

Majority viewed as very unhelpful, not interested in RCF residents and/or as dementia not being in the remit of mental health.

MHSOP/POP teams:

Develop a formally recognised named person/role as the main contact for RCF. Explore how out of hours support can be provided – possibly via phone advice only.

GPs:

Education for GPs regarding recognising/diagnosing/managing symptoms and referral process for BPSD.

Crisis teams:

Education with regard to BPSD/possible advice that could be given to RCF/dementia being under the remit of mental health.

Education

All RCF accessed some training regarding BPSD but this varied greatly in content and frequency. Cost issues limited access greatly.

Develop a Dementia Care training series. Deliver education session in RCF.

Desired aspects of advisory role

Education delivery, sharing best practice/research, being a "sounding board" for frustrations of the system and raising awareness of the realities of caring for someone living with dementia to the general public.

Introduce Dementia Champions in every RCF. Continue to undertake face to face support visits. Formally launch the service.

RCF Audit Process

Conflicting interpretations between Service Standard Audits and DHB Contract audits. Audits tend to be purely paper based and not care based.

Stop routine contract audits and work with RCF where improvements are needed most. Advocate for audits to be more person based.

These are the people who's well being depends on what and how we do what we do.