TIDES OF CHANGE

DBMAS SYMPOSIUM

FRIDAY 13 JUNE 2014

RENDEZVOUS HOTEL, SCARBOROUGH, PERTH

9.25AM

GLENN REES AM

CHIEF EXECUTIVE

ALZHEIMER'S AUSTRALIA

DEMENTIA IN HOSPTIALS

I WOULD LIKE TO THANK ALZHEIMER'S AUSTRALIA WA THIS EVENT FOR INVITING ME TO SPEAK TO YOU ALL TODAY ON THE IMPORTANT TOPIC OF DEMENTIA IN THE ACUTE CARE SETTING AND FOR ORGANISING SUCH AN IMPRESSIVE CONFERENCE.

IT WOULD NOT HAVE BEEN POSSIBLE EVEN A FEW YEARS AGO TO HOLD A CONFERENCE OF THIS KIND. WE OWE A LOT TO PROFESSORS BRIAN DRAPER, JACQUI CLOSE, MARK YATES, LEN GRAY AND MANY OTHERS FOR GENERATING THE EVIDENCE BASE WE HAVE BEFORE US TODAY.

THE FIRST POST-BUDGET REACTION IN ALZHEIMER'S AUSTRALIA WAS RELIEF THAT THE 2012 AGED CARE REFORMS WE FOUGHT SO HARD FOR ARE LARGELY IN PLACE – WITH THE EXCEPTION OF THE REDUCTION IN THE GROWTH OF THE HOME CARE PROGRAM FROM 2018.

BUT IT IS EVIDENT THAT THESE ARE UNCERTAIN TIMES FOR THE HEALTH SECTOR WHICH WILL MAKE MORE DIFFICULT PLANNING FOR THE FUTURE.

THERE ARE CONCERNS ABOUT HOW THE CHANGES IN RELATED HEALTH PROGRAMS WILL IMPACT ON AGED CARE – FOR EXAMPLE THE CHANGES IN HOSPITAL FUNDING ARRANGEMENTS AND THE DECLINE IN FEDERAL FUNDING, THE CO-PAYMENTS IN PRIMARY CARE AND THE TERMINATION OF THE AUSTRALIAN MEDICARE LOCAL ALLIANCE, INCLUDING THE IMPACT

THAT WILL HAVE ON THE WORK NEEDED AT THE LOCAL LEVEL TO BETTER INTEGRATE CARE.

THERE IS A RISK THAT CONSUMER ADVOCATES ARE SEEN AS ALWAYS CRITICISING THE QUALITY OF CARE IN HOSPITALS AND RESIDENTIAL CARE. WELL IT OF COURSE IS OUR ROLE TO IMPROVE THE QUALITY OF CARE BUT IT SHOULD BE SAID THAT CONSUMERS ARE APPRECIATIVE OF THE WORK THAT CARE STAFF DO IN HOSPITALS AND RESIDENTIAL CARE, OFTEN IN VERY DIFFICULT CIRCUMSTANCES.

IT IS OF COURSE THE CASE THAT HOSPITALS CAN OFTEN BE A FRIGHTENING AND CONFUSING PLACE FOR THE PERSON WITH DEMENTIA. AS MANY OF YOU ARE NO DOUBT AWARE, PEOPLE WITH DEMENTIA FREQUENTLY STAY IN HOSPITAL FOR LONGER PERIODS OF TIME AND INVARIABLY HAVE WORSE CLINICAL OUTCOMES THAN THOSE ADMITTED TO HOSPTIAL DUE OTHER HEALTH CONDITIONS.

THE HOSPITAL ENVIRONMENT IS DRIVEN BY EMERGENCIES AND IS SIMPLY NOT DESIGNED TO CATER FOR THE NEEDS OF SOMEONE WHO MAY BE CONFUSED OR HAVE OTHER FORMS OF COGNITIVE IMPAIRMENT.

ALL TOO OFTEN, PEOPLE WITH DEMENTIA ARE NOT IDENTIFIED AS HAVING A COGNITIVE IMPAIRMENT. IT IS ESTIMATED THAT NEARLY HALF OF PEOPLE WITH DEMENTIA STAYING IN HOSPITAL DO NOT HAVE A RECORDED DIAGNOSIS.

THESE FACTORS CAUSE A GREAT DEAL OF DISTRESS FOR BOTH THE PERSON LIVING WITH DEMENTIA AND THEIR FAMILY MEMBERS AND CARERS AND RESULTS IN THE CARE NEEDS OF THE PERSON WITH DEMENTIA GOING UNMET.

THE EVIDENCE SUGGESTS THAT IN MANY CASES THE AUSTRALIAN HOSPITAL SYSTEM IS FAILING PEOPLE WITH DEMENTIA.

I HAVE HEARD SOME HARROWING STORIES OF THE EXPERIENCES OF PEOPLE WITH DEMENTIA IN HOSPITAL. STORIES OF PEOPLE BEING PHYSICALLY RESTRAINED WITH NO CONSULTATION. PEOPLE NOT GETTING FED BECAUSE A FOOD TRAY IS LEFT WITHOUT ANYONE PROVIDING ASSISTANCE AND THE COMMON STORY OF FALLS HAPPENING IN HOSPITAL AS A RESULT OF SIDE EFFECTS OF ANTIPSYCHOTIC OR SEDATIVE MEDICATIONS.

SLIDE 2 TODAY, I WILL FOCUS ON THE EXPERIENCES OF PEOPLE LIVING WITH DEMENTIA IN THE HOSPTIAL SETTING INCLUDING:

- THE DIFFERENCES IN CLINIAL OUTCOMES FOR PEOPLE WITH DEMENTIA COMPARED TO OTHERS IN HOSPITAL
- THE IMPORTANCE OF IDENTIFICATION OF COGNITIVE IMPAIRMENT AND TRAINING FOR STAFF ON GOOD COMMUNICATION
- ISSUES RELATING TO THE INAPPROPIRATE USE OF MEDICATIONS TO RESPOND TO BPSD

- DESIGN OF HOSPITALS
- INVOLVEMENT OF CARERS
- AND REDUCING AVOIDABLE HOSPITALISATIONS FOR PEOPLE WITH DEMENTIA

THESE AND OTHER TOPICS WERE EXPLORED RECENTLY AT THE DEMENTIA CARE IN HOSPITALS SYMPOSIUM HELD IN SYDNEY IN APRIL.

RESEARCHERS, POLICY MAKERS AND CLINICIANS CAME TOGETHER TO DISCUSS THE LATEST RESEARCH IN DEMENTIA CARE IN HOSPITAL AND TALK ABOUT STRATEGIES AND PRACTICAL APPROACHES TO IMPROVE THE QUALITY OF CARE IN HOSPITALS.

IT IS WITH GREAT PLEASURE THAT I LAUNCH THE REPORT ON THE SYMPOSIUM WHICH DETAILS THE FINDINGS OF THE SYMPOSIUM AND HIGHLIGHTS THE GREAT WORK BEING DONE AROUND THE COUNTRY TO IMPROVE THE QUALITY OF CARE IN HOSPITALS FOR PEOPLE WITH DEMENTIA. THE DOCUMENT PROVIDES A RANGE OF STRATEGIES WHICH COULD BE IMPLEMENTED TO IMPROVE HOSPITAL CARE FOR PEOPLE WITH DEMENTIA.

WE HAVE SOME COPIES AVAILABLE HERE AND IT IS ALSO AVAILABLE FOR DOWNLOAD ON THE ALZHEIMER'S AUSTRALIA WEBSITE WWW.FIGHTDEMENTIA.ORG.AU.

DIFFERENCES IN OUTCOMES

SLIDE 3 PEOPLE WITH DEMENTIA ARE HIGH USERS OF HOSPITAL SERVICES. EACH YEAR A QUARTER OF ALL PEOPLE WITH DEMENTIA REQUIRE HOSPITAL SERVICES AT SOME POINT DURING THE YEAR WHICH IS TWICE THE RATE OF PEOPLE OF THE SAME AGE WHO DO NOT HAVE DEMENTIA.

THEY ALSO STAY IN HOSPITAL ALMOST AS TWICE AS LONG AS THOSE WITHOUT DEMENTIA, AVERAGING A STAY OF 16.4 DAYS OF CARE COMPARED WITH 8.9 DAYS FOR OTHER PATIENTS OF THE SAME AGE.

PEOPLE WITH DEMENTIA HAVE POORER CLINICAL OUTCOMES AND ARE MORE LIKELY TO BE READMITTED TO HOSPITAL THAN THOSE PEOPLE WITHOUT DEMENTIA. THEY ARE TWICE AS LIKELY TO EXPERIENCE FALLS, PRESSURE ULCERS, FRACTURES AND DELIRIUM.

SOME OF THESE DIFFERENCES ARE TO BE EXPECTED DUE TO THE NATURE OF THE DISEASE, BUT THE EVIDENCE SUGGESTS THAT WITH BETTER CARE, OUTCOMES FOR PEOPLE WITH DEMENTIA COULD BE SIGNIFICANTLY IMPROVED.

SLIDE 4 THERE ARE HIGH COSTS ASSOCIATED WITH PROVIDING HOSPITAL CARE TO THE PERSON WITH DEMENTIA. IN 2006/2007, THE AVERAGE COST

OF HOSPITAL CARE FOR THE PERSON WITH DEMENTIA IN NSW WAS $7,720 PER EPISODE COMPARED TO $5,010 FOR A PERSON WITHOUT DEMENTIA.

IT IS IMPORTANT TO RECOGNISE THAT IMPROVING CARE WILL NOT NECESSARILY CUT COSTS FOR THE HOSPITAL SYSTEM. ENSURING APPROPRIATE STAFFING AND TRAINING DOES HAVE COST IMPLICATIONS EVEN IF IT REDUCES THE AVERAGE LENGTH OF STAY.

THE ECONOMIC IMPACT OF IMPROVING CARE NEEDS TO BE FURTHER EXPLORED. BUT REGARDLESS, IMPROVING CARE WILL RESULT IN BETTER HEALTH OUTCOMES FOR PEOPLE WITH DEMENTIA AND THEREFORE MORE EFFICIENT HEALTH CARE SPENDING.

IDENTIFICATION OF DEMENTIA

SLIDE 5 THE CORRECT IDENTIFICATION OF COGNITIVE IMPAIRMENT IS ONE OF THE FIRST STEPS IN PROVIDING QUALITY CARE. IT IS HARD TO PROVIDE GOOD CARE IF YOU DO NOT KNOW THAT THE PERSON NEEDS ADDITIONAL SUPPORTS.

COGNITIVE IMPAIRMENT OFTEN GOES UNIDENTIFIED - WITH NEARLY 50% OF PEOPLE WITH DEMENTIA NOT HAVING THEIR DIAGNOSIS DOCUMENTED DURING THEIR HOSPITAL STAY. THIS MAY BE DUE TO A RANGE OF THINGS INCLUDING TIME CONSTRAINTS, POOR CLINICAL CODING AND DIFFICULTIES ASSOCIATED WITH DIAGNOSING DEMENTIA.

THERE IS A NEED FOR CLINICIANS TO DISTINGUISH BETWEEN PROGRESSIVE COGNITIVE CHANGES WHICH OCCURS AS A RESULT OF DEMENTIA AND ACUTE CONFUSIONAL STATES CAUSED BY DELIRIUM. DELIRIUM CAN BE CAUSED BY INFECTION, MEDICATION OR OTHER MEDICAL ISSUES AND WITHOUT TREATMENT CAN LEAD TO DEATH.

THERE IS SOME DEBATE OVER WHETHER THERE SHOULD BE WIDESPREAD SCREENING IN HOSPITALS FOR COGNITIVE IMPAIRMENT AS SCREENING CAN RESULT IN FALSE POSITIVES.

BUT MOST EXPERTS AGREE WE NEED TO DO BETTER IN IDENTIFYING PEOPLE WHO ARE AT GREATEST RISK FOR IMPAIRMENT AND ENSURING THEY ARE ACCURATELY ASSESSED AND THAT THEIR NEEDS ARE APPROPRIATELY DOCUMENTED.

OF COURSE IT IS NOT ENOUGH TO IDENTIFY DEMENTIA - APPROPRIATE STRATEGIES NEED TO BE IN PLACE TO IMPROVE CARE.

SLIDE 6 HOSPITAL STAFF DO NOT RECEIVE ADEQUATE TRAINING ON DEMENTIA. ONE STUDY FOUND THAT LESS THAN HALF OF HOSPITAL STAFF HAD RECEIVED ANY TRAINING ON DEMENTIA AND THOSE WHO DID RECEIVE TRAINING FELT IT WAS INADEQUATE.

ANOTHER STUDY FOUND THAT 80-90% OF HOSPITAL STAFF REPORTED DIFFICULTY CARING FOR PEOPLE WITH COGNITIVE IMPAIRMENT.

THE DEMENTIA CARE IN HOSPITAL PROGRAM (DCHP) IN VICTORIA IS AN EXAMPLE OF A PROGRAM THAT ENCOURAGES SCREENING OF PATIENTS AT RISK, PROVIDES A WAY OF DOCUMENTING COGNITIVE IMPAIRMENT THROUGH A BEDSIDE ALERT/SYMBOL AS WELL AS PROVIDES TRAINING FOR ALL LEVELS OF STAFF TO ENSURE THEY KNOW HOW TO BEST COMMUNICATE WITH A PERSON WHO HAS DEMENTIA.

THIS PROGRAM HAS LED TO BETTER OUTCOMES FOR BOTH CONSUMERS AND STAFF. YOU WILL HEAR MORE ABOUT THIS PROGRAM FROM MARK YATES WHO IS SPEAKING LATER TODAY.

SLIDE 7 ANOTHER IMPORTANT PROJECT IS THE CONFUSED HOSPITALISED OLDER PERSONS (CHOPS) WHICH FOCUSES ON THE FOLLOWING APPROACHES TO IMPROVE CARE FOR PEOPLE WITH DEMENTIA AND DELERIUM:

1) IDENTIFICATION OF OLDER PEOPLE WITH CONFUSION IN HOSPITAL
2) INVESTIGATION OF THE CAUSE OF CONFUSION
3) IMPLEMENTATION OF EFFECTIVE TREATMENT AND MANAGEMENT INCLUDING COMMUNICATION TO SUPPORT PERSON CENTRED CARE.

EARLY EVIDENCE SUGGESTSTHIS PROJECT HAS LED TO STAFF BEING MORE CONFIDENT IN RECOGNISING AND MANAGING PEOPLE WITH DELERIUM.

INAPPROPRIATE USE OF MEDICATION

SLIDE 8 GOOD CARE IS OF COURSE MORE THAN JUST COMMUNICATION. IT IS ABOUT ENSURING APPROPRIATE SUPPORT AND MANAGEMENT OF DEMENTIA, INCLUDING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS. I AM SURE PROFESSOR BANERJEE WILL HAVE MUCH MORE TO SAY ABOUT THIS ISSUE IN THE NEXT TALK.

THE MAJORITY OF PEOPLE WITH DEMENTIA WILL EXPERIENCE BPSD AT SOME POINT IN THE COURSE OF THEIR DISEASE. OFTEN MORE SERVERE EPISODES OF BPSD CAN LEAD TO HOSPITALISATION WHEN AN AGED CARE FACILITY NO LONGER FEELS EQUIPPED TO PROVIDE CARE.

BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA HAVE A RANGE OF PHYSICAL, ENVIRONMENTAL AND SOCIAL CAUSES.

UNFORTUNATELY, ANTIPSYCHOTIC MEDICATIONS ARE OFTEN USED AS A FIRST LINE OF RESPONSE TO BEHAVIOURAL SYMPTOMS IN HOSPITAL. THIS IS DESPITE THE SERIOUS SIDE EFFECTS, INCLUDING FALLS AND DEATH, WHICH ARE ASSOCIATED WITH THEIR USE AND THE EVIDENCE THAT THERE IS LIMITED CLINICAL BENEFIT TO THE PATIENT.

OFTEN APPROPRIATE CONSENT IS NOT OBTAINED FROM THE PERSON WITH DEMENTIA OR THE APPROPRIATE SUBSTITUTE DECISION MAKER. PHYSICAL RESTRAINTS ARE ALSO STILL USED IN HOSPITAL, AGAIN SOMETIMES WITHOUT APPROPRIATE CONSENT BEING SOUGHT.

A CONSUMER WHO SPOKE AT OUR FORUM IN SYDNEY TOLD US ABOUT HER HUSBANDS EXPERIENCE IN HOSPITAL:
“ON THE THIRD NIGHT AT THE HOSPITAL HE TRIED TO CLIMB OVER HIS BEDRAILS TO FOLLOW US WHEN WE LEFT. SOMEONE ON DUTY MADE THE JUDGEMENT TO GIVE HIM FIVE TIMES HIS DOSE OF THE ANTIPSYCHOTIC RISPERIDONE TO QUIET HIM DOWN. HE WAS RENDERED UNCONSCIOUS FOR THE NEXT FIVE DAYS.”

ON ANOTHER OCCASION OF HOSPITALISATION HE WAS PHYSICALLY RESTRAINED:

“BOTH WRISTS AND ANKLES WERE TIED TO THE BEDRAILS FOR 48 HOURS SO HE WOULD NOT PULL HIS TUBES OUT. THIS OCCURED WITHOUT THE CONSULTATION OF MYSELF AND OUR FAMILY.”

THIS TYPE OF CARE IS JUST SIMPLY UNACCEPTABLE.

WE KNOW THAT THERE ARE BETTER WAYS TO SUPPORT PEOPLE WITH BPSD.

SLIDE 9 EXPERT CONSENSUS GUIDELINES RECOMMEND THE USE OF INDIVUALISED PSYCHO-SOCIAL APPROACHES AS A FIRST LINE APPROACH TO BEHAVIOURAL SYMPTOMS.

THIS CAN RANGE FROM ENSURING THAT THERE ARE ENGAGING ACTIVITIES AVAILABLE, PROVIDING EXERCISE, ASSESSMENT AND MANAGEMENT OF BEHAVIOURAL TRIGGERS TO INSURING A CALM QUIET ENVIRONMENT.

TO PUT IT SIMPLY, THE CULTURE OF THE CARE APPROACH NEEDS TO BE SHIFTED TO ONE THAT IS INDIVIDUALISED AND PERSON CENTRED AND WHERE THE NEEDS OF THE PERSON WITH DEMENTIA ARE BEING ADDRESSED, RATHER THAN SEDATING THE PERSON.

MONITORING THE RATE OF ANTIPSYCHOTIC MEDICATIONS IN OLDER PATIENTS IS BEING DONE BY SOME HOSPITALS AND HAS LED TO INITIATIVES TO REDUCE THE RATE OF PRESCRIBING. PRINCE OF WALES HOSPITAL IN NSW FOR EXAMPLE REDUCED ANTIPSYCHOTIC PRESCRIBING TO PATIENTS ACROSS MEDICAL AND SURGICAL WARDS AS A MARKER OF QUALITY CARE. THIS WAS ACHEIVED IN PART THROUGH TARGETED TRAINING.

THERE ARE ALSO NOW RESOURCES AVAILABLE THROUGH DBMAS WHICH HAS BEEN FUNDED TO EXPAND THEIR REACH INTO HOSPITAL AND PRIMARY CARE. THIS IS AN EXCITING OPPORTUNITY AND I LOOK FORWARD TO SEEING HOW THE PROGRAM DEVELOPS.

PHYSICAL DESIGN

SLIDE 10 ADAPTING THE PHYSICAL DESIGN OF THE HOSPITAL IS ALSO IMPORTANT IN SUPPORTING PEOPLE WITH DEMENTIA AND MAY REDUCE BPSD.

SIMPLE THINGS SUCH AS INSTALLING APPROPRIATE LIGHTING AND PROVIDING SAFE AREAS OF INTEREST INCLUDING GARDENS CONTRIBUTES TO A CALM YET ACTIVE ENVIRONMENT.

MUCH WORK HAS BEEN DONE IN THIS SPACE AND I AM SURE JASON BURTON WILL HAVE MORE TO SAY IN THIS SPACE DURING HIS WORKSHOP SESSION.

THERE ARE A RANGE OF EVIDENCED BASED AUDIT TOOLS THAT CAN BE USED TO HELP HOSPITALS DESIGN APPROPRIATE ENVIRONMENTS AND THE DTSCS HAVE DONE WORK IN THIS AREA WITH WORKSHOPS AND A FREE CONSULTANCY SERVICE.

AGAIN MANY OF THE PRINCIPLES SEEM LIKE COMMON SENSE BUT IT SEEMS FEW HOSPITALS HAVE CONSIDERED THE IMPACT OF PHYSICAL DESIGN ON THE CARE OF THEIR RESIDENTS.

INVOLVEMENT OF CARERS

SLIDE 11 THERE ARE 1.2 MILLION AUSTRALIANS INVOLVED IN THE CARE OF A PERSON WITH DEMENTIA. INFORMAL CARERS PROVIDE THE VAST MAJORITY OF CARE TO PEOPLE WITH DEMENTIA. THEY CAN PLAY AN ESSENTIAL ROLE IN SUPPORTING THE PERSON IN HOSPITAL.

BUT CARERS OFTEN TELL US THAT THEY FEEL IGNORED IN HOSPITALS AND THAT STAFF DO NOT LISTEN TO THEIR ADVICE ON HOW TO BEST CARE FOR A PERSON WITH DEMENTIA. CARERS HAVE AN INDEPTH UNDERSTANDING OF THE PERSON WITH DEMENTIA AND THEIR NEEDS. THEY KNOW WHAT WORKS AND WHAT DOESN'T. WHEN CARERS ARE ABLE, THEY SHOULD BE INCLUDED AS A PART OF THE CARE TEAM IN THE HOSPITAL.

SLIDE 12 AN EXAMPLE OF AN EFFECTIVE TOOL FOR ENGAGING WITH CARERS IS THE TOP5 PROGRAM IN NSW HOSPITALS. TOP5 ENABLES CARERS TO TELL STAFF THE TOP 5 TIPS OR STRATEGIES FOR SUPPORTING THE PERSON WITH DEMENTIA. THIS INFORMATION IS NOTED IN A BEDSIDE CHART AND USED BY HEALTH PROFESSIONALS IN THEIR CARE. BOTH CARERS AND HOSPITAL STAFF HAVE REPORTED POSITIVE OUTCOMES FOR STAFF AND THE PERSON WITH DEMENTIA.

THIS PROGRAM IS BEING FUNDED BY THE CLINICAL EXCELLENCE COMMISSION TO BE ROLLED OUT ACROSS NSW.

REDUCING HOSPITAL ADMISSIONS

SLIDE 13 HOSPITALS ARE NOT ALWAYS THE BEST PLACE FOR PEOPLE WITH DEMENTIA TO RECEIVE CARE. SOME HOSPITAL ADMISSIONS MAY BE AVOIDABLE. TREATMENT OF HEALTH ISSUES SUCH AS FRACTURES, DEHYDRATION AND RESPIRATORY INFECTIONS CAN OCCUR IN THE COMMUNITY SETTING AND YET MANY PEOPLE WITH DEMENTIA ARE ADMITTED TO HOSPITAL FOR THE TREATMENT OF SUCH AILMENTS.

SIMILARLY, THE MANAGEMENT OF PAIN AND NAUSEA CAN OCCUR THROUGH PALLIATIVE CARE SERVICES RATHER THAN THE ACUTE CARE SETTING.

SLIDE 14 THERE ARE A RANGE OF STRATEGIES WHICH COULD BE PUT IN PLACE TO REDUCE AVOIDABLE HOSPITAL ADMISSIONS INCLUDING

- HOSPITAL IN THE HOME PROGRAMS
- SPECIALISED CARE UNITS WITHIN RESIDENTIAL CARE OR SUBACUTE SERVICES WHICH CAN PROVIDE MORE INTENSE MEDICAL CARE FOR PERIODS OF TIME
- TIMELY ACCESS TO MEDICAL SERVICES IN THE COMMUNITY AND IN RESIDENTIAL AGED CARE
- ACCESS TO PALLIATIVE CARE SERVICES IN COMMUNITY AND RESIDENTIAL CARE

THERE IS EVIDENCE TO SUGGEST THAT THESE APPROACHES CAN WORK AND LEAD TO BETTER OUTCOMES. A SYSTEMATIC REVIEW OF RANDOMIZED CONTROLLED TRIALS ON HOSPITAL IN THE HOME PROGRAMS FOUND THAT THE MORTALITY RATE FOR HOSPITAL IN THE HOME PATIENTS WAS ALMOST 40% LOWER COMPARED TO PATIENTS IN HOSPITAL.

ANOTHER STUDY FOUND THAT PEOPLE WITH DEMENTIA WHO RECEIVED HOSPITAL IN THE HOME SERVICES HAD FEWER BEHAVIOURAL SYMPTOMS AND LOWER RATES OF ANTIPSYCHOTIC PRESCRIPTIONS THAN THOSE PLACED IN HOSPITAL.

AN INITIATIVE THAT TAKES THIS APPROACH IS A PROGRAM FUNDED THROUGH THE QUEENSLAND HEALTH DEPARTMENT THAT FOCUSES ON REDUCING AVOIDABLE HOSPITALISATIONS FOR AGED CARE RESIDENTS.

THIS PROGRAM OPERATES AS A PARTNERSHIP BETWEEN PRINCESS ALEXANDRA HOSPITAL AND THREE OTHER ACUTE FACILITIES, RESIDENTIAL CARE FACILITIES, GPS AND THE MEDICARE LOCAL IN THE REGION.

THE MODEL INCLUDES A TELEPHONE TRIAGE SERVICE, AN EMERGENCY MOBILE ASSESSMENT SERVICE IN THE COMMUNITY AS WELL AS PATHWAYS FROM THE AGED CARE FACILITY TO SPECIALIST REFERRALS AND SERVICES. IT ALSO INCLUDES TRAINING FOR GPS AND AGED CARE STAFF TO ASSIST WITH CARE AND TO DETERMINE THE LEAST DISTRESSING INTERVENTION FOR A PATIENT.

IT IS THIS TYPE OF MULTIDISCIPLINARY, CREATIVE APPROACH THAT CAN LEAD TO BETTER OUTCOMES FOR PEOPLE WITH DEMENTIA.

CONCLUSIONS

AS YOU CAN SEE THERE IS MUCH THAT NEEDS TO BE DONE TO IMPROVE HOSPITAL CARE FOR PEOPLE WITH DEMENTIA. CREATIVE LEADERSHIP HAS THE POTENTIAL TO LEAD NOT ONLY TO BETTER OUTCOMES FOR PEOPLE WITH DEMENTIA BUT ALSO A MORE EFFICIENT USE OF HOSPITAL SPENDING.

CONSUMERS HAVE BEEN SPEAKING OUT ABOUT THE NEED TO ADDRESS HOSPITAL CARE FOR MANY YEARS. I AM PLEASED IT IS NOW FIRMLY ON THE GOVERNMENTS AGENDA. AS PART OF THE 2012 AGED CARE REFORMS, THE GOVERNMENT COMMITTED $39.2 MILLION OVER FIVE YEARS TO IMPROVE HOSPITAL CARE FOR PEOPLE WITH DEMENTIA AS WELL AS PROVIDING ADDITIONAL FUNDING TO DBMAS TO EXPAND THEIR SERVICES INTO HOSPITALS.

THE DECISION TO MAKE DEMENTIA A NATIONAL HEALTH PRIORITY AREA ALSO ENSURED THAT DEMENTIA IS SEEN AS NOT ONLY AN AGED CARE ISSUE BUT AN IMPORTANT HEALTH PRIORITY AREA.

SOME OF THE WORK TO IMPROVE HOSPITALS IS ALREADY UNDERWAY INCLUDING:

- FUNDING FOR TRAINING AND INFORMATION TO SUPPORT CHANGES TO PHYSICAL DESIGN OF HOSPITALS THROUGH THE DTSCS
- WORK OF THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE TO DEVELOP A RESOURCE FOR HOSPITALS TO GUIDE IMPROVEMENTS IN CARE IN THE CONTEXT OF THE NATIONAL SAFETY AND QUALITY STANDARDS.

BUT THERE IS AN URGENT NEED FOR FURTHER WORK TO IMPROVE QUALITY OF CARE AND TO ENSURE THAT THE POSITIVE INTIATIVES WHICH ARE HAPPENING IN SOME HOSPITALS ARE ROLLED OUT FURTHER.

AND BEYOND HOSPITALS THERE IS A NEED FOR A HEALTH SYSTEM THAT RESPONDS TO THE NEEDS OF PEOPLE WITH DEMENTIA AND ENSURES ACCESS TO TIMELY DIAGNOSIS,QUALITY HEALTH CARE AND APPROPRIATE END OF LIFE CARE, AS WELL AS PROMOTING THE BENEFITS OF A BRAIN HEALTHY LIFESTYLE.

SLIDE 15 AS PART OF ALZHEIMER'S AUSTRALIA'S FIGHT DEMENTIA CAMPAIGN FOR THE NEXT THREE YEARS WE NEED THE AGREEMENT OF HEALTH MINISTERS TO A NEW NATIONAL ACTION FRAMEWORK ON DEMENTIA THAT INCLUDES A FOCUS ON:

1. PROGRAMS TO IMPROVE TIMELY DIAGNOSIS INCLUDING THE OPTION FOR COGNITIVE SCREENING USING CULTURALLY AND

LINGUISTICALLY APPROPRIATE TOOLS AT THE 75+ HEALTH CHECK (AND YOUNGER FOR ABORIGINAL AND TORRES STRAIT ISLANDERS, DUE TO SHORTER LIFE EXPECTANCY) AND A GP, NURSE PRACTITIONER AND PRACTICE NURSE TRAINING PROGRAM TO ASSIST WITH RECOGNISING THE SYMPTOMS OF DEMENTIA

2. INITIATIVES TO IMPROVE HOSPITAL CARE FOR PEOPLE WITH DEMENTIA INCLUDING COGNITIVE SCREENING FOR ALL PEOPLE OVER 75 WHO ARE ADMITTED TO HOSPITAL AND THE IMPLEMENTAT ION OF A COGNITIVE IMPAIRMENT SYMBOL AND TRAINING FOR STAFF TO ASSIST IN THE IDENTIFICATION AN D COMMUNICATION WITH PEOPLE WITH DEMENTIA
3. SERVICES TO AVOID UNNECESSARY HOSPITALISATIONS INCLUDING DEMENTIA AND CULTURALLY-SPECIFIC PALLIATIVE CARE SERVICES
4. SERVICES TO ENSURE SMOOTH TRANSITIONS FOR OLDER PEOPLE BETWEEN HOSPITAL CARE AND RETURNING TO THE COMMUNITY
5. INITIATIVES TO RAISE PUBLIC AWARENESS PROGRAMS AND THE CONNECTIONS BETWEEN DEMENTIA AND OTHER CHRONIC DISEASES.

THANK YOU FOR THE OPPORTUNITY TO PARTICIPATE IN THIS IMPORTANT SYMPOSIUM.