Implementation or education – changing dementia care practices in hospital

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Work-based learning

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Presentation overview

Challenge: People with dementia experience unintended harm in hospital

How to improve?
  Focus on individuals and teams
  Focus on practice and systems

Learnings
Hospitals are changing
AIHW 1997, 2015

Population aged 65+ years
Hospital separations 65+ years

1995-96
2013-14
Hospitals are changing

- Bed occupancy is often higher than 90%, where 85% established as the safe level
- Focus on efficiency, reduced length of stay (churn)
- Increased specialisation; more standard operating procedures for complex treatments; more frequent procedural revisions/improvements; more accountability; more documentation
What do we know about people with dementia in hospital?

Acute care management of older people with dementia: a qualitative perspective

Wendy Moyle, Sally Borbasi, Marianne Wallis, Rachel Olorenshaw and Natalie Gracia
Consequences of being in hospital

- Care environment
- Cultures of care
- Volunteers
- Attitudes
- Challenges for staff
- Challenges for carers
- Challenges for people with dementia as an ‘acute’ patient

Dewing & Dijk 2016
What do we know about people with dementia in hospital?

- More likely to be admitted for fractured femur, lower respiratory tract infection, urinary tract infection and head injuries (compared with people without dementia)
- Mean length of stay was 16.4 days compared with 8.9 days for people without dementia
- More likely to be re-admitted within three months

Draper et al. 2011
### Table: Hospital-acquired complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>Sample (medical)</th>
<th>RR (medical)</th>
<th>Sample (surgical)</th>
<th>RR (surgical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI</td>
<td>58 223</td>
<td>1.79** (1.70 to 1.90)</td>
<td>7680</td>
<td>2.88** (2.45 to 3.40)</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>38 480</td>
<td>1.61** (1.46 to 1.77)</td>
<td>5904</td>
<td>1.84** (1.46 to 1.31)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>59 523</td>
<td>1.37** (1.26 to 1.48)</td>
<td>8184</td>
<td>1.66** (1.36 to 2.02)</td>
</tr>
<tr>
<td>Delirium</td>
<td>61 307</td>
<td>2.83** (2.54 to 3.15)</td>
<td>8251</td>
<td>3.10** (2.31 to 4.15)</td>
</tr>
</tbody>
</table>

*Bail et al 2013*
‘Failure to Maintain’: A theoretical proposition for a new quality indicator of nurse care rationing for complex older people in hospital

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A better way to care
Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

Why so difficult to change practice?
Practice change

Education: Individual & group

Implementation: Practice & systems
Staff label behaviours negatively

Frightened patient

Staff seek move patient to another place

Educate individuals and teams: Conceptualising the problem

Teodorczuk et al 2013
Education that works….

- Delirium recognition improved following 11 on-line modules (n=59) [Detroyer et al, 2016]
- Knowledge of patient fears, attitudes, delirium and dementia recognition improved following 2-day course (n=48) [Teodorczuk et al 2014]
- The View from Here improved confidence (n=59) [Nayton et al 2014]
- Four facilitator delivered modules improved confidence (n=468) [Martin et al 2016]
1. Reaction
   • Training is engaging
2. Learning
   • Acquire knowledge, skill, attitude, confidence and commitment
3. Behaviour
   • Application of training to work
4. Results
   • Targeted outcomes achieved
Evidence on education for practice

Forsetlund et al 2009

- Educational meetings alone or in combination with other interventions can improve health care practice and outcomes for patients
- Effect is likely to be small
- Effect consistent with audit and feedback approaches
- Educational meetings alone are unlikely to be effective for changing complex behaviours
When education…

- Incorporates training on use of assessment or care technology [Surr & Gates 2017]
- Grows capacity to learn from practice [Toye et al 2015]
- Is supported by a credible expert [Martin et al 2016; Griffiths et al 2014; Travers et al 2017]

….there can be behaviour change
Paucity of robust evidence to inform successful dissemination and implementation of evidence-based dementia care

Lourida et al 2017
Scoping review and evidence map

Lourida et al 2017

- 88 studies
- 94% focused on training and education
- 60% described implementation strategies
- 70% conducted in RACF
- Barriers to implementation are consistent = time constraints + Increased workload
- Facilitators for implementation are consistent = leadership + managerial support
Four phases of implementation
Aarons et al 2012

Explore  Prepare  Implement  Sustain
Explore
• Search literature for EBP to suit context
• Assess organisational readiness for change

Prepare
• Assess for implementation challenges
• Initial audit

Implement
• Multifaceted; target barriers
• Stakeholder engagement

Sustain
• Evaluate
• How to continue practices
Organisational readiness: important

Attieh et al 2013

Key overarching concept to assess collective motivation and capability to implement change

Five elements

- Organisational dynamics
- Change process
- Innovation readiness
- Institutional readiness
- Personal readiness
Program logic model 1

FIGURE 1. Basic generic logic model.

Savaya & Waysman 2005
FIGURE 2. Uses of the logic model (LM) along the life span of a program.

Program Inception -> Program Modification -> Program Operation -> Program Dissemination

LM for assessing program feasibility and its readiness for evaluation
LM for program development
LM for developing performance monitoring system
LM for knowledge building

Savaya & Waysman 2005
Multiple sites...

- Stages of implementation [Chamberlain et al 2011] – how many completed at each site?
- Adapt & tailor to context or ‘voltage drop’/ ‘program drift’ [Chambers et al 2013]
- Dynamic Adaptation Process [Aarons et al 2012] provides a framework for incorporating cultural differences at each site e.g. Luxford et al 2015
The science of changing practice

Knowledge dissemination

Implementation

Knowledge utilisation

Quality improvement

Practice development

Science
Evaluation: How do we know it worked?

Curran et al 2012
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Processes</th>
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<tbody>
<tr>
<td>Patient improvements</td>
<td>Education:</td>
</tr>
<tr>
<td>• Reduced complications</td>
<td>Kirkpatrick model</td>
</tr>
<tr>
<td>• Reduced transfer to RACF from</td>
<td></td>
</tr>
<tr>
<td>home</td>
<td></td>
</tr>
<tr>
<td>• Carer satisfaction</td>
<td></td>
</tr>
<tr>
<td>Organisational improvements</td>
<td>Implementation:</td>
</tr>
<tr>
<td>• Efficiency – LOS, re-presentation</td>
<td>Acceptability, adoption, appropriateness,</td>
</tr>
<tr>
<td>• Effectiveness – reduced</td>
<td>feasibility, fidelity, implementation cost,</td>
</tr>
<tr>
<td>complications</td>
<td>penetration, sustainability [Proctor et al</td>
</tr>
<tr>
<td>• Cost - benefit</td>
<td>2011]</td>
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<td></td>
<td>NOMAD [Finch et al 2015]</td>
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</table>
Learnings...

- Involve all stakeholders, including consumers
- Use a program logic model – incorporate education
- Monitor and feedback
- Any intervention to change practice should be evaluated
- Practice change is an investment - Evaluation should consider ‘value’
Reference list provided on request
THANK YOU

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