NSW Health

Evaluation of the Mental Health Aged Care Partnership Initiative (MHACPI)

Summary report

June 2011
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GLOSSARY OF TERMS

3MS
The Modified Mini Mental State Examination
The 3MS (not subject to copyright) is a screening tool built on the original MMSE scale (incorporating four added test items) that assesses the resident's cognition. The 3MS scores range from 0 – 100. The higher the score the greater the level of cognitive functioning. This tool is included in the standard Mental Health Outcomes and Assessment Tools mandated for use by NSW mental health services.

ACAT
Aged Care Assessment Team

AHS
Area Health Service

Badr
Bristol Activities of Daily Living

BEHAVE-AD
Behaviour Pathology in Alzheimer’s Disease Rating Scale

BPSD
Behavioural and Psychological Symptoms of Dementia

CAC
Clinical Advisory Committee

CHCS
Catholic Health Care Services

CMAI
Cohen Mansfield Agitation Inventory. The scale measures the frequency of behaviours and systematically assesses agitation. The scale's 29 activities are rated on a 7-point scale indicating the frequency of a particular activity (range; never to a few times per hour). The activities are organised into 4 subscales: physical/aggressive, physical/non-aggressive, verbal/aggressive, and verbal/non-aggressive. The total aggression score is the sum of the physical and verbal aggression subscales. The total non-aggression score is the sum of the verbal and physical non-aggression subscales.

CSDD
Cornell Scale for Depression in Dementia

DoHA
Department of Health and Ageing

GP
General Practitioner

HC
Hammond Care

HOI
Health Outcomes International

HoNOS 65+
Health of the Nation Outcomes Scales 65+. **Explanation.** This tool is included in the standard Mental Health Outcomes and Assessment Tools mandated for use by NSW mental health services.

ICER
Incremental Cost-Effectiveness Ratio

LGA
Local Government Area

MHACPI
Mental Health Aged Care Partnership Initiative

MMSE
Mini Mental State Examination. This tool assesses the level of cognition within the resident. The MMSE ranges from 30 (full cognition) to 0 (severely restricted cognition).

MOU
Memorandum of Understanding

NSW
New South Wales

OPMHWG
Older People’s Mental Health Working Group. A key consultative group convened by NSW Health comprising a range of key stakeholders in older people’s mental health. The OPMHWG was the key reference group for the evaluation.
PAS: Psychiatric Assessment Scale. This tool assesses subject symptoms and consists of eight categories, each with a four-point scale. The higher the score, the greater the severity of the symptoms.

QOL-AD: Quality of Life – Alzheimer’s Disease. This tool has been developed to assess the quality of life of Alzheimer’s patients and their caregivers and is a recommended national dementia outcome assessment tool. The final score varies from 13 to 52 points, with the best quality of life corresponding to the highest score.

RACF: Residential Aged Care Facility

RUG ADL: Resource Utilisation Groups – Activities of Daily Living. The tool measures the need for assistance in four areas: bed mobility; toileting; transfer and eating. The scores for this assessment tool range from 4 (resident is independent) to 18 (resident is dependent). This tool is included in the standard Mental Health Outcomes and Assessment Tools mandated for use by NSW mental health services.

SCP: Special Care Program

SDC: Specialist Dementia Carer

SIRP: Supported Internal Relocation Program

SMHSOP: Specialist Mental Health Services for Older People

SSWAHS: Sydney South West Area Health Service
1. **INTRODUCTION**

1.1 **BACKGROUND**

Older people with severe and persistent behavioural disturbance associated with dementia and/or mental illness often have difficulty accessing appropriate assessment, management and long-term care options. The *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015* incorporates as a key component of the service model, a focus on improving responses to the needs of older people with severe behavioural and psychological symptoms of dementia (BPSD) and/or mental illness. To inform service responses for this group, NSW Health funded the Faculty of Psychiatry of Old Age (FPOA), NSW to conduct the Severely and Persistently Challenging Behaviours Project. The project, which examined issues and approaches to the management and accommodation of older people with severely and persistently challenging behaviours highlighted the potential for partnership transitional and long-term care models for older people with severe BPSD and/or mental illness. The key elements of these care models identified by the project included: increased staffing; a multidisciplinary approach (including nursing, medical and allied health input); enhanced staff psychiatric knowledge and skills in behavioural management; access to specialist psychogeriatric and geriatric medical support, and prosthetic architectural and interior design1.

1.2 **THE MENTAL HEALTH AGED CARE PARTNERSHIP INITIATIVE**

In response to the FPOA findings, NSW Health developed two pilot services within residential aged care facilities (RACF) operated by Catholic Health Care (CHC) and the Hammond Care Group (HC). These pilot ‘Special Care Programs’, part of the Mental Health Aged Care Partnership Initiative (MHACPI), incorporate key components of care as follows:

- Purpose-designed Special Care Units within RACFs, operated by residential aged care providers;
- Specialist consultation-liaison and case management support from Specialist Mental Health Services for Older People (SMHSOP) with Aged Care Services/Aged Care Assessment Teams input as required, and
- Supported transition to mainstream RACFs – either to the facility in which the Special Care Program (SCP) sits or other facilities – or community care.

1.2.1 **Special Care Program pilot service models**

The two SCP service models that were piloted by CHC and HC differed in their operational and funding arrangements as outlined below and in further detail in Sections 2.2 and 2.3:

1. **CHC SCP.** This SCP comprised of a 13-bed special care unit and supported discharge program located at the Holy Spirit Nursing Home at Croydon, in Inner Western Sydney. This SCP was delivered by CHC, in partnership with Sydney South West Area Health Service (SSWAHS) and was jointly funded by the Australian Government Department of Health and Ageing (under the Aged Care Innovative Pool Program), CHC and SSWAHS. Specialist clinical support and in-kind support was provided by SSWAHS SMHSOP (and Aged Care as required).

2. **HC SCP.** This SCP comprised of an 8-bed special care unit and supported internal relocation program located at Hammondville, in South Western Sydney. The SCP was delivered by HC, in partnership with SSWAHS, and was jointly funded by the NSW Health Department and HC, with HC receiving standard residential aged care funding from the Australian Government Department of Health and Ageing, and providing capital funding. Specialist clinical support was provided by SSWAHS SMHSOP (and Aged Care as required).

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1 NSW Health, Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours, 2006.
1.3 **PURPOSE OF THIS REPORT**

This report summarises the findings from the evaluation conducted by Health Outcomes International (HOI) of the MHACPI, as piloted in the CHC and HC facilities. The purpose of this report (as per the evaluation itself) is to:

1. Provide a description and assessment of the MHACPI model, highlighting strengths and weaknesses, areas for improvement in the existing SCPs and limitations of the evaluation information.
2. Provide recommendations regarding the future implementation of the model across NSW.

1.4 **EVALUATION OF THE MENTAL HEALTH AGED CARE PARTNERSHIP INITIATIVE**

HOI was engaged by the NSW Department of Health in June 2007 to undertake a two-year evaluation of the Mental Health Aged Care Partnership Initiative (MHACPI).

1.4.1 **OBJECTIVES OF THE EVALUATION**

The objectives of the evaluation were to assess the impacts, processes and outcomes of the MHACPI pilot services in the context of:

- Clients families and carers;
- Pilot facilities and service providers;
- NSW Health, and
- The broader health system

1.4.2 **KEY QUESTIONS**

The key questions examined in the evaluation in relation to the processes, outcomes and the four key focus areas are outlined below.

**Processes**

- Are the two mental health-aged care partnership services being delivered in accordance with their design and objectives?
- How are the two mental health-aged care partnership services being delivered and can delivery be improved?

**Outcomes**

- Is the initiative achieving the outcomes to warrant its continuation and/or expansion?
- How can the services and initiative be improved to achieve better outcomes?

**Clients, Families and Carers**

- Is the initiative delivering good client outcomes, including improved physical, cognitive and psychosocial functioning, better quality of life, discharge to less restrictive care settings, better outcomes for special needs groups, and client, family and carer satisfaction?
- What is the profile of clients that are, or are not, suitable for program?

**Pilot Facilities & Service Providers**

- How is the service model being delivered from a provider perspective and is this consistent with program design and funding agreements?
- What is the impact of Special Care Unit and Program on staff skills, knowledge and attitudes and operational functioning within the Special Care Unit and the rest of the host facility?
• What are the critical success factors in delivering the service model from facility/provider perspective, how can delivery be improved and what are the implications for evidence-based practice?

• How can the service model be improved to achieve better outcomes, from a facility/provider perspective?

**NSW Health**

• How is the service model being delivered from a NSW Health perspective and is this consistent with program design and funding agreements?

• What is the impact of the service model on NSW Health staff skills, knowledge and attitudes?

• What are the critical success factors in delivery of the service model from a NSW Health perspective and what are the implications for evidence-based practice?

• Is the initiative achieving the outcomes to warrant its continuation and/or expansion from a NSW Health perspective, and how can it be improved?

**Broader service system**

• How are the two pilot services being delivered relative to one another (where comparisons are appropriate), and relative to other services such as Transitional Behavioural Assessment & Intervention Service (T-BASIS) non-acute inpatient units, dementia-specific RACFs or RACFs specialising in BPSD?

• How is the service model and initiative being implemented with regard to service relationships and partnership arrangements and the practices and administrative arrangements of the health and aged care service systems, and how can partnership processes and program arrangements be improved?

• What is the impact of the service model on client pathways through, demand for and pressure on SMHSOP community teams/mental health services, Aged Care Services, acute hospitals (including geriatric medical units), mental health inpatient facilities, GPs, RACFs, community aged care services (eg Home and Community Care)?

• Does the service model address service gaps between NSW Health inpatient services and mainstream aged care services, is it cost-effective and what are the key factors for the sustainability of the model?

**1.4.3 Evaluation methodology**

The evaluation utilised both quantitative and qualitative data to assess the MHACPI pilot services. A range of data was provided from participating pilot sites including resident activity and demographic data, clinical profile and cost.

Focus groups, interviews and self administered surveys were used to elicit feedback from families and carers, pilot facilities and service providers, NSW Health and the broader health system on the impact of the pilot services. Successful aspects of the pilot services and areas for improvement were also highlighted.

The evaluation of the MHACPI pilot services was overseen by the NSW Older People’s Mental Health Working Group convened by the Mental Health and Drug and Alcohol Office (MHDAO) to provide advice on a range of issues relating to older people’s mental health.

**Evaluation Timeframes**

The timeframe for the evaluation of the two pilot services varied due to differences in stage of service development and implementation. This meant that the evaluation of the HC service was prospective, while the evaluation of the CHC was part-retrospective and part-prospective.

**CHCS Pilot SCP**

The timeframe for the operation of the CHC pilot was January 2006 to March 2008. Given that this service was to continue under a new Memorandum of Understanding to be re-negotiated by the SSWAHS and CHC, the evaluators were requested to continue the collection and analysis of SCP activity and expenditure data. CHC continued to report this data to HOI to September 2008. As a result the analysis contained in this report relates to the period January 2006 to September 2008.
Data was collected and analysed for the period November 2007 to June 2009.

2. **MHACPI PILOT SERVICES**

The thrust of the MHACPI pilot services is to provide additional resources and expertise to assess and manage people with severe behavioural and psychological symptoms associated with dementia and/or mental illnesses and to support their transfer to mainstream residential care. Key elements of the SCPs included:

- An increased level of staffing;
- A multidisciplinary approach (including nursing, medical and allied health input);
- Enhanced staff psychiatric knowledge and skills in behavioural management;
- Access to specialist psycho geriatric and geriatric medical support and advice;
- Clear clinical governance arrangements regarding personal, medical and specialist care needs of clients, and
- Prosthetic architectural and interior design.

2.1 **MHACPI OBJECTIVES**

The common objectives of the MHACPI pilot services are:

- To achieve better quality of life and clinical care outcomes for older people with complex, severe behavioural and psychiatric symptoms, maximising physical, cognitive and psychosocial functioning by providing optimal management;
- To improve access to residential mainstream aged care services for this target group, whose challenging behaviours prevent them from being accepted into, or managed appropriately under usual aged care arrangements;
- To improve access to integrated, multidisciplinary assessment for this target group, encompassing a collaborative approach between specialist aged care and mental health services;
- To improve specialist aged care and mental health support to the aged care sector to facilitate and maintain accommodation arrangements for this group;
- To facilitate care in a least restrictive care setting (including community, supported accommodation and residential aged care settings);
- To facilitate discharge to lower level (and lower cost) care options, including:
  - Community care and supported accommodation options, where appropriate (CHC);
  - Other Hammond aged care places which provide the best person-environment fit (HC), and
- To reduce levels of care required when discharge or relocation to a residential aged care facility occurs.

2.2 **Catholic Health Care Services SCP**

Established in 1994, CHC is a not-for-profit organisation that provides community and healthcare services to older people in metropolitan and regional NSW. Christina House, a 13-bed SCU and 15-place supported discharge program was commenced in December 2004 and was located in the Holy Spirit Croydon complex, a 127-bed facility. The majority of the residents admitted to the SCP required high care services. As well as the SCP, the CHC provided a secure dementia unit and 27 psycho-geriatric beds to accommodate residents transferred from Rozelle Hospital as part of a de-institutionalisation and service redevelopment process.

2.2.1 **Objective of the Service**

In addition to the objective above, the CHC SCP was to trial a model of care and accommodation for older people with severe BPSD and/or mental illness that is jointly funded by the Australian Government.
Department of Health and Ageing and the NSW Health in recognition that this is an area in which both jurisdictions hold the required expertise and responsibility for ensuring the provision of quality care and services.

2.2.2 Service Agreement, Operational and Funding Arrangements

In June 2005, a Memorandum of Understanding (MOU) for the SCP was developed between the Department of Health and Ageing (DoHA), NSW Health, SSWAHS and CHC. The MOU defined the responsibilities and contributions of each party involved in the pilot throughout the stages of establishment, operation, monitoring and evaluation of the MHACPI. It was aligned with a broader partnership agreement between SSWAHS and CHC covering access to residential care for SMHSOP clients, including those requiring placement as part of service redevelopments at Rozelle Hospital and Concord Hospital.

Australian Government funding and arrangements were part of the Aged Care Innovation Pool Program. Under this program, the Australian Government agreed to subsidise the SCP as a flexible care service which was subject to the operation of the Aged Care Act 1997. The allocation of flexible care places (essentially places for time-limited care before transition to permanent placement) was subject to a time constraint of two years which concluded in February 2008. The arrangements meant that the SCP could operate as a transitional service and while operating within a RACF, was not subject to security of tenure arrangements in the same way as RACFs generally are. The funding model for CHC SCP was a mixture of occupancy-based funding (DoHA) and block funding plus in-kind clinical support (SSWAHS).

It was expected that 40 residents would be admitted to the pilot site annually and the SCP would operate at 80-100% occupancy. It was anticipated that an average length of stay of 12 weeks (84 days) would be required to effectively implement program interventions and establish a level of stability to allow the resident to be discharged into a mainstream care setting.

2.2.3 Eligibility Criteria

The target group for the SCP was older people with complex, severe behavioural and psychiatric symptoms associated with mental illness and/or dementia whose care needs could not be met in a high care residential aged care facility but who did not need acute hospital care. Residents eligible for admission to the SCP included those in the target group who were:

- Assessed by an Aged Care Assessment Team (ACAT) as requiring high level residential aged care;
- Likely to benefit in terms of improved physical, cognitive and psycho-social functioning from a period of intensive behavioural assessment and intervention;
- Medically stable at the time of assessment for admission and if entering from an acute facility, no longer in need of attention from an acute facility;
- Permanent residents of the Local Government Areas of SSWAHS (Eastern Zone) residing within a residential aged care facility, boarding house, group home, personal home or hospital, and
- Judged unsuitable for a mainstream residential care facility.

The older person’s carer or guardian was required to consent to their participation in the pilot project.

2.2.4 Number of Places

DoHA allocated 28 flexible care places to this pilot: 13 beds in a special care unit in a residential care setting, and 15 ‘top-up places’ to be provided as flexible support packages in residential and community settings. The aim of the flexible support packages was to facilitate a seamless discharge of residents from the SCP into the community or alternative residential aged care facility, provide opportunities to improve service integration, and increase the skills of other community and residential aged care providers.

2.2.5 Staffing

CHC assigned twenty two (22) FTE to the SCP and 2 FTE to the discharge program. Staff were predominantly personal care assistants (11 FTE) and registered nurses (7 FTE). Allied health staff assigned to the SCP varied according to need. CHC engaged the services of a clinical neuropsychologist employed by Sydney South West Area Health Service (SSWAHS) when required.
2.2.6 **Admission and Discharge Procedures**

The key activities supporting the pathway of care from admission to transition to long-term care following referral to the Program are detailed below in Table 2.1.

**Table 2.1: Catholic Health Care Pathway of care from admission to the SCP to transition to long-term care**

<table>
<thead>
<tr>
<th>Key Step in care pathway</th>
<th>Action</th>
<th>People involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess client eligibility for admission</strong></td>
<td>Conduct a full medical &amp; behavioural assessment</td>
<td>SSWAHS senior clinical staff</td>
</tr>
<tr>
<td><strong>Approved clients awaiting admission to program</strong></td>
<td>Develop &amp; implement interim management plan</td>
<td>SSWAHS Aged Care/SMHSOP</td>
</tr>
<tr>
<td></td>
<td>Consultation between resident and/or residents’ carer and/or legal guardian and GP (where possible)</td>
<td>Admission team (CHC Case Manager and SSWAHS senior clinical staff)</td>
</tr>
<tr>
<td></td>
<td>Delegate representative to liaise with carer and GP, and if necessary identify a GP who is closer to the facility</td>
<td></td>
</tr>
<tr>
<td><strong>Admission to the Special Care Unit</strong></td>
<td>Nursing assessment within first 2 days of admission</td>
<td>CHC Case Manager</td>
</tr>
<tr>
<td></td>
<td>Full assessment and referral to allied health within first week</td>
<td>SSWAHS clinician</td>
</tr>
<tr>
<td></td>
<td>Development of care plan, review of management plan, and initiation of discharge planning within the first week</td>
<td>SSWAHS, CHC, carer and GP</td>
</tr>
<tr>
<td></td>
<td>Management of routine medical care</td>
<td>GP</td>
</tr>
<tr>
<td><strong>Identify long-term accommodation placement</strong></td>
<td>Conduct formal discharge planning when resident outcomes are met (generally to be considered once the resident has been stable for 2 months)</td>
<td>Holy Spirit, other RACFs or a community setting</td>
</tr>
<tr>
<td><strong>Support transition to long-term care arrangements</strong></td>
<td>Implement and support flexible ‘top-up’ packages to give residents increased options regarding post-discharge accommodation needs.</td>
<td>Case Manage, transition coordinator and specialist services from SSWAHS.</td>
</tr>
<tr>
<td><strong>Transferred to long-term facility within SSWAHS (Eastern Zone)</strong></td>
<td>Re-assess resident on GP request. Includes review of the care plan (including medication and management strategies)</td>
<td>SSWAHS old age psychiatrists and geriatricians</td>
</tr>
<tr>
<td><strong>Transferred to long-term facility outside SSWAHS (Eastern Zone)</strong></td>
<td>Re-assess resident and advice on management by phone and forward advice to the local ACAT.</td>
<td>SSWAHS old age psychiatrists and geriatricians</td>
</tr>
</tbody>
</table>

2.2.7 **Governance Arrangements**

A SCP Steering Committee, comprising representatives from Memorandum of Understanding partners (CHC, SSWAHS, NSW Health, and DoHA), was established to advise on the SCP pilot and monitor implementation. A Clinical Advisory Committee was established in February 2008 to provide governance for the SCP, redevelop the service agreement and maintain CHC and SSWAHS partnership arrangements. An internal complaints...
process was instituted in the program for participants, their families and carers. An in-service training program for staff was also implemented.

### 2.3 Hammond Care SCP

Founded in the early 1930s, HC was established to provide aged care services to older people, residing in both community and residential facility settings. In particular, the organisation provides care and services to older people who suffer from dementia as well as those who experience financial hardship.

The HC facility at Hammondville (Hammond Village) is an accredited and licensed 83-bed dementia-specific high-care RACF comprising of five 15-bed cottages. In November 2007, an 8-bed Special Care Unit was opened at “Southwood” in the Hammond Village to function as a dedicated facility caring for older people with dementia who have severe and challenging behaviours, as well as providing the full spectrum of aged care services. It was to be supported by an 8-place supported internal relocation program.

#### 2.3.1 Objective of the Service

In addition to the objectives outlined on page 4, the design of the HC SCP was to create a model of excellence in residential aged care for intensive behavioural care and supported internal relocation, to enable the best person-environment fit for individual residents.

#### 2.3.2 Service Agreement, Operational and Funding Arrangements

The HC SCP pilot was established under a Deed of Agreement, between HC and the NSW Health Department (or Health Administration Corporation for the purpose of the Deed), for a period of 15 years. The duration of the Deed was agreed on to accommodate the capital funding invested by HC to develop the Special Care Unit. The Deed specifies the legal obligations of all parties and provides details of the SCP services to be provided, standards of operation, protocols for SCP admission, and discharge and reporting and review arrangements. A Memorandum of Understanding (MoU) between SSWAHS and HC was also developed to support the Deed. The MoU outlines the practical arrangements between SSWAHS and HC in the admission of older people to the SCP, the delivery and review of clinical services within it, and discharge/transfer planning.

The SCP was delivered by HC, in partnership with SSWAHS. As the SCU beds were operated by HC as part of the broader Hammond Village facility to which SCU clients would be transitioned, no special arrangements were required under aged care legislation to support the operation of the SCU as a transitional unit.

The funding model for the HC SCP combined block funding from NSW Health (tied to the Deed of Agreement with HC) and capital and recurrent from HC, with HC receiving standard residential aged care funding from the Australian Government Department of Health and Ageing.

#### 2.3.3 Eligibility Criteria

The target group for HC SCP was people over 65 years or older, with dementia or other age-related organic impairment, and/or pre-existing psychiatric illness, with consideration given to younger people with disease states normally associated with ageing (e.g. Alzheimer’s or Parkinson’s disease) whose care needs are not met in their usual RACF. Prospective residents with pre-existing psychiatric illnesses are not to be excluded if they meet the criteria. The target group criteria for the SCP include people:

- Assessed by an ACAT as requiring high level residential aged care;
- Medically stable at the time of assessment for admission and if entering from an acute facility, no longer in need of attention from an acute facility, and
- Ambulant or ambulant with mobility aids.

The target group was predominantly from the SSWAHS (Western Zone) catchment area.

#### 2.3.4 Number of Places

The pilot service comprised of:

- An 8-bed, purpose-built, fully equipped Special Care Unit (SCU) – designated as a residential aged care facility, and
• An 8-place supported internal relocation program (SIRP) to facilitate discharge of SCP clients into other permanent aged care places in the HC facility.

The SCU made an additional bed available to accommodate emergency readmissions to the SCU, or as part of the SIRP. The purpose of the additional bed is to avoid inappropriate admission to SSWAHS hospital facilities of residence that experience difficulty in the SIRP phase.

2.3.5 Staffing

Staffing levels were adjusted as required with a minimum staffing complement in the SCP of 1.0 FTE SCP Manager, 3.0 FTE registered nurses and 8.4 FTE senior carers. SCP staff that accompanied residents commencing SIRP to other cottages within the facility, were replaced in the SCP to ensure specified minimum staffing levels were maintained. Allied health staffing included 0.6 FTE psychologist, a minimum of weekly physiotherapy consultations (depending on need), and a six weekly podiatrist consultation. Other allied health input varied and was dependent on the SCP residents’ needs.

2.3.6 Governance Arrangements

A steering committee comprising of representatives from NSW Health, DoHA, HC and SSWAHS was established. Once established, the SCP was monitored by NSW Health based on the reporting protocols in the Deed of Agreement. A Clinical Advisory Committee (CAC) was established to provide clinical governance for the SCP and, maintain HC and SSWAHS partnerships arrangements. The CAC advised on admission and discharge of SCP clients, provided clinical review of SCP clients and provided advice and support across the SCP. The CAC is responsible for:

• Weekly clinical review processes;
• Monitoring and advising on the clinical practices and activities of the SCP, as well as progress of all clients of the SCP, through meetings convened at no less than quarterly intervals, and
• Regular review of CAC processes and effectiveness, initially in concert with an independent evaluation of the SCP.

Membership of the CAC included SSWAHS senior mental health representatives, HC management and key staff. A representative from Aged Care, when required was also invited to the CAC.

2.3.7 Admission and Discharge Procedures

The key activities supporting the pathway of care from admission to transition to long-term care following referral to the Program is detailed below in Table 2.2.
Table 2.2: Hammond Care pathway of care from admission to the Special Care Program to transition to long-term care

<table>
<thead>
<tr>
<th>Key Steps in care pathway</th>
<th>Action</th>
<th>People involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess client eligibility for admission assessment</td>
<td>Clients referred to Braeside Hospital intake for assessment</td>
<td>SSWAHS</td>
</tr>
<tr>
<td>Assess client suitability for admission</td>
<td>Collaborative assessment</td>
<td>SSWAHS and HC</td>
</tr>
<tr>
<td>Eligible clients waiting for admission to program</td>
<td>Maintain waiting list</td>
<td>SSWAHS</td>
</tr>
<tr>
<td>Decision if and when to admit to program</td>
<td>Collaborative process with HC making final decision</td>
<td>SSWAHS and HC at Clinical Advisory Committee</td>
</tr>
<tr>
<td>Clinical Review</td>
<td>Collaborative assessment</td>
<td>SSWAHS and HC</td>
</tr>
<tr>
<td>Discharge from SCU to SIRP</td>
<td>Recommend supported relocation to another part of HC facility on improvement of presenting behaviours and presence of a management plan</td>
<td>Weekly clinical meeting including SWAHS and HC</td>
</tr>
<tr>
<td>Discharge from SIRP to long-term care</td>
<td>Monitored by Manager SCP with discussion at weekly CAC at clinically indicated times</td>
<td>Weekly Clinical meeting</td>
</tr>
<tr>
<td></td>
<td>Liaise with resident, carers/legal guardian, GP in relation to long-term care</td>
<td>Manager SCP after discussion at weekly clinical meeting</td>
</tr>
</tbody>
</table>

2.4 SERVICE DELIVERY CONTEXT

Figure 2.1 below illustrates the service delivery arrangements for older people with BPSD in SSWAHS and the place of the SCP pilot projects in the care pathway. The delivery of SCP services is predicated on effective collaboration across the mental health and aged care sectors in both acute care and community care sectors. The pilot services have the potential to facilitate transitional care between hospital settings and RACFs and also to provide an alternative to hospital admission.
Figure 2.1 Service Arrangements for Older people with BPSD

*Acute care in hospital can mean both mental health and non mental health
3. PROCESS EVALUATION: DESIGN & PLANNING

**EVALUATION QUESTION:**
How is the service model being delivered from a provider perspective and is this consistent with the program design and funding agreements?

3.1 METHOD AND SCOPE OF EVALUATION

Key stakeholders from the two pilot sites, NSW Health, SSWAHS and DOHA were consulted on their views of SCP establishment and operations. Discussion focused on the development and implementation of the service agreements and governance arrangements.

3.2 DESIGN AND PLANNING PROCESSES

3.2.1 SERVICE AGREEMENTS

Highlights of discussion of service agreement development and implementation are summarised below

<table>
<thead>
<tr>
<th>Memorandum of understanding on the establishment and operation of an innovative care mental health and aged care services interface pilot in the NSW Health SSWAHS and DOHA Aged Care planning region Inner West between DOHA, NSW Health, SSWAHS and CHC</th>
<th>Specialist Mental Health Aged Care Partnership Service (Special Care Program) Deed between NSW Health and Hammond Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Formulated without clear understanding of operational implications of providing the service, particularly in relation to ensuring appropriately skilled workforce levels</td>
<td>• Formulation of agreement involved iterative process of negotiation between HC and NSW Department of Health, with SSWAHS also involved.</td>
</tr>
<tr>
<td>• Limited specification of services to be provided, particularly ‘top-up’ flexible services. As a result, these packages to support transition from SCP to lower care facilities/arrangements were not utilised and funding was withdrawn by DoHA. This affected service viability.</td>
<td>• Greater specification of services, informed by previous experiences of CHC.</td>
</tr>
<tr>
<td>• Estimated SCU occupancy levels outlined in the Service Agreement did not take into account lead-in time for establishing the service. Lower than estimated occupancy levels in the initial months of establishment of the service resulted in a reduction in Commonwealth funding as it was allocated on a bed occupancy formula. This affected service viability.</td>
<td>• Agreement was strong basis for operations and performance monitoring.</td>
</tr>
<tr>
<td>• During the evaluation period, a new SCP Service Agreement was developed between SSWAHS and CHC which was informed by the HC agreement.</td>
<td></td>
</tr>
</tbody>
</table>

3.2.2 GOVERNANCE ARRANGEMENTS

An assessment of the appropriateness of the operational arrangements of the pilot CACs was undertaken. The CAC was seen as a critical factor in effective partnership and clinical governance and a number of improvements regarding CAC operations were identified, including:

• Clear terms of reference and guidelines are required to ensure the appropriate membership and utilisation of expertise of Committee members.
• Meetings need to be well organised, well supported (including administration support) and conducted in line with the terms of reference and governance arrangements.

• Strategies are required to ensure that the decisions emerging from the CAC are implemented.

### 3.3 Summary of Process Assessment Findings

Key stakeholders identified strengths and areas of improvement of the model of care as it developed in one or both of the SCPs.

#### 3.3.1 Strengths of Current Model

- Development of a well designed service agreement in collaboration with service providers supports effective establishment, operations, CAC functioning and monitoring of the SCP.

#### 3.3.2 Areas for Improvement

- Service agreements need to take into account the establishment of the service and the time delay in reaching capacity.

- Development of clear Terms of Reference and organisational arrangements are critical to ensure effective operations, partnership arrangements and clinical governance of the CAC.

#### 3.3.2 Recommendations from HOI Evaluation

**Future Service Agreements**

- Rec 2: It is recommended that future service agreements specify the required service outputs and outcomes and that there is provision for ongoing program monitoring and evaluation to inform the future directions of the MHACPI in New South Wales

- Rec 7: It is recommended that service agreements acknowledge the time delay that occurs at the commencement of a SCP in reaching capacity and that appropriate time frames are developed to monitor the ‘start-up’ costs.

**Governance Arrangements**

- Rec 4: It is recommended that the NSW Health Department, SSWAHS and the SCP facilities establish an ongoing program of service improvement. This should be undertaken by the CAC in each SCP through the development of business plans that include specified objectives and strategies to be implemented. Progress against these plans should be monitored on a regular basis.

- Rec 5: It is recommended that evidence based governance practices are adopted by the CAC to ensure that the decisions made by the CAC are implemented.

- Rec 6: It is recommended that CAC meetings be scheduled to calendars at least 3 months prior to ensure adequate time is provided to committee members and appropriate administrative support be made available so minutes are taken and disseminated in a timely manner and meetings run as scheduled.

The NSW Health Policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.
4. **Outcomes Assessment: SCP Clients**

**Evaluation Questions:**
- Is the initiative achieving the outcomes to warrant its continuation and/or expansion?
- Is the initiative delivering good client outcomes, including improved physical, cognitive and psychosocial functioning, better quality of life, discharge to less restrictive care settings?

**4.1 Method and Scope of Evaluation**

Findings reported in this section are for 33 months of operation of the CHC SCP (Jan 2006 to Sep 2008) and 21 months of operation of HC SCP (Nov 2007 to June 2009).

The evaluation focuses on the demographic and clinical profile of residents at admission; resident activity (source of referral, discharge destination, length of stay, time waiting for admission and discharge); readmission rates, medications, adverse events and use of restraints.

Data for the evaluation was provided by CHC and HC.

**4.2 Resident Activity and Demographic Profile**

There were 59 admissions to the CHC SCP over the 33 month period of operation and 18 admissions to HC SCP over a 21 month period. Resident capacity was met by CHC SCP in 21 months and HC in 4 months.

The average age of residents admitted to the SCP was slightly higher in HC (76 years) compared with CHC (75 years). CHC had a higher proportion of male residents (61%) than HC (56%). Half (50%) of HC SCP residents were Australian-born compared with 34% in CHC.

The majority of SCP CHC admissions were referred from a psychiatric hospital (39%) or non-psychiatric hospital (36%), while in the HC SCP 56% of admissions was from a nursing home in this 2-year establishment phase. HC referral patterns in the evaluation period reflected HC and SSWAHS arrangements for the establishment phase of the SCP and changed as the SCP became fully operational. Due to limitations in the evaluation data, it was not always clear if the referral source related to a resident’s location immediately prior to admission to SCP.

At the end of the evaluation period, 47 residents had been discharged from CHC SCP and a further 12 remained in the CHC SCP. Of the residents discharged, 38 (81%) were discharged to a nursing home, of whom 27 were discharged to a nursing home external to CHC. The HC SCP discharged, in total, 10 patients (of 18) from the program. Of these residents discharged, 7 were discharged via the SIRP to beds within the HC facility, 1 was discharged to a general hospital (for medical reasons) and 1 to a psychiatric facility due to an escalation of behavioural issues. The destination for one resident was not stated. These findings reflect a difference between the CHC and HC model of care in relation to transition program design.

On average, clients stayed in the HC program 50 days longer (161 days) than in the CHCS program (111 days). However, the median length of stay was the same for both pilots (97 days) – noting the limitations of excluding the non-discharged residents. Clients still in the SCP at the data cut-off date for evaluation data had comparable lengths of stay, with CHCS pilot clients averaging 267 days (almost nine months) and HC clients averaging 282 days (just over nine months). These findings reflect that both SCPS had a number of clients who required much longer than average lengths of stay.

CHC had 70% and HC 96% average bed occupancy per month in the evaluation period. The time clients spent waiting for transfer from the SCP to an appropriate placement (once assessed as ready for discharge) was the same at each pilot site at 50 days. Resident activity and demographic profile is summarised in Table 4.1.
Table 4.1 Resident Activity and Demographic Profile

<table>
<thead>
<tr>
<th>Activity and Demographic Profile</th>
<th>Catholic Health Care SCP</th>
<th>Hammond Care SCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of data collection</td>
<td>January 2006 to September 2008</td>
<td>November 2007 to June 2009</td>
</tr>
<tr>
<td>Capacity of SCU (no of beds)</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Number of admissions</td>
<td>59</td>
<td>18</td>
</tr>
<tr>
<td>Number of discharges</td>
<td>47 days</td>
<td>10 days</td>
</tr>
<tr>
<td>Mean age (range)</td>
<td>75 (55-59 to 90+) years</td>
<td>76 (60-64 to 85-89) years</td>
</tr>
<tr>
<td>Cultural background*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Australia</td>
<td>34%</td>
<td>50%</td>
</tr>
<tr>
<td>- UK</td>
<td>5%</td>
<td>28%</td>
</tr>
<tr>
<td>- Europe (excluding UK)</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>- USA</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>- Asia</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>- Africa</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>- Middle East</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>- (Pacific) Islands</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Average time spent waiting for admission</td>
<td>na**</td>
<td>16 days</td>
</tr>
<tr>
<td>Average (mean) length of stay in SCU for residents discharged</td>
<td>111 days 97 days</td>
<td>161 days 97 days</td>
</tr>
<tr>
<td>Average time spent waiting for discharge from SCU (once ready for discharge)</td>
<td>50 days</td>
<td>50 days</td>
</tr>
<tr>
<td>Average length of stay (still admitted at the end of the evaluation period)</td>
<td>267 days</td>
<td>282 days</td>
</tr>
<tr>
<td>Average bed occupancy per month (SCU)</td>
<td>70% (of 13 beds)</td>
<td>96% (of 8 beds)</td>
</tr>
<tr>
<td>Source of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychiatric hospital</td>
<td>39%</td>
<td>33%</td>
</tr>
<tr>
<td>- Non-psychiatric hospital</td>
<td>36%</td>
<td>11%</td>
</tr>
<tr>
<td>- Nursing home</td>
<td>17%</td>
<td>56%</td>
</tr>
<tr>
<td>- Home</td>
<td>5%</td>
<td>-</td>
</tr>
<tr>
<td>- Other</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>Discharge destination (of residents discharged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Within Nursing home</td>
<td>23%</td>
<td>60%</td>
</tr>
<tr>
<td>- Other Nursing home</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>- Psychiatric hospital</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>- Non-psychiatric hospital</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>- Hostel</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>- Home</td>
<td>6%</td>
<td>20%</td>
</tr>
</tbody>
</table>

* Although not reported here, the CHC admitted a higher proportion of people with a European background (including UK) than the SSWAHS average.

**unable to be calculated as referral dates not provided
CHC identified 3 readmissions to the SCP, 2 of which were still being cared for in the Program at the end of the data collection period.

### 4.3 Clinical Profile

#### 4.3.1 Principal Diagnosis

All 18 residents admitted to HC were diagnosed with various forms of dementia (vascular dementia 33%); Alzheimer’s disease (17%); alcohol-related dementia (3%); dementia not classified (44%). Of the 31 CHC residents with principal diagnosis recorded and available for analysis, 74% were diagnosed with dementia (Alzheimer’s disease 9%; dementia not classified 65%), 23% were diagnosed with a psychiatric illness (not specified) and 3% with a brain injury.

#### 4.3.2 Clinical Assessment

Data collected from administering a number of clinical assessment tools was analysed for the purpose of undertaking an assessment of client outcomes from the SCP. The assessment tools chosen were standard tools recommended in the NSW Mental Health Outcomes Assessment Tools (MH-OAT) suite, Aged Care Funding Instrument (ACFI) requirements, and/or National Dementia Outcomes Measurement project. Due to small numbers of admitted residents assessed at discharge - 18 of 59 admissions for CHC and 6 of 18 admissions for HC – it is difficult to draw any conclusions about clinical outcomes from the evaluation and clinical outcomes on discharge have not been reported. However, clinical assessment scores on admission are reported below.

**Catholic Health Care**

In the CHC SCP, residents were assessed on average as requiring some assistance with activities of daily living and having high levels of agitation, significant cognitive impairment and minimal signs of depression (Table 4.2).

<table>
<thead>
<tr>
<th>Characteristic assessed &amp; name of assessment tool</th>
<th>Catholic Health Care SCP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of data collection</td>
<td>January 2006 to September 2008</td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>Mean</td>
<td>median</td>
</tr>
<tr>
<td>Independence with ADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol Activities of Daily Living (BADL)$^1$</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Behavioural Disturbance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour Pathology in Alzheimer’s Disease Rating Scale (BEHAVE-AD)$^2$</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Level of agitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohen-Mansfield Agitation Inventory (CMAI)$^3$</td>
<td>107</td>
<td>100</td>
</tr>
<tr>
<td>Cognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mini-Mental State Examination (MMSE)$^4$</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cornell Scale for Depression in Dementia (CSDD)$^5$</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

1. possible scores range from 0 (resident independent) to 60 (resident dependent)
2. possible scores range from 0 (no behavioural problems) to 75 (severe behavioural problems)
3. Catholic Health Care used the long form; possible scores range from 29 (no agitation) to 203 (extremely agitated)
4. possible scores range from 30 (full cognition) to 0 (severely restricted cognition)
5. possible scores range from 0 (no signs) to 38 (severe)

**Hammond Care**

In the Hammond SCP, residents were assessed on average as having a fair quality of life, a reasonable level of independence with activities of daily living, high levels of agitation and significant cognitive impairment (Table 4.3).
Table 4.3: Clinical assessment scores on admission to Hammond SCP

<table>
<thead>
<tr>
<th>Characteristic assessed &amp; name of assessment tool</th>
<th>Hammond Care SCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of data collection</td>
<td>November 2007 to June 2009</td>
</tr>
<tr>
<td>Score</td>
<td>Mean</td>
</tr>
<tr>
<td>Quality of life</td>
<td>23</td>
</tr>
<tr>
<td>Quality of Life – Alzheimer’s Disease (QoL-AD)</td>
<td>23</td>
</tr>
<tr>
<td>Independence with ADLs</td>
<td>7</td>
</tr>
<tr>
<td>Resource Utilisation Groups – Activities of Daily Living (RUG ADL)</td>
<td>7</td>
</tr>
<tr>
<td>Level of agitation</td>
<td>86</td>
</tr>
<tr>
<td>Cohen-Mansfield Agitation Inventory (CMAI)</td>
<td>86</td>
</tr>
<tr>
<td>Cognition</td>
<td>6</td>
</tr>
<tr>
<td>Mini-Mental State Examination (MMSE)</td>
<td>6</td>
</tr>
<tr>
<td>Cognition</td>
<td>19</td>
</tr>
<tr>
<td>Psychiatric Assessment Scale (PAS)</td>
<td>19</td>
</tr>
<tr>
<td>Mental health outcomes</td>
<td>19</td>
</tr>
<tr>
<td>Health of the Nation Outcome Scales (HoNOS)</td>
<td>19</td>
</tr>
</tbody>
</table>

1 possible scores range from 52 (excellent quality of life) to 13 (poor quality of life)
2 possible scores range from 4 (resident is independent) to 18 (resident is dependent)
3 Hammond Care used the long form: possible scores range from 29 (no agitation) to 203 (extremely agitated)
4 possible scores range from 100 (full cognition) to 0 (severely restricted cognition)
5 possible scores range from 0 (no impairment) to 21 (significant impairment)
6 possible scores range from 0 (no problems) to 48 (significant problems)

### 4.4 Medication

Data on medication for usage for SCP clients on admission (for both pilots) and during the admission (for HC) was collected for evaluation. It is difficult to draw meaningful conclusions from this data, so it is not included in this report.

### 4.5 Adverse Events

The following data was reported by pilot sites on all unanticipated adverse events that resulted in harm to residents or staff.

**Catholic Health Care**

The data provided by CHCS regarding adverse events covered a four month period from September to December 2009, which was outside the timeframe of the evaluation. The majority of the events that occurred during this period (10 out of 14) related to aggressive behaviour of the resident or falls. Two of the events required the resident to be taken to hospital for medical attention and the resident returned to the SCP once discharged. During this reporting period, restraints were utilised for two patients.

**Hammond Care**

For HC data, collected over 10 months, from November 2007 to September 2008, identified that 37 adverse events occurred. These events mainly involved resident aggression, however, falls, verbal abuse and destruction of property were also reported. Six of the incidents of aggression were attributed to one resident.

### 4.6 Use of restraints

**Catholic Health Care**

Data was received for restraint use outside the period of the pilot evaluation in October 2008 where two residents required restraint.

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June 2011
Hammond Care

There was no reported usage of restraints in the HC SCP up to the end of June 2009.

### 4.7 Assessment of Outcomes: Summary of Key Findings

Data provided by HC and CHC illustrated that there were a range of strengths in the SCPs in relation to SCP clients, as well as improvements and limitations that can be addressed to strengthen the model of care.

#### 4.6.1 Strengths of Current Model

The strengths of the model were:

- The clinical profiles of admitted residents in both SCPs were consistent with the proposed target groups, and included older people with BPSD and/or functional mental illness;
- Residents were successfully transitioned through the SCPs to mainstream residential aged care facilities;
- Median length of stay was similar in both SCUs (97 days) and was generally consistent with expectations (with average length of stay affected by a number of outliers, as anticipated);
- Despite limitations in the referral data, the number of referrals apparently from NSW Health inpatient services to the SCP highlighted the potential of the service to relieve the pressure on NSW Health services and facilitate more appropriate use of inpatient beds, and
- The impact of the SCP was sustainable post-discharge with only a small number of residents readmitted to the SCP.

#### 4.7.2.1 Areas for Improvement

Areas for improvement were:

- The time taken for CHC SCU to reach capacity (21 months) could be improved with better attention to planning and establishment processes.
- Transition support packages were under-utilised in both cases (although slightly more used in HC).
- The time that SCU clients spent awaiting discharge/transition from the SCU to an RACF bed (50 days for both sites) requires further consideration.
- The utilisation of and factors contributing to the use of restraints requires regular reporting.

#### 4.7.2.2 Limitations

Limitations of the evaluation were:

- It is difficult to assess resident outcomes due to small numbers of clinical assessments conducted at discharge (beyond the positive outcomes of transition to a less restrictive care setting).
- It is difficult to identify the source of referral to SCPs as it was not always clear if the referral source related to residents’ location immediately prior to admission to SCP.
- It is difficult to draw any conclusions regarding the impacts of the SCP with regard to medication, and
- It is difficult reporting of adverse events were not conducted on a regular basis and it is difficult to draw any conclusions from this data.

#### 4.7.4 Recommendations from the HOI Report

**Source of referral**

- Rec 8: It is recommended that future data collections provide clear data definitions for source of referral to facilitate future analysis.

**HoNOS**

- Rec 9: It is recommended that the HoNOS 65+ scores for Hammond be reviewed as the score on admission is higher than national averages, including inpatient scores. This is to identify any issues that may relate to the application of the tool or any issues relating to complexity of admissions.

**Client outcomes**
Rec 10: It is recommended that suitable assessment tools are consistently implemented by the pilot facilities to facilitate a more comprehensive assessment of clinical outcomes. These tools should be clearly specified as a requirement in future service agreements.

**Adverse events**

Rec 11: It is recommended that adverse events are reported by pilot sites on a monthly basis and analysis of these data be considered an indicator of safety and quality of services provided.

The NSW Health Policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.

**5. IMPACT ASSESSMENT: CLIENTS, FAMILIES & CARERS**

**EVALUATION QUESTION:**
Is the initiative delivering client, family and carer satisfaction?

**5.1 METHOD AND SCOPE OF EVALUATION:**

Focus groups and surveys were utilised to assess carer and family satisfaction with the services provided through the SCP. Focus group discussions were conducted at each site with three groups of families. The range of family members participating in the focus groups included husbands, wives, daughters, sons, brothers and a grand-daughter. Family members of 5 residents at each of the sites participated in a survey. The small number of participants in the survey and focus groups is a limitation of the evaluation.

**5.2 ASSESSMENT OF IMPACT OF SCP ON CLIENTS AND FAMILIES**

All participants in the focus groups and/or survey expressed a high level of satisfaction for the services provided by both SCP pilots and their staff. It was also indicated that there was ongoing communication between families and SCP staff and that a high level of trust had been established. Families noted that the quality and standard of care in the SCP was an improvement on that provided in the inpatient setting, particularly in relation to the management of challenging behaviours and the use of restraint. Key findings are summarised below in Table 5.1.

**Table 5.1: Assessment of impact on clients and families: key findings**

<table>
<thead>
<tr>
<th></th>
<th>Catholic Health Care</th>
<th>Hammond Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td>Families were regularly informed of the resident’s progress.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family views were considered important to the staff in caring for the residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Families indicated they were involved in the care planning for the resident</td>
<td></td>
</tr>
<tr>
<td><strong>Restraints</strong></td>
<td>Families understood the need for the use of restraints, but were happy with the perceived decreased use of them in the SCP compared to that witnessed in inpatient settings.</td>
<td></td>
</tr>
<tr>
<td><strong>Person-centred care</strong></td>
<td>Families noticed that staff tailored their care to suit the individual rather than adopting the same approach to all.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The SCPs provided a home-like environment with the atmosphere being more relaxed and support was provided from the staff and other families.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SCP staff demonstrated a preparedness to explore new approaches to caring for residents when more traditional approaches were not working.</td>
<td></td>
</tr>
</tbody>
</table>
Improved outcomes

- Some families were able to take their family member home for the day or even overnight.
- All family members indicated that residents’ quality of life had improved which was considered one of the most important changes attributable to the program.

Survey assessment

- Families were satisfied with the levels of care being provided to the residents.
- Families expressed a high level of satisfaction with the level of communication between themselves and SCP staff.
- Concern was raised regarding the catering arrangements for meals which had led to a decrease in options for the residents.
- Families were very satisfied with the quality of care provided by SCP staff.
- Families expressed satisfaction with the SIRP and the SCP's ability to move residents into lower care and less restrictive environments.
- Concern was raised about additional resource requirements when dealing with aggressive residents.

### 5.2 ASSESSMENT OF IMPACT: SUMMARY OF KEY FINDINGS

Families and carers expressed high levels of satisfaction with the SCPs and suggested some areas for improvement.

#### 5.2.1 STRENGTHS OF CURRENT MODEL

From the perspective of families and carers, the strength of the SCPs included:
- Improved quality of life of their family member being treated in the SCP
- Good communication between SCP staff and themselves.
- Person-centred approaches to care and high quality of care provided by SCP staff.

#### 5.2.2 AREAS FOR IMPROVEMENT

Families and carers identified the need for:
- Additional resources for SCPs when managing particularly aggressive residents
- An increased variety of options for meals (at one site)

#### 5.2.3 LIMITATIONS

- Whilst the feedback from families and carers was consistent and positive, it is limited by the small number of focus group and survey participants.

#### 5.2.4 RECOMMENDATIONS FROM THE HOI REPORT

Families and carers
- Rec 12: It is recommended that the pilot sites conduct ongoing consumer satisfaction surveys with families and carers to compliment the other quality assurance activities that are in place and to monitor and improve services.

The NSW Health Policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.
6. **IMPACT ASSESSMENT: PILOT FACILITIES & PROVIDERS: SCP STAFF**

**Evaluation Question:**
What is the impact of the Special Care Unit and program on staff skills, knowledge and attitudes and operational functioning within the Special Care Unit and the rest of the host facility?

6.1 **METHOD AND SCOPE OF EVALUATION**

A key element of the impact assessment of the model of care on service providers was the surveys of staff working in the pilot sites. These surveys were conducted at three points over the course of the evaluation timeframe: at the commencement of the pilot; one year following implementation of the SCP and at the end of the evaluation data collection period. A detailed analysis was undertaken on completion of the final survey and where possible comparisons were made to the results of the previous surveys. The survey covered the areas of staff skills and knowledge; staff attitudes; staff satisfaction; operations and management, and perceived resident outcomes as a result of the services provided by the SCP.

6.2 **RESPONDENTS**

6.2.1 **Catholic Health Care**

Fourteen (14) staff members from the CHCS who work inside and outside the SCP responded to the survey.

**Respondent Information**
- Eight of the staff members worked full-time with the remaining six working part-time;
- Eight of the staff had been working at Holy Spirit for over one year, four had been there over six months and the remaining two over three months, and
- Ten respondents classified themselves as nursing, one as allied health, one as an art therapist and two classified themselves as “other”.

6.2.2 **Hammond Care**

Eleven (11) staff members of HC who work in the SCP completed the survey.

**Respondent Information**
- Two of the staff members worked full-time and nine worked part-time;
- Nine staff members had been working at HC for one year or longer, one staff member had been there six months and the remaining staff member had been employed less than three months, and
- Nine of those surveyed classified themselves as specialist dementia carers (SDCs), one was a nurse and the remaining staff member was a psychologist.

6.3 **ASSESSMENT OF STAFF PERCEPTIONS**

Participants were asked to indicate their level of agreement with a series of statements on a 5 point scale from “1” strongly disagree to “5” strongly agree.

**Staff skills & knowledge**

Staff at both sites agreed that their skills and knowledge in working with the SCP target group had improved since the SCP commenced (Table 6.1).
Table 6.1: Staff perceptions: skills and knowledge

<table>
<thead>
<tr>
<th>Statement</th>
<th>Catholic Health Care (14 respondents)</th>
<th>Hammond Care (11 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My skills have improved since the SCP has been operating</td>
<td>Median (Range)* 4 (3 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>I am able to perform my work better since the SCP has been operating</td>
<td>Median (Range)* 4 (3 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>My skills and knowledge of behaviour management of complex clients has</td>
<td>Median (Range)* 4 (3 to 5)</td>
<td>5 (3 to 5)</td>
</tr>
<tr>
<td>improved since the SCP has been operating</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I have a high knowledge of mental illness in older people</td>
<td>Median (Range)* 4 (2 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>I have a high level of skills in working with older people with mental</td>
<td>Median (Range)* 4.5 (3 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Median of 5 point scale from “1” strongly disagree to “5” strongly agree.

Staff indicated the SCP met the needs of the residents and functioned well and that the SCP was a benefit to the wider residential aged care facility. There was also a strong level of commitment among staff to helping residents with difficult behaviours (Table 6.2).

Table 6.2: Staff perceptions: staff attitudes

<table>
<thead>
<tr>
<th>Statement</th>
<th>Catholic Health Care (14 respondents)</th>
<th>Hammond Care (11 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The SCP is able to meet the needs of the residents</td>
<td>Median (Range)* 4 (2 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>I think the SCP functions very well</td>
<td>Median (Range)* 4 (3 to 5)</td>
<td>No response 4 (3 to 5)</td>
</tr>
<tr>
<td>The SCP is a benefit to the wider residential aged care facility</td>
<td>Median (Range)* 5 (3 to 5)</td>
<td>5 (4 to 5)</td>
</tr>
<tr>
<td>Residents with behavioural issues are more difficult to care for</td>
<td>Median (Range)* 5 (4 to 5)</td>
<td>No response 4 (2 to 5)</td>
</tr>
<tr>
<td>I do not believe I should have to care for residents with behavioural</td>
<td>Median (Range)* 1 (1 to 3)</td>
<td>1 (1 to 2)</td>
</tr>
<tr>
<td>issues</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I am confident in handling residents with difficult behaviours</td>
<td>Median (Range)* 5 (1 to 5)</td>
<td>4 (4 to 5)</td>
</tr>
<tr>
<td>I am committed to helping residents with difficult behaviours</td>
<td>Median (Range)* 5 (1 to 5)</td>
<td>No response 5 (4 to 5)</td>
</tr>
</tbody>
</table>

* Median of 5 point scale from “1” strongly disagree to “5” strongly agree.

Staff satisfaction

Respondents from CHC indicated that on average they felt indifferent (neither agree nor disagree) to the support they received in their role, but on the whole enjoyed working in the SCP. By contrast, staff at HC strongly agreed that they are well supported in their role and had access to support and training. HC staff also enjoyed working in the SCP (Table 6.3).
Table 6.3: Staff perceptions: staff satisfaction

<table>
<thead>
<tr>
<th>Statement</th>
<th>Catholic Health Care (14 respondents)</th>
<th>Hammond Care (11 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (Range)*</td>
<td>Median (Range)*</td>
</tr>
<tr>
<td>I feel supported in my role by the management of the aged care centre</td>
<td>3 (1 to 5)</td>
<td>5 (3 to 5)</td>
</tr>
<tr>
<td>I am able to obtain support when it is needed</td>
<td>4 (2 to 5)</td>
<td>5 (3 to 5)</td>
</tr>
<tr>
<td>I have had access to training and development opportunities suited to my role</td>
<td>3 (1 to 5)</td>
<td>5 (4 to 5)</td>
</tr>
<tr>
<td>On the whole I enjoy working in the SCP</td>
<td>4 (3 to 5)</td>
<td>5 (4 to 5)</td>
</tr>
</tbody>
</table>

* Median of 5 point scale from “1” strongly disagree to “5” strongly agree.

OPERATIONS AND MANAGEMENT

Staff from both pilot sites indicated that the SCP works well with the other sections of the aged care facility and interacts with other service providers. While HC staff agreed that the service reflected a multidisciplinary approach, in general CHC staff neither agreed nor disagreed that the SCP reflected a multidisciplinary approach (Table 6.4).

Table 6.4: Staff perceptions: operations and management

<table>
<thead>
<tr>
<th>Statement</th>
<th>Catholic Health Care (14 respondents)</th>
<th>Hammond Care (11 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (Range)*</td>
<td>Median (Range)*</td>
</tr>
<tr>
<td>The SCP works well with other sections of the aged care centre</td>
<td>4 (2 to 5)</td>
<td>4 (3 to 5)</td>
</tr>
<tr>
<td>The SCP has involvement with other service providers</td>
<td>4 (2 to 5)</td>
<td>4 (4 to 5)</td>
</tr>
<tr>
<td>The service model reflects a multi-disciplinary approach</td>
<td>3 (2 to 5)</td>
<td>4 (3 to 5)</td>
</tr>
</tbody>
</table>

* Median of 5 point scale from “1” strongly disagree to “5” strongly agree.

OUTCOMES

Staff from both sites indicated that they felt the SCP had brought about access to more appropriate services for residents and also positive outcomes for residents (Table 6.5).

Table 6.5: Staff perceptions: resident outcomes

<table>
<thead>
<tr>
<th>Statement</th>
<th>Catholic Health Care (14 respondents)</th>
<th>Hammond Care (11 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (Range)*</td>
<td>Median (Range)*</td>
</tr>
<tr>
<td>The SCP has increased access to more appropriate assessment and service options for residents</td>
<td>4 (2 to 5)</td>
<td>4 (3 to 5)</td>
</tr>
<tr>
<td>The SCP has resulted in better outcomes for residents</td>
<td>4 (2 to 5)</td>
<td>4 (4 to 5)</td>
</tr>
</tbody>
</table>

* Median of 5 point scale from “1” strongly disagree to “5” strongly agree.

SPECIAL CARE PROGRAM ACHIEVEMENTS, STRENGTHS AND WEAKNESSES

Some of the key findings from responses to open ended questions in staff surveys are summarised in Table 6.6 below
Table 6.6: Assessment of Impact on Service Providers - Key Findings

<table>
<thead>
<tr>
<th></th>
<th>Catholic Health Care</th>
<th>Hammond Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths</td>
<td>• Staff stated the following were the strengths of the SCP:</td>
<td>• Staff stated the following were the strengths of the SCP:</td>
</tr>
<tr>
<td></td>
<td>o Leadership from the Manager</td>
<td>o Personalised care for residents</td>
</tr>
<tr>
<td></td>
<td>o Communication</td>
<td>“…providing an environment where some behaviours can be accepted and normalised”</td>
</tr>
<tr>
<td></td>
<td>o Staff working in the SCP</td>
<td>o Staff working in the SCP</td>
</tr>
<tr>
<td></td>
<td>o Increased confidence to care for residents</td>
<td>o Teamwork</td>
</tr>
<tr>
<td></td>
<td>“experience made the job interesting”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A strength is getting challenging patients out of hospital beds and into an environment where they can be assessed on a one to one basis”</td>
<td></td>
</tr>
<tr>
<td>Weaknesses</td>
<td>• Lack of training was stated to be a weakness and staff indicated that they would benefit from more refresher courses.</td>
<td>• Staff stated there was a need for improved communication between shifts in the SCP.</td>
</tr>
<tr>
<td></td>
<td>• Staff stated there was a need for improved communication between shifts in the SCP.</td>
<td>• Another weakness was stated to be the inability to move residents on as quickly as desired.</td>
</tr>
<tr>
<td>Support and Training</td>
<td>• Survey responses indicated a desire for more training to be provided to staff however it was recognised that this would require funding that may not be available.</td>
<td>• Staff stated there was training and support provided but there was scope to improve the mental health education.</td>
</tr>
<tr>
<td>Program Impact</td>
<td>• The responses were mixed when staff were asked about the impact of the program.</td>
<td>• The majority of respondents stated the program had had an impact and this impact was positive. (attributed to the SCP’s ability to progressively transition patients into new environments when they were ready for transfer through the SIRP)</td>
</tr>
<tr>
<td></td>
<td>“The residents seem generally settled which must have a positive effect on the wider community”</td>
<td></td>
</tr>
</tbody>
</table>

6.4 ASSESSMENT OF IMPACT: SUMMARY OF KEY FINDINGS

Staff generally expressed satisfaction with the SCP (both for SCP staff and staff of the broader facility), and identified positive attributes of the models of care and areas for improvement.

6.4.1 STRENGTHS OF CURRENT MODEL

• The strengths of the SCP model identified by staff included committed, confident and skilled staff, strong leadership and teamwork, and strong training and support for staff
• Staff considered that the SCP met the needs of residents and functioned well in transitioning clients to lower level, less restrictive care.

6.4.2 AREAS FOR IMPROVEMENT

Identified areas of improvement include:
• A need for more staff training and education in some areas such as mental health.
• A need to address delays in transitioning of residents from the SCU to mainstream residential beds.
• A need for improved communication between shifts (one site)
6.4.3 Recommendations from the HOI report

Service Providers

- Rec 13: It is recommended that handover procedures between shifts be reviewed to improve the safety of care, improve communication with staff and improve the efficiency of the unit.
- Rec 14: It is recommended that staff training and support needs be reviewed and where indicated to provide mental health education earlier in the program.
- Rec 16: It is recommended that staff training refresher courses are provided in basic nursing care.

The NSW Health policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.
7. **IMPACT ASSESSMENT: PILOT FACILITIES & PROVIDERS**

<table>
<thead>
<tr>
<th>EVALUATION QUESTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the critical success factors in delivering the service model from facility/provider perspective, how can delivery be improved and what are the implications for evidence-based practice?</td>
</tr>
<tr>
<td>How can the service model be improved to achieve better outcomes from a facility/provider perspective?</td>
</tr>
</tbody>
</table>

7.1 **METHOD OF EVALUATION**

Consultations (face to face and telephone) were conducted with pilot project staff at both operational and management levels to consider the evaluation questions above.

7.2 **CRITICAL SUCCESS FACTORS**

Factors that were considered to underpin successful SCP operation included:

- A committed service provider with an effective and committed Board of management;
- A well designed facility/unit, including a relaxing (homely) environment to increase comfort, maximise abilities and reduce agitation in residents;
- An effective CAC;
- Passionate and skilled staff;
- The ability to access on-call staff support when required, and
- Psychiatric services complemented by the services of an interested GP

There were observed improvements in resident behaviour resulting in residents requiring lower levels of care with some discharged from the program to other community settings.

The SCP operations were focused on creating a family environment, effective leadership and the development of a comprehensive understanding of mental health conditions. Respondents observed improvements in residents during their stay in the SCP. One stakeholder commented that the model of care humanised the residents. The non-medication management protocols that were used by the SCPs in the management of resident behaviours were seen as a strength. The SCPs were seen to support deinstitutionalisation and more community-based, less restrictive care for residents.

It was noted that the SCP model was dependent on having an appropriate staffing complement (i.e. nurses, carers, psychologists) that were appropriately trained and committed to the delivery of quality services. Some stakeholders commented that the experience of the staff was more important than the number of staff employed in SCPs although there was still a minimum level of staffing required. The role of the Nursing Unit Manager (NUM) was pivotal to the operations of SCP pilots. Both sites had appointed experienced NUMs who were acknowledged by staff as providing leadership and training to SCP and RACF staff. In addition to this, it the low staff turnover in the SCPs was noted as both a sign of and factor in the success of the model. This provided stability and consistency in the care provided to residents and resulted in the establishment of a high level of trust between staff members.

At both SCP sites GPs were requested or engaged to provide case visits to residents in the SCP on a sessional basis. These arrangements proved to be relatively satisfactory for the GPs and psychiatrists working together in the prescription and management of medication. This arrangement involved the psychiatrist recommending the medication and the GP prescribing it as soon as possible. The objective of this practice was to enable the psychiatrist to assess the impact of the medication changes by the following weekly psychiatric assessment. This aspect of the SCP model had its challenges and requires strong collaboration between the GP and psychiatrist.

The impact assessment of the operations of the SCP pilot projects identified a number of gaps and barriers to service delivery, including delays in access to permanent places to which to transition SCU, clients (preventing
others from accessing SCP beds), continuity of staff and limitations in access for younger residents under the age of 65 years. Staff resignations from the SCPs had the potential to create significant additional burden on remaining staff by necessitating a period of readjustment to the staff changes and creating agitation in the residents.

There was an identified need and demand for SCP services to be provided to younger residents. Younger residents fell into two categories:

- Persons aged under 65 years; and
- Younger aged people (around 65 years) who were able to ambulate and who were not suited to a unit with frailer aged people.

It was noted that the needs of these younger residents could not be met by the SCPs where admissions targeted older people. It is considered that the needs of and options for younger people with challenging behaviours warrant further exploration by relevant agencies, including the NSW Department of Health.

The SCP pilot models operate under the Commonwealth Aged Care Act and other relevant Commonwealth and state legislative and policy frameworks. However, the NSW Mental Health Act 2007 and other NSW legislation and policy frameworks also underpin the operation of and partnership arrangements for the SCPs, as well as the services and care provided by NSW Health clinicians. The interfaces between these legislative and policy frameworks can present issues in the successful operation of and partnership arrangements for the SCPs in areas such as assessment of mental health clients for admission into the RACFs and the transitioning of residents from the SCP, and SCP staff and clinical in-reach staff need to have an understanding of these various legislative and policy frameworks.

### 7.3 INFRASTRUCTURE IMPROVEMENTS

Stakeholders identified a number of improvements to the current infrastructure to enhance the quality of service delivery and improve resident outcomes.

1. **Additional equipment.** Consideration should be given to installing bed monitors for every room to assist in monitoring adverse behaviours.
2. **Observation unit.** The inclusion of an observation unit with the SCP would provide staff the opportunity to observe the resident prior to the resident being integrated with other unit residents.
3. **Sensory room.** In addition to the diversional therapy activities, the use of a sensory room may also decrease agitated behaviours.

### 7.4 ASSESSMENT OF IMPACT- SUMMARY OF KEY FINDINGS

Through consultations with SCP host facilities and providers, the evaluators the following strengths of the current model (also identified as critical success factors), areas for improvement and limitations, in addition to the strengths and areas for improvement already identified by SCP staff.

#### 7.4.1 STRENGTHS OF CURRENT MODEL

- Committed service providers with effective and committed Boards of management;
- Well designed facilities that provide a home-like environment, and support effective, person-centred care
- Effective CACs;
- Passionate and skilled staff, with appropriate (multidisciplinary) training, experience and expertise (and low staff turnover);
- Effective leadership of the SCP;
- Use of psychosocial approaches and alternatives to medication;
- The ability to access on-call staff support when required, and
• Psychiatric services complemented by the services of an interested GP

7.3.2 AREAS FOR IMPROVEMENT

• Some aspects of the collaborative arrangements between SCP GPs and psychiatrists, and
• Delays in access to permanent places to which to transition SCU clients (increasing SCU length of stay preventing others from accessing SCU beds).

7.3.3 LIMITATIONS AND AREAS FOR FURTHER INVESTIGATION

• Understanding and managing the interface between relevant Commonwealth and State legislative and policy frameworks in the operation of the SCPs requires further investigation, and
• The needs of and options for younger people with challenging behaviours warrant further investigation.

7.3.4 RECOMMENDATIONS FROM THE HOI REPORT

SCP

• Rec 15: It is recommended that future SCPs should have facilities that are purpose built, where possible, to ensure the layout of the facility is optimal for residents and staff. In particular, the nurses’ station needs to be designed to provide all staff with an optimal view of the facility.
• Rec 17: It is recommended that a workforce professional development plan be formulated and implemented for all SCP staff. This plan should be formulated in collaboration with SCPs and SSWAHS clinicians. The plan should also specify the staffing structure required to optimally run the SCP.
• Rec 18: It is recommended that the SCPs develop and implement strategies to increase the level of engagement with GPs in a more systematic and coordinated way. Where GP involvement is not possible substitutable primary health care should be investigated.
• Rec 19: It is recommended that the needs of young people with challenging behaviours be further explored by NSW Health and the SSWAHS.
• Rec 20: It is recommended the NSW Department of Health undertake ongoing discussions with the Commonwealth, Department of Health and Ageing to progressively address the SCP operational barriers that have been attributed to the legislative disparities between the Mental Health Act and the Aged Care Act that have resulted in SCP operational barriers.

The NSW Health policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.
8. **Impact Assessment: NSW Health & The Broader Service System**

### Evaluation Questions

How are the two pilot services being delivered relative to one another (where comparisons are appropriate), and relative to other services such as T-BASIS non-acute inpatient units, dementia-specific RACFs or RACFs specialising in BPSD?

How is the service model and initiative being implemented with regard to service relationships and partnership arrangements and the practices and administrative arrangements of the health and aged care service systems, and how can partnership processes and program arrangements be improved?

What is the impact of the service model on client pathways through, demand for and pressure on SMHSOP community teams/mental health services, Aged Care Services, acute hospitals (including geriatric medical units), mental health inpatient facilities, GPs, RACFs, community aged care services (e.g. Home and Community Care)?

Does the service model address service gaps between NSW Health inpatient services and mainstream aged care services, is it cost-effective and what are the key factors for the sustainability of the model?

### 8.1 Method of Evaluation

Both qualitative and quantitative data was collected in order to complete an impact evaluation for NSW Health and the broader health system. Consultations (face to face and telephone) were conducted with CHC & HC senior staff (operational and management), SSWAHS senior mental health staff, SSWAHS geriatricians and NSW Health project staff. These consultation findings are outlined below. Data regarding client profiles, lengths of stay and client outcomes was collected from a number of control and comparison sites, in order to assess the distinctiveness and relative effectiveness of the MHACPI model of care. However, the comparison data was inadequate to draw any conclusions.

### 8.2 Assessment of Service Linkages

The establishment of effective partnerships arrangements and service linkages is a key component of the SCP model, and was generally found to be strong (as noted previously). This is critical to ensure residents have access to the multidisciplinary services required to meet their complex care needs.

#### 8.2.1 Organisational Considerations

Stakeholders identified a number of potential strategies to improve the effectiveness of service linkages aimed at fostering good working relationships between SCPs and hospitals and improving client referral and discharge processes. The summary of issues and suggestions for improvement is below.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Issue</th>
<th>Suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of information on SCP Services</td>
<td>Limited information outlining the SCP service provided to acute care and community service providers</td>
<td>Development of written guidelines to alleviate potential misinformation and encourage referrals to the SCP.</td>
</tr>
</tbody>
</table>
| Multi-disciplinary referral pathways | Need for development of multi-disciplinary referral pathway to support transition of patients to SCPs | Development of care pathway to facilitate:  
  - Referrals from hospitals to SCPs  
  - Mechanism for evidence-based standardisation & service development  
  - Development of hospital admission or readmission avoidance strategies  
  - Identification of service gaps  
  - Waiting list management processes |
8.2.2 General Practitioner Services

There is a requirement for GPs and psychiatrists to work together due to the limitations of psychiatrists’ prescribing rights for community patients. At times, the psychiatrist’s recommendations and GP’s prescriptions of psychiatric medication were not consistent. Issues identified by stakeholders and suggestions for improvement of the linkages with GPs are noted below.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Issue</th>
<th>Suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP collaboration with psychiatrists</td>
<td>Psychiatrist recommendations and GP prescription of medication was different</td>
<td>Participation of the GP on the CAC and in weekly case management activities</td>
</tr>
<tr>
<td>Access to GP services for SCP clients</td>
<td>Medicare reimbursement rate for GPs attending the SCP was low when compared to consultation undertaken in the GP surgery</td>
<td>—</td>
</tr>
</tbody>
</table>

8.2.3 Acute Care Services

The key issues relating to the linkages between SCP and other stakeholders and suggestions for improvement of these linkages are noted below.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Issue</th>
<th>Suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuum of care from acute setting to residential aged care setting.</td>
<td>Lack of protocols to support transfer of patients from acute setting to residential aged care.</td>
<td>Development of pathways to support transfer of patients from acute setting to SCP.</td>
</tr>
<tr>
<td>Linkages with acute geriatric units</td>
<td>Barrier to potential expansion of the SCP</td>
<td>Development of strategies to facilitate linkage including:</td>
</tr>
<tr>
<td></td>
<td>Specialised knowledge required when providing medical assessments to this target group to ensure appropriate medical intervention.</td>
<td>• Communication processes between the SCP and acute geriatric unit service providers;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promotional information explaining the role and responsibilities of the SCPs;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Processes to encourage acute geriatric service providers to become involved in relevant SCP meetings and seeking opportunities for the SCP to have an involvement in service provider meetings;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral protocols; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cooperative working arrangements with service providers to streamline referral processes where possible.</td>
</tr>
</tbody>
</table>

8.3 Cost-effectiveness Analysis

It was initially proposed to conduct a cost-effectiveness analysis to determine the cost effectiveness of the SCP pilots compared to the traditional treatment option for older people with severely challenging behaviours, in this case Braeside Hospital. The cost effectiveness analysis was dependent upon calculation of a change in the residents Cohen-Mansfield Agitation Inventory (CMAI) Score between admission and discharge. Due to the limited outcome data available from the CHC and HC pilot programs at discharge, the cost effective analysis was not informative. However, the analysis of costs did show that there were significant bed day savings at CHC relative to traditional treatment (approximately $383 lower per bed day; total $1.56 million bed day savings in
There were also bed day savings at HC but these were considerably less. Further analysis is required to understand the cost-effectiveness of the MHACPI model and the most efficient and appropriate funding arrangements.

8.4 OPPORTUNITIES FOR IMPROVEMENT AND FUTURE DIRECTION

**Evaluation question:**
Is the initiative achieving the outcomes to warrant its continuation and/or expansion?

Stakeholders identified a range of opportunities for improving the SCP models and issues to be considered in the future including infrastructure improvements, opportunities for transitioning of residents and the expansion of the client base. Some of these were identified by service providers in Chapter 7.

8.4.1 Transitioning of Residents

It was suggested that a review of resident discharge pathway should be undertaken by the CAC at each site in order to develop a protocol for the more efficient flow of residents to lower care facilities, thereby freeing up beds in the SCP to accept more referrals.

8.4.2 Expanding client base/model of care

Both models focussed on the care of older people with dementia and/or mental illness with severe and complex behavioural problems. Discussions with stakeholders suggested that this model of care could be of benefit to people outside the current admission criteria. In particular, the evaluators noted that there was an increasing demand to admit younger residents. It was suggested that the SCP model could be adapted and operated in other facilities to deal with varied populations requiring this type of care, for example younger physically active males cannot necessarily be co-located with older, frailer residents. This is an area that warrants further consideration in the future.

8.3.4 Extension of SCP Model

The evaluation was able to identify many strengths of the SCP model. However, the evaluators noted that further assessment of the impacts of the model and ongoing evaluation of the pilots would be necessary over a period of time. As one stakeholder commented “the real measure will be what the models are doing in five years”.

8.5 Assessment of Impact: Summary of Key Findings

Although there were significant limitations to the evaluation in relation to its assessment of the impacts of the SCPs on NSW Health and the broader service system, and the cost-effectiveness analysis, following are some of the strengths and areas for improvement identified in this component of the evaluation.

8.5.1 Strengths of current model

- Bed saving days are demonstrated in both SCPs relative to traditional treatment options
- The SCP model of care could be applied to target groups outside the current admission criteria

8.5.2 Areas for improvement

- Infrastructure/facility design improvements
- Provision of information on SCP to relevant stakeholders
- Development of multi disciplinary referral pathways
- Partnership and funding arrangements for allied health staff to provide services in SCPs

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2 Younger residents fall into two categories, the first are those aged under 65 years who are not considered aged. The other category is the younger aged (around 65 years) who are able to ambulate and who may not be suited to a unit with frailer aged.
• Collaboration between and access to GPs and psychiatrists
• Linkages between SCPs and acute geriatric units
• A clear and agreed clinical pathway between SCPs and the residential aged care sector

8.5.3 LIMITATIONS AND AREAS FOR FURTHER INVESTIGATION

• Further analysis is required to understand the cost-effectiveness of the MHACPI model and the most efficient and appropriate funding arrangements
• Further assessment of the impacts of the model and ongoing evaluation of the pilots will be necessary over a period of time

8.5.4 RECOMMENDATIONS FROM THE HOI REPORT

• Rec 1: It is recommended that the pilots continue for a further three years to enable outcomes to be assessed over a longer time span.
• Rec 3: It is recommended that the Area Health Service works with the pilot sites to improve the data collection and reporting capabilities to support ongoing quality assurance and evaluation of the service models.
• Rec 21: It is recommended the NSW Department of Health, SSWAHS and SCPs develop a multi-disciplinary referral pathway and associated guidelines in collaboration with acute care clinicians to:
  o Improve the referral process to SCPs;
  o Promote the service model; and
  o Improve communication between hospitals and the SCP facilities
• Rec 22: It is recommended the NSW Department of Health and SSWAHS review the extent to which the allied health service needs of SCP residents are being met. The findings of this review should be addressed in future service planning and resource allocation decisions
• Rec 23: It is recommended that the future evaluation of the SCP initiative include the conduct of a cost-effectiveness analysis which will allow a more detailed comparison of the outcomes of the service model. This will require both SCPs to collect an agreed set of evidenced based outcomes indicators that will be used as the basis of the economic analysis
• Rec 24: It is recommended that a further evaluation of the SCP initiative is undertaken in 2012 to facilitate a comprehensive assessment of the outcomes and impacts of the service model. The findings of this evaluation should also inform decision making regarding the extension of the model to other Area Health Services in NSW. In relation to future evaluations, it will be necessary to establish a framework for the evaluation as soon as possible to ensure that the right information is uniformly being collected and reported by SCPs to inform outcomes.

The NSW Health policy response to the evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.
9. **Summary & Conclusions**

The evaluation identified many strengths of the MHACPI model, as well as areas for improvement. These findings will be useful in informing improvements to the existing SCPs and future directions with the model. There are also limitations to the evaluation findings, particularly in the area of client clinical outcomes, cost-effectiveness and the MHACPI funding model. These need to be considered in further development, monitoring and evaluation of the MHACPI model.

The key findings of the evaluation in relation to program design and planning processes, client and service delivery outcomes, and the impacts of the pilots/model on clients, families and carers, SCP staff, pilot facilities and providers, NSW Health and the broader service system are summarised below.

**Process evaluation: Design and planning**

The evaluation highlighted that the MHACPI had resulted in the development of a well designed service agreement that provided a good basis for the SCP model of care. The collaborative development and negotiation of the service agreement was seen by key SCP partners to be a strength of the design and planning process. It was noted that service agreements need to take into account the establishment of the service and the time delay in reaching capacity, and that development of clear Terms of Reference and organisational arrangements are critical to ensure effective operations, partnership arrangements and clinical governance by the CAC.

**Outcome assessment: SCP clients**

During the evaluation period, the clinical profiles of admitted residents were consistent with the proposed target groups, and included older people with BPSD and/or functional mental illness. Residents were mostly successfully transitioned through the SCPs to mainstream residential aged care facilities, demonstrating the effectiveness of the program. Median length of stay was similar in both SCUs (97 days) and was generally consistent with expectations (with average length of stay affected by a number of outliers, as anticipated).

Despite limitations in the referral data, the number of referrals apparently from NSW Health inpatient services to the SCP highlighted the potential of the service to relieve the pressure on NSW Health services and facilitate more appropriate use of inpatient beds. The small numbers of residents being readmitted post-discharge illustrates the sustainability of SCPs.

The areas for improvement noted in the evaluation included: attention to planning and establishment processes to reduce the time taken for one SCU to reach capacity (21 months) following commencement; further exploration of the transition support component of the model (which was under-utilised in both cases); further consideration of the time that SCU clients spent awaiting discharge/transition from the SCU to an RACF bed (50 days for both sites), and further consideration of the utilisation of and factors contributing to the use of restraints.

Limitations of the evaluation related to: assessing resident outcomes (beyond the positive outcomes of transition to a less restrictive care setting); some issues with evaluation data regarding the sources of referral to SCPs; assessing the impacts of the SCP with regard to medication, and drawing any conclusions regarding adverse events.

**Impact assessment: Clients, families and carers**

The qualitative responses of families and carers highlighted their satisfaction with the models of care. Particular reference was made to the improved quality of life of residents, effective and appropriate communication between SCP staff and families and carers, and the person-centred approaches to residents displayed by SCP staff. Families and carers responses also highlighted a need for additional resources for SCPs when managing particularly aggressive residents. Whilst the feedback from families and carers was consistent and positive, it is limited by the small number of focus group and survey participants.

**Impact Assessment: SCP Staff**
In the evaluation survey, staff generally expressed satisfaction with the SCP models of care (both for SCP staff and staff of the broader facility). The commitment, confidence and skills of staff; strong leadership and teamwork, and strong training and support for staff working was seen by staff as positive aspects of the SCP contributing to the overall satisfaction of the model of care. Staff considered that the SCP met the needs of residents and functioned well in transitioning clients to lower level, less restrictive care.

To further strengthen the existing models, staff suggested that further consideration should be given to addressing delays in transition of residents from the SCU to mainstream residential beds. Staff also identified the need for more training and education in some areas such as mental health.

Impact Assessment: Pilot facilities and providers
Pilot facility staff and providers identified a number of strengths and critical success factors for the SCP model of care:

• Committed service providers with effective and committed boards of management;
• Well designed facilities that provide a home-like environment, and support effective, person-centred care;
• Effective CACs;
• Passionate and skilled staff, with appropriate (multidisciplinary) training, experience and expertise (and low staff turnover);
• Effective leadership of the SCP;
• Use of psychosocial approaches and alternatives to medication;
• The ability to access on-call staff support when required, and
• Psychiatric services complemented by the services of an interested GP.

It was noted that some aspects of the collaborative arrangements between SCP GPs and psychiatrists, and delays in access to permanent places to which to transition SCU clients could be areas for improvement. Two areas were identified for further consideration: understanding and managing the interface between relevant Commonwealth and State legislative and policy frameworks in the operation of the SCPs, and the relevance of the MHACPI model in relation to accommodation options for younger people with challenging behaviours. It was also noted that the infrastructure/facility design could benefit from improvements.

Impact Assessment: NSW Health and the broader system
Although there were significant limitations to the evaluation in relation to its assessment of the impacts of the SCPs on NSW Health and the broader service system, and the cost-effectiveness analysis, the evaluation found that there were significant bed day cost savings in the SCPs relative to traditional treatment options. It also found that the SCP model of care could be applied to target groups outside the current admission criteria. Areas identified for potential improvement included: provision of further information on SCP to relevant stakeholders; further development of multi disciplinary referral pathways; further development of partnership and funding arrangements for allied health staff to provide services in SCPs; further collaboration between and access to GPs and psychiatrists; further linkages between SCPs and acute geriatric units, and development of clear and agreed clinical pathways between SCPs and the residential aged care sector.

Further analysis is required to understand the cost-effectiveness of the MHACPI model and the most efficient and appropriate funding arrangements. Also, further assessment of the impacts of the model and ongoing evaluation of the pilots will be necessary over a period of time.

The MHACPI evaluation report addressed the areas for potential improvement and evaluation limitations in its recommendations. The NSW Health policy response to the MHACPI evaluation addresses these recommendations and proposes additional recommendations based on this evaluation and an analysis of further SCP program developments since the evaluation period.