



Repat Neuro-Behavioural Unit

Model of Care

Division of Mental Health
Southern Adelaide Local Health Network

February 2022

Document Information

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Valid From	02/02/2022
Review Date	02/02/2023

Document History

Date	Version	Approved By	Change Reference~
10/03/21	V 1.0	Dr Michael Page	Initial version
02/02/22	V 1.1	Dr Michael Page	Review

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Acknowledgement of Country

SA Health would like to acknowledge that the lands the Neuro-Behavioural Unit is located on are the traditional lands for the Kurna people and we respect their spiritual relationship with this country. We also acknowledge the Kurna people as the custodians of the greater Adelaide region and their cultural and heritage beliefs are still as important to the living people today.

This model of care has been constructed in consultation with representatives from the Aboriginal and Torres Strait Islander community, inclusive of a SA Health developed Aboriginal health impact statement. Cultural consultation has occurred in the development of the new unit environment and model of care.

“The term “Aboriginal” is used respectfully in this document as an all- encompassing term for Aboriginal and Torres Strait Islander people and culture”



Identifying Aboriginal Consumers

Australian Aboriginal Culture is the oldest living culture in the world and yet Aboriginal people continue to experience the poorest health outcomes compared to non-Aboriginal Australians.

Definitions and Acronyms

Aboriginal	The term Aboriginal is used respectively in this document as an all-encompassing term for Aboriginal and Torres Strait Island people and culture
BPSD	Behavioural and Psychological Symptoms of Dementia
CEWG	Cultural Expert Working Group
Carer	The term carer is used to describe informal caregivers which may include family, friends, and neighbours
Consumer	A person who has used, currently uses or will use health care services, includes family and care givers
ERT	Emergency Response Team
KPI	Key Performance Indicator
MAPA	Management of Actual or Potential Aggression – recent name change to Safety and Intervention training
MOC	Model of Care
MOCEWG	Model of Care Expert Working Group
NALHN	Northern Adelaide Local Health Network
NMHSPF	National Mental Health Service Planning Framework
NBU	Neuro-Behavioural Unit
OCP	Office of the Chief Psychiatrist
Older persons	Is defined as a person who is 65 years or older; 50 years or older and identify as Aboriginal or Torres Strait Islander
OPMHS	Older Persons Mental Health Service
Places-of-care	A term to describe 'beds' in the NBU that is in keeping with the intent of the service not having an acute hospital focus
PIP	Project Implementation Plan
RACF	Residential Aged Care Facility
Resident	The term to describe the person living with dementia who will be the recipient of care at the Neuro-Behavioural Unit, after consultation with families and staff this is the preferred terminology.
RHP	Repat Health Precinct
SACAT	South Australian Civil and Administrative Tribunal
SADU	Specialist Advanced Dementia Unit
SALHN	Southern Adelaide Local Health Network
SBRT	Severe Dementia Response Teams
SHEP	Southern Health Expansion Plan
SPEWG	Staffing Profile Expert Working Group
SMHSOP	Specialist Mental Health Services for Older People

Executive Summary

In April 2017, the South Australian Chief Psychiatrist submitted the Oakden Report to the Chief Executive Officer of the Northern Adelaide Local Health Network (NALHN) and the Minister for Mental Health and Substance Abuse. The report documented significant failures of care provided to older people with severe to extreme BPSD. As a result, the Oakden Report Response Plan Oversight Committee developed the six recommendations in the report. The committee proposed a state-wide NBU model for people living with Tier 7 BPSD.

The reactivation of the Repat Health Precinct (RHP) presented an opportunity to open the first beds of the model of care. Lived experience stakeholders were actively engaged by the Office of Chief Psychiatrist and SA Health Infrastructure Unit in 2018-2019 to ensure the new Repat NBU space adopted appropriate environmental and cultural factors to support future clients of the service.

The new unit (located within buildings 9 and 10) at the RHP site was completed in July 2020. It has a maximum capacity of 18 places-of-care, divided into three pods of six. This enables the unit to have residents group together in smaller shared-living arrangements to better support their care needs, such as gender or nature and severity of responsive behaviours.

The Division of Mental Health, Southern Adelaide Local Health Network (SALHN) has operational governance for the Repat NBU.

The first pod opened successfully in February 2021 with the second pod opening in June 2021.

Governance

The Southern Adelaide Local Health Network provides overarching governance of the Repat NBU. The Division of Mental Health's Older Person's Mental Health Service (OPMHS) provides direct operational oversight including the clinical governance through the Older Person's Mental Health Head of Unit.

The Repat NBU operates under a state-wide model in collaboration with Northgate House (NALHN OPMHS) and other referral providers inclusive of other Local Health Networks.

Southern Adelaide Local Health Network
Repat Neuro-Behavioural Unit – Governance Structure 2022
 SALHN Mental Health Services

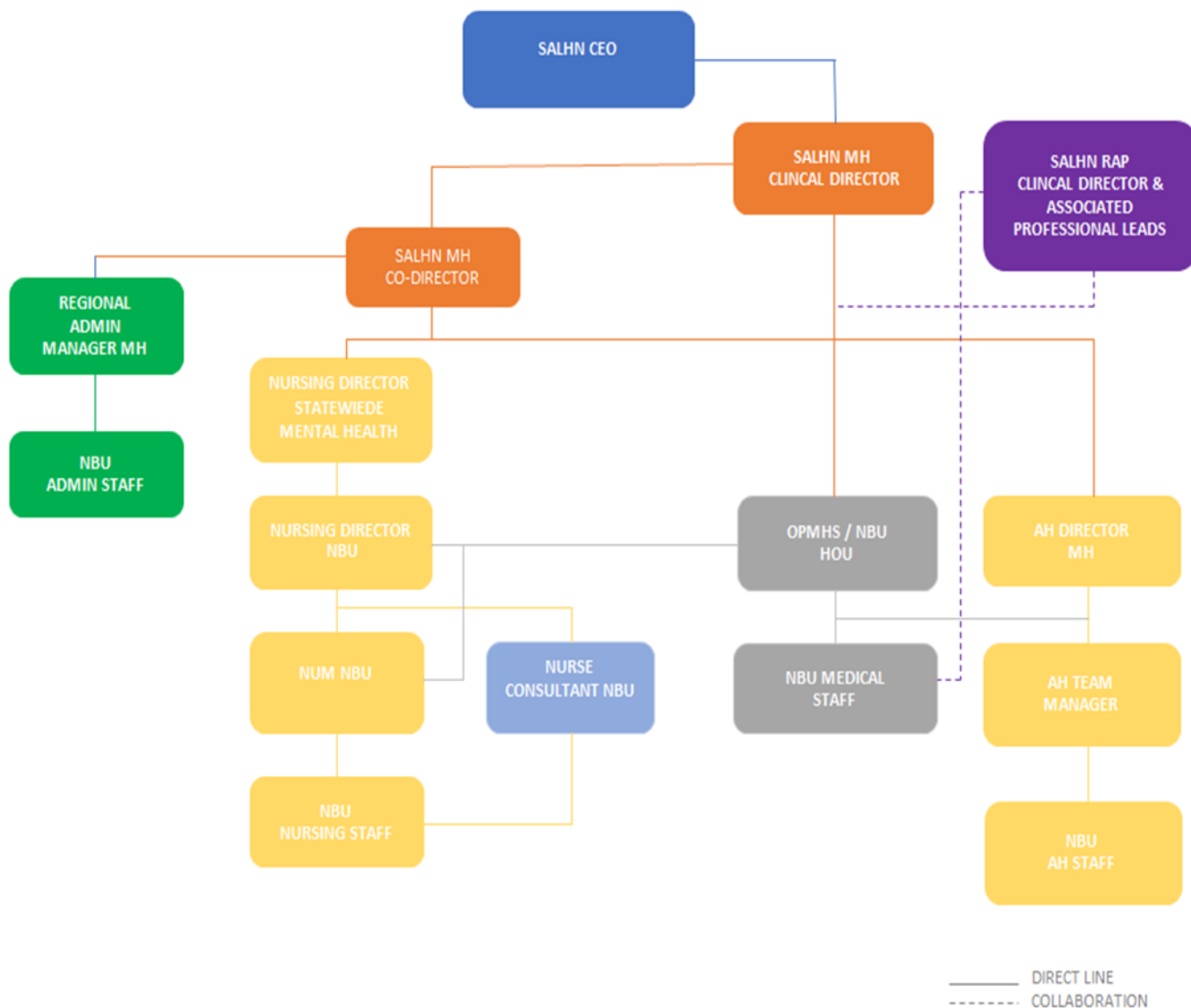


Figure 1. SALHN Repat NBU Governance Structure

Model of Care

The Repat Neuro-Behavioural Unit (RNBU) is a specialised, high dependency unit for people with the most severe presentations of BPSD. In understanding the activity of this service, it is most analogous with an older person's mental health intensive care unit, with a specific focus on people presenting with complex needs, particularly high levels of agitation and aggression, as a reflection of unmet needs in the context of dementia.

In noting this, a highly medicalised or clinical model is not recommended. Application of the recommended Model of Care and Staffing Profiles from the Oakden Report Response in Northgate House, NALHN has positively reinforced their expected outcomes and supported the process.

The Repat NBU Model of Care reflects the significant lessons learned from the Oakden Report and the operationalisation of the specialised service, similar to Northgate House, governed by NALHN OPMHS. The Repat NBU Model of Care is based on the work undertaken in consultation with interested parties and stakeholders as part of the SPEWG and the MOCEWG.

Framework to deliver clinical care for the Repat NBU

SALHN OPMHS has an excellent and established collaborative working relationship with the Division of Rehabilitation, Aged Care and Palliative Care (RAP) and both are committed to providing quality, consumer-focused and research led, evidence-based practice, in partnership with peak bodies, non-government organisations, universities, Carer Consultants, other Local Health Networks and the SA Innovation Hub.

Together they provide services for older people covering inpatient, subacute and community care in the home and in-reach into Residential Aged Care Facilities, including orthogeriatric services, psychiatry in-reach and consultation for consumers across SALHN campuses.

The Repat NBU is under the governance of SALHN Division of Mental Health/OPMHS, and delivery of care aligns with the values of the OPMHS, as detailed below.

SALHN Division of Mental Health / OPMHS

Our Aim

SALHN Mental Health Services aims to provide person centred care for people living with mental illness, supporting optimal recovery through a compassionate and evidence-based approach. This is delivered by partnering with you, your carers and your community.

Our Purpose

Partnering for recovery, because mental health matters.

Our Vision

To provide a connected and responsive service which inspires excellence and integrity. An environment immersed with meaningful engagement which promotes inclusiveness, respect and human connection through holistic person-centred care.

The Repat NBU Model of Care incorporates an individualised comprehensive older person's assessment by clinicians guiding the development of a multidisciplinary care plan, based on the physical, emotional, social, sensory and functional status of the person.

Referrals

The Repat Neuro-Behavioural Unit is intended for people living with dementia and experiencing only the most severe and extreme behavioural and psychological symptoms of dementia. Therefore, there are clear inclusion and exclusion criteria that residents need to meet. Formal substitute decision makers have to consent to the referral, the applicable daily fee, and have a Section 32 a,b,c order in place.

To assist referrers and carers/substitute decision makers to consider if the Repat NBU is the appropriate place-of-care for the person living with dementia, there is a suite of documents designed to be read and acknowledged prior to completing the referral form. The Repat Neuro-Behavioural Unit senior team will appraise the referral and will notify with the referrer once received. Please find further information via [Repat Neuro-Behavioural Unit \(RNBU\)](#) | [SA Health](#)

Expected journey of care

The Repat NBU is not a permanent bed and the care received will be with the purpose of transitioning into a less specialised, mainstream residential or supported care setting. This will be achieved through individualised care planning, encompassing evidence based non-pharmacological and pharmacological strategies, that will be transferrable in other care environments. The natural progression of people living with advanced dementia is that care needs also change in parallel to interventions, hence it is envisaged that most people would likely require a 3-to-12-month length of stay, with some who may stay longer or shorter depending on individual situations. The anticipated length of stay enables interventions to be trialled and evaluated in a measured way to avoid reactive or rushed changes, which is often not possible in acute care environments. It also allows for cautious deprescribing of psychotropic medications (ceased or reduced medication burden) so that when transfer of care is appropriate, ongoing care plans are able to be supported in less specialised services.

It is expected that most residents of the Repat NBU will be in the advanced stages of dementia, and consistent with individual Advanced Care Directives and/or Substitute Decision Maker considerations there will be discussions about ceilings of care, medical up-transfers to Flinders Medical Centre and end-of-life care. If a resident advances to a terminal phase of their care prior to an appropriate alternate care setting being identified, then dignified Palliative Care will be provided through the Repat NBU.

Transfer of care

Given the complexities of supporting the care of people living with dementia and BPSD in mainstream care environments, transfer of care planning in Repat NBU underpins care plans and regular Wellbeing Reviews. It is acknowledged that this requires transitional appraisal of progress and care needs, and a period of negotiation and advocacy with all key stakeholders such as families, formal substitute decision makers, Aged Care providers, My Aged Care, NDIS, Dementia Support Australia (access to SDCU and for RACF support), and OPMHS Rapid Access Services Statewide. This is a phase of care that cannot be rushed and relies on clear communication of care needs and capacity for services to meet these, in addition to personal and location preferences. In-reach support post-transfer including the potential for short-term 'wrap-around' support will be considered as required for individual residents.

While the Repat NBU is a service governed by the Division of Mental Health/OPMHS the care environment not designed to provide services for acute, subacute or enduring mental illness. As a result, the infrastructure, designed environment and specialised care is for people living with dementia and extreme BPSD informed by principles, such as:

Best Practice Dementia Care

- Stakeholder engagement in the Oakden Response Models of Care EWG consultation process also provided strong resonance with care that is provided in a homelike environment with a focus on completing tasks more subtly rather than clinical hospital or even hotel-like environments with strong task orientation. Approaches to care delivery that incorporate sensory modulation and have a considered position on balancing quality of life and risk mitigation were also preferred.
- Approaches such as the ones advocated by: Dementia Australia, formerly Alzheimer's Australia; the Dementia Care Matters organisation; the Hogeweyk Dementia Village in Holland and the Pines of Sarasota program developed by occupational therapist Teepa Snow, have all been evaluated by the EWG. The EWG supports a shift from task-oriented service delivery to emotionally-informed and person-centred care as the focus of how care is delivered with the implementation of these models. This will be consistent with a best-practice approach to care as evidenced by peak care providers globally.
- It is also acknowledged that this area of service provision remains in development around the world and the redevelopment of South Australian services presents an opportunity to contribute to service evaluation and research to further inform the development of these approaches, to populations living with very severe and extreme BPSD.

Dementia Enabling Environments Principles

The Dementia Enabling Environment Principles are based on the work of Professor Richard Fleming and Kirsty Bennett, University of Wollongong. These principles are evidence-based and have been constructed from reviewing research literature of studies looking at maximising enablement and wellbeing for people living with dementia through physical design.

These are applied across the Repat Neuro-Behavioural Unit.

1. Unobtrusively reduce risks



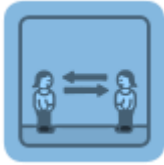
People living with dementia require an internal and external environment that is safe, secure and easy to move around if they are to maximise their abilities. However, obvious safety features and barriers may lead to frustration, distress and anger and so potential risks need to be reduced unobtrusively.

2. Provide a human scale



The scale of a building will affect the feelings and behaviour of a person living with dementia. The experience of scale is determined by three factors; the number of people the person encounters, the overall size of the building, and the size of the individual component, such as doors, rooms and corridors. A person should not be intimidated by the size of the surroundings or confronted with a multitude of interactions and choices. Rather the scale should help the person feel in control.

3. Allow people to see and be seen



The provision of an easily understood environment will help to minimise confusion. It is particularly important for people living with dementia to be able to recognise where they are, where they have come from and what they will find if they head in a certain direction. When they can see key places, such as a lounge room, dining room, their bedroom, kitchen and an outdoor area they are more able to make choices and find their way to where they want to go. Buildings that provide these opportunities are said to have good visual access. Good visual access opens up opportunities for engagement and gives the person living with dementia the confidence to explore their environment.

4. Reduced unhelpful stimulation



Because dementia may reduce the ability to filter stimulation and attend to only those things that are important, a person living with dementia may become distressed by prolonged exposure to large amounts of stimulation. The environment should be designed to minimise exposure to stimuli that are not helpful. The full range of senses must be considered. Too much visual stimulation is as stressful as too much auditory stimulation.

5. Optimise helpful stimulation



Enabling the person living with dementia to see, hear and smell things that give them cues about where they are and what they can do, can help to minimise their confusion and uncertainty. Consideration needs to be given to providing redundant cueing i.e. providing a number of cues to the same thing, recognising that what is meaningful to one person will not necessarily be meaningful to another. A person may recognise their bedroom, for example, because of a view, the presence of furniture, the colour of the walls, the light fitting and/or the bedspread. Cues need to be carefully designed so they do not add to unhelpful stimulation.

6. Support movement and engagement



Orientation and safe walking can be supported by providing a well-defined pathway, free of obstacles and complex decision points. The pathway should guide people past points of interest and opportunities to engage in activities or social interaction. The pathway should be both internal and external, providing an opportunity and reason to go outside when the weather permits.

7. Create a familiar space



A person living with dementia may be more able to use and enjoy spaces and objects that were familiar to them in their early life. The environment should afford them the opportunity to maximise their abilities through the use of familiar building design (internal and external), furniture, fittings and colours. This will involve an understanding of the personal background of the

people living in the environment. The person living with dementia should be encouraged to personalise the environment with their familiar objects.

8. Provide opportunities to be alone or with others



People living with dementia have the right to choose to be on their own or spend time with others. This requires the provision of a variety of spaces, some for quiet conversation with one or two others and some for larger groups, as well as spaces where people can be by themselves. These internal and external spaces should have a variety of characters, e.g., a place for reading, talking or looking out the window, to cue the person to what is available and stimulate different emotional responses.

9. Provide links to the community



Without constant reminders of who they were, a person living with dementia may lose their sense of identity. Frequent interaction with friends and relatives can help to maintain that identity. Where the unit is a part of a larger site, there should be easy access around the site so people living with dementia, their families and friends can interact with other people who live there.

10. Respond to a vision for way of life



The environment should support the person living with dementia to lead a life that has meaning and value to them. The choice of this lifestyle, or philosophy of care, will vary between facilities. Some will choose to focus on engagement with the ordinary activities of daily living and have fully functioning kitchens. Others will focus on the ideas of full service and recreation, while still others will emphasise a healthy lifestyle or, perhaps, spiritual reflection. The way of life offered needs to be clearly stated and the building designed both to support it and to make it evident to the residents and staff. The building becomes the embodiment of the philosophy of care, constantly reminding the staff of the values and practices that are required while providing them with the tools they need to do their job.

Principles of Care

- **Meaningful Engagement** Having a staff profile and skill mix that is attentive and individualised to the lived experience of the resident and their important loved ones. . Staff engage with those in our care to support the maintenance of ability and involvement in all aspects of their care and quality of life. Care plans are individualised and informed by multi-disciplinary assessment and profiles and collaborative with carers and all staff providing connected care. Residents are encouraged to use the NBU's lived experience designed spaces to explore. There is opportunity to develop connections with others through small and larger group activities. Bedrooms have the capacity to be personalised with photos and meaningful items providing a sense of familiarity and connection with a person's life and the important people to them. A workforce model of Nursing and Allied Health staff is provided across 7 days ensuring meaningful engagement and responding to unmet needs is consistent.
- **Home-like clinical care** that is holistic and not traditionally "hospital" focused, despite there being a highly skilled workforce. The Repat NBU aims to be homelike and while designed to facilitate quality and safe care, enables a space to interact in that does not seem sterile. Absence of a formal 'nurses' station' allows for care provision and engagement in the shared resident space, which not only facilitates a closer connection, but also allows for timely and attentive intervention around potential escalations, conflicts between residents or frailty based physical or functional risks such as falls. This reduces avoidable escalations and facilitates least restrictive care principles. A flexible model for food delivery and service has been implemented to better replicate home like meals and atmosphere, encouraging using all the senses for residents to maximise their nutrition, personal choices and wellbeing. Celebrations and regular opportunities for social and cultural events are encouraged and actively planned for by all staff, residents and loved ones.
- **Culture** aligned to the principles of the OPMHS Cultural Framework in the Oakden Response Culture Expert Working Group, the culture of the Repat NBU defines how staff are recruited and inform the values that are embedded in all aspects of care. A values-based recruitment process supports all staff appointments and includes lived experience representation on panels for leadership positions. The cultural framework informs the transparent connections with carers and ensures that all stakeholders in the care of residents (including where possible the person themselves) feel safe to contribute and identify where care can be improved or needs to be reviewed. Principles and resources of the My Home Life program have been embedded as a deliberate cultural framework in the Repat NBU. This is driven by key staff having undertaken advanced leadership training in the My Home Life program, with the framework being incorporated in routine Repat NBU business and staff, resident and carer connections. Staff incorporate honest self and team reflection in how safe quality care is delivered and engage in and drive for continuous improvement. There is transparent oversight and management of key performance indicators (KPIs), incidents, and resident / carer feedback through the local, Divisional and SALHN Executive governance structures, in addition to the reporting of key deliverables to the Chief Psychiatrist and the Department for Health and Wellbeing as per the Specialised Aged Care Reform Program.

Values in the Repat NBU

Key values essential to the care of residents in an NBU were identified in the Oakden Response Project Models of Care Expert Working Group, which were also adopted by NALHN OPMHS in developing their Model of Care at Northgate House. These values are embedded in the SALHN Repat NBU, and inform staff recruitment and continuous development, as well as being incorporated in all aspects of care and connections with residents and carers.

The key values are:

- Person-Centred Care
- Trauma-Informed Care
- The Triangle of Care - Consumer, Carer/Family & Clinician
- 10 Dignity in Care Principles
- Right Care, Right Time, Right Place, First Time

As referenced in the Oakden Report Response and NALHN MOC documents, expanded and adapted explanations of these values are:

Right Care, Right Time, Right Place, First Time

Delivery of the Repat NBU in SALHN reflects SA Health's commitment to delivering 'the right care at the right time and in the right place, first time.' This is expanded as follows:

- **Right care:** ensuring the availability of staffing, skills, expertise, and resource for the management of the individual's specific health care needs.
- **Right time:** ensuring the availability and access to the required services to meet the individual's needs in a timeframe that will minimise adverse outcomes and/or complications.
- **Right place:** ensuring that the individual's care is provided in a health facility that will best meet their specific needs.
- **First time:** ensuring that the required care is provided in the most appropriate place within necessary timeframes first time and that transfer to various facilities, services and personnel is not required.

Person-Centred Care

- The Repat NBU reflects a fundamental commitment to person-centred care. Person-centred care is terminology first developed in relation to dementia care by Kitwood (1993)⁴. There is a large body of literature that describes person-centred approaches. Alzheimer's Australia has developed useful definitions as follows:
- Person-centred care is a philosophical approach to service development and service delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for them.
- Key principles of person-centeredness are:
 - **Valuing people**
Treating people with dignity and respect by being aware of and supporting personal perspectives, values, beliefs and preferences. Listening to each other and working in partnership to design and deliver services.

- **Autonomy**

The provision of choice and subsequent respect for choices made. Balancing rights, risks and responsibilities. Optimising a person's control through the sharing of power and decision-making. Maximising independence by building on individual strengths, interest, and abilities.

- **Life Experience**

Supporting the sense of self by understanding the importance of a person's past, their present-day experience, and their hopes for the future.

- **Understanding relationships**

Collaborative relationship between the service provider, service user and their carers' and between staffing. Social connectedness through the local community through opportunities to engage in meaningful activities.

- **Environment**

Organisational values underpinned by person-centred principles. Responsive support that is responsive to individual needs. A planned, organisation-wide effort to individual and organisational learning.

Trauma Informed Care and Practice

The experience of trauma and its impact on individuals, communities and society as a whole are substantial. Many people who engage with mental health services are trauma survivors. Responding appropriately to trauma and its effects requires knowledge and understanding of trauma, workforce education and training and collaboration between residents and carers, policy makers and service providers.

Living with dementia with potential loss of the narrative history related to past trauma does not negate the importance of the trauma experience and how this may manifest itself in responsive behaviours in relation to trauma-triggers. Staff at the Repat NBU have training in Trauma Informed Care which assists in ensuring the individualised care needs of residents are met, and triggers to behaviours that may complicate those connected to BPSD are minimised. Prioritising least restrictive practice and reporting and reviewing all instances of supported care requiring any type of physical restraint informs the team and carers around developing a more tailored approach for the person and reducing distress.

Trauma Informed care and practice (TICP) (Mental Health Coordinating Council Trauma Informed Care and Practice, 2013⁴) involves not only changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic.

The eight foundational principles that represent the core values of trauma-informed care and practice are:

- **Understanding trauma and its impact**

Understanding traumatic stress, and how it impacts people, and recognising that many challenging behaviours and responses represent adaptive responses to past traumatic experiences.

- **Promoting safety**

Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place particularly in relation to responding to suicidality, and provider responses are consistent, predictable, and respectful.

- Ensuring cultural competence**
 Understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.
- Supporting consumer control, choice and autonomy**
 Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy. Providing opportunities for consumers to make daily decisions and participate in the creation of personal goals and maintaining awareness and respect for basic human rights and freedoms.
- Sharing power and governance**
 Promoting democracy and equalisation of power differentials; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures.
- Integrating care**
 Maintaining a holistic view of consumers and their recovery process and facilitating communication within and among service providers.
- Healing happens in relationships**
 Understanding that safe authentic and positive relationships can aid recovery through restoration of core neural pathways.
- Recovery is possible**
 Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resilience and establishing future-oriented goals.

The Triangle of Care – Consumer, Carer/Family & Clinician

Stakeholders provided resonance around the idea that care should be delivered through collaborative relationships that involved partnership between consumers, carers and families, and clinicians. This was characterised as a 'triangle of care'.

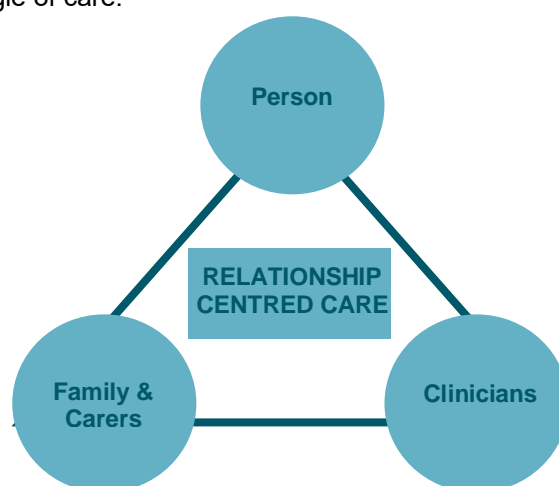


Figure 5. Triangle of Care

Nolan has developed this concept by building on the person-centred care introduced by Kitwood (1993) and exploring the principle of relationship centred care which recognises that quality care is dependent on strong, reciprocal and interdependent relationships between the resident, family members and staff.

Key aspects of this approach are:

- The focus is on enhancing the care experience for residents, family and staff.
- Efforts are directed toward building and nurturing relationships.
- Attention is given to meeting the needs of residents, family and staff.

The Senses Framework developed by Nolan et al. (2008)⁵ includes six senses that support strong relationships in care. Quality care happens when the Senses Framework is experienced by all involved in the care relationship. These are outlined as follows:

A sense of security

Residents feel safe and receive knowledgeable and sensitive care; staff feel safe, free from threat and work within a supportive culture; family feel confident in their ability to provide good care and have the support they need.

A sense of belonging

Residents experience reciprocal relationships and feel part of a community; staff feel like they are part of a team; family maintain valued relationships and feel like they have a support network.

A sense of achievement

Residents have opportunities to develop and meet goals; staff and family feel they have grown because of their caring experience.

A sense of continuity

Residents receive consistent care from people they know; staff have consistent positive work assignments; family and residents maintain shared pursuits.

A sense of purpose

Residents have opportunities to engage in purposeful and meaningful activity; staff have clear, shared goals and direction; family have opportunities to contribute to life in the home

A sense of significance

Residents feel recognised and valued; staff feel like their work matters; family feel that their care role is valued by staff.

Further developing this concept as reflected in the OPMHS Cultural Framework, a framework to enable compassionate relationship-centred care has been developed by Dewar and Nolan (2013)⁶. Staff caring for older people can maximise compassionate care relationships with residents and their families, by engaging in 'caring conversations'. This leads to knowledge and understanding of 'who people are and what matters to them' and 'how people feel about their experience', and ultimately allows those in our care, carers and staff to 'work together to shape the way things are done'.

Seven elements of the Caring Conversations (the 7 'C's'), as tabulated and described in Dewar and MacBride (2017)⁷ are:

Be courageous

Being courageous relates to willingness to take risks, feeling confident to ask questions, working with uncertainty and an ability to stick up for practices that people believed in without feeling that there would be negative consequence.

Connect emotionally

Connecting emotionally relates to staff asking others how they feel and sharing how they feel.

Be curious

Being curious relates to asking questions that genuinely seek to find out something. It is about trying to open up conversations and suspend preconceived ideas and assumptions one might have.

Consider other perspectives

This attribute involves exploring another's point of view, acknowledging that they may not hold the same beliefs as you and feeling comfortable to discuss any differences in an open way.

Collaborate

Collaborate involves talking together, involving people in decisions, bringing others on board, and developing a shared responsibility.

Compromise

Compromise is about striving for consensus through discussion and reflection and involves being prepared to 'give and take'.

Celebrate

Celebrating involves making a conscious effort to explore what works well and understand why, and to let people know that their contribution is valued.

10 Dignity in Care Principles

1. Zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possibly level of independence, choice, and control
5. Listen and support people to express their needs and wants
6. Respect people's privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation (SA Health 2020)⁸

Emergency Response for Repat NBU

Staff, residents and visitor safety are of the utmost importance in maintaining a safe environment to deliver therapeutic interventions.

A trained Emergency Response Team (ERT) is in place at the Repat Health Precinct and acts as a safety/security team for the entire site. Whilst there were SALHN wards already onsite prior to 2020, the addition of the Specialist Advanced Dementia Unit (SADU) and now Repat NBU led to the implementation of a skilled workforce over a 7-day model, including but not limited to security and clinical (nursing and medical) resources in August 2020. Specific training is provided for all members of the ERT including the Advanced Safety Intervention programme. The training promotes a respectful and professional approach to the high-risk responsive behaviours. The Foundation Safety Intervention training is also included for all on boarding staff within the Repat NBU at orientation and a goal for Advanced Safety Intervention training to follow

A key value embedded within the model of care is for the Repat NBU will be free from mechanical restraint. The Code Black response by ERT will be led by a clinician (Senior Nurse or Medical Officer) supported by non-clinical members (such as security guards) to ensure the least restrictive and highest therapeutic alliance is maintained. If as a result of an extreme risk situation and last resort restrictive practice has been utilised by the ERT there will be appropriate reporting (in line with SA Health Policy), post-incident debriefing and a clinical review of the residents care plan.

Minimising the instance of Restrictive Practice begins with the Unit based individualised support plans that include re-direction, responsive intervention and therapeutic engagement principles. Continuous improvement and incorporating contemporary evidence-based techniques are ongoing and include engaging security staff in developing skills in engaging with people living with dementia.

Evidence

Evidence utilised to inform these approaches has been sourced from the following resources:

- The National Mental Health Service Planning Framework Version 2.1 (NMHSPF)¹⁰
- The Brodaty et al. tiered classification model of the behavioural and psychological symptoms of dementia (Brodaty et al 2003)¹¹
- The NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015¹²
- A national framework for recovery-oriented mental health services (2013)¹³

The National Mental Health Service Planning Framework (NMHSPF)

The NMHSPF is an excel-based planning tool that allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population. The NMHSPF builds on state and territory expertise in population-based mental health service planning and has collated expert input from over 100 service managers and planners, public and private sector clinicians, community sector professionals, consumers, carers, technical experts and academics.

The NMHSPF is the result of a commitment under the Fourth National Mental Health Plan to 'develop a national service planning framework that establishes targets for the mix and level of the full range of mental health

services, backed by innovative funding models' (Department of Health, 2009)¹⁴. The development of the tool has been funded by the Australian Government Department of Health and has been led by NSW Health and the University of Queensland.

In the development of the NMHSPF, as it relates to people over 65 years, there has been heavy reliance on the research undertaken by Brodaty et al (2003).

The Brodaty Tiered Classification Model of the Behavioural and Psychological Symptoms of Dementia

In 2003, Brodaty, Draper and Low, described a seven-tiered classification of the Behavioural and Psychological Symptoms of Dementia (BPSD) together with a description of both the prevalence and incidence of these tiers and the nature of services required to respond to these levels of behavioural disturbance (**Figure 6**).

At the time the classification was developed, services for people with BPSD in Australia were described as ad hoc and fragmented. The planning model proposed by Brodaty was based on a comprehensive analysis of the prevalence of various Dementia-related symptoms and the level of care that is considered necessary to satisfactorily assist that person.

The classification divides BPSD presentation into seven tiers in an ascending order of symptom severity with corresponding bands of service intervention that are required for each tier. The seven-tier classification was supported by a thorough analysis of the available literature on population prevalence rates for each tier of the classification.

This classification is now widely accepted as the best international classification of Dementia and corresponding service needs. Since 2003, Brodaty, Draper and Low and their associates have published widely and dominated not only the national, but also international literature on epidemiological planning for people with BPSD. The model originally described by all three authors is usually referred to as the Brodaty 7 tier model and, in keeping with this, this document will refer to the model as the 'Brodaty model' whilst recognising the equal contributions of Draper, Low and others to Australia's rich knowledge about BPSD.

The Oakden Report placed appropriate emphasis on the apex of the model (Tiers 6 and 7). The Brodaty model articulates that people with presentations of BPSD Tiers 2 through to 5 can successfully be supported with services from Commonwealth funded services, albeit with the support of specialised teams at Tier 5, which may include some input from state funded community based OPMHS.

Critical areas of service provision are required for those with very severe (Tier 6) and extreme (Tier 7) BPSD. The Brodaty model describes the level of interventions needed for this group of individuals as "Neurobehavioural Units" (Tier 6) or "Intensive Specialist Care" (Tier 7) that is care types that exceeds the level of care able to be provided by Dementia-Specific Nursing Homes. In South Australia, places-of-care that support the needs of people living with dementia with BPSD that oscillates between very severe to extreme (Tier 6/7) are supported in the Repat NBU and Northgate House. The Commonwealth Specialist Dementia Care Program supports people with BPSD at severe to very severe levels (Tier 5/6) in Specialist Dementia Care Units (SDCUs). Transition out of the Repat NBU places-of-care would most likely to be a SDCU or a Memory Support Unit in a mainstream Residential Aged Care Facility.

Seven-tiered model of management of behavioural and psychological symptoms of dementia (BPSD)



Figure 6. Brodaty et al. (2003) Seven-tier model of management of BPSD

NSW Health Model

The NSW Health Older Persons' Mental Health Policy Unit has developed a comprehensive approach to service planning. This has resulted in two service plans informing the development of the range of OPMHS, from acute inpatient through to extended care and community-based services. In undertaking work around the development of the new Model of Care for services following the closure of the Oakden Campus, the Oakden Report Response MOCEWG has referred closely to the NSW Health documents and experience. Building on this, and with specific reference to the work relating to acute inpatient units and community OPMHS, this document draws on the research, reflection and planning of the NSW Health policy unit.

A National Framework for Recovery-Oriented Mental Health Services

The national framework for recovery-oriented mental health services brings together a range of recovery-oriented approaches developed across Australia and internationally to provide a best-practice approach to recovery-oriented mental health service delivery.

The framework supports cultural and attitudinal change and encourages a fundamental review of skill mix within the workforce of mental health services, including increased input by those with expertise through experience.

The framework defines and describes recovery and lived experience and articulates the key capabilities necessary for the mental health workforce to function in accordance with the recovery-oriented principles and the domains of recovery-oriented practice.

These are summarised as follows:

Domain 1: Promoting a culture and language of hope and optimism

A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism – this is central to recovery-oriented practice and service delivery.

Domain 2: Person first and holistic

Putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person's life situation holistically.

Domain 3: Supporting personal recovery

Personally, defined and led recovery at the heart of practice rather than additional tasks.

Domain 4: Organisational commitment and workforce development

Service and work environments and an organisational culture that are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.

Domain 5: Action on social inclusion and the social determinant of health, mental health and wellbeing

Upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.

Recovery-orientation is an underpinning aspect of mental health service delivery. It has been suggested that the language of recovery-orientation may create tension for residents, carers and clinicians in OPMHS, in relation to dementia. It has been proposed that there is a valid role for orientations such as palliative care where concepts such as 'recovery' may be more difficult to define (McKellar et al. 2014)¹⁵. Nevertheless, the underpinning principles of recovery-orientation relate to personhood, autonomy, equity and hope and, in developing the models described in this document, these were supported as important underpinning principles that would inform development of the model. A focus on quality of life is central to all care planning and delivery which also includes dignity of risk and supportive end of life care.

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For more information

Mental Health Services

Southern Adelaide Local Health Network

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