WIDE BAY HOSPITAL AND HEALTH SERVICE

HEALTH SERVICES INVESTIGATION

MANAGEMENT OF PATIENTS WITH COGNITIVE IMPAIRMENT

SURGICAL WARD HERVEY BAY HOSPITAL

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Review Team

This report is provided by the review team appointed as investigators under section 190(2) of the Hospital and Health Boards Act 2011 (Qld). The Terms of Reference for the investigation are attached as Appendix One.

The appointed investigators are:

a. [redacted], Health Service Investigator
b. [redacted], Director Geriatrics, [redacted]
c. [redacted], Principal Work Health Safety Advisor, Queensland Health
d. [redacted], Clinical Nurse Consultant (Dementia and Delirium), [redacted]
e. [redacted], Consumer Representative

Executive Summary.

This report addresses the matters requested in the Terms of Reference (TOR).

The team notes the cooperation of the staff of the Wide Bay Hospital and Health Service (WBHHS).

The team extends it sympathy to those patients, relatives, and staff members affected by the events leading to this review.
The team found a number of areas where policies, procedures, training, staffing and models of care should be improved. This report makes recommendations to improve the standard of care provided.

The review team believes that the care provided to the patients under review would be similar to the care which would have been provided by many other hospitals in Queensland Health (QH) when managing patients with challenging behaviours due to cognitive impairment. The investigators suggest that many of the recommendations in this report would benefit other Queensland Health Hospital and Health Service (HHS) hospitals.

The team did not find that the care provided by any individual health care professional fell below the expected professional standards of health care within public sector health services and makes no recommendations concerning individuals.

The investigating team suggest that the issue of challenging behaviours associated with cognitive impairment is not receiving the whole of system response required. Metro North HHS has recently advised of a prevalence audit in 2023 which found that *40 percent of all inpatients had cognitive impairment*. These patients span all admitting units and service lines.

In addition, SA (South Australia) Health has provided, as part of its Challenging Behaviour Strategic Framework (attached), data recording *that 77 percent of challenging behaviour incidents involve consumers in the 70-89 age group.*

QH currently does not have a strategic framework addressing this issue.

The team is aware of the complexities of caring for patients with challenging behaviours. The team also recognises that the numbers of patients cared for in the hospital setting with behavioural issues associated with Delirium and Dementia is already high and rapidly increasing in WBHHS.

The WBHHS has a disproportionately aged population, the area is undergoing rapid population increase and the existing services are attempting to deal with overwhelming demand both in numbers and also in the complexity of the care required to adequately manage patients with cognitive impairment.

A recurring theme of this report is that there was clear evidence of a commitment by the surgical unit staff to provide compassionate person-centred care approaches throughout their care of patient [redacted], a complex patient with challenging behaviours, delirium and previously undiagnosed dementia. However, this patient, and others who with similar clinical conditions, require specialist management by staff trained and experienced in the speciality of geriatrics and the management of cognitively impaired patients with challenging behaviours.

The report will recommend specific initiatives, as requested by the TOR, to improve the care of patients with cognitive impairment in the surgical ward of Hervey Bay hospital. It will also, based on information provided to it during the review process, recommend significant improvements in service provision to the cognitively impaired inpatients at Hervey Bay Hospital more generally, including other inpatient wards. The review team has concluded that, given the demographic and patient data it has seen, meaningful improvement to the care of this group of patients in the surgical ward is inextricably linked to the provision of service more generally at the hospital.
The team will also reference the current extreme pressure on staff to manage the demand for inpatient accommodation as a high risk to best practice patient care.

The team acknowledges the difficulties in recruiting and retaining staff in many areas, particularly nursing and medicine and pharmacy, which reflect national shortages but can be even more pressing in regional areas.

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Specific recommendations relating to the Surgical Ward at Hervey Bay include the addition of a nurse with specific skills in the management of Dementia and Delirium. This nurse will have specific aims and will be full time in the surgical ward working for surgery. In addition, formal geriatrician allocation of time to the surgical ward is recommended (two half days per week). A preoperative cognitive screening process for all patients over 65 undergoing elective surgery will be recommended, and it is recommended that current admission guidelines to the surgical ward be reviewed to ensure that complex elderly patients are managed in the most appropriate physical setting. In addition, there are recommendations applicable to the surgical ward and more generally to the whole hospital. These include recommendations around Assistant in Nursing (AIN) training and AIN deployment to wards to "special" patients with complex behaviours. The importance of placing patients in the room configuration most suited to their clinical needs will be discussed whilst acknowledging the extraordinary capacity pressures facing the hospital staff.

The lack of geriatric resources and support for the volume and complexity of cognitively impaired elderly patients in the hospital is striking. The TOR includes

"(b) the ways in which identification and prevention of occupational violence in acute care settings can be maintained and improved; "

The review team is firmly of the opinion that the incident that occurred in the surgical ward might have happened in other acute wards due to the deficiencies in the systems and resources available to assist patients with cognitive impairment. The occupational violence reports available to the team suggest that staff occupational violence is more frequent in [redacted] and [redacted] than in the surgical ward. A significant uplift to establish a geriatric team with an inpatient bed platform to assist the management of geriatric patients with complex conditions is recommended to assist care at both HBH and MH.

The review team recommends establishing two new inpatient areas.

The first is an Acute Care of the Elderly (ACE) Unit for the care of elderly patients with complex needs not suitable for medical or surgical wards. The twelve bed ACE unit could be located within the current hospital footprint initially, when the additional medical beds are commissioned in 2025.

The second area requires the building of a purpose designed six bed Special Care Unit for patients with severe Behavioural and Psychological Symptoms of Dementia (BPSD).

Whilst the governance of these two units would be under the care of the same geriatrician, the patient mix of these two units is very different. Mixing frail geriatric patients with patients with severe BPSD poses an unacceptably high risk of violence to a frail inpatient group.

The need for specifically designed and staffed inpatient geriatric facilities, already urgently required, will inevitably grow as the population continues to rapidly age.

There are also recommendations around the management and follow up of incidents of violence in the hospital which may have benefit if implemented widely in QH HHS hospitals.

This report has thirty recommendations, and the reviewing team suggest that many of these recommendations may be of benefit to other HHSs.

Methodology

This investigation report is based on information obtained from a number of sources.

Patient demographic data and current hospital activity data was made available. Interviews with relevant staff were conducted both face to face and via video link. Material contained in medical records as well as training material and records of attendance was available to the investigators. Occupational violence records were also made available.

Demographic and patient activity data

Local Area Needs Assessment (LANA) June 2022

The care of older patients with complex needs is rated as the number one health priority for the WBHHS after extensive research and staff and community consultation when reporting the WBHHS LANA report (attached).

Key factors driving demand for health services, as identified by the LANA report findings, include:

• *Ageing population – The Wide Bay community is one of the oldest in the state,* ***with 25.9% of the population aged over 65 years (compared to Queensland average of 15.7%)***
• *Population growth – the WBHHS population is projected to grow from 219,420 (2019) to 258,112 by 2036. This represents a Compound Annual Growth Rate (CAGR) of 0.96% percent.*
• *Socio-economic disadvantage – Over half of the population falls within the most disadvantaged quintile. Health care access for lower socioeconomic populations is compounded by the fact that only 35% of Queenslanders in the most disadvantaged quintile have private health insurance.*
The need to manage older patients (especially those with changed behaviours and memory loss issues or with complex medical comorbidities) is impacting capacity and performance*. Additional staffing and general medical beds are required to care for complex*

older patients who typically have a longer length of hospital stay, require more rehabilitation and clinical resources.
More than 50% of WBHHS bed days attributable to persons aged over 65 years.
29.5% of WBHHS emergency department presentations attributable to persons aged over 65 years.
15.0% of the population in Wide Bay over 65 years live with a profound or severe disability in the community, compared to just 13.4% of over 65s in Queensland.

Patient Activity Data

Qld Statewide Comparison FY23 to FY24 (QH top 21 reporting hospitals)

Growth in total ED presentations:

Facility	YTD 2024:	YTD 2023:	% growth:
Redcliffe	73000	66123	10%
Maryborough	24377	22403	9%
Hervey Bay	42743	39295	9%
Mt Isa	30868	28771	7%
SCUH	96534	90147	7%
Glad	36678	34849	5%
Mackay	53526	51699	4%
Logan	105338	102341	3%
GCUH	122945	119800	3%
Toowoomba	63550	62398	2%
QEII	63513	62489	2%
RBWH	83268	82490	1%
TVL	95012	94336	1%
BBG	44106	43943	0%
Ipswich	76005	75787	0%
TPCH	111400	111423	0%
PAH	64606	64774	0%
Cairns	85618	86066	-1%
Rocky	48250	48512	-1%
Redlands	56852	58497	-3%
Cab	60940	62717	-3%

Growth in Cat 1-3 ED presentations:

Facility:	YTD 2024 Cat 1-3:	YTD 2023 Cat 1-3:	% growth:
Hervey Bay	26128	23146	12.9%
Redcliffe	47838	43041	11.1%
SCUH	70799	64683	9.5%
Maryborough	13647	12639	8.0%
Ipswich	62372	58848	6.0%
Toowoomba	50883	48783	4.3%
GCUH	94282	90640	4.0%
Mackay	39030	37542	4.0%
Logan	85004	81773	4.0%
TPCH	74150	71383	3.9%
Rocky	32637	31437	3.8%
QEII	49366	47803	3.3%
Glad	17901	17341	3.2%
Cairns	57177	55510	3.0%
Mt Isa	13317	12945	2.9%
Redlands	42718	42032	1.6%
Cab	49203	48588	1.3%
BBG	30239	29910	1.1%
PAH	50169	49732	0.9%
TVL	64200	64438	-0.4%
RBWH	46035	46422	-0.8%

Growth in QAS arrivals to ED:

Facility	YTD 2024 QAS Presentations	YTD 2023 QAS Presentations	% growth
QEII	24644	21112	16.7%
Hervey Bay	15662	13946	12.3%
TPCH	33484	30440	10.0%
Redcliffe	24790	22764	8.9%
Cab	24506	22647	8.2%
Ipswich	36291	33949	6.9%
Maryborough	6479	6062	6.9%
Glad	9637	9072	6.2%
PAH	31425	29686	5.9%
SCUH	36672	34922	5.0%
Redlands	14553	13908	4.6%
RBWH	33617	32326	4.0%
GCUH	40931	39448	3.8%
Toowoomba	24569	24254	1.3%
BBG	17706	17513	1.1%
TVL	39083	39147	-0.2%
Mackay	17167	17198	-0.2%
Cairns	29904	30066	-0.5%
Rocky	17505	17825	-1.8%
Mt Isa	5517	5713	-3.4%
Logan	32574	34799	-6.4%

The Statewide Comparison table above demonstrates the startling information that between July 2022/June 2023 and July 2023 and June 2024, HBH had the highest growth rate for high acuity Emergency Department (ED) presentations in the State with a 12.9% growth in Cat 1,2 and 3 patients.

In addition, HBH tied with MH as the second and third highest growth rate in ED presentations in Queensland, both at 9%. HBH also had the

second highest growth rate in ambulance (QAS) arrivals in the State with a growth of 12.3%.

These growth rates place extraordinary pressure on health systems.

These emergency presentations manifest in hospital occupancy. The table below shows the occupancy of the two hospitals (HBH and MH).

The table demonstrates that both HBH and MH are filled to overcapacity with nearly 100% occupancy. This results in intense bed pressure and the action to place the next ED patient in whatever bed is available.

Best practice recommends having patients in the right place at the right time.

Occupancy of Funded Beds	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
HERVEY BAY HOSPITAL	**96%**	**92%**	**96%**	**95%**	**94%**	**96%**	**99%**	**98%**	**98%**	**98%**	**99%**	**100%**
MEDICAL UNIT	100%	96%	99%	99%	99%	102%	102%	102%	102%	102%	102%	101%
MEDICAL WARD 2	95%	96%	97%	96%	96%	96%	97%	96%	97%	95%	98%	98%
SURGICAL UNIT	92%	87%	91%	90%	90%	92%	97%	96%	95%	96%	99%	99%
MARYBOROUGH HOSPITAL	**93%**	**92%**	**94%**	**94%**	**94%**	**95%**	**96%**	**98%**	**97%**	**96%**	**97%**	**98%**
REHABILITATION WARD	99%	97%	94%	96%	96%	95%	95%	97%	96%	97%	99%	98%
WARD 1	91%	79%	86%	84%	84%	91%	92%	95%	94%	94%	92%	95%
WARD 2	90%	95%	97%	97%	97%	97%	98%	99%	98%	96%	98%	99%
WARD 3	94%	95%	97%	95%	97%	96%	98%	98%	98%	95%	97%	98%

Relative Stay Index, by type & demography

FAC	ALOS	Separa…	Bed Days	Sepa… with HAC	RSI	RSI - with HAC	RSI - Indig…	RSI - Age 75+	RSI - Plan… Admi…	RSI - Unpl… Admi…	RSI - Stays 30+
Totals	**3.26**	**24,372**	**79,398**	**224**	**1.05**	**1.77**	**0.97**	**1.14**	**1.04**	**1.05**	**2.87**
Bundaberg	3.39	10,052	34,089	93	1.10	1.91	1.00	1.16	0.97	1.14	4.22
Maryborough	3.23	2,898	9,356	26	1.08	2.59	0.95	1.48	1.49	0.94	6.24
Hervey Bay	3.15	11,422	35,953	105	1.00	1.48	0.95	0.98	0.97	1.01	1.84

Consequences of the growth in patient volumes.

The team interviewed staff from both the medical and surgical wards at HBH.

Every day there is an average of 15 patients in the ED waiting for a bed to become available.

A snapshot of the “medical” inpatient load provided showed that, on the day of the interview, Internal Medicine had 99 inpatients spread across 10 wards.

Surgical staff report an average of approximately 10 medical “outliers” in the surgical ward, with at times up to 15 (of a 44-bed surgical ward). Various staff reported that the incidence of Cognitive Impairment at the HBH is high, with approximately four identified in the surgical ward on the day of interview, and approximately 25% (10) in Medical Ward 1 at Hervey Bay.

In addition, Medical Ward 3 at MH often has up to 23 patients with cognitive impairment of whom a high percentage have challenging behaviours.

This demographic and patient data has led the review team to conclude that real improvement in the care of the cognitively impaired patient in the surgical ward is not possible without an uplift in the resources available to these patients in the whole hospital.

Management of Patients with challenging behaviours due to Cognitive Impairment in the Surgical Ward Hervey Bay Hospital

The review team was provided with the opportunity to walk through the surgical ward at the HBH which was important to adequately address this aspect of the Terms of Reference (TOR).

Physical Environment and occupancy.

The surgical ward is an extremely busy, noisy, and crowded clinical setting, being always fully occupied and operating above its funded capacity. Normally staffed for forty-two beds, additional above budget funding is provided to ensure the ward operates at its full physical capacity of forty-four built beds. There is no additional physical capacity for more beds. As the surgical ward is always full, patients often stay in the ED for many hours awaiting a bed to become available. Daily, there are many patient movements associated with both elective and emergency admissions and discharges.

Furthermore, on any given day, at least ten surgical beds (often more) are filled by “medical outliers” i.e., medical patients with non-surgical issues, overflowing from full medical wards. Staff also report that, at least four patients a day will have cognitive impairment, placing an extra burden on clinical work. This number relates to only those with recognised delirium and/or dementia, it is likely that, were formal testing of all the inpatients to be done, this number would be far higher and in keeping with current evidence.

A recent publication from Metro North Hospital and Health Service (MNHHS) quotes prevalence rates of cognitive impairment of inpatients of 40% across all admitting units and service lines. It is therefore likely that the rates of cognitive impairment in the surgical ward patients, if screened, is much higher than the 10% noted.

The current mismatch between available inpatient resources and demand is worsened by a number of factors when attempting to appropriately manage patients with cognitive impairment.

Single rooms may provide a therapeutic setting for managing delirium with behaviours of distress for specific individuals. The HBH surgical ward has limited single rooms on which there are many competing priorities. Specifically, a priority for these rooms is to manage infection control risks, particularly risks posed by multi-resistant organisms, especially Vancomycin Resistant Enterococci (VRE), as well as respiratory borne infections. Consequently, the opportunity to use single rooms as “low stimulus” settings when indicated for therapeutic care of surgical patients with delirium and/or cognitive impairment rarely occurs. This situation combined with ward bed pressures, means that individual patients with cognitive impairment may experience multiple bed moves over their admission, compounding their risk of delirium.

Review of the built environment of the surgical ward reveals a less-than-optimal setting for care of older people with cognitive impairment. Person-environment interaction is well recognised as contributing to changed behaviours in people with dementia and/or delirium, and the built environment contributes to development of changed behaviours and their management. Organised around two long corridors intersecting centrally at a busy nursing station (presumably to facilitate clear lines of sight), the ward’s cross-shaped layout allows no escape from the busy milieu of clinical activity, with noise funnelled down each corridor, to and from the central nursing station. All corridors lead to dead ends for patients, creating bottlenecks in which people may get trapped in behavioural crises. Considering the high clinical activity of the ward and its physical design, the built environment is clearly overstimulating and likely to trigger stress-induced behavioural responses and/or delirium in already cognitively impaired patients, who are mostly frail and older.

Nursing and medical expertise

The main purpose and priorities of the ward, and the predominant specialist skill set of the allocated nursing and medical staff is the care of surgical patients. This is entirely appropriate as surgical patients require expert nursing and medical skills related to the surgical process, preparation, recovery and care. Care of people with delirium and cognitive impairment should be part of this expertise

and skill set, especially regarding pre and post operative delirium prevention and management. This review notes the surgical ward's use of appropriate end-of-bed nursing assessments and care planning documents specific to cognitively impaired patients (i.e., Abbey Pain Scale, Pittsburgh Agitation Scale linked to a Cognitively Impaired Patient Care Plan form, 4AT delirium screening forms). The review panel is also keenly aware that the time required of nurses to assist in basic cares for patients experiencing delirium is significantly higher than that required for cognitively intact patients (i.e., assistance with mobilising, toileting, hygiene, meals) and that there will be a constant tension for surgical nurses between achieving timely preparation of patients for surgery and immediate post operative care versus achieving quality delirium care. Such a tension is associated with an increased risk of "missed nursing cares" i.e., cares that are not essential to achieving immediate pre- and post-surgical procedures are not prioritised, and therefore, often not completed. Missed cares in frail older people contribute to delirium and changed behaviours. In high activity units like the HBH surgical ward, the risk that missed nursing cares become normalised in practice is high, impacting quality management of delirium. This review found that while no care was negligent and all cares were achieved, the day-to-day clinical reasoning and management of Patient [redacted]'s delirium lacked evidence of specialist expertise regarding pain management, room location, and risk of delirium tremens.

This review will recommend a specialist delirium and dementia nursing role be added to the nursing establishment of the surgical ward and that a specialist medical consultation liaison service be developed to provide support in the management of surgical patients with complex delirium and/or dementia presentations.

Recommendation One.

This review recommends the appointment (full time) of a nurse to the surgical ward HBH with specialist skills and knowledge in the management of dementia and delirium. The role of this nurse is specific and full time to the surgical ward. The role will be accountable for reviewing, planning, and evaluating (but not directly providing) the care delivered to all patients in the ward identified as having cognitive impairment. The role will also engage in upskilling the knowledge of surgical nurses in the ward in their management of cognitive

impairment through experiential learning approaches and point-of-care role-modelling. The role will work collaboratively with the older persons service later recommended in this report however, the role is to remain clinically orientated and situated in the surgical ward HBH. The review team recommends progressing this role and appointment as a matter of urgency as it is likely to make a material improvement in the care of cognitively impaired patients in the surgical ward.

Geriatric and General Medicine Support for Surgical Patients.

There is no specific geriatrician or older persons service allocated to the surgical ward. Geriatrician services and General Physician services to surgical patients are provided “ad hoc” in response to requests from surgical staff. It is noteworthy that in the case of one of the patients, this consultation was provided at 7PM, reflecting the commitment of the medical staff and also their workload.

This lack of Geriatric support services to the surgical ward is reflected more generally across the hospital and will be the subject of several major recommendations in other sections of this report.

Recommendation Two

It is recommended that a specialist geriatrician be allocated to the surgical ward for two five-hour sessions per week. This time is not currently available and represents an additional 0.25FTE.

Pre-operative screening for cognitive impairment.

It is also apparent that there is no cognitive screening imbedded in the elective surgery process. Patients with cognitive impairment have significant risk of delirium post-operatively. Pre-operative screening will allow for appropriate decision making around the surgical procedure, appropriate consent and post-operative planning and management.

Recommendation Three

It is recommended that as part of the pre-admission process, structured cognitive screening by appropriately trained staff is implemented for all elective surgery patients greater than sixty-five years old.

Cohorting of patients with behavioural disturbance

The standard practice, prior to the incident on 24.03.24 was to cohort patients with behavioural disturbance in rooms for multiple patients, often with an extra Assistant in Nursing (AIN) nursing resource allocated to the room – referred to as a 4-bed AIN special room. This is done, presumably, to allow one staff member to manage multiple patients with behavioural disturbances. This practice has changed since the incident leading to this investigation and patients with behavioural disturbance, as far as possible, are managed in single rooms. It is reported that this change in practice, whilst presenting some additional complexity in terms of the AIN needing to move between rooms, has reduced the incidence of one patient either escalating or being escalated by, other patients in the shared room. However, single rooms are prioritised for managing patients who have VRE, so there are competing priorities around infection control management and safer settings for patients with behavioural disturbance.

It is acknowledged that not all patients with cognitive impairment are best managed in single rooms, and the placement of patients should be based on the individual requirements of the patient rather than a blanket policy to cohort patients. In the case of the patient ([redacted]) who was the aggressor in the incident on the night of the 24.03.24, a thorough collateral history taken later in the admission by the geriatrician identified a clear history of his sensitivity to lots of people and busyness. This history, and the observed behaviours of his increasing agitation in the hospital, should have influenced any clinical decision regarding his optimal placement. The clinical picture suggests that optimal management would likely require an environmental setting that was least stimulating (i.e., a single room).

The reviewing team is aware that it is common practice in QH hospitals to cohort patients with behaviour disturbance in multi-bed bays to allow one nurse (usually an AIN) to be allocated as the "special" for both staffing and financial reasons. This report will recommend that the placement of patients with cognitive impairment should be based on an assessment of the individual needs of the patient. The review team also notes that the presence of a specialist clinician in geriatrics would likely have been able to establish that the patient would have been better placed in a low stimulus single room setting. This review argues that adoption of the recommendations made earlier in this report would therefore assist in better clinical decision-making regarding the best ward setting in which to deliver care i.e., recommendation one (a specialised surgical nurse for dementia and delirium) and recommendation two (specialist geriatrician support to surgery).

Recommendation Four

It is recommended that patients with cognitive impairment be placed, whenever possible, in a room configuration that most assists in the management of that specific patient, which may be either a single room or a multi-patient room.

The use of Alcohol Withdrawal Scale Plans (AWS)

This review identified that increasing symptoms of agitation and confusion in an older cognitively impaired patient with a history of past alcohol overuse triggered an Alcohol Withdrawal Scale (AWS) protocol with subsequent multiple administrations of Diazepam over several days.

The AWS was commenced by a nurse on a late shift and the Diazepam order sought from the ward call doctor on noticing worsening confusion and agitation three days into an admission set within a background of documented high alcohol use several years ago. At this time there was no access to an informant who could corroborate recent alcohol consumption. Based on the information available that evening, the commencement of an AWS was reasonable.

However, the following day, during normal working hours, consideration should also have been given in this case to the alternative hypothesis, that these symptoms were directly related to multifactorial delirium from infection and untreated pain in an older patient with undiagnosed cognitive impairment.

This alternative hypothesis is particularly important, as an AWS protocol allows multiple administrations of a benzodiazepine, in this case Diazepam, a drug to avoid in the treatment of delirium and/or dementia due to its psychoactive properties and likelihood of worsening delirium and/or existing agitation rather than alleviating it. In other words, the treatment administered in an AWS protocol could have the opposite therapeutic effect and worsen the agitation symptoms it is supposedly treating. It is therefore a potentially dangerous protocol if mistakenly applied and requires clear justification.

There should have been an opportunity the next day to seek a recent alcohol history from a relevant person.

The Wide Bay HHS AWS form includes instructions that Delirium Tremens is a medical emergency and requires specialist review in which a full contemporary alcohol and drug history has been established.

For the patient [redacted], a recent alcohol consumption history was only properly established when the geriatrician review occurred, two days after the critical behavioural event pertinent to this review. The geriatrician review documented collateral history from the patient's caregiver/friend of no recent heavy alcohol use and Delirium Tremens was therefore unlikely.

With the information provided by the caregiver, it seems probable that the symptoms for which the AWS was commenced were more likely to have been changed behaviours in a multifactorial delirium superimposed on an undiagnosed dementia. This investigation noted that besides a notation of past alcohol intoxication and heavy alcohol use from two years prior, there was no clear documentation by the ongoing surgical team or medical consultation liaison teams to explicitly justify Delirium Tremens as the working diagnosis.

The underlying causes of delirium are generally multifactorial, and it is possible that multiple administrations of Diazepam over several days may have contributed and prolonged the patient's delirium rather than improved it.

A geriatric specialist clinician (nurse and/or doctor) is likely to have questioned the AWS protocol early and commenced a focussed search for collateral information to determine whether there was clear justification to suspecting alcohol withdrawal as the explanation of symptom onset rather than to explain symptoms as changed behaviours in multifactorial delirium.

Again, this review argues that adoption of recommendations one and two made earlier in this report would assist in better clinical decision-making regarding the delirium, clinical interventions and assessments of behaviours in patients with cognitive impairment. (Recommendation one - a specialised surgical nurse for dementia and delirium and recommendation two - specialist geriatrician support to surgery).

Recommendation five

It is recommended that, in all instances where an AWS is to be commenced in patients over 65 years of age, that this prescription be first discussed with the relevant Internal Medicine consultant and that the clinical reasoning for this decision be contemporaneously documented by the prescribing doctor and confirmed by the Senior Medical Officer in the clinical record the next business day.

Pharmacy Support

The review team noted that the clinical records did not suggest that there was ward pharmacy review occurring. A ward pharmacy review may have alerted the treating team to concerns about the implementation of the AWS. It is also possible that the presence of a ward pharmacy review may not have triggered an alert with the information readily available.

In the care of the older person, often with complex medical conditions and pharmacological support, it is highly desirable to have inpatient ward pharmacy review.

The reviewers are aware that currently, 50% of the pharmacy positions at HBH are vacant and that recruitment continues. The team is aware that because of these unfilled positions, pharmacy staff are prioritising the dispensing of medications. This review recommends that, when staffing is improved, that ward pharmacy review of patients in the surgical ward recommences.

Recommendation Six

It is recommended that, when staffing allows, ward pharmacy review is implemented in the surgical ward of HBH**.**

Pain Assessment in Cognitively impaired patients

This review identified that acute pain from leg ulcers and chronic lower-back pain was not recognized and managed as a significant contributor to the ongoing agitation and delirium in patient [redacted], the patient who received the AWS protocol.

Although this patient presented to hospital clearly self-reporting intense pain in their legs, for which they did initially receive strong pain treatment on day one, once their delirium worsened over the coming days and their agitation symptoms developed, nurses and medical staff did not use the evidence-based approach required to explore the possibility of a pain-related agitation. Although on a regular order of paracetamol, this was intermittently administered due to resistance to cares i.e., patient refusal in context of increased confusion and agitation. In this context, there was no evidence of appropriate consideration as to whether pain management was adequate. Therefore, unmanaged pain could have contributed to symptom escalation.

Although pain is a well-known cause of agitation and contributor to the development of delirium in cognitively impaired patients, the international literature consistently demonstrates that pain is underrecognized and undermanaged in hospitalised cognitively

impaired patients. One reason for this is that behaviours like agitation often mask clear pain expression. Best practice requires clinicians to triangulate the following information in their clinical reasoning: (1) seek a self-report of pain, (2) identify painful conditions or treatments, (3) observe for pain-related behaviours, preferably on a scale, (4) seek collateral from a surrogate about past pain-related behaviour, and (5) if pain is suspected, commence an analgesic trial and evaluate the behavioural response, adjusting dose and drug type if required. This is a complex and specialised clinical reasoning process. While self-report is always sought, it is only one of several cues used in the assessment as often patients in distress with delirium and/or dementia can no longer accurately self-report their pain. Crucially, in an agitated patient, when pain is denied or the patient is not engaging with pain enquiry, this should not be interpreted as automatically meaning the patient does not have pain. In the case of the patient of this review, it was clear that the surgical ward nurses were "privileging" the patient's self-report above other behavioural indicators of pain, not realising that an ever-increasing severity of agitation and/or delirium could have been directly related to underlying and inadequately managed pain. Consistently, nurses' notes over many days documented worsening, frequent and ongoing agitation and confusion, and yet, in the same passage, stated that the patient is not in pain. Even though the HBH end-of-bed assessment forms for cognitively impaired patients included the Abbey Pain Scale (i.e., a recommended observational pain-behaviour scale), an Abbey Pain Scale was not undertaken until many weeks into the admission.

The review panel acknowledges that this gap in practice is common across most hospital health services and that contemporary research identifies poor recognition of pain-related agitation as common to hospital nurses. To further compound the clinical conundrum of achieving better pain management in cognitively impaired patients, recent international consensus is that most clinically available observational pain-behaviour scales lack overall clinical validity. The reason for this is that to achieve clinical utility i.e., to not be too burdensome for busy acute-care clinicians to administer, nearly all developed scales only measure a select few of the more-than-sixty domains of pain behaviour features that may exist. Therefore, if a clinician only depended upon the score on an observation pain-behaviour scale to determine if pain-related behaviours exist it is

often likely to be inaccurate, missing a swathe of other pain-related behaviours.

However, most specialist geriatric clinicians receive training on applying appropriate pain-related clinical reasoning. Therefore, they are primed to search for the possibility of pain when agitation is observed, testing any pain-related behaviour hypothesis through administering a time-limited analgesic trial. It is noteworthy therefore that on the first full patient review and workup by a geriatrician, their impression (working diagnosis) was a multifactorial delirium from infection and unmanaged pain in an undiagnosed dementia.

This review team is confident that a specialist nurse trained in the care of patients with dementia and/or delirium would have identified the need to trial a regular long-acting analgesia stronger than the prescribed regular paracetamol.

In this case, pain is likely to have made a significant contribution to the presence of agitation and if identified earlier may have alleviated the severity of these symptoms.

As argued previously, these clinical events provide further justification for adopting recommendation one and recommendation two of this report to ensure accurate specialised clinical reasoning for surgical patients with delirium and experiencing agitation and/or pain.

Surgical Admission Criteria

This report suggests that the population of the surgical ward is changing from one where the surgical condition appears in otherwise healthy people to one where much of the patient population will be elderly with multiple chronic disease and have cognitive impairment.

As previously stated, the physical environment of the surgical ward at HBH and the “busyness” and noise and movement of the ward is not best suited to the care of the elderly and cognitively impaired.
This review recommends that the admission criteria to the surgical ward be reviewed with the aim of placing only those patients who need expert surgical nursing in the surgical ward. Patients who have

multiple chronic disease and who do not need operative intervention may be better placed in a medical ward with surgical consultation.

The reviewing team also notes that, regardless of the admission criteria, the current mismatch of available medical beds to manage the inpatient demand means that there is likely to be continued "medical outliers" in the surgical ward.

Recommendation Seven

The current admission guidelines for the surgical ward be reviewed by a multidisciplinary group of surgeons, nurses, allied health and general physicians to agree on the optimal placement of admitted patients.

AIN rostering

The approach to supporting patients with cognitive impairment in HBH wards appears to primarily depend upon using Assistants in Nursing (AINs). Rostered as "specials", they are allocated to provide closer attention and constant oversight of behaviourally disturbed patients. Approximately 40 of 100 AINs within the causal/permanent pool are active. HBH nursing workforce managers normally allocate at least one AIN every shift to each medical and surgical ward and the ED. These allocations are used for one-to-one specialling and/or the 4-bed collocation strategy role, predominantly involving patients with dementia and/or delirium. A decision was made at HBH to include this AIN FTE in the causal/permanent nurse pool roster rather than within each ward's roster to assist with more consistent and timely management of competencies and training. However, this practice limits the ability for the AINs to be integrated into the treating team.

Under the Nursing Standards as set by the Nursing and Midwifery Board of Australia (NMBA), AINs should never be considered the sole carer of a patient and must provide care under delegation of the RN responsible for that patient. As such, AIN specials are likely to provide far more effective caregiving support if they were integrated into the

local team working under delegation of an RN and in tune with local practices and approaches rather than an AIN external to the ward being allocated each shift. Such integration would allow them to be part of the local ward's routines, clinical communications and capacity building practices. It would facilitate the development of the types of embedded skills, confidence, and interdisciplinary care and communication required in dementia and delirium care. Considering that on average the volume of patients with cognitive impairment in the surgical ward is so consistently high, it is justifiable that AINs be included into a ward's established FTE and roster. These staff would then form part of the surgical nursing team, able to be included in their education and local clinical communications.

While adding AINs to the wards' regular staffing compliment, it should also be noted that there is general concern across many HHS that care is often poorly communicated and delegated between the RN and the AIN special and this needs to be prioritised in local ward routines when specialling and delegation of care support is undertaken.

Recommendation Eight

It is recommended that the AIN staff be included in the ward staff complement rather than be rostered from the casual pool.

Recommendation Nine

It is recommended that the professional development of the AIN staff be the responsibility of the relevant nurse in the surgical ward to mirror the current responsibilities for the Registered Nurse staff.

Recommendation Ten

It is recommended that the clinical handover and information sharing include the relevant AIN as it would for an RN.

AIN Training

Currently, the AINs allocated to manage patients with cognitive impairment on surgical and medical wards at HBH have received minimal training in the management of what are often extremely challenging behaviours that manifest in some patients. All AINs at HBH receive a general two-day clinical orientation about operational matters, followed by a specific AIN competency day in which they become familiar with documentation and routines and achieve required online learning. Undergraduate Students in Nursing (USINs) are also included in the competency day. Online learning specific to care of cognitively impaired patients, requires the AINs to complete, at minimum: (1) an online PowerPoint module outlining point-of-care processes, approaches and documentation used in the wards at HBH specific to the care of cognitively impaired patient; and (2) the online education regarding the WBHHS Cognitive Impairment Procedure. As of August 2024, AIN completion rates were 68% for the online cognitive impaired education, and 78% for the WBHHS Procedure. Online education is delivered through a well-designed learning portal. The online learning portal includes appropriate contemporary education packages from Dementia Training Australia (DTA) such as the “The View from Here”.

However, whilst exact uptake of the extra learning modules is unclear, as this education is not mandatory, uptake was reported as minimal in the context of overall workforce engagement.

The AIN competency day that follows on from the two-day clinical orientation attended with all nurse levels, is focused on the AIN becoming familiar with point-of-care documentation and routines. It includes some orientation and familiarisation (one 30-minute session) regarding the end-of-bed forms used in care of patient with cognitive impairment e.g., behaviour observations and care plans. The WBHHS also provides an optional 3-day face-to-face Dementia Essentials training package by Dementia Australia (DA) once a year to each of the local hospitals in WBHHS (i.e., 4-hospials in a year in WBHHS). For 2023, 62 Wide Bay nurses attended this training, with 17 RNs and 1 AIN from HBH. It should be noted that the Dementia Essentials package is

tailored to staff wanting to complete their certificate three competency and is therefore ideal for AINs. However, it may not be the most cost-effective program for training licensed nurses in management of changed behaviours. Other training could be explored for this. For example, Dementia Training Australia offer a One-day in-person training workshop suitable for hospital staff called Navigating Changed Behaviours.

Other opportunities to attend face-to-face skills uplift for delirium are provided through daily interprofessional simulation sessions. These are available to all staff from the surgical ward. A 45-minute simulation session on delirium held daily for one week is offered twice a year. However, since simulations have limited space and are multidisciplinary, scalability is likely to be minimal for RN and AIN attendance.

Overall, the training of AINs at HBH is consistent with what is offered at many other hospitals across the state and the suite of training resources offered to those who voluntarily engage in extra learning reflects much of the latest contemporary online education available for hospital care of cognitive impairment in Australia. However, considering the prevalence of cognitive impairment on surgical and medical wards at HBH and that the clinical support provided by AINs is primarily for care of those patients experiencing dementia and/or delirium, often with complex changed behaviours, this review notes a lack of adequate in-person training of AINs around skills uplift in dementia care. Key areas of skills development like engaging in person-centred interactions, communication and clinical observations routinely required in quality dementia and delirium care are best acquired through in-person experiential learning and role modelling, not by online PowerPoint presentations or other modes. These approaches are missing for AINs at HBH and for RNs.

Training of AINs and RNs will be the subject of several recommendations as the team considers current practices both in HBH and more generally in other HHSs are insufficient for the types of

case mix now present as inpatients i.e., namely patient with complex behaviours in the setting of dementia and/or delirium.

Recommendation Eleven

It is recommended that AIN training at HBH undergoes a significant skills uplift involving at least a 3-4hr in-person training session integrating simulation, role play, and case-scenarios focussed on skills development around communication, person-centred care and managing resistance-to-cares and changed behaviours of distress. This approach should also be integrated into the initial orientation of new AINs.

This report will recommend the HBH adopt more iterative regular experiential-based methods for developing skills in dementia and delirium care in all nursing staff and the interprofessional team.

Management of incidents threats to personal safety (Code Black)

The management of incidents where there is the threat to personal safety (Code Black) suggests that improved teamwork and communication would enhance staff and patient safety. This area will be discussed in detail in the whole of hospital recommendations.

Management of patients with cognitive impairment throughout the Hervey Bay Hospital

The demographic information included in this report, combined with the reality of the medical outliers in the surgical ward, the ubiquity of patients with cognitive impairment in the surgical ward and the information regarding the significant numbers of cognitively impaired patients in Medical Ward 1 of HBH and Medical Ward 3 of MH is strong evidence of a gap in service provision. The reviewing team was also provided with information regarding other recent incidents (outside the TOR for this review) involving challenging behaviours due to cognitive impairment within the HBH and MH.
The TOR also requires

3(b) "the ways in which identification and prevention of occupational violence in acute care settings can be maintained and improved; "

The TOR, the population demographics and the prevalence of cognitive impairment in the hospital has led the reviewing team to conclude that adequately responding to the TOR in a meaningful way requires broader recommendations for the management of inpatients with cognitive impairment in HBH.

The clinical journey of patient [redacted] in this report reveals a complex medical presentation that was admitted to a surgical unit location when they did not obviously require surgical intervention. Although there was clear evidence of a commitment by the surgical unit staff to provide compassionate person-centred care approaches throughout their care of this complex patient with challenging behaviours and delirium, the clinical reasoning behind a range of decisions about the patient's clinical management lacked the required specialist lens.

This review has outlined previously how: (a) pain was not optimally explored and managed, (b) the patient was cohorted in a less-than-optimal care setting for their disposition and cognitive deficits, and (c) an AWS protocol was continued without timely collateral of recent alcohol use. Combined, these clinical decisions are likely to have

impacted the severity and duration of the patient's delirium and agitation symptoms.

Although this report outlines several recommendations specific to the surgical unit, the clinical specialists on this review emphasise that patient [redacted] represents a complex presentation of BPSD compounded by functional decline, social isolation, delirium, pain, sensitivity to new and busy social situations and psychosis in the setting of an undiagnosed dementia. It is the view of this investigation that such a presentation would have been equally challenging to manage in the medical ward and that many of the clinical decisions critiqued by this report are likely to have also been made on the medical ward. Like surgery, the medical ward uses a 4-bed AIN cohorting strategy. The medical teams that consulted patient [redacted] in surgery are the same medical teams. The ward-built environment and layout are very similar to the surgical ward, being noisy, busy and overstimulating.

Considering the high prevalence of inpatients with geriatric syndromes at HBH and the increasing incidents of aggression in patients with BPSD across HBH and MH, this review team emphasises the need to provide specialised care for patients with BPSD, a complex geriatric syndrome to manage. While severe BPSD comprise a relatively small number of individual patients, these inpatients have a very high impact on clinical service delivery in terms of safety, time and resources. They generally stay in hospital for at least 20 days and usually much longer. For example, at the time of conducting the interviews for this report, patient [redacted] was still an inpatient of the medical ward at HBH, a length of stay of at least 122 days.

The review team emphasises that effective care provision for this cohort of patients requires a team of health professionals that specialise in management of complex geriatric syndromes like BPSD, and that HBH currently lacks this team. Furthermore, for complex or severe BPSD presentations to hospitals, evidence suggests that specific geriatrician-led models of care delivered in specially designed built environments are most effective for behaviour management, improving patient outcomes and safety for all. On face value, the other cases provided to this investigation team from across the health

service further emphasise the need for such a tailored built environment and model of care.

The investigating team noted that at HBH there are local plans and some already undertaken environmental modification works on the medical ward. These works have provided access to an outdoor garden space for frail older patients enabling a space for social-wellbeing and relief from the noisy, cluttered ward setting. However, the team also noted that key clinical leads and stakeholders for this patient cohort such as the geriatrician and medical consultants had not, up to this point, been included and engaged in such plans. It is critical that the geriatricians and medical consultants responsible for providing the models of care are involved in any clinical redesign, whether building modifications or other plans. Models of care must be carefully considered and underpin any built clinical environment design.

Models of care should be designed around a specific patient cohort (diagnoses) so that clinical treatments are appropriately tailored, and a defined, manageable group of staff can be trained in the specific nuances and skills uplift required for effective therapeutic care delivery. For management of BPSD, the interface between the built and social environment, and the treatment strategies (both pharmacological and psychosocial) are critical, necessitating a specialised unit design under the care of a geriatrician.

A concern of this investigating team relates to ongoing shared use of the recent garden works extensions. Providing a setting where both older frail patients and patients experiencing severe BPSD co-exist presents significant risk of patient-to-patient harm for those older frail patients. Patients with severe BPSD will need their own separate access to outdoor therapeutic and social spaces. Caution should be exercised around the temptation of mixing diagnostic groups like acute stroke and dementia (which should be avoided). This review will recommend as a priority, commencement of a geriatrician led model of care and that any further environmental redesign be carefully integrated with this model of care.

The transfer of patients with BPSD to Ward 3 at MH appears to be a normalised pathway for patients that are not requiring treatments for acute medical or surgical issues at HBH. Prior to the critical incident involving patient [redacted] there was clearly documented evidence of

a normalised clinical transfer process (pathway) in which patients with complex or severe BPSD are transferred to Ward 3 at MH. Patient [redacted] was accepted for this transfer before the critical incident. Yet, the built environment of Ward 3 at MH is as equally inappropriate as HBH for managing complex and/or severe BPSD. Set on the third floor of an old hospital building with no outdoor spaces and communal areas, rooms are crowded and overstimulating and there is limited if any security staff presence to respond to crises.

The review team notes that the tendency to attempt to transfer to subacute or community care patients with severe BPSD is common and pervasive across many hospital services. It demonstrates the downplaying of the clinical importance of severe BPSD and how it is generally not conceptualised as an acute clinical condition. It is common for severe and acute presentations of BPSD to be transferred to subacute settings awaiting placement or be described as medically stable awaiting discharge planning. Yet, in many instances these patients are so acutely disturbed that no community care facility/service would be able to manage them in their current state.

Interviews with patient flow managers and clinicians at HBH during this investigation revealed the challenges HBH already experiences in discharging patients with BPSD into Aged Care Facilities due to a lack of expertise and specialist services available in the community.

These issues provide further justification for a fit-for-purpose built environment integrated with a geriatrician led model of care for therapeutic management of patients with complex and severe BPSD.

Such models have a range of potential benefits for a hospital health service, as they may:

- improve patient outcomes and decrease length of patient stay for this complex cohort
- enable sustainable discharges to community settings
- improve patient flow within the hospital (including in-hospital pull strategies)
- facilitate direct admissions for clear diagnosed cases of BPSD, avoiding traumatic ED management

- increase safety for staff and patients across the hospital by providing timely care to the right patient in the right location with the right staff and care.
- facilitate more targeted and specialised education to those staff delivering specialised care
- provide a more achievable, scaffolded education strategy for generalist staff in surgical and medical settings.
- strengthen relationships and trust with community care providers through avoidance of inappropriate discharges where effective management plans for BPSD have not been developed.

Currently there is no identifiable team expert in the management of the elderly patient with cognitive impairment in HBH. There is one full time geriatrician, who has no support staff or inpatient bed access to respond to the needs of both the inpatients in the hospital and the outpatient demand.

The demographic data included earlier strongly suggests that the current resourcing is woefully inadequate.

A previous recommendation (Two) requests an increase of 0.25 FTE geriatrician to be included in the staffing profile of the surgical ward.

The large number of patients in the medical wards with cognitive impairment requires addressing if the patients are to receive clinically appropriate care and staff and other patients are in an environment with clinically appropriate setting.

This report recommends that the HBH, as a matter of urgency, establish an Acute Care of the Elderly (ACE) unit , led by a geriatrician and a specialised interprofessional team working within an allocated built environment of appropriately designed inpatient beds.

In addition, a purpose-built Special Care Unit (SCU) for BPSD management comprising 6-secure beds should be established and serviced by a Geriatrician led model of care with a specialist interprofessional team (i.e., the same team as the ACE team). These two models would work together to provide a pathway of care for patients admitted with dementia and/or delirium resulting in better

outcomes for patients and staff while also enabling focussed dementia and delirium care skills uplift for nursing staff working within those pathways and/or units.

Acute Care Elderly unit at Hervey Bay Hospital

This report recommends the establishment of a 12 –bed unit purpose-designed specialist Acute Care of the Elderly (ACE) unit under the medical governance of a geriatrician. ACE units are evidenced based to improve the functional outcomes of older patients with acute geriatric syndromes.

The ACE unit should have an older person-friendly designed environment. Design advice should be sought from Dementia Training Australia to establish an appropriate physical environment, including access to a safe outdoor recreation area.
The Model of Care comprises geriatrician-led interdisciplinary care and nursing staff trained with geriatric expertise. There is a focus on early delirium detection and management, patient-centred care to prevent cognitive and physical decline and early discharge planning.

The multi-disciplinary team would consist of a Staff Specialist Geriatrician (dedicated solely to the unit), a registrar or Principal House Officer (PHO), Resident Medical Officer (RMO) and a Nurse Practitioner NP (or Clinical Nurse Consultant CNC) and a dedicated allied health team.

Establishing an inpatient geriatrician led service is urgent, given the demands previously discussed. It is feasible, as an interim measure, to establish such a service within the existing hospital footprint, when new medical inpatient beds are commissioned in 2025. This interim action would provide urgently needed mitigation until a purpose designed facility is commissioned.

Special Care Unit for BPSD at Hevey Bay Hospital

This report also recommends the establishment of a 6-bed secure unit purpose designed for management of independently mobile patients with severe BPSD. The SCU should be under the medical governance of a geriatrician. Hospital based SCUs are evidenced-based for decreasing BPSD severity while reducing psychotropic use and restraint and developing effective Behaviour Support Plans (BSPs) that can be sustained in community settings.
The SCU should have a carefully considered built environment which prioritises a dementia enabling design, including a footprint that enables social, leisure and functional independence with access to a safe outdoor space, and careful design consideration to mitigate safety risks for staff and patients regarding behaviour (i.e., emergency egress or safe spaces). Architectural design advice should be sought from Dementia Training Australia services around designing for dementia.

The SCU model of care should comprise a geriatrician-led interprofessional care team focussed on specialised assessment, development and evaluation of tailored individualised behaviour support plans that can safely provide BPSD management in various community care settings. It is envisaged that the interprofessional team and geriatrician-led medical team for the SCU would be the same team as the ACE. Therefore, the medical team should comprise a Staff Specialist Geriatrician (dedicated solely to the inpatient ACE and SCU unit), a registrar or Principal House Officer (PHO), and a Resident Medical Officer (RMO). The interprofessional team would comprise at minimum, a specialised senior nurse role (CNC or NP), and a basic allied-health team with skills in BPSD (i.e., physiotherapist, occupational therapy, social work). However, individual roles could be replaced by more specialised roles/disciplines like a clinical psychologist and/or a leisure therapist, depending on availability. It is recommended that the SCU is staffed by specially trained nurses at roughly a one-to-two ratio. For six patients, the skill mix would be as follows: two licensed and one unlicenced nurse in the morning, two licensed and one unlicensed nurse for the late shift and one licensed and one unlicensed for the night shift.

Recommendation Twelve

It is recommended that an Acute Care of the Elderly (ACE) inpatient unit be established as part of the HBH. The staffing for this unit is outlined in this report.

Recommendation Thirteen

It is recommended that the ACE inpatient unit be implemented as a matter of urgency. It is recommended that, coinciding with the commissioning of new medical inpatient beds in 2025, a 12-bed geriatrician led unit be established within the Division of Medicine bed footprint.

This recommendation is an interim measure pending the construction of a purpose designed ACE inpatient unit.

Recommendation Fourteen

It is recommended that a new nursing position, a CNC Delirium and Dementia be appointed to work in Medical Ward 1 at HBH as soon as possible. This role will then transition to the ACE unit when it is commissioned in 2025.

Recommendation Fifteen

It is recommended that a Special Care Unit (SCU) for BPSD be established at HBH. The staffing for this unit is outlined in this report. This unit requires a specially designed built environment. It is recommended that architectural design services expert in dementia enabling clinical design, be engaged for any redesign works (can be accessed through Dementia Training Australia).

Recommendation Sixteen

It is recommended that the current project to modify an existing ward to improve the physical environment should be paused to enable input from the specialist architect and geriatrician stakeholders. The design should be an output of the agreed model of care that is to be implemented in the area.

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Recommendation Seventeen

It is recommended that the clinical governance for both the ACE unit and the SCU unit would be the same and led by a geriatrician, as described in this report.

Behaviour Response Team

The investigating team were advised of a new initiative currently being implemented at HBH, a Behaviour Response Team.

This team appears to be an allied health focussed initiative and is to be implemented both at HBH and MB as well as Bundaberg Hospital. It is apparently based on work being done at Metro North HHS. It will have a focus on long stay inpatients as well as patients with BPSD. It is planned to be community facing and is proposed to support the transition of patients to community places, including Residential Aged Care Facilities (RACF).

The reviewers note that this team, as currently planned, will have no geriatrician involvement, and presumably a focus on symptom control rather than diagnosis.

It would also, for inpatients, seem to be a “consultation “service to existing inpatient services and not have direct clinical input or authority.

This reviewing team believes that, in the absence of a designated geriatric inpatient service, the Behaviour Response Team will have limited impact on the management of the inpatient group with challenging behaviours. It may lack both the authority and skill mix to appropriately diagnose and implement appropriate interventions, given that its role will be “advisory” as a consultation service.

The reviewers also strongly suggest that a team, such as the Behaviour Response Team, perhaps renamed, if combined with the recommended ACE unit and SCU would function extremely well to facilitate the management of inpatients, and even more, facilitate the discharge of a group of patients who otherwise will have very long inpatient stays.

The presence of the Behaviour Response team with the role to work with the RACF when placing a group of patients who are extremely difficult to have accepted should significantly reassure the accepting facility of expert support and rapid response to issues that will inevitably arise. Such support should be time limited to allow resources to be distributed to new placements when needed.

Recommendation Eighteen

It is recommended that the current initiative of WBHHS to fund and staff a Behaviour Response Team be modified to include specialist medical input (Geriatrician) 0.25 FTE.

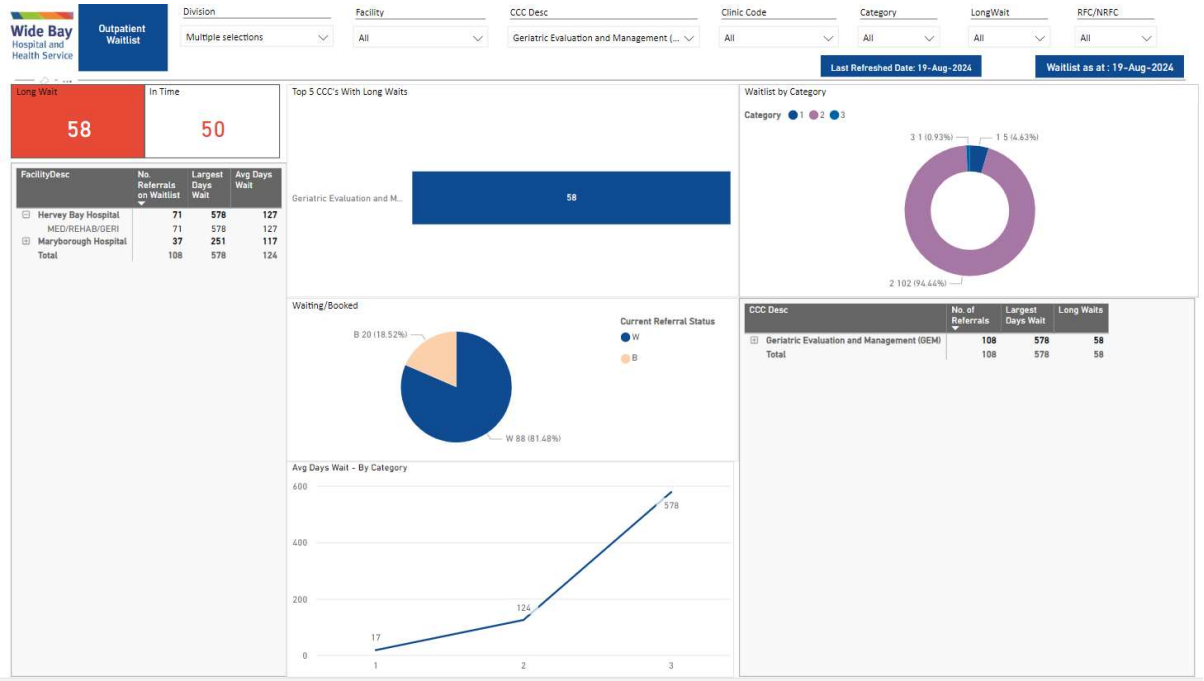
Recommendation Nineteen

It is recommended that, when the ACE unit is established, the Behaviour Response Team are within the clinical governance of the ACE unit to ensure a coordinated approach to inpatient management and discharge planning as well as supported community placement. The Behaviour Response Team will provide an excellent adjunct to discharge planning and supported community placement in addition to assistance with inpatient challenging behaviours.

Geriatric OPD Wait List

In addition to the many issues currently being experienced in the inpatient units, the data provided on community needs, reflected in the current geriatric outpatient waiting list, demonstrates the mismatch between demand and service provision.

The table below shows that currently, approximately 58% of patients waiting for outpatient review are ‘Long Waits” with some patients waiting over five hundred and fifty days for an appointment.



Recommendation Nineteen

It is recommended that adequate resources be provided to assess and treat the current outpatient waiting list. Some short term and rapid assistance might be sought by a hub and spoke arrangement with a metropolitan service.

Eat Walk Engage.

The HBH and MH have implemented a modified model of the Eat Walk Engage program. It seems that the model at HBH and MH is mostly focussed on Occupational Therapy Clinical Assistant service. Eat Walk Engage does not seem to be the widely implemented model of care for inpatients involving all staff and the cultural shift required from traditional nursing care to the Eat Walk Engage model of care.

It is previously noted that up to 40% of inpatients have cognitive impairment to some degree. Eat Walk Engage has demonstrated that it reduces this prevalence and can potentially prevent delirium.

Recommendation Twenty
It is recommended that the Eat Walk Engage model of inpatient care be implemented at HBH and MH as part of the State-wide network. This is likely to require a significant investment in change management for all staff.

Nurse education and training

Providing high-quality care to patients with cognitive impairment requires considerable knowledge and skills. The educational resources and efforts required to build such workforce capacity has been largely unrecognised. This situation is exacerbated by the fact that all undergraduate training for most health disciplines (certainly medicine and nursing) involves very little curriculum regarding dementia and delirium. Undergraduates often receive just one to two lectures on the subject.

Therefore, the burden of training falls to hospital education units and quality and safety teams. These units often lack expert skills and knowledge regarding this patient cohort. The required skills development is likely to need more intensive education resourcing integrated with clinical experts and the adoption of different training methodologies when compared to those that have been traditionally allocated and adopted by hospital education units.

This report has already focussed on AIN preparation and training to care for dementia and/or delirium on the surgical and medical wards. This is because the primary model in the hospital has been allocation of specials and 4-bed AIN special rooms. However, preparation of Registered Nurses (RNs) to provide this care is arguably even more important.

The literature on specialling regularly highlights how RNs will abrogate their responsibility for patient care in specialling situations, expecting AINs to know what to do with little to no direction nor support. There is something inherent within this delegation-dynamic that requires careful consideration for any quality improvement work. As the nurse ultimately responsibility for the care of patients, RNs (licensed clinicians) must delegate care to AINs (unlicensed clinicians). In doing so, they should use appropriate assessment and management strategies for this cohort of cognitively impaired patients. In delegating this care RNs should be able to role model the skills that are expected of AINs. This investigation did not find clear examples of whether appropriate delegation was occurring or not. However, it recognises that appropriate care delegation is usually lacking across most hospital and occurs in a context where adequately formulated care plans are also absent. Furthermore, current approaches to specialling and delegation of care to specials, tend to ignore the fact that most RNs usually do not have adequate skills in management and care for people with dementia and/or delirium. It is therefore imperative that HBH focus on skills uplift for RNs as well as AINs.

Educating all nursing staff about dementia and/or delirium care is considered a significant contemporary challenge facing hospitals. The evidence around the best approach to providing hospital-wide education for nursing on dementia and delirium care remains an unclear and emerging science. However, the literature is clear that currently hospital staff, on the whole, are not well educated and do not possess requisite skills for providing high-quality responsive dementia and/or delirium care.

This investigation found that HBH training for all nursing staff related to cognitive impairment is based on a well-developed, comprehensive online portal, but that there is little practical, experiential learning being provided which focusses on dementia skills uplift. The optional 3-day in-person Dementia Essentials training offered by Dementia Training Australia is encouraged but because it is not able to be mandated, only extends to a small number of nurses within the larger group of HBH nursing staff.

The purpose of an education and training program is to improve clinical practice and performance (i.e., modes of translation of knowledge into practice. Traditional classroom teaching approaches, including online learning modules, are unlikely to be successful and will do little more than scaffold basic awareness-raising around clinical care issues. Significant skills uplift with regard to person-centred care approaches, communication, recognition and management of responsive behaviours and other symptom management will require more embedded, routinised experiential learning approaches involving a variety of modes like simulation, role-play, and regular reflective multidisciplinary case-study discussion sessions (i.e., ideally, weekly 30-minute sessions).

A challenge to providing hospital wide education relates to the scale of any program. There is a tension around the level of specialist skills uplift that should be expected of a generalist workforce.

It is difficult to capture all nurses in a hospital and provide the experiential, case-based type learning scenarios necessary for improved clinical performance in dementia care. A pragmatic operational view might suggest to not focus on this type of training for nurses not specialised in this care. However, the high prevalence of dementia and/or delirium in most hospital general wards (at least 40% and likely higher at HBH), demands that the workforce is better prepared for delivering care to this cohort. Within this context the review team believes that HBH should prioritise efforts at localised unit-based experiential learning for all nurses to some degree. This report's recommendations of a specialist surgical and medical delirium and dementia nurse would provide an excellent opportunity for this type of experiential case-based-learning approach.

This investigation's other recommendations regarding the implementation of two specialised models of care (i.e., an ACE and a SCU) provides a mechanism by which more focussed skills training can be provided to a smaller specific group of staff involved in those models. This presents a resource efficient opportunity to provide intensive training to those most likely to be providing specialist care to the more complex cases within this patient cohort. At the same time, it

enables the education to the remaining general medical and surgical nurses to be tailored at less intensive specialist level and dose.

A considered education program for the entire hospital nursing workforce is therefore dependent upon whether and when these models are implemented. As already written in this report, it is recommended that an ACE unit be recruited for and commenced immediately when the new extra ward is implemented at HBH. The following recommendations assume an ACE unit is adopted and also that a specialised BPSD unit is adopted and planned for.

Recommendation Twenty-one

It is recommended that all nurses employed to the establishment of the new ACE and BPSD-units complete the online learning package from Dementia Training Australia (DTA), “The View from Here” and that they also attend an in-person training delivered by a clinical expert on managing changed behaviours (for example, DTA offer a one-day workshop on Navigating Changed behaviours).

Recommendation Twenty-two

It is recommended that the ACE and BPSD-Special Care Unit (SCU) staff attend regular case-based reflective sessions held for nurses and the interprofessional team which focus on discussing the care and management of a current case on the ward. Ideally, these sessions would run strictly to time of only 30-minutes and be held at crossover of morning and late shifts to facilitate maximum nursing attendance. These types of sessions are invaluable for capacity building care staff knowledge and skills as they: (1) lean into knowledge and skills deficits that are revealed in the discussions, (2) enable ownership of the care plan by all staff as they problem solve issues in the case, and (3) provide a mechanism to address operational matters that come to light, to name a few.

Recommendation Twenty-three

It is recommended that an in-person education program be developed for all general ward staff not involved in the specialist models covering principles of managing symptoms of delirium and dementia. This should consider use of simulation and other interactive, practice-based modes of education.

Recommendation Twenty-four

It is recommended that HBH adopt a more iterative in-person approach to ongoing skills and capacity building of the care teams localised to individualised wards. Like the ACE and SCU, general surgical and medical wards at HBH should also adopt a regular routine practice of experiential case reflection and capacity buildings sessions. However, these may not need to be as regular as the ACE model of care.

Future workforce development

The investigation noted that HBH have University Student in Nursing (USIN) program embedded. Like AINs, USINs are often deployed to specialling of cognitively impaired patients. The investigating team encourage exploration of other innovative models that embed skills uplift for USINs in the care of cognitively impaired patients. For example, Gold Coast University Hospital (GCUH) have a program whereby a Psychologist and CNC in Geriatrics are employed to run a USIN support program that involves three days of in-person training with the specialists learning about fundamentals of care and the ageing brain. The psychologist then rounds daily with the USINs and AINs who are specialling to provide support, role modelling and experiential learning around the symptoms they are managing. The investment in these USINs has had a long-term benefit to the hospital as up to 40% of them are employed as new graduate nurses and therefor the workforce is slowly being capacity built for care of cognitive impairment.

Management of Code Black events (Personal Threat)

The management of Code Black incidents (personal threat) is performed by a variety of staff at HBH and MH.

At HBH one security officer is rostered 24 hours per day, seven days per week. In addition, wards persons also assist in responding to Code Black incidents. At MH, all Code Black incidents were responded to by wards persons.

The team found that the processes at HBH, which mirror what occurs in many other HHS hospitals, is that the incident is left primarily to the security staff/wards persons, with the clinical staff playing a minor role in terms of communication both before and after the event. The team is also advised that, as in many other hospitals, there is a disconnect between the security staff and the clinical decision makers. It is reported to the investigators that a patient may have many Code Black incidents over a number of weeks before the clinical team comes together to formulate a comprehensive behaviour management plan.

The situation at HBH and MH is not uncommon, almost usual practice in QH hospitals, however, given the frequency of inpatients now with behavioural disturbance for a range of reasons, the existing practice should be improved for the safety of staff and patients.

This team will recommend an approach which integrates the security staff and response into the clinical team model.

This review will recommend a governance escalation path to ensure that patients with repeated behaviours which imperil themselves, staff or other patients are identified early so that the best possible management plan can be put in place.

The incident which occurred on 24.03.24 was preceded by an incident on 22.03.24 when a Code Black was called to security staff.
The only documentation in the clinical record of that incident is the comment “Code Black attended”. A security report written some weeks later included information about the behaviour of the patient [redacted] and a suggestion from the security staff member that the patients walking stick is not given back. This information appears to have been a conversation. It appears the walking stick was left in the room.

The absence of a subsequent clinical review or risk assessment after this Code Black, when no actual injury occurred, would be extremely common in most hospitals. It is now common in many hospitals for security staff to not be given a clinical handover of the patient's condition and it is common (almost normal) that there is no subsequent clinical review.

The first documentation in the clinical record referring to his walking stick is found on 25.03.24, after the incident being reviewed, in a “Variance to Plan of Care” when it is recorded “do not provide walking stick as patient is very aggressive and using stick as a weapon”. The reviewers believe this was written after the incident as, in the same handwriting, it records that there is a “wardie special” and “multiple code blacks”. The time and date of this change is not recorded however it contains information that was only available after the incident on the night of 24.03.24

Therefore, the reviewers suggest that, had there been some form of clinical incident review after the Code Black on 22.03.24 there may have been an opportunity to assess the mobility requirements of patient [redacted] and make a clinical decision about his access to his walking stick. This is a primarily a clinical decision which should balance the competing priorities of patient safety and mobility and the safety of others, and, if the decision to remove the walking stick was taken, an alternative aid provided for mobility.

The reviewing team emphasises that the process which occurred and subsequent documentation after the Code Black on 22.03.24 is usual practice in most hospitals.

The reviewers believe that this process should be changed both at HBH and more widely throughout QH hospitals.

Recommendation Twenty-five

It is recommended that at HBH and MB a new procedure be approved which provides an escalation path for patients with multiple Code Black episodes. The review team suggests, subject to local consultation, that, if a patient has two code blacks within a two week period, that this situation is notified by the security supervisor to the Director of Clinical Governance who will review the current management to ensure that an appropriate multidisciplinary review has occurred and an appropriate complex care plan is in place.

Recommendation Twenty-six

It is recommended that a new procedure be implemented which mandates that within 24 hours of a Code Black occurring in an inpatient unit, the incident is reviewed by the CNC/NUM (or Team Leader on the weekend) of the relevant ward and any relevant information obtained from the attending security staff.

Recommendation Twenty-seven

It is recommended that multidisciplinary simulation training be implemented for Code Black responses to include clinical nursing and medical staff and security/wardspersons staff together on a regular basis.

Occupational Violence Information
provided by the Work Health and Safety Unit, WBHHS.

Hervey Bay "*2024 OCCUPATIONAL VIOLENCE RISK CHECKLIST*", dated 25.07.2024.

This document adapted from a older Queensland Health tool was developed from the original 2014 OVRA tool and provides a high-level quantification of aspects of the Hervey Bay Hospital.

- The assessment demonstrated that reported occupational violence (OV) incidents shown a slight increase over the past two years in both physical threats and physical actual violence. This was quantified as the whole of hospital:
    - 2023 (128 OV incidents)
    - 2022 (127 OV incidents).
    - Past 12 months (Security Register)
        - 90 Code Black (Bravo)
        - 53 Clinical Assist/Force Used
        - 184 Security interventions
        - Qld Police Service callouts 1 (2022/23 and 1 (2022/23) noted response time of 15 – 20 minutes.
- The assessment team members included clinical nursing leaders from Medical Ward 1, Surgical Ward, Frailty Virtual and Acting Director of Nursing. Additional team members included a program manager Mental Health, Security Manager, and Health and Safety Advisors.
- The two work units with a heightened level of OV incidents in 2023 were identified as
    - Hervey Bay Emergency Department (29 OV incidents)
    - Hervey Bay Medical Ward 1 (42 OV incidents)
- Within the 2024 assessment noted that "Not all OV incidents are reported" leading to a recommendation that incident education (training) be provided. Evidence of limited OV incident reportage is demonstrated by the limited number of reported verbal aggression incidents to threatened/actual aggression incidents.
- A norm within most healthcare environments would be a higher ratio of verbal aggression incidents to actual physical aggression incidents. The paucity of verbal aggression incident reports in

work units with higher levels of physical aggression indicates a potential that workers are not reporting verbal aggression. This potential is noted by De Cieri, H., Shea, T., Dalton, B., Donohue, R., Cooper, B., and Greenwood, M. (2023). “Health, Safety, and Violence in the Healthcare Sector 2023 Summary Report”. Monash University, Caulfield East, Victoria; and Dafny, H. A., Beccaria, G., & Muller, A. (2022). “Australian nurse'' perceptions about workplace violence management, strategies and support services”. Journal of Nursing Management, 30(6), 1629-1638).
- This factor is notable as verbal aggression is frequently a precursor to physical aggression incidents.

Maryborough Hospital “*2024 OCCUPATIONAL VIOLENCE RISK CHECKLIST*”, dated 23.07.2024.

- Reported occupational violence (OV) incidents shown an increase over the past two years in both physical threats and physical actual violence. This was quantified as the whole of hospital:
    - 2023 (274 OV incidents)
    - 2022 (136 OV incidents).
    - Past 12 months (Security Register)
        - 143 Code Black
        - 260 Clinical Assist/Force Used
        - 292 Security interventions
        - Qld Police Service callouts 8 (2022/23 and 18 (2022/23) noted response time of 15 – 20 minutes.
- The assessment team members included clinical nursing leaders from Medical Ward 1, Surgical Ward, Frailty Virtual and Acting Director of Nursing. Additional team members included a program manager Mental Health, Security Manager, and Health and Safety Advisors.
- The work unit with a heightened level of OV incidents in 2023 was identified as Ward 3 Medical Ward (86 OV incidents).
- Overall, for the facility, OV risk rating is High however this result is driven by the incidents in Ward 3.
- Possible control measures are identified however there is no evidence of the OV assessment being approved with requisite actions on the document provided.

A variety of historical occupational violence assessment documents were provided for Hervey Bay Hospital and Medical Ward 3 Maryborough Hospital.
This listing of assessment documents demonstrated a variety of assessment tools with significant durations between review and re-assessment. Information included in the VAMP and AAMP documents state re-assessment annually for priority 1 areas, biannual for priority 2 and if any significant incidents for priority 3 areas.

- Violence Aggression Mitigation and Prevention (VAMP) Risk Assessment for Surgical Ward dated 01 July 2015.
    - The VAMP document provides a level of information that is difficult to interpret.
    - Incident data identifies 11 OV incidents (3 verbal aggression, 7 physical aggression by patients, and 1 verbal by relative/other).
    - There is no data indicating security callout.
    - The level of risk varies from low to medium.
    - The most common statement made for actions taken is “Risk has been managed at a local level through established controls”.
    - There is no assigned priority area found on the VAMP.
- Violence Aggression Mitigation and Prevention (VAMP) Risk Assessment for Medical Ward dated 27 May 2015.
    - The VAMP document provides a level of information that is difficult to interpret.
    - Incident data identifies 19 OV incidents (18 physical aggression and 1 verbal aggression by patients with nil security or QPS callouts.
    - The document states a level of risk as medium 7.
    - There are no identified risk factors, assessment of adequacy of controls and no additional controls (suggested strategies).
    - There is no assigned priority area found on the VAMP.
- Aggression Assessment and Management Plan Surgical Ward dated 14 June 2017.
    - The document has identified a response to the element question using an X to indicate a Yes or No response. 18 of the elements are scored as X current controls adequate,
    - Additional controls/actions required identified 19 actions. The actions listed examples: “risk has been managed at local level through existing admission procedures”;

"managed at local level through existing procedures with security called at all times when required"; "security called at all times when required"
    - No additional controls or actions have been designated to a responsible person with no proposed completion dates.
    - These controls and actions provide limited guidance to management of the hazard and subsequent risk.
    - There is no assigned priority area found on the AAMP.
- Aggression Assessment and Management Plan Medical Ward dated 16 April 2018
    - The document has identified a response to the element question using an X to indicate a Yes or No response.
    - 13 of the elements are scored as current controls adequate, 3 elements are indicated as inadequate with a signoff from NUM of proposed additional controls.
    - The document when identifying a Yes response does not quantify a risk level (all of the column elements are unrated).
    - The document does not provide any quantification of clarity of the hazard and risk control.
    - There is no assigned priority area found on the AAMP.
    - There is no assigned risk rating found on the AAMP

- Aggression Assessment and Management Plan Medical Ward 3 Maryborough Hospital dated 23 February 2017
    - This AAMP document has been completed in a different manner to the AAMP documents above.
    - The AAMP does not provide any data in relation to risk.
    - Most responses to current controls are blank with two yes responses.
    - There is no assigned priority area found on the AAMP.

There is no assigned risk rating found on the AAMP.

- Aggression Assessment and Management Plan Medical Ward 1 dated 16 May 2019
    - This AAMP document has been completed in a different manner to the AAMP documents above.
    - The AAMP document lists 6 risk ratings as low with an additional control/action required (Yes responses to Are current controls adequate).
    - 14 additional yes responses do not provide an additional control/action required.

- The tool instructions state that each question answered No to “Are current controls adequate”, that the identified element then becomes a realised risk.
- The AAMP tool design is confusing in instruction and consequent interpretation of a negative or positive answer to a Yes or No question.
- The generalised nature of the AAMP assessment and resultant actions do not provide clarity nor quantification of OV risk.
- There is no assigned priority area found on the AAMP.

The assessment of occupational violence risk should provide a comprehensive analysis of the risk of harm from occupational violence to staff and patients and others. The analysis should include staff consultation, occupational data collection, an environmental scan and the completion of an assessment tool to determine levels of risk and suitable controls. It should also include agreement and implementation of the actions by the line manager or senior officer relevant to the work unit.

The variety of different occupational violence assessment tools utilised over time complicates the ability of WBHHS to accurately assess the level of risk, and in turn limits its capacity to evaluate recommended actions when instituted.

A detailed analysis of the existing occupation violence incident data relevant to HBH and MH should be performed by the HHS.

The reviewing team suggests that the data described below should first be checked to ascertain its accuracy. The workers compensation data described below has not been verified by the reviewers. It is suggested that it is reviewed by the WBHHS to determine its accuracy.

Information provided by the WBHHS WHS Unit reveals that the WorkCover Conversion for 2021- 2024 has a stated rate of 16.75% for HBH Medical Ward 1, Medical Ward 2 and Surgical Ward. In comparison, the statewide average range of occupational violence incident WorkCover Conversion for this period averages a range of 2% to 3.5%. A review of the data, if it is confirmed as accurate, may provide the HHS with options to evaluate actions taken in response to recommendations, based on outcomes.

Data related to individual work units may show hot spots which may not be apparent using aggregated facility wide data.

Additionally, the analysis may detail incident types and severity, benchmark organisation costs in lost time/replacement and inform an evaluation of the effectiveness of risk controls and safety practices.

A review may also provide the HHS with an opportunity to highlight broader systemic issues related to the management of claims, the degree of psychosocial support for affected workers, and demonstrate the effectiveness of return-to-work programs.

In addition, developing a dynamic review of incident data may identify repeated incidents from an individual UR instigator, to inform clinical review (recommendation 25). Whilst there are statements within the occupational violence assessment tools of the frequency of assessment (with significant durations between assessment), the potential exists for WBHHS to conduct dynamic reviews triggered by repeated incidents.

Similarly, the reviewing of perpetrator factors within specific work units may enhance the ability of WBHHS to tailor appropriate intervention strategies. In the work units with high occupational violence incidence, ongoing incident reviews may assist identify areas for staff education.

Recommendation Twenty-eight

It is recommended that the WBHHS review the current occupational violence data it reports to check that it is accurate. After validation of the data, it should undertake a detailed analysis of its occupational violence data for HBH and MH to identify existing areas of high risk and to assess the efficacy of existing actions to mitigate these risks.

Recommendation Twenty-nine

It is recommended that the WBHHS review the existing process of occupational violence risk assessment for individual work units. This should include an ability to re-evaluate in response to significant incidents. This review should include the required instruction and training for persons assigned the task of occupational violence risk assessment to enable accurate OV assessment of workplaces. It is

suggested that WBHHS consult with the Queensland Occupational Violence Strategic Unit to advise and assist as required in utilising a more accurate process of occupational violence risk assessment. To support this strategy, it is recommended that WBHHS promote ongoing occupational violence reportage through incident education and training by appropriate methods aligned within the health and safety calendar activity.

Recommendation Thirty

It is recommended that, to assist the analysis of occupational violence, the WBHHS utilise the security module available within the NOGGAN platform. This will assist the HHS to accurately capture Code Black and Security assistance call out data.

Summary of Recommendations

Recommendation One.

This review recommends the appointment (full time) of a nurse to the surgical ward HBH with specialist skills and knowledge in the management of dementia and delirium. The role of this nurse is specific and full time to the surgical ward. The role will be accountable for reviewing, planning, and evaluating (but not directly providing) the care delivered to all patients in the ward identified as having cognitive impairment. The role will also engage in upskilling the knowledge of surgical nurses in the ward in their management of cognitive impairment through experiential learning approaches and point-of-care role-modelling. The role will work collaboratively with the older persons service later recommended in this report however, the role is to remain clinically orientated and situated in the surgical ward HBH. The review team recommends progressing this role and appointment as a matter of urgency as it is likely to make a material improvement in the care of cognitively impaired patients in the surgical ward.

Recommendation Two

It is recommended that a specialist geriatrician be allocated to the surgical ward for two five-hour sessions per week. This time is not currently available and represents an additional 0.25FTE.

Recommendation Three

It is recommended that as part of the pre-admission process, structured cognitive screening by appropriately trained staff is implemented for all elective surgery patients greater than sixty-five years old.

Recommendation Four

It is recommended that patients with cognitive impairment be placed, whenever possible, in a room configuration that most assists in the management of that specific patient, which may be either a single room or a multi-patient room.

Recommendation Five

It is recommended that, in all instances where an AWS is to be commenced in patients over 65 years of age, that this prescription be first discussed with the relevant Internal Medicine consultant and that the clinical reasoning for this decision be contemporaneously documented by the prescribing doctor and confirmed by the Senior Medical Officer in the clinical record the next business day.

Recommendation Six

It is recommended that, when staffing allows, ward pharmacy review is implemented in the surgical ward of HBH**.**

Recommendation Seven

The current admission guidelines for the surgical ward be reviewed by a multidisciplinary group of surgeons, nurses, allied health and general physicians to agree on the optimal placement of admitted patients.

Recommendation Eight

It is recommended that the AIN staff be included in the ward staff complement rather than be rostered from the casual pool.

Recommendation Nine

It is recommended that the professional development of the AIN staff be the responsibility of the relevant nurse in the surgical ward to mirror the current responsibilities for the Registered Nurse staff.

Recommendation Ten

It is recommended that the clinical handover and information sharing include the relevant AIN as it would for an RN.

Recommendation Eleven

It is recommended that AIN training at HBH undergoes a significant skills uplift involving at least a 3-4hr in-person training session integrating simulation, role play, and case-scenarios focussed on skills development around communication, person-centred care and managing approach should also be integrated into the initial orientation of new AINs.

This report will recommend the HBH adopt more iterative regular experiential-based methods for developing skills in dementia and delirium care in all nursing staff and the interprofessional team.

Recommendation Twelve

It is recommended that an Acute Care of the Elderly (ACE) inpatient unit be established as part of the HBH. The staffing for this unit is outlined in this report.

Recommendation Thirteen

It is recommended that the ACE inpatient unit be implemented as a matter of urgency. It is recommended that, coinciding with the commissioning of new medical inpatient beds in 2025, a 12-bed geriatrician led unit be established within the Division of Medicine bed footprint. It seems that there is a potential reasonable area in the existing bed footprint.

Recommendation Fourteen

It is recommended that a new nursing position, a CNC Delirium and Dementia be appointed to work in Medical Ward 1 at HBH as soon as possible. This role will then transition to the ACE unit when it is commissioned in 2025.

Recommendation Fifteen

It is recommended that a Special Care Unit (SCU) for BPSD be established at HBH. The staffing for this unit is outlined in this report. This unit requires a specially designed built environment. It is recommended that architectural design services expert in dementia enabling clinical design, be engaged for any redesign works (can be accessed through Dementia Training Australia).

Recommendation Sixteen

It is recommended that the current project to modify an existing ward to improve the physical environment should be paused to enable input from the specialist architect and geriatrician stakeholders. The design should be an output of the agreed model of care that is to be implemented in the area.

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Recommendation Seventeen

It is recommended that the clinical governance for both the ACE unit and the SCU unit would be the same and led by a geriatrician, as described in this report.

Recommendation Eighteen

It is recommended that the current initiative of WBHHS to fund and staff a Behaviour Response Team be modified to include specialist medical input (Geriatrician) 0.25 FTE.

Recommendation Nineteen

It is recommended that, when the ACE unit is established, the Behaviour Response Team are within the clinical governance of the ACE unit to ensure a coordinated approach to inpatient management and discharge planning as well as supported community placement. The Behaviour Response Team will provide an excellent adjunct to discharge planning and supported community placement in addition to assistance with inpatient challenging behaviours.

Recommendation Twenty

It is recommended that the Eat Walk Engage model of inpatient care be implemented at HBH and MH as part of the State-wide network. This is likely to require a significant investment in change management for all staff.

Recommendation Twenty-one

It is recommended that all nurses employed to the establishment of the new ACE and BPSD-units complete the online learning package from Dementia Training Australia (DTA), "The View from Here" and that they also attend an in-person training delivered by a clinical expert on managing changed behaviours (for example, DTA offer a one-day workshop on Navigating Changed behaviours).

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It is recommended that the ACE and BPSD-Special Care Unit (SCU) staff attend regular case-based reflective sessions held for nurses and the interprofessional team which focus on discussing the care and management of a current case on the ward ward. Ideally, these sessions would run strictly to time of only 30-minutes and be held at crossover of morning and late shifts to facilitate maximum nursing attendance. These types of sessions are invaluable for capacity building care staff knowledge and skills as they: (1) lean into knowledge and skills deficits that are revealed in the discussions, (2) enable ownership of the care plan by all staff as they problem solve issues in the case, and (3) provide a mechanism to address operational matters that come to light, to name a few.

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It is recommended that a new procedure be implemented which mandates that within 24 hours of a Code Black occurring in an inpatient unit, the incident is reviewed by the CNC/NUM (or Team Leader on the weekend) of the relevant ward and any relevant information obtained from the attending security staff.

Recommendation Twenty-seven

It is recommended that multidisciplinary simulation training be implemented for Code Black responses to include clinical nursing and medical staff and security/wardspersons staff together on a regular basis.

Recommendation Twenty-eight

It is recommended that the WBHHS undertake a detailed analysis of its existing occupational violence data for HBH and MH to identify existing areas of high risk and to assess the efficacy of existing actions to mitigate these risks.

Recommendation Twenty-nine

It is recommended that the WBHHS review the ongoing process of occupational violence risk assessment for individual work units, including the factoring of re-evaluation in response to significant incidents. It is strongly recommended that WBHHS provide instruction and training for persons assigned the task of occupational violence risk assessment to enable accurate OV assessment of workplaces. It is suggested that WBHHS consult with the Queensland Occupational Violence Strategic Unit to advise and assist as required in utilising a more accurate process of occupational violence risk assessment.
To support this strategy, it is recommended that WBHHS promote ongoing occupational violence reportage through incident education and training by appropriate methods aligned within health and safety calendar activity.

Recommendation Thirty

It is recommended that, to assist the analysis of occupational violence, the WBHHS utilise the security module available within the NOGGAN platform. This will assist the HHS to accurately capture Code Black and Security assistance call out data.