Quality in residential care – from evidence to practice

Five pilot tests approaching BPSD

Øyvind Kirkevold, Assistant Research Director, Norwegian National Advisory Unit on Ageing and Health, Vestfold Hospital, Norway; Kari Midtbø Kristiansen, Director, Norwegian National Advisory Unit on Ageing and Health, Vestfold Hospital Trust, Norway; Marieke den Breejen , Policy advisor, Ministry of Health, Welfare and Sport, The Netherlands; Brigitte Verhage, Policy advisor, Ministry of Health, Welfare and Sport, The Netherlands; Antonis Politis , Associate Professor, 1st Department of Psychiatry Division of Geriatric Psychiatry, Eginition Hospital,National and Kapodistrian University of Athens, Greece; Antonis Mougias, Psychiatrist, Director of Alzheimer Centre of the Greek Psychogeriatric Association "Nestor", Athens, Greece; Ioanna Petroulia, Center for Health Services Research Medical School, National and Kapodistrian University of Athens, Greece; Latchezar Traykov, Professor of Neurology, Alexandrovska University Hospital, Department of Neurology, Medical University, Sofia; Bulgaria; Margarita Raycheva, Associate Professor of Clinical Psychology, Neuropsychologist, Alexandrovska University Hospital, Department of Neurology, Medical University, Sofia, Bulgaria; Shima Mehrabian, Assistant Professor of Neurology, Alexandrovska University Hospital, Department of Neurology, Medical University, Sofia, Bulgaria; Ileana Botezat-Antonescu, Director of National Mental Health Centre, Romania; Ana Giurgiuca, Assistant Professor, Psychiatry Department of the 'Carol Davila' University of Medicine and Pharmacy, Bucharest, Romania.

ACT ON DEMENTIA
QUALITY IN RESIDENTIAL CARE

At the ned of 2017 WP-6 “quality in residential care” of the EU Joint Action dementia 2 program (Act on Dementia) delivered an evidence report on quality in residential care. The evidence report described several recommendations regarding how to approach behavioural and psychological symptoms in dementia BPSD in residential care. It is recommended to implement person centred care (PCC), normalization of the physical environment and adapted activities to prevent BPSD. Further, it is recommended to use systematic method for identifying, analysing, evaluating and approaching BPSD. Du to different health care system the partners of WP 6 have chosen different approaches to BPSD, but all based on the principles of PCC and the recommendations in the evidence report.

The Bulgarian team has developed and tested a learning program inspired by the models described in the evidence report. **The Greek team** has introduced a “tool-box” for prescribing antipsychotics aiming to more correct prescribing and raise the awareness of the use of antipsychotics, and hopefully end up with less use of antipsychotics. **In Romania** an educational project for a better management of BPSD in residential care inspired by the TIME model, has been tested. **In the Netherlands and Norway** recommended models for approaching BPSD have been tested and shown to have effect on patient level. These models have not been implemented in any of the two countries. Thus, the Netherlands and Norway have focused on programs for implementation. In the Netherlands, a “tool-box” has been distributed, and in Norway, a program for “train the trainers” has been tested.

IMPACT - IMPlementation of Advanced Care Training - pilot study protocol for implementation of residential care staff training in Bulgaria

The Bulgarian pilot study focused on staff training as evidence-based non-pharmacological method for BPSD management and improvement the quality of care in residential settings.
The aim was to introduce an Advanced care training - learning and training program based on evidenced intervention models and to evaluate its implementation for BPSD management in Home for older people and people with dementia in Bankya, Bulgaria.

The project had three phases:
1. Pre-pilot activities (exploring the staff needs/attitudes and adjustment the education/training program to the local needs, assessment of physical, cognitive and functional level of residents),
2. Education and training program for the staff to understand and face the problematic situations and BPSD in residents and
3. Development and adoption of personalized activities for management BPSD.

The staff was trained to develop individualized intervention activities based on information about the personal history of the residents, his/her social relations, resources, and preferences.
The target is residential care staff (26 members) - 7 nurses, 16 caregivers, 1 social worker, 1 occupational therapist and 1 physician. People with cognitive impairments/dementia and BPSD who live in the Home for elderly will be discussed during the training course and the implementation phase.

Status September 2018
March (pre-pilot) Four weekly visits to the Home, assessed 46 residents (physical, cognitive, behavioural, functional assessment), medication review and 21 residents were selected for further discussion during training and implementation. Four weekly meetings with the staff to explore the needs/attitudes

April – June (education and training)
The staff had 16 hours face-to face-training sessions - 4 hours lectures and 12 hours (4 x 3 hours) focus-like groups (guided reflection meetings with videos and role play). The participants had two possible options to attend the course according to their work schedule. Lectures (10 April 2018 and 17 April 2018) - all the staff attended.

Eight guided reflection meetings for multidisciplinary training case discussions. Four training cases of people with dementia and different BPSD were presented.

June – September (Implementation phase)
The staff had to develop and adopt personalised care activities and to improve individual care plans for the residents with BPSD. The staff received additional support with two-hours face-to-face monthly discussions with experts concerning individual care plans, evaluation and coping with BPSD, antipsychotic drugs used after the training course

Antipsychotic Review Implementation Strategy (ARIS):
An implementation pilot study for Health care personnel in Greek Nursing Homes

The main aim was to introduce a translation of the evidence-based recommendations into actions in practice from the “Evidence report”. Antipsychotic Review Implementation Strategy (A.R.I.S) is a specific action aiming on implementing Clinical Practice Guidelines on Dementia in Health care personnel. The objective of A.R.I.S is to design BPSD Care Coaches (BPSD-CC). BPSD-CC are nursing home personnel whose role is to implement Clinical Practice Guidelines on antipsychotic use in BPSD and who are responsible for supporting other staff by sharing best practices in recognising BPSD and reviewing anti-psychotic drug prescriptions.

Secondary objectives: 1) antipsychotics use rate and prescription attitudes and association with specific BPSD symptoms 2) adopt from these Dementia specialized care services of the guidelines for the appropriate use of antipsychotics through the development of BPSD-CC.

Two specialized care units for dementia patients were included. One private specialized dementia nursing home, “Aktios Odigos, Aktios elderly care unit” (a 99 beds nursing home) and one specialized in dementia care NGO, “Nestor Psychogeriatric Association” (a 10 bed short-term Hospitalization for people with dementia).

Two participants from each specialized dementia care unit were trained in two-day blocks/ one-month period. Training was followed by one-month supervision period in which BPSD-CC implemented the learning experience, through supervision, in their own care home. The themes for the training were:
- Good dementia care: person centered care
- Update on Dementia and BPSD
- “Four Ds” approach on BPSD
- Neuropsychiatric Inventory training
- Clinical Practice Guidelines on antipsychotic use in Dementia patients with BPSD
- Antipsychotic Review

Pre-pilot mapping
Total number of nursing homes were 150. Staff ratio vs residents was 1/15. 70% of the nursing home staff had no training on nursing home care. Part time Physicians, 10% and 50% respectively of the two nursing homes residents had private non nursing home medical care, 80% of residents were above 80 years old. 70% of residents were female. 70% of residents were not married or windowed. 80% of residents had dementia. 90% of the residents presented BPSD. BPSD were recognized but the nursing home staff were not able to define and identify the type of BPSD (eg. Depression, apathy ecc).

40%-70% of the residents were under treatment with one antipsychotic, it depends from the nursing home and 20% of the residents were under treatment with two antipsychotics. The nursing home staff were not able to distinguish between psychotropic

Educational project for a better management of BPSD in residential care
pilot study protocol - for implementation of residential care staff training in ROMANIA

The main aim was to introduce an Advanced care training - learning and training program based on evidence-based intervention models and to evaluate its implementation for BPSD management in two Care Centres for older people and people with dementia.

The staff were trained to develop individualized intervention activities based on information about the personal history of the residents, his/her social relations, resources, preferences and other comorbidities. The design of the pilot study had three steps:

STEP 1 - Identifying the need for staff training – 3 days
The analysis for exploring the staff needs/attitudes and adjustment of the education/training program to the local needs; assessment of physical, cognitive and functional level of residents in the “Ana Aslan Academy” Public Centre and “Geron” Private Centre.

STEP 2 - Theoretical training sessions – 3 days, 18 hours
Training sessions for the staff to understand and face the problematic situations and BPSD. An 18 hours education and training course. The sessions will be organized into three groups: one group for doctors, one nurses group and one group for formal and informal caregivers. The last day of the course (practical activities) will be in common for all staff members.

STEP 3 - practical training sessions – 1 day, 24 hours
Practical training sessions for the staff to understand and face BPSD. This approach considered a continuous observation the person with dementia from all perspectives. Practical sessions will consist in the completion of a patient's diary by each team. Scale will be used to measure psychiatric and psychological symptoms in dementia. The observation time will be 24 hours. About fifty patients are eligible for the observation.

The target group of the project consists of 60 residential care staff: doctors, nurses, caregivers, occupational therapists, psychologists, physiotherapists.

The step 1 was finished in May 2018.

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Implementation of a complex intervention in a complex setting: manage the preconditions first?

The Netherlands would like to know if a practical intervention in nursing homes (NH) (such as 'Less is more') aimed at reducing the use of psychotropic drugs, prior to the implementation of a complex intervention aimed at a better management of BPSD (such as GRIP), ensures better adaption of the preconditions by nursing homes, so complex intervention can be implemented more easily.

The GRIP model consists of four steps. Step 1: detect BPSD; Step 2: analyse behaviour; Step 3: treatment; Step 4: evaluation. The implementation of GRIP has identified several barriers to use the GRIP model. Thus ‘Less is more’ were introduced as a smaller and easier to implement intervention.

The aim of ‘less is more’ is to reduce the inappropriate prescription of psychotropic drugs and to create awareness on an easily accessible level. ´Less is more´ is a program, that consists of - among others- an online toolkit filled with possible interventions. The intervention is followed and supported by an external coach.

To evaluate ‘less is more” and the possible improvement of preconditions for implementing GRIP were evaluated in 12 nursing homes that have finished the ‘less is more’ program’.

A questionnaire is sent to the contacts, followed by a telephonic Interview. On basis of the interviews three NH were selected.
- At each NH, a meeting was organized. Everyone who works with the toolbox were invited
- On basis of the interviews several focus-groups were organized.
- Final meeting with all the people and organizations involved.

Status September 2018
Questionnaires are sent to all the 12 NH followed by telephonic Interviews. Focus groups have been performed in the three selected nursing homes. Final meeting has not been organized yet. The intention is to organize a meeting in October 2018 with all the nursing homes involved, to confirm the results and conclusions.

Preliminary results
The main reasons for a nursing home to choose for a relatively small intervention and the 'large' recognized systematic intervention 'GRIP' are a) Residential care facilities search for a intervention for a specific (small) question/ problem and b) Several residential care facilities already have a method and they are looking for a piece that fits in their system.

GRIP does not seem too complex to implement and it seems to fit well in practice. However, it requires a large (time) investments.

Residential care facilities mainly need support, time, facilities created for employees to learn to work with GRIP, a motivator and integrate GRIP in the custom system of residential care facilities are necessary elements for a successful implementation.

Residential care facilities are satisfied with their current approach and interventions. If a NH doesn’t use GRIP, a specific reason (e.g. inspection report) can be a trigger to implement it. Also, the enthusiasm of a key person can promote the introduction of GRIP

The coach did not influence the choices. The coach provided a lot of possible interventions from the toolbox, NH made their own choices.

Train the trainer in TIME – a study protocol for the dissemination and implementation of an evidence-based model (TIME) for BPSD in residential care

Targeted Interdisciplinary Model for Evaluation and Treatment of Neuropsychiatric Symptoms (TIME) consists of a comprehensive assessment of the patient and one or more case conferences with the goal to create, and put into action, a tailored treatment plan. This approach has shown to be effective in a randomised controlled study.

The main aim is to perform a process evaluation of a method for the dissemination and implementation of an evidence-based model (TIME) for BPSD in residential care.

The train the trainer course is a two days course which consists of face-to face-training sessions including lectures and roleplay in performing case conferences. The educational group for the train the trainer course will be composed of specialist registered nurses in geriatrics or old age psychiatry and one physician with competence in nursing home medicine, all well familiar with TIME for both clinical and educational purposes.

The participants of the course will during and after the course have access to a website, where they can find all necessary lectures, handouts, The TIME manual, an educational film and other educational support they need for performing lectures and training sessions in their performance of the TIME basic course.

Status
Two courses have been arranged with 55 attendees from all over Norway. A new course will be arranged in February 2019 (30 attendees). An evaluation questionnaire is sent to the attendees of the first course (25). Seven of the attendees at the train the trainer course have arranged courses at their nursing home. With about 70 attendees at each municipality/nursing home. Thus, more than 400 persons are introduced to the TIME model.

Experience from the attendees who have arranged local courses.
Important to have basic course in TIME before start to use the model. Overall it was experienced that TIME was a useful tool that was feasible to implement. However, engaged and involved leader were an important facilitator. A TIME administrator on each ward and cooperation between the TIME administrators were useful.

Evaluation

The main aim of the pilots is not to measure effect on resident level (does it improve behaviour), but to test the if it is possible to implement theoretical models or models that are tested in research programs, into practice.

All the five pilots use an adapted version of the RE-AIM frame work for evaluation. The abbreviation RE-AIM means:
Reach - proportion/number and characteristics of attended patients
Efficacy – the ability to change desired outcomes; to be filled before and after the pilot
Adoption - the number or proportion who actually adopted the intervention (organisation level)
Implementation – how well the intervention was delivered as designed
Maintenance – how well program effects are maintained and the continued use of the program.

At each of the steps in RE-AIM it will be described important facilitators and barriers for the implementation. I final report will be finished in the first half of 2019.