

Evaluation of the Transitional Behavioural Assessment and Intervention Service (T-BASIS) Unit Initiative and Model of Care

Executive Summary

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	2
TABLE OF CONTENTS	3
INTRODUCTION TO BPSD: FROM CADE TO T-BASIS	4
THE CURRENT EVALUATION	6
Methodology	6
Key findings	7
RECOMMENDATIONS	8
RECOMMENDATION 1: CONTINUATION AND REQUIREMENTS OF THE CURRENT T-BASIS UNITS	8
Recommendation 1.1 Deficiencies in individual units mean that this recommendation is made with the following provisos. Over the next two years:	8
RECOMMENDATION 2: REVISIONS TO THE T-BASIS MODEL OF CARE	9
Recommendation 2.1: Functions	9
Recommendation 2.2 Staff cover and characteristics	9
Recommendation 2.3. Governance, Security, and Education/Support	10
Recommendation 2.4. Patient characteristics	11
Recommendation 2.5. Clinical process and practice	12
RECOMMENDATION 3: STRATEGIES TO SUPPORT FURTHER CLINICAL SERVICE REDESIGN TO THE T-BASIS MODEL, MONITORING AND REVIEW.	14
Recommendation 3.1	14
Recommendation 3.2	14
RECOMMENDATION 4. FUTURE DIRECTIONS FOR THE T-BASIS PROGRAM AND MANAGEMENT OF BPSD	14
Recommendation 4.1 In relation to the future of the T-BASIS program:	14
Recommendation 4.2 Wider coverage for BPSD	14

EXECUTIVE SUMMARY

This report, commissioned by the Mental Health and Drug & Alcohol Office (MHDAO) of the NSW Department of Health, outlines the key findings of an evaluation of the Transitional Behavioural Assessment and Intervention Service (T-BASIS) model of care and NSW Health T-BASIS initiative. Broadly, it finds that the five remaining T-BASIS units have moved substantially towards the T-BASIS model of care (a non-acute assessment-treatment/management-discharge inpatient service for older people with severe behavioural and psychological symptoms of dementia), with an increase in the severity and complexity of patients admitted and in the number of patients treated annually, and a decrease in average length of stay. It finds that where the T-BASIS model is more fully implemented, it can be both clinically effective and cost effective, with few readmissions and high family and carer satisfaction. Significantly, it finds that senior residential aged care staff referring patients into T-BASIS units reported that in the absence of a T-BASIS unit, some of their key strategies would have been to increase sedation (59 % respondents), take the patient to a Specialist Mental Health Services for Older People (SMHSOP) acute inpatient unit or Emergency Department, or 'special' the individual.

To inform further development of the T-BASIS initiative this report makes four key sets of recommendations relating to:

- 1) Continuation and requirements of the current T-BASIS units;
- 2) Revisions to the T-BASIS model of care;
- 3) Strategies to support further clinical service redesign, monitoring and review; and
- 4) Future directions for the T-BASIS program.

It should be noted that T-BASIS units represent one model for non-acute/sub-acute SMHSOP inpatient care, focussing on people with dementia and challenging behaviour. However, other complementary non-acute/sub-acute models for the broader SMHSOP target group need to be explored. In addition, T-BASIS units need to be considered within the spectrum of care for the entire SMHSOP target group, which includes acute inpatient care, non-acute/sub-acute inpatient care, and community and community residential care.

Introduction to BPSD: from CADE to T-BASIS

Challenging behaviour in dementia, commonly labelled Behavioural and Psychological Symptoms of Dementia (BPSD), includes phenomena such as screaming, violence, sexual disinhibition, repetitive questions and apathy. It causes distress to family members and is one of the most common reasons they surrender care to residential aged care facilities (RACF), where the behaviour tends to be even more florid and causes equivalent distress to staff. Treatment is problematical and complex, and may involve a range of psychosocial and/or pharmacological interventions. Standard interventions are rarely effective; cases need to be treated on a case-specific basis, addressing a wide spectrum of potential bio-psychosocial causes including reasons why the behaviour is perceived as challenging.

The most holistic long-term attempt to do this has been dementia specific units, where the physical design and ambience and the way care is carried out are intended to address psychosocial causal factors, backed up by treatment of medical and psychiatric problems. Between 1989 and 1991 NSW Health invested in nine such

facilities across Area Health Services (AHS) for what were termed the Confused and Disturbed Elderly (*CADE*). The CADE units were to provide long-term residential accommodation and care for people with dementia and difficult behaviours who had previously been housed in psychiatric hospitals. Over time, mainstream aged care began developing dementia specific units for this population while the CADE units evolved differently in each AHS due to differing funding and reporting arrangements, and with limited state-wide policy direction from the NSW Department of Health. Some units ceased to admit patients with even moderately difficult behaviour.

In 2004 the CADE unit in Wagga Wagga (Yathong Lodge) received Commonwealth Aged Care Innovative Pool Program funding to move to a short to medium stay assessment-treatment model. The funding provided for a higher level of care to manage relatively difficult patients. It also funded the development of a small team working out of the Unit to build capacity in RACFs and other community services, manage cases in situ and, where this was not possible, facilitate admissions to and discharge from Yathong Lodge. A similar service had developed independently at Terilbah (located in Long Jetty, Northern Sydney Central Coast Area Health Service).

In 2006 NSW Health, under the auspices of what was then Centre for Mental Health, (now the Mental Health and Drug & Alcohol Office), commissioned a study of the remaining eight CADE units. The brief was to examine current operations and determine whether the units still had a role to play within the continuum of care for older people with behavioural disturbance associated with dementia and/or mental illness. Contemporaneously, the NSW Branch of the Faculty of Psychiatry of Old Age produced a report for NSW Health (*The Management and Accommodation of Older People With Severely and Persistently Challenging Behaviours*, NSW Health, 2006), which recommended specialist community based Behaviour Assessment and Intervention Services (BASIS) together with short to medium stay (interim) residential assessment and treatment facilities for this population.

The *Review of Confused and Disturbed Elderly (CADE) Units in New South Wales* (2006), hereafter called the *CADE Review*, concurred with the idea of specialist community teams and linked interim in-patient assessment and treatment facilities. Though there have been great advances in development of facilities for people with BPSD, the CADE Review therefore recognised that there remains a place between the acute hospital and RACF sector for public sector inpatient services for older people with severe BPSD. Terilbah and Yathong Lodge, including its outreach team, were already providing such a step up/step-down service and the CADE Review recommended that the NSW Department of Health undertake clinical service redesign to enable the remaining CADE Units to adopt the same model. Terilbah has since closed, leaving Yathong Lodge as the sole exemplar for the State. The new services were to be called T-BASIS (Transitional Behavioural Assessment and Intervention Service) Units and managed under the Specialist Mental Health Services for Older People (SMHSOP) stream of the Mental Health Program. Area Directors of Mental Health were to hold operational responsibility at the AHS level but, because of the need for both mental health and aged care clinical input to the care of this population, work collaboratively with Directors of Aged Care.

The review also made a number of recommendations to support good clinical care. Each T-BASIS unit was to have a Medical Director, ideally a specialist in ageing such as a geriatrician or psychogeriatrician, and in any case there was to be regular access to specialist geriatric and psychogeriatric support. The importance of an outreach

team liaising between the Unit and both acute and community services including Aged Care Assessment Teams (ACAT) and the RACF sector was stressed, as was the need for clear lines of governance, multi-disciplinary bio-psychosocial care, and ongoing education and training for staff in management of BPSD. Other recommendations related to individual units, capital works, charging and revenue arrangements.

As a result of the CADE Review, the Mental Health and Drug & Alcohol Office (MHDAO) of the NSW Department of Health provided funding and implementation support for a clinical service redesign initiative to develop the T-BASIS model of care. This included:

- Recurrent ‘top-up’ funding to support staffing and other requirements to operate the T-BASIS model;
- Two rounds of one-off funding for minor capital works to support the safe and effective operation of the units as per the T-BASIS model;
- One-off funding for each of the four affected AHS to employ a project officer for 12 months to facilitate the clinical service redesign process at a local level; and
- Engagement of two successive state-wide project managers to lead the implementation process: the first to coordinate AHS implementation planning and the first round of minor capital works funding, and the second to facilitate and monitor implementation, mentor the units through the process and facilitate clinical networking, coordinate a second round of minor capital works funding, and undertake policy work to support the T-BASIS initiative.

Concurrently with the T-BASIS program, MHDAO provided funding under the OPMH program for BPSD community clinicians/services through the Behavioural Assessment and Intervention Services (*BASIS*) and the Commonwealth Dementia Behaviour Management and Advisory Service (*DBMAS*) initiative. These initiatives linked to and supported the T-BASIS program.

The current evaluation

In 2009 the authors were funded to undertake an evaluation of the T-BASIS units to assess the effectiveness of the initiative and support improvements to and further implementation of the model. By the time we had obtained both lead and site-specific ethical approval, five T-BASIS units remained across three AHS: Yathong Lodge and Giles Court in the then Greater Southern Area Health Service (GSAHS), Hilltop and Riverview in the then Hunter New England Area Health Service, (HNEAHS) and Rupertswood in the then Sydney West Area Health Service (SWAHS). Terilbah (Northern Sydney Central Coast Area Health Service) had been closed due to staffing and clinical governance issues, and the unit at Lottie Stewart Hospital (SWAHS) had also ceased to operate due to the closure of the facility in which it was located.

Methodology

We used unpublished but well-circulated NSW Health documents to develop a list of variables. They included in particular the CADE review, and *Transitional Behavioural and Intervention Service (T-BASIS) Units: Model of Care* – the MHDAO document used as the basis for implementing and monitoring the T-BASIS model in the five units. To retain control of a vast amount of data, we have grouped them under six headings.

A. Staff cover and characteristics reports on medical, nursing and allied health cover, demographics, and other care staff variables including stress levels and attitude to dementia.

B. Governance, security and education/support looks at reporting lines, security cover and education of staff, including clinical supervision.

C. Patient characteristics examines basic demographics, primary diagnoses on admission, co-morbidities and reason for admission, where patients came from, severity of behaviour, length of stay and occupancy rates, and discharge patterns.

D. Clinical process and practice describes the process from admission to discharge including care reviews and care plans. It also looks at the types of care including psychotropic medication, psychosocial and nursing methods, use of restraint, and response to falls.

E. Evidence of change compares demographic, clinical and service data from 2009/10 with 2006/7 to assess changes in practice since the introduction of the model.

F. Clinical and cost effectiveness looks at statistical and clinical data, including brief descriptions of six typical cases, to determine whether the T-BASIS units are providing a useful clinical service. It also compares T-BASIS financial costs with other relevant in-patient psychiatric care.

To collect this data we undertook numerous site visits, interviewed key personnel including medical staff and outreach clinicians, administered a range of standard instruments on repeated occasions, examined medical records, and interviewed families and staff of residential aged care facilities who dealt with the T-BASIS units.

Key findings

All T-BASIS units have made the transition to the assessment-treatment/management-discharge model. Twice as many patients have passed through the units in 2009/10 than in 2006/7 and median length of stay varies between 8 and 15 weeks. One unit has taken almost five times as many patients as in 2007. However, low occupancy in Riverview and Rupertswood has limited the number of cases treated and this is a serious problem which threatens their viability. There is indirect evidence that the units are accepting more difficult patients but Yathong Lodge is still the benchmark. The units continue to service people with dementia and challenging behaviour primarily, though a minority has mental illness as their primary diagnosis. A significant proportion of patients have mental health co-morbidities and almost the entire sample has multiple medical/physical co-morbidities, emphasising the need for continuing input from both geriatricians and psychogeriatricians.

Medical cover was barely adequate at the outset but shortages in cover when medical specialists are absent have been addressed recently in three units. It remains problematic in two. Nursing staff levels are adequate but may need to be enhanced in some units. A measure of morale suggests that some staff are emotionally exhausted. There is evidence that some nursing staff have pejorative or at least un-enlightened attitudes to people with dementia, though the majority do not.

There is circumstantial evidence of the beginnings of 'drift', similar to the way the CADE units went their own way in the absence of strong central direction. There were significant changes during the early stages of the transition to the T-BASIS model, particularly when the state-wide project managers and AHS T-BASIS project officers were operating, then substantial further change - for example, development of outreach clinicians - only after we began collecting data, suggesting the evaluation itself has had at least a 'Hawthorn Effect'.

On the whole the units are following the new model of care but there are exceptions. Patients are staying longer than the 8-10 weeks recommended in the CADE Review (based on Yathong Lodge 2005/2006 figures) but we have evidence that this was an underestimate of the actual length of stay. Contrary to the guidelines three units take emergency admissions. Most of them turn out to be appropriate and we recommend that this guideline be re-examined. Patient reviews do not occur as frequently as recommended but we believe they are adequate. The quality of multi-disciplinary case reviews was quite high, though most were dominated by discussions about psychotropic medication and in many only two disciplines were present. Behaviour meetings amongst care staff were more holistic. Care plans range from unrealistic and filled in by rote to extremely practical and holistic, and there are examples of both in most facilities.

Statistical evidence using standard instruments to assess decline in behaviour as a result of the patient's stay is equivocal at best but overall our conclusion, based on a mix of clinical, qualitative and quantitative data, is that the T-BASIS units are performing a useful clinical function which is actually or potentially more cost-effective than treating people with dementia in acute inpatient settings. Case examples presented in the last section of the Results show that there are serious human as well as financial costs when people with BPSD are treated in the wrong setting. The quality of care and also demographic trends need to remain part of the equation when considering the future of the T-BASIS program.

RECOMMENDATIONS

Our recommendations relate to four key aspects of the evaluation.

1. Continuation and requirements of the current T-BASIS units;
2. Revisions to the T-BASIS model of care;
3. Strategies to support further clinical service design, monitoring and review; and
4. Future directions for the T-BASIS program.

A detailed rationale for the components of each recommendation may be found in the Discussion section at the end of this document.

Recommendation 1: Continuation and requirements of the current T-BASIS units

It is recommended that the current T-BASIS units continue to operate, working towards the revised T-BASIS model of care outlined in Recommendation 2, but subject to the requirements outlined in Recommendation 1.1.

Recommendation 1.1 Deficiencies in individual units mean that this recommendation is made with the following provisos. Over the next two years:

- *All units increase mean annual occupancy to at least 75% (i.e. at least 12-13 beds filled);*
- *All units which do not have them develop integrated outreach teams;*
- *All units begin to match Yathong Lodge in taking a larger proportion of more difficult patients;*
- *Giles Court, Hilltop, and Riverview increase their geographic reach;*

- *Hilltop shorten median length of stay (LOS) to match the other units (with a median LOS target of 8-12 weeks); and*
- *Rupertswood in particular greatly increase the proportion of admissions coming direct from the community.*

Recommendation 2: Revisions to the T-BASIS model of care

It is recommended that the revised model of care outlined below is adopted in the further implementation of the T-BASIS initiative.

Note that most of the key points are reiterations or amplifications of the original model of care circulated in 2007. For comparisons see Table G2, at the end of the Discussion section of this document. Note also that there are a number of aspects of the model of care where we either lack the expertise to be prescriptive and/or feel that it is more appropriate to utilise the considerable combined expertise of the T-BASIS NUMs, T-BASIS Medical Directors and SMHSOP Clinical Directors, SMHSOP Clinical Coordinators and other senior staff to decide details of practice which they themselves must implement. These aspects are indicated in the relevant component of the model of care in the Discussion/Recommendations section at the end of this report.

Recommendation 2.1: Functions

The T-BASIS units will provide multi-disciplinary assessment, care planning, and case-specific bio-psychosocial treatment for older people manifesting challenging behaviour associated with dementia which cannot be managed at their current place of residence. Where deemed suitable for the unit by the Medical Director and NUM, they must also provide this service for older people with challenging behaviour associated with mental illness in the absence of dementia. The units will provide primarily a 'step-up' function by taking most admissions direct from the community (either home or residential care) but a certain proportion will be 'step-downs' from acute medical or psychiatric care though, ideally, this should be no more than 35% of admissions.

Recommendation 2.2 Staff cover and characteristics

Medical staff

- *Each unit will have a Medical Director who may be a geriatrician or psychogeriatrician/old age psychiatrist. Failing that, a general psychiatrist or GP with extensive experience in ageing should be Medical Director. Failing that, a general psychiatrist or GP willing to accept clinical supervision, at least at the outset, from a geriatrician or psychogeriatrician should be appointed.*
- *The Medical Director should be willing to be contacted at other times by the NUM or other senior staff, subject to negotiating the circumstances when this can occur.*
- *Each unit will have regular access to clinical input from both a geriatrician and old age psychiatrist (one of whom is likely to be Medical Director). The same provisos obtain about experience in ageing and/or being willing to accept clinical supervision from a medical specialist in ageing, if these roles have to be filled by a general psychiatrist or GP.*
- *Aged health specialist medical staff should attend for a minimum collectively of 1.5 days a week.*

- *There should be additional medical cover/attendance (aged health specialist or general, including a GP), on at least 2 hours a day 3 days a week to facilitate admissions and deal with routine medical matters. The clinician or clinicians concerned needs to be present at case reviews.*
- *There must be arrangements for 24 hour medical coverage, and cover arrangements when the specialist medical staff are on leave or sick.*

Nursing/Care/Allied Staff. *The staff profile for each unit should include:*

- *A Nursing Unit Manager, minimum NUM level 2.*
- *Part-time (minimum 0.4 FTE) senior clinician (CNC level 1 or equivalent) to train, mentor and supervise staff and students on placement, run staff 'mentoring and behaviour support' meetings, and raise the profile of psychosocial interventions in case reviews.*
- *Registered and Enrolled Nurses providing 24 hour RN coverage, with at least two staff for night shifts, approximately four staff for day and evening shifts, with at least 1.5 FTE further staff allocated to shifts at the discretion of the NUM. Suitably qualified and experienced AINs should also be considered as potential T-BASIS staff.*
- *Formal arrangements for additional staff experienced in BPSD when needed to assist with acutely difficult patients.*
- *Student RNs or ENs on placement at all possible times, and structured support for them throughout the placement.*
- *A dedicated position, or part-time positions combined, to undertake discharge planning, liaison with and support of family members, liaison with residential care facilities and other services, guardianship and other tasks requiring clinical expertise. Can be allied health (e.g. social worker) or nursing position/s depending on availability and expertise.*
- *Part-time diversional therapist.*
- *A designated, part-time ward clerk/administrative assistant (at a minimum).*
- *Access to (and identified funding for) sessional allied health such as physiotherapists, speech therapists etc.*
- *A minimum of two FTE outreach clinicians, at least one a senior clinician (CNC level 1 or allied health equivalent), to promote linkages with all community aged services across the Area including the RACF sector, facilitate admissions and discharges, and increase capacity for cases to be managed in situ.*

Recommendation 2.3. Governance, Security, and Education/Support

The following arrangements should be in place for governance, security and staff education and support:

- *Clear lines of reporting and accountability to Local Health District (LHD) Management.*
- *Formal mechanisms for regular consultation between the LHD Director of Mental Health Services, SMHSOP Clinical Coordinator and/or SMHSOP Clinical Director, Director of Aged Care Services (or equivalent), and relevant*

hospital/community health managers on planning and service issues affecting T-BASIS units.

- *Written admission and discharge policy and formal processes in place to consider the admission and discharge of each patient, with the Medical Director and NUM having ultimate authority. Admission criteria are to be widely distributed and publicised.*
- *Written security policy in place which is familiar to all staff and which spells out procedures in case of a security event (including specific procedures to cover uncontrolled patient aggression) and regular staff training to deal with such critical incidents.*
- *Strategies to minimise risk (e.g. duress alarms, 24 hour medical cover, identified and immediately accessible trained hospital response teams, regular training in aggression response). In the absence of a local hospital team, a local security company which can arrive within a few minutes should be considered.*
- *Built-in furniture and secure fastening of other features (e.g. wardrobes, refrigerators) which could cause injury to staff or patients if dislodged.*
- *Consideration should be given to the appropriateness of establishing suitably furnished safe areas for short term use to reduce risk of harm to self and others for highly agitated or aggressive patients.*
- *Access to and quarantined funding for on-going education and training for T-BASIS staff in dementia care and BPSD assessment and management (including understanding, coping emotionally with, assessing causal factors for, and delivery of interventions for challenging behaviour in dementia).*
- *Expansion of the role of behaviour meetings for staff, which already exist in two units, so that they explicitly become support, mentoring, and skills training sessions, with a title that recognises this (see recommendations regarding 'Clinical Process and Practice').*
- *Development of resources for clinical supervision, at least in the group format, for all care staff who wish to receive it.*
- *Clinical supervision and support for senior staff, including the NUM.*

Recommendation 2.4. Patient characteristics

- *The main target group for the T-BASIS units will be older people with severe challenging behaviour associated with dementia, defined as behaviour which fails to respond to treatment or attempts to manage it in the patient's usual setting, and where treatment in another setting is unsafe or inappropriate – including the risk of chemical or physical restraint.*
- *Subject to bed availability, T-BASIS units may admit people with dementia and BPSD who have developed delirium overlaid on dementia, and where the NUM and Medical Director agree the patient can most appropriately and safely be treated in the T-BASIS unit. People with delirium who do not have an underlying dementia should not be admitted.*
- *T-BASIS units may also admit older people with severe behavioural and psychiatric symptoms associated with mental illness, even in the absence of*

dementia, where in the opinion of the NUM and Medical Director the patient's care needs can most appropriately be met in the T-BASIS unit.

- *T-BASIS units are generally inappropriate for patients in the acute phase of a medical or psychiatric illness but, where the primary problem is challenging behaviour and the NUM and Medical Director agree that the acute condition can be treated in the unit, the patient may be admitted at their discretion.*
- *T-BASIS units are more appropriate for patients who are ambulant, though those with walkers or whose loss of mobility is temporary may be considered at the discretion of the NUM and Medical Director.*
- *Admissions should be planned but emergency admissions that have been screened and meet the admission criteria should be considered at the discretion of the NUM and Medical Director.*
- *All referrals to both the T-BASIS units and their BPSD outreach teams must be recorded through the Mental Health Access Line but the complexity of presentations associated with this population dictates that a significant proportion will continue to be direct referrals which are back-triaged to Access Line only after initial assessment has determined whether they fit the admission criteria.*
- *Median length of stay should be 8-12 weeks, accepting that a small proportion may have to stay longer, and mean occupancy over a calendar year should be a minimum of 75%.*
- *Patients should be discharged when the presenting problem has remitted sufficiently to permit safe return to the community (including residential aged care facilities) or it is considered that a longer stay is not likely to achieve significant further gains, or the patient is suffering acute medical or psychiatric illness which requires urgent in-patient treatment.*

Recommendation 2.5. Clinical process and practice

- *Nursing and care staff will be active participants in devising, monitoring, adapting and sharing bio-psychosocial treatment strategies, with structures put in place to ensure this occurs. Examples would include: the discussion of a patient at 'staff mentoring and behaviour support' meetings (as outlined below) and then routine incorporation of the strategies derived into the care plan at the multi-disciplinary meeting, and, staff being required to write in detail what they actually did when a behavioural incident is resolved by psychosocial means.*
- *Staff mentoring and behaviour support meetings should be held at least weekly chaired by the T-BASIS CNC (or equivalent) or the NUM. These meetings will focus on discussion of new patients, existing patients with current acute behavioural problems, and other patients at regular intervals so that all are eventually covered. Ideally only one to three patients should be discussed. The focus should be on how the patient must be feeling, how staff are feeling, brainstorming possible causal factors for the behaviour and sharing strategies to treat or minimise the effects of these factors. These sessions should be overtly both about improving understanding and care of the patient, and also supporting and educating staff. The psychosocial/nursing intervention derived from staff at these meetings will inform the multi-disciplinary clinical review meetings.*
- *There should be weekly multi-disciplinary clinical review meetings including medical staff, NUM, the T-BASIS senior clinician, social worker/discharge*

planner, a representative of the outreach service and, where appropriate, other service providers such as ACAT.

- *Measures of good clinical practice will include:*
 - *Multi-disciplinary care plan started within one week and committed to writing within two weeks of admission. Care plans should cover medications, physical/medical problems, and psychosocial interventions and reflect decisions taken at the staff mentoring and behaviour support meetings, and the multi-disciplinary clinical review. The T-BASIS senior clinician (CNC or equivalent), or the NUM should have responsibility for ensuring this occurs.*
 - *Care plans should follow MH-OAT guidelines and be reviewed at the multi-disciplinary meeting as soon as possible after admission, and thereafter according to clinical need (for example in response to a clinical incident or periods of acute behaviour disturbance, physical illness, or other change in circumstance, including if the patient settles and appears ready for discharge). If the patient does not require review based on clinical need, the second review should be five weeks post admission and, thereafter, if the patient stays longer than the recommended 8-12 weeks, at intervals of thirteen weeks.*
 - *Patients who stay longer than 12 weeks should have a clear practicable discharge/transfer of care plan, or at least such a plan in development.*
 - *A structure must be in place (e.g. family meetings, regular telephone contact immediately after case reviews), so that families are consulted formally regarding care plans, medication changes, and discharge/transfer of care plans.*
 - *In addition to mandated measures (such as HoNOS 65+, RUG-ADL), there should be assessment of clinical progress or outcomes for patients using pre- and post measures designed for this population which focus on the domain of behaviour, both for acute behaviour disturbance (e.g. QUEBAGS or equivalent) or for longer term outcomes (e.g. CPAT, Cohen-Mansfield Agitation Inventory). There should be standardisation of at least some of these measures across the units.*
- *There should be routine monitoring and analysis of adverse incidents such as falls, restraint use etc.*
- *At discharge, patients must be provided with a detailed management and care plan, and outreach clinicians and/or the discharge planner must facilitate the settling process by frequent contact in the first few weeks post-discharge.*

Recommendation 3: Strategies to support further clinical service redesign to the T-BASIS model, monitoring and review.**Recommendation 3.1**

It is recommended that NSW Health provides further central clinical and strategic leadership for the implementation of the T-BASIS initiative through the appointment of a project manager with relevant senior clinical experience to:

- facilitate the full implementation of the T-BASIS model of care and the recommendations of this report; and

- develop processes for mentoring and supporting T-BASIS staff (particularly NUMs), clinical networking (including regular meetings/forums), benchmarking, monitoring and evaluation, quality improvement and other relevant strategies.

The T-BASIS project manager would be required to liaise with T-BASIS NUMs, T-BASIS Medical Directors, SMHSOP Clinical Directors and SMHSOP Clinical Coordinators in relevant LHDs, the OPMH Policy Unit and other relevant experts, and to coordinate further monitoring and review of the T-BASIS units and initiative.

Recommendation 3.2

It is recommended that relevant LHDs support the involvement of relevant staff, including with T-BASIS NUMs, T-BASIS Medical Directors, SMHSOP Clinical Directors and SMHSOP Clinical Coordinators in T-BASIS clinical networking and service improvement activities as part of the T-BASIS initiative.

Recommendation 4. Future directions for the T-BASIS program and management of BPSD**Recommendation 4.1 In relation to the future of the T-BASIS program:**

- If the targets/requirements outlined in Recommendation 1.1 are substantially met by all units, they should continue to operate as they are and consideration be given to expanding the T-BASIS program.

- If, given the level of central leadership and support outlined above, some T-BASIS units consistently fail to reach the targets specified in Recommendation 1 (regarding target group, LOS and occupancy), and there are no grounds for assuming the situation will improve, consideration should be given to changing the function of the units concerned or closing them. If this is the case, alternative arrangements will need to be made for skilled in-patient assessment and treatment of people with severe BPSD. This could involve partnerships between LHDs and non government organisations (NGOs) and/or addressing the needs of older people with severe BPSD in SMHSOP acute and sub-acute inpatient units and geriatric behavioural units.

Recommendation 4.2 Wider coverage for BPSD

Given demographic trends and the consequent large and increasing need for specialist appropriate services for older people with severe BPSD and the limited number of T-BASIS units, it is recommended that NSW Health continues to undertake planning and service development to provide optimal inpatient and community care for this group across the spectrum of care through the OPMH Program and other relevant state-wide and local processes. Other complementary models of non-acute/sub-acute inpatient care for the broader SMHSOP target group should also be explored.