GCHHS Part 9 Health Boards Act 2011

Health Service Investigation – Final Report

Gold Coast Hospital and Health Service

Gold Coast Health
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1. Investigation Details

The purpose of this health service investigation is to investigate the report on matters relating to the management, administration, and delivery of public sector health services for patients with Dementia or Behavioural and Psychological Symptoms of Dementia (BPSD) and the escalation and management of concerns at both the Gold Coast University Hospital (GCUH) and Robina Hospital within the Gold Coast Hospital and Health Service (GCHHS).

The GCHHS Chief Executive formally commissioned the review in accordance with Part 9 of the Hospital and Health Boards Act 2011 (Qld) (HHB Act).

This investigation focuses on a clinical incident that occurred in the Complex Management Unit (CMU) at Robina Hospital on [redacted] 2023 where a [redacted]-year-old [redacted] with a background of severe dementia entered another inpatient's room and physically assaulted them resulting in a large subdural haemorrhage and death.

The review team also reviewed the care of a [redacted] year-old [redacted] who was admitted to [redacted] at GCUH [redacted]

A team of Health Service Investigators with extensive experience in Gerontology (medical and nursing), Psychiatry, Allied Health, Workplace Health and Safety and Clinical Governance. This report addresses the matters requested in the terms of reference.

In conducting the investigation, the HSI team:

- reviewed the clinical record of the three patients identified in scope of review
- visited CMU (H2E) and B1 RACE (Robina Acute Care of the Elderly) at Robina Hospital and C5W (Neurology) and B5N (Respiratory) at Gold Coast University Hospital
- interviewed 28 GCHHS staff from departments and specialties including: Geriatrics, General Medicine, Neurology, Psychiatry, Allied Health, Nursing, Nursing Education, Medical Education, Work Health Safety and Security
- reviewed CCTV footage from Robina CMU
- reviewed extensive documentation and information including: GCHHS policy procedural documents, training records, RiskMan data (including occupational violence), committee minutes, Business Planning Frameworks, Work Health Safety data such as duress alarm activations and security assistance call outs.

2. Executive Summary

This investigation identified a lack of specific models of care, treatment pathways and appropriately designed clinical settings for BPSD management at GCHHS leading to ineffective and inadequate management of patients experiencing significant BPSD.

Individual management of BPSD of the cases under review was not in keeping with best-practice and was not responsive to escalations in symptom severity and ongoing behaviour crisis. The lack of a Model of Care for BPSD directly impacted the outcomes of the reviewed patients. It was also found to impact the preparation, training, and capability of GCHHS staff to provide effective, safe, and therapeutic care to patients experiencing clinically significant BPSD. Furthermore, it was identified that there was no clear model of service that is consistent across GCUH and Robina hospitals for Geriatrics.

Relevant to duties held by the GCHHS under the *Work Health and Safety Act 2011, the* investigation found potential risk exposures.

Evidence of risk management related to occupational violence risk assessment when reviewed demonstrated variance from best-practice and GCHHS procedural documentation. Information in the form of occupational violence incident data was found to demonstrate variation between system records in two separate recording databases. Systematic variance in data and processes limits the capacity of GCHHS to accurately define and manage occupation violence risk.

Historical evidence of training in occupational violence prevention was not made available to the investigation team. Evidence provided of current year occupational violence training attendance did not match employee establishment.

3. Findings

3.1 Model of Care

GCHHS Models of Care

This investigation identified that there is no Model of Care for BPSD at GCHHS, including a treatment pathway, a specialised care setting and functional interface with geriatric medicine and/or psychogeriatrics. Furthermore, there is no clear model of service that is consistent across GCUH and Robina hospitals for Geriatrics. Determination of which specialty and ward patients with dementia are admitted to is dependent upon which hospital they present to and the severity of their symptoms, with severe symptoms restricted to acute medical wards only. The Robina CMU service model is a patient flow-based model. The unit was established to assist with patient flow of non-acute general medical patients from GCUH. The Robina RACE unit is for older frail patients cared for by Geriatric Medicine. However, due to the frailty of the main cohort, it is not considered appropriate for management of patients presenting with clinically significant BPSD.

In discussing a specialised Model of Care for BPSD, several key facts and concepts relating to clinical need and approach must be recognised. First, the prevalence of older patients with dementia in acute hospitals is high, with two-in-five older inpatients experiencing dementia and/or delirium (i.e., one-in-four inpatients have dementia) [1-3]. Complex behaviours and psychological symptoms are common to both syndromes, with 75-92% of patients with dementia experiencing some level of agitation/aggression [4, 5]. Second, many patients have pre-existing BPSD, while others develop new or exacerbated behavioural symptoms of distress due to delirium, acute illness, the environment, and care routines that are mismatched to an individual's needs, preferences and comprehension [1, 6, 7]. A proportion of these responsive behaviour symptoms can be managed in-place through good delirium care, fundamentals of nursing care, and supportive multidisciplinary consultation liaison services specialised in geriatrics/psychogeriatrics. However, there is a subgroup of patients with significant BPSD that will require more extensive and tailored care. Third, person-environment interactions are recognised as significant to the development of BPSD with symptoms often resulting from a disease-induced deterioration in a person's ability to cope with various physiological and environmental stressors—psychological, social, and physical [8-10]. Because of this increased vulnerability to stressors, busy hospital wards, with their complex system-related priorities, lack of dementia-enabling design and lack of clinicians skilled in dementia-care tend to precipitate or exacerbate BPSD [6, 8-11]. Fourth, effective therapeutic care for BPSD often depends upon successful integration of the right physical environment, practice culture, skilled staff, specialised assessments, prescribing practices and nonpharmacological approaches [12]. Fifth, most general acute-care wards as they are currently designed and operate are unable to provide this level of specialised evidence-based care [12].

This investigation identified that the lack of a Model of Care for BPSD directly impacted the outcomes of the reviewed patients. It was also found to impact the preparation, training, and capability of GCHHS staff to provide effective, safe, and therapeutic care to patients experiencing clinically significant BPSD. These factors will be elaborated on further throughout this report. The following section outlines: (a) the current Models of Care at the GCHHS hospitals, (b) how they performed in relation to best practice care for the patients included in the review and (c) how a specialised Model of Care might have led to different outcomes.

GCUH Model of Care

The model of care at GCUH involves older medical patients with dementia being cared for by acute medical teams on general medical wards incorporating an allied health team. Referral for transfer to subacute Geriatric Medicine at Robina hospital can be made for older frail patients, however, this subacute care is not designed to accommodate clinically significant BPSD and would also depend on bed occupancy. Patients with dementia and/or delirium allocated a 1:1 special are reviewed by an Enhanced Care Service (ECS) – see separate section on ECS below. The Consultation Liaison psychiatry service is available across the hospital to see patients with primary mental health disorders. However, this service is not a specific Psychogeriatric Consultation Liaison service and furthermore do not see or provide assistance in the assessment and management of patients with severe BPSD. There is no specialised dementia-enabling environment at GCUH and no specialist service for managing severe presentations of BPSD.

The GCUH patient included in this investigation represents a particularly revealing example of how the absence of a Model of Care and care-environment specific to BPSD and/or Geriatrics culminated in a "stranded patient" narrative, by which the attempts of the [redacted] responsible for care were largely ineffective in managing the patient's behavioural symptoms over their admission. The impact of not having a model of care for BPSD is outlined further in this report in reference to standard of care.

Robina Hospital CMU

The CMU is a model of care designed by GCHHS. The main and perhaps only admission criterion is patients with prolonged hospital stay due to complex discharge needs. While this patient cohort does include patients with behavioural and psychological symptoms of dementia, there does not appear to be a standardised approach to dementia care in CMU as can be observed in other sites in Queensland with dedicated dementia /BPSD units that utilise best practice models and co-management between geriatrics and old age psychiatry. The investigation team were informed that patients with severe BPSD who were admitted to acute medicine in Robina would more likely be transferred to B1RACE as opposed to the CMU. This contrasted with patients who were admitted to GCUH with severe BPSD. Such patients would be considered for transfer to the CMU. The CMU therefore routinely has potential for older patients with dementia to be cohorted with robust younger patients with acquired brain injury. The CMU model falls under the governance of the Director of Allied Health & Rehabilitation. There is a consultant geriatrician and a consultant rehabilitation physician who provide the medical management of the patients within the CMU. The Consultation Liaison psychiatry service does provide consultations for patients with primary mental health issues but BPSD would not fall under this rubric. There is no Psychogeriatric service input which contrasts with the service that is provided to patients in B1RACE. The review team noted the planning of a new sub-acute hospital being built near GCUH. At time of the review, the Models of Care for the facility were being developed with specific specialty groups. An additional CMU was being proposed to be established based on the current model.

Robina Hospital B1RACE unit

Patients with BPSD regularly get transferred to B1RACE from acute medical teams at Robina Hospital. While the ward environment is not suited to BPSD severity, the clinical model of care is more aligned with evidence-based dementia care. Nursing staff are dementia trained and it is under the governance of Geriatrics with 0.2FTE Psychogeriatric support.

Enhanced Care Service (ECS)

The Enhanced Care Service (ECS) incorporates a CNC and Advanced OT at both GCUH and Robina Hospitals. The service commenced in mid-2023 with the purpose to reduce nursing "specials". This service does not see mental health patients, or those in the CMU and B1RACE units at Robina. A request was made for a model of care regarding this service – nil model of care available. A summary was provided via email of the service. The service is based on the Vona du Toit Model of Creative Ability (VdTMoCA) (Van der Reyden et al. 2019), integrated with the nursing Fundamentals of Care Framework. The Vona du Toit model is stated to be applicable to any diagnosis or severity of illness however there is minimal evidence in the literature regarding its use in BPSD. ECS provides consultation, expert knowledge, and assessment to support patients with increased care needs as a result of cognitive impairment; enabling patients to participate in their own care needs to help drive health recovery for improved patient outcomes and experience; including:

- Formulation of Personalised Support Strategies based on patients' level of sensory and cognitive ability
- Support with weaning/cessation of current need for increased patient supervision
- Point of care support/modelling and education to staff
- Support with sustainable discharge transitions (upon further service expansion)

The current ECS implemented is a scaled down version of a previous pilot [redacted]. The investigation team requested a report / evidence as to the previous pilot success – this was not provided. [redacted]

[redacted].

[redacted]

The team have distributed a staff survey (results pending).

Investigators queried the framework utilised by ECS to formulate behaviour support plans. The staff interviewed from the service stated that the behaviour support plans were developed based on the Vona du Toit model. [redacted].

3.2 Environment

Established theories of human-environment research posit that the well-being and behaviour of people with dementia depend on the interaction of environmental factors and their individual coping skills [11, 15]. Recommendations for dementia-enabling design in hospitals have been developed based on this understanding and involve 10 overarching salutogenic principles [16] as follows:

1. unobtrusively reduce risks,
2. provide a human scale,
3. allow people to see and be seen,
4. mange levels of stimulation – reduce unhelpful stimulation,
5. manage levels of stimulation – optimise stimulation,
6. support movement and engagement,
7. create a familiar place,
8. provide a variety of places to be alone or with others – in the unit,
9. provide a variety of places to be alone or with others – in the community,
10. design in response to vison for way of life

This investigation applies these principles in evaluating the clinical environments under review at GCHSS.

GCUH environments

The GCUH ward environments reviewed by this investigation were C5W and B5W. It is noted that these have not been specifically designed to accommodate patients with clinically significant BPSD who require low stimulus and small scale environments of 8-12 beds [11], and well-designed communal spaces for leisure and socialisation, enabling safe unconstrained walking. Whilst acknowledging this, these wards do have a range of positive design features for care of older patients with dementia and/or delirium who do not have significant BPSD. The layout/footprint of each ward provides a large circuit type corridor, reducing risk of patients getting lost while facilitating opportunity to walk. Wards have keypad security doors which also manages risk of harm through misadventure from leaving the ward. Corridors are wide and relatively uncluttered, facilitating activity and reducing overstimulation. Contrasting colour schemes are commensurate with wayfinding and assist in identifying important cues in the environment. For B5W the toilets have been fitted with coloured toilet seats to aid in self-sufficient independent toileting (i.e., making toilet clearly visible). The ward layouts had several lounge/leisure spaces designed at each end (North and South) and a small lounge alcove midway down the ward. The lounge/leisure spaces have large windows facilitating generous views and access to the natural world, allowing good natural lighting to enter the spaces. However, these spaces have recently been repurposed as overflow patient care spaces, permanently housing a spare patient bed, ready to be occupied for care to accommodate emergent bed pressures. This now prevents opportunity to use these spaces as therapeutic wellbeing spaces for patients, their families, and guests. Rooms are single bedroom, which can hamper visual supervision of at-risk patients to a degree, but conversely, allows for quieter bedroom spaces.

Bedrooms also have large windows allowing good natural lighting and facilitating an element of access to the natural outside world.

Robina CMU environment

The CMU is positioned in an older building than the GCUH. Its footprint/layout is generous and quite conducive to managing BPSD. There is a circuit type layout and large social spaces at the end of three corridors. One social/leisure space encompasses a caged balcony space of generous proportions, where patients can do a range of outdoor style arts and crafts like potting plants. The corridors are wide and uncluttered, rooms include 14 single including one bariatric and three double bedded rooms. The furnishings and use of colour in the ward is bland and not particularly dementia-enabling. There are cooking facilities and a multitude of leisure spaces and breakout rooms. There is a space that has been redesigned as a Modified Safe Environment (MSE) where individual patients with severe symptoms can be cared for and secluded from the rest of the ward during the day. This environment presents several safety and dignity concerns and possibly needs to be rethought. While providing a restricted area that can safely isolate very agitated patients it may unnecessarily deprive them from appropriate freedoms and socialisation with others. The investigation team noted that there were several patient activities in the space however they were stored behind glass in a bookcase which was secured shut with zip ties preventing access. The investigation notes that it can have flexible use and be opened up to the entire ward when not required for isolation. There was also a significant safety concern noted regarding ligature points (handles, rails) within this space. This space encompasses a large communal area that has been given up for just one patient. There is an uncaged balcony which is not accessible. Overall, the ward footprint/layout of CMU is large, with many breakout areas and would be well suited to a refurbishment into a Special Care Unit for Dementia accommodating severe BPSD. Some thought to modularising the bed number down to 8-10 bed spaces (for example two of these) would be recommended. The challenges faced by the CMU in managing BPSD do not rest with the environment but instead, with the Model of Care.

Robina B1RACE unit environment

The B1RACE ward functions ostensibly as a Geriatric Emergency Medicine unit for frail older patients, of whom many will have dementia and/or delirium. It has a cross shaped corridor layout with two corridors intersecting in the middle of the ward. At one end of each corridor there is a space for leisure/socialisation. One corridor's lounge space is indoors with a large window looking over the surrounding countryside, the other corridors leisure area involves a generously proportioned outdoor garden. However, patients cannot access this space without staff assistance, which means it is likely not used as much as it could be. There are several safety risks in the garden related to uneven surfaces and that it is not enclosed sufficiently to prevent climbing out of the enclosure, thus presenting significant risk of harm through misadventure. At the opposite end of each corridor, is a wall overlayed bookshelf images to camouflage doors or provide illusion of a meaningful space. The corridors are narrow, cluttered, and noisy, allowing little room for free unencumbered movement especially if people are using mobility aids. Overall, the environment is not optimal for caring for frail older people with dementia and/or delirium. As such, it is also completely unsuitable for the management of severe BPSD. It also presents little opportunity for redevelopment into a specialist unit for BPSD due to its inappropriate crossed-corridor footprint/layout.

3.3 Standard of Care

[redacted], the lack of a standardised model resulted in practices that did not align with best practice. This investigation identified a lack of specific models of care, treatment pathways and appropriately designed clinical settings for BPSD management at GCUH and Robina [redacted].

The GCUH patient included in this investigation represents a particularly revealing example of how the absence of a Model of Care and care-environment specific to BPSD and/or Geriatrics culminated in a "stranded patient" narrative, [redacted]

significant severity, requiring thorough specialist assessment and management for BPSD. The Australian Clinical Practice Guidelines for Dementia (2016) articulate that all patients with dementia presenting with BPSD have the right to be appropriately assessed and managed by specialists in BPSD [13]. Instead, this patient was immediately "snapped" to "maintenance"—the lowest funding category, indicating stability and readiness for discharge. The documented treatment plan was for "discharge planning", even though the patient's [redacted] An overall abrogation of medical responsibility for this patient's disease-induced behaviours epitomised the [redacted] clinical approach for the patient's entire hospitalisation and seems symptomatic of an underlying conceptualisation of responsibility which dichotomised medical stability against behavioural stability—the first being considered the responsibility of medicine, while the second, the responsibility of nurses and their deployment of psychosocial strategies. Evidence of this divided clinical responsibility was pervasive throughout the treating team's documentation in the patient's progress notes. [redacted] entries comprised repeated confirmations of medical stability, repeated requests for ongoing delivery of "behavioural strategies" and the sporadic seeking of advice from Geriatric Medicine, culminating in several behavioural medication optimisations. Further evidence of this dichotomised perspective was revealed in the content of the email responses to the [redacted] who had escalated nursing concerns over deprioritised care not commensurate to the level of behavioural severity being witnessed. Email correspondence revealed a perspective of medical stability with nothing more that could be done for the patients' behaviours as they were "stranded" in hospital. This investigation speculates that such an overlaying medical narrative partially explains why the patient did not receive a medical review or medical progress note entry for 10-days, and on a different occasion, 8-days, despite repeated behavioural crisis and escalations by nursing staff for review. While referrals to Geriatric Medicine were made, no referrals to Consultation Liaison psychiatry or old-age psychiatry were attempted as a second opinion or new perspective on an unresolving clinical situation. There was also clear evidence that the ongoing ineffective approach to [redacted]. The family meeting did not take place due to lack of medical attendance. The inability of the medical team to provide more meaningful management of the patient's BPSD clearly highlights a lack of specialist BPSD knowledge within the existing Model of Care.

Although the ECS was engaged early in the patient's admission the prescribed management plans over the first 14 days were predominantly generic approaches for people with dementia, not individualised formulations and did not prevent [redacted]. There was little evidence of an interprofessional collaboration between ECS, the allied health, nursing and medical teams. Evidence-based approaches to developing BPSD management plans should involve careful formulation of biopsychosocial approaches based on in-depth assessments of the individual within the context of their experiential, autobiographical and social world. This usually involves intensive interviews and collaboration with family and others. Furthermore, it requires regular interprofessional collaboration across all disciplines including medicine.

Medications need careful titration based on evaluation of the day-to-day effectiveness of psychosocial strategies and in response to the emergence of clinical features like pain, anxiety, oversedation, new behaviours and delirium, to name a few. In the GCUH case, pain was a clearly identifiable feature early in the admission, with the patient frequently self-reporting pain. Yet a time-limited trial of regular analgesia over several days to evaluate its effect on behaviour severity was never implemented. While the predominantly stand-alone psychosocial strategies provided by the ECS might prove effective for lower severity of behaviours that can manifest in delirium and/or dementia, the complexity of this patient's [redacted] signalled the need for an interprofessional collaborative approach. There was no evidence of such an approach, nor evidence that such an approach comprised normal practice for any of the teams involved. On [redacted] of the admission, [redacted], the ECS formulated a more individualised plan. However, its format was overly long for bed-side translation and [redacted], its effectiveness remains questionable. The investigation sensed a disjointed approach where the ECS operated separately, effectively siloed from the medical team. The investigation found no evidence that collaborative interprofessional problem-solving and care planning were normal operational approaches to addressing serious behavioural management issues in medical patients. The

investigation noted that the purpose of ECS was to specifically "reduce specials" not to manage clinically severe BPSD.

This patient was not able to be transferred to the Robina Acute Care of the Elderly Unit (RACE) due to the [redacted] and the risk posed to the predominantly older frail patient cohort on the geriatric unit. The RACE ward is not designed to accommodate or treat clinically significant or severe BPSD and has an environmental design that is not conducive to BPSD (see environment section). The admission criteria to the CMU ward at Robina was designed for complex long-stay patients to assist patient flow, not specifically for severe BPSD. Transfer to CMU was considered in the later part of the admission, however it was felt that transferring them to a new environment may further exacerbate his agitation. Therefore, due to a lack of a suitable Model of Care, this patient was left "stranded" on the [redacted] at GCUH.

This assessment of patient care at GCUH reveals the lack of a specialised Model of Care for BPSD and how this absence shapes the clinical lens and decision-making of clinicians. It must be recognised that evidence-based management of BPSD is complex and challenging, requiring specialised environments and teams. For instance, the failure of ECS management plans to prevent behavioural crisis in this case could just as likely have been related to a lack of an appropriate dementia-enabling physical environment than to whether the content and formatting of the psychosocial management plan was appropriately targeted.

Several hospital-based Special Care Units for Dementia and BPSD management have been successfully implemented in other Australian hospitals and can be used for benchmarking—Concord Hospital (Sydney Local Health District), The Prince Charles Hospital (Metro North Health, Brisbane) and Princess Alexandra Hospital (Metro South Health, Brisbane). They generally involve secure built-environments of 8-12 beds with dementia-enabling designs situated within models of care specialised in geriatric medicine and/or psychogeriatrics. They are specifically designed for patients with dementia and do not admit other diagnoses. After an in-depth review of the GCUH patient's admission, and based on their clinical experience, this investigation's clinical experts believe it reasonable to suggest that had the patient presented at those sites, their symptom severity and length of stay could possibly have been halved. Published evaluations of two of the benchmark sites report a median length of stay of 21-23 days [12, 14], while GCUH patient's length of stay was double that, at 54 days.

The lack of medical review in the context of increasing challenging behaviours and restrictive practices being employed through multiple Code Blacks was evident and dominant feature in both the CMU and GCUH patients care. This is contrary to GCHHS procedure Behavioural Emergencies in the Elderly PRO1861, which outlines care for patients over age of 65 who are inpatients with cognitive impairment or suspected of suffering dementia and/or delirium. Section 9.1.3 states "all medications for management of behavioural and psychological symptoms must be reviewed frequently (minimum every 24 hours) with intention to cease where possible due to increased mortality risk." 11.2.2 "In cases of BPSD any medication commenced must be reviewed frequently and evaluated in relation to its effectiveness with an implemented behavioural management plan". As already outlined in the report, there were two occasions during the GCUH patient's admission where there was no medical review for 8 and 10 days respectively [redacted]. Section 7 of the procedure sets out guidelines for pain assessment in people with cognitive impairment including a time-limited analgesia trial, noting that regular dosing is preferred to PRN. [redacted]. Yet a time-limited trial of regular analgesia over several days to evaluate its effect on behaviour severity was never implemented.

[redacted]

[redacted]

3.4 Clinical Governance

The investigation team noted that the [redacted] raised concerns through several reporting structures about the lack of regular medical review and increasing risk of occupational violence to staff. The structures included RiskMan reports, escalation through operational hierarchical leadership structures and operational meetings. These attempts had limited success in achieving an effective response in a timely manner. The investigation team noted that staff relied on interprofessional relationships rather than leadership roles to navigate issues. It was noted during the investigation that GCHHS were piloting the Patient Safety Net program which provides staff a new way to escalate concerns around potential or actual patient safety physical and/or psychological. The program launched in early October 2023 at GCUH and was available during the time the escalations were taking place but not utilised by the [redacted].

The GCHHS Clinical Governance Framework 2020-2024 was reviewed. The GCHHS Clinical Governance Framework outlines the clinical governance committees that provide assurance that safety and quality systems are actively managed, monitored and evaluated. The GCHHS Clinical Governance Committee reports through to GCHHS Safety, Quality and Clinician Engagement Board Sub Committee. Several sub committees report through to the GCHHS Clinical Governance Committee inclusive of but not limited to:

- Clinical incident review Committee
- Complex case review Committee
- Directorate safety and quality Committees
- Executive triage meeting – clinical incidents

The areas included in this investigation were aligned to the Medicine Division and Allied Health and Rehabilitation Services. With respect to the GCUH patient on [redacted] under [redacted] – the Terms of Reference (TOR) for the GCHHS Medicine Division Quality, Risk and Safety Committee (draft only – developed November 2021) states in purpose to "advise GCHHS Clinical Governance Committee about matters contained in terms of reference". The TOR states the committee meets quarterly and monitors several quality indicators, clinical incidents and operational risks. Meeting minutes provided indicate the committee meets more frequently (bi-monthly). The committee noted as part of their reporting that BPSD patients being treated in acute care areas was contributing to an increase in safety incidents. Furthermore, concern regarding short staffing of security officers was also raised in the context of potentially not being able to respond to increasing number of Code Black calls. The committee reports directly to GCHHS Clinical Governance Committee (as per item 6 in TOR). Thus, a clear escalation pathway to appropriate committee for clinical governance issues.
With respect to Robina CMU (H2E). This ward sits within the Allied Health and Rehabilitation Services which operationally reports through to the Emergency and Specialty Services. TORs were reviewed for "Allied Health" and "Rehabilitation" Safety and Quality Committees (two separate meetings), noting the meeting of relevance to this investigation is the Rehabilitation Safety and Quality Committee as that encompasses CMU.

The TOR for the Allied Health Quality and Safety Committee were reviewed (draft only, approved Feb 2022, due for review February 2023 – out of date). The TOR states that "the committee may make recommendations to the Clinical Governance Committee for approval and noting. Issues unable to be resolved by the committee will be escalated to the clinical governance committee." Thus, a clear escalation pathway to appropriate committee for clinical governance issues.

In contrast, the TOR for the Rehabilitation Services Safety and Quality Committee (draft only – no date of development or review date) states in scope and functions to "escalate appropriate issues to the Allied Health and Rehabilitation Services Clinical Business Unit Committee and the relevant governance body when required". The committee reports to the Allied Health and Rehabilitation Services Clinical Business Unit Committee Meeting (as per item 6.1 in TOR). The Allied Health and Rehabilitation Services Operational and Business Meeting meets monthly and appears to primarily function as an operational/business meeting. There was no evidence of safety and quality indicators being reported through this committee.

The TOR for the Allied Health, Rehabilitation Services, and Integrated Care Clinical Business Unit Committee (note slightly different name to that referred to in the Rehabilitation Safety and Quality Committee TOR) were reviewed (draft only – created June 2022, due for review July 2023 – out of date). The purpose states "to advise the Emergency and Specialist Service (ESS) senior leaders/ ESS Governance Committee about matters contained in the Terms of Reference". The committee reports directly to the ESS Senior Leaders/ESS Governance Committee. The TOR for the ESS senior leaders / ESS Governance Committee was requested by the review team but no TOR was available.

GCHHS monitoring and reporting on minimising restrictive practices includes seclusion rates for Adults and Children in Mental Health. There was no evidence of any other reporting or monitoring of restrictive practices (chemical or physical) outside of Mental Health or a process for how Code Black data is reviewed.

The GCHHS intranet was reviewed – the link to GCHHS Clinical Governance org structure was not available (stated not published).

3.6 Training and orientation

Nursing and Allied Health workforce

This investigation explored the training and orientation of nurses and allied health staff who are predominantly working with patients with dementia and/or delirium. The investigation commends an innovative body of work undertaken by the Nursing and Midwifery Education and Research Unit (NMERU) at GCUH focussed on educating and supporting nursing in its delivery of the fundamentals of nursing care to patients with cognitive impairment. This work involves a [redacted] and a [redacted] who act as translation officers running a series of in-services and workshops for University Students in Nursing (USINs), Assistants in Nursing (AINs) and Registered Nurses (RNs) about the Ageing Brain and reframing behaviours as expressions of unmet needs and discomfort within a fundamentals of nursing care perspective. While most Nurses from the medical wards are encouraged to attend, all commencing USINs will participate in three 4-hour workshops on the Ageing Brain facilitated by the [redacted] and a [redacted] Once working on the wards as specials or fundamentals of care assistants, the [redacted] and [redacted] regular round with the USINs providing support and bedside role modelling and education for individual cases. This model of embedded experiential learning and skills acquisition through practice is commended and in keeping with evidence-based principles of clinical learning on the wards that it has been embedded Nursing staff are also expected to have completed the Dementia Training Australia (DTA) online package "the View from Here – Acute care nursing for cognitive impairment". This overall body of education work builds on previously published research and grants led by the clinician in the CNC role [17-20]. The investigation therefore finds that the USINs involved in specialling the patients with BPSD on the medical wards have received in depth preparation for understanding the symptoms they are encountering.

Outside of the medical wards in GCUH, this investigation found that because there was no established Model of Care for BPSD, the training of staff working in many of the areas that have high prevalence of patients with BPSD was virtually non-existent or sporadic. Interviews with [redacted] revealed that none of those staff had received dedicated training on BPSD or dementia care e.g., one-day workshop on BPSD. The [redacted] seemed to assume that because many of the staff had worked in aged care setting in their past, they were already appropriately skilled to care for clinically significant BPSD. This is an unwise assumption considering the outcomes of the royal commission into aged care and management of BPSD. While various workshops are run over the year for dementia care and care of cognitive impairment these are voluntarily attended and only have capacity to take 30-40 at any given time. The result is a workforce that has received ad hoc preparation for the speciality care required in managing patients with dementia who may have BPSD or develop BPSD. A further difficulty in educating and training nursing and allied health staff in dementia care and BPSD management is the requirement for in-depth and ongoing experiential learning. When a specialist Model of Care is in place, an effective long term education plan can be enacted. With foundational learning providing a scaffold for in-depth targeted experiential learning and skills development to capacity build a workforce confident and specialised in the care of patients with BPSD. Special Care Units for Dementia provide excellent learning environments for development of these nursing and allied health skills [21, 22].

3.7 Work Health and Safety

Security Special

Procedural documentation can be considered as being standard operating procedures. Queensland Health Security Guidelines QH-GDL-502:2022 quote AS 4485.1:2021 s2 Policies and procedures (which) states: "Where appropriate, security policies and procedures should be developed to address specific needs of the individual areas within the facility."

Further explaining that HHS standard operating procedures (SOP)s should concisely and accurately describe the way workers are to perform certain security tasks. These SOPs ensure healthcare and security teams work in unison, expectations are clear, and tasks are completed cohesively with stakeholders, with a degree of consistency. Expectations can be set and expressed through consultation with relevant stakeholders such as leadership positions within Health and Safety Units (or equivalent), Emergency Departments, Mental Health Inpatient Units, and security services.

The contents of SOPs should address specific risks or required functions that reinforce a positive security culture, when establishing or reviewing written instructions for HSOs or facility workers performing security functions. Local SOPs may be summarised and consolidated in the HHS security plan and / or maintained as a list of separate procedures which work cohesively to inform operations and provide evidence of the security function.

It is recommended that GCHHS review Procedure Gold Coast Hospital and Health Service Document ID PRO2118 Security Specials in comparison with industry standards such as other Queensland Health Hospital and Health Service documentation. By example Townsville HHS has integrated the categories of special observations using the following definition:

> *Patient Special: A short-term nursing / midwifery / Health Security Officer (HSO) staffing resource required to provide a one-on-one Nurse / Midwife patient ratio (if clinically appropriate) or a dedicated nursing / midwifery staffing resource for a patient cohort. The Nurse / Midwife / HSO allocated to a patient special must always remain with the patient during their shift (THHSCLI060319v7).*

The integration of approach fosters the principle of patient centred care and assists cross discipline awareness and understanding.

An example Security Management Plan (Gold Coast Hospital and Health Service Protective Services Patient Security Plan (SNP)) dated current as of 11/10/2023 relevant to the incident was provided to the team. The Plan developed with the NUM of H2E CMU provided Protective Services Staff with background to the patient (general history, name preference and advice on position of special), general information (triggers, signs of escalation, warning signs, intervention options and noted factors the patient enjoys). Clear directions are made in the Plan providing the Protective Services Staff with an understanding of their role, Action plan in relation to change of risk, Safe approaches and disengaging. The SMP demonstrated an understanding of OV risk and management of same and is commended as good practice.

It is open for GCHHS to append an example SNP to Procedure PRO2118 Security Specials to integrate the approach and provide comprehensive guidance to employees of the process. Additionally, the GCHHS may review how similar information is provided to nursing employees engaged in increased supervision procedures.

Occupational Violence Risk Assessment (OVRA)

The Part 9 review of the level of assessed risk performed by use of the OVRA using the iAuditor tool on CMU H2E failed to evidence a quantified level of occupational violence risk additionally failing to identify risk controls for the ward. GCHHS supplied the most recent OVRA for Robina Complex Management Unit H2E conducted on 18 May 2023. The OVRA score 94.26%, flagged items 7, actions nil.

The Global Risk Assessment Work Health and Safety dated 25.07.2023 evidenced a risk rating with current controls as "Medium". Effectiveness of current controls are noted as "mostly effective". The Global document cross references to the OVRA regarding "has the risk been minimised so far as is reasonably practicable? If not, what additional controls are required". There is a notation "Occupational Violence Risk Assessment (VAMP) 2 yearly".

It is recommended that the GCHHS review OVRA and Global Risk Assessment documents to identify risk formulation is mirrored and informed by each document when subsequently conducted. It is further recommended that the Occupational Violence Risk Assessment Process Guideline GL1029 V4 be reviewed to inform the process. It is strongly recommended that GCHHS provide instruction and training for persons assigned the task of OVRA completion to enable accurate OV assessment of workplaces.

GL1029 notes that "An Occupational Violence Risk Assessment (OVRA) must be conducted at a facility, or individual work unit level depending upon the size and complexity of facility", however does not indicate the frequency of the assessment. Ideally the OVRA would also be reviewed in response to severe incidents as part of the incident response prior to a fixed time. GL1029 further notes that: "Analysis of available occupational violence data to identify the who, what, when where and why of violent incidents. Sources of information include incident reporting systems, workers' compensation claims, security activity and reports, community violence and crime profile from Queensland Police Service, including rate of call outs.

The review of the OVRA for Robina Complex Management Unit H2E conducted on 18 May 2023 did not evidence analysis of data. The fields of the OVRA report state "Yes" to the question "has there been a reported increase in occupational violence data since the last OVRA", this increase was not validated with data. It is acknowledged that at the time of OVRA assessment data within 2022/23, would be indicative.

Comparative OVRAs completed in 2023 were provided to the team, significant variation in the depth of assessment, identification of risks requiring action and linkage to OVP training needs assessment were demonstrated. It was noted that in most examples of OVRAT and VAMP (historical tool), no signature or indication of responsible officer sign off was made. Whilst this may indicate a process error in provision of an assessment at the drafting stage, the final assessment document contradicts the guidance of GCHHS Work Health and Safety – Risk Management Procedure PRO1850. To enable the GCHHS to demonstrate effective governance and accountability of risks the Procedure PRO1850 clearly identifies requirements to inform and record risks at different levels. The potential failure to communicate and demonstrate the system of process from risk assessment to risk registers held by GCHHS exposes the HHS to risk of regulatory scrutiny.

Occupational Violence Incident Data

Data in relation to level of occupational violence within clinical areas at Robina hospital requires review to include all valid information sources to ensure accuracy.

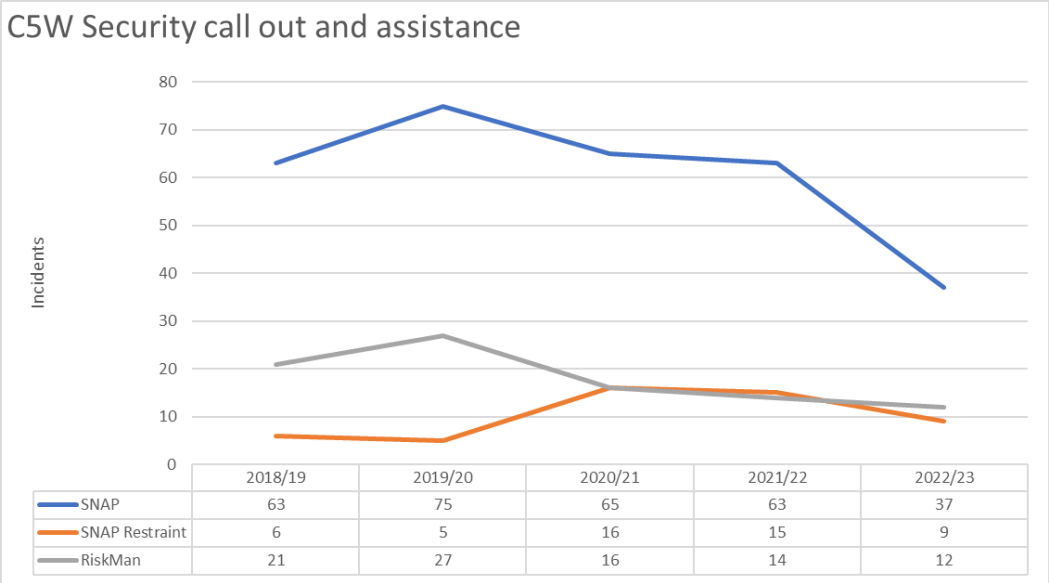
GCHHS's process of reflecting accurately the level of occupational violence risk in work units (using tools such as the VAMP and OVRA) may be compromised when not utilising all available sources of information. Evidence provided by the Work Health and Safety unit provided in the document WHS Requested Information provided a reduced number of security call out/ Code Black responses compared to the SNAP data provided by the security manager.

Security incident responses maintained on the SNAP database provide a greater degree of accuracy to inform the assessment of occupational violence risk. GCHHS staff performing occupational violence risk assessment, should access diverse incident information sources to ensure accuracy of the assessment.

Protective Services Officer (Security) responses – Code Black and request for Assistance

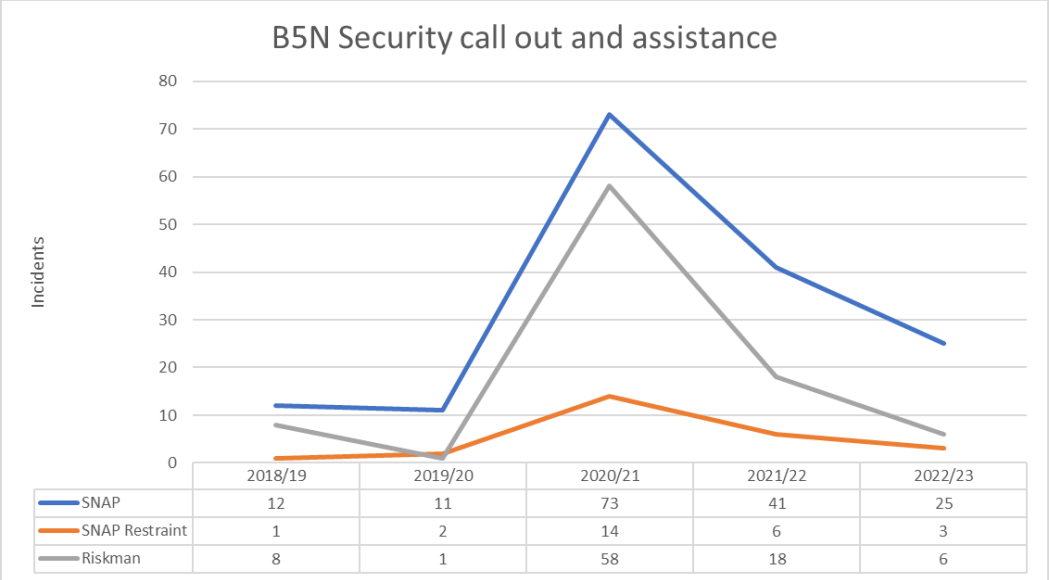
Data sources: SNAP (Service Now database): Security Operations Manager, Robina Hospital, RiskMan data: Health and Safety GCHHS

Figure 1



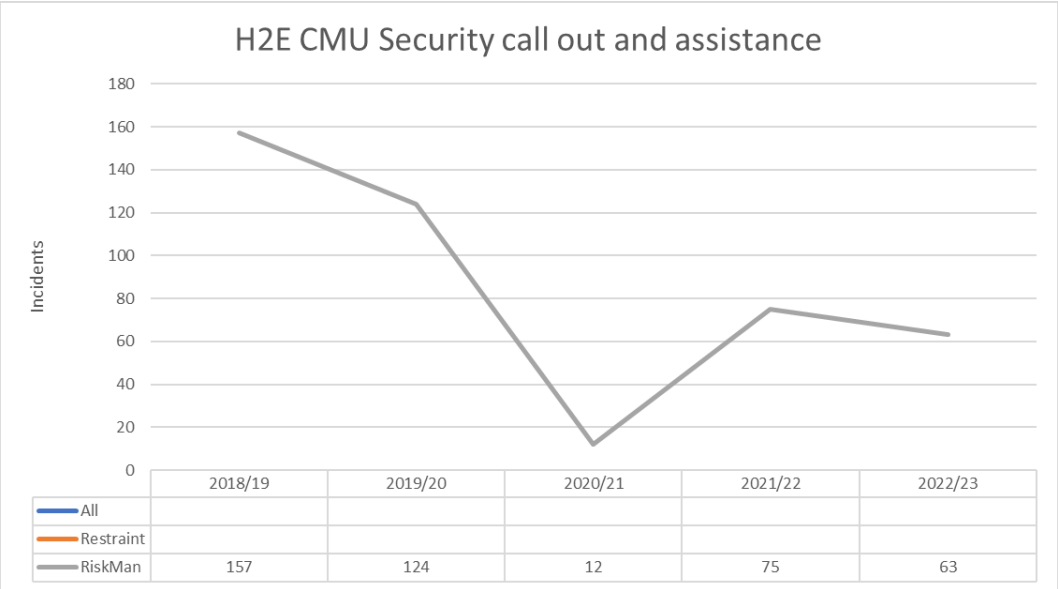
	2018/19	2019/20	2020/21	2021/22	2022/23
SNAP	63	75	65	63	37
SNAP Restraint	6	5	16	15	9
RiskMan	21	27	16	14	12

Figure 2



	2018/19	2019/20	2020/21	2021/22	2022/23
SNAP	12	11	73	41	25
SNAP Restraint	1	2	14	6	3
Riskman	8	1	58	18	6

Figure 3



Note: requested SNAP data for H2E CMU was not available at time of report.

Closed Circuit Television (CCTV)

It is open for the GCHHS to consider the function and operation of CCTV cameras within the Robina facility. The current functions of the CCTV system provide both a deterrent effect, and a function of evidence gathering available after an incident. Current resourcing to create a dedicated security monitor room limits the potential ongoing development. Active CCTV monitoring aims to provide capability to aid in the detection of persons, events, and incidents.

The GCHHS may consider the expansion in function of the current CCTV system with a framework of a safeguard to managing risk and vulnerabilities. Enhancement of the system may additionally provide capacity for covert surveillance of locations in relation to security of an area or if there is suspected criminal or corrupt conduct. It is open for GCHHS to review the function of CCTV within the current framework of expanded numbers of cameras to fully utilise the investment made.

Occupational Violence Prevention Training

GCHHS Occupational Violence Prevention Training (OVPT) Guideline GL1028 provides statements regarding work health and safety obligations of GCHHS by referencing PRO1850 Work Health and Safety Risk Management. An OV training needs analysis for CMU H2E was not supplied.

OVP training data requested was supplied by GCHHS for the current financial year only for CMU H2E, noted the following data: Total 39 Staff 1. CM/CBA – 39 PS-LL – 23 PS-HL – 2(NA) *OVRA PS-LL

- CM/CBA – MAYBO online module Conflict Management and Challenging Behaviour Awareness (GCHHS LOL).
- PS-LL – Physical Skills – Low Level
- PS – LL Physical Skills – High Level

The inclusion of PS-LL level of training is indicative of an occupational violence risk assessment greater than Low. The training report advises that “PS-HL – Not required as only for security & CTC’s”. PS-HL is reflective of clinical holding skills also known as restrictive practices or restraint.

The H2E Business Planning Framework (BPF) Service profile 2023/24 on page 19 identifies a core staff profile of 30.79 Nursing FTE and an additional 13.6 FTE Non-Nursing staff on page 20. Note that Medical Officers on CMU H2E are not identified in the Non-Nursing FTE. Similarly tertiary students on clinical placement are not identified. The total staff compliment for CMU H2E is defined as 39 staff (headcount) from the data provided

(OV training report). However, the BPF page 24, identifies 86% compliance rate of OVP - Conflict Management & Challenging Behaviours Awareness.

There is no notation of the level of training or completion of training for casual staff employed to the role of Increased Patient Supervision on CMU H2E. On site visit, the review team identified four IPS with an additional floater (five AIN grade staff additional to staff profile).

The data anomaly of 39 headcount versus 44.39 FTE can be considered to understate the actual number of staff headcount. It is recommended that the GCHHS consider a methodology to calculate headcount instead of FTE in relation to OVP training needs analysis.

Historical OVPT completion data by employee location on wards was requested by the Part 9 team and was not made available. Failure to provide training and instruction data exposes the GCHHS to a risk in relation to demonstration of Work Health and Safety duties under the *Work Health and Safety Act 2011*.

Interview of the [redacted] determined that the GCHHS has supplemented the MAYBO OVP training program with an additional module developed inhouse. Request for clarification and HHS authorisation to adapt and institute different training techniques related to restraint was not provided following request. It is open to the GCHHS to review the additional inhouse module status in relation to a potential risk exposure held by the GCHHS relevant to departure from an endorsed training program.

4. Recommendations

Recommendation:

GCHHS establish a Model of Care for BPSD management including:

a. A specialised unit (repurpose CMU or undertake a green-site development), co-managed by geriatrician and psychogeriatrician.

b. A multidisciplinary consultation liaison service across GCUH and Robina Hospitals, led by geriatric/psychogeriatric clinicians to consult patients with dementia and/or delirium on general wards who are experiencing changed behaviours or complex care needs.

Recommendation:

Enhance and expand the University Students in Nursing (USIN) Training Model for skills development on wards. Including, increasing availability to ensure more nursing students and AINs can benefit from this comprehensive training.

Recommendation:

GCHHS implement a comprehensive interprofessional scenario-based simulation training program. The program should aim to enhance understanding, improve multidisciplinary collaboration, and develop practical skills to manage patients with delirium and Behavioural and Psychological Symptoms of Dementia.

Recommendation:

Education programs for interns, RMOs and medical registrars (basic physician trainees) include training on delirium, dementia and Behavioural and Psychological Symptoms of Dementia.

Recommendation:

Ensure staff are fully aware of their responsibilities in monitoring and reporting restrictive practices as outlined in published procedures.

Recommendation:

GCHHS review and implement the Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard with clear monitoring and reporting through its clinical governance structure with feedback to clinicians.

Recommendation:

The Enhanced Care Service (ECS) is to be reviewed and evaluated with a clear model of care prior to any extension/additional funding of the service.

Recommendation:

The Clinical Governance Meeting structure is reviewed for the Allied Health and Rehabilitation Service to ensure a direct clear reporting and escalation pathway to the GCHHS Clinical Governance Committee.

Recommendation:

GCHHS review Procedure Gold Coast Hospital and Health Service Document ID PRO2118 Security Specials in comparison with industry standards such as other Queensland Health Hospital and Health Service documentation.

Recommendation:

GCHHS review Occupational Violence Risk Assessment and Global Risk Assessment documents to identify risk formulation is mirrored and informed by each document when subsequently conducted. The Occupational Violence Risk Assessment Process Guideline GL1029 V4 be reviewed to inform the process.

Recommendation:

GCHHS provide instruction and training for persons assigned the task of OVRA completion to enable accurate OV assessment of workplaces.

Recommendation:

GCHHS consider a methodology to calculate headcount instead of FTE in relation to OV training needs analysis.

5. Conflict of Interest

All 6 reviewers declare no conflict of interest with the findings or recommendations with this investigation.

6. Investigation Methodology

Level of Investigation:

Macro - The highest (strategic) level of the system, an umbrella including all intersecting areas, departments, providers and staff.

7. References

1. Feast, A.R., et al., *The effectiveness of interventions to improve the care and management of people with dementia in general hospitals: A systematic review.* International Journal of Geriatric Psychiatry, 2020. **35**(5): p. 463-488.
2. Mudge, A.M., et al., *Cognitive impairment in older hospital inpatients: prevalence, care needs and carer perceptions.* Australian Health Review, 2021.
3. Tannenbaum, R., et al., *Hospital practices and clinical outcomes associated with behavioral symptoms in persons with dementia.* Journal of Hospital Medicine, 2022. **17**(9): p. 702-709.
4. Sampson, E.L., et al., *Behavioural and psychiatric symptoms in people with dementia admitted to the acute hospital: Prospective cohort study.* The British Journal Of Psychiatry, 2014. **205**(3): p. 189-196.
5. Berish, D., A. Kuzmik, and M. Boltz, *Behavioral and psychological symptoms of dementia and adverse patient outcomes post-hospitalization.* Aging & Mental Health, 2024: p. 1-9.
6. Featherstone, K., A. Northcott, and J. Bridges, *Routines of resistance: An ethnography of the care of people living with dementia in acute hospital wards and its consequences.* International Journal of Nursing Studies, 2019. **96**: p. 53 - 60.
7. Boltz, M., et al., *Delirium and Behavioral Symptoms in Persons With Dementia at Hospital Admission: Mediating Factors.* Alzheimer Disease & Associated Disorders, 2023: p. 10.1097/WAD.0000000000000552.
8. Molony, S.L., et al., *Person-centered assessment and care planning.* The Gerontologist, 2018. **58**(suppl_1): p. S32-S47.
9. Kales, H.C., L.N. Gitlin, and C.G. Lyketsos, *When less is more, but still not enough: Why focusing on limiting antipsychotics in people with dementia is the wrong policy imperative.* Journal of the American Medical Directors Association, 2019. **20**(9): p. 1074-1079.
10. Sefcik, J.S., et al., *Person-Centered Care Plans for Nursing Home Residents With Behavioral and Psychological Symptoms of Dementia.* Journal of gerontological nursing, 2020. **46**(11): p. 17-27.
11. Kirch, J. and G. Marquardt, *Towards human-centred general hospitals: the potential of dementia-friendly design.* Architectural Science Review, 2021: p. 1-9.
12. Graham, F.A., et al., *The impact of a hospital-based special care unit on behavioural and psychological symptoms in older people living with dementia.* Age and Ageing, 2024. **53**(4): p. afae081.
13. National Health and Medical Research Council [NHMRC] Guideline Adaption Committee. *Clinical practice guidelines and principles of care for people with dementia: Recommendations [Clinical Guideline]*. 2016; Available from: http://sydney.edu.au/medicine/cdpc/resources/dementia-guidelines.php
14. Djekovic, K., et al., *A retrospective study of the behavioural and psychological symptoms of dementia in patients admitted to a Specialist Dementia Care Unit.* Australasian Journal on Ageing, 2022. **41**(4): p. e397-e405.
15. Lawton, M.P., *Environment and other determinants of well-being in older people.* The Gerontologist, 1983. **23**(4): p. 349-357.
16. Fleming, R., et al., *Towards a dignity manifesto of design-for people living with dementia*. 2023, Taylor & Francis. p. 358-359.
17. Bail, K. and L. Grealish, *'Failure to Maintain': A theoretical proposition for a new quality indicator of nurse care rationing for complex older people in hospital.* International Journal of Nursing Studies, 2016. **63**: p. 146-161.
18. Grealish, L., et al., *Using a general theory of implementation to plan the introduction of delirium prevention for older people in hospital.* Journal of nursing management, 2019. **27**(8): p. 1631-1639.
19. Grealish, L., et al., *Education for delirium prevention: Knowing, meaning and doing.* Nurse education in practice, 2019. **40**: p. 102622.
20. Grealish, L., et al., *Feasibility of a two-part person-centred care initiative for people living with dementia in acute hospitals: A mixed methods study.* International Journal of Nursing Studies Advances, 2021. **3**: p. 100040.
21. Hermann, D., S. Muck, and H.G. Nehen, *Supporting dementia patients in hospital environments: health-related risks, needs and dedicated structures for patient care.* European Journal of Neurology, 2015. **22**(2): p. 239-e18.
22. Goldberg, S.E., et al., *Caring for cognitively impaired older patients in the general hospital: A qualitative analysis of similarities and differences between a specialist Medical and Mental Health Unit and standard care wards.* International Journal Of Nursing Studies, 2014. **51**(10): p. 1332-1343.