



TRACS Community of Interdisciplinary Practice
for People with Dementia

Interprofessional (IP) Responses to BPSD Management

For Residents with Dementia in RACF
(Week 11)



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Learning Objectives

- Introduce a paradigm for interprofessional (IP) practice in RACF, specific to the assessment and management of people with dementia experiencing behavioural and psychological symptoms (BPSD)
- Review personal and professional characteristics conducive to achieving IP outcomes
- Complete BPSD-focused case study activities designed to assist in the development of IP small team problem solving



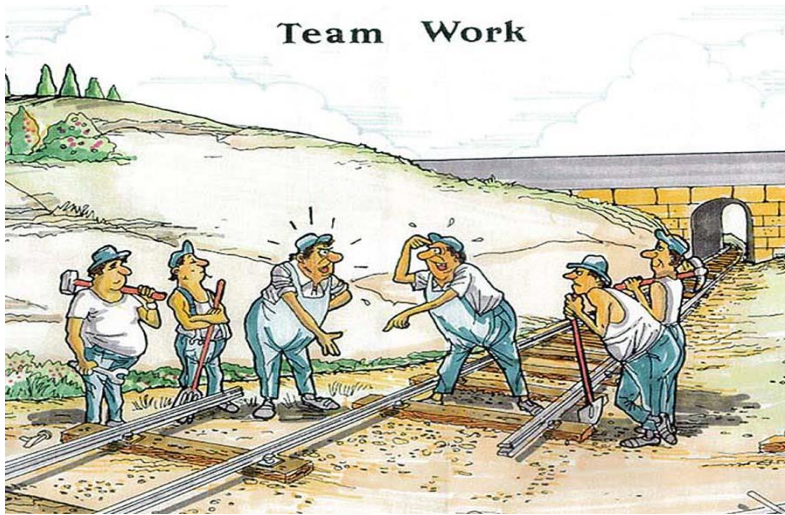
Multidisciplinary team approach

- Professional Silos are common
 - “A multidisciplinary approach to service delivery means that persons from several disciplines are involved in the delivery of services
 - The approach, however, is **discipline-oriented** with each team member responsible only for the activities related to his or her own discipline (Melvin, 1989; Rothberg, 1981)
 - One team member is affected very little by the efforts of the other team members...”

• Melvin, J. L. (1989, April). Status report on interdisciplinary medical education. *Archives of Physical Medicine and Rehabilitation*, 70, 273–276.
 • Rothberg, J. (1981, August). The rehabilitation team: Future direction. *Archives of Physical Medicine and Rehabilitation*, 62, 407–410.
 (as cited in Catlett, C. & Halper, A. (1992, Summer). *Team Approaches: Working Together to Improve Quality ASHA Quality Improvement Digest*. <http://www.asha.org/uploadedFiles/aud/TeamApproaches.pdf>)

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“A team of experts does not make an expert team”



Source: <http://funconrate.com/teamwork-cartoon/>


Swezey, Salas, eds. *Teams: Their training and performance*. 1992:3-29.

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Definition of Interprofessional team collaboration

“Interprofessional collaboration is a ‘partnership’ between a team of health providers and a client in a participatory collaborative and coordinated approach to shared decision making around health and social issues.”



Canadian Interprofessional Health Collaborative. A national interprofessional competency framework. February 2010.
Available from: http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

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Interprofessional Education (IPE) argues that:

- “... **how** care is delivered is as important as **what** care is delivered”*
- Evidence supports effectiveness of IP care[†]
- Gap between training and practice realities
 - Need “collaborative practice-ready” graduates*

* Interprofessional Education Collaborative Expert Panel (2011)
† Partnership for Health in Aging (PHA) Position Statement (2010)

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Interprofessional Collaborative Practice Principles

- A process by which professionals:
 - Reflect on and develop ways of practicing that provide an integrated and cohesive response to the needs of the resident/family/RACF community
 - Participate in continuous interaction and knowledge sharing between professionals
 - Organise to solve or explore care and social issues while seeking to optimise the resident's participation to the extent possible

Adapted from Morrison S. Working together: why bother with collaboration?
Work Bas Learn Prim Care. 2007;5:65–70.

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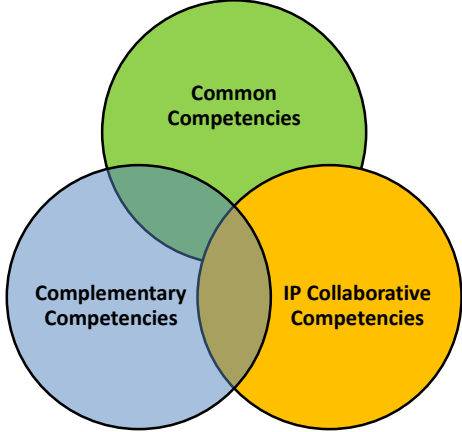
RACF Realities Impacting IP BPSD Practice

- Limited number of representatives from the full compliment of an 'aged care health care team'
- Predominant disciplines: Nursing, Occupational Therapy, Medicine (GPs, Geriatric Specialists), Psychology
- Limited number of IP-experienced professional staff
- High proportion of non-professionally educated care staff
- Developing, but still highly variable, core skills in dementia care among staff
- Limited access to additional specialty practice, e.g., via DBMAS

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3 Types of Professional Competencies*




Core competencies for interprofessional collaborative practice: Report of an expert panel.
Washington, D.C.: Interprofessional Education Collaborative (2011, p.19)

* The term 'competencies' here refers to capacities of the clinician NOT competencies required for registration as a health practitioner.

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Curriculum Overload



**LIMITED BUT DEEP
FOCUS ON
ASSESSMENT AND
MANAGEMENT OF
BPSD IN RESIDENTS
WITH DEMENTIA**

Source: https://www.flickr.com/photos/the_narrow_corner/5219252269/

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Key Aims of IPE (as applied to dementia and BPSD)

- Interactive learning about dementia and BPSD
- Improved interprofessional communication
- Enhanced collaborative competencies
- Reduced/resolved interprofessional rivalries
- Improved quality of assessment, care and communication

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Spectrum of Care

- IP collaborative practice
- IP teamwork
- IP team-based care



Increasingly intentional team-based care for the vulnerable resident with BPSD

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Important Domains of IP Practice (adapted for dementia and BPSD)

- Domain 1: Values/Ethics for IP Practice
- Domain 2: Roles/Responsibilities
- Domain 3: IP Communication
- Domain 4: Teams and Teamwork
- Domain 5: Reflection and Revision

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