contact have been made or reported against a resident while they were accessing a previous service, ensure that all staff at the current service are aware and contact an appropriately trained health professional (eg, The Dementia Behaviour Management Advisory Service or a geriatrician) to develop strategies to prevent reoccurrence.
- Ensure that the strategies to prevent reoccurrence are documented, communicated to all staff and regularly evaluated, and that all staff comply with the strategies.
- When concerns arise, discuss these with family members.

These principles focus on giving staff permission to discuss their concerns about sexual abuse. The act of facilitating these conversations builds the confidence and competence of staff. It is about organisational leadership – letting staff know what is expected of them and it assumes an adequate level of staff and basic staff training.

Education to build capacity

There is a need for Government-mandated education programs to build the capacity of service providers to better respond to and prevent sexual abuse. This education also needs to include information on older people's sexuality, sexual rights and the importance of intimacy. Understanding sexuality more broadly will assist service providers to recognise that people with dementia have sexual rights, including the right to be free from sexual abuse. ■

The AAG report referred to in this article, *A Fair Future For Older Women Who Experience Sexual Abuse – What Needs To Be Done*, by Tonye Segbedzi and Dr Catherine Barrett, is freely available at: www.aag.asn.au/documents/item/2878

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References

Burgess AW, Stevens SL (2006) Sexual Abuse, Trauma And Dementia In The Elderly: A Retrospective Study. *Victims And Offenders* 1(2)193-204.

Cain R, Wyatt R (2019) *Older, Better, Together: The Primary Prevention Of Elder Abuse By Prevention Networks* [Internet]. Seniors Rights Victoria. Not yet available online.

Clark H, Fileborn B (2011) *Responding To Women's Experiences Of Sexual Assault In Institutional And Care Settings* (ACCSA Wrap No10) Melbourne: Australian Centre for the Study of Sexual Assault.

Connolly A (2019) *Aged care home carried on 'business as usual' and ignored sexual assault of resident, family says.* ABC News. Available at: https://ab.co/2KHwwV1.

Department of Health (2019) *Guide For Reporting Reportable Assaults. Ageing And Aged Care*. Available at: http://bit.ly/2YXd13P.

Fanning E (2019). *Sexual Abuse In Aged Care*. The Drum, ABC News. Available at: https://ab.co/2GXTB4P.

Fileborn B, Barrett C, Roberto K (2017) Sexual Assault Of Older Women: Breaking The Silence. In: Barrett C, Hinchliff S (Eds) *Addressing The Sexual Rights of Older People: Theory, Policy and Practice.* Routledge.

Ibrahim J (2019) *Transcript of Proceedings*: Royal Commission Into Aged Care Quality And Safety. Auscript Australasia. Available at: http://bit.ly/2H36jPD.

Mann R, Horsley P, Barrett C, Tinney J (2014) *Norma's Project. A Research Study Into The Sexual Assault of Older Women In Australia* (ARCSHS Monograph Series No 98). Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia.

McGuire M (2013) *Voices Against Violence, Paper Four: A Review Of The Office Of The Public Advocate's Records On Violence Against Women With Disabilities*. Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria, Melbourne.

Our Watch (undated) *Facts and Figures*. Available at: www.ourwatch.org.au/understanding-violence/facts-and-figures.

Ramsey-Klawsnik H, Teaster PB (2012) Sexual Abuse Happens In Healthcare Facilities – What Can Be Done To Prevent It?. *Generations* 36 53-59.

Segbedzi T, Barrett C (2019) *A Fair Future For Older Women Who Experience Sexual Abuse – What Needs To Be Done*. Report of the Australian Association of Gerontology Workshop and Policy Recommendations. Available at: www.aag.asn.au/documents/item/2878.

Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J, Bugeja L (2019) The Epidemiology Of Sexual Assault Of Older Female Nursing Home Residents, In Victoria Australia, Between 2000 And 2015. *Legal Medicine* 36 89-95.

Speck PM, Hartig MT, Likes W, Bowdre T, Carney AY, Ekroos RA, Faugno DK (2013) Analysis Of Possible Sexual Assault Or Abuse In A 67-Year-Old Female With Early Dementia Post-Brain Attack. *Advanced Emergency Nursing Journal* 35 217-239.

World Health Organisation (undated) *What is Elder Abuse*? Available at: www.who.int/ageing/projects/elder_abuse/en/.

Yon Y, Ramiro-Gonzalez M, Mikton C, Huber M, Sethi D (2019) The Prevalence Of Elder Abuse In Institutional Settings: A Systematic Review And Meta-Analysis. *European Journal of Public Health* 29(1) 58-67.

Yon Y, Mikton C, Gassoumis Z, Wilber K (2017) Elder Abuse Prevalence In Community Settings: A Systematic Review And Meta-Analysis. *Lancet Global Health* 5:e147-156.

Ananda Aged Care operates two homes in Adelaide, South Australia – Findon and Hope Valley. Findon's Rose Wing is an eight-bed, female-only Memory Support Unit (MSU) which, until December 2018, was a secure unit. Hope Valley is a one-level, 137-bed home. Its Derwent Wing MSU became an open unit in February 2019 and its occupancy was reduced from 19 residents to 17.

Opening the doors to the MSUs has been a key part of Ananda's new Resident Focused Care Model, which was implemented in 2018 with the aim of changing the model of care from a traditional task-oriented approach to a person-centred approach. It places each resident at the centre of care, emphasising the value of staff relationships and engagement with residents over tasks.

To support this changed model of care, Ananda signed an agreement in January 2019 for Dementia Training Australia (DTA) to provide a one-year Tailored Training Package (TTP), which started in March. The TTP included an environmental assessment of the MSUs using DTA's Built Environment Assessment Tool – Dementia (BEAT-D) app. This assessed the strengths and weaknesses of the MSUs based on 10 principles of design found to be important in reducing confusion, agitation and depression while improving wayfinding, social interaction and engagement with life for people living with dementia (Fleming & Bennett 2017; Fleming *et al* 2016). Changes have already been made to the environment based on the results of the environmental assessment. Longer-term alterations to building design will be incorporated into Ananda's continuous improvement plan.

The TTP also included an Ananda-branded website which offers all staff access to about eight hours of high-quality dementia training, and staff training through DTA's Responsive Behaviours Consultancy (Beattie 2017).

Freedom of movement

Dementia-specific units (or MSUs) are standard practice within aged care, with the aim to 'manage' and restrict mobile residents at risk of leaving the home and getting lost (Aros 2018). They are generally considered to be the 'safest' environment for people living with dementia.

The new Aged Care Quality Standards, which came into effect on 1 July 2019, compel residential aged care homes to provide freedom of movement inside and out, and not make separate provision

Opening the doors on a new standard of care

A changed model of care, supported by a partnership with Dementia Training Australia, has helped Ananda Aged Care transition to the new Aged Care Quality Standards and improve the confidence of its staff to provide best practice dementia care. In this, the second of two articles*, **Michael Page, Karen Daniels** and **Pooja Newman** discuss the results of Ananda's decision to open the doors to its dementia-specific units, and the benefits for residents and staff of the new model of care and tailored training program

for dementia-specific units. There is also an ongoing conversation in the industry around restraint, and environmental restraint of residents must be justified on a resident-by-resident basis. Providers must balance duty of care with the quality of life of residents and employ a dignity of risk approach, where some consensual risk is seen as beneficial to quality of life.

Ananda took the view that locked MSUs were counterproductive and did not meet the individual needs of each resident with dementia. Learning from others who have taken a dignity of risk approach (Aros 2018; Blackledge 2018) we believed that enabling freedom of movement would allow mobile residents to explore the homes and discover spaces within them that they found comfortable, as opposed to being constrained to seeing the same environment and residents each day. We felt this would reduce responsive behaviours for some residents.

In December 2019 we opened the doors of Rose Wing in our Findon care home, initially for a few hours per day, then quickly moving to 9am to 5pm. Times were chosen for practical reasons as reception staff were available to monitor residents who were at the main entrance (secured by keypad) and also when staffing levels are highest.

Staff and families of residents were initially apprehensive, but were interested to see that on the first day of the trial none of the residents left the unit. Several residents soon became inquisitive and began to regularly walk out and around to different areas. It took a few days before staff felt relaxed enough not to shadow the resident or limit their time away before they were encouraged to return.

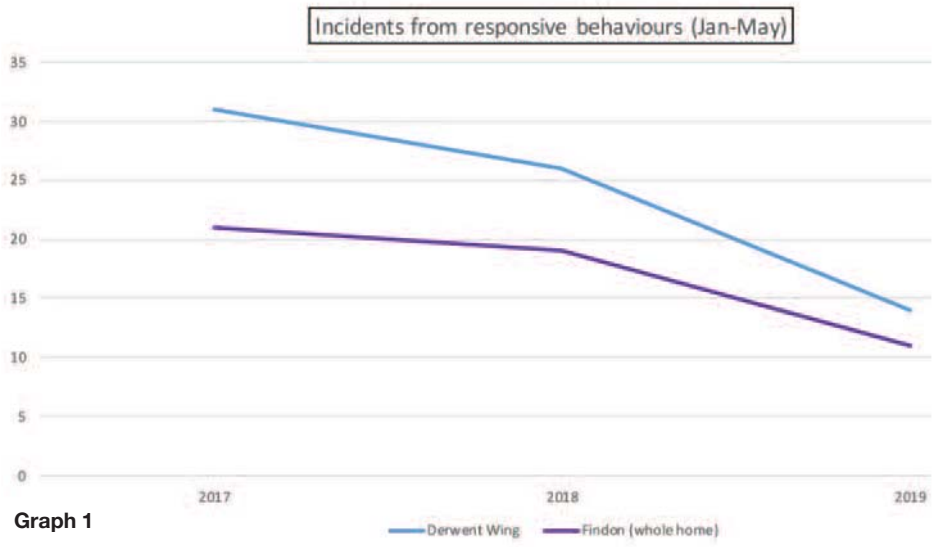
One MSU resident, Gina, would previously be seen at the locked doors trying to open them, and would become agitated when staff tried to redirect her. However, Gina enjoyed the freedom of going out and this responsive behaviour all but disappeared once she knew the doors would be open during the day. On one occasion when helping staff post some flyers around the home she said: "Come on, let's go home now".

Two residents from Hope Valley's Derwent Wing MSU playing basketball in an activities area on the first day that the doors were opened between the unit and the rest of the care home.
Photos courtesy Ananda Aged Care

Closing the MSU doors until 9am and after 5pm enables freedom while also reducing excess stimulation first thing in the morning and promoting the transition to bedtime in the evening. Rose Wing is a female-only unit and closing the doors in the evening would appear to be a natural thing for the women to experience and may provide a sense of safety.

At Hope Valley we opened the doors to Derwent Wing in February 2019, from 1pm-3.30pm. Staff were quite resistant to the change and some found it difficult to understand the dignity of risk concept. They believed it would lead to increased falls or residents would leave the home, despite proximal card entry systems. This delayed the start of the trial as education was needed to explain what we were trying to achieve. Merging the care and leisure and lifestyle teams helped to support a resident-focused care approach.

On the first day we opened the doors to Derwent some residents immediately walked around the home, exploring all areas including the gardens, with two of the men immediately and enthusiastically using the basketball rings in an activities area. This amazed some staff and helped them visualise the difference that could occur with a simple



Graph 1

initiative. We have continued to increase opening times and now open 9.30am-4.45pm.

Residents' families have welcomed the move, especially due to increased freedom and reduced isolation stigma. Rosa Esposito, wife of a resident in Derwent Wing, said: "It's much better. They can have freedom, it's more like a home".

There have been no adverse incidents following the opening of the doors in the MSUs. Our long-term aim is to replace the MSUs with a dementia-friendly community. This is a longer-term project using evidence-based principles (Grogan 2019) and learnings from our Responsive Behaviours Consultancy with DTA. The overarching aim is for residents with dementia to be central to the activity of the home and not separated or seen as different from other residents based on a medical diagnosis.

After the BEAT-D environmental assessment and opening the doors in Derwent Wing we realised that 19 residents was too many for this area, so we reduced the number of beds to 17 in February 2019. A double room was converted to a quiet room which is being developed into a sensory space later this year as one of the actions from our Responsive Behaviours Consultancy.

Creating additional quiet space, reducing the number of residents and opening the doors to the MSUs, whilst maintaining the same staffing levels, has reduced unhelpful stimulation which likely contributed to responsive behaviours.

Behavioural incidents, falls, medication use

Whilst difficult to compare the past three years' data for documented incidents from responsive behaviours, both Derwent Wing at Hope Valley and the whole home at Findon have reduced incidents significantly – by almost 50% since 2017 in both homes (see Graph 1 above).

Use of Schedule 4 medication also reduced by 5% for the period January to May 2019 compared to the same period in 2018 and has continued to decline with as required prescribed (PRN) psychotropic medications requiring approval from the Director of Nursing and following all other non-pharmacological strategies being used. This included use of a tool we introduced called 'Follow the Five' which prompted care staff and nursing staff to consider common underlying unmet needs before any proposal to use medication. The 'Five' are: pain, continence, boredom/over stimulation, repositioning, and hunger/thirst.

These data are encouraging and believed to be a result of improved staff knowledge and confidence as a result of training and other initiatives, including the new model of care. Month-to-month fluctuations and spikes in incidents are often associated with new residents being admitted to the units, though overall there has been a clear decline in incidents as the project was implemented and we hope to further reduce incidents over the course of the TTP.

Ananda clinical staff at both sites are currently working with DTA staff at the University of Western Australia on a monthly Medication Management Consultancy with the aim of reducing psychotropic medication use to as close to zero as possible.

Virtual reality experience

As part of the TTP, Ananda also was able to pilot an innovative immersive virtual reality (VR) experience called Meaningful Spaces VR, which was developed by DTA. Twenty-five staff attended and this pilot workshop is described in a separate article on pp25-6.

Positive staff changes

Supported by the training related to Ananda's changed care model and the tailored training provided by DTA, staff have increased their foundation knowledge of dementia (see Graph 2) and responsive behaviours. DTA's 'lead and learn' Responsive Behaviours Consultancy has helped develop champions in the organisation who have the skills, knowledge and attitude to translate knowledge to the broader workforce.

The introduction of a 'uniform-free' policy (described in Part 1 of this article in the August/September 2019 issue of *AJDC*) and the dedicated staffing model have also proven popular, with staff telling us they now like to work in Rose and Derwent wings. Previously these were seen as areas where workload and anxiety amongst staff were highest in our homes.

Many staff chose not to work in the MSUs for extended periods, yet since we introduced the dedicated staffing model we have retained consistent staff in the MSUs and no-one has asked to work elsewhere. This has also fostered a strong team ethos and allowed us to emphasise the messages about resident-focused dementia care.

Staff who previously were not included in training have valued it. Hospitality staff, especially our cleaners, were the most enthusiastic group when it came to online training as it provided a theoretical underpinning of skills they had developed intuitively over a number of years. Unfortunately, outside of their cleaning activities, previously they had not been seen as valued members of the care team. This change has allowed us to reinforce a message from the Resident Focused Care model that residents value relationships above tasks.

In June 2019 an anonymous online survey of staff who regularly work in the MSUs showed 90% (n=30) of respondents stated that their confidence and/or enjoyment had 'definitely improved' over a six-month period, as a result of recent training, and the average scores improved for all items including 'knowledge of dementia' and 'confidence of working in MSU' (see Graphs 2-5 p23).

Conclusion

Full evaluation of the project will be undertaken at the end of Ananda's TTP

in March 2020. However, at the time of publication, there have already been significant improvements in staff confidence in communicating with residents living with dementia; a greater awareness of responsive behaviours; reduced behavioural incidents; and a reduced use of antipsychotics (compared to the same periods over the past three years).

The TTP has supported a changed care model with the Ananda Resident Focused model mapping to DTA's salutogenic approach to dementia care (www.dta.com.au/dta-salutogenic-approach).

This is about focusing on factors that support health and wellbeing rather than risk and problems, and finding opportunities for people with dementia to live as full a life as possible.

The TTP has enabled Ananda to implement several evidence-based initiatives and more will be introduced during the 12-month partnership. This DTA partnership is considered a key part of Ananda's transition to the new Aged Care Quality Standards and development of the Ananda Resident Focused Care model. ■

Acknowledgments
The authors are very grateful to all Ananda staff who have championed this change process. We would also like to thank Dementia Training Australia and all staff involved in the TTP for their continued guidance and support.

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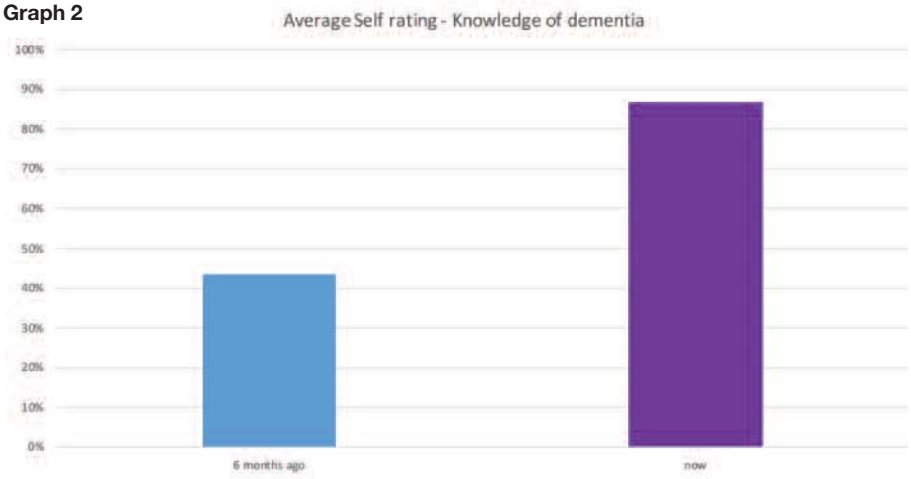
DTA's Designing for People with Dementia (DPD) Service
To learn more about the 10 key environmental design principles referred to in these articles and find out how you can use Dementia Training Australia's (DTA's) Built Environment Assessment Tool – Dementia (BEAT-D) to guide changes to your care environment, visit DTA's Designing for People with Dementia (DPD) Service website at www.dta.com.au/designing-for-people-with-dementia/. The DPD design handbook is listed as the primary resource in Standard 5 of the 2019 Aged Care Quality Standards.

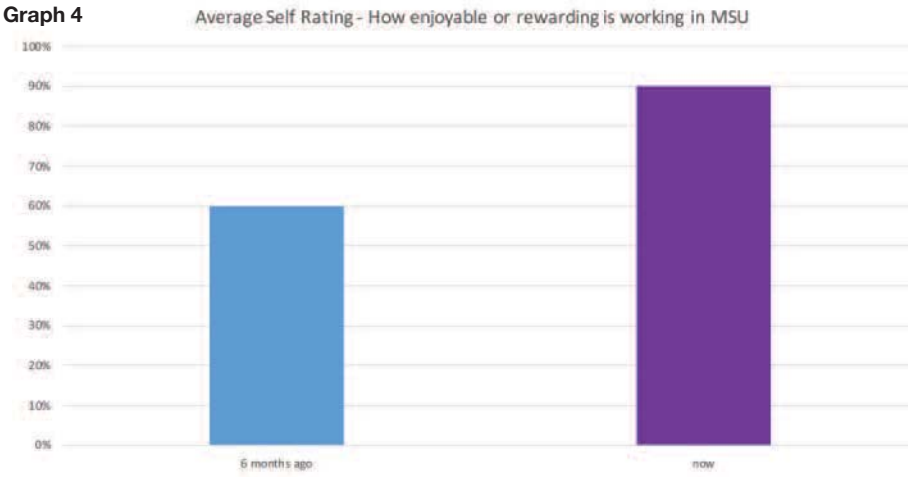
Tailored Training Packages
Read more about accessing DTA's Tailored Training Packages (TTPs) at www.dta.com.au/dta-tailored-training-packages/. TTPs are designed to bring about sustainable change within aged care organisations to improve the wellbeing of people living with dementia and the staff who care for them. ➤

Graph 2



Graph 3

Graph 4



Graph 5

Gina dancing with a carer at Findon's weekly Mediterranean Club (inset) and cooking in the garden of Rose Wing. Gina enjoyed the freedom of going out and her responsive behaviour all but disappeared once she knew the doors to the MSU would be open during the day

References

Aros M (2018) Challenging Tradition: Unlocking The MSU. *Australian Journal of Dementia Care* 7(4) 18-21.

Beattie M (2017) Building Capacity To Provide Responsive Care. *Australian Journal of Dementia Care* 6(6) 10-11.

Blackledge, R (2017) Taking The Risk: Strategies To Support Getting Out And About. *Australian Journal of Dementia Care* 6(2) 13-15.

Fleming R, Bennett KA (2017) Applying the Key Design Principles in Environments for People with Dementia. *Environmental Design Resources*. Available at: https://bit.ly/2LKRoN9.

Fleming R, Goodenough B, Low L-F, Chenoweth L, Brodaty H (2016) The Relationship Between The Quality Of The Built Environment And The Quality Of Life Of People With Dementia In Residential Care. *Dementia* 15(4) 663-680.

Golmbiewski J (2019) A Salutogenic Retrofit. *Australian Journal of Dementia Care* 8(2) 15-19.

Grogan (2019) Making Communities More Dementia-Friendly. *Australian Journal of Dementia Care* 8(4) 21-23.

From left: Michael Page is Ananda Aged Care's Resident Focused Care Advocate and Workforce Development Manager; Karen Daniels is the Director of Nursing; and Dr Pooja Newman is the Clinical Director. To follow up on this article, contact Michael at michael@anandaagedcare.com.au

In recent years, a number of innovative resources that use emerging technologies have been developed for dementia training. Several of these resources involve virtual reality (VR), which allows users to explore and manipulate computer generated three-dimensional multimedia sensory environments in real time (Kyaw *et al* 2019). VR may be displayed using a variety of tools, such as computer or mobile device screens, specifically designed rooms or head-mounted displays. Differing VR experiences involve varying levels of immersion, but all aim for the user to perceive the digital world as being real, and therefore to literally see or experience the world through the senses of another person (Kyaw *et al* 2019).

Currently available training resources include Dementia Australia's Virtual Dementia Experience and Educational Dementia Immersive Experience (EDIE) (Dementia Australia 2018), Alzheimer's Research UK's A Walk Through Dementia, and the Dutch simulation Into D'mentia (Jutten *et al* 2018). The target audience for these resources range from family carers of people living with dementia to healthcare professionals who encounter dementia within their clinical practice. Most resources aim to increase the participants' understanding of the experience of a person living with dementia, develop their empathy and positively change their dementia care practice.

As most of these resources are quite newly developed, there is limited information regarding their outcomes for participants and for people living with dementia. However, there is evidence associating these training resources with improved understanding of, and empathy and attitudes towards, dementia (Jutten *et al* 2018; Gilmartin-Thomas *et al* 2018; Slater *et al* 2019).

Developing Meaningful Spaces

Based on these positive signals, for the past two years Dementia Training Australia (DTA) has been investigating how VR may be used to facilitate some of its key knowledge translation objectives. Recognising the value of Dementia Australia's popular EDIE resource (Dementia Australia 2018), particularly within the context of DTA's Tailored Training Package (TTP) program, DTA sought to develop a resource that complemented this offering, to broaden the suite of VR resources available to the Australian dementia-care workforce. DTA's work has focused on two key areas where there is expertise within DTA, yet no existing VR resource: