Specialised Dementia Units & Cognition Support Units

Model of Care Guidance

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Specialised Dementia Units and Cognition Support Units – model of care guidance

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Introduction

This document is a best practice guideline for Specialised Dementia Units (SDU) and Cognition Support Units (CSU) which support best practice dementia care in Queensland hospitals by:

- Outlining the key principles, processes, workforce, education requirements and care environments developed as part of the Practical Redesign Options for Violence in Dementia and Delirium (PROVIDE) model of care framework.
- Providing guidance to Hospital and Health Services (HHSs) in the development of local structures, models, policies, procedures and clinical pathways
- Supporting the standardisation of effective and safe delivery of inpatient cognition support services across Queensland Health.

This model of care guidance is based on the following guiding principles:

- it sets the vision for services in the future.
- it is centred on the outcomes and experiences of the patient, their carers and family members.
- it supports safe, quality care for patients that is integrated and coordinated.
- it has localised flexibility and considers equity of access.
- it is innovative, evidence based and considers new ways of organising and delivering care

Background

Severe agitation, aggression, and violence in older adults with cognitive impairment are increasingly common and difficult to manage on general wards. Following three serious clinical incidents (SAC 1) involving people with dementia and/or delirium across separate Hospital and Health Services (HHSs), the *Practical Redesign Options for Violence in Dementia and Delirium* (PROVIDE) project was launched in January 2025. Led by the Healthcare Improvement Unit, the project aimed to address critical gaps in managing behaviours of concern in dementia and delirium, including aggression and violence. The PROVIDE project identified that Queensland currently operates largely through a "dispersed care" approach, where patients with severe behavioural symptoms are managed wherever a bed is available rather than in settings specifically designed to meet their needs. This approach produces substantial variation in care and leaves many clinicians managing highly complex behavioural presentations without access to specialist expertise, contributing to poorer outcomes for patients.

Specialised Dementia Units

Hospital-based SDUs are specialist units designed to safely manage moderate to severe Behavioural and Psychological Symptoms of Dementia (BPSD) in secure 6-12 (± 2) bed, dementia-enabling settings, staffed by a specialist interprofessional care team. The focus is on safe person-centred management of severe symptoms. SDUs may also reduce the impact and burden of care for standard wards by locating people with severe BPSD in a dedicated unit, rather than dispersing them within standard wards and disrupting usual ward-based care approaches.

SDUs have demonstrated:

- clinically significant decreases in aggression severity by 50%[1]
- reduced odds of psychotropic use by 3.4 [1]
- an 80% decrease in readmission rates for BPSD[2]

- increased well-being and functional independence for people with dementia and a median length of stay of 23-days[3-5]

Cognition Support Units

CSUs are dedicated units providing a specific model of care involving a 6-14 (± 2) bed area with modest dementia-enabling environmental modifications and are *nested* within an existing medical ward (or surgical ward). These beds are allocated increased specialist staff resources to manage moderate-to-severe behaviours (including aggression) in older cognitively impaired patients. The allocated unit has a broader admission criterion than that of a SDU, admitting cognitive impairment of broader aetiology than dementia.

CSUs (also known as geographic cohorting units in the literature) have demonstrated:[7]

- Reductions in mortality, length of stay
- Reduction in use of nursing specials
- Reduction in use of restraints and psychotropic use

Expected Benefits

The expected benefits of implementing these infrastructure enabled models of care are:[1,2,7]

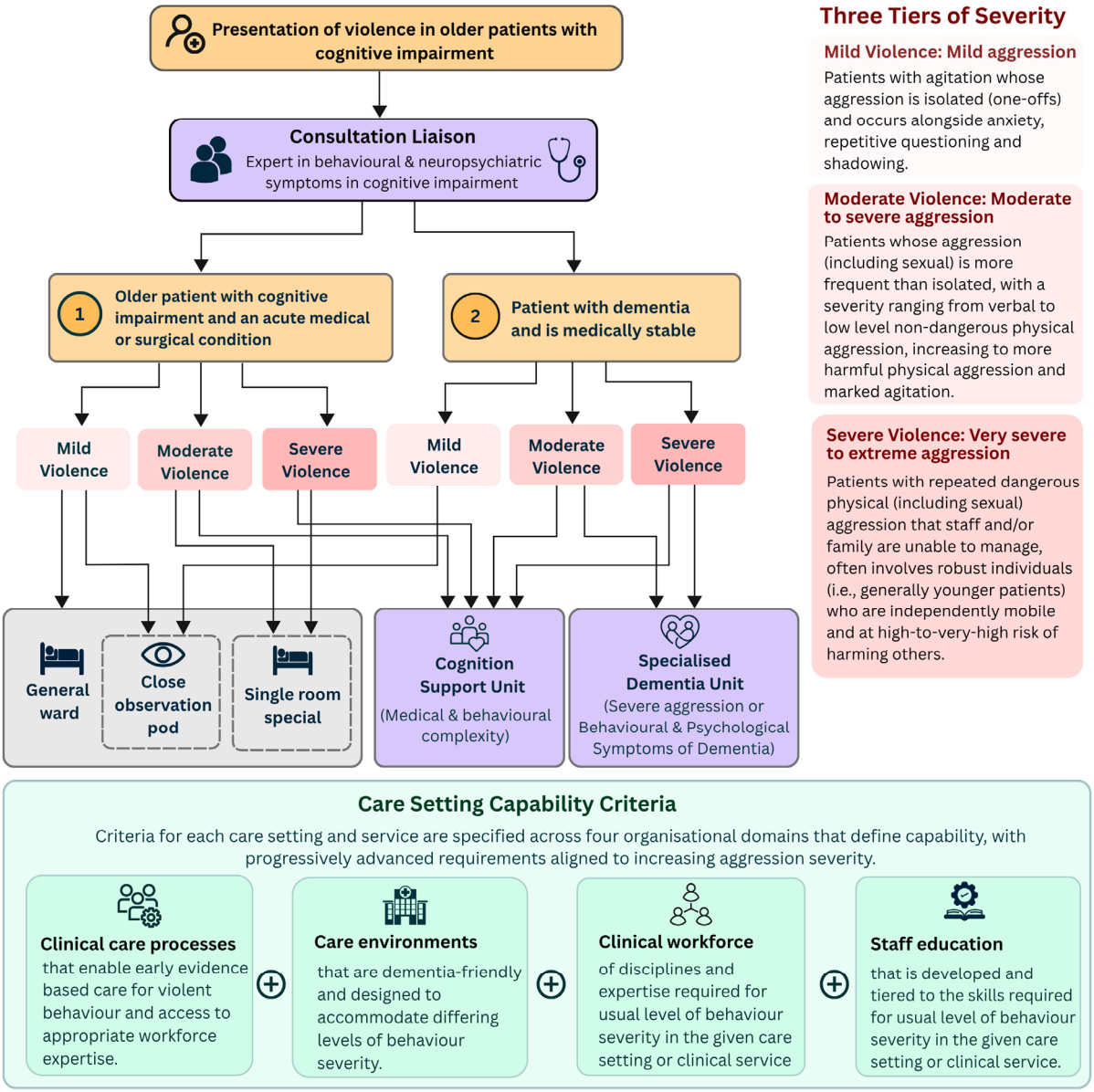
- Reduction of patient aggression and BPSD symptoms
- Reduction of occupational violence to staff
- Reduced length of stay for aggressive and violent patients
- Reduced adverse events
- Reduced restrictive practices such as antipsychotic use and physical restraint
- Reduced hospital readmissions for aggression and violence
- Reduced burnout of workforce
- Reduced harm to other patients from patients with violence and aggression

PROVIDE Model of Care Framework

The PROVIDE project developed a hospital-wide, infrastructure enabled model of care framework that has endorsement for statewide adoption. These specialist units sit within the broader PROVIDE hospital-wide framework (Figure 1), which promotes a structured approach to the assessment and management of cognitive impairment and behaviours of concern.

While SDUs and CSUs provide dedicated environments for patients with more complex behavioural presentations, they represent only one component of a comprehensive system of care. Not all patients experiencing cognitive impairment and behaviours of concern will require admission to a specialist unit. Many patients, including those with mild symptoms or ongoing acute medical needs, may be effectively managed through specialist consultation-liaison support while remaining in a general ward. The framework therefore combines specialist units with hospital-wide supports to ensure patients receive the right level of care in the right setting. Resources and further information can be found here: Practical Redesign Options for Violence in Dementia and Delirium - PROVIDE - Home

Figure 1: PROVIDE Model of Care Framework



Model of Care

Service scope

Facilities operating a Specialised Dementia Unit should operate at a Clinical Services Capability Framework (CSCF) Geriatric services – Geriatric Cognitive Impairment Services Level 5 or above.

Facilities operating a Cognition Support Unit should operate at CSCF Geriatric Services – Geriatric Cognitive Impairment Services Level 4 or above.

These capability levels support access to the specialised workforce, operating hours and supporting services required to safely deliver care.

Service objectives

The service objectives of SDUs and CSUs are to:

- Deliver person-centred management of patients with cognitive impairment and behaviours of concern.
- Deliver interprofessional assessment and clearly articulated care planning underpinned by evidence-based frameworks and regular case conferencing
- Utilise standardised behaviour management plan formulation processes and documentation (i.e. Behaviour Support Plans or an equivalent care plan)
- Assess behaviour severity with validated behaviour severity scales where indicated (e.g. Neuropsychiatric Inventory (NPI), Pittsburg Agitation Scale (PAS), Cohen-Mansfield Agitation Inventory (CMAI))
- Utilise validated behavioural observational pain scales to support clinical reasoning about pain
- Partner with caregivers in setting goals of care and developing discharge plans
- Provide care routines that are flexible and responsive to the needs of individual patients inclusive of consistent and structured activity

Service description

Hours of operation

The units are staffed 24 hours a day, 7 days a week, with designated nursing ratios. Admissions and discharges occur within business hours unless prior approval has been provided by the treating team. These units maintain established processes to prevent after-hours admissions without specialist approval. Patients referred to the service but not immediately admitted to the specialist unit should receive specialist outreach support where available.

Patient eligibility

Criteria	Specialised Dementia Unit (SDU)	Cognition Support Unit (CSU)
Inclusion Criteria		
Diagnosis	Older person with known or suspected dementia or a younger person with known dementia	Older person with cognitive impairment, including dementia, delirium, cognitive disability, acquired brain injury, and alcohol-related dementia
Behavioural symptoms	Be experiencing complex behavioral symptoms and/or exhibiting symptoms of violence and aggression.	
Medical acuity	Medically stable	Medically stable, or requiring low-acuity medical care that can be managed within the local CSU environment
Mobility	Independently mobile (including independent wheelchair users)	Any mobility
Admission	Assessed and accepted for care by the admitting team	
Episode of care Type	Suitable for a Sub and Non-Acute Patient (SNAP) care type	Any care type

Criteria	Specialised Dementia Unit (SDU)	Cognition Support Unit (CSU)
Exclusion Criteria		
Diagnosis	Primary mental health diagnoses, intoxication, and drug abuse	
	Longstanding neurodevelopmental disorders unrelated to dementia (e.g. intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder)	
Medical acuity	Medically unstable	Requiring high-acuity medical care that cannot be provided within the local CSU environment (e.g. haemodynamic instability, invasive or non-invasive ventilation, infusions, or high-frequency clinical observations)

Clinical care processes

Recommended admission processes

- Following referral, patients should be assessed by the treating team at the earliest opportunity and prior to transfer to the specialised unit.
- Behaviour severity is assessed for all patients before admission using a validated tool (i.e. Neuropsychiatric Inventory (NPI), Pittsburg Agitation Scale (PAS), Cohen-Mansfield Agitation Inventory (CMAI))
- Admission nursing and medical assessments are to be completed within 24hours. Other assessments should be completed if clinically relevant (e.g. Comprehensive Geriatric Assessment, Health of the Nation Outcome Scales (HONOS), Pain Assessment in Advanced Dementia (PAINAD)).
- Standardised Behaviour Support Plans (BSPs) should be developed collaboratively by the multidisciplinary team for patients within the first three (3) days of admission, where a BSP is not already in place. BSPs should be discussed at routine case conferences and reviewed and updated throughout the admission as required. All patients admitted to an SDU should have a BSP. Not all patients admitted to a CSU may require a BSP.
- Family/carer meeting held within 1-2 weeks of admission to establish goals of care (as applicable).
- Patient episode of care type is updated as appropriate to a Sub and Non-Acute Patient (SNAP) code if not already completed in the referring ward.

Recommended discharge processes

- Behaviour Support Plans, where available, should be handed over to receiving care providers.
- Appropriate transition planning and support should be provided to facilitate continuity of care and a smooth transition to the next care setting.

Care of the patient with cognitive impairment

Age friendly principles of care underpin care in the unit in the first instance. This incorporates the four (4) evidence-based elements of high-quality care, known as the "4Ms" (What Matters, Medication, Mentation, Mobility). Further, the specialised units incorporate practices which align to the NSQHS standards for cognitive care as part of the Comprehensive Care standard and outlined in the NSQHS publication "A Better Way to Care".

Clinical workforce

These units should be supported by a multidisciplinary workforce with expertise in the assessment and management of patients experiencing dementia, delirium, and/or behaviours of concern.

Workforce	SDU	CSU
Medical	On-site Geriatrician-led medical team. Access to Psychogeriatric and/or Psychiatric consultation services. *	On-site Consultant-led medical team (with experience in managing behaviours of concern). Access to Geriatrician. * Access to Psychogeriatric and/or Psychiatric consultation services. *
Nursing	Access to specialist dementia and delirium nursing expertise, preferably embedded within the unit. * Nursing staffing levels and skill mix should be sufficient to safely and proactively manage patients with complex behavioural and psychological symptoms, with capacity to increase staffing levels in response to periods of heightened acuity and complexity. This is likely to be above the minimum legislated requirements.	
Allied Health	Dedicated allied health roles with experience in managing behaviours of concern allocated to and working within the unit to deliver each of the following functions:* • Complex social and financial discharge needs (e.g. Social Work) • Engagement strategies for social and leisure activities (e.g. Occupational Therapist, Leisure/Recreational Therapist) • Behavioural specialist (e.g. Neuropsychologist, Psychologist, Occupational Therapist, Dementia & Delirium Clinical Nurse Consultant) • Medication review and management (e.g. Pharmacy) The specific disciplines may vary according to local service requirements.	
Safety Response Teams	24/7 Access	
Support Roles	The above roles may be supported to deliver patient care by other suitably trained staff such as Assistants in Nursing and Allied Health Assistants.	

**Virtual service models may be utilised where local access is not available.*

Care environments

The physical environment is a critical enabler of safe, person-centred care for people experiencing dementia and/or delirium. Units should incorporate dementia-enabling design principles that support independence, engagement, mobility, comfort and safety, while minimising distress and behavioural escalation. Environmental design should be informed by recognised dementia-enabling design principles and be adapted to local infrastructure and service requirements. For more information see the PROVIDE SharePoint page: Specialist Dementia Units: Environments.

SDUs and CSUs should include:
A maximum unit size of approximately 12-14 beds, with larger services preferably configured into smaller sub-units.
Capacity for at least one single room, with consideration of additional single-room capacity where feasible.
Secure (locked) access with camouflaged exit control measures.
Duress alarm systems and emergency egress for staff safety.
Unsupervised patient access to an outdoor space and/or indoor leisure space. Unit design should support patient mobility and staff visibility (including the use of cameras and technology systems where required)
Communal dining and social spaces with recreational resources available to promote interaction, activity and meaningful engagement.
Adequate storage to minimise clutter and maintain a calm, functional environment.

Staff training

Ongoing education and capability development are essential to supporting the delivery of safe, evidence-informed care for patients experiencing behaviours of concern. Staff working within these units should have access to a range of training that includes workplace-based learning and reflective practice opportunities that build confidence and competence in the management of behaviours of concern. The below is recommended for staff working in these units:

- Completion of online BPSD and delirium training on commencement, such as nationally recognised training programs (e.g. Dementia Training Australia Responsive Behaviours packages).
- Participation in at least one of the following ongoing education activities:
    - Regular short education sessions.
    - Weekly interprofessional case reflections “on-the-deck”
- “At-the-elbow” learning opportunities that are embedded within interdisciplinary routine clinical practice, including debriefs, huddles, specialist-led rounding.
- Access to specific education resources as they become available through the PROVIDE project.

Evaluation and outcome measures

HHSs implementing these models are encouraged to undertake local evaluation activities to assess implementation, outcomes and opportunities for improvement. A statewide evaluation framework is currently being developed through the PROVIDE project and will be made available to support local evaluation and performance monitoring to inform continuous quality improvement.

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