

Developing a model of best practice for teams managing crisis in people with dementia: A consensus approach

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Abstract

Background: Teams delivering crisis resolution services for people with dementia and their carers provide short-term interventions to prevent admission to acute care settings. There is great variation in these services across the UK. This article reports on a consensus process undertaken to devise a Best Practice Model and evaluation Tool for use with teams managing crisis in dementia.

Methods: The Best Practice Model and Tool were developed over a three stage process: (i) Evidence gathering and generation of candidate standards (systematic review and scoping survey, interviews and focus groups); (ii) Prioritisation and selection of standards (consultation groups, a consensus conference and modified Delphi process); (iii) Refining and operationalising standards (consultation group and field-testing).

Results: 165 candidate standards arose from the evidence gathering stage; were refined and reduced to 90 through a consultation group exercise; and then reduced to 50 during the consensus conference and weighted using a modified Delphi process. Standards were then operationalised through a clinical consultation group and field-tested with 11 crisis teams and 5 non-crisis teams. Scores ranged from 48-92/100. The median score for the crisis teams was 74.5 (range 67-92), and the median score for non-crisis teams was 60 (range 48-72).

Conclusions: With further psychometric testing, this Best Practice Model and Tool will be ideal for the planning, improvement and national benchmarking of teams managing dementia crises in the future.

Background

United Kingdom (UK) health and care policy is committed to enabling more people with dementia to live longer in their own homes, and fewer people with dementia admitted to hospital unnecessarily [1]. This is underpinned by a desire to maintain and enhance independence for people with dementia, in order to improve their quality of life and that of their carers [2], and to reduce the financial costs associated with admission to acute settings [3, 4]. Specific community-based services, typically operating within a Home Treatment Team model, exist to support people with dementia and their carers during times of crisis when the ability to remain independent is compromised and an admission to hospital is a likely outcome [5]. Such situations often arise due to a change or deterioration in physical and/or mental health function of the person with dementia, or a breakdown in care being provided by either formal or informal carers. Teams delivering crisis resolution services for people with dementia and their carers are referred to in this article as 'Teams Managing Crisis in Dementia' (TMCDs), and typically provide short-term interventions to manage risk by undertaking home visits and assessments to determine which community health and social care services should be engaged to provide ongoing support.

A recent systematic review and scoping survey revealed that TMCDs vary greatly in several aspects such as their titles, eligibility criteria, model of working, and approach to crisis resolution or prevention [5, 6]. Neither policy documents nor commissioning guidance provide exact details on how TMCDs, or any form

of crisis resolution service for people over the age of 65 or for people specifically with dementia, should be designed or implemented [7]. This contrasts with crisis resolution services for working age adults [8], and with other mental health services for older people. For example, Memory Assessment Services have clear specifications and are able to gain accreditation from the Royal College of Psychiatrists through demonstrating adherence to agreed standards of good practice [9]. Various national policy documents such as the Dementia Well Pathway [10] and the Prime Minister's Challenge on Dementia (2015) [11] emphasise the importance of supporting people with dementia and their carers, but fall short of detailing how services should be commissioned to maintain the person's independence at the point of crisis. Therefore, a lack of established and validated guidelines for TMCDs results in a substantial variation in quality and effectiveness amongst teams, and a consequent postcode lottery of access to services required to live well with dementia.

Variation in the delivery of health services has benefits in enabling services to be responsive to local needs, responding to the demographics of the local population which may differ to that of other areas, and provide patient centred care. However, some variation in service delivery is unwarranted, raising problems which are recognised as a challenge to implementation in healthcare [12]. These include: lack of understanding by other health and social care professionals and the public regarding the remit and eligibility criteria of the team [13], a mismatch between people with dementia and carers' expectations of what the team is able to offer, and lack of equitable access for all people with dementia and their carers. Therefore, a series of agreed standards that underpin how TMCDs deliver their service, and resources to implement practices outlined in these standards, is required to achieve effective, consistent, and high quality performance and measurement.

The approach followed in this study is similar to established methodologies such as those utilised by the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI), and the National Implementing Evidence-Based Practices Project. The CCQI leads quality improvement networks across a range of mental health services in the UK and conducts work to develop standards and then audit the fidelity to such standards on a national scale, resulting in accreditation of services. Whilst standards and accreditation exist for Crisis Resolution and Home Treatment Teams, no such standards or audit processes exist for TMCDs. This study also closely followed the methods used in the CORE study [14] which constructed a fidelity scale for adult crisis resolution teams (CRT) in the UK. The CORE study used the following procedure: (i) concept mapping to identify potential characteristics of CRT services from a review of the literature, a national survey, and interviews and focus groups with relevant stakeholders; (ii) an expert panel discussion group to sort the resulting 'longlist' of potential components of a CRT model into a set of fewer than 100 statements; (iii) stakeholder meetings, where statements were sorted into groups based on conceptual fit and order of importance in delivering an effective CRT service; (iv) field-testing of the scale during review days with several teams, where psychometric properties of the scale were established.

This work is part of the Achieving Quality and Effectiveness in Dementia Using Crisis Teams (AQUEDUCT) research programme (RP-PG-0612-20004). AQUEDUCT aims to improve the quality and

effectiveness of care for people with dementia experiencing a mental health crisis through the development of an evidence-based Best Practice Tool and Toolkit, and to investigate the consequential impact on hospital admissions, experiences of people with dementia and carers receiving input, and costs. The programme is divided into three work packages. This article describes the development of the Best Practice Model and Best Practice Tool forming part of Work Package 1.

The aim of this study was to use a consensus process to develop a model of best practice (the Best Practice Model) which encompasses a set of standards for all TMCDs to work towards, and a measurement to test their fidelity to this model (the Best Practice Tool).

Methods

Design

A detailed protocol for Work Package 1 is published elsewhere [15]. A consensus approach was chosen to determine a model of best practice as it can provide sense-making insightful information on priorities in situations where there is limited empirical evidence, and can be helpful in supporting future decisions concerning ambiguous or controversial topics [16]. The iterative nature of this process allowed new insights to be incorporated into its later stages, thus creating a dynamic and practical design, using the best available evidence at each point.

Participants

Participants involved in the consensus process were staff from TMCD services and those from other health and social care teams that interfaced with TMCDs, people with dementia and carers who were service users of TMCDs and older adult services, and academics. The consensus process involved several phases including a systematic review and scoping exercise, interviews and focus groups with TMCD staff, people with dementia, carers and stakeholders, two consultation groups, a consensus conference and field-testing.

Procedure

The study occurred between July 2015 and April 2018. The consensus process took place in three phases: (i) Evidence gathering and generation of candidate standards (systematic review and scoping survey, interviews and focus groups); (ii) Prioritisation and selection of standards (two consultation groups, consensus conference and modified Delphi process); (iii) Refining and operationalising standards (consultation group and field-testing). Figure 1 shows a flow chart detailing the participants and activities involved in each phase of the consensus process.

Stage 1: Evidence gathering and generation of candidate standards

Systematic review and scoping survey

A systematic review of existing literature regarding TMCDs was conducted which included seven studies. This supported the concept that TMCDs are effective and commented on aspects of service delivering. An additional scoping survey of TMCDs in the UK was undertaken to provide a picture of current TMCD service delivery. Results of the systematic review and scoping survey are published elsewhere [5].

Interviews and Focus Groups

Sixty interviews and nine focus groups were undertaken with nine TMCDs across different geographical areas within England, to explore how the team was set up, the services offered/available, and to gather examples of best practice, or practice that had not gone as well, and operational factors that are considered important for effective working of the TMCD. Participants in the interviews were 30 TMCD staff members, with representation across all bandings and disciplines, 15 family carers of people with dementia who had used the TMCD service in the last six months, and 15 people with dementia who had used the service in the last six months. Carers and people with dementia were not required to be dyads so that carers of people with more severe dementia, who were themselves unable to participate, were still able to take part. The focus groups included 17 TMCD staff members, 10 carers of people with dementia who had recently accessed the service, three people with dementia who were recent service users, and five members of staff from health and social care services that regularly interfaced with the TMCD. TMCDs were selected to participate from a pool of teams that had indicated willingness to participate during data collection for the earlier scoping survey [5], chosen to be demographically and geographically diverse, and to reflect different models of crisis intervention provision. Data were analysed by the first two authors using thematic analysis, following Braun and Clarke's six stages (see Fig. 2). The analysis was combined with evidence from the systematic review and scoping survey [5] and used by the research team to develop 165 standards that were considered to capture the essence of effective TMCD working. Standards were developed by identifying where themes occurred within the transcribed data and selecting the component of TMCD service provision being described. These were documented in an initial list, with new components added each time one was identified, until no further components were found.

The standards detailing similar or related aspects of practice were grouped together by the research team using the themes developed in the analysis to create categories that represented distinct aspects of working practice or service provision. The categories were used to present the standards to the consultation groups and consensus conference participants, and were refined at each stage of the consensus process, as the standards were reduced and edited.

Stage 2: Prioritisation and selection of standards

Consultation groups (1)

Two consultation groups with 14 stakeholders were held to reduce the number of standards to a number more manageable prior to the consensus conference. Stakeholders attending the groups were not considered participants, but rather represented critical friends to the project in the form of clinicians from TMCDs, other health and social care professionals, and members of the Patient and Public Involvement (PPI) group. Stakeholders were selected to represent a diverse range of disciplines and expertise (e.g. a

consultant geriatrician, an occupational therapist, and a person with dementia) and were drawn from the local research and health service communities. The consultation group process involved the groups reviewing each category of standards at a time, facilitated by two members of the research team. Each group reviewed half of the original 165 statements. Stakeholders were asked to assign one of the following levels of importance to each item: 'highly important', 'moderately important', or 'not important' to TMCD working. Some items were also rated 'Undecided' if it was thought that a decision could not be made on the standard in its current iteration. These standards were prioritised for discussion at the consensus conference. Items deemed highly important by the majority of the group were retained for inclusion in the consensus conference. Items deemed not important by the majority of the group were discarded from further inclusion in the Best Practice Model. Items considered moderately important by the majority of the group were discussed in depth to determine whether they could be combined with other items in the category or modified to increase their relevance to TMCD working. The research team provided background evidence from the systematic review, scoping survey and qualitative work that took place earlier in the work package to provide context for the standards and ensure that any changes made to the standards still aligned with the evidence. The initial 165 standards were reduced to 95 standards by the end of the consultation groups.

Consensus Conference

The aim of the consensus conference was to further refine and reduce the statements to a Best Practice Model that could be taken forward to field-testing. The consensus conference was a one day event involving 39 participants. Participants were selected via local and national research, practice, and PPI communities through contacts developed by the research team during the earlier stages of the research. Participants included seven TMCD staff members, 25 members of staff from other health and social care services that interfaced with TMCDs (including community mental health teams, social services, community nursing, memory assessment services, ambulance services, third sector organisations, the police service, primary care services, and residential care settings), two academics, three people with dementia, and two carers. All participants had a working knowledge of crisis in dementia through personal or professional experience and represented expert viewpoints. The process used here was similar to a consensus development panel, which involves organised meetings of experts in a given field from a variety of disciplines [16]. Unlike nominal group techniques, the consensus conference approach is not anonymised, nor does it rely on standards having to reach a particular threshold of agreement to be retained in the best practice model. The face-to-face interactive aspect of the consensus conference provides a means to synthesise the best available evidence by encouraging interactions between people drawing on and expressing multidisciplinary perspectives, with experts taking ownership of the material on topics that have a direct impact on them. It is also an iterative, systematic but practical approach, which enables consensus to be reached by the end of one day.

Participants were allocated to one of five discussion groups, each group consisting of approximately six participants. Groups were facilitated by two members of the research team and a member of the PPI group. Participants were allocated to groups on the basis of likely experience of the components of

TMCD service delivery contained in each category, and where possible included a person with dementia and a family carer, and professionals from a variety of disciplines and backgrounds. Prior to the consensus conference all group facilitators had received training in facilitation skills and were therefore able to effectively moderate group discussions to ensure that no single participant dominated the discussions and that all had the opportunity to participate. Participants received the standards via email before the consensus conference and were informed of their group allocation so that they could focus their reading on the standards they would be discussing. Each group considered one or two categories of standards (depending on the size of the category) but were encouraged to cross reference standards included in categories reviewed by other groups.

Each participant received a workbook containing the 95 standards. Each standard was detailed in full and presented with quotes from the qualitative work that provided an evidence-base and contextual background. Participants were required to rate each item as one of the following: 'highly important', 'moderately important' or 'undecided'. Presenting participants with the data from previous stages of the consensus process helps this methodology to be more reliant on evidence-based opinions rather than solely the personal experience of an individual. The facilitators of each group guided discussions of the standards in the categories allocated to them by following the decision-making process outlined in Fig. 3. Participants were asked to: discard any standards that were viewed as unnecessary; discuss elements of contradiction in the evidence provided; highlight the most important standards; identify confusion in wording; note any gaps not covered by the standards; combine standards where possible; and edit for clarification the working of the standards. Participants were also asked to bear in mind that the standards would have to be measurable, specific to dementia crisis working and comprehensive. Consensus was achieved when the whole group was in agreement about the inclusion and wording of each standard. Standards that did not reach consensus at the group discussion level were discussed across the whole conference with further ideas put to the original group until agreement was reached by all.

By the end of the consensus conference the number of standards had reduced to 50. The research team then reviewed the 50 selected statements to check that there was no duplication or missing elements and that, based on the knowledge gained from the systematic review, scoping survey, and qualitative work the standards were a good fit with current practice.

Modified Delphi process

Consensus conference participants acknowledged and agreed that not all standards could be considered equal in their contribution to delivering best practice. This was because some standards needed to be completed before other standards could be implemented, and thus a need to weight standards for their impact on effective TMCD working. A modified Delphi approach [16] was used to conduct a points allocation task, where stakeholders were invited to allocate a total of 100 points to the 50 standards by giving each standard a score of 1, 2, 3, or 4. The task was distributed using a spreadsheet with conditional formatting ensuring the total box turned green when all 100 points were allocated, red if too many points were allocated, and blue if not enough points were allocated. Stakeholders were instructed

to return the task only when all 100 points were correctly allocated, and incorrectly completed tasks were returned to participants to re-attempt the scoring.

Twenty-three stakeholders participated in round one of the points allocation task. Stakeholders consisted of participants who had attended the consensus conference, stakeholders from the consultation groups, members of our PPI group, and academics. Scores from the first round were collated and averaged to produce a score from one to four for each standard, with the scores totalling 100 points. In round two, the points allocation task was returned to the stakeholders, but this time with the average score shown next to each standard. Stakeholders were asked to score the standards again, in the same way as in round one, but on this occasion taking account also of the average score. Seventeen stakeholders were available to participate in round two, and the scores were again collated, averaged, and allocated to each standard.

Stage 3: Refining and operationalising standards

Consultation groups (2)

A third consultation group was held with seven clinicians from TMCDs or similar community health and social services to determine the type and availability of evidence (information from services) required to demonstrate whether each standard was met, and what questions should be asked of TMCD staff, people with dementia and carers who had accessed the TMCD, and staff from other services who interface with the TMCD. The group considered what documentation TMCDs typically kept or could access at Trust level. Standards developed earlier in the consensus process that were not retained in the final 50 were discussed and refined for use, where relevant, as potential indicators of evidence for each standard.

The research team created scoring sheets to be used when reviewing TMCDs, based on the feedback gained from the consultation groups, and drawing inspiration from the earlier CORE study [14], which used a similar review process to the present study (see Fig. 4 for an example).

Field-testing

A field-testing process was developed based on the process used in the CORE study [14] to pilot the implementation of the Best Practice Tool with TMCDs. Review days were held with 12 TMCDs and five non-crisis teams. Non-crisis teams included Community Mental Health Teams for older people (CMHT-OPs). Some CMHT-OPs were in areas where a TMCD also operated, and there was little overlap in working practices or service provision between these teams and the local TMCD, but other CMHT-OPs operated in areas where there was no TMCD provision. On the review days, a reviewing team comprising two members of the research team, a member of staff from a different TMCD, and a member of the PPI group visited each team with the scoring sheets developed from the last consultation group. In preparation for the review day, the research team contacted the team to be reviewed to explain the process, and support the teams in collating evidence and arranging various groups of people for the reviewers to speak to on the day in order to complete the scoring for each team. Evidence sources required for the review included;

people with dementia who had accessed the team within the last six months; carers of people with dementia who had accessed the team within the last six months; members of staff within the team; staff from external teams that liaised with the team; the team manager; a review of anonymised case notes of the six most recent consecutively discharged people with dementia who had accessed the team; all relevant service or NHS organisational level policies; and the organisation's related routinely collected data.

Reviewers began the day with a tour of the team base, and then conducted all other activities to fit with the needs of the team. Reviewers typically split into pairs to conduct interviews or review cases and policies so that all evidence could be collected within one day, although outstanding interviews or documents could be followed up beyond the review day. The reviewers then met together to share their information, complete the master scoring sheet (see Fig. 3) and then provided brief feedback to the manager of the team. Draft reports were provided to teams, allowing for clarifications, further evidence to be collected, additional examples of aspects of team working to be considered, and any changes to the service's fidelity score to be agreed by the reviewing team. Comparison of scores between TMCD and non-crisis teams were undertaken to determine discriminant validity of the measure, to assess for floor or ceiling effects, and (in conjunction with feedback from team managers) to determine face validity of the best practice model.

Results

Qualitative data

Thematic analysis of the qualitative data revealed an initial 168 standards, which formed 18 distinct categories that each captured something about the essence of crisis working for TMCDs. Table 1 displays the original categories identified at this stage of the process, with an example standard from each category, and supporting quotes from the qualitative interviews.

Table 1

Original categories, example standards, and supporting quotes, identified from the qualitative work

Category	Example Quote	Original standard
Service purpose	So we get a lot of referrals asking us 'Please can you just maintain contact' or 'Please can you just pop in a keep visiting this person'. As much as we would love to do that, we are not commissioned to do that, and we don't have the staffing to do it. (Staff 04 - 02)	Staff members are aware of the aim of the service and can communicate it clearly to other healthcare professionals, service users, and people who support service users (e.g. family carers)
Team values	He kept looking at his watch, you see, and I thought, I know they've only got so much time. (Carer - 05-08)	Service users and carers should not feel rushed during face to face contact with service users and carers
Reflexivity	So for about two hours we just talk about what is going on in the team, like how we can improve, like anything wrong that we need to iron out. (Staff 03 - 02)	Team members are informed of quality improvement of the service, team performance, policies, changes, and development opportunities
Coordination of the service	They always just did exactly what they said they would do (Carer 01-05)	The team is reliable in keeping appointments and then actioning what is agreed
Decision making	I will work out my case load and who is the priority and within my case load I have got at the moment somebody who needs seeing weekly. I will work out with them what they need at that time (Staff 04 - 03)	Team members are able to make day to day decisions autonomously
Outcomes	It's really, really hard to quantify a person's recovery (Staff 02-04)	Outcome measures are appropriate to the service user and carer's needs and can document their progress whilst in contact with the team
Accessibility of the service	Sometimes most of the feedback we get is 'you call yourself a crisis team?', you know when someone is in dire need of help and they call in the office about 9 o' clock...you just almost wish someone was there (Staff 01-04)	The service is operational during hours that are appropriate to patient needs
Responsiveness of the service	So we sort of put them in terms of their needs to red, amber, green, or inpatient and that would determine the contact we make (Staff 01-03)	The service prioritises service users according to level of risk to themselves or others involved in their care

Category	Example Quote	Original standard
Staffing the service	Band 6 s would be expected to go and see somebody in their own home because of the risks involved...whereas a band 5 would do this in the care home because there is always people around afterwards (Staff 03 - 01)	There are clear job roles and boundaries within bandings for team members
Leadership	The good thing about the team here is the manager, one of the managers [manager name] is actually more based, she used to work in older people's services so she understands older people's services much better, the needs of people with dementia (Staff 02-03)	The team leader has specialist knowledge in older adults and dementia
Supervision and training	Yes and we ran a training course, me and my colleague here, on safeguarding and procedures and things like that and the Managers attended and the Psychiatrists attended, you know it was kind of, it was and then the Psychiatrists run training on areas that we feel we are lacking as well and so it's good, exchange is good (Staff 02-04)	Team members have the opportunity to engage in training led by experienced and senior members of the team
Joint working	Some of the referrals aren't very deep, three or four lines. Some of them are brilliant, they give you loads of information. But others they don't. It can be a bit frustrating (Staff 04 - 01)	Crisis teams are explicit with GPs about what information is required in a referral, and what physical health checks must be completed prior to referrals
Team base environment	We hot desk, which is a bit of a nightmare if there's no computers, but we've all got laptops, so you can be sat on your knees sometimes at a little desk in the corner (Staff 02-04)	The crisis team have access to an appropriate space to facilitate MDT meetings, complete paperwork and conduct telephone calls
Referrals	I can't even make a guess [at referral rates] (Staff 03 - 02)	Service user flow should be measured for the purposes of service planning and all team members are made aware of this information
Assessments	I didn't want to do writing. Writing has been a down-turn for me all my life (Service User 01-21)	The purpose and outcomes of assessments conducted by the team should be clearly explained to service users and carers

Category	Example Quote	Original standard
Psychosocial interventions	Well mostly they would sit and talk to you and just give you tips on how to handle dementia...he would say 'well, next time why don't you try this' or 'maybe he did that because...'. Do you know what I mean? (Carer 01–05)	The team provides education and support to carers to help them support the service user at home, which may include information about dementia, including basic information about what diagnosis the service user has and what the symptoms may include and signposting to available resources and services for service users and carers where relevant
Pharmacological interventions	Medication reviews, just like is part and parcel of what you would do if you get called out. (Stakeholder Focus Group 01)	The team should review or be able to arrange for a review of medication that the service user is prescribed
Onward referral	And then they would come perhaps a couple of times and then they would say, "well we think everything is ok now, we are going to close the books on you" which is the one thing that I find a bit unacceptable really, because the trouble is, once they have closed the book down on you, you then have to get in touch with your doctor and get the doctor to call them out again (Carer 03–17)	Service users and carers are adequately prepared for discharge from the service, are aware of how to re-access the team if necessary and are involved in the decision to discharge. Written and face-to-face information is offered.

Consultation groups (1)

The consultation groups reduced the number of standards from 165 to 95. One hundred and fifteen standards were rated as 'highly important', 10 as 'moderately important', 7 as undecided and 33 as 'not important'. Examples of standards rated are: highly important '*The team uses established and streamlined documentation that is appropriate to team member needs and kept up to date*'; moderately important '*Team members should be distinguishable by service users and carers from other health and social care professionals*'; undecided '*The team set expectations of the service with service users and carers at the beginning of the service's involvement with the service user*' and not important '*The crisis team is co-located with other relevant services*'. Of the original 165 statements 61 were combined with at least one other statement, 25 were retained in their original wording, 19 were modified, 27 prioritised for consideration at the consensus conference and 33 discarded. Standards were re-grouped into five overall themes by the consultation groups and the research team at this stage as follows: (1) management, (2) resources available to support rapid assessment and intervention, (3) assessment, (4) interventions, and (5) onward referral. The categories were based on the original groupings developed from the thematic analysis, but refined to conceptually match the components of TMCD working included in each group.

Consensus Conference

Activity at the consensus conference resulted in a reduction of standards from 95 to 50. Of the 95 statements 58 were combined with at least one other statement, 26 were modified and 11 were discarded.

The resulting list of standards represented a set of measurable principles that were either specific to TMCDs, or were essential characteristics of high quality community healthcare teams, that underpinned crisis work. For example, a standard specific to TMCDs was: *'Service staff work to build a rapport with the person with dementia and their carers/families to ensure they are involved in decision making'*, whereas a standard representing an essential quality was: *'All service staff feel confident to contribute to decision making in an open and supported process'*. An example of two standards that were combined and edited to clarify wording was: *'Team members have the means to communicate effectively and efficiently within the service'*; and *'The team uses established and streamlined documentation that is appropriate to team member needs and kept up to date'*, which became *'Service staff have the means to communicate effectively using established documentation that is organised to avoid duplication and is up to date'*. For the aetiology and development of each standard see Supplementary file 1.

The reduced number of standards enabled a restructuring of how the standards were grouped, resulting in three overall themes of (1) the crisis service, (2) rapid assessment and intervention, and (3) service resources. Participants at the consensus conference also reached consensus on the terminology used to refer to the various people described by the standard, resulting in a change from referring to 'service users' to instead referring to 'people with dementia', and the terms 'teams' and 'staff' changing to 'service staff'.

Modified Delphi process

The finalised list of statements and their average scores from both rounds of the Delphi process can be seen in Table 2. Two standards were allocated a score of 4, nine were allocated a score of 3, twenty-six were allocated a score of 2, and thirteen were allocated a score of 1. This totalled a maximum score of 100 points that a TMCD could potentially achieve when measuring their practice according to these standards.

Table 2

The finalised standards agreed at the consensus conference with allocated scores following the Delphi process

Standard	Delphi Round 1	Delphi Round 2	Final allocated score
The Crisis Service			
The service provides a timely and intensive level of support, working with people with dementia and carers/families to reduce risk, including inappropriate hospital admission.	3.4	3.8	4
The service communicates a clear, flexible definition of crisis and its own aims to other services, people with dementia and their carers/families.	2.0	2.2	2
The service has a definition of when a crisis is resolved to a point where intensive support from the service is no longer required.	1.7	1.5	2
Service operational policies outlining the purpose and eligibility criteria are accessible by service staff.	1.3	1.1	1
The service is person-centred and care is planned to meet the needs of the person with dementia and their carers/families. Service staff are caring, approachable and professional, and treat people with empathy and understanding.	3.3	3.5	4
Service staff work to build a rapport with the person with dementia and their carers/families to ensure they are involved in decision making.	2.3	2.3	2
All service staff feel confident to contribute to decision making in an open and supported process.	1.5	1.3	1
Service staff explain the care to be delivered to the person with dementia and their carers/families at the start and throughout their involvement. Information is timely, accurate and relevant to the needs and wishes of the person with dementia and their carers/families.	2.5	2.4	2
People with dementia and their carers/families have the opportunity to speak with service staff separately and together; they are not rushed during face-to-face contact.	2	1.9	2
Staff are aware of cultural and minority group issues that may affect people with dementia and their carers/families, and know how to enhance their approach to support them.	2	1.9	2
People with dementia and their carers/families have a named worker to support consistency of staff working with them.	2	2.1	2
The service has a system for prioritising risk and assessing required levels of support for people with dementia.	2.8	2.9	3
Each service has a senior qualified 'duty worker' (shift coordinator) who allocates work each day and who oversees all calls about patients.	2	1.7	2

Standard	Delphi Round 1	Delphi Round 2	Final allocated score
Service staff are able to make day-to-day decisions autonomously, in keeping with their levels of experience and in line with their professional competencies where relevant.	1.9	1.9	2
Service staff have the means to communicate effectively using established documentation that is organised to avoid duplication and is up to date.	1.7	1.5	1
A daily handover takes place to communicate information about people with dementia between service staff.	2.1	1.8	2
The service uses a centralised diary system led by the shift coordinator to know where service staff are and availability for new referrals.	1.5	1.3	1
Case load, mix and flow are measured and used to assist the organisation and planning of the service, with the staff working rota allowing for flexibility regarding staff absence and working patterns.	1.6	1.3	1
Service satisfaction information is collected from people with dementia and their carers/families using an appropriate measure. The whole service is aware of how it is evaluated in terms of satisfaction and performance, and how these results are acted upon. The service has a process to manage all feedback.	1.7	1.5	1
Service staff are informed of and involved with quality improvement initiatives, affording the flexibility to think creatively.	1.4	1.3	1
All service staff have regular clinical supervision that is separate from managerial supervision and is in accordance with professional and NHS Trust standards.	2.3	2.3	2
All service staff have regular opportunities for continuing professional development to support clinical and non-clinical skills related to the range of crises that affect older people with dementia.	1.9	1.7	2
The service operates outside normal working hours and signposts to other community-based support when the service is closed outside of these hours.	2.6	2.7	3
The service communicates its referral process to people with dementia, their carers/families, and other relevant organisations.	1.5	1.7	2
Rapid Assessment and Intervention			
Following referral, the service makes initial contact on the same day and the person with dementia is seen within the next working day for appropriate crisis referrals.	2.6	2.7	3
At a minimum, the service is accessible by telephone and if an answerphone or voicemail system is used, calls are returned and responded to according to risk.	1.9	2.0	2

Standard	Delphi Round 1	Delphi Round 2	Final allocated score
Service staff can see the person with dementia at their usual place of residence.	2.2	2.2	2
Service staff use a comprehensive assessment that includes standardised measures where appropriate, risk assessments, and the views of the person with dementia and their carers/families to inform care planning.	2.8	2.8	3
The purpose and outcomes of assessments used by service staff are clearly explained to the person with dementia and their carers/families.	2	1.9	2
Service staff take an holistic approach, considering physical health, mental health, and social needs.	2.7	2.9	3
Service staff provide information and education relevant to the specific dementia diagnosis, tailored to individual needs, to help carers/families support the person with dementia at home.	2.3	2.1	2
Service staff provide interventions to improve quality of life for the person with dementia and their carers/families by providing practical assistance and problem solving techniques.	2.4	2.5	3
Service staff review medication and monitor its effectiveness. Service staff have access to prescription of medication and are able to dispense it.	2.4	2.0	2
Service staff engage in interventions to prevent further crisis; these may include assessment, advice and support for other professionals.	2.3	2.4	2
Service staff signpost and facilitate referrals to other services including respite care.	1.7	1.4	1
People with dementia and their carers/families are involved in the decision to discharge, are adequately prepared for discharge, and are aware how to re-access the service if necessary. Verbal and written information is offered which includes information about onward services organised by the crisis service.	2.2	2.5	3
The service takes a multidisciplinary approach and has awareness of, and immediate access to, other relevant professional disciplines.	2.4	2.6	2
The clinical lead for the service has specialist knowledge and skills relevant to working with older people and with dementia.	2.5	2.3	2
Service staff have specialist dementia knowledge and skills through training and/or appropriate clinical experience.	2.5	2.7	3
The service has administrative support that is sufficient to meet current demand.	1.6	1.6	1
The service has an operational plan which includes staff mix and bandings, and roles and responsibilities.	1.4	1.2	1

Standard	Delphi Round 1	Delphi Round 2	Final allocated score
Service staff understand all relevant legislation.	1.9	1.7	2
The service is embedded within established pathways of care and policies exist for working with all other relevant agencies, to include social care, emergency services, charities, and the voluntary sector. Other agencies and services have an accurate perception of the crisis service and its remit.	2.4	2.6	3
Agreements are in place to support cross-boundary working across geographical and commissioning areas, for example, with neighbouring health services and local authorities.	1.6	1.4	1
The service liaises with the person with dementia's General Practitioner (GP). The service is explicit with GPs about what timely information is required in a referral, and what physical health checks should be undertaken prior to referral. The service includes GPs in decision making where relevant and through correspondence.	2.4	2.1	2
The service has good communication with other services involved in the care of the person with dementia and their carers/families to avoid unnecessary duplication of assessments.	1.8	1.6	2
Joint visits between service staff and professionals from other agencies take place when necessary.	1.4	1.2	1
Service staff and professionals from other services attend each other's meetings when necessary, and appropriate escalation procedures are established and shared when required for complex cases.	1.1	1.0	1
Service Resources			
The service has access to appropriate space to facilitate Multi-disciplinary Team (MDT) meetings, and for staff to complete paperwork and conduct telephone calls of a confidential and/or sensitive nature.	2	1.9	2
There is provision of Information Technology (IT) resources and associated IT support appropriate to the needs of the service. This includes access to computer systems, including electronic notes, to enable working remotely from various locations.	1.8	1.7	2

Field-testing

The Best Practice Tool was piloted with 16 teams (11 TMCDs and five non-crisis teams). Reviews were completed in all teams, and all the participating teams received a report and total score. The majority of TMCDs scored higher than the non-crisis teams, suggesting good discriminant validity for the measure. Initially, ceiling effects occurred in scoring across both types of teams, therefore changes were made to the criteria required to achieve the maximum scores for each standard in the Best Practice Tool. This made it more difficult for teams to achieve high scores resulting in greater variation in scores across participating teams at this field-testing stage, thus allowing for a more nuanced exploration of areas for

improvement. Changes made to the scoring were documented and implemented after ten teams (seven TMCD and three non-crisis) were reviewed. These teams were re-scored with the updated criteria, whilst the final six teams using the refined scoring system only. Scores ranged from 48 (non-crisis team) to 92 (TMCD) within a possible score range of 0-100. The median score for all 17 TMCDs using the revised scoring criteria was 74.5, with a range of 67 to 92, and the median score for non-crisis teams was 60, with a range of 48 to 72. Scoring for one non-crisis team was incomplete as the team were unable to provide sufficient evidence on or after the field-testing day to generate a meaningful score. Feedback from managers suggested good face validity, in that the Best Practice Tool captured what was happening in the teams, and managers generally found the process useful, non-threatening, and appreciated identification of areas for improvement. In particular, teams who provided a member of staff to act as a reviewer for a different team found the experience positive, commenting that it was helpful to see how other teams operate and create networks with other professionals in services similar to their own. The review days were, however, lengthy, and required preparation in advance, which was found to be burdensome by teams who were already experiencing a great deal of demands on their time.

Discussion

Main findings

This study shows that comprehensive, succinct and usable standards can be developed to assess the quality of TMCDs. The Best Practice Model described in this article is a product of a clear and objective consensus process that involved stakeholders who are experts by experience, qualification, or professional training, and is a model for practice that represents the very essence of crisis care for people with dementia. Field-testing the Best Practice Tool with both TMCDs and non-crisis teams demonstrated that it can be successfully implemented with TMCDs, and can distinguish them from non-crisis teams, to provide helpful feedback, celebrate areas of good practice and identify areas for service improvement specific to dementia-crisis working. The development of the model demonstrates a clear distinction between TMCDs and CMHT-OPs. It provides a clear role and method of working for teams that manage crisis, where TMCD service provision is necessary to meet the needs of people with dementia and their carers who experience crisis situations.

The process followed in developing the Best Practice Model also highlights the utility of consensus methodology in establishing agreement on a topic where there is limited empirical evidence. This study has showed the process can be conducted rigorously [16]. The stages involved in this process ensured that equal voice was given to different groups of stakeholders, including people with dementia and TMCD practitioners, and that the model developed was realistic in the context of current service provision.

Limitations

This research and the resultant Best Practice Model focus on services provided in England, UK. It is likely that our findings will apply to services provided in the devolved nations of the UK as they follow similar health and care provision structures, but applicability to crisis services beyond the UK setting is currently

unknown. The conceptualisation of crisis for people with dementia itself at an international level is under-researched, but definitions of crisis and how services are organised to assist with resolution seem similar [17]. Important differences in service provision at an international level are likely to arise from differing demographics and geographies, for example in rural parts of Australia where workers from assessment teams are only able to visit older people in the community infrequently [18]. This research therefore provides a solid starting point for planners in other countries wishing to build upon existing services or develop new services that meet the needs of people with dementia who experience a crisis.

Whilst working towards developing the Best Practice Model, it was clear that being overly prescriptive would be counter-productive, as ways of achieving best practice are often dependent on responding to the local health and care context and factors such as case-mix, which will vary according to local demographics. This approach does sacrifice precisely defined standards, for which a high degree of reliability could be calculated, in favour of creating a set of standards that have an enhanced contextual validity and reflect the need for warranted variation that enables patient centred care. Consequently, some standards in the Best Practice Model are quite general. However, these standards have captured crisis team working since non-crisis teams tended to score lower in the field-testing of the Best Practice Tool. The standards also require clinical judgement to determine whether they are met. In this study, a TMCD staff member or similar clinician was part of each reviewing team, which increased confidence in this process.

The psychometric properties of the Best Practice Tool were not identified during this consensus development process and will need to be established in future work. The number of teams involved in the field-testing was too small for meaningful statistical comparisons to be conducted at this stage. Test-retest reliability could not be established given the substantial burden of performing a review day for both the participating teams and reviewers, a finding consistent with conclusions drawn by the CORE study [14]. Similarly, inter-rater reliability could not be established due to the large number of raters involved, but this calculation would be desirable in future research. No single reviewer looked at every piece of evidence gathered, as the reviewers completed separate tasks in pairs during the day. Therefore the score was a product of discussion rather than individual decision making. Training and the agreement of a score by the whole reviewing team aimed to enhance scoring reliability. Not all information was necessarily present on the review day, and, consequently, the score received by the team could have been lower than expected, as scores could only be given for evidence demonstrated to the reviewers. However, TMCDs that were reviewed had the opportunity to challenge provisional scores and provide additional evidence where available. These features of the process, and the involvement of the third consultation group to determine the type and availability of evidence that teams could access, was another way to enhance reliability of the Best Practice Tool, and that the tool can be usefully applied as a self-assessment tool in the future, where reviewers are likely to be different each time. The criterion validity of the tool should also be explored, since it is currently unknown how well a score on the tool relates to outcomes for people with dementia and carers accessing these services.

Strengths

A key strength of this research is the involvement of people with dementia and their carers, and TMCD practitioners. People with dementia and their carers formed our PPI group and not only provided opinions grounded in their experience on how the research was being conducted, but also played a vital role in research delivery. PPI members collected data, co-facilitated consensus discussion groups, and were members of reviewing teams when field-testing the Best Practice Tool. People with dementia, their carers, and clinicians were involved as critical friends at various stages during the development of the Best Practice Model and Tool including the consultation groups and modified Delphi process. The involvement of people who will use the Best Practice Tool in their clinical practice, and people supported by health and care services, ensured that the Best Practice Tool is realistic and achievable.

Clinical implications

The use of the Best Practice Tool as a self-assessment exercise is feasible and the Tool can highlight areas of service improvement. A similar fidelity process, which allows services to identify their strengths and target areas for service improvement, provided a means to improve the quality of service provision in the US EBP project [19]. This suggests that the standards developed here can be utilised by TMCDs to improve their practice. Additionally, as a by-product of the review process, clinicians from different teams were able to visit teams in other NHS organisations and share examples of good practice, suggesting potential opportunities for building a community of practice across TMCDs in the future. The use of the Best Practice Model and Tool, and knowledge sharing amongst teams, has scope to spread innovation and ideas for achieving quality care, as well as providing opportunities for standardisation of good practice at a national level. The TMCD standards may also be used to provide national-level benchmarking data about current practice and variation in TMCD services, information which is useful to policy makers and service planners nationally. The CORE adult crisis team fidelity scale provides a clear example of this due to it being used in a national survey that collected data from 75 services [20], and is now recommended in national policy guidance [21].

Crisis teams specifically for people with dementia do not appear to be standard practice at a national or an international level and appear rarely in research. A systematic review identified crisis resolution or home treatment teams not specific to dementia existing in other countries [22], and studies have evaluated not dissimilar hospital at home concepts for mental health support in Australia [23], France [24], and Spain [25]. The teams included in these studies are not specific to supporting people with dementia who experience crises. Recommendations regarding care and support systems by Alzheimer Europe encourage the development of services that can operate with a flexible approach and react to crisis situations at home in a timely and immediate fashion [26]. However, the nature of this distinct function makes other elements of general best practice, such as continuity of staff, a challenge [27] and these issues need to be considered in the planning of services. The Best Practice Model developed here, and the process by which it was developed, will be of interest internationally to planners who could benefit from establishing TMCDs as a model of working to avoid unnecessary inpatient admissions for people with dementia.

Research implications

Psychometric testing is needed to further quantify how the Best Practice Tool performs in terms of inter-rater reliability, and criterion validity to ensure that the scores achieved on the Tool relate to measurable outcomes for the TMCDs. Additionally, a factor analysis is required to confirm that the standards contained within the Tool actually map on to the three groups formed by the consensus process. This aspect of the work forms part of a larger programme of research to develop a Best Practice Toolkit designed to support TMCDs in providing high quality and effective care. The areas for service improvement highlighted through field-testing the Best Practice Tool will be used to identify strategies and resources that teams might use to improve the service they currently provide. The resulting Toolkit developed from this work will be evaluated alongside the Best Practice Model in an RCT.

Conclusion

This article describes the development of a Best Practice Model for services that provide support to people with dementia who experience a crisis. Key aspects of TMCD working that position them as distinct from other mental health services for older people are the high intensity and short duration of support provided, and the ability to be responsive at short notice. TMCDs typically conduct a range of assessments to establish on-going needs, and broker support from other services to ensure needs are met over a longer time frame. Although these standards focus on TMCDs in England and require further psychometric testing, their broad evidence base and non-prescriptive nature make this Best Practice Model and Tool ideal for use in TMCD practice for service planning, service improvement and national benchmarking in the future.

Declarations

Ethics approval and consent to participate: Ethical approval was granted by the West Midlands-Black Country Research Ethics Committee (ref: 16/WM/0273) for this study (Work Package 1). All participants gave informed consent to taking part in this research.

Consent for publication: Not applicable

Availability of data and materials: Most data generated or analysed during this study are included in this published article, its supplementary information files or in other published work. The complete data for the qualitative data analysis is available on reasonable request from the corresponding author.

Competing interests: None

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Authors' contributions: The research was originally designed by DC, DCS, TD, JH, BLE, EMC, FP and MO. Qualitative work was undertaken and analysed by JY, MS and AS. The consensus workshop was

facilitated by JY, MS, DCS, TD, JH, KJ, EMC, FP, AS, ET and MO. The field-testing of the best practice model was facilitated by JY, MS, KJ, AS and ET. This manuscript was drafted by JY, and amended by JY, MS and BLE. All authors commented on and suggested amendments to the manuscript. All authors read and approved the final manuscript.

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Figures

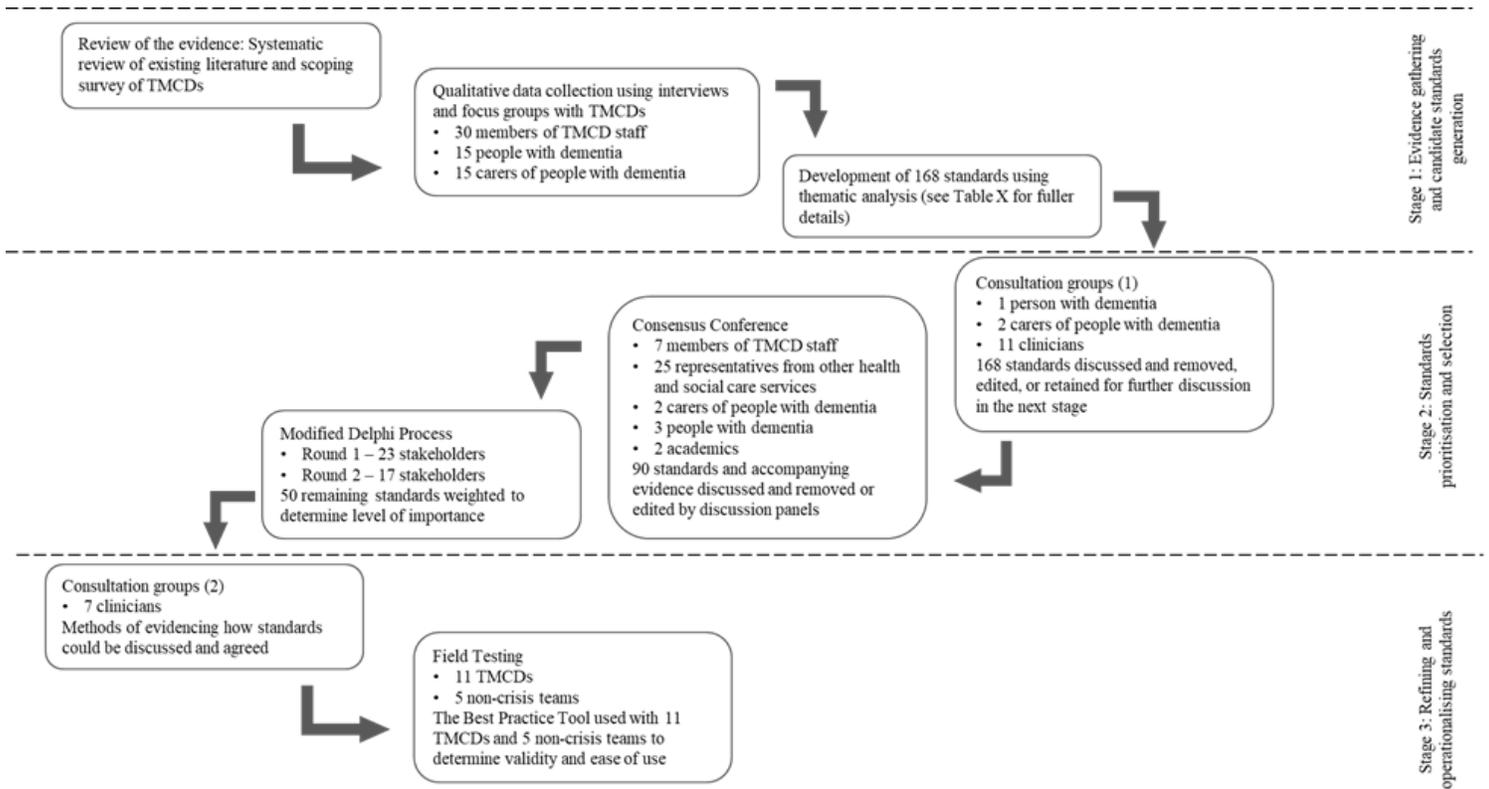


Figure 1

Participant and stakeholder flow through the consensus process

Braun and Clarke stages	Our methodology
Familiarising yourself with your data	Data were transcribed verbatim by a transcription company, and quality checked by a researcher (ET). Two researchers (JY and MS) each read half of the whole set of transcripts and noted similarities, contrasting accounts, common patterns, and insights.
Generating initial codes	JY and MS discussed these notes to develop initial codes, paying particular attention to aspects of crisis team practice or service provision that were mentioned, and the outcomes that participants reported as resulting from these activities. This drew on the research team's existing knowledge from conducting a scoping survey (deductive analysis), but also left space to identify patterns of ideas discussed by the interviewees.
Searching for themes	JY and MS discussed the codes and collated similar codes into potential themes. A theme index of the themes and subthemes was created, where each theme and subtheme was given a numerical identifier.
Reviewing themes	Themes were mapped back on to transcripts in the left hand margin using the theme index numerical identifiers. Every instance of each theme and subtheme was identified and transferred to a framework, which consisted of a matrix for each theme, with a column for each subtheme and a row for each participant. JY and MS checked that all themes remained independent, and any that did not were combined with other themes. Thematic models were discussed with the wider research team as they were developed and refined.
Defining and naming themes	JY and MS used the framework for each theme to summarise the content of each subtheme as a short statement. This enabled the themes and subthemes to be thoroughly operationalised and named accurately, capturing the essence of each theme.
Producing the report	Examples that provided the best and most representative evidence for each theme were highlighted in the framework of each theme. Narrative summaries of the themes were documented and stored for use in further report writing. For the purposes of the consensus process, all aspects of crisis team working and service provision were identified and documented, clustered by similarity or relatedness.

Figure 2

Stages of thematic analysis

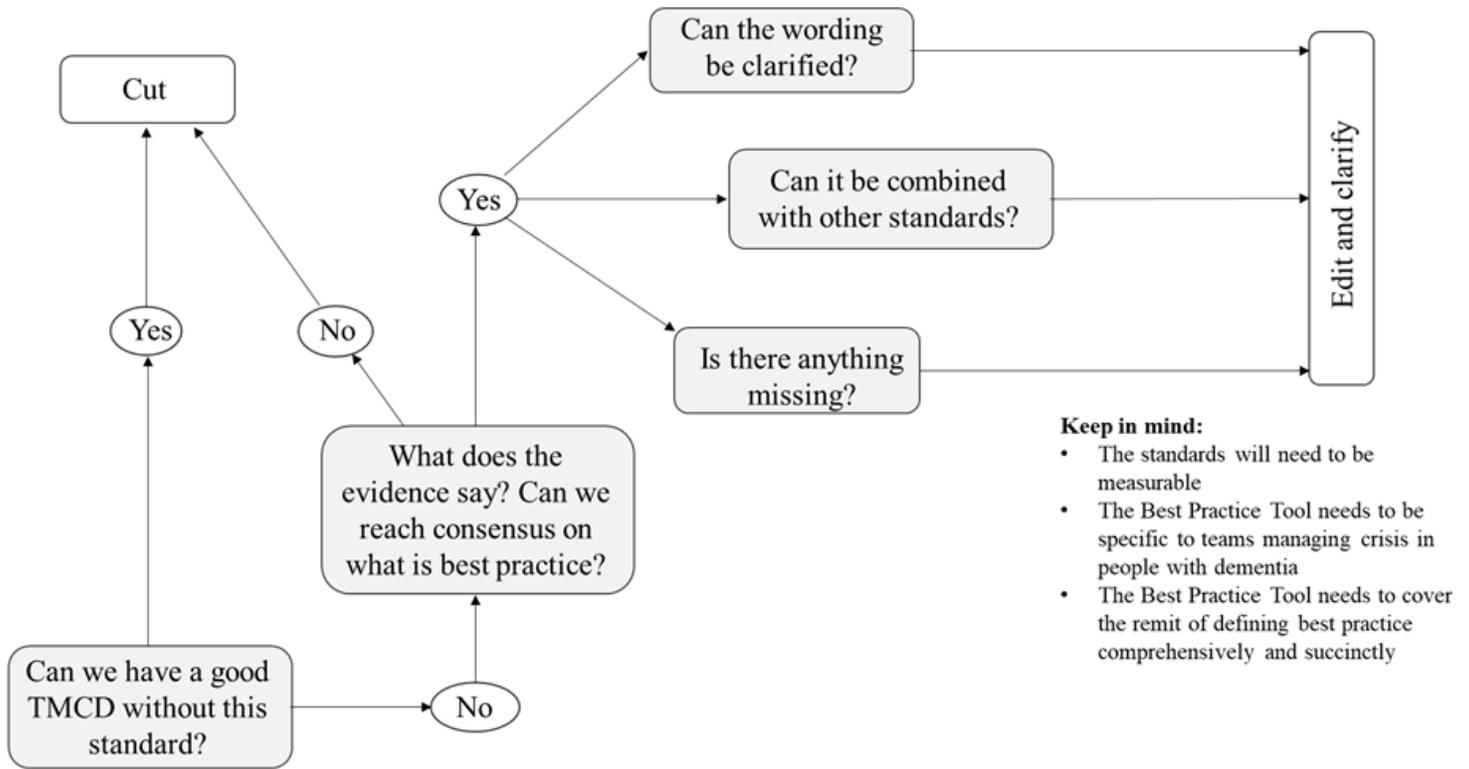


Figure 3

Decision making process used by participants of the consensus conference

Item 1

Evidence sources: Paperwork review = P, Case notes = C, Staff interviews = S, Manager interview = M, interviews with staff members from other services = O, Interviews with people with dementia = PwD, Interviews with family members/caregivers = FF, Visual check = E

Item	Evidence	Scoring criteria	Met/unmet	Item definitions and scoring guidance
1. The service provides a timely and intensive level of support, working with people with dementia and carers/families to reduce risk, including inappropriate hospital admission	C, S, P, PwD, FF	a) The service provides and intensive level of support to people with dementia and carers		Criterion A: Score as met if all source agreement indicated that up to three visits per day are provided to People with Dementia and carers and the level of input provided was enough to resolve the crisis
	P, C	b) The service is able to reduce risks to people with dementia and others involved with their care to enable them to avoid inappropriate hospital admission		
Scoring		Score 4 if two criteria are met Score 2 if one criterion is met	Item score	Criterion B: Score as met if case notes indicate that a risk assessment was carried out during assessment and an intervention was put in place to address that risk. Audit paperwork should show that hospital admissions were avoided

Figure 4

An example of the scoring sheets used in field-testing the Best Practice Tool

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [Supplementaryfile1.pdf](#)