MINISTRY OF HEALTH
MANATŪ HAUORA

HealthCERT

HealthCERT Bulletin

Information for the sector

Issue 18 – February 2017
ISSN 2423-0523

New Zealand Government

Welcome to this edition. Our focus remains on Pressure Injury Prevention and Management (PIPM).

Based on the success of the PIPM Programme, we will be continuing it through 2017.

Providers: Keep completing s31s for PI stage 3 and above.

DAAs: Keep reporting in line with the audit template.

HealthCERT Work Programme 2016 and beyond: Pressure Injury Prevention and Management (PIPM)

We hope you managed to have a break over the Christmas and New Year period and are ready to make the most of the new year. As mentioned in the previous Bulletin, we are continuing to focus on PIPM this year.

The purpose of carrying on with this work programme is to gather sufficient data to provide meaningful information on the issue. Our methods of data collection will remain the same – that is, through the reports of your designated auditing agency (DAA) at audit, and via section 31 reporting of injuries at stage 3 and above. As always, your ongoing support is appreciated.

We are always looking for good news stories. We would be particularly interested to receive success stories about pressure injuries, so if you and your team have had a positive outcome in this area, please contact me at donna_gordon@moh.govt.nz.

Inside: **HealthCERT Work Programme 2016 and beyond: Pressure Injury Prevention and Management (PIPM)** • PIPM Work Programme: s31 reporting form • Who can I talk to? • Update on pressure injuries measure work led by the Health Quality & Safety Commission • Research of interest: PIPM • **Operating matters** • Section 31 incident notification • Bulk supply medication dual services • Home and community support sector • Electrical testing: certified residential disability providers • **Sector matters** • Medical Care Guidance: A new 'end-of-life' wishes idea for Canterbury • LiLACS New Zealand: Life and living in advanced age • Requirement to measure the food temperature • **Websites of interest** • **Good news stories** • Tamahere Eventide Home Trust: Education Unit • Heritage Lifecare Limited – Puriri Court link nurse • Te Kete Marie – the peaceful basket: inpatient hospital care for people with dementia, delirium and related cognitive impairment at the Mary Potter Hospice Foundation •

PIPM Work Programme: s31 reporting form

As you will be aware, HealthCERT has a dedicated form for s31 reporting of pressure injuries at stage 3 and above. Following our initial look at the data – which we summarised in the previous Bulletin – we have decided to add another field to the form. We are asking that reports of an injury identify the level of care the resident is receiving, that is, hospital, rest home, dementia or psychogeriatric. With this information, we can stratify data further in the formal analysis.

For the updated form, go to the Ministry of Health's website (www.health.govt.nz): 'Notifying of an incident or other matter required under section 31'.

Who can I talk to?

If you have any queries or concerns about PIPM or just want to discuss this work programme, please feel free to contact Donna Gordon by phoning (04) 496 2429 or emailing donna_gordon@moh.govt.nz.

Update on pressure injuries measure work led by the Health Quality & Safety Commission

(Part of a cross-agency approach with the Accident Compensation Corporation and the Ministry of Health on pressure injury prevention and management)

In 2014 a KPMG report estimated the cost of pressure injuries in New Zealand and discussed the likely benefits of a national quality improvement initiative (www.hqsc.govt.nz/assets/Pressure-Injuries/PR/KPMG-pressure-injury-report-Jan-2016.pdf).

A key need in any quality improvement initiative is to take a consistent approach to measurement and surveillance to monitor for change. As part of a joint initiative with Accident Compensation Corporation (ACC) and the Ministry of Health, the Health Quality & Safety Commission (the Commission) is focusing on two work streams, one of which is measurement and surveillance.

The Commission engaged Sapere Research Group and an expert reference group to understand the different approaches to pressure injury prevention and management in public hospitals, residential care and community settings. The groups considered surveillance approaches across different settings (www.hqsc.govt.nz/our-programmes/other-topics/publications-and-resources/publication/2658) and were able to define a recommended approach for public hospitals, but further work will be needed to understand the needs of other sectors.

The recommended approach for public hospitals is monthly surveillance of hospital-acquired pressure injuries (all stages including 'unstageable'). This would be based on a skin assessment of a minimum of five randomly sampled patients per ward (assuming a ward size of 20–25 patients). The number of patients with hospital-acquired pressure injuries out of all patients surveyed will allow us to estimate the prevalence of hospital-acquired pressure injuries in each district health board (DHB).

As hospitals increasingly embed the measurement approach part of their practice, they will supply DHB-level data to the Commission, as they do for quality and safety markers for other national projects.

The Sapere report showed some DHBs are already taking a range of surveillance initiatives, including some that could be adapted to the recommended approach.

The Commission will work initially with three DHBs (Waikato, Whanganui and Southern) over the coming months. This will give it a better understanding of what resources and support will be needed to adapt or implement the recommended surveillance approach. The Commission will then consider how to support a wider rollout across other DHBs. Dr Andrew Jull RN PhD, Nursing Advisor – Quality and Safety, at Auckland DHB is helping with this work.

Planning is also under way to work with aged residential care facilities (then with community service providers) on a surveillance approach to suit their needs. One consideration is whether the recommended approach in the Sapere report can be refined for these sectors.

The other area of focus for the Commission is identifying a suite of consumer stories that will help with planning a potential co-design project aimed at developing resources and tools to help improve skills and knowledge on pressure injury prevention and management.

We will keep you up to date on developments with this work. If you have any questions, please contact Gabrielle Nicholson, senior project manager at the Commission, at gabrielle.nicholson@hqsc.govt.nz.

As part of the cross-agency work, ACC is leading the work on developing guidance for pressure injury prevention and management. Now nearly complete, this work has involved input from an expert reference group and consultation on across the sector. If you have any questions on this work, please contact Sean Bridge, ACC at sean.bridge@acc.co.nz.

Research of interest: PIPM

Because of HealthCERT's ongoing focus on pressure injury through our PIPM Work Programme, it remains the topic for our research of interest. The resources below may be of interest to your service.

Ahn H, Cowan L, Garvan C, et al. 2016. Risk factors for pressure ulcers including suspected deep tissue injury in nursing home facility residents: analysis of National Minimum Data Set 3.0. *Advances in Skin & Wound Care* 29(4): 178–90; quiz E171.

Baumgarten M, Margolis DJ, Localio AR, et al. 2008. Extrinsic risk factors for pressure ulcers early in the hospital stay: a nested case-control study. *Journals of Gerontology A. Biological Sciences and Medical Sciences* 63(4): 408–13. URL: www.ncbi.nlm.nih.gov/pmc/articles/PMC2841290 (accessed 3 March 2017).

Baumgarten M, Rich S, Shardell M, et al. 2012. Care-related risk factors for hospital-acquired pressure ulcers in elderly adults with hip fracture. *Journal of the American Geriatrics Society* 60(2): 277–83. URL: www.ncbi.nlm.nih.gov/pmc/articles/PMC3532032 (accessed 3 March 2017).

de Souza DM, Santos VL. 2007. Risk factors for pressure ulcer development in institutionalized elderly. *Revista Latino-Americana de Enfermagem* 15(5): 958–64. URL: www.scielo.br/pdf/rlae/v15n5/v15n5a11.pdf (accessed 3 March 2017).

Ferreira Chacon JM, Nagaoka C, Blanes L, et al. 2010. Pressure ulcer risk factors among the elderly living in long-term institutions. *Wounds: A Compendium of Clinical Research & Practice* 22(4): 106–13.

Magalhães MG, Gragnani A, Veiga D, et al. 2007. Risk factors for pressure ulcers in hospitalized elderly without significant cognitive impairment. *Wounds: A Compendium of Clinical Research & Practice* 19(1): 20–4.

Michel JM, Willebois S, Ribinik P, et al. 2012. As of 2012, what are the key predictive risk factors for pressure ulcers? Developing French guidelines for clinical practice. *Annals of Physical and Rehabilitation Medicine* 55(7): 454-465. URL: www.sciencedirect.com/science/article/pii/S1877065712011530 (accessed 3 March 2017).

Moore ZEH, Cowman S. 2014. Risk assessment tools for the prevention of pressure ulcers. *Cochrane Database of Systematic Reviews* (2). URL: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006471.pub3/full (accessed 3 March 2017).

Pinkney L, Nixon J, Wilson N, et al. 2014. Why do patients develop severe pressure ulcers? A retrospective case study. *BMJ Open* 4(1): e004303. URL: http://bmjopen.bmj.com/content/4/1/e004303.long (accessed 3 March 2017).

Sternal D, Wilczynski K, Szewieczek J. 2017. Pressure ulcers in palliative ward patients: hyponatremia and low blood pressure as indicators of risk. *Clinical Interventions in Aging* 12: 37–44. URL: www.ncbi.nlm.nih.gov/pmc/articles/PMC5207332 (accessed 3 March 2017).

Operating matters

Section 31 incident notification

As you know, section 31 of the Health and Disability Services (Safety) Act 2001 requires providers to report prescribed events. Thank you all for your diligence in supplying this information. Remember from our last edition that providers are not required to report falls resulting in fracture and outbreaks on a section 31 form. Instead they should report these incidents via internal quality and risk management systems, and to other relevant agencies.

Where an outbreak is prolonged (that is, it continues beyond the normal time period), HealthCERT asks providers to notify us.

For an updated guidance sheet, go to the Ministry's website (www.health.govt.nz): 'Notifying of an incident or other matter required under section 31'.

Bulk supply medication: dual services (rest home and hospital)

The Medicines Care Guides state, 'Bulk supply is only suitable for facilities with hospital certification.' For this reason, rest homes (including dementia units) do not hold bulk supply and they dispense medications for individual residents only.

One question, however, is whether rest homes can use bulk supply medicines in dual services situations, the prescription medicines are being sold or supplied to a hospital care certified provider, who also provides rest home services in the same premises.

As long as the provider complies with the other provisions of the Medicines Act 1981 and Regulations, and Health and Disability Services Standards, there would seem to be no legal restriction on using these supplies throughout the dual service.

Here is an example of how this might work with a provider of a dual service.

> A GP reassesses a rest home resident and charts an antibiotic on Friday at 4.00 pm as the provider's pharmacist cannot fill the medical prescription.
>
> In this case, the registered nurse can access and administer from the bulk supply until the resident's individual medication is provided. The registered nurse must be the one to access the bulk supply and complete the relevant administration.

Use of bulk supply medications should only occur in acute instance or after hours.

Home and community support sector

As we mentioned in the last Bulletin, HealthCERT has been providing administrative support to the home and community support services (HCSS) audit programme. As part of this role, we are processing HCSS audit reports through an electronic database, the Provider Regulation Monitoring System (PRMS). We have now set up all contracted HCSS providers in PRMS and are beginning to see audit reports coming in from your conformity assessment body (CABs).

The other piece of work that we are finalising is a review of the publication, *Auditing Requirements: Home and Community Support Sector Standard. NZS 8158:2012*. You are probably aware this document outlines the requirements for CABs that are auditing and certifying providers of HCSS against the Home and Community Support Sector Standard. As this is the first significant review of this document, the consultation period has been extensive. The Oversight Committee will consider the feedback at the next scheduled meeting (February), after which we'll give stakeholders an overview of the agreed changes before publishing them.

If you wish to discuss any of the changes, please contact either Donna Gordon (donna_gordon@moh.govt.nz) or Rosie De Gregorio (rosie_degregorio@moh.govt.nz).

Electrical testing: certified residential disability providers

From a certification perspective, auditors will consider resident personal equipment as part of auditing standard 1.4.2 (facility specifications). Providers are expected to have a policy that covers monitoring of 'personal' electrical equipment, including following the manufacturer's warranty instructions. It is assumed that in an environmental audit of residential disability homes, auditors will consider the integrity of electrical cords and similar items.

Sector matters

Medical Care Guidance: A new 'end-of-life wishes' idea for Canterbury

Medical Care Guidance will document and share the future medical care wishes of people with permanent legal incompetence. A significant number of aged residential care residents (many

with dementia) are permanently incapable of expressing their thoughts and wishes and making the decisions about their own end-of-life care that an advance care plan (ACP) usually captures.

We sought a mechanism that gave guidance, similar to ACPs, about end-of-life treatment and wishes when a person is permanently incompetent. This is called Medical Care Guidance, or MCG. The MCG is designed to cover any reason for permanent incapacity including intellectual disability and neurological incapacity, which might result from, for example, a head injury.

The planning phase

The planning group was made up of people closely involved with ACPs. They noted that in some cases, Enduring Power of Attorney (EPOA) or parent carers were completing ACPs. This showed that there was a consumer group who wished to provide well-thought-out guidance for their loved ones if they had a serious health crisis. For people permanently unable to make health decisions for themselves, an ACP was not the right solution, but their loved ones were using it to fill this need.

Considerations

One challenge was how to format a document to cover the wide range of needs of people who may be involved in completing an MCG. For example, it might involve an EPOA, welfare guardian, next of kin, or aged residential care staff.

To understand an MCG, it is important to know that:

- MCG is a document that a patient's usual health care team creates together with the patient and their family
- health care professionals such as general practitioner teams and care facilities create the plan – it is not designed to be given to the family to complete alone (unlike an ACP)
- an MCG, like an ACP, is very useful in an acute situation, where the attending general practitioner may not be familiar with the patient they have been asked to visit and assess
- the EPOA or other spokespeople giving information on behalf of the patient must have the best interests of the person at heart.

Through a number of meetings, the planning group refined the MCG concept. Over the next year, it revised the MCG document several times until it had one ready for testing.

After the planning group approached six Canterbury aged residential care facilities individually, the facilities agreed to use the updated version of the MCG plan. An independent and local senior nurse from Nurse Maude oversaw the implementation of MCG in these six trial facilities.

The planning group also prepared a family/patient information sheet.

The ACP facilitator visited the general practitioners associated with the facilities to explain the MCG and the responsibilities linked with it.

Feedback and review

The six trial facilities gave positive feedback on the completed forms and MCG planning process. After three auditing agencies reviewed the results, the planning group modified the draft MCG plan where appropriate. This strengthened the document's authority and made it

easier to audit. Throughout the process, the planning group has focused on future-proofing the MCG and pre-empting possible glitches in the hope it will be used more widely.

Rollout and education during 2017

In July 2016 the rollout phase began with a presentation at a Grand Round, with Dr Rachel Wiseman, a consultant in respiratory and palliative medicine, publicising the MCG initiative. Education involving general practitioners, care facilities and nursing staff is our main focus for 2017. We look forward to updating you on progress.

Currently MCG is in hard copy format and the ACP team scans the copy into Health Connect South. We anticipate that care facilities will become better electronically connected in future and able to access both MCG and ACP documents held in Health Connect South.

To see the information we developed for families and EPOAs to prepare for the meeting to complete an MCG, go to: www.healthinfo.org.nz and follow the links through 'End of life planning and care' to 'Medical care guidance plan'.

For further information about this project, contact Elaine McLardy,
Advance Care Planning Facilitator | Canterbury Initiative, Canterbury DHB.
DDI (03) 3644178
Email Elaine.McLardy@cdhb.health.nz

LiLACS New Zealand: Life and living in advanced age

In 2016 the University of Auckland completed an exciting body of research about successful advanced ageing. In this work, known as Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu: Life and Living in Advanced Age, a Cohort Study in New Zealand (LiLACS NZ), the university had help from local community partners and funding from the Ministry of Health.

Because there has been a dearth of knowledge about how well the 'oldest-old' New Zealanders age, LiLACS NZ studied the predictors and trajectories of successful ageing over six years. It covered a diverse range of people in this advanced age group, considering different health, psychological and social groups (see Table 1). Starting in 2010, the study enrolled 937 older Māori and non-Māori from aged care facilities and the Bay of Plenty and Rotorua communities. Participants were interviewed and their health assessed yearly.

Table 1: Selected demographic data for LiLACS NZ participants

Widowed	**74% Māori women** **42% Māori men**	**67% non-Māori women** **31% non-Māori men**
Living alone	**51% Māori women** **27% Māori men**	**63% non-Māori women** **32% non-Māori men**
Living in residential care	**7% Māori**	**9% non-Māori**

While the study found evidence for chronic disease and reduced functional ability, its good news is that many people remain well and engaged in life through their 80s and 90s. In fact, 15–18 percent of people improved in physical function during the first four years of the study. Around one in three people was in a position to give some type of care or assistance to others. Interviews with participants' caregivers revealed a high overall cost is involved in providing informal and formal care to this age group (up to $4.3 million a year), suggesting a need to

support people in advanced age to be as functional as possible so that they can be more independent.

Another down side to physical and mental health decline is that people have a higher rate of comorbidity and use health care more. Data from the first four years of LiLACS NZ shows that when depression occurred along with a common physical condition such as cardiovascular disease, chronic lung disease or diabetes, a person's functional status worsened and their health service use and costs increased. However, on the positive side, effective treatments for mental health conditions may improve physical health and reduce health service use among those in advanced age with chronic health conditions, as well as lessening the burden of the conditions themselves.

Overall, higher quality of life for people of advanced age was linked with economic wellbeing, higher functional status and receiving care. Importantly, it was also linked with giving care or help and volunteering, confirming findings from overseas that people in advanced age are often resilient in the face of impaired health and function.

The University of Auckland shared the final results from all years of the study with study participants and aged care stakeholders in October and November 2016. See the LiLACS NZ website for more information about the research and its findings, including the latest report funded by the Ministry of Health: www.fmhs.auckland.ac.nz/en/faculty/lilacs.html

Requirement to measure the food temperature

Regulation 30 of the Food Regulations 2015 deals with procedures for hazard control because temperatures are important in controlling pathogens. Providers should identify undercooked or insufficiently reheated food as a risk/hazard and should take cooked/reheated food temperatures as a risk mitigation strategy.

Providers will need to have the Ministry for Primary Industries' template for Food Control Plans (suitable for rest homes and hospitals) in place by March 2018. That template makes the following points about food temperatures.

30 Procedures for hazard control

(1) The operator must have procedures for controlling hazards during the production and processing and handling of food.

(2) The procedures must—

(a) identify each step or combination of steps in the process of production or processing and handling at which it is essential to prevent or eliminate a hazard or to reduce a hazard to an acceptable level; and

(b) set out—

(i) the criteria that must be met to ensure that the hazard has been prevented or eliminated or reduced to an acceptable level; and

(ii) the reason for each criterion.

(3) The operator must ensure that hazards are controlled in accordance with the procedures.

(4) In this regulation, acceptable level means a level at which a hazard will not prevent food from being safe or suitable.

Processes

Because the temperature of food is so important, you must check (and keep records to show) that potentially hazardous food, such as chicken, meat or dairy products, is:

- stored at the right temperature (as identified in your plan)
- cooked to the right temperature
- cooled to the right temperature in the right timeframe
- transported at the right temperature.

Websites of interest

Health Quality & Safety Commission: **www.hqsc.govt.nz**

interRAI: **www.interrai.co.nz**

Nursing Council of New Zealand: www.nursingcouncil.org.nz

The New Zealand Wound Care Society Inc: www.nzwcs.org.nz

Good news stories

In this growing section of our Bulletin, you will find stories from residential disability services, aged residential care and a district health board. Thank you all for your contributions.

Tamahere Eventide Home Trust: Education Unit

Tamahere Eventide Home and Retirement Village is set on 26 acres of land on the outskirts of Hamilton. Belonging to the Methodist Church Charitable Trust, the facility includes 108 villas, and provides rest home and secure dementia care to 84 residents.

The organisation sees supporting professionals working in aged care as a priority. In July 2015, it established the first community-based Dedicated Education Unit (DEU), in partnership with Waikato Institute of Technology (WINTEC) and the Waikato DHB Professional Development Unit. Its goal was to enhance clinical teaching and learning in an aged care environment, specific to rest home and dementia care, and show the benefits of working in the sector.

The DEU has up to 10 bachelor of nursing students in their third semester, who are supported by both an academic liaison nurse and a clinical liaison nurse, in a four-week placement. It provides students with ‘hands-on’ experience in a supportive environment, working alongside registered nurses, enrolled nurses, care staff and diversional therapists. The registered nurses have completed preceptorship training and, as a result, feel their practice has improved because they are more active in teaching students. Students have also said they feel important and empowered, knowing they are contributing to the skills of a future workforce. In March 2016, WINTEC gave Tamahere Eventide the Best Clinical Placement Award.

Although the point of the DEU is to support nursing students, an evaluation of the project shows that it has also improved resident care. There have been more people on the floor providing one-on-one time to residents, leading to measureable reductions in aggressive behaviour and preventable falls.

Tamahere Eventide also supports the Nurse Entry to Practice (NETP) programme designed to attract more young people to the industry. Because of the opportunities it provides, Tamahere has young nurses who are motivated, knowledgeable and highly skilled.

In October 2016 Tamahere received a four-year certification. It gained a Continuous Improvement rating based on its implementation of the DEU, which produced measureable results and helped to retain registered staff in a younger age bracket.

Heritage Lifecare Limited – Puriri Court link nurse

In May 2015 the contracted medical centre of Puriri Court Rest Home and Hospital told the provider that it could not continue to provide a home visiting service for residents. These visits were time consuming and reduced the time staff could spend with other patients. In addition, the availability of general practitioners (GPs) in the area was limited, so it was not easy to transfer care to an alternative service provider.

To maintain a viable service, Puriri Court came up with a plan to introduce an alternative service delivery process that supported its medical service team. It would work to reduce both the number and length of required visits to the home.

We developed the idea of a GP link nurse to, in the first instance, triage and support the residents who would be suitable to attend the medical centre for their appointments. The link nurse would also support these residents to attend the medical centre, such as by providing transport and accompanying the person to provide a link of information between the home and the GP.

For those who needed a home visit due to either the severity of their condition or their immobility, the link nurse would triage them too and give all relevant information to the visiting GP. By having the relevant information and help at hand, the GP would then need less time for these visits. Triage would also reduce the number of visits required.

Puriri Court began advertising for a GP and gave the information about the role of the link nurse as part of the recruitment information.

It also told the medical centre about the proposed role. The medical centre agreed to a short-term trial of the service during the period that Puriri Court would work to find an alternative GP service.

When Puriri Court shared this change in service with its residents and families, they agreed to trial it. The link nurse notified families of appointment times and invited them to attend as well.

Appointment times were made at the Medical Centre that suited the residents cares and transport was provided using Puriri Court wheelchair access vehicles.

All residents continued to receive their medical care from the medical centre, with the support of the link nurse, until Puriri Court appointed a new GP.

The medical centre reported great satisfaction with the link nurse's service.

When Puriri Court employed a new facility GP, it kept the link nurse role and widened it to enhance health services to its residents. The broader role includes educating residents on their health needs, coordinating with all multidisciplinary services, managing lab results, and following up treatment changes, medication changes and specialist referral – to name a few.

The survey of residents and families showed service outcomes were very positive for them. Residents said they enjoyed preparing for the social aspect of visiting the medical centre.

All GPs, the wider community and hospital multidisciplinary team commented on the efficiency of the service.

The facility RN staff feel fully supported and informed by the link nurse, acknowledging that within a team the role is pivotal to improving the delivery of health care to the residents of Puriri Court.

Te Kete Marie – the peaceful basket: inpatient hospice care for people with dementia, delirium and related cognitive impairment at the Mary Potter Hospice Foundation

'Kete' – a basket or kit

In 2011, an occupational therapist and two nurses identified that caring for increasing numbers of people with dementia and delirium in the Mary Potter Hospice inpatient unit (IPU) was a challenge for staff. Supported by the management and executive teams, the three clinicians took a collaborative quality improvement approach to address the problem, engaging both the hospice interdisciplinary team and external community partners.

Information gathering identified that the quality initiative would need to promote and provide team education, as well as provide a toolbox of activities and reality orientation equipment for patients and families. The name chosen for the initiative – 'Te Kete Marie' or the peaceful basket – reflects the concept of empowering both a confused patient and the interdisciplinary team, with a peaceful approach to the provision of care.

Launched in June 2013, Te Kete Marie continues to draw on elements that support and sustain 'best practice' peaceful care (see Table 1), to become a dynamic, living resource. The initiative has noticeably changed culture within the IPU interdisciplinary team, with nurses feeling more confident and positive when caring for a patient with a dementia or delirium. A recent study that explored carer experience found a clear endorsement for Te Kete Marie and the new, enriched approach to people with cognitive impairment in the IPU.

Table 1: Te Kete Marie toolkit of care

Resource role
Interdisciplinary team members
Education
This is me booklet
Activity toolbox
Environmental and reality orientation resources
Core care plan guidelines
Micro-management of individual patients
MoCA – Montreal Cognitive Assessment
Consumer feedback

For further information, please contact tanya.loveard@marypotter.org.nz.

Leanne Bolton, Clinical Nurse Specialist and Tanya Loveard, Occupational Therapist
Mary Potter Hospice, Wellington

Bibliography

Bolton L, Loveard T. 2016. Te Kete Marie – the peaceful basket: an initiative for supporting people with dementia or delirium. *International Journal of Palliative Nursing* 22(3): 130–6.

Bolton L, Loveard T, Brander P. 2016. Carer experiences of inpatient hospice care for people with dementia, delirium and related cognitive impairment. *International Journal of Palliative Nursing* 22(8): 396–403.