Dementia in the acute gener

Philip Thomas, Elizabeth Ward and Daryl Leung describe the wide range of interventions to drastically improve care for people with dementia at New Cross Hospital in Wolverhampton – and look in detail to explain what good care means in six real-life case studies

Dr Philip Thomas is Senior House Officer and Elizabeth Ward is Specialist Registrar in the Department of Elderly Care, New Cross Hospital, Wolverhampton. Daryl Leung is Clinical Director for Care of the Elderly and Lead Clinician for Dementia, New Cross Hospital, Wolverhampton

It is well known that older people occupy the vast majority of hospital inpatient beds in the UK. A significant proportion of these individuals have cognitive impairment or an established diagnosis of dementia and are at increased risk of receiving poor quality care. The recent publication of the Francis Report into the substandard care given to patients at the Mid Staffordshire NHS Foundation Trust has brought this issue to the forefront of public and political debate.

In November 2009, NHS West Midlands commissioned the project ‘Delivering Excellence in Dementia Care in the Acute Hospital’. The aim of this ambitious and innovative venture was to address deficiencies in patient care. The Royal Wolverhampton Hospitals NHS Trust was chosen to undertake this project in collaboration with Wolverhampton Primary Care Trust and Wolverhampton Metropolitan Borough Council. Its aim was to develop a collection of patient care interventions with the sole purpose of improving the care and experience people with dementia receive during their stay in the acute hospital.

The project involved a range of complex interventions, described below.

Establishing a specialist dementia acute medical ward

The Dementia and Physical Illness ward was specifically designed with the needs of people with dementia in mind. This included:

• the provision of day rooms which form the focal point for activities and therapy sessions
• proper tables and chairs to allow people to eat their meals together at a table
• clear signposting of where the toilets are in the ward and wall clocks to help with orientation
• use of colour to demonstrate to patients which parts of the ward they can wander in safely – for example, doors to ward areas such as the sluice and store room are painted the same colour as the surrounding wall to reduce the likelihood of patients wandering into these areas
• moving the nursing station into each of the bays to increase the level of interaction between healthcare staff and patients and reduce the risk of unwitnessed falls.

Developing a ‘care bundle’

The care bundle includes ‘About me’, a document specifically designed for use in the hospital. This is completed in collaboration with the patient’s relatives and details the patient’s likes and dislikes; what they enjoy doing and topics for conversation which staff members can use to engage with the patient. In addition to this, hourly hydration and nutrition rounds minimise the risk of dehydration and malnourishment. Finger foods are on offer too.

Establishing a volunteer training scheme

This scheme offers befriending to patients on the ward. The positive attitude and enthusiasm of the volunteers has improved patient participation in group activities. The volunteers also contribute greatly to improving patients’ hydration and nutrition through constant encouragement.

Forming a Dementia Outreach Team

This operates in both a reactive (patients are referred to the Outreach Team) and proactive (Outreach Team actively seeks out patients with dementia in the hospital) capacity. This team provides practical advice and support to ward staff caring for patients with dementia on other wards and where necessary can facilitate transfer to the Dementia and Physical Illness ward.

Running a bespoke one-day Dementia Training Programme

This is run on a monthly basis and extensive dementia awareness training now forms part of the Royal Wolverhampton Hospitals NHS Trust corporate induction. This ensures that all individuals have at least a basic understanding of what dementia is and how it can affect patients.

This project had huge ambitions and collaboration between a variety of clinical and social care organisations was essential to achieve these goals. One of the most challenging aspects of this project was engaging staff members within the hospital to take on board these messages and utilise their new skills to improve the standard of care patients with dementia receive.

The project’s effectiveness

In June 2012 the University of Worcester published a report to try to quantify the effectiveness of the Dementia and Physical Illness ward and the impact of the newly developed interventions. Data was analysed for the project’s first year of operation (2010-2011) and there were many positive findings. Some key findings were:

• Patients with dementia admitted to the specialist ward had fewer ward moves due to streamlined admissions processes; this reduced the risk of further confusion and disorientation caused by repetitive ward transfers.
• Implementation of the nutrition and hydration rounds has resulted in more patients maintaining or gaining weight during their hospital stay.
Distress could have been avoided
Mr A, aged 78, has a diagnosis of vascular dementia. He is cared for by his brother and niece and is reviewed in the community by the psychogeriatric team. He has paranoid thoughts about the waste paper bins in his home; he often believes there are babies in the bins. When these are emptied Mr A becomes distressed thinking the babies are being disposed of in the refuse system. He is admitted to hospital and on the ward his bed is next to the bin. Each time the bin is used or emptied he becomes more distressed and agitated due to his delusions. The ward staff see only an agitated man and are worried he may become aggressive. A little more time spent taking personal information from his family could have established the trigger factor for his behaviour. Simply removing the waste paper bin from the patient’s bed space could have avoided the ensuing altercation with hospital security guards.

Look for the underlying cause
Mr B, an 80-year-old man living alone, is admitted to hospital with confusion. The patient’s daughter pushes for admission as she is concerned that he is unsafe at home. A urinary tract infection is confirmed and he begins a course of antibiotics. Throughout the first two nights he wanders, is very agitated and is incontinent of urine. The next day his daughter visits and finds him in wet pyjamas, barely recognising him as her father. Finally, an experienced nurse wonders if, despite being incontinent, he might be in pain due to urinary retention. This is confirmed by a bladder scan. He is catheterised and his behaviour dramatically improves. Abnormal behaviour almost always has an underlying cause; it is our job to find out what it is. A diagnosis of chronic urinary retention should always be considered in elderly patients with incontinence. A post-micturition bladder scan to assess the residual volume of urine in the bladder can easily exclude urinary retention.

Preparing for end of life care
Mrs C has end-stage dementia and is bedbound. She lives at home with her devoted daughter, her main carer, who has not been out of the house for longer than forty minutes in four years. Two weeks earlier, Mrs C was treated for a chest infection with amoxicillin syrup by her GP; she improved dramatically only to deteriorate again prompting this admission. In casualty she is reviewed by a consultant who diagnoses end stage dementia. He tells the daughter that nothing can be done; Mrs C is dying and should be kept comfortable with end of life care. By the time Mrs C is admitted to the medical ward her daughter has written a complaint stating that only two weeks ago the GP was prepared to treat her mother; what has dramatically changed? A geriatrician discusses the case and agrees to try subcutaneous fluids as there is no venous access and allow the daughter to feed her mother. She does this by using a teaspoon to give her mother a few drops of a nutritional supplement drink, and it takes 90 minutes for her mother to swallow the contents of the 200ml bottle. The nurses are unhappy about feeding the patient in such a way because of time constraints, but they do not invite the daughter to do this instead. During the ensuing week several conversations are had with the daughter who now agrees that her mother might die.

This case demonstrates two points: firstly that we often neglect involving carers to help us care for their relatives. Protected mealtimes are important to minimise disruption, however in the above scenario, the daughter’s willingness to assist in her mother’s care should have been utilised. This case also highlights that preparation for end of life care is often lacking – these conversations should have occurred in the community months earlier. Even for those patients who have acute admissions and are subsequently discharged, there is often a paucity of discussion about prognosis with relatives unless the patient is admitted under an elderly care physician.

Challenges
Despite these positive gains, not all of the anticipated improvements have been realised on the new specialist ward. The hospital length of stay has not been significantly reduced. However, the proportion of patients returning to their own home is increasing. The delay to discharge may reflect difficulties in arranging care packages. The new ward is also more expensive to run compared to a standard elderly care ward but it is unclear if these increased running costs will continue year on year or represent one-off expenses as part of establishing the ward.

Improvements
Overall, this project has improved the care that patients with dementia receive both on the specialist ward and in the hospital at large through the efforts of the Dementia Outreach Team and the extensive staff education programme. Improving staff members’ awareness and knowledge of dementia

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Assessing for pain is critical

Mrs D is admitted unwell to hospital. She has dementia and a swollen left foot. Her main carer is her son-in-law who is also looking after his wife who is dying from terminal cancer. He is mentally and physically exhausted. Mrs D is reviewed by a geriatrician who feels she has an ischaemic foot. A vascular surgeon reviews Mrs D who, although a little muddled, is deemed competent to decline surgery. During her wait for twenty-four hour care, she becomes increasingly confused. By week three, she is heard to be moaning and groaning but the nurses and doctors do not recognise this as pain because she is taking paracetamol occasionally although (it is prescribed to be taken regularly). It takes a night nurse practitioner to work out Mrs D is delirious and, from her non-verbal communication, is in significant pain from her foot.

Non-verbal assessment of pain is critical. The Abbey pain scale (2004) is a method of assessing pain in a non-verbal patient. Look at body language, watch when a patient is turned in bed, look at the face for signs of pain. Dementia patients with fractured neck of femur receive less analgesia than their peers who have normal cognitive function (Morrison & Siu 2000). They don’t receive adequate analgesia because we don’t assess their pain properly. We will only improve this situation with greater education and training of healthcare professionals about how to assess pain in patients with dementia.

Always scrutinise medication

Mr E was admitted to hospital following a collapse at home. He is known to have alcohol-induced dementia with possible Korsakoff’s syndrome. In addition he has epilepsy and has had a previous stroke. He is under review by the community mental health team and his GP. On admission, his ECG is abnormal with first degree heart block and right bundle branch block. His medication list is extensive including sodium valproate, citalopram, quetiapine and trazodone. Mr E is treated for aspiration pneumonia with clarithromycin as he is allergic to penicillin. This is a potentially disastrous mixture of medications. Each year there is an estimated 1800 excess deaths from cardiovascular causes as a consequence of using antipsychotic medications in patients with dementia (Banerjee 2009). Who is responsible for rationalising this man’s medication or considering significant drug interactions? We should always scrutinise a patient’s medications and rationalise them where appropriate. Failure to do so exposes the patient to the harms of adverse drug reactions.

Facilitate eating and drinking

Ninety-year-old Mr G has been admitted to hospital from residential care not eating and drinking. He also hits and scratches staff and has become too difficult for them to care for. Rather than arrange his transfer to a nursing home he is moved into an even more hostile environment, the acute medical ward. Despite putting full glasses of water in front of him along with coffee and tea, he does not drink. Instead of sitting out, he is nursed in bed due to his high falls risk and is also at risk of silent aspiration having never had a thorough swallow assessment. Dementia can affect the brain like a stroke; initiation of ideas and thoughts are sometimes lacking. Facilitation of drinking by putting Mr G’s hands round the glass may be required. His visual perception may also be affected and apraxia (inability to plan and perform complex tasks) and agnosia (inability to recognise objects) are common but under-recognised. The clear glass of water to him looks empty rather than full. Gentle touch and hand contact by staff and carers is what is necessary here. This seems to be common sense but will only become common sense when someone takes the time to explain it.

Ensuring adequate nutrition and hydration is a key component of patient care. Positioning patients appropriately at meal times and ensuring that food and drink is within their reach and field of view can help facilitate eating and promotes independence.

will hopefully result in the type of care that we all aspire to provide for our patients.

Person-centred care, as defined by Tom Kitwood (1997), is a description of the essence of holistic care that anyone should expect to have in any medical setting. In the context of dementia and the acute hospital environment, it refocuses our attention to the person in front of us. Counting the cost, a landmark paper from the Alzheimer’s Society (2009) unearthed a lack of understanding of the needs of patients with dementia and their carers in the acute hospital. This is echoed in government initiatives and the National Dementia Strategy (2009). Above and on p21 are several real-life case vignettes representing typical situations faced daily in any general medical or elderly care ward in the country. The approach to care and knowledge of staff shape patient outcomes both in terms of quality of care but also governance and safety of our hospital system for the frail and vulnerable, especially those with dementia and delirium.

Conclusion

Physical illness in patients with dementia presents a difficult challenge to us all. Our system separates us into mental health and physical health, doctors and nurses. And doctors too are split into our different specialities. Excellent dementia care allows us to become whole again and as Kitwood (1997) says, “see the PERSON not the dementia” rather than the disease and bed number. The National Dementia Strategy and its implementation are important but equally so are the hearts, hands and minds of hospital staff. Culture change is only brought about by an understanding, knowledge and empathy for the patient and carers affected. To achieve this in the acute hospital means it really is time for a change.

References


