Dementia care in acute hospitals

Prof Rowan H. Harwood

Nottingham University Hospitals NHS Trust

& University of Nottingham

rowan.harwood@nuh.nhs.uk

This presentation is on independent research commissioned by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research funding scheme (RP-PG-0407-10147). The views expressed in this presentation are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

Bad press

NHS failing in basic care of some elderly patients, warns watchdog

Care Quality Commission says some NHS trusts do not provide dignity and nutrition for some senior citizen patients

Denis Campbell, health correspondent
The Guardian, Thursday 26 May 2011
Article history

The Royal Free Hampstead NHS trust is failing to meet basic standards, accord to the Care Quality Commission. Photograph: Bruno Vincent/Getty Images

The NHS regulator today criticises the service for failing some elderly patients by giving them what the health secretary, Andrew Lansley, called "appalling levels of care" in hospital.

theguardian

News | Sport | Comment | Culture | Business | Money | Life & style

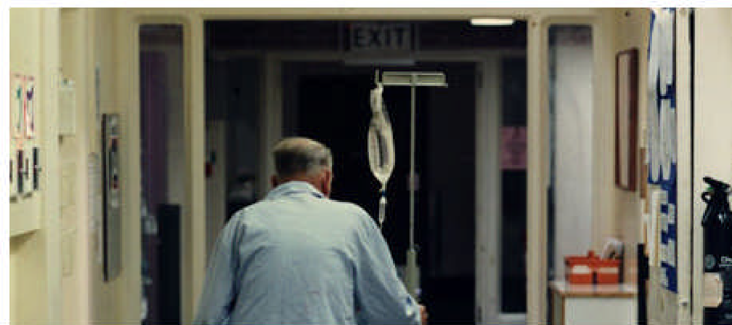
News › Society › NHS

Half of NHS hospitals failing to care for elderly

Care Quality Commission finds 'truly appalling and shocking' levels of dignity and provision of nutrition during spot visits

Reality check: why are some hospitals failing older people?

Denis Campbell and James Meikle
guardian.co.uk, Thursday 13 October 2011 11.39 BST
Article history

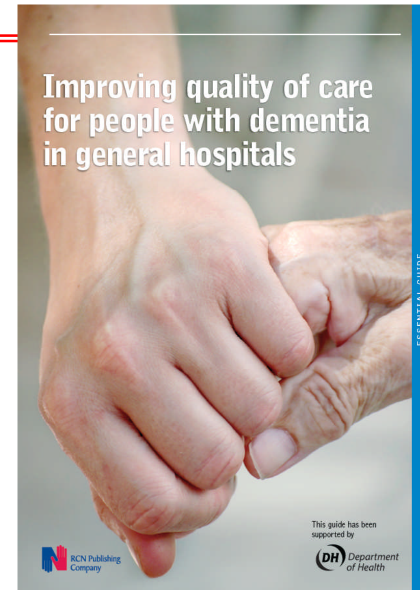


Current orthodoxy?

Right place, wrong person

Tadd W et al, 2011

Problems for people with dementia



- noisy busy environments
- fast pace of work
- intensive questioning
- multiple new faces
- moving through different departments and wards
- inability to express wishes
- taking account of other patients' needs

RCN Guidelines 2010

NIHR MCOP programme

Medical Crises in Older People: 3 linked studies over 5 years.

- Observational phase
  - Follow up study
  - Patient/carer interviews
  - Workforce study
- Service development
- Service evaluation and economic study

Mr A - history

- 82 years old
- Slumped in chair having lunch in day centre
- Brought to Emergency Department
- Agitated and combative; observations, exam resisted.
- Given Haloperidol 2.5mg i.m. x2
- Diagnosis: pneumonia

Mr A –medical admissions unit

- 10pm ‘Agitated and very confused’
  - Refused to go to CXR
  - Given haloperidol
- 8am ‘Agitated, tearful’
  - Hitting self over head, ‘wants to be shot’
- Called GP. Normally on trazodone 50mg bd.
- Called psycho-geriatrician; unable to get through
- Talked to wife

Mr A: day 3-10

- Positive blood culture
- Ongoing agitation, upset, aggression.
- More haloperidol
- Integrated discharge team referral
  - ‘not a rehab candidate due to dementia’
  - refer social services

Mr A – outcome

- Fell out of bed and fractured neck of humerus
- Discharged to a nursing home after 30 days

There is a lot of it about

- 60% geriatric medical patients
- 30% general medical admissions
- 40% hip fractures
- 25% of hospital beds

Medical admissions over 70

- 9% delirium alone
- 19% delirium complicating dementia
- 23% dementia alone

- Total delirium 28%
- Total dementia 41%
- Previously diagnosed dementia 28%

Whittamore et al, unpublished

People with dementia in hospital are complex

Presenting functional problems amongst patients over 70 with cognitive impairment admitted to a general hospital (n=53)

- Falls 42 (81%)
- Immobility 38 (73%)
- Pain 28 (54%)
- Incontinence 24 (46%)
- Breathlessness 12 (23%)
- Dehydration 11 (21%)

Harwood et al, unpublished

An array of diagnoses

Final diagnoses amongst patients over 70 with cognitive impairment admitted to a general hospital (n=53)

- fractured neck of femur 7 (1 peri-prosthetic)
- other fractures 6
- pneumonia 4
- multi-factorial fall 4
- multi-factorial functional problem 3
- AF with fast ventricular response 3
- dehydration/renal failure 3
- urinary tract infection 1 (+ 3 contributory)
- alcohol intoxication 2
- adverse drug reactions 2
- seizures 2 (alcohol excess, brain mets)
- unresponsive episode/syncope 2
- painful hip post fall 2
- unexplained delirium 2
- cancer 2 (gastric, lung)
- infective exacerbation of COPD 1
- infected leg ulcer 1
- gastroenteritis 1
- stroke 1
- ruptured Achilles tendon 1
- rheumatoid arthritis 1
- progression of vascular dementia 1
- acute urinary retention 1 (with a fall)
- anxiety, old stroke 1.

Harwood et al, unpublished

People with dementia in hospital are dependent

Prevalence amongst patients over 70 with cognitive impairment admitted to a general hospital (n=195)

• delusions	14%
• hallucinations	11%
• agitated	18%
• depressed	34%
• anxious	35%
• apathetic	38%
• disinhibited	10%
• sleep problems	34%

- help to transfer 65% (hoist 13%)
- help feeding 58% (unable 15%)
- incontinent of urine 67%

Goldberg et al, 2012

Poor outcomes six months later

- 31% dead
- 27% did not return home
- 18% 30-day readmission, 42% 6-months readmission
- 24% recovered to pre-acute illness level of function
- 16% spent >170/180 days at home

Bradshaw et al, 2012

New model of care

- Environment
- Specialist mental health staff
- Training in person centred dementia care
- Purposeful activity
- New approach to family carers

Spot the difference: standard ward

Yellow bay

Red bay

Spot the difference: MMHU

Yellow bay

Red bay

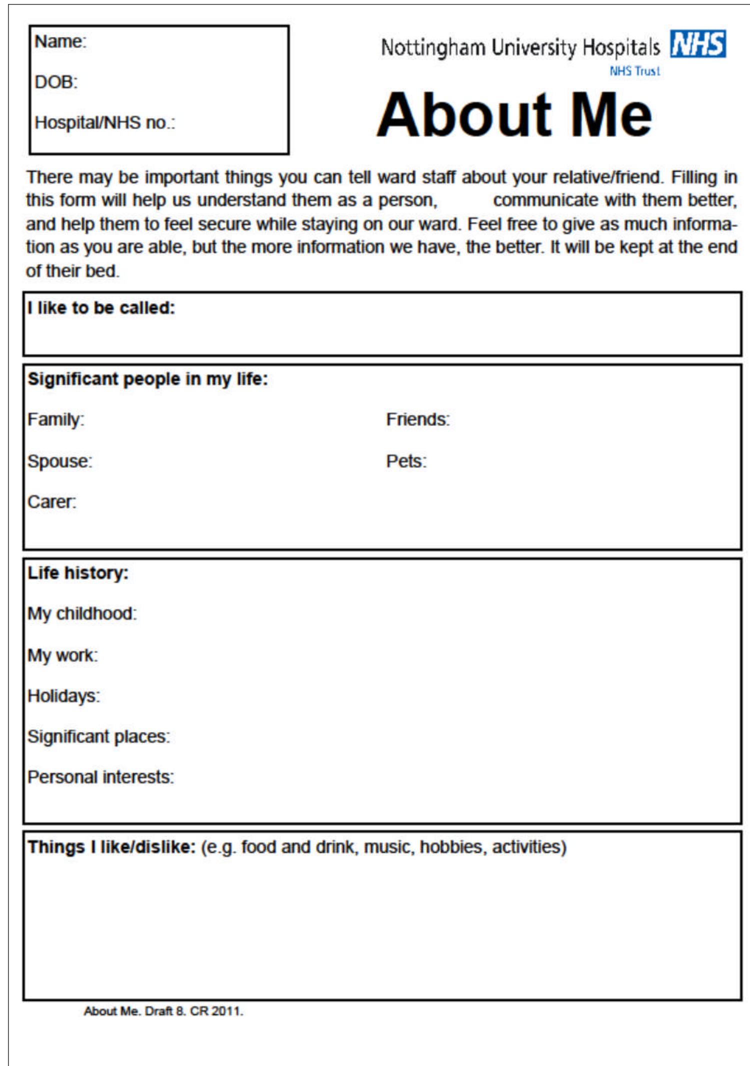
Environment

Person-centred care

- Value people with dementia and protect their rights
- Recognise and respect what makes each person unique
- Understand the perspective of the person with dementia
- Use relationships to reduce distress and enhance well-being

DH Commissioning Framework for Dementia 2011

Personal Profile



Name:

DOB:

Hospital/NHS no.:

Nottingham University Hospitals NHS

NHS Trust

About Me

There may be important things you can tell ward staff about your relative/friend. Filling in this form will help us understand them as a person, communicate with them better, and help them to feel secure while staying on our ward. Feel free to give as much information as you are able, but the more information we have, the better. It will be kept at the end of their bed.

I like to be called:

Significant people in my life:

Family:

Friends:

Spouse:

Pets:

Carer:

Life history:

My childhood:

My work:

Holidays:

Significant places:

Personal interests:

Things I like/dislike: (e.g. food and drink, music, hobbies, activities)

About Me. Draft 8. CR 2011.

Name:

DOB:

Hospital/NHS no.:

Important aspects of my daily routine:

Day time:

Night time:

How I respond to stress: (e.g. become quiet, pace around, shout out)

How I respond to pain:

What helps me to relax: (e.g. spend time alone, go for a walk, talk to someone)

About my relative/friend(s)

This form has been completed by:

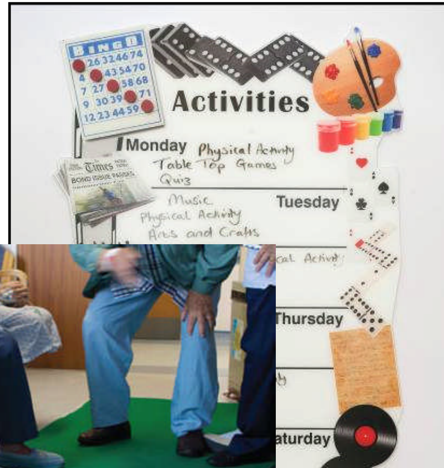
Relationship:

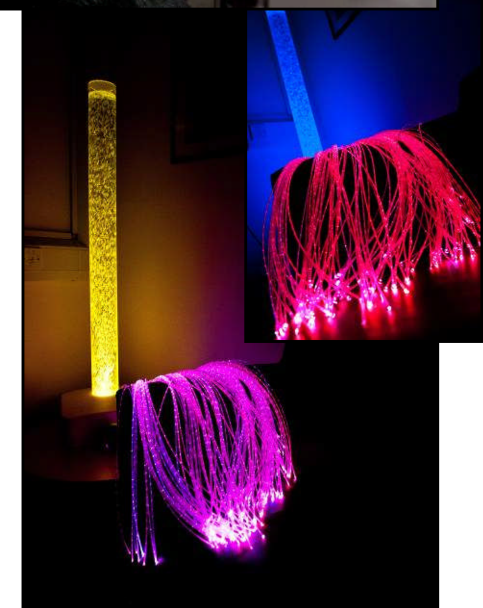
During my stay in hospital my relative/friend(s) would like to be involved in my care by: (e.g. assisting with meal times, out-of-hours visiting if required)

You can ring my relative/friend(s) when: (e.g. at night, to advise about care)

About Me. Draft 8. CR 2011.

Activities





Clothes

As our patients recover, it helps if they get up and dressed.

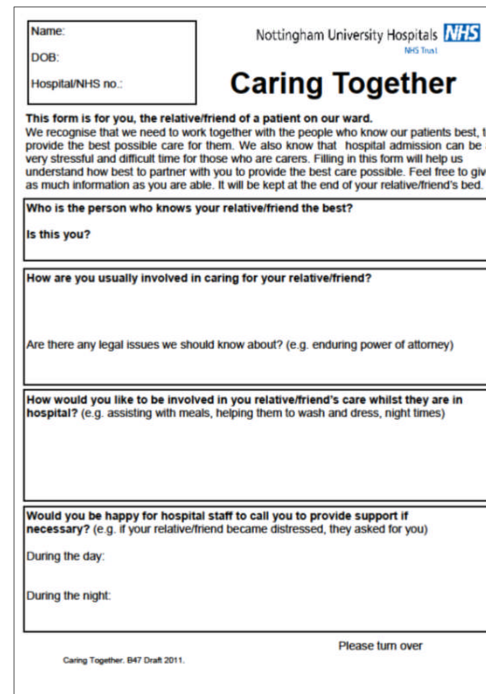
Please ensure that your relative has something to wear, preferably labelled.

Ask the nurse about arrangements for returning clothes for washing.

Thanks, B47

Families

- Recognizing family carer needs
- Gaining and giving information
- Decision making
- Liberal visiting times



Name:
DOB:
Hospital/NHS no.:

Nottingham University Hospitals NHS
NHS Trust

Caring Together

This form is for you, the relative/friend of a patient on our ward.
We recognise that we need to work together with the people who know our patients best, to provide the best possible care for them. We also know that hospital admission can be a very stressful and difficult time for those who are carers. Filling in this form will help us understand how best to partner with you to provide the best care possible. Feel free to give as much information as you are able. It will be kept at the end of your relative/friend's bed.

Who is the person who knows your relative/friend the best?

Is this you?

How are you usually involved in caring for your relative/friend?

Are there any legal issues we should know about? (e.g. enduring power of attorney)

How would you like to be involved in you relative/friend's care whilst they are in hospital? (e.g. assisting with meals, helping them to wash and dress, night times)

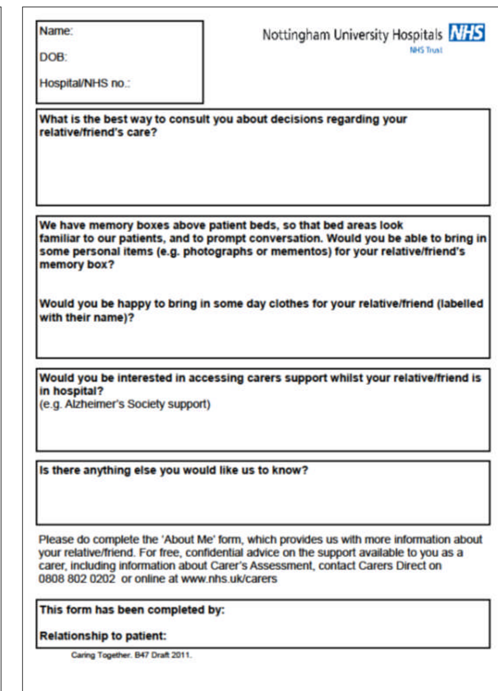
Would you be happy for hospital staff to call you to provide support if necessary? (e.g. if your relative/friend became distressed, they asked for you)

During the day:

During the night:

Please turn over

Caring Together. B47 Draft 2011.



Name:
DOB:
Hospital/NHS no.:

Nottingham University Hospitals NHS
NHS Trust

What is the best way to consult you about decisions regarding your relative/friend's care?

We have memory boxes above patient beds, so that bed areas look familiar to our patients, and to prompt conversation. Would you be able to bring in some personal items (e.g. photographs or mementos) for your relative/friend's memory box?

Would you be happy to bring in some day clothes for your relative/friend (labelled with their name)?

Would you be interested in accessing carers support whilst your relative/friend is in hospital?
(e.g. Alzheimer's Society support)

Is there anything else you would like us to know?

Please do complete the 'About Me' form, which provides us with more information about your relative/friend. For free, confidential advice on the support available to you as a carer, including information about Carer's Assessment, contact Carers Direct on 0808 802 0202 or online at www.nhs.uk/carers

This form has been completed by:

Relationship to patient:

Caring Together. B47 Draft 2011.

Mr B – day 2 MMHU

- Delirium diagnosed
- Treated with antibiotics and low dose haloperidol (1mg/d) for 5 days
- Nursed out of bed
- Wife engaged

Mr B – day 2 wife

- Vascular dementia 2005
- Specialist psychiatric day centre, CPN there
- Aggression and mood swings at home. No clear pattern. Helped a little by trazodone.
- Worn out by night time disturbance
- Determined she cannot cope at home, but reluctant for care home

Mr B – next 2 weeks

- On edge, needs careful handling
- Some altercations with other patients
- Gets aggressive during care tasks
- Nights variable
- Defined behaviour plan. No more antipsychotic drugs
- Fine when occupied, or with wife
- Clear ‘warning signs’

Mr B – behaviour plan

- Understand his distress
  - Anxious, disorientated, wants wife
  - Threats and misinterpetations
  - Can't process complex or overwhelming information
  - Fatigue, sleep disturbance
- Respond
  - Programme of appropriate activities
  - Talking, distracting, reassuring
  - Non-confrontation, backing off
  - Judicious use of one-to-one nursing and time out
  - Identifying triggers and early signs
- Hand over to intermediate care

Mr B – outcome

- Specialist mental health intermediate care
- ‘Staged discharge’ with dementia specialist home care

Mr B – outcome

- Died at home 2 weeks later

Randomised controlled trial

Constraints

- Minimise ward moves for confused patients
- Intense bed pressures
- No waiting on Acute Medical Unit (for assessment/recruitment/ consent/bed)
- No empty beds on MMHU, with suitable patients

Other issues

- Need to persuade AMU to do something of no benefit to them
- Majority lack capacity to consent: effort and delay
- 10% lack a personal consultee

Evaluation

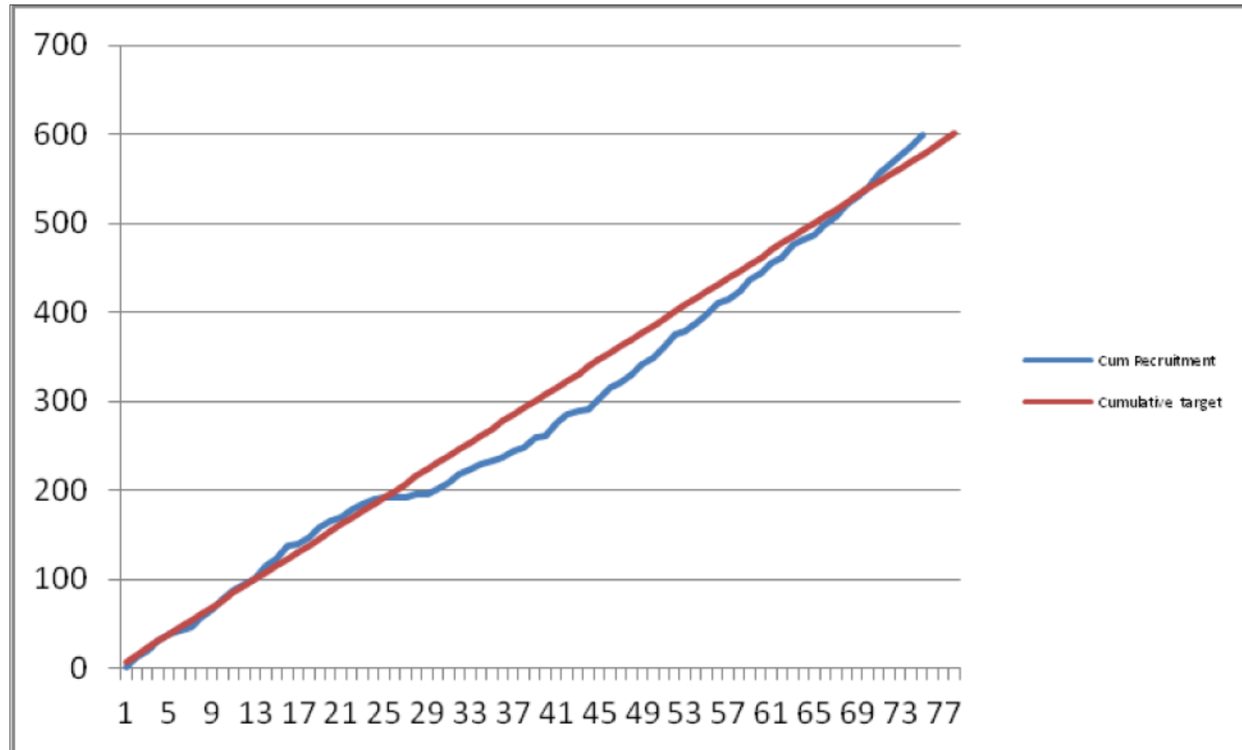
Randomisation *by clinical service*

- ‘Confused, over 65’
- Transferred to MMHU or standard ward
- Patient and carer recruited to follow up study
- Baseline data
- Outcomes at 90 days

Outcomes at 90 days

- number of days spent at home or original care home:
  - length of stay, readmissions, deaths, new care home placements
- health status scales:
  - Quality of life, behaviour, disability
  - Carer satisfaction
  - Carer strain and psychological wellbeing
- resource use and costs
- non-participant observer study
- recorded assessments and interventions
- interview study of carers

Recruitment



Target recruitment

Actual recruitment

Consultant on call 24/7

Recruitment

	Cumulative totals
Allocated	874
Recruited	600 (69%)
Carers recruited	485 (81%)
Reason for non-recruitment	
Patient Refused	62
Consultee Refused	116
Died	12
Discharged prior to researcher approach	31
No English	0
Discharged before interview arranged	26
Too ill	11
Other	16
Carer Satisfaction Questionnaires	455 (94%)
Patient Outcomes complete	511 (85%)
Carer Outcomes completed	289 (64%)
Deceased	144 (24%)

Baseline characteristics

	MMHU (n=310)	Standard Care (n=290)
Median age	84y	84y
Care home resident	28%	21%
Median MMSE	14/30	13/30
Delirium*	53%	62%
Median Barthel ADL	9/20	8/20
Presented with fall	42%	44%
Any hallucinations	37%	40%
Any agitation	69%	64%
Poor sleep	50%	57%
Problems eating	57%	54%

$*p<0.05$

Bradshaw et al, unpublished

Process differences, from casenotes

	MMHU (n=110)	Standard care (N=95)
Cognitive assessment (MMSE)**	52%	26%
Delirium recorded	37%	28%
Collateral cognitive history**	64%	33%
Collateral function**	81%	42%
OT**	83%	37%
SLT**	18%	2%
Clear medical diagnosis*	92%	77%
Progress discussed with family*	86%	75%
Antipsychotic drugs	14%	20%
CMHT referral*	20%	9%

$*p<0.05$, $**p<0.001$

Kearney, unpublished

Non-participant observation study

	MMHU Median (IQR)	Standard Care Median (IQR)
Positive Mood/Engagement*	79%	68%
Active State	82%	74%
Number Enhancers**	4 (1-8)	1 (0-3)
Number Detractors	4 (2-7)	5.5 (3-10.5)

***p<0.05, **p<0.001**

Goldberg et al, unpublished

NIHR TEAM Trial: carer very satisfied

	MMHU (n=234)	Standard care (N=228)
Overall*	48%	38%
Admission arrangements	34%	33%
Car parking	6%	6%
Feeding and nutrition*	35%	28%
Medical management	37%	33%
Kept informed	33%	29%
Dignity and respect*	58%	52%
Needs of confused patient**	42%	28%
Discharge arrangements*	37%	30%
Prepared for discharge*	79%	70%
Discharge about right time	73%	67%

***p<0.05, **p<0.001**

Bradshaw, unpublished

NIHR TEAM Trial: carer very dissatisfied

	MMHU (n=234)	Standard care (N=228)
Overall*	5%	10%
Admission arrangements	6%	7%
Car parking	20%	26%
Feeding and nutrition*	6%	12%
Medical management	8%	13%
Kept informed	11%	17%
Dignity and respect*	3%	8%
Needs of confused patient**	5%	13%
Discharge arrangements*	12%	19%
Not prepared for discharge*	21%	30%
Discharge too soon	17%	22%

***p<0.05, **p<0.001**

Goldberg, unpublished

NIHR TEAM Trial: outcomes at 90 days

	MMHU (n=309)	Standard care (N=290)	P (adjusted)
Median days at home	51d	45d	0.3
Not returned home	26%	30%	0.5
Died	22%	25%	0.9
Median initial LOS	11d	11d	0.2
Readmission	32%	35%	0.8
Total LOS in 90d	16d	16d	0.8
Move to care home	20%	28%	0.3

Bradshaw, unpublished

NIHR TEAM Trial: health status at 90d

	MMHU (n=241)	Standard care (N=219)	P (adjusted)
Median MMSE/30	16	16	0.6
Median total NPI/44	19	17	0.5
Median Barthel/20	12	13	0.8
Median London Handicap/100	33	42	0.9
Median DEMQOL	84	84	0.7
Median proxy DEMQOL	93	93	0.8

NPI: Neuropsychiatric Inventory, behavioural and psychological symptoms

MMSE: mini-mental state examination

DEMQOL: Dementia Quality of Life scale

Bradshaw, unpublished

NIHR TEAM Trial: summary

- Care was different on MMHU
- Patient experience better (mood, activity, staff interactions)
- Carer satisfaction better
- Health status unchanged
- Length of stay, readmissions, care home placement unchanged

Bradshaw, unpublished

How would you evaluate a palliative care unit?

NHS

The NHS Outcomes Framework 2011/12

Domain 1: Preventing people from dying prematurely

Domain 2: Enhancing quality of life for people with long-term conditions

Domain 3: Helping people to recover from episodes of ill health or following injury

Domain 4: Ensuring that people have a positive experience of care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Summary

- Special needs of people with delirium and dementia in hospitals need to be better met
- Systematic research yields data useful for planning
- Difficult to access research population…
- … but not impossible
- Better care can be delivered…
- … but efficiency savings unlikely