

MCOP discussion paper: Listening event

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Mental health problems on hospital medical wards: a listening event

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Workstream 1: towards improving the care of people with mental health problems in general hospitals.
Development and evaluation of a medical and mental health unit.

Workstream 2: Development and evaluation of interface geriatrics for older people attending an AMU

Workstream 3: Development and evaluation of improvements to health care in care homes

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Abstract

Introduction

We wished to ascertain the views of those representing patients with dementia about their care in a general hospital, so that we could design services that are more person-centred.

Method

A "listening event" was undertaken to which carers of people with dementia, their representatives and staff from the hospital were invited to give their views.

Results

Large numbers of comment were elicited, and grouped according to themes: admission arrangements, discharge arrangements, care on the wards, transfers between wards and general comments. Overall the comments from carers were highly critical of hospital care.

Discussion

Many potential service developments arose from these results such as the provision of accommodation for the carers of people with dementia while in hospital and specific relatives' clinics. The process may help facilitate development of a more person-centred service in the hospital.





Introduction

One work stream of the NHS NIHR Programme Grant “Medical Crises in Older People” concerned older people with mental health problems on general hospital wards. We wished to have patient and public involvement in this research and so we arranged a ‘listening event’, aimed at ascertaining patient and carer experiences of admission to acute hospitals, and how care might be improved.

Method

The event was co-hosted between the Nottingham Branch of the Alzheimer’s Society and Nottingham University Division of Rehabilitation and Ageing. The meeting heard presentations from the manager of the advice service at the Alzheimer’s Society, an Alzheimer’s Society advocate from Leicester, and the co-author of the National Dementia Strategy, but the main part of the meeting, reported here, was to elicit views.

Participants included carers of people with dementia, ward staff (mainly from the acute geriatric medical ward which was destined to become a specialist unit for confused older patients, the Medical and Mental Health Unit [1]), other NHS and social care professionals, staff representatives from the Alzheimer’s Society, representatives from Age Concern, nursing home staff and NUH management.

The “listening” part of the event brought participants into groups of 8-10 people for a 20 minute discussion. Groups were mixed, but participants to an extent segregated themselves, such that one of the groups predominantly comprised carers and another one predominantly comprised ward staff. Some people spoke both in their capacity as a professional and from experiences dealing with their own family members. There was a facilitator from the University of Nottingham, Department of Rehabilitation and Ageing for each group.





Groups were encouraged to speak freely, but were asked to concentrate on two of the following topics: admission arrangements; communication with family/carers; communication with other agencies; care on the wards, and discharge arrangements. The groups were asked to record their discussion on paper. At the end of the discussion, each group fed back their main point to the wider group. All comments arising from the discussion were collected. The opportunity was given to provide further or confidential comments by post, but no one took up this opportunity.

This report summarises comments recorded by the groups and reported by facilitators, sorted by general theme. Some comments were not elaborated upon at the time and minimal elaboration or justification to these comments has been undertaken by the authors. Some explanations to help a reader unfamiliar with the local health care setting are given and these are given as footnotes.

Results

The comments recorded by groups were grouped into themes and are transcribed here.

Admission arrangements

- More information needs to be sought by hospital staff from the patients' carers and the community services (e.g. community psychiatric nurses) who have a particular knowledge about the patients.
- Is the GP was the best person to contact about a patient with dementia?
- The appropriateness of some admissions of patients with dementia was questioned. Many people were understood to be admitted for a 'social sort out', which could be better dealt with by the community.
- Some admissions from nursing homes were considered inappropriate, and it was suggested that they might be 'turned around' in the Emergency Department or admissions unit.
- The question was raised of whether some of these inappropriate admissions reflected a lack of respite care in the community.
- It would be useful to have outreach teams liaising with GPs about admissions.





Discharge arrangements

- Concerns were raised about discharge arrangements for patients. Patients have been discharged in inappropriate clothing, without the correct equipment and without medication.
- It was felt that the discharge could be too quick.
- There may be no follow up or aftercare such as from community psychiatric nurses.
- Carers wanted to be included in the discharge planning process.
- Ward staff thought that some carers did not want to engage with the discharge planning, but wanted decisions made for them.
- Some patients had to wait too long in the discharge lounge before getting home¹.
- Nursing home staff felt that insufficient information was given about the mental state and behaviour of the patient (such as confusion) on discharge. Some patients were reported to be agitated and upset when they returned to the nursing home, yet the staff might not have been forewarned.
- Following discharge, there needs to be a “contingency plan” or a plan for what to do in the event of a further health problem.
- Home visits were seen as a valuable part of the discharge process, but there were concerns about whether there would be enough resources for them.
- Staff with a specific role to co-ordinate hospital discharge were a possible solution to improve discharge planning.
- The hospital system and targets resulting in pressure on beds was raised as a reason for poor discharge planning.
- There needs to be longer discharge target dates for patients with confusion².

Care on the wards

- Both training and having time to put training into practice was considered very important on the ward.
- All staff need to ensure they keep up to date.

¹ in the local hospital, patients due for discharge are sometimes moved to a discharge lounge while awaiting transport home, to free their bed a few hours sooner than otherwise would have been possible

² in local hospitals, it is increasingly routine for predicted dates of discharge to be estimated early in the course of a hospital stay – and these estimates may not take into account the effect of confusion upon discharge planning





- One group recommended that ward staff do a four day distance learning course in dementia.
- More involvement of carers and families was thought necessary. Families who were willing could be used more by ward staff.
- Carers wanted to have discussions with practitioners before medical decisions were made for example, decisions about whether it is appropriate to give antibiotics where there is severe dementia.
- Carers wanted more information from the wards such as information packs, phone numbers, and names of key-workers.
- Carers wanted to be acknowledged as “experts” and share their skills even after the loss of their loved one
- Some carers felt that on some wards the attitudes of staff towards patients with dementia needed improving.
- Ward staff need to be more approachable.
- Carers sometimes felt unable to challenge poor practice.
- Carers disliked staff making assumptions about patients. Specifically staff should not assume that dementia is an inevitable process of old age, nor that it accounted for all problems that a patient with dementia was having.
- It was suggested that more nursing staff are needed on the wards, as staff are always ‘in a rush’.
- Ward staff felt that the public do not understand what they have to put up with on the wards and how hard their work is.
- More advocates or dementia champions were recommended for improving care on the wards. Key workers were also a possible solution to improve care.
- More attention was needed towards basic needs of patients for example, promotion of dignity and basic nutritional needs.
- The ward environment was poor and confusing and side rooms were disliked.
- There is a lack of recognition of ‘end of life’ care for patients with dementia.
- There was a concern that good specialist psychiatric care does not transfer to medical wards.
- The visiting times were felt to be for the wards convenience not the visitors and wards were not person centred.
- There are insufficient chairs on the wards for visitors.





- Better facilities were needed for visitors. For example, there are no rooms available for the family of patients with dementia to stay in, but there are for families of children.

Transfers between wards

- It would be better to avoid multiple moves of wards for people with dementia, such as moving directly from the Emergency Department to an appropriate ward.
- Transferring confused patients between wards should be avoided, particularly at night.
- There could be better communication between wards.
- There is no standardised approach between wards.

General comments

- There was a general mistrust of the formal complaints process within the hospital which was seen as “screenwashing” and deliberately time consuming in the hope that bereaved relatives would simply give up chasing the complaint. One carer is now taking legal advice and feels unable to grieve properly until this matter is dealt with.
- There is no named person allocated to a complaint case so a carer has to explain her case every time she phones to a different person. This compounds the frustration and the magnitude of the problem.
- There needs to be more hospital and public awareness of the issues of patients in hospital with dementia.

Ward staff reaction

As is evident from the content of the comments elicited by this process shown below, a highly critical view of hospital care was expressed by the patients and public present at this event.

The intention was to elicit carers’ experiences and problems, and we anticipated the risk of alienating staff members who attended. However, one group of predominantly ward staff took great exception to proceedings, feeling a lack of understanding of the realities of ward nursing, generally unappreciated and ‘got at’. It was pointed out that staff





attending an event like this were likely to be those sympathetic to the problems, and (from their point of view) that most of the instances of poor care described were unlikely to have originated on an acute geriatric medical ward.

Discussion

Despite the unhappiness of ward staff who felt that they were being accused or blamed for the failings of other parts of the hospital, the event was generally considered successful, and evaluation was mostly good. The meeting exposed considerable amounts of dissatisfaction with the hospital care of people with dementia particularly from the perspectives of carers.

The findings of an event such as this need careful interpretation. The staff who attended were already interested and knowledgeable about the topic, having come from a geriatric ward. The carers may have been those wishing to use this event to nurse particular grievances. In retrospect, if the main purpose was to move towards a user-centred service, the event could have been run to ensure that carers gave views and others simply listened, as it is now not clear whether some of the comments listed came from staff or carers. The findings of this event may be highly local in their relevance and may not be true in other settings. The findings may have been relevant for 2009, but may not now apply.

Nevertheless, it was helpful for ward staff to be aware of how negative some carers were of the hospital experiences of the people for whom they cared. We think that ward staff were somewhat taken aback. We suggest that one reason for this is the lack of frequent patient and public involvement in services in this hospital: if there had been more frequent dialogue then these comments might not have been so surprising to staff or perhaps so vehemently expressed by carers.

Furthermore, the event gave rise to a number of potential improvements to service that acknowledge these concerns. We suspect that some of these potential improvements





might be applicable in other settings. Examples of potential changes to the local service that arose from these comments include (and this list is far from exhaustive):

- The provision of accommodation for relatives / carers caring for people with dementia while in hospital. This could improve the likelihood of better communication between staff and carers, the convenience could enable carers to take an active part in caring
- Relative / carer clinics by appropriately trained staff such as mental health nurses or specialist doctors. These could improve information flow, manage expectations, and aid discharge planning
- Routine and real engagement of patients, carers and representatives in ward practice as part of a quality assurance, improvement and education programme
- Programme of staff education and development

It was beyond the scope of this exercise and the scope of this paper to establish if and how these changes could be implemented, or whether they would have the desired effects on patient and carer outcome and experience. However, the findings of this exercise were presented to the group responsible for the hospital's dementia strategy (its response to the challenges set by the National Dementia Strategy [2]). Some of the ideas identified by this exercise have been incorporated into the development of a specialist unit for older people with mental health problem in the hospital (the Medical and Mental Health Unit – MMHU) [1]. This demonstrates that there are means of responding to the findings of such events.

In summary, we suggest that this "listening event" was valuable. It demonstrated that valuable information could be obtained from the perspective of carers, such as the extent of their distress as well as prompting practical suggestions for improvement. We suspect that all too often this approach is not taken in many hospitals: in this case it was driven by a research team and not by the operational or even the patient and public involvement mechanisms of the hospital. We chose to publish our experience so that it might encourage others to try a similar exercise.





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