INNOVATIVE INPATIENT DEMENTIA CARE

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Reading
Overview

• Numbers/ Evidence/ Policy
• People
• Clinical Challenges
• Environment
NUMBERS

• 1 in 4

adult inpatient beds occupied by a person with dementia
NUMBERS

- Prevalence of dementia increases with age

1.3% in ages 65 - 69

32.5% over age 95
NUMBERS

• Prevalence dementia in general hospitals

40% over 75s in hospital have dementia

50% never diagnosed before admission
COSTS

Health care costs are relatively small in dementia – £1.2 billion

But social care costs are huge – £9.1 billion
POLICY

• 3 themes
• Public and professional awareness
• Early diagnosis
• Improved care quality

2009
POLICY

Gearing Up | Coming On Stream | Full Implementation

O1 Public information campaign
O2 Memory services
O3 Information for people with dementia and carers
O4 Continuity of support for people with dementia and carers
O5 Peer support
O6 Improved community personal support
O7 Implementing carer’s strategy
O8 Improved care in general hospitals
O9 Improved intermediate care for dementia
O10 Housing including telecare
O11 Improved care in care home
O12 Improved end of life care
O13 Workforce competencies, development and training
O14 Joint local commissioning strategy and World Class Commissioning
O15 Performance monitoring and evaluation including inspection
O16 Research

2009-10 | 2010-11 | 2011-12 | 2012-13 | 2013-14
ECONOMIC EVALUATION

• Reduced Length of Stay
• Increased rates of discharge at MAU
• Increased rates of discharge from wards
• Destination of discharge changed
• Reduced rates of re-admissions
• £4 SAVED FOR £1 SPENT

2012
A 12-month follow-up study of people with dementia referred to general hospital liaison psychiatry services

BART SHEEHAN1, RANJIT LALL2, HEATHER GAGE3, CAROLINE HOLLAND4, JEANNE KATZ4, KATE MITCHELL5

1John Radcliffe Hospital, Headley Way, Oxford OX3 9DU, UK
2Clinical Trials Unit, University of Warwick, Coventry, UK

Six-month outcomes following an emergency hospital admission for older adults with co-morbid mental health problems indicate complexity of care needs

LUCY E. BRADSHAW12, SARAH E. GOLDBERG1, SARAH A. LEWIS5, KATHY WHITTAMORE13, JOHN R. F. GLADMAN13, ROB G. JONES15, ROWAN H. HARWOOD13
Quality of psychiatric care in the general hospital: referrer perceptions of an inpatient liaison psychiatry service


aSouth London and Maudsley NHS Foundation Trust, London, UK
bInstitute of Psychiatry, King’s College London and Division of Mental Health Sciences, St. George’s, University of London, UK
cKings College London, London, UK
dGuy’s and St. Thomas’ NHS Foundation Trust, London, UK

SPEED
- Response times
- Frequency of review in complex cases

QUALITY
- Note-keeping
- New dementia diagnosis

PATIENT FOCUS
- Patient satisfaction
- Carer satisfaction
UNDERSTANDING REFERRERS

Nurses

On ‘frontline’
As patient advocates

Demand ‘hands on’ support
Prefer verbal handover

Medics

See patient briefly at ward rounds
Focus on overall risks and discharge

Want short diagnoses and plans
Written notes
GOVERNANCE UMBRELLA

DEMENTIA STEERING GROUP

- Clinical Audit/ governance
- Incident reporting
- Complaints/ compliments
- Future planning
- Research

Berkshire Healthcare FT (Mental Health)
Adult Directorate

Royal Berkshire FT (Acute Care)
Networked Care Directorate

LIAISON PSYCH SERVICE
CLINICAL CHALLENGES
TRAINING: DEMENTIA CHAMPS

• Bottom up approach – 4 Ds
• Aim is to have ALL staff dementia competent
Audit themes

1. Governance
2. Assessments
3. Antipsychotic prescription: protocol and practice
4. Liaison psychiatry services
5. Hospital discharge and transfers
6. Information and communication
7. Staff training
DIAGNOSES

- Delirium: 7%
- Alz Dem: 16%
- Vasc Dem: 27%
- Other Dem: 7%
- MCI: 9%
- Functional illness: 34%
DEMENTIA: DIFFERENTIALS

• Depression
• Anxiety
• Hypothyroidism
• Nutritional deficiencies – thiamine, B12, folate
• Hyponatremia and electrolyte imbalances
• Hypoxemia – CCF/ arrhythmias
Anticholinergic COGNITIVE BURDEN

• OPTIMISATION OF MEDICATION

• ACBS – score 3
Tricyclic Antidepressants, Paroxetine
Phenothiazines, Quetiapine, Olanzapine, Procyclidine
Hyoscine, Oxybutynin, Propantheline, Tolterodine

• ACBS – score 1
Benzodiazepines, opiates, atenolol, cimetidine and ranitidine
Furosemide, Digoxin, Nifedipine
Haloperidol, Risperidone, Aripiprazole, Trazadone, Venlafaxine

(Boustani 2008)
COGNITIVE TESTING: MOCA

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

VISUOSPATIAL / EXECUTIVE

[Diagram of a maze with points A, B, C, D, E and numbers 1 to 5]

NAME: ____________________________ Date of birth: ____________
Education: ________________________ Sex: ____________

Copy cube: [ ] [ ] [ ] [ ] [ ] 5 Points

Draw CLOCK (Ten past eleven): [ ] [ ] [ ] [ ] [ ] 3 Points

POINTS 5

NAMING

[Images of a lion, a rhinoceros, and a camel]

POINTS 3

MEMORY
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

<table>
<thead>
<tr>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st trial</td>
<td>No points</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.mocatest.org
IMAGING

T1-weighted coronal magnetic resonance imaging scan showing extensive hippocampal atrophy (arrows).

Feldman H H et al. CMAJ 2008;178:825-836

©2008 by Canadian Medical Association
HOLISTIC CARE

Bio

psycho social approach
ASSESS CAPACITY/ MCA ADVICE

• ALWAYS ASSUME THE PATIENT HAS CAPACITY
• STEPS:

  Is the person able…

  1) to UNDERSTAND (in preferred language and with explanation) what the particular investigation, treatment or arrangements involve?
  2) to BELIEVE and RETAIN the information relevant to the decision (eg, common risks and benefits) long enough to reach a decision.
  3) to be able to WEIGH THE INFORMATION and options in the balance to ARRIVE AT THE DECISION.
  4) to COMMUNICATE the decision
CHALLENGING BEHAVIOUR / BPSD

COMMUNICATION DIFFICULTIES IN ADVANCED DEMENTIA. CONSIDER:

PHYSICAL HEALTH:
• Pain or discomfort
• Side effects of medication
• Bowels and continence
• Sleep – wake pattern
• Hunger and diet

MENTAL HEALTH:
• Depression/anxiety
• Psychosis
• Boredom/ isolation
• Poor quality environment
• Wandering
Antipsychotic drug 'stroke risk'

More people than previously thought could be at higher risk of having a stroke caused by their antipsychotic drugs, say UK scientists.

Previous research suggested only some types of the drug increased the risk, particularly for people with dementia.

Antipsychotics death risk charted in dementia patients

By James Gallagher
Health and science reporter, BBC News

Some antipsychotic medication may increase the risk of death in patients with dementia more than others, according to US research.

The drugs have a powerful sedative effect so are often used when dementia patients become agitated or agressiv
IDENTIFY PAIN

• Common and under-treated (McLachlan et al 2011)

• Pain itself can worsen cognition (Clegg and Yong, 2011)
Pain – CIPAL TOOL

The Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Name and designation of person completing the scale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>Pain relief given:</td>
<td>at</td>
</tr>
</tbody>
</table>

Q1 Vocalisation eg. whimpering, groaning, crying
Absent 0  Mild 1  Moderate 2  Severe 3

Q2 Facial expression eg. looking tense, frowning, grimacing, looking frightened
Absent 0  Mild 1  Moderate 2  Severe 3

Q3 Change in body language eg. fidgeting, rocking, guarding part of body, withdrawn
Absent 0  Mild 1  Moderate 2  Severe 3

Q4 Behavioural change eg. increased confusion, refusing to eat, alteration in usual patterns
Absent 0  Mild 1  Moderate 2  Severe 3

Q5 Physiological change eg. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or palmar
Absent 0  Mild 1  Moderate 2  Severe 3

Q6 Physical changes eg. skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0  Mild 1  Moderate 2  Severe 3

Add scores for Q1 to Q6 and record here
Total pain score

Now tick the box that matches the total pain score

0-2 No pain 3-7 Mild 8-13 Moderate 14+ Severe

Finally, tick the box which matches the type of pain

Acute  Chronic  Acute on chronic

Abby J, de Bals, A., Pilier N, Sloman A, Ellis L, Parker J, Lowery R. The Abbey Pain Scale. Funded by the A & L Croydon Medical Research Foundation 1988-1989. This document may be reproduced with this acknowledgement retained.

ASSESSMENT TOOLS

Behavioural & Psychological Symptoms (BPSD) in Dementia Care Bundle

Ward / Department

Patient label

Date and Time

Aim of care bundle: Optimisation of Dementia Care

Is there a documented diagnosis of dementia or cognitive decline?

Can this be delirium? (Short history < 1 week, hallucinations & delusions with fluctuating cognition – use CAM scoresheet and use Delirium Bundle)

Consider causes for behavioural problems
- physical pain – adequate analgesia given?
- Mental distress – psychosis/ depression – refer to Liaison Psychiatry

Consider other causes for problems – environment – noisy, bright, wandering – will side room be better?
- Hunger, thirst – feeding required?
- Activity related – washing, dressing – more

Is your friend or relative in pain?
Help us to look after the people you care about
SLEEP DISTURBANCES

- Day night reversal common in delirium
- Disrupted sleep is linked to falls, agitation and sedative misuse
- Dementia severity correlates with sleep disruption

(Bliwise, 1993, 2004; Motohashi 2000)
SLEEP MONITORING

Polysomnogram vs Actigraphy
ACTIGRAPHY READOUTS
DISCHARGE PLANNING

• MDT essential – OT/physio opinions invaluable but need to be supported by senior clinician decision maker
• Nursing Home is NOT the ‘default’ option – can the person go HOME?
• Risks such can never be eliminated, so positive risk taking
PREDICTORS OF POOR OUTCOMES

- Co-morbidity
- Nutrition
- Cognitive function
- Reduction in activities of daily living ability prior to admission
- Behavioural and psychiatric problems
- Depression

(Bradshaw, 2013)
MAP tool

Adapted from MAP tool developed by Susi Lund, Royal Berks Hospital
Psychiatric Liaison Accreditation Network

ACCREDITATION CERTIFICATE

Older People’s Mental Health Liaison Team, Royal Berkshire Hospital

has been accredited by the Royal College of Psychiatrists for the period:

17/07/2013 – 17/07/2015

M Crawford

Professor Mike Crawford
Director of the Royal College of Psychiatrists’ Centre for Quality Improvement
DEMENTIA FRIENDLY WARDS

• DoH Announced £50 million for projects to improve the environment of care for people with dementia
• Awarded just under £500,000
• Transformed 4 acute elderly care wards
• Aim to reduce number of falls and use of antipsychotic medication
Is your ward dementia friendly?

• Enhancing the Healing Environment – Kings Fund
• Toolkit
• Visits
• Empowerment Group
  – Corridors are scary and confusing
  – Hard for visitors to find a nurse
  – Noisy flooring
  – Don’t want to just sit staring at the wall.
  – Everyone laughing and joking round the nurses station, when you’d like someone to talk to you – makes you feel ignored.
Benefits

Communal activities

- Reminiscence group
- Breakfast club
- Social dining
- No bake baking
- Bake off afternoon tea
- Singing for the brain
- Card and jewellery making
- Card and dominoes
- Tea dancing
- Hand massage
- Art group
THANK YOU

References available on request

Questions/ comments: Luke.solomons@berkshire.nhs.uk