

Dementia care in the acute district general hospital

Daryl Leung and Jasdeep Todd

ABSTRACT – Morbidity and mortality for any physical illness treated in hospital and complicated by dementia is increased. Length of stay is also prolonged for any physical illness and dementia. Poor uncoordinated hospital care contributes to increased rates of nursing home admissions. Improvement in acute sector care for dementia patients should have a higher priority. Enhanced communication with patients and carers, more attention to hydration and nutrition and improved environmental factors within the hospital would be a start. All NHS staff require an increased insight and training about the consequences of physical illness complicated with dementia.

KEY WORDS: acute hospital care, dementia, physical illness

The demographic statistics for elderly patients suffering from dementia in the UK are staggering. Yet with such a high prevalence and poor recognition it outnumbers many other common diseases.^{1,2} A paradigm shift and culture change are needed to respond to the requirements of patients with dementia in the acute hospital system.³

As part of its recommendations the National Strategy for Dementia demands improved acute hospital care.⁴ The problem, however, is that we do not yet have the holistic service to deliver this demand. What constitutes excellence of care for dementia sufferers in the busy acute hospital? There are unfortunately many examples of poor if not negligent care. What approach should be adopted to address the needs of this vulnerable group presenting to all medical and surgical specialties excluding paediatrics in the acute setting?

Physical disease in patients with all stages of dementia is common. Sometimes it is coincidental, sometimes it is intrinsically linked to the relentless progression of the dementing disease. The implications for the NHS are intimidating, they include appropriate care pathways, pain relief, nutritional support and palliative care.^{5–7} The services for dementia surrounding the emergency acute admission and, as a consequence, outpatient service demands need to be addressed.

Organisational change

There are organisational and clinical pathway issues to review. For example, people who are unable to cope at home alone

because of their progressive dementia should not really be admitted to the acute hospital. In this strange environment, they are moved like pawns in a chess game. From accident and emergency units through to medical receiving rooms, medical assessment units and finally then on to an inappropriate renal ward. Here, nursing staff have no wish or desire to address the needs of a bed blocker. There must be closer links with liaison psychogeriatric teams. There should be much more thought and consideration to fostering better working relationships between the two services. More importantly the actual role of dementia coordinators needs to be defined. Even if such coordinators become common place, the dementia services available may well be inadequate to deal with the numbers involved. Appropriate follow-up arrangements in the community are vital after hospital discharge. Dementia is a long-term condition. While discharge of care back to the general practitioner is common place, who provides the growing numbers of patients with continuity of specialist follow up? There are particular issues around the time of diagnosis. Pre- and post-counselling for patients and family at this point would be beneficial.

Hospital and interior design

Improved hospital design and dementia friendly environments need to be cultured within this dementia naive organisation. The typical ward is four bays of six patients hopefully now nearly all single sex. If you put confused people with dementia or delirium in this bay with identical beds, chairs, curtains, tables and bed linen, is it surprising they climb into each others beds?⁸ There will often also be no reality reinforcements to remind the patient with dementia where they are. Dementia patients are sensitive to colour and pictures. The simplest task of making all toilet doors in the acute trust the same recognisable colour would help. Signs in words and pictures must become more important. Good colour contrast of toilet seat, floor and wall colouring can help prevent falls. Much of this is common practice in good nursing homes licensed to care for patients with dementia and behavioural disturbances. It certainly is not entrenched in the acute sector. Perhaps one area of each ward could be made more dementia friendly.

Dementia specific training for staff

There are significant gaps in the training of all staff in dementia care.⁹ In this multidisciplinary environment of nurses, doctors, middle grade managers, physiotherapists, speech therapists, social workers, technicians, cleaners, auxiliaries, porters and

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catering staff, how little understanding of the dementia patient must there be? Most will have had little or no specific training regarding the care needs of patients with dementia. Typical examples of such specialised training would include management of the confused aggressive patient, training in person-centred care, dementia care mapping and the use of personal photographs, picture albums and life histories.^{8,10,11} All these techniques are designed to improve insight and hopefully the quality of care given by the health professionals to patients with dementia.

The acute dementia ward (for physical complications of dementia)

Different types of specialty ward now exist. What would be the characteristics of a ward specifically focused on dementia patients with physical illness?^{12,13} One priority must be to acknowledge the patient then the dementia and its particular stage. In doing this everything else hopefully would fall into context. Inappropriate tablets, investigations and operations could be avoided. One specialist ward, however, will never be the whole answer. Dementia services with specialist nurses are needed. The admiral nurses trained in dementia care are similar to specialist nurses in diabetes or Parkinson's disease. They are in short supply.

The care process

Continuity of care for dementia patients is not always provided as they are not easy to identify in the acute ward. Would a special wrist band help? Should we use technology to prevent them coming to harm when they wander out of the ward? What other technology can we use to aid care? Lack of personal information from carers and nursing homes is a major concern. Getting to know what the patient is like and what they can do at the particular stage of their disease is vital. This information is needed at the front door of the hospital but often it is not obtained or provided early enough. Understanding patients and their needs can be difficult. Unfortunately few, if any, entertaining activities are available once admitted to the ward. Patients with dementia sit for days and weeks by their beds physically and mentally deteriorating and leave the hospital physically, mentally and psychologically far worse than when they arrived.

Dementia is a terminal illness. The Mental Capacity Act 2005 provides ways of supporting patients with dementia when they are at their most vulnerable. Independent mental capacity advisors are available for the unbefriended patient with dementia.¹⁴ There should be advanced planning of future care to prevent inappropriate futile antibiotics and investigations. Planned appropriate palliative care for these patients should be their entitlement.⁷

The specialty of elderly care

Many of the care needs of frail vulnerable adults have traditionally been met by wards run by geriatricians brought up on

holistic patient-centred care.¹⁵ The experience of coping with multiple pathology, polypharmacy, frailty and end-of-life care within the multidisciplinary team environment and culture needs to be re-energised back into acute medicine. The skills required to deliver this care must be disseminated into the accident and emergency rooms and medical assessment units. Fortunately many such units have physicians trained in elderly care to help facilitate this. The new specialty of acute medicine needs to acknowledge that care of the patient with dementia will be an increasing challenge to the acute sector.

Patients are lost without appropriate services in primary care to address social issues.¹⁶ Essentially personal care, carer support, respite care and adequate functioning health professional teams are required. These services and teams need to be fit for purpose and required to respond in a timely fashion. Hospital admission is all too often a reflection of delay and inadequate community services for dementia patients. Without comprehensive primary care for these patients, acute hospital care will always be too little too late.¹⁷

The national audit of dementia (care in general hospitals) will highlight the current position and how far there is to go. Things are beginning to improve. NHS West Midlands, for example, has hosted a dementia services event to select five priority areas in dementia to improve. Thankfully care in the acute hospital setting was one of these priorities.

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WORKING PARTY REPORTS

Palliative care services: meeting the needs of patients

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Palliative care deals with an area of modern medicine that raises many ethical dilemmas, both in respect of treatment decisions and the formidable obstacles in undertaking research. For

although palliative care is generally considered a ‘good thing’, it should be subject to rigorous scrutiny and justification of both process and fundamental precepts.

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Report of a Working Party

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