Introducing the New Cross Hospital Dementia Project

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This project aims to improve acute dementia care in the district general hospital, with a holistic and comprehensive design.

Acute physical illness and the care for dementia patients with delirium, falls, infections and frailty pose district general hospitals with multiple problems(1, 2, 4). Social issues and lack of resources in the community delay discharge. Neuroleptic medication too often replaces expert dementia care(3, 7). Increased morbidity, admission to twenty four hour care, loss of independence and death result: all are previously well documented.

The project was proposed by NHS West Midlands via Pauline Smith and Karim Saad.

The Chief Executive David Loughton CBE and the Director of Nursing Cheryl Etches accepted the project for New Cross Hospital, almost eighteen months ago.

Grace Hampson is the Project Manager and Daryl Leung is the Clinical Lead Geriatrician.

Lead roles taken by Professor Dawn Brooker, Head of Department of Dementia at Worcester University, and Dr Roger Resar from America, have given specific advice for Care Bundle design and implementation(5).

Aims

The Project’s aims are to improve dementia care in the acute setting. Hard end points include reduced length of stay, better quality care - as evidenced by reduced discharges to 24 hour care and improved carer and patient satisfaction survey results(1, 3) - coupled with comprehensive education for all acute staff caring for dementia patients (hostesses, porters, nurses, and doctors alike).

A whole systems approach is required as described below:

The Ward

The new ward has 20 beds for dementia and physical illness. Special features include a dining area, a relative’s bedroom, a reminiscence area from which activities will run daily and a garden. The Kings Fund provided funding for the above as well as new cubicles in our medical assessment unit(6).

Staff and Education

We have established admission criteria for the ward and will have an Outreach Dementia Service as well as an appointed Consultant Nurse.

We also have an Educational Nurse for dementia and are running training programmes for all hospital staff including training our Elderly Care Nurses specifically in dementia care, our Care Bundle and an “About Me” document. Other key components are our trained volunteers, Physiotherapists, Occupational Therapists and Psychogeriatric Liaison Team.
Patient Pathway

This involves work before, during and after admission. We have been in close liaison with Primary Care, General Practitioners and Social Services to achieve this. We have looked particularly at facilitating discharge, including rehabilitation facilities for dementia patients (at present there are none in Wolverhampton).

Audit and Evaluation

A point prevalence study of dementia throughout the hospital has been done and we, like most hospitals, have been involved in the National Audit in Dementia. We are currently auditing the use of neuroleptic medication across the Trust.

There is external evaluation of the project from an economic and patient perspective by Professor Dominic Upton, Worcester University. This whole system is backed by a new database and new IT facilities.

There are two parts of the pathway we would particularly like to highlight; namely the Care Bundle and the “About Me” document.

The Care Bundle

Our Care Bundle was devised with the help of Professor Dawn Brooker from Worcester Department of Dementia Studies and Dr Roger Resar from the States(5). It requires regular and repeated focus of three main facets; (1) enhanced communication through the “About Me” and “Reach Out” documents, (2) hydration and nutrition and (3) concentration on the appropriate environment.

The Purpose of the “About Me” Document

The “About Me” document is designed to gain a deeper understanding of the patient. It helps tailor a nurse care plan to the individual needs of the dementia patient in the acute hospital setting.

If we don’t understand our patients how can we address their needs and fears.

Project Culture

The whole project is a work in progress. The learning curve for all involved has been a steep but exciting process.

Due Credit

Thanks are owed to so many people including Pauline Smith & Karim Saad from NHS West Midlands. Grace Hampson our Project Lead and everyone at New Cross Hospital (especially David Loughton CBE CEO and Cheryl Etches Director of Nursing).

Thanks are also due to Matron Karen Bowley, Sister Rose Mathewson, John Homer our Carer’s Representative and Lynn Fieldhouse Lead for Trust Education.

References


NICE Guidance on Alzheimer’s Drugs: Consultation Paper & Evaluation Report

The National Institute for Health and Clinical Excellence (NICE) is reviewing its guidance on the use of donepezil, galantamine, rivastigmine and memantine in the NHS in England and Wales. If approved, this guidance will rule that three drugs, (Aricept, Exelon and Reminyl) which cost only £2.80 per person per day, are cost-effective and should be available on prescription for the treatment of the early and moderate stages of Alzheimer’s disease.

Donepezil, galantamine and rivastigmine usually help people enjoy a better day-to-day functioning and quality of life, by improving memory, concentration and attention span at all stages of Alzheimer’s disease.

A fourth drug, named Ebixa, may be made available to people in the moderate to late stages.

A consultation paper summarises the evidence and sets out the draft recommendations.

Antipsychotics and Risk of Venous Thromboembolism

Use of antipsychotics, often off licence, increases morbidity and mortality for dementia patients. Such misuse is observed both in primary care with ad hoc prescription by general practitioners and in the acute sector where behavioural and psychological symptoms of dementia (BPSD) are problematic.

Venous thromboembolic risk is a national concern, as is better care for patients suffering from dementia in any setting.

Problems arising from the misuse of antipsychotics are numerous. They include falls and fractures resulting from drug induced parkinsonism, dehydration due to excessive sedation, aspiration pneumonia, orthostatic hypotension, thromboembolism (leg, lung and brain) and arrhythmias.

Hypersensitivity in Lewy Body dementia is also a matter of concern, especially given that antipsychotics are regularly used in end of life care for dementia syndrome with no specific dementia categorisation.

Better education of all staff in dementia care is vital.

Prescription of antipsychotics should be preceded by documented alternative non-pharmacological interventions.

Careful review and follow-up of these patients and their prescriptions should be mandatory.

Reference:


Readers may also wish to refer to the 2009 document: ‘Report on the prescribing of anti-psychotic drugs to people with dementia: time for action’
Doctors Told to Cut Anti-Psychotic Drugs for Dementia

The Care Services Minister, Paul Burstow, has informed doctors that use of anti-psychotic drugs for dementia patients must be cut by two-thirds by November 2011. These drugs are prescribed "off label" for dementia patients because of their strong sedative effects. Doctors over-rely on them to deal with the behavioural symptoms of dementia patients.

Mr. Burstow commented that the evidence for cutting the use drugs to control aggressive behaviour is clear. They are supposed to be used as a last resort and only prescribed for short periods and one at a time. The government currently spends more than £80m on anti-psychotic drugs for dementia patients per year. It spends £8.2bn overall in the treatment of dementia.

Full Text Link
Reference:

Adverse Events from Antipsychotics in Elderly People with Dementia: a Systematic Review

This systematic review reinforces the view that there is a need for better reporting of harms in randomised controlled trials of antipsychotics for the behavioural and psychological symptoms of dementia.

Full Text Link
Reference: 

End of Life Care for People with Dementia

This guide provides professionals working in health and social care / allied professions with links to information and resources about good practice in end of life care (EoLC) for people with dementia.

The importance of good end of life care for people with dementia is discussed, in the context of phases in the end of life care pathway, namely (1) discussions as the end of life approaches, (2) assessment, care planning and review, (3) co-ordination of care, (4) delivery of high quality care in a range of settings, (5) care in the last days of life and (6) care after death.

There are sections relating to putting end of life care into practice; end of life care tools; commissioning end of life care for people with dementia; care settings; support for carers; education and training of the workforce; research and evaluation; and example case studies.

Full Text Link
Reference: 
Care towards the end of life for people with dementia: a resource guide. NHS National End of Life Care Programme, 26th October 2010.
Nothing Ventured, Nothing Gained: Risk Guidance for People with Dementia

“Nothing ventured, nothing gained” gives guidance on best practice in assessing, managing and enabling risk for people with dementia. It is based on evidence and person-centred practice.

This document fits philosophically into the context of the “Living Well With Dementia: a National Dementia Strategy” and the “Putting People First” reports.

The guidance is aimed at commissioners and providers in health and care across all sectors, but would be of interest to everyone involved in supporting persons with dementia. It advises people to take a proportionate, measured and “enabling” approach to risk.

The “personalisation” of services and care is about positioning choice, control and independence with the individual.

This guidance is aimed at people involved in all aspects of supporting people with dementia using health and care services (including housing support) within any setting. The setting may include sufferer’s own home, in the community or in a care home, in primary care or in hospital, and in the public, independent or third sectors.

Section A: Summary provides a summary of the key issues relating to risk enablement and risk management.

Section B: Risk Enablement Evidence Review reviews the evidence on risk and dementia.

Section C: Risk Enablement Framework offers a framework for assessing and managing the risks faced by people with dementia. The framework could be used to assess each individual’s risks in many areas and might also supply the framework for the assessment and management of specific risk issues and “risky” behaviour.

Readers are advised to familiarise themselves with the evidence supplied in Section B before going on to use the framework in Section C.

Depression in Older People Linked with Higher Risk of Developing Dementia

Depression appears to be associated with an increased risk of dementia in older people.

Almost 1000 older adults (average age 79 years; 63.6% women) were included in the Framingham Heart Study, between 1990–2008.

This study shows that depression is associated with a more than 50% increase in risk for dementia, and the risk increases with the severity of depression. The analysis takes into account other factors such as age, gender, education, homocysteine levels and APOE e4 genotype.

While there is no evidence at the moment that treating early and midlife depression would reduce the incidence of dementia, depression is itself disabling and must be treated.

The article adds to previous evidence concerning this risk association, because it spans a follow-up period of 17 years.
A Test for Susceptibility to Alzheimer’s Disease

A test might be available soon to indicate which people in their 40s are more likely to develop dementia later in life.

This article explores the dilemma of whether it is better to know in advance about one’s proneness to such a devastating, heart-breaking, life-shattering condition. There is also the danger that this information could be misused by insurers and other organisations to discriminate against such people.

Scientists at Brunel University have developed the test. It does not offer an absolutely certain prediction that the patient will develop (or be free from) dementia, but it allows persons displaying the indicators - small areas of damage in the brain - to receive early treatment and begin to adapt their lifestyles.

This test has the potential to improve the long-term condition of thousands of people, providing suitable support and counselling is available.

The Alzheimer’s Society comments that the present low rate of diagnosis for dementia is attributable not just to patients not wishing to confront their condition, but also to lack of awareness and specialist training for GPs.

Full Text Link
Reference:

National Dementia Strategy for Scotland

Dementia is a national priority for the Scottish administration, and the strategy outlined in this document reflects the importance of this agenda. It reinforces significant work already underway in Scotland in key areas including early diagnosis, improving care pathways, and public awareness.

The Scottish National Dementia Strategy runs broadly in parallel with the National Dementia Strategy for England, featured in earlier issues of this newsletter.

It will be of interest in that it shows how Scotland aims to transform its dementia services, in particular by ensuring all staff who provide care and support are skilled and knowledgeable about dementia.

Other priorities include significantly improving care pathways and improving integration of health and social care services (including better information sharing). Earlier diagnosis and higher rates of diagnosis of dementia are recognized to be important, as is working to reduce the use of psychoactive drugs.

This report includes sections on:

- The rights of people with dementia and their carers.
- Key challenges.
- Preparatory changes to deliver world-class dementia care and treatment.
- Actions to support the change programme.
- An outline scheme for monitoring the implementation of the strategy.

Full Text Link
Reference:

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