Dementia Patients and Hospital Discharge: Mind the Gap

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Introduction
Acute sector care for patients with physical illness and dementia has been criticised as too often poor and lacking an empathic understanding by NHS staff. Specialist acute hospital wards of today run at a fast pace. Pathways and protocols force early discharge back into the community. This process is driven by the rising cost of such care and the chances of hospital acquired infections or other patient harm. Dementia patients in acute hospitals have a higher rate of mortality, increased morbidity and a higher chance of going into supervised twenty-four hour care.

Progress Since 2008
An influential West Midlands SHA report, written in 2008, identified a worrying lack of access to dementia services, lack of continuity between services and service providers, inconsistencies between funding sources during the disease journey and a lack of advanced care planning. Less than perfect coordination between NHS and social services remains an issue today.

Real progress may indeed have been achieved in some areas since 2008, of which we should all be justifiably proud, but concerns do remain and there is scope for further improvement. Discharge decisions concerning home alone with a package of care, or residential or nursing home placements are relatively easy in principle but commonly hit barriers in practice. Saad’s 2008 diagnosis of there being an inadequate over-arching co-ordination of services for dementia sufferers across the patient pathway applies today, particularly in regard to hospital discharge.

Discharge In Practice
Continuing healthcare assessments, both for physical and mental health, coupled with seemingly lengthy delays in response can be frustrating at best. A home alone care package, involving two carers four times a day, may take weeks to arrange and agree financially. Intermediate brokerage agencies may be involved between Social Services and private home care providers. Progress may be complicated by occupational home visits, waits for special beds and hoists, installation of telecare devices etc. Improved coordination in the planning of these necessary components could usher in the delivery of a more speedy, higher quality, safer, personalised and more effective service.

Choice?
Discharge to private twenty four hour care is no less complex. Elderly Mental Health homes, with special registration to care for dementia and challenging behaviour, are in short supply. The good ones are, not surprisingly, full; making the “choice” of care facilities slim and delays to hospital discharge unfortunately common and protracted. The patient may be left waiting for weeks, sitting in a chair, blocking an NHS bed, deteriorating. An adverse event waiting to happen... The New Cross Hospital Dementia
Dementia Patients and Hospital Discharge: Mind the Gap (continued)

Project has achieved much in identifying and ameliorating some of the underlying risks within the acute setting, but it must be remembered that the hospital is only one link in the chain.

Step Down
So called “Step Down” beds, purchased by the hospital to move “bed blockers” out of acute care are not necessarily helpful for patients with dementia. They are purchased by the hospital out of frustration with lengthy delayed discharge processes. They present a financial saving to the hospital, because one week in a residential home costs the taxpayer little more than one day in an acute hospital bed.

Too Many Unintended Consequences
Once in these beds, however, arguments may ensue as to ownership of the patient. Following such moves, the general practitioner may effectively disown patients. The Acute sector says it’s not their problem, Social Services say they are under-resourced and lack the capacity to respond in a timely fashion.

Vulnerable adults may end up being bounced about in the system, causing confusion and unnecessary issues for people with dementia and their carers. Discharged from hospital they may be appointed to a new social worker who might not know them.

Dementia Pathway Coordination?
Where is the all-important psychogeriatric liaison? Where is the joined up care, the leadership, the Dementia Pathway Coordination? Our attitude as a society to frail and vulnerable older patients may be the problem. These problems could be fixed.

Building a Better Future...
We are proud to celebrate innovative developments in dementia care on the part of the New Cross Hospital, Wolverhampton City Council and Wolverhampton City Primary Care Trust (and of charitable and voluntary organisations such as the Alzheimer’s Society’s Wolverhampton Branch). These initiatives might be strengthened further by facing up to the need for a more cohesive, seamless and pro-active strategic approach to hospital discharge for dementia patients.

References:

"Dementia services straddle Mental Health Services and Older People services alongside Primary Care, Social Care, Acute Care, Care Homes, and the Independent, Charity and Voluntary sectors. Funding sources vary and there is no overarching coordination of services for dementia sufferers across their disease journey." (Saad, 2008)
Alistair Burns, National Clinical Director for Dementia, has written a letter notifying PCT Medical Directors of the proposed data collection exercise starting in May 2011, on the establishment of memory services. This initiative is part of a National Audit of Dementia Services being undertaken by the NHS Information Centre for the Department of Health. The NHS Operating Framework 2011/12 states that people with dementia and their carers need information to help them to understand the range and quality of local services. There is a NICE Commissioning Guide. NHS organisations are expected to make progress on the National Dementia Strategy, including the priority areas stated in the implementation plan published in September 2010. £150 million was made available to PCTs in the first two years (£60 million in 2009/10 and £90 million in 2010/11) to implement the National Dementia Strategy, without a ‘ring-fence’ on the funding. The National Audit Office, in its review of services for people with dementia, has been consistently critical of the lack of data to monitor progress in developing such services. Implementation of the National Dementia Strategy, and appropriate use of the funding, are issues of great interest to Ministers, Parliament and the public. As there is a lack of data on dementia services, the Strategy includes a commitment to establish national baseline measures of these services. The expiry date for this particular data collection is April 26th 2012. The questions for PCTs to answer will involve:

- Does your PCT currently provide memory assessment services?
- How much was spent by your PCT on memory assessment services during 2008/09 and 2009/10?
- Can you clarify the range of services provided by the memory assessment services?
- Are the memory services accredited by the Royal College of Psychiatrists?

Reference:

The collection of data on memory services will enable local organisations to monitor progress in this area and allow local populations to hold health authorities accountable for progress.

NICE–SCIE Guideline on Supporting People with Dementia and Their Carers in Health and Social Care

The review and re-appraisal of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer’s disease has changed parts of the 2006 guideline. Specifically:

- Donepezil, Galantamine and Rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer’s disease, and
- Memantine is now recommended as an option for managing moderate Alzheimer’s disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer’s disease.

See pages 31–33 for the updated information.

Reference:

This NICE guideline has been amended to reflect the updated NICE technology appraisal of drugs for Alzheimer’s disease, published in March 2011 (NICE technology appraisal of drugs for Alzheimer’s disease).
A new way of delivering drugs to the brain uses the body’s own “transporters”, called exosomes. Exosomes might be the basis of future nanoscale drug delivery systems.

Community Support Services: Specialist or Generic Domiciliary Care Services?

This report was commissioned by the Department of Health in support of the National Dementia Strategy (Objective 6). It adds to the evidence base for effective community support services for people with dementia. It covers the economic and individual outcomes for the efficacy of different models of community support to persons with dementia. In particular, it assists in decisions concerning whether it is more cost-effective to provide specialist or generic domiciliary care services for people with dementia.

This research presents evidence collected through multiple approaches: a literature review of existing models (UK based); re-analysis of existing Personal Social Services Research Unit (PSSRU) studies; consultation with carers; a survey of local authority arrangements; plus a national data set analysis of associations between patterns of commissioning / care provision and rates of admission to care homes.

The final chapter draws together the information into guidance for commissioners and discusses the findings under five main headings: quality, intensity, service mix, service linkages, and costs and effectiveness.

Exosomes: a Breakthrough in Delivering Gene Therapy to the Brain

In a study using mice, exosomes have been used to cross the blood-brain barrier. Researchers harvested exosomes from mouse dendritic cells, and then fused these exosomes with targeting proteins so that the exosomes would target the brain.

The exosomes were filled with a piece of genetic code, siRNA, and injected into mice. The siRNA was delivered to the brain cells and “turned off” a gene, BACE1, which is involved in Alzheimer’s disease. There was no immune response to these modified cells.

This method could be modified to treat various conditions and can be made specific by changing the drug delivered. The team hopes to begin trials on humans in five years.

Note: This is still early research and the approach has not been tested in human cells. There are several genes associated with Alzheimer’s Disease so it is unclear whether switching off the activity of one of them would yield benefits. More research is needed. There are technical and ethical issues associated with gene therapy in humans.

Full Text Link (a)


Full Text Link (b)

Main Reference:
The mhGAP Evidence Resource Centre: Dementia (WHO)

The WHO’s mental health Gap Action Programme (mhGAP), provides simple protocols and flowcharts which offer guidance about diagnosis and the psychosocial interventions available (including those for caregivers).

The mhGAP Evidence Resource Centre supplies process documents, evidence profiles and recommendations in electronic format. It provides easy access to evidence-based clinical and non-clinical information for people involved in health and social care internationally, to assist them in making decisions about policy, planning, and in the management of individual patients. These evidence-based recommendations and resources include:

- **Role of Acetylcholinesterase inhibitors.**
- **Role of Memantine.**
- **Conventional and atypical antipsychotics and antidepressant (Trazodone) for behavioural and psychological symptoms in people with dementia.**
- **Role of antidepressants in people with dementia and associated depression.**
- **Cognitive and psychosocial interventions.**
- **Diagnosis of dementia.**
- **How to deliver the diagnosis of dementia.**
- **Role of a medical review.**
- **Interventions for carers of people with dementia.**
- **Respite care for carers of people with dementia.**

Full Text Link
Reference:

Brain Scans Detect Risk of Alzheimer’s Disease

MRI brain scans may indicate potential Alzheimer’s Disease years before symptoms appear, according to results from a small study on sixty-five patients published in Neurology. Parts of some patients’ brains show signs of shrinkage up to a decade before Alzheimer’s becomes evident as a symptomatic disease. Click here to view the PubMed abstract.

The regions of the brain showing thinning in Alzheimer’s Disease are the medial temporal lobe, the temporal pole and the superior frontal gyrus. This cohort study showed that 55% of those with low thickness within the Alzheimer’s Disease “signature regions” developed the disease, compared with 20% of those with average thickness and none of those with high thickness. A reduction of one standard deviation in the thickness of the Alzheimer’s Disease signature areas of cortex was associated with a 3.4 times greater risk of developing Alzheimer’s during follow-up.

Changes associated with Alzheimer’s disease begin years before symptoms appear. Alzheimer’s Research UK thinks there is strong evidence that the disease starts to develop in mid-life.

This small study needs to be expanded and confirmed in order to determine the accuracy of this method for predicting Alzheimer’s Disease.

Full Text Link (a)
Reference:
Brain scans may detect future Alzheimer’s. London: NHS Choices, April 14th 2011.

Full Text Link (b)
Reference:

Earlier diagnosis may help in developing more effective treatments in future. One in 14 people over the age of 65 in the UK has Alzheimer’s Disease.
Overweight People More Likely to Develop Dementia

Previous research has indicated a link between obesity and the risk of dementia. This study of 8,534 of Swedish twins suggests that simply being overweight is a risk factor too. Middle aged people who are overweight (but not obese) appear to be 71% more likely to develop dementia than people of normal weight. People with a body mass index (BMI) greater than 30, i.e. who are classified as obese, are 288% more likely to develop dementia than those with a BMI between 20 and 25, according to this study. The clinically overweight, with a BMI between 25 and 30, are 71% more likely to get dementia. Approximately 1.6 billion adults worldwide are overweight. Eating healthily and exercising regularly should help reduce the risk of developing dementia.

**References:**


### Drug Discovery Programme

A new translational research project has been designed to identify powerful Alzheimer’s treatments within the next 10 years. Therapies already in use for other conditions will be tested to monitor their effectiveness in tackling dementia. The successful treatments could then be adapted quickly. Six drugs are being “fast-tracked” for study. As these drugs are already available they should be cheaper and quicker to translate into dementia treatments. Of the six drug candidates, the three most promising candidates will be tested on people with dementia in full clinical trials.

**Reference:**

### Genes Involved in Late-Onset Alzheimer's Disease

Five more genes which increase the risk of developing late-onset Alzheimer’s Disease have been identified, taking the number of identified genes linked to Alzheimer’s to 10. The disease is thought to be up to 80% genetic. If the effects of all 10 genes could be eliminated then the risk of developing the disease might be cut by 60%.

The new genes affect three bodily processes and could become targets for treatment in future. New treatments could be 10 to 15 years away. Three processes involved are: (1) the way fat and cholesterol are processed; (2) the mechanism by which brain cells process large molecules (endocytosis); and (3) the immune system.

**Reference:**


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*Immune system genes:* CLU, CRI, ABCA7, CD33 and EPHA1.

*Fat processing genes:* APOE, CLU and ABCA7.

*Cell membrane genes:* PICALM, BIN1, CD33 and CD2AP.*