Connolly Hospital Dementia Pathways Project

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Overview

* Background to the project
* Overview of the project
* Dementia Nurse Specialist Role
46.8 million living with dementia worldwide
151 million by 2050
7.7 million new cases per year
604 billion US Dollars per annum in 2010
1 Trillion US Dollars in US alone in 2050
(Alzheimer’s Disease International 2015)
49,000 living with dementia
150,000 by 2046
4,000 young onset dementia
29% of all admissions to acute hospitals
40,500 euro per person per annum
21 Million euro- acute care provision
807 million- informal care

(Department of Health 2014)
Context

- World Health Organisation (2012)- Dementia- Public Health Priority
- First National Audit of Dementia Care in Acute Hospitals 2013- Poorer outcomes for people with dementia in acute settings
- Irish National Dementia Strategy 2014- set out guidelines for dementia care in Ireland
Connolly Hospital Dementia Pathways Project - key points

* Develop integrated pathways for people with dementia availing of acute services
* Create opportunities for appropriate acute hospital avoidance through key nursing roles (Dementia In reach - Outreach)
* Drive cultural change through educational initiatives
* Deliver person centred dementia care- dementia care bundle
* Develop partnerships to improve care and outcomes
Baseline data was collected on each area of the project.

Ward audit, environment audit, chart review, interviews, focus groups, knowledge and awareness survey.
Clinical audit that details sequence of steps between two points - admission and discharge

- Involved chart review (10), observation (5),
- Important to know where we were at before we proceeded
Emphasis on task orientated care

Variations in care given, assessments carried out-dependent on ward, team

Little emphasis on person centred communication- all SALT assessments were swallow assessments, communication rarely mentioned

Poor evidence- behaviour support- identifying triggers

Poor evidence- pain assessment- end of life care planning or meaningful day, maintenance of independence
Activities developed under 4 headings

- integration
- Person centred care
- Education
- Environment
Consortium model

* All activities driven and overseen by a consortium of key stakeholders from hospital and community
* PwD and carer involvement at each stage - meaningful engagement
* Sub groups for each key element of the project
Person Centred Care

- Dementia care bundle
  - “getting to know me” tool: Pt council, Alzheimer’s cafe
  - Individualised communication: skilled, responsive workforce: role modeling, education
  - Nutrition and hydration
  - Safe and orientating environment
  - Pain assessment

(Upton et al 2012, Brooker et al 2013)
Areas identified for dementia friendly design
Sub group identified three key areas of interest
1. Flexibility/adaptability- to needs of PwD, activities
2. Orientation- signage, personalised bedsides
3. Sensory experience- colour, sound, scent

Tenders sent out for key area in Medicine for the Elderly Ward.
Integration

- Links and referral pathways developed / under development with primary care teams/public health nurses/ community mental health teams
- Development of Memory Assessment and Support Clinic
- Development of standard operation procedures, policies, assessment/review forms to support the nursing roles- DNS, Community Link PHN- in conjunction with Nurse practice development
Five competencies for CNS role

1. Clinical
2. Advocacy
3. Education
4. Research and audit
5. Consultancy
Referrals:

- Inpatient/Holly- referral system/criteria developed-MFTE
- New referral pathway to MAS clinic through OT/MSW for inpatients
- Cappagh- through MFTE
- GP/ PCT currently being developed in Dublin 15
Clinical contd.

- MAS clinic assessments - 86
- Nurse led MAS assessment clinic in development - 7 to date
- Inpatient/Holly assessments - 109
- Family meetings/support (phone/ face to face) - 384-developing virtual clinic
- Follow up activities - 269
- Nursing home support - 6
- Getting to know me document - 29
- Inpatient reviews - 184
Clinical contd.

- Assessment and management of distressed/Responsive behaviours- New behaviour charts introduced, fact sheets developed, informal and formal education- 56
- DNS assessment forms/documentation developed in conjunction with nurse practice development department
Process mapping - Memory assessment and support clinic (MAS)

- Chart review
- Informal conversations with PwD and families
MAS- Process mapping

- Seen in assessment clinic, Reviewed in different clinic
- No written information given
- DNA- letter sent to GP- little follow up, no calls prior to appointments
- No formal post diagnostic dementia specific supports
MAS clinic

* Day 1- Assessment, ACE R, MOCA, MMSE, IQCODE, IADLS, BARTHEL, Collateral History, blood tests, neuroimaging (ordering). Written information of next steps given. May involve home visit.
* Consensus meeting
* Day 2- Feedback with Consultant, Reg, DNS. Written information and contact numbers given. Next steps/supports planned with PwD and family
Follow up support

- DNS point of contact - PwD and families
- Referrals made to Primary care teams, PHNs, ASI
- Follow up phone calls between visits or as necessary (Virtual Clinic)
- Information leaflets, links to further information
Advocacy

- Be a point of contact for PwD and their families
- Promotion of person centred care
- “Getting to know me” document
- Informal education for staff, communication
Research/Audit

- TCD evaluation
- Research- Qualitative study into the experiences of staff and families using personal passports to support dementia care in the acute hospital
- Ongoing evaluation of each element of the project
- Process mapping
Consultancy

- Provide advice and support for staff caring for people with dementia
  - Pain management
  - General wellbeing, maintenance of independence
  - Management of distressed/responsive behaviours
  - Communication techniques
  - Eating and drinking
  - Dependent on need at the time
Dementia champions - 13

Two day elevator dementia education - 59

Four hour elevator acute care programme - 25

One hour dementia awareness education session - 72

Whiteboard micro education sessions 84 / Nursing skills fair 38 / Informal education - ongoing
Fact sheets developed as part of whiteboard sessions
* MDT involvement
* Each education session is evaluated and feedback used to inform subsequent education sessions
* Resource packs for each ward under development
* 75 year old lady referred by GP
* Hx: CVA 20 years ago, had gallbladder removed recently but unable to recall, anxiety, depression
* mmse- 15/30, moca 11/30
* Lives alone, no family, one good friend
* Deterioration in ability to self care- reported by friend
* Had 2-3 car accidents- still driving
Case study contd.

* Hiding purses- lost 800 euro
* Friend unsure how to support her
* Lady wanted to remain as independent as possible and reluctant to admit anything wrong
* Not taking medications correctly/at all
* Full assessment completed and neuroimaging ordered- pt and friend supported with reminders for ctb and blood tests follow up
* Home help arranged, initially reluctant to accept same
* PHN contacted and home visit completed
* Pharmacy contacted re blister packing medication and PHN aware of difficulties- friend relates medications are now being taken
* Referral to community mental health services and day centre. Initially refused.
* DNS follow up phone calls to pt and friend
Case study contd

* Not driving and keys given to friend
* Advice ongoing re future planning
* Regular reviews in the MAS clinic with the same team
* Her friend and PHN reports that she is doing well
Case study 2

* 71 year old gentleman, retired Garda, referred by GP
* Medical History: Mixed Alzheimer’s and Vascular dementia (2012), Osteoarthritis
* MOCA 5/30 (2014), aphasia predominant feature, needs assistance with all ADLs
* Attending the memory support clinic since 2014
* Lives with his wife, two adult children- wife main carer
Case study 2 contd.

* Attends day centre 5 days per week, HCP (2015), availing of respite
* LTC options discussed as had become increasingly difficult to manage at home- reluctant to avail of same – continued to support
* Easter 2016- on holiday became increasingly aggressive, paranoid, unpredictable- possible physical causes ruled out by GP on holiday
Case study 2- contd.

* Went directly into prearranged respite- failed due to unmanageable behaviour
* Wife made contact with DNS (Friday)
* Links made with GP, respite provider, discussion with consultant
* Appointment given to review clinic (Monday)
* Medication reviewed, commenced on Risperidone 0.5 mgs then 1mg, discussion re non pharmacological interventions.
Case study 2 - contd.

- Referral made to Psychiatry of Old Age
- Community Dementia Liaison Nurse - Home Visit
- Further respite arranged and was successful
- Gentleman much calmer and his wife is better able to cope
- Continued links with DNS and Team
- Continuing conversations re future planning
Conclusion

* A lot done, a lot more to do
How to eat an elephant is in small pieces