Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Dementia Strategy 2013 - 2017

Looking *forward* to *our* **future**

‘Who can say whether we shall ever see them again?’ said Morrel with tearful eyes. ‘Darling,’ replied Valentine, ‘Has not the count just told us that all human wisdom is summed up in two words? – ‘Wait and hope.’’

Alexander Dumas
The Count of Monte Christo

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2. INTRODUCTION

2.1. Executive Summary

Outlined below is the new dementia strategy for Doncaster and Bassetlaw NHS Foundation Trust. The strategy covers all aspects of care for patients living with dementia during their interactions with the Acute Trust, whether inpatient or outpatient.

The increasing number of people living with dementia is a challenge to all health and social care organisations in our society. This document highlights low-cost and effective strategies that can be utilised to improve the quality of care and reduce harm.

This strategy is an outline of the care that all patients will receive. Once we are able to provide sound and consistent care to patients with dementia, all of the patients we care for will benefit directly or indirectly by finding themselves in a more holistic, person-centred environment.

By working towards the models of excellence detailed below across our wards and clinics, we will improve quality of care for patients and improve the working environment and experience for our staff.

2.2. Where Are We In 2014?

Doncaster & Bassetlaw Hospitals NHS Foundation Trust has developed many systems to improve the care of those living with dementia and delirium in both inpatient and outpatient settings.

In 2011 following an unannounced dignity and nutrition inspection visit from the Care Quality Commission, we passed both standards.

The care quality indicators (CQUINNs), both local and national have significantly stimulated improvement in the quality of care for inpatients with dementia. We have improved the level and quality of communication with patients and relatives in relation to their care, diagnosis and treatment as well as discharge arrangements. In 2012, with the introduction of the dementia screening CQUINN we developed a trust-wide questionnaire for the assessment of all people over the age of 75 admitted acutely to our Trust.

From 2011, we have worked closely with Rotherham, Doncaster and South Humber Mental Health Foundation Trust (RDaSH) and NHS Doncaster (now Doncaster Clinical Commissioning Group) to facilitate the growth and development of an enhanced Older Peoples' Mental Health Liaison Team. Through assessment, caring, training and education these staff have significantly improved the quality of care patients with dementia, delirium and depression receive on our wards.

In January 2013, with the opening of Mallard ward, part of the Gresley Unit at Doncaster Royal Infirmary, we are running the first specialist delirium unit in South Yorkshire.

2.3. Where We Want To Be In 2017?

There is still much to achieve.

This strategy document has many challenging recommendations that will be difficult to achieve without significant change to working practices across our Trust and the health and social care community as a whole.

1. Adapting all environments to support people with dementia, expediting investigation and discharge and raising the standard of care we provide on all our wards, not just those focusing on the care of older people will be difficult.

2. We want to achieve consistent and collaborative working with acute, community and social care to provide the highest standards of care, no matter the location, the time of day or week or the staff involved.
3. We want to ensure we provide the very best treatment and care and when cure is no longer an option, we provide timely and sensitive palliation.
4. We want our Trust to stand at the forefront of delivery of excellent care for people living with dementia. We want to see reductions in length of stay and readmissions, a reduction in adverse events such as falls and pressure injuries, individual empowerment and patient satisfaction.
5. We want our Trust to share its learning with other local Trusts to improve standards across all of Yorkshire and the Humber.

2.4. How Will We Measure Success?

We will know that we have achieved the standards of this strategy by using transparent performance indicators that we will share with our patients, our staff, commissioners and the public.

The measures below do not exclusively relate to the experiences of those living with dementia or their carers. In most situations, patients with dementia, experience a disproportionate level of harm from adverse events such as falls, pressure ulcers and hospital acquired infection.

Success of this strategy will be indicated by:

- Reduction in the proportion of people entering long-term care
- Reduction in number of inappropriate admissions for people with dementia
- Reduction in the numbers of readmissions
- Reduction in inpatient falls and hip fractures
- Reduction in numbers of people with dementia dying in the acute trust
- Shorter length of stay for those diagnosed with dementia
- Fewer cases of Clostridium difficile diarrhoea
- Reduced numbers of anti-psychotic prescriptions
- Increased understanding of dementia across all trust staff
- Increased research relating to dementia and delirium
- Reduction in complaints and concerns about care
- Improved experiences for patients and carers
- Improved experiences for staff.

3. DIAGNOSIS & ASSESSMENT

3.1. Person Centred Care

All patients with dementia will receive Person Centred Care, regardless of the department, ward or location. Person Centred Care places the needs and desires of the patient central to all clinical encounters. Every test, investigation or treatment must be assessed considering the overall cost and benefit to the patient within the context of their disease, their desires, beliefs and attitudes, in collaboration with members of the multi-disciplinary team, family and carers.

3.2. This is Me

All patients with dementia will have access to 'This Is Me' (or equivalent) produced by the Alzheimer's Society. This will help families communicate important information to hospital staff and allow hospital staff to better understand the needs of their patients.

3.3. Diagnosis of Dementia in Acute Trust and Community

Approximately 44% of people living with dementia in Doncaster receive no diagnosis or are diagnosed late in their disease. There is good evidence that suggests the earlier a person is diagnosed with dementia, the better the outcome. Receiving a diagnosis is the right of every person living with the condition.

In the Trust, as part of our screening questionnaire, we use the question, 'Have you noticed that you have been more forgetful in the past year?' If the answer to this question is positive, a further assessment is undertaken. A referral to the local memory services, if appropriate, is undertaken prior to discharge.

The responsibility for diagnosis and screening for dementia rests with every member of the multi-disciplinary team providing inpatient care.

3.4. Delirium Units at DRI and BDGH

The care of patients with significant or advanced dementia is a specialist area. Patients with significant dementia deserve care from staff who have undergone adequate training and who are resourced to provide this care. Although up to 40% of inpatient beds are occupied by patients with dementia, the numbers of patients with more significant symptoms such as agitation, wandering and severe anxiety are smaller. All patients requiring specialist inpatient care will be nursed in an appropriate unit.

The first delirium and dementia unit opened at Doncaster Royal Infirmary in January. The unit provides daily consultant review and multidisciplinary care for those experiencing delirium and significant dementia.
We are working with the Trust executive and other Clinical Service Units to develop a similar facility in Bassetlaw Hospital.

3.5. Patients with Dementia not on Specialist Unit

Most patients diagnosed with dementia will not be managed on a specialist unit.

Appropriate assessments must be undertaken by clinical staff to decide the best location for patients during their inpatient stay.

Patients with dementia will not be admitted to outlying wards.

Patients will not encounter repeated bed moves during their inpatient stay. Moves within a ward should be minimised also.

In line with national best-practice guidelines, a member of the Older Peoples' Mental Health (OPMH) service will assess every patient with dementia admitted to the Acute Trust as soon after admission as possible.

3.6. Comprehensive Geriatric Assessment

All patients with dementia will undergo a Comprehensive Geriatric Assessment (CGA) – a multi-factorial, multi-disciplinary assessment of needs undertaken by Geriatricians in collaboration with nursing, physiotherapy, occupational therapy and other support staff, addressing mobility, pain, cognition, falls risk, continence, polypharmacy, mood and social environment.

Currently, there is no provision for review by geriatricians in Bassetlaw Hospital, we are working with Trust executives and other Clinical Service Units to develop this facility through the expansion of consultant numbers and development of the multi-disciplinary service for older people in Bassetlaw.

3.7. Collaboration

The care of patients with dementia demands the cooperation of different health-care sectors working together seamlessly.

- Rotherham, Doncaster and South Humber Community Mental Health Trust
- Nottinghamshire Healthcare NHS Trust
- Doncaster Clinical Commissioning Group
- Bassetlaw Clinical Commissioning Group
- Doncaster Metropolitan Borough Council
- General Practice
- Voluntary Sector
- Education Sector
- Sheffield University Medical School
- Sheffield University
- Sheffield Hallam University
- Yorkshire and Humber Deanery
- Health Education England – Yorkshire and Humber Local Education and Training Board
- Private Sector.

3.8. Older Peoples Mental Health Liaison Service

Our services in Doncaster and Bassetlaw are the most developed in Yorkshire, with more assessments of older patients with dementia than any other Acute Trust in the region. The collaborative work between DBH, RDaSH, Nottinghamshire Healthcare NHS Trust and NHS Bassetlaw and NHS Doncaster (Clinical Commissioning Groups) has created a dynamic service that responds to the needs of patients with dementia, improving training and education, minimising length of stay and reducing patient harm.

An independent evaluation of the service by ARC Research, Sheffield, published in December 2012 revealed a significant reduction in length of stay for patients with dementia in addition to fewer overall admissions, reduced adverse incidents such as falls and complaints, improved patients and carer satisfaction and a financial saving of approximately £1.4M to the local health economy.

The team in Doncaster consists of eight OPMH liaison nurses and a mental health physiotherapist working predominantly with orthopaedic patients.

In Bassetlaw, the service comprises two OPMH liaison nurses, and one mental health occupational therapist. The system in Bassetlaw accepts referrals through the liaison office.

All patients with dementia admitted to our Trust will receive an assessment by the OPMH service.

4. CARE–CLINICAL

4.1. Delirium Pathway for Acute Trust

Delirium or acute confusional state is a common medical complication of acute illness in older people and those with cognitive impairment. It is present in up to 40% or older people admitted to the Trust and over half of older people undergoing surgical procedures. Patients with delirium are susceptible to harms such as falls, prolonged length of stay and inappropriate diagnosis of dementia.

All patients with significant symptoms will be managed on the specialist unit.

We are creating a delirium pathway in collaboration with RDaSH and Nottinghamshire Healthcare NHS Trust to guide the management of patients with delirium by the general medical, surgical and orthopaedic teams. This will be completed by the end of 2014.

4.2. Antipsychotic Prescriptions in the Acute Trust

The overuse of sedatives and antipsychotic agents is a marker of poor quality of care. antipsychotics when used to control symptoms of agitation and anxiety, particularly in older people with dementia often result in a deterioration in their physical and mental health. Falls, and secondary cerebrovascular (strokes) and cardiovascular injuries (heart-attacks) are more common in older people treated with antipsychotic agents. Only a very small number of people with dementia with associated psychotic symptoms are appropriate to receive such drugs, which in all cases will be following a comprehensive review by the OPMH team.

4.3. Continence Assessment and Management

All patients with dementia will receive an initial continence assessment by nursing staff. No patient will be assumed to be incontinent, in particular, continence aids such as pads, access to toilets and nurse call systems will be available to patients at all times.

For new cases of urinary incontinence, a full continence assessment must be undertaken with referral to the continence nurse if appropriate.

4.4. Falls

Patients with dementia are at particular risk of experiencing falls in hospital. Such falls often result in significant injury and can result in pain, long-bone (hip, femur or humerus) and skull fractures, immobility and institutionalisation.

All patients admitted to hospital receive a falls-risk assessment. Particular attention will be given to those with dementia and delirium.

All patients admitted to the Trust with a recent history of falls will receive lying and standing blood pressure measurements in line with Trust policy.

All patients with a history of falls and on-going confusion will be nursed on specialist low-beds.
All patients experiencing repeated falls will receive a comprehensive geriatric falls assessment either prior to discharge or shortly after discharge (for example from the medical assessment unit) in the geriatric clinic.

4.5. Catheter Care

Catheters significantly increase the risk of infection and associated antibiotic use. All patients with catheters will have their condition reviewed and an attempt to remove the catheter must be undertaken if appropriate (i.e. not to be used long-term).

Advice on the treatment of urinary sepsis in catheterised patients is complex and will be coordinated with support from the Care of Older People and infection control teams.

Catheter care by ward staff is a priority issue and patients' privacy and dignity in relation to catheter care must be respected at all times.

Long-term catheters must only be placed following discussion with the continence and urology teams.

4.6. Use and Abuse of Antibiotics in Patients with Dementia

Classic geriatric teaching suggests that a common cause of confusion in older people, particularly those with pre-existing cognitive impairment is urinary infection. Whilst this is sometimes true, the frequent over-diagnosis of urinary tract infection and over-treatment in older people often results in sub-standard care (i.e. missed alternative diagnosis) and the use of inappropriate antibiotics.

All patients, for whom the diagnosis of urinary tract infection is suspected, must have a urine sample sent to the lab.

If a patient is unable to provide a mid-stream sample of urine, intermittent catheterisation must be considered to obtain a sample prior to the commencement of antibiotics.

Before the initiation of antibiotics, other surrogates to confirm the diagnosis of infection will be calculated – fever, raised white cell count, tachycardia, systemic sepsis, etc.

All simple urinary tract infections should be treated with oral antibiotics for three days.

All patients who receive hospital initiation of antibiotics will have complete antibiotic prescription reconciliation, detailing any antimicrobials received in the past three months in the Trust or community.

Consideration as to the use of probiotic dietary supplements must be given on an individual basis.
Patients receiving antibiotics must have their requirement for acid-suppressing medication reviewed.

Oral antibiotics are the preferred route of administration unless clinically dictated (for example, drug not available in oral form). Those patients who struggle with compliance must be offered alternatives, such as syrup or crushed tablets.

Once an intravenous cannula is not in use, it will be removed immediately.

4.7. Polypharmacy and Medicine Rationalisation

Many older people are prescribed multiple drugs which result in increased confusion, falls and toxicity. (Any older person prescribed four or more medicines has a significantly increased risk of falling.)

All patients admitted to the Trust have their medicines reconciled by a pharmacist. All older people admitted to the Trust will receive a medication review, specifically assessing those drugs which increase confusion (as well as falls and length of stay) – such as opiate analgesics, anti-psychotics, benzodiazepines, anti-histamines and anti-emetics. Further guidance is available from the consultants and the pharmacy team.

4.8. Investigations–Inpatient and Outpatient/Appropriateness

Patients with dementia often do not benefit from inpatient admission unless essential – for example in relation to significant physiological deterioration – hypoxia, sepsis, immobility (eg social crisis). The inpatient environment at its best causes a worsening in cognition and increases the chance of injury. All efforts will be made to maintain patients in their own homes for treatment by community teams.

Outpatient clinic assessments are potentially traumatic to older people with dementia. If appointments are necessary, specific care should be taken to ensure the patient is accompanied by a relative or carer. Patients with dementia should not be kept waiting longer than necessary. Coordination of follow-up via GPs, community matrons or specialist nurses will be made the norm rather than the exception.

Many invasive tests are inappropriate and potentially harmful in patients with dementia – for example, endoscopic investigations are poorly tolerated and imaging studies such as MRI add little to the subsequent treatment of patients but increase their anxiety. All patients with dementia should be counselled in detail about alternatives to investigation – where appropriate relatives and carers will be involved in these decisions.

4.9. Nutrition

4.9.1. Support at Mealtimes with Food

Following admission, the nursing assessment of nutrition must determine whether a patient requires assistance or support during mealtimes. Given the complexity of the hospital environment and the mechanics of hospital beds and tables it is likely that many patients will require some form of assistance or support during mealtimes.

All patients will have access to a picture menu to assist in deciding the meal options for the day.

All patients requiring additional assistance are identified to staff by the use of a red tablemat.

If able, all patients will have the choice of taking their meals at a dinner table on the ward.

Relatives are invited to support patients at meal-times on the wards.

Finger-foods and snacks will be available to all patients at all times.

All patients with dementia will have dietary monitoring within the context of the Malnutrition Screening Tool (MUST).

4.9.2. Support with Drink and Hydration

As with nutrition, following admission all patients will be assessed as to the extent of support they require managing fluids. Many older people in hospital wards are at risk of dehydration as they struggle to cope with the mechanics of hospital tables and beds.

All patients will be offered the least restrictive form of drinking utensil – ideally a china cup or coloured/ melamine plastic glass.

Patients with dementia often struggle with the application of intravenous fluids if required to treat dehydration. Guidance on the best form of rehydration is available from the Care of Older People team.

It should never be assumed that patient with dementia require beakers or sippy-cups.

We encourage families and carers to bring a patient’s favourite cup or mug to the ward to aid hydration.

All patients will have their fluid balance monitored during their inpatient stay.

4.10. Dysphagia

The onset of dysphagia in patients with dementia is often a sign that suggests either terminal deterioration in dementia or an intercurrent illness. All patients must be assessed for their risk of dysphagia.

To minimise dysphagia and aspiration in all patients; food and fluids will be provided with the patient being in as upright a position as possible.

Patients unable to manage normal diet must receive an assessment by both the speech and language therapy and dietician teams to determine their optimum diet.

Patients who are at constant risk of aspiration because of the severity of their dementia must be discussed with the consultant and next of kin to determine the trajectory of their palliative care needs.

In general, patients with dementia experience dysphagia as the result of the progression of their disease and often do not warrant treatment with invasive devices, parenteral fluids or PEG tubes. Patients with inter-current illnesses (for example, urinary sepsis, pneumonia) could be candidates for parenteral fluids, following individual assessment of a patient's ability to cope with peripheral venous cannulae.

If venous access is not possible or difficult to maintain, short-term treatment with subcutaneous fluids can be considered.

Patients experiencing dysphagia who receive staged diets (thickened or pureed) will be offered smoothies, milk shakes and other forms of beverage rather than just thickened tea or coffee, which can be unpalatable.

4.11. Pain Management

Up to 50% of patients with dementia experience pain not classically expressed or detected by clinical staff. Nursing and Healthcare staff and in particular family members are often most astute at detecting physical pain in a patient with dementia, whether through a change in behaviour, position or mood.

All patients must have regular pain reviews using methods appropriate to the severity of their dementia.

If there is doubt as to the experience of pain in a patient with dementia, they must be discussed with a member of the team from medicine for older people.

4.12. Capacity Assessment

All Trust patients must be assumed to have mental capacity unless proven otherwise. The details of care, decision-making and communication are detailed in the Mental Capacity Act 2005. All clinical staff have responsibility for understanding and following this legislation. If there are questions or lack of clarity regarding patient capacity, assessments and support is available from the Care of Older Peoples Medicine team, the OPMH team or the Trust adult safeguarding lead.

4.13. Deprivation of Liberties Safeguards (DoLS)

Any patient for whom the benefits of hospitalisation are deemed to outweigh the risks of self-discharge and who wish to leave hospital premises must be subjected to rigorous mental health and capacity assessment and if appropriate an application for Deprivation of Liberties Safeguards must be made through the standard Trust route (Adult Safeguarding Team).

4.14. Enduring Power of Attorney & Advanced Directives

Staff will enquire if an enduring power of attorney exists for those patients who lack mental capacity. If such a power exists, requests will be made for confirmatory documentation. If such documents do not exist, families must not be disadvantaged but included in best-interests meetings when appropriate and included in all decisions relating to treatment or care.

We will ensure any Advanced Directives, if available, are acted on in accordance with the patient's wishes.

5. CARE–GENERAL

5.1. Open Visiting

All wards in the Trust caring for patients with dementia will have open visiting between 11.00am and 8.00pm to allow maximum support by family members, in particular with respect to orientation and mealtimes. There may be occasions when relatives are asked to leave the ward for a period because of specific treatments, investigations or cleaning. Visiting outside of these times is at the discretion of the ward manager.

5.2. Protected Mealtimes

Ward rounds and routine clinical activities must be avoided at mealtimes. All staff on the ward will focus on supporting patients with their meals at this time.

Family and friends are encouraged to attend the wards at mealtimes to support eating or feeding if necessary. Family are friends are also encouraged to bring favourite foods, if not available from the hospital kitchens.

5.3. Role of Carers & Family

All patients with dementia will receive specific person-centred care that treats them as an individual, at no time bypassing their autonomy or capacity, no matter how limited. The needs of the patients and their wishes and those of their family or next of kin must be considered at all times. During an inpatient experience, all aspects of care must be considered from the perspective of the patient, how they might be affected and how they might perceive what is happening to them.

We encourage relatives and friends to attend investigations such as radiology with the patient or to participate in mealtimes or other ward activities.

Relatives and carers are invited, with the agreement of the patient, to attend all ward rounds and outpatient clinics.

5.4. Staffing Levels

Patients with dementia can be highly dependent. Hospital areas which regularly have high numbers of patients with significant dementia require a higher ratio of nursing numbers. Ideally, patients with significant behavioural disturbance or needs will be grouped in one area with supervision from skilled staff trained in dementia care.

The role of 'specialing' (enhanced supervision by clinical staff) will receive an increased profile, not merely deferred to the least qualified member of staff, but identified as a highly skilled and important opportunity for therapy and patient interaction.

We will develop a standardised document to allow consistent assessment of patients across the Trust for their need for close supervision.

5.5. Access to Hygiene and Bathing

Patients with dementia often have prolonged acute hospital admissions. All inpatients will have daily access to cleaning and washing facilities. All patients will be offered and receive either a shower or a bath on the ward. Hand-washing facilities must be available to all patients prior to meal times and after toileting.

5.6. Access to Nurse Call System

All patients will have easy access to working nurse call alarms. For patients unable to operate call alarms, alternative means will be used for gaining attention – such as increased frequency of rounding or specific location of patient beds in clear line of site of nurse stations.

5.7. Patient Experience

5.7.1. Emergency Department (Accident and Emergency)

The Emergency Department (ED) is amongst the most challenging environments for patients with dementia. The constant movement, noise and disruption allayed with an individual's acute medical illness frequently exacerbate underlying delirium and behavioural disturbance. Relatives are often stressed at this time, which can contribute to a patient's discomfort.

Patients with dementia must have access to their relatives upon arrival in the department, through to decision to admit or discharge.

No patient with dementia should remain in the ED longer than four hours. We will adapt the Trust triage criteria to include the presence of delirium or dementia as a clinical indicator.

If a patient with dementia requires acute hospital admission, they will be prioritised over other patients in their wait for a bed.

All patients with dementia in the ED will be identified by staff and extra attention provided to their nutrition, hydration, pain and dignity.

5.7.2. Medical Assessment Unit (MAU)

Patients with dementia often experience heightened levels of anxiety on the MAU. Patients are also at significant risk of harm from falls. Nursing staff will be alert to the greater needs of patients with dementia, ensuring easy access to the nurse call alarm and ensuring regular – up to half hourly checks on patients for pain and continence needs.

Additional support will often be required with nutrition and hydration.

If patients with dementia require isolation, regular checks will be made to maintain their wellbeing. Family and carers will be welcomed in to the ward to support with orientation, hydration and nutrition.

Soon after admission, patients will be assessed by consultants to determine whether hospital admission or discharge to the home or another community provider is appropriate.

Patients with dementia on MAU should, unless experiencing a treatable organ-specific condition, be transferred to a Care of Older People ward as soon as possible after consultant review.

Patients with dementia must not be transferred during the night (after 2100 hours) unless for sound clinical reasons. If patients are moved after dark or at night, consideration must be given to contacting next of kin so that they can accompany the patient during the transfer.

During times of bed crisis, patients with dementia must not be transferred to non-medical wards ('slept-out') without staff undertaking a detailed risk assessment which must be approved at senior management level.

5.7.3. General Wards

5.8. Surgical

Most commonly, patients with dementia admitted to surgical wards are those who have fallen and sustained a head injury. The Care of Older People team should assess all such patients and arrange transfer to medicine for older people if necessary.

All patients sustaining head injuries must undergo a formal falls assessment.

Patients with significant dementia often do not benefit from elective or emergency surgical procedures; all such treatments must be discussed with the patient if they retain capacity and their relative or next of kin if not. Prior to any planned surgical procedure, consultation from the Care of Older People team must be sought.

5.8.1. Medical

Patients with dementia must be considered for transfer to a Care of Older People ward in the first instance (Doncaster - Ward 25 or Gresley, Bassetlaw – ward A4) – the extent of a patient's dementia will dictate the ward and environment in which they can be nursed. All wards must receive clear information regarding the level of nursing required prior to transfer to ensure that the dependency of the ward is not exceeded.

5.8.2. Orthopaedic

Many older people with dementia are cared for on orthopaedic wards following an admission with a hip fracture. All patients must receive assessment, Monday to Friday by a member of the Orthogeriatric team. All patients with dementia must receive assessment by the OPMH team.

5.9. Volunteers in the Trust

Volunteers work in many different areas of the Trust, we have some experience of working with volunteers on the wards; more must be done to increase support and training for the role. There is tremendous value in utilising volunteers to provide social and psychological support for patients with dementia on the wards. We will work with the Alzheimer's Society, Age UK and the WRVS to increase the profile of volunteers in the Trust.

5.10. Assurance for Medicine Administration in Patients with Dementia

Patients with dementia require additional support in the administration of medicines – patients must be overseen in their administration, which along with formal drugs reconciliation and review of polypharmacy will improve compliance and concordance.

5.11. Adverse Incidents

Patients with dementia in the Acute Trust experience disproportionate harm. All incidents must be recorded using standard Trust procedures. Specifically, the following will be adopted:

5.11.1. Falls

All patients admitted to hospital with a fall will receive a specialist falls assessment, specifically reviewing postural blood pressure and medication. If necessary, falls alarms will be used on the wards to support ward staff caring for unsettled patients.

Patients at very high risk of falls who experience hyperactive delirium will be considered for the use of hip-protectors and 1 to 1 supervision.

The Trust has recently purchased a number of low-beds to support patients at risk of falling – any patient deemed at risk will receive such a bed at the earliest opportunity. Reliance on safety-sides to keep patients in beds will not be undertaken for confused patients.

5.11.2. Tissue Viability Injuries

Increased vigilance and assessment of patients with dementia in ward areas.

5.11.3. HCAI – Clostridium difficile diarrhoea

Patients inappropriately given antibiotics are at increased risk; strict adherence to Trust policy and application of best practice guidelines to the treatment of patients will minimise this development. If possible, the intravenous route should be avoided, particularly in patients who are agitated.

5.11.4. Safeguarding, Deprivation of Liberties and Issues relating to the Mental Capacity Act

All adult safeguarding issues will be discussed with the adult safeguarding lead.

5.11.5. Prolonged Length of Stay

Patients with dementia often experience a prolonged length of stay for non-clinical reasons. Patients whose discharge is delayed will be highlighted as soon as possible for the Trust to specifically support and target their discharge.

5.11.6. Institutionalisation

The acute hospital will always be the final option for the care of a patient with dementia. Prior to admission, particularly in relation to physical deterioration, pathways utilising community support such as Community Intervention Team (CCIT), run by Rotherham, Doncaster and South Humber NHS Trust or Short-term Enablement Programme (STEPS), provided by Doncaster Metropolitan Borough Council, must be considered. All inpatient stays for people with dementia must be reduced to as short a time as possible.

Patients with dementia and acute medical needs must be managed in a Care of Older People ward.

There is currently no inpatient ward for older people in Bassetlaw hospital, much experience exists on ward A4 which provides rehabilitation for patients with stroke. We plan to develop this service, with further development of services for older people in the Trust.

5.11.7. Wandersome patients

Some patients with delirium and dementia are at times wandersome. Such restlessness has many causes and requires specialist assessment. Such patients will not receive sedation unless they have undergone a specialist review; their care will be facilitated on the most appropriate ward, which has facilities for observation and restricted entry and exit to ensure safety.

Consideration will be given to the potential for such patients' risk of falling, with a detailed falls risk assessment. Patients on wards who wish to walk or move about will be supported to do so by staff. There will be a general acceptance that advising a patient with dementia to, 'sit down or you will fall' is not always appropriate and can result in deconditioning, which once lost is difficult to regain.

6. DISCHARGE ARRANGEMENTS

6.1. Specialist/Streamlined Social Work Support for Patients and Relatives

The longer people with dementia remain unnecessarily in the Acute Trust the slower their overall recovery. Delays relating to therapy and social care must be minimised. Patients with dementia will be prioritised in the discharge process and involved in multi-disciplinary team assessments on the ward involving medical, nursing, therapy, OPMH, family and social care staff.

6.2. Liaison with Social Assessment Units

The recent development of social assessment units has offered an alternative to patients with dementia to direct admission to residential or nursing care. Often patients who previously would have been institutionalised gain a further chance to return home. It is critical that open lines of communication exist between the OPMH team, the integrated discharge team and the specialist dementia unit.

6.3. Discharge Arrangements for Patients

All discharge arrangements for patients with dementia will be clarified with their next of kin or carers. Discharges from inpatient wards may only take place at night (after 1900 hours) in exceptional circumstances. Patients and carers will receive information relating to their discharge in writing prior to the day of discharge. The discharge of patients with dementia will be a Trust priority; no discharges will be cancelled because of issues relating to transport.

6.4. Re-admission Avoidance

The readmission of patients with dementia suggests poor initial care and poor discharge arrangements. The return of patients to a ward environment is psychologically harmful and impairs physical recovery. All efforts must be made to avoid readmission.

All patients or next of kin will receive a follow-up phone call after discharge, to ensure that all arrangements have been adequate or successful. If more support is required, clinical staff must decide whether to coordinate this from the Acute Trust or the patient's general practitioner.

Information relating to discharge – specifically resuscitation status, medicines started or stopped, relevant investigation results, etc will be conveyed and or coordinated with the patient's GP and community matron or district nurse.

6.5. Communication and Liaison with General Practice

Discharge letters for patients with dementia will contain clear information for the GP relating to the physical and psychological experiences of the patient. Specific issues such as agitation, pain control, insomnia or falls will be communicated to the GP and community teams.

6.6. Discharge Arrangements

The discharge home of patients with dementia is a priority and must be undertaken at the earliest possibility notwithstanding the constraints of need for acute hospital care.

Discharge planning and estimated discharge date will be set at the time of first consultant or multi-disciplinary assessment. Patients if able and their families or next of kin will be made aware of this estimated date with an understanding that the team will work towards this.

Clearly documented and robust communication between patient, next of kin or carer must take place prior to discharge. All patients and carers or next of kin must be provided an opportunity to raise concerns or ask questions about discharge to any member of the clinical team. If a request is made for medical involvement, every effort will be made to involve the consultant.

Discharge summaries must include all relevant information relating to a patients level of capacity, abilities and potential for further recovery.

All discharge summaries must include details as to whether their morbidity is consistent with inclusion in the Gold Service Framework.

6.7. Community Geriatrics and Liaison with Care Homes–Admission Avoidance

The best way to care for patients with dementia is often in their own home, care or nursing home. By proactively managing patients in the community, admission can be avoided, acute illnesses can be treated and recovery can be expedited.

It is the intention of DBH to collaborate with the community matron and district nursing teams to develop a community geriatric model working across the Trust, proactively supporting general practitioners and patients in care homes.

In Bassetlaw, a Dementia Outreach Nurse and the Mental Health Intermediate Care team provided by Nottinghamshire Healthcare NHS Trust support patients in the community. We plan to integrate community geriatricians with the expansion of the service in Bassetlaw.

7. EDUCATION

7.1. Staff Education and Awareness

All Trust staff will have, depending on the extent of their patient contact will receive Dementia Awareness training appropriate to their needs. Training is provided in-house through collaborative work with RDaSH and Nottinghamshire Healthcare NHS Trust in Bassetlaw.

7.2. Dementia Champions Throughout Trust

Every ward and clinical environment in the Trust will have a nominated dementia champion who can act as a link to the Trust developments in dementia, provide support and training to staff and work as a champion for excellence in care. Dementia champions will be trained by Alzheimer’s Society alongside the Dementia Friends programme. They will also have support from OPMH team for on the job training and development.

7.3. Research and Development to Support Improvement in Treatment and Care of Patients with Dementia

The amount of research in dementia over the coming years is likely to increase significantly. With the development of a specialist delirium and dementia service, DBHFT will be in a position to lead in new directions of care.

Improved links with the research and development team in the Trust as well as nationally are critical.

8. COMMUNICATION

8.1. Patients and Relatives Often Know Best

Patients know best. Listening to a patient relay their story will explain more than any number of investigations. Carers who have intimate knowledge of a patient's like and dislikes are invaluable sources of information and must if possible be involved. Patients are often fatigued and attempts should be made on as many occasions as necessary to gain essential information such as preferred sleeping patterns, foods, continence issues.

8.2. Information for Patients and Relatives about Dementia & Hospital Experience

All patients admitted to the Acute Trust will receive printed information detailing consultant's name, ward routine, what to bring in to hospital, what to expect and how to seek support or advice. Details such as phone numbers, visiting times and support available to patients and relatives will be provided.

8.3. 'Hospitalisation Happens' Document

All patients with dementia will receive the 'Hospitalisation Happens' document, to allow people opportunity to prepare for potential hospitalisation.

8.4. Communication with Patients–Written and Spoken

All patients will receive a written summary of clinical contact – reviews, assessments and tests both inpatients and outpatients to help their recollection and communication with others after the event.

8.5. Communication

The use of medical jargon or NHS abbreviations will be minimised when communicating with both patients and relatives. If jargon is used, its meaning will be made explicit to non-clinical staff, patients and relatives.

9. GENERAL

9.1. Outpatient Facilities and Arrangements

Inpatients will, if possible, be reviewed by specialists at the bedside (rather than taken to the outpatient department).

Patients will not be taken to outpatient appointments in pyjamas.

Inpatients with dementia will not have to wait for assessment in outpatients – they will be taken out of turn. Arrangements will be made to ensure that all patients with dementia have the opportunity to attend with their carers or next of kin for support. If no one is available, consideration will be given to rearranging appointments to suit carers or the clinicians will endeavour to contact next of kin or general practitioner during or after clinic. All attempts will be made to avoid bringing patients with dementia to outpatient clinics – maximal use should be made of GPs, community matrons and specialist nurses.

9.2. Patients having tests or investigations

Patients requiring x-rays or other forms of investigation are transferred by a porter from the ward to the relevant department. This journey can be disorientating and frightening for a person with dementia, particularly if they have additional sensory impairment.

Patients with dementia will be accompanied to other departments by a familiar member of staff, family or a carer. The purpose of all transfers will be clearly communicated to patients and their families. Patients will not be left for prolonged periods lying on stretchers or in chairs, attention will be paid to patient dignity and comfort during these moves.

9.3. Complaints and Concerns Management

Patients with dementia, their relatives and carers should be encouraged to question aspects of care they do not understand, accept or disagree with. Early resolution of complaints and concerns will be attempted at ward level by proactive communication, involvement of the MDT and open discussion.

If patients with dementia wish to complain, they will receive additional support with this process.

9.4. Dementia Friendly Hospital

9.4.1. Lighting

With ageing, there is a significant increase in the ambient light level required for adequate vision. Patients with dementia have further perceptual difficulties relating to their disease and older people often experience macular degeneration or cataracts.

Lighting must be adequate in all ward areas caring for patients with dementia.

Appropriate adjustment of the lighting must be possible to differentiate between day and night to allow good quality sleep.

Adequate lighting will help reduce the number of falls sustained by older people with dementia.

9.4.2. Stimulation

Sensory deprivation is harmful to patients with dementia and exacerbates underlying behavioural and emotional disturbance. There will be adequate but not excessive mental stimulation for patients in hospital wards, in the form of reading material, music, radio and television. Reminiscence items are also helpful to stimulate conversation and can be used to modulate behavioural disturbance.

Patients must have access to oversized clocks with day and date facilities.

All side-rooms must have facilities for television and radio.

Ward areas must be de-cluttered to prevent perceptual disturbance and over stimulation. Use of laminated signs on walls will be restricted.

All patients must have a minimum of ten-minutes' interpersonal conversation or interaction per shift– this is beyond the matter-of fact interactions relating to activities of daily living – washing, dressing etc.

9.4.3. Environment

All signage must be consistent and easy to read.

All signage must be of high quality.

Toilets and washrooms must be clearly marked.

9.4.4. Reading Material, etc

Patients will have access to a range of reading items, books and newspapers. Such items can act as focal points for conversation and assist in reorientation or distraction techniques.

9.4.5. Clothing and Footwear

Patients will always have access to footwear. In the first instance relatives or carers will be asked to provide these. If relatives or carers are unable to provide appropriate footwear, wards will have a stock of indoor slippers which are adequate to provide comfort and support as well as minimising the risk of slipping and falls. Family and carers will be asked to help launder patient clothing. If this cannot be done, the ward staff will access the in-house laundry service. Efforts will be made to ensure that clothing is not lost or misplaced, particularly when patients move between wards.

9.4.6. Dentures, Hearing Aids and Spectacles

The loss of dentures or hearing aids can have a devastating effect on the ability of a person with dementia to eat or interact.

Ward staff will be extra vigilant to ensure that dentures, hearing aids and spectacles are not lost during a patient's time on the ward. This will be part of the ward routine, ensuring that such aids are clean, available and in reach.

Consideration may need to be given to attaching identification labels to these aids.

10. END OF LIFE ISSUES

10.1. Palliative Care Facilities in the Acute Trust

Patients with severe dementia are often admitted to the Acute Trust during the terminal phase of their physical or dementia illness. Each patient will be reviewed by the palliative care team for support and guidance.
If, following a discussion with the carer of next of kin, a decision is made for the patient to remain in the Acute Trust to die; patients will be nursed in a specialist environment, preferably a side-room with palliative care support.

10.2. End of Life Plan of Care

10.2.1. Acute Trust

All efforts will be made to ensure that patients with palliative care needs, in the terminal phase of chronic illness do not die in the Acute Trust. If patients are admitted to the Acute Trust by their GP or via the Emergency Department, and it is not possible to discharge them for palliative care in the community, support from the palliative care team will be sought and the patient and their family must be supported on the ward in comfort, with appropriate respect and sensitivity.

10.2.2. Community

Patients with dementia living in the community will have received a review by their GPs, community matrons or community geriatricians to identify a management plan for those who experience deterioration. Working with the community palliative care team and community geriatric teams, patients and their families will receive maximal support in the community to avoid acute admission at the end of their lives.

10.3. Amber Care Bundle

Clinicians will initiate conversations with patients and their relatives in situations where it is likely that they would not survive a significant deterioration in their health.

Forward planning, supported by the palliative care team should be considered.

Patients who are identified to be in the last months of their lives will be identified and this communicated with general practitioners at discharge to facilitate improved community care and reduce unnecessary admissions in the future.

10.4. Do-Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Patients with significant dementia will have their resuscitation status considered at every acute admission. The presence of a diagnosis of dementia does not mandate the completion of a DNACPR. Each individual will be assessed on the basis of their presentation and clinical co-morbidity.

A diagnosis of dementia alone must never be considered an adequate or sufficient reason to not actively treat or escalate care.

It is sometimes inappropriate to resuscitate patients with dementia if they experience a cardiac arrest – all communication with patients, their relatives, carers and next of kin must be clearly documented in medical notes and on the DNACPR form.

Relatives, carers or next-of-kin of patients discharged from the Acute Trust with an active DNACPR must be informed of this – it is also critical to communicate this with community teams.

11. MONITORING THE IMPLEMENTATION OF THE STRATEGY

We make a clear commitment to action in respect of dementia and have identified key changes, some of which are already under way and others which will begin as a consequence of this Strategy.

We will put in place robust arrangements to ensure delivery of our agreed commitments and to enable us to track and monitor improvement in outcomes over time through the establishment of a Dementia Strategy Implementation and Monitoring Group which will report quarterly on progress and review the Strategy by March 2014.

11.1. Shared Commitment

There is a shared commitment to take forward transformational change, the actions and objectives that will deliver that change operate across a range of services both within the Trust and throughout partner organisations with different governance and accountability arrangements.

11.2. Ensuring Delivery

We will introduce robust arrangements to ensure delivery of our agreed commitments and to enable us to track and monitor improvement in outcomes. To do this we will convene a Dementia Strategy Implementation and Monitoring Group. The Implementation and Monitoring Group will be chaired by a member of the Non-Executive Directors and include representatives from all areas of the organisation, as well as service users, patients and carers.

11.3. Key Tasks

The Group's key tasks will be to:

Ensure delivery of the twelve key areas to support these improvements, including being responsible for considering next steps in relation to particular actions, such as the work on the development of Dementia Friendly Doncaster.

Monitor the impact of funding pressures and the capacity of services to deliver on those commitments within the dementia strategy that have a potential resource implication.

Establish a monitoring framework which is valid to track change and improvement over time in respect of dementia services. The framework will where possible will be based on existing data sources or data which is provided within the organisation or nationally as part of the National Dementia Audit.

It will monitor and receive reports regarding items such as:

- The number of people with a diagnosis;
- The number of people receiving post-diagnostic information and support;
- Reductions in unnecessary admissions to and reduced period of admission for those for whom it is appropriate;
- Reductions in the use of antipsychotic prescribing;
- Compliance with Deprivation of Liberty Act;
- Increases in social therapies/activities, including physical activity as part of patient's well-being within hospital;
- Improvements in the experience of people with dementia and their carers
- Prepare an Annual Report on progress to be published in June 2014 and June 2015.
- Commission a revision of the Dementia Strategy, which takes account of progress and learning, to be in place from April 2015.

11.4. Meeting Frequency

The Group will set a timetable for its work, however, the aim is to meet bi-monthly. It will publish progress minutes, papers and reports on the Trust website. The group will be accountable directly to the Trust Clinical Governance Committee.

12. KEY PERFORMANCE INDICATORS

It is imperative that as an organisation we are held to account for the delivery of our Dementia Pledge. This will be done via the Dementia Strategy Implementation and Monitoring Group. Mentioned above are the points which will be assessed and consider, detailed below highlights the way in when we intend to have achieved this by.

The years of progression are based on a calendar year

No	Key Performance Indicator	Year 1 goal (2013)	Year 2 goal (2014)	Year 3 goal (2015)
	Patient Centred Care	All patients with a diagnosis of Dementia within the Trust will have a 'This is me' form which will follow them through the patient journey	All patients within the Trust will have a 'This is me' form	All patients within the locality will have a 'This is me' form which will follow them through community and acute setting
1	Diagnosis and Assessment:			
	Diagnosis	Training plan developed for all staff to be able to make an assessment of patients who may have dementia	Work with commissioners and partners to agree a training and development plan for the diagnosis of dementia	Begin and complete a phased implementation of training and education plan for dementia diagnosis within both acute trust and community
	Older Peoples Mental Health Liaison Team	All inpatients who have been identified as having potential symptoms of dementia will be referred to OPMH Team for further assessment		
	Comprehensive Geriatric Assessment	Develop a pathway for patients who have had an assessment of potential dementia	75% of all patients assessed to have dementia will have a comprehensive geriatric assessment	100% of all patients assessed to have dementia will have a comprehensive geriatric assessment
	Care – Clinical:			

	Delirium Pathway	Development of a delirium or acute confusional state pathway in conjunction with RDaSH and Nottingham Healthcare Providers	Implementation of pathway across both Doncaster and Bassetlaw	Audit the finding from implementation and make appropriate improvements
	Antipsychotic Prescriptions	Pathway development for review of all antipsychotic prescriptions throughout the organisation	Every antipsychotic prescription will trigger a comprehensive review from OPMH Liaison Team	Full analysis of antipsychotic prescriptions and impact on all patients
	Continence Assessment and Management	All patients with dementia will receive an initial assessment from the nursing staff. This will be done in conjunction with the patients relative or carer	Audit compliance with standards and strive for further improvements or service enhancement	
	Falls	Write a standard and guidance for patients living with dementia who have experienced falls	All patients with dementia will receive an assessment from a member of the multi-disciplinary falls team	Audit compliance with standards and strive for further improvements or service enhancement
	Catheter Care	Write a standard and guidance for catheter care in relation to patients with dementia	No patient with dementia will receive a urinary catheter unless they meet criteria consistent with Trust standard	Audit compliance with standards and strive for further improvements or service enhancement
	Antibiotic use	In line with Trust antibiotic policy develop a standard and guidance for antibiotic use in relation to patients with dementia	Audit compliance with standards and strive for further improvements or service enhancement	

	Polypharmacy and Medicine rationalisation	All patients with dementia will receive the standard Trust reconciliation and further specialist geriatric assessment		
	Investigations	Care of Older People CSU and Outpatients will work together to develop an internal register of those who either have dementia or those who are the main carer of someone with dementia. This will develop a 'flag' system for the booking clerks	Booking clerks will assess the appointments requested to ensure patients and relatives are given appointments in an appropriate manner, including consideration of timing when outpatient department is at its most quiet or when it best suits the relative or patient	Booking will be rolled out throughout the organisation
	Nutrition	All patients will have a pictorial menu available Baseline audit of feasibility for meals to be available at dining tables Baseline audit of trust staff who would be happy to help assist patients at mealtimes Audit of finger food trial within Care of Older people CSU	Develop a nutrition assistant training programme for all staff who would like to assist at mealtimes. Develop finger food options on the basis of outcome of audit Ensure all patients have the option for dining table meals	
	Dysphagia	In collaboration with the Speech and Language Therapy team develop guidance for treating and caring for dementia patients suffering from dysphagia	Implement guidance	Audit compliance with standards and strive for further improvements or service enhancement

	Pain Management	In collaboration with the Pain management team develop guidance for treating and caring for dementia patients suffering from any pain	Implement guidance	Audit compliance with standards and strive for further improvements or service enhancement
	Care – General			
	Open Visiting	All wards will operate an open visiting policy (11am – 8pm) any visiting outside of this will be at the discretion of the Ward Manager.		
	Staffing Levels	Patients with dementia often required 1:1 attention. This can be for a number of reasons, either to prevent falls, promote appropriate stimulation or support to wander. Baseline audit for feasibility for non-clinical staff to support in 1:1 care. AUKUH specific assessment of patients requirements	Discussions with all CSUs (clinical and corporate) re commitment of staff to work with patients throughout trust Develop a plan for implementation	Assess sustainability of programme for including non-clinical staff in caring for patients Assess staff survey in line with more engagement with patients.

	General Wards:			
	Surgical	In partnership with the surgical team develop a pathway for review of inpatients with dementia on surgical wards	Implementation of pathway throughout DBHFT	Audit the changes in pathway and publish results for further improvement
	Medical	In partnership with the medical team develop a pathway for review of inpatients with dementia on medical wards	Implementation of pathway throughout DBHFT	Audit the changes in pathway and publish results for further improvement
		Develop operational policy for patients with dementia in times of bed crisis within organisation (sleepers out)	Implementation of pathway throughout DBHFT	Audit the changes in pathway and publish results for further improvement
	Discharge Arrangements:			
	Specialist Support:	Pilot a dedicated Patient Quality Co-ordinator to patients with dementia to ensure a supported discharge with telephone follow-up with patient or carer Specialist professionals to work alongside Care of Older People's wards and the general wards who are discharging patients with dementia	Audit length of stay and re-admission rates for patients with dementia who have been supported by specialist teams	

	Re-admission	Pilot a dedicated Patient Quality Co-ordinator to patients with dementia to ensure a supported discharge with follow-up ones discharge has taken place.	Implementation of pathway throughout DBHFT	Audit the changes in pathway and publish results for further improvement
	Dementia Register:	Work with local GPs, OPMH and community services to develop a dementia register		
	Community Geriatric Services:	Develop pathway with community service teams to support patients living at home or in a care setting in the community	Implement pathway and new ways of working	Audit pathway and develop new ways of working based on learning from pilot
	Education, Training and Research:			
	Dementia Champions:	Re-launch the dementia champions programme Work with Alzheimer's Society to educate staff for Dementia Friends	Every ward and corporate area to have a Dementia Champion 65% of all staff to be a trained dementia friend	
	Research and Development	Develop a research programme for dementia care	Implement first phase of dementia research programme	
	Communication:			
	Information about the hospital	This is in line with current hospital policy. All hospital information will be available for patients and their carers/relatives		

	Hospitalisation Happens	Development of "Hospitalisation Happens" document to be written and taken through all appropriate committees	Publication of "Hospitalisation Happens" and dissemination throughout the organisation	Promote 'Hospitalisation Happens' with local community services and GPs in order to prepare all patients for an admission and how they will be supported throughout their stay
	General:			
	Outpatient Facilities and Arrangements this is to include outpatient appointments, tests and investigations	Develop pathways for most common outpatient appointments for patients who may be an inpatient at the time of their outpatient appointment	Implement pathways for ensuring patients who have outpatient appointment while they are an inpatient	Disseminate all learning for pathways for all outpatient appointments
	Dementia Friendly Hospital:			
	Lighting and Sensory	Develop a specific lighting and sensory plan for across the Trust	Implement rolling programme in line with upgrades	
	Environment	Develop a facilities plan to ensure all upgrades are in line with dementia friendly hospitals standards	Implement rolling programme in line with upgrades	
	AMBER Care Bundle and SPICT	Integrate current guidance with best practice in relation to AMBER Care Bundle and SPICT guidelines	Audit the changes in pathway and publish results for further improvement	

	Last days of life	In partnership with Care Homes develop guidance for those patients in final days of life to avoid inappropriate acute admission	Implement guidance for the reduce the number of admissions of patient with dementia from care homes	Audit the changes in pathway and publish results for further improvement
		Ensure those inpatient in final days of life receive specialist palliative assessment and care	Audit the changes in pathway and publish results for further improvement	

13. REFERENCES

- The State of Health Care and Adult Social Care in England CQC 2010/11
- NICE – Dementia Guideline (CG42) http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf
- NICE – Delirium Guideline (CG103) http://www.nice.org.uk/nicemedia/live/13060/49909/49909.pdf
- National Dementia Strategy 2009 – Living Well with Dementia
- Dementia – Out of the Shadows – Alzheimer's Society, 2008
- My Name is not Dementia – Alzheimer's Society, 2010
- Delivering the National Dementia Declaration for England – Action plans 2010 – 2014 – Dementia Action Alliance
- The State of Health Care and Adult Social Care in England – CQC 2010/11
- The Use of Anti-psychotic Medication for People with Dementia: Time for Action, 2009
- Dignity and Nutrition Inspection Programme – Care Quality Commission 2011
- Care and compassion? Report of the Health Service Ombudsman of Ten Investigations in to NHS Care of Older People - Parliamentary and Health Service Ombudsman 2011
- Doncaster Dementia Strategy Progress Report – NHS Doncaster 2011
- Caring for the person with dementia – Alzheimer's Society 2011
- Dementia 2013: The hidden voice of loneliness – Alzheimer's Society 2013

14. FURTHER READING

Have the Men Had Enough – Margaret Forster, Vintage 2004
Contented Dementia – Oliver James, Vermillion 2009
The Diving Bell and the Butterfly – Jean-Dominique Bauby, Harper Perennial 2008
My Bonnie – John Suchet, Harper 2011
The Count of Monte Cristo – Alexandre Dumas, Wordsworth Editions 2007
The Man Who Lost His Language – Sheila Hale, Penguin Books 2003
Iris: A memoir of Iris Murdoch – John Bayley, Abacus, 1999

15. GLOSSARY

Below are some words or phrases you may encounter when reading the strategy document

A&E – Accident and Emergency department; see ED

Alzheimer's disease – a form of dementia related to the deposition of a protein 'Beta Amyloid' in the brain of patients which results in a slow, progressive deterioration in mental and physical health.

Amber Care Bundle – a tool to support clinicians in determining whether a patient is in the final months of life, facilitating appropriate discussions with patients and relatives and planning for future events.

Anti-Psychotic medication – Drugs developed in the 1950s to help people suffering from psychotic illnesses such as Schizophrenia. Modern derivatives of these drugs 'atypical antipsychotics' have been used on older people in the treatment of agitation and disturbed behaviour. Recent evidence has shown a link between the use of these drugs and strokes and heart-attacks in older people. Best-practice guidelines aim to reduce the reliance on these drugs.

Aspiration – the movement of gastric and other contents into the respiratory tract resulting often in infection or pneumonia

ATC – Assessment and Treatment Centre – Bassetlaw Hospital runs the equivalent of a Medical Assessment Unit which caters for patients referred from medical and other specialties to the general hospital

BCCG – Bassetlaw Clinical Commissioning Group

Best Interests Meeting – a meeting that is convened to discuss the care or place of residence of an individual who lacks mental capacity as defined by the Mental Capacity Act 2005. In attendance are representatives from clinical and social work staff and either next of kin, those in position of next of kin or Independent Mental Capacity Advisors (IMCAs)

DCCG – Doncaster Clinical Commissioning Group

DBH - Doncaster & Bassetlaw Hospitals NHS Foundation Trust

DoLS – Deprivation of Liberty Safeguards – A standard set within the Mental Capacity Act 2005 which ensures protection for those individuals who are kept in a hospital or care setting against their wishes in the context of impaired mental capacity.

C. difficile – Clostridium difficile is a spore forming bacteria, present in the atmosphere which can result in severe, debilitating diarrhoea in older people, often precipitated by the excessive use of antibiotics. Patients require treatment with powerful antibiotics and strict isolation.

CCIT – Community intervention team (community care provided by RDaSH)

CGA – Comprehensive Geriatric Assessment – evidence based assessment using multi-disciplinary work (MDT) to establish the optimum level of function, treatment and care for older people, which improves

Community Geriatrics – A branch of medicine for older people that works to support people in their place of residence – private or care home; working in collaboration with general practitioners and community clinical staff.

CQUINN – Care Quality Indicator

Dementia – progressive disease affecting personality, mood, memory and behaviour, usually in people over 65 years. This can have a variety of causes such as Alzheimer's disease, Vascular Dementia, Dementia with Lewy Bodies, Frontotemporal Dementia, etc

Dementia Friendly Environment – Environment in hospital, care home or public building that is designed to support people with dementia, taking into account lighting, signage and contrasting colours to help with orientation.

Delirium – acute deterioration in mental function, often the result of infection, dehydration or medications. Often reversible, can follow a fluctuating course lasting days or weeks.

Discharge Summary – A type-written letter compiled by ward staff prior to a patient leaving hospital. This

communicates vital information such as reason for admission, investigations undertaken and medications reviewed.

DMBC – Doncaster Metropolitan Borough Council

DNACPR – Do Not Attempt Cardiopulmonary Resuscitation - Regional document that demonstrates the advanced decisions of patients, relatives and doctors as to whether an individual will benefit from resuscitation should they experience a cardiac arrest.

Dysphagia – difficulty or inability to swallow fluid or solid foods. Sometimes a feature of stroke and other neurological disease, is often a feature of end-stage dementia. This can, result in the aspiration of foods and gastric contents

ED – Emergency Department – the department within an acute hospital that offers emergency care for patients, formerly named Accident and Emergency

EMI – Elderly Mentally Infirm – relates to residential or nursing care; facilities staffed with staff trained in understanding the complexity of dementia care.

End of Life Pathway – A process that supports patients who are entering the terminal phase of their disease by facilitating a dialogue between patients, relatives, carers and clinical staff aimed at providing the highest quality care to people at the end of their lives.

Gold-Service Framework – A system used by general practitioners to identify those patients in their final year of life who would benefit from pro-active palliative care planning.

Geriatric – This term relates to diseases affecting mainly although not exclusively older people who are suffering from a range of co-morbid illnesses affecting physical and mental well-being

Gresley Unit – 48 bed unit at Doncaster Royal Infirmary consisting of Mallard ward, 16 beds for people with delirium and dementia, Kestrel ward, 10 beds for acutely unwell older people and Kingfisher ward – 22 beds for 'post-acute care' – patients who have recovered from their initial medical illness but require further acute inpatient care including comprehensive geriatric assessment (CGA).

HCAI – Health Care Associated Infection – infections which are more common in hospitalised patients, such as MRSA, Clostridium difficile and Norovirus

IDT – Integrated Discharge Team – team of social workers and nurses who focus on organising support for old and frailer people following discharge from hospital

IMCA – Independent Mental Capacity Advisor – individual appointed to act in the capacity of next of kin, ensuring the best-interests of an incapacitated adult are met

Long-term care – residential or nursing home care. This qualifies as a change of residence and requires agreement from the individual involved, or in cases where an individual lacks capacity, a Best Interests Meeting

Low-bed – Specialist bed which can be electrically positioned so that patients at risk of falls are less likely to injure themselves should they fall from bed.

MAU – Medical Assessment Unit – Department in an acute hospital that receives patients from ED or following referral from a General Practitioner. This department determines whether patients require admission to specialist inpatient care or management as outpatients

MCA – Mental Capacity Act 2005 – this act details the standards required in the assessment, care and treatment of all patients in the NHS, addressing issues such as capacity, consent and power of attorney.

MDT – multidisciplinary team – collaborative team working between physicians, nurses, therapists, pharmacists and others to establish the most accurate picture of a patients overall condition. This helps to tailor the most appropriate care to an individual patient.

LoS – Length of Stay – period of time an individual is expected to remain in hospital care. An estimate, this is generally calculated at time of admission and can reduce the time a person remains in hospital.

Opiates – pain killing drugs such as morphine, codeine, Dihydrocodeine and Tramadol. All these drugs must be risk assessed as to whether the benefit they bring through pain relief out-weighs the disadvantages of confusion, constipation and falls associated with their use.

OPMH Liaison – Older Peoples' Mental Health Liaison – a team consisting of mental health nurses, a pharmacist and physiotherapist who work collaboratively with ward staff in the hospital to support older people with delirium, dementia and depression.

Orthogeriatrics – Branch of medicine for older people that specialises in the care of patients who have suffered 'fragility fractures' or those often associated with osteoporosis

PEG – Per Cutaneous Gastrostomy – a synthetic rubber feeding tube that allows patients at risk of aspiration to receive diet directly into their stomach. Generally considered as part of a rehabilitation process in stroke disease and cancer affecting the throat, does not improve length or quality of life in patients with dementia

Person Centred Care – methodology arising out of mental health practice, whereby the care of the patient (as opposed to the disease) is placed physically and philosophically at the centre of all actions done in a healthcare setting.

Polypharmacy – the prescription of potentially unnecessary and harmful medications to older people. Best current evidence suggests that the prescription of four or more drugs significantly increases the risk of falls in older people. Each patient with dementia should receive a regular detailed review of their medication from either their general practitioner or geriatrician

RDaSH – Rotherham South Humber NHS Foundation Trust

Re-admission – The return of a patient to acute care shortly after (28 days or less) a period of inpatient care. Readmission is often seen as a failure of the initial episode of care, although can at times be unavoidable.

Safeguarding – Branch of clinical care associated with the assurance and protection of vulnerable adults and children from all forms of abuse, whether physical, psychological or emotional.

Social Assessment Unit – Facility run by Doncaster Metropolitan Borough Council to support those patients who have not recovered sufficiently to return home, but require a longer period of convalescence and assessment in a supported environment

SPC – Specialist Palliative Care – a branch of medicine concerning the care for people suffering symptoms relating to terminal illness. The treatment offered is not just for people at the end of their lives, but through the terminal phases of their illnesses

SPICT – Supportive and Palliative Care Indicators Tool – tool developed by The University of Edinburgh to guide clinicians in determining appropriate level of intervention and support for those in the last year of life

STEPS – Short-term enablement programme (social care provided by DMBC)

Systemic Sepsis – syndrome associated with severe overwhelming infection, demonstrated by raised temperature and heart rate, with falling blood pressure, confusion and reduced level of consciousness

Tachycardia – raised heart rate (>100 beats per minute)

Tissue Viability – Branch of clinical care that manages the health of tissues in patients. Usually assessing the care and treatment of patients who have developed pressure sores, specialist nurses in this area provide vital guidance and support to patients and nursing staff on skin and tissue care

Urinary Catheter – a latex or other synthetic device used to assist patients in the elimination of urine. These devices can be useful in assisting the assessment of critically ill patients and in supporting the healing of tissue wounds in patients suffering incontinence; they are however strongly associated with urinary tract infections and generally considered to provoke infections, particularly in older people

Vascular Dementia – Form of dementia, found in people suffering who have experienced strokes, high blood pressure, diabetes or atrial fibrillation. The disease progresses more erratically with periods of stability followed by occasional sharp declines in cognition and behaviour.

Voluntary Sector – Also referred to as the ‘third sector’ – any agency which is funded solely or predominantly by fundraising and public donation. Doncaster& Bassetlaw Hospitals NHS Foundation Trust work closely with the Alzheimer’s Society, Age UK and WRVS amongst others

Yorkshire and Humber Deanery – The statutory body that oversees the post-graduate medical education of doctors and dentists in Yorkshire and the Humber region.

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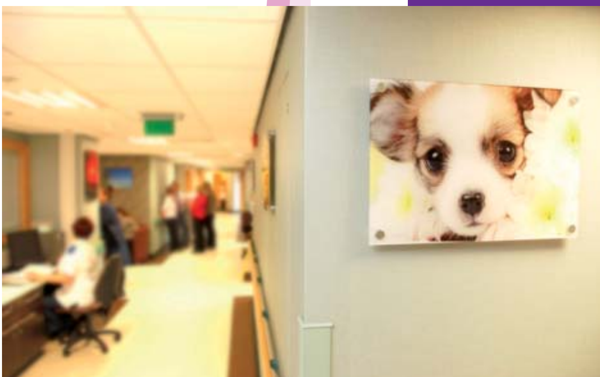
Dementia Strategy 2013 - 2017



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