Dementia Care in Hospitals:

The Private Setting
• Standard of care working groups

• Cabrini Health cognition working group 2011-2012

  Michael Butler          Sue Hewat
  Michael Rose           Amanda Kingham
  Jo McLeod              Tory Whitman
  Rachel Simmons        Donna Papas
  Maddy Cosgrave        Alison Hutchinson

• BUPA Funding Body
• Develop a standard of care for patients with cognitive impairment

• Identify patients with cognitive impairment

  “broad principal: delirium, dementia depression”

• Implement some sort of strategy

• The aim: “this will help our patients and decrease adverse outcomes”
Two Issues:

(1) The concept of “screening”

(2) The intervention
Screening in Dementia as a concept

Beneficial because:

**Community**

- The traditional role of cognitive screening has focused on the early detection of dementia to facilitate the appropriate diagnosis and management of this disorder.

- The benefits of early diagnosis are well documented, and include the future planning of patient’s medical, financial and lifestyle affairs while decision making capacity still remains. If needed safety issues such as driving, or assistance with patient’s personal activities can be attended to.

- Caregiver dissatisfaction with diagnostic delay may be minimized, and relevant pharmacologic therapies can be commenced.
Burden

- Dementia represents a significant burden to the health care system.

- It is anticipated that by the year 2016 dementia will have overtaken cardiovascular disease, cancer and depression as the major cause of disability in this country. Significantly the morbidity of dementia occurs in years of healthy life lost rather than of years of life lost through mortality.

- The disease burden from dementia and gain from early intervention (as described above) are sufficient to rationalize screening for this disease.

Hospital

- Communication, medication errors, delirium, falls, patient/carer satisfaction

“Sounds good but......”
Can there be harm?

“US preventive services task force (USPSTF) 1998”

- Against population cognitive screening, largely on the basis that there is no convincing evidence of an intervention which when used early in the course of a dementing process (mostly Alzheimer’s disease) would alter the process

“US preventive services task force (USPSTF) 2003”

- Evidence is insufficient to recommend for or against routine screening in older adults.

“Australian perspective (Flicker et al). 1997”

- Concerns that the use of “screening tests “in unselected elderly populations may produce more false positives than true cases of dementia

- Detection of milder forms of cognitive impairment has not been established mainly because therapeutic strategies have not been proven
Screening

“An organised attempt to detect among apparently healthy people in the community a disorder, or risk factors for which they are unaware”

Case finding

“Population in an at risk group”
Which groups?

*Probable risk population*
- ED (emergency department)
- GP (general practitioners) rooms
- Pre-surgical screening

*High risk population*
- Residential care facilities
- ACAS (aged care assessment services)
- General hospital wards
- GEM (geriatric evaluation and management) units

*At risk of dementia*

*Whole population*

*With dementia*

*Monitoring*
- Disease progression
- Response to treatment
Population to be “screened” or case-finding in the following

“Flicker et al. 1997”

• Patients seen by geriatric liaison teams in acute hospitals
• Acute Geriatric medical admissions
• Patients reviewed by aged care assessment teams (ACAT)
• Elderly individuals seeking institutional care
• Patients >75 in acute hospitals

“US preventive services task force (USPSTF) 2003”

• Clinicians should assess cognitive function whenever cognitive impairment or deterioration is suspected, based on direct observation, patient report, or concerns raised by family members, friends or care takers.
Traditional approach to “cognitive screening” tests

- Global assessment of cognitive fragments
- Limited assessment of cognitive domains
- MMSE most widely recognised test
- However >30 such tests reported........(I’m not going to describe them)
- Ceiling and floor effects
- Time consuming
Dementia is a disease of aging

<table>
<thead>
<tr>
<th>Age group</th>
<th>Prevalence rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-64</td>
<td>0.72</td>
</tr>
<tr>
<td>65-69</td>
<td>1.42</td>
</tr>
<tr>
<td>70-74</td>
<td>2.82</td>
</tr>
<tr>
<td>75-79</td>
<td>5.60</td>
</tr>
<tr>
<td>80-84</td>
<td>11.11</td>
</tr>
<tr>
<td>85+</td>
<td>23.60</td>
</tr>
</tbody>
</table>

Delirium is not well recognised

Positive predictive value a function of prevalence

Resources to screening in the Private Sector
Appendix Identification and Management of Delirium

Delirium Suspected:
Has the patient demonstrated:
an acute onset of confusion or change in mental state?
fluctuation in symptoms? (variation in severity over time)
difficulty in focussing attention (eg, easily distracted)
disorganised thinking (eg. rambling or incoherent conversation)
altered consciousness (eg, hyperalert, drowsy, unrousable)

Monitor Behaviour & Condition:
(Consider Supervision, orientation/validation, Day/night routines,
Medication review, Nutrition/hydration/pain, Family/Carer involvement, Behaviour/sleep chart, Cognitive Impairment Identifier)
Refer to "Strategies to assist in the prevention and management of delirium"

Referral to:
Treating Consultant immediately for management
Escalate to Nurse Manager if assistance required to obtain management plan
Cognitive Impairment Pathway
Improving and supporting the lives of patients and carers

Patient Age ≥ 65

- Yes
  - Clearly known to have delirium or dementia or Observations of acute confusion / agitation during admission
    - Yes
      - CI Considered Possible
        - Yes
          - OT (referral via PAS required) or nursing to administer MMSE within 24hrs if possible
            - No
              - MMSE ≤ 24
                - Yes
                  - Offer CII and CII pamphlet
                    - 2 - Implement communication strategy
                    - 3 - Enter relevant information into PAS (Refer to CII protocol)
                - No
                  - Usual Care
          - No
            - Usual Care
    - No
      - Usual Care

- No
  - Usual Care

If there are any concerns about your patient's cognitive state or you suspect delirium, then refer to the managing doctor
The Dementia Care in Hospitals Program (DHCP)

- Well established across many of Victoria’s public hospitals

- It is an educational-communication based intervention, aimed at improving communication between staff and patients with cognitive impairment

- Significantly, this program is regarded to provide improved hospital care to both patients with cognitive impairment and their care providers.

- Program relies upon the identification of cognitive impairment in selected patient groups that are most at risk.

- A bedside alert symbol, which encourages a trigger towards improving communication.

- We are trialing the Dementia Care in Hospitals Program at Cabrini. Selected wards at the Malvern and Brighton sites are participating in a twelve month pilot project.
Thank You
What is Cabrini’s ultimate aim?

- To test the use of the DCHP in the private sector, and to evaluate the effect of the program on falls risk, medication error, length of stay & time required with one-to-one care.
• To date, DCHP has not been introduced to the private hospital environment, nor has it been shown to directly impact on risk or hospital costs.

• Ultimately, this pilot will:

  (1) test the ability of the DCHP to deliver improved outcomes for people with dementia seen in the public sector when the program is transferred to the private sector; and

  (2) expand its evidence base by evaluating its impact on commonly measured adverse events.
What have been the pilot’s key drivers for Cabrini?

- Cognitive impairment inadequately identified and managed
- Significant work & support from BHS
- Opportunity with BUPA as the funding sponsor
- Commitment from Executive
- Cabrini Institute’s research expertise
- The importance of strengthening clinical governance
• Point Prevalence audit results highlight the demonstrated need to engage in person-centered practice, that fosters better outcomes for people with memory & thinking difficulties, and their carers.

**Acute Wards – Malvern Campus:**
- 3 Central  – General Medicine – 33 beds (43% of patients with CI)
- 3 South   – General Medicine and Neurology – 32 beds (50%)
- 4 South   – Oncology – 30 beds (8%)

**Acute Wards – Brighton Campus:**
- 1 North   – General Medicine – 24 beds (33% of patients with CI)
- 1 South   – Orthopaedic and Urology – 31 beds (33%)
Cabrini DCHP Insights and Learnings so far:

• Different projects/pilots being conducted simultaneously has impeded this pilot’s flow and momentum

• The project manager’s role & time as a resource has not been well quarantined for the pilot’s demands across two campuses

• Concerns expressed by Cabrini’s DCHP Steering Committee members & ward staff about the use of the term “dementia” on DCHP documents, as it could be perceived as “labeling” by patients and carers

• Routine screening of cognitive impairment has only become embedded as routine practice in recent times, coinciding with DCHP pilot requirements

• The stepwise approach, as a measure of cognitive impairment, has been viewed as time consuming, and an added responsibility on an already comprehensive admission process

• Cabrini’s medical model & clinical workforce is different to that of the public health sector. The differences between that of the private health setting & of the public health structures may require further exploration and comprehensive organisational workforce analysis
“At times I have felt like the accommodating carer, doing my utmost to nurture and empower the Cabrini DCHP team in an ever-changing and busy environment, with increasing demands.

All the while, aiming to ensure that the DCHP core principles are expressed in Cabrini’s service delivery for people with cognitive impairment, dementia and delirium.”

Donna Papas.

Thank you