National Institute for Health Research

Service Delivery and Organisation Programme

Care of Older People with Cognitive Impairment in General Hospitals

Executive Summary

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This project is funded by the Service Delivery and Organisation Programme

NHS National Institute for Health Research

Project 08/1809/227

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This report should be referenced as follows:

Gladman J, Porock D, Griffiths A, Clisset P, Harwood RH, Knight A, Jurgens F, *et al.* Better Mental Health: Care for Older People with Cognitive Impairment in General Hospitals. Final report NIHR Service Delivery and Organisation programme; 2012.

Relationship statement:

This document is an output from a research project that was funded by the NIHR Service Delivery and Organisation (SDO) programme based at the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) at the University of Southampton. The management of the project and subsequent editorial review of the final report was undertaken by the NIHR Service Delivery and Organisation (SDO) programme. From January 2012, the NIHR SDO programme merged with the NIHR Health Services Research (NIHR HSR) programme to establish the new NIHR Health Services and Delivery Research (NIHR HS&DR) programme. Should you have any queries please contact sdoedit@southampton.ac.uk.

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Criteria for inclusion:

Reports are published if (1) they have resulted from work for the SDO programme including those submitted post the merge to the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors. The research in this report was commissioned by the SDO programme as project number 08/1809/227. The contractual start date was in xxxx. The final report began editorial review in November 2011 and was accepted for publication xxx. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The SDO editorial team have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report documentation. However, they do not accept liability for damages or losses arising from material published in this report.

Executive Summary

Background

Mental health problems are common in acute hospitals. In a typical district general hospital with 500 beds, 330 beds will be occupied by older people and 220 will have a mental disorder. Dementia is the most common of these conditions (31% of all older people in hospital). Delirium is also common (20%) and frequently co-exists with dementia. Outcomes for patients with cognitive impairment are worse than for older people in hospital without cognitive impairment, and there are widespread concerns about the quality of care they receive. The care of such people needs to be improved.

Aims

- To elicit staff and organisational attitudes to dealing with older patients with cognitive impairment
- To elicit staff concerns about their training and competence in this area and suggestions for organisational change to improve care
- To understand the effect of hospitalisation on older adults with cognitive impairment, their carers, co-patients and staff
- To identify potential improvements in this process.

Methods

Two linked empirical research studies were undertaken.

An interview study was conducted of general hospital staff's confidence, competence and training and of the organisational factors affecting their ability to provide care for patients with cognitive impairment. The sampling frame was 11 acute hospital wards representing acute medical, geriatric and orthopaedic specialties. Sixty staff interviews were conducted across specialties and professional disciplines.

An observational and interview study was conducted of patients with co-morbid cognitive impairment, their carers and co-patients. This study used non-participant observation in the hospital setting and interviewing after discharge at the patient's home. An ethnographic approach, taking the perspective of the patient was used. Seventy two hours of non-participant observations of care were performed on the 11 study wards. Thirty-five interviews in 34 patients with mental health problems and their carers were

conducted. Four co-patients without mental health problems who had shared the ward with a study patient were also interviewed after discharge.

Results

The staff study found four super ordinate themes:

- Staff perceptions of patient group characteristics
- The challenges and impact on them of working with this patient group
- The ward environment
- Organisational factors affecting staff.

Interpretation of these findings found two key deficits:

- Lack of education and practical training to recognise and manage complex older patients with confusion.
- Inflexibility of a system that imposed unrealistic targets on those caring for such patients and detracted from their time and ability to provide appropriate care.

The observation and interview study elaborated a "core problem" and a "core process". The core problem was that admission to hospital of a confused older person was a disruption from normal routine for patients, their carers, staff and co-patients. The core process described was that patient, carer, staff and co-patient behaviours were often attempts to gain or give control to deal with the disruption (the core problem). Attempts to gain or give control could lead to good or poor outcomes for patients and their carers. Poor patient and carer outcomes were associated with staff not recognising the cognitive impairment which precipitated or complicated the admission and to diagnose its cause, and staff not recognising the importance of the relationship between the patient and their family carer. Better patient and carer outcomes were associated with a person-centred approach and early attention to good communication with carers.

Conclusions

A hospital admission of a person with cognitive impairment represents a disruption to normal routine to them, their carers, staff and cognitively intact patients sharing a ward with the confused patient. The behaviours that all parties engage in can be interpreted as attempts to regain or give control in response to this disruption. Some attempts to gain control are successful and are associated with good outcomes for patients and carers, but some are associated with poor outcomes.

Hospital staff, from all professional groups and at all levels of seniority, feel ill-prepared to understand this process. Indeed, despite older people with cognitive impairment due to dementia and delirium representing a core population within general hospitals, delivering appropriate care to them often seems to represent a disruption to core business. Many staff recognise that the care provided is not of high quality but do not know what they can do to improve things. Staff cite lack of adequate training as a problem, and that environments and systems are not configured in ways that are conducive to the care of older people with cognitive impairment. Staff express frustration and exhaustion as a result of dealing with disruptive patients within an ill-equipped system.

Our findings are likely to explain and understand how dissatisfaction with the hospital care of older people with cognitive impairment arises, and points towards how it can be improved. We propose that changes are necessary to recognise that care of older people with cognitive impairment is core business of general hospitals. This represents nothing less than a culture shift. Failure to do so will perpetuate poor outcomes and negative experiences of hospital care for patients and carers, and will fail to support staff properly.

All staff groups regularly caring for older patients, irrespective of their specialty and seniority, should be trained to meet the needs of these patients and the other parties affected by their admission. *A guide to training the social care and health workforce (1)* elaborates these key training points. It details 8 core principles inherent to high quality care for older adults with dementia regarding early identification of signs; timely diagnosis; good communication; promoting independence; recognising distress; valuing patient-carer relationships; staff training; and multidisciplinary teamwork. Identifying and correcting deficiencies in the current system in the context of these principles will enable organisations to improve care delivery.

Workplace-based training may be the most feasible and acceptable way to deliver such training, not least to allow staff to reflect on the degree to which they are disrupted and how they respond to this disruption. Prevention and management of aggressive behaviour is a core feature of training for staff in the mental health sector and this training should be replicated for staff in general hospital settings. New practices should arise from such training, and may include routine discussions with carers of patients, to ascertain patient-specific information that will enhance the hospital process and experience for all parties. This information may allow staff to reduce challenging behaviour and other problems, and may also help reduce excessive lengths of stay by improving decision making and the chances of successful discharge home.

More explicit support for carers and encouragement for them to contribute to patient care may help improve patients' safety and nutrition, relieve patient boredom, ameliorate co-patient concerns and help reduce demands

upon nursing staff. The timing and duration of visiting times should be re-considered. Hospitality and accommodation for carers should be available.

Since older adults with mental health problems are cared for on all wards in most departments of general hospitals, provision of information for co-patients and visitors may promote understanding and empathy.

Staff support mechanisms, as would be routine in mental health settings, should be established to help prevent staff burnout and long-term stress from untoward events such as episodes of violence.

Hospital environments need to be designed and renovated with the needs of cognitively impaired older people and their carers in mind. In the physical environment, examples might include improved signage and visual contrast, and more explicit removal of hazards such as storing bins for used hypodermic syringes in locked areas. Activity areas could be protected and made suitable for use by patients and their carers. More volunteers and activities coordinators are needed to facilitate activities.

Hospital processes and organisation also need to be changed. Frequent moves of older people with cognitive impairment should be avoided as they will cause further disruption. Ward nursing staff establishments need to take account of the emotional and psychological needs of the patients. The more patients with cognitive impairment there are on a ward the more time and effort will be required to deal with them. Failure to recognise this represents failure of the organisation to respond to a core need.

The National Dementia Strategy in England has called for the commissioning of liaison psychiatry services. These could potentially provide resources and leadership for ongoing workplace-based education and facilitate changes in the structure and process of acute hospitals.

General hospitals could develop a specialist ward for older people with cognitive impairment which could not only provide care for the most difficult management problems, but serve as a resource for workplace-based training and a hub for development of an expert workforce.

Since care of older people with cognitive impairment is core business, provision of a liaison service or a specialist unit alone should not be seen as a sufficient response by a general hospital. Education and changes to practice are needed wherever patients with co-morbid cognitive impairment are managed, including surgical and specialist medical wards. This requires high level organisational leadership and investment in the care for this patient group.

Further research should evaluate interventions such as: hospital at home; liaison old age psychiatry services; specialist units for delirium and dementia; interventions to improve staff competence and confidence in their competence; interventions for wandering or sleeplessness; innovations in the design of the physical environment; and systematic engagement of family carers.

Concerted efforts are required to avoid a vicious spiral of poor care and replace it with a virtuous cycle of high quality patient-centred care, with well-trained staff, good communication, a suitable environment and an engaged organisation at its core.

Project 08/1809/227