Improving care in acute hospitals

24th Alzheimer Europe Conference, Glasgow

16.00–17.30 (Argyll I-III) Plenary Session PL4: Innovation and care

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Scottish Government
IMPROVING THE EXPERIENCE OF CARE IN ACUTE GENERAL HOSPITAL SETTINGS (COMMITMENT 10)
Scotland’s Dementia Strategies 2010-2016

Standards of Care for Dementia in Scotland

Promoting Excellence:
A framework for all health and social services staff working with people with dementia, their families and caregivers

Scotland’s National Dementia Strategy: 2013-16

The Scottish Government
What we know…the costs to people with dementia and families

- Hospitals can pose greater risks than for other patients
- Noisy, stressful, unfamiliar hospital environment can cause distress
- Difficult to communicate effectively with staff – nutritional issues, physical and cognitive functioning decline, tissue viability and falls
- Independence and autonomy can be quickly eroded
What we know...the costs to the system and resources

• Identification and recording of dementia is often poor in hospitals (5%-10%) - In the majority of episodes of care, dementia has not been recorded as a principle or secondary diagnosis (Phillips 2011; HDS 2013)

• A quarter to a third of hospital beds are occupied by people with dementia over 65 years of age (Alz Society 2011)

• Reasons for admission:
  – Most common reasons for acute hospital care – Hip fractures and other injuries, respiratory infections, urinary tract infections and delirium (Toot et al 2013)
  – People with dementia are twice as likely to have a hospital admission (Midlothian Dementia Demonstrator 2008/09 IRF Dementia Report 2013)
Length of Stay in Hospital

- Length of stay:
  - 73% of people with dementia had a longer stay than those without a dementia diagnosis (HDS 2013)
  - Twice length of stay (Draper 2011) due to complications in care but also availability of care packages and/or specialist dementia care
  - Cost of additional bed days in NSW Australia (150,00) one year = $45 million ($7720 compared to $5010 per episode)
  - Alzheimers Society estimate that £117 million in UK could be saved by reducing length of stay by one week (AS 2009)
  - Primary reasons for admission have moved from dementia related care and rehabilitation to care for other conditions and comorbidities (HDS 2013). In Mental Health the reverse?

- In summary - people with dementia are more likely to have a hospital admission, generally stay in hospital longer, and have higher associated costs of care
Experience, outcomes and costs

• Changes outside the acute hospital
• Changes at the front door on admission
• Changes within the hospital – including environmental, resources and therapeutic milieu
• Cross sectorial changes – inc Specialist Dementia Care, End of life care
• Discharge changes
CHANGES OUTSIDE THE ACUTE HOSPITAL
Policy and Priorities

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.
Admission Avoidance Hospital at Home

- Treatment in the patients own home
- Would otherwise require admission to hospital
- Always for a limited time

Reduced Mortality at 6/12
Reduced Costs
Increased Satisfaction

Age Specialist Service
Emergency Team (ASSET) NHS Lanarkshire
Focus on Dementia
(National Dementia Improvement Programme)

Timely Diagnosis

Post Diagnostic Heat Target

Testing Alzheimer Scotland 8 Pillar Model

10 Dementia Care Actions in Acute Hospitals

Supporting the use of data to drive improvement in dementia
CHANGES AT THE FRONT DOOR ON ADMISSION
Extended Liaison Psychiatry Service for Older People
Nicola Wood – Team Leader; Dr Gillian McLean – Consultant Psychiatrist; Julie Reilly – Nurse Specialist; Margaret Anne McCafferty – Nurse Specialist

The Problem
2/3 of general hospital beds are occupied by those >65 yrs. 60% will have a psychiatric co-morbidity - **50% of this is undiagnosed**
Undiagnosed, these patients will experience increased lengths of stay, increased morbidity and mortality, delays in rehabilitation and institutional care.

Methodology
1. Staff reconfiguration – 1 x Band 7; RMN; 2 x band 6; 1 x band 5; plus 4 consultant sessions
2. Increased from 5 to 7 day service.
3. New easy access referral documentation.
4. Daily input into acute admissions unit.
5. All >65 checked for psychiatric history, and relevant information shared.
6. Education sessions for acute staff – use of AMT, CAM, AWI, delirium and dementia.
7. Engagement with carers.
8. Referral to other agencies to improve seamless care for patient.
9. Audit of patient, carer and staff satisfaction.

Aims
- Reduced length of stay
- Visible, Proactive approach
- Involvement of carers
- Educational staff
- Early identification of Psychiatric co-morbidity
- Holistic approach to care through better MDT working

The Team

The Scottish Government
Extended Liaison Psychiatry Service for Older People (NHS Forth Valley 2014)
Healthcare Improvement Scotland

Older People in Acute Care (OPAC) Improvement programme

THINK DELIRIUM

What is delirium?
Delirium (sometimes called acute confusional state) is a common serious condition for older people. This medical emergency is often under-recognised and often poorly managed. Delirium is the most common complication of hospitalisation in the elderly population. The incidence is also higher in those with pre-existing cognitive impairment.

The prevalence of delirium in people on medical wards in hospital is about 30% for 30%, and 10% to 50% of people having surgery develop delirium. People who develop delirium may:

- need to stay longer in hospital or in critical care
- have delirium (sometimes undiagnosed)
- have more hospital-acquired complications, such as falls and pressure sores
- be more likely to need to be admitted to long-term care if they are in hospital and
- be more likely to die. (NICE, 2011)

Recognising delirium

- Sudden onset of:
  - confusion or worse when normal confusion
  - impaired concentration and awareness
  - disorientation
  - agitation
  - reduced mobility and appetite
  - hallucinations or delusions
  - emotional or psychological
    - fluctuations in these symptoms

Suspecting delirium

- If you suspect a diagnosis of delirium:
  - refer to the Scottish Delirium Association (SDA) Delirium Pathway or Local Pathway
  - remember that delirium is one of the commonest problems in hospital

www.healthcareimprovement.scotn.org  www.knowledgesrc.scotn.org/improvingcareforolderpeople.iso
CHANGES WITHIN THE HOSPITAL SETTING
Healthcare Improvement Scotland
Older People in Acute Hospitals (OPAH) Inspections

- 32 inspections – 11 unannounced - 8 additional unannounced follow up inspections

- Inspectors trained in dementia care – Dementia Specialists as part of the process

- 10 Care Actions as the framework for inspection

- Improvements seen – lack of consistently
Scotland’s National Dementia Strategy: 2013-16

COMMITMENT 10:

We will develop and deliver a 3-year National Action Plan to improve care in acute general hospitals
Dementia Care Actions in Hospital

1. Identify a leadership structure within NHS Boards to drive and monitor improvements
2. Develop the workforce in line with Promoting Excellence
3. Plan and prepare for admission and discharge
4. Develop and embed person-centred assessment and care planning
5. Promote a rights-based and anti-discriminatory culture
6. Develop a safe and therapeutic environment
7. Use evidence-based screening and assessment tools for diagnosis
8. Work as equal partners with families, friends and carers
9. Minimise and respond appropriately to stress and distress
10. Evidence the impact of changes against patient experience and outcomes
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Shifting the Paradigm: Lessons from Acute Care (Simmons 2014)

Negative paradigm
• Don’t get stuck in older persons care
• Care of the “elderly” is not that skilled
• Why are they here?
• I did not sign up for this
• We need more dementia specialist units
• We are too busy for this

New paradigm
• Caring for older people is Acute Care and it is highly skilled
• Dementia, delirium and depression in an over 65 year old person is most common presentation
• We all need skills and confidence in dementia care
• We can provide quality care in situ
Paradigm Shift in Acute Care

Negative paradigm

Damaged psychological contract

Impacts on:
- Behaviour
- Commitment
- Motivation
- Morale
- Engagement

Poor standards
- Stress
- Denial
- Dissatisfaction
- Move the problem
- Poor outcomes

ASDN
DC
Standards
PE
10 actions

Repairs broken psychological contract

Leads to:
- Embracing
- Engaging
- Change
- Leadership
- Transforming

New Paradigm
Jointly funded Alzheimer Scotland Specialist Nurses
500 Dementia Champions from across Scotland in Nursing, Allied Health Professionals and Social Work
This publication features practice examples provided by some of the AHP Dementia Champions, illustrating how they are implementing new ideas and developing innovations in practice. There are accounts that describe the impact that AHP Dementia Champions are having as they work in partnership with healthcare support workers, paid carers in care homes, home care services, relatives, students, GPs and Alzheimer Scotland.
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‘Getting to know me’

We want to get to know you

We want you to have a good experience when you are in our care

Completing a personal profile (e.g. ‘Getting To Know Me’) and bringing it with you when you come into our service.

We will:
Treat your information with respect and keep it in a safe place.
Make sure we give it back to you when you leave our service.

If you don’t already have a personal profile you can find ‘Getting To Know Me’ online at:


Or ask a member of staff involved in your care to provide you with a copy.
Dementia Care Actions in Hospital

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Develop a safe and therapeutic environment: Shifting the Paradigm

• **Safe - Environmental changes – fabric**
  • Staffing – attitudes, resource, specialist, skill mix, working patterns

• Therapeutic milieu – deeper changes to culture/, for example?
  – Dining and Social areas
  – Single rooms
  – Meaningful Activities
  – Visiting hours
  – Outdoor space
Shhh......
Quieter hospitals promote healing!!
Noise reduction project, D.M. McGroarty, Charge Nurse, Ward 2, Monklands Hospital

Stop
Aim
To reduce noise levels and improve patient, carer and staff experience. To promote healing by creating and maintaining a relaxed, respectful, environment, assisting in the provision of person-centred care.

Listen
Survey results - Were you disturbed by noise during your hospital stay/visit/shift?

Top sources of noise for patients, relatives, carers and staff:

- Trolley wheels
- Blurred voices
- High heels
- Conversations
- Shouting
- Ward phones
- Infant crying
- Staff talking
- Phone calls

Comments before the project:
- "Shhh is the new norm" (South Lanarkshire Healthcare NHS Trust)
- "I used to feel embarrassed to walk around with a trolley"

Comments after the project:
- "The ward is so quiet now - I feel relaxed" (South Lanarkshire Healthcare NHS Trust)
- "I used to feel embarrassed to walk around with a trolley"

Think
What are we doing?
- Posters around the ward area
- Notes: reduced noise levels
- Staff awareness
- Feedback from patients

Actions you can take now to help
- Turn mobile phones off or put on silent
- Consider your footwear - High heels and studded shoes are noisy
- Avoid hanging bits and bobs - source/proximity low volume items
- Avoid large numbers of visitors and reduce chatter in corridors
- Keep volumes low on patient electronic equipment (TV, phone, i-pod)
- Ask relatives & patients to escalate noises and alarms to staff
- Explain noise calls buttons are for patient use only

Can you hear the healing?
We need to start thinking clearly and find as a team, as a unit - we need to work together to make a difference.

NHS Lanarkshire

You are now entering a quiet zone
Shifting the paradigm of acute care: Therapeutic milieu – deeper changes to environment paradigm
for example Dining and Social areas; Single rooms; Meaningful Activities; Visiting hours; Outdoor space??
‘The way we see dementia and dementia care models will reflect the way that the environment is designed and organised’

(Nele Spruytte 2014)

Berger and Luckman (1966) *The social construction of reality*
Develop a safe and therapeutic environment: Shifting the Paradigm

**Old Paradigm**
- Treatment and Cure focus
- Single clinical speciality
- Separate - Mental Health/Geriatric specialists
- Clinical milieu
- Traditional staffing
- Professional care
- Secondary care

**New Paradigm**
- Treatment, Reablement, Rehabilitation and Recovery
- Multiple conditions
- Integrated holistic teams
- Therapeutic milieu
- New staffing skills, resource and environment
- Shared care with carers/family
- Primary and social care
Develop a safe and therapeutic environment: Shifting the Paradigm

• **Staffing** – attitudes, resource, specialist, skill mix, working patterns

NHS Scotland
Nursing and Midwifery Workload and Workforce Planning Tools

The Scottish Government
A multifaceted, multi-agency, multi-disciplinary and integrated approach between acute hospitals, mental health, social care, third sector and other community resources – combining educational, improvement and assurance - is essential in ensuring that the care in hospitals is safe, effective and person centred.
Thank you for listening

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