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Overview

- Background
- Method
- Findings
- Conclusion
Dementia care in hospitals

- Approximately 25% of hospital patients have a dementia
- Co-morbidities are common
- People living with dementia are more likely to experience adverse events when admitted to hospital
- Adverse events contribute to longer length of stay, reduced functional abilities, and new admissions to care homes

Improving the quality of dementia care in hospitals

- Leadership that addresses quality improvements in dementia care
- Defined care pathways
- Use of liaison mental health teams
- Education and training to dementia awareness within the healthcare workforce

(Department of Health 2009, Health Education England 2015, Royal College of Nursing 2013)
Dementia Friendly

At the patient level, dementia-friendly healthcare

- Is the practice and organisation of care that is aware of the impact dementia has on a person’s ability to engage with services and manage their health.

- It promotes the inclusion of people living with dementia and their carer in treatments, care decisions and discussions, with the aim of improving outcomes for the person living with dementia and their carer.
Method

- Realist evaluation is a theory-driven approach that recognises the context-dependent nature of complex interventions (Pawson and Tilley 1997)
- Aims to build plausible, evidence-based accounts that explain what works, for whom, in what circumstances and why
  - Programme Theory
  - Context-mechanism-outcome configurations (CMOCs)
- A two phase study:
  - Phase 1 realist review
  - Phase 2 two-site case study using observation, interviews, and documentary review over 3 months
- An evidence review (Handley et al 2017) informed study design for phase 2
- Ethics and research governance were obtained.

(Pawson and Tilley 1997, Handley, Bunn, Goodman 2017)
Aim of the realist evaluation

To test and refine a theory-based explanatory account of what supports hospital staff to provide good dementia care, and with what outcomes for people living with dementia and their carers.
Two case study sites

- Two case study sites in hospitals at two NHS Trusts
- Interviews
  - Staff (n=36)
  - PLWD (n=4)
  - Carers (n=2)
- Non-participant observations (total of 80 hours in bays on wards, 41 at site 1, 39 at site 2)
- Documentary review
## Case study site characteristics

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
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<tbody>
<tr>
<td><strong>Dementia care provision</strong></td>
<td>Dual-frailty ward</td>
<td>Team providing dementia support across the hospital</td>
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<tr>
<td><strong>Environment</strong></td>
<td>Dementia-friendly environment</td>
<td>Traditional hospital environment</td>
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<tr>
<td><strong>Organisation of expert support</strong></td>
<td>Integrated into ward</td>
<td>Referral on case-by-case basis</td>
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<tr>
<td><strong>Transfer to ward</strong></td>
<td>Referral after admission (Median 4 days)</td>
<td>Admission to treatment ward</td>
</tr>
<tr>
<td><strong>Staff to patient ratio</strong></td>
<td>1:2</td>
<td>1:6 (1:7 at night)</td>
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## Patient characteristics by site (n=28)

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<thead>
<tr>
<th></th>
<th>Site 1 (n=18)</th>
<th>Site 2 (n=10)</th>
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<tbody>
<tr>
<td>Age</td>
<td>Median 77 (62 - 92)</td>
<td>88 (72 - 99)</td>
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<tr>
<td>Length of stay in days</td>
<td>21 (4 - 106)</td>
<td>23 (12 - 42)</td>
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<tr>
<td>Number returning to same place of residence yes/no/RIP</td>
<td>9/8/1</td>
<td>3/6/1</td>
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<tr>
<td>Dementia Diagnosis Yes/No</td>
<td>9/9</td>
<td>10/0</td>
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<tr>
<td>Delirium Yes/No</td>
<td>8/10</td>
<td>1/9</td>
</tr>
<tr>
<td>Comorbid conditions</td>
<td>Median 5 (1 - 13)</td>
<td>4.5 (1 - 11)</td>
</tr>
<tr>
<td>Number of medications on admission</td>
<td>Median 9 (3 - 15)</td>
<td>11 (4 - 26)</td>
</tr>
<tr>
<td>Recorded adverse incident during stay Yes/No</td>
<td>12/7</td>
<td>3/7</td>
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Refining the programme theory

<table>
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<tr>
<th>Initial CMOCs developed during the realist review</th>
<th>Revised CMOCs from realist evaluation</th>
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<tbody>
<tr>
<td>1) Understanding behaviour as communication improves staffs’ ability to respond</td>
<td>1) Knowledge and authority to respond to an unmet need</td>
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<tr>
<td>2) Experiential learning and empathy encourages reflection on responsibilities of care</td>
<td>2) Role relevant training and opportunities for reflection</td>
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<tr>
<td>3) Clinical experts who legitimise priorities for care</td>
<td>3) Clinical experts and senior staff promoting practices that are patient-focused</td>
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<tr>
<td>4) Staff with confidence to adapt working practices and routines to individualise care</td>
<td>4) Staff with time and the authority to resist competing demands</td>
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<tr>
<td>5) Staff with responsibility to focus on psychosocial needs</td>
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<tr>
<td>6) Building staff confidence to provide person-centred risk management</td>
<td>5) Supporting staff to be confident approach risk management using least restrictive practices</td>
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<td></td>
<td>6) Valuing dementia care as skilled work</td>
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CMOC: Valuing dementia care as skilled work
How expertise is recognised

- “If someone gets anxious we don’t get anxious, we actually deal with it in a way that’s calm.” (Healthcare worker, Site 1)

- “And they do the same job as the other care assistants, but they just have that time to do things with them and they’ve probably had a bit more training for how to calm people down, how to talk to people.” (Senior Nurse, Site 2)
Recognising skilled work

“I know that when it’s good here it’s really good and when it’s bad it’s horrible and I think that when people see it being good I think that people see it as an easy ward to work on and I think it is that lack of understanding that it takes a lot for the ward to be good. And you do get lots of benefits from it when it is good but it takes a lot of work from the staff for it to be, settled shall we say.

And that can cause a bit of ill feeling from my experience of other wards not really understanding that the guys down here work incredibly hard and they have a lot of challenges with patients which are really poorly from a mental health point of view, not just a physical health point of view.”

(Allied Health Professional, Site 1)
Preoccupations with losing clinical skills

- The ward manager sat down with me and said what a difficult time she was having. She was facing losing 7 members of nursing staff by the end of the year, 2 through pregnancy and the others through new jobs. Some were moving to jobs in A&E and the ward manager accepted that for nurses who had recently qualified that they wanted to be in a more clinically focused area so they would not lose their clinical skills. (Fieldnote, Site 1)

- “I’d been hoping actually that I’d be learning new things, but I feel like I’ve lost a lot of my skills.... for example, in the hospice I changed a lot of stoma bags, and things like that. But I’m worried, I’m worried that I’m going to lose my skills. (Healthcare worker, Site 2)
Discussion

- Staff being dementia aware is important but on its own is not enough to change patient outcomes.

- Need to ask
  - if they recognise dementia care as skilled work
  - if staff have the authority to offer person-centred care
  - what is in place to enable them to balance these demands with ward priorities and needs of other patients

- How initiatives are developed, discussed and implemented into different clinical settings is as important as the training and preparation of staff in dementia care.

- Dementia-friendly healthcare in hospitals makes a difference to the patient experience but takes time and has to be valued as skilled work by practitioners and the organisation.
References

- Royal College of Nursing (2013). Dementia: Commitment to the care of people with dementia in hospital settings. London.
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