Why are people with dementia admitted to acute hospitals?

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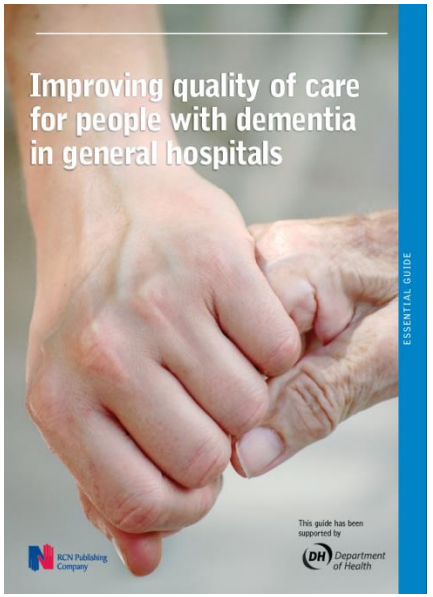
‘Right place, wrong person’

A key message echoed by staff at all levels in the organisations involved in this study was that the acute hospital is not the ‘right place’ for older people.

This chapter examines how the prevalence of this view has resulted in the physical environment, staff skills and education and organisational processes acting as barriers to delivering dignified care to older people.

Tadd W, Dignity in Practice 2011

Problems for people with dementia



- Noisy busy environments
- Fast pace of work
- Intensive questioning
- Multiple new faces
- Moving through different departments and wards
- Inability to express wishes
- Taking account of other patients' needs

RCN Guidelines 2010

“Toxic” environment

- Lack of exercise/movement
- Intermittent noise and light control
- Environmental manipulation
- Sleep deprivation/adjustment
- Controlled fear
- Disorientation
- Sensory deprivation (hearing and vision)

Thanks to Liz Sampson

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Thanks to Liz Sampson and Amnesty International

There is a lot of it about

- 60% geriatric medical patients
- 30% general medical admissions
- 40% hip fractures
- 25% of hospital beds

RCPsych Who cares Wins 2005

NIHR MCOP programme

Medical Crises in Older People

- Observational phase
  - Prevalence and follow up study
  - Diagnostic study
  - Patient/carer interviews
  - Workforce study
- Service development
- Evaluation and economic study

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Recruitment

- Approached 1578 acute admissions over 70y to 12 wards
  - 66 (4%) discharged
  - 285 (18%) repeatedly unavailable
  - 66 (4%) too ill
  - 79 (5%) declined
  - 78 (5%) other
- Screened 1004
  - 361(36%) no MH problem (or anxiety alone)
  - 147 (23%) declined
  - 48 (7%) consultee declined
  - 61 (9%) no family/consultee, 108 (17%) unable to contact in time
- Recruited 250 with possible MH problem, not anxiety alone
- 53 diagnostic assessment by geriatrician

Functional presentations

Presenting problems amongst patients over 70 with cognitive impairment admitted to a general hospital (n=53)

• Falls	34 (64%)
• Immobility	38 (73%)
• Pain	28 (54%)
• Incontinence	24 (46%)
• Breathlessness	12 (23%)
• Dehydration	11 (21%)
• Confusion	11 (21%)

Glover et al, 2014

Not just UTI

Final diagnoses amongst patients over 70 with cognitive impairment admitted to a general hospital (n=53)

MEDICAL

- pneumonia 4
- urinary tract infection 4
- multi-factorial fall 4
- multi-factorial functional problem 3
- AF with fast ventricular response 3
- dehydration/renal failure 3
- alcohol intoxication 2
- adverse drug reactions 2
- seizures 2 (alcohol excess, brain mets)
- unresponsive episode/syncope 2
- painful hip post fall 2
- unexplained delirium 2
- cancer 2 (gastric, lung)
- fractures 2
- infective exacerbation of COPD 1
- infected leg ulcer 1
- gastroenteritis 1
- stroke 1
- rheumatoid arthritis 1
- progression of vascular dementia 1
- acute urinary retention 1
- anxiety 1

ORTHOPAEDIC

- fractured neck of femur 7
- other fractures 4
- ruptured Achilles tendon 1

Glover et al 2014

Very physically dependent …

Prevalence amongst patients over 70 with cognitive impairment admitted to a general hospital (n=195)

ON ADMISSION

- help to transfer 48%
  - hoist 13%
- help feeding 58%
  - unable 15%
- incontinent of urine 53%
- Barthel Index <5/20 31%

PRIOR TO ACUTE ILLNESS

- help to transfer 13%
- help feeding 23%
- incontinent of urine 23%
- Barthel Index <5/20 7%

Goldberg et al, 2012

… and mentally

Prevalence amongst patients over 70 with cognitive impairment admitted to a general hospital, of at least moderate severity (n=195)

• delusions	14%
• hallucinations	11%
• agitated	18%
• depressed	34%
• anxious	35%
• apathetic	38%
• disinhibited	10%
• sleep problems	34%
• MMSE <9/30	25%

Goldberg et al, 2012

Medical admissions over 70

- 9% delirium alone
- 19% delirium complicating dementia
- 23% dementia alone

Total delirium	27%
Total dementia	41%
Previously diagnosed dementia	28%

Whittamore et al, 2013

Medical admissions over 70

Cornell Scale for Depression in Dementia

	TOTAL	COGNITIVE IMPAIRMENT
• No depression	68%	49%
• Possible major depression	24%	37%
• Definite major depression	8%	13%

Goldberg et al, 2012

Intervention

	Recorded	Suggested
Any assessment	100%	36 (68%)
Investigations	42 (79%)	17 (32%)
Collateral history	13 (35%)	17 (32%)
Any therapy	53 (100%)	40 (75%)
New drug	36 (68%)	18 (34%)
Drug review	21 (40%)	7 (13%)
PT	39 (74%)	21 (40%)
OT	8 (15%)	7 (13%)
Information giving	19 (36%)	9 (17%)
Planning	18 (34%)	20 (38%)

Glover et al 2014

Poor outcomes six months later

- 27% did not return home
- 31% dead within 6 months
- 18% 30-day readmission, 42% 6-months readmission
- 42% recovered to pre-acute illness level of function
- 16% spent >170/180 days at home

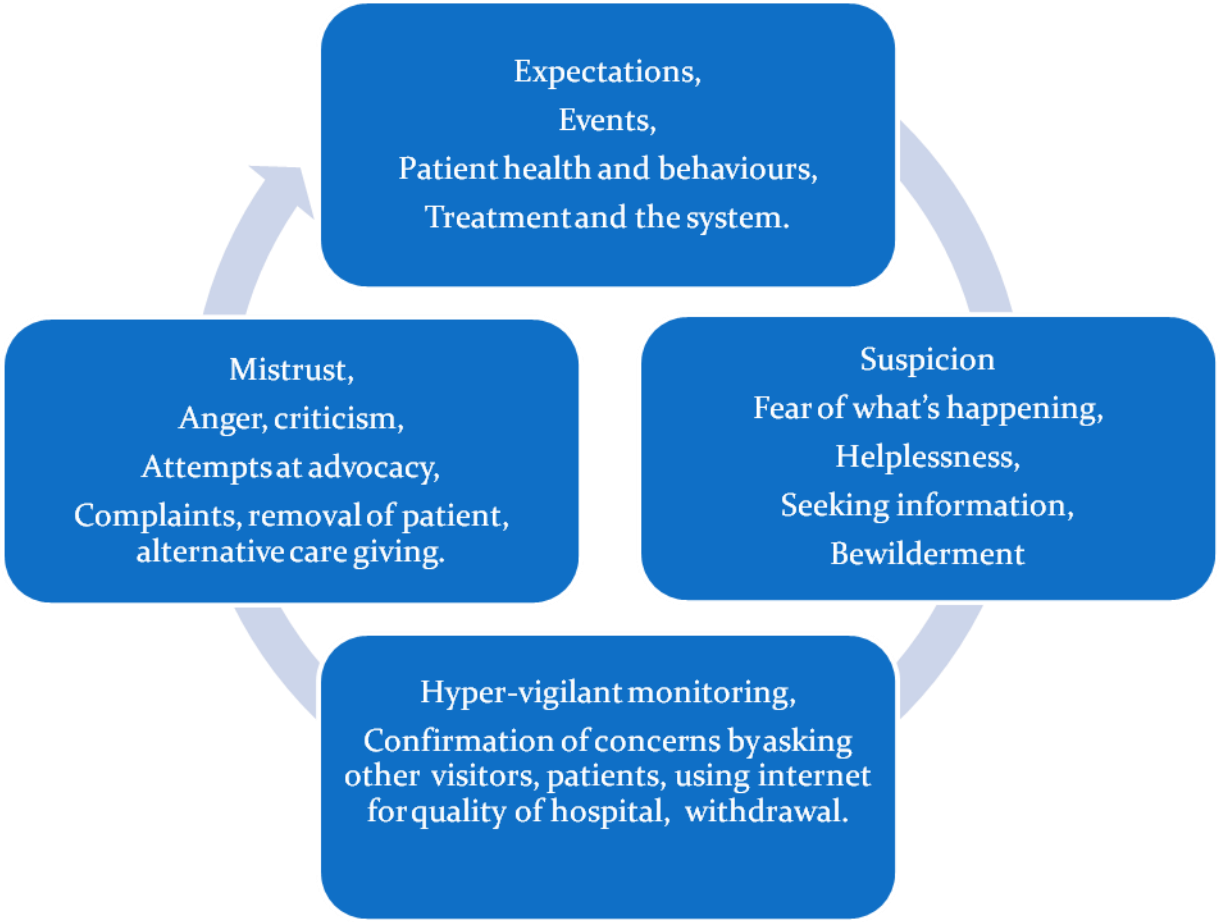
Bradshaw et al, 2013

Carers

- 180 carers of participants with cognitive impairment
- 32% lived together, 40% apart, 28% care home
- 25% spouse, 50% son or daughter, 25% other
- 59%>60y; 73% sole carer
- 57% co-resident carers reported 24h supervision
- 30% carers had mobility or ADL problems
- 42% high carer strain, associated with BPSD
- Little change at 6 months follow up

Bradshaw et al, 2013

The cycle of discontent



Jurgens et al, 2012

Communication

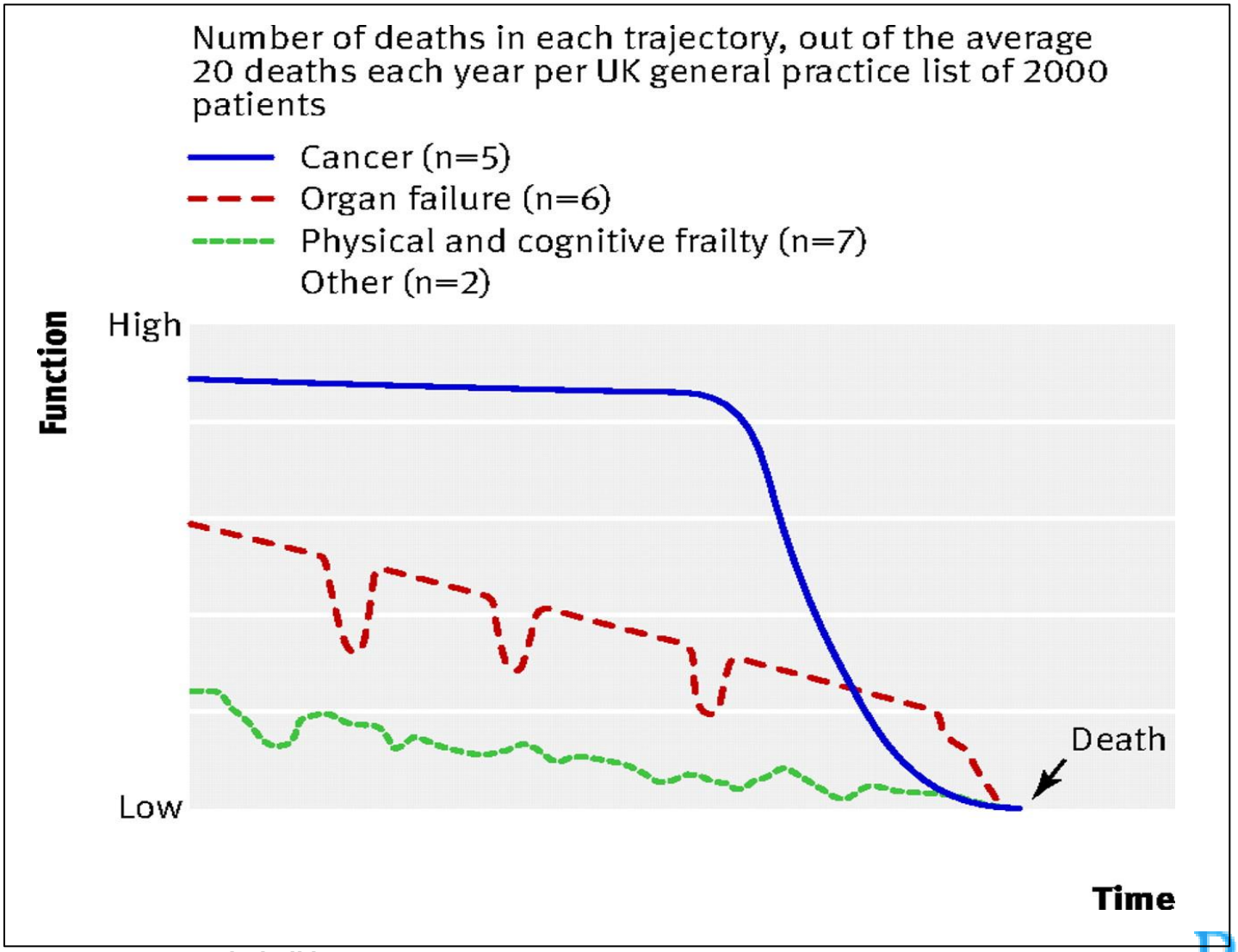
- I was shocked by the lack of communication to the family members
- If a family member is offering to help they don’t take it, maybe there's a policy
- Nobody will tell you … so you just don’t know. I had no control and that bothered me
- I’ve spent most of my life in America, and dealt with hospitals there, and I used to be a nurse, but this is so foreign to me

Dementia in crisis

- Super-added delirium
- Physical illness in person with dementia
- Progression of dementia especially vascular
- Behavioural problem, disability, coping, misjudgment
- Carer and social crises

… physician role may be to *exclude* physical disease

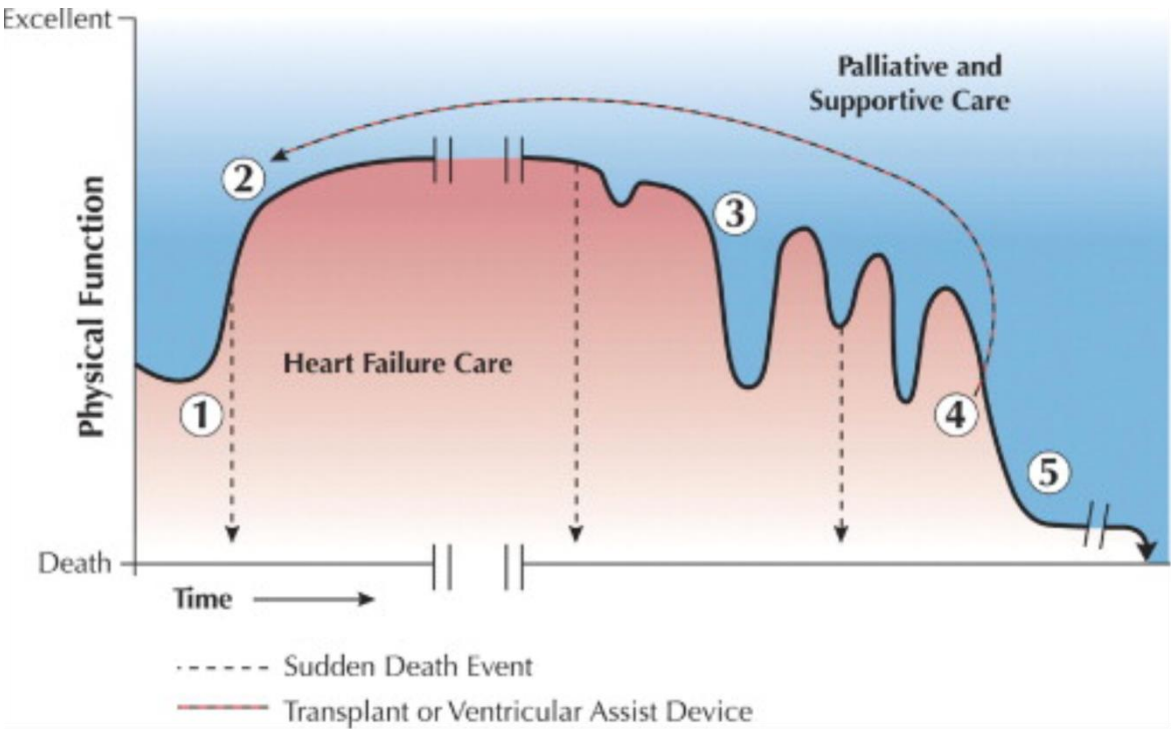
Three trajectories of decline at the end of life.



Murray S A , and Sheikh A BMJ 2008;336:958-959

BMJ

From: Palliative Care in Congestive Heart Failure



Goodlin S. J Am Coll Cardiol 2009; 54: 386

Prognostic indicators

- MMSE <18, hip fracture or pneumonia: 50% patients die <6m
- MMSE <12: median survival = 1.3y
- Care home admission: 71% die <6m
- Hospital admission, all dementia: 31% die <6m

- Appetite and swallow failure
- Immobile, no communication, dependent in ADL, weight loss
- Recurrent hospital admission, recurrent infections

MDS Mortality Risk Index

The MDS Mortality Risk Index – Revised (MMRI-R)

		Weighted points
Admission to nursing home in the past three months	Yes ☐ No ☐*	(8)
Lost weight unintentionally in the last three months	Yes ☐ No ☐	(5)
Renal failure	Yes ☐ No ☐	(6)
Chronic heart failure	Yes ☐ No ☐	(4)
Poor appetite	Yes ☐ No ☐	(4)
Male	Yes ☐ No ☐	(5)
Dehydrated	Yes ☐ No ☐	(4)
Short of breath	Yes ☐ No ☐	(8)
Cancer (if yes – see Age and Cancer worksheet; if no continue)	Yes ☐ No ☐**	
Age of patient/resident at last birthday ____	Age score **without** cancer	(2-9)
	Age score **with** cancer	(13-20)
Deteriorated cognitive skills or status in the past three months	Yes ☐ No ☐***	
Activities of Daily Living score ____	ADL score **without** cognitive decline	(0-16)
(see ADL and cognitive decline worksheet)	ADL score **with** cognitive decline	(-2-21)
	TOTAL MMRI-R SCORE	**(0-85)**

Score 26: sensitivity and specificity about 70%

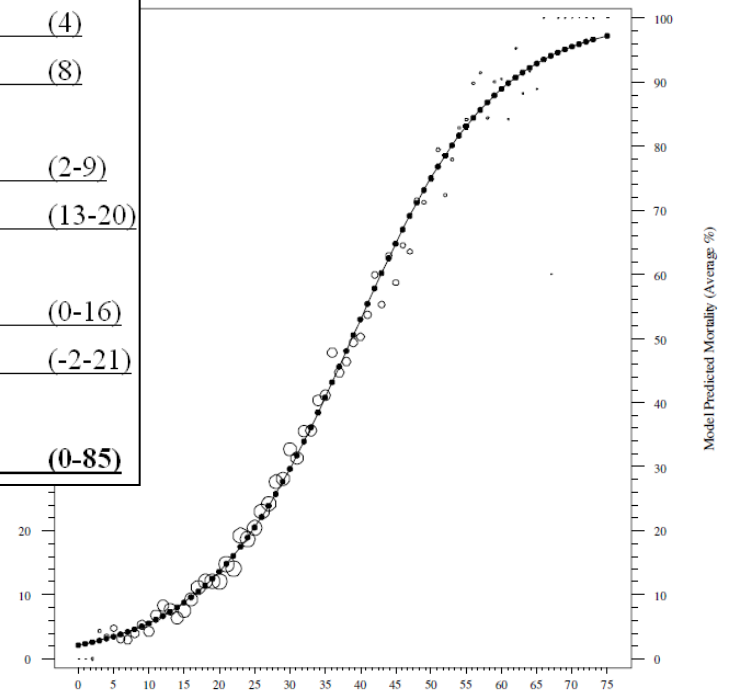
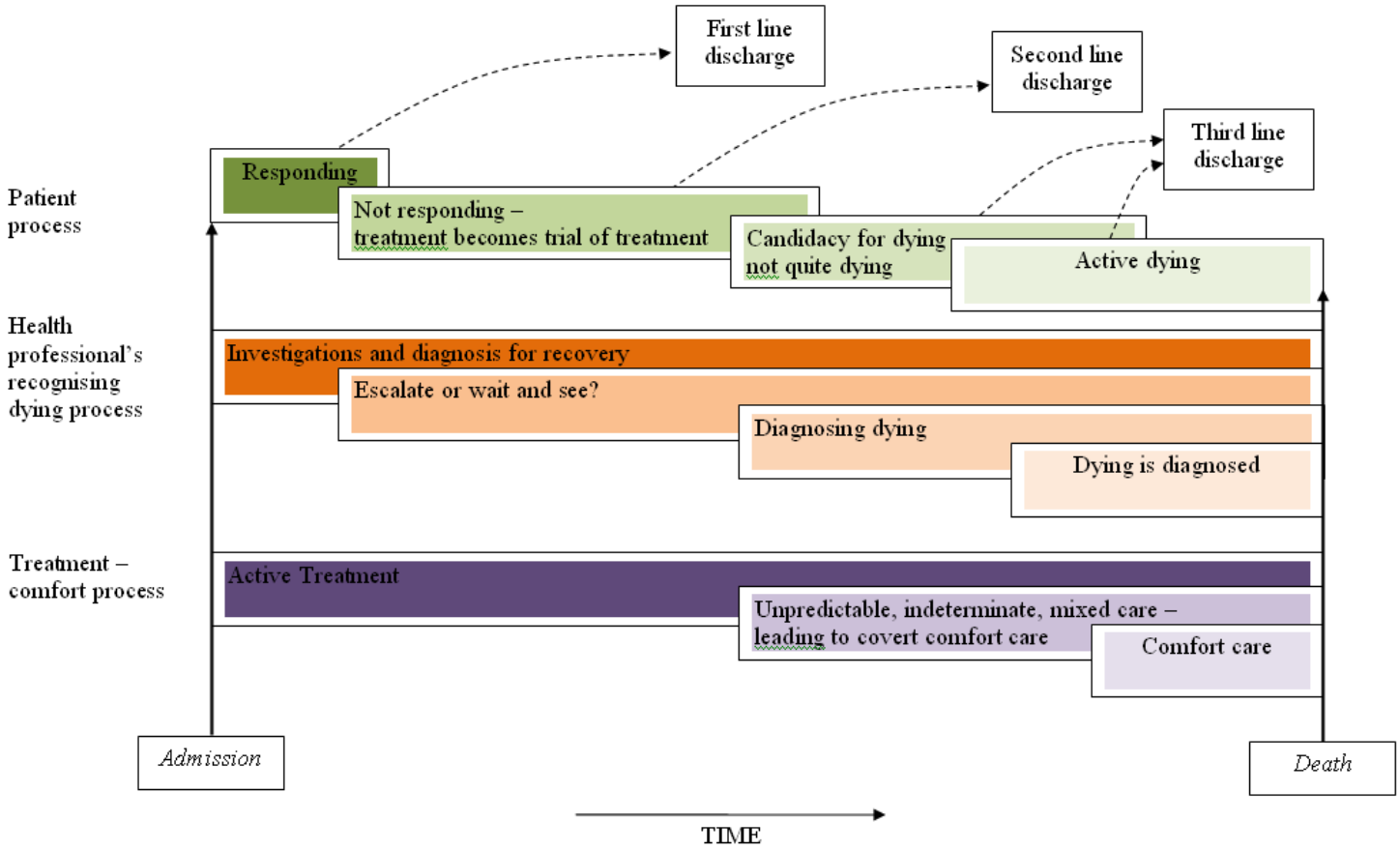


Figure 1 Observed and Predicted Six Month Mortality by MMRI-R Score - Validation Data. Open circles denote observed mortality. Dots denot model-predicted average mortality and MMR-R value.

Candidacy

Figure 1. The Process of Recognising Dying and Transitioning to Comfort Care in Hospitalised Older Adults



Davina Porock

What is hospital admission for?

- Acute medical care (rescue, cure)
- Rehabilitation
- End of life care
- Sanctuary, asylum
- Explanation, reassurance, risk management
- Decision making, care transitions
- …

Medical model

- Diagnose
- Treat
- Discharge

Comprehensive Geriatric Assessment

- Diagnosis
- Function
- Mental Health
- Social
- Environmental

Recovery model

- Focus on hope
- Positive attributes and abilities
- Achievable goals
- Taking risks and accepting failure

Principals of palliative care

- Meticulous management of symptoms or problems
- Open communication
- Psychological, emotional and spiritual support of the patient and those close to them

Social model (disability movement)

Disability is an oppression by the majority in Society on those with different abilities

Oliver 1990

Person-centred care

- Value people with dementia and those who care for them
- Individualised care
- Perspective of person with dementia
- Social environment and relationships

Brooker 2007

Clash of cultures

ACUTE

- Rescue, cure
- Safety
- Individuals
- Diagnosis
- Pathways
- Episodic

PERSON-CENTRED

- Palliation, experience
- Risk enablement
- Families, stakeholders
- Function, behaviour
- Individualisation
- Continuity, follow-on

Medical and Mental Health unit

- Environment
- Specialist mental health staff
- Training in person centred dementia care
- Purposeful activity
- New approach to family carers
- Medical staff interested and expert in delirium and dementia

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NIHR TEAM Trial: summary

- Care was different on MMHU
- Days at home 52/90 vs 46/90
- Patient experience better (mood, activity, staff interactions)
- Carer satisfaction better
- Small reduction care home placement
- Mortality, health status unchanged
- Length of stay, readmissions unchanged
- Cost-saving

Process differences, from casenotes

	MMHU (n=110)	Standard care (N=95)
Cognitive assessment (MMSE)**	52%	26%
Delirium recorded	37%	28%
Collateral cognitive history**	64%	33%
Collateral function**	81%	42%
OT**	83%	37%
SLT**	18%	2%
Clear medical diagnosis*	92%	77%
Progress discussed with family*	86%	75%
Antipsychotic drugs	14%	20%
CMHT referral*	20%	9%

***p<0.05, **p<0.001**

Goldberg 2013

A Radical Suggestion

David Nicholson, chief executive of the NHS Commissioning Board, asserts that 'Hospitals are very bad places for old, frail people' and suggests alternatives must be found.

Here is a radical suggestion – make hospitals good places for older people….

Marion ET McMurdo
BMJ, 16th Feb 2013

Summary

- 1 in 3 acute hospital admissions is of a confused older person
- Presentations non-specific, most are admitted for good reason
- People with dementia often have super-added delirium, active psychopathology and new or worse disability
- Many are approaching the end of life
- EOLC and person-centred dementia care are almost identical
- Can we adapt the acute care model for this population?

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