

ULHT Dementia Care Bundle

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes and when multidisciplinary and multi-agency teams work together there are proven benefits to patients and their carers. National audits and research show us that patients with dementia in acute hospitals experience poorer outcomes for all types of admission, stay longer in hospital, and are more likely to be discharged to a care home rather than to their own home.^{1,2}

Whilst there are a number of specific clinical pathways and care bundles it is believed that a greater focus on the experience and emotional needs of our patients and their families will have a significant impact on all aspects of their care and their stay³.

This Dementia Care Bundle⁴ has been developed in partnership with the Alzheimer's Society, Carers First and commissioners.

Together we have identified 5 aims that are based on best evidence and practice and from these aims we have designed a simple set of actions for staff to consider and to follow.

ULHT Dementia Bundle aims:

1. Swift identification of patients with dementia and delirium to enable appropriate prompt intervention and necessary referral or follow up after they leave hospital.
2. Knowing key information about patients who are unable to communicate this to enable a person centred care approach to care and communication that is frequent, skilful and compassionate.
3. Nutrition and hydration needs that are not only adequately identified and provided but are in line with patient preference and provided in a way that is tailored to their needs and capability.
4. A safe, caring and therapeutic environment is provided.
5. Family and carers are welcomed, involved and have their needs considered and supported

The evidence, research, publications and national guidance relating to each of these aims is available at Appendix 1.

Using the bundle

Every patient aged 75years or over is already required to have dementia screening assessment (*formerly known as the CQUIN questions*) and this will continue as per current processes. This bundle plays an integral part in that any patient, aged 65 years or above who **shows any sign of confusion** should be considered using the bundle set criteria. It is acknowledged that some patients may have early onset dementia however it is anticipated that in these circumstances existing assessments and investigations will determine this. This bundle has been designed to focus on the greater majority of our patients with dementia who have reached the age of 65 years and over.

The following ULHT Dementia Care Bundle form will be started in the Emergency Department or Admissions Unit and then continued and completed once admitted to a ward.

The bundle is a prompt or an aide-memoire for the core considerations and interventions for every patient who presents with some level of confusion; it is not designed to replace current documentation or care planning.

The DCB form:

Dementia Care Bundle (DCB)



Date: DDMM/YYYY Time of assessment: HH:MM

This form is designed to help clinicians consider the needs of emergency care patients with diagnosed or suspected dementia and to guide and signpost to additional support and interventions. Please complete and **retain at the front of the patients notes** so that on transfer all relevant health care professionals are aware.

Hospital number:
Surname:
First names:
Date of birth:
NHS number:

AFFIX STICKER

DCB 1: Swift identification of patients with dementia and delirium to enable appropriate prompt intervention and necessary referral or follow up.

DCB1 TO BE COMPLETED IN EMERGENCY DEPARTMENT / ACUTE ADMISSIONS UNIT

Action 1: Determine whether there is a history of confusion:

- > All patients aged 75+ should be asked the national dementia screening question; this will help to determine swiftly whether there is a history of confusion that needs to be taken into account: 'has the person been more forgetful in the past 12 months to the extent that has significantly affected their daily life?'
- > Speak to family or carers to establish usual level of cognition, function and support to enable care planning.

Action 2: Determine whether delirium is present:

	Please tick appropriate response	Yes	No
1. Are there signs of delirium for e.g.: acute onset of confusion; fluctuating level of confusion; inattention; disorganised thinking; altered level of consciousness??	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there risk factors of delirium for e.g.: cognitive impairment; dehydration; immobility; visual or auditory impairment; sleep deprivation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have carers, family members, staff from community settings raised concerns about changes in behaviour, ability or function?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the 6 item cognitive impairment test (6CIT) been completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Delirium is a medical emergency - if the answer to any of these is Yes then follow:

- > Sepsis 6 Policy and Bundle of care
- > ULHT Delirium Care Pathway for Frail Adults (via Intranet)

DCB2, 3, 4 AND 5 TO BE COMPLETED ON ADMISSION TO WARD

DCB2: Knowing key information about patients who are unable to provide this themselves to enable person centred care and communication that is frequent, skilful and compassionate.

	Date	Signature
Action 1: Follow ULHT Dementia Care Pathway (via Intranet).		
Action 2: Speak to family, carers or community staff to understand core information about the patient.		
Action 3: Refer to Dementia Care Practitioner (LCH & PHB only) for advise and review.		
Action 4: Ask if the patient has an All About Me booklet; if so ensure all staff are aware; if not offer a copy.		
Action 5: Ensure care plans highlight specific individual needs, consider equality and diversity and that all staff are aware.		
Action 6: Ensure capacity assessment and DoLs scoping tool have been completed		

DCB 3: Nutrition and hydration needs are not only adequately identified and provided but are in line with patient preference and provided in a way that is tailored to their capability.

	Date	Signature
Action 1: Complete MUST assessment		
Action 2: Identify & document usual routines, likes, dislikes and preferences for food and fluids.		
Action 3: Complete Nutritional MCA where meeting nutritional needs are more complex.		
Action 4: Identify & document level of assistance required.		
Action 5: Ensure hotel and domestic staff aware of individual needs.		

DCB 4: A safe, caring and therapeutic environment is provided

	Date	Signature
Action 1: Consider the physical ward environment for noise, lighting, level of stimulation; do any adjustments need to be made?		
Action 2: Ensure patient is orientated to where personal items and facilities are such as bathroom, call bell, glasses.		
Action 3: Consider interventions such as RITA, group activities.		
Action 4: Ensure care plans highlight specific individual needs and that all staff are aware.		

DCB 5: Family and carers are welcomed, involved and have their needs considered and supported.

	Date	Signature
Action 1: Consider the family & carers as <u>expert partners</u> in the patient's care; offer a Carers Badge.		
Action 2: Ensure family members are consulted as part of best interest planning.		
Action 3: Agree a communication plan with family, who and when.		
Action 4: Ask family and carers if they would like to be referred to the Alzheimer's Dementia Family Support Service (DFSS).		
Action 5: Ask family and carers if they would like to be referred to Carers First for advice and support in their role as carers.		
Action 6: Ask family to complete a carers survey on discharge.		
Action 7: Provide a Join Dementia Research leaflet.		

REFERRALS & ADDITIONAL SUPPORT

For medical referrals please use usual referral pathways.

	Name	Contact
Dementia Practitioner - Lincoln	Jenny Meng	01522573764
Dementia Practitioner - Pilgrim	Jodie Barwick	01205446593
Dementia Family Support Services - Lincoln		01522 692681
Dementia Family Support Services - Pilgrim		01522 692681
Dementia Family Support Services - Grantham		01522 692681
Carers First - Lincoln	Kate Marshall	07391 418572
Carers First - Pilgrim	Joanne Fox	07391 418565
Carers First - Lincoln	Louise Higgins	07391 418575
Carers First - Grantham	Kate Marshall	07391 418572

APPENDIX - EVIDENCE BASE

Aim 1: Swift identification of patients with dementia and delirium to enable appropriate prompt intervention and necessary referral or follow up after they leave hospital.

- Few cases of dementia are diagnosed in the early stages as many of the associated symptoms, such as memory loss, could be attributed to general aging or other conditions such as depression, diabetes, thyroid abnormalities or alcoholism. ⁵
- Early diagnosis of dementia could potentially allow people with dementia and their carers to plan for the future whilst the patient still retains the capacity to participate in decision making, and to start any potential treatment earlier. It could also support the early education of caregivers on how to manage the patient, and the management of any co-morbid health conditions. ⁶
- Diagnosing dementia can be difficult owing to its insidious onset, symptoms resembling “normal ageing” memory loss, and a diversity of other presenting symptoms—for example, difficulty in finding words or making decisions ⁷
- An individual’s ability to accommodate, compensate, or even deny his or her symptoms in the early stages should also be considered. The individual’s family may also have noticed difficulties in communication and personality or mood changes; family concern is of particular importance. Increasing frequency of patients’ visits to their general practice, missed appointments, or confusion over drugs may also be warning signs. ⁸
- Dementia diagnosis provides access to a pathway of evidence-based treatment, care, and support across the disease course. Early therapeutic interventions can be effective in improving cognitive function, treating depression, improving caregiver mood, and delaying institutionalisation. ⁹
- Think Delirium: evidence shows that persistent delirium is associated with poor outcomes in terms of mortality and cognition, supporting the need to be aware of delirium and the need for vigilance in patients presenting with hypoactive delirium, which has been shown to be associated with prolonged delirium. ¹⁰

Aim 2: Knowing key information about patients who are unable to provide this themselves to enable person centred care and communication that is frequent, skilful and compassionate.

- Knowing key information about patients who are unable to readily provide this for themselves is a cornerstone to good dementia care for those with moderate to severe dementia. ^{11, 12}
- The ‘All about Me’ document was developed in partnership with patients, carers and local agencies and is designed to hand held and kept by the patient’s bed to be accessible to staff to aid care planning, family members and the patient themselves. It is to be transferred with the patient when they move or visit another department or discharged.
- The principles of person centred care underpin good practice in the field of dementia care assert: ¹³
- the human value of people with dementia, regardless of age or cognitive impairment, and those who care for them
- the individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia
- the importance of the perspective of the person with dementia and the importance of relationships and interactions with others to the person with dementia, and their potential for promoting well being
- Person-centred communication involves a commitment to including the perspective of the person living with dementia, and an understanding of who the person is, their life history and preferences. ¹⁴
- A common misconception is that people with dementia eventually lose their ability to communicate and that there is little point in trying to communicate with someone who is, apparently, unable to engage. People in the early stages of dementia are able to communicate with little difficulty, requiring only minimal prompts and cues to orientation. As the disease progresses, memory loss, poor comprehension, concentration and word-finding difficulties lead to frustration and distress, limiting individuals’ expressive ability and eroding their self-confidence and sense of identity. In later stages they may lose ability to communicate verbally and efforts need to be made to adapt strategies to the needs of the individual. ¹⁵

Aim 3: Nutrition and hydration needs are not only adequately identified and provided but are in line with patient preference and provided in a way that is tailored to their capability.

- Multi-component oral nutrition support for older people started during acute hospitalisation and continuing after discharge may reduce mortality and increase weight. It may also improve functioning (namely, ability to perform everyday activities such as climbing stairs). There is some evidence that such interventions may also be cost effective in terms of functioning. Oral nutritional supplements in older patients after hospital discharge may increase energy intake and weight, and may also be associated with a cost-effective improvement in quality of life.
- Older people are particularly at risk of malnutrition. Physical causes are partly attributable to body changes that occur with increasing age. Other factors include: impaired vision and hearing, loss of taste or smell, dementia or depression. ¹⁶
- Older people suffering from dementia are at increased risk of malnutrition due to various nutritional problems, and the question arises which interventions are effective in maintaining adequate nutritional intake and nutritional status in the course of the disease. It is of further interest whether supplementation of energy and/or specific nutrients is able to prevent further cognitive decline or even correct cognitive impairment, and in which situations artificial nutritional support is justified. ¹⁷

Aim 4: A safe, caring and therapeutic environment is provided

- A secure and orienting environment in the vicinity of the patient decreases the likelihood of falls and accidents, improves continence and helps maintain daily living skills. General principles include de-cluttering, personalising, good signage and ensuring calm surroundings. ^{18,19,20,21}
- Core themes have been identified within research including; fabric of the building and the ambience, activities and safety, information and communication. ²²
- Meeting individual needs must consider not only the clinical needs such as pain relief, reducing the risks of harm from falls and pressure ulcers but also consider person centred care needs for activity and inclusion. Person-centred care focuses on the individual needs of a person rather than on efficiencies of the care provider; builds upon the strengths of a person; and honours their values, choices, and preferences A person-centred model of care reorients the medical disease dominated model of care that can be impersonal for those oriented to holistic well-being that encompasses all four human dimensions: bio-psycho-social-spiritual. ²³

Aim 5: Family and carers are welcomed, involved and have their needs considered and supported.

- Meaningful involvement and inclusion of carers can lead to better care for people with dementia. In an ideal situation the needs of the carer and the person with dementia are both met. Inclusion of people with dementia and support in making decisions is therefore fundamental.
- Carers and relatives should have the opportunity to be involved in decisions about care and treatment. Dementia is a degenerative condition which can affect a person's insight, capacity and ability to make decisions. This can result in differing views and needs between people with dementia and those caring for them. While the person with dementia has capacity they must be supported to make their own decisions and articulate views. However, if they lack capacity, health and social care professionals must act in the 'best interests' of the person with dementia, bearing in mind the provisions of the Mental Capacity Act (2005). Balancing the needs and views of carers with those of the person with dementia is essential within this. ²⁴
- Carers of people with dementia can experience high levels of anxiety, depression and stress as a result of caring, and their needs often go unrecognised. It is essential that carers are identified and assessed as having their own needs – a hospital admission for the person with dementia may provide an ideal opportunity to identify potential concerns. ²⁵
- There should not be an enforced disconnection between carers and those who need care. When someone with dementia is hospitalized, the medical staff should do all within their power to make access easy for family carers and utilise their expert knowledge and their love. Behind its simple statement of purpose lies the belief that carers should not just be allowed to stay with their loved one in hospital but should be welcomed, and that a collaboration between the patients and all connected with them is crucial to their health and their well-being. ²⁶

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