Acute Hospitals Dementia Champions Meeting

Wednesday 12th July 2017

Dr Rod Kersh (chair)

Consultant in Holistic & Person-Centred Medicine for Older People Secondary Care Clinical Advisor, Dementia & OPMH Clinical Network
Action Log and matters arising from last meeting
What is an STP?

- Formally known as ‘Sustainable Transformation Plans’ NOW Sustainability & Transformation Partnerships
- Systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health
- As STPs evolve, they will become accountable care systems (ACSs), working as a locally integrated health system.
- Intended to provide joined up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area and work closely with local government and other partners to keep people healthier for longer, and out of hospital.
- **STP booklet** now available to help you understand what is happening in each area and their priorities
- **STP animation** reflects the evolution of 'plans' to 'partnerships', now organisations are moving away from strategy and towards implementation.
STP Focus on Depression, Delirium and Dementia (3Ds)

Why should this be an STP Priority?

Health & Wellbeing Gap
- Loss of independence and de-conditioning
- Social isolation
- Lack of community cohesion
- Lack of accessible services
- Loneliness
- Higher levels of ill health among carers
- High risk vulnerable group with high falls risk. May be frail and/or housebound
- 62% of hospital bed days are used by older people
- 30-40% of older people admitted to hospital will have depression (?source)
- Care home residents 40 – 50% more emergency admissions than the general population

Quality Gap
- Lack of comprehensive assessment & identification of 3Ds
- Poor access to IAPT
- No wellbeing/recovery approach for older people
- Over-medication/ inappropriate meds
- High risk of unplanned hospital admission & longer LoS (on average 7 days longer for dementia)
- Admitted too early to long-term residential care
- Inequity in access to dementia post-diagnostic support (PwD and carers)
- Lack of clear diagnosis and support pathway for dementia in specific services

Financial Gap
- Pressure on working age carers esp. some BAME groups
- Costs of older people’s admissions – 25% of acute hospital beds estimated to be occupied by someone with dementia
- Delayed discharges of care
- Costs associated with early admission to residential care
- Medication costs
- People with complex residential care needs related to dementia frequently placed out of area at significant cost to both system and family
Education and Training Update
Acute Hospitals Dementia Champions meeting

Danielle.farrar@hee.nhs.uk
Training Count

Positive increases in dementia training across the country in all ‘tiers’ in line with the Dementia Core Skills Education and Training Framework via a biannual census of dementia training

- 799,391 episodes of tier 1 training
- 55,178 episodes of tier 2 training
- 17,597 episodes of tier 3 training

21% increase on tier 1 since March 2016
Yorkshire and Humber Count

Tier 1 – 55,751

Tier 2 – 9,655

Tier 3 – 2,083

The focus in 2017/18 onwards will be on increasing uptake of training at tier 2 and 3
Training Films

Launched dementia awareness training films ‘Finding Patience’ (focussing on the African Caribbean Community) and ‘Finding Patience – The Later Years’, (set in a care home and focusing on person-centred care).

Both films featured at the UK Dementia Congress in Brighton in November 2016.
Undergraduate Healthcare Curricula Assurance

Obtained assurance that 98% of undergraduate healthcare curricula include dementia education and training to at least tier 1.

This followed a review of evidence collected by local offices from their HEIs throughout November-December 2016.

An overview was provided to the Department of Health 2020 Dementia Programme Board on 25th January 2017.
DEALTS2

Refreshed Dementia Education and Learning Simulation Training (DEALTS) ‘train the trainer’ package developed in partnership with Bournemouth University focusing on tier 2 training.

20 attendees from trusts across Yorkshire and Humber

Slides will be made available on HEE website once final course delivered
National Activities

‘What Works’ Project - Resource Audit Tool (draft format)

Collaborative project with Skills for Health and Skills for Care to develop a training package to support tier 2 training using the ‘Finding Patience’ films

Updated e-learning programmes
http://www.elfh.org.uk/programmes/dementia

2 x Films with Manchester University
  Mental capacity assessment short film for an individual living with dementia
  Cartoonist Tony Husband and his personal experiences following his father’s diagnosis of dementia.
Thank you

Questions?

danielle.farrar@hee.nhs.uk
Discussion – Tiers 2 & 3

• How are tier 2 & 3 training being delivered in your trust?
• Which staff groups are being targeted for training?
• Has any work been done to standardise training delivered across different care settings e.g. acute trust, primary care, social care?
Tier 2 and Tier 3 training currently being used are:

- Person Centred dementia care training (Bradford University level full day course) – Requires staff to be released for a full day, which we are actively trying to promote the importance and benefits of attending this.
- The Butterfly Scheme training – currently in the process of rolling this out again.
- CAPER training- following the last Acute dementia hospitals meeting, we are pilot this with our brand new team of 20 enhanced care workers initially.
- DEALTS Simulation training- Kirsty Jowett and Caroline Sellers attended the DEALTS train the trainer day and are in the process of revamping the person centred training to incorporate some of the aspects, resources and exercises acquired from this training day.
- Online e-learning dementia awareness mandatory for all staff
- Dementia Friends training being rolled out to all areas to raise the profile again, and promote awareness.
- Johns campaign
  We have delivered posters to all ward areas to display the re launch of johns campaign, we are also in contact with Julia Jones around her looking at possible prompt cards being designed.
- We will be printing leaflets out to hand to patients/families and carers also
Meeting Theme: Discharge Planning & Readmission Avoidance
Introduction to DTOCs

Bev Gallagher, Clinical Quality Manager for Care Homes and Domiciliary Providers, NHS Bradford Districts CCG
What are delayed transfers of care?

According to NHS England (2015), a ‘delayed transfer of care’ occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so.

Sometimes referred to in the media as ‘bed-blocking’, delayed transfers of care are a problem for the NHS as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients.
When is someone ready for transfer?

NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

• a clinical decision has been made that the patient is ready for transfer, and
• a multidisciplinary team has decided that the patient is ready for transfer, and
• the patient is safe to discharge/transfer.

As soon as an adult patient meets these three conditions and remains in hospital, the clock starts and they are classified as ‘a delayed transfer’.
Who would be most likely to have a delayed transfer of care?

Older people account for most delayed discharges
- 85% of patients who have a DTOC are aged 65 or over
- Admitted to A & E as an emergency admission
- Care home residents 40 – 50% more emergency admissions than the general population (Smith et al, 2015)
- Common conditions include pneumonia, Alzheimer's disease, dementia and epilepsy.
- Average length of stay 11.9 days
- Patients with dementia stay in hospital for seven days longer than others (Alzheimer’s Society 2009).
- 62% of all bed days occupied by older patients in 2014/15 (NAO, 2016)
What is the impact of DTOCs on patients?

- Patient experience – people don’t want to be stuck in hospital when they don’t need to be!
- Longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation, which can affect a patient’s health after they’ve been discharged and increase their odds of re-admission.
- The National Audit of Intermediate Care shows that, for older patients, ‘a wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength’.
How are delayed transfers of care measured?

**NHS England publishes two measures:**
- the number of patients still delayed at midnight on the last Thursday of the month
- the total number of bed days taken up by all delayed patients across the whole calendar month.

**Limitations**
- It is not clear whether all providers are using the definitions of delayed transfers of care or reasons for delay in the same way; small differences in interpretations could lead to large changes in reported numbers.
- Counting patients at midnight on one evening per month will hide lots of variation within the month.
What is the extent of the problem at a National level?

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<th>Delayed Transfers of Care</th>
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<td>Number of patients</td>
<td>Total days delayed</td>
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<tr>
<td></td>
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<td>1,380,475 (1.38 m)</td>
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<td>2014/15</td>
<td>56,941</td>
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<td>2015/16</td>
<td>63,167</td>
<td>1,809,883 (1.8m)</td>
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Statistical press notice annual national delayed Transfer of care data. Prepared by Government Statistical Service (December 2016)
We are seeing similar trends at a local level

<table>
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<th>Years</th>
<th>Delayed Transfers of Care</th>
<th>Total days delayed</th>
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<td>4739</td>
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<td>15/16</td>
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Information for Bradford District Care Trust and Bradford Teaching Hospitals NHS Foundation Trust – A comparison of DTOCs annually between 2011 – 2016 (NHS England 2016)

But what are the reasons for DTOCS in Bradford?
DTOCs in Bradford by reason for 2015/16

There was a total of 4907 DTOCs noted locally for 2015/16. Top 3 reasons account for 76% of all DTOCS.

- 26% (1292) of all DTOCS related to waiting for either a residential or nursing home placement or availability.
- 32% (1599) Personal Choice
- 17% (90) waiting further NHS non acute care.

- A) COMPLETION OF ASSESSMENT
- B) PUBLIC FUNDING
- C) WAITING FURTHER NHS NON-ACUTE CARE
- D) AWAITING RESIDENTIAL HOME PLACEMENT OR AVAILABILITY
- DII) AWAITING NURSING HOME PLACEMENT OR AVAILABILITY
- E) AWAITING CARE PACKAGE IN OWN HOME
- F) AWAITING COMMUNITY EQUIPMENT AND ADAPTIONS
- G) PATIENT OR FAMILY CHOICE
- H) DISPUTES
- I) HOUSING - PATIENTS NOT COVERED BY NHS AND COMMUNITY CARE ACT

Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group
Factors affecting DTOCS

- Getting in-depth nursing needs assessment and social care assessment completed (3 days)
- If potential Continuing Healthcare assessment needed - timescales for getting everyone together to do a DST (family, SW, CHC, Discharge)
- Finding a care home that family like that has a vacancy
- Family ability to pay top – ups
- Ability to find care home placements for complex needs
- Some homes refusing to accept patients back
- Timescales around care homes being able to come to the hospital to assess
- Ordering and waiting for equipment etc.
What does the guidance say?

The Local Government Association (2015) identified eight high impact changes which will have the greatest impact on managing transfers of care and reducing delayed discharge:

1. early discharge planning
2. systems to monitor patient flow
3. multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
4. home first/discharge to assess
5. seven-day services
6. trusted assessors
7. focus on choice
8. enhancing health in care homes.
What other work is being done to reduce DTOCs and improve patient experience?

NHSE National CQUINS 2017/19 - improving patient experience by supporting safe and proactive discharge

- Across acute, community and care homes
- Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories
- Monitor effectiveness of pathways through data collation and patient experience
- Monitor re admissions
- Implementation of a discharge to assess model
What work is being done to reduce DTOCs and improve patient experience?

‘Discharge to assess’ model definition

• Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

• Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

• Lots of different terms used for this ‘step down beds’, home first etc.
What work is being done to reduce DTOCs and improve patient experience?

May also have heard of ‘Trusted assessors’

Many local health systems have introduced ‘trusted assessment’ or ‘generic assessment’ where one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

NHSE, 2016
Useful documents

• NHS Providers (2015) RIGHT PLACE, RIGHT TIME BETTER TRANSFERS OF CARE: A CALL TO ACTION ‘Doing the obvious thing is the radical thing’. Available online at: https://www.nhsproviders.org/media/1258/nhsp-right-place-lr.pdf

• NICE Guideline 2015 (updated Dec 16) – Transition between inpatient hospital settings and community or care home settings for adults with social care needs available at: https://www.nice.org.uk/guidance/ng27


• The Queens Nursing Institute 2016 – Discharge planning Best practice in transitions in care available at: http://www.qni.org.uk/for_nurses/policy_and_practice/discharge_planning
Doncaster Integrated Discharge Pathways

Amanda Storrs
Integrated Discharge Lead
July 2017
Discharge Pathways from Doncaster and Bassetlaw

First choice is home…

Integrated Discharge Team…complex patients - multi disciplinary/multi-agency…health and social care working together

- Referral…Fact Find…Trusted assessor
- Identify pathway
- Daily IDT meeting…drive pts discharge…EDD…plan in place…case manager
- Minutes matter…healthy challenge

If first choice cannot be home…
Rehabilitation and Intermediate Care

Hospital based rehabilitation – Fred and Ann Green
Rehab Centre Rehabilitation
Intermediate Care
under review…3 workstreams
  - rapid response…Falls…expansion
  - medium term response...community
  - bed based response - reduce bed base
Social Care Assessment Unit – PSU

- EMI (22)/non-EMI (11)...set up initially for further social care assessment
  - what is the learning?
    - v. dependant pts all in the one place...access to community nursing...access to GP x1/wk or prn
    ltd therapy...impact on criteria for acceptance
  - medical/nursing needs v dependancy of pts...cognitive...behavioural
- PSU is part of the intermediate care review
Discharge/Transfer To Assess

Bassetlaw

Short term Nursing Care

• Evolved +++
• Checklist completed in hospital
• Request agreed by CCG
• Personalised – placement in definitive care home
• 21 days
• DST date agreed prior to discharge
• Fewer numbers

Doncaster

Complex Assessment Pathway

• Re-procurement
• 3 care homes currently…nursing (19)/EMI (5)…waiting list
• Redress balance with procurement
• Virtual checklist
• Consultant Geriatrician assessment
• LOS +++
• Learning
• MDT…SC…CCG…Therpay
York Discharge Team – pathways, challenges & opportunities

Sara Kelly, Discharge Team Manager, Scarborough, York & Bridlington
Group Discussion: Next Steps with this work & proposal for group
Proposal - for consideration & discussion

- Re-align remit and membership of group with Acute Care Pathway
- Expand membership to include primary care, commissioners, care home representation, liaison MH, community staff e.g. nurse practitioners, therapists & ED staff
- Align work of this group with the acute care pathway workstream in the Network work programme
Outcomes

- Reduction in urgent non-essential hospital admissions, LoS and reduced re-attendance and admission for older adults with dementia
- Reduction in falls and harm from falls in people aged 65 years and over
- Increased number of people who return to usual place of residence following hospital admission
- Improved experience of people living with dementia who i) access A&E ii) are admitted to hospital
- Improved support for carers & reduced admissions due to carer crisis
- All three STP PMOs are provided with support on eliminating OAPs for older people and/or those with dementia
- All hospitals in Y&H signed up to John’s Campaign, Y&H Delirium Charter and meeting criteria for dementia-friendly health and care setting.

Plus links to liaison MH workstream: Improvement in the number of providers offering 24/7 LMH care that reaches a minimum (core24) quality standards and includes appropriate older adults expertise, in EDs and inpatient wards
Deliverables

- Collated evidence base for what works in reducing crisis admissions in older people, particularly those with dementia, e.g. older people’s CRHT, use of comprehensive geriatric assessment, medication reviews, telecare and AT and support for carers.
- Identify 'centres of excellence' for reducing harm from falls (e.g. vanguards) and support implementation elsewhere.
- Identify and share models of enhanced care and meaningful activity within acute and residential care settings.
- BPSD?
- Continue to promote delirium toolkit within acute hospital settings, evaluating impact of resource in raising awareness and improving management. Initiate, develop and implement the Y&H Delirium Charter.
- Adapt delirium toolkit for use within community and primary care settings, including care homes.
- Lead and maintain the Acute Hospitals Dementia Champions Group including dedicated webpage and on-line forum for sharing practice and addressing common concerns.
- Provide older people's expertise and clinical guidance to LMH and crisis programmes of work to support equitable access for older aged adults to LMH/crisis services.
Questions

• Thoughts and comments on:
  • Proposed focus – does it fit with the priorities for group members?
  • Expanded membership
  • Deliverables – are they the right ones to have an impact for patients, carers & the ‘wider system’
  • Expanded remit – doesn’t just focus on dementia. How could we make sure the dementia didn’t get ‘lost’
  • Name for the group if these changes went ahead
Delirium toolkit update

Charlotte Whale
Quality Improvement Manager (Mental Health Urgent and Emergency Care)
Delirium Toolkit Update

Delirium can be prevented and treated. Remember the causes of delirium.

**TIME AND SPACE**

- T = Toilet
- I = Infection
- M = Medication
- E = Electrolytes
- A = Anxiety / Depression
- P = Pain
- N = Nutrition / Hydration
- D = Disorientation
- S = Sleep
- C = Constipation
- E = Environment

Assess toileting needs frequently. Monitor for urinary retention avoiding catheters if at all possible.

Treat and monitor any underlying infection if present.

Review medication.

Check for electrolyte disturbances (e.g. Na+ and Ca2+).

Assess and manage anxiety and depression.

Provide adequate attention to nutrition and hydration.

Be aware of disorientation, orientate wherever possible.

Minimize sleep disturbances.

Identify and manage pain.

Be aware of withdrawal from alcohol / drugs.

Prevent and where necessary treat constipation.

Remember that environmental changes can increase the severity of delirium. Where possible, avoid moving people between care settings.

Always remember to be kind, calm, patient and mindful of emotional needs.

Information for patients, relatives, carers and staff.

What is delirium?
Delirium is a condition where people have increased confusion, changes in thinking and a reduced ability to pay attention. Symptoms can develop quickly and disappear. Delirium can be a disorienting and frightening experience.

How common is delirium?
It is quite common. It affects around 1 in 10 patients in hospital. It can affect anyone of any age. Delirium is more common for people in certain situations, for example, if they have a serious illness, if they have been treated in an intensive care unit, or if they have recently had surgery. If someone is elated or manic, it is also more likely to affect older people and people being treated for a medical condition.

Who gets delirium?
It can happen to anyone but there are some things that put you at a higher risk of it. These include:
- Older age
- Sensory impairment
- A diagnosis of dementia
- Having one or more other health problems
- Being in hospital with a limited dietary or sensory inputs.

What are the symptoms of delirium?
People are affected in different ways. But people with delirium can:
- Be victims, agitated or inattentive
- Be withdrawn, quiet or more sleepy

What causes delirium?
Delirium has many causes. They range from one time event to ongoing, these causes are:
- Infection (e.g. urinary or respiratory)
- Polypharmacy (or poly- prescription - not eating or drinking enough)
- Pain
- Fluid issues (e.g. dehydration, electrolyte disturbances)
- Constipation
- Being unable to get up
- Problems with internal body clocks
- Being in an unfamiliar place
- The use of alcohol or withdrawal

How is delirium diagnosed?
Delirium is diagnosed by identifying that the symptoms of it are present.
Next Steps…

- Request to Pilot – response from 7 acute trusts.
- Plans to pursue with trusts as ‘early implementers’
- Meeting with Improvement academy to discuss evaluation framework.
- Charter now ready for consultation.
- Launch in line with international older peoples day in October.
Critical Incident Case Study

Dr Dan Harman - Consultant Physician in Elderly Care & Dementia Care Lead, Hull and East Yorkshire Hospitals NHS Trust
Hand Gel & The Agitated Patient

Hospital Acquired Harm
Acute Hospitals Dementia Champions
Dr Dan Harman
Consultant Geriatrician
Outline

• Case History
• Coroner’s inquest
• Hand-sanitisers and Hospital Acquired Harm
• Acute Alcohol Toxicity
• BPSD Policy
  – NICE guidance
• John’s Campaign
• Enhanced service
Hospital Safety Culture

• Improvements in many areas
• Harm can occur through interventions
• Infection Control:

More children getting drunk on hand sanitizer

By John Bontfield, CNN

Updated 12:23 GMT (20:23 HKT) September 15, 2015

News & buzz
Who organsms most and least, and why

Town is shocked by pink water

Bitbucket
For the code that comes to life

Hull and East Yorkshire Hospitals
NHS Trust
Difficult Case: Mr JH

- Mr JH: 76yr old – Admitted 22:05, 1/9/15
- Previously independent
- Ex-smoker, previous ETOH excess
- Previous depressive episode (bereavement)
- Acute confusion
- 9 month history of cognitive decline
- Presenting symptoms:
  - Change in behaviour – stopped eating and drinking
  - Labile mood
  - Aggression
  - Muddled
  - Forgetful
  - Delusional
Mr JH

- Examination
  - Nil
  - AMTS 3/10 ($\leq 8/10 = \text{abnormal}$)
- Initial investigations:
  - FBC, BCP normal (Bilirubin 30)
- Plan:
  - IV fluids
  - CT Head
  - Urine dip
  - ECG
  - Admit to AAU
Ongoing Care

- AAU – 2 days
- Ward 80:
  - CT Head – Small Vessel disease
  - CXR – Nil acute
  - Nil else

Diagnosis: Delirium + Undiagnosed Dementia
Awaiting Assessments

• Social Services
• Mental Health
• Therapies
• During which time he became increasingly agitated
• ..6\textsuperscript{th} Dec
Hospital Acquired Harm

• Agitated state
  – Aggressive both physically and verbally to staff members

• Approx 19:30
  – Consumes unknown volume of alcohol hand sanitiser (attached to his bed)

• On call team:
  – Rapid assessment
  – TOXBASE called (approx 60-70% Ethanol)
  – Advised monitor for signs of alcohol toxicity and carry out regular observations
Patient Still Agitated

- Security guard present
  - Threat to staff and other patients
  - Lorazepam 0.5mg IM given
- Still agitated
  - Haloperidol 1mg IM given
- GCS = 3 at 01:54hrs
  - Acidotic
  - Blood alcohol level 463mg/ml
  - Approx 30-35 units of alcohol
- Period of 6-7hrs of unprotected airway
- ICU
  - DNACPR
  - Extubated within 24hours
  - Required further Haloperidol as agitated
Transfer Back to Ward 80

• NG Tube
• Mittens
• Drowsy (GCS 10/15)
• Decision for treatment at ward level not for re-escalation of care
• On Haloperidol and Lorazepam
• Haloperidol weaned off
• Mittens removed (NG no longer required)
Deterioration

- Episode of aspiration on the ward
- Acute Respiratory Distress
- Bronchopneumonia
- Deteriorated and died on 12/9/15
- Complaint through PALS
- Coroner’s Inquest
- Litigation Case: Family (Hudgells) Vs Trust
Coroner’s Inquest

The medical cause of death was given in accordance with the post mortem report as follows:

1a  Bronchopneumonia, due to
1b  Acute alcohol toxicity
2   Acute delirium: coronary artery atherosclerosis

A narrative conclusion was given as follows:

"was admitted to Hull Royal Infirmary with a nine month history of increasing confusion. Whilst on Ward 80 on 6 September 2015 he consumed a large amount of hand wash that contained alcohol in high concentration, and developed acute alcohol toxicity that was treated by ventilation in expectation that alcohol would be naturally metabolised. His airway was unprotected for seven hours from 6 to 7 September and as a result it was likely he developed pneumonitis that resulted in pneumonia affecting both lungs, from which he died at Hull Royal Infirmary on 12 September 2015."
Coroner’s Inquest

I accept the evidence that on the balance of probabilities that the unprotected airway for seven hours from 21.05 to when he was intubated and ventilated contributed to the chest infection. The chain of causation between alcohol ingestion is unbroken. Had he not consumed alcohol, he would not have died when he did.

There was a tension between need to prevent infection and confused patients consuming alcohol hand sanitiser. Such incidents are rare. There is evidence this risk was not foreseeable, and culminated in his death. I am satisfied with the measures implemented by the Trust to prevent recurrence. I am not convinced this has been extended to the NHS more widely. I will exercise my duty under Regulation 28 to hope prevent future deaths.
Concerns Raised

- Coroner’s and Family Concerns
  1. Alcohol Hand Sanitiser
  2. Management of Acute Alcohol Toxicity
  3. Care of confused patient
     - Butterfly Scheme
     - Family visiting
     - Use of antipsychotics
     - Use of security

- Regulation 28
  - Response from National Medical Director, NHS England
    - Reviewing product design
    - Guidance: what to do if consumed?
Hand Sanitisers

- WHO – 2009: Hand Hygiene in Health care
- Health Care Associated Infection (HCAI)
Alcohol Based Hand Sanitisers

Alcohol-based handrub is the preferred means for routine hand hygiene in health care

- Alcohol-based handrubs have the following immediate advantages
  - elimination of the majority of germs (including viruses)
  - the short time required for action (20 to 30 seconds)
  - availability of the product at the point of care
  - better skin tolerability
  - no need for infrastructure (clean water supply network, washbasin, soap, hand towel)

- Hands need to be washed with soap and water when:
  - they are visibly dirty or soiled with blood or other body fluids,
  - when exposure to potential spore-forming organisms
  - after using the lavatory.

- Perform hand hygiene at the point of care
• Alcohol-based handrubs with optimal antimicrobial efficacy usually contain 75 to 85% ethanol or isopropanol.
• WHO recommend formulations contain either 75% isopropanol, or 80% ethanol
• Alcohol-based handrubs show little efficacy against Clostridium Difficile
Alcohol Handrub Ingestion

• Accidental and intentional ingestion of alcohol-based preparations used for hand hygiene have been reported.

• In the “cleanyourhands” campaign incidents summary:
  – 189 cases of ingestion were recorded in healthcare settings:
  – 174 no or low harm,
  – 12 as moderate,
  – 2 as severe,
  – 1 death (patient admitted with severe alcohol intoxication)

• In paediatric and psychiatric wards, security measures are needed.
• These may involve:
  – placing the preparation in secure wall dispensers
  – labelling dispensers to make the alcohol content less clear at a casual glance
  – adding a warning against consumption
  – inclusion of an additive in the product formula to reduce its palatability

• Medical and nursing staff should be aware of this potential risk.
Practice at HEYHT

- Purell foaming hand sanitiser
- Contains 62% ethyl alcohol (ethanol)
- 535ml receptacles
- Liquid that dispenses as a foam
- Placed on end of bed
- No child-proof top
- No contents listed on the bottle
Local Practice

• 7 previous cases at HEYHT
  – All intentional
• Serious Incident Investigation
  – Balance risk: Life-threatening HCAI vs. product ingestion
  – Alert to all staff groups
• Product placement
  – Fixed to wall away from the bed / cubicle
  – Concerns raised on recent CQC inspection (Surgical wards)
• Volume
  – Tottles vs. Bottles
• Child-proof tops
• COSHH (Control of Substances Hazardous to Health)
  - See website
COSHH Assessments...

Hazardous substances can cause skin or eye irritations, respiratory problems, loss of consciousness, poisoning and long term health problems such as cancers. The Control of Substances Hazardous to Health (COSHH) Regulations require employers to control the exposure to hazardous substances in order to protect both employees and others who may be exposed through work activities.

Hazardous substances can be used directly in work activities (such as disinfectant or paint), they can be generated during work activity (such as fumes from soldering), they can be naturally occurring (such as dust) or they can be biological agents (such as bacteria).

A COSHH assessment evaluates the risks that may be present and the precautions that must be taken when using a substance.

- **Step 1**
  - Assess the risks to health from hazardous substances used in or created by your workplace activities.

- **Step 2**
  - Decide what precautions are needed. You must not carry out work which could expose your employees to hazardous substances without first considering the risks and necessary control measures.

New substances/processes must not be introduced within the Trust without a prior assessment being carried out by the Safety Department. New substances must not be purchased where disposal cannot be effected safely.

Control measures for COSHH related substances **must** be considered in the following order:

1. Eliminate use of substance
2. Substitution by a substance which is less hazardous
3. Total/partial enclosure of the process and handling systems
4. Local Exhaust Ventilation and/or sufficient general ventilation
5. Limit employee exposure
6. If additional means are required, Personal Protective Equipment may be considered although the use of PPE must always be the 'last resort' consideration. In event of an emergency PPE may be necessary.

COSHH substances have their own Risk Assessments and are all done in the Safety Department and forwarded on to the appropriate area. The idea behind this is to avoid much duplication of effort in wards and departments, given that most substances will be used in the same way in most areas of the Trust. If you have any substances that need assessments, contact Dave Bovill on ext. 807880.

If a substance has one of these labels on it, then it must have a COSHH assessment. The Safety Team completes all COSHH assessments.
Acute Alcohol Toxicity

- **Patient’s Blood Alcohol Level: 463mg/ml**
- Ethanol's acute effects - central nervous system depressant
- Dependent on blood alcohol concentrations:
  - 20–79 mg/ml – Impaired coordination and euphoria
  - 80–199 mg/ml – Ataxia, poor judgement, labile mood
  - 200–299 mg/ml – Marked ataxia, slurred speech, poor judgement, labile mood, nausea and vomiting
  - 300–399 mg/ml – Stage 1 anaesthesia (progresses to analgesia with amnesia)
  - 400+ mg/ml – Respiratory failure, coma
Acute Alcohol Toxicity

Although the mainstay of management of alcohol toxicity is supportive, in this situation the probability of severe / life threatening levels of alcohol resulting was so high the initial management plan should have included:

- Discussion with consultant staff in Intensive care / medicine
- Trial of flumazenil to reverse the benzodiazepine element of factors suppressing consciousness/respiration
- In expectation of severely reduced consciousness and respiratory drive, acidosis, hypoglycemia a pre-emptive transfer to a level 2/3 facility for close monitoring of these criteria
- Early intervention with IV fluids / intubation for compromised airway and inotropes for hypotension / acidosis
- Early monitoring of blood alcohol level, given that blood levels would be expected to peak 30-60 minutes after ingestion
- Consideration of dialysis
- Earlier discussion with relatives given the likely events that would follow this level of alcohol ingestion
Dementia (+ Delirium) Friendly Hospital

S taff who are skilled
P artnership working
A ssessment & early identification
C are that is individualised
E nvironments that are dementia friendly
Dementia: Policy and Practice

Dementia

The NICE-SCE guideline on supporting people with dementia and their carers in health and social care

September 2018
Recommendations 1.3.2 has been updated and replaced by recommendations 1.2.3, 1.6.3, 1.8.4, 1.7.5 and 1.8.17 in the NICE guideline on mental health problems in people with learning disabilities (NICE guideline NG56). Recommendations 1.5.1.2 and 1.5.2.7 have been updated and replaced by recommendation 1.8.18 in the NICE guideline on mental health problems in people with learning disabilities.

May 2019
Recommendations 1.6.2.1-1.6.2.2 and 1.6.2.1-1.6.2.6 have been updated and replaced. See the addendum to this guideline for more details.

National Collaborating Centre for Mental Health
Dementia

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia, their length of stay is longer than people without dementia and they are often subject to delays on leaving hospital.

The National Dementia Strategy (DoH, 2009) identified five areas which must be prioritised in order to enable people to live well with Dementia:

- Early diagnosis and intervention for all
- Living well with Dementia in care homes
- Improved quality of care in general hospitals
- Reduced use of antipsychotic medication
- Coordinated End of Life Care

To address these key areas HEY created a Dementia Program Board chaired by Dr Dan Harman, Consultant Geriatrician. The Dementia Program Board are working with their partners across health, social and voluntary sectors to ensure there is a lasting improvement in the quality of care received by patients with Dementia in our organisation.

The Dementia CQUIN

In order to improve early diagnostic rates, HEY will be required to screen all patients aged 75yrs+ admitted as emergencies (i.e. non-elective admissions).

The CQUIN has 3 steps: FAIR - Find, Assess + Investigate and Refer

1: FIND:
Members of staff ask “Has the person been more forgetful in the last 12 months to the extent that it has significantly affected their daily life?”
THE FIND STEP MUST BE COMPLETED WITHIN 72 HOURS OF ADMISSION

2: ASSESS + INVESTIGATE:
If there is evidence of a problem with their memory, then a dementia diagnostic assessment should be completed (Assessment tool is in ACTP’s)

3: REFER:
to specialist. All patients suspected of having dementia to the single point of access (SPA) Old Age Psychiatry Service (Tel. 617560, Fax: 617590)

To incentivise the identification of these patients with possible Dementia, HEY will receive £1.05m if it achieves this CQUIN target of screening 90% of all such patients for 3 consecutive months. If successful, I this money can be used to improve the care of patients with Dementia within our organisation.
Policies

- Policy 337: Behavioural and Psychological Symptoms of Dementia (BPSD) in acute hospital care
- Policy 343: Diagnosis and Management of Patients with Delirium in acute hospital care
Patient Management

- Identify cognitive impairment early
- Consider delirium and BPSD in all patients with behaviour that challenges
- Identify and treat the cause of delirium
- Use pharmacological measures only when necessary
- Prevent reoccurrence and educate
**Dementia and Delirium Care Pathway**

**Step 1: Find**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Does the patient already have a formal diagnosis of dementia?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YES, ensure BUTTERFLY SCHEME offered and review Ward Placement.
If Behavioural and Psychological Symptoms of Dementia [BPSD] then please refer to BPSD policy.

<table>
<thead>
<tr>
<th>1b. Delirium Assessment:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask relative or carer: “Do you think [patient’s name] has been more confused in the past three days? OR If the relative or carer is not available then complete ‘Test of Attention’ [“Count Down from 20 to 1”] Delirium suspected?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YES, ensure OUTLINE BUTTERFLY SCHEME offered and please refer to the Delirium Policy

| 1c. Ask the Patient, Relative or Carer the following Question: |
| “HAS THE PERSON BEEN MORE FORGETFUL IN THE PAST 12 MONTHS, TO THE EXTENT THAT IT HAS SIGNIFICANTLY AFFECTED THEIR DAILY LIFE?” | YES | NO |

**Step 2: Assess and investigate**

<table>
<thead>
<tr>
<th>Questions for Patient (AMTS)</th>
<th>Score 1 if correct</th>
<th>Consider Reversible Causes of Confusion:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>P</td>
<td>Pain Assessed: Give pain relief as appropriate</td>
</tr>
<tr>
<td>2. Date of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Repeat 42 West Street</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Time (nearest hour)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Name of hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Recognise 2 people (e.g. Dr, Nurse)</td>
<td>C</td>
<td>Infection: Dipstick Urine</td>
</tr>
<tr>
<td>8. Year WW II ended (1945)</td>
<td></td>
<td>if positive MSU</td>
</tr>
<tr>
<td>9. Who is the Monarch (Elizabeth)</td>
<td>H</td>
<td>Constipated: Excluded</td>
</tr>
<tr>
<td>10. Count backwards from 20</td>
<td></td>
<td>Treated</td>
</tr>
<tr>
<td>11. Recall 42 West Street</td>
<td></td>
<td>Hydration status: Commence fluid balance chart</td>
</tr>
<tr>
<td>12. Who is the Monarch (Elizabeth)</td>
<td>M</td>
<td>Refer to Pharmacist or Medical staff for review of routine medication</td>
</tr>
<tr>
<td>13. Total out of 19</td>
<td></td>
<td>Environmental Factors Addressed</td>
</tr>
</tbody>
</table>

**Step 3: Refer**

Impression of Suspected Dementia: [Delirium Excluded]

Refer to Psychiatry via the Hospital Mental Health Team
Tel: 01482 226226 Fax: 01482 675389

The Hospital Mental Health team will decide whether an Inpatient or Outpatient review is required.

Impression: Inconclusive/unable to exclude resolving delirium on discharge; Request GP: to repeat cognitive screen in the community and refer to the Mental Health team as appropriate.
Add screening results and referral information to patient ID.

Signature: ........................................ Designation: .........................
Date: ........................................... Time: .........................
Data entered onto database (Administrator only)
• This wasn’t completed for 3 days!
• Early collateral history
The Collateral History

- Onset and course of memory problems
- Previous cognitive status (history of dementia, delirium or depression)
- Functional status (activities of daily living) and ability to manage household affairs- e.g. money, compliance with medications
- Full drug history - any recent change
- Symptoms suggesting any underlying cause-e.g. infection
- Bladder and bowel function
- Sensory aids- hearing aids, glasses
- Pre-admission social circumstances care package

A Collateral history may identify the cause and prompt treatment which may avoid prolonged hospitalisation
Dementia vs. Delirium

The duration of symptoms should help to determine if the patient has dementia, delirium, or possible dementia and superimposed delirium:

Cognitive impairment identified on assessment and collateral history obtained

- Known dementia with no change in cognition
- Known dementia with slow change in cognition (weeks/months)
- Known dementia with acute change in cognition
- Acute confusion with no history of previous cognitive impairment

- History suggestive of possible dementia with or without acute deterioration

- Undiagnosed dementia with or without delirium

- Stable dementia
- Progressive dementia
- Dementia with delirium
- Delirium
# DEMENTIA AND DELIRIUM CARE PATHWAY

## Step 1: Find

**TICK ALL BOXES THAT APPLY**

1a. Does the patient already have a formal diagnosis of dementia?  
   - YES □  NO □

   If YES, ensure BUTTERFLY SCHEME offered and review Ward Placement.
   If Behavioural and Psychological Symptoms of Dementia (BPSD) then please refer to BPSD policy.

1b. Delirium Assessment:
   - Ask relative or carer: “Do you think [patient’s name] has been more confused in the past three days?”
   - OR: If the relative or carer is not available then complete Test of Attention [Count Down from 20 to 1]

   Delirium suspected?  
   - YES □  NO □

   If YES, ensure OUTLINE BUTTERFLY SCHEME offered and please refer to the Delirium Policy.

1c. Ask the Patient, Relative or Carer the following Question:

## Step 2: Assess and investigate

### PINCH ME

<table>
<thead>
<tr>
<th>Questions for Patient (AMTS)</th>
<th>Score 1 if correct</th>
<th>Consider Reversible Causes of Confusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>P Pain Assessed: Give pain relief as appropriate</td>
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<tr>
<td>Date of Birth</td>
<td></td>
<td>IN Infection: Dipstick Urine</td>
</tr>
<tr>
<td>Repeat 42 West Street</td>
<td>N/A</td>
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</tr>
<tr>
<td>Year</td>
<td></td>
<td>H Hydration status: Commence fluid balance chart</td>
</tr>
<tr>
<td>Time (nearest hour)</td>
<td></td>
<td>M Refer to Pharmacist or Medical staff for review of routine medication</td>
</tr>
<tr>
<td>Name of hospital</td>
<td></td>
<td>E Environmental Factors Addressed</td>
</tr>
<tr>
<td>Recognise 2 people (e.g. Dr, Nurse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year WWII ended (1945)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who is the Monarch (Elizabeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count backwards from 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recall 42 West Street</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL OUT OF 19**

[S8 consider Dementia and complete MMSE and refer to Hospital Mental Health Team – see STEP 3]

### Blood Tests to Consider:

- FBC, BCP, Folate, TFT’s, CRP, Glucose, Vitamin B12

### Review Antipsychotic Medication:

- If a patient with dementia is on an antipsychotic (e.g. risperdone, quetiapine, haloperidol) please refer to the Hospital Mental Health Team for Medication Review.

## Step 3: Refer

**Impression of Suspected Dementia:** Delirium Excluded

Refer to Psychiatry via the Hospital Mental Health Team.

Tel: 01482 226226  Fax: 01482 675389

The Hospital Mental Health team will decide whether an Inpatient or Outpatient review is required.

**Request GP** to repeat cognitive screen in the community and refer to the Mental Health team as appropriate.

Add screening results and referral information to patient IDL.

**Signature:** ___________________________  **Date:** ___________________________  **Time:** ___________________________  **Designation:** ___________________________  

Data entered onto database (Administrator only)
Assessment

• Physical examination
• Neurological and cognitive assessment
• Review medication chart
• Investigations
• PINCH ME:
  - Pain
  - INfection
  - Constipation
  - Hydration
  - Medication
  - Environment
Investigations

• Routine Investigations:
  – Bloods: FBC, BCP, CRP, Glucose,
  – Urine dip + MSU (if urine dip positive)

• Non-routine:
  – TSH, Vitamin B12, Folate
  – CXR & ECG
  – Blood culture
  – CT HEAD OFTEN UNHELPFUL
    • Only consider in presence of
      – Focal neurology OR
      – New confusion post head injury / fall OR
      – Evidence of raised Intracranial Pressure
Review Medication Chart

Delirium is strongly associated with anticholinergic drug activity. Review of medication should consider the anticholinergic burden and aim to reduce this where possible.

<table>
<thead>
<tr>
<th>Risk of Delirium</th>
<th>Drug Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Tricyclics</td>
<td>amitriptyline hydrochloride</td>
</tr>
<tr>
<td></td>
<td>Phenothiazine antipsychotics</td>
<td>Chlorpromazine, levomepromazine</td>
</tr>
<tr>
<td>Medium</td>
<td>Benzodiazepines†</td>
<td>Diazepam, Lorazepam</td>
</tr>
<tr>
<td></td>
<td>Sedatives †</td>
<td>Lorazepam†</td>
</tr>
<tr>
<td></td>
<td>Dopamine-activating drugs</td>
<td>Zopiclone</td>
</tr>
<tr>
<td></td>
<td>Anticonvulsants (antiepileptics)</td>
<td>Co-Beneldopa (Madopar), Co-Careldopa (Sinemet)</td>
</tr>
<tr>
<td></td>
<td>H₂ receptor antagonists</td>
<td>Levetiracetam, Sodium Valproate</td>
</tr>
<tr>
<td></td>
<td>Cardiac Medications</td>
<td>Ranitidine, Cimetidine</td>
</tr>
<tr>
<td></td>
<td>Opioids†</td>
<td>Digoxin, Beta-blockers</td>
</tr>
<tr>
<td></td>
<td>NSAIDs</td>
<td>Morphine, Diamorphine</td>
</tr>
<tr>
<td></td>
<td>Corticosteroids</td>
<td>Diclofenac Sodium</td>
</tr>
</tbody>
</table>

Abrupt withdrawal of some drugs & alcohol can cause delirium. See drugs marked “†” for drugs where gradual withdrawal must be prescribed. Benzodiazepines especially should not be stopped abruptly in the elderly.
Management of Delirium

- Identify cognitive impairment early
- Consider delirium in all patients with behaviour that challenges
- Identify and treat the cause of delirium
- Use pharmacological measures only when necessary
- Prevent reoccurrence and educate
The Butterfly Scheme®
reaching out to people with dementia

REACH out to me

I prefer to be called: __________________________

My usual warm drink (milk/sugar?): __________________________

My usual cold drink: __________________________

I prefer a beaker / cup / mug: __________________________

Foods I like: __________________________

Foods I dislike: __________________________

When I eat, you need to know (swallowing, cutting food, etc.): __________________________

I’m right-handed / left-handed: __________________________

Equipment I need (glasses, hearing-aid, stick, etc.): __________________________

My bedtime routine, night-time habits, pillows, rails: __________________________

Skills I could quickly lose if not actively maintained (standing, walking, etc) – although I realise success can’t be guaranteed: __________________________
John’s Campaign

What it does:-

• Gives a carer the right to stay with a patient who has dementia
• Welcomes a carer to stay beyond the allocated visiting times
• Can improve communication between carers and ward staff
• Offers reassurance to the patient that a familiar face will stay with them

What it doesn’t do:-

• Provide a hotel service for friends/relatives
• Expect the carer to carry a full range of cares on the patient
• Doesn’t give priority for treatment

Carers must:- maintain Health and Safety rules, eg handwashing
maintain confidentiality and may be asked to leave an area
eg. during consultant rounds, treatments.
## Non-Pharmacological Management

<table>
<thead>
<tr>
<th>Butterfly Scheme</th>
<th>Medication Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ensure Butterfly Scheme offered</td>
<td>- Stop all non-essential medication</td>
</tr>
<tr>
<td>- Integral carer sheet complete</td>
<td>- Adequate analgesia if in pain</td>
</tr>
<tr>
<td>- Butterfly symbol placed above bed and on patient identifiable (e.g. case notes,</td>
<td>- If already on antipsychotic medication ask for Hospital Mental Health review</td>
</tr>
<tr>
<td>CAYDER board)</td>
<td>(Tel: 01482 226226)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environment</th>
<th>ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ensure calm, quiet environment</td>
<td>- Avoid dehydration and constipation</td>
</tr>
<tr>
<td>- Appropriate lighting</td>
<td>- Encourage exercise/physical activity (e.g. gentle stretching/walking)</td>
</tr>
<tr>
<td>- Ensure have their glasses/hearing aid</td>
<td>- Promote nutrition</td>
</tr>
<tr>
<td>- Signage/cues/clocks to help with orientation</td>
<td>- Involve carers</td>
</tr>
<tr>
<td>- Personalising Bed Space e.g. photos/familiar objects from home</td>
<td></td>
</tr>
<tr>
<td>- Adaptations to soften ward environment</td>
<td></td>
</tr>
<tr>
<td>- Consider ward room temperature</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relatives/Carers</th>
<th>Avoid Confrontation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Involve relatives and carers in care planning</td>
<td>- Use the REACH approach (see Butterfly scheme)</td>
</tr>
<tr>
<td>- Promote John’s Campaign</td>
<td>- Avoid sudden actions</td>
</tr>
<tr>
<td>- Assist overnight stay for family/carer where appropriate</td>
<td>- Approach from front</td>
</tr>
<tr>
<td>- Reminiscence therapy (if available)</td>
<td>- Be calm but confident</td>
</tr>
<tr>
<td>- Consider open visiting to assist in delivery of care (e.g. meals)</td>
<td>- Avoid standing over patient</td>
</tr>
<tr>
<td></td>
<td>- Use eye contact</td>
</tr>
<tr>
<td></td>
<td>- Reassure patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wandering (purposeful walking)</th>
<th>False Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consider why?pain, ?need the toilet</td>
<td>- Discuss and understand</td>
</tr>
<tr>
<td>- Observe in safe environment (refer to trust restraint policy)</td>
<td>- Change the subject tactfully</td>
</tr>
<tr>
<td>- Provide meaningful activities and involve carers (e.g. dusting, folding)</td>
<td>- Acknowledge expressed feelings and document them. Try not to</td>
</tr>
<tr>
<td></td>
<td>- agree</td>
</tr>
</tbody>
</table>

**AVOID**

- Catheters
- Restraining
- Inter-ward transfers
- Intimidating/noises i.e. pump alarms
Pharmacological

- Antipsychotic/sedative medication should only be considered after non-pharmacological interventions have been tried.
- They should be started at a low dose & titrated to response\textsuperscript{3}
- They should be prescribed as a short course (usually 1 week or less)\textsuperscript{3}

When to consider antipsychotic / sedative medication
1. If needed to allow essential investigations/treatment to take place
2. If the patient is at risk of endangering themselves or others
3. To relieve distress in highly agitated or hallucinating patients
### Pharmacological (Non-Urgent)

#### Focus on the Symptom

**Table 1: Drug choices in BPSD**

<table>
<thead>
<tr>
<th>Key Symptom</th>
<th>Alzheimer's/ Vascular Dementia</th>
<th>Lewy Body/Parkinson's disease Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Sertraline, Citalopram</td>
<td>Sertraline, Citalopram</td>
</tr>
<tr>
<td>Apathy</td>
<td>Sertraline, Citalopram</td>
<td>Sertraline, Citalopram</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Risperidone*</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Aggression</td>
<td>Risperidone*</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Moderate agitation/anxiety</td>
<td>Sertraline, Citalopram</td>
<td>Sertraline, Citalopram</td>
</tr>
<tr>
<td>Severe agitation/anxiety</td>
<td>Risperidone*, Olanzapine*</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Poor Sleep</td>
<td>Zopiclone</td>
<td>Zopiclone</td>
</tr>
<tr>
<td>REM Sleep Behaviour (nightmares, hyperactivity)</td>
<td>Clonazepam</td>
<td></td>
</tr>
</tbody>
</table>

* Use extreme caution in Vascular dementia i.e. antipsychotic use in patients with an established cerebrovascular risk.

**TABLE 2: Dosing guidelines in BPSD**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dose</th>
<th>Maximum dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram* Tablets or liquid*</td>
<td>10mg OD</td>
<td>20mg OD*</td>
</tr>
<tr>
<td>Sertraline Tablets</td>
<td>50mg OD</td>
<td>200mg OD</td>
</tr>
<tr>
<td>Risperidone† Tablets, liquid or oro-dispersible</td>
<td>250micrograms BD</td>
<td>1mg BD</td>
</tr>
<tr>
<td>Quetiapine Tablets</td>
<td>12.5mg BD</td>
<td>150mg OD</td>
</tr>
<tr>
<td>Olanzapine Tablets or oro-dispersible</td>
<td>2.5mg OD</td>
<td>10mg OD</td>
</tr>
<tr>
<td>Zopiclone Tablets</td>
<td>3.75mg ON</td>
<td>7.5mg ON</td>
</tr>
<tr>
<td>Clonazepam Tablets</td>
<td>500micrograms ON</td>
<td>1mg ON</td>
</tr>
</tbody>
</table>
Pharmacological (Urgent)

- Parenteral medication may be considered by the intramuscular (IM) route only and only after oral medication has been tried.

- **Lorazepam 0.5-1mg IM (Can be repeated after 6 hours if necessary)** OR

- **Haloperidol 0.5mg IM (Can be repeated after 4-8 hours if necessary)**

- **Avoid Haloperidol in Parkinson’s disease or Lewy Body Dementia**

- Blood pressure, pulse, temperature and respiratory rate must be measured at regular intervals until the patient becomes active again.

- Advice should be sought from the Hospital Mental Health Team (Tel: 01482 226226)
Hospital Support

- Mental Health
- DME
Enhanced Care Team (ECT)

With thanks to
Simon Knopp
Findings of the scoping audit

- Nine patients required security patient-watch
- All had a level of cognitive impairment as described in the table
- Two of the patients with dementia were outside of the DME base wards
Risk Factors

- All patients had multiple risk factors identified
- Seven patients primarily identified as being aggressive; either verbal or physical
- Two patients identified as being a high risk of absconding
Security occurrence Log-
75 x 12hr shifts logged over seven days

- A total of 10 occurrences logged over one week
- Four occurrences logged to one patient
- Four patients with no occurrences logged for the length of their patient-watch
- A total of sixty five shifts logged with no occurrences
Spend per ward HRI April – Jan 2017
Spend per ward CHH April – Jan 2017
The Doncaster and Bassetlaw Hospitals (DBH) Model:

- Six month pilot at Bassetlaw site only
- Employed 4 x enhanced care nurses (ECN) at band 2
- Working hours 0700-2000, seven days a week
- Report to ANP for Dementia Care and Falls Prevention Practitioner
- Deployed by site management team
Options

Option 1
Continue with the use of agency security guards to provide one to one supervision of our most vulnerable patients

Option 2 (recommended)
Run a PDSA cycle
Will require 1 x Band 7 to lead and approx 5 x Band 2 WTE to provide cover to the HRI site

Option 3
Implement a Trust wide service to all patient groups
Requiring approx 20WTE band 2, plus band 7 management
## Options Being Considered at HEYHT

<table>
<thead>
<tr>
<th>Band</th>
<th>WTE employed</th>
<th>£ per WTE</th>
<th>£ Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>44,000</td>
<td>44,000</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>20,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>144,000</td>
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</table>

### Option 2

<table>
<thead>
<tr>
<th>Band</th>
<th>WTE employed</th>
<th>£ per WTE</th>
<th>£ Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
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<tr>
<td>2</td>
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<tr>
<td>Total</td>
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<td>444,000</td>
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Conclusion

• Challenging case

• Implications for delivery of care

• Consideration of environmental hazards
Questions?
Round the patch updates
Quickfire Online Forum Queries

• Does anybody have any examples of good practice to help patients/carers find their way to the right department when being sent for tests such as CT Scans etc.

• Hi all, I have been asked by staff re the best background colour for staff name badges - not ID badges but more in line with 'Hello my name is.....’ Any suggestions? (Suzy)

• We are looking at collecting good practice examples relating to Delirium Outreach Team services. Does anybody have any examples/experiences of a delirium outreach team service, so we can look at their model of care? (Danni)

• We are currently looking at what mental health training is given to A&E, AMU staff and Older adult wards. Do any Trusts offer any training on things like:
  - recognition of MH symptoms and risks
  - de-escalation techniques
  - Environmental factors for safety

JOIN THE FORUM AT:
http://www.yhscn.nhs.uk/forum
Any other business

Dear Colleagues,

As part of my work with NHS Improvement I would like to collect some examples of good practice for dementia care in acute general hospitals.

If you were able to give me or direct me to say, one example of which you are aware, that would be really very helpful. The briefest of descriptions, or a website or e mail of someone to contact would be great.

With best wishes,
Alistair Burns

www.england.nhs.uk
I have been asked by the Royal College of Psychiatrists to lead on an audit of the diagnosis/care of people diagnosed with depression in acute hospitals.

It LOOKS as if this will be a retrospective case note audit of about 20 or so patients to see if there is any evidence of depression being diagnosed and how it was managed.

The purpose of my email is to invite the hospitals in our region to volunteer to participate. The aim is to get about 20 nationally.

At the moment all I am seeking is potential expressions of interest and no definite commitment. More details of what’s involved will be passed on to those hospitals/Trusts interested and they can drop out if it’s not for them.

I am obviously keen for the North to be heavily involved in this audit which I believe will improve patient care in the long term.

Could you kindly also ask the Y and H Dementia Champs if they use/have any guidance or protocols in their hospitals for the diagnosis and management of suspected new cases of depression in their hospitals?

Best Wishes, Oliver
OliverCorrado@aol.com
www.england.nhs.uk
Any other business

- John’s Campaign – collation of practice
- National Audit of Dementia – timescales and webinar
- UTI resources
Dates of future meetings

Wednesday 11th October, 2-4.30pm
Holiday Inn Wakefield, Queens Drive, Ossett, WF5 9BE

Wednesday 10th January 2018, 2-4pm – webinar

Wednesday 14th March 2018, 2-4.30pm
Holiday Inn Wakefield, Queens Drive, Ossett, WF5 9BE