The Role of the Advanced Nurse Practitioner in Advancing Dementia

By:
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Dementia is a progressive condition and is associated with complex care needs, high levels of dependency and morbidity which can increase with progression.

Complex care needs in advancing Dementia require a co-ordinated input from a range of healthcare professionals.

Complex care needs often challenge the skills and capacity of carers and services.

Due to the presence of complex care needs in advancing Dementia the individual may not fit into traditional services or move smoothly through existing services.
All people with Dementia are individual & unique. Different reality to family/carers. Carers abilities vary. Aging population with increased frailty as condition progresses.

- 2.5 chronic conditions (average)
- 5+ medications (average)
- 3 times more likely to be hospitalised
**Complex Responsive Behaviours**

* Dementia is viewed as a ‘complex syndrome’ due to the multiple physical, psychological, social implications and healthcare needs both for the individual with Dementia and their family/carer, thus requiring interagency collaboration and support across services.

* No one healthcare professional will meet the needs of the person with Dementia and/or their family/carer – a web of care...

* **Responsive Behaviours:** This term reflects a response by the person with Dementia to something in his/her environment that is negative, frustrating or confusing placing the reasons or triggers outside rather that within the individual (Alzheimer’s Society Ontario, 2011).

* Research suggested that untreated behavioural symptoms are associated with faster disease progression (Rabins et al, 2011)
Complex Responsive Behaviours Contd:-

* NICE (2011) identify complex behaviours in advancing dementia such as; aggression, restlessness, wandering, delusions and hallucinations which often challenge the skills and capacity of carers and services.

* Responsive behaviours can occur across all types and stages of dementia, affecting 98% of individuals at some point of their illness (Lyketsos et al, 2011)

* People with dementia are more likely to be referred to specialist services for assessment when responsive behaviours are identified (O’Connell, 2012)
ANP in Dementia Care

* The ANP in Dementia care is an integral member of Donegal Mental Health Service for Older People MDT

* Practices as an autonomous practitioner responsible for leading a comprehensive Dementia Nursing Service for individuals diagnosed with dementia and presenting with associated complex responsive behaviours and healthcare needs.

* The purpose of the role is to enhance the provision of care for individual’s with dementia experiencing complex responsive behaviours and associated care needs in Donegal.
Key aspects of Role of RANP in Dementia Care

Clinical

- Nurse Consultant/role model/mentor to MDT members and other professionals across services Co-work complex cases. Regular clinical supervision with Consultant Psychiatrist.

Education

- Education: MDT – Dementia Specific Supervision and Dementia Specific Education programme. Dementia specific training to other healthcare facilities.
- Undergraduate training programme. National dementia training programmes.
- ANP CPD requirements – ANP + Nurse Prescribing

Research & Audit

- Working as critical stakeholder with NDO in Developing PDCP
- Working in developing QCM’s Delphi Study representing Mental Health strand.
- Ongoing practice & service development
- Audit of training to-date
- Audit of impact of ANP role to-date - questionnaire
Referral Criteria and Pathway for RANP in Dementia Care

Referral Criteria for RANP (Dementia care):-
Diagnosis of Dementia, irrespective of age, experiencing associated complex responsive behaviours and healthcare needs.

* Direct referrals will be accepted from GPs, Consultant Psychiatrists, Consultant Geriatricians and in-house from MHSOP MDT.

* Patients can be assessed either in LUH, Community Hospitals, OP Depts, Nursing Homes, Day-care Facilities, or in their homes.
The RANP will triage referrals and decide on a timely & appropriate response. If not fulfilling referral criteria or deemed outside RANP’s scope of practice referrals will be returned to referral agent with rational & guidance, as appropriate.

- Assess in Private Nursing Home
- Assess in Inpatient Facility
- Assess in Outpatient Facility
- Assess at Home

Initial Specialist Assessment Completed

- Interventions and Treatment Plan Agreed with Ongoing Input from RANP and/or other MHSOP Team Member
- No RANP interventions required. Discharge back to MHSOP for Further Discipline follow-up

ANP Dementia Discharge
The key to success.. Take home Message

• Work together – locally & nationally
• Share knowledge and good practice
• Access further education and training
• No one care plan/approach fits all
• Learn from what works – become confident in crossing the bridge to support PwD in their reality.