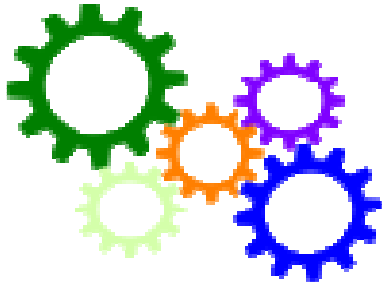

Connolly Hospital / Dublin NW Dementia Project

Integrating care for People with Dementia

Dr. Siobhan Kennelly, Project Lead

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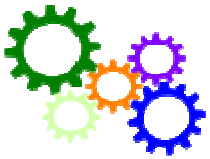
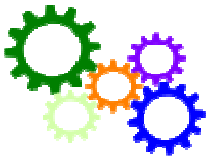
Background



- First National Audit of Dementia Care in Acute Hospitals (INAD) (2014) Connolly Hospital-
- Poorer care outcomes for people with dementia than older people without dementia
- ⇧ length of stay, (AvLOS 18 days)
- ⇧ discharge to long-term care facilities (58% to NH)
- ⇧ use of antipsychotic medications (50% prn)
- ⇧ adverse incidents and mortality

Background



- HSE Level 3 Hospital 230 AH BEDS
- Well developed community and acute hospital specialist older persons services
- Wanted to build on roles and expertise around needs of Person with Dementia
- Use of key clinical roles and services to ‘join up’ elements of the patient journey

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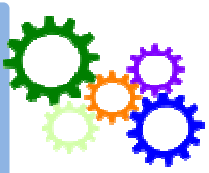
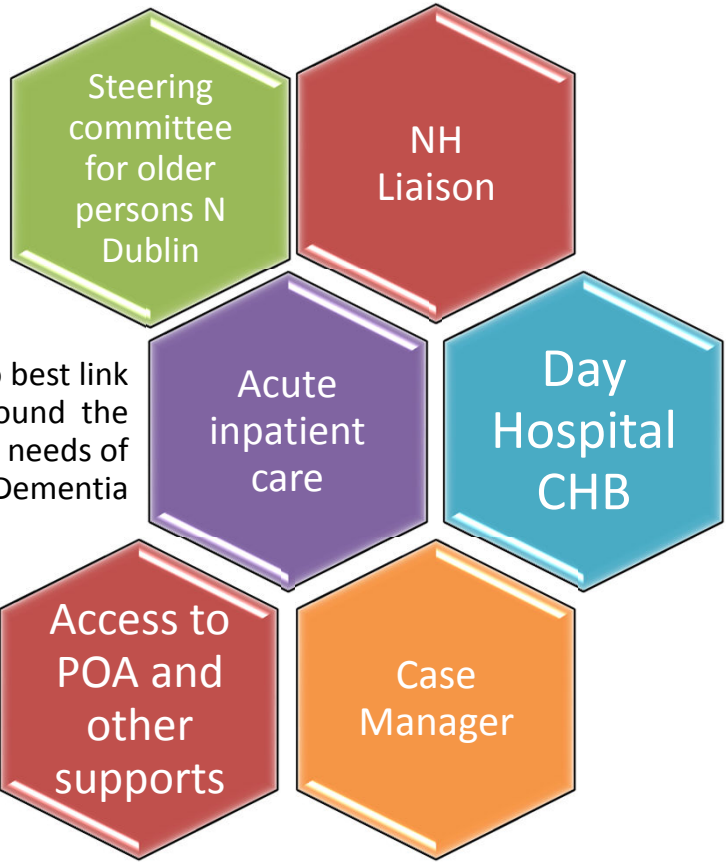
Services and Structures

aimed at integrating care for older people in Connolly and LHO

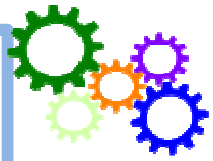




? How to best link these up around the specific needs of People with Dementia

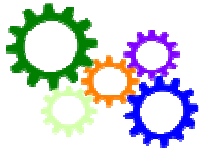
Process mapping

What was the journey for PwD in our own OPD / Day Hospital



- Chart review
- HIPE data (Day Hospital Assessments)
- Feedback from service users, families and the complaints department!
- Own Observation

Process Mapping - pre ICP



Key findings for Person with Dementia:

- Seen in general MFTE assessment clinic
- Reviewed in different clinics (sometimes with different teams)
- No written information given to PwD or family
- DNA- letter sent to GP- little follow up
- No formal post diagnostic dementia specific supports for either inpatients or out-patients
- No formalised pathway for patients with delirium
- Significant Provision of 1:1 Care
- Patient Complaints in relation to PwD

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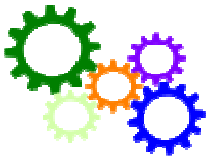
Connolly Hospital Dementia Pathways Project

Genio funded project to develop integrated pathways for people with dementia availing of acute services.

Project activities developed under four key headings.

Clinical Roles Supporting Integration



- 1.0 WTE CNS Dementia- Leadership role in driving overall Genio project (April 2015)
- 0.5 WTE PHN – Community role
- Existing Geriatrician support and clinical case managers for older persons
- Good management engagement from consortium process
- Had to be seen as part of wider project building on other elements of acute inpatient and outpatient care for PwD

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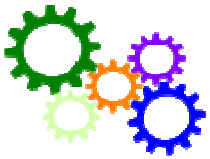
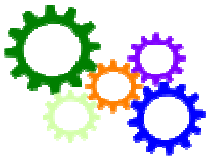
Where We Are



- Consortium
- CNS
- MAS- ambulatory support for PwD
- Support for inpatients- Personal Passport, Dementia Care Bundle
- Education
- Environmental design
- Early Indicators re activity/ embedding culture change

MAS Clinic Assessments

New Diagnosis



Day 1

- Nurse Lead Assessment, MOCA, MMSE, ACE III, IQCODE,IADLS,BARTHEL, Collateral History, Blood Tests, Neuroimaging.
- Written information on next steps given.

Day 2

- Feedback with Consultant, CNS.
- Referrals to community supports as necessary
- Weekly case review MDT for complex cases (inpatient and outpatient)
- CNS Virtual clinic

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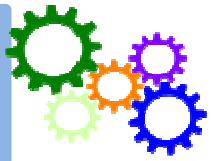
MAS - Urgent Referral Service

(est. Feb 2016)



- Early Supported Discharge/ admission avoidance pathway through MAS
- Relies on early identification of delirium / dementia
- Linked with other key elements that support integration including Nursing Home Liaison, Discharge Coordinator, Frailty Service, Day Hospital
- Phone contact with CNS (often family member) is the key.
- Clinic twice weekly –links with frailty clinic

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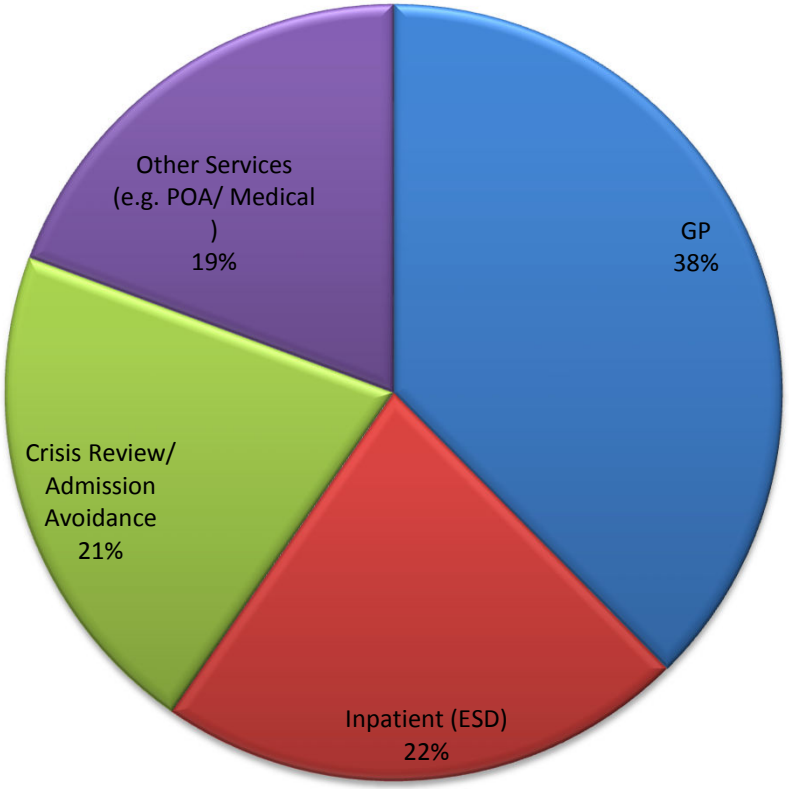
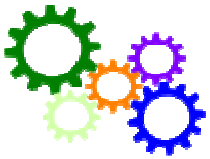
Initial Experience 2015 / 2016

MAS Clinic Referrals n = 181



Initial Outputs



Patients Seen Nov 2015- 2016

N= 181 (140 = new patient assessments)

2 clear groups emerging in model

- 'New diagnoses' – younger, higher functional level, less co-morbidity, need ++ emotional support around diagnosis, future care planning
- 'Established' – with moderate / significant cognitive impairment; around half of these not previously known to services, more comorbidity, need significant social supports and 'crisis management' (Referrals post acute hospital discharge)
- Establishing data set to monitor longer-term experience with services of this caseload

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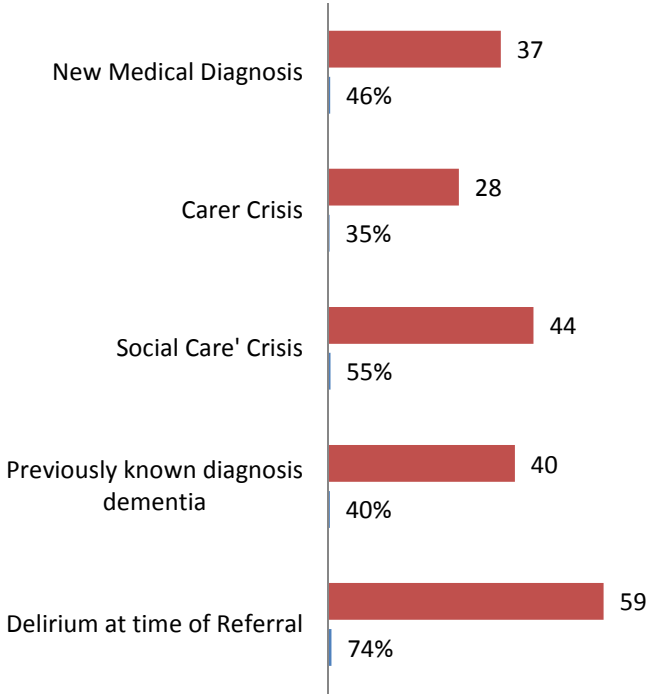
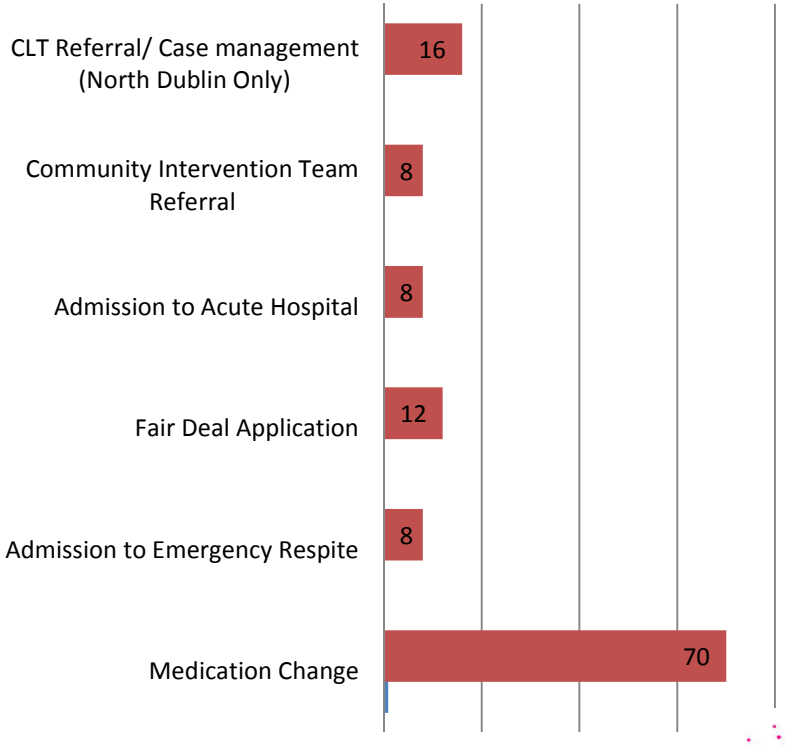
Urgent Referrals to MAS Service

2015 /2016 n= 80

Clinical Findings at time of Referral

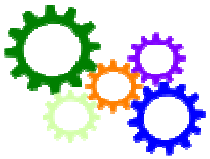


Outcome of Referral



Person-Centred Care-?

Potential for impact at system level

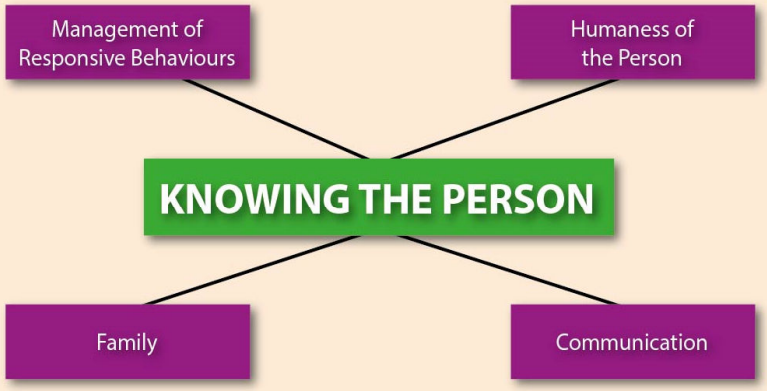


- 1:1 Care
- Weekly input by CNS at Management team review
- Forum for discussion, education, culture change
- Significant reduction in 1:1 care since 2014
- Introduction of Personal Passport system and other measures that support structured use of appropriate high quality 1:1 care
- Training of HCAs in Dementia Care
- ? Reflects staff feeling supported and enabled in delivering care to PwD

Thematic Network Staff Focus Group 2

"….it gave you an insight in to how to approach him..."
(staff member HCA group)

"We had a family meeting yesterday and the patient's name is Margaret and she has a level of cognitive impairment, but in the same meeting with one MDT she was called Maggie, Meg, Peggy and Marge, all in the space of one meeting, each one of us convinced that we had the right name" (staff member nurses group)

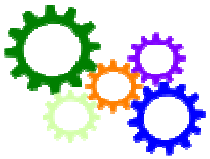


"... the personal passport was… given to the family to try and work with them….they were at their wits end …seeing their relative agitated and aggressive and this was kind of like a joint venture to try and help with that without going own the road of medication…"
(staff member, nurses group)

"...Give each staff member an equal footing to be able to engage with the patient…..even if its only for three minutes….there will be something in the whole passport you can identify with…"
(staff member, nurses group)

Applying Learning-

Personal Passport



- “One size does not fit all” in supporting people with dementia- personal passport acknowledges individuality.
- Personal passport is a tool and needs to be used in conjunction with other dementia friendly initiatives.
- Both families and staff feel this simple, non medical document has the potential, if used appropriately to hugely impact on the provision of person centred, compassionate care for people with dementia in acute settings.
- There are challenges to using the document in the acute setting- conflicting care priorities, dementia awareness, resources, culture.

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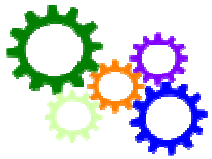
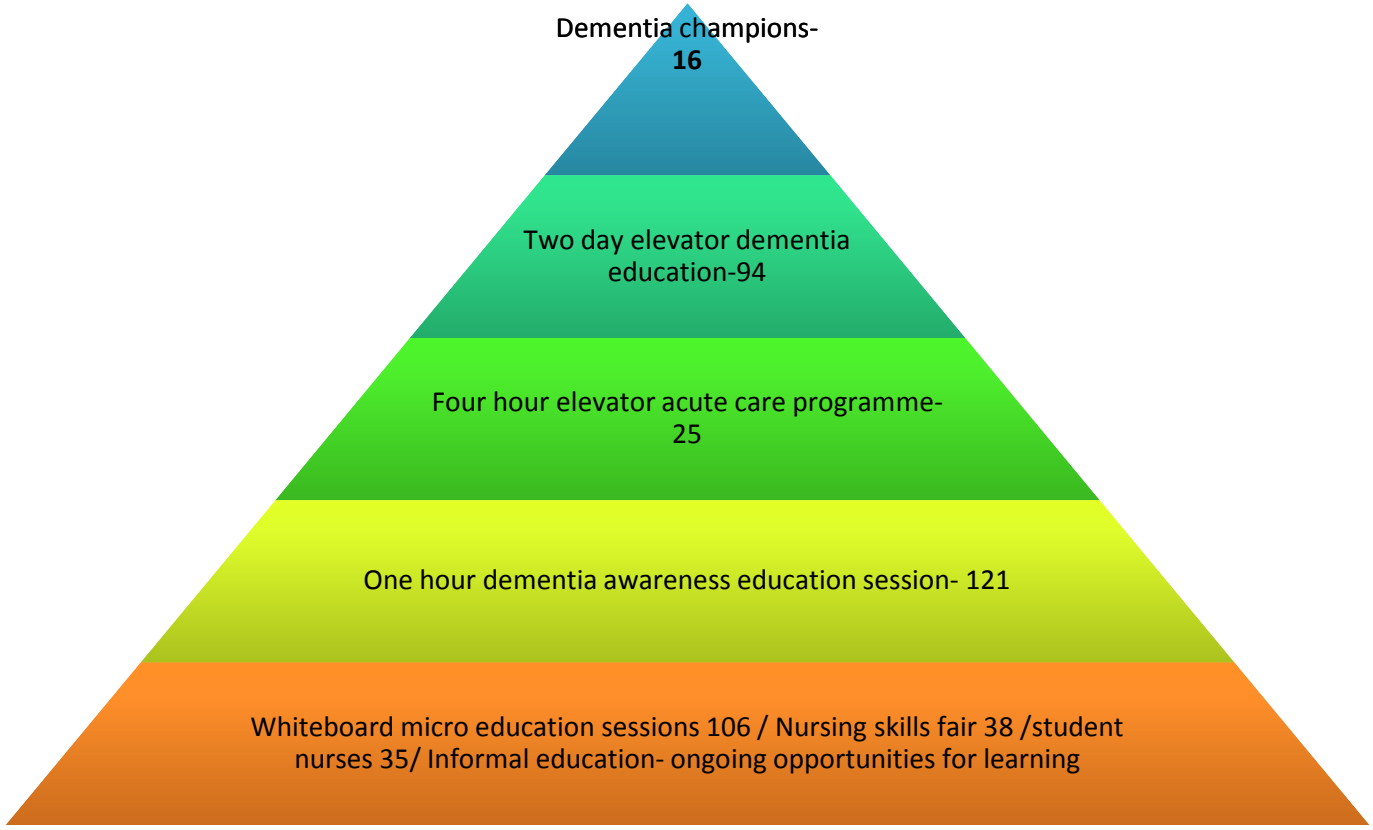
Educational approach

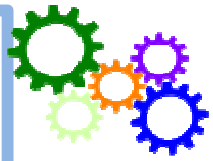
Multidimensional and across acute + community





Whiteboard at work

CLAN Telementoring Service



- Collaborative Learning at Nursing Homes
- Inter-Professional, Dementia focus, Case-based with Didactic
- Facilitated Video-conferencing
- Initial Pilot, now run once-monthly
- Each NH ‘hosts’ in rotation- de-identified case details sent to faciltator beforehand
- CPD accredited for medical and nursing. Pharmacy and AHPs also participate
- Evaluation

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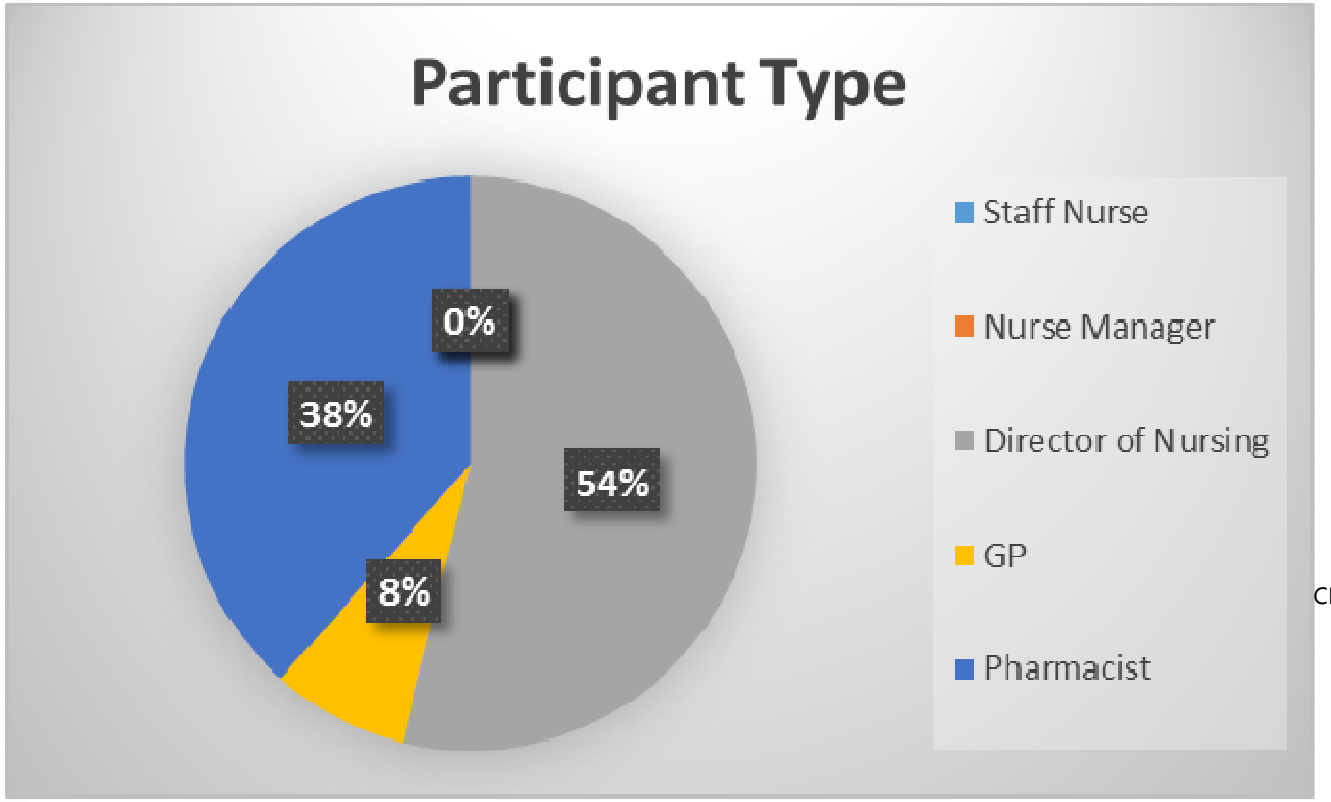
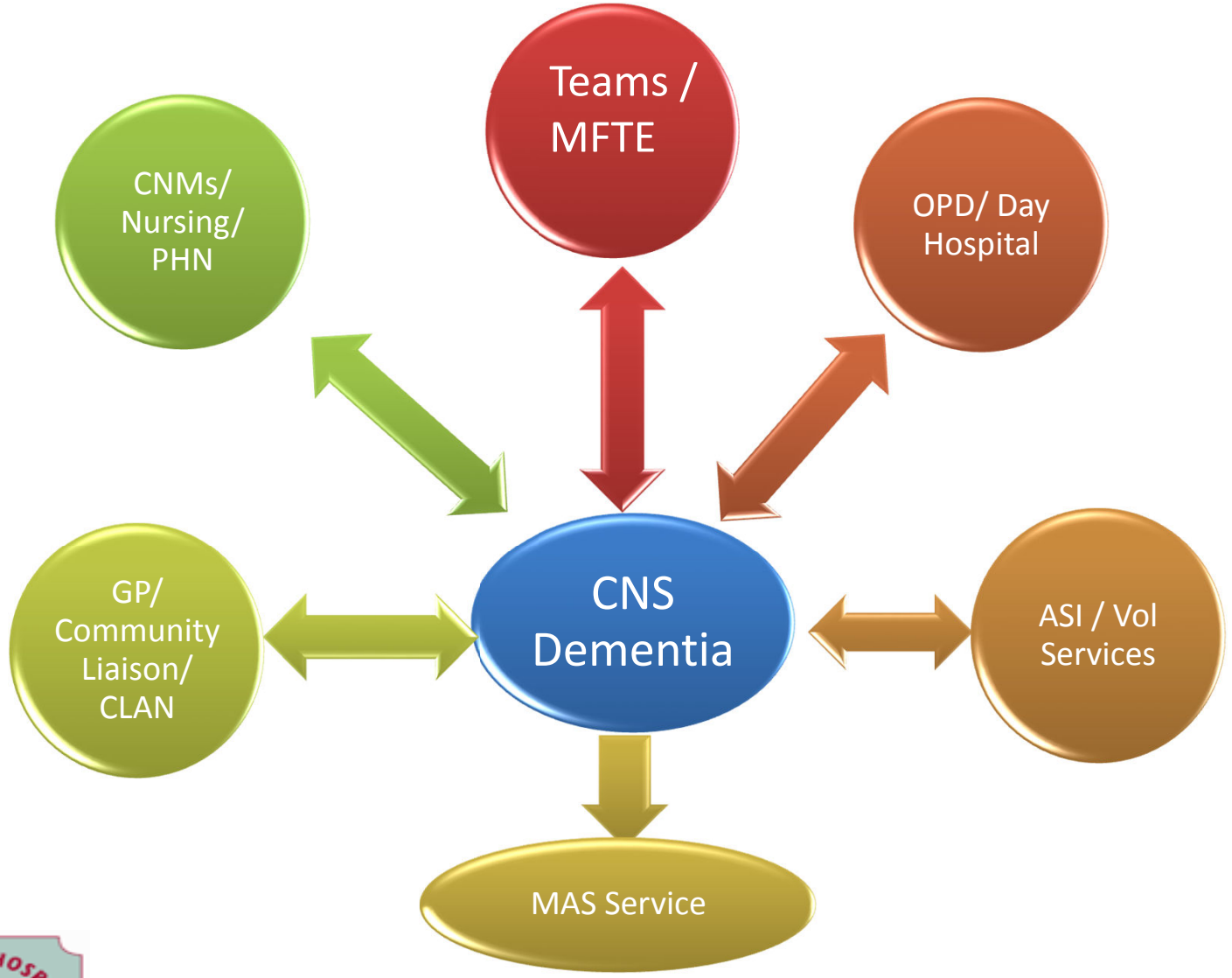
Q3: Participant Type



CLAN version 1.mp4


Teams / MFTE
CNMs/ Nursing/ PHN
OPD/ Day Hospital
GP/ Community Liaison/ CLAN
CNS Dementia
ASI / Vol Services
MAS Service

Connolly Hospital Dementia Project

Journey so far

Supporting the Patient Journey in Community	Improving the acute inpatient experience
Memory Assessment and Support Service	Early Supported Discharge Process through MAS
CNS Dementia Virtual Clinic	CNS Dementia formal links with patient flow/ Frailty CNS and MDT
Established Point of Contact via all services including PHNs, Case Managers, GPs through Dementia CNS	Established Point of Contact in Acute Hospital for HCPs and families and PwD
Formal Diagnostic Process for PwD including nurse led assessment, MDT meeting, follow up and support	Assessment and Documentation Procedures in place and embedded around Delirium and Dementia (white board round)

Connolly Hospital Dementia Project

Journey so far

Supporting the patient Journey in the Community	Improving the acute inpatient experience
Formal Dementia Specific Supports established with voluntary groups	Promoting an enabling acute environment - supportive management
Supported acute hospital avoidance with clinical and MDT input	Introduction of Personal passport system
Outreach Education programme with carers, PHNs, Practice Nurses, GPs, Nursing Homes (CLAN Telementoring)	Proactive approach to culture change through access to formal and informal education- supportive management team
Consortium guiding overall strategic approach to management of PwD across AH and Community services	Consortium guiding overall strategic approach to management of PwD across AH and Community services

10 Step Integrated Care Framework for Older Persons

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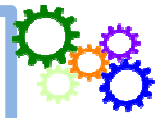
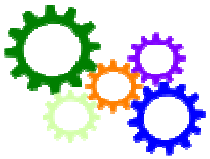
Learning so far



- Not just a project, more of a movement!!
- Care for PwD reflects core care culture
- Organisational support key to unlocking and driving cultural change
- Reflecting the significant systemic dividends from adopting a person-centred approach

Where to from here.....



- Evaluate
- Sustain
- Enable
- Environment

Disclaimer!