

DEMENTIA CARE IN THE ACUTE HOSPITAL SETTING: ISSUES AND STRATEGIES

A REPORT FOR ALZHEIMER'S AUSTRALIA

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**TALKING ABOUT ALZHEIMER'S
ACROSS AUSTRALIA**
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Alzheimer's Australia respectfully acknowledges the Traditional Owners of the land throughout Australia and their continuing connection to country. We pay respect to Elders both past and present and extend that respect to all Aboriginal and Torres Islander people who have made a contribution to our organisation.

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FOREWORD

The increasing numbers of people living with dementia in Australia poses a considerable healthcare challenge both now and in the future. One in every four people with dementia requires hospital services each year. People with dementia experience worse clinical outcomes including longer stays in hospital and higher mortality than those who do not have dementia.

The very nature of a busy hospital environment is problematic for people with dementia and they are also more prone to sustaining injuries such as falls and developing other additional ailments such as pressure ulcers which may prolong their stay. Dementia often goes unrecognised or undocumented and can contribute to the needs of the person with dementia not being adequately met.

Carers can play an important role in supporting people with dementia and advocating for better care during their hospital stay. They should be encouraged to support people with dementia when possible, but at the same time there also must be recognition that not all people with dementia will have a carer who can assist and that many carers cannot provide support 24 hours a day.

Consumers, policy makers and researchers have been talking about the need to improve dementia care in hospitals for a number of years. There has been some progress, with the decision in 2012 to make Dementia a National Health Priority Area and the funding in the 2012 Aged Care Reforms targeted to improve hospital care for people with dementia.

The Australian Commission on Safety and Quality in Health Care has done some initial work to develop a resource for hospitals to guide improvement in care in the context of the National Safety and Quality Health Service Standards. The Dementia Training Study Centres have also been funded to provide training

and information on appropriate physical design for dementia in hospitals. This work is an important start but there is an urgent need to ensure that the 2012 funding continues to be rolled out to ensure that hospitals can provide high quality care to people with dementia.

In April 2014, I had the privilege of taking part in a Symposium on dementia care in hospitals hosted by Alzheimer's Australia. This meeting brought together researchers, policy makers and clinicians to talk about the latest research on dementia care in hospital and to discuss strategies and practical approaches to improve the quality of care. This paper draws together the outcomes from that valuable meeting and provides a snapshot of the evidence base as well as some strategies for improving quality of care.

We need action now to ensure that Australia's hospital system is prepared for the increasing number of people with dementia in our community.

I would like to thank Professor Brian Draper for his involvement in developing the Symposium and conducting a national seminar series as well as the eminent researchers and others who were involved in the Symposium. I would also like to congratulate Dr Ellen Skladzien for the work she has done in following up what I thought was an excellent Symposium.



Ita Buttrose AO, OBE
June 2014

EXECUTIVE SUMMARY

Australia is facing a huge healthcare challenge with an ever increasing demand for appropriate acute care services for people with dementia. Yet, people with dementia still struggle to get the care they need in the acute care setting. People with dementia experience unacceptably worse clinical outcomes, longer lengths of stay as well as a higher likelihood for readmission compared to people without dementia at a high cost to the health care system.¹ With good care, the costs of dementia care in hospital may be the same but the outcomes for people with dementia would be improved leading to a more efficient use of health care spending.

Alzheimer's Australia held a Dementia Care in Hospitals Symposium in Sydney on the 29th of April 2014, where the most recent Australian research in dementia care in hospitals was presented and discussed by leading researchers and experts. This included latest findings on current dementia care as well as interventions and strategies to improve the quality of care. This report provides a summary of the issues and strategies that were discussed at this Symposium.

To improve outcomes for people with dementia in the acute hospital setting, this report outlines urgent issues that need to be addressed. These include:

- Better identification of cognitive impairment in our hospitals
- Increased training for all staff including how to communicate with a person with dementia and how to respond to behavioural and psychological symptoms
- More extensive and systematic involvement of carers as partners in the health care of people with dementia
- Creation of appropriate physical hospital environments to reduce confusion and distress of people with dementia.

This report also identifies a range of strategies to improve the outcomes for people with dementia including:

1. Identify and manage dementia at hospital admission and plan for discharge from the outset
2. Involve family carers in the care and support of patients
3. Train staff to better understand dementia and communicate more effectively with people with dementia
4. Use alternatives, such as psychosocial interventions, to the use of antipsychotic medication and sedatives
5. Adapt the hospital physical environment to reduce distractions and help orientate patients with dementia
6. Reduce avoidable hospital admissions.

While there are already some successful programs in place that improve acute care for people with dementia, more needs to be done. Sustained commitment and leadership from policy makers, senior management and healthcare professionals is essential if we are to achieve the cultural change that is required to improve the outcomes for people with dementia in the acute hospital setting.

BACKGROUND: AUSTRALIA'S HEALTHCARE CHALLENGE

Australia is confronting a huge healthcare challenge. More than 330,000 Australians are living with dementia with this number forecast to increase to nearly 900,000 by 2050. Regardless of whether they live in the community or in aged care, people with dementia need access to appropriate health care, including acute care.

The challenge is immense because the acute care context is by definition driven by emergencies and an environment that is not designed to cater for the needs of someone who may be confused or have other forms of cognitive impairment. Evidence suggests that the Australian health care system is failing people with dementia and is not adequately equipped to provide services to the future numbers of people who will have dementia.

People with dementia are high users of acute care services with about one in four people with dementia being admitted to hospital every year, which is twice the rate of people of the same age who do not have dementia.³ Hospitalisation can occur due to dementia or unrelated conditions such as hip fractures and urinary tract infections. In 2009-10 only 15% of dementia hospitalisations were due primarily to dementia and not other conditions.⁴

People with dementia have unacceptably worse clinical outcomes with longer lengths of stay, higher mortality as well as a higher likelihood for readmission compared to people without dementia.⁵ Some of these differences are to be expected due to the nature of the disease, but the evidence suggests that with better care, outcomes for people with dementia could be improved.

These are not new concerns. Consumer advocates, policy makers and researchers have been raising this issue for many years. As part of the 2012 Aged Care Reforms, the Australian Government committed

\$39.2 million over 5 years to improve hospitals for people with dementia. The Minister's Dementia Advisory Group held a Dementia in Acute Care Forum in November 2012 which identified strategies to improve the care of and outcomes for people with cognitive impairment in the acute care setting. These strategies included:

- Establishing a national dementia education strategy, possibly through Dementia Training and Study Centres (DTSCs), relevant to all staff who work in the acute care setting, and that builds on existing education and training programs
- Using existing evidence to articulate the best practice models of care for people with cognitive impairment in the acute care setting through the involvement of people who can provide clinical leadership, such as cognition clinical nurse consultants
- Developing national standards on acute care for people with dementia and delirium, including quality improvement measures, and ensure cognitive function is integrated into the National Safety and Quality Health Service Standards
- Ensuring that cognitive status is adequately assessed and that this information is used to provide appropriate care
- Ensuring that hospital processes encourage better dissemination of information between the patient, the patient's carer/family, the admitting doctor and hospital staff
- Providing an appropriate physical environment for people with dementia, including orientating cues for patients, carer facilities and special care areas
- Ensuring a funding model that enables hospitals to provide good care to people with dementia.

As a result of this Forum and the 2012 Aged Care Reforms, the Government has funded work through the DTSCs to improve the physical design of hospitals through training and audits, and the Australian Commission on Safety and Quality in Health Care to develop a resource for hospitals to guide improvement in care in the context of the National Safety and Quality Health Service Standards.

It is encouraging that the issues dementia care presents in the acute care sector are now better documented and recognised. Despite this important work and focus on the issue, it is clear that people with dementia still struggle to get the care they need in hospitals.

Alzheimer's Australia held a Dementia Care in Hospitals Symposium in Sydney on the 29th of April 2014, where the most recent Australian research in dementia care in hospitals was presented and discussed by leading researchers and experts. This included latest findings on current dementia care as well as interventions and strategies to improve the quality of care. This report provides a summary of the issues and strategies that were discussed at this Symposium.

ISSUES THAT NEED TO BE ADDRESSED

'Dementia is terminal but the person with dementia is no less worthy of the best care.' Carer

Hospital can be an unsafe place for a person with dementia. Compared to patients without dementia, those with dementia are twice as likely to experience an adverse event such as falls, sepsis or pressure ulcers, while in hospital.⁶ Fractures and delirium are also up to three times more likely to occur for someone with dementia. As a result, patients with dementia in hospitals face a five-fold increase in mortality rates.⁷ People with dementia also stay in hospital almost twice as long as those without dementia, averaging 16.4 days of care compared with 8.9 days for other patients.⁸

Care for people with dementia in hospitals is a significant cost to the health care system. In New South Wales (NSW), the average cost of hospital care for a person with dementia was \$7,720 per episode compared with \$5,010 for a person without dementia. The total cost of care in NSW public hospitals for patients who had dementia in 2006–07 was estimated to be \$462.9 million.⁹ It is unclear if improving care would lead to savings to the health care budget. With good care, the costs may be the same but the outcomes for people with dementia would be improved leading to a more efficient use of health care spending.

It is important to recognise that not all hospitals are the same. Some provide better care to people with dementia and, as a result, have better clinical outcomes. Research suggests that outcomes for people with dementia vary according to the type and location of the hospital to which they are admitted. Hospitals with comprehensive geriatric medical services, including on-site geriatricians, and emergency departments with dedicated aged care staff, tend to result in better outcomes and shorter stays for people with dementia.¹⁰ However, these

geriatric medical resources are often only available in large urban hospitals.

To improve quality of care for people with dementia we need to tackle several issues:

Identification of cognitive impairment

Cognitive impairment can be caused by dementia, delirium or stroke and inadequate assessment can lead to poor outcomes for patients. People at risk of cognitive impairment need to be assessed promptly so that appropriate care can be provided.

There is a need to distinguish between progressive cognitive changes which occurs as a result of dementia and acute confusional states caused by delirium. Delirium can be caused by infection, medication or other medical issues and fatal outcomes can occur if left untreated.¹¹ People with dementia are three times more likely to develop delirium compared to those without dementia. Often when a person with dementia presents as confused to an emergency department, the assumption is that this confusion is due to their cognitive impairment rather than recognising that the confusion represents delirium. As a result, the underlying condition causing the delirium may not be identified and appropriate care may not be provided.

In addition to distinguishing between acute delirium and other cognitive decline, there is a need to ensure that dementia is appropriately assessed and documented and the patient linked to appropriate support. Research suggests that nearly 50% of people with dementia do not have their diagnosis documented during their hospital stay. Possible reasons for this include time constraints on the interactions between patients and hospital staff, clinical coding practices, and the challenges associated with diagnosis of dementia.

There is some debate over whether there should be widespread screening in hospitals for cognitive impairment as screening can result in false positives. The need for identifying dementia must be balanced with the risk of inaccurate diagnosis as well as the resources involved in screening. Many experts suggest that screening people in hospital who are at higher risk of cognitive impairment (those over the age of 65) could contribute to better identification of people who have dementia.

Few hospitals and emergency departments provide routine cognitive assessment and appropriate follow up of patients who are at risk of dementia or delirium. There are of course exceptions, with some hospitals having a well structured procedure for assessing the cognitive status of incoming patients and linking this to appropriate support. The low rate of screening and appropriate follow up is partly due to issues around resources as routine screening and consequent action requires time and trained personnel which are often lacking in the emergency department.

Where screening does take place, and cognitive impairment is detected, the evidence suggests that this information is not necessarily used systematically. Being able to detect whether a patient can, for example, sign documents authorising treatment, remains variable. Often staff do not have the training required to provide appropriate care and support.

'The doctor at the hospitals asked my mother which hip is broken. My mother would have no idea which hip it was.' Carer

'Nursing staff assume that the dementia patient can convey their wishes and ask for assistance (for example, 'Just ring the bell if you need anything'). But the dementia patient may not remember there is a bell and may not be able to indicate what their needs are.' Carer

Staff training

Hospital staff need skills and knowledge to be able to provide good care to a person with dementia. This includes knowledge on how to identify and communicate with a person with dementia and how to respond to behavioural and psychological symptoms.

Hospital staff also need to understand the impact cognitive impairment has on a patient's ability to be involved in their care. Often there is an expectation that patients can and will co-operate in their own care including following instructions, and managing nutrition and hydration. For a person with dementia, these expectations can be unrealistic unless they are modified with person-centred approaches to care.

'The rehab staff said Mum wasn't motivated. I told them that was because she didn't have her slippers. She wouldn't walk in bare feet at home without her slippers so no way would she walk on a hospital floor without them! As soon as she got the slippers, she did all her exercises.' Wilma Robinson, Carer

Hospital staff often do not receive adequate training on dementia. One study found that less than half of hospital staff had received any training on dementia and those who did receive training felt it was inadequate. Another study found that 80 to 90% of hospital staff reported difficulty caring for patients with cognitive impairment.¹³

Involvement of carers

An estimated 1.2 million Australians are involved in the care of a person with dementia.¹⁴ Carers often have an in-depth knowledge and understanding of the person with dementia and their particular needs. For example, they generally know what communication methods work, what certain behaviours mean, what the person's preferences are and what medications they need. When carers are able to and willing, they can play a key role in providing support and care in the hospital environment. Carers need to be seen as an essential partner in care.

Yet carers are sometimes excluded from consultations and care decisions in the acute hospital setting. This can occur because of privacy concerns, communication difficulties or time constraints. Recent research found that approximately a third of hospital staff have difficulty communicating with carers.¹⁵ Family members, often informal carers, tend to be seen as fulfilling a socialisation role rather than a crucial care role. As a result, their voices are often omitted from care consultations.

Lack of consultation with carers means opportunities for gathering baseline information about the patient's usual condition may be missed. In the clinical setting, this information can be critical. For example, when screening for acute change in the emergency department, the carer may well be the best authority on whether a patient has experienced a rapid deterioration.

A carer's experience

My husband Michael was diagnosed with younger onset dementia in 2001. Some of the most challenging experiences were during his last year of life in 2010 when he had four acute hospital admissions spanning over 18 weeks for other medical conditions.

The first admission was for acute renal failure. On his third night at the hospital, he tried to climb over the bed-rails to follow us when we left. Someone on duty made the judgement to give him five times his dose of the antipsychotic, Risperidone, to 'quieten him down'. He was rendered unconscious for the next five days. After five weeks, he was finally discharged from the aged care acute unit with noticeably diminished capacities and incontinent.

A second admission about a month later involved a resection of his prostate gland. He was nursed post-operatively in the urology ward with both wrists and ankles tied to the bed-rails for 48 hours, so he would not 'pull his tubes out'. This occurred in the absence of consultation with myself and our family. As I arrived on the first evening after surgery and walked into his room a nurse was sitting at the end of his bed writing notes. She glanced up at him, picked up a roll of bandage, threw it at him and said 'Here, play with this!' The fear on Michael's face, in that moment in his physically constrained and confused state, was palpable.

Following an unwitnessed fall in residential care leaving him with four fractured ribs, Michael was admitted to hospital for the third time. In acute care this was managed with significant doses of pain relief medications. When his swallow reflex became unreliable, he was placed on a thickened fluid diet. He then became drowsy and

unresponsive, and couldn't be mobilised by the two physiotherapists who came to see him once a day for 15 to 20 minutes. Mobilising someone with dementia was not a priority in acute care. Michael never regained his mobility. After six weeks he was declared palliative.

With the one-to-one care we were able to give him at home, he improved. However, during his fourth, subsequent admission in the local hospital to review his medication he developed aspiration pneumonia. In the entire time Michael was at home he never aspirated. Following treatment for this in hospital, he was discharged home but he died two days later.

Physical environments of hospitals

Hospitals are busy, noisy and often confusing places. The level of noise, bright lighting, lack of clear signage and confusing layouts of emergency departments can be particularly alarming and disorientating. For people with dementia, the physical environment of the hospital can lead to increased confusion and disorientation, contributing to their distress. It may not be obvious, for example, where the toilet is, or how to find your way back from the toilet to your designated bed. Recent research suggests that only 14% of hospitals have secure, safe, user friendly wards or areas for confused patients.¹⁶

STRATEGIES TO IMPROVE DEMENTIA CARE IN HOSPITALS

There is a compelling case for change to improve quality of care in hospitals built through formal research and the direct experience of patients, carers, and healthcare professionals. The following strategies for improving outcomes for people with dementia were discussed at the Alzheimer's Australia 2014 Symposium.

Strategy 1: Identify and manage dementia

Identifying cognitive impairment is the first step to provide quality care. A range of approaches can be used to identify whether a person has a cognitive impairment. For example, questions about cognitive impairment can be included on a pre-admission form, or hospitals can require screening of people at risk of cognitive impairment within 24 hours of admission. The Centre for Research in Geriatric Medicine (The University of Queensland) has developed a suite of screening tools for assessment of dementia and delirium in hospital. These tools can be used with telemedicine and is designed to be compatible across settings (for example, residential aged care facilities, emergency departments, acute care and community care).

Once identified, people with cognitive impairment need different management and care during their stay in hospital, and appropriate discharge planning. The ideal approach to care for a person with cognitive impairment is for someone, such as a clinical nurse consultant in the emergency department, to start the journey with the person, ensure they have adequate support during their hospital stay and appropriate care. This allows for a discharge plan to be developed from the earliest stages. It is also an opportunity for the person with cognitive impairment and their carer to be informed about rehabilitation services as well as possible alternatives to admission.

An example of this working well, is the use of Aged Care Services in Emergency Team (ASET) in NSW, which is a multi-disciplinary, emergency department

based team that focuses on older patients. The team can help with screening and assessing cognitive impairment, determining care needs and planning. They can also bridge the gap between hospitals and the non-acute sector to ensure the person has a seamless transition between care facilities.¹⁷

Care pathways, such as the three year Dementia Care Pathways program funded by the Victorian Department of Health in 2014, is another example of good management that can improve outcomes. A dementia care pathway is a structured, multi-disciplinary care plan designed to ensure delivery of high quality care to people with dementia in acute care settings. Care pathways have been shown to reduce the length of hospital stay, reduce complications and improve hospital efficiency.

Strategy 2: Involve carers

Communication with carers of people with dementia is vital. There is significant anecdotal evidence that improving communication with carers, as advocates for patients, has beneficial effects on patient experience and outcomes. Involving carers in developing care pathways can also help deliver quality care.

An example of an effective tool for engaging with carers is the TOP5 Program used in some NSW hospitals. TOP5 enables carers to communicate the top five care strategies for the person with dementia. Health care professionals are then able to use this information to provide better quality care. For example, a carer might note on a TOP5 bedside chart that the person with dementia becomes agitated if she cannot find her purse. Hospital staff would then be aware of a simple strategy they could use to reduce agitation in this patient.

The program has been trialled at several hospitals in NSW and has resulted in improved clinical handover and patient safety. Both carers and staff have reported very positive outcomes, including:

- Patients were observed to be more settled
- Carers' satisfaction with hospital care was enhanced
- Staff were better equipped to individualise care, and to communicate with patients and carers, leading to greater job satisfaction

The TOP5 scheme has been granted funding by the Clinical Excellence Commission to expand across NSW.

Strategy 3: Communicate effectively

Staff are often unaware that a patient has cognitive impairment, and therefore it can be difficult for them to determine the type of care that would be appropriate to provide. However, once cognitive impairment has been identified, staff can still struggle to know how to best communicate with a person who has cognitive impairment. If care is to be improved, there is a need for all frontline staff, including cleaners and caterers, to gain a better understanding of how to communicate with a person who has dementia.

Although each person with dementia is unique, there are simple techniques that staff can learn, such as keeping sentences short, to communicate with people with dementia more effectively. Showing empathy and care towards the person with dementia will also improve communication and reduce frustration for both staff and patients alike.



Figure 1. Cognitive Impairment Identifier – Ballarat Health Services

© Ballarat Health Services.¹

¹ Image used with permission from A/Professor Mark Yates, Ballarat Health Services.

The Dementia Care in Hospitals Program (DCHP), launched in Victoria in 2003, is an example of an effective program which aims to improve communication between people with cognitive impairment and hospital staff. The program combines appropriate screening for cognitive impairment with hospital wide staff training and a visual bedside alert, known as a Cognitive Impairment Identifier (CII). The CII was developed in consultation with carers and features an abstract design to signify the cognitive impairment (Figure 1).

The all-hospital DCHP education program is not restricted to clinical staff, includes caterers and cleaners, and focuses on communication, engagement with carers and understanding of dementia. Staff are encouraged to adhere to simple communication protocols such as:

- Introducing themselves
- Maintaining eye contact
- Remaining calm
- Keeping sentences short
- Involving carers
- Not presenting patients with too many choices at once

Evaluation of the program has shown significant improvements in staff perceptions (self-assessed). Staff have reported higher levels of confidence and job satisfaction in dealing with cognitively impaired patients as well as increased organisational support.

'I thought more about the communication mode and made sure the patient understood what I was saying. Previously I might have assumed they understood.' Nurse feedback, Dementia Care in Hospitals Program, Ballarat

The program is being used in 22 hospitals in Victoria, and is now being trialled in the private sector.

Another project that has developed strategies to improve the care of older people with confusion in hospitals through the use of effective communication is the Confused Hospitalised Older Persons (CHOPs) model of care.

The program focuses on the following approaches to improve dementia care:

1. Identification of older people with confusion in the hospital system
2. Investigation of the cause of the patients' confusion
3. Implementation of effective treatment and management for these patients, including communication processes to support person-centred care

The program strongly encourages communication between staff, carers and families to promote their involvement in assessment, care planning and decision making to allow staff to recognise care needs and support person-centred care for the patient.

After the implementation of the CHOPs model of care in selected hospitals, hospital staff were more confident in recognising and managing a patient with delirium and dementia.

"The cleaner at our hospital came to me and said there is something not quite right with Mrs W, her behaviour has changed. Not sure how but the CHOPs work is increasing awareness of all the staff" Health Care Professional

Strategy 4: Provide alternative care to antipsychotic drugs

Behavioural and Psychological Symptoms of Dementia (BPSD) often worsen during hospitalisation. Although antipsychotics have often been prescribed to patients with dementia to manage symptoms, the use of these drugs have been associated with severe adverse side effects and limited clinical benefit to the patient.¹⁸ Increasingly, the consensus amongst healthcare professionals is that there is very little justification for using antipsychotics, night sedation and hypnotics amongst older people. For example, routine use of sedatives at night increases the chance of falling while trying to use the bathroom in an unfamiliar environment.

'Older people go into hospitals and they are cared for poorly as their needs as an older person are not understood. When they act out the response from staff is restraint.' Nurse

There are a range of alternative approaches to managing BPSD including assessing for potential underlying causes of the behaviour including hunger or physical pain. Working with the carer to understand the triggers for certain behaviours is crucial. Alternatives to the use of antipsychotic medication and sedatives can include the use of psychosocial interventions.¹⁹ For example, determining whether the patient is trying to communicate pain, providing familiar items such as photographs to reduce confusion or creating quiet areas removed from the over stimulating hospital environment. The care approach can also be shifted to individualised, person-centred care with increased supervision and monitoring by staff.

Monitoring the rate of prescription of antipsychotic medications in older patients as part of a risk management strategy is already used by some hospitals. For example, Prince of Wales Hospital in NSW

regards reduced levels of antipsychotic prescribing to patients across all medical and surgical wards as a marker of quality dementia care. This reduction was achieved in part through targeted training.

There are resources available to assist acute care staff in the management of BPSD. The Dementia Behaviour Management Advisory Service are now funded to provide services within the acute care setting. There are also a range of documents and resources available to clinicians on management of BPSD. For example, The Faculty of Psychiatry of Old Age, Royal Australian & New Zealand College of Psychiatrists in collaboration with the NSW Ministry of Health has produced a free Handbook for health clinicians on the Assessment and Management of BPSD in acute care settings.²

Strategy 5: Create an appropriate physical environment

Adapting the hospital environment to reduce distractions and help orientate patients with dementia around a hospital can reduce disorientation and distress. Simple measures, such as colour coding areas of privacy, or installing clocks that tell the day as well as the hour, can help to relax and reassure patients. A well designed space might include the installation of sensitive lighting, areas of interest (such as gym or couch nooks), or a garden. This contributes to a calm, yet active environment.

Several audit tools have been designed to help hospitals develop appropriate physical environments. These tools and other resources can be found at the Dementia Enabling Environment Project website: <http://www.enablingenvironments.com.au/>.

In mid 2013 the NSW/ACT DTSC conducted national two day workshops on designing dementia-friendly hospitals. The DTSC Director Professor Richard Fleming and architect Kirsty Bennett led the workshops which

were attended by architects, health planners, clinical and allied health managers. The NSW/ACT DTSC also provide a consultancy service for residential aged care facilities and hospitals across Australia.

Strategy 6: Reduce avoidable hospital admissions

Hospitals are not always the best place for people with dementia to receive care. In some situations, it is best for people with dementia to receive care within the home or within specialised residential aged care facilities.

Hospital-in-the-home models of care which are already operating in Australia could be developed to specifically support people with dementia. A review of randomised controlled trials found that older patients who received hospital-in-the-home care experienced higher levels of satisfaction than those with equivalent care needs who received care in an acute setting. The mortality rate for hospital-in-the-home patients was almost 40% lower during follow up at 6 months. The cost of treatment was also significantly less, although this did not take into account the cost of informal care provided by family and friends.²⁰ Another study found that people with dementia who received hospital-in-the-home services had fewer behavioural symptoms and lower rates of prescription of antipsychotic medications than those who were placed in hospital.²¹

Hospitalisations of aged care facility residents can also be reduced. Strategies, such as specialised care units, can provide more intensive medical care for periods of time for people with dementia. Research has found that these units can significantly reduce rates of hospitalisation from residential care.²² Timely access to medical services, including general practitioners, specialists, nurse practitioners and physiotherapists as well as appropriate palliative care services, has also been shown to reduce need for hospitalisation for people in residential care.²³

² Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW Health Clinicians. <http://www.health.nsw.gov.au/dementia/Pages/assessment-mgmt-people-bpsd.aspx>

CALL FOR ACTION

Inadequate screening, lack of staff training coupled with a hospital culture that labels patients with dementia as 'difficult', contradicts the best interests of people with dementia in the acute hospital setting.

There are some successful programs in place that improve acute care for people with dementia but more needs to be done. Not only do we need education and culture change in our hospitals, we need sustained commitment and leadership from policy makers, senior management and healthcare professionals. Creative leadership has the potential to lead not only to better outcomes for people with dementia but also to create a more efficient hospital system. The Australian Government's commitment of \$39.2 million over 5 years to improve hospitals for people with dementia is a crucial first step. But we need action and we need it now.

With our rapidly aging population, providing appropriate acute care for people with dementia is a necessity. People with dementia are the canaries of the hospital system. By recognising and meeting the needs of these patients in the acute hospital setting we can improve health outcomes and reduce costs to our health care system.

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ADDITIONAL RESOURCES

Slides from the Dementia Care in Hospitals Symposium, Sydney, (2014)

<http://www.fightdementia.org.au/research-publications/dementia-care-in-hospitals-not-good-enough.aspx>

Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW health Clinicians, (2013)

The Faculty of Psychiatry of Old Age, Royal Australian & New Zealand College of Psychiatrists and NSW Ministry of Health
<http://www.health.nsw.gov.au/dementia/Pages/assessment-mgmt-people-bpsd.aspx>

Australian Commission on Safety and Quality in Health Care Consultation draft handbook, (2013)

Improving safety and providing high quality care for people with cognitive impairment
http://www.safetyandquality.gov.au/wp-content/uploads/2013/10/Draft-Handbook_Consultation_Improving-Care-for-People-with-Cognitive-Impairment-in-Acute-Care.pdf

Australian Institute of Health and Welfare, (2013)

Dementia Care in Hospitals: Costs and Strategies.
<http://www.aihw.gov.au/publication-detail/?id=60129542746>

Dementia Behaviour Management Advisory Service (DBMAS) <http://dbmas.org.au/>

Dementia Enabling Environments Program (DEEP)

<http://www.enablingenvironments.com.au/>

Dementia Services Development Centre (UK)-

Dementia friendly hospitals:
<http://dementia.stir.ac.uk/design/virtual-environments/virtual-hospital>

Dementia Training Study Centres

<http://www.dtsc.com.au>

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Or for information and advice contact the
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