NHS

London Clinical Networks

Supporting people with dementia to live well in London care homes

London Dementia Clinical Network

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March 2018

This talk

- The issues
- Models of NHS care for people in care homes
- How to support people with dementia
  - Individualised approach
  - Systemic approach
  - How can health and social care work more closely to support care homes
- The future- training and integration

Care Homes

- 70% of residents have dementia
- 300k people with dementia live in care homes in the UK
- 40% have depression
- Diagnosis of these problems less likely if you live in a care home
- People in care homes have reduced access to NHS primary and secondary care (AlzSoc Fix Dementia Care, 2016) eg GPs charging for regular visits, reduced access to dentistry, physiotherapy.
- Services not tailored to the needs of the ill in care homes eg Parkinson's disease clinics
- Traditional mental health services (CMHTs) traditionally are more interested in "functional illness" and diagnosis
- Polypharmacy common and a cause of 10% or more of acute hospital admissions

Models of NHS care in care Homes

- GPs
  - One GP practice per care home
  - Regular visits at set times
- Medicines management
  - Pharmacists doing medicines management
  - Working with GPs
- MDTs and shared care
  - Joint working with geriatricians, CMHTS and GPs
  - Evidence that MDT approach does reduce admissions
- Staff development
  - Can the care home staff do more if they have support?
  - Specialist mental health teams

Behavioural and psychological symptoms

- Almost universal in dementia
- Fluctuate- but 80% of severe presentations persist over 6 months
- Tend to increase with severity of dementia
- Types
  - Biological- sleep, appetite
  - Motor- restlessness, pacing, vocalisation, aggression- these are often termed “agitation”
  - Psychological- depression, anxiety, irritability, delusions, hallucinations

Supporting individuals with dementia

- **Prevention**- living well is supported by person-centred care planning with advance statements/care plans
- **Treatment** - distressed or distressing behaviour represents an unmet need and should lead to a plan to identify the need and a detailed care plan to and address this need

BPS briefing document (2013)

An example- The SLAM dementia care pathway for BPSD in care homes

- Care pathways in SLAM Mental Health of Older Adults (available at this link http://mhoad.slam.nhs.uk/)

- **Assessment** requires life history, history from carers supplemented by accurate recording (eg sleep, food charts, ABC charts, clinical outcome measures) observation
- A **formulation** session with care home staff informs the development of a person centred, holistic care plan that addresses quality of life and identified unmet needs (Cohen-Mansfield et al. 2007, British Psychological Society, 2013). Communication issues are often key.
- **Review**- regular visits to assess use of behaviour support plan and re-formulate where necessary

Communication a key part of dementia care e.g. Validation

- “Correcting” patients (“I’ve told you before , your mother’s dead”) increases distress
- Lying to patients is usually unethical and can make things worse (“You said my mother was visiting me this afternoon- where is she?”)
- **Validation** is acknowledging the emotion that is driving the question and can open the way to a more therapeutic interaction (“You must be missing your mum. Tell me about her…”)
- Can be used with **distraction** (“I think you’ve got a photo of your mum in your mum, shall we see if we find it?..)

How can you apply this approach to all people in a care home

Livingston et al, 2014 – systematic review

- Training care staff in person-centred care techniques and communication skills can reduce agitation
- **Interventions directed at care homes rather than individual residents may be more cost effective than indivdually focussed treatment**
- Multicentre WHELD study – “dementia champions” to deliver simple structured interventions” provided with coaching from specialists

Joint working between health social services and care providers

- Joint protocols for 1:1 carer funding requests
- An agreement of principles and culture of collaboration
- Protocol for when placement at risk of breaking down/safeguarding issues – urgent multi-agency meeting and action plans supporting all three parties to work together
- Guidance for care homes when assessing potential residents – especially in hospital
- Discharge planning from hospitals to involve CMHTs or care home teams when these exist – can prevent inappropriate placements
- Commissioning of integrated care home working- see next slide

Conclusion

1. Get basics in place first- A named GP who visits regularly. This is not optional
2. Effective joint working relationships between care homes, Soc Services, and health teams with protocols for difficult issues
3. Pharmacists to support GPs can implement quick and important wins- reduce fall risk, reduce delirium (Medichec.com), audit etc
4. Ideally- MDT with GP pharmacist and geriatrician or psychiatrist – but keep it brief, monthly is fine, and no rambling on- decisions and actions!
5. Specialist teams have a place – eg mental health teams to manage complex residents but also to deliver training interventions eg WHELD

Good joint commissioning vital.

In all these service models empower the care home manager and staff eg DEAR-GP, Kent care pathways