The Dementia Care Bundle

Improving the quality and safety of hospital care for patients with acute physical illness who have co-existing dementia

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Synopsis
This case study outlines how the Dementia Care Bundle (DCB) was implemented and how it has improved patient safety.

Background
Patients with dementia in acute hospitals experience poorer outcomes for all types of admission, stay longer in hospital, and are more likely to be discharged to a care home rather than to their own home.1,2 The National Audit of Dementia3,4 identified a mismatch between hospital policy and frontline practice that undermines patient safety and quality, and showed that the hospital workforce receives little or no training on dementia. While old age liaison psychiatry services can greatly assist in improving quality outcomes for people with dementia,5 there is also a need for a consistent response from acute hospital staff to develop a culture of care in which these patients’ needs are met as part of routine practice.

The setting was New Cross Hospital, The Royal Wolverhampton NHS Trust – a 700-bed acute NHS hospital within an urban area of the UK.

Objectives
In developing the DCB, our aim was to improve the experience and safety of the hospital for patients with dementia, utilising the ‘care bundle’ approach, and to develop staff knowledge, skills and confidence in supporting patients with dementia. More specifically, we wanted to reduce untoward incidents, and the levels of falls, infections, dehydration, weight loss and delirium for this vulnerable patient group.

Design
Initial research suggested that a ‘care bundle’ approach to dementia could provide an effective means of changing behaviour towards best practice for these patients.6-8 A bundle is defined as ‘A small set of evidence-based interventions for a defined patient segment/population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually.9

Systems were established for strategic and operational culture change management, utilising the active involvement of staff through away-days, consultation, conferences and feedback.

A hospital-wide, multi-disciplinary Person Centred Care Group had responsibility for DCB development and implementation, covering four reflexive phases over two years.

− Phase 1: Initial development of the DCB
− Phase 2: Building the suite of interventions to support the DCB implementation
− Phase 3: DCB implementation and compliance on one ward
− Phase 4: DCB implementation in the rest of the hospital.
The DCB intervention

The DCB consists of four elements that are delivered to each patient who is identified as having dementia. These elements are:

Staff know key information about the patient within 24 hours of admission
Knowing key information about patients who are unable readily to provide this for themselves is a cornerstone to good dementia care for those with moderate to severe dementia.\textsuperscript{10-13} The ‘All about Me’ document was developed from existing source materials,\textsuperscript{14,15} resulting in a three-page proforma completed by families/carers, before or upon admission, to support care bundle delivery. The document is kept by the patient’s bed and is accessible to staff, family members and the patient themselves. It can be added to during the patient’s stay in hospital, and is transferred with the patient when they move or visit another department.

Personalised communication takes place with the patient frequently, skilfully and compassionately
Utilising information from ‘All about Me’ enables staff to communicate confidently with the patient. Personalised communication is provided frequently, with the aim of providing orientation and reassurance,\textsuperscript{13,16,17} and decreasing the likelihood of patients becoming highly agitated or distressed.\textsuperscript{18,19} Worries and fearfulness are addressed so as to decrease the chance of patients developing psychological or psychiatric symptoms.\textsuperscript{20} Regular interaction with staff means that indications of pain or physical symptoms can be treated before they escalate into delirium or the deterioration of the patient’s physical state.\textsuperscript{13,16,21-23}

Nutrition and hydration are adequate for the individual patient, are in line with patient preference, and are provided in a way that is geared to patient capability
Many reports indicate that patients with dementia are at particular risk of not getting adequate food and drink in hospital.\textsuperscript{2,24,25} With adequate nutrition and hydration, healing and rates of recovery are improved, the occurrence of delirium and urinary infections decreases, and patients’ sense of wellbeing is enhanced.\textsuperscript{20,26} Information from ‘All about Me’ enables staff to ensure that culturally acceptable food and drink is provided and is in keeping with patient preferences, at times when the patient is used to eating, and in a way that the patient can manage.

A safe and orienting environment is maintained
A secure and orienting environment in the vicinity of the patient decreases the likelihood of falls and accidents, improves continence and helps maintain daily living skills.\textsuperscript{13,27,28} General principles include decluttering, personalising, good signage and ensuring calm surroundings.\textsuperscript{20}
Implementation

Initial trials demonstrated that elements of the bundle were well received by staff and had good face validity. However, it quickly became apparent that it was not possible to implement the DCB as part of the existing ward routine. Over a period of two years a number of supporting structures were developed in the hospital that enabled us to deliver the care bundle in a consistent and reliable manner to all patients with dementia. These structures included:

The dementia specialist ward as a centre of excellence
An existing 28-bed care of the elderly ward was converted and staff were transferred to a 20-bed dementia specialist ward to provide a visible demonstration of excellent practice and design within the hospital, utilising the King’s Fund’s ‘Enhancing the Healing Environment’ principles.28

The Dementia Outreach Team
The Dementia Outreach Team, led by a Consultant Nurse, is the gateway for dementia advice and support in the hospital and identifies patients needing admission to the specialist ward. The team promotes the use of the DCB in all clinical areas through a link nurse network, delivers on-going education, and works with families and liaison psychiatry.

Staff training and development
All staff need to understand the importance of implementing the DCB on a consistent basis. Dementia training and competency development have taken a tiered approach from novice to expert, from general induction aimed at all staff, through to specialist courses designed for key staff.

Trained volunteers
Volunteers can assist in helping with the care of older vulnerable patients. The Volunteers Coordinator recruited volunteers specifically to work with patients with dementia. They have a one-day training course and receive ongoing support to enable them to support staff in the delivery of the DCB. In an average week, seven to nine volunteers provide around 32-35 hours of input.

Measurements

On-going data on the impact of the Dementia Care Bundle was collected. Data included interviews with staff, compliments and complaints, patient weights, catheterisations, prescriptions of anti-psychotic medication, acquired pressure ulcers, mobility, acquired urinary infections, falls, delayed discharges, and discharge destination. In addition questionnaires, interviews, observations of practice and a point prevalence survey were undertaken. Data was collected at baseline and at different time points within the intervention.

Results

Through successive phases of reflexive practice a Dementia Care Bundle was developed that could be delivered consistently and reliably. Staff noted significant improvements in care delivery. Patients receiving the DCB showed good weight and mobility improvement, and experienced low levels of catheterisation and acquired pressure ulcers, and low use of antipsychotic medication. Over time there was a downward trend in acquired hospital urinary infections, and in falls and injury from falls in patients with moderate and severe dementia. Overall, patients
were more likely to return to their original address rather than be admitted to a care home on discharge, although there was no impact on length of stay. Feedback from families was very positive and there was a reduction in complaints over time. Staff viewed the DCB positively. A positive attitude towards patients with dementia was present before the intervention, and this did not diminish. Staff turnover and sickness levels were maintained at a low level in the areas where the DCB was implemented.

Limitations
The DCB was implemented within a highly motivated staff team that was well supported by its management structures. Even so, an extensive suite of interventions was necessary to ensure consistent delivery of all elements of the DCB.

Conclusions
The DCB and its associated suite of interventions had a significant impact on the quality of care and safety for patients with dementia, who often have significantly poorer outcomes than other patient groups. The intervention was well received by staff and led to better job satisfaction. This composite approach, implemented directly by hospital staff, has much to offer.
References


14 Alzheimer’s Society. This is Me. Available online at alzheimers.org.uk/site/scripts/download_info.php?downloadID=399 (accessed 13 July 2012).


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