Improving quality of care for people with dementia in general hospitals
Going into hospital offers an opportunity for people to receive the care they need in crisis situations and for acute illness to be treated. But when individuals are feeling ill and in pain, or have experienced an accident or fall, noisy environments, fast pace of work, new faces, intense questioning and moving through different hospital settings can be traumatic and confusing. Acute services are geared towards fast and effective responses, assessment, diagnosis, intervention, cure, if possible, and discharge (Cunningham and Archibald 2006).

Care is based on an assumption that patients will be able to express their wishes, acknowledge the needs of other patients, move through the system as required, have their acute needs addressed and be discharged home or to other services. As Archibald (2002, 2003) identifies, a person with a dementia may be unable to comply in many of these areas. Small considerations in how care is delivered can help to create a more positive hospital experience for individuals, such as making the environment as trauma free as possible, trying to preserve continuity with what is familiar to the individual, taking time to reassure, and giving information and support in ways appropriate to the individual.

**Going into hospital**

People with a dementia come into hospital for the same reasons as older people generally. For example, acute illness, stroke, fall or fractured hip. There is often a single factor that triggers a hospital stay, and Sampson et al (2009) identified that 43 per cent of people with a dementia were admitted with pneumonia and a urinary tract infection. Among unplanned acute hospital admissions of individuals aged 70 and over, Sampson et al (2009) found that 42 per cent had a dementia, rising to 48 per cent in those aged 80 years and over. Only 21 per cent had received a diagnosis of dementia before the research. In fact, although it is commonly an incidental condition when people are admitted to hospital, dementia is often recognised for the first time in a general hospital (Sheehan et al 2009).

For someone who is frail, vulnerable or has a dementia, who may be on the edge of his or her limits of coping at home in a familiar environment, who is seeing the same people and doing the same things each day, the effect of going into hospital can be overwhelming.

Cognitive impairment and dementia, whether or not a formal diagnosis has previously been given, are major issues in general hospitals. In an Alzheimer’s Society (2009) study, 97 per cent of nursing staff and nurse managers reported that they always, or sometimes, care for someone with dementia. The pace in acute hospitals places high demands on staff and, in these environments, their priority is monitoring and managing the acute needs of all the patients in the unit. Someone needing additional time and support, whose behaviour can affect ward routines, can be perceived as disruptive or difficult (Cunningham 2006). Almost nine out of ten nursing staff respondents in the Alzheimer’s Society (2009) study identified that working with people who have dementia is quite or very challenging: particularly managing unpredictable behaviour; communicating; wandering; keeping people safe; and not having enough time to spend with patients and provide one-to-one care. Other studies have shown that,
although nurses strive to provide optimum care, they find that this is not always achievable (Nolan 2006, 2007, Cowdell 2010).

What happens in general hospitals can have a profound and permanent effect on individuals with a dementia and their families, not only in terms of their inpatient experience, but also their ongoing functioning, relationships, wellbeing, quality of life and the fundamental decisions that are made about their future (Sheehan et al 2009).

Whole hospital approach

If general hospital settings are to provide effective care for people with dementia, all staff and services have a role to play (Box 1). The National Dementia Strategy for England, Objective 8 (Department of Health (DH) 2009) prioritises the identification of leadership for dementia in general hospitals, defining the care pathway for dementia and the commissioning of specialist liaison older people’s mental health teams to work in general hospitals.

Health and social care managers should co-ordinate and integrate the work of agencies involved in the care of people with dementia (National Institute for Health and Clinical Excellence/Social Care Institute for Excellence (NICE/SCIE) 2006), including:

- Jointly agreeing written policies and procedures.
- Involving service users and carers in joint planning to help identify local populations.
- Working closely with intermediate care and rehabilitation services.
- Working towards combined care planning that takes into account the changing needs of the person with dementia and carers.

Disease-specific pathways of care are not always conducive to meeting the needs of people with a dementia (Sturdy 2010) and distinct pathways

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**BOX 1**

**An example of a whole hospital approach**

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust is improving the care environment and supporting increased independence for people with dementia through a range of measures including improved signage and the removal of potential hazards. Wards use colour to highlight certain objects, making it easier for patients to distinguish them, for example brightly coloured toilet seats. Clocks with large faces are visible from all beds. Relatives are being encouraged to bring in personal items to help patients to recognise their own bed space. Detailed information about dementia is displayed on wards.

Staff have ownership of the changes and are actively encouraged to think about how the trust can make the ward a better environment for patients who are confused.

One member of staff has recently suggested that bright footsteps are painted on the floor from each ward leading to the toilet.

Sue Hazel, lead consultant for implementing the National Dementia Strategy, said: ‘Hospitals can be challenging environments for patients with dementia. Small but effective changes can create improved environments to reduce anxiety and confusion.’

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for people with a dementia, including pathways out of hospital, should be developed in consultation with local social services and user and carer organisations. Such pathways could also specify the arrangements for local leadership and accountability for dementia in general hospitals (DH 2009).

NICE/SCIE (2006) recommend that hospitals review their facilities and service function so that they promote independence and maintain function in people who have a dementia. Consistent, stable staffing, retaining a familiar environment and minimising relocations can enhance care for people with dementia. Support services should include assistive technology, for example to enable people to stay in touch with their families. NICE/SCIE (2006) also identify that physical exercise, advice on activities of living and skills training from physiotherapists and occupational therapists, along with meaningful, enjoyable activity while people are in hospital, can help.

A report produced by the NHS Confederation (2010) includes a list of questions for hospital managers and NHS boards to consider when reviewing their dementia services.

Multiprofessional specialist liaison older people’s mental health teams can provide valuable specialist assessment and input into care planning, including to ongoing care and planning for discharge from hospital (Box 2). They can also work with designated hospital lead clinicians to build skills and improve care throughout the hospital (NICE/SCIE 2006, DH 2009). It is important to remember, however, that the hospital clinicians retain responsibility and accountability for the person’s care and treatment; intervention and support must remain consistently proactive and not be put ‘on hold’ awaiting input from specialist teams.

**BOX 2**

**Specialist hospital mental health team for older people**

The Leeds mental health team has been functioning for ten years and, in 2006, became multidisciplinary. The team offers:

- Advice and support to the general hospital ward teams on mental health diagnosis, management and discharge planning, which can be provided on an ongoing basis where the admission is prolonged.
- Training and education for all general hospital staff working with older people.

Service evaluation has been ongoing. Evidence shows that the team responds rapidly to referrals, with 85 per cent of the past 50 referrals seen within one working day. There is also evidence that the team has had a significant impact on reducing the length of stay, some figures suggest up to 11 days have been saved. Referrals to the service have increased by more than 500 per cent over ten years.

A hospital mental health team for older people can improve the understanding and skill base of general hospital staff and increase access to appropriate services to best meet the needs of older people with better rates of successful discharge home. An important role for the team is to challenge the stigmatisation of ageing and mental health.

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Environment and orientation

Emergency departments are commonly the first point of contact for patients coming into hospital and, due to the pace and noise of emergency care, these environments can be among the most challenging faced by people with a dementia and their carers (Cunningham and McWilliam 2006, James and Hodnett 2009). Poor experiences in these settings can increase stress, communication difficulties and the risk of delirium, which can affect patients through the remainder of their hospital journeys (British Geriatrics Society and Royal College of Physicians (BGS/RCP) 2006).

The key to managing the emergency department experience for a person with a dementia lies in understanding that person’s needs and responding to them in a flexible and creative way (Bridges et al 2009, James and Hodnett 2009) (Box 3). Dementias generally cause progressive changes in how people interpret what they see, hear, taste, feel and smell. While the changes experienced are uniquely individual, people with a dementia commonly find it difficult to orientate to an unfamiliar environment and have a reduced stress threshold to many environmental stimuli (Archibald 2003).

Environmental modification requires systematic planning. The commitment of hospital management to making changes and staff contributions are essential (Nolan 2007). Good design with effective use of lighting, colour contrast, noise-limiting measures and clear orientation cues can considerably affect someone’s ability to understand and function.

**Box 3**

Improving emergency department care

In St Mary’s Hospital in Paddington, London, a designated cubicle was identified in a quiet but visible part of the department for older people. This was redecorated using tranquil colours, low level pictures and a large-face clock. Clinical equipment in the room was reduced and relaxing music was provided. Toilet signage was improved. These changes were replicated in the admissions unit to reduce transfer trauma.

To support the environmental changes, the nurses were given training in communication, stress responses, mental capacity and pain recognition. The Abbey pain tool (Abbey et al 2004) was implemented to improve recognition of pain and an alternative analgesic ladder was used specifically to support patients with dementia. Alongside this, the use of anaesthetic gel before cannulation was introduced to reduce discomfort and agitation. A specialist volunteer was trained to provide companionship and support to patients and their carers, and leaflets were produced for patients and their carers to explain that the department would try to accommodate their needs.

These changes were inexpensive and easy to implement but they sent a message to patients with a dementia and their families – that thoughtful and patient-centred care can be delivered in the pressured environment of the emergency department.

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within a hospital environment. Large clear signs, particularly to toilets, and clocks showing the correct time can aid orientation. In the absence of this, a clock beside a person’s bed can be helpful.

Some aspects of hospital environments, including mirrors, pictures and cluttered notice boards, can be confusing for people searching for their reality.

Quality of light is important for orientation. Some people may want to be near a window with natural light. Older people can be sensitive to glare and fluorescent light can reflect from polished floors, tables or walls. Bright light can have a measurable impact on sleep (Dewing 2009).

However, older people usually require more light than younger people to undertake detailed tasks, such as reading, therefore lights that the patient can turn on or off and which can be moved to suit the task are useful.

Although hearing acuity tends to deteriorate with age, older people’s hearing can be particularly sensitive to some sounds and background noise from machines, equipment, telephones, trolleys, televisions and other people’s conversations. Exposed to periods of such continuous noise, people with dementia can experience less efficient sleep, increased agitation, reduced tolerance for pain and some decline in cognitive functioning and memory (Dewing 2009).

For someone with a dementia who is new to a hospital environment, being able to recognise his or her own bed and locker can be a lifeline. Personalising a bed with, for example, a recognisable item of clothing, placing photographs or other familiar items on a locker and showing the person around the surrounding area can be helpful. It is important to consider how someone might feel on waking in the middle of the night. What would they see and hear, and how would they be able to orientate themselves in the hospital environment to avoid becoming distressed?

Environmental audits, including the use of light and noise meters, can offer evidence on the potential impact of environments on individuals, and design checks for people with a dementia in healthcare premises are available (for example www.hfs.scot.nhs.uk/online-services/publications/property).

As Dewing (2009) identifies, when environments support person-centred care, patient wellbeing is enhanced and a therapeutic setting and more pleasant working situation are created.

**Caring for individuals and the people close to them**

Despite the pressures and pace in acute hospital settings, knowing and respecting each person remains central to the relationship between patients and healthcare professionals (Nolan 2006). It is vital to understand that, while some general statements can be made about dementias, each individual will be affected differently. Also, while a dementia fundamentally changes the way in which a person functions, it is only one aspect of his or her life. Rather than seeing ‘someone with a dementia’, it is essential to seek to understand the individual.

The term dementia is used to describe a range of illnesses that result in an overall impairment of the person’s brain function and a decline in
thinking. People may experience changes in personality and behaviour that disrupt their ability to live independently and which may affect social relationships. The most common dementia is Alzheimer’s disease, where there tends to be a progressive and gradual decline over time. Another common type is vascular dementia, or ‘small vessel disease’, where small blood vessels in the brain become damaged and the circulation is affected (see the Alzheimer’s Society website for detailed explanations of the different types of dementias).

One of the most common features of dementia is loss of memory, particularly short-term memory, which becomes worse as the disease progresses. As Archibald (2003) describes, the person may also have difficulty in recognising things, for example a drink or food – visual agnosia. Individuals may have difficulty carrying out purposeful actions so they may become muddled when getting dressed – dressing apraxia. As the illness progresses a person may lose insight into his or her actions. People’s physical health will also affect their cognitive functioning, for example if they have an infection their memory may become worse and they may become more disorientated.

While staff working in acute areas would possibly state that they do not need further paperwork, documents recording aspects of a person’s biography can be particularly helpful in understanding how he or she responds to situations. Cultural and religious aspects can be particularly important. This is Me, a guide to an individual’s needs, preferences, likes, dislikes and interest – produced by the Alzheimer’s Society (2010) – that people with dementia can bring into hospital, has been found to be particularly helpful. A more detailed life story profiling template can be found in May et al (2009).

Effective care also acknowledges the needs of families and/or those individuals who have been supporting the person with dementia in the home, usually for some time and often with limited support. Carers report that they often do not know what role to adopt in hospital settings and consequently feel disempowered (Douglas-Dunbar and Gardiner 2007). Carers understand the person with dementia and how he or she functions best in everyday situations. It is, therefore, important to learn from carers and encourage their contribution to the support of the person with dementia in the hospital setting. However, as Douglas-Dunbar and Gardiner (2007) highlight, it is also important to recognise that carers may themselves feel vulnerable and in need for many reasons. If carers are to offer support in communal hospital units, the privacy of other patients also has to be considered.

Archibald (2003) recommends that staff speak with carers to ask how they want to be involved
and what is possible. For example, asking: 'How would you like to be involved in the person’s care?' ‘Would you like to help at mealtimes or offer some personal care?’ ‘Could you bring in things to do or to talk about?’

**Communication**

Good communication is essential in supporting the wellbeing of someone with dementia and in preventing stressful situations from developing. The full range of communication strategies should be used. Through observation and listening, staff can identify the most effective means of communicating with individuals, including which senses – auditory, visual, kinaesthetic, olfactory – predominate in the person’s perceptions (Dewing 2003a). Also, while some individuals are unable to communicate verbally, staff can enhance communication by recognising that these individuals often become expert in communicating on an emotional level (Archibald 2003).

In common with many older people, individuals with a dementia may have visual or hearing impairments, compounded by the organic changes accompanying the dementia. As Archibald (2003) describes, it can take someone with dementia longer to understand what is being said to them. She recommends that staff:

- Speak clearly and at a steady pace.
- Keep language as uncomplicated as possible.
- Approach the person from the front, engage eye contact and speak face to face.
- Show an attitude of warmth and firmness.
- Address constantly by name and provide identifying information.
- Do not use complicated idioms of speech, for example saying ironically: ‘It is a lovely day when it is raining.’
- Use non-verbal means of communicating such as facial expression, touch and gesture to give additional clues.

While staff may feel frustrated that conversations are not straightforward or that the same issues are raised repeatedly, Dewing (2003a) highlights that this offers an excellent opportunity to rehearse responses to identify those that are most effective for the individual.

**Delirium**

Delirium is defined as a ‘...disturbance of consciousness and a change in cognition that develop over a short period of time and which can fluctuate during the course of the day. In addition, there is evidence from the patient’s history, examination or investigation that the delirium is a direct consequence of a general medical condition, substance intoxication or withdrawal, use of a medication, toxin exposure, or a combination of these factors’ (American Psychiatric Association 1994).

Delirium affects up to 30 per cent of older hospital patients and people who develop delirium have high mortality, high complication rates and longer hospital stays (BGS/RCP 2006). People with a dementia have a fivefold risk of developing delirium (Faculty of Old Age Psychiatry, Royal College of Psychiatrists 2005) and, in someone with a dementia, precipitating factors for delirium include medications, immobilisation, malnutrition, infection, an indwelling catheter, environment or psychosocial influences (Schofield and Dewing 2001). It is vital that staff remain vigilant in case delirium should develop.
Screening for cognitive impairment is recommended (BGS/RCP 2006) and the Confusion Assessment Method (CAM) (Inouye et al 1990) differentiates delirium from other causes of cognitive impairment. The CAM focuses on:
1. Acute onset and fluctuating course.
2. Inattention.
3. Disorganised thinking.
4. Altered level of consciousness.

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4. (A guide to nursing assessment of cognitive decline, delirium, depression and dementia is offered by Insel and Badger 2002.)

Delirium may be prevented in up to one third of older patients (BGS/RCP 2006) through effective interdisciplinary care, medical diagnosis and treatment of the underlying cause and supportive nursing care (Schofield 2008).

Nursing measures to prevent delirium encompass those outlined in this guide, and particularly (Schofield 2002):
- Orientation to time and place.
- Ensuring that the person has spectacles and hearing aid.
- Keeping the person stimulated and abreast of daily events.
- Ensuring uninterrupted sleep at night by minimising noise.
- Ensuring adequate fluid intake.
- Promoting movement and mobilisation.
- Minimising the use of interventions such as catheterisation.


**Preventing challenging behaviours**
It is not only people with a dementia who have disturbed behaviour in hospital and not all people with a dementia show disturbed behaviour (Archibald 2003).

Due to illness or the stress of hospitalisation, people with dementia can be pushed beyond their limit of coping, become distressed and behave in ways that demonstrate they are disturbed. Understanding individuals through personal profiling and discussions with those closest to them can help to predict and prevent distress. It is important to understand that disturbed behaviours are not always due to dementia. People with dementia show disturbed patterns of behaviour for a reason, but they may be unable to explain this. Check whether they are thirsty, hungry, too hot, too cold, in pain, need the toilet or are constipated. Check how they are feeling – are they anxious? Have they forgotten they are in hospital and are trying to find the way home? Are they feeling unwell? Sometimes disturbed behaviour is the only sign of an underlying physical illness such as an infection. It is important to act immediately if someone is showing any signs of distress. As Dewing (2003a) highlights, the best management of disturbed behaviour is not through containment, but by seeking to respond to the person’s immediate needs and to understand deeper unmet psychological needs.

Walking about, or wandering as this is often described, is commonly seen as a problem behaviour. Dewing (2005) describes wandering
as: ‘A complex, meaningful human activity which may take on various forms over time and place in the same person and between people.’ Dewing also (2005) emphasises the importance of full assessment to help identify individuals who are likely to wander and possible reasons for this, and offers a screening tool for wandering. Structured observation can also be helpful so that proactive decisions can be made about risk, supervision and helpful interventions to respond to the person’s need to wander.

‘Sundowning’ – cognitive and behavioural changes that take place in the late afternoon or early evening – occurs for a range of reasons. Such changes can be prompted by hospital environments that affect the person’s cognition, for example changes in lighting levels, or alterations in the person’s routine, such as sleeping in the afternoon. They can be exacerbated by sleeping problems, fatigue, over- or under-stimulation, feelings of illbeing, agitation and concern about separation from family members (Dewing 2003b).

Changes in behaviour may be a consequence of multiple medications.

A behaviour seldom reported as ‘challenging’ is when the person is withdrawn or not very responsive, but this can also be a sign of illness, illbeing, depression or delirium, and healthcare professionals should be vigilant for this. Comprehensive assessment is essential to understand the reasons for changes in behaviour and offer appropriate support. Stokes (2000) offers a framework for assessment using ABC:

▶ A – antecedents or triggers, what was happening before the behaviour occurred, who was present, when and where did it occur?
▶ B – behaviour. Describe exactly what the behaviour was, be specific is this new behaviour, what form did it take, how long did it last?
▶ C – consequences of the person’s behaviour.

Pain and people with a dementia
People with a dementia experience physical and psychological pain but, particularly if the dementia is advanced, may not express this in conventional ways. It is important to identify appropriate terminology for individuals. For example, do they describe aching or discomfort? It is also important to recognise non-verbal ways in which people might express pain. For example, through grimacing, flinching or guarding the painful area, restlessness or aggressive behaviour or pulling at tubes. In advanced dementia, Briggs (2002) recommends observing for noisy breathing, negative vocalisation, absence of a look of contentment, looking sad, looking frightened, frowning, absence of relaxed body posture, looking tense and fidgeting.

As Archibald (2003) highlights, often when people are assessed for pain they are lying or sitting, whereas most pain occurs on movement, particularly with arthritis or surgery. Pain should be assessed systematically when people are moving as well as still. It is important to give analgesia before doing anything that may cause pain. Pain assessment tools for use with people who have a dementia are available (Briggs 2001).

Food and drink
Nutrition and hydration are vital for health and wellbeing and for recovery from illness, surgery or accident. Nutrition for older people in hospital has been recognised as a major issue (Age Concern
2006) and dehydration is estimated to be present in one quarter of older patients (Archibald 2006a).

The needs of each individual are distinct but, broadly, people with a dementia can experience particular challenges in maintaining adequate hydration and nutrition (Archibald 2006a, 2006b):

- **Memory** People can forget how to eat, drink, chew or swallow. Identifying and offering favourite drinks and food, reminding people to drink and offering frequent drinks, even if in small quantities, can help. If a person is unable to chew, Archibald (2006b) suggests that staff moisten food, offer small bites at a time, role model chewing or try applying light pressure under the chin.

- **Visual agnosia** People with a dementia may not be able to recognise a cup or glass, a plate or food or cutlery. Presenting food that is uncomplicated, along with placing a cup or fork in someone’s hand and gesturing how to drink or eat, can be helpful.

- **Receptive and expressive dysphasia** A person with dementia may be unable to understand what staff are saying or to express that he or she is hungry or thirsty. Learning to understand individual needs and clear communication, described above, are essential. People may also be reluctant to eat if they are feeling anxious or agitated, unwell, tired, constipated, or if other problems, such as infections, are imminent.

People with a dementia can be particularly at risk of dehydration if ward environments are hot and dry. Adequate nutrition is essential, particularly if the person is active, for example walking. Supplemental foods and snacks may be necessary. A range of mealtime schemes has been tried, including red trays for people who need assistance, protected mealtimes and using volunteers to help patients to eat. People with dementia should receive nutritional screening to ensure those at risk of undernutrition or dehydration are identified and appropriate care plans implemented. The British Association for Parenteral and Enteral Nutrition (BAPEN) (2003) offers a nutritional screening tool and Archibald (2006b) provides profiling, observation and alert tools. Dietician advice should be sought when appropriate, and swallowing difficulties should be referred to a speech and language therapist.

**Preserving functioning, re-enablement and rehabilitation**

Time spent in hospital can result in the deterioration of daily living skills, confidence and independence for all patients and, while the effects of a dementia cannot be ignored, it is vital that the multiple abilities and needs of individuals are acknowledged. To prevent excess disability compounding functioning that is already compromised, care should proactively promote re-enablement and rehabilitation to optimum individual potential. Each person’s abilities and coping strengths, along with those of their carers, should be maximised, and rehabilitative approaches could incorporate memory skills support, the use of memory aids and maintaining skills for everyday living. The ultimate goal is: ‘The equipping of individuals to live in ways that they have previously enjoyed, with or without the assistance of others’ (Dewing 2003a).

People with a dementia have commonly been excluded from access to multiprofessional rehabilitation services on the mistaken
assumption that they will be unable to benefit from such input (Alzheimer’s Society 2009). Multiprofessional assessment of individuals should determine which services are offered and improved systems of care will result in more people with dementia accessing rehabilitative support and intermediate care (DH 2009).

Leadership, education and training
Each hospital should identify a senior clinician to take the lead for quality improvement in dementia and for defining the care pathway (Alzheimer’s Society 2009, DH 2009). Dementia champions have been widely appointed in acute trusts. It is also vital that all hospital personnel who encounter people with dementia, including reception and portering staff as well as health professionals, have the education and skills to work effectively with them (Cunningham and McWilliam 2006).

Trusts need to review their staff capacity for delivering high quality dementia care and to prioritise workforce developments for dementia (NICE/SCIE 2006). The National Dementia Strategy (DH 2009) suggests that core competencies for all staff who have contact with people affected by dementia (including patient advice and liaison services and local involvement networks) could be developed, and training provided on these competencies (Box 4).

BOX 4
An example of leadership, education and training
South Tees Hospitals NHS Foundation Trust has been working to support the Department of Health’s Dignity in Care campaign and the National Dementia Strategy. The motivation to improve services came after complaints about the levels of care for older people with mental ill health and dementia. Observation and analysis of patient records provided insight into the need for all levels of staff to develop their knowledge and understanding of mental ill health and dementia.

Two clinical matrons, Julie Suckling (Essence of Care, privacy and dignity lead) and Jeanette Power-Jepson (dementia lead) began their journey after finding a Let’s Respect toolkit* in their office. Their first task was to gain commitment from senior level managers and peer group matrons. The matrons worked with the trust training department and a local college, and developed level 2 and level 4 City & Guilds programmes for healthcare assistants and nurses, which are now included in mandatory training for new staff.

A further development was to create a trust-wide privacy and dignity policy which supports the delivery of care standards for all patients, relatives, carers and families. The matrons’ forum worked in partnership with private finance initiative providers Carillion, who now include privacy and dignity in annual training. Carillion has developed a ‘don’t walk by’ policy – if a member of staff sees anything that compromises patient dignity or safety, they intervene where appropriate and report it immediately. As delivery of care is supported by Carillion it was vital to collaborate to ensure that a consistent message was delivered across the trust.

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*Information on the Let’s Respect campaign and toolkit are available at: www.mhdu.org.uk/our-work/mhep/later-life/lets-respect
Conclusion

People with dementia are a major client group in general hospitals (Sampson et al 2006, 2009) and the numbers of people with dementia coming into acute services will increase with the ageing of the population. The needs of these individuals could also become more complex as new populations experience dementia.

It is vital that all staff see beyond the label of ‘dementia’ to work with patients and their families in all the complexity of their individual needs. There is growing evidence on the measures that can be most effective in meeting the needs of people with dementia in acute settings, and this guide has outlined key aspects such as environment, communication, assessment, sound care practices, rehabilitative and supportive approaches and effective multiprofessional team working. There is also international evidence that interventions such as staff education and standard care protocols can help to meet the needs of people with dementia in acute settings (Moyle et al 2008). The National Dementia Strategy (DH 2009) recommends:

- The identification of a senior clinician to take the lead for quality improvement.
- The development of an explicit care pathway.
- The gathering and synthesis of existing data on the nature and impact of specialist liaison older people’s mental health teams.
- Thereafter, the commissioning of specialist liaison older people’s mental health teams to work in general hospitals.

Professor Alistair Burns has been appointed as the national clinical director for dementia to lead on the strategy.

Offering effective care to people with dementia in general hospitals can reduce the trauma of a hospital admission, the length of the inpatient stay and other healthcare-related complications, and enhance the health, wellbeing and quality of life for individuals and their families (Box 5).

**BOX 5**

**A new model of care**

The Royal Wolverhampton Hospitals NHS Trust has been sponsored by NHS West Midlands to develop a care bundle for dementia care in the acute hospital and to use this as the basis for raising clinical outcomes and providing more cost-effective care for people with dementia. This two-year programme will adopt a person-centred approach to care and the environment.

The proposed model centres on a dedicated ward, opening in August 2010, which will provide a calm and quieter environment than a standard ward. To test the efficacy of the interventions and refine them accordingly, the staff group will be encouraged to recognise the importance of approaches sensitive to individual needs. They will be equipped with knowledge of dementia and its management.

Transferring patients in the hospital will be minimised to reduce disorientation. An outreach team will be closely linked to the ward. The team will also be available to support and advise other wards and departments in providing high quality care.

*The trust's lead is Cheryl Etches, director of nursing and quality. For further information contact Grace Hampson, project manager: grace.hampson@nhs.net*
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RESOURCES