

# Acute Hospital Care and the National Dementia Strategy

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## THE IRISH NATIONAL DEMENTIA STRATEGY

STRICTLY CONFIDENTIAL: NOT FOR CIRCULATION OR QUOTATION

**DRAFT**

# Consultation?



*"We want to include you in this policy without letting you affect it."*

# Implementation?



*"I'd like to stall this project — hand it over to one of our action committees"*

# Exciting Times...

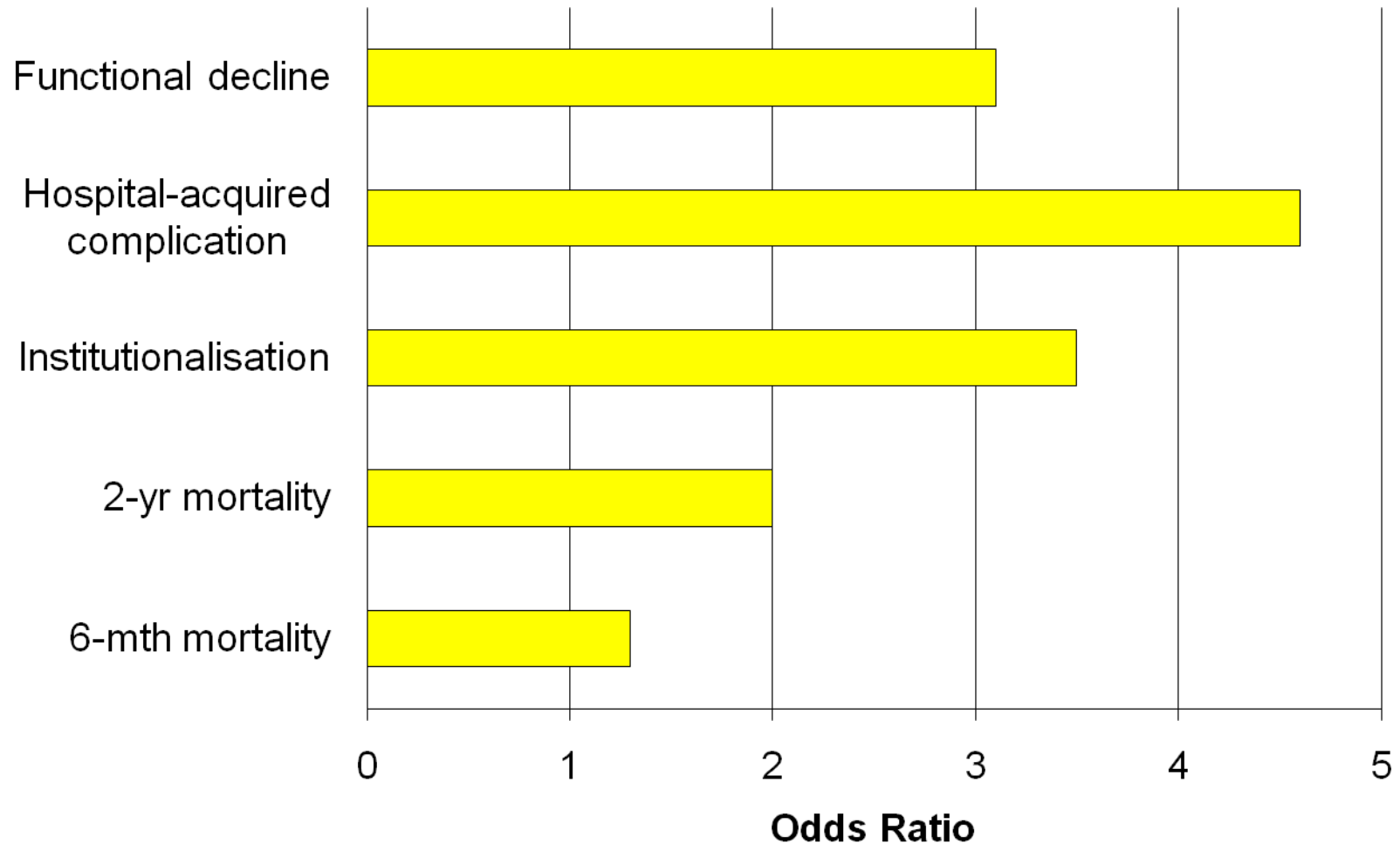
- Irish National Dementia Strategy
- Irish National Audit of Dementia Care in Acute Hospitals
- Dementia in Acute Cork Hospitals Study
- HSE National Consent Policy
  - Consent
  - Resuscitation, advance care planning
- Assisted Decision Making (Capacity) Bill

# Why Does Cognitive Impairment Matter in Acute Hospitals?

- Common
- Atypical presentation of illness in later life
- Unpleasant
- Serious consequences

# Outcomes of Delirium

(adjusted for confounding variables)



Even worse if....Delirium superimposed on dementia: a systematic review. Fick et al. JAGS 2002

# Dementia in the acute hospital: prospective cohort study of prevalence and mortality

Elizabeth L. Sampson, Martin R. Blanchard, Louise Jones, Adrian Tookman and Michael King

**Table 4** Cox proportional hazard models for death during index admission associated with cognitive impairment and dementia in people over 70 years of age during acute hospital admission

|                 |                       |                  | Mortality during index admission |                     |        |                       |                     |        |
|-----------------|-----------------------|------------------|----------------------------------|---------------------|--------|-----------------------|---------------------|--------|
|                 |                       |                  | Unadjusted                       |                     |        | Adjusted <sup>a</sup> |                     |        |
|                 | Median survival, days | Deaths, % (n=75) | Hazard ratio (95% CI)            | $\chi^2$ (d.f. = 1) | P      | Hazard ratio (95% CI) | $\chi^2$ (d.f. = 1) | P      |
| MMSE score      |                       |                  |                                  |                     |        |                       |                     |        |
| 24–30 (n = 321) | 18                    | 7.5              | 1                                |                     |        | 1                     |                     |        |
| 16–23 (n = 141) | 12                    | 10.0             | 1.57 (0.73–3.39)                 |                     |        | 1.34 (0.60–3.15)      |                     |        |
| 0–15 (n = 155)  | 11                    | 24.0             | 4.02 (2.24–7.36)                 | 22.50               | <0.001 | 2.62 (1.28–5.39)      | 34.14               | <0.001 |



# Why Do People with Cognitive Impairment Do Badly in Hospital?

- Dementia and delirium have adverse physical and mental consequences
- Acute illness as a stress test for the brain - delirium a marker for physical and mental frailty
- Failure of hospital systems and design
- Failure of 'health care professionals'
  - Poor recognition and delayed treatment
  - Preventative and environmental measures not used
  - Misuse of medications, restraints
- Failure of the 'experts'
  - Limited evidence base
  - Poorly taught

Cognitive  
impairment

Falls, instability

Restraints/  
Psychoactive meds

Poor hydration

Skin breakdown

Nosocomial infections

Poor nutrition

Incontinence/  
Catheter

Functional decline  
Institutional care  
Prolonged stay  
Mortality

# Is Cognitive Impairment Missed?

- Dementia: 50% acute hospitals (Bynum, JAGS 2004)
- Delirium
  - General wards: 40-60%
  - Hip fracture patients: 90% missed (Milisen, J Geront Nurs 2002)
  - Emergency dept: 83% (Hustey, Ann Emerg Med 2002)
  - Cork: CUH wards – 2/3 ‘recognized’, 2/5 documented (Ryan et al BMJ Open 2013)

# Why Is Cognitive Impairment Missed?

- Cognition, except orientation, not assessed
- Style of interaction by staff minimises chance of detecting problems (Treloar & MacDonald, J R Soc Med 1995)
- Hypoactive delirium easily misdiagnosed as depressed
- Hyperactive delirium difficult to miss but labelled as 'confused' / 'agitated'

# How to Miss Cognitive Impairment

- Keep any talk with patients to a minimum and do not assess cognitive function
- If by bad luck you identify cognitive impairment, assume it is long-standing
- Never talk to nurses, especially night staff
- If patient is withdrawn, start an antidepressant
- If patient is noisy, start a benzodiazepine

# Pejorative labels instead of diagnosis?

(O'Keeffe Eur Ger Med 2011)

‘Vague’

‘Poor  
historian’

‘Poorly  
motivated’

| Dx | (N=28) | (N=76) | (N=21) |
|----|--------|--------|--------|
|----|--------|--------|--------|

|           |          |          |         |
|-----------|----------|----------|---------|
| Cognitive | 16 (57%) | 44 (58%) | 8 (38%) |
|-----------|----------|----------|---------|

|           |         |          |          |
|-----------|---------|----------|----------|
| Depressed | 3 (11%) | 10 (13%) | 14 (67%) |
|-----------|---------|----------|----------|

|        |          |          |          |
|--------|----------|----------|----------|
| Either | 17 (61%) | 51 (67%) | 18 (86%) |
|--------|----------|----------|----------|



## **Patient Deemed Poor Historian**

Unable to identify five causes of Pelopponesian Wars

PHILADELPHIA, PA--COPD sufferer Hank Spencer was found to be an extremely poor historian by admitting house staff.

Dr. Karen Filmer, a junior doctor, was one of the first to evaluate Spencer in the Emergency Department.

*"He knew something about post-Civil War American history. But when it came to the ancient civilizations of Egypt, Greece, and Rome, he simply didn't have a clear grasp of the basic principles underlying the important events in those eras."*

# Delirium: A Useless Differential Diagnosis

TABLE 3. Putative causes of delirium

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Medications

Psychotropics (anxiolytics, sedative-hypnotics, barbiturates, antidepressants, antipsychotics, lithium)

Anticonvulsants

Analgesics

Anticholinergics (antihistamines, antispasmodics, antiparkinsonian agents)

Antiarrhythmics

Antihypertensives

Aminoglycoside antibiotics

Miscellaneous (cimetidine, steroids, nonsteroidal anti-inflammatory drugs, salicylates)

Drugs of abuse (phencyclidine and hallucinogenic agents)

Alcohol

Poisons (heavy metals, organic solvents, methyl alcohol, ethylene glycol, insecticides, carbon monoxide)

Withdrawal syndromes

Alcohol

Sedatives and hypnotics

Cardiovascular

Congestive heart failure

Cardiac arrhythmia

Myocardial infarction

Neurologic

Head trauma

Space-occupying lesions: tumor, subdural hematoma, abscess, aneurysm

Cerebrovascular diseases: thrombosis, embolism, arteritis, hemorrhage, hypertensive encephalopathy

Degenerative disorders: Alzheimer disease, multiple sclerosis

Epilepsy

Infection

Intracranial: encephalitis and meningitis (viral, bacterial, fungal, protozoal)

Systemic: Pneumonia, septicemia, subacute bacterial endocarditis, influenza, typhoid, typhus, infectious mononucleosis, infectious hepatitis, acute rheumatic fever, malaria, mumps, diphtheria, AIDS

Metabolic

Hypoxia

Hypoglycemia

Acid-base imbalance: acidosis, alkalosis

Electrolyte imbalance: elevated or decreased sodium, potassium, calcium, magnesium

Water imbalance: inappropriate antidiuretic hormone, water intoxication, dehydration

Failure of vital organs: liver, kidney, lung

Inborn errors of metabolism: porphyria, Wilson disease, carcinoid syndrome

Remote effects of carcinoma

Vitamin deficiency: thiamine (Wernicke encephalopathy), nicotinic acid, folate, cyanocobalamin

Endocrine

Thyroid: thyrotoxicosis, myxedema

Parathyroid: hypo- and hyperparathyroidism

Adrenal: Addison disease, Cushing syndrome

Pancreas: hyperinsulinism, diabetes

Pituitary hypofunction

Hematologic

Pernicious anemia

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# Delirium: A Useful Differential Diagnosis

- Meds
- Meds
- Meds
- Infection
- Hypoxia
- Metabolic problems
- Some combination
- Something else

Acute disturbance in dementia

+Pain

+Full bladder

Rockwood & MacKnight, 2001

# Real Life Pharmacotherapy

- Antipsychotics: Too much, too late
  - Intermittent 'chemical cosh' rather than regular low-dose treatment in suitable cases
  - No dose titration, and disregard of age, weight, sex
- Overuse of benzodiazepines
  - Routine use of sleeping tablets on prn sheet
  - Primary use to treat delirium

# Perils of Diagnosing Dementia in Acute Hospitals

- Lumping and Labelling
  - The 'Alzheimer patient'
  - 'His MMSE is only ....'
- Us and Them



*"Because of your age, I'm going to recommend doing nothing."*



*"It says here that you'd prefer someone with regular bowel movements....."*

*"Does it matter if they're involuntary?"*

## Dementia friendly wards

- *'They shouldn't be here'*
- Geriatric medicine as a 'take-away' service

## Advance care planning

- *'They should have a DNAR'*

## Assisted decision making/ capacity

- *'Have they capacity to make their own decisions'*
- *'Are they safe to go home'*

# A (hyper)cognitive view of capacity...

- Define important (cognitive) aspects of capacity
- Standardize assessment of these aspects of capacity
- Empirical research shows there's a lot of unsuspected incapacity about
  - Maintain a high level of suspicion if people make decisions you don't agree with!
  - Might be worth 'screening for incapacity' in 'vulnerable' populations before accepting their consent or refusal of consent

# Unfair?

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## Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study

Vanessa Raymont, William Bingley, Alec Buchanan, Anthony S David, Peter Hayward, Simon Wessely, Matthew Horoptf

### Summary

**Background** Although mental incapacity is becoming increasingly important in clinical practice, little information is available on its frequency in medical inpatients. We aimed to estimate the prevalence of mental incapacity in acutely admitted medical inpatients; to determine the frequency that medical teams recognised patients who did not have mental capacity; and to identify factors associated with mental incapacity.

**Methods** Over an 18-month period, we recruited 302 consecutive acute medical inpatients. Participants were assessed with the MacArthur competence tool for treatment and by clinical interview. Cognitive impairment was measured by the mini-mental state examination.

**Findings** 72 (24%) patients were severely cognitively impaired, unconscious, or unable to express a choice and were automatically assigned to the incapacity group. 71 (24%) refused to participate or could not speak English. Thus, 159 patients were interviewed. Of these, 31% (95% CI 24–38) were judged not to have mental capacity. For the total sample (n=302), we estimated that at least 40% did not have mental capacity. Clinical teams rarely identified patients who did not have mental capacity: of 50 patients interviewed, 12 (24%) were rated as lacking capacity. Factors associated with mental incapacity were increasing age and cognitive impairment.

**Interpretation** Mental incapacity is common in acutely ill medical inpatients, and clinicians tend not to recognise it. Screening methods for cognitive impairment could be useful in detecting those with doubtful capacity to consent.

*Lancet* 2004; 364: 1421–27

See Comment page 1383

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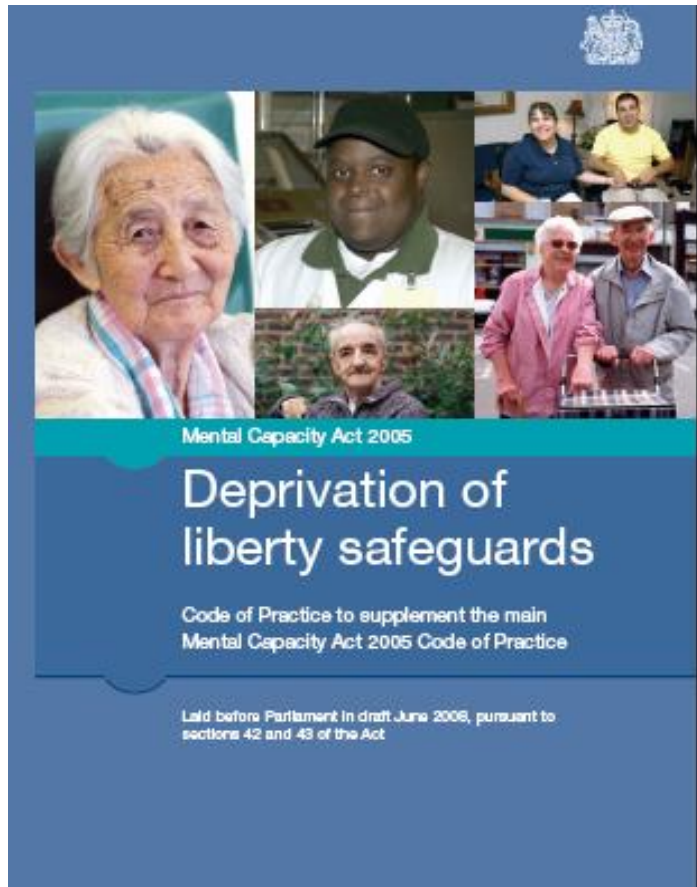
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- 231 consecutive acute medical inpatients
- 72 (31%) patients had clear incapacity (coma, severe dementia or aphasia, etc.)
- 159 patients were asked using MacCAT-T about the main treatment or investigation for which they were hospitalised
  - 50 (31%) lacked capacity
  - Only one-quarter of the those judged to lack capacity were identified as such by their treating clinical teams or their relatives.
  - Those lacking capacity:
    - Older: 76y vs 59y
    - Lower MMSE: 22 vs 29
    - No difference in psychiatric diagnoses

# England and Wales Mental Capacity Act 2005: Deprivation of Liberty



Deprivation of Liberty Safeguards:

- lack capacity
- deprived of liberty
- in a hospital or care home

Required by ECHR following the Bournemouth case

# Common Scenario

- Consult to old age medicine/psychiatry
- Tx of acute illness in older person completed
- Residual physical/cognitive problems
- Family/doctors/social worker want long-term care
  - ‘Best interests’
  - ‘At risk’
  - ‘Can’t cope’
  - Family ‘won’t take her home’
  - ‘MMSE is only.....’
- Person wants to go home

# Capacity Bill 2013

- No specific protections – yet...
- Account must be taken of a person's past and present wishes, where ascertainable?
  - “Don’t put me in a home” probably the commonest advance directive!
- Decisions should be the least restrictive of the person's rights and freedom of action
  - Involuntary detention for life?



## Monitoring the use of the Mental Capacity Act **Deprivation of Liberty Safeguards** in 2012/13

### Thousands more elderly care home residents subject to restraints

Steep rise in attempts by care homes to restrain and lock up the elderly, figures show



# Social workers took out court order to stop couple going on HOLIDAY because wife had dementia

By EMMA REYNOLDS

UPDATED: 17:39 GMT, 21 January 2012

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An elderly couple were banned from going on holiday together after their local council said it was too risky.

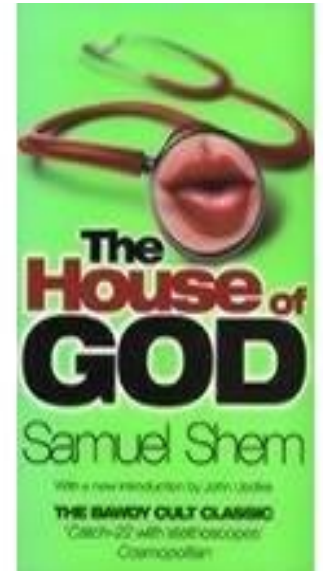
In an astonishing example of the nanny state at work, Norman Davies and Peggy Ross were told by Cardiff Council that they could not go on the planned Mediterranean cruise, just days before they were due to leave.

Over-zealous social workers claimed Mrs Ross, who suffers from dementia, was in danger of wandering off or falling overboard.



# Laws of the House of God

- At a cardiac arrest, the first procedure is to take your own pulse.
- There is no body cavity that cannot be reached with a 14 needle and a strong arm.
- If the radiology resident and the medical student both see a lesion on the chest x-ray, there can be no such lesion there.
- The delivery of good medical care is to do as much nothing as possible.
- The patient is the one with the disease.



# Not Them - Us!

- At 55 years of age, lifetime risk of developing dementia (Seshadri Lancet Neurol 2007)
  - 21% (1/5) for women
  - 14% (1/7) for men
- Delirium – ‘Everyman’s Psychosis’



# Visual hallucinations in Delirium (N=155)

|                      |           |
|----------------------|-----------|
| Complex              | 149 (96%) |
| ‘Presence’/’Passage’ | 18 (12%)  |
| People               | 104 (67%) |
| Animals              | 62 (40%)  |
| Hybrids              | 5 (3%)    |
| Body parts           | 11 (7%)   |

# Animals (N=62)

- Dogs (12)
  - 3 familiar



- Cats (5)
  - 2 familiar



- Cattle (15)

- Sheep (8)
  - 1 familiar



## General themes

- Rats (8)
  - Snake (5)
  - Bats (4)
  - Spiders (3)
  - Ants (2)
  - Birds (2)
  - Frogs (1)
  - Tiger (1)
  - Giraffe (1)
  - Monkey (1)
  - Zoo/farm scene (6) – ‘like Noah’s Ark’
- Fighting
  - Fornicating
  - Eating
    - Other patients
    - Each other



# Where do we go?

- Attitudes towards dementia
  - Societal
  - Hospital staff - all
- Research into how to achieve
  - No innovation without evaluation and monitoring
  - Improve evidence base