Implementing a nursing dementia care bundle tool nursing essay

The purpose of this paper is to complete a diagnostic assessment and analysis to determine organisational readiness for an evidence-based service change linked to an action plan within Outer North East London Community Services (ONEL CS) Inpatient Unit within the London Borough of Havering. This paper will discuss how change can be achieved through completion of a diagnostic analysis. The evidence based change to be implemented and discussed in the paper, is the introduction of a Dementia Care bundle to improve dementia nursing care on the inpatient wards within Havering - ONELCS. Through the use of a service improvement audit conducted within the Inpatient Unit; this paper will reflect upon the application of research methodologies that can support the diagnostic analysis; and the development and implementation of the action plan developed to achieve service innovation.

The paper begins by giving the background information on the area of health care selected for review and service innovation. This will include the rationale for choosing this area, it importance and the explanation and definition of the key terms that will be used throughout the paper. The process by which the literature review was conducted will be detailed so that it could be replicated by the reader where necessary. Following on from this, the evidence pertaining to the chosen area of health care will be critically appraised to identify its merit in informing the diagnostic analysis assessment.

Diagnostic analysis is the process of gathering information prior to the implementation of change, and is designed to identify the barriers and facilitators for change within an organisation; assessing organisational

readiness for change (Hamilton, McLaren and Hamilton 2007). Theories and models relating to organisational change will be discussed; with the aim to informing and developing a strategy or action plan tailored to the local context for implementation.

Background

Dementia care is generally often overlooked on the acute inpatient hospital wards (Leung and Todd 2010). Up to 70% of acute hospital beds are occupied by older people (Department of Health (DOH) 2001; Alzheimer's Society 2009). It is estimated that up to a of these patients, up to half of these patients in general acute care at any one time may have cognitive impairment including delirium and dementia (Royal College of Psychiatrists 2005). The unacceptable variation in the quality of dementia care provided on general wards in hospitals across England is well documented in numerous reports such as the 'Counting the Cost: Caring for people with Dementia on Hospital Wards' report(Alzheimer's Society 2009). The 'Healthcare for London: A framework for Action' document (2007) and the National Audit Office report 'Improving services and support for people with dementia' (2007), highlight the fact that services were not provided consistently well across London for people with dementia and their carers; that people with dementia in general hospitals have worst outcomes in terms of length of stay, mortality and institutionalisation.

Patients with dementia and their carers experience, have confirmed the above reports: patient feedback has highlighted an urgent need for research into care for older persons in general hospitals as is recently reported in media reports and Parliamentary and Health Service Ombudsman(2011)

report investigating ten complaints into National Health Service(NHS) care of older people. Furthermore the National Audit Office(NOA) report (NOA 2007) provides potent evidence of the current costs of care for those with dementia diagnosis in the hospital setting; and highlights that acute general hospitals are not delivering a 'value for money' service. As results of all this evidence the National Dementia Strategy (DOH 2009) (- a five year plan to transform dementia care) was developed by the Department of Health. It is against this backdrop that this paper was developed; to focus on the improving dementia nursing care provided on the inpatient wards by implementing a dementia nursing care bundle..

Definition of key terms:

For the purpose of this paper key terms have been defined in particular the meaning of Dementia and care bundles.

What is Dementia?

The term dementia is used to describe a collection of symptoms, a syndrome which includes changes in memory, reasoning and communication skills, with a gradual loss of ability to carry out daily activities (Alzheimer's Society 2009, Commissioning Support for London 2009; DOH 2009 NDS-a/b). There are a number of different types of dementia; with the most common being Alzheimer's disease that accounts for about 60% of cases (Gupta, Fiertag and Warner 2009). The different types of dementia are outlined in Appendix one.

Dementia in Havering- the local picture

Dementia presents a unique challenge for London; with estimates of around 65000 people over the age of 65 in London diagnosed with dementia(Commissioning Support for London 2009); projections suggest that the number of people over 80 in London with dementia can be expected to rise by almost 50 per cent to 96000 by 2030(POPPI 2010).

Dementia is an under-diagnosed condition in the London Borough of Havering. This paper focuses on improving inpatient nursing care delivered for dementia patients at St Georges Hospital. St Georges Hospital is a community hospital within Havering. Predominately for patients aged 65 and over it consists of a day hospital and 45 in-patient beds across two wards. There is one rehabilitation/assessment ward; and a stroke unit. In common with all members of the community, people with dementia can become physically unwell and require general hospital care. St Georges Hospital admits patients with dementia from the neighbouring acute hospital, Barking Havering and Redbridge University Hospital NHS Trust. Demographic changes and an ageing population in Havering mean there will be a disproportionate increase in the common conditions of old age, such as cancer, stroke, and dementia. A Freedom of Information (FOI) Request revealed that the estimated number of people with dementia is 1015. this represents 0. 4% of all registered General Practitioner population and is below the national average of 1. 1%. This figure is anticipated to rise and as is outlined by Appendix two. The evidenced based change to be introduced is a nursing dementia care bundle with the aim of improving the nursing care provided on the inpatient wards.

What Is A Care Bundle?

A " care bundle" is an evidence based protocol (Resar, Pronovost and Haraden, Simmonds, Rainey and Nolan 2005). Successfully used in Critical Care; it is a collection of interventions (usually three to five) that may be applied to the management of a particular condition (Fulbrook, and Mooney 2003, Resar, Pronovost Harden et al 2005; Belt 2006). The theory behind care bundles is that when several evidence-based interventions are grouped together in a single protocol, it will improve patient outcome (Resar, Pronovost and Haraden, et al 2005). The concept of care bundles was introduced by the NHS Modernisation Agency (DOH 2004) and continues to be fully supported by the Department of Health. A heavy reliance on the use of care bundles is evidenced the development and recent review of High Impact Interventions in reducing Healthcare Associated Infections by the Department of Health(DOH 2010).

Although most specialities are using 'care bundles' for the dementia care they are relatively a new concept. It is expected that by grouping dementia related evidence based practices or interventions together, within a single protocol that guides patient management, the overall quality of care nursing care delivered to dementia patients will improve. A dementia nursing care bundle has been developed by the Royal Wolverhampton Hospitals NHS Trust, through a freedom of Information (FOI) Request (Appendix three); a copy was requested and was to be locally adapted for the inpatient unit at St Georges Hospital ONELCS-Havering.

Method of Searching for Literature

An electronic search of the literature was undertaken on dementia care on hospital wards on the 30th of January 2011. Using an Athens NHS Log in details and advanced search of healthcare databases using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) was completed. Appendix four outlines how literature was identified and selected for appraisal.

Literature Review:

The evidenced based change to be introduced is a nursing dementia care bundle with the aim of improving the nursing care provided on the inpatient wards. The current health care policy context and recent national reports along with initiatives, have recognised the need to improve care in hospitals on general wards; these include the Lord Darzi report, 'High Quality Care for all' (DOH 2008); the National Service Framework for Older People'(DOH) and the National Institute of Clinical Excellence(NICE) dementia clinical guidelines(NICE/Social Care Institute of Excellence(SCIE) 2006). Increasingly there has been a move towards a more focused attention on dementia care in the acute setting (Alzheimers Society 2009).

Delivering nursing care for people with dementia is a challenging (Borbasi , Jones , Lockwood and Emden 2006) and stressful task (Cunningham and Archibald 2006). Behaviours associated with dementia include wandering, agitation, aggression and resistance to care (Prtichard and Dewing 2001, Cunningham 2006, Cordwell 2010). It is expected that these behaviours will change with time however this is dependent on the type of dementia (Insel and Badger 2002). As a patient's dependency increases, their care becomes

more complex and demands more direct nursing time for both patients, relatives and or carer(Cunningham 2006). Given the challenges of caring for patients with dementia and their at most time their inability to communicate care needs or report concerns about care, they are at risk of suboptimal care, neglect, or abuse(Ballard, Fossey, Chithramohan, Howard, Burns, Thompson, Tadros and Fairbairn 2001, Ouldred and Roberts 2004, Sturdy 2010). This can leave nurses experiencing stress when trying to respond to such behaviour (Burgess and Page 2003).

Following on from this, researchers (Cunningham and Archibald 2006, James and Hodnett 2009) write that the rapid nature and capacity demands of general hospital care; the focus of care is strongly geared towards treating acute medical problems, discharging patients and meeting the demands of the service such as staffing levels, fast turnover of patients; these alone present challenges to nursing staff in the hospital environment. Patients with dementia may find this difficult to conform and adapt to rapid treatment protocols and to a dominant culture of curing the patient(Archibald 2002, 2003); for example they may find the regular ward moves confusing; the busy, noisy clinical wards frightening and stressful for people with dementia; adversely affecting how they behave (Schofield and Dewing 2001, Cunningham and Christie 2009, Dewing 2009). Cunningham (2006) goes so far as to suggest that dementia patients can feel disempowered, infantilized and intimidated; and the likelihood of this increases in busy hospital settings. What is clear is that the hospital staff; faced with the challenges of decreasing length of stay statistics, creating capacity, meeting other

performance targets - dementia patients present a challenge to nursing staff; leaving them at risk of receiving sub-optimal care.

" Sub-optimal" care- for someone who is frail and vulnerable with a dementia diagnosis, and needing additional time and support from nursing staff, with perhaps displaying behavior which is not perceived as 'normal ' by staff, can be seen as difficult(Cunningham 2006). Norman (2006) found that nurses' perceptions of the person with dementia were central to whether their experience was positive or negative in hospitals settings. A study conducted by the Alzheimer's Society (2009) reported that almost nine out of ten respondents working with dementia patients do not have enough time to spend with patients and provide one to one care. Nolan (2006, 2007) and Cordwell(2010) recognize that although nurses strive to provide optimum care they find that practically day to day- this is not always achievable. It is interesting that Archibald (2006a, 2006b) in his work noted that outcomes for dementia patients are usually poor, they note that nutrition, hydration, pain management, communication needs are often overlooked. Other studies confirm that dementia patients have the worst outcomes in relation to length of stay and mortality(Sampson, Gould and Lee 2006, Sampson, Blanchard and Jones 2009) Whilst this is not surprising, the Parliamentary and Health Ombudsman report (2011)'Care and Compassion' found similar outcomes for in their report on ten investigations into NHS care of older people.

Fennessy (2007) writes that this should be expected as dementia care is often carried out in general hospital settings and not in designated dementia units where specialist knowledge is available to help manage these

challenges effectively. Furthermore, a lack of knowledge and understanding among nurses on how to respond to dementia-related challenging behaviour is also likely to contribute to the provision of sub-optimal care (Fennessey 2007). Packer (2001) suggests that few staff understand what dementia is and how to cope with the behaviour that can ensue. The primary aim of this work is to support frontline staff in changing practice-improving dementia care delivered within the inpatient unit by introducing a dementia care bundle. Completing a diagnostic analysis will identify barriers and facilitators to implementing this tool.

METHODOLOGY

NICE (2007) guidance on changing practice, suggests that a number of methods can be used to assess barriers to change. They suggest that a choice of methods should be based upon local context, resources and the number of staff(NICE 2007). Previous studies (Pollock, Legg, Langhorne and Sellars 2000; Davis, Jamison , Brumley, Engu and Danos 2006; Solomons, and Spross 2011) in their work exploring barriers and facilitators to implementing evidence based change; utilising diagnostic analysis identified a mixed methods approach to be of benefit in planning for successful implementation of the planned change. Following on from this Solomons and Spross (2011) write that the chosen method should be valid and reliable; the choice of model will depend mostly on what the target for change is and the group involved in changing (Lewin 1951, Bennis, Benne and Chinn 1985, Haffer 1986).

The mixed method approach was therefore chosen for this diagnostic analysis. The premise behind the use of both qualitative and quantitative

methods would allow the researcher to best answer the research question or problem(Andrew and Halcomb 2009); specifically for this paper, it would allow the researcher to capture the multiple realities and the various individual staff perspectives that made up the social situation of dementia care at the Trust. The notion of 'multiple realities' was important in this work (Lincoln and Guba 1985), the use of a mixed methodology, would allow the researcher to capture the views of both the powerful stakeholders/decision makers as well as the frontline staff. Furthermore it had the potential to add breadth, rigor and credibility (Cresswell 2002/2009). Cresswell, Vicki and Clark (2011) write that mixed method designs combine the benefits of qualitative methods and quantitative methods to create a more complete picture.

The study received Audit approval from the ONEL CS Audit department as well as sign off by the Associate Director of Operations Havering. Three data collection methods were used: as part of the triangulation of data, documentary analysis was conducted; focus groups was held along with a questionnaire, that was circulated to all staff involved with dementia care at the 2 inpatient wards at St George's Hospital

Documentary analysis:

Documentary analysis was completed on six authentic, verifiable Trust documents in the public domain to obtain evidence on supporting evidence-based practice, clinical effectiveness, organisational priorities and quality outcomes. The range of documents analysed included the ONEL CS Monthly Board report for December 2010, ONELCS Trust profile online, Havering

Primary Care Trust (PCT) Human Resources and Organisational development strategy(2005-2008); ONELCS Clinical Audit and Policy strategy(2009), Havering PCT Education Training and Development Strategy(2008-2011) and the ONEL CS five-year vision for health service delivery-Intergrated Business plan(2009-2014). Documentary data was abstracted and analysed thematically.

Focus groups:

Focus groups were used to elicit the views and experiences of professional staff who would be affected by changes in implementing the dementia care bundle. Andrew and Halcomb(2009) write that focus groups can capture the particularities and breadths of opinions about a particular topic; and are useful as they provide the social context of how opinions are formulated. The participants, eight staff with strategic or operational accountability for aspects of inpatient care were purposively sampled. In attendance was a Ward Manager, Modern Matron, Medical Senior House Officer, Practice Development Lead, Physiotherapist and 3 ward- based staff nurses.

The focus group focused on organisational culture, dementia assessment, and documentation. The focus group schedule was semi- structured, containing sequential questions exploring staff experiences caring for dementia patients from the time of admission to discharge, focusing on care processes, satisfaction with care delivered, activities of daily living, physical problems/challenges encountered, and the awareness of these potential problems on assessment. The focus group was tape-recorded and

transcribed with the permission of the participants, and analysed thematically.

Questionnaire

The study population consisted of 90 staff members who regularly participated in the care of dementia patients. This included registered nurses, nursing health care assistants, clinical administration staff and inpatient therapy staff.

The questionnaire chosen for this work used was the approved Approaches to Dementia Questionnaire developed by Lintern, Woods Phair (2000); a Likert-type instrument with 19 items. The ADQ measures hopefulness and person-centered approaches. The ADQ questions were graded on a Likert scale of response alternatives including: strongly agree, agree, uncertain, disagree and strongly disagree. A copy of the questionnaire is included in appendix five.

The ADQ is made up of two domains: the 'hope' attitude items and the 'person -centred 'attitude items (Lintern 2001). The hope attitude items were measured with eight questions, whereas the person-centred caring attitude items were measured with 11 questions. The dimension of hope is made up of questions relating to the participants' thoughts about characteristic disease-related features, for example 'there is no hope for people with dementia', or 'dementia sufferers are sick and need to be looked after'. A 'person-centred' attitude was indicated by a response in the positive to questions such as 'It is important for people with dementia to have stimulating and enjoyable activities to occupy their time' and 'people with

dementia are more likely to be contented when treated with understanding and reassurance'.

Questionnaires, with an accompanying memorandum, were then sent to the Ward Managers to distribute the memorandum to staff, who were directly involved in the daily care of persons with dementia; including administration staff. The memorandum outlined the aim of the project, provided brief information about the aims of the questionnaire. The questionnaires were collected after two weeks. Reminder letters were sent to non-respondents with another copy of the questionnaire.

Results

Data Analysis

The researcher took an interpretative approach to analyse the data for themes (Grbich 2007). Following verbatim transcription of the focus groups, each transcript was read several times to determine 'what is going on here'. That is, what meanings, values and intentions were coming through and what competing or alternative perspectives are being put forward? The Data were then classified into themes.

Results

Documentary analysis: three themes were identified:

1. Innovative forward thinking organisation

2. Staff training, development and empowerment

3. Improving patient health and care

Theme one

Innovative forward thinking organisation

The ONELCS Trust Profile on online provides a clear and concise vision; ONELCS clearly pride themselves as forward thinking and innovative; this is noted in their Integrated Business Plan and online profile, so much so that the organisation is described as:

In our view ONEL CS is an exemplar of a community provider organisation.

It is believed that this ethos benefits both patients and staff; with delivering quality care to patients at the heart of the organisation.

Theme two

Staff training, development and empowerment

A strong emphasis on staff training and development was identified in all the documents analysed, explicit commitment to training and development was demonstrated in all documents reviewed. A high profile was given to education as part of continuing professional development, and explicit links were made between education and improved patient care. Education was also presented as creating a positive environment that would improve staff recruitment. ONELCS is committed to involving staff engagement in shaping the organisation and ensuring improvements in patient care.

" Valuing people involves developing education, training and career pathways that focus on individual as well as organisational need and demonstrate an appreciation

of the staff and the vital role they have in ensuring quality services". (Organisational Development and Human Resources Strategy 2005-2008)

Strategically the Trust publicly shows its support from board level to ensuring all staff have equal access to training and development opportunities to meet the requirements of the Knowledge and Skills Framework. This commitment to the ethos of lifelong learning is demonstrated in their Training and development policy's the online Trust profile. Again staff development is linked to delivering and developing a quality service for patients:

… It should enable the Trust to deliver its strategic aims and objectives, through a workforce and organisation that is competent, motivated and confident to continuously learn, change and develop in order to deliver high quality and responsive patient care and services. (Education, Training and Development Strategy 2008-2011)

While there was clear support for education and training none was demonstrated for research and research development.

Theme three

Improving patient health and care

The Integrated Business Plan (2009-2011) ONELCS shows a commitment to Improving patient health and care; it has...

" always been our priority. Our vision is that ONELCS will be an independent

organisation that delivers consistent and excellent healthcare, proven to be safe and

effective."

The organisation emonstrates that it supports evidence-based practice and initiatives identifying opportunities to change practice and to improve the quality of patient care. The Clinical Audit Policy (ONEL CS 2009)is concise in describing the organisations objectives:

It is the responsibility of all health professionals to critically review their work to

ensure care is given according to the best available evidence.

……. The Objectives for 2009-2011 are: Ensure that audit results lead to changes in clinical practice and inform policy and training needs.

Focus groups

Four themes were identified: dementia knowledge and skills, attitude towards dementia patients and organisational change- constant change at the Trust

Theme one: dementia knowledge: skills and assessments

Lack of knowledge and understanding about 'dementia' and the needs of dementia was strong theme. Both qualified and unqualified staff (HCSW and RGN) expressed:

" I am not even sure what having dementia means.... are there different types of dementia"

Staff commented that they had not received dementia specific training

The assessment of dementia patients was fragmented, separately documented, and lacked cohesion. Medical staff in their patient clerking-noted a diagnosis; nursing and therapy staff in their individual initial assessments noted dementia diagnosis. One Registered Nurse asked the following:

" do we actually provide personalised dementia care that we can evidence; for example in our care plans?"

Currently the teams have no specific dementia documentation such as care plans for dementia care. The medical teams utilise The Abbreviated Mental Test(Hodkinson 1972) whilst the therapy teams utilise the Mini Mental State Examination(Folstein, Folstein and McHugh 1975) validated assessment tools

Furthermore the staff felt that the teams could have specialist links with the community mental health teams - to obtain specialist training and assessments and to develop " dementia champions".

Theme two: Multidisciplinary working

Staff expressed the multidisciplinary team working was not working well and would impact on improving dementia care. Staff present at the focus group, acknowledged that comprehensive multidisciplinary working did not occur,

'The level of multidisciplinary working varies, they could work better on

the for dementia patients'(registered nurse)

Lack of communication was highlighted as a major issues as part of multidisciplinary working, with mixed views expressed : the nursing staff expressed that ..

'Its hard keeping track of patients, there's no dedicated

Dementia care pathway, that's the problem, if there was a specific pathway/guidance

it would be so much easier for all staff to liaise with therapists and other professionals...

Theme three: Organisational change

Participants expressed that organisation changes were most recently frequent and difficult to understand; the concept of Change fatigue came to mind. Currently the organisation has a new management structure, at present the inpatient wards are participating in an consultation with reduction in substantive posts

'Staff do not feel they are involved in current management decisions'

Staff expressed that there was limited communication and moral amongst staff was very low; furthermore, shortages of nursing staff were evident.

" we do not know what is going on"

" Too many changes at present and these are poorly communicated"

" first TUPE transfer to NELFT, then Reducing managing costs consultation, now inpatient reduction beds consultation all within 3 months...."

" No one listens to us...staffing levels are being reduced and we cannot provide the care we want to"

The general consensus from participants was that the Trust responded positively to change and that this was a constant feature of working in the NHS.

" Staff are open to change and understand that change is the nature of the NHS"

Many exemplars of well-managed change were cited, including the implementation of the Productive Ward Series, where staff were fully involved in the programme. Key characteristics of these changes were good communication, planning, involvement of staff, and training provided prior to implementation.

Questionnaires:

A total of 90 questionnaires were distributed. Initially, there were 33 respondents (36. 7%), however, this rose to 43. 3% after the reminder memorundum was sent (n = 39). Hence, a total of 39 (43. 3%) respondents were included in the study. Thirty of the respondents (76. 9%) were clinical staff, 4 (10. 3%) were Non clinical administration staff and 5 (12. 8%) respondents did not identify their role.

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Hope attitude Items

Where the positive hope attitude was obvious, more staff members selected it and this is evident in the response to statement 5- " Nothing can be done for people with dementia, except for keeping them clean and comfortable" where 62. 9% of the respondents strongly disagreed. However when it was not so obvious, there emerged a variety of responses. Consider the statement 'People with dementia are unable to make decisions for themselves'; a variety of responses are obtained.

People with dementia are unable to make decisions for themselves

Answer Options

Response Percent

1 strongly disagree

25. 7%

2 disagree

25. 7%

3 neither agree nor disagree

25. 7%

4 agree

14. 3%

5 strongly agree

8. 6%

don't know

0. 0%

answered question

skipped question

This is a similar outcome for the remaining 7 hope attitude questions. With the remaining 7 of the questions, almost equal numbers of respondents agreed or disagreed with hope and non-hope approaches. Consider the question 'Dementia sufferers are sick and need to be looked after'- are dementia sufferers sick? And in what sense are they sick? Those questions pose a dilemma and therefore it is not surprising that the respondents show this in the data below.

Dementia sufferers are sick and need to be looked after

Answer Options

Response Percent

1 strongly disagree

17. 1%

2 disagree

17. 1%

3 neither agree not disagree

20. 0%

4 Agree

14. 3%

5 Strongly agree

31. 4%

don't know

0. 0%

answered question

skipped question

This again demonstrates the lack of consistency in the choices of approach, with some choosing the best considered approach and some not. It also highlights a need for further development of understanding and knowledge of the best available approach to caring for those with dementia as almost half the respondents agreed or strongly agreed the non-hope items for each of these questions. This indicated that staff have some knowledge and ability in delivering dementia positive care, but that this is usually only evident where this is a clear option. When it is a less obvious choice, some dilemmas are raised.

The hope attitude items are characteristics of disease related features;, the responses suggest that indeed, some staff may have limited specific dementia care awareness and skills or perhaps there are areas of practice or

experience that gives them some understanding of the dementia; it is remains clear that there is a gap in their knowledge. This supports the premise that more learning is required.

Person Centred Attitude Items

Responses to 9 out of the 11 person centred attitude items were strongly positive; and as they were obvious the responses were selected by most staff members.

The questions raised issues of trying to maintain independence, choice and dignity while attending to physical care needs and managing the care. The responses suggest that as these were standards of caret hat healthcare staff strive for, in their day to day practice; however these are aspects of