Dementia care in acute care settings

Failing to plan for dementia is planning to fail

Chris Frank MD CCFP(COE)(PC) FCFP Frank Molnar MSc MD CM FRCPC

Clinical question

How can we best care for patients with acute illness in a hospital setting who also have dementia?

Bottom line

Family physicians play an important role in hospital care, particularly in smaller communities. Canada's hospitals are buckling under the rising numbers of patients with dementia, but many hospitals and health policy makers seem unaware. Acute illness and hospitalization are challenging for people with dementia, as hospitals are not well structured to optimally care for these patients, resulting in negative outcomes for patients and impacting our limited hospital capacity.

Evidence

- Canada has one of the lowest numbers of hospital beds per capita of the Organisation for Economic Co-operation and Development nations.[1]
- Seniors with dementia are 1.5 times more likely to experience harm in hospital and have twice the hospital length of stay (LOS) compared with seniors without dementia.[2]
- Almost half of alternate level of care (ALC) days in Canada are now related to dementia.[2]

Approach

With such low numbers of hospital beds, we must use these valuable resources efficiently; yet Canadian Institute for Health Information statistics show us we are inefficient (and ineffective) in the care of hospitalized persons with dementia.[2] Few bodies responsible for decreasing ALC rates formally recognize dementia as a main driver, and fewer still make better dementia care a core part of ALC reduction strategies. Even fewer Canadian acute care hospitals have corporate dementia strategies to plan for the escalating number of persons living with dementia, which is driving up ALC days and LOS. Marginalizing dementia care in this manner carries a high price for persons with dementia, their families, and hospitals themselves.

Family physicians can play a critical role in bringing the care of hospitalized persons with dementia out of the shadows by helping hospitals recognize that dementia care is a core element of their business and mandating the implementation of acute care dementia strategies.

Such strategies have been developed in several countries[3-5] and contain the following core elements (further reviewed in a *Canadian Geriatrics Society Journal of CME* editorial available from **www.hospitaldementiacare.ca**).[6]

Hospital-level data. At a minimum we need to accurately identify and quantify persons with dementia in hospital at any given time, which will help measure the impact of dementia on hospital LOS and ALC days, and measure the effectiveness of interventions for hospitalized persons living with dementia.

Strong leadership and corporate commitment. Strong support and commitment of senior management teams and boards of governors are needed to mobilize resources. This must be complemented by strong multidisciplinary dementia quality improvement teams.

Detection and documentation. Screening for cognitive impairment (caused by dementia, delirium, etc) in all patients older than 65 years should start in the emergency department. A diagnosis of dementia should be flagged in electronic medical records so staff are aware of it and will consider referral to services with dementia care expertise.

Family members as essential care partners. The coronavirus disease 2019 pandemic showed us the negative impact of leaving family caregivers out of hospital care. We need to value and support family members as essential care providers, especially for persons with dementia, who sometimes cannot express their needs or advocate for themselves.

Person-centred, timely care that meets basic physical needs that persons with dementia sometimes cannot express. Practical care plans must exist to proactively address the needs of persons with dementia through all parts of their stay, from emergency department to inpatient ward to discharge and follow-up.

Education, ongoing training, and support for staff. To prevent compassion fatigue and burnout, staff members need support with timely access to education and real-time, front-line coaching. They also need assistance in dealing with the emotional impact of dementia care.

Dementia care expertise. Services with dementia care expertise (eg, geriatric medicine, care of the elderly, geriatric psychiatry) should be available in the emergency department and throughout the hospital. These experts can also support staff education and front-line coaching. Strategies for critical illness conversations and palliative care approaches specifically for persons living with dementia need to be developed.

Nonpharmacologic prevention and management of responsive behaviour. To promote nonpharmacologic management of responsive behaviour, physicians should use pathways, protocols, policies (including minimal restraints), education, and training based in dementia care.

Individualized, proactive discharge planning. This includes early discharge planning, consideration of patient and caregiver or care partner needs, engagement of key community organizations, provision of support and resources to caregivers, and clarification of goals and limits of care.

Supportive physical environments. Small changes to the physical hospital environment—for example, to reduce overstimulation and to promote ease of movement—can have positive impacts.[7] More practical tips are available from the Dementia Enabling Environment Virtual Information Centre (**http://www.enablingenvironments.com.au**).

Implementation

Having hospital-level data to accurately identify and quantify persons with dementia (element 1) is critical—if hospitals were able to measure the day-to-day impact of dementia, hospital senior management teams would recognize that it is essential to prioritize acute dementia care strategies to improve patient flow, decrease ALC days, and decrease hospital overcrowding. Accurate measurement would drive prioritization and policy. The principle of "one cannot manage what one cannot measure" is foundational. For an emergency medicine perspective, please see the *Healthy Debate* article by Melady and Molnar.[8]

Making better in-hospital dementia care a priority will need the vision, drive, and leadership skills of hospital executives, hospital boards, and provincial and territorial ministries of health to mobilize and guide the necessary resources and expertise (element 2). We will also need the driving force created by the advocacy of physicians, including *Canadian Family Physician* readers.

Without the recognition that improving the care of persons with dementia is critical to ALC reduction, ALC rates will rise, hospital overcrowding will worsen, and postpandemic recovery will be severely hampered, affecting Canadians of all ages. The time for us all to speak out is now.

Dr Chris Frank is a family physician specializing in care of the elderly and palliative care at Queen's University in Kingston, Ont. **Dr Frank Molnar** is a specialist in geriatric medicine practising in the Department of Medicine at the University of Ottawa in Ontario and at the Ottawa Hospital Research Institute.

Competing interests
None declared

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