New ways of working with patients with dementia

Reorganising health-care workers' functions is necessary to improve the quality of care in residential homes and to achieve the objectives of the National Dementia Strategy. General practitioners with a special interest in the mental–health of older people and consultant psychiatrists for older adults with exclusive commitment to the community will be useful roles to develop.

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Living well with dementia: a National Dementia Strategy[1] was a major contribution to the debate on how to address the wellbeing of individuals with dementia and their carers. Recommendations for improving the quality of care in residential homes rightly emphasised the need for early diagnosis and intervention, help for carers, and reducing stigma. Many recommendations were based on intuition and the experiences of carers and professionals over many years rather than empirical data. The strategy encompasses the best principles and practice for dementia care but we need to start initiatives in our local populations, we cannot wait while data are gathered.

Old-age psychiatry is increasingly community-based; hospitals have a decreasing number of beds for assessing the mental health of older adults. Continuing care beds are already either extinct or close to extinction. Out-patient sessions and memory clinics will probably move from psychiatric hospital settings (still very often refurbished units in old out-of-town mental hospitals) to centrally situated general practice surgeries or polyclinics.

Care homes should be regarded by health-care workers as being part of the community. By concentrating on the early implementation of the dementia strategy in care homes, we can make the greatest impact on care for all older adults with mental health problems. Doctors have an opportunity to contribute to improving the quality of care in care homes by developing new ways of working.[2]

As life expectancy increases, people enter care homes at a more advanced age, and also have more physical and mental disabilities. Degenerative diseases are more prevalent and, medication lists are both large and pharmacologically complex. Care homes are becoming our modern equivalent of the much criticised mental-health wards of the 50s, 60s, and 70s.

Yet, care homes are a greater cause for concern because their populations are older and frailer than the mainly middle-aged schizophrenic patients that occupied those chronic-care wards. Residential homes also lack the expert input and supervision provided on mental-health wards, which generally had an experienced ward sister, and weekly visits by a junior psychiatrist to supervise mental and physical health and to review medication.

The problems in care homes and opportunities for addressing them were comprehensively reviewed in Alzheimer's Society`s Home from home.[3] We should reorganise the input of general practice, the community mental-health team, and the consultant older adult psychiatrist to kick-start improvements in services and facilitate achievement of the National Dementia Strategy's objectives. With current resources we can make considerable progress in some of the most pressing psychiatric problems in care homes; dementia, depression, unreviewed prescription of psychotropic drugs, and lack of psychiatric knowledge in care staff. If we can improve care homes, then we can reduce the stigma associated with dementia and dementia care.

Dementia and depression are the two main psychiatric problems in care homes: in the UK, 820,000 people are thought to have dementia and one third of those

live in care homes. Dementia is the strongest prognostic factor for predicting admission to a care home[4,5] and 40% or more of residents will have depression, with many undiagnosed.

Working in care homes

Each surgery should have a general practitioner with a special interest in older adults with mental health problems. This doctor should liaise with the community mental-health team and the consultant psychiatrist. If no general practitioners have such an interest one doctor in each practice should look after all the practice's patients in specified homes. Neighbouring practices could agree to have one practice take responsibility for all patients in a particular care home. The increased continuity of care would offset the risk of curtailing a resident`s choice of practitioner.

Practices without an organised model may have patients distributed among 17 local homes, and health-care workers visiting those institutions can have to liaise with up to 70 doctors in various practices—this is bad for rapport, and for coordinated care.[6,7] Although general practitioners with special interests in mental health exist, widespread interest in older adults' mental health is not forthcoming. We can do better.

We need doctors willing to pioneer these new ways of working, who can work with a flexible job description until a successful scheme becomes established. Important functions are close liaison with the community mental-health team and the consultant including weekly or fortnightly visits to care homes and regular reviews of psychotropic prescriptions, ideally with a monthly collaboration with a community pharmacist.

The Government`s general-practice tsar said: "Patients trust general practitioners. We are highly-trained, offer high-quality services, and our communities respect us, so why are we not doing even more. Our training allows us to spot the first signs of cancer, give advice on weight loss, and deal with depression and desperation. Many of us specialise in particular aspects of medicine".[8] Indeed, why not specialise in the mental health of older-adults?

Change from the inside

Once the general practitioner and community mental-health team have established relationships with the management of care homes, they can then influence further positive change. This could be by encouraging management to allow their hands-on staff to attend courses in dementia care and mental health. Alzheimer's Society runs some well established courses. Input from an occupational therapist or a community support worker can be suggested.

Setting up a group for residents' relatives may help to alleviate relatives' anxiety and facilitate raising concerns about aspects of care. Care-home managers should not feel that a pressure group has been set-up to subject them to additional scrutiny. Management must be involved from the start and made to feel part of the endeavour to improve care. The coming and going of visitors and professionals into homes helps to raise morale and opens up the home. It creates what Murphy[9] described as "a satisfying bustle".

General practitioners with a special interest in older people will become a focus around which primary and secondary care can address the needs of this group of patients. By being active in care homes, they can guide the private sector into a better quality of care. The private sector will always have an important role to play in the care of older adults with mental health problems, and my experience suggests that therapeutic interest from the NHS is welcomed in care homes.[10]

Developing a special interest

General practitioners should be trained in accordance with the guidelines of the primary-care trust and the local deanery but local psychiatric and medical services must be major contributors. Guidance on the general procedures and principles of progressing to general practitioner with specialty status are available from the Department of Health and primary-care sources.[11] All professionals with special interests must have the same quality standards and had to be re-accredited by March 2009.[12]

Practical involvement with local older adult services and support agencies in several care settings over months should be given greater recognition of expertise, rather than on written demonstrations of knowledge. The general practitioner should be considered part of the community mental-health team for the elderly, to some degree, to bond primary and secondary care, which have been viewed as separate entities that very often function with little liaison or coordination.[2] This approach would benefit not only

residents of the care homes, but also individuals in the wider community, such as those seen at the specialist outpatients and in their own homes.

The specialist general practitioner would have a central role in organising teaching sessions for care-home staff, who are often not held in high esteem by society, are poorly paid, and who do a very specialised job with little or no training. Although general practitioners show an admirable willingness to refer cancer patients to services such as Macmillan nursing, doctors do not refer enough older patients to organisations such as Alzheimer`s Society, or social services. These organisations are very knowledgable and can be highly supportive of patients and relatives.

Doctors need to be able to manage all the medical, psychiatric, and social connotations of dementia. General practitioners lead the race to run Darzi's polyclinics, since they are skilled in various forms of management and would be off to a good start.[13] Indeed they have far greater potential for flexible working than consultants, because general practitioners are contracted rather than employed and are not controlled in a system managed by Trusts.

The function of the consultant

The Royal College of Psychiatrists recommends one consultant old-age psychiatrist for every 12,000–13,000 people aged 65 years and older. The psychiatrist, in agreement with their Trust, can decide how best to use their time and skills to address the needs of the local population they serve. For example a population of 22,000–23,000, as in our area, with two consultant psychiatrists could decide that one consultant will concentrate on the community and outpatients and the other on inpatient facilities and hospital liaison. Both consultants and their teams should meet weekly to discuss their services and to facilitate transfer of patients between the hospital and the community. A swap of community and hospital duties after 5 years would help to maintain energy and fresh ideas.

The community psychiatrist should have a role in developing and providing community services with the general practitioner, be recognised among local statutory and voluntary bodies, and be available for advice on complex challenging patients. The consultant will have an educational role, similar to that of the general practitioner. The department needs to project a user-friendly image, which has not always been the perception of outside agencies. New Ways of Working[2] demands a blurring of primary and secondary care roles to allow coordinated, one-stop management of complex cases.

Why target care homes?

By concentrating on care homes we target the final hub of the problem, if we function badly for the most severe patients, then all those in the early and moderate stages will be adversely affected. The more extreme patterns of behaviour disorders are generally seen in care homes, and present the most demanding physical and mental challenges. We need to understand each patient's circumstances to make sense of their behaviour.

The patient by the door trying to abscond may have been admitted recently. The one described as a having a behaviour disorder may be trying to communicate or could be in distress. A restless and agitated person in bed may be tucked-up with a bedsore. The threat of long-term unreviewed medication hangs over all residents.

Relatives visiting care homes, often say that although the physical and mental burden of care has moved out of their home, they are more worried than ever about their relative's wellbeing. They often do not discuss their anxieties with staff, but visit frequently to try to allay their burden of anxiety and grief.

The next step

Once the quality of care in homes has improved, the next target group is those patients whose relatives are too anxious about the reputation of homes to have their relative move to a care home, even though they may have long exceeded their individual caring ability. Once the improved quality of care and the better ambience of the facility is obvious, carers may feel more comfortable about respite or ongoing care.

Care homes will be more willing to accept problematic patients from hospitals knowing that they will have the support of the doctors and the mental-health team. This will reduce blocked beds and, in turn, facilitate the availability of assessment beds in hospitals for early diagnosis—another prime objective of the Dementia Strategy. Care homes could be ideal teaching centres since all aspects of diagnosis and care of older adults with mental-health problems are readily demonstrable.

No model of new ways of working is universally applicable to all patients or all regions. However, the status quo cannot continue with the changing demographics of the elderly and

increased pressure on diminishing hospital facilities. We need to try new ways of working and discuss the benefits and drawbacks in our communities.[14] From this action we can develop financially viable efficient schemes, with increased quality of care. Small changes can have major beneficial changes, not only on residents' morale and behaviour, but also on the morale and work enjoyment of staff.[15]

Local experience

We implemented new ways of working similar to those described (box 1). We gave educational input to care homes via the community mental-health team and provided a free booklet for all staff, written by our team, on the principles and practice of management for older adult mental-health residents. Our help was welcomed by the care homes,[10] and our offer to give talks based on the booklet after members of staff had read it, was readily accepted.

We do not yet have a specialist general practitioner. While it is too soon to come to definitive conclusions on its impact, first impressions are good. A retrospective audit of number of admissions, length of stay, pressure on beds, quality of care in care homes and morale of care staff and carers, will be worthwhile. What is good practice for our area, may be only relevant locally.

I have no conflict of interest.

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Box 1: Changes made to our local services

- One consultant psychiatrist assigned to the community and one to the hospital
- All care homes listed and divided between the community consultant and the staff grade doctor
- Community psychiatric nurses allocated to specific homes
- A senior member of staff identified in each home who will take the lead in liaising with the team and improving care
- Psychotropic medication for all residents known to the team under review
- Free team handbook on The Principles and Practice of Management of Older Adult Mental Health Residents delivered to homes and talks on the content provided by the team.*

*Copies of the Handbook are available free from Ms Aileen Thaddeus at: The Meadow's Assessment Unit, West Park Hospital, Horton Lane, Epsom, Surrey KT19 8PB; 01372 203350