Dementia Academy®

Education with impact: Dementia Academy

Learning captured from workplace projects 2022-23

Neurology Academy®

NEUROLOGY ACADEMY: EDUCATION WITH IMPACT

Introduction

Dementia Academy has supported a range of projects over the years designed to impact people living with dementia and the healthcare professionals supporting them via group projects. These included developing the national interactive dementia pathway toolkit (2016), and the brain health clinic blueprint (2020). In 2022, we reported on a collection of projects resulting from our mild cognitive impairment course, 'Quality improvement in MCI', and this year, 2023, our 7th Dementia MasterClass spurred the first individual workplace projects in dementia services.

'There was a fantastic output in terms of quality and number of projects resulting from this Dementia MasterClass. Most delegates followed a really robust audit or quality improvement methodology.

Many delegates said that, without the Academy structure and support, they wouldn't have carried out this work. This demonstrates how the course can have a real impact on individuals with dementia.'

Prof Iracema Leroi, head of Faculty

Projects ranged from assessing cognition to screening for delirium, developing pathways to improving post-diagnostic support. This short report reviews some of these projects, the key themes and learning arising from them, and the impact they have had on the lives of people affected by dementia across the UK.

'It's so rewarding to hear our delegates presenting the work that they have carried out as a result of their learning and to hear about the impact it's having on their patients. Learning in action; education with impact. This is what Neurology Academy is for.'

Sarah Gillett, managing director

Collaborative care

An area of increasing focus over the past few years, forms of collaborative working have been seen in more and more projects Academy-wide. Healthcare professionals across the country are trialling new ways of working that better utilise their skill-sets to meet the varied needs of patients including through shared care pathways, multidisciplinary team working and cross-departmental meetings.

The class's winning project was one of collaborative care, and focused on joining the dots between frailty and cognition. Dr Michelle McCarthy, a community consultant geriatrician, developed her service with occupational therapist (OT) colleague Clare after recognising that their frailer patients often struggled to access memory services They developed a diagnostic pathway, including signposting to post-diagnostic support, and piloted a monthly multidisciplinary team meeting dedicated to frailty and memory which was supported by the psychiatrist, geriatrician and specialist OT. After seeing 35 patients in this frailty memory service during the pilot, they have detected a higher rate of dementia in patients with a higher level of frailty, and are looking to develop a business case to continue providing this new service.

Other work improving collaborative services this year included Dr Kerri Ramsay's project to improve the interface between rapid response liaison psychiatry (RRLP) and geriatrics. Using staff surveys to understand the challenges, Kerri set up a steering group with the RRLP nurse and psychiatrist, and established a new system for streamlining referrals. This included regular telephone discussions to review patients, a new proforma for referrals and a dedicated whiteboard listing all patients. This has resulted in better resource use for both departments, improved cross-departmental referral and better patient management.

Geriatrician Jo Russell scoped out current working models and communication across different older people's services including the psychiatry, Parkinson's and elderly medicines teams. Identifying where the pressures on those services were, Jo then outlined various solutions including a pilot cognitive-focussed clinic, regular cross-departmental meetings, and improved patient-facing education, all of which are underway.

Psychosis and delirium

Until this year, none of our 400 plus workplace projects stored online had addressed psychosis or delirium, yet amongst this delegate group, six of the 19 projects focused on just that. Projects ranged from identifying delirium in a number of different settings to testing different screening and assessment tools to detect delirium, to monitoring antipsychotic medications in-clinic.

Three projects reviewed or initiated screening for delirium in acute settings. Geriatricians Yoghini Nagandran & Aws Hindi initiated use of the 4AT given its sensitivity and simplicity to complete after finding poor compliance with the SQID. They rolled this out across two departments for seven weeks and found that screening rates improved by 27% and 18% respectively in those two departments. After evaluating causes for poor compliance to the 4AT, they then set about overcoming some of those barriers, including establishing the tool on the Trust's digital system.

Dr Micaela Forster's hospital already uses the 4AT, but in reviewing this, she found that only 3% of patients were being screened despite the tool being part of the standard assessment form. She is pioneering staff education and has liaised with the dementia and delirium services who are supporting her in this.

Some projects were initiating a form of screening for the first time. Dr Claire Kershaw found that her Trust did not routinely screen for delirium and decided to use the opening of a new frailty unit as a good opportunity to pilot this. She has worked with stakeholders to establish the 4AT on their electronic form for new admissions. Dr Wiebke Wentzlau also wanted to encourage a formal approach to identifying cognitive issues in their outpatient rehabilitation unit and so developed a flowchart to prompt staff to consider this and guide them through potential next steps.

Dr Rachel Bradley and her colleagues approached delirium from a different angle. They focused on learning more about patient and carer experience and understanding of delirium when in hospital. Gathering information via surveys, they have used the results to inform staff training and patient communication, with the aim of improving the experiences of families and individuals who experience delirium during a hospital stay.

Screening and improving early identification

Delirium was not the only area seeing an increase in screening; a number of projects dealt with other forms of early identification, including cognitive testing, and self-screening for sensory impairment.

Consultant psychiatrists Siobhan Collins and Yetunde Faluyi developed a survey around sensory impairment for all people over 65 in their clinic to complete regardless of their cognitive state, to understand where people experienced visual and hearing impairment and to signpost them to onward services, reducing this risk for dementia.

Parkinson's specialist nurse Alison Kearney wanted to improve early detection of cognitive problems within frailer Parkinson's patients who are at a high risk of developing dementia. She trained a healthcare assistant within the movement disorders team to carry out assessments using the MoCA. Patients calling their care and advice helpline as well as those attending clinics were assessed, and Alison was able to see improved recognition of cognition within this population, as well as of falls and delirium.

Reducing inappropriate medications

The relationship between anticholinergic medications and cognition has been established for some time. Anticholinergics, used to manage myriad health conditions and symptoms from allergies to bladder problems and mood disorders, have been found to be robustly associated with dementia (Richardson 2018) even being suggested as a modifiable risk factor for it (Zheng 2021). As a result, over the past few years a number of delegates across Academies have been seeking to review anticholinergic use and reduce it where possible to help preserve and protect cognitive function.

Consultant Dr Murudappa Bhattad, with colleague William McKeown, implemented a prescription review of medications for in-patients with dementia to assess any inappropriate medication which might adversely affect their cognition and amend their medications accordingly including anticholinergics. They succeeded in reducing unnecessary medications in people with dementia by 27% across a one month period.

One of the MCI course graduates, geriatrician Dr Henry Cabeza set about reducing anticholinergic medications within his falls clinic by introducing screening for polypharmacy, anticholinergic burden (via the ABC tool), and cognition (via MoCA) at the initial clinic visit, and again at one and three months thereafter. Of 32 patients with a mean age of 84 years, he reduced the proportion experiencing mild cognitive impairment from 58% down to just 15% in those three months.

Top tips and takeaways

Here are some ideas you could consider replicating based on this project work, centred around five statements made by the delegates.

1. Whether to reduce risk or preserve cognition, anticholinergic medication should be minimised wherever possible. Ways to do this include:

- routine medication reviews or screening for polypharmacy in falls, frailty or memory clinics like Murudappa Bhattad and William McKeown did
- use the ACB calculator to assess burden and initiate some medication changes like Henry Cabeza

2. Hearing and vision impairment is a modifiable risk factor for dementia. You could:

- introduce a brief self-assessment in the waiting room before a clinic like Siobhan Collins and Yetunde Faluyi
- add in some patient education or signposting around clinic spaces
- add routine questions about hearing and vision checks into clinic and encourage colleagues to do the same

3. Delirium is common amongst older people on in-patient wards. You could

- find out whether there is an agreed tool or system in place and audit whether it is working like Micaela Forster
- pilot a screening tool like Claire Kershaw
- consider how education or communication might support people's experiences of delirium in your hospital like Rachel Bradley

4. Patient management is improved by cross-departmental working. You might:

- find out whether there are any referral pathways, proformas or other systems in place across common older people's services such as medicine for the elderly and psychiatry services like Kerri Ramsay, or frailty and cognition like Michelle McCarthy
- lead a collaborative effort to renew, update or create a shared system like Jo Russell
- initiate an agreed form of routine cross-departmental communication, such as a weekly call, shared MDT meetings, or a whiteboard, as Kerri did

5. Certain groups of people are at higher risk of cognitive impairment or dementia - screening them could detect changes in cognitive function earlier. Could you consider:

- adding an agreed cognitive screening or assessment tool into clinics for people at higher risk such as falls, Parkinson's or frailty like Alison Kearney
- training a healthcare assistant in MoCA use to carry out when patients contact the service for support as Alison did
- adding some specific questions into routine clinics that would trigger referral for cognitive assessment if potentially needed like Siobhan Collins and Yetunde Faluyi

Neurology Academy: education with impact

Dementia Academy is part of Neurology Academy.

Neurology Academy is an innovative educational provider for healthcare professionals including consultants, specialist nurses, pharmacists, therapists and other allied health professionals. Our courses are developed by practising specialists who combine their experience and expertise into case-based learning designed to create specialists in their field with confidence in effecting change.

We specialise in education, networking and mentorship, encourage the sharing of good practice, and promote clinical leadership across a range of conditions. Each condition or healthcare theme has its own 'Academy'.

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