Canadian Geriatrics Society

EDITORIAL

HOSPITALS "FAILING TO PLAN FOR DEMENTIA IS PLANNING TO FAIL": ALL CANADIAN HOSPITALS MUST LAUNCH ACUTE CARE DEMENTIA STRATEGIES IF THEY ARE SERIOUS ABOUT DECREASING HOSPITAL OVERCROWDING, DECREASING ALTERNATE LEVEL OF CARE (ALC), AND THEREBY INCREASING HOSPITAL CAPACITY TO PERMIT PANDEMIC RECOVERY AND TO MEET FUTURE ESCALATING NEEDS

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Conflict of Interest: The author is a specialist in Geriatric Medicine with decades of experience caring for persons living with dementia in hospital.

Acknowledgement: Many of the ideas expressed in this article were developed in collaboration with Natasha Poushinsky and are included with her permission.

This editorial has not been peer reviewed. The author accepts sole responsibility for the opinions expressed, which are intended to stimulate thoughtful discussion.

This editorial was published in June 2021.

Key words:
dementia, acute care, hospital, alternate level of care, ALC

Why we need acute care dementia strategies

Hospitals are not properly designed to care for persons living with dementia who are extremely vulnerable to *hospital-acquired delirium* and *hospital-acquired deconditioning*, leading to *hospital-acquired disability.* This is supported by CIHI data demonstrating seniors with dementia are 1.5 times more likely to experience hospital harm than seniors without dementia (https://www.cihi.ca/en/dementia-in-canada/dementia-care-across-the-health-system/dementia-in-hospitals).[1]

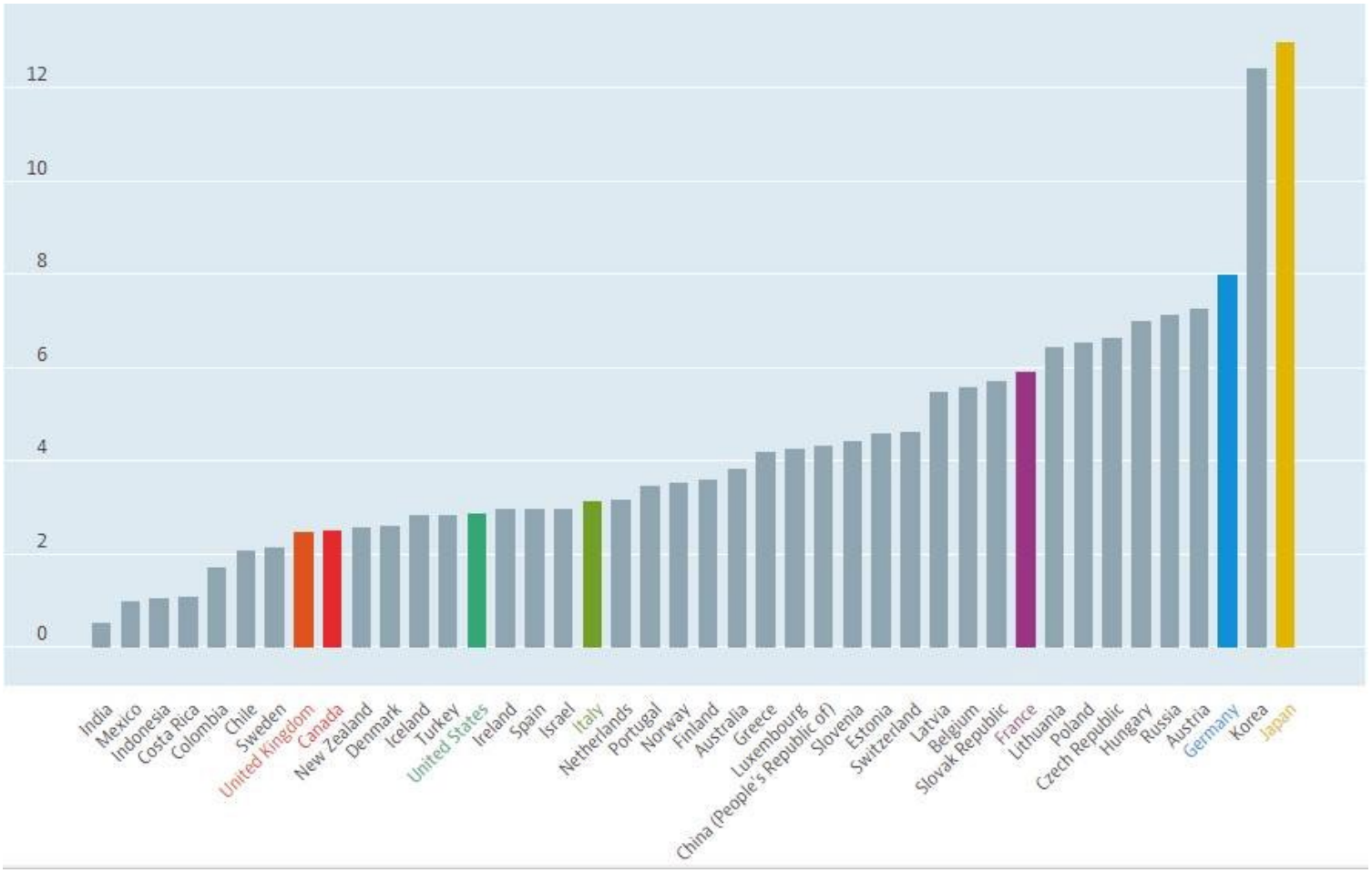
Hospitals pay a high price for this lack of attention to the special needs of hospitalized persons living with dementia in terms of increasing hospital overcrowding (sometimes referred to as "hallway medicine" or "bed gridlock"). According to CIHI, when seniors living with dementia are admitted to hospital, they have twice the length of stay (LOS) of seniors without dementia, and dementia now accounts for almost ½ of alternate level of care (ALC) days (https://www.cihi.ca/en/dementia-in-canada/dementia-care-across-the-health-system/dementia-in-hospitals).[1] Despite these seemingly compelling facts, few bodies responsible for decreasing ALC rates formally recognize dementia as the main driver of ALC and fewer still make better dementia care a core feature of their ALC reduction strategies. Many ALC reduction committees focus on discharge destination rather than on improving in-hospital care. Merely focusing on opening more long-term care beds while ignoring better in-hospital care is not patient-centred, is a disservice to patients, and disregards the critical role and responsibility hospitals have in improving patients' health trajectories. Ignoring dementia, the main cause of ALC, in ALC reduction strategies represents a major oversight and is self-defeating. Such ALC reduction strategies cannot hope to succeed if they do not implement better in-hospital dementia care strategies.

While some hospitals have implemented small-scale innovations to improve dementia care, the complexities of patients with dementia require larger, more comprehensive approaches to acute care of persons with dementia spanning the spectrum from prevention through to management throughout the entire hospital in order to be effective. If hospitals and ministries of health are serious about reducing ALC, reducing hospital overcrowding, and improving person-centred care then they must start developing and supporting comprehensive acute care dementia strategies.

Why this a critical time to launch acute care dementia strategies: pandemic recovery and beyond

Canada has one of the lowest numbers of hospital beds per capita of OECD nations as illustrated in Figure 1.[2] Some of the counties at the lower end of the range of hospital beds have far stronger home care sectors than Canada and can compensate for their relatively low number of hospital beds by better supporting discharge from hospital than we can in Canada.

Figure 1: Hospital beds—total per 1,000 inhabitants in 2019 or latest available (OECD (2021), Hospital beds, printed with OECD permission, accessed at https://data.oecd.org/healthreqt/hospital-beds.htm)



Many Canadian hospitals were already bursting at the seams, chronically running over 100% capacity prior to the pandemic. Canada's low number of hospital beds per capita directly contributes to hospital overcrowding. Given the above realities, our hospitals will not be able to efficiently accommodate the huge backlog of patients whose non-urgent (also known as elective or non-essential) surgeries are being delayed by the pandemic unless our hospitals change the way they practice by providing better care specifically designed to decrease the LOS and ALC rates of vulnerable populations such as persons living with dementia. This is not currently the rule—few, if any, Canadian hospitals have corporate acute care dementia strategies to proactively plan for the escalating numbers of persons living with dementia that will be presenting to hospital even though dementia is already the main driver of their ALC problems. Hospitals and ministries of health seem to be turning a blind eye to the "elephant in the room" of escalating numbers of hospital patients with dementia despite being crushed by it. The status quo will predictably result in worsening hospital overcrowding, which, in turn, will prevent us from addressing the backlog of non-urgent surgeries in a timely manner. Some of these delayed non-urgent surgeries will then become urgent, creating unnecessary risk for Canadians of all ages. Beyond the pandemic recovery period, the rising numbers of hospitalized patients with dementia with long LOS and high ALC rates will worsen hospital overcrowding.

Now is the time to develop comprehensive acute care dementia strategies to mitigate the effect of dementia on rising ALC rates if we hope to deal effectively with pandemic recovery and with subsequent escalating

patient needs. Now is the time for all hospitals to recognize that dementia care is a core element of their business, to include dementia care in their strategic plans, and to invest accordingly in strategies that include both [1] *prevention* (e.g. of avoidable delirium, deconditioning, responsive behaviours, etc.) and [2] *treatment and management* of issues that arise (e.g. behaviour that arises despite preventive measures). Where does one start in developing such strategies?

Published acute care dementia strategies

Three acute care dementia strategies developed in different health care systems highlight elements that, when combined, represent a comprehensive acute care dementia strategy.[3–9] There are likely other acute care dementia strategies, but it is reasonable to expect that the following three strategies capture the essential elements and serve as a solid starting point for ministries of health and hospitals to follow in developing their own provincial/territorial and individual hospital acute care dementia strategies. These three acute care dementia strategies are:

1. Improving BC's care for persons with dementia in emergency departments and acute care hospitals (2011): see page 13 in https://www2.gov.bc.ca/assets/gov/people/seniors/about-seniorsbc/pdf/improvingcaredementiareport2011.pdf [3]
2. Dementia care in the acute hospital setting: issues and strategies, a report for Alzheimer's Australia (2014): see page 12 in https://www.dementia.org.au/sites/default/files/Alzheimers_Australia_Numbered_Publication_40.PDF [4]
3. Irish National Audit of Dementia Care, version 2 (2020): see page 26 in http://dementiapathways.ie/permacache/fdd/cf3/1ce/00bd672fac7c0ef730d753ea3b10c112.pdf [5]

Examining these three strategies in detail, the required elements for a comprehensive strategy emerge as outlined in Table 1.

Table 1: Required elements of a comprehensive acute care dementia strategy*

Hospital-level data *"one cannot manage what one cannot measure"*	**Accurate identification of patients with dementia in each individual hospital to measure hospital-level outcomes:** 1. Prevalence of dementia in each hospital tracked over time (to determine if hospital diversion, interventions, and discharge measures are effective). 2. The effectiveness of new in-hospital interventions on outcomes for hospitalized persons living with dementia (i.e. the analysis must be able to isolate this population) including: • Hospital harms (*hospital-acquired delirium* and *hospital-acquired deconditioning* with decreased mobility and falls, leading to *hospital-acquired disability*) • Alternate level of care (ALC) • Length of stay (LOS) • Return to hospital (readmissions) • Number of code whites (violent patient codes) • Rate of use of antipsychotic (neuroleptic) medications • Sitter use
Strong leadership and corporate commitment	1. **Strong support and commitment of senior management team and board of governors** to direct needed resources and remove barriers to move the strategy forward. 2. **Multidisciplinary dementia quality improvement teams** with clear governance structure and a **communication path to senior management.**

Detection and documentation	**Screen** for cognitive impairment (caused by dementia, delirium, etc.) in all patients over 65 years old, starting **in the Emergency Department.** Flag diagnoses of dementia in the **electronic medical record (EMR)** so all staff are aware and will consider referral to services with dementia expertise. This will also enable an efficient mechanism to generate reports on quality metrics for this population using EMR-based analyses.
Value and support families as "Essential Care Partners"	Directly engage families in care planning, and ensure families are provided with peer support and training (ideally through direct engagement of community organizations who specialize in dementia) to increase their resilience as Essential Care Partners. Build in multiple strategies to obtain their feedback on an ongoing basis to refine the strategy (e.g. through surveys, committee membership, focus groups). Value and embed their role of Essential Care Partners in care planning, staff orientation, and training processes.
Person-centred, timely, individualized care that meets basic physical needs that persons living with dementia sometimes cannot express	With assistance of caregivers, develop practical care plans (within an established target timeline) that proactively address the needs of the person with dementia through all parts of their journey from the emergency department to inpatient ward to discharge and follow-up in ambulatory care services. Examples of approaches include: **1.** The **TOP5 program** where caregivers share the top five care strategies for care (e.g. preferences, likes, dislikes, routines, triggers of behavioural decompensation, approaches to employ if the person is upset, etc.) with clinical staff, who then incorporate these strategies in their professional care.[4] **2. Dementia care pathways**.[9] **3.** The **48/6 approach**[3] : develop care plans to address needs in the following six areas: cognition/delirium (screening, prevention, treatment), medications, functional mobility, nutrition/hydration, bowel/bladder, and pain. Additions to the 48/6 approach would include an assessment of adequacy of sleep and assessment for mood disorders (e.g. depression and anxiety)—a **48/8 approach.**
Staff education, ongoing training, and support	Support staff with timely access to education and real-time frontline coaching (e.g. positive, caring, and slow communication strategies with patients to maximize collaboration and minimize behavioural issues; partnership with and guidance from caregivers; assessment of capacity to make specific decisions; best approaches during code white (violent patient code), etc.) as well as supporting staff in dealing with the emotional impact of dementia care to prevent compassion fatigue and burnout.
Dementia care expertise	Require services with dementia care expertise be present in the Emergency Department and available specialist services (e.g. Geriatric Medicine and Geriatric Psychiatry) with expertise in dementia care be available throughout the hospital. In addition to clinical care, these experts can also support staff education and real-time frontline coaching. Additions to previously published strategies would include: Develop Serious Illness Conversation guides specifically designed for persons living with dementia and their caregivers/care partners. Develop Palliative Care approaches specifically designed for persons living with dementia.
Non-pharmacological prevention and management of	Prioritize non-pharmacological behavioural prevention and management through the development of dementia care pathways/protocols, policies (including a policy of minimal restraints), and hospital-wide education and training.

responsive behaviours	Use medications as a last resort where non-pharmacological approaches are inadequate or where the person is an imminent risk to self or others, with subsequent review by specialists in dementia care who have expertise in the use of these medications given their potentially serious side effects. In terms of prevention of behavioural issues, attention should be given to the value of engaging the person in meaningful activity, including availability of tactile activities (e.g. activity boxes with objects that can be handled and manipulated), reading or visual materials, interaction with their Essential Care Partner, and engagement of recreation therapy and volunteers.
Individualized proactive discharge planning	Initiate early discharge planning, assessing both the patient and caregivers' /care partners' needs, engaging key community organizations, providing support and resources to caregivers, and clarifying goals of care and limits of care (advance care planning resources such as https://www.advancecareplanning.ca/ can be employed but do not yet have modules specific to dementia), and including the patient with dementia in the discussion whenever they are cognitively and emotionally capable of participating. In the context of a comprehensive strategy, acute care hospitals, community organizations, and long-term care should have the capability to effectively collaborate and communicate online to facilitate effective hand-offs during the discharge/transition process.
Supportive physical environment	Create an appropriate physical environment to reduce distractions, help orient patients, and minimize responsive behaviours (e.g. Dementia Enabling Environment Project https://www.enablingenvironments.com.au/). Recognize that simple changes such as labelling items, using whiteboards for messages, calendars, and clocks can all assist in helping to orient patients and minimizing responsive behaviours. In addition to upgrading or retrofitting existing hospitals, consider the above design features in the design of any new hospitals.
* While implementation across these elements may be incremental, the success of an acute care dementia strategy rests on the importance of making progress across all elements. The first two rows are essential to support the remaining elements.	

While acute care dementia strategies must eventually contain all the elements in Table 1 to be effective, the first two rows of Table 1 are critical to success. Most hospitals cannot accurately identify how many admitted patients have dementia.[10,11] Consequently, the impacts of dementia on hospital metrics (e.g. LOS, ALC) are nearly invisible to senior management and boards, and dementia subsequently becomes lost in a sea of other priorities and often becomes marginalized. It is therefore a challenge to secure corporate support to implement and evaluate even small-scale, low-cost interventions to improve dementia care. "Out of sight is out of mind" when it comes to prioritizing dementia care—this must change with better data systems that accurately measure the numbers of patients with dementia in hospital.

A small number of regions utilize CIHI and ICES methodology that better captures the impact of dementia on individual hospital LOS and ALC by employing multiple linked data sources. While capturing the number of persons with dementia in hospital more accurately than less-sophisticated hospital-based data systems, the information is often months or years old—this does not provide hospitals with the real-time data required to

optimize acute care dementia strategies. If hospitals were able to measure the day-to-day impact of dementia on their patient flow, hospital senior management teams would then recognize that it is essential to prioritize comprehensive acute dementia care strategies to improve patient flow, decrease ALC, and decrease hospital overcrowding. Accurate measurement would drive prioritization and policy.

Conclusion

As the population of persons living with dementia grows, we must make better hospital care of persons living with dementia a core part of hospital strategic plans if we hope to decrease hospital overcrowding and ALC rates. Making better in-hospital dementia care a priority will not be easy—we will need the vision, drive, and leadership skills of hospital VPs, CEOs, boards, and ministries of health to mobilize and guide necessary resources and expertise.

Unless hospital leadership and ministries of health start to recognize that improved care of persons living with dementia is critical to ALC reduction, ALC rates will rise, hospital overcrowding will worsen, and post-pandemic recovery will be severely hampered, placing Canadians of all ages at risk.

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