In this article...

- Description of the dementia activities coordinator role
- Report on a pilot of the role on an acute ward
- Results of the pilot

**5 key points**

1. Admission to hospital can be particularly distressing for people with dementia or cognitive impairment.
2. The disruption to their lives can lead to challenging behaviour that adversely affects other patients and staff.
3. A dedicated staff member providing activities and supporting patients in achieving their goals can aid person-centred care.
4. Activities can boost patients’ mobilisation and provide social and cognitive stimulation.
5. The role can reduce wards’ reliance on agency staff to provide one-to-one care.

**Person-centred dementia care in acute settings**

**Improving care**

The ward manager on an elderly care ward at Maidstone Hospital felt we could improve the experience of patients with dementia or cognitive impairment, and gained funding for the role of dementia activities coordinator. Although similar roles have been implemented in care home environments, acute hospitals tend to use volunteers as “befrienders” and “buddies” to provide some aspects of the role. We believe a designated role to incorporate social stimulation, activities, continuation of physiotherapy and exercise and support lunch clubs has not previously been used in the acute hospital environment.

A six-month pilot was funded and data collected as well as feedback from staff, patients and relatives to ascertain the impact of the role on the nursing care of patients with dementia or cognitive impairment during their stay on the ward. The aims of the role are listed in Box 1. Before the pilot, data was collated on:

- Number of “This Is Me” documents in

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A dementia activities coordinator role was created in an acute hospital environment with the aim of improving the experience of patients admitted to an elderly care ward who have dementia or cognitive impairment. Patient and carer feedback has confirmed the benefits of the role for patients and the increased confidence of carers in the support offered during hospital admission.

Approximately 42% of patients aged over 70 years with an unplanned admission to hospital have dementia; this rises to 48% in those aged over 80 (Sampson et al, 2009). In 2001, the National Service Framework for Older People pointed out that people over 65 years accounted for 60% of hospital bed days in the UK (Department of Health, 2001); up to 40% of these patients have dementia (Holmes and House, 2000).

Research by the Alzheimer’s Society (2009) suggests the prevalence of dementia in the hospital population increases with age. Carers reported that patients often deteriorate while in hospital, experiencing a worsening in symptoms of dementia and the development of physical health problems, including perceived weight loss, malnutrition and dehydration and a decline in mobility. The research also highlighted that carers reported patients becoming more confused, less independent and more distressed. This exacerbated behavioural and psychological symptoms such as shouting out. Other effects included a loss of communication skills, depression and a loss of confidence.

Patients with dementia experience poorer outcomes for all types of admission, stay longer and are more likely to be discharged to a care home than return home (Royal College of Nursing, 2014; Suarez and Farrington-Douglas, 2010; Alzheimer’s Society, 2009; Banerjee, 2009).

The RCN (2010) reported the effect of going into hospital can be overwhelming for patients who are frail, vulnerable or have dementia. They are often on the edge of their limits of coping at home in a familiar environment.

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Games can aid cognitive stimulation
Pre-pilot services

The use of bank or agency nurses to provide one-to-one care in the six months before the pilot cost approximately £25,000; these staff were used mainly to support patients with dementia or cognitive impairment who were exhibiting challenging behaviours.

At the time, patients ate meals at the bedside, and while support was given to those needing it, the environment was not conducive to encouraging nutritional intake. No additional exercise classes were offered, and physiotherapy resources were limited. No cognitive stimulation sessions were offered, while normal activity in a six-bed bay sometimes proved too stimulating or left patients bored. No patients with dementia had a “This Is Me” document.

The ward had a large day room, but this was rather bland and unwelcoming (Fig 1). It was also located slightly off of the ward and therefore not easily staffed so at the time was used only for staff meetings.

Staff were surveyed to ascertain what improvements they would like to see for patients with dementia or cognitive impairment and how they thought these could be achieved. The team were all keen to develop the dementia coordinator role and felt a lunch club would provide a stimulating social environment to improve patients’ nutritional intake and social stimulation. The physiotherapy team were willing to work alongside staff to assist patients undertaking repetitive practice of their goals and further support the continuity of physiotherapy. All staff felt the coordinator role would increase their awareness of the additional support needed by patients with dementia, and of the importance of carers’ support and involvement.

BOX 1. AIMS OF THE ROLE

- Improve the experience of all patients admitted with dementia or cognitive impairment
- Promote person-centred care by ensuring the use of the “This Is Me” document
- Promote cognitive stimulation through activities, for example puzzles, books, dominoes and memory cards
- Support the launch of the lunch club, to encourage oral intake and provide stimulation
- Continue physiotherapy goals set by the physiotherapist

The pilot

We used Dementia Challenge fund money to make the day room a homely and relaxing environment by adding colour and murals to the walls and purchasing comfortable furniture with contrasting colours (Fig 2). A bubble tube provides stimulation and relaxation, a music system and television helped to reduce the clinical feel and a board displaying the day, month and year assisted with orientation and helped patients to identify what activities were planned.

The use of bank and agency nurses to offer one-to-one care plus the cost of the coordinator for the six-month pilot cost approximately £15,000, reducing costs by £10,000. One-to-one nurses are now booked occasionally at night and weekends, but rarely on weekdays as staff feel they are no longer needed; patients with dementia are spending time with the activities coordinator and nurses have more time to dedicate to them.

Lunch clubs have been run on most days, with 325 patients with dementia attending over the pilot. The day room is more welcoming and makes patients keen to go there for meals. This has also benefited mobilisation. Previously, patients were often reluctant to “go for a walk”, but they are happy to go to the day room as they do not perceive this as exercise but for a purpose and structure to their day. The dietitians have seen improvements in patients’ nutritional intake and in the variety of food consumed. This has led to the introduction of tea parties in the day room for these patients.

Exercise classes were offered for seven weeks, with 69 patients attending. These were run in conjunction with the physiotherapists. The physiotherapy team saw a marked increase in patients achieving their goals, and also relish the opportunities to undertake group exercise sessions as they motivate and stimulate patients and enable physiotherapists to spend more time with them than they could previously. The activity coordinator is able to continue working with patients on their goals and encouraging them to mobilise.

Games and activity sessions were offered for nine weeks, with approximately 81 patients attending; sessions included seated ball games, bean bag games, puzzles, reading and bingo.

After-lunch activities, which ran for four months, attracted 255 patients; activities include watching films, sitting and chatting, reminiscing and crafts. Patients took great pride in making decorations for the room and Christmas tree – in addition to providing an activity, this gave them a purpose and sense of achievement.

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BOX 2. STAFF COMMENTS ON THE ROLE

“Were we all very supportive of the role, but were unsure how well it would work. It has surpassed all our expectations.”

“The coordinator is truly inspiring, we now feel these patients are getting the support and attention they deserve that we were struggling to provide on a day-to-day basis previously. Patients feel they have a purpose in the mornings – the only downside is when the service is not running as the patients miss it. However, we try to continue some aspects of the role at the weekends where possible.”

“Patients are looking out for the coordinator as they have got to know her so well, and will ask where she is if she is not around. If they have been on the ward for a while they also know that this service is not provided at the weekends and really look forward to Monday, which is helping orientate them to time and place as well.”

“Even if it is the first time you have met the patient, by having the ‘This Is Me’ document, provides a means to commence a conversation with somebody about something that is important to them, rather than beginning a conversation in a clinical format. This assists in gaining trust and confidence from the patients and they are more willing to continue to discuss other things.” (Therapist)

On average 74% of patients with a known diagnosis of dementia or cognitive impairment on the ward had a “This Is Me” document completed over the pilot – the remaining 26% did not because the patient or carer either did not want to complete the document or did not return it in time for audit.

Results of the pilot
The role has proved successful; the environment and atmosphere on the ward have changed considerably and morale has improved as staff have seen the benefits of the dementia coordinator. Box 2 lists some of the comments from staff about the role.

Challenging behaviour has decreased as patients are being stimulated and undertaking activities that help them to settle and give them a purpose; this is demonstrated by the reduction in bank and agency staff used to provide one-to-one care. Having a member of staff dedicated to them and a more structured routine has helped patients to settle and feel more reassured.

Most patients with dementia now have a completed “This Is Me” document, supporting a person-centred approach to care. Patients are seen as individuals, and a better knowledge of their past life enables staff to easily engage with them.

Length of stay on the ward has reduced and will be monitored along with discharge figures to see whether the dementia coordinator role has assisted with the timely discharge of patients with dementia. Some patients whose families had thought required residential care have been able to return to their homes thanks to activities improving their confidence and abilities.

Feedback
Patients and carers were given feedback forms to complete about the experience they had received or witnessed. Comments included:

“I would like to say a special thank you to the activities coordinator for the wonderful activities and lunch club, which was so good and stimulating.”

“A brilliant job organising activities for the patients in lunch club – my grandmother has perked up leaps and bounds since the club started and it has done her the world of good with battering boredom.”

“I was able to sit with my mother during these mealtimes and felt completely removed from the hospital routine, almost as though transported to a little oasis.”

Conclusion
The pilot surpassed all expectations and the dementia coordinator role is now supported by the patient experience committee and the trust board have also been supportive. As a result of the benefits of the dementia coordinator role it has been made substantive and is to be rolled out to other wards.

References
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Royal College of Nursing (2010) Improving Quality of Care for People with Dementia in General Hospitals. London: RCN

BOX 3. CASE STUDY

Marjorie Baker*, aged 87, was admitted from home after a fall. She arrived with declining interest in things around her and reduced nutritional intake. Previously she had mobilised well, was keen to read newspapers each day and interact with her daughter, and had a good appetite. Mrs Baker had been well supported by her daughter and family, but this was becoming increasingly difficult. Her daughter told staff that she was considering whether her mother now needed residential care, although she knew her mother did not want this.

During her stay on the ward, Mrs Baker’s confidence in mobilising increased and she progressed from requiring a roller frame to mobilising independently.

Although initially reluctant to participate in activities and the lunch club, she was soon making her way to the day room independently and staying all day. Due to the cognitive stimulation and sociable environment, she was soon eating three meals a day, with good size portions.

When discharge was discussed again, Mrs Baker’s daughter felt there had been such a significant change that her mother should be discharged back home. We gave her information about local clubs and services that could offer continuing support and maintain the stimulation and social element Mrs Baker enjoyed. Her daughter was also referred to a carer group for additional support.

The patient’s name has been changed.

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