How do peri-operative staff deal with patients who, beyond the challenges of having emergency surgery, are also struggling with the cognitive symptoms of dementia? How might a patient with dementia experience the peri-operative setting? This article explores the challenges of caring for people with dementia who have surgery and recommends ways to improve practice.

Dementia in the peri-operative setting

Up to 850,000 people in the UK are currently living with dementia, a number set to increase to 1 million by 2025 (Alzheimer’s Society, 2014). Dementia is considered an acceptable generic term encompassing a range of discrete diseases manifesting as reduced cognitive function across domains including attention, executive function, memory, language and perception (Alcorn and Foo, 2017). Dementia is associated with, but not restricted to, older people.

With a rapidly ageing population (Age UK, 2017), the chance of receiving patients with reduced cognitive ability in theatre departments is increasing. Many of these will be emergency admissions, as hip fractures make up a large proportion of the surgeries associated with this patient demographic. According to the Royal College of Physicians (2016), 37.5% of patients admitted for hip fractures in the UK in 2016 had reduced Abbreviated Mental Test (AMT) scores. A recent audit of emergency laparotomy indicates that >50% of patients were aged >70 years (National Emergency Laparotomy Audit Project Team, 2017).

Awareness among theatre staff

In many settings, hospital staff may be aware of dementia and its challenges, but the particular challenges in peri-operative care have not been so widely investigated. Many of the existing policies and protocols are not easily applied to the theatre setting (Edis, 2017) and, when faced with a patient who may not conform to expected behaviours, peri-operative staff seem to rely heavily on previous experience. This is not always helpful. Patients with dementia are
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not a homogeneous group – they are individuals who can be affected by cognitive impairment to varying degrees, alongside comorbidities that may further inhibit communication (for example, poor eyesight, hearing loss). Patients will present with a range of symptoms, each with their own distinct challenges for peri-operative staff.

Dementia education
Pre-registration nursing education may include an introduction to the care needs of patients with dementia; however, this is a relatively recent development so many nurses will have qualified without this input. Historically, educational input on dementia care varied significantly; Pulsford et al (2007) found that adult nursing courses contained between zero and six hours of dementia content and several higher education institutions did not provide any dementia content to students.

Post-registration theatre courses focus mostly on clinical skills and knowledge in scrub or anaesthetic disciplines, and do not generally include specific teaching on how to support patients with additional needs. The National Care Curriculum for Perioperative Nursing (Perioperative Care Collaborative, 2017) includes caring and support skills, but these are generic and not specifically geared towards patients with dementia or other cognitive impairment.

Staff who have recognised a need to improve this aspect of their practice through self-managed training may have studied core principles associated with the care of patients living with dementia (Skills for Care and Skills for Health, 2011) but these are difficult to apply to peri-operative care and in the peri-operative setting.

Published guidance
The Alzheimer’s Society provides a wealth of advice and publications to support people with dementia and their families or carers, but no specific guidelines for peri-operative care staff (Edis, 2017). In 2017, to improve the support of patients with dementia in hospital settings, NHS Improvement produced a dementia strategy – the Dementia Assessment and Improvement Framework (NHS Improvement, 2017) states that, to deliver outstanding care “the workforce [must have] the right knowledge and skills to meet the needs of people living with dementia”; however, there is no indication of how this might be achieved (or measured) in acute settings.

The framework specifically requires that all non-clinical staff are trained, but does not mention training clinical staff – it simply states they should have an adequate skillset.

The community-based Dementia Friends initiative (dementiafriends.org.uk), which staff may have accessed for themselves, is referenced, but only as a foundation level of understanding, and not training in itself.

Box 1. Limitations of the Dementia Assessment and Improvement Framework

- In its standard on workforce education and training, the Dementia Assessment and Improvement Framework (NHS Improvement, 2017) states that, to deliver outstanding care “the workforce [must have] the right knowledge and skills to meet the needs of people living with dementia”; however, there is no indication of how this might be achieved (or measured) in acute settings.
- The framework specifically requires that all non-clinical staff are trained, but does not mention training clinical staff – it simply states they should have an adequate skillset.
- The community-based Dementia Friends initiative (dementiafriends.org.uk), which staff may have accessed for themselves, is referenced, but only as a foundation level of understanding, and not training in itself.

- Avoiding post-operative reduced cognitive function;
- The possibility of interaction between anaesthetic drugs and a patient’s dementia medication;
- The need to account for comorbidities associated with advancing age.

Little has been written about the nursing care of patients in peri-operative settings and the realities of supporting potentially confused and distressed patients through a stressful episode in their hospital journey.

The development of specific guidance for the management of patients with dementia in the peri-operative setting could improve staff’s knowledge, confidence and competence, thereby helping to improve care in an at-risk patient group.

Compounding factors
For older patients, appropriate care planning or the use of care pathways should theoretically ensure adequate preparation ahead of the patient’s arrival in theatre. However, the reality can be very different: surgical care plans may arrive in the theatre department at the same time as the patient and information may be confined to clinical detail and patient history, without detailing any cognitive difficulties.

Dodds et al (2013) outlined the importance of undertaking a pre-operative assessment of cognitive function, which they deemed essential. They acknowledged that many patients in this demographic will access the theatre department as an emergency, in which case the routine, coherent pathway approach used in elective procedures is not always practicable.

A diagnosis requiring surgical intervention may be arrived at quickly – for example, in the case of a fractured hip after a fall – but other conditions may not be known until much later, partly because of the communication difficulties caused by dementia (Rance et al, 2015). Patients’ desire to not make a fuss and inability to articulate the location and severity of pain all contribute to them potentially being taken into theatre without optimal planning.

Patients with dementia are more at risk of comorbidities such as cardiovascular disease and chronic obstructive pulmonary disease (Alcorn and Foo, 2017), and have higher rates of post-operative complications (Hu et al, 2012). This can further complicate their care and limit the support the peri-operative team can provide.

Identifying patients
How would you know that a patient you are supporting through anaesthesia is also dealing with difficulties associated with dementia? Would this information form part of the team briefing prior to starting on the theatre list? Does your trust have a scheme to discreetly identify patients with a clear diagnosis of dementia, such as the Butterfly Scheme (butterflyscheme.org.uk) or the Forget Me Not initiative?

NHS Improvement (2017) recommends these schemes as useful ways of recognising when additional help may be required, but the recommendation only extends to having the identifying item above the patient’s bed, where only ward staff will see it. If it was added to the patient’s identification band or notes, for example, it would be more useful, as it would alert any staff coming into contact with the person that special adjustments may be necessary.

One concern with giving a label or identifier to patients with dementia, however, is that labels can produce stigma and encourage stereotypes, which can negatively affect interpersonal relationships (Garand et al, 2009). Krupić et al (2016) acknowledge that there are negative attitudes towards patients with communication deficits or behavioural disorders.

Attaching a single identifying symbol to flag up a condition that significantly varies in terms of presenting symptoms...
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may be problematic. Staff may find it helpful, but they will need to understand the range of difficulties patients may experience. Knowing simply that a patient has dementia may indicate very little about their individual needs.

Current schemes

Some hospital trusts describe themselves as ‘dementia-friendly’ (Dementia Action Alliance, 2012), but this will not change practice by default. The fact that somewhere, buried in case notes, there is a sentence saying that a patient has been diagnosed with dementia may not be helpful in a busy clinical environment.

The need for relatives or carers to repeatedly greet staff with phrases such as “Stella has a diagnosis of Alzheimer’s and may not be able to answer your questions accurately” can become frustrating. It is more compassionate for the patient and carer, if such exchanges started with informed staff saying something like “I understand, Stella, that you sometimes get confused over small details. Do you mind if I talk to your daughter as well?” This could be achieved with adequate information readily available to all staff and would go a long way towards allaying patients’ and relatives’ fears.

Many hospitals use the Alzheimer’s Society’s This is Me document (Bit.ly/ASThisIsMe) in which relatives and carers provide useful background information about patients with dementia. However, this does not necessarily inform care in all departments as it can often get filed in case notes, rather than being used in a dynamic way to inform staff in different departments. Edis (2017) indicates that this document does not always accompany patients to theatre and recovery.

As a theatre nurse or operating department practitioner, have you been able to use this document when welcoming a patient into the operating department? Or when trying to calm an anxious patient recovering from a general anaesthetic?

Preparing for surgery

For some people with dementia, the inability to make sense of situations can lead to frustration and extreme behaviours; the same can be said of encounters with health professionals in unfamiliar and frightening circumstances (Mahoney, 2014). In the past, management strategies have focused on getting patients anaesthetised as quickly as possible in an attempt to reduce stress – for teams as well as patients.

Tappen (1991) indicated that, historically, the belief was that patients with advanced dementia would not be stressed by impending events such as surgery, because they were apparently unaware of their surroundings. We now know that this is not necessarily the case. While some people with dementia may not understand or remember why they are in a certain situation, they are still capable of experiencing emotional distress (Alzheimer’s Society, 2015). This outdated belief did not take into account the wide-ranging levels of disability caused by dementia, and a ‘nothing-can-be-done’ approach does not represent holistic care of the individual.

More recent research by Krupic et al (2016) clearly indicates that, as well as having more time with the patient and a less-hurried approach to anaesthetic room procedures, a particular set of skills is required to communicate successfully with pre-operative patients who have reduced cognitive ability. These include:

- Patience;
- Empathy;
- A detailed understanding of how patients with dementia respond.

In patients with pre-existing cognitive impairment, general anaesthesia has been associated with an increased risk of post-operative cognitive decline (Funder et al, 2009). It is, therefore, not always the safest option for patients with dementia. This is slightly at odds with the RCP’s (2016) report on hip fractures, which indicates that 55.1% of patients with reduced AMT scores were given general anaesthesia – it raises the question of whether the practice of anaesthetising patients quickly to ‘reduce stress’ is still commonplace in some settings.

Regional anaesthesia should be the preferred option when it is practicable. When it is not possible or appropriate, exposure to anaesthetic agents should be minimised (Alcorn and Foo, 2017) and shorter-acting agents such as desflurane be considered. Further factors indicating the need to consider regional anaesthesia as the safest option for the patient include:

- Frailty;
- Poor nourishment;
- Significant circulatory comorbidities.

Regional anaesthesia has its own potential pitfalls; for example, spinal anaesthesia requires the patient to keep still in a given position. Asking a patient who may have forgotten where they are or why to stay still during a procedure involving local anaesthesia will require constant reassurance and reiteration of information, delivered without any sign of irritation at having to repeat it (Krupic et al, 2016). All theatre staff should have further training in the needs of people with dementia.

“Imagine being in a room full of strangers saying they need to inject something into your arm, while you have no idea how you got there or why. This may help you understand how a patient with dementia may feel in an operating theatre”

Other standard procedures

According to Funder et al (2009), other standard procedures in peri-operative care that may present a challenge include (but are not limited to):

- Gaining and maintaining intravenous access;
- Gaining consent;
- The patient not having properly fasted;
- Post-operative delirium;
- Pain interpretation and management.

For patients already stressed by being in an unfamiliar environment and potentially unaware of why they are in an operating theatre, being asked to submit to several invasive procedures may cause further anxiety. Many patients have been brought up to submit to healthcare interventions without making a fuss, but that relies on a cognitive ability to understand that short-term discomfort or anxiety may be necessary for long-term health or wellbeing. When this ability to rationalise has deteriorated, patients may – validly and appropriately – respond by retreating to innate defence mechanisms and refusing to cooperate.

Imagine being in a room full of strangers saying they need you to let them inject something into your arm, while you have no idea how you got there or why. This may help you understand how a patient with dementia may feel in an operating theatre.

Non-verbal communication

A key skill for supporting patients with dementia is effective communication. This requires time, patience and gentleness – all of which may be difficult to find within the pressures of a busy theatre list. Non-verbal communication skills are paramount, both in sending the correct message to patients and reading their non-verbal responses – which will generally be more accurate than their words.
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Box 2. Improving peri-operative care for people with dementia

There are potentially three actions that, if combined, could contribute to meeting the care needs of peri-operative patients with dementia:

- Hospitals that deem themselves dementia-friendly to commit to increasing the visible effects of such an undertaking by investing in education and some simple measures as described here to support patients with dementia and their carers
- Incorporating into practice a tactful way of informing staff of the patient’s cognitive condition that is effective at the point of engagement – something as simple as putting the Forget Me Not logo on the patient’s identification label is unobtrusive and enables all staff to make any adjustment needed
- Ensure that staff have adequate training so that they understand the wide range of additional requirements patients with dementia may have and know what strategies to use to respond to these

Patients may become withdrawn or disengaged but this is not necessarily due to reduced cognitive ability; it may be a normal psychological response to a distressing situation. While compassion, patience and positive regard may be important for all patients, they are paramount when dealing with those who have lost their inbuilt psychosocial compass due to dementia’s dehumanising effects (Mahoney, 2014).

When addressing someone with significant cognitive impairment, staff should be even more aware of the need to convey warmth, compassion and acceptance in a non-verbal manner (Krupic et al, 2016). This is what a person with dementia will notice, rather than the content of the verbal message you are delivering. Imagine, for example, needing to welcome a patient into the department while trying to process negative feelings caused by a surgeon just being rude to you. How can you be sure your body language will echo the friendly verbal greeting you address to the patient, rather than give away your thoughts and feelings?

Cognitive impairment

Verbal expression is one of the more obvious difficulties for people with cognitive impairment. They may struggle to find the right word when asked to reply to questions, especially complex or quick-fire ones. Less visible but equally relevant difficulties are the inability to process abstract ideas and deal with new information.

Tappen (1991) explains that much of what nurses or health professionals need to share with patients is complex and unfamiliar, even to fully cognisant patients. For patients with dementia, long and complicated questions may result in them having forgotten the beginning of the sentence by the time they are expected to answer. The usual practice of asking open-ended questions requiring more detailed answers is not always appropriate. A standard question such as “How are you feeling?” may elicit little response, as the patient is trying to process exactly what information you require. Closed-ended questions using simple language (“Are you cold?” “Does it hurt?” “Are you OK?”) are often more appropriate – but even these can be fraught with difficulties. Krupic et al (2016) quote a study participant who said: “Sometimes I ask ‘Are you in pain?’ and the patient responds ‘Where is my mother?’”

Psychological support – for example, through comforting touch and effective non-verbal communication – should help patients feel cared for rather than attended to, and this is likely to reap rewards in terms of adherence to, and engagement with, their treatment.

Changing practice

Change in practice always has to start somewhere and often starts with a question: what can I do about this? Box 2 outlines three actions that, if taken together, could contribute to meeting the care needs of peri-operative patients with dementia.

An increased awareness of the varied needs of people living with dementia will enhance peri-operative nurses’ ability to provide effective care to these patients when they present for surgery. Effective care plans or integrated care pathways may be of some use when preparing these patients to undergo elective procedures but, given their demographic, a substantial proportion may arrive in theatre for emergency procedures so staff will have little prior information about them.

An ability to respond to the individual needs of the person in front of you is a good starting point and a solid understanding of what needs this cognitively impaired person may have is paramount. As Krupic et al (2016) explain, you cannot assume that this person is just ‘an ordinary patient with dementia’ – there is no such thing. NT

References

Alcorn S, Foo I (2017) Perioperative management of patients with dementia. BJU Education; 17: 3, 94-98.
NHIS Improvement (2017) Dementia Assessment and Improvement Framework. Bit.ly/NHIS-Dementia

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● A ‘VIP pathway’ for vulnerable people receiving elective surgery Bit.ly/NTVIPPathway