Meeting Date	**10 January 2022**	**Agenda Item**	
Report Title	**Memory Impairment Advice Team; Pilot Update Report**		
Report Author	Sharron Price, Head of Nursing Adult Services		
Report Sponsor	Lesley Jenkins, Group Nurse Director		
Presented by	Lesley Jenkins, Group Nurse Director		
Freedom of Information	Open		
Purpose of the Report	To provide and update and evaluation on the pilot of the Memory Impairment Advice Team at Neath Port Talbot Hospital(June 2021 – December 2021)		
Key Issues	• Effective and safe care of patients with memory impairment; • Person centred assessment and effective therapeutic approaches to care; • Increasing staff knowledge and skills; • Reducing harm from falls; • Reduced incidents of violence and aggression towards staff; • Improving patient and staff experience.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐
Recommendations	Members are asked to: • **To note the report**		

MEMORY IMPAIRMENT ADVICE TEAM

1. INTRODUCTION

The paper will provide a six month evaluation and update a pilot to introduce a Memory Impairment Advice Team at Neath Port Talbot Hospital.

2. BACKGROUND

The Memory Impairment Advice Team (MIAT) commenced on 1st June 2021 at Neath Port Talbot hospital in response to concerns that the approaches to care for older people within our hospitals at times increased the incidences of expressive behaviour and did not allow for individualised care plans for those who may have cognitive impairment.

- It is estimated that Dementia costs the UK economy £26.3 billion a year and there is an estimated 25% of acute beds occupied by people with dementia. The Welsh Government Dementia Action Plan for Wales (2018 – 2022) aims to embed a rights based approach to the care of people with dementia admitted to hospital.
- Admission to an acute hospital can be both confusing and frightening for a person with memory loss or cognitive impairment, and whilst they may need in-patient hospital treatment the negative impact on the physical, mental and cognitive abilities can be significant. Admissions often leads to an increase in behavioural and psychological symptoms and for patients with dementia there are risk of poor outcomes and higher incidences of harm and further cognitive impairment. (Herman et al 2015)
- The pilot was launched on 1st June 2021, as a 6 month service development based at Neath Port Talbot Hospital. The aim of the service was to provide advice and support to the ward teams to enable individuals to participate in daily activities, addressing expressive behaviour which can be often indicative of unmet needs. The team also aimed to develop the knowledge and skills of the wards multi-disciplinary team regarding cognitive impairment.
- MIAT is an initiative to provide specialist nursing and therapy advice, providing assessments and recommending interventions for this group of patients. Providing targeted education to the multi-disciplinary teams.
- The funding of the service has come from repurposing existing resources within the Service Group and agreement to provide some funding “at risk” to support the initiative.
- The team consists of 1 WTE Band 6 Occupational Therapist (OT) with specialist skills in Older Persons Mental Health and 0.8 WTE Practice Development Nurse (Mental Health) which are funded from existing establishments and 1 WTE Band 3 Senior Health Care Support Worker (HCSW) (unfunded post)

- The Team were unable to recruit into the 2nd Band 3 Senior HCSW post due to lack of availability of suitable candidates. This individual came into post during September 2021
- Referrals came from ward nurses, therapists, medical teams and via team attendance at board rounds and review of enhanced observation bays.

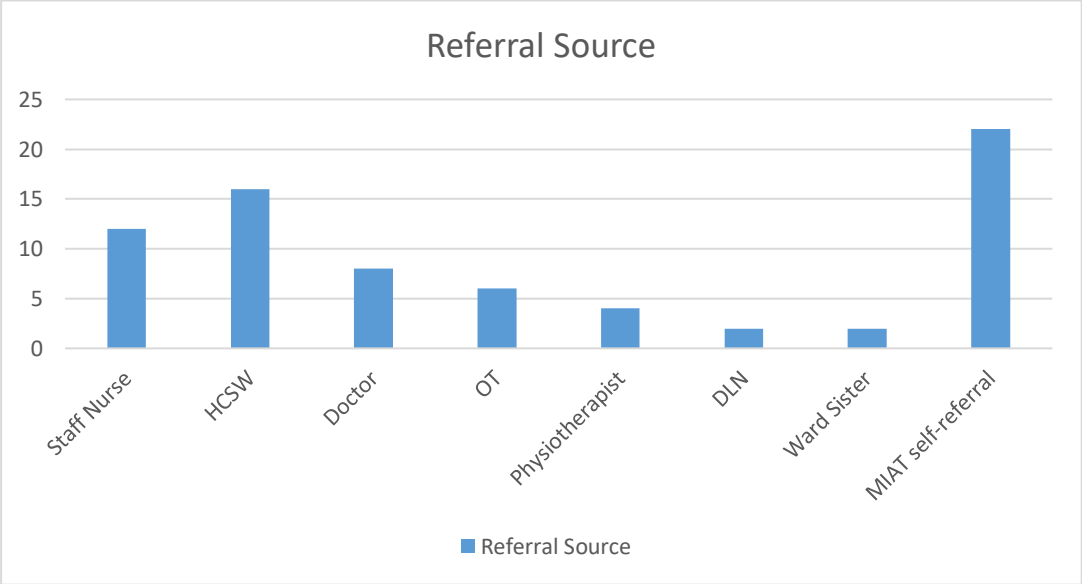
3. ANALYSIS

3.1 REFERRALS

The referral pathway into the MIAT team has been somewhat problematic, with ward teams either not identifying patients who required support until expressive behaviour had become very difficult to manage, or not recognising patients who would benefit from further assessment and input from the team.

Referrals are completed either via paper (designated box on each ward for staff to fill in and MIAT to collect), verbally or received via email.

During the pilot there have been 73 patients referred with assessment and advice given.



The team identified the majority of patients by using the medical buzz (a safety huddle with the medical matrons and ward sisters held at 830 am), There have also been referrals from Staff Nurses and HCSWs. Developing relationships with the ward staff and multi-disciplinary team (MDT) has been key in identifying patients who would benefit from assessment. (Referral form Appendix 1)

3.3 Outcome: Increased cognitive assessment and advice

Of the 73 patients referred to MIAT, none had any form of social history taken prior to assessment and intervention, despite the knowledge of the Butterfly Scheme within the hospital.

The team have undertaken 123 assessments during the pilot period.

Patients have been assessed using:

- Crichton Royale Behavioural Rating Scale,
- the All Wales Nursing Acuity tool (via the Enhanced Observation Framework)
- Pool Activity Level (PAL) (which provides a comprehensive assessment of function and self-care and is a framework for providing activity based care for people with cognitive impairment)
- Personal Activities of Daily Living Assessment (PADL)

Summary of assessments undertaken:

- 64 patients were assessed using the Crichton Royale Scale

Of those, only 6 patients had a deterioration in score, those patients have been identified as requiring specialist Mental health Intervention or end of life care, 15 had no change in score and 32 patients showed an improvement in the level of dependency assessed. (Appendix 2)

- 26 PAL assessments have been carried out between June-December, and where the PAL has not been appropriate, the Reach Out to Me document has been completed.

- 15 ROTM since commencing the pilot

- 11 patients have received a PADL assessment between June-December and these have been repeated to measure any changes in performance pre and post recommendations which is reflected within the Crichton Royale Behavioural Rating Scale.

- 7 patients have been assessed Allen's Cognitive Level Screen (ACLS) which is a more specialist assessment undertaken by the Occupational therapist. This assesses estimated cognitive functioning level and likely care needs on discharge.

3.4 PATIENT REPORTED OUTCOME MEASURES

A number of outcomes were identified within the proof of concept to measure success and demonstrate quality improvement. As part of the evaluation these outcomes have been reviewed

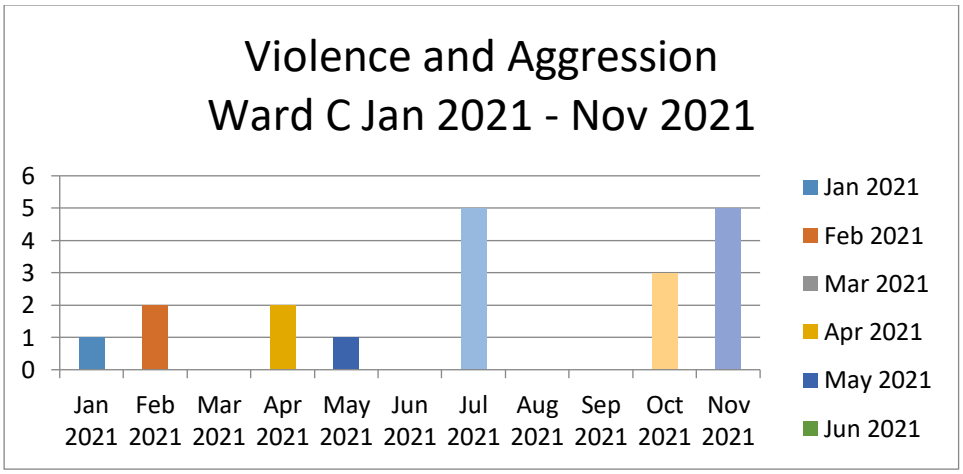
3.4.1 Outcome: Decreased expressive / challenging incidents. Reduced incidents of violence and aggression towards staff

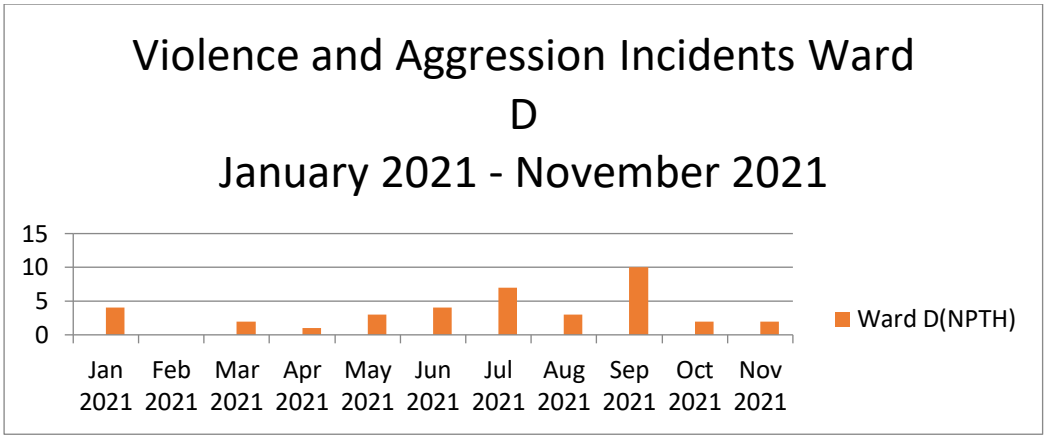
The numbers of incidents towards staff has fluctuated throughout the period, the team have been able to review Datix incidents and where there are peaks in reporting activity relating to Violence and Aggression (V and A) towards staff, the incidents can be attributed to specific patients.

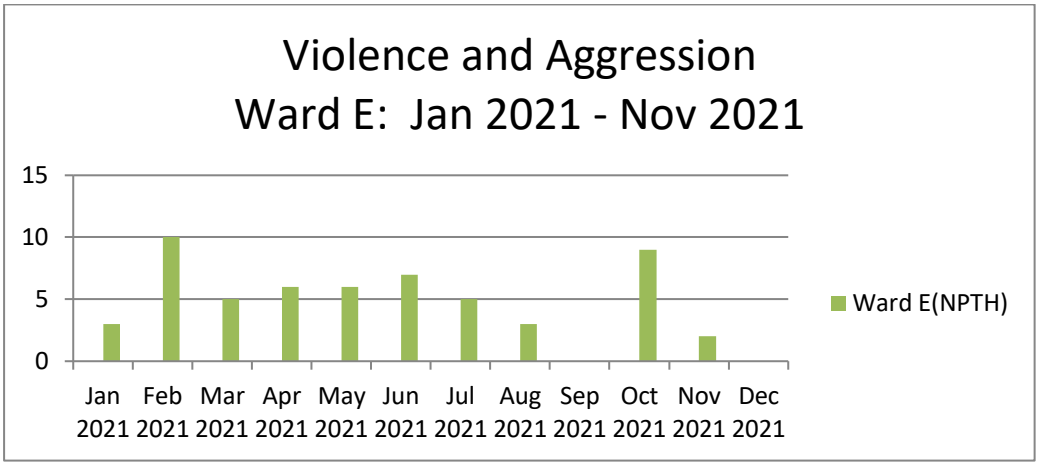
The team are able to intervene and reduce the expressive behaviour and there are examples where as a result of the team's intervention the patients have been transferred to more appropriate mental health services for care.

Patients who displayed increasing expressive dangerous or elevated behaviours, MIAT have referred to the appropriate mental health teams for review.

4 following assessment were referred to and transferred to Cefn Coed Hospital. All assessments and paperwork are sent with the patient.







3.2.3 Outcome: Reduce level of enhanced supervision, length of enhanced supervision, reduced restrictions and deprivation of liberty

Patients are assessed as part of the Enhanced Supervision Framework against the All Wales Levels of Care. Additionally as part of the team's data collection patients who were or were not detained under the Deprivation of Liberty Safeguards were noted.

During the pilot it was noted that reductions in level of care are impacted largely by the patient being a high falls risk without supervision. This has been difficult to influence to reduce LOC due to risk adversity regarding falls.

There has been a decrease in patients requiring:

- **Level 5** care from 14 to 2
- **Level 4** care from 19 to 14
- There has been an increase in patients requiring **level 3** care, which would be expected with the reduction in the higher levels of care. (Appendix 3)

3.2.4 Outcome: Decreased harm from falls

Whilst there is not an evident reduction in the overall falls data, there have been several individual patients where MIAT intervention has reduced falls. Where a patient

is identified as a high falls risk, the MIAT provide advice on the impact of footwear, lighting, the environment and a person's abilities (mobility, vision etc.) on falls and advice on strategies to prevent falls as much as possible.

There have been a number of patients who had experienced multiple falls and following assessment and intervention did not fall again during the admission.

Advice has also been provided on positive risk taking, encouraging patients to be more mobile and engaged throughout the day with the aim to reduce deconditioning in hospital. The OT completing PADLs has been extremely valuable in maximising patient's potential, where it has been identified that some patients who were nursed in bed were able to have a strip-wash in the armchair and sit out for longer periods of the day (see quantitative data outcomes in Crichton Royal Behavioural Rating Scale pre and post).

Whilst this enabling approach has increased their functional independence and improved their engagement, it has exposed more patients to falls which may have contributed to the mixed data – as well patients' changing medical status, co-morbidities and the progressive nature of Dementia. Falls Data can be seen in appendix 4

3.3.5 Outcome: PREMS (Patient reported experience measures) Improved patient / carer experience

There have been a number of activities introduced using the band 3 Senior HCA to support improved patient experience, examples of these are:

- Book Club

In December- 11 books, 23 magazines, 4 puzzle books and 1 photo copy of a team own book has been provided.

100% of patients of who was offered a questionnaire stated that they liked the book club, all patients stated that their wellbeing improved and that their hospital stay has improved.

- Music groups

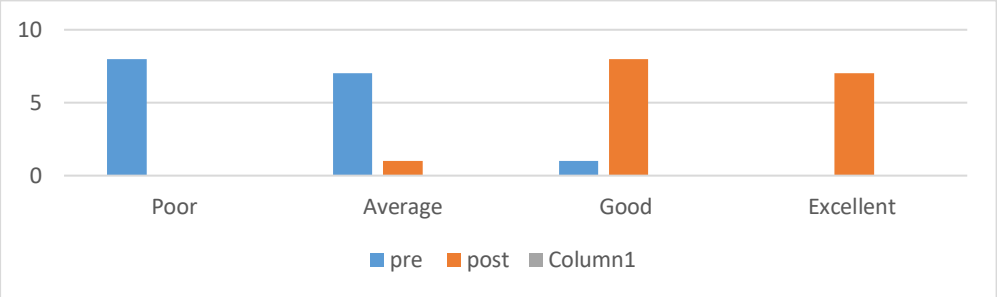
The overall mood and wellbeing improved from average to excellent using the quality of life questionnaire pre and post groups.

MIAT Quality of Life Survey

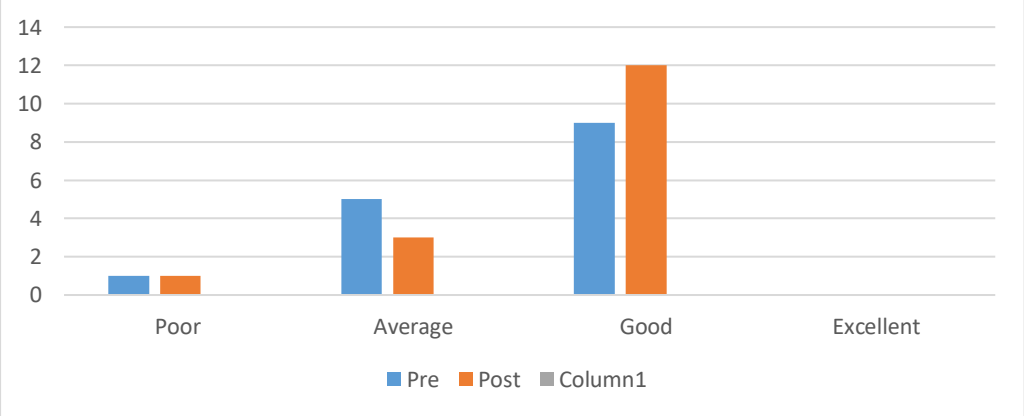
Appendix 5 shows the quality of life survey which is completed pre and post an individual or group activity. This can be completed with the patient, family member or staff member.

The feedback provided from patients and their families has been overwhelmingly positive, and demonstrates that the majority of the patients felt that their mood/wellbeing improved, that meaningful activity is essential to their stay in hospital.

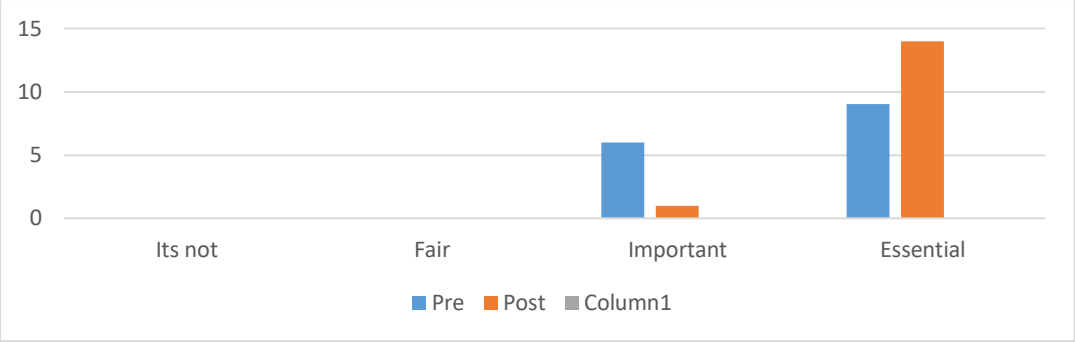
1. How would you describe your overall mood/well-being today?



1. How do you rate your opportunity to engage in meaningful activity during your stay in hospital?



1. How important in meaningful activity to you?



Appendix 6 has captured some case studies demonstrating the benefit patients have experienced as a result of the teams intervention

3.3.6 **Outcome: Improved Staff experience**

Staff feedback has been captured both formally (following training) and informally after advice and interventions provided by the team. Some comments from staff are detailed in appendix 6

4. RECOMMENDATIONS

R1. Continuation of the service utilising the Band 6 OT and Band 6 RMN within their substantive posts;

R2. Review the Job Description and role of the band 3 Senior Health Care Assistant to encompass activity co-ordination;

R3. Support at risk funding of the band 3 for a further 6 months pending the CSP service changes;

R4. Include the role of the HCSW - activity coordinator into the future rehabilitation model of care.

5. FINANCIAL IMPLICATIONS

The RN and OT are established substantive posts.

The continuation of 1.78 WTE Band 3 HCAs working a 7 day week for the 6 month duration of the project will cost £26,415.

No backfill of the registered posts is required to continue with the project.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

- Rights based approach to the care of people with dementia admitted to hospital. Improving patient, relatives and staff experience of care of the cognitively impaired patient.
- Improving quality outcomes and reducing variation in care.
- Reducing bank and agency

Financial Implications

A cost of £26,415 has been identified for the project to employ 1.78 WTE Band 3 Senior HCAs,

Legal Implications (including equality and diversity assessment)

None identified.

Staffing Implications

Recruitment and training and competency development of to 1.78 WTE Band 3 Senior HCAs for the team.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

No impact.

Report History	First report.
Appendices	None

Appendix 1

Memory Impairment Advice Team

Referral Form

*Please note **any staff member** can complete the referral. Please send/provide to Loren.Evans@wales.nhs.uk AND Nia.Lewis7@wales.nhs.uk.*

Patient name: **Ward:**

DOB:

NHS no:

NOK & contact details:

Diagnosis/History of Presenting Condition & Past Medical History

Reason for referral- please tick (please provide as much relevant information as possible)

Level 4 ☐ Level 5 ☐ High acuity bay ☐ sleep disturbance ☐
Resistive upon intervention ☐ Restless periods ☐ expressive behaviour ☐
Need for meaningful engagement ☐
Any further information:

Priority (please underline)

Urgent Routine

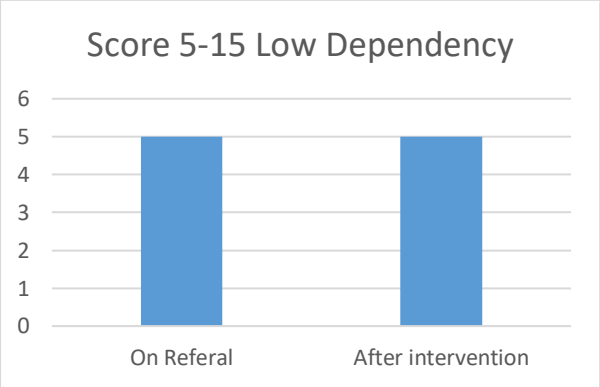
DOLS in place (please underline)

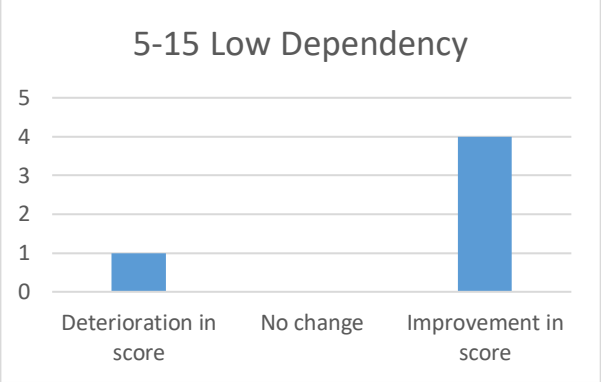
Yes No Date sent:

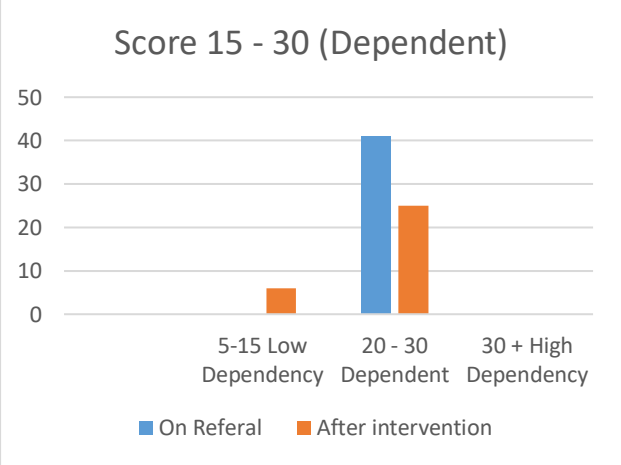
Completed by:

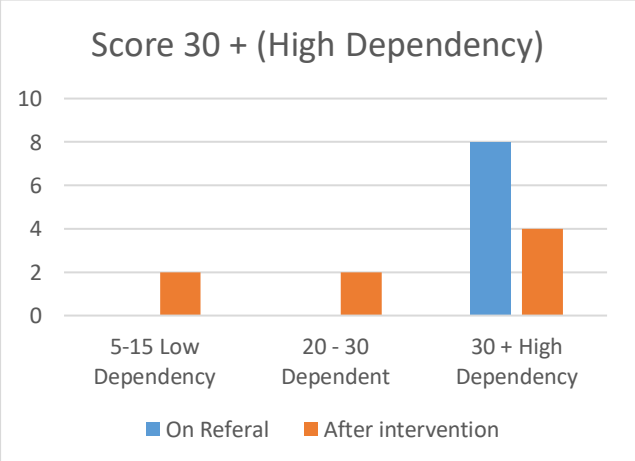
Name: Designation: Date:

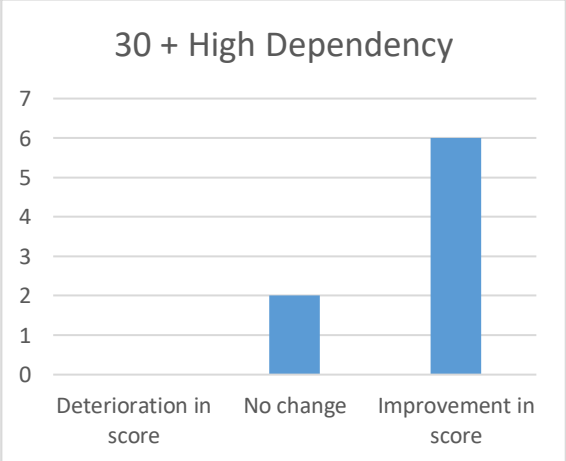
Appendix 2 – Outcomes from Crichton Royale Behavioural Scale



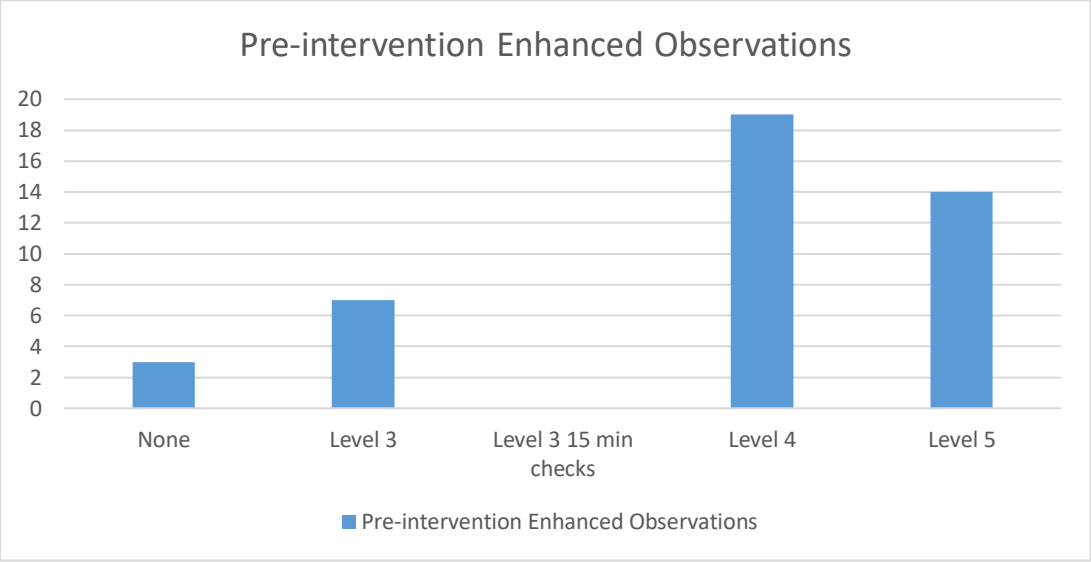


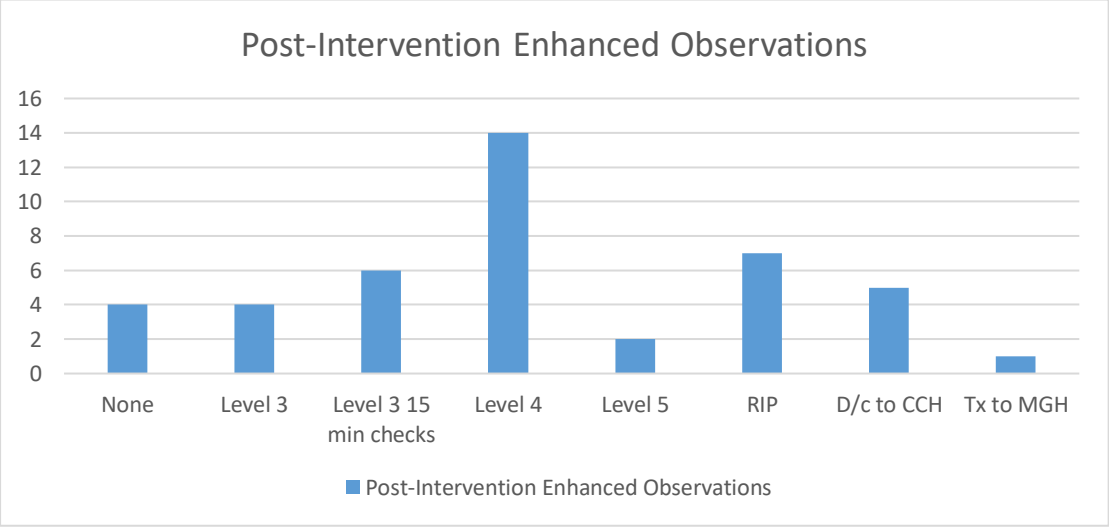




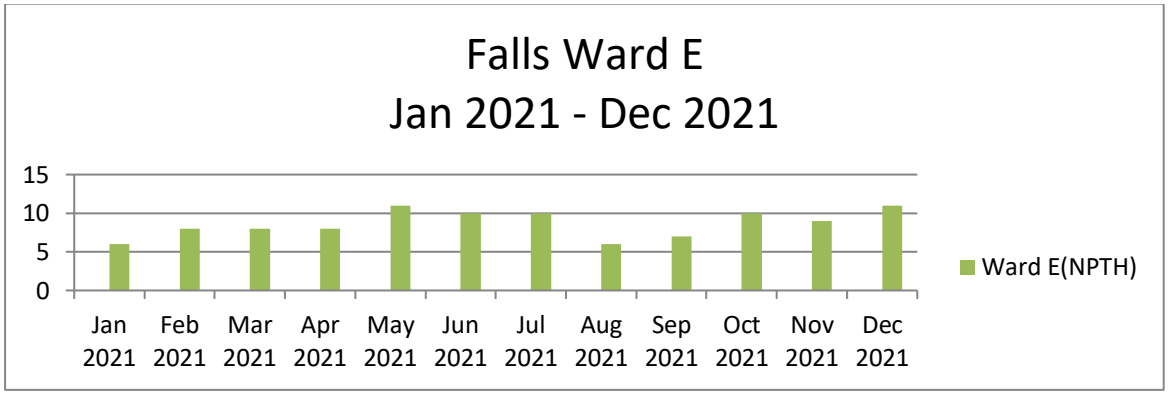


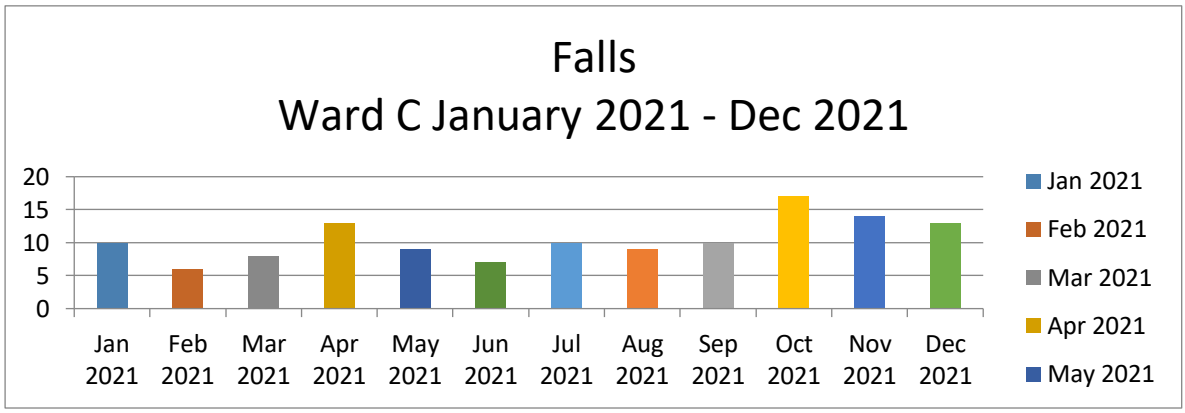
Appendix 3 – Levels of care

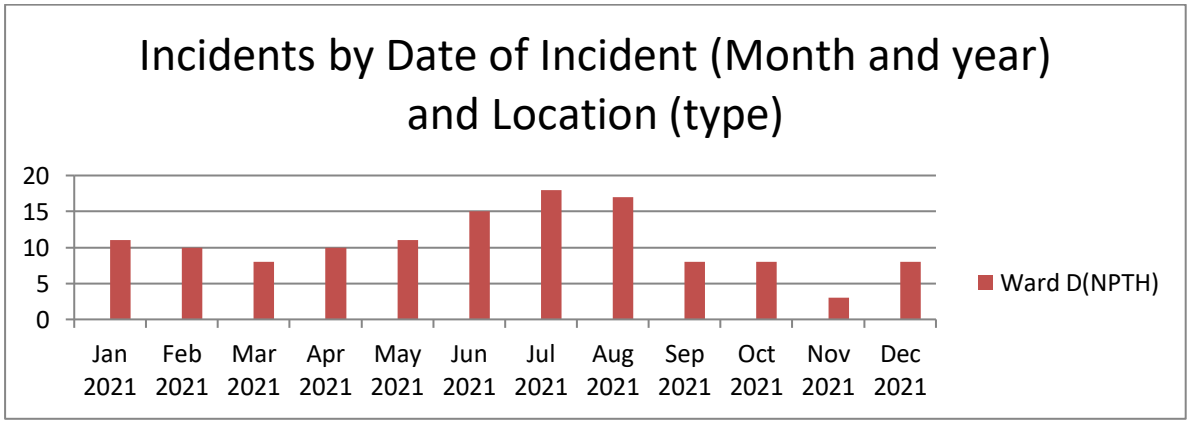




Appendix 4 – Falls Data







Appendix 5

Quality of Life Survey

Memory Impairment Advice Team

1. How would you describe your overall mood/well-being today?

Poor	Average	Good	Excellent

2. How do you rate your opportunity to engage in meaningful activity during your stay in hospital?

Poor	Average	Good	Excellent

3. Why?

4. How important in meaningful activity to you?

It not	Fair	Important	Essential

5. How do you feel after spending time with us?

Appendix 6

Case Studies

Patient 1.

Purpose of this case study

The purpose of this case study is to recognise the importance of meaningful activity for a patient and how it has an effect on their mood, quality of life and their overall presentation on the ward with the aim for a speedier and appropriate discharge and to make their stay in hospital as pleasant as possible.

Why this patient

DC was initially referred to the team on the 21st July 2021 for 'aggression upon intervention, unable to distract and de-escalate'. At this time DC would not engage, was very tired and was not appropriate for the service.

DC then went to SGH and come back to NPT and was referred to MIAT on 25/10/21 for sleep disturbance, expressive behaviour, resistance upon intervention and restless periods.

DC has a diagnosis of dementia also severe SVD with cellular atrophy and has been in secondary care since 3/5/2021 and has requires EMI nursing care, as a team we believe that DC can be managed in a general nursing home with the correct care plan and the DLN team have reassessed. Our mission is to discharge asap to the appropriate care setting.

Setting the scene

DC has had various assessments by MIAT including a Pool Activity Level Profile & social history, Crichton Royale Behaviour Rating Scales, Quality of life Survey and a PADL assessment. The assessments were completed to complete an advice form to provide the best care possible for DC.

MIAT B3 is currently provided 2 x weekly therapy sessions which has including sensory garden activity, family photographs, pictures of flowers in his room which has appeared pivotal in DC decrease in expressive behaviour and more engaging in personal care.

Outcomes

Since providing advice and therapy there has been no datix for v & a, reduced documentation for being resistive upon intervention, better engagement and DC family feeling apart his care and his daughter stating 'its nice that someone is actually treating him as a human being'.

Flow team is also looking at general nursing homes instead of an EMI placement which in turn opens up more options for care, reduced costing for the health board and better quality of life.

CR has decreased from 30 to a 27- restlessness and co-operation has reduced.

Two quality of life questionnaires have been completed which shows the impact of meaningful activity has on DC life, please see appendix 1 & 2

Staff Feedback

Please see appendix 3.

MIAT reflection

To have identified the need to input earlier on in DV first admission – however- the MIAT was not fully established at that point.

Following intervention

Staff appear to be engaging well with DC and understand the need for meaningful activity to have a benefit on DC care and quality of life. DC family have provided resources for activity. DC appears a lot happier in himself.

Patient 2.

Purpose of this case study

The purpose of this study is to evidence that if a situation can be appropriately de-escalated by having the knowledge of a patient's social history and the understanding of expressive behaviour that a non-pharmacological approach can be used instead of medication (oral/IM) to calm a patient.

Why this patient?

HE was admitted to NPT on the 11th May 2021 due to having an unwitnessed fall at home and her mobility was poor. HE has a diagnosis of Alzheimer's and various other co-morbidities which contributed to her presentation on the ward. HE on a DOLS. I chose this particular patient to evidence as HE displayed unpredictable expressive behaviour over a 24-hour period and every day would be different scenario; depending on HE mood that day. HE pushed the team out of their comfort zone with distraction and de-escalation techniques as it was a thinking on our feet exercise and it was opportunity to role model our skills to ward staff in hope that it would be used in future episodes of expressive behaviour. The MIAT team advocated for HE on many aspects of her life and we believe that our input and role modelling influenced a positive approach to her care and discharge.

Setting the scene.

HE was referred to the MIAT for increased agitation, incidents of V & A and dis-engaging with ward staff.

MIAT undertook various assessments to provide guidance and advice to the ward. This included an in depth social history finding (using the PAL) and measurable data of HE presentation on the ward (using the Crichton Royale Behaviour Rating Scale).

Prior to intervention HE had 1x datix for V & A and 0 post advice. Also, HE had 2x fall datix prior and 1 post advice.

HE was a very sensitive lady and could become tearful out of the blue and wouldn't always express why- it was identified staff to initiate conversation about this.

HE was religious and enjoyed singing church hymns, colouring and bingo.

MIAT also identified a pattern to expressive behaviour- as HE would not drink much over the weekend, which in turn would cause de-hydration and therefore expressive behaviour would be exacerbated at the beginning of the week.

Scenario

MIAT (RMN & OT) attended ward to review HE as when reviewing nursing notes it stated that HE had had poor fluid intake over the weekend and we expected a display of expressive behaviour.

On attending the ward there was an increased amount of staff at the end of the ward, louder than usual and we were ushered by a HCSW stating that HE is 'kicking off' and they are going to 'IM her'. Due to HE being on a DOLS and a frail elderly lady we had to intervene and advocate for this lady.

Initially we observed- there was a female doctor, staff nurse (with visible medication in a pot in her hand), 3x hcsw and 3 fellow patients in the bay. The doctor was attempting to reason with HE-however- due to the nature of her personality HE completely disengaged and was refusing treatment.

We overheard the doctor say to the staff nurse draw up IM lorazepam (HE was sitting in the chair, slightly agitated- however did not appear to be a risk to herself or others).

MIAT approached the scene and asked could we please try to de-escalate the situation before medication is used.

The doctor stated 'good luck- you need it' and left.

We asked the hcsw to leave and the nurse observed out of eye view from afar.

RMN sat at eye level and offered her hand to HE while OT played hymns on her phone quietly. RMN entered HE reality and told HE that RMN was on her side and that I am here to keep her safe. HE remained agitated however, could visibly see that HE was tiring and was engaging with the music.

HE then stated 'F**k this, I am going to bed'. HE stripped down to her pants, and went into bed and went to sleep.

At that moment NO medication was used- pure social skills, patience and knowing the patients background.

We retuned a few hours later- HE was dressed, having a drink and a biscuit.

MIAT Reflection

Nothing- we advocated for the patient, we followed our own advice that was provided for the ward and succeeded in our aim for a non-pharmacological approach to de-escalation.

We hope that we role modelled that knowing the patient and being kind and in the patients world is much more beneficial than medication in this situation.

Following Scenario

HE continued to have expressive episodes- however, staff were identifying her triggers and engaging before it escalated to aggression and the need for intrusive medication. Off listed from service, however, on visiting the ward HE was much more calm, engaging well and usually participating in meaningful activity.

Patient 3

Purpose of this case study

The purpose of this case study is to recognise that approach of staff to a patient can have a massive influence on their co-operation when intervention is being undertaken.

Why this patient

PL was referred to MIAT on the 18th July 2021 due to expressive behaviour during personal care tasks and any hands on intervention. PL was being nursed in bed by two members of staff due to apparent risk of violence to staff during intervention and in turn, PL was not engaging with physiotherapy. PL had a diagnosis of Vascular Dementia and was assessed to lack capacity however was able to communicate well and clearly. PL also had multiple co-morbidities increasing his frailty, including Stage 4 Kidney Failure and he suffered with global pain. MIAT accepted the referral with the view of providing assessment and advice on approaches to care to reduce expressive behaviours on intervention.

Setting the scene

PL required an advocate to promote an enabling approach towards his care; maximising his independence and role modelling that a kind and open approach to care upon intervention can be successful with the right skills and understanding the core of your patient.

PL was known by staff to be aggressive, hostile upon intervention and sometimes 3 members of staff would provide care to him. MIAT completed various assessments including a Personal Activities of Daily Living (PADL) (OT completed alongside a ward HCSW), the Crichton Royale Behaviour Rating Scale, PAL History Profile & action plan to provide advice to ward staff.

The PADL demonstrated that with an enabling approach, PL was able to attend to the majority of his personal care/toileting needs with minimal assistance whilst sat out on his armchair. It evidenced that through explaining each step of task and being patient,

PL felt in control and that his dignity was upheld; resulting in very little expressive behaviour being displayed. In turn,

Through completion of the PAL, we were able to identify that PL had always been a very proud gent who was an introvert and highly valued privacy, and therefore receiving support with personal care was very sensitive and a trigger for him. We were also able to gage appropriate conversation starters for staff to utilise during intervention to provide a distraction and comfort him.

In addition to this, RMN had numerous conversation with ward doctor about medication and showing team members appropriate body stance when there is a risk of hurting themselves.

Outcomes

PL remained on level 4 on enhanced observations, despite MIAT advocating that he could have been trialled at a level 3 as expressive behaviours only ever occurred on intervention.

PL had one v&a datix prior to MIAT intervention and zero after and no falls prior to advice with one reported after due to him being more active and independent. There was reports of V&A stated in the nursing entries, however, none datixed and no evidence of MIAT advice being trialled or followed in these instances.

Family appreciated input from MIAT – felt we were an advocate and a voice for their father when he could not use his and advised we "sussed him down to a T."

SW feedback following BIM - Yes, I definitely found it very helpful. The level of understanding, for individuals with cognitive impairment, was much more in-depth which in turn, allowed for a different approach and understanding of better ways of engaging individuals with Dementia – what works well and what doesn't work so well. I particularly found it very helpful that you focused on what the individual can do, and **how** this can be promoted and encouraged despite the memory difficulties, rather than what the individual cannot do.

CR outcome reduced by 3 from 23 to 20- improvements in washing & dressing, mobility and co-operation.

Prior to intervention, PL would spend most of his time in bed. Through completing PADL and functional assessments, we were able to encourage PL to sit out in the chair and actively participate listening to his favourite music and small bursts of activity. OT also encouraged the Physio to encourage PL to walk- in which he did. OT also participated in BIM and advocated for PL that with the correct approach PL could be managed in a general NH not EMI.

PL sadly became medically unwell during and passed away before discharge.

MIAT reflection

MIAT was in the early phase of its pilot and it was a change for MDT to have input from a team that was newly implemented. There was resistance from staff- who believed that PL behaviour would not change and that our advice wouldn't work

despite role modelling and proving that change in approach would work. MIAT provided quality of life to PL, was an advocate for him and provided the ward with the tools they needed to provide holistic care for him.