

DEMENTIA: ASSESSMENT AND PRACTICAL MANAGEMENT

YP Shukla, Clinical Assistant in Psychiatry
Royal Lancaster Infirmary

As outlined in my previous article 'Dementia and mental health services for older people in the Lancaster district'⁽¹⁾ the assessment unit for sufferers of organic mental health disorders is based at Gaskell Unit, Royal Lancaster Infirmary. This unit was, until April 1998, sited at Lancaster Moor and is still part of the Bay Community NHS Trust.

The unit provides short-term admission assessment for elderly people in the Lancaster district, over the age of 65 years, with mental health problems/dementia and for those under 65 who are suffering from severe dementia and significant behavioural problems and are a risk to themselves and others. It is a 19-bedded mixed sex unit, staffed by one full-time and two part-time consultants. The allocation of beds is as follows:

Morecambe East and Carnforth	7
Morecambe West and Heysham	5
Lancaster area	6
Flexible	1

The referrals to the psychogeriatricians come mainly through the patients' GPs and occasionally through community mental health nurses or day hospitals, the GP having been informed. Referrals can also come from an RLI consultant or out-of-hours to the duty doctor or consultant at Ridge Lea Hospital.

On occasions it has been necessary to use the Mental Health Act (1983), in the interests of the patient's own health or safety or for the protection of others, when a patient's condition has been such that they have been unwilling or unable to agree to informal admission to the unit.

There is a multi-disciplinary assessment process, involving medical and nursing staff, community mental health nurses, the day hospital, occupational therapists, physiotherapists and social workers, which gives particular emphasis to the early return of the patients to their own surroundings. Other disciplines which may be involved are chiropody, dietetics, audiology, ophthalmology, psychology and speech therapy.

The role of the main disciplinary team is briefly outlined below.

Medical assessment

The medical input includes the following:

- physical examination and investigation
- mental state examination including cognitive assessment
- capability assessment re handling finance
- discussion with the family about the assessment process, plans, feelings about resuscitation, and their views regarding future care

- subsequently the multi-disciplinary team will meet the family to outline the results of the assessment processes and discuss plans for future care.

Physical examination

An elderly person generally has a high incidence of multiple pathology (IHD, CVA, COAD, recurrent infection, diabetic complications, osteoarthritis, Parkinson's Disease, carcinoma etc). A thorough physical examination assists in identifying potentially reversible causes of dementia, such as hypothyroidism, B₁₂ deficiency etc.

The presence of cardiovascular disease alone does not indicate a vascular aetiology and additional evidence is needed. The following guidelines are helpful in identifying different types of dementia:

- multi infarct dementia is suggested by focal CNS signs and supported by evidence of cerebrovascular disease on brain imaging
- pseudobulbar palsy, gait abnormalities and supranuclear ophthalmoplegia are suggestive of either vascular or degenerative subcortical disorder
- peripheral neuropathy may be associated with Vit B¹² deficiency or alcohol-related dementia
- in early-onset dementias, choreiform movement may indicate Huntington's Disease
- prominent or early myoclonus is suggestive of Creutzfeldt-Jacob Disease (CJD)
- extrapyramidal symptoms (e.g. rigidity and akinesia) are common in patients with dementia with Lewy bodies (DLB) and symptoms increase with use of anti-psychotic medication.
- Alzheimer's Disease: generally, in the absence of the above signs (absence of focal neurological signs), insidious onset, deterioration of specific cognitive functions (aphasia, apraxia, agnosia)

Investigation includes FBC, ESR, profile (U&E, LFT), blood glucose, thyroid function tests, serum B¹² and folate, and MSU. CXR, EEG, ECG, CT brain scan and other tests may be undertaken as required.

Mental state examination (in brief):

- observing behaviour: is there any restlessness, agitation, aggression (verbal or physical)?
- mood: is it flat, withdrawn, depressed or pleasantly confused/elated/disinhibited? (frontal lobe damage)
- psychotic symptoms: is there any thought disorder, paranoia or disorder of perception (visual, auditory, tactile)?

Cognitive function

It is particularly useful to test functions from each of the following:

- orientation
- language abilities (aphasia – receptive/expressive)
- memory (short- and long-term)
- knowledge of current events
- construction abilities (apraxia – clock drawing)
- concentration

Standardised tests

A variety of cognitive assessment tools is available. The mini-mental state examination is used within the Gaskell Unit.

- mini mental state examination (MMSE) – assesses orientation, memory (old and recent information), ability to learn new material, concentration, language (comprehension and expressive) and praxis interpretation (maximum score 30)
 - 27-30 normal
 - 25-26 possible dementia, after excluding other causes for poor performance
 - 10-24 mild to moderate dementia
 - 6-9 moderate to severe dementia
 - <6 severe dementia
- Hodkinson Abbreviated Mental Test Score (AMTS) – only covers orientation and memory interpretation (maximum score 10)
 - 0-4 severe dementia
 - 5-7 moderate dementia
 - 7-9 mild dementia
- Newcastle score (does not test visuospatial ability) interpretation (maximum score 32)
 - 25-29 possible dementia
 - 15-25 mild to moderate cognitive impairment
 - <15 severe cognitive impairment
- Alzheimer's Disease Assessment Scale – cognitive subscale (ADAS Cog) is sensitive to changes in people over time and can predict functional decline.

Scores range from 0-70 with higher score indicating greater impairment. It assesses word recall, naming, commands, constructional and ideational praxis (tested by asking the patient to perform complicated tasks on command, such as touching the left ear with the right middle finger whilst placing the left thumb on the right elbow), orientation, word recognition, spoken language, comprehension, word finding and recall of test instructions.

Capability assessment

Medical opinion may be sought about the patient's ability to make a will and if a patient is deemed incapable of managing his/her financial affairs, the medical certificate CR3 is completed by an involved doctor and forwarded to the Court of Protection for a receiver to be appointed. The court protects the property and affairs of persons who, through mental disorder, are incapable of managing and administering their own financial affairs.

Nursing assessment

- Pre-admission home visit: prior to planned admission, the person who has been allocated named nurse responsibility will meet the patient's main carer to explain the function of the Gaskell Unit and discuss care needs
- key nurse
- letter to relative
- nursing care plan/initial assessment (first three days)
- nutritional assessment chart score >10 refer to dietician
- sleep chart
- medley score (risk factor of developing pressure sore): 0-9 low risk, 10-19 medium, 20-33 high risk
- Crichton Behaviour Rating Scale: score <10, can settle in EMI (elderly mentally infirm) residential home
- self-help skills: personal hygiene, behaviour, social interaction, continence assessment
- communication

Occupational therapy

- information from relative/carer: patient's life history, interests, hobbies, likes and dislikes
- assessment re aids to daily living (ADL)
- functional: dressing assessment, assessment of motor and process skills (AMPS), designed to allow the therapist to assess the quality or efficiency of motor and process skills and the level of ADL task performance
- behaviour in group activity
- domestic and kitchen assessment
- home assessment with physiotherapist
- cognitive/behavioural (Clifton assessment tool: see table)

	severe impairment/maximum dependency	marked impairment/high dependency	moderate impairment/medium dependency	mild impairment/low dependency	no impairment/independent
cognitive score	0-8	9-15	16-23	24-29	>30
behaviour	18+	13-17	8-12	4-7	0-3
likely to need	continuing care	EMI nursing home/continuing care	residential care	stay in community with a package of care	

Table: Clifton assessment tool

Additional assessment tools

Severe Impairment Battery (SIB) – evaluates cognitive abilities at lower end of range

Geriatric Depression Scale (GDS) – score >5 indicates probable depression

perceptual – various nonstandard tests

Physiotherapy

- mobility assessed continually
- aids provided
- ability to use stairs assessed
- pressure area/wound care
- home assessment with occupational therapist
- advice to carers and other professionals

Social worker

- relatives contacted
- social history
- information given re benefits, mobility allowance, meals on wheels, home care, sitting service
- support given to relatives
- finance: any individual with a total of less than £16,000 is entitled to state funding at present. Those who have assets greater than £16,000 will only be entitled to state funding once those assets fall below £16,000
- information re residential homes
- relatives to multi-disciplinary meeting
- after discharge, continuing to support the carer/relative as required
- approved social worker's responsibilities in respect of Mental Health Act 1983

Other disciplines

Specialist input may be required from other disciplines, such as chiropody, dietetics, audiology, ophthalmology, clinical psychology, speech therapy, community mental health nurse (who will identify deterioration before crisis and offer support to relatives) and also staff from the day hospital if the patient has been or will be attending.

Relatives' involvement

Initial involvement in assessment process/plan/their expectations/resuscitation/finance after completion of assessment, involvement in discussions about future care

Care Programme Approach

The government introduced the Care Programme Approach in April 1991 with the aim of providing a network in the community for people with mental health problems, which is to be achieved by the effective use of multi-disciplinary meetings for patients whether they are in the community or prior to discharge from hospital, and no-one vulnerable is allowed to fall through the net.

The Supervision Register was set up to identify those people with severe mental illness who may be a significant risk to themselves or others.

FUTURE CARE – PRACTICAL MANAGEMENT

1 Home with support

OT and physiotherapy input re adaptation to home

A package of care including:

home help morning, afternoon and evening
meals on wheels
sitting service, day and night
day hospital attendance
outpatient follow-up (ideally should be home visit)
respite care
CPN/social worker follow-up support from Alzheimer's Disease Society or other voluntary agencies

2 Part III residential home

For those who require minimal assistance and guidance, are cooperative and compliant with treatment yet are in need of some level of care and supervision. Currently there are 75 residential homes within the Lancaster district.

3 EMI residential home

Approximate total 88 beds, for those with a mild degree of confusion, in need of some social care (prompting and supervision re washing and dressing), minor behavioural problems, but no significant physical problem. Usually a Crichton score under 10.

The following are EMI homes in the district:

local authority: Woodhill House, Morecambe
Slyne House, Lancaster

private: Bowland House, Heysham
Westmoor, Morecambe
Grey Gables, Bare
Hillcroft, Carnforth and Heysham

4 General nursing home

Approximate number in Lancaster area is 29. For those who require a significant degree of nursing, especially physical care (stable medical condition), with a mild degree of behavioural problems.

5 EMI nursing home

Approximate beds 130. For those who require full nursing care (physical and psychiatric nursing) and have no severe behavioural problems.

Hillcroft, Caton Green, Caton
Hillcroft, Carnforth
Hillcroft, Morecambe
Morecambe Bay Care Centre
Fluke Hall, Pilling
Hazelwood Hall, Silverdale

6 Continuing care in elderly medical ward

Requires specialised physical nursing and medical care without any significant psychiatric problems (immobile, high degree of physical problems, no behavioural problems).

7 Continuing care in the NHS mental health setting

Requires specialised psychiatric nursing, also medical care for elderly because of significant behavioural problems (full nursing care and behaviour problems).

There are three units (Lancaster, Morecambe and Heysham) with a total of 80 beds. The interim units are sited at Lancaster Moor Hospital until November 1999, after which they will transfer to the community in purpose-built units.

Some patients have been discharged into the community under Guardianship Orders (section 7 of the Mental Health Act, 1983). Longterm treatment of patients in the community – guardian who is usually, but not always, social services department is given authority for supervision in the community. All patient will be subject to the CPA (Care Programme Approach). Some may be on supervision registers and some may be subject to Section 117 aftercare.

FACTORS DELAYING DISCHARGE

1 PATIENT

Physical illness: exacerbation of underlying physical illness
recurrent chest infection, UTI (diabetes)
reduced mobility, falls, unsteadiness
(Parkinson's Disease)

Psychological: further deterioration in the mental state
behaviour, e.g. becoming restless, agitated,
resistive, trying to leave ward
difficulties in achieving optimal treatment

Family: next of kin sometimes do not attend multi-
disciplinary meetings
living away (geographical distance)
prefer particular placement (long waiting
lists)

2 SOCIAL SERVICES

Some time delay in approval re funding because of Social Services perception of patient's future management.

Finance: patient's capability/Court of Protection/enduring
Power of Attorney (time-consuming)

3 WAITING FOR BED

Private sector/continuing NHS care

BRIEF REVIEW SINCE GASKELL UNIT MOVED TO RLI

- Good liaison with physicians – quicker review re physical illness and management
- Length of stay has been reduced (comparing audit of stay of patients 1st April 1998 with audit 13th November 1998)
- admissions from medical ward, RLI, have increased
- admissions under Mental Health Act 1983:

during Bournemouth Ruling 40% were admitted under MHA (between December 1997 and June 1998). The Bournemouth Ruling was a court of appeal ruling in December 1997 concerning the care of an autistic man, which decreed that

informal admission of non-resisting adults who are unable to give informed consent, to hospital for treatment of their mental health problems was unlawful. This resulted in many dementia sufferers having to be admitted and detained under the Mental Health Act, 1983, and caused much distress to families of dementia sufferers. It was overturned on appeal to the House of Lords in June 1998.

- admissions under MHA after July 1998 were 10%
- discharge to home with extra support has been increased.

CONCLUSION

The multi-disciplinary team members recently had discussions about a faster and more efficient assessment procedure and outlined the system shown in the figure below.

This article is intended to provide a practical guide to the work undertaken by the multi-disciplinary team working within the Gaskell Unit; more detail is available from the author if required.

Although certain targets require individual disciplines to meet timescales, the whole multi-disciplinary team continue to be involved throughout the patient's stay in the Gaskell Unit.

MEDICAL WORK-UP	Week 1	medical: see family re assessment process, plans, expectations, finances, resuscitation screen: blood, MSU, CXR, EEG, scan nursing: nursing care plan OT: letter re patient's likes, dislikes, hobbies, interests, life history physiotherapy assessment Crichton score
	Week 2	chiroprody assessment OT assessment: formal and dressing, SIBS, AMPS
PARAMEDICAL WORK-UP	Week 3	home visits (if returning home) by physio and/or OT social work input
	Week 4	see family at MDM and decide fill in CPA or MBHA eligibility criteria placement form
SOCIAL WORK WORK-UP		family to look at residential care options and suggest first and second choices social worker to explain financial assessment/seek social service funding
	Week 5	leave of absence
	ongoing	a review as to why patients are still in the service

Figure: Gaskell Unit, RLI. Assessment protocol following admission

REFERENCES

- 1 Shukla, YP Dementia and mental health services for older people in the Lancaster district. Morecambe Bay Medical Journal 1999; 3(5):181-184