Introduction
This individual care pathway discussed in this article concerns an elderly gentleman who was diagnosed with a multi-infarct vascular dementia fifteen months ago. In accordance with the NMC Code of Conduct (NMC, 2008) he shall be referred to with the pseudonym of Mr Smith to protect his confidentiality. Mr Smith is currently in secondary care in the south of England and attends the memory club on a weekly basis where Cognitive Stimulation Therapy (CST) is delivered by both nurse trained and untrained NHS employees. Mr Smith lives at home with his wife who is his primary carer. Mr Smith’s symptoms include difficulties with short term memory recall, and disorientation to time and place.

Dementia in the U.K
‘Population ageing is one of humanities greatest triumphs. It is also one of our greatest challenges’ (World Health Organization, 2001, p6).

There are currently 700,000 people in the UK with dementia, of whom approxi- mately 570,000 live in England. Dementia costs the UK economy £17 billion a year, and in the next 30 years the number of people with dementia in the UK is set to double to 1.4 million, resulting with predicted costs trebling to over £50 billion per year (Department of Health, 2009).

The role of the mental health nurse
“Treat people as they are, and they will remain that way. Treat them as what they can be, and you help them become what they are capable of being” (Goethe, 2011)

In the multifarious and complex role of the nurse individuals and multidisciplinary care teams are entrusted with the wellbeing, health and happiness of those in their care. How they conduct themselves is essential to their integrity, and the wider nursing profession in its entirety. The Nursing and Midwifery Council (NMC) states that nurses and midwives must use their professional knowledge, judgment and skills to make decisions based on evidence for best practice and the person’s best interests (NMC, 2009). It is through a combination of obligatory professional accountability, the choice to work in the caring profession, and indeed our very humanity itself that those in the caring profession strive for optimum practice and safe individualized patient care. These individuals are ethically responsible for the rectitude of their actions, which impact upon our pride in their work, and upholding the profession and public confidence in nursing and the National Health Service (NHS).
Dementia care in the U.K.

CST was designed through systematically reviewing the literature on the main non-pharmacological therapies for dementia. The most effective elements of the different therapies were combined to create the CST programme, which was then evaluated as a multi-centre randomised controlled trial (incorporating services run by residential and day centres) in 2003. The results of the trial showed that CST led to significant benefits in people’s cognitive functioning, and further research showed that CST made a significant impact on language skills including naming, word-finding and comprehension.

CST treatment involves delivering sessions of themed activities. They were originally designed to run twice a week over a seven week period. However, people often prefer to run groups themselves and this often involves repeating sessions and offering new sessions as outlined in a new treatment manual. Sessions aim to actively stimulate and engage people with dementia, whilst providing an optimal learning environment and the social benefits of a group. CST treating people with dementia, such as care workers, Occupational Therapists or nurses and can take place in settings including residential homes, hospitals or day centres.

The use of Cognitive Stimulation Therapy (CST) for the treatment of dementia

Of the further care options, Mr Smith accepted the offer of attending the Memory Club, which delivers Cognitive Stimulation Therapy (CST) on a weekly basis at a local venue. CST is an evidence based therapeutic intervention which is delivered by NHS nurses and support workers, through structured treatment and cognitive stimulation: the CST programme was designed through systematically reviewing the literature on the main non-pharmacological therapies for dementia. The most effective elements of the different therapies were combined to create the CST programme, which was then evaluated as a multi-centre randomised controlled trial (incorporating services run by residential and day centres) in 2003. The results of the trial showed that CST led to significant benefits in people’s cognitive functioning, and further research showed that CST made a significant impact on language skills including naming, word-finding and comprehension.

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Assessing health risk in dementia care

Another important aspect of holistic assessment is assessing for health risk, an imperative component in dementia care in light of the anticipated strain on the health services. Risk covaries multifarious areas including immediate health risk, anticipated years of life remaining, need for long term care and potential disease progression. Incorporated into Mr Smith’s holistic assessment was a standardized Clinical Risk Management Tool (Morgan, 2000). This tool is designed to bring together all the necessary information and analysis of the potential outcomes identified of behaviours and identifying specific risk factors of relevance to an individual, and the context in which they may occur (page 2). As with the rest of the assessment Mr Smith was actively involved with the process of gathering information, and also consented for his wife to contribute, so that patient, carer and psychiatrist were all equal and the experience was one that was more of enlightenment than interrogation for both Mr Smith and his wife, and no major risks were identified for him at this point. Mr Smith was also offered an assessment with an Occupational Therapist (OT) who could make alterations in his home to reduce risk, he declined at this juncture but remains entitled to OT assessment in the future.

Mr Smith’s diagnosis of vascular dementia means that the potential to develop clinical control underlying conditions that may exacerbate his condition. Mr Smith used to smoke and had a history of high cholesterol, factors that can accelerate vascular dementia, however due to education and wellbeing promotion he now no longer

Figure 1. An introduction to Cognitive Stimulation Therapy (adapted from www. cdstementia.com)

Dementia care in the U.K.
Dementia care in the U.K:

The Care Quality Commission (CQC) discovered when researching for their five year dementia care plan that patients and carers wanted more value placed on their experience and views of dementia (CQC, 2010). In order to achieve this care needs to become individualized, or person centered. Both NICE (2011) and the CQC (2010) emphasize the need for person centered care, which involves considering the perspective of the person with dementia and their carers, embedding the individuality and nuances of different people and respecting their human value regardless of age or cognitive ability. Kwitko (2008) agrees, and believes that it is essential that we respect people’s diverse, idiiosyncratic and elaborate personal experiences of dementia. Person centered care is part of the phenomenological school of psychology (Brooker, 2007), which can put it at odds with the medical model, as it is only concerned with phenomena that are measurable and quantifiable (Zigmond, 2010). However, modern approaches to dementia care are no longer restricted to a biochemical or neuropsychological point of view and now include social sciences and other approaches that reflect the development of psychopathology over the last century (Lehman, 2000). As an anonymous ANMH blogger ‘CJ’ wrote, in one of his pieces before he had to shut down his site, perhaps trying to fit all situations into previously presented ‘models’ is at odds with the need to think creatively and individually (CJ, 2010). The same author also proposed a ‘recovery model’ for dementia, explaining that recovery is not necessarily about ‘cure’ or getting back to the place one was prior to diagnosis but more as working towards an optimum with the person at the center of their own care and decisions. Conceivably greater accreditation could be given to theories compared to models, such as Peplau’s theory of interpersonal relations, relations, first published in 1952 (see figure 2). This considers nursing an interpersonal process that is both therapeutic and a healing art and perceptibly embraces the same ideology as person centered care. Regardless of doctrine the philosophy governing all care should be that it is tailored to the individual, acknowledging and appreciating their views and the lived experience of the patient and their/her carer with safety underpinning all practice.

Critical analysis of the Mini Mental State Examination (MMSE)

The widely used Mini Mental State Examination (MMSE) was used to assess Mr Smith’s cognitive abilities which is a short series of questions which measure cognitive ability over a range of domains.

Peplau’s Theory of Interpersonal Relations

The four components of the theory are: person - which is a developing organism that tries to reduce anxiety caused by needs; environment - which consists of existing forces outside of the person in the context of culture; health - which is forward movement of personality and other human processes; and nursing – which functions cooperatively with other human processes to make health possible for individuals in communities.

The nursing theory identifies four sequential phases in the interpersonal relationship:

1. Orientation phase
2. Identification phase
3. Exploitation phase
4. Final phase

Orientation phase describes the problem, which starts when the nurse meets the patient. After defining the problem, the orientation phase identifies the type of service needed by the patient and is essentially the nurse’s assessment of the patient’s health and situation.

The identification phase includes the selection of the appropriate assistance by a professional. The patient begins to feel as if he or she belongs, and feels capable of dealing with the problem which decreases the feeling of helplessness and hopelessness. The identification phase is the development of a nursing care plan based on the patient’s situation and goals.

The exploitation phase uses professional assistance for problem-solving alternatives. The advantages of the professional services used on the needs and interests of the patients. In the exploitation phase, the patient feels like an integral part of the helping environment, and may make minor requests or use attention-getting techniques. This phase is the implementation of the nursing plan.

The final phase is the resolution phase. It is the termination of the professional relationship since the patient’s needs have been met through the collaboration of patient and nurse. This can be difficult for both if psychological dependence still exists. The patient drifts away from the nurse and breaks the bond between them. This is the evaluation of the nursing process and whether the set goals have been achieved or not.

functions such as memory and language (see figure 3 for cognitive domains test), Mr Smith scored 26/30 when originally assessed at the Memory Club he scored 25/30, losing two marks for orientation to time, one for orientation to place and one on recall. On his last assessment at the Memory Club he scored 25/30, losing two marks for orientation to time, two for orientation to place, and one for recall. From his MMSE scores he is appearing to be retaining the majority of his cognitive functioning abilities and has only dropped one mark over the past fifteen months. Despite its widespread usage the quantitative nature of the MMSE is contradictory to the modern ethos of person centered care, amongst other limitations. Constructed in 1975 the creators Folstein, Folstein and Hugh claimed the MMSE to be quick, acceptable to patients and testers, and both valid and reliable. However more recently in 2008 Crinelli and Ostberg retested the reliability and validity and found from their contextual analysis that the MMSE had low reliability, too many easy items, too many cutoff points and lack of standardized scores and concluded that the MMSE should not be used on its own for cognitive screening assessment. Although they did acknowledge that the parameters to assess validity and reliability have changed since the test was published (Crinelli and Ostberg, 2008). What is of further magnitude was the small sample sized used to originally test the MMSE, only 33 patients from one of the sample were retested, and only 24 of those were compared with a degree of confidence. Furthermore Kowal et al (2008) found that the MMSE cut off point score of 24 does not yield optimal classification accuracy with highly educated individuals and instead suggested a more stringent cut off score of 27 for people in this category; and Scacchi et al (2008) discovered whilst the MMSE was adequate for screening older adults with minimal literacy skills, misclassification was unacceptable high for older adults who are illiterate, which yields high consequences for the use of the original tool in middle income countries where illiteracy is high. Guerrero-Berrosa et al (2009) found that orientation for time was the only MMSE domain for which poor baseline performance was significantly associated with a faster rate of overall cognitive decline. However, this is of relevance to Mr Smith as he dropped two points for orientation to time both on his initial and his most recent MMSE. A meta analysis of over 42 studies concluded that MMSE offered only modest accuracy and was best for ruling out dementia in primary care settings. It is also likely that a variable subject demographics may have introduced heterogeneity. Ostberg (2009) is compelling but naturally, it is a step in the right direction. The ethos underpinning the Dementia Strategy (2009) is compelling but naturally quite formidable as it requires such an expansive overhaul of services, plus the added pressure of the predicted rise in people accessing dementia care can make for an at times overwhelming. But as has been recognized, the crucial fundamental element to improving quality of life for older people and reducing the strain on the NHS is the promotion of wellbeing and disease prevention, which are united together. Therefore responsibility for the fate of our older people and their carers, perhaps ourselves, rests with everyone to promote dementia awareness and implement wellbeing in our everyday lives. Ongoing research is essential into person centered, efficacious and cost effective therapeutic interventions, while those while working in the field of dementia, or nursing in any domain, are...
Dementia care in the U.K:

References


