What is a Special Care Unit for BPSD (SCU-B)?

Consensus Conference of RECAGE Project (GA No: 779237)

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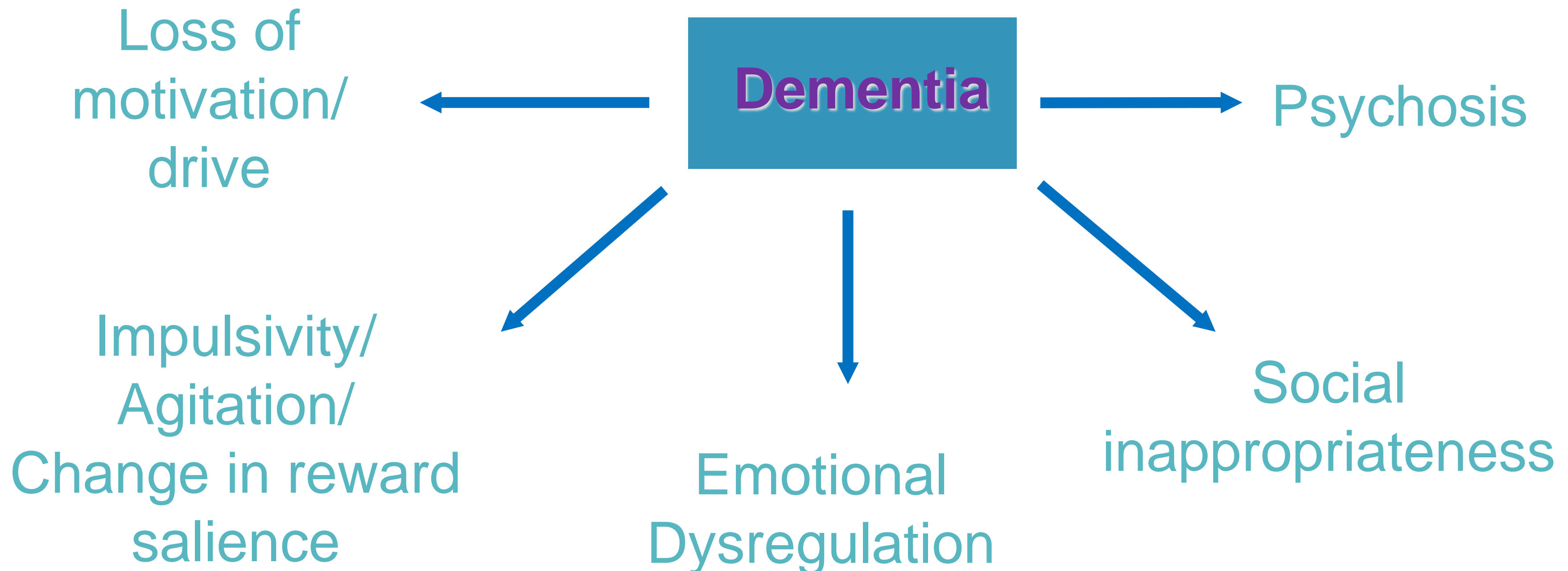
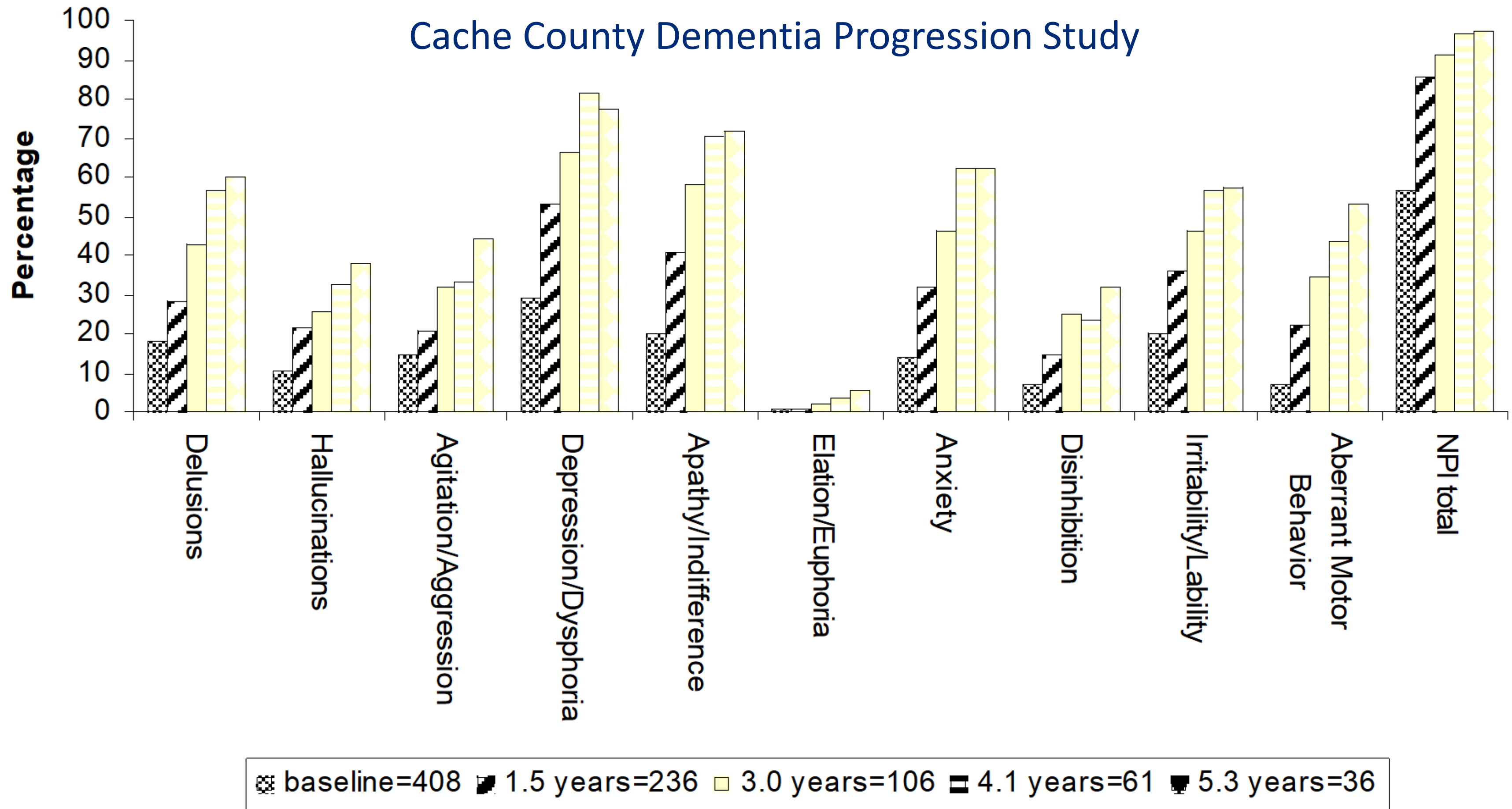
Dementia: More than Cognitive Impairment

Neuropsychiatric Symptoms or Behavioral and Psychological Symptoms



Neuropsychiatric symptoms are universal in 98% people with dementia



Steinberg et al, Int J Ger Psychiatry 2008

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Worldwide consensus guidelines recommend non-pharmacological approaches as first line treatment of BPSD.

Examples of non-pharmacological or psychosocial interventions:

- *general:* extended diagnostics, validation, behavioral management, education of caregivers/nurses, appropriate environment (e.g., light and noise).
- *patient-centered:* cognitive stimulation, structured social interaction, relaxation, music therapy, sensory stimulation (music, aromatherapy), reminicence treatment

strongest evidence: family/caregiver interventions, e.g. caregiver education, training in problem solving, and targeted interventions for specific behaviours.

Medical interventions (psychopharmacological treatment and/or drug discontinuation) should always be complemented by psychosocial and environmental interventions.

A safe and comfortable environment with a staff of appropriate competence in treating BPSD is mandatory.

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Algorithms for psychosocial interventions

specific interventions according to defined syndromes/symptoms				
Psychotic symptomes	**Agitation Aggression**	**Depression**	**diurnal rhythm disturbances**	**Failure to thrive**
Individualized care	aroma therapy	Leisure activities	Structured daily activities	Emotional support
	music therapy	Physical activity		Family-like eating situation

DGPPN / DGN S3 – Leitlinie Demenzen 1. Revision, 2016

Agitation

physical cause/ discomfort?	Depression?	hallucinations/ delusional symptoms	Anxiety/ loneliness?	social or sensory deprivation?
Medical treatment nursing care	Psychotherapy emotional support	inappropriate medications check hearing / vision increase confidence	social interactions Simulated Presence	social interactions meaningful activities

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SCU-B : Definition

A residential medical structure lying outside of the usual home where dementia patients are temporarily admitted for treatment when their behavioural disturbances are not amenable to control at home. The mission of the unit is to improve patients' behaviours and its goal is to permit, wherever possible, her/his return to the previous living situation"

The European Action ALCOVE Synthesis Report, 2013

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SCU-B: The reality of the consortium

lack of uniformity, including the situation in our Consortium.

a. Most of them are exclusively dedicated to patients with dementia and BPSD (typical SCU-B), offering temporary admission to patients with severe BPSD, able to walk, aiming at controlling their behaviours and rehabilitate them, in order to enable them to return to their previous living situation
b. Others can also admit patients directly from Emergency Departments with delirium developed during acute diseases (infections etc.)

Moreover, as regards institutional context,

a. some SCU-Bs are located inside acute general hospitals, for instance in the framework of (or connected with) acute geriatric wards (Geneva is an example of this)
b. others are inside psychiatric hospitals (Mannheim, Ottestad)
c. still others are located in rehabilitation facilities (like the French Unités Cognitivo-Comportementales or the Italian SCU-Bs (Gazzaniga and Modena)

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Proposed Statements: Values and attitude of working

- a person-centred approach to caring, focusing on the person's needs and preferences with consistent communication
- a flexible team approach based on dialogue amongst staff members
- Respect for patients' needs and rights. Focus on identifying the demented patient's unmet needs.
- The SCU-B is a place where the staff can explore alternative solutions for the safety of the demented persons.

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Proposed Statements: Architectural features

- An appropriate, possibly home-like and dementia-friendly environment: "a place to live, where patient needs are the primary target, not just a place of care, where the most efficient work of the medical team is the primary target”.
- Architectural features like dementia-friendly design are necessary and provide both, a prosthetic and safe environment.
- Restrained access to and exit from the ward
- Enough room for walking (wandering), possibly a circular corridor
- Mainly two beds per room, some rooms with single beds (agitated/hyperactive patients)
- Large seating area for patients / extra room for meeting with relatives
- Direct access to an outdoor area and indoor kitchen, access to occupational and physical therapy

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Proposed Statements: Staff number and professions / Nursing model

- Composition of the staff: The team should be multidisciplinary, involving physicians (geriatricians, neurologists, psychiatrists), nurses, (neuro)psychologists, speech therapists, physical and occupational therapists, Dieticians, and social workers
- Person-centered approach to caring: a dementia-informed system that should be implemented by culture and specific training.
- Providing personalized interventions. This implies that the staff should be informed about the patients' preferences and aversions and be educated to implement these features into their interventions.

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Proposed Statements: Physical restraints and psychopharmacological measures

- physical restraints should be reduced to a minimum
- limited in time as a medical/nursing intervention
- multidomain intervention encompassing psychological and psychosocial interventions and drug therapy, if appropriate
- This requires input from physicians with expertise in psychopharmacological treatment of PwD.
    - Since restraints can also be exerted by pharmacological nature, e.g. with behavior-modifying drugs, such as tranquilizers, sedatives, and antipsychotic drugs, adherence to state-of-the-art guidelines for treatment of BPSD must be assured.

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Open questions

- **<u>Values:</u>** SCU-B is a medical unit, priority is given to prevention, diagnosis and treatment
  - ➢ state-of-the-art evidence including psychosocial treatment and appropriate skilled nursing should be the basis
  - ➢ A prevailing "social attitude" limits biological understanding of disease and symptoms
- **<u>Architecture</u>**: the hospital setting almost always sets some limitations
  - ➢ re space, beds per rooms, safety aspects, usability, access to outside areas These limitations may differ in long-term care institutions
- **<u>Staff number and professions</u>**: Psychiatric, geriatric, neurologic expertise – multiprofessional team
  - ➢ Staff number is different according to medical speciality,
  - ➢ Level of professionalism differs: psychopharmacology, nursing model
- **<u>Physical restraints (PR) and psychopharmacology:</u>** integral part of treatment
  - ➢ In some countries, PR are restricted and organized by law, in others not
  - ➢ Psychoactive drugs must be used evidence-based – guidelines and algorithms

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Recommendations: To be discussed and adopted by the consensus process in our consortium

- Values and attitudes
- Architectural features
- Staff number and professions / Nursing model
- Physical restraints and psychopharmacological measures

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