Treatment of patients with dementia at Mendota Mental Health Institute

2. What services are provided at Mendota Mental Health Institute (MMHI) for individuals with dementia? Does DHS believe that facilities such as Mendota are the appropriate place for individuals with a primary diagnosis of dementia?

There are several ways in which the Geriatric Treatment Unit at MMHI is uniquely equipped to treat patients with dementia and differs from other psychiatric units and from the nursing home level of care. The most dramatic is the staffing of the unit. Minimally there is one line staff person for every 2 patients during the day and one line staff for every 3 patients at night. Additional staff are added when patients require 1:1 staffing for their safety, most often a risk of falling due to impulsive behavior or a risk of aggression toward others.

Although the ability to do seclusion and restraint is one of the ways the geriatric unit differs from nursing home care, there is a very low rate of seclusion and restraint used on the unit, 0.29 hours per 1000 patient hours. Aggression is generally handled with increased staffing, supervised activities, and medications where appropriate as determined by the psychiatrist.

The Geriatric Treatment Unit provides extensive specialized therapies for patients with memory impairment. Groups and activities specially designed to meet the needs of severely cognitively impaired patients are provided by Occupational Therapy and nursing staff. Occupational therapy staff offer an average of 25 groups per week. They also do evaluations of individual patients' daily living skills and determine the level of supervision memory impaired patients may need for their safety. Neuropsychological testing is also available when needed.

The Geriatric Treatment Unit at MMHI provides comprehensive services to patients with dementia. These include but are not limited to:

1. High intensity nursing care, staff consists of a nurse manager, an assigned senior RN to assist with treatment planning and supervision of line staff, 2 licenses nurses on AM and PM with at least one who is an RN and one RN on nights, RCT's in a ratio appropriate to the needs of the patient population.
2. Full time psychiatrist specializing in the treatment of elderly patients.
3. 24 hour physician coverage and an internal medicine physician who evaluates each patient and rounds on the unit Monday thru Friday. Other subspecialty care including consultation as needed.
4. Psychological consultation including neuropsychological testing at the request of the treating psychiatrist.
5. Podiatry sees all patients once per month.
6. Physical Therapist consultation and treatment three days per week. With instruction from Physical Therapists, Nursing staff provide ambulation, range of motion and other physical therapy needs on days the therapist is not present.

7. Occupational Therapy provides assessment of ability to perform daily living skills and treatment groups geared toward people with cognitive impairment.
8. Speech and Language, swallowing evaluation performed on all admissions, special needs for feeding, special diets and supervision of meals are provided by staff as recommended to accommodate swallowing problems or other feeding difficulties.
9. 1.5 Social Work positions to discharge planning and coordination of care and facilitate timely discharge.
10. Nutritional evaluation on all admissions.
11. Consultation with Hospice is done on an as needed basis for patients who would benefit from comfort care as determined by the patient, the unit physicians and the patient's guardian or POA where applicable.

MMHI's geriatric unit is specifically designed and staffed to care for patients with dementia both as a primary diagnosis and in combination with other psychiatric disorders. However MMHI is an acute unit and not an appropriate long term placement for any patient. It is the goal of MMHI treatment teams to stabilize patients and transfer them to a lower level of care as soon as it is safe to do so.

3. Some individuals have stayed at Mendota for years. What would DHS say is the reason for that? How could it be addressed?

Our Geriatric unit is intended to be an acute care unit. There were 84 patients admitted during the past 12 months (9/1/2011 through 8/31/2012). The average length of stay for patients admitted during this past year was 32.5 days. The majority of patients admitted during this time (60%) were discharged within 30 days of admission. Only 5 patients (6%) were or have been here more than 3 months. The patient with the longest length of stay who was admitted during this past year was here for 6.7 months.

While some individuals have stayed on the unit for years these very long stays represent a very small number of patients. There are currently 2 patients receiving treatment on the unit that represent very long stays, 1.6 years and 2.6 years respectively, well beyond what we would expect for an acute stabilization unit. I have the benefit of knowing and having cared for each of these individuals.

Patient 1. Has advanced dementia, is frequently aggressive, randomly striking out at caregivers. This patient no longer recognizes family members, is unable to speak except occasional guttural sounds or repeated sounds or words that are not obviously related to the situation, is incontinent of bowels and bladder, eats when fed by staff but otherwise would take no food or fluids. Medication treatments and 1:1 supervision have been helpful. The frequency of attempting to stand, and the frequency of aggression has gradually decreased over years. This patient will be discharged next week.

Patient 2. Had an aneurism and also has dementia. Patient 2 is diagnosed with a mood disorder which is the direct result of the aneurism. Medications are used to treat mood problems and are effective however this patient is disoriented, and frequently is driven to stand and ambulate despite being very

unsteady. 1:1 staffing has been in place for over a year. The patient can become aggressive toward the staff who is assigned to assist with the walker and steady the patient using a gait belt. The patient does not recognize the need for assistance and becomes irritated with the staff at times. The patient often thinks they are in another situation, for example, that they are going to the store, or on an errand to meet someone. No amount of reorientation is effective in dissuading them about their ideas, distraction is useful. The patient loves music and loves to sing, they participate in many groups and are often delightfully social and interactive but moods and ideas can shift quickly and 1:1 remains necessary.