EDITORS

Education, hospital staff and the confused older patient

The true prevalence of confusion due to both cognitive impairment and physical illness amongst older hospital inpatients is unknown; however rates of dementia are estimated to be as high as 40% and delirium 61% [1]. Despite encountering older people with confusion on a daily basis, general hospital clinical staff are continually challenged by such patients [2]. Unfortunately, all too often, the relationship between staff and patients becomes more custodial than therapeutic [3]. Advances in understanding the personhood of the older ill hold much promise in helping clinical staff meet these challenges [4]. However, training may fail to bring about the change in staff behaviour that ultimately may improve patient care.

Though effectiveness of medical education interventions has been extensively reviewed in long care settings [5], the literature in relation to education, hospital staff and the confused older patient remains sparse. The last comprehensive review of educational interventions was nearly 10 years ago [6]. Major findings were the modest evidence for effectiveness of well-established educational programmes and the existing gap in the literature in terms of understanding learning needs of medical staff.

Recent studies demonstrate a significant benefit of educational interventions in the prevention of delirium. An educational package aimed at medical and nursing staff reduced the prevalence and increased recognition of delirium on acute medical wards [7]. This multicomponent educational strategy consisted of presentations, guidelines and importantly, small group follow-up sessions. In line with these findings, Naughton and colleagues report that an affordable knowledge and skill-based programme improved various healthcare outcomes amongst older adults [8]. The educational intervention, delivered on an emergency department as well as in an acute geriatric unit, importantly also reduced length of stay.

However, despite these grounds for optimism, there remain considerable difficulties in translating research findings into effective guidelines which ultimately may improve best practice [9]. Disseminating educational interventions represents a major problem for educational advancement [10]. The two main stumbling blocks are negative social attitudes amongst staff and organisational factors within the hospital [11].

What can be done to bridge the notorious know-doing gap? Drawing on educational theory and the literature, we propose that local implementation of a multidisciplinary learning curriculum facilitated by liaison old age psychiatry (LOAP) teams could effectively drive change.

Increasingly, it is recognised that LOAP teams are central to educating hospital healthcare professionals. By working in an integrated fashion with medical colleagues, LOAP teams are in a unique position to bridge the gap and empower hospital staff to better meet the needs of confused older patients. An effective method to help change attitudes is to demonstrate that a different strategy works [11]; hence, by modelling a more person-orientated management approach other healthcare professionals may follow the example of LOAP teams. Furthermore, due to their constant presence in the hospital setting, LOAP teams can educate in a more serendipitous and developmental fashion rather than by way of more traditional and didactic ‘delivered’ teaching events. Evidence suggests that LOAP teams are not only effective in terms of improving key outcomes but also cost effective [12]. Consistent with this view, in the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) emphasises the central educative role of LOAP teams in managing confused older patients [13].

Drawing on a more developmental approach to learning, we contend that educational approaches are tailored around the local learning needs of health professionals. Structuring programmes around learning needs have been shown to most effectively change behaviour in the acute setting [14]. From qualitative studies we now have a clearer understanding of the putative learning needs in relation to managing the older person with confusion [15, 16]. Important messages are that nurses identify older people through their behaviour and feel that they are deficient in key skills required to manage mental illness. Unfortunately, those studies which have explored attitudes tend to focus on staff’s perceptions. Blind learning needs, those attitudes which are unknown to professionals but evident to others, are rarely considered in educational planning.

Organisational barriers to best practice, which define the ‘hidden curriculum’ of educational interventions [10], equally require consideration in educational planning. Typically these include poor management support [11]. This view is echoed by the NICE guidelines for dementia which state that training alone is insufficient and that, to bring about effective changes in the quality of care, attention must be provided to obstacles to change [13]. Unfortunately, unlike in nursing homes, there is little research into the factors that may be associated with the effectiveness of education [17].
To manage the complexity of older people with confusion, educational interventions with greatest effectiveness should be multidisciplinary. Educational research demonstrates that interprofessional strategies have the added benefit of improving care to a higher standard via enhancing the quality of learning as a result of sharing insights and learning skills from other professions [18]. Central to developing an effective strategy, an assessment of learning needs of all the professions represented in the ward environment must be undertaken. Most studies have focused on the learning needs of nurses and less is known about the needs of other healthcare professions, especially those who are responsible for managing systems of care and setting the organisational culture, such as managers and leaders.

To date the focus of educational studies in managing patients with confusion has been on evaluating whether content-based interventions work. Since education is a highly complex process, no blueprint for a ‘teacher proof’ approach will exist and hence educators in the acute setting need to tailor approaches to their own environments. To quote the distinguished educationalist Vic Kelly the key challenge for educational advancement is ‘to shift the focus of attention from the seed to the soil in which it is to be planted’ [10]. Only then will we be able to translate best evidence into best practice and ultimately improve care for the confused older patient.

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