

DEMENTIA
NATIONAL AUDIT OF
DEMENTIA



National Audit of Dementia Care in General Hospitals 2012-13

Second Round Audit Report and Update



The audit is commissioned and funded by the Healthcare Quality Improvement Partnership and managed by a project team based at the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

The collaborators in this project are the professional bodies for five of the main disciplines involved in providing dementia services, and one of the main voluntary sector providers of supports and services:

- The Royal College of Psychiatrists
- The British Geriatrics Society
- The Royal College of Nursing
- The Royal College of Physicians
- The Royal College of General Practitioners
- The Alzheimer's Society

Representatives from the above organisations and experts in the field of dementia care comprised the Steering Group together with the project team.

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Among the Hills by Mildred Doyle, 2009.

Alzheimer's Association of Colorado Memories in the Making® Art Program.

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Finally, many thanks to the Alzheimer's Association, Memories in the Making, for kindly permitting the use of the image on the front cover of this report. Alzheimer's Association [Memories in the Making®](#) is an art program for individuals with Alzheimer's disease or related dementias. The artwork *Among the Hills* used on the cover of this report was painted by Mildred Doyle, and is a vividly colourful interpretation of the mountains in Colorado. Mildred passed away in 2010.

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At any one time, a quarter of acute hospital beds are in use by people with dementia. The National Audit of Dementia was established in 2008 with funding from the Healthcare Quality Improvement Partnership to examine the quality of care delivered to this growing sector of the community who are likely to be particularly vulnerable to care shortfalls⁸.

In 2011 our baseline report showed disappointing results overall and a lack of attention to basic care needs. Nutritional assessments, for example, were undertaken in fewer than 10% of patients in some hospitals.

Throughout both rounds of audit, dementia care has been a high priority at government level in both England and Wales. Improving acute hospital care is a priority in the 2012 Prime Minister's Dementia Challenge¹⁶ and in the Welsh Government's *1000 Lives Plus* programme²⁸. National, local and regional initiatives have maintained a focus on dementia, supported by dedicated input from hospital staff.

This second round of audit demonstrates general hospitals can make changes which improve the quality of care provided to people with dementia. That said, performance in the 2010 audit set a fairly low baseline, which means that despite significant positive change, many best practice standards remain unmet.

There are positive findings within this report. Dementia champions are now in place in most hospitals, and the majority of hospitals have begun to collect personal information about people with dementia to help improve care. More people with dementia are now having their essential health needs assessed and we are seeing dementia care feature much more in hospital training strategies. A reduction in the use of antipsychotic drugs, some of which increase risk of death, was found. These are all welcome steps forward.

Further improvement is required and there remains a gap between written policies and actual practice. Too few patients are being assessed for delirium risk and for cognitive function, and may therefore fail to receive vital care. Despite more systematic collection of personal information about patients' needs, preferences and communication requirements, this is often not recorded in the patient notes, so staff remain unaware of how best to care for the individual. Discharge plans often fail to record important details about ongoing health needs. At the point of audit, only 36% of hospitals had a fully developed care pathway in place, and we recommend that hospitals now address this with urgency. In terms of dementia awareness, there remains a huge need for much better staff training and support if we are to provide comprehensive, safe and dignified dementia care across the board.

The issue of governance remains key. The Report of the Francis Inquiry⁴² stated that active involvement of the board and directors is necessary in guarding against catastrophic breakdowns in care. The findings of this audit suggest that hospital boards are still not sufficiently engaged in scrutinising dementia care. We strongly recommend that every board take full responsibility for examining key issues such as readmission rates, delayed discharge, falls and complaints. Where problems are found, boards must act promptly.

The Francis Report⁴² also highlighted the collective responsibility of hospital clinicians to ensure that duty of care to patients is implemented. This cannot take place without effective systems for listening to the concerns of patients and staff. We suggest that future audit in hospitals includes feedback from these groups.

This report presents updated recommendations to regulators, commissioners and clinicians. It is vital that measurement of progress is continued over time. The structure and commissioning of NHS services may be changing but the need for good quality dementia care remains paramount. Future audits could usefully contain additional modules on the use and effectiveness of non-drug approaches to behavioural and psychological symptoms, and the treatment of patients with suspected but as yet undiagnosed dementia. It is hoped that more effective care at home will help reduce the need for hospital admission for some people with dementia. However, the growth in the older population and the development of new treatments mean that the treatment and care of older people with dementia will continue to be core hospital business. The findings and recommendations in this report mark the distance travelled and the greater journey ahead.



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Perspective from a person living with dementia

"You can't replace the experience and human touch that nurses and staff give to patients. Staff need to know about all forms of dementia and how it affects people.

You can't have too much information about patients with dementia – it makes your job easier and their lives better."

Trevor Jarvis, Alzheimer's Society Ambassador, speaking at the launch of the Call to Action, October 2012

Trevor Jarvis is an Ambassador for the Alzheimer's Society and has given many talks to hospital staff about his experiences of living with dementia and admission to hospital. Trevor spoke at the launch of the Call to Action "The Right Care, Creating Dementia Friendly Hospitals" in October 2012. His speech highlighted the need to increase the levels of awareness and skills of hospital staff, and how important their understanding of dementia is to the patients they care for.

Audit background

The National Audit of Dementia (care in general hospitals) was established in 2008 with funding from the Healthcare Quality Improvement Partnership to examine the quality of care received by people with dementia in general hospitals.

The first round of the National Audit of Dementia was carried out in 2010/11. The national report³⁹ concluded that hospitals needed to design and implement an integrated approach to the care of people with dementia and highlighted improvements to be made at all levels.

The second round of audit collected data between April and October 2012. Each hospital was asked to complete:

- **a hospital organisational checklist** to audit the service structures, policies, key staff and care processes that impact on service planning and provision for the care of people with dementia within a general hospital.
- **a retrospective case note audit** of the records of a minimum of 40 patients with a diagnosis or current history of dementia, audited against a checklist of standards that relate to their admission, assessment, care planning/delivery, and discharge. Audit was of a single admission, and eligible admissions were of 5 days or longer between the period of September 2011 to February 2012.

Participation

210 hospitals registered to participate in the audit. This represents 98% of eligible hospitals and 100% of eligible Trusts and Health Boards in England and Wales.

Data received

- Organisational checklists – 210 checklists received (1 from each participating hospital).
- Case note audit – 7987 case note submissions received (from 206 of the participating hospitals).

Summary of results by theme

1. Governance

Overall, there have been encouraging improvements made at an organisational level, suggesting more attention is given to governance related issues within the general hospital. However there is much improvement needed in the involvement of the Executive Board reviewing information related to people with dementia, so that when concerns arise these can be addressed in a timely manner and with authority.

- 81% of hospitals have a senior clinician responsible for the implementation of the care pathway, which is either in place or in development. Just over a third of hospitals had a care pathway in place for people with dementia at the time of audit, and around half of hospitals had a care pathway in development.
- Executive Boards are not regularly involved in reviewing key information related to the care of people with dementia. Readmissions, delayed discharges and in-hospital falls are reviewed by less than 50% of Executive Boards.
- 82% of hospitals have a champion for dementia at directorate level and around three quarters of hospitals have a champion for dementia at ward level.

2. Assessments

Results overall show some improvement in essential assessments, but assessment for delirium and of mental state is alarmingly low. Delirium is associated with greater risks of longer admission, hospital acquired infections, admission to long term care, and death. Failure to assess and plan for mental health needs may also prevent appropriate assessment and care for physical health needs.

- All hospital assessment procedures included assessment of nutritional status, and 89% of case notes had a record that this assessment had been carried out.
- Over 90% of case notes recorded that an assessment of mobility and a pressure sore risk assessment had been carried out. Over 85% of case notes recorded that the patient had been asked about any continence needs and the presence of any pain.
- Approximately half of hospitals had a policy or guideline in place to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation. A further 41% of hospitals had a policy in development. 62% of case notes had no record that an initial assessment for indicators of delirium had been carried out.

- Nearly all hospitals reported that their written procedure for multidisciplinary assessment includes assessment of mental state, but half of the case notes had no record that patients had received this assessment.

3. Antipsychotic prescription: protocol and practice

A proportion of hospitals still do not have a fully developed protocol governing interventions for behavioural and psychological symptoms of dementia. Overall, the number of patients prescribed antipsychotics in the hospital has decreased.

- 61% of hospitals have a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, aggression and extreme agitation, which considers the needs of patients who present behavioural and psychological symptoms of dementia. A further 30% of hospitals are developing such a protocol. In the first round of audit, only around a third of hospitals had this in place.
- 19% of case notes recorded that the patient was prescribed antipsychotics during their admission to hospital (existing and new prescriptions). 8% of these contained prescriptions made during the admission. This is a drop of 10% overall since the first round of audit, and a drop of 4% for in-hospital prescription.
- The proportion of patients admitted from care home settings with an existing prescription of antipsychotics is still higher than the proportion of patients admitted from elsewhere, such as their own home, with a prescription, although overall prescription has fallen in both groups in the sample.
- 8% of patients in the total sample left hospital with a prescription for antipsychotics in place.

4. Liaison psychiatry services

Although nearly all hospitals report having access to a liaison psychiatry service, lower out-of-hours provision for older people's services is likely to affect people with dementia admitted to hospital, particularly where services are only available offsite.

- Nearly all hospitals report access to a liaison psychiatry service. Most of these had a Consultant Psychiatrist lead.
- Nearly all hospitals reported their liaison service provides routine mental health care to older people. In around two thirds of cases, this was combined with working age adult services.

- 96% of the hospitals reported having access to a liaison psychiatry service provided by a specialist mental health team. Only one third of hospitals had access to an older people's service both during the day, and out-of-hours during evenings and weekends.
- Out-of-hours availability is higher when onsite services are available and this particularly affects weekends.
- 16% of case notes contained a referral to liaison psychiatry. Only 42% of all referrals were seen within two days.

5. Hospital discharge and transfers

Case note evidence shows that information important to future care is not being supplied at the point of discharge. The majority of case notes showed evidence that discussions about discharge had taken place with carers and relatives. Hospitals should aspire to have these discussions with all carers and people with dementia, whenever this is appropriate, to ensure that suitable discharge arrangements can be made.

- 46% of hospitals do not have a process in place to regularly review hospital discharge policy and procedures, as they relate to people with dementia.
- Only 19% of case notes showed that the person's level of cognitive impairment was included in summary discharge information. Only 9% of people with dementia who lived in a care home when they were admitted to hospital had this included.
- Less than half of the patients who had had symptoms of delirium, or of behavioural or psychological symptoms of dementia (such as agitation, distress or aggression) during admission had this in their discharge summary.
- 80% of case notes contained evidence that discussions had taken place with the person's carer about appropriate place of discharge and support needs. 57% of case notes contained evidence that these discussions had taken place with the person with dementia, when this was possible.
- In half of the case notes, there was no record that information about support on discharge had been given to the person with dementia or the carer.
- In a quarter of case notes, there was no record that notice of discharge from hospital had been given to carers or family.

6. Information and communication

Overall, the audit found the collection of personal information needs to be improved, particularly in areas that could help prevent distress and challenging behaviour in people with dementia. Information sharing and communication between staff, carers and patients should be improved to ensure that all staff coming into contact with people with dementia are aware of their diagnosis and associated needs.

- Approximately three quarters of hospitals had a formal system in place for gathering information pertinent to caring for a person with dementia. When this information is recorded in the notes, less than half contained information about details which aid communication with the person; support or actions that can calm the person if they become agitated; and recurring factors that may cause or exacerbate distress.
- Approximately half of hospitals do not have a system in place to ensure that all staff in the ward or care area are aware of the person's dementia or condition and how it affects them. 59% of hospitals have no system in place to ensure that staff are aware of the person's dementia or condition whenever the person accesses other treatment areas.

7. Staff training

There is notable improvement in the number of hospitals having a training and knowledge framework in place. However, a large proportion of hospitals do not include dementia awareness training in their induction programmes. This should become part of the organisational training strategy to ensure all staff have access to awareness training through induction as well as ongoing training programmes.

- Over three quarters of hospitals had a training and knowledge framework or strategy that identifies necessary skill development in working with and caring for people with dementia. In the first round of audit, under a quarter of hospitals had this in place.
- 41% hospitals do not include dementia awareness training in their staff induction programmes.
- When looking at dementia awareness training hospitals provided in the 12 months prior to audit:
 - Under a quarter of hospitals did not provide dementia awareness training to doctors or other allied healthcare professionals;
 - 11% of hospitals did not provide dementia awareness training to nurses and 10% did not provide dementia awareness training to healthcare assistants;
 - 40% of hospitals did not provide dementia awareness training to support staff in the hospital.

Commissioners/Health Boards

- Commissioners/Health Boards should ensure that contracts, incentives and outcome measures support hospitals in providing high quality care for people with dementia, taking account of specific guidance on resources for care and dementia specialist roles such as that published by the Royal College of Nursing³³.
- Commissioners/Health Boards should ensure that liaison psychiatry services are in place to provide adequate access over 24 hours for treatment and referral of people with dementia in hospital. This should include the ability to provide an emergency or urgent response over 7 days. Response times, together with patient outcome measures as they are developed, should be a key performance indicator for these services.

Trust Boards/Council of Governors/Board of the Health Board

- The Trust Board/Council of Governors/Board of the Health Board should ensure they are presented with information on the review of key policies and procedures to include the needs and perspective of people with dementia and their carers, including the following as evidence that action is taken:
 - Evidence relating to Trust performance against Dementia CQUIN targets on identification, assessments and referral for people with suspected cognitive impairment and of identification and management of delirium.
 - Clinical information on admission rates, falls, intra-hospital ward transfers, treatment and discharges, in which people with dementia can be identified.
 - Evidence that person centred care is practiced throughout the Trust, for example using "This is Me"⁹ or a similar personal information document.
 - Evidence that a training programme is underway addressing competencies and skill development for staff working with people with dementia, and that this is suitable for a range of competency levels and roles.
 - Evidence from local audit of in-hospital prescription of antipsychotics that their prescription is in line with guidance.
 - Trust Board members should undertake training to become a dementia friend.Trusts should consider including this information in their Quality Accounts. Health Boards should consider including this information in their Quality and Safety Committee Reports.
- The Trust Board/Council of Governors/Board of the Health Board should be made aware of any incidents of discharge taking place after midnight or when carers/family receive less than 24 hours notice of discharge. This should be a routinely reported statistic, and these occurrences should be reviewed and investigated.

Chief Executive Officer

- The Chief Executive Officer should ensure that the Trust/Health Board identifies a senior clinician in each hospital to oversee high quality care for people with dementia and specifically to take charge of developing, implementing and monitoring the care pathway for dementia. This should be implemented by June 2014.
- The Chief Executive Officer should ensure that dignity leads and dementia champions are employed in all hospitals, and dementia specialist nurses are employed in line with Royal College of Nursing guidance³³.
- The Chief Executive Officer should ensure routine audit of in-hospital prescription of antipsychotics is carried out, which allows for comparison between wards and different departments.
- The Chief Executive Officer should ensure that their hospital is committed to being dementia friendly¹³.

Medical and Nursing Directors, and Heads of Therapy Directorates

- The Director of Nursing should ensure through regular and frequent review that protected mealtimes are fully implemented and ensure that this does not exclude support for people with dementia at mealtimes from their carers and families.
- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that:
 - People with dementia admitted to hospital receive a standardised or structured assessment of functioning based on activities of daily living, and that this is recorded.
 - People with dementia receive a pain assessment, suitable to the individual's cognitive functioning and ability to respond, leading to a full pain assessment in line with good practice guidance produced by the Royal College of Physicians, British Geriatrics Society and the British Pain Society³⁶.
 - All staff responsible for the assessment of older people have had training in the assessment of mental state using standardised measures.
- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that all staff (including support staff roles such as porters, housekeepers, administrators) are provided with basic training in dementia awareness and a locally agreed and specified proportion of ward staff receive higher level training. This should be implemented by June 2014.

- The Medical and Nursing Directors, with the Learning and Development departments, should conduct a skills gap analysis across different staff groups (including non-clinical staff) who are involved in delivering care and support for people with dementia, and draw up an action plan to meet the needs of their hospital. Competencies for each staff level/discipline should be developed and agreed. This should be implemented by March 2014.

Senior Clinical Lead for Dementia

- The Senior Clinical Lead for Dementia should ensure that the hospital has a care pathway in place that takes account of the needs of people with dementia at each stage of admission. This should be implemented by June 2014.
- The Senior Clinical Lead for Dementia should liaise with the Directors of Nursing and of Therapy, and the Medical Director to identify dementia champions and to support their role on wards.
- The Senior Clinical Lead for Dementia should ensure that a personal information document (e.g. "This is Me"⁹) is in use throughout the hospital, and is recorded and accessible in the patient's notes.
- The Senior Clinical Lead for Dementia should implement systems to ensure that all staff can easily identify people with dementia on the ward or when transferred to different departments, and provide an appropriate response to care and treatment needs (e.g. "Butterfly Scheme").
- The Senior Clinical Lead for Dementia should ensure that clinical teams can ascertain the involvement of patients' carers in treatment decisions, and all staff involved in the patient's care are aware of this. This should take into consideration mental capacity, stated wishes and best interests decisions (as defined under the Mental Capacity Act).
- The Senior Clinical Lead for Dementia should regularly review discharge policies with particular reference to the needs of people with dementia/their carers to ensure that they describe the task of discharge coordination and the importance of carer assessments.

Ward Managers and Multidisciplinary Teams

- Ward Managers should ensure that there is clear leadership and supervision available to staff on the ward regarding the care of people with dementia, and that this is supported with appropriate training and learning resources.

- Ward Managers should ensure that the care of the person is informed by their capacity, expressed wishes and their best interests. Taking this into account at all times, carers' views, knowledge and expertise should be sought and used to inform care planning and provision. Carers should be regularly updated and involved in discussions on care, treatment and discharge planning and receive adequate notice of discharge.
- Ward Managers should ensure that staff summarise and record pertinent information related to the person's dementia and/or delirium in the discharge documentation.
- Clinicians and Multidisciplinary Teams in the hospital should ensure, in line with their duty of care, that people with dementia receive a full assessment based on the British Geriatrics Society's guidance on comprehensive assessment of the frail older patient¹⁰.
- Clinicians and Multidisciplinary Teams in the hospital should carefully consider whether or not a prescription for antipsychotic medication is appropriate for someone with dementia and review the prescription on discharge from hospital to transfer to another setting.

Regulatory and Professional Bodies

- The General Medical Council and the Nursing and Midwifery Council should work with higher education institutions to deliver appropriate curricula for enhanced and specialist skills in dementia care, including requirements in undergraduate and postgraduate medical and nursing curricula.
- The Royal College of Psychiatrists, Royal College of Nursing, and Royal College of Physicians, with the British Geriatrics Society, should provide guidance on any circumstances in which PRN (as required) prescription of antipsychotics is appropriate.
- Future audit should include a module looking at whether people with dementia who are prescribed antipsychotics are receiving care and treatment in hospital according to guidance, whether prescription is appropriately reviewed, and take into account inappropriate prescription of other drugs used for sedation.

Background

The National Audit of Dementia (care in general hospitals) was established in 2008 with funding from the Healthcare Quality Improvement Partnership to examine the quality of care received by people with dementia in general hospitals. The first round of the National Audit of Dementia was carried out in 2010-11. The national report³⁹ published in 2011 concluded that hospitals needed to design and implement an integrated approach to the care of people with dementia and highlighted improvements to be made at all levels, including:

- Active involvement and leadership of the Executive Board.
- Comprehensive assessment of physical and mental health needs for adequate planning of care.
- Access to specialist services, including liaison psychiatry, ensuring timely response.
- Attention to nutritional standards and support.
- Collection of important personal details.
- Providing staff with support to understand best practice in communicating with people with dementia and carers.
- Training strategies in place to ensure dementia awareness for all staff and access to expert knowledge and leadership.
- Consistency in assessing required staffing levels for patients in need of extra support.
- Design that supports orientation, personal care choices and maintenance of independence.
- Discharge planning to adequately address ongoing healthcare needs and support family carers.
- Support for person-centred care based on awareness of dementia and acknowledging the person when addressing their care needs.

Findings from the first national audit of dementia care in hospitals

The first round of audit contained a hospital level (core) audit and the optional ward-level (enhanced) audit. The national report³⁹ for the first round of audit was published in 2011 and presented the findings from both the hospital-level and ward-level audit. The report can be downloaded from the audit's [website](#).

Context

The initial report findings reflected long standing concerns regarding the care and treatment of people with dementia and frailer older people in hospital reported by patients and carers, professional organisation and regulatory bodies. The *National Dementia Strategy*¹⁴ and *1000 Lives Plus*²⁸ brought together evidence on the need for improved care and presented key objectives and guidance.

Audit background and context

In 2011 a number of initiatives were underway to improve the quality of care and support, including at a national level the *Common Core Principles for supporting people with dementia*⁴¹ commissioned by the Department of Health, the Welsh Government's *1000 Lives Plus* guide²⁸, and the Royal College of Nursing's Dignity in Dementia project³⁰ which launched the five step plan for good dementia care, known as the SPACE principles³².

Government and organisational level initiatives

During the current audit period the care of people with dementia continues to be addressed as a high priority at government and organisation level. Hospital care was highlighted in the *Prime Minister's Challenge on Dementia*¹⁶ in 2012, working alongside the introduction of the CQUIN for dementia (Commissioning for Quality and Innovation payment framework)¹⁷. The new CQUIN aims to ensure identification of at least 90% of patients aged 75 or over with dementia or delirium on admission to hospital, to ensure appropriate assessment and follow up. Guidance is clear on the need for staff to be aware of and understand the reasons for data collection and to be appropriately skilled to carry out investigation, assessment, referral, and to record this accurately. The CQUIN was also updated in April 2013 to include local audit to ensure that carers feel adequately supported. The [progress report on the Challenge](#) shows CQUIN targets on track.

In Wales the national healthcare improvement programme, *1000 Lives Plus*²⁸ has produced a set of data collection tools specialised for different care settings to measure quality improvement targets in assessment and support. [Action plans](#) have been developed for each of the four priority areas identified in the National Dementia Vision for Wales to create dementia supportive communities: improved service provision, early diagnosis and assessment, improved access to information, and delivery of dementia awareness and ongoing training to all frontline health and social care staff.

The Dementia Action Alliance¹³ launched the National Dementia Declaration in 2012, and together with the NHS Institute, the call to create dementia friendly hospitals. This focuses on the key areas of the care environment, knowledge and skills of the workforce, the ability to identify and assess cognitive impairment, the ability to support discharge back home, and person-centred care plans involving families and carers. In 2013 the Dementia Action Alliance produced the [D:Kit](#), a self assessment resource to support hospitals in working towards becoming dementia friendly. This is based on questions derived from National Audit of Dementia standards⁴⁰ and audit tools, and aligned with the Dementia CQUIN¹⁷, the five core domains of the Royal College of Nursing³² SPACE principles and the NICE Quality Standards²³.

Ongoing focus on hospital care from patient/carer representative and professional bodies

The Alzheimer's Society⁶ report *Dementia 2013* recommends i) a focus at the strategic planning level, ii) dementia leads for commissioning groups and iii) that hospitals sign up to the Dementia Action Alliance Call to Action on dementia friendly hospitals.

Knowledge and awareness for staff is raised as key concern by the Alzheimer's Society as well as professional bodies. Staff who are skilled with time to care is a key principle of The Royal College of Nursing's³² SPACE principles. They also set out the importance of adequate staffing levels to support good care. In 2012 the Royal College of Nursing³¹ produced *Safe Staffing for Older People's Wards*, with detailed guidance on assessing staffing levels, and supported by a toolkit. Following on from the SPACE recommendation for dementia-specific roles, a study for the Royal College of Nursing³³ carried out by the University of Southampton, supports the development of the role of dementia specialist nurse, recommending one full time post for every 300 admission of people with dementia per year.

A comprehensive up to date overview of key national strategy documents, setting-specific guidance, and good practice resources can be found on the Royal College of Nursing's [website](#).

Audit structure and methodology

Data for the second round of audit were collected between April and October 2012. Local reports were sent to participating hospitals in February 2013 with an action planning form to be completed locally.

Each hospital was asked to complete:

- **a hospital organisational checklist** to audit the service structures, policies, key staff and care processes that impact on service planning and provision for the care of people with dementia within a general hospital;
- **a retrospective case note audit** of the records of a minimum of 40 patients with a diagnosis or current history of dementia, audited against a checklist of standards that relate to their admission, assessment, care planning/delivery, and discharge. Audit was of a single admission, and eligible admissions were of five days or longer between the period of September 2011 to February 2012.

Data for both modules were submitted via a secure online survey.

Audit standards

The National Audit of Dementia is underwritten by a manual of standards⁴⁰. Standards for audit were compiled for the first round of audit and were developed from a literature review and in consultation with stakeholder groups and organisations. The literature review identified source documents for the audit. These included:

- national reports and guidelines;
- standards, guidelines and recommendations issued by professional bodies;
- reports and recommendations issued by organisations representing service users and carers. A secondary review identified key areas of concern for service users and carers in terms of experience of care received.

For the second round of audit, standards have been updated where necessary in line with national guidance and recommendations. As a main aim of the second round of audit is to measure progress, in general, standards have remained the same. As only hospital-level data were collected in the second round of audit, some standards applicable in the first round were not measured.

Inter rater reliability

For each hospital site, five case notes from the sample submitted were re-audited by a second auditor and results compared. We advised that the first five case notes should be re-audited. Where this was not possible any five were chosen. The inter rater reliability analysis can be found on the audit's [website](#).

Changes made to the data

- When auditors commented that there was no record of any history or diagnosis of dementia, case notes were excluded from the sample.
- Specific answers were removed and left blank if comments indicated that an answer was not provided for certain questions on the audit tool.
- When it was possible to confidently identify errors in responses from comments returned, these responses were marked and the answer changed. Where it was not possible to identify error with complete confidence from the comment, no change was made.
- Where comments indicated that some of the questions were not applicable to all patients in the sample, e.g. patients receiving end of life care, these patients were excluded from the analysis of these questions.

Second round of audit

The National Audit of Dementia was open to all general acute hospitals, or those providing general acute services on more than one ward that admit people over the age of 65, in England and Wales. All identified eligible hospitals received initial and follow up invitations to register.

151 Trusts/Health Boards and 215 hospitals were identified as eligible across England and Wales. Recruitment for the audit was carried out over a 6 month period, with Trusts/Health Boards still registering their hospitals a month before data collection began.

At the time of data collection 100% of Trusts/Health Boards had registered one or more of their eligible hospitals. This gave a total of 210 hospitals participating in the audit (98% of eligible hospitals identified).

Table 1: Participation breakdown by region.

Region in England and Wales	Number of eligible hospitals	Number of participating hospitals	Percentage of hospitals participating
London	32	32	100%
North (formerly North West, North East, Yorkshire and the Humber)	66	63	95%
Midlands (formerly West Midlands, East Midlands, East of England)	51	50	98%
South (formerly South West, South Central, South East Coast)	48	48	100%
Wales	18	17	94%

All registered hospitals submitted data for the audit: 210 hospitals submitted a hospital organisational checklist and 206 hospitals audited case notes.

Table 2: Data received in both modules.

Audit module	Number of hospitals (N=210)	Data received
Organisational checklist	210	210 checklists
Case note audit	206	7987 case notes

Of the hospitals that participated, 78% met the minimum target sample of 40 case notes. All participating hospitals submitted sufficient case notes to receive a local report.

Table 3: Breakdown of case notes submitted, per hospital site.

Sample size	Number of hospitals (N=206)	Percentage of hospitals
40 – 50 case notes	161	78%
30 – 39 case notes	35	17%
20 – 29 case notes	10	5%

Participation in both rounds of audit

201 hospitals participated in both rounds of audit. All of these hospitals submitted an organisational checklist for both rounds and 195 hospitals submitted case note audit data in both rounds. Please see the list of participating hospitals on the audit's [website](#).

Case note sample patient information

The tables below show information about the people with dementia whose notes were audited. A total of 7987 case notes were submitted from 206 hospitals.

Table 4: Patient information from the audited case notes.

Age range	Percentage of case notes
33 – 65	2%
66 – 80	25%
81 – 100	73%
101 – 106	0.3%

Age range	Average age (years)
33 – 106	84

Gender	Percentage of case notes
Male	38%
Female	62%

Ethnicity	Percentage of case notes
White British	81%
Not documented	14%
Other ethnic group	5%

First language	Percentage of case notes
English	77%
Not documented	19%
Other language	4%

Speciality of the ward patients spent the longest time in	Percentage of case notes
Care of the elderly	40%
General medical	25%
Orthopaedics	11%
Surgical	6%
Stroke	5%
Other medical	11%
Other speciality	2%

Case note sample patient information

Length of stay in the hospital	Percentage of case notes
4 – 10 days	38%
11 – 20 days	28%
21 – 30 days	14%
31 – 40 days	8%
41 – 50 days	5%
51 – 60 days	3%
61+ days	5%

Range in length of stay (days)	Median length of stay (days)
4 – 257	14

Place of residence before/after admission	Percentage of case notes	
	Before	After
Own home	55%	35%
Respite care	1%	2%
Rehabilitation/long stay care	1%	3%
Psychiatric ward	1%	1%
Carer's home	2%	2%
Intermediate care	1%	3%
Residential care	19%	20%
Nursing home	20%	31%
Palliative care	0%	0.4%
Transfer from/to another hospital	1%	4%

Change in residence	Percentage of case notes
No change	69%
Own/carer's home to nursing/residential care	14%

Patients who:	Percentage of case notes
Died in hospital	13%
Self-discharged from hospital	1%
Received end of life care in hospital	11%

How the audit findings are presented

National results

This report contains the amalgamated data submitted by all hospitals in England and Wales that participated in the second round of audit. Results from both modules of the audit, the organisational checklist and case note audit, are presented together:

- 210 hospitals submitted organisational checklist data in the second round of audit.
- 206 hospitals submitted case note audit data in the second round of audit.

Comparison between first and second rounds of audit

Audit tools have been revised since the first round of audit, in line with the updating and amendment of the standards. This has meant modification or replacement of some questions. Comparisons between rounds are made where questions in each round were identical, or where only minor changes were made.

Where possible, in this report we present the overall change that has taken place since the first round of audit, using the national results from the first and second rounds of audit. National results comprise all hospitals that participated in each round of audit, including hospitals that participated in the first or second round of audit only.

210 hospitals submitted data for each round of audit. Of these, 201 submitted an organisational checklist in both rounds and 195 submitted case note audit data in both rounds. A table comparing results from those hospitals that submitted data for both rounds of audit can be found on the audit's [website](#).

Audit themes

Results are presented thematically, with data from each audit module presented together. The themes are:

1. **Governance**
2. **Assessments**
3. **Antipsychotic prescription: protocol and practice**
4. **Liaison psychiatry services**
5. **Hospital discharge and transfers**
6. **Information and communication**
7. **Staff training**

This chapter presents findings from the organisational checklist. It looks at systems and processes in place within the hospital, and how they take into account the needs of people with dementia; the involvement of the Executive Board in reviewing information related to people with dementia; and support and leadership in place to oversee the delivery of care for people with dementia across the hospital.

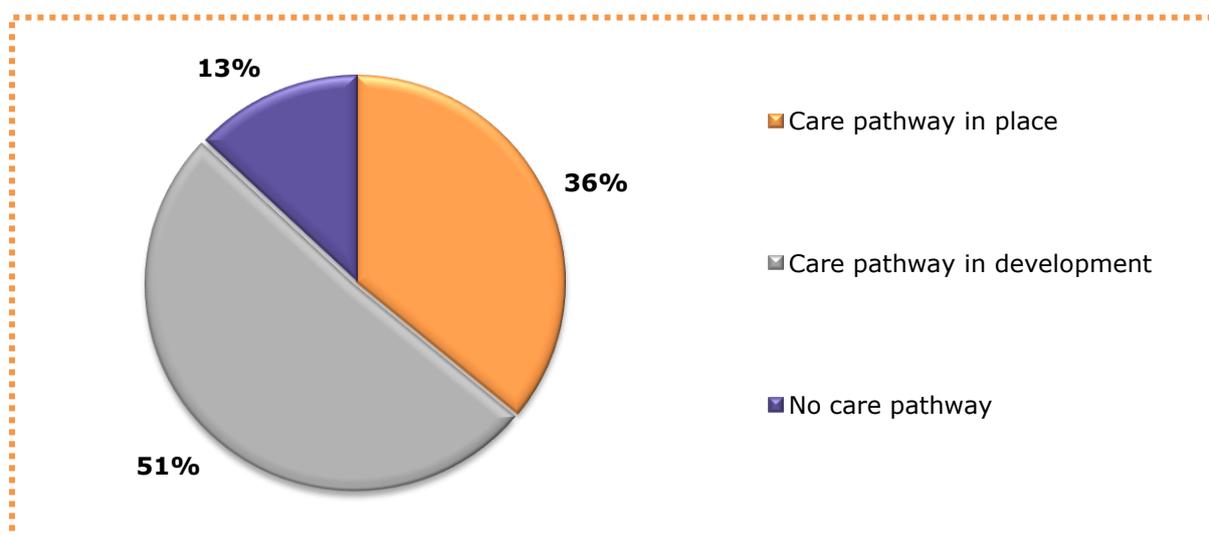
The first round of audit found a general lack of leadership within hospitals with respect to measures and resources relating to the care of people with dementia and a lack of involvement from Executive Boards. In the audit's first national report³⁹ we made several recommendations related to these areas:

- The care pathway for dementia should be adaptable for use within, or fitted to, existing acute care pathways.
- A senior clinician should be appointed to develop, implement and review the care pathway for people with dementia.
- The Executive Board should be reviewing clinical information on admission rates, falls, treatment and discharges, in which people with dementia can be identified.
- Dementia champions should be identified in each department in the hospital, and at a ward level.

Care pathway

In the first round of audit only 6% of hospitals reported having a care pathway for dementia. Irrespective of the primary cause of admission to hospital, it is vital that the dementia is taken into account throughout the admission so the patient's whole-person needs are considered in their care plan³². Figure 1 shows that in the second round of audit, the majority of hospitals now have a care pathway either in place (36%, 75/210) or in development (51%, 106/210).

Figure 1: Hospitals with a care pathway for people with dementia (N = 210).



Care pathway and clinical leadership

The 2011 national report recommended every hospital should appoint a senior clinician who has designated time to undertake the implementation of the care pathway across the hospital.

In the second round of audit the majority of hospitals (81%, 171/210) had a senior clinician responsible for the implementation of the care pathway, which was either in place or in development. In the first round of audit less than half of hospitals had this in place.

Integrated care pathways for people with dementia

The first national report recommended hospitals should have a care pathway in place for dementia that is adaptable for use within, or fitted to, existing acute care pathways. In the second round of audit, additional information about the care pathway was collected:

96% (72/75) of hospitals' care pathways for dementia were adaptable for use within, or fitted to, acute care pathways.

81% (61/75) of hospitals' care pathways for dementia were adaptable for use within, or fitted to, palliative care pathways.

87% (65/75) of hospitals' care pathways for dementia were adaptable for use within, or fitted to, end of life care pathways.

Involvement of the Executive Board

Executive Boards should ensure the standards of care in hospitals are acceptable by monitoring information regarding quality effectiveness, patient safety and patient experiences²⁵. It is their responsibility to review this information, and to take action when concerns arise from the feedback collected, particularly if issues have been raised by patients themselves, and their carers.

The Francis Inquiry into the Mid Staffordshire NHS Foundation Trust⁴² showed that the Trust's Executive Board did not appropriately act when concerns were raised and when evidence showed that standards of care were low. The Inquiry highlighted concerns about Executive Boards failing to lead, resulting in poor care for patients.

The first round of audit found Executive Boards were not routinely reviewing information related to people with dementia: the number of readmissions, delayed discharges and in-hospital falls, complaints, and patient feedback. The audit's first national report recommended Executive Boards should ensure they review key procedures to include the needs and perspectives of people with dementia. Results from the second round of audit show some improvement has been made in all areas (see figures 2 and 3). Shortfalls are still evident, with all audited areas of patient information being reviewed by less than 50% of Executive Boards.

Figure 2: Patient information reviewed by the Executive Board (N=210).

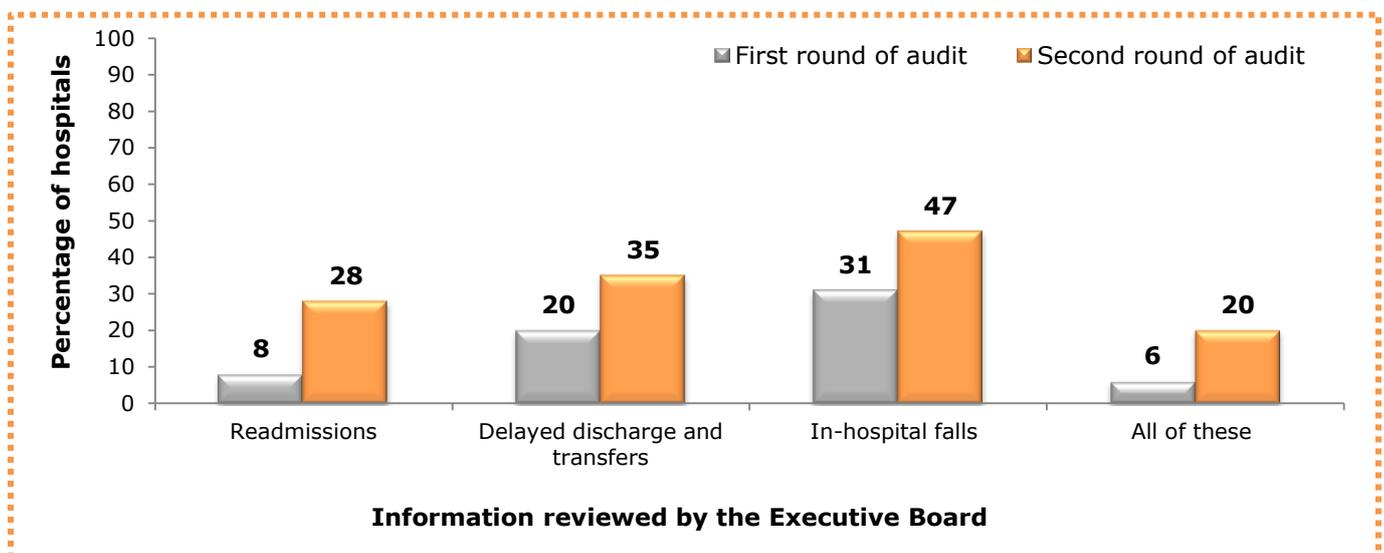
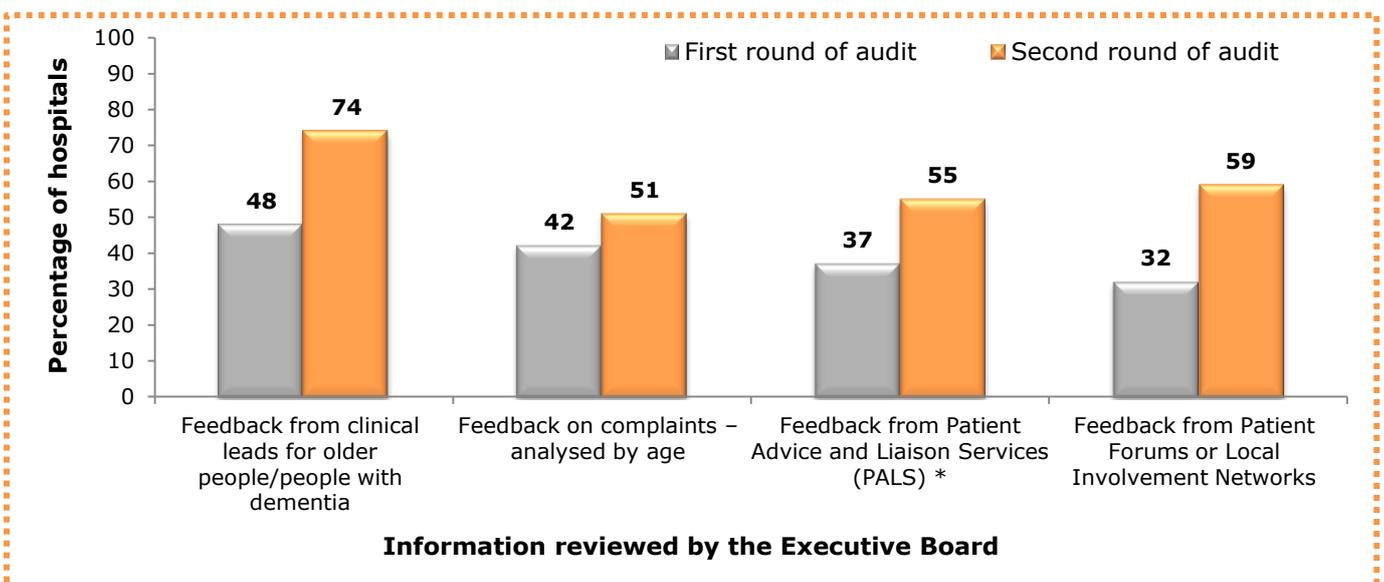


Figure 3: Executive Boards reviewing feedback about older people and people with dementia (N=210).



* Hospitals in Wales were excluded from this question as they do not have PALS.

Dementia champions

The Royal College of Nursing's Commitment to Dementia³² sets out as a key principle that hospital staff caring for people with dementia have the right skills, knowledge and attitude. Surveys of people with dementia, their carers and professionals have indicated that a specialist post dedicated to dementia is associated with changes in practice and delivery of good quality care³². This dementia-specific post was seen to be particularly important for carers and people with dementia in supporting them during the admission to hospital³². In the audit's first national report we recommended that dementia champions should be identified in each department in the hospital, and at a ward level. In the second round of audit we found:

82% (172/210) of hospitals have dementia champions at directorate level.

76% (160/210) of hospitals have dementia champions at ward level.

It is important that dementia champions receive the appropriate support and training to carry out the responsibilities of this role. The Royal College of Nursing survey³⁰ reported healthcare professionals felt there was a lack of support in the development of dedicated roles for dementia. The survey also identified a need for more in-depth training for ward champions and leaders, which may indicate there could be variance in relation to the knowledge, experience and commitment of these specialist roles. The Royal College of Nursing³³ recommends the development of dementia specialist nurse roles in the acute setting to improve health outcomes for people with dementia, and to provide education and leadership to non-specialists within the organisation. The report, based on findings prepared by the University of Southampton, recommends one full time specialist nurse for every 300 admissions to hospital per year of people with dementia.

Protected mealtimes

Implementing protected mealtimes on wards admitting people with dementia is key to ensuring patients' individual needs are met and adequate support is provided at mealtimes. Age UK² recommends hospitals should implement strategies to increase the effectiveness of protected mealtimes and to ensure all mealtimes are covered. The second round of audit found:

96% (202/210) of hospitals have protected mealtimes established in all wards admitting adults with known or suspected dementia. Of these hospitals, 97% (196/202) report the wards' adherence to protected mealtimes is reviewed and monitored.

It is reassuring that nearly all hospitals have implemented protected mealtimes across the hospital and are monitoring them. However, inconsistencies have been reported across the NHS in England and Wales, such as variance in the number of wards that had protected mealtimes in place and whether all mealtimes were included^{2,26}.

Sufficient staffing levels should be in place to support patients in eating, as protected mealtimes will only be effective if patients are able to get the help and assistance they need. Carers, family and volunteers can also provide extra support, encouragement and company to patients at mealtimes¹.

Conclusion

The audit shows evidence that a high number of hospitals now have a care pathway in place or in development, with a senior clinician responsible to develop and oversee this work. Dementia champions have been appointed in the majority of hospitals at both directorate and ward level.

There is still a need for Executive Boards to be more involved in reviewing information related to people with dementia when admitted to general hospitals, such as readmissions, delayed discharges and in-hospital falls.

Overall, there are some encouraging improvements at an organisational level, suggesting more attention is being given to governance related issues within the general hospital. It is now important to establish whether these improvements and leadership in place are reflected in actual practice and are leading to better care experiences and outcomes for people with dementia. Future audits should report on the experiences of care from the perspective of patients and carers.

Recommendations

- The Chief Executive Officer should ensure that the Trust/Health Board identifies a senior clinician in each hospital to oversee high quality care for people with dementia and specifically to take charge of developing, implementing and monitoring the care pathway for dementia. This should be implemented by June 2014.
- The Chief Executive Officer should ensure that their hospital is committed to being dementia friendly¹³.
- The Senior Clinical Lead for Dementia should ensure that the hospital has a care pathway in place that takes account of the needs of people with dementia at each stage of admission. This should be implemented by June 2014.

- The Trust Board/Council of Governors/Board of the Health Board should ensure they are presented with information on the review of key policies and procedures to include the needs and perspective of people with dementia and their carers, including the following as evidence that action is taken:
 - Evidence relating to Trust performance against Dementia CQUIN targets on identification, assessments and referral for people with suspected cognitive impairment and of identification and management of delirium.
 - Clinical information on admission rates, falls, intra-hospital ward transfers, treatment and discharges, in which people with dementia can be identified.
 - Evidence that person centred care is practiced throughout the Trust, for example using "This is Me"⁹ or a similar personal information document.
 - Evidence that a training programme is underway addressing competencies and skill development for staff working with people with dementia, and that this is suitable for a range of competency levels and roles.
 - Evidence from local audit of in-hospital prescription of antipsychotics that their prescription is in line with guidance.
 - Trust Board members should undertake training to become a dementia friend.

Trusts should consider including this information in their Quality Accounts. Health Boards should consider including this information in their Quality and Safety Committee Reports.

- Commissioners/Health Boards should ensure that contracts, incentives and outcome measures support hospitals in providing high quality care for people with dementia, taking account of specific guidance on resources for care and dementia specialist roles such as that published by the Royal College of Nursing³³.
- The Chief Executive Officer should ensure that dignity leads and dementia champions are employed in all hospitals, and dementia specialist nurses are employed in line with Royal College of Nursing guidance³³.
- The Senior Clinical Lead for Dementia should liaise with the Directors of Nursing and of Therapy, and the Medical Director to identify dementia champions and to support their role on wards.
- The Director of Nursing should ensure through regular and frequent review that protected mealtimes are fully implemented and ensure that this does not exclude support for people with dementia at mealtimes from their carers and families.

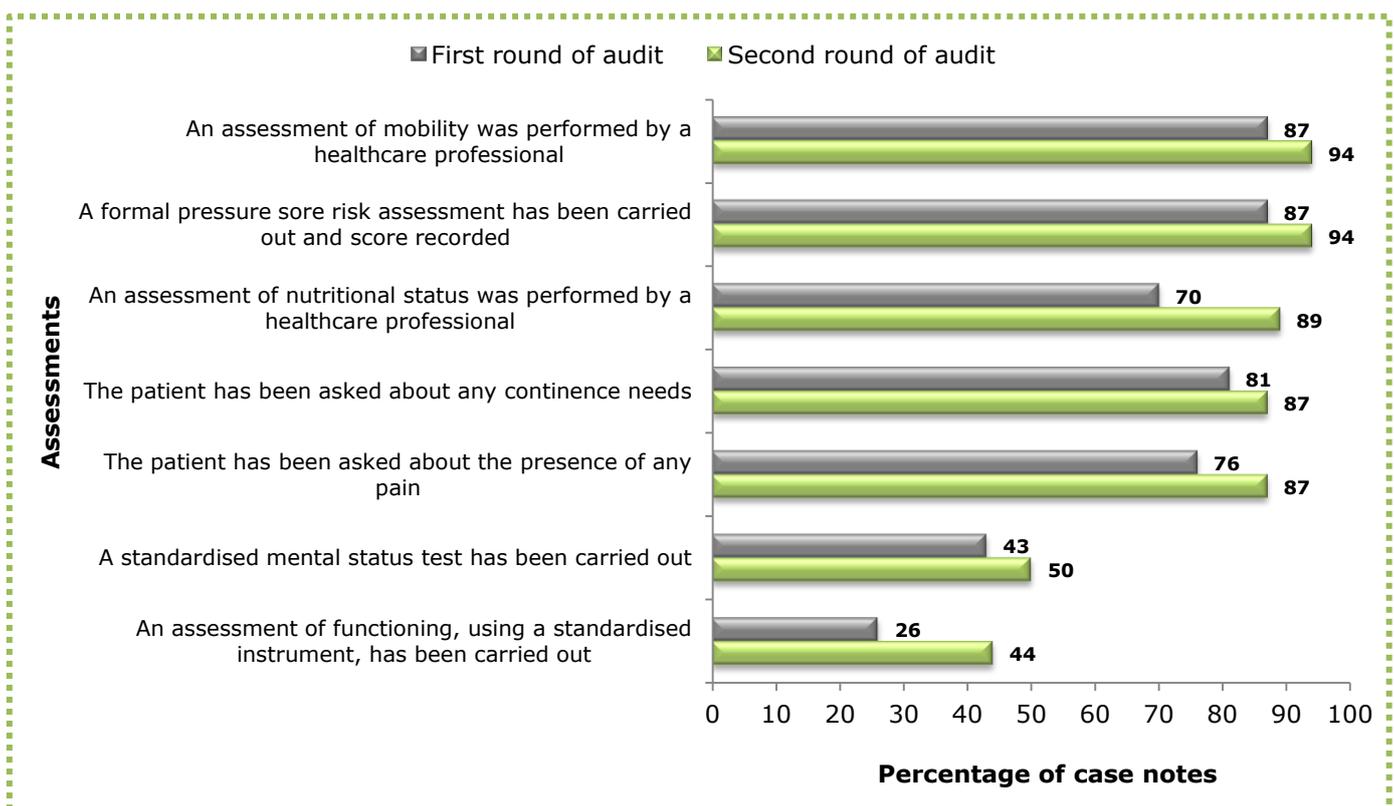
This chapter presents findings from both the organisational checklist and the case note audit. It looks at healthcare assessments received by people with dementia when they are admitted to hospital.

The first round of audit found there was a disparity between the policies hospitals had in place, and their actual practice. Assessments of physical health were carried out more frequently, compared to mental health needs. In 2011, the audit's first national report³⁹ recommended the Trust Board should require evidence that assessments of nutritional status, pressure sore, cognitive functioning and delirium had been carried out.

Comprehensive assessment for older people in hospital

Comprehensive assessment of health needs is key to the quality of in-hospital care delivered, and to longer term outcomes for frailer and older patients, including people with dementia^{10,34}. The British Geriatrics Society¹⁰ recommends all older patients admitted to hospital should have a comprehensive assessment which takes into account their physical, psychological and emotional needs. There is evidence this holistic approach leads to better outcomes for older people¹¹. The audit's first national report highlighted several elements of assessment as requiring improvement. Figure 4 compares findings from the case note audit in this round, with findings from the first round of audit.

Figure 4: Evidence of assessments in case notes in the first and second round of audit.



2. Assessments

The assessments shown are those where audit questions were directly comparable between rounds. The second round of audit shows significant increases in the proportion of patients receiving these assessments.

Mental status test

While nearly all hospitals (97%, 203/210) reported their written procedure for multidisciplinary assessment includes assessment of mental state, only half (50%, 3548/7069) of the case notes included evidence that a standardised mental status test had been carried out.

Assessment of functioning

The proportion of patients receiving an assessment of functioning appears to be considerably lower. The audit did not ask about the structured, but unstandardised assessments, commonly contained in routine nursing assessments, which could affect the figure.

Assessment of delirium

New questions for assessment of delirium were included in the second round of audit, based on the NICE clinical guideline²². An assessment for indicators of delirium should be carried out in all patients at risk. People with dementia have a five fold increased risk of developing delirium³⁷, so if any indication of delirium is present, a healthcare professional trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis²². The second round of audit found:

55% (115/210) of hospitals had a policy or guideline in place to ensure patients with dementia are assessed for the presence of delirium at presentation. 41% (86/210) of hospitals had this in development.

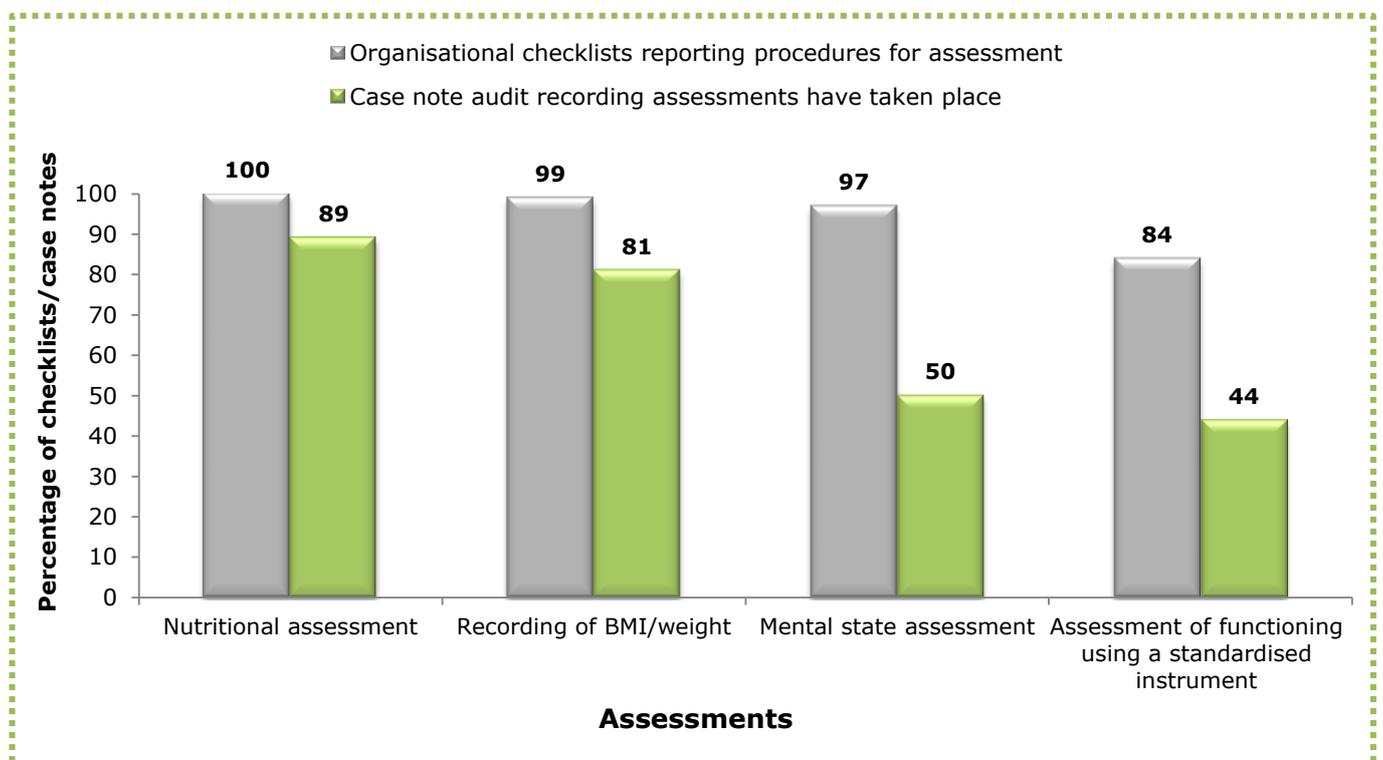
Approximately half (49%, 103/210) of hospitals had a policy or guideline in place to ensure patients with dementia with behaviour changes suggesting the presence of delirium, are clinically assessed by a healthcare professional who is trained and competent in the diagnosis of delirium. 43% (91/210) of hospitals had this in development.

38% of case notes (3000/7986) showed an initial assessment for indicators of delirium had been carried out. Of the case notes showing indications that delirium may be present, 86% (1497/1747) showed the patient had been clinically assessed by a healthcare professional.

Assessment and governance

In both rounds of audit, hospitals were asked about the policies and procedures they had in place, and case notes of people with dementia were audited, looking for evidence of assessments that had been carried out. The first round of audit established that having policies in place did not necessarily reflect in practice.

Figure 5: Percentage of hospitals including assessment items in their policies, compared with the percentage of case notes containing evidence of the assessment.



Conclusion

Results overall show improvements in physical health assessments, although there is still room to improve further. These are basic healthcare needs for which all frail or vulnerable patients will require assessment.

In terms of mental health and delirium assessments, much remains to be done to ensure people with dementia are adequately assessed. The NICE clinical guideline²² on the diagnosis, prevention and management of delirium highlights the association of delirium with longer length of stay, hospital acquired infections, admission to long term care, and death. Proper assessment, therefore, will improve care and outcomes.

Failure to assess and plan for mental health needs, impacts significantly on people with dementia admitted to hospital, and may prevent physical health needs from being adequately assessed and cared for³⁷. For example, a person experiencing confusion may resist or refuse attempts to carry out assessments. Assessing cognitive function is also an essential part of discharge planning.

Recommendations

- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that:
 - People with dementia admitted to hospital receive a standardised or structured assessment of functioning based on activities of daily living, and that this is recorded.
 - People with dementia receive a pain assessment, suitable to the individual's cognitive functioning and ability to respond, leading to a full pain assessment in line with good practice guidance produced by the Royal College of Physicians, British Geriatrics Society and the British Pain Society³⁶.
 - All staff responsible for the assessment of older people have had training in the assessment of mental state using standardised measures.
- Clinicians and Multidisciplinary Teams in the hospital should ensure, in line with their duty of care, that people with dementia receive a full assessment based on the British Geriatrics Society's guidance on comprehensive assessment of the frail older patient¹⁰.

3. Antipsychotic prescription: protocol and practice

This chapter presents findings from both the organisational checklist and the case note audit. It looks at the guidance hospitals have in place for interventions for behavioural and psychological symptoms of dementia; and evidence of prescription of antipsychotic drugs in the case notes.

The first round of audit highlighted the need to assess and review antipsychotic prescription. In 2011, the audit's first national report³⁹ recommended:

- Admission to hospital should be highlighted as a review point for any use of antipsychotic medication.
- Clear guidance should be in place for interventions for behavioural and psychological symptoms of dementia.

Approaches to behavioural and psychological symptoms of dementia (BPSD)

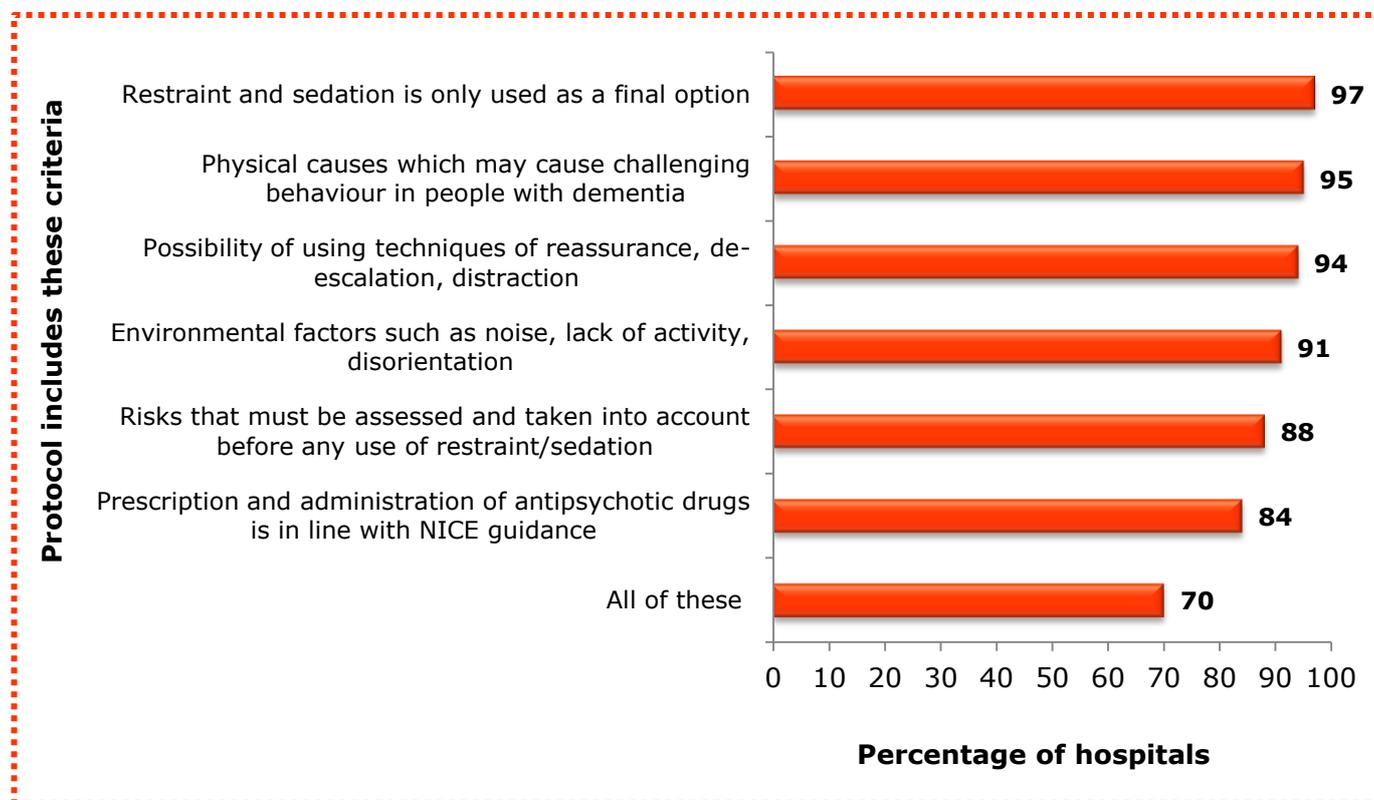
The second round of audit found 61% (128/210) of hospitals now report having a protocol in place governing the use of interventions for patients displaying violent or challenging behaviour, aggression, and extreme agitation, which is suitable for use with patients who present with behavioural and psychological symptoms of dementia. A further 30% (63/210) of hospitals state that such a protocol is in development.

In the first round of audit, only around a third of hospitals had such a protocol in place.

In order to meet its purpose, the protocol should clearly set out a stepped approach to any challenging behaviour, including low intervention techniques such as distraction and ensuring that any possible causes of distress are taken into account.

3. Antipsychotic prescription: protocol and practice

Figure 6: Key criteria included in the protocol governing response to behaviour that challenges (N = 128).



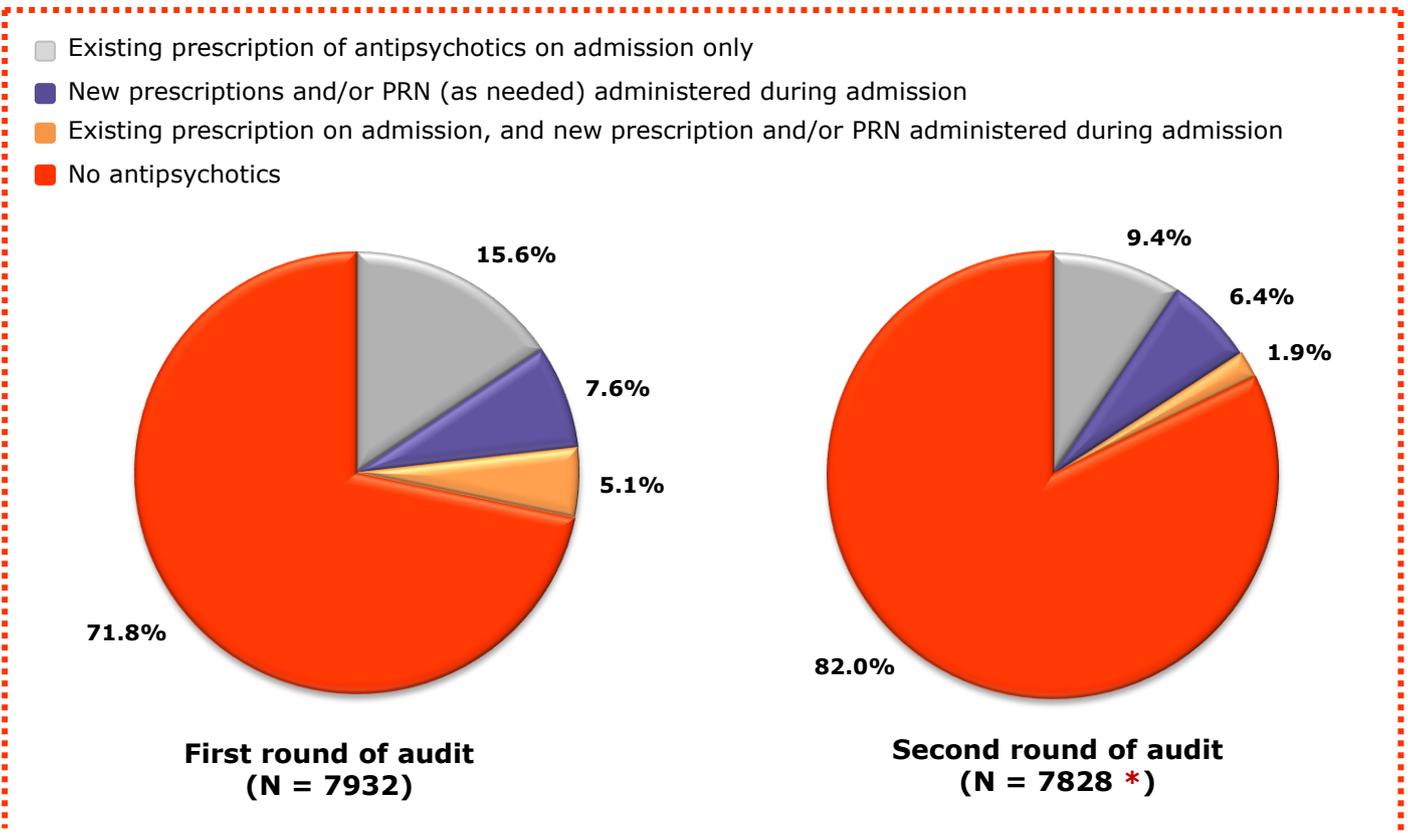
Prescription of antipsychotic drugs

The requirement to reduce prescription of antipsychotics to people with dementia has remained a point of focus for campaigns and initiatives for person-centred care in the hospital setting. The NHS Institute and Dementia Action Alliance²⁷ highlight this, calling for hospital doctors and multidisciplinary teams to consider whether or not a prescription for antipsychotic medication is appropriate for someone with dementia when in hospital. They should also be committed to reviewing the prescription of antipsychotics on transfer or discharge from hospital to another setting.

The audit looked at information in case notes about antipsychotic drugs given to people with dementia during their admission.

3. Antipsychotic prescription: protocol and practice

Figure 7: Prescription of antipsychotics recorded in case notes in both rounds of audit.



* In the second round of audit, there was an 'information cannot be found' response option available. In this figure, these case notes have been excluded.

The figures show a decrease of approximately 10% overall in the proportion of people with dementia who received any antipsychotics during their admission. This decrease in existing prescriptions may represent a fall in prescription in the community, as the *National Dementia and Antipsychotic Prescribing Audit*¹⁹ (health and social care) showed a reduction in GP prescription between 2006 and 2011.

When a PRN prescription (as needed) was in place, it was administered in 75% (404/538) of cases.

3. Antipsychotic prescription: protocol and practice

Care homes and antipsychotic use

In the second round of audit, 17% (514/3110) of patients admitted from residential care or nursing homes were taking antipsychotics on admission. This is twice as high as the proportion of patients admitted from other settings with a prescription of antipsychotics (8%, 392/4877), such as own home or carer's home.

The proportion overall is smaller than in the first round of audit, when 30% of patients admitted from a care home, and 14% of patients admitted from other settings, were taking antipsychotics on admission. Relative proportions are the same.

Continuation of prescription

We included a further question in this round of audit to ascertain whether prescriptions were continued post discharge. This was asked only when there was evidence of any antipsychotic prescription and the patient was discharged directly to a community setting (for example, the patient's own home or to residential care).

58% (623/1068) of these patients had a continuing prescription. This represents 8% (623/7987) of patients in the total sample, leaving hospital with a prescription in place.

Conclusion

Most hospitals now report protocols governing interventions for behavioural and psychological symptoms of dementia are in place or in development.

Antipsychotic prescriptions overall have fallen. To determine the need and extent of in-hospital prescription, a more in-depth audit module should ask whether people with dementia who are prescribed antipsychotics are receiving care and treatment in hospital according to guidance, and whether prescription is appropriately reviewed.

Such an audit should take into account that other drugs, such as sedatives, used for sleep disorders and anxiety, can be inappropriately prescribed in community and hospital settings.

3. Antipsychotic prescription: protocol and practice

Recommendations

- The Chief Executive Officer should ensure routine audit of in-hospital prescription of antipsychotics is carried out, which allows for comparison between wards and different departments.
- Clinicians and Multidisciplinary Teams in the hospital should carefully consider whether or not a prescription for antipsychotic medication is appropriate for someone with dementia and review the prescription on discharge from hospital to transfer to another setting.
- The Royal College of Psychiatrists, Royal College of Nursing, and Royal College of Physicians, with the British Geriatrics Society, should provide guidance on any circumstances in which PRN (as required) prescription of antipsychotics is appropriate.
- Future audit should include a module looking at whether people with dementia who are prescribed antipsychotics are receiving care and treatment in hospital according to guidance, whether prescription is appropriately reviewed, and take into account inappropriate prescription of other drugs used for sedation.

4. Liaison psychiatry services

This chapter presents findings from both the organisational checklist and the case note audit. It looks at the reported availability of liaison psychiatry services and referrals to liaison psychiatry.

The first round of audit found most hospitals reported access to liaison psychiatry, but a lack of availability at evenings and weekends. Hospitals commented that provision of liaison psychiatry for working age and older adults may differ. In 2011, the audit's first national report³⁹ recommended that liaison psychiatry services should be in place and accessible over 24 hours for referral and treatment of people with dementia.

Access to a liaison psychiatry service

*Liaison Psychiatry in the Modern NHS*²⁹ states that older people should be a priority for liaison psychiatry services as they account for about 80% of all hospital bed-days that are occupied by people with physical and mental health problems. The report also provides an analysis of current liaison psychiatry provision, highlighting the "striking degree of variability which is found around the country both in levels of provision and in models of service delivery". The report recommends a dedicated specialist liaison service based in the hospital for every general and acute hospital, with provision on an all ages, all conditions basis, wherever possible.

The audit gathered information about services in place, consultant leadership and availability of services by age group and according to where they are based.

Availability, leadership and specialism

Nearly all hospitals (94%, 198/210) reported having access to a liaison psychiatry service, and 85% (168/198) of these were able to provide emergency or urgent assessment.

Of the hospitals that do have access to a liaison psychiatry service:

- 82% (162/198) had a named Consultant Psychiatrist lead. In the first round of audit, 75% of hospitals reported having this.
- 68% (135/198) had a Consultant Psychiatrist lead with dedicated time and specialising in the care and treatment of older people. In the first round of audit, 50% of hospitals reported having this.
- Nearly all (96%, 189/198) reported the service is provided by a specialist mental health team (rather than individual practitioners).

4. Liaison psychiatry services

This round of audit asked whether liaison psychiatry services, provided by specialist mental health teams, were able to regularly provide assessment and treatment to working age and to older adults:

69% (130/189) of hospitals reported the service regularly provides routine mental health care to working age and older adults.

28% (52/189) of hospitals reported the service covered older adults only.

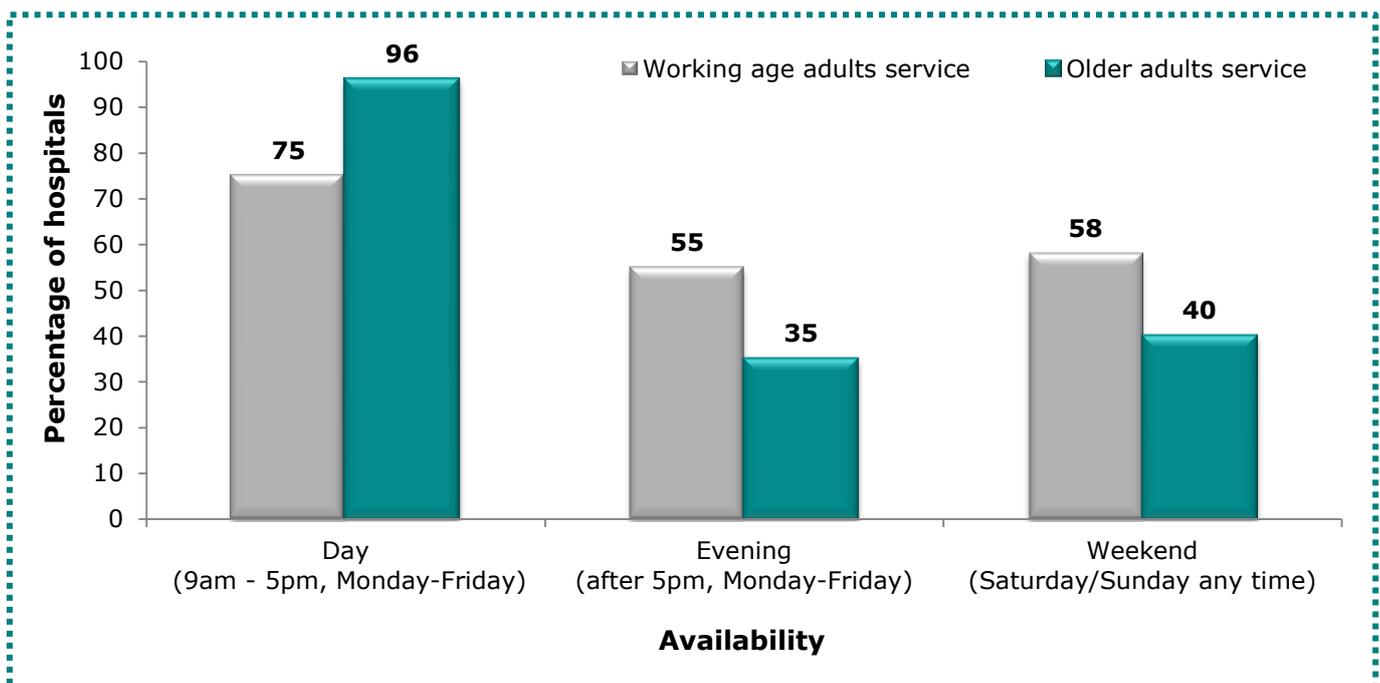
Variation in provision

Feedback from hospitals in the first round of audit highlighted a lack of availability at evenings and weekends, and hospitals also commented that provision of liaison psychiatry for working age and older adults may differ. The second round of audit found:

Only a third (33%, 62/189) of hospitals with access to a liaison psychiatry service provided by specialist mental health teams, had access to an older adult's service during the day, evening, and weekend.

Out-of-hours availability

Table 8: Availability of liaison psychiatry services provided by specialist mental health teams (N = 189).



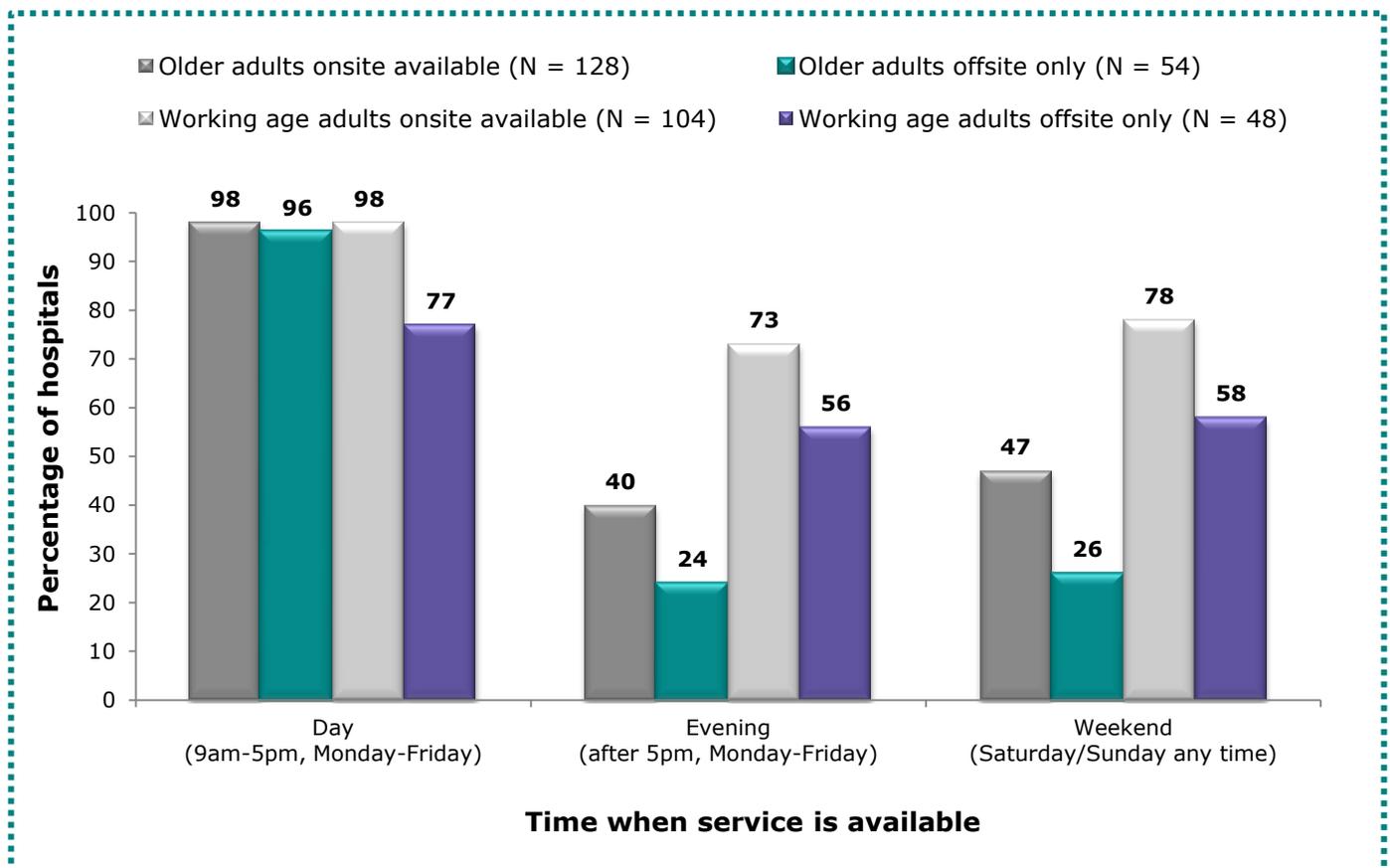
NB Audit questions were confined to day, evening and weekend provision and therefore do not cover 24 hours (evening may have included night in some instances).

4. Liaison psychiatry services

On and off site provision

The audit found out-of-hours availability is higher where onsite services are available than when provision is offsite only, particularly at weekends. Overall, 22% (42/189) of hospitals access working age adults and/or older people services offsite only.

Figure 9: Availability of liaison services out-of-hours: offsite/onsite comparison.

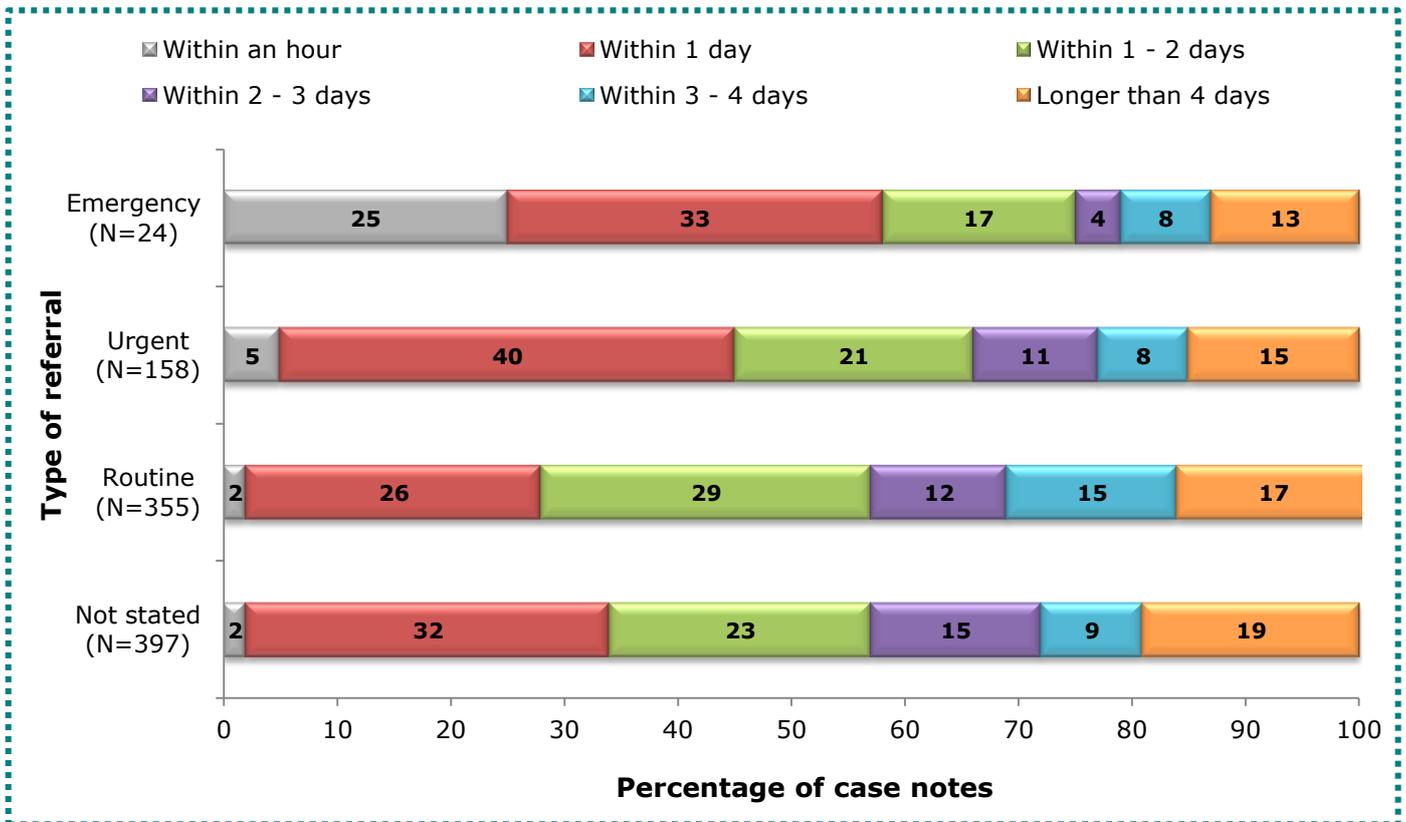


Referral to liaison psychiatry

16% (1291/7916) of case notes contained a referral to liaison psychiatry. We asked about the response time between referral and assessment, depending on urgency. The audit found only about half of the case notes (49%, 629/1291) contained any information about the urgency of the referral. Response times were not documented in approximately a quarter of case notes (24%, 315/1291).

4. Liaison psychiatry services

Figure 10: Time between referral and assessment by urgency of referral.



It should be noted that the total numbers, particularly for emergency and urgent referrals, are very small in comparison with the main dataset. The target response times for referrals are within an hour for emergency referrals, within a day for urgent referrals, and within two days for routine referrals³⁸. The audit found:

A quarter (25%, 6/24) of case notes met the target response time for emergency referrals.

45% (71/158) of case notes met the target response time for urgent referrals.

57% (200/355) of case notes met the target response time for routine referrals.

Only 42% (546/1249) of all referrals were seen within two days. This is likely to be affected by the lack of out-of-hours provision (as seen in figure 9).

4. Liaison psychiatry services

Conclusion

Nearly all hospitals report having access to a liaison psychiatry service. We do not have information on the commissioned status of the services and this could be important in terms of different models in place and their ability to respond. Some hospitals may not be clear on the distinction between general mental health services, and the more specialised service of liaison psychiatry, which provides expertise in treating general hospital patients and is the preferred model in a general hospital setting.

The variation in service models for liaison psychiatry, particularly variation in out-of-hours provision, is likely to affect older people's care. Audit data shows provision is not adequate to provide access over 24 hours, and availability is lower where services are offsite. Response times, where referrals are categorised, typically do not meet target times for emergency and urgent responses. It should also be noted that although there has been a significant increase in services led by a psychiatrist specialising in the care and treatment of older people, 36% of hospitals do not have this in place.

Although improvement in access and in specialist leadership can be discerned from these figures, it will be an important objective for commissioners to ensure that an onsite dedicated liaison psychiatry service, with the ability to respond to the needs of people with dementia and other patients, is available in all general hospitals.

Recommendations

- Commissioners/Health Boards should ensure that liaison psychiatry services are in place to provide adequate access over 24 hours for treatment and referral of people with dementia in hospital. This should include the ability to provide an emergency or urgent response over 7 days. Response times, together with patient outcome measures as they are developed, should be a key performance indicator for these services.

5. Hospital discharge and transfers

This chapter presents findings from the organisational checklist and the case note audit. It looks at hospitals' discharge and transfer policies; discharge coordination and the involvement of carers and people with dementia in the discharge process; the support available to carers; and notice of discharge.

The first round of audit found that more attention should be given to early discharge planning, and people with dementia and carers should be given a copy of the discharge plan to ensure discharge discussions and decisions were understood. The 2011 national report³⁹ made recommendations related to these areas:

- Discharge policies, with particular reference to the needs of people with dementia and their carers, should be reviewed to ensure they describe the task of discharge coordination and the importance of a carer's assessment.
- Notification of discharge should be a routinely collected statistic for reporting to the Executive Board.

Discharge and transfer policies

In the first round of audit, less than a third of hospitals had a process in place to regularly review hospital discharge policy and procedures for people with dementia. In the second round of audit, just over half of hospitals (54%, 113/210) reported this process is now in place.

Moving people with dementia between wards and units in the hospital can be very distressing and can be a barrier to providing good quality care³². Moves should be kept to a minimum to ensure continuity of care, as each time a move takes place within the hospital, the patient will be cared for by a different nursing team and often by a different medical team³⁵. If the move is needed, hospitals should make every effort to ensure this is carried out during the day to avoid further distress and confusion, and carers and relatives must be kept informed. In the second round of audit, hospitals were asked additional questions about whether their discharge and/or transfer policies included these specifications:

83% (175/210) of hospitals' discharge policies and 74% (155/210) of hospitals' transfer policies specify that discharge/moves should take place during the day.

Nearly all hospitals (97%, 204/210) had discharge policies specifying that relatives and carers should be informed and updated about prospective discharge dates, and 87% (183/210) of hospitals' transfer policies specify that relatives and carers should be kept informed of any moves within the hospital.

60% (126/210) of hospitals' transfer policies specify that people with dementia should be moved only for reasons pertaining to their care and treatment.

5. Hospital discharge and transfers

Discharge coordination

Identifying a named lead coordinator is an essential step in discharge and transfer planning^{15,20}. The benefits of having a discharge coordinator in place, especially for patients with complex needs, have been highlighted in the King's Fund's report *Continuity of Care for Older Hospital Patients*¹² that looked at a small audit of transfers of care in one NHS Trust. The study found a number of issues occurred when patients were transferred from acute care into rehabilitation settings without a discharge coordinator facilitating the process. Patients were likely to:

- have a longer length of stay;
- be moved out-of-hours and in the evening;
- not be informed of the reasons for being transferred;
- be transferred between more than one medical team.

These are particularly problematic issues for patients with dementia who have cognitive and memory problems. It is therefore crucial that a named person oversees all aspects of the discharge process.

The second round of audit found 83% (175/210) of hospitals reported a named person is in place who takes overall responsibility for complex needs discharge in the hospital, which includes people with dementia.

Involvement of people with dementia and their carers

Discussions with patients and carers about discharge

Whenever possible, patients and carers should be involved at all stages of discharge planning, and be given support to make care planning decisions and choices¹⁵. Effective communication with patients and carers, considering their needs, expectations, and the information they can provide, can ensure a more effective discharge takes place^{15,32}. In the second round of audit, we asked whether the discharge coordinator or the person planning discharge had discussed appropriate place of discharge and support needs with patients and carers, when this was possible. Audit results show:

57% (2796/4944) of case notes had evidence that discussions with the person with dementia had taken place. In the first round of audit, 42% of case notes had evidence this had been carried out.

80% (4506/5625) of case notes had evidence that discussions with the person's carer or relative had taken place. There has been no change since the first round of audit.

5. Hospital discharge and transfers

Information sharing with patients and carers

The Francis Inquiry into the Mid Staffordshire NHS Foundation Trust⁴² recommended that the patient and, where appropriate, those close to them, should always be given information about their care and treatment, as well as given access to their discharge plan.

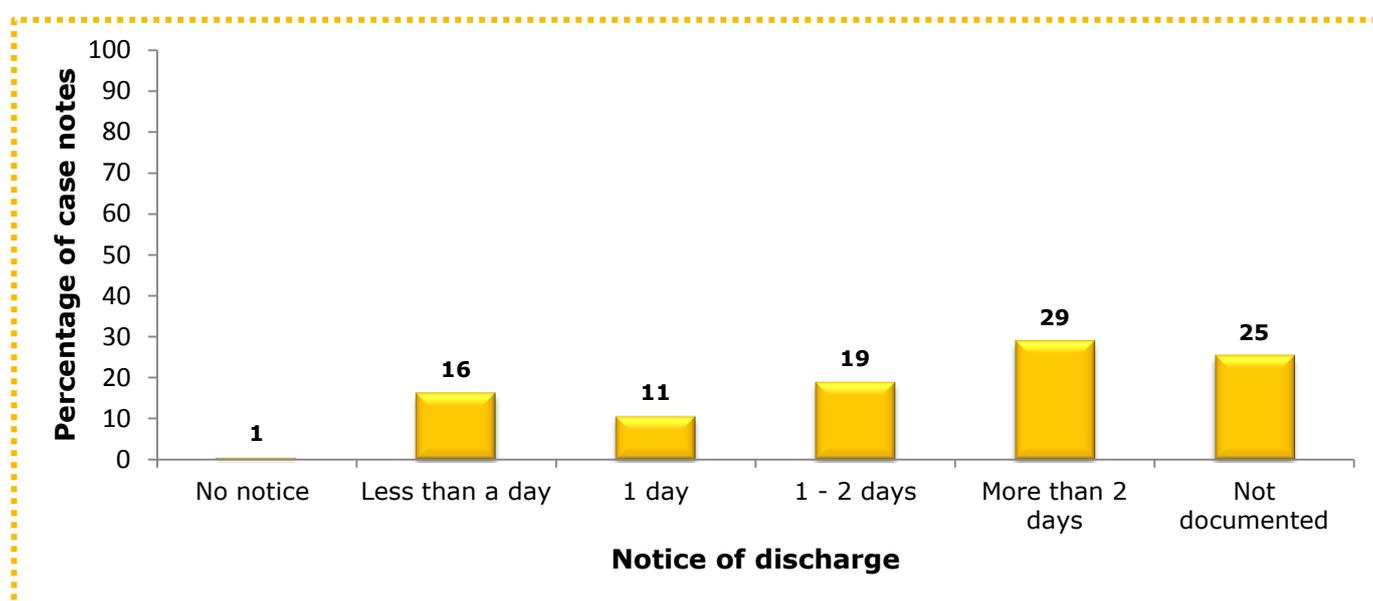
66% (3949/6008) of case notes had evidence that the patient or the carer had received a copy of the discharge plan or summary. In the first round of audit, less than half of case notes showed evidence that this had been done.

Only half of case notes (50%, 1268/2539) had evidence that information about support on discharge had been given to the patient and/or carer.

Notice of discharge

Carers and family should be given sufficient notice of discharge, so they have enough time to make any necessary arrangements. In the case note audit we collected information from patients who had stayed a minimum of four nights in hospital. Around 27% (1611/5913) of these case notes recorded that a day's notice or less had been given to carers and family. Only around 29% (1699/5913) of case notes recorded that more than two days notice had been given to carers and family. In 2011, the audit's first national report recommended that notification of discharge should be a routinely collected statistic for reporting to the Executive Board. Audit results show that one quarter (25%, 1491/5913) of case notes did not record this information.

Figure 11: Notice of discharge given to carers and family (N = 5913).



5. Hospital discharge and transfers

Assessment before discharge

Patients' mental health needs should be summarised at point of discharge to ensure these needs are taken into consideration when discharge arrangements and continuing care plans are being made.

In the second round of audit, only around a quarter of hospitals (26%, 54/210) reported that their general discharge summary had a section or prompt for mental health diagnosis and management. In the first round of audit, only 9% of hospitals reported that their discharge summaries contained this information.

The audit asked whether information relevant to mental health disorders common to people with dementia admitted to hospital, had been summarised at point of discharge:

19% (1117/6008) of case notes had evidence that the patient's level of cognitive impairment, using a standardised assessment, had been summarised and recorded at the point of discharge.

Around half (48%, 828/1729) of patients who had symptoms of delirium identified during the admission, had these symptoms summarised for discharge.

Less than half (43%, 646/1494) of patients who had persistent behavioural and psychiatric symptoms of dementia (e.g. distress, agitation or aggression) during the admission, had these symptoms summarised for discharge.

The first round of audit found that people living in care homes seemed less likely to have mental health assessments carried out at discharge.

In the second round of audit, 9% (216/2373) of people with dementia, who came from and returned to a care home (nursing or residential), had their level of cognitive impairment assessed at discharge. Around a quarter (23%, 535/2288) of people with dementia, who came from and returned to their own home, had their level of cognitive impairment assessed at discharge.

There has been no notable change in these figures since the first round of audit.

5. Hospital discharge and transfers

Conclusion

Although there has been an improvement in the involvement of people with dementia in discussions about discharge, there is still a need to do this for all patients with dementia when this is possible. The audit found the majority of case notes showed evidence that discussions had taken place with carers and relatives. Hospitals should aspire to have these discussions with all carers when this is appropriate.

The audit found a considerable proportion of patients and carers were not given a copy of the discharge plan or summary, or information about support on discharge. Less than a third of carers and family received more than two days notice of discharge, and the audit found that hospitals do not consistently record information about notice of discharge being given to family.

Assessment of mental health needs before discharge is very important if up to date information is to be transferred to family carers and practitioners in the community. This supports successful discharge. Hospitals must take continuing mental health care needs of people with dementia into account in the discharge process.

It is important that responsibility is allocated for planning the discharge process and involving people with dementia and their carers so appropriate and successful discharge arrangements can be made. This will increase the likelihood of discharge being properly planned and drawing in the professionals involved in supporting ongoing care needs. This would include GPs, community health services, and importantly housing providers to help people to be successfully discharged to their own home²¹.

Recommendations

- The Trust Board/Council of Governors/Board of the Health Board should be made aware of any incidents of discharge taking place after midnight or when carers/family receive less than 24 hours notice of discharge. This should be a routinely reported statistic, and these occurrences should be reviewed and investigated.
- The Senior Clinical Lead for Dementia should regularly review discharge policies with particular reference to the needs of people with dementia/their carers to ensure that they describe the task of discharge coordination and the importance of carer assessments.
- Ward Managers should ensure that staff summarise and record pertinent information related to the person's dementia and/or delirium in the discharge documentation.

This chapter presents findings from both the organisational checklist and the case note audit. It looks at whether hospitals have systems in place to collect information about the person with dementia; if there are systems in place to communicate a person's diagnosis of dementia to staff in the ward and in other areas of the hospital; and how information is shared with carers and family members.

The first round of audit found that hospitals were not routinely collecting personal information about the patient that could improve their experiences of care; few hospitals had systems in place to ensure that staff who came into contact with patients were aware of their dementia; and carers and family members were often not involved in care and treatment decisions. The 2011 national report³⁹ made several recommendations for the Trust's senior clinical lead for dementia:

- Procedures should be in place to determine how patients' carer and family will be involved in care and treatment decisions.
- A document to collect personal information about the patient with dementia should be used.
- There should be systems in place to identify people with dementia in the ward and other areas of the hospital.

Collecting information about the person with dementia

The collection of information about the person with dementia is key to ensuring that care is person-centred⁴. This will ensure that staff are aware of a person's diagnosis of dementia, and can respond to their needs accordingly.

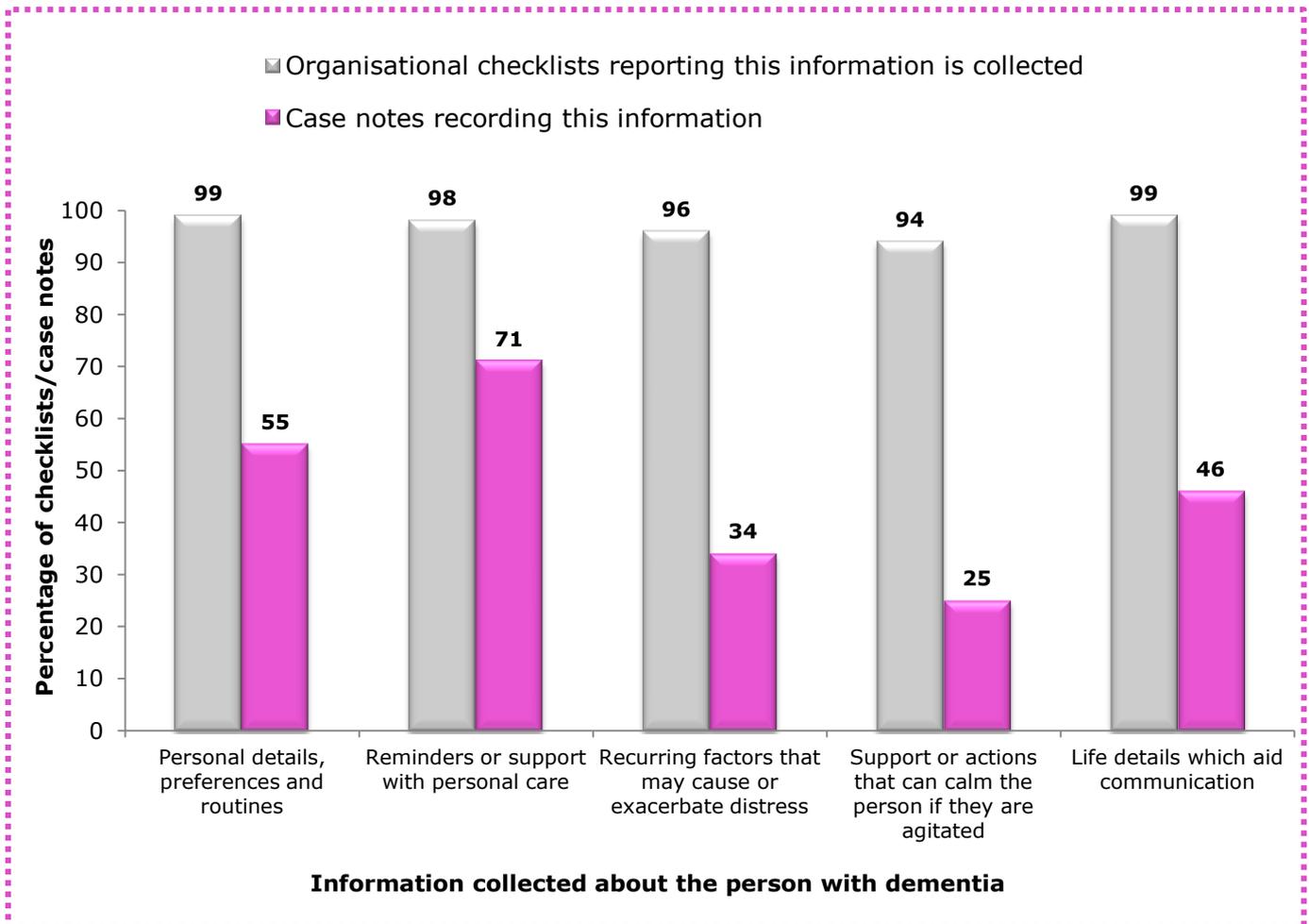
At an organisational level, around three quarters of hospitals (74%, 155/210) reported having a formal system in place for gathering information pertinent to caring for a person with dementia. In the first round of audit only 30% of hospitals had this in place.

In the case note audit, 45% (3589/7987) of patients' records had a section dedicated to collecting information from the carer within the care assessment notes.

These findings suggest a mismatch between the procedures in place at a hospital level, and what is evidenced in the patient notes. The Alzheimer's Society's "This is me"⁹ document remains with the patient, and auditors' comments suggest that often the information is not captured, although this could assist in the case of readmission.

6. Information and communication

Figure 12: Hospital guidance on information collected about the patient, compared with actual information recorded in their notes.



Information about the person's diagnosis of dementia

As well as personal information about the patient, information about their dementia should be easily accessed in the notes so that all healthcare staff involved in caring for the patient are aware of their diagnosis and their consequent needs. The auditors found documentation relating to the dementia diagnosis was not always easily located in the case notes:

61% (4851/7987) reported that information about the person's dementia was quickly found in a specified place in the file.

55% (4376/7987) reported that information about related care and support needs were quickly found in a specified place in the file.

6. Information and communication

Communication between staff

In the first round of audit, few hospitals reported having a system in place across the hospital to ensure all staff in the ward or care area are aware of the person's dementia or condition, how it affects them, and that staff are aware when the person accesses other areas. This finding was worrying, as it is known that people with dementia may access many care areas within the hospital and can be transferred between different departments³⁵. In 2011, the audit's first national report recommended all hospitals should implement systems to ensure staff can identify people with dementia on the ward, during care and treatment. The second round of audit found:

Around half (49%, 102/210) of hospitals have a system in place across the hospital to ensure all staff in the ward or care area are aware of the person's dementia or condition and how it affects them. 70% (71/102) of these were a visual indicator, symbol or marker.

41% (87/210) of hospitals have a system in place across the hospital to ensure all staff from other areas are aware of the person's dementia or condition whenever the person accesses other treatment areas. 62% (54/87) of these were a visual indicator, symbol or marker.

Initiatives have been launched to support staff in caring for people with dementia in the hospital setting, and communicating the diagnosis of the patient to all staff involved in their care. This can encourage a partnership approach to care and treatment where interaction and information exchange are better facilitated.

The [Butterfly Scheme](#), for instance, aims to improve staff attitudes towards dementia care; improve the communication between patients; and enable staff to understand the needs of people with dementia, such as causes of anxiety and aggression.

The role of the carer

Carers can play an important role when people with dementia are admitted to hospital, particularly when relaying personal preferences and routines if the patient cannot communicate this information themselves. Nevertheless, it is also imperative that a patient's right to confidentiality is respected in accordance with their capacity and best interest, and for that reason hospitals should have clear guidelines about what information can be shared with carers, and this should be established on an individual basis.

6. Information and communication

In the second round of audit, two thirds of hospitals (66%, 138/210) reported having clear guidelines on making sure the carer knows what information will be shared with them. In the first round of audit, 40% of hospitals had these guidelines in place.

The Royal College of Nursing³² highlights the importance of hospitals adopting an approach to care and treatment which involves the person with dementia, their family and friends, and healthcare professionals. If carers and family members are to be involved in care planning and decision making, it is important to establish the extent to which they would like to be involved in this process, both during the admission to hospital and after discharge.

The second round of audit found around two thirds of hospitals (65%, 137/210) have clear guidelines on asking the carer about the extent to which they preferred to be involved with the care and support of the person with dementia whilst in the hospital. In the first round of audit, 40% of hospitals had these guidelines in place.

71% (150/210) of hospitals have clear guidelines on asking the carer about their wishes and ability to provide care and support of the person with dementia post discharge. In the first round of audit, 52% of hospitals had these guidelines in place.

Support for carers

The *Common Core Principles*⁴¹ commissioned by the Department of Health recognises the importance of family members of people with dementia, and stresses they should be supported by healthcare services. Carers and family members may themselves have health problems, or experience anxiety, depression and stress, which may affect their ability to assist in caring for other people³². Caring for someone with dementia can be challenging at times, so whilst the person with dementia is receiving care and treatment during their stay in hospital, the carer should also be assessed for their current needs and be supported to plan ahead.

The second round of audit found around two thirds of hospitals (67%, 141/210) reported having a system in place to ensure carers are advised about obtaining a carer's assessment and support. In the first round of audit, 57% of hospitals reported having this system in place.

Around three quarters of the case notes sample (72%, 2337/3258) had a record that an assessment of the carer's current needs had taken place in advance of the patient's discharge. There has not been a significant change since the first round of audit.

6. Information and communication

Conclusion

There has been notable improvement in the number of hospitals reporting a formal system is in place for gathering information pertinent to caring for a person with dementia. However this is not reflected in the case note audit. Information such as factors that may cause distress, and support that can calm the person if they become agitated, is not often collected and recorded in the patient notes. Access to this information could help prevent challenging behaviour in people with dementia, and thereby limit the use of antipsychotic medication.

It is imperative that all staff who are involved in the care and treatment of people with dementia are aware of their diagnosis and how it affects them, so their dementia-related needs are considered throughout the admission. Over half of the hospitals did not have such a system in place to communicate this information.

Overall, the findings show the collection of personal information still needs to be improved, as well as information sharing and communication between staff, carers and patients. Collecting direct feedback from carers and people with dementia would give us a better picture of how they are being involved in care and treatment decisions, and whether they feel satisfied with their level of involvement.

Recommendations

- The Senior Clinical Lead for Dementia should ensure that a personal information document (e.g. "This is Me"⁹) is in use throughout the hospital, and is recorded and accessible in the patient's notes.
- The Senior Clinical Lead for Dementia should implement systems to ensure that all staff can easily identify people with dementia on the ward or when transferred to different departments, and provide an appropriate response to care and treatment needs (e.g. "Butterfly Scheme").
- The Senior Clinical Lead for Dementia should ensure that clinical teams can ascertain the involvement of patients' carers in treatment decisions, and all staff involved in the patient's care are aware of this. This should take into consideration mental capacity, stated wishes and best interests decisions (as defined under the Mental Capacity Act).
- Ward Managers should ensure that the care of the person is informed by their capacity, expressed wishes and their best interests. Taking this into account at all times, carers' views, knowledge and expertise should be sought and used to inform care planning and provision. Carers should be regularly updated and involved in discussions on care, treatment and discharge planning and receive adequate notice of discharge.

7. Staff training

This chapter presents findings from the organisational checklist. It looks at whether hospitals have a training framework or strategy in place that identifies necessary skill development in working with and caring for people with dementia; dementia awareness training that is made available to hospital staff; the involvement of people with dementia and carers; and the inclusion of mental health liaison teams in the provision of training.

In the first round of audit, we found further training was needed across all job roles for a range of competencies related to the care of people with dementia. In 2011, the audit's first national report³⁹ recommended a training and knowledge strategy should be developed to ensure all staff are provided with basic training in dementia awareness and a locally agreed and specified proportion of ward staff receive higher level training.

Training and knowledge framework

In 2011 the Department of Health released the *Common Core Principles for Supporting People with Dementia*⁴¹. These are statements of the type of care which people with dementia and their carers can expect. The *Principles* provide a general, easy to understand, framework to support services achieve a workforce that can fully understand and respond positively to people with dementia. The *Principles* highlight the need for staff to know and understand dementia, communicate sensitively with people with dementia, recognise distress, support carers and value their input, and the need for managers to take responsibility for training and supporting members of their team.

In the second round of audit, over three quarters of hospitals (78%, 164/210) reported having a training and knowledge framework or strategy that identifies necessary skill development in working with and caring for people with dementia. In the first round of audit, only 23% of hospitals reported this was in place.

Dementia awareness training

The Royal College of Nursing³² highlighted that one of the barriers to providing good care was a lack of understanding about dementia and how it affects the person. *Common Core Principles*⁴¹ specifies that basic awareness training in dementia should be provided to all staff, and that induction programmes for new staff should include dementia awareness.

In the second round of audit, 59% (124/210) of hospitals reported staff induction programmes include dementia awareness.

Training provided for specific staff groups

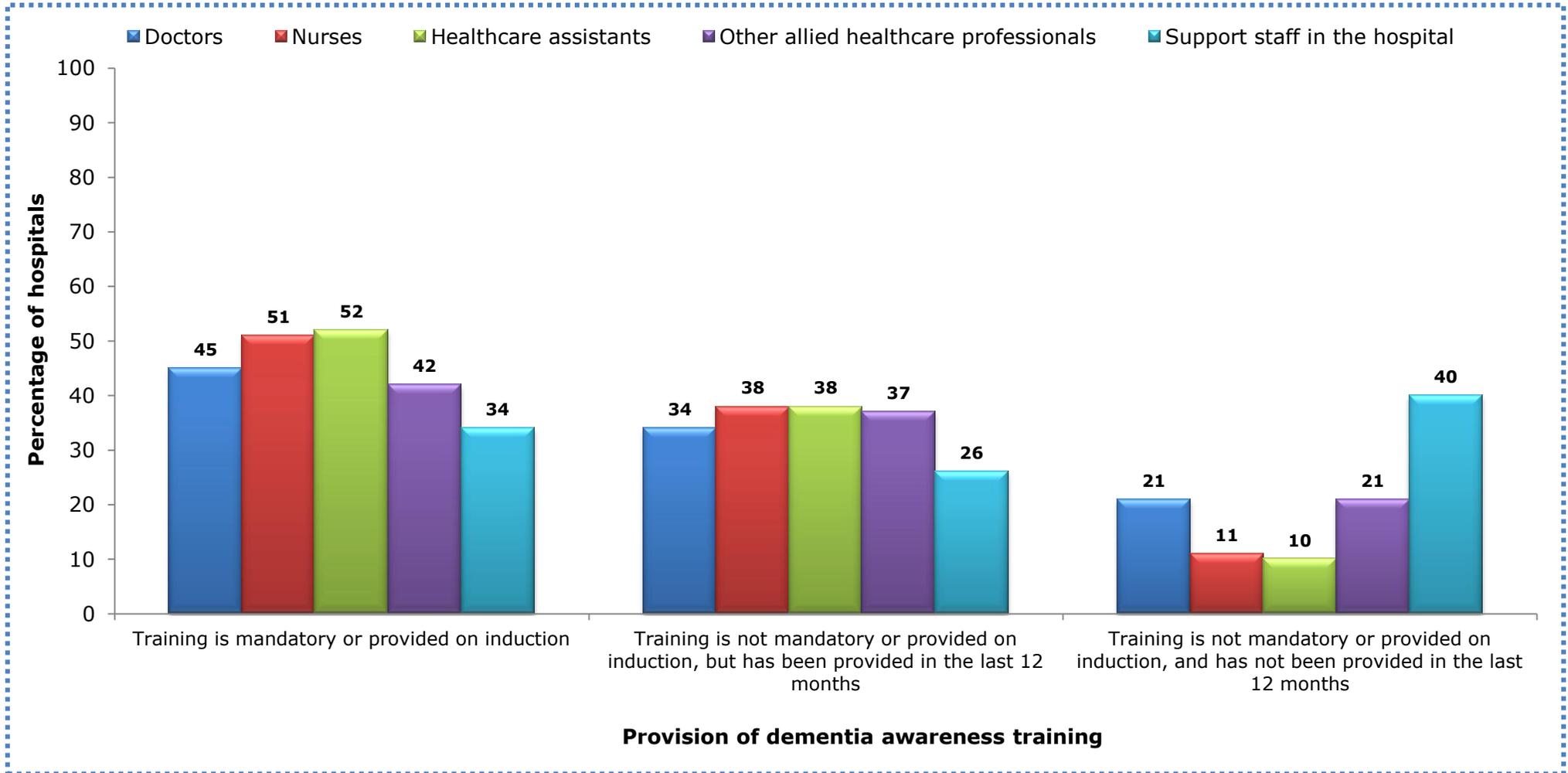
Support staff are not directly involved in providing care but their roles will bring them into frequent contact with people with dementia. Figure 13 shows that support staff (for example, housekeepers, administrators, porters) are least likely to have dementia awareness training provided to them, on induction or ad hoc.

Ensuring staff have an understanding of dementia and of arising needs, can help enhance the care experience for people with dementia and provide a more supportive environment for care. For example, observations carried out for the first round of audit found that housekeeping staff had often not been encouraged to engage in simple social interactions with people with dementia (for instance, greeting them) and action planning resulting from observations set out to address this³⁹.

21% (43/209) of hospitals said that they had not provided mandatory, induction or other dementia awareness training in the 12 months prior to data collection (March 2011-12) for allied healthcare professionals, which would include speech and language therapists, physiotherapists, occupational therapists, phlebotomists and pharmacists among others.

The same proportion of hospitals (21%, 44/209) had not provided dementia awareness training for doctors in the 12 months prior to data collection (March 2011-12). Doctors and other healthcare professionals will necessarily be directly involved in the treatment of people with dementia on a daily basis. Again, observations from the first round of audit described many instances where understanding a person's need for social interaction, communicating clearly, and working at their pace, could have helped to prevent confusion or distress and aided in carrying out essential care³⁹.

Figure 13: Proportion of hospitals providing dementia awareness training to different staff groups, and whether training is mandatory/provided on induction or provided in the 12 months prior to data collection (March 2011-12).



NB The figure shows training provision reported by hospitals to different staff groups. It **does not** show the percentage of staff receiving training.

Involvement of people with dementia and carers

Involving people with dementia and carers in training can be a powerful tool in the provision of training for hospital staff, and has been recommended by the Alzheimer's Society⁷ and the Royal College of Nursing³².

In the second round of audit, two thirds (66%, 138/210) of hospitals reported people with dementia and carers, and the use of their experiences, are included in the training for ward staff. In the first round of audit only 29% of hospitals reported patients with dementia and carers were involved in staff training.

Involvement of mental health liaison teams

Liaison teams can play an important part in the provision of training to acute hospital staff, and their involvement has been recommended in quality standards³⁸.

In the second round of audit approximately two thirds (65%, 136/210) of hospitals reported mental health liaison teams provide training for ward staff.

Conclusion

There is an encouraging increase in the number of hospitals having a knowledge framework or strategy to identify skill development when caring for people with dementia. However, over a third of hospitals audited do not yet include dementia awareness in induction programmes.

It is important that dementia awareness is a key part of the organisational training strategy, ensuring that all staff have access via induction and ongoing training programmes. Provision of dementia awareness training is improving. As curricula for higher level and expert competencies become more defined, future audit should look into the proportion of staff in hospitals accessing these programmes.

Around a third of hospitals do not yet include patient and carer experiences within their awareness and training programmes, and attention to this could enhance the impact of training and learning for staff.

This round of audit did not collect feedback directly from staff about training received and this will be a necessary step to gauge the accessibility and effectiveness of training provided.

Recommendations

- The Medical and Nursing Directors, and Heads of Therapy Directorate, should ensure that all staff (including support staff roles such as porters, housekeepers, administrators) are provided with basic training in dementia awareness and a locally agreed and specified proportion of ward staff receive higher level training. This should be implemented by June 2014.
- The Medical and Nursing Directors, with the Learning and Development departments, should conduct a skills gap analysis across different staff groups (including non-clinical staff) who are involved in delivering care and support for people with dementia, and draw up an action plan to meet the needs of their hospital. Competencies for each staff level/discipline should be developed and agreed. This should be implemented by March 2014.
- Ward Managers should ensure that there is clear leadership and supervision available to staff on the ward regarding the care of people with dementia, and that this is supported with appropriate training and learning resources.
- The General Medical Council and the Nursing and Midwifery Council should work with higher education institutions to deliver appropriate curricula for enhanced and specialist skills in dementia care, including requirements in undergraduate and postgraduate medical and nursing curricula.

Overall performance against standards

Measurement against standards in this audit

Standards⁴⁰ for the audit were compiled from national and professional guidance and informed by a literature review of priority areas for patients and carers. Standard topic areas were used to develop the audit tools. Questions in the tools relate to an audit standard with the exception of: demographic information; contextual questions used for routing so that subsidiary questions could be asked; and case note sections on liaison psychiatry and antipsychotic prescription (where information could not determine that standards were met).

The standards were classified in accordance with the following broad principles:

Type 1: failure to meet these standards 100% would result in a significant threat to patient safety, rights or dignity and/or would breach the law;

Type 2: standards that an organisation/ward would be expected to meet in normal practice;

Type 3: standards that an organisation/ward should meet to achieve excellent practice.

Comparing standards met between rounds of audit

The first round of audit identified a low performance by hospitals against the standards, particularly in the case note audit, which recorded actual practice. Overall, the median number of standards met was 6% (3/50).

In the first round of audit, a hospital met a standard if it had been met in 100% of the case notes they submitted. As standards were classified as either a Type 1, Type 2 or a Type 3 in terms of importance, this helped hospitals to identify and prioritise items for improvement.

When comparing standards met between the two rounds of audit, routed items (those not applicable to all patients in a hospital's sample) were excluded, to allow reasonable sample size for comparison. Only questions asked in both rounds of audit (with minor or no wording changes) have been used in the comparison.

This reduces the items measured in the case note audit in the first round from 50 to 33. The median percentage of standards met in the first round of the case note audit remains unaffected at 6% (2/33).

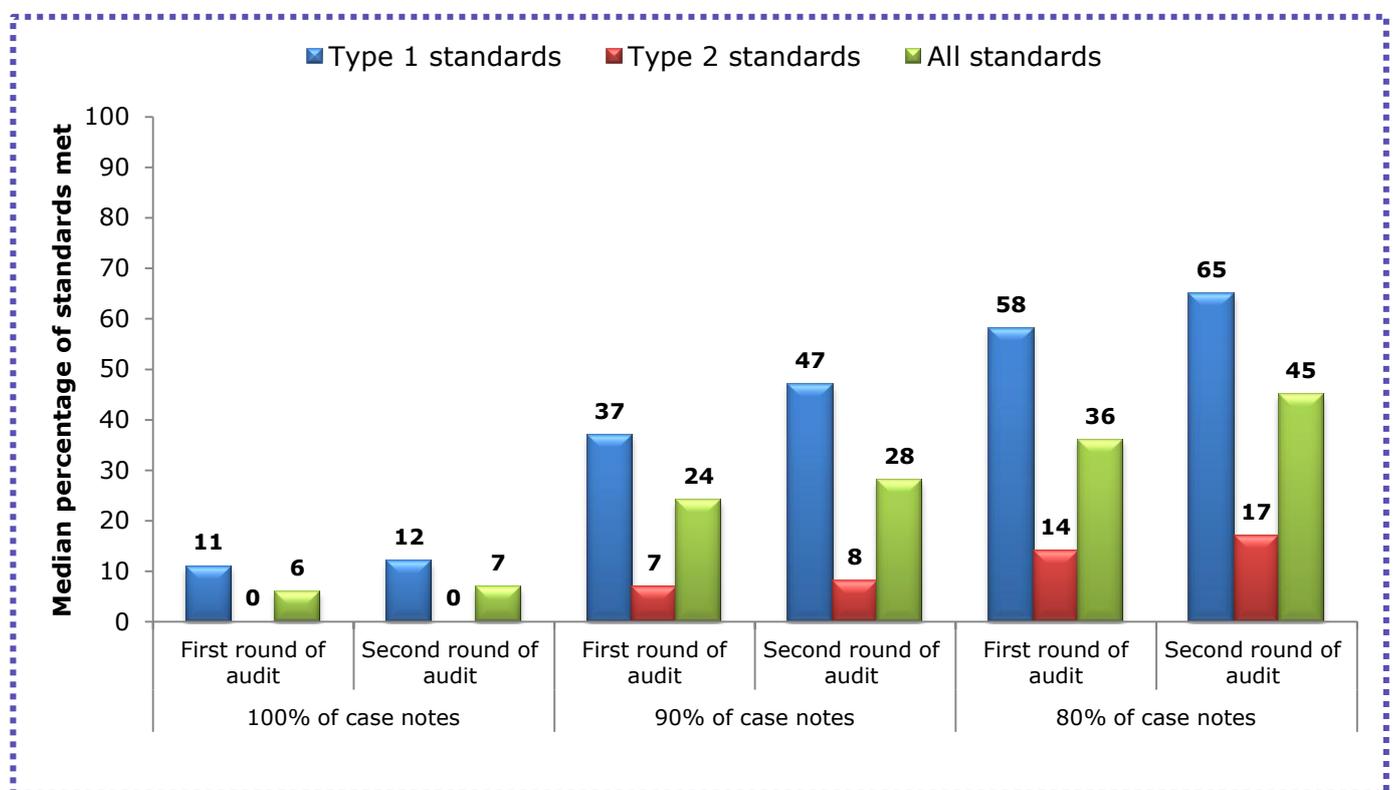
Comparison of both rounds of case note audit based on a reduced number of items is used in the following section.

Overall performance against standards

Progress between rounds of audit

The audit's first national report³⁹ presented the median number of standards met per hospital. For the case note audit, this was shown varying the requirement for meeting a standard at 100%, 90% and 80%. This is repeated below including the second round of audit results. This gives an overview of how close hospitals are to achieving standards in each round.

Figure 14: Measurement of median percentage of standards met in both rounds of the case note audit, when varying the benchmark to 100%, 90% and 80%.



When the benchmark is set at 100%, there is not a notable difference in the median percentage of standards met between the first and second round of audit. However, when the benchmark is lowered to 90% there is greater increase between the two audit rounds, and even greater increase when it is lowered to 80%. Varying the benchmark has a greater effect on Type 1 standards, compared to Type 2 standards, and this is likely to have been affected by the standards classification, with Type 1 standards being viewed as a priority.

Overall performance against standards

Overall national results and site variation

Findings discussed in the chapters of this report are based on national results. These consist of amalgamated data from all participating hospitals across England and Wales. A full presentation of the data showing national totals against each item measured can be found on the audit's [website](#).

In these data tables, site variation data have been presented to show the degree of variation between hospitals participating in the audit. This information can be seen by looking at:

- The median percentage (the middle point of the dataset).
- The percentage interquartile range (the spread of the results between sites).

As in the first round of audit, the second round found wide variation between hospital level results for many items, indicating the extent of improvement needed across hospitals. For example, although a high proportion of patients nationally have received an assessment of nutritional status, the interquartile range shows that in one quarter of hospitals this was carried out in fewer than 85% of the patient sample (interquartile range = 85% – 97%).

Items showing low performance nationally indicate that the majority of hospitals have not performed well. Results for delirium and mental health assessments show low proportions of patients received these assessments in most hospital samples. This is also the case for most items related to hospital discharge.

Governance and second round of audit case note results

The first round of audit raised concerns about governance of policies and procedures in hospitals. Where hospitals reported a procedure in place in the organisational checklist, this was not always reflected in a higher proportion of patients receiving the care or treatment that the procedure specified. Examples of this occur in the second round.

Table 5 looks at assessment of delirium. In the organisational checklist, 115 of the 210 participating hospitals (55%) reported having a policy in place to ensure that patients with dementia are assessed for the presence of delirium. Case note audit results do not show these hospitals are more likely to carry out these assessments. The table illustrates this, as the case note percentage mean, range and interquartile range have not varied greatly between those hospitals that have the policy in place and those hospitals that do not.

Overall performance against standards

Table 5: Case note audit comparison between hospitals by presence of delirium policy.

Case note audit: Assessment of presence of delirium being carried out	Organisational checklist: Policy in place to ensure patients with dementia are assessed for the presence of delirium	
	Policy in place (N = 114)	No policy or policy in development (N = 92)
Mean	39%	37%
Range	0 – 100%	0 – 90%
Interquartile range	18 – 58%	22 – 50%

NB 210 hospitals submitted an organisational checklist in the audit, but 206 checklists have been used in this analysis as four hospitals did not submit case note data for the audit.

In this and other areas, discrepancy is still apparent between policy and practice, which needs to be addressed with more active governance.

Patient level analysis

To put into context the impact of a shortfall in standards for individual patients, we carried out additional analysis on items of assessment measured in the audit. Individual elements of assessment are each important. Comprehensive assessment is recommended for people with dementia to gain a full picture of their care and treatment needs. By combining responses at the patient level, it can be seen that a comprehensive assessment is often not received.

Table 6 presents the percentage of patients in the sample receiving seven assessments which contribute to the comprehensive assessment of the frail older patient¹⁰: mobility, nutritional status, pressure sore risk, pain question, continence question, mental status and delirium initial question.

Overall performance against standards

Table 6: Percentage of patients, per hospital, receiving all seven assessments in the second round of audit.

Percentage of patients receiving all seven assessments	Number of hospitals
0	17
1% – 25%	121
26% – 50%	57
51% – 75%	9
76% – 80%	2

Only two hospitals in the sample carried out all seven assessments in more than three quarters of their sample. 17 hospitals did not carry out all seven assessments in any of their patients. These inconsistencies will affect the planning and delivery of care and treatment.

Conclusion and next steps

The audit shows a welcome increase in individual items measured but low performance against essential standards for many hospitals is apparent. The care of people with dementia in hospital continues to be a national level strategic priority.

Hospitals have shown commitment to identifying and carrying out improvements to the care of people with dementia. As well as participating over two rounds of audit, hospitals are engaged in local and national initiatives to drive up quality. This includes the [Dementia Action Alliance call to action](#) to create dementia friendly hospitals and in Wales *1000 Lives Plus*²⁸ and associated work. Hospitals are currently engaged in producing action plans based on these initiatives using their audit results to inform these plans.

Future audit in this area will need to provide focus on meaningful change in organisational practice, and should include measures which reflect the experiences of people with dementia and the staff providing care. With this in mind, future audit should:

- Report on the experiences of care from the perspective of people with dementia and carers, including people with suspected dementia (as yet undiagnosed) within the hospital. This should:
 - include feedback about the extent of their involvement in care and discharge processes;
 - report on the quality of communication and information exchange with staff.
- Report on availability of training to support different levels of competencies for staff, and collect feedback from staff on training, learning and support to care for people with dementia.
- Ascertain which standardised assessments are commonly in place, and if these are carried out consistently for patients across the hospital.
- Contain a dedicated module on pharmacological/non pharmacological approaches to behavioural and psychological symptoms of dementia.

References and bibliography

1. Age UK (2010). *Still hungry to be heard: The scandal of people in later life becoming malnourished in hospital*. London: Age UK.
2. Age UK (2011). *Still hungry to be heard – in London*. London: Age UK.
3. Alzheimer's Society (2009). *Counting the cost: Caring for people with dementia on hospital wards*. London: Alzheimer's Society.
4. Alzheimer's Society (last updated December 2011). *Care on a hospital ward*. Factsheet 477. Accessed at: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=118
5. Alzheimer's Society (2012). *Dementia 2012: A national challenge*. London: Alzheimer's Society.
6. Alzheimer's Society (2013). *Dementia 2013: The hidden voice of loneliness*. London: Alzheimer's Society.
7. Alzheimer's Society (accessed March 2013). *Involving people with dementia*. Accessed at: http://www.alzheimers.org.uk/site/scripts/document_pdf.php?documentID=1040
8. Alzheimer's Society (accessed May 2013). *Stafford Hospital yet to commit to improve dementia care*. Accessed at: http://www.alzheimers.org.uk/site/scripts/news_article.php?newsID=1482
9. Alzheimer's Society and Royal College of Nursing (2010). *This is Me*. London: Alzheimer's Society.
10. British Geriatrics Society (2010). *Comprehensive assessment of the frail older patient*. Accessed at: <http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcassessment>
11. British Geriatrics Society (2013). *BGS responds to the Francis Report*. Accessed at: <http://www.bgs.org.uk/index.php/press/2410-bgs-francis-report>
12. Cornwell J *et al* (2012). *Continuity of care for older hospital patients: A call for action*. London: King's Fund.
13. Dementia Action Alliance (2012). *National dementia declaration for England*. Accessed at: http://www.dementiaaction.org.uk/assets/0000/1157/National_Dementia_Declaration_for_England.pdf

References and bibliography

14. Department of Health (2009). *Living well with dementia: A national dementia strategy*. London: Department of Health.
15. Department of Health (2010). *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care*. London: Department of Health.
16. Department of Health (2012). *Prime Minister's challenge on dementia: Delivering major improvements in dementia care and research by 2015*. London: Department of Health.
17. Department of Health (2012). *Using the Commissioning for Quality and Innovation (CQUIN) payment framework guidance on new national goals for 2012-13*. London: Department of Health.
18. Ellis *et al* (2011). Comprehensive geriatric assessment for older adults admitted to hospital: Meta-analysis of randomised controlled trials. *BMJ*; 343: d6553.
19. Health and Social Care Information Centre (2012). *National dementia and antipsychotic prescribing audit*. Leeds: Health and Social Care Information Centre.
20. Hospital 2 Home (2012). *Essential Information for: Hospital-based staff*. Accessed at: <http://www.housinglin.org.uk/library/Resources/Housing/H2H/H2Hhospitalbasedstaffleaflet.pdf>
21. National Housing Federation (2013). *Dementia: Finding housing solutions*. London: National Housing Federation.
22. National Institute for Health and Clinical Excellence (2010). *Clinical guideline 103. Delirium: Diagnosis, prevention and management*. London: National Clinical Guideline Centre.
23. National Institute for Health and Clinical Excellence (2013). *Quality standard for supporting people to live well with dementia. QS30*. Accessed at: <http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30/how-this-quality-standard-fits-into-the-nice-pathway>
24. National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2006) (last modified October 2012). *Clinical guideline 42. Supporting people with dementia and their carers in health and social care*. London: National Clinical Guideline Centre.
25. National Leadership Council (2010). *The healthy NHS board: Principles for good governance*.
26. National Patient Safety Agency (2007). *Protected mealtimes review: Findings and recommendations report*. London: NPSA.

References and bibliography

27. NHS Institute and Dementia Action Alliance (2011). *The right prescription: A call to action on the use of antipsychotic drugs for people with dementia*.
28. NHS Wales (2010). *1000 Lives plus, improving care, delivering quality: Improving dementia care*. Cardiff: NHS Wales.
29. Parsonage M, Fossey M and Tutty C (2012). *Liaison psychiatry in the modern NHS*. London: Centre for Mental Health.
30. Royal College of Nursing (2011). *Dignity in dementia: Transforming general hospital care. Summary of findings from survey of professionals*. London: Royal College of Nursing.
31. Royal College of Nursing (2012). *Safe staffing for older people's wards: An RCN toolkit*. London: Royal College of Nursing.
32. Royal College of Nursing (2013). *Dementia commitment to the care of people with dementia in general hospitals*. London: Royal College of Nursing.
33. Royal College of Nursing (2013). *Scoping the role of the dementia nurse specialist in acute care. Findings from a report prepared by the University of Southampton on behalf of the Royal College of Nursing*. London: Royal College of Nursing.
34. Royal College of Physicians (2012). *Acute care toolkit 3: Acute medical care for frail older people*. London: Royal College of Physicians.
35. Royal College of Physicians (2012). *Hospitals on the edge? The time for action*. London: Royal College of Physicians.
36. Royal College of Physicians, British Geriatrics Society and British Pain Society (2007). *The assessment of pain in older people: National guidelines. Concise guidance to good practice series, No 8*. London: Royal College of Physicians.
37. Royal College of Psychiatrists (2005). *Who cares wins. Improving the outcome for older people admitted to the general hospital: Guideline for the development of liaison health services for older people*. London: Royal College of Psychiatrists.
38. Royal College of Psychiatrists (2011). *Quality standards for liaison psychiatry services (3rd ed)*. Editors: Soni M, Webb J, Palmer L, Dupin M, McGeorge M. London: Royal College of Psychiatrists.
39. Royal College of Psychiatrists (2011). *Report of the national audit of dementia care in general hospitals*. Editors: Young J, Hood C, Woolley R, Gandesha A and Souza R. London: Healthcare Quality Improvement Partnership.

References and bibliography

40. Royal College of Psychiatrists (2012). *Second round of the National Audit of Dementia (care in general hospitals)*. Standards document. London: Healthcare Quality Improvement Partnership.
41. Skills for Care & Skills for Health (2011). *Common core principles for supporting people with dementia*. Leeds: Skills for Care & Skills for Health.
42. The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). *Report of the Mid Staffordshire. NHS Foundation Trust public inquiry. Executive summary*. Chaired by Robert Francis QC. London: The Stationery Office.
43. Welsh Assembly Government and Alzheimer's Society (2011). *National dementia vision for Wales. Dementia supportive communities*. Cardiff: Welsh Assembly Government.

The following documents can be downloaded on the audit's website:

www.nationalauditofdementia.org.uk

- **Data tables and comparison of results between first and second rounds of audit**
 - Full sample of hospitals (all hospitals – includes hospitals that participated in both or only one of these rounds)
 - Selected sample of hospitals (only hospitals that participated in both rounds of audit)
- **Standards document and audit tools from both rounds of audit**
- **Reports from the first round of audit**
 - National report published in December 2011
 - Interim report published in December 2010
- **List of participating Trusts/Health Boards and hospitals in both rounds of audit**
- **Case note audit inter rater reliability**
- **Update on recommendations from the first round of audit**

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